OPINION EDITORIAL

# Granting Agency to Mothers in Decision Making Over Breastfeeding in Fragile Humanitarian Settings: A Call for an Emancipatory Feminist Approach

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## BACKGROUND

In 1981, the World Health Assembly (WHA) adopted the World Health Organization's (WHO) International Code of Marketing of Breastmilk Substitutes (IC) to promote healthy infant and young child feeding (IYCF) practices through more stringent regulation of the marketing of breastmilk substitutes (BMS) [1]. This action was largely in response to prior allegations of ethical misconduct by corporations complicit in the scientifically inaccurate advertisement of BMS as nutritionally superior [2]. The 1981 WHA adoption of the IC was thus justifiably viewed as a laudable global health achievement for it marked a fundamental shift in how governments responded to aggressive lobbying by formula companies in the defence of public health [3].

Not surprisingly, the IC's adoption catalyzed an equally radical change in the global ethos surrounding breastfeeding. As major multilateral institutions, including the WHO, United Nations Children's Fund, and International Baby Foods Action Network, passed subsequent resolutions supportive of breastfeeding, the promotion of breastfeeding began appearing in the national public health strategy formulations of national governments. This resulted in rates of breastfeeding worldwide to rise sharply in response to public recognition of its nutritional superiority [3,4,5]. Unfortunately, when the IC was adopted, little consideration was given to the pragmatic realities faced by mothers in fragile humanitarian settings, leaving minimal allowance for operational divergence from best practices in contexts fraught with social, political, cultural, and physical barriers to breastfeeding.

## CHALLENGES TO BREASTFEEDING IN FRAGILE HUMANITARIAN SETTINGS

Field workers and researchers operating in fragile humanitarian settings including, but not limited to, disaster relief shelters, refugee camps, and internally displaced persons (IDP) camps have commented widely upon the apparent and self-expressed challenges that mothers in these settings face in adhering to optimal breastfeeding practices. Mothers' inadequate nutrition in these settings can pose a restraint to sufficient breastmilk production [6]. Reduced nutrition can also impact individual's impression of self-efficacy in breastfeeding, as noted in Iraq where mothers perceived an inability to breastfeed on the basis of their own poor access to good nutrition [7]. Reduced lactation in such settings is also attributed to be a result of stress and trauma from recent or ongoing traumatic events [6]. In a study conducted on internally displaced persons in Eastern Ukraine, 45.7% of mothers who discontinued breast-feeding when their infants were aged less than six months listed stress related to the conflict as the primary reason [8]. Physical fractures and injuries due to trauma resulting from recent conflict or natural disasters have also been reported as a barrier to breastfeeding in that they can prevent mothers from physically holding and appropriately positioning their babies [6].

Finally, various sociocultural barriers to breastfeeding have been reported in fragile humanitarian settings. The most notable one is the lack of a safe and private environment, particularly where tent shelters result in tight clustering of family members and relatively open exposure to outside passersby [6,9]. In contexts where religious and cultural norms favour private breastfeeding and/or where there are strict prohibitions on outside men witnessing women engaging in breastfeeding, the risk of public exposure can be particularly distressing [6,9].

Considering the abundance of barriers present, it is not surprising that sub-optimal breastfeeding rates and practices have been reported in many refugee and IDP camps. In studies conducted on Saharawi and Palestinian refugees, rates of exclusive breastfeeding in children under the age of six months have been reported as low as 11.7% and 34% respectively. In a study conducted in IDP camps in Northern Syria, 41% of children surveyed could not be nourished by their own mother at the time of the study [10,11,12].

## INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES: CURRENT OPERATIONAL GUIDANCE

Recognizing the unique circumstances and pragmatic challenges associated with IYCF in fragile humanitarian settings, the Operational Guidance on Infant Feeding in Emergencies (OG-IFE) aims to provide concise, practical guidance in support of *"emergency preparedness, response and recovery worldwide to maximize child nutrition, health and development"* [13]. In practice, this means ensuring that the IC is adhered to in emergency settings where suboptimal breastfeeding conditions may provide a gateway for companies to unethically market and sell BMS.

Accordingly, the most recent iteration of the OG-IFE calls upon fieldworkers to *"protect, promote and support exclusive breastfeeding in infants less than six months of age and continued breastfeeding in children aged six months to two years or beyond"* and to *"support mothers to transition to exclusive breastfeeding in cases where mixed feeding is practiced"* [13].

These findings on suboptimal breastfeeding in fragile humanitarian settings are undoubtedly concerning, and indeed warrant international attention. However, the response of the international community to the realization of sub-optimal breastfeeding in fragile humanitarian settings has not been one of loosening stringent enforcement orders on exclusive breastfeeding in situationally unique contexts. Rather, there exists widespread consensus that where barriers to breastfeeding are present, an appropriate response should aim to mitigate such barriers by providing more support to breastfeeding mothers as opposed to introducing infant formula as an alternative [14-21]. In some cases, international actors have even cast doubt on the degree to which perceived barriers to breastfeeding in humanitarian crises constitute real threats or are simply myths that have become normalized under corporate influence [22-24]. In either case, the assumption underlying the advised action is that international stakeholders and humanitarian responders, rather than mothers themselves, are the most suitable actors to make decisions on best IYCF practices.

While in some cases additional supports for breastfeeding have helped mothers to effectively overcome barriers and adopt better breastfeeding practices [25,26], the challenges to achieving this are reflected in the still sub-optimal rates of breastfeeding in many refugee and IDP camps [10-12]. When breastfeeding ceases to occur and no alternative is made available, the nutritional health of infants is placed under grave threat.

## A CALL FOR A NEW APPROACH

Recognizing the dignity, self-worth, and inherent right of mothers to exercise autonomy in decision making and to actively participate in the design of policies governing them, this article calls for a more emancipatory feminist approach to breastfeeding practice in fragile humanitarian settings. This call is derived from the following evidence-backed assumptions:

1. While breastfeeding can and should be encouraged where possible, it is not an option for all women, particularly for those living in socially, politically, and physically imperilling environments [27];
2. BMS, when designed in a nutritionally optimal manner and provided in a setting where safe and clean water is made accessible for infant feeding purposes, can fully meet the nutritional needs of infants and support adequate growth and development while not posing other health risks [28,29]; and
3. The provision of BMS to women who, despite full knowledge of the benefits of breastfeeding, make the autonomous decision to forgo the practice due to preference, physical, or emotional inability, can have a net positive impact on child nutrition in fragile humanitarian settings by ensuring the availability of an alternative option where breastfeeding otherwise would not occur [30].

By supporting rather than policing mothers' decision making over IYCF practice in exceptional circumstances, an approach which rids mothers of agency and generates unwarranted feelings of pressure and guilt can be re-envisioned as one which places the mother at the front and center of decision making on infant feeding while ensuring the provision of adequate nutrition for infants. This need not represent a reversal of progress made since the adoption of the IC; rather, it can represent a fundamental step in the quest to balance both empowering women and optimizing children's health in fragile humanitarian settings.

## REFERENCES

1. World Health Organization. International Code of Marketing of Breast-milk Substitutes [Internet]. 1981. Available from https://www.who.int/nutrition/publications/code_english.pdf

2. World Health Organization. Long-term effects of breastfeeding: a systematic review [Internet]. 2013. Available from https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.832.2036&rep=rep1&type=pdf

3. Ahmed A. The International Code of Marketing of Breast-milk Substitutes: Update on the Global Implementation. Journal of Human Lactation. 2020;36(4):803-807.

4. Wright A, Schanler R. The Resurgence of Breastfeeding at the End of the Second Millennium. The Journal of Nutrition. 2001;131(2):421S-425S.

5. Ryan A, Wenjun Z, Acosta A. Breastfeeding Continues to Increase Into the New Millennium. PEDIATRICS. 2002;110(6):1103-1109.

6. MirMohamadalile M, Khani Jazani R, Sohrabizadeh S, Nikbakht Nasrabadi A. Barriers to Breastfeeding in Disasters in the Context of Iran. Prehospital and Disaster Medicine. 2019;34(1):20-24.

7. Haidar M, Farhat J, Saim M, Morton N, Defourny I. Severe malnutrition in infants displaced from Mosul, Iraq. The Lancet Global Health. 2017;5(12):e1188.

8. Summers A, Bilukha O. Suboptimal infant and young child feeding practices among internally displaced persons during conflict in eastern Ukraine. Public Health Nutrition. 2017;21(5):917-926.

9. Akbar Ali Hirani S. Facilitators and Barriers to Breastfeeding Practices of Internally Displaced Mothers Residing in Disaster Relief Camps in Pakistan: A Critical Ethnography [Internet]. 2019. Available from https://idl-bnc-idrc.dspacedirect.org/bitstream/handle/10625/57621/IDL-52621.pdf?sequence=3

10. Aakre I, Lilleengen A, Lerseth Aarsand M, Strand T, Barikmo I, Henjum S. Infant feeding practices in the Saharawi refugee camps Algeria, a cross-sectional study among children from birth to six months of age. International Breastfeeding Journal. 2016;12(1).

11. Takai K, Kamiya Y, Hababeh M, Khader A, Kitamura A, Zeidan W et al. Prevalence of exclusive breastfeeding and associated factors among refugees from Palestine in Jordan: a cross-sectional study. The Lancet. 2019;393:S51.

12. Elsafti A, van Berlaer G, Al Safadi M, Debacker M, Buyl R, Redwan A et al. Children in the Syrian Civil War: the Familial, Educational, and Public Health Impact of Ongoing Violence. Disaster Medicine and Public Health Preparedness. 2016;10(6):874-882.

13. UNHCR IFE Core Group. Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Programme Managers [Internet]. 2017. Available from https://www.unhcr.org/45f6cd022.pdf

14. Gribble K, McGrath M, MacLaine A, Lhotska L. Supporting breastfeeding in emergencies: protecting women's reproductive rights and maternal and infant health. Disasters. 2011;35(4):720-738.

15. Binns C, Lee M, Tang L, Yu C, Hokama T, Lee A. Ethical Issues in Infant Feeding After Disasters. Asia Pacific Journal of Public Health. 2012;24(4):672-680.

16. Carothers C, Gribble K. Infant and Young Child Feeding in

Emergencies. Journal of Human Lactation. 2014;30(3):272-275.

17. Pothiawala S. (2016). Food and Shelter Standards in Humanitarian Action. Turkish journal of emergency medicine, 15(Suppl 1), 34–39. doi:10.5505/1304.7361.2015.98360

18. Walsh T. Breast is best even in emergency situations, humanitarian orgs say [Internet]. 2018. Available from https://www.devex.com/news/breast-is-best-even-in-emergency-situations-humanitarian-orgs-say-93212

19. Bauer B. Breastfeeding: how one group fought the spread of formula milk in refugee camps [Internet]. 2016. Available from https://www.theguardian.com/global-development-professionals-network/2016/nov/30/baby-bottles-camps-dangerous-refugee-mothers-breastfeed-greece

20. International Lactation Consultant Association. Emergency Preparedness Checklist for Breastfeeding Mothers [Internet]. 2009. Available from https://portal.ilca.org/files/in_the_news/Emergencies/Checklists09_PRINT.pdf

21. UNICEF, World Health Organization, World Food Programme, Save the Children, World Vision International. Joint Statement: Infant and Young Child Feeding in Emergencies [Internet]. 2019. Available from https://reliefweb.int/report/mozambique/joint-statement-infant-and-young-child-feeding-emergencies-mozambique-march-27

22. Theurich M, Grote V. Are Commercial Complementary Food Distributions to Refugees and Migrants in Europe Conforming to International Policies and Guidelines on Infant and Young Child Feeding in Emergencies?. Journal of Human Lactation. 2017;33(3):573-577.

23. International Baby Food Action Network. IYCF-E Briefing for All Aid Workers and Volunteers in Disasters Infant and Young Child Feeding – Why should it Matter to Me? [Internet]. 2017. Available from http://www.babymilkaction.org/wp-content/uploads/2017/03/2.-IYCF-E-Briefing-for-All-Aid-Workers-and-Sectors-1.pdf

24. International Baby Milk Action Network. Ensuring correct messaging about breastfeeding in emergencies [Internet]. 2017. Available from https://www.babymilkaction.org/archives/12505

25. Azad F, Rifat M, Manir M, Biva N. Breastfeeding support through wet nursing during nutritional emergency: A cross sectional study from Rohingya refugee camps in Bangladesh. PLOS ONE. 2019;14(10):e0222980.

26. Ayoya M, Golden K, Ngnie-Teta I, Moreaux M, Mamadoultaibou A, Koo L et al. Protecting and improving breastfeeding practices during a major emergency: lessons learnt from the baby tents in Haiti. Bulletin of the World Health Organization. 2013;91(8):612-617.

27. Haidar M, Farhat J, Saim M, Morton N, Defourny I. Severe malnutrition in infants displaced from Mosul, Iraq. The Lancet Global Health. 2017;5(12):e1188.

28. Salminen S, Stahl B, Vinderola G, Szajewska H. Infant Formula Supplemented with Biotics: Current Knowledge and Future Perspectives. Nutrients. 2020;12(7):1952.

29. Martin C, Ling P, Blackburn G. Review of Infant Feeding: Key Features of Breast Milk and Infant Formula. Nutrients. 2016;8(5):279.

30. Emergency Nutrition Network. ENN's perspective on the nutrition response in the Syria crisis [Internet]. 2014. Available from www.ennonline.net/fex/48/perspective