WVI MANAGEMENT POLICY

TITLE: World Vision Policy Governing the Procurement and Use of Milk Products in Field Programmes

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1. OVERVIEW

1.1. Purpose

Goal: To contribute to the fulfillment of the highest attainable standards of health including the right to adequate nutrition as stated in the Convention on the Rights of the Child by all children in World Vision programme areas.

To ensure effective infant and young child feeding practices and avoidance of harm to children, World Vision has set an internal policy regarding the procurement and use of milk and milk-derived products in field programmes, in both emergency and non-emergency contexts. This policy is reviewed on a periodic basis to ensure alignment with the latest technical findings and standards[1]. The policy was initially drafted in 1991, updated in 2007, 2011 and 2017.

1.2. Scope

This World Vision International Management Policy applies to all World Vision corporate entities (which includes all WVI branch offices; Global Centre offices; Regional offices; National Office branches, and programme/project offices). It supersedes and replaces the World Vision International Policy Governing the Procurement and Use of Milk Products in Field Programmes written in 1991 and revised in 2007, 2011, 2017.

1.3. Effective Date

The effective date of this revised Policy is the 1st of December 2017.

1.4. Retired/Related Policies

1.5. Contextualisation

Contextualisation of policies is addressed in the Contextualization Guidelines available on WV Central (Alternatively, please search for 'Contextualization Guide' on WV Central in the event that the direct link provided does not work)

[1] 2016 WHO/UNICEF Guidelines on HIV and Infant Feeding; Infant and Young Child Feeding in Emergencies Operational Guidance (IFE-OG), Version 3.0, October 2017; International Code of Marketing of Breastmilk substitutes and World Health Assembly (WHA) resolutions.

2. POLICY

2.1. World Vision will support, protect and promote immediate and exclusive breastfeeding of infants for the first six months of their lives and continued breastfeeding for two years or beyond, with timely and correct use of adequate complementary foods starting at six months of age in all programming, advocacy, internal policies and practices and marketing (Annex 1).

2.2. World Vision will uphold and promote the provisions of the International Code of Marketing of Breast Milk Substitutes (the Code) and subsequent World Health Assembly resolutions (Annex 2). World Vision will not accept donations of breast milk substitutes, and feeding equipment (e.g. bottles, teats, breast pumps).

2.3. World Vision will not accept unsolicited donations of commercial baby foods and other milk products. (point 2.13.-2.14.)

2.4. World Vision endorses the Operational Guidance for Emergency Relief Staff and Programme Managers on Infant and Young Child Feeding in Emergencies, version 3.0, October 2017 (key points in Annex 3). World Vision recommends that the full operational guidance is referenced and implemented in conjunction with this policy.

2.5. World Vision's handling of milk products in refugee settings will be in accordance with the United Nations High Commissioner for Refugees' (UNHCR) Standard Operating Procedures for the Handling of Breast Milk Substitutes in Refugee Situations for Children 0-23 months (UNHCR 2015).

EXCEPTIONAL SITUATIONS FOR TEMPORARY OR LONGER-TERM USE OF INFANT FORMULA

2.6. World Vision will only purchase and distribute infant formula in an exceptional situation where the infant cannot or should not be breastfed. Infant formula requirement may be *temporary* or *longer-term*. The exceptional situation must be identified by an infant and young child feeding needs assessment using established and agreed criteria (Annex 4) and conducted by personnel who have received training on infant and young child feeding in consultation with health and nutrition personnel. Indications for ***temporary infant formula use*** include: during relactation; short-term separation of infant and mother; transition from mixed feeding to exclusive breastfeeding; short-term waiting period until wet nurse or donor human milk is available. Indications for ***longer-term infant formula*** use include: orphaned infant; very ill mother; specific infant or maternal medical conditions; mother not wishing or unable to relactate; infant rejected by mother; infant not breastfed prior to the emergency; rape survivor not wishing to breastfeed; infant established on replacement feeding in the context of HIV.

2.7. When the use of infant formula is indicated, World Vision will only distribute to the infants requiring it and will ensure that the supply is continued for as long as the infants concerned require it. Where resources are limited, infant formula should be prioritized to infants < 6 months of age.

PROCUREMENT, HANDLING AND USE OF BREAST MILK SUBSTITUTE, MILK PRODUCTS AND SUPPLIES

2.8. In exceptional circumstances confirmed by health or nutrition personnel, World Vision will purchase infant formula after recommendation by a senior health and nutrition staff and approval by National Office Operations Director or Emergency Response Manager. Infant formula procured by World Vision will be manufactured and packaged in accordance with Codex Alimentarius standards, have a shelf-life of at least six months of local receipt of supply, labelled in the appropriate language and compliant to the labelling requirements of the Code, and used carefully in ways that reduce the risk of World Vision being associated with or implying endorsement of the formula. Consideration regarding local versus international procurement include: Codex Alimentarius and Code compliance of available product, stocks available in country, cost, importation legislation, appropriate language of labels and instruction, and safeguarding against creating new markets for products.

2.9. When the use of infant formula is indicated, training on how to use infant formula will be given to the primary caregiver and none other. World Vision will not purchase and distribute infant formula in areas without access to adequate clean water, without resources to provide sufficient infant formula and to prepare formula safely, without family support and without access to comprehensive health services. Where the affected population is in transit, World Vision will provide feeding support in accordance with the Interim Guidance for IYCF support in refugee and migrant transit settings (Annex 5)

2.10. World Vision will assess the availability of fuel, water and equipment for safe preparation and use of breast milk substitute and milk products prior to distribution. Interventions to support artificially-fed infants should budget for the purchase of breast milk substitute supplies along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation and staff training (Annex 6). Use of Ready to Use Infant Formula (RUIF) may minimise health risks while support services for use of powdered infant formula are established. In situations where safe preparation and use of infant formula cannot be assured, World Vision will consider on-site reconstitution and consumption or provision of communal preparation and sterilization facilities.

2.11. World Vision will not accept donations of infant formula for use in the health care system in accordance with the Code, or for general distribution to pregnant women and lactating mothers. Where criteria for the use of breast milk substitute are met (point 6 above), breast milk substitute supplies that have been purchased by World Vision may be used within the health care system. The health care system refers to governmental, non-governmental or private institutions or organisations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries or childcare institutions. It also includes health workers in private practice. It does not include pharmacies or other established sales outlets.

2.12. World Vision will not accept or supply bottles and teats (nipples) and will take all possible steps to actively discourage the distribution and use of infant feeding bottles and artificial teats in all its programmes and projects. World Vision will not use pictures of bottles and teats or bottle-feeding in their training materials or media communications that would promote or condone their use. Where an infant or young child is not breastfed, World Vision encourages use of cups (without spouts) and spoons for feeding. Immediate transition to cup feeding for bottle-fed infants may not be feasible or acceptable to caregivers. In such circumstances, to minimize risks, World Vision will advise on bottle sterilization at the household level or, where necessary, through on-site sterilization services, accompanied with hygiene messaging.

2.13. World Vision will accept, source and distribute dried milk products only if they can be used under strict control in hygienic conditions either for on-the-spot consumption in a strictly supervised environment, such as therapeutic feeding programmes and wet supplementary feeding programmes, or pre-mixed centrally with cereal flour, sugar and oil to produce a dry take-away premix for cooking at household level. Dried milk should not be distributed as a single commodity.

2.14. World Vision will accept, source and distribute milk products received in dry form (for use as specified in point 2.13.). World Vision will not accept, source and distribute liquid or semi-liquid milk, including evaporated, condensed and Ultra High Temperature milk products. RUIF may be used when it is acceptable in the country context and where sanitation and storage conditions are guaranteed and with prior approval as for any breast milk substitute (Point 2.8.).

2.15. World Vision will accept, source and distribute dried skim milk (for use as specified in point 2.13.) only if it has been fortified with vitamin A. In this case, staff involved should be made aware that it is NEVER appropriate to feed dried skim milk on its own to infants. When given in calorically adequate amounts it can cause dehydration and death due to its excessive protein and mineral content.

2.16. World Vision will accept, source and distribute pre-formulated therapeutic milk or dried skim milk to prepare therapeutic milk only for treatment of severe malnutrition in accordance with current international guidelines.

2.17. All milk products must have a shelf life of at least six months at time of arrival to World Vision in-country.

HIV SPECIFIC CONTEXT

2.18. World Vision recognises the challenges regarding infant and young child feeding in the context of HIV infection. World Vision promotes, supports and advocates for the accessibility of HIV care and supports for pregnant women as part of primary health services.

2.19. Wherever HIV status of the mother is unknown or known to be HIV uninfected, World Vision encourages and supports the mother to exclusively breastfeed her infant for the first six months of life with continued breastfeeding for two years or beyond, with timely and correct use of adequate complementary foods.

2.20. The 2016 WHO/UNICEF guidelines on infant feeding in the context of HIV (Annex 7) urge national or sub-national health authorities to establish one recommendation for infant feeding (that is, either breastfeeding plus anti-retroviral (ARV) prophylaxis or total avoidance of breastfeeding) as the strategy that will most likely give infants the greatest chance of HIV-free survival. World Vision supports the 2016 WHO/UNICEF Guidelines on HIV and Infant Feeding and encourages mothers known to be living with HIV to feed their infants in accordance with their country's national or sub-national Infant Feeding Strategy based on these guidelines. World Vision promotes, supports and advocates for availability and accessibility to timely and regular ARV prophylaxis provision for mothers known to be living with HIV who choose to breastfeed.

2.21. If the mother is known to be living with HIV and conditions needed to safely formula feed (see Annex 6) are not met (whether or not ARV drugs are available), then World Vision promotes:

- Exclusive breastfeeding in the first six months of life and continued breastfeeding for 2 years or beyond.
- After six months, continued breastfeeding with appropriate and adequate complementary foods unless environmental, economic and social circumstances are safe for and supportive of replacement feeding.

2.22. In all circumstances, decisions about infant feeding options for women known to be living with HIV will be made in consultation with a World Vision National Office senior health and nutrition technical staff (refer to Annex 7).

STAFF TRAINING

2.23. World Vision will provide training, or access to training where it is available, to technical and non-technical staff to promote, protect and support optimal infant and young child feeding practices (including assessment, infant feeding counselling, skilled breastfeeding support, infant feeding emergency preparedness, targeting needs for breast milk substitutes, artificial feeding management).

2.24. World Vision Health, HIV, Nutrition, Disaster Management, Gifts-in-Kind and Water, Sanitation and Hygiene staff working in communities will be trained to understand the evidence around the negative impact (that is, much higher risk of death) of using infant formula when conditions are not met to safely formula feed, even when mothers are known to be living with HIV.

COORDINATION

2.25. World Vision will work with the coordinating agencies for infant feeding in the field on dissemination and implementation of the milk policy to ensure that purchased or solicited milk products and specific distributions are in compliance with the Code and in respect to principles endorsed by World Vision. In emergencies, World Vision will work in close association with the designated Infant Feeding in Emergencies coordination authority (e.g. Government, UNICEF or UNCHR).

ACCOUNTABILITY

2.26. The Operations Director (National Office) or Emergency Response Manager is responsible for approving procurement of all milk products, and breast milk substitutes in line with the Milk Policy, as advised by the National Health/Nutrition Advisor. Where local capacity is unavailable, World Vision Global Centre Health & Nutrition technical advisors and/or Disaster Management (DM) technical team can advise.

2.27. Any issues regarding the World Vision policy on the procurement and use of milk products in field programmes should be reported to the Health/Nutrition advisor, and Operations Director and/or Emergency Response Manager in the National Office, Strategic Director of Operations at the Regional Office, and where necessary, reported to the Global Centre

Global Director Health and Nutrition and and Disaster Management Director – Global Technical Team.

3. DEFINITIONS

Milk Products

Dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed milk; soya milk; evaporated or condensed milk; fermented milk or yogurt.

Infant Formula

A breast milk substitute formulated industrially in accordance with applicable Codex Alimentarius Standards (developed by the joint FAO/WHO Food Standards Program) to satisfy the normal nutritional requirements of infants to six months of age and adapted to their physiological characteristics. Commercial infant formula is infant formula manufactured for sale, branded by a manufacturer and may be available for purchase in local markets. Powdered Infant Formula (PIF) is an infant formula product which needs to be reconstituted with safe water before feeding, Ready-to-use infant formula (RUIF) is a type of infant formula product that is packaged as a ready-to-feed liquid and does not need to be reconstituted with water.

Breast Milk Substitute

Any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not it is suitable for that purpose. In terms of milk products, this includes any milks that are specifically targeted for feeding infants and young children up to the age of three years.

Note: In practical terms, foods may be considered breast milk substitutes depending on how they are marketed or represented. These include infant formula, other milk products, therapeutic milk and bottle-fed complementary foods marketed for children up to three years of age and complementary foods, juices and teas marketed for infants less than six months. In some markets, products not suitable as the sole food of infants are perceived or used as such. One of the more common examples is commercial cereals which can be over-diluted and fed by bottle.

4. BACKGROUND

World Vision protects, promotes and supports immediate and exclusive breastfeeding until six months of age and continued breastfeeding with appropriate complementary feeding until two years or beyond as priority interventions essential to the well-being of infants and young children (Annex 1).

There are only very few specific situations as described in this policy where breast milk substitutes may be necessary. Inappropriate handling of milk products can negatively impact infant feeding practices and directly contribute to increased morbidity and mortality in infants and young children.

World Vision recognises the challenges posed by the HIV pandemic and emergencies on infant feeding. Fully aware of these challenges and in alignment with the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health

Assembly resolutions, the Innocenti Declaration, UNICEF/WHO Global Strategy on Infant and Young Child Feeding, Baby-friendly Hospital Initiative, the WHO/UNICEF 2016 guidelines on HIV and Infant Feeding, and SPHERE standards, World Vision is committed to promote appropriate infant and young children feeding practices, contributing to the achievement of the Sustainable Development Goal targets (Goals 2, 3 and 6) and in support of the United National Decade of Action on Nutrition (2016 - 2025).

ANNEX 1 - CRITICAL IMPORTANCE OF BREASTFEEDING TO MATERNAL AND CHILD HEALTH OUTCOMES

World Vision interventions seek to provide the maximum benefit for children using internationally recognised standards and context-appropriate approaches. The interventions target underlying causes of mortality and morbidity of children and avoid harm.

Undernutrition causes almost one half of all deaths of children under 5—more than three million children out of 6.9 million child deaths in 2011 (Black et al. Lancet 2013). Many of these deaths occur during the first year of life and are often associated with inappropriate feeding practices. More than 820,000 lives (87% of them infants under 6 months of age) would be saved annually with increased breastfeeding. (Lancet Breastfeeding Series, 2016)

The protection, promotion and support of immediate and exclusive breastfeeding and appropriate complementary feeding are essential to the well-being of infants and young children. WHO/UNICEF recommendations are clear in the first two years of life: Infants should be put to the breast within an hour of birth and exclusively breastfed (fed only breastmilk) on demand for the first six months. Children six to 24 months of age need more food to grow and, in addition to breastmilk, should be fed nutritionally adequate and safe (hygienically prepared, stored and fed with clean hands and clean utensils) complementary foods. Breastfeeding is recommended to continue up to two years of age or beyond.

1. Appropriate breastfeeding has a high impact on reducing infant and child mortality. Babies not exclusively breastfed in the first six months of life have a 14 times higher risk of death than infants who are exclusively breastfed. About 50% of all diarrhea episodes and 1/3 of respiratory infections would be avoided by breastfeeding as recommended (Victoria et al. Lancet 2016).
2. Breastfeeding protects against the development of chronic disease later in life (e.g. obesity, diabetes).
3. Breast milk provides all the energy and nutrients that the infant needs for the first six months of life and it continues to provide up to half or more of a child's nutritional needs during the second half of the first year, and up to one-third during the second year of life.
4. Breast milk promotes sensory and cognitive development of the infant, promotes bonding between infant and mother and can protect mother's emotional well-being.
5. Breastfeeding contributes to the health and well-being of mothers. Breastfeeding mothers have less post-partum haemorrhage, quicker recovery after childbirth, less anaemia and have natural birth spacing, unlike non-breastfeeding mothers who have more post-partum haemorrhage, slower recovery from childbirth, more anaemia, and an early return of menses. Women who do not breastfeed increase their risk of ovarian cancer and breast cancer.
6. Breastfeeding increases family resources; it is free and is safe for the environment.

Replacing breastmilk with other milk products (e.g. infant formula) can result in serious problems in many contexts, such displacement of breastfeeding practices, contamination of milk products and incorrect reconstitution of milk, which in turn, can lead to malnutrition and even death. Powdered infant formula is not a sterile product, and can be contaminated during the manufacturing process. Milk products may also be contaminated by use of unsafe drinking water, and lack of sterilisation of bottles and cups. If over-diluted milk is fed to children, the resulting inadequate dietary intake will lead to malnutrition. Conversely, the consumption of concentrated milk products such as dried-skim milk or dried-whole milk by young children can result in renal failure or even death due to high concentrations of sodium and protein.

Even in populations accustomed to using infant formula, their use carries additional risks in an emergency context as conditions that permitted 'safe' BMS use prior to the emergency are often disrupted. For example, outbreak of infectious disease, poor access to supplies, lack of fuel and equipment for safe preparation, WASH conditions and lack of health care. Infants who are dependent on BMS should be urgently identified and appropriately supported by qualified health or nutrition personnel through the provision of a targeted package of essential support, to minimise risks associated with artificial feeding in this context and to protect all infants and young children.

ANNEX 2 - THE INTERNATIONAL CODE

The International Code of Marketing of Breast-milk Substitutes (the Code), and Relevant World Health Assembly (WHA) Resolutions http://www.who.int/nutrition/netcode/resolutions/en/

WHAT IS THE CODE?

The Code is a human rights instrument which describes the minimum requirements for the regulation of the marketing of breast-milk substitutes, feeding bottles and teats. The Code aims to stop the aggressive, unethical, and inappropriate marketing of breast-milk substitutes. The 34th session of the World Health Assembly (WHA) adopted the International Code of Marketing of Breast-milk Substitutes in 1981 as a minimum requirement to protect and promote appropriate infant and young child feeding.

The Code aims to contribute "to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution" (WHO, 2017)

KEY PROVISIONS OF THE CODE

1. Promote and support immediate (within one hour of delivery) and exclusive breastfeeding for six months as a global public health recommendation with continued breastfeeding for up to two years of age or beyond.

2. Foster appropriate complementary feeding from the age of six months recognising that any food or drink given before or in larger amounts than nutritionally required may interfere with breastfeeding or displace breast milk in the infant diet.

3. No advertising of products under the scope of the Code to the public.

4. No free samples to mothers.

5. No promotion of products in health care facilities, including the distribution of free or low-cost supplies.

6. No company representatives to advise mothers.

7. No gifts or personal samples to health workers.

8. No words or pictures idealising artificial feeding, including pictures of infants and/or women, on the labels of the products.

9. Health workers should be trained on how to support mothers to immediately and exclusively breastfeed for six months. Information to health workers should be scientific and factual. Health claims on labels are inappropriate.

10. All information on artificial feeding, including the labels, should explain the benefits of breastfeeding and all costs and hazards associated with artificial feeding.

11. Unsuitable products such as sweetened condensed milk should not be promoted for babies.

12. All products should be of a high quality and take account of the climatic and storage conditions of the country where they are used.

13. Complementary foods are not to be marketed in ways to undermine exclusive and sustained breastfeeding.

14. Financial assistance from the infant feeding industry may interfere with professionals' unequivocal support for breastfeeding. Using free gifts (even something as seemingly harmless as a pen) results in associating oneself with and unintentionally endorsing the product.

ANNEX 3 – KEY POINTS INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES

from Operational Guidance for Emergency Relief Staff and Programme Managers on Infant and Young Child Feeding in Emergencies, Version 3.0, October 2017

KEY POINTS

1. Appropriate and timely support of infant and young child feeding in emergencies (IFE) saves lives, protects child nutrition, health and development and benefits mothers.
2. Emergency preparedness is critical to a timely, efficient and appropriate IFE response (Box 1).
3. Key provisions regarding IFE should be reflected in government, multi-sector and agency policies and should guide emergency responses (Section 1).
4. Sensitisation and training on IFE is necessary at multiple levels and across sectors (Section 2).
5. Capacity to coordinate IFE should be established in the coordination mechanism for every emergency response. Government is the lead IFE coordination authority. Where this is not possible or support is needed, IFE coordination is the mandated responsibility of UNICEF or UNHCR, depending on context, in close collaboration with government, other UN agencies and operational partners (Section 3).
6. Timely, accurate and harmonised communication to the affected population, emergency responders and the media is essential (Section 3).
7. Needs assessment and critical analysis should determine a context specific IFE response (Section 4).
8. Immediate action to protect recommended infant and young child feeding (IYCF) practices and minimise risks is necessary in the early stages of an emergency, with targeted support to higher risk infants and children (Section 5).
9. In every emergency, it is necessary to assess and act to protect and support the nutrition needs and care of both breastfed and non-breastfed infants and young children. It is important to consider prevalent practices, the infectious disease environment, cultural sensitivities and expressed needs and concerns of mothers and caregivers when determining interventions (Section 5).
10. Multi-sector collaboration is essential in an emergency to facilitate and complement direct IYCF interventions (Section 5).
11. In every emergency, it is important to ensure access to adequate amounts of appropriate, safe, complementary foods and associated support for children and to guarantee nutritional adequacy for pregnant and lactating women (Section 5).
12. In emergencies, the use of breastmilk substitutes (BMS) requires a context-specific, coordinated package of care and skilled support to ensure the nutritional needs of non-breastfed children are met and to minimise risks to all children through inappropriate BMS use (Sections 5 and 6).
13. Donations of BMS, complementary foods and feeding equipment should not be sought or accepted in emergencies; supplies should be purchased based on assessed need. Do not send supplies of donor human milk to an emergency that is not based on identified need and part of a coordinated, managed intervention. BMS, other milk products, bottles and teats should not be included in a general or blanket distribution (Sections 5 and 6).
14. It is essential to monitor the impact of humanitarian actions and inaction on IYCF practices, child nutrition and health; to consult with the affected population in planning and implementation; and to document experiences to inform preparedness and future response (Section 4).

ANNEX 4 – CRITERIA FOR BMS USE & ASSESSMENT GUIDANCE

Breastmilk substitute requirement may be for temporary or longer-term use.
Temporary BMS indications include: during relactation; transition from mixed feeding to exclusive breastfeeding; short-term separation of infant and mother; and short-term waiting period until wet nurse or donor human milk is available. ***Longer-term BMS indications*** include: infant not breastfed pre-crisis; mother not wishing or unable to relactate; infant established on replacement feeding in the context of HIV; orphaned infant; infant whose mother is absent long-term; specific infant or maternal medical conditions[2][3]; very ill mother; infant rejected by mother; a rape survivor not wishing to breastfeed.

Caregiver-Baby Assessment Guidance available here:
https://sites.google.com/site/stcehn/documents/iycf-e-toolkit-v3/related-annexes (see Rapid & Full Assessment templates)

[2] Acceptable Medical Reasons for the Use of BMS. WHO, 2009. www.who.int/maternal_child_adolescent/documents/WHO_FCH_CAH_09.01/en/

[3] ABM Clinical Protocol #3: Supplementary Feedings in the Healthy Term Breastfed Neonate, Revised 2017 http://www.bfmed.org/Media/Files/Protocols/Protocol%203%20Supplementation%20English%20Version.pdf

ANNEX 5 - Interim Operational Considerations for the feeding support of Infants and Young Children under 2 years of age in refugee and migrant transit settings
Full Guidance available here: http://www.ennonline.net/interimconsiderationsiycftransit

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 minimizes 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

Key Protective Actions:

- Base the IYCF support you provide on a minimum level of assessment *(see section F, in full guidance).*
- Target & manage infant formula supplies *(see section I in full guidance)*:
    - Where infant formula is needed, purchase supplies. Adhere to minimum requirements regarding quality and labelling.
    - Do not seek and act to prevent donations[4] 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.
- 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.

[4] 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.

- 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.

ANNEX 6 – MINIMIZING RISKS OF ARTIFICAL FEEDING[5]

Powdered infant formula (PIF) is not a sterile product. The risk of serious illness and death associated with artificial feeding increases dramatically if feeds are not prepared appropriately. Also, reconstituted infant formula provides an ideal environment for the growth of harmful bacteria.

Ready to use infant formula (RUIF) has the advantage that it does not require reconstitution with water. RUIF may minimise health risks while support services for use of powdered infant formula are established'. RUIF is not a guarantee of safety – appropriate use, hygiene of feeding utensils and storage considerations remain essential.' RUIF provides an ideal environment for the growth of harmful bacteria. The risks of using PIF or RUIF in an emergency setting have not been researched. There are advantages and disadvantages with using PIF and RUIF.

Use of infant formula by an individual carer should always be linked to education, one-to-one practical demonstrations of proper preparation and feeding and home-visits to assess preparation and feeding practices.

Infant Formula (PIF or RUIF) should ONLY be given to the caregiver if they are hygienically able to prepare it at home. This means:

- Understanding all the steps in preparation
- Having all the resources needed for hygienic preparation
- Having shown their ability to correctly prepare and manage the feed

If the caregiver cannot prepare PIF correctly at home then the caregiver should come to a central area for on-site reconstitution and consumption (wet feeding) until they can do this at home (this has logistical and safety issues), or in some circumstances RUIF may be an appropriate option in the short-term.

Close follow-up is necessary to ensure that the conditions continue to be met and that artificially fed infants get the medical support that they may need (as they are at higher risk as they are not breastfed). Also, artificially fed infants need regular (fortnightly) weight monitoring by a skilled health professional at the time of distribution.
To ensure this level of monitoring and to ensure that it is used as intended:

- **No more than 2.5kg of powdered infant formula should be supplied to carers at any one time.**
- **No more than 1 week's supply of RUIF should be supplied to carers at any one time.**
- Mothers should be instructed to bring back empty formula packaging in order to ensure that it is being used and not being sold.

Breastfeeding can be undermined by artificial feeding programmes for many reasons. One of the main reasons is that the provision of formula and supporting resources in an emergency situation may be a pull factor for people to try to enrol in the programme, even if they can breastfeed. For this reason, any programme to support non-breastfed infants should always include a component to protect breastfed infants e.g. provision of incentives (ie. cash, vouchers, goods) of equal or greater value to breastfeeding mothers.

[5] Materials from IYCF-E toolkit, Save the Children https://sites.google.com/site/stcehn/documents/iycf-e-toolkit; Safer BMS kit https://drive.google.com/file/d/0B5uBNDhhrtqbamMyMFg2cldrM1U/view

BMS Equipment

To minimize the risks of artificial feeding, the following supplies are required. Not all of these items need to be provided or purchased depending on household availability.

SAFER BMS KIT		
Item Description	**Unit**	**QTY**
High quality thermos flask (one to hold water for cleaning water and one to make formula) (Optional – depending on the situation, see 'Storing Hot Water' below)	Pce	2
Large cup (or jar with wide opening) for formula	Pce	1
Measuring scoop for water (Note: This can be a steel cup or glass with a line etched on it to indicate the exact amount of water to be mixed with one scoop of formula powder, as indicated by the manufacturer.)	Pce	1
Paper napkins (approximately 2 per feed x 8 feeds a day =16 + 5 extra a day to clean preparation area = 21 a day)	Pce	21 paper napkins a day
Purification Treatment (Aquatab) if necessary	Tablet	N/A
Shallow bowl to contain safe cold water for cooling the feed	Pce	1
Small pot/kettle (for boiling water)	Pce	1
Small spoon	Pce	1
Small cup/medicine cup for cup feeding infant	Pce	1
Small basin (for washing equipment)	Pce	1
Soap (for washing hands and equipment) – when runs out it should be replaced.	Pce	2
Solid plastic box with lid (for storage and preferable to have a smooth flat lid which can be used as a washable preparation surface. If it does not have a smooth flat lid then plastic sheeting will be needed as a preparation surface)	Pce	1
Jerry can (20L)	Pce	1
Water (approx. 3 litres per day if using PIF)	Pce	N/A
Fuel (wood, charcoal, electricity) for boiling water	Pce	N/A
Guidelines for caregiver	Pce	1

ANNEX 7

WHO/UNICEF GUIDELINES ON HIV AND INFANT FEEDING, 2016

(Principles and recommendations for infant feeding in the context of HIV and a summary of evidence)

KEY POINTS

1. Infant feeding practices recommended to mothers known to be living with HIV should support the greatest likelihood of HIV-free survival of their children and not harm the health of mothers. To achieve this, prioritisation of prevention of HIV transmission needs to be balanced with meeting the nutritional requirements and protection of infants against non-HIV morbidity and mortality.
2. National or sub-national health authorities should decide whether health services will principally counsel and support mothers known to be living with HIV to:
   - breastfeed and receive ARV interventions,

     or
   - avoid all breastfeeding,

   as the strategy that will most likely give infants the greatest chance of HIV-free survival. This decision should be based on international recommendations and consideration of the:
   - socio-economic and cultural contexts of the populations served by maternal and child health services;
   - availability and quality of health services;
   - local epidemiology including HIV prevalence among pregnant women; and,
   - main causes of maternal and child under-nutrition and infant and child mortality

KEY RECOMMENDATIONS

1. Mothers known to be living with HIV should be provided with lifelong ART or ARV prophylaxis interventions to reduce HIV transmission through breastfeeding according to WHO recommendations.
2. In settings where national or sub-national authorities have decided that maternal, newborn and child health services will principally promote and support breastfeeding and ARV interventions, the following recommendations apply:
   a. Mothers known to be living (and whose infants are HIV uninfected or of unknown HIV status) should:
      i. exclusively breastfeed their infants for the first six months of life,
      ii. introduce appropriate complementary foods thereafter, and
      iii. should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population) while being fully supported for ART adherence.
   b. Mothers known to be living with HIV and health-care workers can be reassured that ART reduces the risk of postnatal HIV transmission in the context of mixed feeding. Although exclusive breastfeeding is recommended, practising mixed feeding is not a reason to stop breastfeeding in the presence of ARV drugs.
   c. Mothers known to be living with HIV and health-care workers can be reassured that shorter durations of breastfeeding of less than 12 months are better than never initiating breastfeeding at all.

d. Mothers known to be living with HIV who decide to stop breastfeeding at any time should stop gradually within one month. Mothers or infants who have been receiving ARV prophylaxis should continue prophylaxis for one week after breastfeeding is fully stopped. Stopping breastfeeding abruptly is not advisable.

e. When mothers known to be HIV-infected decide to stop breastfeeding at any time, infants should be provided with safe and adequate replacement feeds to enable normal growth and development.

f. National and local health authorities should actively coordinate and implement services in health facilities and activities in workplaces, communities and homes to protect, promote and support breastfeeding among women known to be living with HIV.

3. Mothers known to be living with HIV should only give commercial infant formula milk as a replacement feed to their HIV-uninfected infants or infants who are of unknown HIV status, when **all** the following conditions are met:

   a. safe water and sanitation are assured at the household level and in the community; **and**

   b. the mother, or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant; the mother should have no expectation that current income could reasonably be expected to decline within the coming months **and**

   c. the mother or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition; **and**

   d. the mother or caregiver can, in the first six months, exclusively give infant formula milk; **and**

   e. the family is supportive of this practice; **and**

      i. the family has reason to expect that their source of infant formula is unlikely to be disrupted during the coming months**; and**

      ii. the mother or caregiver can access health care that offers comprehensive child health services

4. If infants and young children are known to be living with HIV; mothers are strongly encouraged to exclusively breastfeed for the first six months of life and continue breastfeeding as per the recommendations for the general population, that is, up to two years or beyond.

5. When antiretroviral drugs (ARVs) are not (immediately) available and in contexts where the conditions for safe formula feeding (i.e. #3 above) are not **all** met; breastfeeding is recommended and will provide infants born to mothers living with HIV with a greater chance of HIV-free survival. In circumstances where ARVs are unlikely to be available, such as acute emergencies, breastfeeding of HIV-exposed infants is also recommended to increase survival.

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