

Infant Feeding in Emergencies

Request for Ready to Use Infant Formula

Name of the requesting organisation : _____

Justifications of the request including breastfeeding counseling and support provided :

Explain how the organisation requesting is protecting, supporting and promoting initiation of breastfeeding within an hour after birth, exclusive breastfeeding from birth to 6 months, and continuation of breastfeeding with inclusion of complementary food at 6 months and beyond?

If not, why? _____

Please indicate the location of the supply provision to mothers

Orphanage Institution Hospital Clinic Dispensary Baby tent

Distribution strategy :

Nombre of units requested **per month** :

	item	
	125 ml	200ml
Number of <6 months		
Number of infants 6 months to 1 year		

(Use supply guidance document)

Other supplies needed: _____

Dates for the distribution : beginning: _____ end : _____

Frequency of monitoring of morbidity and nutritional status of beneficiaries:

Date of validation of the request ___ / ___ / ___ > **UNICEF and requesting agency must complete the Programme Agreement form** before this request can be accepted

If refused :

→ reason for refusal: _____

→ solutions proposed:

(recommendations for correction of the request, training support, referencing system, technical support)

Date ___ / ___ / ___ Organization referent for follow-up _____