Support for breastfeeding and young child feeding in emergencies

Experiences gained during the migrant and refugee crisis in Croatia in 2015 and 2016

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Terms and abbreviations

IYCF-E – "*Infant and Young Child Feeding in Emergencies*".

Mother – Children who received support during the transit were most often taken care of by their mothers. Although some of the children who did not have a mother were taken care of by their fathers, relatives or other caregivers, the word "mother" is used instead of "caregiver" in order to simplify the text.

MBC – "*Mother and Baby Centre*", a safe area where one can find a paediatrician, a lactation consultant, and other associates who provide assistance to expectant mothers, parents and young children.

Migrants – Although this crisis includes both migrants and refugees, for simplification only the word "migrants" is used instead of "migrants and refugees".

Infant formula – breastmilk substitute that is used when the mother does not breastfeed; most often it is adapted cow's milk, it can be powdered or a ready-to-use infant formula (RUIF). It is also called **milk formula**.

RUIF – "*Ready to Use Infant Formula*", an entirely pre-made adapted milk in liquid form, packed in Tetra Pak containers.

WHO – "World Health Organisation"

USOC – Union of Societies "Our Children", Croatia

CALC – "Croatian Association of IBC Lactation Consultants"

IBCLC – "*International Board Certified Lactation Consultant*",

CRC – Croatian Red Cross

International Code – used in the text instead of the full title of the "International Code of Marketing of Breastmilk Substitutes", a Code that regulates the mechanisms for the protection of breastfeeding.

Foreword

Hardly anyone could stay indifferent after the scenes of late August and September 2015. Daily images showing thousands of people fleeing war, terror or poverty simultaneously aroused feelings of anger, sadness, fear, compassion and helplessness. Those were the days when a better Croatia started to emerge, one of solidarity and one that did not cave in to fear and helplessness. Before the refugee wave crossed our borders, members of RODA organised the collection of used baby carriers that were distributed in the parks of Belgrade, where fathers and mothers with young children were spending the night before moving on. We saw children being fed with powdered milk mixed with cold water in dirty bottles. We should have known then that the same would happen in our country. Since early summer, we had been appealing to responsible institutions to ensure optimum child nutrition when preparing for the emergency. Croatia has no plan or allocated resources for children's healthcare in the case of emergencies, an issue we have been warning about since the floods in Gunja.

On the day thousands of people came into our country, RODA's members were at the train stations and border crossings, along with numbers of other volunteers. Members of our *Facebook* groups filled the boots of their cars with baby carriers, children's jackets and shoes, hats, food, water and vitamins. For days, and then weeks, RODA's office stopped all other activities. As parents ourselves, there were no other priorities. As lactation consultants, we knew that we would have to start working on breastfeeding support immediately.

But how to talk about the importance of regular breastfeeding to a mother who just wants you to approach with little boots for her freezing baby? Or to a family who is afraid they will miss the chance to board a train for good if they lose just one minute? Or to a woman whose sister drowned in the sea two days previously, or a woman whose husband was held at the border, and she is alone with her six children, terrified? How to talk about breastfeeding at all if nobody understands you? A mother whose language you cannot even recognise does not understand you. Perhaps it is Arabic, Urdu, Pashto, Farsi, or Kurdish. Other volunteers in the refugee camp do not understand you. Your vocabulary consists of words such as breast, breastfeeding, can, have, sit. Their vocabulary consists of words such as blanket, food, sardine, water, red sector, first sector, blankets, more blankets, no blankets. Blanket is the only word all of us understand.

Does it make sense to talk about breastfeeding in a situation where the word blanket is the most important word in the world? These are the people that learned how to ask for *ćebe* yesterday, who ask you for a *deka* today, and tomorrow it will be *die Decke*.

We talked about breastfeeding. We talked about it to thousands of mothers, we caressed their babies, we learned their names, and they learned ours. We listened to their stories. We imagined what they had gone through and nodded at their silence with understanding. In our room, time was moving slowly, just like colostrum. When all you have is half an hour or fifteen minutes, you can do everything. Sometimes you can even bathe a baby, maybe for the first time after delivery, or do a physical examination, breastfeeding counselling, or pack some clothes for the journey, a toy for an older sister, candy for the brother.

While we were volunteering and working in Opatovac and Slavonski Brod, and later in Zagreb and Kutina, in close cooperation with and with financial support from the UNICEF Office in Croatia that recognised the importance of supporting breastfeeding immediately, we developed an efficient and friendly system of support for the mothers aimed at encouraging breastfeeding. We succeeded in this, thanks to our numerous volunteers, RODA's lactation consultants, IBCL consultants, midwives and physicians, and with the support of other local and international organisations that worked in the camps, relying on other people's experience and handbooks for crisis situations.

This publication is a kind of a memento of our work, but it is also a tool, a recommendation, and a lesson for acting swiftly in similar situations. Optimum nutrition for young children must be a priority in an emergency, and breastfeeding saves the lives of children!

Ivana Zanze, Executive Director of RODA

Foreword

Every journey with a young child is a unique challenge. Each person who has had the opportunity to pack and go on a longer journey with a young child understands very well that even such a small "achievement" requires careful planning and preparation. Parents usually prepare a separate bag with all the necessary things for their child, so that the journey can pass with as little stress as possible. Their journey is made easier by the fact that they are probably travelling by car, bus, train, or plane, with a general itinerary sketched out. Now let us imagine what it is like to flee from war and suffering with a young child in your arms, to set off on an unpredictable journey thousands of kilometres long [IZ1]. Imagine travelling on foot or crossing rough seas in a boat that can hardly be called a boat. Imagine having to rely on the help of people who profit from human trafficking and from other people's misfortune. Imagine not knowing where you will sleep the coming night, not having a moment of privacy for days on end, or not knowing what you will feed your child on. Scenes we witnessed at the border crossings or in the transit and reception centres in Opatovac and Slavonski Brod, for example Syrian parents holding their newborn baby, an Afghan mother carrying on her back her 12-year-old child suffering from cerebral palsy, or a 6-year-old boy who lost both of his legs in one of the airstrikes on Aleppo, cannot leave anyone indifferent. We spent those first days and weeks in the field, and besides feelings of empathy, sorrow and anger that anyone in the 21st century should be faced with such an ordeal, we also developed a strong feeling of responsibility and willingness to react and help the women and children who needed our help the most. We were especially keen to help nursing mothers who, during their journey, had experienced various difficulties in caring for their child that depended exclusively on them, and women with non-breastfed young children who were particularly vulnerable.

Our experience in supporting mothers and children has made us proud of everything we have managed to achieve under quite challenging circumstances. We owe gratitude to donors and partners of UNICEF who enabled us to provide the necessary assistance to a large number of children and mothers. We have received many words of deep appreciation from the parents and children on their departure, and we are also grateful to them. Many doubts that we had while providing support encouraged us to write this handbook which presents a collection of experiences and lessons learned in a very specific context. It is not out of the question that we might expect a similar response in the unlikely event of a major natural disaster in Croatia. I believe this handbook will be useful to anyone in a similar situation, and serve as guidelines on how to work swiftly and more efficiently in potential emergencies, because breastfeeding support and ensuring optimum nutrition for young children in emergencies saves the lives of children, and therefore must be a priority for all those involved.

Valentina Otmačić, Head of the UNICEF Office in Croatia

Aim and target group of this publication

The migrant and refugee crisis affecting a large part of Europe, along with many countries in this region, including Croatia, from September 2015 to April 2016, mobilised a large number of organisations and individuals to help those in transit. Although there are many experts in Croatia dedicated to infant and young child feeding, who also have a strong awareness of the importance of breastfeeding, they had never before encountered such large numbers of children in an emergency situation that poses specific challenges to children's nutrition and health. Following the initial unpreparedness of other institutions involved in providing support for infants and young children, UNICEF brought together local and international organisations and associates who, through joint effort in a time of crisis, built a support system that helped thousands of infants and young children.

While there are international recommendations and operational plans for child feeding in emergencies, this migrant and refugee crisis showed that they are not always entirely applicable, and that there are some specific issues in the procedures used to respond to such crises. In this type of unprecedented crisis, due to their brief stay at reception and transit centres, it was impossible to keep track of children and their caregivers so as to provide them with continuous support, which is usually such an important factor.

This publication includes knowledge gained during those months, along with the protocols we established and an awareness of the need for further action, in order to serve as a lesson on how to facilitate action planning in similar situations in the future.

The introductory chapter, titled "*The importance of breastfeeding and an introduction to providing support for young child feeding in emergencies"*, is intended for all those involved in the response to potential crises, and who do not have awareness or knowledge of breastfeeding and the specific difficulties and risks that arise in relation to child feeding in emergencies. The aim of this chapter is to introduce all main participants to the key issues and to facilitate intersectoral collaboration.

This handbook is designed for various government institutions and organisations that might be included in the planning, distribution and mobilisation of resources for **Infant and Young Child Feeding in Emergencies (IYCF-E)**, and especially for those organisations and individuals directly supporting IYCF-E. It is also intended for all parties interested in monitoring a crisis situation, reporting on it in the media, and helping in any way.

1. Importance of breastfeeding and an introduction to providing support for young child feeding in emergencies

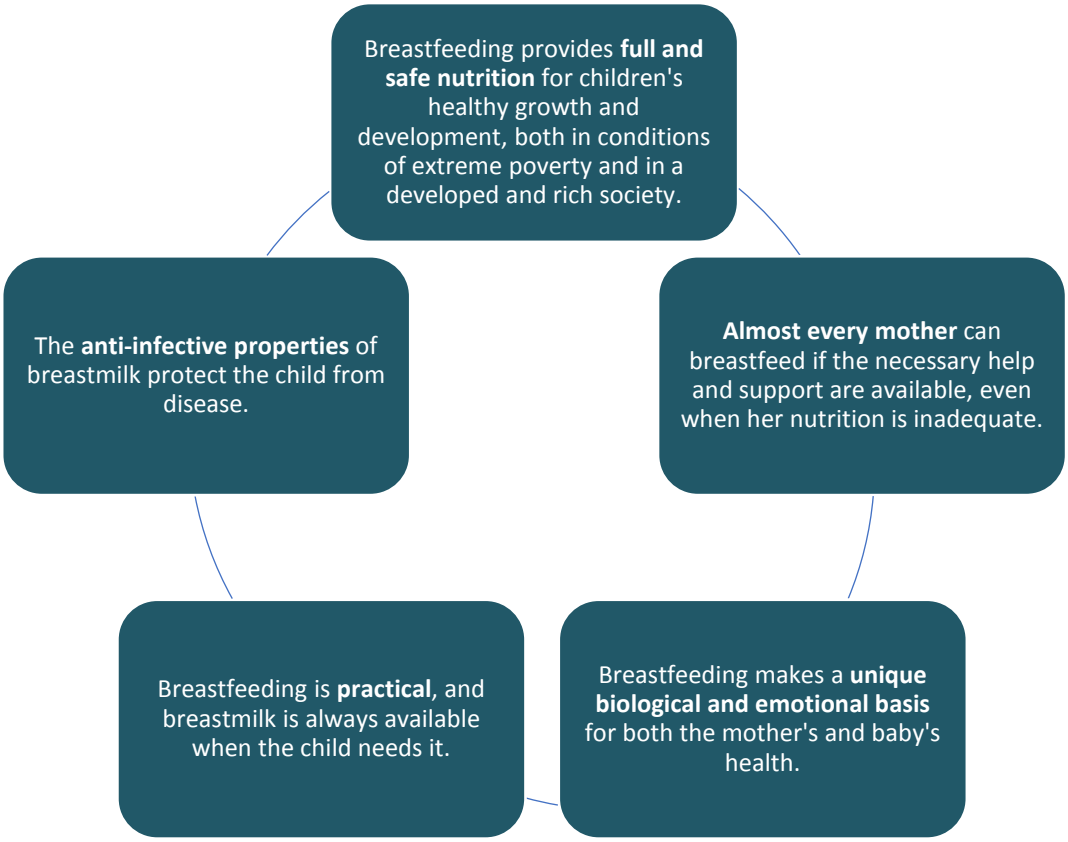
During natural disasters or political crises, the lack of safe drinking water and food puts the health, and even lives, of the population in danger. Children under the age of five are particularly at risk, while children under the age of one are the most vulnerable. Recent crises in the world have shown that, of the total mortality rate due to inadequate nutrition, 50% are children under the age of one. The leading causes of death are diarrhoea, dehydration and the resulting malnutrition.

While looking for a way to help people in distress, our response and the help we provide with the best intentions sometimes do more harm than good. One example of this is the inadequate nutrition of infants and young children whose mothers are able to breastfeed them, but who are indiscriminately and unnecessarily given infant formula, which has direct negative consequences, such as an increase of diseases among children, and where even their lives are put in danger. This is a scenario that repeats itself whenever a large-scale crisis occurs. This is why everyone who wants to help those at risk to respond to a crisis must put an emphasis on infant and young child feeding.

Just as there are strategic food reserves for extreme emergencies, there should be financial reserves for infants to ensure that the necessary human resources are available to support them, such as healthcare professionals and experts on breastfeeding and young child feeding, who would help to reduce the risks of inadequate nutrition. In the case of a migrant crisis, sufficient numbers of interpreters are crucial, without whom providing care and support is almost impossible.

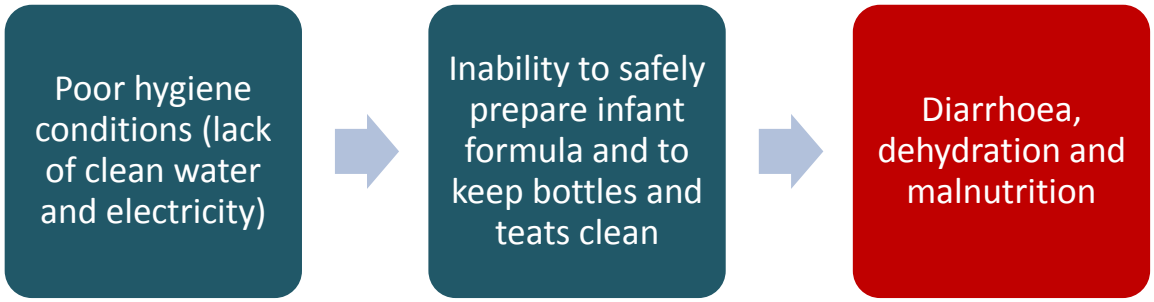
1.1. Why is it important to encourage breastfeeding in emergencies?

> *"There is no awareness at all of the importance of breastfeeding. Consequently, in situations where people are intent on saving their lives, breastfeeding seems of very little importance, because this will not help to save anybody's life. Everybody thinks that in this situation it is important to provide real food and help in terms of clothes or healthcare, but they do not take into account the most vulnerable group – infants and expectant mothers. Breastfeeding ensures optimum nutrition for children, and it saves lives, but the facts about it are completely distorted."*
> *Branka, RODA*



All relevant world health institutions recommend exclusive breastfeeding (with no additional food or water) in the first six months of a child's life. After the sixth month, breastmilk, which is rich in calories, proteins, fats and other nutrients, is still a basis of the child's nutrition, but the gradual introduction of more diverse nutrition begins. Breastfeeding is recommended at least until two years of age or even beyond if the mother and child so desire.

Breastfeeding is even more important in an emergency than in a state of peace and abundance when other safe and healthy food choices are available. In an emergency, the risks related to formula feeding increase immensely. According to the World Health Organisation (WHO), children fed infant formula in emergencies are 14 times more likely to die than exclusively breastfed children in the same situation. The risk is caused by **poor hygiene conditions (the lack of clean water and electricity needed to sterilise and heat water)** which makes it impossible to prepare infant formula safely, and to keep bottles and teats clean. Furthermore, non-breastfed infants **lack antibodies that fight diseases**; these antibodies are usually passed on through breastmilk. Children under the age of two do not yet have a sufficiently developed immune system, so they are particularly sensitive to food contaminated by bacteria. This makes them susceptible to diarrhoea, dehydration and, consequently, malnutrition.



Infant formula becomes an even bigger **risk in terms of the long-term sustainability of such nutrition,** because non-breastfed children depend on the logistics and supply of infant formula, which can be questionable in different emergencies. The price of infant formula is high, and it is a significant burden on the household budget, even in the everyday life of a family living in a developed country. In emergencies, when financial resources are limited, and transport and delivery are uncertain, an infant depending on milk formula as the sole source of nutrition is at a serious, life-threatening risk.

According to the physiology of breastfeeding, women's breasts will continue to produce milk for as long as milk is removed frequently and effectively, i.e. for as long as the infant is nursing. Once the infant switches from breastfeeding to solid food, milk production decreases or ceases, and resuming breastfeeding is a slow and challenging process that requires professional assistance, which is very difficult to provide in an emergency, especially when people are in transit. Consequently, children in emergency situations whose mothers **breastfeed them regularly and continuously have the best chance of staying alive and of having the opportunity for healthy growth and development**.

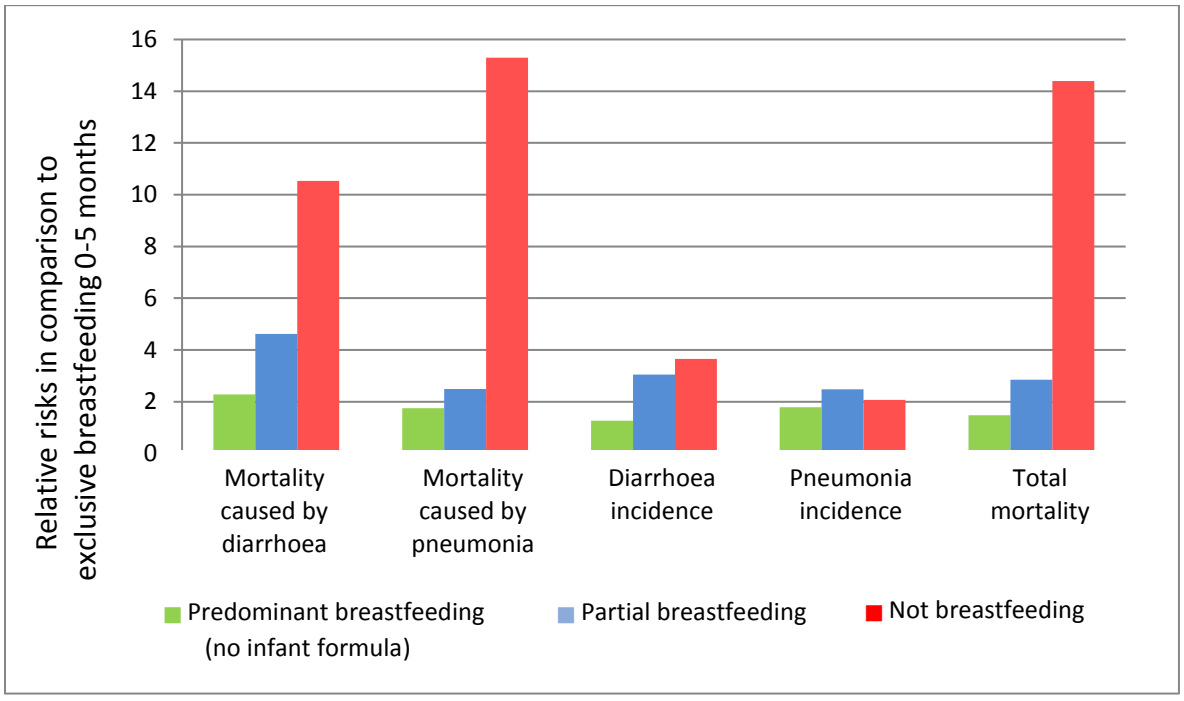
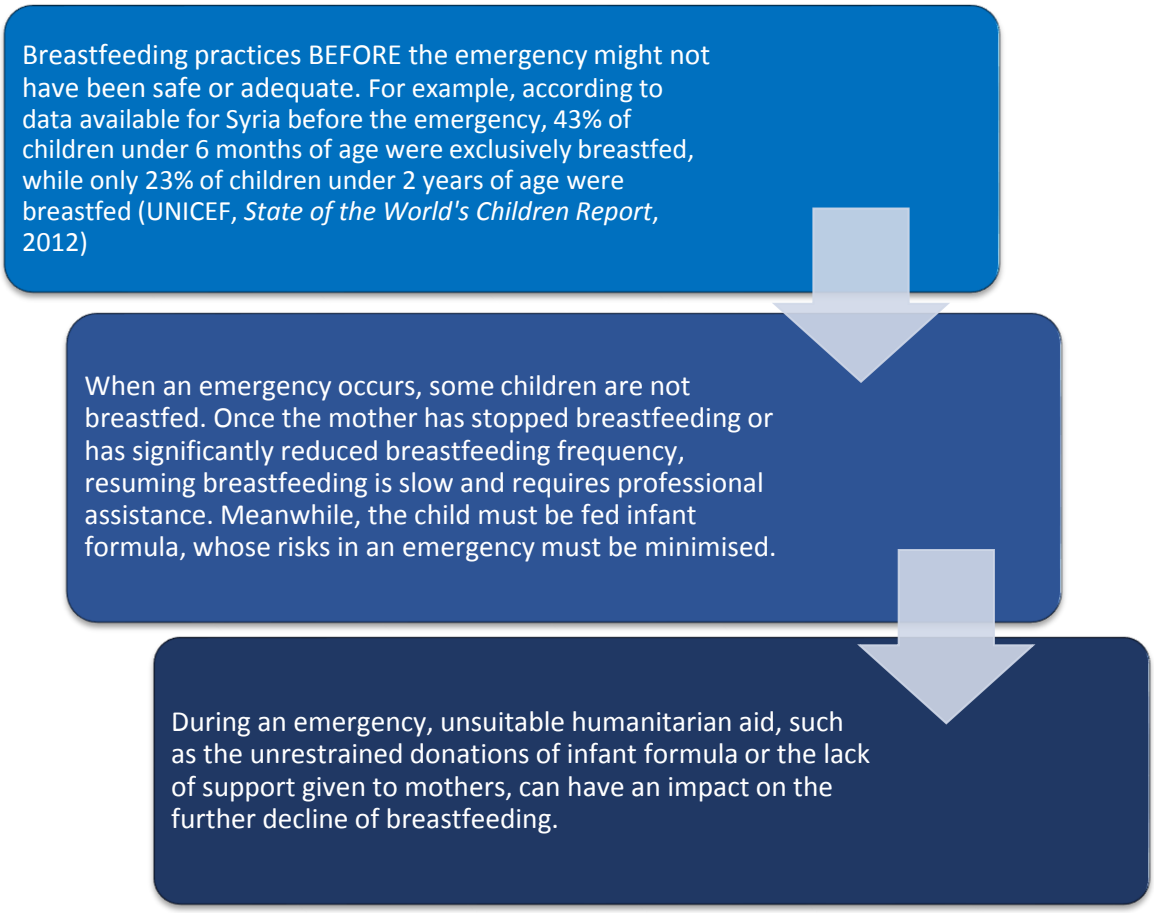


Figure 1. The risks of suboptimum feeding practices in infants and young children. Source: R.E. Black et al, Lancet 2008; 371: 243–60

Figures 2 and 3. Conditions in which it was impossible to safely prepare infant formula.

If breastmilk protects children, especially in emergencies, then why do mothers and service providers not ensure that all children in emergencies are breastfed?



1.2. Why does the distribution of infant formula and feeding accessories need to be controlled?

Unrestrained distribution of breastmilk substitutes to mothers who are **able to successfully breastfeed** (exclusively or partially) can cause the **earlier cessation of breastfeeding or the reduced frequency of breastfeeding**, which in turn increases the risk of disease and mortality among children.

Decision on whom to give infant formula

Responsibility for the distribution of breastmilk substitutes should not be left to any humanitarian organisation that is able to procure the substitutes, or companies and volunteers in the field, but to an organisation whose **personnel are trained in child feeding in emergencies**.

In emergencies, it is necessary to ensure breastmilk substitutes **specifically for and limited to children who were not breastfed before the emergency** or who were fed a combination

of breastmilk and infant formula. It is also essential to make a good assessment of which mothers should be given infant formula, how and in which quantities.

Decision on the type of milk formula

In situations where there are inadequate sanitary conditions, i.e. while travelling, at transit and reception centres, or immediately after a natural disaster, when parents have no access to clean, boiling water, the first choice among breastmilk substitutes is the ***Ready to Use Infant Formula*** **(RUIF), a fully prepared adapted milk in liquid form,** packed in sealed and secure packaging, in the approximate amount of one meal. This form of substitute is more difficult to obtain, and many persons involved in providing help in emergencies do not know it exists. Powdered infant formula is the best known and the most common and available substitute in our shops. It can be safely prepared, but it is not appropriate for use in emergencies. Clean, boiling hot water and a clean container are needed to prepare the powdered infant formula, but they are only sporadically available, far less often than is needed to feed an infant (at least every three to four hours). Due to the child's hunger, it often happens that powdered infant formula is prepared with unboiled water and unclean accessories, which promotes the development of bacteria.

Once prepared with water, powdered infant formula must be thrown away as soon as it becomes cold, but many mothers in an emergency continue using the prepared formula to feed the child, due to the insufficient quantities of formula distributed. Furthermore, it often happens that powdered infant formula is mixed with inadequate amounts of water, because the instructions for preparation are not in a language that the mother understands, or because there are insufficient quantities of powdered infant formula, and the mother decides to save on it. The recent refugee crisis was specific precisely because of the immense language barrier, but also because of the low level of literacy of some mothers who had difficulties understanding even instructions written in their mother tongue. Feeding a child with over-diluted infant formula leads to malnutrition, while feeding it with infant formula that is too thick can cause dangerously high levels of sodium and protein in the child's blood, and can increase the load on the kidneys and provoke kidney failure.

> *"In the first few months in the camp, there was almost no RUIF to give to mothers for the journey. The greatest challenge for me was sending a non-breastfeeding mother and her child whose only option is infant formula on a journey, knowing that the child will not have anything to eat while travelling."*
> *Renata, RODA*

Distribution of pasteurised cow's milk commonly used by adults also brings risks in an emergency. The nutrients in cow's milk are not suitable for an infant, so it should not be given to children under the age of 6 months, and it is not recommended for children under the age of 12 months. However, if it is used to feed older children, it must be taken into

account that cow's milk is easily contaminated after opening if it is not stored in a refrigerator. It has been shown that the distribution of cow's milk in emergencies to adults and older children causes a decline in breastfeeding because mothers feed it to children who are too young. This is why organisations involved in emergencies sometimes have a policy not to distribute cow's milk. Its nutritive properties can be replaced with other foods, so distributing cow's milk sometimes brings more risks than benefits for infants.

Decision on accessories and methods of feeding

The first choice in formula feeding accessories, even for newborn babies and the youngest children, are **cups**, because they are easy to clean and inexpensive to obtain in large quantities intended for single use. Bottles and teats are a poor choice because they are impossible to clean and sterilise in poor sanitary conditions, which makes them a perfect place for the development of pathogenic organisms and they become a source of infection. Although Croatian maternity hospitals have been offering cups as the optimum feeding accessory for more than ten years, they are not widely accepted or commonly used for feeding in normal living conditions. This makes the presence of trained individuals necessary in order to show mothers how to cup-feed their children.

> *"At first, the biggest shock for me was being able to see whether the child was being breastfed or not just by its appearance. I felt the greatest unease over non-breastfed children because they were in a poor condition, some of them were malnourished and ill, of greyish complexion and suffering from diarrhoea. Sometimes you could see the child's facial bones protruding due to malnutrition. I could not do anything significant for them to make their onward journey easier. I was also shocked by every dirty and foul-smelling bottle that moms would bring and ask us to use to prepare infant formula."*
> *Renata, RODA*

1.3. Why infant formula is still distributed in such large quantities?

Despite the adoption of international recommendations for IYCF-E, an increase in infant formula feeding still occurs in emergencies in comparison with the normal living conditions of the population in question. It is due to the combination of the following:

Donations and promotion by the producer of breastmilk substitutes

Unrestrained distribution of donated breastmilk substitutes is a violation of the International Code.[1] However, in any emergency, there are bigger or smaller donations by manufacturers whose products are marked with logotypes of their brands and pictures that make breastfeeding substitutes appealing and build mothers' trust in them, in order to persuade

[1] The "International Code of Marketing of Breastmilk Substitutes" regulates the mechanisms that protect breastfeeding.

the mother to start using their breastmilk substitute, and continue buying it after the crisis has passed.

> *"Sometimes, the mothers had three boxes of different types of formula, and each box was open. There was no control over the distribution of infant formula along the entire route. I believe that such situations could have been avoided by training the personnel at the camp, not only at Croatian camps, but also at the camps in Serbia, Macedonia, Greece, etc. Infant formula cannot stay open for a long time, and nobody was keeping track of that. We had several cases of children with severe diarrhoea, because they were fed powdered formula mixed with cold water, prepared in unsterile conditions."*
> *Suzana, RODA*

Organisations providing support in emergencies are not familiar with the risks of infant formula

A number of different national, humanitarian and nongovernmental organisations are usually included in providing help to people in emergencies. Umbrella organisations, such as police forces, the Croatian Red Cross and the National Protection and Rescue Directorate must coordinate other organisations, and, due to their functions, they have the greatest contact with persons in emergencies. Individuals belonging to these and other organisations, with the best of intentions, often consider that giving infant formula to any infant as a way of satisfying their nutritional needs, and are unaware of the great risks the formula presents in emergencies. This is why educating and training all individuals providing support in an emergency is one of the crucial tasks of organisations involved in infant and young child feeding. Education and training while establishing regular procedures of formula distribution is not enough. Training needs to be conducted continuously, due to the fluctuation of personnel in all organisations.

> *"I believe that the people working at Opatovac were simply not familiar with the basic facts. The leading causes of death in children under the age of two are diarrhoea and pneumonia, and artificial feeding contributes to an increase in these two diseases. Only breastfeeding can minimise that risk. They did not know that."*
> *Martina, UNICEF*

Myths

When people are insufficiently educated about the child's nutritional requirements and breastfeeding practices, their actions are based on a variety of misinformation and myth. Unfortunately, the myths that spread among parents and the people helping them in an emergency have a significant effect on mothers deciding to feed their child infant formula, regardless of having successfully breastfed them before. One of the most common myths in

emergencies is that if the mother is stressed or not eating good food, she cannot produce enough breastmilk or her breastmilk is of low quality, which is false. If there is no control over the distribution of infant formula at such moments, and no verification of how the child was previously fed, breastfeeding is unnecessarily interrupted, and the only healthy food source that is available is removed from the child.

It should be kept in mind at all times that breastmilk has survived through evolution from prehistory onwards as the most efficient way of feeding human offspring, in circumstances when harsh nature offered many fewer food sources than in today's emergency situations.

"Once, a mother, a father and a six-day-old baby came to me. The parents were very young, probably underage, and the older family members were waiting outside and rushing them. The baby was suffering from severe jaundice, and it was sleeping all the time. While we were changing the baby that had been born prematurely, barely weighed two kilograms and obviously was not hydrated well, I asked the mother about breastfeeding. Both she and the father became very upset by that question.

The interpreter could not get a coherent answer, only agitated exclamations. I was seriously worried about the baby, because the mother was feeding it infant formula that was unsuitable for preterm babies, and it did not wake up at all while being changed, so I called a paediatrician and a psychologist from the international organisations. It took a while before we realised what the mother was telling us – the child's father was hearing-impaired, and she could not breastfeed because the child would become hearing-impaired, too. The father was the only breastfed child among his brothers and sisters, and he was the only one with a hearing impairment. The rest of them had been artificially fed and were "healthy".

Aware that we do not have enough time to overcome such misconceptions that had been supported for years by their family and environment, we did the only thing we could. The paediatrician prepared infant formula and bottles, and I told the mother to wake the child up when feeding it, and to ask for a physical examination of the baby at the next stop in Slovenia."

Ivana, RODA

Media

The media play an important role in all emergencies. Citizens and companies respond to their appeals, and people take action. We have witnessed a huge humanitarian response of our community in every emergency. The message that "children's food is needed the most" is the first one we hear in the media, and yet this type of information often does not come from people in the field or from the competent institutions, but is only presumed by the media.

Competent institutions

The Ministry of Health should ensure that an emergency response plan exists, along with the resources, the infrastructure, and a team ready to implement the plan quickly and efficiently when an emergency arises. The response plan must be adapted to the circumstances of the particular emergency. Unfortunately, the experience of Croatia, other countries in the region, and even of other, more developed and organised countries of the European Union, has shown that there is no plan for child feeding in emergencies.

An emergency response plan in accordance with the international guidelines that give priority to infant and child feeding is crucial for effective action in emergencies. If such a plan exists, and if all the organisations involved in an emergency act in accordance with it, oversights and an unnecessary waste of time due to a lack of coordination among different organisations could be avoided. It would be easier and faster to ensure adequate human and material resources, and unrestrained donations of breastmilk substitutes could be prevented.

1.4. Why is professional assistance with breastfeeding often necessary?

Although natural, **breastfeeding can be a challenge and pose difficulties** even in normal living conditions. Many mothers need assistance and support from professionals: healthcare workers – paediatricians and community nurses, lactation consultants, or other experienced mothers.

Professionals can help to correct the feeding mistakes causing the child to eat insufficiently, teach the mother the basics of breastfeeding, and solve the issues that commonly arise in the first days of nursing. It is also important to give support to insecure mothers, and to destroy the myths that negatively affect breastfeeding by means of education and training.

In Croatia, there are organisations involved in breastfeeding education and that provide support to nursing mothers. Approximately twenty healthcare and other professionals helping mothers and young children have the international IBCLC certificate, which is the highest level of expertise in the area of breastfeeding (members of CALC). Members of RODA include dozens of mothers who are trained lactation consultants who have been providing peer support for fifteen years now, by giving counsel on breastfeeding over the telephone, and organising training for expectant and nursing mothers, and fathers. Some community nurses and midwives have additional training in breastfeeding, and some of them are involved in the Croatian breastfeeding support group. Apart from them, many other healthcare professionals and mothers have a certain degree of knowledge of breastfeeding, and with additional training from the above organisations, they can qualify to provide professional assistance with breastfeeding in emergencies.

"There was a need for professional assistance, because some of the mothers had serious difficulties. I remember one night, when RODA was not present at the camp yet, a mother came with her 20-day-old baby, fed with both breastmilk and infant formula. The baby was not breastfed exclusively, because the mother was breastfeeding it only when she was alone, i.e. when she had some privacy, so she did not breastfeed the baby while in the boat or on a train. She had severe mastitis, manifested by large lumps, with pus oozing from one of the breasts. It was quite serious. I felt completely ill-equipped to cope with this situation. I knew what mastitis is, but I had never seen such a case, I had never seen breasts in such a state. I was truly shocked. The physician told the mother to stop breastfeeding because her milk was harmful due to severe breast inflammation. It was perfectly clear to me that both we and the mothers at the camp need professional assistance, because the emergency medical personnel do not have the specific knowledge of breastfeeding."
Martina, UNICEF

1.5. Why should every emergency reception centre establish a Mother and Baby Centre?

A high-quality assessment of the mother's and child's condition can be conducted in a separate and safe place, so that a better decision can be made on the type of nutrition and assistance needed. Breastfeeding counselling needs a certain amount of time and requires the separation of the mother and the child from the chaos and the pressure of the emergency. Counselling is almost impossible in tents and other areas where there are many people.

A *Mother and Baby Centre* (*MBC)* is a safe area where one can find a paediatrician, a lactation consultant, and other associates who provide assistance to expectant mothers, parents and young children. In different emergencies, apart from counselling on nutrition and health issues, it can also be a place to consider the other needs of a child. In situations of fast transit, it is the place to change children into clean and dry clothes, to wash them and change their diapers. In situations of a longer stay, the MBC can be a place for different types of work with children, from playing to providing psychological support.

Since the child's health issues are often related to nutritional issues, it is advisable that medical assistance and professionals trained in child feeding in emergencies are located in the same place, so they can refer the child to one another quickly and efficiently. The lack of these types of staff is common in every emergency, and in a situation of people in transit, the time to provide assistance is exceptionally short, which is a further indication that placing all assistance services in the Mother and Baby Centre is the most efficient solution.

It is best to conduct control over the distribution of breastmilk substitutes with the help of professional staff in as few places as possible, preferably in a Mother and Baby Centre.

Figure 4. The Mother and Baby Centre, Opatovac, October 2015.

1.6. What are the nutritional requirements of a child?

A newborn baby and a child under six months of age

Mother's milk satisfies all the child's needs through exclusive breastfeeding in the first six months of a child's life. A child **does not need any additional foods or liquids** because breastmilk contains enough proteins, carbohydrates, fats and liquid. In the beginning, the baby should be breastfed **at least eight to twelve times a day** (night included), depending on the child. One feeding can last for 5 to 40 minutes, or more. The intervals between feedings may be different during the day, so the baby can be fed more frequently in one part of the day (even **every half an hour**), and less frequently in the other part of the day, or during the night. It is recommended to breastfeed on demand – putting the baby on to the breast whenever it asks for it by wriggling, putting its hands in its mouth, smacking its lips, moaning or crying, because this method ensures that the baby eats enough.

If the baby is not nursing, but is fed **infant formula** instead, the meals should follow a feeding schedule in accordance with the manufacturer's instructions, based on the total amount of formula a child eats in 24 hours. A 10-day-old baby needs about 500 ml of infant formula, and a 1-month to 6-month-old baby needs 600 ml to 800 ml of infant formula. In the first month, you can feed the baby **60 ml of infant formula every two to three hours**, and in the following months **90 ml (or more) every three to four hours.**

A child above six months of age

At six months of age, the child continues to breastfeed, but **other foods, i.e. complementary foods**, are also introduced. Complementary foods are solid or semi-solid (soft) foods, and, in the beginning, it is essential that they contain iron and zinc. The share of complementary foods in overall nutrition later increases and fulfils more of the child's energy and nutritional requirements. **Breastfeeding in combination with complementary feeding is recommended at least until two years of age or beyond,** for as long as the mother and her child desire.

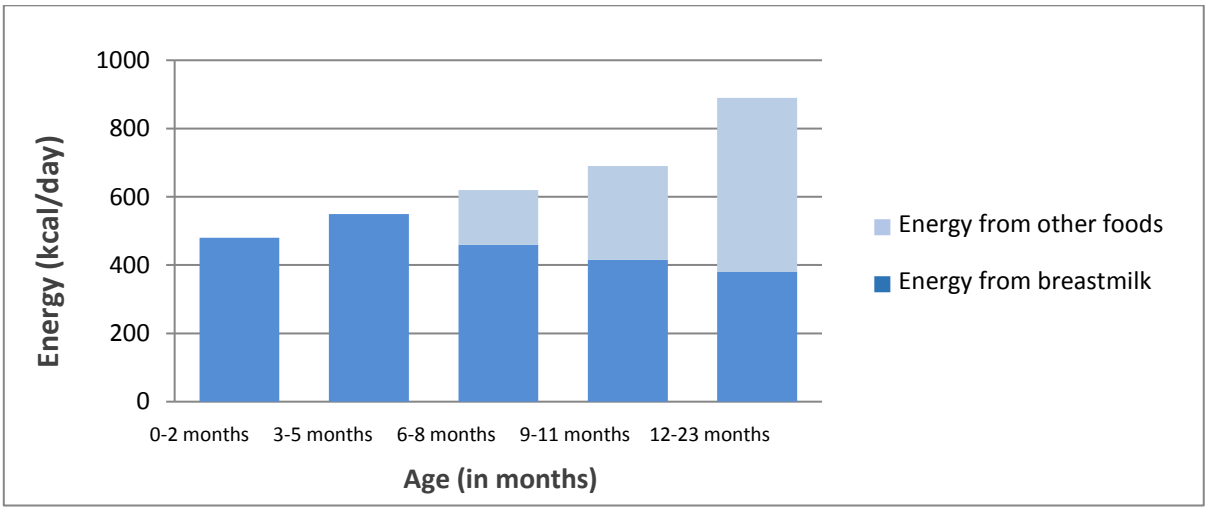


Figure 5. Energy requirements of a child from birth to the age of two, based on breastmilk and other foods (Source: WHO).

There is a large variety of ready-made commercial baby food on the market, but health organisations recommend feeding children with locally grown, seasonal produce. The international guidelines on child feeding in emergencies also recommend locally grown, fresh seasonal produce, not only because of its optimum nutritional value, but also due to its availability and affordable prices. However, in transit situations or in situations of a longer stay at reception centres, when people are unable to prepare food safely, this choice is not possible. The only remaining possibility is to distribute ready-made food, which raises the following issue: the usual, commercially produced children's food does not meet nutritional and energy requirements, because it is only used as complementary food, along with breastmilk or infant formula which form the basis of nutrition, and along with other fresh foods. There are nutritious and energy-rich bars on the market especially made for children above six months of age in emergencies, and they are the first choice in this situation.

1.7. How can breastfeeding be successful for almost every mother and child?

Breastfeeding is a resilient physiological process, and almost every mother can breastfeed with a certain amount of help and support when necessary.

When initiating breastfeeding, it is highly important that **the position of the child on the mother's breast is correct,** i.e. that the child latches onto a sufficiently large part of the breast so the milk can flow smoothly when breastfeeding. Some mothers need assistance with this. A proper latch can be disturbed by bottle-feeding and by giving teats to a child who gets used to a different way of sucking, after which the child cannot or does not want to breastfeed properly.

After delivery, the mother is under the increased influence of hormones that cause the production of breastmilk, which can lead to the oversupply of breastmilk several days after giving birth. If the baby does not remove milk efficiently, breast inflammation can develop. The initial surge of hormones gradually decreases with time, but they are secreted again every time the baby is breastfeeding, i.e. removing milk. This is the way the baby regulates milk production – **the more milk removed from the breast, the more is produced. If the baby is not breastfeeding frequently, and an oversupply of breastmilk occurs, less milk will be produced in the following period.** This is the basic principle of supply and demand, which is the most essential method of ensuring sufficient amounts of milk for the baby. **Nothing, either the mother's diet or stress, decreases milk production** as much as postponing feeding or inefficient milk removal.

Many women notice at a certain moment that their milk supply is low. This can occur when infant formula is introduced, when feeding is skipped, or because the breastfeeding latch is poor and the milk flow is inefficient, etc. Milk supply decreases gradually, over several days. Although the baby surely needs the addition of infant formula at such a moment, it is possible to increase breastmilk supply again by frequently latching the child onto the breast, and by removing the milk effectively. This process is called *relactation* and it requires a certain amount of time, professional assistance and the mother's perseverance.

> *"People actually do not know the rules of breastfeeding. The more you breastfeed, the more milk is produced. Stress does not affect milk production, and milk does not disappear just like that. Most people do not know these things. If they knew that a mother can successfully breastfeed in an emergency, that she only needs to breastfeed her child as often as possible, and if they believed just a little bit more that breastfeeding can be successful, they would not offer the bottle so readily."*
> *Renata, RODA*

2. Context and overview of the situation that occurred

"Although it might seem logical that needs such as food and sleep are a priority, this was not the case most of the time. All of them shared the same basic need – to continue the journey and arrive at the desired country, and to be safe. To achieve that, people were willing be without food and sleep for days. They were in constant fear that the borders would close, and that they would not be able to continue their journey. They lacked a sense of security and information."
Tena, RODA

In the spring of 2015, the number of refugees and migrants arriving in Europe unexpectedly began to increase significantly. Many of them were refugees from the Middle East who were travelling through Turkey, Greece, Macedonia, Serbia and Hungary, towards Northern and Western Europe, mostly to Sweden, Germany and Austria.

In the middle of 2015, when Hungary erected a fence and closed its borders with Serbia, the refugee route was redirected to the eastern borders of Croatia. In the morning of 16 September 2015, the first group of refugees and migrants arrived in Tovarnik. From approximately three hundred people on the first day, the number of refugees grew to several thousand in the following days, and during the peak there were more than 10,000 people entering Croatia daily. In September and October 2015, accommodation for refugees was organised at the temporary reception centre in Opatovac, and in November 2015 the Winter Reception and Transit Centre in Slavonski Brod was established.

According to official data from the Ministry of the Interior, from 16 September 2015 to 4 March 2016, a total of 658,068 refugees and migrants entered Croatia, 558,724 of that number in 2015.

The percentage of women and children in this period varied from around 18% at the beginning, to 55% in the period before the border closed. After the borders closed, as a consequence of the agreement between Turkey and the EU signed in Brussels, there were nearly 60,000 refugees stranded in Greece, mostly women and children, and around three hundred refugees in Croatia, at the Reception Centre in Slavonski Brod. The Winter Reception and Transit Centre in Slavonski Brod was closed in April 2016.

After the centre in Slavonski Brod closed, assistance for asylum seekers was organised in the reception centres in Zagreb and Kutina.

In accordance with the *Core Commitments for Children in Humanitarian Action*, the UNICEF Office in Croatia provided support for the reception of refugees and migrants organised by the Croatian Government in the areas of health, nutrition, hygiene, and child protection. Based on an assessment of the situation, UNICEF, in partnership with the Croatian Government and in cooperation with non-governmental organisations, ensured material help and support in the form of human resources, in order to adjust the reception of refugee mothers and children according to their needs as far as possible. Within its mandate, and at the invitation of institutions of the Republic of Croatia, UNICEF and its partners joined in providing humanitarian aid and support to mothers and children by participating in the activities aimed at expectant and nursing mothers, and mothers with children under 15 years of age. The partners providing support were both local and international non-governmental organisations, such as RODA, the "Our Children" association from Vinkovci, the Society for Psychological Assistance, the Red Cross, the MAGNA organisation, *Save the Children,* and others.

Partnership among the NGOs "Our Children" from Vinkovci, the Society for Psychological Assistance, and Parents in Action (RODA), as the implementation partners, along with MAGNA and *Save the Children* as operating partners, were crucial for responding to the needs of refugee and migrant women and children.

The UNICEF Mother and Baby Centres in Opatovac and Slavonski Brod were open around the clock.

3. Establishing support for IYCF-E in the Reception and Transit Centres in Opatovac and Slavonski Brod

"At seven in the morning on 16 September, the first 300 refugees arrived. After all of them were registered and given food and water, we were wondering how come there was such chaos in Serbia and Hungary. When another 3,000 people arrived in the next 3 hours, we began to realise what it was all about. It was impossible to conduct any activity in Opatovac. Everything was chaos and improvisation. All the procedures fell apart. There was not enough food in the first two days."
Suzana, RODA

3.1. The situation in the migrant and refugee population regarding breastfeeding and young child feeding

Most children coming to the Reception and Transit Centre were not breastfed exclusively. A number of mothers were combining breastfeeding and infant formula, and many of them gave up exclusive breastfeeding and introduced infant formula on the journey itself.

During their journey through various counties, the mothers would get different and poor advice on child feeding. Even the mothers who were breastfeeding exclusively would receive dangerous advice supported by myths from healthcare professionals and other staff, such as instructions to stop breastfeeding if the child was suffering from diarrhoea or vomiting, if the mother was exhausted, has an unhealthy diet or eats insufficiently, or if she is pregnant. **Many mothers were concerned that, due to their poor nutrition and the stress they had been through, their breastmilk was not good enough.** These are *not* indications to stop breastfeeding, and the mother's poor nutrition and stress do *not* affect the milk. Some mothers stopped breastfeeding or **reduced the frequency of breastfeeding** because they did not have a safe, intimate nursing area, or they were exhausted and under stress from the constant movement and uncertainty, and in a poor mental state due to the traumatic experiences.

Mothers arrived with donated powdered infant formula, or without any sort of milk supply for their child. **None of the children who were not exclusively breastfed had a sufficient amount of appropriate food items in accordance with the IYCF-E guidelines on their arrival at the Reception and Transit Centre.** Parents mostly had infant formula with instructions written in a language they did not understand, so they were preparing the formula in poorly cleaned bottles, sometimes using cold water, and sometimes diluting the formula too much. **None of the bottles and teats brought by parents to the Reception and Transit Centre was**

in a suitable state for child feeding. This is one of the reasons for the high incidence of diarrhoea in infants arriving at the Reception and Transit Centre. In combination with the cold weather and a large number of people in one place or indoors, infrequent breastfeeding also contributed to the high incidence of respiratory diseases. There were instances of dehydration and malnutrition. Children over the age of one, even some three-year-olds, were unnecessarily fed infant formula, which put their health at risk due to inadequate preparation.

Annex G provides a list of myths which caused mothers to adopt poor child feeding practices, accompanied by appropriate responses to these myths.

3.2. Reception and Transit Centre in Opatovac – development of support for IYCF-E

The Reception and Transit Centre in Opatovac was divided into four sectors, and it was planned that persons accommodated in one sector could not leave their sector until the moment they left the Centre accompanied by police. Special measures were taken to avoid family separation, but there were several instances of separation, when the family members were allowed to enter another sector. Medical assistance for adults was organised in an area close to the entrance/exit of the Reception and Transit Centre. The length of stay in the Centre varied over time. During the day, migrants would spend several hours at the Centre, while at night they were at the Centre mostly the whole time. Only very rarely would they stay longer, up to 72 hours.

When the Centre began to operate, infant formula was distributed without any control by several organisations at the very moment of the registration of families entering the Centre, and there was no safe place for nursing and assisting mothers with child feeding.

> *"A significant number of children were suffering from hypothermia during the night. Their body temperature was dangerously low, and many of them had diarrhoea. It was evident that we had to stop the unrestricted distribution of infant formula and hot water in the camp."*
> *Martina, UNICEF*

"When I came to Opatovac, it was clear that there was no organised response there, no help or support for the most vulnerable children – those under two years of age. Breastfeeding saves lives, but support for breastfeeding did not exist. In fact, some activities conducted by other organisations and participants at the camp were undermining breastfeeding, and actually preventing it. There was a case when a paediatrician told an exclusively and successfully breastfeeding mother of a 1-month-old child to use infant formula. The child was developing properly. A month after birth, you see this newborn child with its beautiful little cheeks, you can see it looks healthy. But the baby was crying at that moment, and children can cry for a variety of reasons, and the paediatrician simply said that the mother's milk supply was low and suggested infant formula."
Martina, UNICEF

With the joining of UNICEF to help organise assistance for families and young children, support for IYCF-E gradually began. A Mother and Baby Centre (MBC) was established, offering support 24 hours a day to families with young children. The MBC was situated in only one of the four sectors, but it offered support to children from the entire Reception Centre. It consisted of four containers. In one of the containers, there was a medical team: a paediatrician and nurses from the MAGNA organisation.[2]

Two containers were assigned for IYCF-E support as a place for changing children's clothes and diapers, and for a brief period of rest for pregnant women and mothers. Associates from "Our Children" and RODA worked there, along with volunteers from the Croatian Association of IBCLC Lactation Consultants, the Osijek Volunteer Centre, the Croatian Red Cross, and the *Save the Children* organisation.[3]

[2] MAGNA is a medical humanitarian organisation based in Slovakia, consisting of physicians-volunteers from Europe providing healthcare in emergencies in different parts of the world (www.magna.sk/en/).
[3] *Save the Children* is an international humanitarian organisation that promotes children's wellbeing, protection and education, and provides support to children in humanitarian crises around the world (www.savethechildren.net/).

Figure 6. In front of the Mother and Baby Centre, Opatovac, October 2015.

According to the international guidelines, a nursing area should be separate from the formula feeding area, and we managed to achieve that.

The preparation and distribution of breastmilk substitutes was the exclusive responsibility of healthcare professionals from the MAGNA organisation, because they were the only ones with the resources for the safe preparation of infant formula, and they were more or less able to assess to whom it should be given. In the MAGNA container, bottles were sterilised, powdered infant formula was prepared, and mothers fed their children infant formula there, or they would take the formula with them to the tent. This method was the only option in this situation, considering the number of people coming to the Centre.

Due to the significant fluctuations and lack of personnel, it was known to happen that, especially in the beginning, since some of the physicians were not quite familiar with IYCF-E, they would prepare breastmilk substitutes as soon as the mother asked for them, or as soon as the baby cried, without any assessment of breastfeeding or without consulting the IYCF-E personnel in the neighbouring container. Besides, it was not sure in the first few months that all associates working at the MBC had sufficient knowledge of IYCF-E and breastfeeding support, so what was offered at the MBC was reduced mostly to dealing with other kinds of "emergencies". In the very cold and humid months (the tents had no heating), these emergencies included finding donations of dry and warm clothes for the freezing children, bathing and changing them, or assisting pregnant women and mothers. Depending on who was on the shift, breastfeeding and proper feeding assistance were often not a priority. If

the mother was breastfeeding successfully, she could use the MBC as a quiet area for nursing and rest, but if she requested infant formula, she would usually get it with no questions asked.

From the beginning, IYCF-E support was continuously being improved. The programme manager and the associates at the MBC created an IYCF-E Protocol (the same Protocol was later revised at the Reception and Transit Centre in Slavonski Brod, and is available in Annex C). Volunteers from RODA who are trained lactation consultants would come at the weekends. They shared their knowledge of breastfeeding support with the other associates by working together with mothers. They also cooperated with the healthcare professionals from MAGNA to make better assessments and decisions on giving breastmilk substitutes. Along with the consultants from RODA, the IBCLC consultants, individual community nurses and midwives were also volunteering as experts on breastfeeding and young child feeding. All of them were working almost exclusively at the weekends, taking their turn in shifts, because they were in their workplaces during the week. From Monday to Friday afternoon, professional assistance with breastfeeding was available only occasionally.

> *"This is how it all started: first we had a few containers in Opatovac where the mothers could come and have an intimate area for nursing, because they do not feel comfortable nursing when they are in a group with men. They had access to a safe place where they could breastfeed their child in peace. And afterwards, apart from providing this warm place, it was important what else was offered there to mothers. A warm place and dry clothes were enough for some, but others needed much more."*
> *Martina, UNICEF*

Figure 7. The Mother and Baby Centre, Opatovac, October 2015.

> *"Our MBC container at Opatovac was a refuge for mothers, and it was always full. Mothers would fall asleep on the military beds, happy that they could rest for at least half an hour. Although it was chaotic, we had everything under control and managed the situation."*
> *Tena, USOC*

As the migrants' movements after entering the Refugee and Transit Centre were limited exclusively to their assigned sector, the volunteers, employees and interpreters working for UNICEF had to actively search for families with young children, and, with the permission of the police, bring them to the MBC. They were standing in the registration area, monitoring people at the entrance, identifying families with young children, and informing them of the kind of assistance they could receive at the MBC, and inviting them to come over once the family had settled at the camp. After the migrants were accommodated in tents, these volunteers passed through the sectors, visiting people's tents, assessing whether a mother and child needed assistance, and asking them to visit the MBC. The greatest challenge of this practice was to prevent **family separation**, given that only mothers and children could visit the MBC. UNICEF staff had the responsibility to reunite the mother with her family and take her and the child back to their sector before transport arrived for them to resume their journey.

Interpreters had an enormous role in the work of all organisations. They were few in number, and were needed at several locations simultaneously. Without their presence, it was considerably more difficult for associates to assess which children and mothers needed assistance, and even much more challenging to explain why it would be good for them to go to the MBC. Many families were afraid of separation, particularly if they were larger in number. Everyone wanted to resume their journey as soon as possible, and they were also worried about losing their turn on the means of transport if they did not remain in the tent and if they were not ready to leave. The interpreters learned very soon what the benefits were for the children if they went to the MBC, and in many cases they were able to independently make a good assessment of the condition the child was in, and call for the UNICEF staff if necessary. Some of the families independently sought help and food for their children, and other staff providing support in the emergency also referred mothers and children to the MBC.

The fact that most of the interpreters were male sometimes posed a challenge, for instance when they were taking part in counselling on breastfeeding or pregnancy. Some women found that unacceptable, which made communication with child feeding consultants more difficult. It would be ideal to hire female interpreters to support IYCF-E, but they were hard to find.

> *"The most important persons in the Reception Centre were the interpreters. Without an interpreter, you cannot conduct counselling. I realised this one night when there was no interpreter for Farsi, and a mother speaking only Farsi came to me with her malnourished infant. I tried to take their medical history, but she did not understand me at all. I could not ask for permission to conduct a physical examination, let alone explain to her how to increase her milk supply.*
> *All I could do was smile and give her an approving "thumbs up" for breastfeeding, while I was looking in desperation at her child with its hollow cheeks and big eyes, barely breastfeeding. I felt useless and helpless. The woman's husband came soon after to take them to the train."*
> *Irena, IBCLC*

In the first months, there were **between 3,000 and 11,000 new migrants entering and leaving the Reception and Transit Centre daily**, which is a huge number. Using the methods of assessment and identification of families with infants and young children described above, it was impossible to detect all the children who needed assistance. We simply could not find a lot of children, so we could not conduct a quick, basic assessment of their condition. Since the number of migrants entering the Centre was fluctuating, when a large group of people arrived, it would get very crowded at the MBC, so several pregnant women, mothers and children were receiving support at the same time. When things calmed down, the associates would find some time to visit the other sectors and look for people in need of assistance.

There was a lack of healthcare professionals, lactation consultants, interpreters and other professionals to support such a large number of people.

Some of the families with very young infants or ill children sometimes stayed for longer, up to several days, in the containers near the MBC. These mothers and children had the opportunity to receive quality support for nursing and feeding, and medical assistance.

From the time the Reception and Transit Centre began to operate, donations of baby carriers would occasionally arrive at the MBC. The associates working at the MBC showed parents how to position the baby sling, which was most practical for parents travelling with young children.

Figure 8. Opatovac, positioning the donated baby sling, September 2015.

3.3. Reception and Transit Centre in Opatovac – protocols established for IYCF-E

Following the protocol established for working with the mothers and children coming to the MBC in Opatovac, a quick assessment was made first, based on the following information:

- the child's age;

- whether the mother nurses or not; if not, when and why did she stop nursing;
- whether the child is receiving other foods and drinks, apart from breastmilk;
- whether there are any difficulties with nursing;
- whether the infant is very thin, lethargic or ill.

Every non-breastfed or partially breastfed child, or a child who has difficulties with nursing, every newborn child and every child with health issues who does not look healthy, was supposed to be referred for more detailed assessment and assistance. Unfortunately, this was not always the case due to the lack of professionals who could make a good assessment.

Many mothers at the MBC were nursing or they had tried to nurse, and the consultants were helping them to work out any difficulties. At the MBC, mothers had privacy, there were mostly just women, and the associates were taking care of the other children and changing them if necessary, and they were also encouraging mothers to continue nursing. Some of the children who were very young were born during the journey, and they were given special attention; the staff made sure that breastfeeding practices were proper, and held a detailed conversation with the mother on the basics and benefits of nursing. Mothers and their children would spend ten to sixty minutes at the MBC.

Some of the mothers had stopped nursing recently, during the journey, or they had reduced the breastfeeding frequency and introduced formula feeding. This was the most common topic of conversation at the MBC. We talked to these mothers about the risks of bottle-feeding and infant formula. It was explained to them that it is possible to resume breastfeeding and to increase milk supply by latching the child onto the breast as often as possible, and by regular milk removal. They were warned that increasing the milk supply is a gradual process, so they would have to bottle-feed the child for a while longer. Unfortunately, relactation is challenging even when the mother is not in an emergency. This was also a situation when it was impossible to keep track of the mother after this intervention and provide further support. In the short time the consultants had, it was most important to:

- try to destroy the myths that caused the mothers to reduce the frequency of breastfeeding;
- underline the importance of continuous, frequent breastfeeding;
- inform mothers of the risks related to infant formula and unclean feeding accessories;
- empower mothers in their role;
- correct any potential mistakes related to latching the baby to the breast.

"It was quite a big challenge to convey the message to mothers who had recently switched to infant formula because somebody had given them wrong information during their journey, or they had the wrong belief that, due to exhaustion and malnutrition, their milk was not good enough for their child. After having talked to many other people on their journey through different countries, they arrive in the fifth country and meet the fifth organisation in a row, and they are suddenly told that their milk IS good enough, and that they can put their trust in it. It was quite a challenge to explain to a woman that her milk is still the optimum food source and the healthiest choice for her child."
Renata, RODA

If the baby was not breastfed, the mother had not been nursing for a long time or she was not interested in relactation even after benefits of nursing were explained, she was referred to the healthcare professionals at MAGNA, where she was given safely prepared formula.

In the first few months, there were insufficient supplies of RUIF (*Ready to Use Infant Formula*) and feeding accessories that could be given to parents for the journey. Powdered infant formula was not distributed due to awareness that parents had no way of preparing this type of formula safely in the Reception Centre, and even less so during the journey. Besides, only one bottle per child was prepared, to ensure that the child was always given freshly prepared formula, in order to reduce the risk of bacterial growth in the stale formula. Occasional supplies of disposable bottles with teats and RUIF, which was the only food appropriate to take on a journey, were insufficient, so they were distributed solely to the mothers of newborn children and particularly vulnerable children.

Complementary feeding for children above six months of age

The IYCF-E guidelines do not recommend commercial "baby food" in glass jars and similar items, because they are expensive to procure and leave waste after use. This type of food is also not the first choice for complementary feeding, because the child should be gradually introduced to a healthy family diet and learn to feed itself. The IYCF-E guidelines recommend locally bought produce and freshly prepared meals, with consideration given to energy value.

But in a transit situation, when a large number of people are passing through extremely quickly, it is impossible to *prepare* meals for people or to distribute local produce for migrants to prepare on their own. Both adults and children were mostly given canned food and commercially packaged food. They were also given fruit because it does not need any preparation. Water was distributed in plastic bottles. Children were given commercial baby food in glass jars with disposable spoons, and packaged biscuits. All these items were safe, packaged foods, appropriate to take on a journey. Even when the people stayed for several

hours, there were no resources available for the preparation of hot meals for such a large number of people arriving at any given time, nor could meals be scheduled because it was unknown when the people would leave. They had to be given something they could take with them, as soon as their transport arrived. Considerations regarding baby food were the following:

1. Fruit and vegetable purées that were distributed **did not have high energy or nutritive value.**
2. Many children did not want to eat baby food or other canned foods, because they had flavours they were not used to.
3. Sometimes parents did not want to give their children baby food with information in a foreign language, without the Halal certificate.

> *"Older children were given the same food as adults – sardines and toast. The MAGNA organisation distributed biscuits and baby food that children often rejected, because in the Arab tradition children do not eat that, since their mothers boil and mash vegetables, and make homemade purée. They were sceptical towards this type of baby food, presumably because they did not know what the ingredients were. One of the mothers told us her child runs away whenever it sees a can of fish."*
> *Diana, RODA*

3.4. Winter Reception and Transit Centre in Slavonski Brod – development of support for IYCF-E in cases of accommodation in different sectors

The Reception and Transit Centre in Slavonski Brod came into operation in November 2015. It was divided into six sectors, and had a larger capacity than the Centre in Opatovac. Despite its large accommodation capacity, people were passing through the Centre quickly because they were being transported by train, so their stay was short (on average three hours).

Migrants were strictly forbidden to cross from one sector to another, and the police did not authorise separating families with young children and accommodating them in the sector where the MBC was located. A group of people who came with one train, usually left together, too. In this way, the chance of the family being separated was minimised, and in this regard the organisation was better than in Opatovac. Before the Centre was open, UNICEF was asked to establish a Mother and Baby Centre (MBC) in every sector, but there were no resources for that. IYCF-E in Slavonski Brod was actively supported by the "*Save the Children"* international organisation. UNICEF and *Save the Children* worked together to establish three Mother and Baby Centres, UNICEF in the first and the third sector, and *Save the Children* in the fourth sector. Each of the two organisations had one IYCF-E team, which

was moving from one sector to another, depending on which sector was full. MAGNA had only one medical team which also moved from sector to sector.

From November to December 2015, the Centre operated following the principle of accommodating the people from one train in one sector. Meanwhile, the associates and the interpreters stood at the entrance or passed by the tents, identifying mothers with infants and young children, and, after a brief assessment, invited them to the MBC if necessary. Support for infant and young child feeding was offered at the MBC, similar to the way in Opatovac. Sometimes, two sectors were full at the same time, so the team would split. UNICEF and *Save the Children* often provided mutual support, depending on whose sector was full or empty.

> *"In every refugee accommodation sector, there were four containers side by side: UNICEF, MAGNA, the Croatian Red Cross, and the Ministry of Health. We were always there when refugees were accommodated in the sector, because this way we were closer to them, and they were not allowed to leave their sector. During my 4-day stint at the Reception Centre, I never saw anyone in the container of the Ministry of Health (it was always locked, with the lights turned off), although there were a lot of ill people, children particularly. I saw the health professionals from MAGNA, physicians from Slovakia and other countries, with bloodshot eyes due to the extended work hours, so I was embarrassed because I did not see a single physician of ours within the sector. I was wondering where they were. Congratulations to the staff from MAGNA – we could not have done it without them."*
> *Irena, IBCLC*

As these were the cold months, and the children were cold, wet and dirty upon arrival, the associates at the MBC instinctively reacted in a humane way, and put the emphasis on finding clean, dry, warm clothes and shoes for the children, to prevent them from falling ill due to the cold. The Red Cross, located in a separate container within the sector, was distributing clothes for older children. At the MBC, there were always donations of clothes for children up to two years of age. Younger children were changed into clean clothes after they were bathed and after their diapers were changed, and bigger children were changed by their mothers (or the mothers would just take the clothes for them). The large storage building of the Red Cross where all the donations of clothes and shoes went was quite a distance from all the sectors, as was the storage place used by UNICEF. This was causing a significant loss of time for the MBC staff, who were wasting their time in finding and fetching clothes, because there were a lot of migrants arriving in need of clothes, especially infants and young children. It was clear that it was necessary to separate the finding and choosing of clothes and changing the children (this time could have been used to make a better assessment of the child's condition) from the activities related to IYCF-E. It was also quite clear that additional trained lactation consultants were needed.

Due to the organisation of work where human resources for IYCF-E were wasted on moving from one sector to another, and on other activities, soon after the Centre in Slavonski Brod came into operation, UNICEF and RODA initiated a project for strengthening the capacities and improving support for IYCF-E. In December 2015, ten new assistants were hired through the Public Works Programme of the Croatian Employment Service. They worked in two daytime shifts. They were involved in activities necessary for assisting mothers and young children, apart from IYCF-E support. Six women with prior knowledge of child feeding and psychological assistance also worked at the Centre, after completing several training courses in December 2015. These consultants were working in 24-hour shifts, seven days a week, while at weekends they were assisted by volunteers from RODA and by the IBCLC consultants.

Children who, following the assessment made by the IYCF-E consultants, needed infant formula were referred to the MAGNA container. *Save the Children* had their own trained consultants, both for lactation counselling and for the distribution of infant formula.

> *"When the trains arrived, it was necessary to perform triage first. Just like the system of emergency medical services – the most vulnerable patients were the priority. During the winter months, I often saw children with diarrhoea, a cold and high temperature, and I would immediately refer them to MAGNA. They would come to our container afterwards (for a change of clothes, breastfeeding, etc.)."*
> *Diana, RODA*

Training courses

Training courses were conducted by experts in breastfeeding and IYCF-E from Croatia and other countries. The training course programmes are listed in Annex H.

A. UNICEF's initial training programme.
B. Training course for lactation consultants providing assistance to mothers at the Reception and Transit Centre in Slavonski Brod, Part 1, 11 - 13 December 2016, Slavonski Brod.
C. Training course for lactation consultants providing assistance to mothers at the Reception and Transit Centre in Slavonski Brod, Part 2, 19 December 2016, Slavonski Brod.

Lactation consultants working on the project led by UNICEF and RODA and the new project coordinator were also present. The largest part of the training course was related to IYCF-E and breastfeeding support, and the other topics included the specifics of working with the refugee population, the organisers' expectations, and the Code of Ethics (Annex I). A training workshop on using baby slings was also organised.

3.5. Winter Reception and Transit Centre in Slavonski Brod – development of support for IYCF-E in cases of fast transit

> *"People were passing through the Centre very fast, and, compared to the initial stay of 48 hours, their stay at the camp became as short as 30 to 60 minutes. Children's essential needs, including care provided by a physician, i.e. medical care, sometimes could not be met. The objective was to get all those people on a bus or a train as quickly as possible, so that they could leave Croatia with the shortest delay. I saw tired mothers carrying a little baby in their arms, with older children walking beside them, and the mom was so weary and exhausted that she could not respond to the emotional and other needs of her children."*
> *Martina, UNICEF*

In December 2016, the organisation of work at the Reception and Transit Centre in Slavonski Brod changed completely. People arriving at the Centre were not accommodated in the tents at all, but instead, after registration, they were directed to the large distribution tent where the basic necessities were distributed, a quick assessment of their condition was made, and they were referred to a physician or to IYCF-E support if necessary. Soon after this, they were taken back to the train to resume their journey. In this way, the migrants' main goal to arrive at their destination as soon as they could was closer to being fulfilled, and consequently there was less uncertainty and concern among the migrants.

The majority of mothers and children were extremely exhausted and hungry, and this method of fast transit gave barely enough time to provide medical assistance and IYCF-E support to those in need. Around the same time, the share of women and children in the total number of refugees changed, and, compared to adult males, there were more women and children than in the early days of the refugee and migrant crisis. In comparison with the initial 18% in September 2015, the share of women and children in the total migrant population increased to 55% in January 2016.

The organisation of IYCF-E support was much more advanced under these circumstances. The benefits of the improved organisation were that IYCF-E support was located in **one** place, and that was **in close proximity to the registration area**, where all migrants were passing through.

A quick assessment to determine if IYCF-E support was needed and the distribution of clothes for older children was conducted in the large distribution tent immediately after registration. In the same tent, food, water and other necessities for children and adults were also distributed. The MBC was located right next to the distribution tent, which enabled the IYCF-E staff and the interpreters to be more efficient in identifying families in need of support, and bringing them to the MBC. The MBC was situated in a heated "Alaska" tent

obtained from the CARE organisation. The tent was spacious enough, and it was divided by room dividers into four zones:

1. the medical assistance zone, belonging to the MAGNA organisation;
2. the nursing and breastfeeding support zone;
3. a zone for children's hygiene and changing, and support for expectant mothers;
4. "the waiting area" next to the entrance, for the short-term accommodation of the rest of the family and other mothers waiting their turn to receive assistance.

The average stay at the MBC was less than 30 minutes. Pregnant women, mothers and children could sit and rest in all of the zones, even if it was just for a short while. The nursing area was quiet and private, located at the back of the tent.

The IYCF-E staff consisted of:

- the coordinator and her assistant, both of whom had completed the training course in IYCF-E support and basic breastfeeding support;
- six trained lactation consultants, along with volunteers, experts in breastfeeding, who were complementing the weekend shifts, and monitoring the lactation consultants' work;
- four consultants from *Save the Children*;
- five assistants who managed clothes and hygiene;
- ten assistants hired through the Public Works Programme, four of whom assisted at the MBC, and four at the distribution tent;
- volunteer-lactation consultants, who would visit occasionally (usually at the weekend).

The infant and young child feeding associates provided support 24 hours a day, organising their work in two 12-hour shifts. One lactation consultant and two assistants did the day shift, and two lactation consultants did the night shift. *Save the Children* always had one lactation consultant responsible for distributing infant formula during her shift.

Clothes for children up to two years of age were still distributed at the MBC, which was justified because children were being changed there, and a detailed assessment of their condition was also made at this spot. It became easier for the lactation consultants once they had their assistants to help them find, choose and bring clothes.

Some of the assistants worked at the distribution tent whenever the trains arrived. The interpreters were also there, welcoming the new group of migrants, and, together with the assistants, they made a quick assessment and selected families that needed to be referred to the MBC.

At the distribution tent, pregnant women and mothers were given packets containing female hygiene products. In both tents, mothers were also given baby hygiene packets, along with a leaflet containing information on the importance of nursing and appropriate complementary feeding written in Farsi or Arabic.
The leaflets can be found at the following website: www.roda.hr/udruga/programi/dojenje-i-zastita-dojenja/dojenje-u-kriznim-situacijama.html.

Figure 9. The distribution tent, Slavonski Brod, December 2016.

Figure 10. The Mother and Baby Centre, Slavonski Brod, December 2016.

Figure 11. The Mother and Baby Centre, Slavonski Brod, December 2016.

In December 2015, MAGNA and *Save the Children* managed to supply the MBC with **sufficient amounts of RUIF**, both for use at the MBC, and for distribution in a sufficient amount for **one day of travelling**. A sufficient number of **cups** and a certain number of replacement bottles with teats were also available for distribution. Because of the fast transit of migrants, MAGNA stopped preparing powdered milk formula. They also stopped sterilising the bottles that were brought to them, because there were so many children in fast transit and not enough time for such things. Instead, they **swapped the old bottle for a new one,** if necessary. The consultants from *Save the Children* were responsible for infant formula distribution, and for showing mothers how to cup-feed their baby. Healthcare professionals from MAGNA were also distributing infant formula.

The RUIF that was given to mothers and children for the journey was kept away from the nursing area, and it was not visible to mothers. From December 2015 onwards, all infant formula packages with brand logotypes were **relabelled** with instructions for use written in Farsi and Arabic. Packages were also **rebranded** by removing the brand names. In this way, the promotion of formula producers that could influence the mothers of children using infant formula was avoided, and the International Code was not violated.

RUIF was distributed as part of a RUIF kit containing cups with lids, soap, a bib for the baby, a leaflet with instructions on cup-feeding, and a leaflet with basic information for the mother.

Almost until the Reception Centre was closed, there were many instances of staff from the Croatian Red Cross and other organisations **distributing hot water**, despite the warnings of organisations involved in IYCF-E on the harmful effects of this. Parents were using hot water to prepare infant formula, but they were unable to clean the bottles first. Organisations involved in IYCF-E were continuously promoting the idea of referring all families with children who ask for hot water to the MBC, so they could have their child's condition properly assessed, and receive breastfeeding support or safely prepared infant formula.

In February 2016, two **training courses on IYCF-E** were organised for all interested volunteers and staff from other organisations working at the Reception and Transit Centre. Apart from these courses, staff from other organisations were trained and informed daily about the issues and protocols of infant and young child feeding through the entire period they worked at the Reception and Transit Centres.

From November 2015, fortnightly **meetings of the IYCF-E coordination group** were regularly held, and coordinators and other staff from UNICEF, RODA, *Save the Children* and MAGNA were always present. Although the representatives of other organisations working at the Reception and Transit Centre were also always invited, they would rarely attend the meetings. These meetings were particularly useful, because the participants managed the division of labour between the IYCF-E organisations, and made action plans. In addition, common protocols and standards of conduct towards children and parents were harmonised in the meetings.

Complementary food for children over 6 months of age

In the first months at the Reception and Transit Centre in Slavonski Brod, distributed food packets contained tissues, a spoon, fruit purée for children over 6 months of age, and chicken purée and a breakfast biscuit for children over one year of age.

In December 2015, a nutritionist with international experience in child feeding in emergencies proposed the following options for complementary feeding of breastfed children:

Option A	Bottled water	0.5l
	LNS - Large Quantity[4] ("*Plumpy'Sup*") energy-dense, nutrient rich supplement – quantity for	1 sachet: 500 kcal 31 g fats

[4] LNS-*Large Quantity* (*Lipid-based Nutrient Supplement – Large Quantity*) is an energy-dense, nutrient rich, lipid-based supplement for children over 6 months of age. The supplement is used to treat moderate acute malnutrition. It comes in the form of a ready-to-use bar (no cooking or preparation required), and its energy value is from 500 kcal to 550 kcal.

	one day; distribute a quantity sufficient for several days	12.5 g carbohydrates
	Fruit (banana, apple, etc.)	50 - 80 Kcal
Option B	Bottled water	0.5l
	Baby food in a glass jar (fruit purée for a 6- to 9-month-old baby, or chicken and rice purée for a 9- to 12-month-old baby)	In 100 grams of chicken purée: 70 kcal 2.8 g fats 7.9 g carbohydrates 2.8 g proteins
	Fruit (banana, apple, etc.)	50 - 80 Kcal
Option C	Bottled water	0.5l
	High energy biscuits (HEB) fortified with vitamins and minerals – quantity for one day; distribute a quantity sufficient for several days	In 100 grams: 450 kcal 15 g fats 12 g proteins
	Fruit (banana, apple, etc.)	50 - 80 Kcal

As *Plumpy'Sup* had not been available for a long time (it is made in France), children received the packets described above until February 2016.

3.6. Winter Reception and Transit Centre in Slavonski Brod – protocols established for IYCF-E

Through the good mutual cooperation of all organisations involved in IYCF-E – UNICEF, RODA, *Save the Children* and MAGNA – improved protocols and procedures were set up. More staff, training courses, an improved division of labour and a better position of the MBC all ensured more efficient IYCF-E support. The basic procedures were still very similar to those in Opatovac.

Interpreters and everyone familiar with IYCF-E that could be present when new migrants were passing through the distribution tent after registration conducted a **quick assessment** to identify families that needed to be referred to the MBC. Those families included every family with young children (provided they were willing to visit the MBC), and special priority was given to:

- infants under one month of age;
- formula-fed infants (i.e. partially breastfed or non-breastfed infants);
- mothers having difficulties with breastfeeding;
- infants under six months of age consuming food or liquids other than breastmilk.

Types of support **the MBC** offered:

- a safe, private and quite nursing area;
- counselling and support related to nutrition;
- a place for expectant mothers to rest and recover;
- changing diapers, providing basic hygiene supplies (blankets, tissues, etc.);
- clothes for children up to two years of age;
- distribution of RUIF for children under 12 months of age who were non-breastfed or partially breastfed;
- promotion of cup-feeding as the safest option (MAGNA was the only organisation distributing baby bottles).

The following **documents** were made to improve the MBC and its activities (listed in Annexes C-F):

- An improved IYCF-E protocol in the form of a diagram (poster);
- The "Recommendations for infant and young child feeding in emergencies" handbook, containing a short introduction to IYCF-E, a protocol in the form of a diagram, and a form for reporting International Code violations. It was intended for all organisations working at the Reception and Transit Centre, especially for the Croatian Red Cross which receives donations of breastmilk substitutes (leaflet);
- Protocol for the prevention of and protection against infectious diseases (leaflet/poster);
- A poster of the MBC sign, and the logos of all organisations working at the MBC. Its purpose is to inform parents and direct them to the MBC.

The following **leaflets** were made for mothers (available at www.roda.hr/udruga/programi/dojenje-i-zastita-dojenja/dojenje-u-kriznim-situacijama.html):

- leaflet on the care and nutrition of a newborn child;
- leaflet for mothers of children over 6 months of age, containing instructions on healthy complementary feeding;
- leaflet on the use of RUIF, with instructions on cup-feeding;
- adhesive labels for relabelling infant formula packages, containing instructions for use in the mother tongue.

3.7. Difficulties and challenges

"The greatest challenge for me in the chaos of fast transit was to find the right time and the right method to talk to a mother about breastfeeding while her mind was probably preoccupied with other, existential issues, different fears, exhaustion, hunger, or family members rushing her, etc. I had to find a way for her to hear me out and see me as a person who wants to help her, a person worth listening to (and not just to hear the words and then leave)."
Sandra, UNICEF

The "mother and child as a priority" intervention was not adopted

One of the basic IYCF-E interventions, the **"mother and child as a priority"**, was not adopted at the reception and transit centres. It resulted in a smaller number of mothers and children who received support. It would have been much easier to organise support for IYCF-E if we could have isolated the families with young children right at the entrance to the Reception and Transit Centre, and if we could have accommodated them near the MBC, or at least in the sector where the MBC was located. It would also have been easier if all the activities related to IYCF-E took place in a single location. But, the organisation of labour and accommodation divided into sectors had the purpose of preventing family separation. This is why most migrants who came by the same train or in a convoy of buses were accommodated together in the same sector, and they also left their sector together. Sometimes, keeping the extended family together had priority over the condition of a child belonging to that family, even when the child's condition was serious and required extended medical assistance. In the period of fast transit, when people were not accommodated in the sectors, the speed of transit was more important than the needs of mothers and children who were hungry, cold or ill, so their needs were barely met in this limited time. Many children did not receive any support at all.

"I think that the whole system of migrant reception was mostly intended for healthy adults and their needs. Everybody else was in the category of vulnerable persons who did not fit into this system. The speed of everything, the lack of information, the lack of interpreters, all of this did not serve adults with special needs, the elderly and ill, pregnant women, mothers with young children, families with several children, etc. It was difficult to meet their needs and give them substantial support, because the system worked in favour of adult men in transit on their own."
Branka, RODA

Lack of cooperation between organisations

Cooperation among organisations involved in the support of infant and young child feeding, and the nutrition of pregnant women and mothers, happened spontaneously because these organisations were familiar with all the problems, and providing support for these groups of people was their priority. Meanwhile, organisations providing other types of support needed to actively commit to cooperation, and to invest great effort into keeping informed. The lack of understanding of the importance of IYCF-E and its protocols by other staff, even some physicians at the Reception and Transit Centre, often caused missed opportunities to provide support, or wrong procedures that harmed the health of the child. With the limited IYCF-E staff, it was challenging to constantly fight the myths and ignorance related to breastfeeding and child feeding held by other organisations that did not even notice there were issues in this particular area.

> *"I saw volunteers from other organisations literally running with bottles of hot water, because some mother asked for hot water to prepare infant formula. They would just pour hot water in a filthy bottle, or they would pour formula from one open box to another. Formula was distributed to children above one or two years of age who really do not need formula, especially not in such poor conditions. These were not the conditions in which you can prepare formula, because we had no access to water or anything."*
> *Martina, UNICEF*

> *"Breastfeeding support was not adequately accepted at the camp. For instance, the Croatian Red Cross was distributing baby food, hot water and milk, without consulting anyone. I believe they did that out of ignorance, with the best intentions. It simply did not occur to them to ask if the baby was breastfed or not. I propose that, in future, the representatives of all organisations meet and agree on a plan and programme of work at the camp. Each organisation should do their job, but they should also know what the other organisations are in charge of. There should be general conditions and protocols that we all adhere to. In this way, we could probably avoid the unnecessary distribution of infant formula."*
> *Diana, RODA*

"Prejudice on the one hand, and outdated, unfounded views on breastfeeding on the other, were also a challenge. It was very difficult to fight them, especially when you have only 15 minutes available. Irrespective of the refugee crisis, when a woman with a 10-day-old child, when relactation can still easily be established, says that she cannot breastfeed, if your first reaction is not to refer this women to a community nurse, a lactation consultant, etc., but if your first response is: 'give this child a bottle', then things need to change. Although we are in the 21st century, and we can check information in one click, we are still misguided by 30-year-old fallacies."
Suzana, RODA

"Cooperation improved with time. The most characteristic feature of this cooperation was a lot of communication and explanations. Why this mother needs to be taken to the MBC, why we simply cannot give her hot water, etc. The more people were engaged in providing support to parents and children, the less explanation was needed. Still, some of the more 'distant' organisations, such as the Red Cross, needed more explanation. Even when you have established some sort of protocol, it is not enough to publish it, you will always have to explain it over and over again to everyone who is still not sufficiently familiar with it."
Renata, RODA

Inconsistent support along the migration route

During the journey, many mothers switched to infant formula or reduced the frequency of breastfeeding because somebody had misinformed them, or there was no efficient IYCF-E support in other countries. It was a great challenge to explain to these mothers in such a short time that the mother's milk is still the optimum food source for the child, and that she can put her trust in it.

"I believe it would be good to create some sort of plan for breastfeeding support and protection along the entire refugee route. This would ensure that women receive information on the importance and benefits of nursing little by little, so they have time to think about it, and develop a positive attitude towards it. The percentage of women deciding to breastfeed their children would probably increase. If a mother was given supplies of infant formula in Turkey or Greece, and she used them to feed the child, it is extremely unlikely that we, in those fifteen minutes that we have, can convince the mother to reject infant formula and switch to breastfeeding."
Diana, RODA

Furthermore, even when a mother was willing to resume nursing, it was impossible to expect that the next organisation she encounters in another country will deliver the same message and provide further support for relactation.

There was no system of monitoring families with very young infants, ill children or expectant mothers. Children just a few days old were coming to the Reception Centre, and because mothers and children were not a priority, they could have easily gone unnoticed. Any method of monitoring individual difficult cases, and the possibility of the further transfer of information, would have reduced the many concerns of lactation consultants at Croatian Reception and Transit Centres.

> *"An expectant mother with a baby entered the container. While the volunteers were bathing and changing her child, she sat on the folding bed. We saw she was in poor condition. We called for a physician, a paediatrician, who examined her and noticed that her stomach was strangely yellow in colour. With the help of an interpreter, we tried to find out what was wrong. She told us that the physician in Serbia gave her medicine, but she did not know which type. She also did not know what the physicians in Serbia told her was the issue, or what it is that she needs. It would have been helpful if we had information on her condition from the country she had arrived from."*
> *Renata, RODA*

Short length of stay

The specific features of this emergency were the short duration of stay of mothers and children at the reception centres, and the inability to provide quality support due to the lack of time. The IYCF-E guidelines had to be modified on the spot, because some of the instructions and procedures based on other emergencies were difficult to implement. Counselling on nursing and child feeding usually requires at least half an hour, and sometimes even one hour. Follow-ups are often necessary for mothers to acquire new skills, change their attitude, or become more confident in themselves when nursing. In this situation, we had no time or opportunity to achieve that.

> *"It is so easy to quickly give up on nursing, to simply say it is not working, and not even stop to think about it for a moment. Particularly if you lack information, and you are not aware of how important nursing is, it is difficult to stop and say: 'oh well, let us stay for 15 more minutes, nothing bad will happen, there is no rush'. The pressure was tremendous, everything was happening very fast, and this was not good for anyone."*
> *Branka, RODA*

"IYCF-E finally started to work well, but we still did not have enough time, and other issues always seemed more important. I noticed that, whenever several women and children came to the container, we, the consultants, did not ask straightaway whether or not they were breastfeeding. First, we helped the woman to put down her things and the baby, then we helped her to change the child's diaper and clothes, and while doing that, if we had the opportunity, we would ask about breastfeeding. It was amazing to see that breastfed children were strong and healthy, and looking good, just like in the ads. It was hard to look at any non-breastfed baby, because you did not know how it would end up, what was going to happen to it, was it going to get sick, would it endure the journey, was there going to be any food for it, etc."
Branka, RODA

Language and cultural differences

Communication with mothers was severely impeded due to the lack of interpreters. Some mothers, or their family members, understood English, but most of them needed a Farsi or Arabic interpreter. Even with the interpreter present, communication was sometimes difficult because the mothers were shy to talk about breastfeeding and pregnancy with male interpreters. There were fewer female interpreters because we could not find more female interpreters for the languages we needed. Sometimes, the mother and her family members were illiterate, so we could not count on them understanding the instructions written on the leaflets or the labels we gave them.

"It seems to me that the biggest challenge was to reach out to a mother and child in need of assistance. You had to identify those who needed assistance first. When I saw a breastfeeding or partially breastfeeding mother, and I tried to offer my support, I could not find an interpreter. It would often happen that the interpreter came for a short while, but, very soon, someone would call for them, or they had to go somewhere else, because somewhere else was a priority. So, the biggest issue was communication."
Branka, RODA

"A lot of information gets lost in translation. When the male interpreters were interpreting, there was an additional loss of quality of counselling due to cultural differences – the women were uncomfortable talking about breastfeeding. I believe that we should have at least two female interpreters who would stay with us at the MBC the whole time. As time passed, we were increasingly mastering the skill of non-verbal communication, but we also learned a word or two of Arabic, so we managed to communicate with mothers."
Diana, RODA

"I came to the container where a mom was resting with the females of the extended family. She was nursing a baby that was constantly interrupting feeding and crying. I heard it making clicking sounds while feeding, so I presumed it was thrush (yeast infection). I came there without an interpreter, but somehow, using gesticulation, I managed to find out that the mom's nipples had been sore for quite a while, and the baby's tongue was completely covered in yeast. Although both mother and her sisters were waving their hands dismissively, indicating it was a normal thing, I took her to the nurse that was on duty then. We also called for an interpreter. While the nurse was preparing a small jar of gel for the mother and her baby, the interpreter was writing down the instructions for the mother on a piece of paper. I noticed the mother was not paying attention to the instructions, and her behaviour was very strange. I told the interpreter to carefully ask if she could read. Neither she nor her sisters were literate. Then we took our time to slowly explain how and for how long to apply the gel, until we were sure she would be able to follow the instructions."
Ivana, RODA

Summary of the challenges

In April 2016, RODA's Annual Milk Conference gathered all the parties included in the IYCF-E response in this migrant and refugee crisis. The participants listed all the challenges they encountered in their work:

Common for all emergencies	Specific for migrant and refugee crises
• Lack of information among pregnant women and mothers • Lack of information among healthcare professionals • No guidelines • Unrestricted donations of infant formula (manufacturers) • Unselective distribution of infant formula (organisations) • Receiving different information about the same topic during the journey • Lack of cooperation among other organisations in the field (lack of knowledge) • Fluctuation of assistants and volunteers • No handbooks for the organisations • Lack of clear instructions for volunteers • Choosing priorities at a given moment • Lack of support from different institutions • Lack of cooperation between the government and the NGOs (they should be partners) • Insufficient resources to procure RUIF • Constant changing of rules • Neglecting the role of fathers	• Language barriers • Short length of stay • Cultural barriers • Lack of cross-border coordination • Illiteracy among women • Lack of information among migrants, and fear caused by the lack information and control • Lack of understanding of the difficulties of migrants and their experiences • The primary objective of the family was to immediately resume their journey towards their final destination • Government did not declare a state of emergency (a question of law) • No clear reporting on the crisis to the general public and on future political moves (Croatia, and Europe in general)

3.8. What we consider a success

From the experience gained through this recent emergency, we must underline, and, if necessary, try to repeat in the next emergency, the following positive experiences:

- ☼ Cooperation among different organisations that worked in the MBCs (UNICEF, MAGNA, RODA, *Save the Children*, and others). The work divided between some organisations sometimes overlapped, and sometimes some organisations were complementing each other, but, with time, their roles were better defined.
- ☼ Successful adoption of protocols and regulations of IYCF-E, and organisations followed them at the Reception and Transit Centre.

- Separate areas for nursing and formula feeding. From Opatovac, through different sectors at Slavonski Brod, and to the unified MBC at the end of the crisis, nursing mothers always had their own area free of breastmilk substitutes. A person from the IYCF-E staff decided on whether breastmilk substitutes were necessary or not, and in another area, sometimes from another member of staff, non-breastfeeding mothers could receive safely prepared infant formula.
- Interpreters. Since most of them were of the same ethnicity as the people in transit, they had a great deal of understanding for them. The immense efforts and active engagement of the interpreters, their experience and knowledge of the support that expanded with every day spent at the reception centres were acknowledged by everyone who worked with them. They often served as IYCF-E staff, assessing the children's condition and referring them to other support services.
- Continuous, around the clock support, which was crucial for the situation of transit where migrants were coming or leaving at any time of the day. This continuity was maintained from the establishment of the MBC at Opatovac, until the Centre at Slavonski Brod was closed.
- Efficient triage and assistance conducted in the last months of the Centre in Slavonski Brod. All support services were located in the same place, a place where all migrants were passing through immediately after registering. One tent was shared by all medical assistance organisations and all IYCF-E supporting organisations. Work was divided between the IYCF-E staff and their assistants, and some of the staff were redirected to the distribution tent, which moved the activity of finding and distributing clothes for children away from the MBC, i.e. from the lactation consultants. The staff hierarchy and their activities were well organised. This type of triage and division of labour are recommended for any other situation of migrants in transit through a reception and refugee centre.
- Training courses on breastfeeding, IYCF-E and acknowledging cultural difference were held for all engaged lactation consultants and other participants.
- Child feeding experts were volunteering at the MBC. From the time the MBC in Opatovac came into operation, at least a few lactation consultants would join the team at the weekends. Apart from directly supporting the mothers, they also had an important role in training the other MBC staff through practice, identifying issues in the process of providing support, making suggestions, cooperating with UNICEF to create a protocol, helping to organise the work at the MBC, and training and monitoring the lactation consultants that were employed.

3.9. Missed opportunities

Quality support for expectant mothers. Shortly before the Reception and Transit Centre at Slavonski Brod closed, we prepared a leaflet for expectant mothers with key messages on their nutrition and basic instructions for breastfeeding after delivery and in the first six months of a child's life. The idea of this leaflet was to prepare the expectant mother for good breastfeeding practice, and to make feeding easier for her and the baby in their country of destination. The leaflet was in English, and there was no time to translate it into Farsi and Arabic before the Reception and Transit Centre was closed. We also prepared additional food packets for expectant mothers, because their nutritional needs increase during pregnancy, but we did not find the appropriate food items for the packets before the Reception and Transit Centre closed.

Wet nurses, i.e. women nursing another woman's child if its mother does not nurse, are recommended in the international guidelines as the first choice for feeding after the mother's milk. But in a situation of fast transit, this is hardly possible because the child's and the wet nurse's family should travel together, and it is difficult to keep even one family together. This could be a possibility if both the child and the wet nurse belong to the same extended family travelling together. There was one instance of wet-nursing in Opatovac, when the child had no mother, and it was a very small preterm baby whose condition was poor on arrival. The family stayed at the Reception and Transit Centre for several days, while the child was breastfed by a woman who was providing support to migrants at the Centre. There were no other wet nurses.

3.10. Working with refugees in the Reception Centre for Asylum Seekers

Reception centres are establishments where asylum seekers are accommodated until they receive a positive or negative decision on their asylum application. Their stay in our country is legal. By applying for asylum in Croatia, their status is legalised, and they are granted the right to stay on the territory of the Republic of Croatia. Their movement outside the Reception Centre is not limited, but, although it is an open-type institution, they have to return before 11 p.m., or announce their planned time of arrival in advance.

RODA has been active at both Reception Centres in Croatia, **in Kutina and in Zagreb (Porin Hotel)**.

While RODA was working in Kutina, there were mostly families there, 18 to 19 of them, accommodated in around twenty rooms with six beds per room, i.e. approximately a hundred people. During the time working at the Reception Centre (Porin Hotel) in Zagreb, approximately 450 to 500 persons were accommodated there, and about half of them were families (around 40 families).

The rooms had multiple beds, and in Zagreb they also had a bathroom (with a shower and a toilet), and in Kutina there was a common bathroom on the top floor. At both reception centres, UNICEF has organised an area for working with children, where the children and their mothers spend a part of their day in each other's company, socialising there, in the rooms, in the hallways, or outside the Reception Centre. Communal washing machines are available. In Kutina, there is a fully equipped kitchenette, while there is no such thing in Zagreb. The beneficiaries at the Centre have the right to three meals a day, and the meals are in accordance with the religious dietary guidelines (free from pork and its derivatives, fasting during Ramadan), but they are not in accordance with the specific nutritional requirements of a child, so children just starting on complementary feeding are given spicy food and the same meals as the adults. Although the parents are aware that this is inadequate nutrition, they do not have the financial resources to buy food and cook meals for their children. The monthly financial aid per family member is HRK 100.

Although persons seeking international protection have the right to healthcare, the latest amendments to the Aliens Act prescribe that **healthcare includes only emergency medical assistance and necessary treatment.** At the reception centres, there are physicians who are team members of international organisations (e.g. *Médecins du Monde*), and occasionally there are physicians on duty from the local health centres. The Aliens Act does not prescribe the right to an antenatal check-up for healthy expectant mothers, or regular paediatric and dental examinations. While no agreement was made on gynaecological examinations of women with healthcare providers in Zagreb and Sisak, individual private gynaecologists were examining expectant mothers and women with gynaecological problems free of charge, which depended on their good will and free time. Assistance from community nurses was provided for. Many organisations provide child care at the reception centres. Their activities include providing humanitarian aid, teaching Croatian, preparing children for school, organising learning and free-time activities, providing healthcare, and supporting mothers and children. These organisations include the Croatian Red Cross, the Jesuit Refugee Service (JRS), *Save the Children*, *Médecins du Monde (MDM)*, the Centre for Peace Studies, *Are You Syrious*, the *International Organization for Migration (IOM)*, the Osijek Volunteer Centre, and others.

RODA – Parents in Action and the Society for Psychological Assistance were active at the reception centres as the implementing partners of the UNICEF Office in Croatia.

On 1 July 2016, RODA hired two lactation consultants for breastfeeding in emergencies to support the expectant mothers and the mothers of young children at the reception centres for asylum seekers in Zagreb and Kutina. They were working in turns with the consultants from *Save the Children*. The consultants also had Farsi and Arabic language interpreters on the team.

Their primary role was to provide support for expectant mothers and the mothers of young children up to two years of age. With the financial support of UNICEF, the Mother and Baby Centre was furnished, and it was a safe and pleasant area to talk to the pregnant women and mothers, while the children were provided with didactic aids.

Counselling was based on individual and group sessions with the women. The consultants worked at the reception centres every day, from Monday to Friday. For expectant mothers, childbirth and breastfeeding classes were organised, along with discussions on the previous experiences of childbirth (if there were any), introductions to common practices at Croatian maternity hospitals, and talks with the older children about the new baby's arrival. The midwives and the IBCLC lactation consultants participated as volunteers in the classes, both in Kutina and in Zagreb.

In the period after delivery, consultants provided support to the women in their rooms, assisting them with nursing difficulties, and counselling them on child care.

Approximately 93% of infants were breastfed successfully while RODA was present at the reception centres. Such a high nursing rate is the result of continuous support provided by the lactation consultants. Non-breastfed children were mostly children returned from other European countries (Austria, Germany), and the reason for giving up on nursing was the mother's new pregnancy (children over one year of age). Counselling on the nutrition of non-breastfed children was led by the Croatian Red Cross and *Save the Children*.

After the Mother and Baby Centre ceased to operate, RODA's consultants and the IBCLC consultants continued to volunteer where possible, and provided support for pregnant women and mothers as needed.

"A mother with her four-week-old daughter came to the Reception Centre. In spite of breastfeeding successfully, she started giving her watermelon juice. She said that she was worried about dehydration because the weather was very hot, and since she was not eating quality foods, she thought that her milk was not good enough.

She pointed at her "empty" breasts and asked if we could give her a bottle and infant formula. She was completely discouraged, and, in fact, she had already given up on nursing.

We were in daily contact for weeks, educating and encouraging her, and monitoring her and the baby girl. It took a lot of time for the mother to regain confidence, but she managed. Her daughter Iman is eight months old now, and she is still nursing."
Andrea, RODA

"Arab women were quieter and introverted, they were smiling broadly and nodding at me, but they also immediately said that they were very embarrassed to talk about female issues in "public", so they wanted to talk individually, just with me and the interpreter. Most of these women listed the issues that appeared to be a consequence of their difficult journey. Lower back pain, a burning sensation during urination, the symptoms of vaginal infection. I assumed that their fluid intake was low during the journey, and they were unable to maintain personal hygiene. Their health issues were a consequence of that.

There were two expectant mothers in this group of women. One of them was in the early stage of pregnancy, but I had noticed that she was pregnant right away, because I could recognise the roundness of her lower stomach very clearly. The second expectant mother was a very thin young woman wearing a jacket. I was surprised when she unbuttoned her jacket, revealed her small tummy, and told me that she was seven months pregnant! I felt and measured her tummy, measured her fundal height and abdominal girth (which was smaller than that of many women who are not pregnant), and a foetal Doppler showed that the baby's heart rate was normal. She said that her first child had a low birth weight.

She had the symptoms of lower urinary tract infection, but as a midwife, I was most worried about her severe malnourishment. In our country, we almost never see malnourished pregnant women whose pregnancy is not monitored. I asked her if she could possibly eat a little bit more now, and told her that she also needed to increase her fluid intake, because I thought she had a urinary tract infection. I also told her that her baby was in a head-down position and that its heart was developing normally, but it was tiny. I was concerned about the intrauterine growth restriction, and the way our health system would treat her in such a condition. I told RODA's consultant that she needed a physician to examine her, just like any other women with such symptoms.

This was actually the biggest issue I encountered – many women I spoke to had symptoms on account of which a midwife should refer them to a physician. But they rarely had access to a physician, apart from the right to emergency medical care, and they did not have the right to antenatal check-ups. For days, I was tormented by the thought of this malnourished, small pregnant women, her thin arms and legs, and her tiny baby in a belly that, at 32 weeks pregnant, looked as though she was only half way through her pregnancy, and the fact that she did not have the right to prenatal ultrasound and a physician, given that her condition was not an emergency. It was simply unfair.

Many of these women suffered terrible losses, not only of their home and family members, but also losses that happened during the journey. Miscarriages, preterm deliveries, and different health issues caused by the long journey, walking, carrying children, and insufficient nutrition. There was a woman who had a Caesarean section while in transit in Turkey, because her twins had died in the womb, and after being discharged from the hospital, she resumed her journey.

By providing warm accommodation and food, we met the basic needs of these people who were living in the middle of nowhere, waiting for a decision on their asylum application, and their days were all the same. They did not have a sense of belonging to anything or anyone, they were scared, traumatised, and were suffering from many health issues. Meanwhile, life was going on, babies were growing in the womb, women were joking and laughing, nursing and caressing their little ones. Children were playing, and they were joyful, because they are were not aware of their misfortune, since their mothers were all they needed to be happy.

I, a white Croatian stranger, was hugged, kissed and warmly greeted as a friend by these women. The murmur of Farsi and Arabic, laughter, liveliness, and, above all, the immense hope – this is the picture I have decided to keep in my memory. I am grateful that they have received that little bit of help I could provide with such great appreciation."

Iva, a midwife


2016
IBRI

4. Experiences and stories

"A mother with 1-month-old twins came in. She was all made up and dressed up and calm. She said she was nursing, and I politely asked her to nurse her baby girls in front of me so I could check if the babies were latched on correctly, although I could already see that they were successfully being breastfed, because their cheeks were chubby, and they looked healthy and happy.
The mother was breastfeeding them both at the same time, and she was unbelievably serene, considering all the chaos she had been through, and that she was still going through. She knew that nursing is more important than anything. These girls started their lives as refugees. I was quite shaken by the thought of it. Such young girls, born during the journey, without access to dignified living conditions. In these kinds of situations, I realised how happy I was, and that it is the little things that make life beautiful."

Suzana, RODA

"I remember a situation when the train arrived, the MBC was full, all the baby changing tables were occupied, and it was raining. One of the mothers took a blanket, spread it across the flood and sat on it with her children. The children were filthy and wet, and there were five of them. At a certain moment, she stood up and started urinating on the blanket. We offered to take her to a toilet, but she refused. It was all the same to her; she had had enough, and she even refused to take dry clothes for herself.

These were the kinds of situations when we needed psychologists. I think that this mother should have stayed for a couple of days and got some rest, because I am not sure that considering her condition she was able to take care of her children. I changed her children who had not eaten for more than 24 hours. In such a situation, I always had the feeling I was not very much help. Many mothers needed psychological assistance that we were not trained to provide. There were so many stories, such as when someone lost their bag with all their valuables and money in the sea, or the story of how someone's family members had drowned in the sea.

I think that, having gone through all of that, a person is in such a condition is not able to engage with us at all in terms of talking about breastfeeding. I was worried about what would happen to these people who did not receive our support. My greatest concern was whether or not a mother was feeding her child, and what was going to happen when they left the MBC."

Tena, RODA

"I remember one time when a mother came with her many children, and we accommodated them in the MBC container. All of them were barefooted and muddy. We rushed to find clothes for everyone. When we returned to the container, the mother was desperate. She had no motivation to change her children. Her youngest, the one-year-old child, lay there alone, motionless. I told her she must change her children, I was even harsh with her. Later I decided to examine the youngest child. I saw she had not changed it, so I decided to do it myself. This child was nearly dead, it had no reflexes. When I took its clothes off, it was the first time I had ever seen this bloated stomach, the same as we see on TV in stories of the children in Africa. I became very frightened. When I took its diaper off, it was full of white stool. The child also had a wound on its leg which was infected and was already starting to smell foul. The mother did not want to take the child to a physician, since all that mattered to her was to continue the journey.

Somehow, I managed to persuade her to let me take the child to a physician at MAGNA, while she waited with the other children. The physicians discovered that the child had not eaten for days, and they wanted the mother to come. We found out that the mother had accidentally spilled some boiling tea over the child's leg, and she had not cleaned or dressed the wound at all. The child's condition was extremely poor. The mother claimed that she had not received food for the child for four days. We fed the child two bottles in a row, and told the mother that they should stay at least until the next day. She begged us to let her continue the journey, because her husband was waiting for her in Germany. Somehow, she managed to get on a bus, and I ran after her and begged her to stay. She took my hands and kissed me. When the social services came, she was already gone. Who knows what happened with this child? There were many similar situations.

By telling this story, I do not want to say that this woman is a bad mother, but that she had probably gone through things we can barely imagine, such as travelling to Greece over the sea, and walking for several days with young children and all their belongings. People were in a state of shock."

Tena, RODA

"I was most impressed by a mother from Syria who had a baby born three days earlier in Macedonia. The second day after delivery, she was walking with the baby in her arms, and came to Opatovac with her husband in the evening. After a paediatric examination was done, I entered the container and told her I was a lactation consultant, and asked her if she wanted to talk to me. Luckily, the interpreter was already there, so I was able to talk to the mother. This was her first child, but she had had the opportunity to watch her sister breastfeed in Syria, so she did not seem insecure. I talked to the mother for almost an hour, because nobody else came to the container, and the family decided to stay until morning to get some rest.

The interpreter herself was also a mother with the experience of nursing, and she was glad to interpret this conversation. The father was also there the whole time, and he was listening carefully. I explained to the mother what she could expect from nursing in the first weeks and how to easily establish breastfeeding. I also showed her how to do breast compression if the baby was tired, and how to monitor the child's progress, etc. The mother was nursing and compressing breasts, and after the talk, we prepared everything the mother needed for personal hygiene.

Then we accommodated the family in an empty container so they could rest until the morning. In the morning, we showed them a baby sling and asked if they wanted to try carrying the baby in that. They were interested, so we helped them to put on the baby sling, and place the baby into it. They resumed their journey after that. This was one of the rare positive examples of breastfeeding support, but only because the interpreter and I were in the right place at the right time, and because the family was willing to stay and rest until the morning, otherwise there would have been no opportunity for the necessary counselling on breastfeeding."

Branka, RODA

"In the early days of the Centre in Opatovac, a nine-year-old child tried to commit suicide. He wanted to cut his veins with a can opener. You could see from his facial expression that he felt all alone. I reacted quickly and grabbed his hand. Some stories were even more serious. We found out later that this boy way travelling just with his uncle, because his father had been killed in Syria, and his mother had died giving birth. At that moment, this boy did not see any future or hope."

Antonija, "Our Children" Society

"I know there was one case of appendicitis. The physician told the family they should go to the hospital, that he could not help them, and that the child must go to the hospital immediately, because its life was in danger. The parents refused, and then somebody from MAGNA went to talk to the police, and they called the Social Services Centre. They assessed that the child's condition was so severe that, if the parents took this child on a train and continued their journey, the child could die. What happened next was that the social workers came, there was a big commotion and everyone was talking; they had to agree on whose responsibility this was, etc. If a physician's assessment was that the child could not continue the journey because its life was at risk, then the Social Services Centre could decide that the child must stay, and tell the parents they would take care of their child, while the parents could choose whether to continue the journey or stay with the child. At that moment, the Social Services Centre had these legal possibilities. But during this discussion and negotiations, the family had left unnoticed.

This was still the period when they travelled from Opatovac to Slovenia for five to six hours, and then walked some more, and then who knows how many hours of waiting there. We would never find out if the child survived. In this situation, the parents did not want to stay and wanted to leave as soon as they could. But we did have some situations when the families actually wanted to stay, but that was not allowed then, and they were sent to the train."

Martina, UNICEF

"While I was walking among the refugees who were waiting for registration, and looking for women with young children, I saw little Maja, a girl who had lost an arm as a victim of the war in Syria. She was travelling to Germany with her father, who was also a physically impaired person. She was hoping that her mom and two sisters who had stayed in Syria could join them once they got settled in Western Europe. She shared her last chocolate biscuit with me after I had helped her and her father (who was walking with crutches) carry their bags. I prayed to God that they succeeded with their plans.

I was surprised by how many young children there were, and how many entire families. Watching the news gives you the impression that the refugees are primarily young males, but the reality is completely different. It was not easy to watch little children carrying bags, but I found comfort in the notion that they had managed to flee from the war, and they were going towards a better life. The thought that only a couple of steps lay between my world of well-being and their world of exile was unbelievable to me."

Irena, IBCLC consultant

"One night, a lovely young mother came to our tent with her husband and their newborn son. She was visibly tired, dehydrated, pale and dispirited. We immediately offered her water, food, and a place to lie down. When I asked her if she was nursing, she gave me a sad smile and said that due to the bombing of the maternity hospital in Syria, there was no physician at her delivery to help her stop the bleeding, and much less someone to instruct her on breastfeeding. I was shocked, I did not know what to say, except to show empathy. We took care of the child while the mother was resting, supplied her with the necessities, and when we went to show her out of the tent, she turned around and kissed us, like a sister would do."

Irena, IBCLC consultant

"The most unbelievable thing was that we could recognise if the baby was breastfed or not as soon as we saw it. Every consultant confirmed this to me later. One day, a mom with two young children came to the tent. A chubby, rosy-cheeked girl, and a severely malnourished boy. She was nursing the girl, but not the boy. He had been hospitalised recently in Greece. All of us in the tent without previous experience with this degree of malnourishment were completely shocked. This is one of those scenes you thought you could see in Africa or Pakistan, but generally only on television. A physician examined the boy, asked the mother about his recent hospitalisation to the extent the mother was willing to talk about it, and gave them a large amount of Plumpy'Sup and baby purées. The mother had several older children, and they were all very impatient to get on the train. When driving to Zagreb, I cried while I was talking about this event to a friend, a consultant. Why did I not insist on keeping that child and the family at the camp? This child was not well at all and he should have been sent to a hospital in Slavonski Brod. Travelling onward was most certainly not in the best interest of this child.

While listening to the news the next morning, it became clear to me that this family boarded the last refugee train going through Croatia. That day, the borders closed."

Ivana, RODA

5. International cooperation

The refugee and migrant crisis during 2015 and 2016 in Croatia showed that support for the families could have been better if there was a more effective method of cooperation and transmission of information between organisations in different countries. The finest cooperation and information transfer occurred within the individual international organisations that have their offices in different countries, but this was not enough. Furthermore, the situation in every country was specific, e.g. in Greece, a country with over 40 entry points that migrants and refugees were using, there were many reception centres. In those reception centres, provision of support for IYCF-E was the responsibility of different organisations that had different practices in child feeding. At the same time, there was only one reception and transit centre in Croatia, and all the organisations providing support for IYCF-E at the Centre were operating at one location, aided by mutual coordination.

In every country, the organisations supporting IYCF-E were adjusting the international guidelines to their specific situations, and implementing them to a greater or lesser extent. Now it is necessary to convey the examples of good practice from one country to another, and to standardise the support system. If parents (caregivers) are given a bottle and powdered infant formula in one country, a cup and RUIF in another country, and something else in some other country, all in a time span too short for good explanations, they are confused and they cannot evaluate on their own what the best choice for them and their child is. A standardised support system is crucial because it can change parents' attitudes to child feeding, increase the confidence of mothers in relation to nursing, and have a strong effect on adopting good feeding practices.

Key participants

Non-governmental organisations involved with IYCF-E were usually in touch with their offices and partners in other countries, but their distribution varies a lot, and the coordination between different countries and the standardisation of support cannot rely only on NGOs. Apart from the umbrella organisation for support (most often the Red Cross), the Government should appoint another organisation to coordinate support for IYCF-E (usually UNICEF). The governments and relevant ministries of neighbouring countries can encourage each other to provide a better response to the issue of infant and young child feeding in emergencies. This would be of help when advocating support offered by NGOs.

The *3W* tool (*Who is doing What and Where*) was developed by *Save the Children* and UNICEF. It includes support services and their locations, and it represents a starting point for coordination.

Every organisation in the field should have a commission or a commissioner for IYCF-E, so that other organisations would know who to contact.

Standardisation of support for IYCF-E

From the experience in Croatia, we learned that parents (caregivers) do not know which organisations to ask about assistance with child feeding, or where at the Reception Centre they can get food for their children. Using the same sign for the MBC and the mother and baby support services along the entire route can help parents to recognise it as soon as they arrive at the reception centre, and to receive the necessary assistance sooner. Annex F contains an example of a poster with a sign for the MBC that was used at the Reception and Transit Centre in Slavonski Brod.

Standardisation of support for children and families

Together with UNHCR, the UNICEF Office in Croatia suggested an improved concept of the availability and quality of the minimum standard aid package for migrant and refugee families and children as part of a regional initiative. According to this concept, all assistance services providing support and help to parents and children would be unified in the *Family Support Hub*. They would have a unique and easily recognisable sign. This would ensure the standardisation and availability of support services. The Family Support Hubs would be situated as close to the families as possible (e.g. at the border crossings and registration points, or in strategic locations in urban areas), and they would also have a mobile support team.

Tracking individual cases

It would be extremely useful to find a way of following up on the individual cases of children and expectant mothers who have a serious health condition or need special support for feeding and nursing. Information from one country, such as diagnosis, medications that have been administered, or the recommended breastfeeding practice, is valuable to the healthcare personnel and IYCF-E staff in another country. Regarding migrants in transit through Croatia, this information was not conveyed in any way, which caused an unnecessary waste of human resources (and the loss of information itself). In relation to the tracking procedure, the confidentiality of personal information must be taken into consideration, so it would be best if people carried their information with them. The problem with information in digital form (e.g. on a USB stick) is that staff in the field do not have constant access to computers, or time to look through information. Information printed on paper (a booklet or a file) may be more practical.

We can see an example of this in Nurture Project International that operates in Greece. They use two different types of documents to keep track of medical history, one in paper form, and the other in digital form, with a data protection system.

Sharing information, materials and experiences

One of the missed opportunities in this crisis was that the organisations included in IYCF-E support were not using social networks as migrants and refugees did. For instance, platforms such as *Internews* (https://internews.org/) were accustomed to getting swift information on the current situation in different countries along the migrant route, changes in policies and routes, etc. Such platforms could be used for posting messages about the availability of support for IYCF-E in individual countries and reception centres. Useful information on infant and young child feeding could also be transmitted to these platforms.

Most of the materials used by the IYCF-E teams, such as the protocols and codes of conduct, guidelines on IYCF-E for partner organisations, forms for reporting International Code violations, instructions on nutrition and nursing for new mothers, etc., already exist on the websites of *Save the Children* or the *Emergency Nutrition Network (ENN,* www.ennonline.net/). They had to be adapted for this emergency, and in Croatia this was done by a team consisting of members of organisations supporting IYCF-E. The adapted materials would be useful in other countries, too.

The experiences that can serve as a basis to build better support for IYCF-E in the future can be found on the platform created by ENN: www.en-net.org/.

6. Recommendations for a crisis management plan

6.1. Guidelines for Government institutions

In every crisis that reduces the availability of safe food and water, children under five years of age are particularly at risk, and children under one year of age are the most vulnerable. Providing assistance in an emergency is unimaginable without strong emphasis on IYCF-E,[5] i.e. infant and young child feeding.

It is impossible to implement support for IYCF-E if only nutritionists are responsible for it. The only way of providing real support for infants and young children is through multi-sectoral responsibility and activities, with mutual collaboration. All relevant institutions and ministries must be included in the response, along with those responsible for the organisation and logistics of the reception centres, health organisations and organisations that have specific knowledge of infant and young child feeding, the media, donors, and the general public.

Although international guidelines for IYCF-E exist, and there are breastfeeding and young child feeding experts in Croatia, this is only a foundation on which to build. Every emergency is different. When it occurs, a demanding process of organisation begins with many new logistic issues and problems related to ensuring necessary resources (both human and material). Without rules of procedure prescribed by a responsible institution putting IYCF-E high on the list of priorities in the organisations involved in the response, all of these issues become much greater and solving them takes more time, while existing professional expertise hardly reaches infants and young children.

In 2015, a group of Croatian experts, in coordination with relevant government institutions, conducted an extensive assessment of the state of infant and young child feeding organised by the WBTI (*World Breastfeeding Trends Initiative*). In the 9th indicator referring to IYCF-E, Croatia scored 1 out of 10. It is evident that in 2015, we were not ready for any sort of emergency, either natural disasters such as the floods that happened in 2014, or the large-scale migration crisis that occurred only a few months after this assessment. In Croatia, there are no official documents protecting breastfeeding and child feeding in emergencies.

Due to their proactive nature, organisations supporting infant and young child feeding (UNICEF, RODA, CALC, *Save the Children*) responded to this emergency by acting in

[5] **IYCF-E** – abbreviation for "*Infant and Young Child Feeding in Emergences*"

accordance with international guidelines, and in six months of working with migrants, gathering experience and improving practices, they developed a system of support suitable for such situations. At the same time, they tirelessly encouraged all other participants by informing and educating them, and urged them to take action and to cooperate. Associated organisations in the field responsible for the work of reception centres were sluggish, and government institutions, without whom it is very difficult to ensure the necessary resources, were lethargic. The Ministry of Health did not ensure medical assistance for the most vulnerable persons – infants and young children. Paediatricians and nurses who were working at the MBCs were exclusively volunteers from abroad, mainly from Slovakia and Austria. RUIF for non-breastfed children, which is the only type of formula that does not endanger health in a situation such as a migrant and refugee crisis, was not ensured by the Ministry of Health before the end of crisis in 2016.

Emergency protocols and procedures cannot be developed when a emergency occurs. At the beginning of an emergency, we need to take action immediately, because every child needs care and safe food when it finds itself in such an unfortunate situation. This is why we need to make emergency protocols and allocate resources now, before the next emergency occurs. Initial supplies also need to be ensured.

We can, and must, be much better prepared for the next emergency. We have the experience and knowledge for that now, but the country has to develop and adopt an emergency management plan and guidelines for action.

In the international guidelines for taking action in an emergency, the **Operational Guidance on Infant and Young Child Feeding in Emergencies** (see Annex A), it is stated that:

> ***relevant Government institutions*** *(the Ministry of the Interior, the Ministry of Health) and* ***every organisation*** *in contact with* ***pregnant women, mothers and children in emergencies*** *need to develop and adopt guidelines and protocols for*
>
> - ***infant and young child feeding in emergencies*** *(IYCF-E), with an emphasis on the protection, support and promotion of* ***breastfeeding,*** *and the adequate and timely introduction of complementary feeding; and*
> - ***the procurement, distribution and use of breastmilk substitutes****, dairy products, commercial baby foods, and bottles, teats and other feeding accessories.*
>
> *The protocols should be in accordance with the International Code of Marketing of Breastmilk Substitutes and the relevant resolutions of the WHO.*
>
> *These protocols should be* ***included in the crisis management plan*** *at the state level. It is also important to* ***harmonise*** *the protocols among government institutions and various organisations.*

Based on the international guidelines and the lessons learned during the crisis in 2015 and 2016, it is recommended to develop **Croatian guidelines on infant and young child feeding in emergencies**, which should include the following:

- Clear instructions for all organisations included in emergency response (not only for those supporting infant and young child feeding) stating that infant and young child feeding is a priority. For this purpose, it is crucial to ensure that procedures prioritising mothers (caregivers) and children exist. It is necessary to encourage all participants to cooperate with organisations supporting IYCF-E.
- Sufficient supplies of RUIF (Ready-to-Use Infant Formula) for non-breastfed children, and feeding accessories in accordance with the International Code and the Operational Guidance on IYCF-E. At the onset of a crisis, formula packaging needs to be relabelled with instructions for use written in a language understandable to the population in crisis. During the crisis, sufficient amounts of breastmilk substitutes need to be procured in coordination with the organisations supporting IYCF-E.
- Sufficient supplies of Plumpy'Sup or other nutrient-rich foods for complementary feeding of children over six months of age, for use in situations when it is not possible to prepare food for these children.
- Measures for minimising the risks of feeding with breastmilk substitutes. This includes an official declaration of the relevant organisations and institutions on the following:
    - Breastmilk substitutes must not be distributed to mothers unselectively. The assessment on giving breastmilk substitutes to any mother is conducted exclusively by the organisation responsible for IYCF-E in the field. It is also necessary to monitor the distribution of hot water, to see if it is used for the preparation of powdered infant formula.
    - Avoiding donations of breastmilk substitutes, bottles and teats.
    - Agreement on the procedures of handling donations of breastmilk substitutes that still arrive, and on procuring and handling all breastmilk substitutes in accordance with the strict rules of the Operational Guidance on IYCF-E.
- Ensuring resources for training courses and the work of the IYCF-E staff, and for medical assistance for the most vulnerable groups (expectant mothers, infants and young children). Encouraging volunteering in the local community, particularly in healthcare institutions that should organise themselves in such a way that some of the physicians and nurses have time to work at the reception centres.
- Description of basic interventions to create a stimulating environment for breastfeeding. This includes support provided by professionals trained in breastfeeding counselling, and safe areas for mothers and children (the MBC).
- Educating members of the crisis headquarters on IYCF-E.
- Encouraging all relevant organisations to allow their key personnel to take part in IYCF-E training courses, and to include course materials related to IYCF-E and cultural

differences in the training courses for staff working in the field. Encouraging better coordination between all organisations.

- Appointing persons responsible for the national coordination of all relevant partners included in the crisis response in terms of infant and young child feeding.
- Informing the local community and the public about the risks of breastmilk substitutes in an emergency, and the risks of unsolicited donations. Make appeals for donations for IYCF-E support.

The only way any support for child feeding in emergencies can succeed is through multi-sectoral collaboration. Every organisation included in the crisis response should have a responsible person who needs to be informed and educated about IYCF-E.

When allocating funds for IYCF-E, resources for supporting nursing mothers must be given importance equal to the procurement of food for non-breastfed children. Funds for IYCF-E should be used to employ staff and to develop skills, instead of to finance the procuring of goods.

"I believe that more thorough education on IYCF-E and the importance of breastfeeding needs to be organised right at the beginning, and it does not include only the staff working in the camp; we have to raise the awareness of this topic and its importance in the entire country, and it would be much easier if the Ministry of Health also participated in this."
Antonija, "Our Children" Society

"My recommendation is that we continue putting pressure on the Ministry to create a crisis management plan and to adopt the guidelines, and to adhere to these guidelines when another crisis situation occurs."
Branka, RODA

"The protocols should be clearer about which organisation is responsible for what. In the next crisis situation, if would be very helpful if there were a certain number of trained lactation consultants in every part of Croatia, e.g. in every county, so they could start providing support immediately. Such teams could work from the very beginning, until the selection and training of new team members is organised. While we were trying to organise ourselves, a large number of people had already passed through Croatia. We should have had lactation consultants and IYCF-E consultants ready on the first day at Opatovac (16 September 2015), so they could raise awareness of the importance of proper nutrition and nursing from the beginning of crisis. Large amounts of infant formula were distributed along the entire route. There should be an international agreement among all the countries along the refugee route to respect the IYCF-E guidelines."
Suzana, RODA

6.2. Recommendations for organisations supporting infant and young child feeding in emergencies

It is recommended for every person supporting IYCF-E to study the international guidelines and tools for IYCF-E listed in Annex A.

The starting document is the Operational Guidance on Infant and Young Child Feeding in Emergencies, version 2.1 (2007) and the Addendum (2010). It contains the elementary international guidelines based on the experience of IYCF-E experts from around the world, and is updated regularly as new insights are provided by new crisis situations in the world. The Operational Guidance was made by the *IFE Core Group* which is currently working (in collaboration with ENN and UNICEF) on a new version that is going to be published in 2017, and will include the experiences gained during the migrant and refugee crisis of 2015 and 2016 in Croatia.

Another document, the Interim Operational Considerations of 2015, was translated into Croatian in full, and can be found in Annex B. UNICEF and a group of other agencies and organisations developed this document precisely for the migrant and refugee crisis in Europe, and it served as an excellent foundation for action for IYCF-E staff in the field.

During the recent emergency, it became evident that some of the recommendations of the Operational Guidance and Interim Operational Considerations needed to be adapted in the field. An example of this includes the recommendations for **choosing the type of infant formula** for non-breastfed children, and **choosing complementary foods for children over six months of age**. Another issue that was noted is the lack of guidelines for intergovernmental and interorganisational collaboration needed to provide **standardised support services and the same messages throughout the migrants' journey**, and to enable the tracking of individual cases.

The choice of infant formula

So far, the international guidelines have suggested powdered infant formula (PIF) as a first choice for non-breastfed children in emergencies, assuming that clean boiled water and clean feeding accessories are available. The reason for this is the affordable price of PIF (2.5 times cheaper than RUIF), the smaller volume of packaging, which is easier for transport and storing, and its greater availability, because it is commonly used whether or not there is a crisis. This is still a good recommendation for situations where safe preparation of powdered infant formula is possible, and where people are staying for a longer period of time.

The recent migrant and refugee crisis has shown that there are situations when **powdered infant formula is wholly inappropriate for use.** Immediately after natural disasters, such as floods, or in overcrowded reception and transit centres, and along the entire migration routes where there are poor sanitary conditions, **the only acceptable choice is RUIF (Ready-to-Use Infant Formula)**.

Powdered infant formula (PIF)	Ready-to-use infant formula (RUIF)
• lack of resources for safe preparation • lack of clean, boiled water • prolonged counselling and monitoring are not possible • safe preparation is difficult during the journey	• sterile until opened • easy to use, one container is sufficient for one meal • no water required for preparation • requires fewer resources (no preparation necessary) • NOTE: it does not guarantee safety, and it is still necessary to instruct the mother in measures of hygiene and proper use

The international guidelines also specify that donations of infant formula should not be actively sought or accepted (except in exceptional situations). Infant formula that is bought should be unbranded (generic), and if it is not possible to procure such infant formula, then a local brand of formula should be procured, rebranded and relabelled with instructions for use written in a language that the mothers understand.

This recommendation was respected in the recent crisis, but a few months had to pass before all the necessary steps were taken. At the beginning of the crisis, a branded variety of powdered infant formula was used (safely prepared by healthcare workers, in an amount sufficient for one meal only), along with the occasional small supply of RUIF provided by the MAGNA organisation. With time, *Save the Children* managed to procure sufficient supplies of RUIF, but it was branded. UNICEF, RODA and *Save the Children* together relabelled the

packages. They came to the conclusion that relabelling is very demanding in terms of human resources, so the question arose whether it would be better to wait a little longer and pay more for generic, unbranded infant formula. It would be best if the supplies of generic RUIF were ready in the commodity reserves before the next emergency occurs, and that the instructions in a language that the mother understands are printed during the emergency and distributed as a leaflet.

RUIF should be distributed as part of a “safe” packet containing:

- RUIF containers, unbranded, in accordance with the International Code;
- soap;
- leaflet containing instructions;
- a bib for the baby;
- a cup for feeding.

It is necessary to emphasise in the leaflet that the contents of an open RUIF container must be used within one hour, and if the baby does not eat everything, the remaining amount needs to be thrown away, or older children or the mother can drink it. It should be taken into consideration that some of the mothers are illiterate, so illustrated instructions for use may be an option.

Cup-feeding

Cup-feeding in emergencies is recommended for non-breastfed children because of the following advantages in comparison with bottle-feeding:

- cups are easier to clean;
- cups are less likely to be carried around and get dirty;
- cup-feeding decreases the risk of diarrhoea and other infectious diseases;
- cup-feeding strengthens the bond between mother and child;
- cup-feeding does not interfere with breastfeeding;
- cups allow the baby to control how much it eats;
- disposable cups are more affordable and easier to procure.

In spite of its advantages, introducing cup-feeding was a great challenge in this recent emergency. This feeding method is a new concept for most mothers who, in a rush and under stress, were not able or willing to change their established method of child feeding (bottle-feeding). The children arriving at the Centre were hungry and upset, and there was not enough time to instruct and assist the mothers. Nevertheless, some of the mothers and children adopted this new feeding method successfully, the mothers of older children in particular. Some mothers readily accepted cup-feeding because they were already aware of the hygiene risks related to bottle-feeding. It was found that the mothers (caregivers) agree to cup-feeding more readily if they are shown pictures or videos of babies cup-feeding. An

example of a picture showing cup-feeding is in IFE Module 2 (link in Annex A), slides IFE 2/26 and IFE 2/27.

Since it is difficult to introduce cup-feeding, it is still necessary to ensure a supply of new, clean bottles, or equipment for cleaning and sterilising the old ones. Which of these two approaches to use depends on the number of people in transit, and the time the staff has available (in a period of fast transit, the only possibility was to replace an old bottle with a new one).

Food choices for children over six months of age

The existing international guidelines for child feeding in emergencies favour locally grown, fresh seasonal produce, not only because it has the best nutritional value, but also because of its availability and affordable price. Apart from this, micronutrient-fortified supplements are recommended if necessary. Commercial baby food is not recommended because it is less affordable and is unnecessary.

The migrant and refugee crisis required new rules: with no chance of preparing food, either hot or cold meals (in a situation of fast transit, people did not even have time to eat the food they were given at the reception and transit centre), it was clear that only ready-made food that can be taken on a journey can be distributed. For a long time, commercial baby food, packaged or canned foods for adults, and some fruit, were the only available choice for children over six months of age.

The issue with ordinary commercial baby foods (purée in a jar) is that this type of food is low in nutrients and energy, because it is commonly used only as complementary food, along with breastmilk or infant formula that make the foundation of a child's nutrition.

It was decided that the best choice in this emergency was a combination of fruit and LNS-LQ (*Lipid-based Nutrient Supplement – Large Quantity*). LNS-LQ is an energy-dense, nutrient-fortified lipid-based supplement. It is specifically formulated to treat moderate acute malnutrition in children. It is packaged in an individual sachet, ready to be used directly, without any prior preparation, and its energy value is 500 to 550 calories. The manufacturer's name for this product is Plumpy'Sup, but the choice was not limited to this product only. In chapter 3.5, there is a table listing the recommended options for the complementary feeding of children over six months of age.

Before supplies of Plumpy'Sup were obtained, and considering that the Ministry of Health prohibited the distribution of pasteurised cow's milk, and since commercial baby food is low in calories, it was decided that infant formula should be distributed to non-breastfed children from 6 to 12 months of age.

6.3. Further actions of organisations supporting infant and young child feeding

Organisations in Croatia that are aware of the importance of IYCF-E (UNICEF, RODA, CALC, etc.) should continue preparing for the next emergency.

In a period of "peace", before the next emergency occurs

- Engage in advocacy for the inclusion of IYCF-E in the crisis management plan of the Ministry of Health, and develop national guidelines for IYCF-E. Send the adopted guidelines to all organisations that will be involved in the crisis response.
- Prepare draft guidelines for IYCF-E.
- Advocate the procurement of initial supplies of RUIF and feeding accessories. Rebrand or at least relabel the supplies if the procured RUIF is not a generic product. Encourage the procurement of RUIF because in the event of a sudden crisis or migration crisis, powdered infant formula is unsuitable, i.e. safe preparation is not possible, and RUIF is needed from the first day. If people are staying longer in one place where they have access to clean water and enough energy needed for safe preparation, powdered infant formula can be procured additionally.
- Advocate the allocation of funds for human resources, i.e. the people that are going to be included in IYCF-E support when the crisis occurs. This refers to IYCF-E staff, and staff providing medical assistance for the most vulnerable groups of people: expectant mothers, infants and young children.
- Promote IYCF-E, good practice and collaboration in the management of key organisations that coordinate support services in emergencies, and in all other organisations responsible for children and the procurement and distribution of food. Conduct training courses in IYCF-E for key personnel in these organisations.
- Educate future parents, healthcare professionals, the public and the media about breastfeeding and its importance.
- Advocate the need for breastfeeding experts, as they are a crucial part of the emergency response, because in the field there is a lack of persons who are familiar with the rules of breastfeeding and who can immediately provide efficient support to mothers and children, and educate the other participants.

At the beginning of a crisis

- Strengthen cooperation with the Ministry of Health, and coordinate with them to ensure resources and develop a division of work.
- Assess the ability of national institutions to ensure sufficient supplies of breastmilk substitutes, and monitor the use of these supplies. If the national institutions are unable to ensure sufficient supplies, alternative source must be found.
- Adapt the IYCF-E guidelines to the situation (if necessary), harmonise with the associate organisations, develop and distribute the modified guidelines.
- Since there will probably be a lack of protocols for IYCF-E in the different organisations involved, offer them training and cooperation so they can prioritise IYCF-E.
- Due to the fluctuation of responsible persons and volunteers in other organisations, advocate and promote the adopted protocols and the rules of IYCF-E regularly, and continue to educate other participants through training courses in IYCF-E in the field.
- Organise regular meetings between the associate organisations.
- Inform the media that donations of breastmilk substitutes are unnecessary and can have a negative impact on the children's health. Shift their focus to the real needs of children and parents in an emergency.

Annex A

List of relevant international guidelines and tools for IYCF-E

Interim Operational Considerations for the feeding support of Infants and Young Children under 2 years of age in refugee and migrant transit settings in Europe (2015), UNICEF, UNHCR, Save the Children, ENN & reviewers, the whole text is in Annex B, and also on the website: www.ennonline.net/interimconsiderationsiycftransit

Operational Guidance on Infant and Young Child Feeding in Emergencies, v 2.1, IFE Core Group – Version 2.1 (2007) and Addendum (2010). www.ennonline.net/operationalguidanceiycfv2.1 IFE Core Group is currently working on a new version for 2016/2017.

Infant and Young Child Feeding in Emergencies (IFE) Module 2, Version 1.1, IFE Core Group (2007) – A training module for health and nutrition workers in emergency situations. It provides basic knowledge and skills necessary to support safe and appropriate infant and young child feeding. It includes a simple, complete and rapid assessment of infant feeding, and supporting activities related to breastfeeding and artificial feeding in emergencies. www.ennonline.net/ifemodule2

Standard Operating Procedures for the Handling of Breastmilk Substitutes (BMS) in Refugee Situations for Children 0-23 months, UNHCR (2015). It includes details on preparing infant formula, different scenarios, calculations of individual feeding needs, and information about cup-feeding and complementary feeding. http://www.ennonline.net/iycfsopbmsrefugee

Module 1 Orientation on infant and young child feeding in emergencies, IFE Core Group (2010) Online modules. http://lessons.ennonline.net/

The International Code of Marketing of Breastmilk Substitutes (The Code) and the related Resolutions, World Health Organisation (WHO). The purpose of this document is to protect all infants and young children by protecting their caregivers from commercial pressures to use breastmilk substitutes. http://ibfan.org/the-full-code

IYCF-E Toolkit: Rapid start-up resources for emergency nutrition personnel – a website containing the documents for an IYCF-E response. https://sites.google.com/site/stcehn/documents/iycf-e-toolkit

Annex B

Interim Operational Considerations for the feeding support of Infants and Young Children under 2 years of age in refugee and migrant transit settings in Europe

V1.0, Issued: 1 October 2015

A. Aim of this guidance

- The note outlines benefits, risks, options, and resources for supporting appropriate infant and young child feeding (IYCF) in children under 2 years of age in refugee and migrant transit situations in Europe.
- Key considerations taken into account in this guidance include prevalent but often sub-optimal breastfeeding practices, prevalent use of infant formula in this context, low contact and follow up opportunities with carers and children, likely lack of skilled IYCF workers, and often limited water, hygiene and sanitation facilities.
- This note draws from key policy guidance[6] and provides direction where guidance is limited for this context. It outlines the minimum level of assessment and support that is needed. A more detailed programmatic guidance is in development. Visit www.en-net.org for updates.
- Key considerations, priorities and protective actions (sections C-E) are elaborated on in sections F to J. Key resources are listed in section K and contacts in section L.
- This guidance was developed with input of agencies and individuals experienced in IYCF in emergencies and with frontline operations in the current humanitarian response. [7]

B. Target audience

- Those involved in planning, delivering and mobilising resources for IYCF for refugees and migrants in transit in Europe.
- This can include generalists supporting the refugee response, health and protection staff/volunteers, as well as nutrition staff/volunteers, fundraisers, and those in media/external communication.
- The note does not supersede any agency specific guidance in this area, unless specifically indicated by the agency concerned.

C. Key considerations

- **Breastfeeding mothers need identification, protection and active support**. For mothers in transit, the conditions can undermine maternal confidence and breastfeeding practices. There is a risk that breastfeeding mothers stop/reduce breastfeeding, especially if also using infant formula (mixed feeding) before the transit.

[6] UNHCR (2015) Standard Operating Procedures for the Handling of Breastmilk Substitutes (BMS) in Refugee Situations for children 0-23 months; Operational Guidance on Infant Feeding in Emergencies (2007); International Code of Marketing of Breastmilk Substitutes and subsequent WHA Resolutions (the Code).

[7] Developed by UNICEF, UNHCR, WHO, Save the Children & ENN with review by ACF, IBFAN-GIFA, IOCC, World Vision, Karleen Gribble & Mary Lung'aho.

- **Formula dependent infants need identification, protection and active support**. For mothers in transit, infant formula supplies and conditions for hygienic feed preparation may be severely limited and different to what they are used to normally.
- **Infant formula use is more risky and difficult to manage in transit.** Babies that are formula fed are at higher risk of illness and malnutrition. The younger the baby, the more at risk they are from diseases like diarrhoea and chest infections, especially if they are not breastfed. In the emergency environment, such conditions can be fatal.
- **Newborn infants are particularly vulnerable** and a key target group in which to establish breastfeeding to reduce the risks associated with alternative, risky feeding practices.
- For those in transit, **it may not be possible to provide all the supports normally considered necessary or to guarantee infant formula supplies** for as long as the infant needs.

D. Priorities

- Be alert for and refer any children that are unwell for medical attention.
- Share key information in this note with mothers of young children regarding feeding options and their consequences to inform her decision-making and choices.
- Use opportunities of contacts with pregnant women and the people accompanying her, to advise her to breastfeed her infant immediately after birth and exclusively until 6 months. For mothers at birth and immediately post-partum, stress the importance of immediate skin-to-skin contact with early initiation of breastfeeding and exclusive breastfeeding. Provide whatever support you can to enable this.
- Identify mothers who are breastfeeding and do everything you can to encourage and support them to continue as long as possible.
- Identify mothers whose children are dependent on infant formula and provide what advice and practical support you can to minimise risks in this environment.
- Encourage mothers who are both breastfeeding and using infant formula to breast feed more frequently to reduce or, ideally, eliminate their dependence on infant formula.
- Provide practical advice and what support you can regarding appropriate and the most nourishing complementary foods to feed children over 6 months of age.
- Manage the sourcing and provision of infant formula to ensure that the needs of both breastfed and non-breastfed infants are protected and met.

E. Key protective actions

- Base the IYCF support you provide on a minimum level of assessment (*see section F*).
- Target & manage infant formula supplies (*see section I for more details*):
    - Where infant formula is needed, purchase supplies. Adhere to minimum requirements regarding quality and labelling.
    - Do not seek and act to prevent donations[8] of infant formula, any products that are marketed for use in infants under 6 months of age or as a replacement for breastmilk in any age group, complementary foods, and bottles and teats.
    - Donations offered/received should be directed to UNHCR/the designated coordinating agency on nutrition/health.
    - Do not provide infant formula (or infant formula vouchers) in any general distributions.

[8] Experiences in emergency contexts have repeatedly found that donations are expensive to manage, are disproportionate to need, vary greatly in type and quality, may be out of date, may not be in the appropriate language and are poorly targeted.

- Provide supportive services:
  - Identify skilled staff to support mothers with difficulties feeding their infants,
  - Provide private spaces (e.g. safe spaces) for mothers to enable them to breastfeed and to connect with other mothers,
  - Provide access to cleaning facilities for mothers to wash feeding utensils, especially mothers who are formula feeding,
  - Where possible, advocate for/prioritise mothers of infants and young children for basic screening of childhood illnesses, access to registration and basic services, shelter and non-food items,
  - Consider provision of baby slings/baby carriers for mothers based on local needs assessment.

- To the best extent possible, share information on resources and services that may be available on their onward journey. Help a mother to practically plan how to manage feeding her child on her journey and if possible, in her country of destination.

For more resources on orientation on IYCF in emergencies, see section K.

F. Minimum assessment of need

To target IYCF support, a minimal level of assessment is needed. If a mother requests infant formula this may be because her baby is exclusively formula fed or it may be because she has difficulties with/has lost confidence in breastfeeding. It is essential to distinguish these needs and target appropriate support.

Key questions to ask in screening mothers of children under 2 years are:

1. What age is your baby/child? (*check: helps assess the feeding issues identified; newborns and infants < 6 months especially vulnerable*)
2. How is your baby/child currently fed? (*check: breastfed or not breastfed; infant formula use; other milks, liquids, foods*)
3. If you have stopped breastfeeding, when did you stop and why? (*check: has mother just stopped during transit – check her interest to restart*)
4. Have you any concerns or difficulties feeding your baby/child? (*check: problems breastfeeding; non-breastfed infants accessing infant formula; access to foods for > 6 months*)
5. How long are you staying here? (*check: opportunities for contact*)

Her responses will help you to figure out the support she needs. She may need help with breastfeeding, infant formula supplies, accessing complementary foods and/or direction to other services, such as health. A mother who has recently stopped breastfeeding, can restart if she wishes to (see section G). An infant under 6 months who is not breastfed will require infant formula supplies. An infant over 6 months who is not breastfed does not require infant formula (see section H). Your support includes providing key information to the mother regarding feeding options and their consequences; should take into account the decision of the mother in feeding her infant; seek to minimise risks of the feeding option, and depends on what resources you have available.

Wherever possible, refer mothers having breastfeeding difficulties or mothers who wish to restart breastfeeding for more skilled support. Connect breastfeeding mothers with each other to facilitate

peer to peer support. Provide advice and, where possible, practical support on hygienic preparation of infant formula (to carers of formula-fed infants) and complementary foods.

G. Key messages for breastfeeding mothers

These messages are addressed to mothers and primary caregivers and are the minimum support you should offer; adapt them as you need and use them to inform the services and support you can provide. It is also useful to share these messages with the people who accompany the mother so that they can also support her.

- **If you are breastfeeding, do not stop.** *Continue to do so until your child is at least 2 years of age. This is the most reliable, cheapest and safest way of feeding your child. Breastfeeding will protect your baby against infections.*
- **Formula feeding your baby is dangerous in the current situation.** *This is why we do not want to give infant formula to breastfeeding women.*
- **If you recently stopped breastfeeding, you can restart. This is by far the safest option for your baby.** *Frequent suckling at the breast, day and night, will help to stimulate breastmilk production. Offer the breast before offering any other food or liquid.*
- **Do not give breastfed babies less than 6 months any extra water, juices, teas or foods.** *Exclusive breastfeeding offers the best nutrition for small babies. Breastmilk contains ingredients that protect your baby from infection. Giving other foods/fluids will reduce your milk supply and increase the chances of infection, especially in this situation.*
- **If you are both breastfeeding and using infant formula or other milks, it is safer to only breastfeed.** *Breastfeed before feeding formula in order to stimulate breastmilk production. You can gradually replace each formula feed with a breastfeed. This may take a few days***.**
- **Do not start to use infant formula if you have never used it.** *It is very difficult to prepare in your situation, we cannot provide you with all the supplies you will need, and it is expensive. Feeding your baby formula makes them more likely to get sick with diarrhoea and chest infections which are serious illnesses for babies.*
- **Stress does not reduce your breastmilk supply but it can slow the release of milk and this can make babies fussy and upset.** *Thinking about your love and hope for your baby will help the milk to flow. If available, being in a private place can help you relax.*
- **If your baby is over 6 months of age, continue to breastfeed as often and for as long as possible (2+ years) in addition to adding other foods.** *Try to offer the breast before other foods.*

For more programming guidance on supporting breastfeeding mothers, see section K.

H. Key messages for mothers of non-breastfed infants

These messages are addressed to mothers and primary caregivers and are the minimum support you should offer; adapt them as you need and use them to inform the services and support you can provide. Wherever possible, refer mothers having feeding difficulties for more skilled support.

- **If your baby is under 6 months, infant formula is the only suitable milk to use.** *Make sure you follow the exact instructions on the label to prepare it.*
- **Hygienic preparation with boiled water is strongly recommended to reduce the risk of contamination (of bottle/cup/feed).** *Bottled water does not have the same sterilising effect. Left over infant formula should be thrown away if not used immediately, as bacteria quickly grow in it.*

- **If your baby is over 6 months, you do not need to use infant formula but can use other milk sources instead.** *Acceptable milk sources include pasteurised full-cream animal milk (cow, goat, sheep), Ultra High Temperature (UHT) milk, fermented milk or yogurt. These may be easier to find supplies of and are less risky than using powdered milk. Condensed milk is not suitable for infant feeding. Adapted full fat evaporated milk is not a viable[9] option in the current context.*
- When using any liquid milk for your baby, use within a couple of hours of opening.
- Avoid using baby juices and teas – they are low in nutrition and high in sugar.
- If your baby is over 6 months of age, you can mix infant formula into your child's food (such as porridge) rather than giving it to him/her to drink.
- **Bottles are more difficult to clean than cups.** *A baby can cup feed. Cleaning of feeding utensils (cups, spoons) is essential to prevent sickness. Disposable plastic or paper cups are one option to remove the need for cleaning.*
- **If you wish to continue to bottle feed, hygiene is essential to reduce the risk of infection.**
- When your baby is using infant formula, he/she is at **higher risk of diarrhoea and chest infections**, especially in these transit conditions. *Find out what medical services are available wherever you arrive so that you are prepared and can get treatment quickly.*
- **If your child becomes ill,** continue to encourage him/her to drink and eat, offering smaller amounts more often if his/her appetite is reduced**.**

Advise the mother on what formula feeding support is being given at this transit point, in terms of supplies available, how long they will last, hygienic preparation, feeding utensils, etc., and help her plan with what she has. Given the bulky nature of infant formula, it is unlikely that transit points will be able to provide all the supplies of infant formula that a mother needs for her journey.

For more detailed programming guidance on supporting non-breastfed infants and children, see section K.

I. Managing infant formula provision

- The most common breastmilk substitute (BMS) is infant formula. Infant formula is available in powdered form or as liquid ready to use milk. Ready to use infant formula has practical and hygiene advantages and is preferable in the transit context, but as an option it may be limited by availability, cost, and bulkiness.
- As a guide, an infant will drink around 600-800 ml of milk per day; a 450g tin of infant formula will last 4-5 days.
- Target supplies to those who need it by asking key questions regarding child's age and regular feeding practice (*see section F*).
- **Do not provide infant formula or infant formula vouchers in general food/commodity distributions.**
- **Purchase** necessary supplies of infant formula. Follow key principles regarding infant formula procurement relating to source (avoid donations), quality (adheres to Codex Alimentarius,[10] well within the expiry date) and labelling (user language).
- **Do not seek donations** of infant formula, baby juices, baby teas, other milks marketed as a breastmilk substitute, complementary foods, or feeding equipment (bottles, teats, breastmilk

[9] Requires addition of measured volumes of water and sugar; higher renal solute load which is risky for younger infants/sick infants/those drinking less; lacks iron and vitamin C.
[10] These are FAO/WHO led international food standards www.codexalimentarius.org/

pumps). Any unsolicited donations of infant formula or other feeding products that are offered/received should be directed to UNHCR/the designated coordinating agency on nutrition/health.

- Ideally, purchase a **generic (unbranded label) infant formula** in the appropriate language. Where only branded formula is available, purchase supplies in the appropriate language. If this is not available, then relabel supplies with preparation information in the **appropriate language** or provide accompanying leaflets where relabelling is not possible.
- Donated infant formula that has already arrived and is within the expiry date should only be used as a last resort where purchased supplies are not available and in full accordance with guidance for purchased supplies.
- **Infant formula supplies should be provided discretely,** not in view of breastfeeding mothers, and there should be no infant formula promotion at the point of distribution, nor any materials displaying infant formula or bottle feeding.
- Do not exclude infant formula from the commodities a mother can choose to access via general cash/voucher schemes. However, accompany such interventions with key information on breastfeeding and on how to minimise the risks of formula feeding.
- Where there is free provision of infant formula to non-breastfed infants, consider matching with a valued incentive for breastfeeding mothers. For example, extra food and drink for breastfeeding mothers or shawls to enable privacy when feeding (based on local needs assessment to avoid waste).
- If you are having difficulty securing infant formula supplies to meet needs you have identified, contact: hqphn@unhcr.org.

J. Complementary foods

- Complementary foods are solid, semi-solid and soft foods suitable for feeding children over the age of 6 months of age.
- Check that the complementary foods being considered are acceptable to the targeted children and their carers; different cultures will have different preferences and practices.
- Identify and, as necessary, provide a **food fortified with vitamins and minerals**, with advice on preparation. These might include fortified porridge-like breakfast cereals.
- **Do not seek donations of complementary foods, baby teas, or juices.** If you are offered donated supplies, direct them to UNHCR/the designated coordinating agency on nutrition/health and alert them.
- **Animal source foods,** such as yogurt and cheese, are good nutrient sources but bear in mind that storage (refrigeration) options will be lacking.
- If appropriate and accepted, commercial 'baby' foods may be a practical stop gap in this situation: provide purchased supplies or recommend products that are labelled for infants over 6 months of age and that are the most nutrient dense (in general, fruit/vegetable only products are less energy and nutrient dense).
- Do not provide baby teas or juices as they have little nutrient value. Do not provide any products recommending or displaying images of bottle feeding.
- Complementary food products should be labelled in the **user language**; if this is not available, provide information sheets with the necessary preparation information.
- Milk and infant formula can be added to children's food to increase the nutrient content. This especially works when preparing cooked food, such as porridges, mashed potatoes, etc.
- Provide advice and, where possible, practical support on **hygienic preparation of complementary foods**.
- **Children over the age of 12 months** can eat the same foods as older children.

For more detailed programming guidance on complementary feeding, see section K.

K. Resources

The UNHCR (2015) Standard Operating Procedures for the Handling of Breastmilk Substitutes (BMS) in Refugee Situations for children 0-23 months. *This includes details on preparation of formula feeds, scenarios, calculation of feed volumes, cup feeding, complementary feeding*. www.ennonline.net/iycfsopbmsrefugee

Module 1 Orientation on infant and young child feeding in emergencies. IFE Core Group 2010. *Online modules*, http://lessons.ennonline.net/

Module 2 For health and nutrition workers in emergency situations. IFE Core Group 2007. Supports basic knowledge and skills to support safe and appropriate infant and young child feeding. *This includes simple and full rapid assessment of feeding in infants, supportive actions regarding breastfeeding, artificial feeding in emergencies.* www.ennonline.net/ifemodule2

Operational Guidance on infant and young child feeding in emergencies, v2.1, 2007 and addendum (2010). www.ennonline.net/operationalguidanceiycf2.1

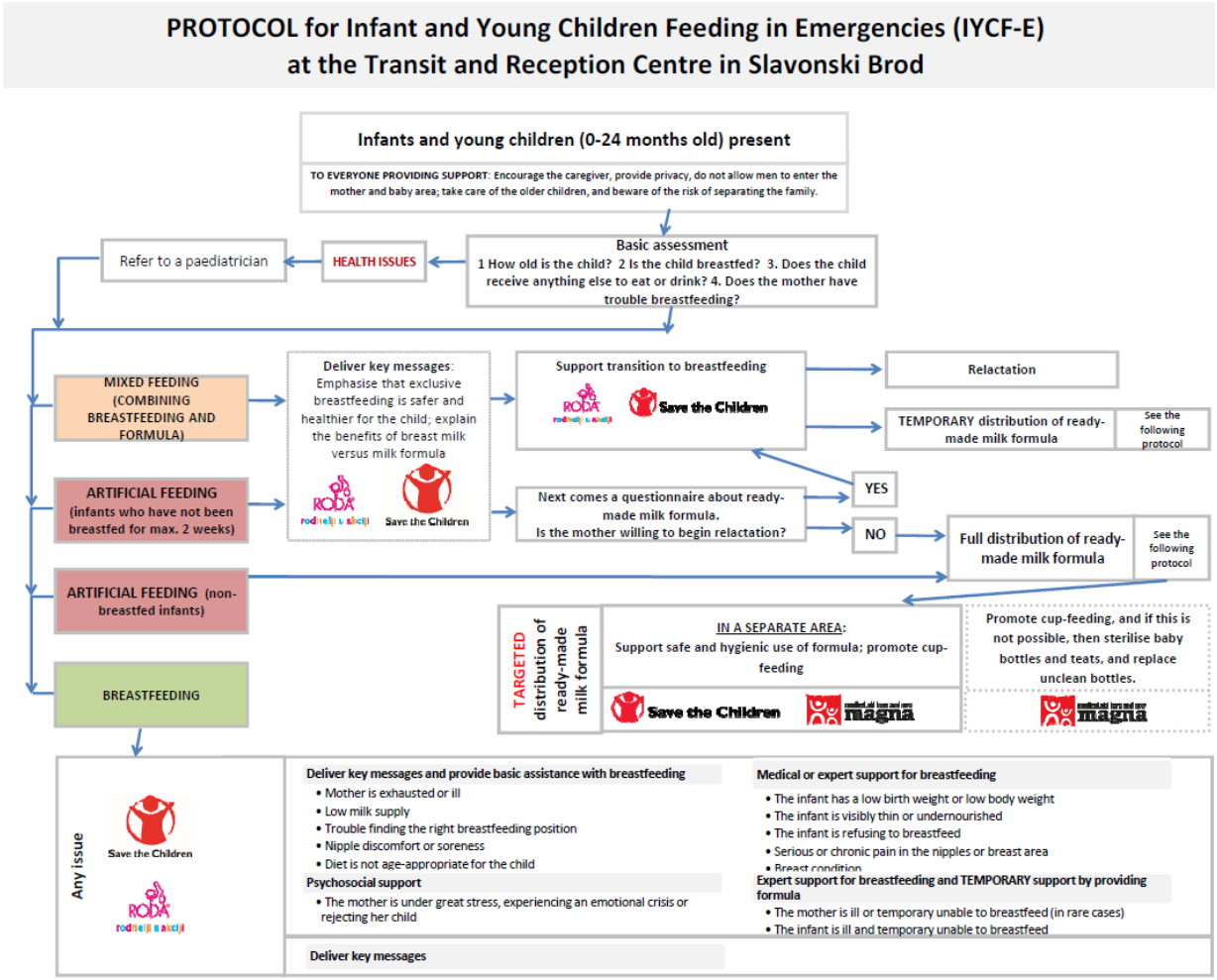
International Code of Marketing of Breastmilk Substitutes and subsequent WHA Resolutions (the Code). *This aims to protect all infants and young children by protecting caregivers from commercial pressures to use breastmilk substitutes.* http://ibfan.org/the-full-code.

L. Feedback

This is a working document and feedback from people using it in the field is welcome. Please provide feedback at the en-net online technical forum www.en-net.org and/or contact directly: Diane Holland, UNICEF (dholland@unicef.org), Caroline Wilkinson, UNHCR (hqphn@unhcr.org) or Christine Fernandes, *Save the Children* (C.Fernandes@savethechildren.org.uk).

Annex C

Protocol for IYCF-E, Slavonski Brod, December 2015



Annex D

Recommendations for infant and young child feeding in emergencies, Slavonski Brod, January 2016

In emergencies, infant and children up to two years old become ill very easily, and acute respiratory infections and diarrhoea are the two leading causes of death in children. The younger the infant is, the more susceptible to diseases it is.
Improving breastfeeding practices could save 820,000 lives per year! Without active support from everyone – even you – breastfeeding practice can easily be undermined.

THIS IS HOW YOU CAN MINIMISE THE RISKS AND SAVE LIVES:

1. **PROTECT, PROMOTE AND SUPPORT BREASTFEEDING**
   Ensure that a mother has a safe place and enough time for nursing – do not rush her to take care of other things when she is nursing. Offer to take her and the rest of the family to a mother and baby area instead.

2. **AVOID SPREADING MYTHS AND MISINFORMATION ABOUT BREASTFEEDING**
   If you think a mother needs support, please **refer the family to the lactation consultant**.

3. **MINIMISE THE RISK OF USING BREASTMILK SUBSTITUTES**

- ✗ **DO NOT DISTRIBUTE dairy products, infant formula, feeding bottles and teats.**
- ✗ **DO NOT DISTRIBUTE hot water for preparing formula in dirty bottles or for reheating milk.**
- ✓ **IDENTIFY, PROTECT AND SUPPORT infants depending on infant formula** – bring both parents and their baby to a **lactation consultant**.
- ✓ **REPORT every distribution of infant formula, feeding bottles, teats, and other milk products without target users** through the BMS Code violation report form.

4. **GIVE PRIORITY TO EXPECTANT AND LACTATING MOTHERS, AND CHILDREN UNDER THE AGE OF FIVE** when accessing food, water, protection and support.

Mother's milk provides all the nutrients, vitamins and minerals that an infant needs in the first six months of its life. Apart from the mother's milk, the infant **DOES NOT require any food or liquids, not even water.**

Mother's milk contains antibodies that **protect and save children's lives.** Children over six months of age need safely prepared, nutritious complementary food in addition to continued breastfeeding up to two years of age or beyond, or, if necessary, the appropriate substitutes.

THIS IS HOW WE CAN PROMOTE AND SUPPORT THE BEST PRACTICE:

THE MOTHER AND BABY AREA

For caregivers of **children up to two years of age, and expectant mothers**

WHAT?	WHEN?
▪ Safe, private and quiet nursing area ▪ Counselling and support regarding nutrition ▪ A place where the expectant mothers can rest and recover ▪ Changing diapers, providing the basic necessities (blankets, baby wipes, etc.) ▪ Clothes for children up to two years of age. Older children can get clothes in the distribution area.	**All caregivers and young children are welcome** at the mother and baby area, but the following will be given **priority**: 1. Infants younger than one month of age 2. Formula-fed infants (e.g. partially breastfed or non-breastfed) 3. Mothers who have difficulties with nursing 4. Infants younger than six months of age given foods or liquids other than breastmilk

THE BREASTMILK SUBSTITUTES AREA

Assessment of the need to distribute infant formula

WHAT?	WHEN?
▪ Distributing **Ready-to-Use Infant Formula for children YOUNGER than 12 months of age**. Other foods are a safer choice for older children. ▪ Promoting cup-feeding; only MAGNA distributes feeding bottles.	The decision on giving infant formula can be made **ONLY by the lactation consultants of *Save the Children*.**

Annex E

The "BMS Code Monitoring in Emergency Situations" form, Slavonski Brod, January 2016

BMS Code Monitoring in Emergency Situations

This form should be submitted to the manager of the Infant and Young Children Feeding programme of the *Save the Children* organisation which coordinates the distribution of the breastmilk substitutes in the Transit and Reception Centre in Slavonski Brod

The International Code of Marketing of Breastmilk Substitutes (BMS Code) and relevant World Health Assembly resolutions are operational in all situations. Communities that have been struck by emergency situations like war or natural disasters may encounter influxes of unsolicited supplies of breastmilk substitutes and other products that run counter to international guidelines. Usual marketing activities may take on different dimensions as companies try to reposition themselves in destabilised markets. Sometimes, it is non-governmental organisations or others involved in the humanitarian response, even governments that are directly violating the International Code rather than companies. Reports of Code violations in emergency situations will enable the right responses to be taken by policy makers and aid agencies.

Name: ..... Organisation: .....

Address: ..... E-mail: .....

The information listed above is required to enable the Child Nutrition Working Group in the camp to double-check the information you have given, if necessary. Your identity will remain confidential.

Type of emergency: *(Please answer all the questions, specifically those asking when, where, who, what and how)*

1. Short description of violation (name of emergency relief programme, heading or slogan found on company/campaign materials)

2. **When** was the violation observed? (dd/mm/yyyy)

3. **Where in the camp?** (The white distribution tent, different sectors, the mother and baby area, etc.)

4. **Who** is violating the Code and **how**?

Company/organisation	*Brand*	*Type of product*[1]	*Type of violation*[2]

[1] **Type of product**

A Infant formula, including special type of formula
B Follow-up formula
C Growing-up milk
D Cereal
E Fruit, vegetable or meat purée
F Juice, tea or mineral water
G Baby bottles
H Teats
I Other (list under "Type of product" in the table above)

[2] **Type of violation**

A Donations of breastmilk substitutes, bottles and teats from agencies, governments, donors, etc.;
B Accepting unsolicited donations of breastmilk substitutes, bottles and teats;
C Blanket allocation of unsolicited or free supplies of breastmilk substitutes, bottles and teats;
D Distribution of formula that has been properly procured other than to mothers and babies that have been professionally assessed as requiring formula;
E Donations of complementary food to children from 0-5 months;
F Distribution of dairy products (including dried milk) that can potentially be used as a breastmilk substitute to the general population;
G Distribution of infant formula with less than 6 months shelf life;
H Inadequate labelling (no health hazard warning, inappropriate language, no statement on superiority of breastfeeding, no information on safe preparation, etc.)
I Promotion of breastmilk substitutes at the distribution point (logos, posters, etc.)
J Other (specify)

If a specimen or a picture is attached to this form, tick here ☐

5. **Details: e.g. describe how the products are distributed, and what their impact is on the affected communities/nature of the relief programme**
(Please use another sheet of paper if necessary)

The tool was developed by the Global Nutrition Cluster with support from IBFAN, IFE Core group and UNICEF

Annex F

Poster showing the sign for the Mother and Baby Centre and the organisations supporting it

Due to the fast transit of migrants, and because some mothers were illiterate, the coordination group for IYCF-E in Slavonski Brod decided that it would be best if the poster for the Mother and Baby Centre was a simple illustration.

Annex G

Myths on breastfeeding and child feeding in emergencies

MYTH	FACT/RECOMMENDATION
"An infant with diarrhoea should be given water."	Mother's milk satisfies all the needs of a child younger than six months of age for fluids, even when it has diarrhoea.
"If the child has diarrhoea or vomits, you should stop breastfeeding."	A child who has diarrhoea or is vomiting needs plenty of fluids to avoid dehydration, and breastmilk provides this. Breastmilk also contains protective factors which help fight the infection that is making the child vomit, and it replenishes the lost nutrients and provides energy.
"If a mother in an emergency is malnourished or does not have a healthy diet, her milk will not be good enough for the baby."	Breastmilk is healthy and completely adapted to the needs of a child, even if the mother's diet is not healthy. The mother's body has supplies of everything a child younger than six months of age needs. Only chronic severe malnutrition of the mother can affect breastmilk production.
"If a mother in an emergency does not eat or drink enough, she will not produce enough milk for her baby."	The amount of breastmilk that is produced depends almost exclusively on how often and how efficiently the milk is removed from the breasts. A mother can have enough milk for the baby even when she is malnourished and thirsty.
"In a crisis, the mother is under stress, and this can reduce her milk production."	The amount of breastmilk produced depends almost exclusively on how often and how efficiently the milk is removed from the breasts. Stress does not affect milk production directly, but it can have an effect on the milk ejection reflex or on the mother postponing the feedings, which, over time and indirectly, lead to reduced milk production. If a mother under stress manages to breastfeed often enough, her milk supply will not decline.
"If the mother is not expressing breastmilk, and delays the feeding, she will have more milk for the baby."	Not removing milk from the breast and breastmilk oversupply are signals for the body to reduce milk production. But the more the mother breastfeeds, the more milk is produced.
"Once the breastfeeding frequency is reduced or the mother stops breastfeeding, it cannot be resumed or increased again."	Breastmilk production can decrease, but it can also increase. Resuming breastfeeding or increasing breastfeeding frequency is called relactation. This can be achieved with more frequent and more efficient milk removal. The mother usually needs support during this process.
"If the mother is under stress or is tired, her milk is not good, i.e. stress and fatigue are transmitted through the milk."	The baby can sense the stress and anxiety of its caregivers, but this cannot be transmitted through the mother's milk. Nursing is relaxing for both the mother and the child. If the mother is exhausted, she might in consequence not be breastfeeding enough, which reduces milk production, and upsets the baby due to its hunger. The mother needs support.
"If the mother is always in a dirty environment, her milk will be dirty, too."	Dirt is only on the outside. The mother needs to wash her hands if and when possible. Breastmilk protects the child against bacteria and other pathogens.
"If the mother is ill, she should stop breastfeeding."	When the mother is ill, her body produces antibodies that fight against her illness, and those antibodies are also in her breastmilk, and they protect the child from becoming ill, too. The child is more likely to become ill if the mother is not breastfeeding, and is less

	likely to become ill if it is breastfed. (Diseases which require the mother to stop breastfeeding are extremely rare, and even then a physician's recommendation is needed. Sometimes it is recommended to breastfeed even when the mother has HIV).
"If the mother is taking medications she should stop breastfeeding."	There are many medications that do not get into the milk or which are not harmful for the baby, so the mother can continue breastfeeding while taking most medications. Breastfeeding is forbidden while some medications are being taken. A physician should be consulted about each medication.
"If the mother is pregnant again, she should stop breastfeeding."	The mother can continue to breastfeed during the entire pregnancy. She can also continue to breastfeed the first child after the second child is born. Breastfeeding the older child does not harm the pregnancy or the breastfeeding of the younger child.
"If the baby is crying constantly, it is probably hungry."	Children cry for many different reasons, especially in crisis situations when people are upset and moving more, living in a different place, etc. More frequent breastfeeding will feed and calm the child.
"The baby is breastfeeding all the time, which means the mother does not have enough milk."	Children younger than six months of age have growth spurts when they are breastfeeding more often than usual, and this is normal behaviour. Apart from this, prior to the longest sleep cycle in a day (usually in the evening), many babies breastfeed very often, which is also normal.
"Donations of infant formula do not affect low breastfeeding rates."	Uncontrolled distribution of infant formula to mothers, along with all the myths that surround breastfeeding, makes mothers unsure about their decision to breastfeed. Giving infant formula also causes the postponement of feeding, which leads to reduced breastmilk production.

Annex H

Training programme for lactation consultants providing support to refugees and migrants at the transit centre, Slavonski Brod, December 2015

Friday, 11 December2015	
9.00 – 11.00	***Leisel E. Talley, nutritional epidemiologist*** ***Isabelle Modigell, Save the Children UK, IYCF-E manager*** **Challenges in infant and young child feeding in emergencies** - Factors affecting the decline of breastfeeding - Breastmilk substitutes and the problems they bring - Challenges for staff providing assistance in emergencies - Donations of infant formula in emergencies can be dangerous **Good practices of infant and young child feeding in emergencies** - Assessment and analysis of the current situation - Action: conditions for supporting breastfeeding - Alternatives to breastfeeding - Action: conditions for minimising the risk of artificial feeding - Rules for artificial feeding
11.30 – 13.30	***Anita Pavičić Bošnjak, MD, paediatrician and IBCLC consultant*** **How breastfeeding works** -Efficient sucking -Good milk flow and the mother's self-esteem -Adequate breastmilk production -Age-appropriate nutrition
14.30 – 16.30	***Anita Pavičić Bošnjak, MD, paediatrician and IBCLC consultant*** **Assessing the condition of the mother-child pair** -Two methods of assessment -Rapid simple assessment of general health condition -Complete assessment of child feeding
16.30 – 17.00	Questions and answers
Saturday, 12 December 2015	
9.00 – 10.30	***Anita Pavičić Bošnjak, MD, paediatrician and IBCLC consultant*** **Severely malnourished young children** -Malnutrition in children younger than six months of age -Overview of procedures -Condition assessment and admission -Choosing the appropriate nutrition treatment -Phases of treatment -Monitoring progress -Procedure when breastfeeding is possible -Procedure when breastfeeding is not possible -Caring for the mother and her nutrition
10.30 – 11.00	Questions and answers
11.30 – 12.30	***Ivana Zanze, lactation consultant, RODA*** **The International Code of Marketing of Breastmilk Substitutes** -Risks of not breastfeeding -Aim and scope of the International Code -The effect of marketing on mothers, healthcare workers and the healthcare system

	-Why boycott Nestlé? ***Code of Ethics*** -Values and the principles
12.30 – 13.00	Questions and answers
14.00 – 16.00	***Dinka Barić, Master of Medical Technology, IBCLC consultant*** **Breastfeeding issues and solutions** -Clogged milk ducts, mastitis, sore nipples -Growth spurts -Jaundice -Preterm babies and twins
16.00 – 16.30	Questions and answers
Sunday, 13 December 2015	
9.00 – 11.00	***Dinka Barić, Master of Medical Technology, IBCLC consultant*** **Child care** -Healthy baby -Sick baby and the signs of illness
11.30 – 13.00	***Adisa Hotić, midwife and IBCLC consultant, Fenix Mother and Baby Centre, Sanski Most*** **Delivery and nursing** -How delivery affects nursing -The importance of skin-to-skin contact -Maternal bond **Infant development** -The first six months -Introducing a varied diet
14.00 – 15.00	***Adisa Hotić, midwife and IBCLC consultant, The Fenix Mother and Baby Centre, Sanski Most*** ***Antenatal and postnatal care*** **-**Needs of the expectant mother -Needs of a parturient woman -Needs of a lactating mother
15.00 – 16.15	***The Milky Way – A journey to successful breastfeeding*** ***A documentary on breastfeeding (RODA and UNICEF)***
16.15 – 16.30	Evaluation of the training course

Saturday, 19 December 2015	
9.00 – 11.00	***Sandra Raković, psychologist*** Communication workshop
11.15 – 13.00	***Neda Mihaljević Zubović, RODA*** Workshop on baby carriers (slings)
14.00 – 15.30	***Željana Tomić, BMedSci, IBCLC consultant*** Myths about breastfeeding in emergencies
15.30 – 17.30	***Irena Zakarija-Grković, MD, IBCLC consultant*** **Relactation** Indications for relactation; Conditions for relactation; How to support the mother; Child feeding during relactation **Different breast conditions** -Oversupply, Nipple conditions, Breast pain
17.30 – 18.00	Questions and answers
18.00 – 18.15	Evaluation of the training course

Annex I
Code of Ethics for working with refugees and migrants, RODA

I. INTRODUCTION

Parents in Action – RODA – is a non-governmental, non-profit organisation operating in the Republic of Croatia. RODA promotes full individual and social responsibility towards children and parents, and towards the family as a basic unit of society. We believe a family is every group of people that feels that way, regardless of the number of their members and their relations.

Since the beginning of the refugee crisis in Croatia, RODA has been active in providing support to mothers and children, mainly promoting and protecting breastfeeding. This Code of Ethics defines the ethical principles that guide all the volunteers and employees of the organisation in providing support and working with refugees and migrants. All of them have to be familiar with the principles of the Code of Ethics, and act in accordance with it.

II. VALUES AND PRINCIPLES

The following are the general values and principles we advocate:

- Respect for fundamental human and children's rights, dignity and the value of human life.
- Honesty, openness and tolerance towards unique differences among individuals.
- Through our activities, we promote the general values of volunteering as a form of civic engagement in the social processes which empowers individuals, builds solidarity, and encourages participation.
- We believe that information and knowledge must be available and free for everyone, so we never charge for our activities and teaching materials for profit, except when this is the only way to achieve them.
- Through our work and actions, we comply with the principles of environmental protection and sustainability.
- We change, rather than conform to, individuals, institutions and the system that do not protect the interests of children, mothers, fathers, families and the natural environment. We are driven by our activist spirit because we believe in the power of united individuals initiating changes. We inform and educate ourselves and the society we live in, and we take full responsibility for our work that is done with the best intentions.
- We support and encourage each other, aware of the synergistic effect of team work. We are open, tolerant and respect our differences (regarding sex, gender, religion, age, race, citizenship, interests and values), seeing them as our advantages.
- We share information and knowledge with each other, without taking credit for the subsequent results, regardless of how much we contribute to the work of the organisation.
- Guided by our values and parental intuition, in our work and in the promotion of the organisation's vision, we use verified information and contemporary scientific research published by local or foreign authorities in the field of our interest.
- We respect the choice of every individual, and believe the freedom to choose is a fundamental human right. Through our activities, we promote choices that are in accordance with our objectives.
- We stimulate and encourage our members to socialise, create a friendly environment and support each other even outside of the organisation and its activities, because we believe this strengthens community spirit and the spirit of friendship that are special and important in our work.

III. RULES OF CONDUCT AND VOLUNTEERING IN A REFUGEE CRISIS

Below are the principles for working with refugees and migrants directly, and for communicating with other participants in the field.

- We are guided by the high standards of humanity, and we strive to protect the dignity and privacy of refugees and migrants as far as possible under the circumstances in the field.
- When providing support, we do not differentiate between refugees and migrants on the basis of citizenship, ethnicity, the colour of their skin, their religious beliefs, race or gender.
- We respect the choices of refugees and migrants, and we do not impose our choices on them.
- When communicating with refugees and migrants, we ask for the help of an interpreter to communicate better. If this is not possible, we speak English (or another language they might understand) and try to understand each other as far as we can. We do not talk about them or to them in a language they do not understand at all.
- In our work, we use the knowledge gained through training courses, and, in case of doubt, we consult with the coordinator responsible for employees and volunteers. We do not give answers that have not been verified.
- We do not take pity on migrants and refugees, but we try to understand and be useful.

IV. GENERAL PRINCIPLES

- We represent RODA through our work, and through our behaviour and actions we aim to maintain the high reputation of the organisation.
- We fulfil all our obligations and responsibilities with diligence and great patience.
- We strive to continuously raise the quality of our work and the support we provide to refugees and migrants.
- In contact with all the participants in the field (representatives of non-governmental organisations, institutions and the government), we cultivate partnerships, good relationships and cooperation which contribute to a stimulating work environment.
- We do not disclose or share any confidential information in public. We protect the privacy of refugees, migrants, our associates and other participants in the field.
- We do not publish information, photographs and statuses related to our work in the field on social networks.
- We do not give individual statements to the press without prior consultation with the coordinator responsible for employees and volunteers.
- We report all irregularities that occur while working in the field to the coordinator responsible for employees and volunteers.
- While working in the field or anywhere else where we represent RODA, we do not consume cigarettes, alcohol or drugs.
- In our homes, while working in the field, or anywhere else where we represent RODA, we do not consume products made by Nestlé (e.g. Nescafe, Nestea, etc., a list is available on the website: www.babymilkaction.org/nestle-boycott-list).

V. VIOLATION OF THE CODE OF ETHICS

- It is the duty of every volunteer and employee to adhere to the Code of Ethics while working.
- If a volunteer or an employee violates the Code of Ethics with her behaviour, her attention will be called to the violation.
- Repeated or serious violations of the Code of Ethics can result in the prohibition to volunteer and work with refugees and migrants.