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UNICEF Standard Operating Procedure on the procurement and use of breastmilk substitutes in humanitarian settings

Cover picture: Newborn baby whose mother died in the first earthquake in Nepal in April 2015 treated in UNICEF tent, with grandmother – Sindhupalchowk © UNICEF/Page (use high resolution for final version)

Table of Contents

Executive summary

This Standard Operating procedure (SOP) is intended for use by UNICEF staff working in a humanitarian setting, who are requested to support the procurement and/or distribution of breastmilk substitutes (BMS).

Breastfeeding is the best way to feed infants under six months of age and remains an important part of children's diets up to the age of two years. UNICEF is committed, as per the Core Commitments for Children in humanitarian action, to protect, promote and support breastfeeding in emergencies.

However, there are children who cannot be breastfed. These include: infants and young children who were orphaned or whose mother has been absent for a long period of time either before the humanitarian situation or in the course of the humanitarian situation, situations where the mother and/or infant has a medical condition during which breastfeeding is not possible, and infants and young children who were not breastfed at the time the humanitarian situation developed regardless of the reason, and for whom wet-nursing or relactation is not possible. These children need to be fed an appropriate BMS in a safe and sustainable way that does not jeopardise breastfeeding in the remainder of the population.

To determine whether there is a need for BMS, a detailed analysis of the situation needs to be made in coordination with the national authorities and with other partners (preferably the Nutrition Cluster). Also, individual assessments need to be done before distributing BMS to specific children. When resources are limited, infants under six months of age should receive priority for support.

The breastmilk substitute which carries the lowest risks in humanitarian settings is ready-to-use infant formula (RUIF), provided with a cup for feeding of the infant. If there is a need to procure BMS, UNICEF is the option of last resort. The procurement needs to be done in accordance with global and UNICEF guidelines.

Offices which are considering the procurement and distribution of BMS need to request permission from UNICEF Headquarters in New York (Nutrition Section, Programme Division) and Copenhagen (Supply Division). This SOP provides a template for such a request.

1. Introduction

Exclusive breastfeeding is the best way to feed an infant from immediately after birth to the age of 6 months (180 days). Breastfeeding should be initiated immediately after birth and continue after 6 months, with adequate complementary feeding, up to two years or beyond.

As documented in the Operational Guidance on Infant and Young Child Feeding in Emergencies endorsed by the World Health Assembly in 2010[i], these recommendations are still valid in humanitarian situations and even more important, given the often limited access to safe water, the increased risk of disease and food insecurity, but despite this, their implementation faces many constraints.

First, there are many myths and misconceptions about the ability of mothers to breastfeed and produce milk under stress, despite evidence and experience to the contrary, and adequate support might be insufficient at times. Everything possible should be done to protect, promote and support breastfeeding in emergencies. This is the reason for prioritizing support for appropriate infant and young child feeding (IYCF) in UNICEF's Core Commitments for Children in Humanitarian Action (CCC).[ii]

Second, there are several situations in which children cannot be, or are not, breastfed. These situations are:

1) Infants and young children who were orphaned or whose mother has been absent for a long period of time before the humanitarian situation and there is no option to wet-nurse,
2) Infants and young children who have become orphaned or whose mother is absent for a long period of time in the course of the humanitarian situation and there is no option to wet-nurse,
3) Extremely rare situations where the mother and/or infant has a medical condition during which breastfeeding is not possible and there is no option to wet-nurse. Some references:[iii, iv]
4) Infants and young children who were not breastfed at the time the humanitarian situation developed regardless of the reason and for whom there is no option to be breastfed (including through relactation or wet-nursing).

While the first two groups are usually relatively small in number, the third and fourth group can be relatively large in specific situations, such as the Ebola crisis in Western Africa and the refugee and migrant situation in Europe.

While reinforcing the need to prioritize the protection, promotion and support for breastfeeding in humanitarian situations, this SOP aims to provide guidance to UNICEF staff for decision making and actions for addressing the nutritional needs of the non-breastfed infant as part of the overall nutrition response.

2. Support for breastfeeding and care of non-breastfed infants in humanitarian settings: policy commitments and global standards

2.1. Core Commitments for Children in humanitarian action

UNICEF's Core Commitments for Children in Humanitarian Action (CCC) outline the commitments, benchmarks and programme actions in humanitarian settings in the phases of preparedness, response and early recovery. While all six nutrition related commitments and related benchmarks and actions are also relevant for infant and young child feeding (IYCF), the specific references to IYCF are copied below for easy reference:

Commitment 3: Support for appropriate infant and young child feeding (IYCF) is accessed by affected women and children.
Benchmark 3: All emergency-affected areas have an adequate number of skilled IYCF counsellors and/or functioning support groups.

Programme Actions
Preparedness: Advocate for and provide guidance on appropriate quantities of quality complementary foods to add to the food basket[1]; define essential infant and young child feeding (IYCF) interventions in emergency scenarios; develop, translate and pre-position appropriate materials for IYCF; and include emergency IYCF in ongoing training of health workers and lay counsellors.

Response:

- Monitor unsolicited donations, distribution and use of breast milk substitutes or milk powder, and take corrective action.
- Protect, support and promote early initiation and exclusive breastfeeding of infants, including establishment of 'safe spaces' with counselling for pregnant and lactating women; support safe and adequate feeding for non-breastfed infants less than 6 months old, while minimizing the risks of artificial feeding[2]; ensure appropriate counselling regarding infant feeding options and follow-up and support for HIV-positive mothers; and, with the World Food Programme and partners, ensure availability of safe, adequate and acceptable complementary foods for children[1].

Early Recovery: Ensure that IYCF activities build on and support existing national networks for infant feeding counselling and support.

2.2. Operational guidance on infant and young child feeding in emergencies

UNICEF has reached consensus about infant feeding in emergencies with its main partners (WHO, WFP,

[1] While complementary foods are included in the CCC programme actions, they are not described in this SOP
[2] Feeding a child with a substitute for breastmilk

UNHCR and several non-governmental organisations (NGOs)). This consensus is reflected in the Operational Guidance on infant and young child feeding in emergencies developed by an interagency group under coordination of the Infant and Young Child Feeding in Emergencies (IFE) Core Group. The first version was published in 2001, and an updated version in 2007. This version was endorsed at the World Health Assembly in 2010. An addendum was added in 2010.[v]

The Operational Guidance emphasizes the importance of breastfeeding for child survival and development, including during emergencies. The guidance also mentions the use of commercial infant formula as a breastmilk substitute as appropriate from a programmatic perspective, for cases in which it is clear that breastfeeding is not an option, with an emphasis on minimizing the risks of artificial feeding.

2.3. Code and WHA Resolutions

The Code itself does not mention emergency situations, but subsequent World Health Assembly (WHA) resolutions have dealt with its application in this context. In 1994, WHA 47.5 urged Member States:

"(3) to exercise extreme caution when planning, implementing or supporting emergency relief operations, by protecting, promoting and supporting breast-feeding for infants, and ensuring that donated supplies of breastmilk substitutes or other products covered by the scope of the International Code be given only if all the following conditions apply:

a) infants have to be fed on breastmilk substitutes, as outlined in the guidelines concerning the main health and socioeconomic circumstances in which infants have to be fed on breastmilk substitutes (Document WHA39/1986/REC/1, Annex 6, part 2);
b) the supply is continued for as long as the infants concerned need it;
c) the supply is not used as a sales inducement;"

Practical guidance to meet these conditions was articulated in the
Operational Guidance which was endorsed through 2010 WHA resolution (WHA 63.23). The resolution urged Member States:

"to ensure that national and international preparedness plans and emergency responses follow the evidence-based Operational Guidance for Emergency Relief Staff and Programme Managers on infant and young child feeding in emergencies, which includes … the need to minimize the risks of artificial feeding, by ensuring that any required breast-milk substitutes are purchased, distributed and used according to strict criteria;"

There is often a lack of understanding around the application of the International Code of Marketing of Breastmilk Substitutes and subsequent World Health assembly Resolutions (the Code) in emergency situations. It is important to point out that the Code

- does not restrict the *availability* of breastmilk substitutes, feeding bottles or teats it only restricts their marketing and distribution

- does not prohibit the *use* of breastmilk substitutes during emergencies, only the way in which they are procured and distributed
- is intended to *protect artificially fed babies* by ensuring breastmilk substitutes will be used as safely as possible on the basis of impartial, accurate information

2.4. SPHERE Standards

The SPHERE project lays out Minimum Standards for Infant and Young Child Feeding in Emergencies in its handbook. [vi]. These standards are:

Standard 1: Policy guidance and coordination
Safe and appropriate infant and young child feeding for the population is protected through implementation of key policy guidance and strong coordination.

Standard 2: Basic and skilled support
Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks and optimises nutrition, health and survival outcomes.

The Handbook also describes key actions, indicators and guidance for each of the standards.

3. Guiding principles for the provision of breastmilk substitutes by UNICEF

UNICEF will:

1) advocate and provide support for optimal infant and young child feeding (IYCF) practices in all humanitarian settings, in line with the CCCs. UNICEF will work in partnership with governments, national and international NGOs and other key actors.

2) adhere to the principle of 'do no harm' related to IYCF practices. Wherever possible, breastfeeding by the mother will be supported, including re-lactation if possible. The second best option is breastmilk from another mother where safe and culturally acceptable (wet-nursing or donor milk from a human milk bank if adequate milk banking facilities are available). The option of last resort is the provision of breastmilk substitutes (BMS) for the individual infant.

3) undertake preparedness planning and an assessment of needs for artificial feeding in every humanitarian situation to ensure there is an appropriate, proportionate and timely response to need. The level of planning, resources and capacity needed, will depend on the context.

4) advocate for and enable the assessment, targeted support and supervision of infants who are not breastfed and/or who are using BMS in humanitarian situations.

5) act to prevent and limit risks of inappropriate BMS use and the "spill over" of the use of BMS in the rest of the population. This includes acting to prevent donations of BMS, managing donations that do arrive, intervening to act on inappropriate, untargeted distributions of BMS in

humanitarian contexts and continue support and promotion of breastfeeding in the rest of the population.

6) only provide BMS when the need has been established by a nutrition survey and/or individual assessments by skilled health workers (see below for details of such an assessment).

If the need for the provision of breastmilk substitutes has been identified by UNICEF and/or the Nutrition Cluster, it is preferred that another partner, or the host country Government, takes the lead in procuring breastmilk substitutes.

If UNICEF is requested to provide BMS in a humanitarian situation, UNICEF will support the management of the appropriate use of BMS with partners in accordance with the provisions of this SOP. UNICEF is the provider of last resort for the procurement and distribution of breastmilk substitutes and will only do so at the specific request of the host country government.

If there is a need for UNICEF to procure and/or distribute BMS, the Country Office involved in the response needs to seek approval from the Nutrition Section, Programme Division, at New York Headquarters via e-mail, with Supply Division in copy (for details see below).

4. Assessing the need for BMS and criteria for its use

4.1. Community and individual assessments of feeding practices

A community assessment, either as a standalone assessment or as part of a larger assessment of the affected population, is an important first step to determine the feeding practices in the community. Evidence from surveys in the affected population that were undertaken before the onset of the humanitarian situation can also help inform the assessment.

Findings that could indicate inadequate infant feeding practices and a need for BMS include: high rate of non-breastfed children prior to the humanitarian situation, infants under six months of age with acute malnutrition, requests for BMS from mothers or local leaders, a history of BMS donations.

In addition and where possible, it is advisable to do a household survey in a sample of the population to determine the current infant feeding practices. In the absence of a household survey, information about (a sample of) infants can be obtained at service points (including child friendly spaces) or distribution points, or other places where the affected population comes together. (suggest annex to be developed as tool)

Before providing BMS to an individual infant, an individual assessment needs to be done. If possible, it is recommended to undertake this assessment in all children under the age of two in the affected population, to determine the need for (breast)feeding counselling and support.

It is suggested to use a simple rapid assessment (SRA) for all infants and only use a full assessment (FA) for specific cases, included non-breastfed infants. Templates for these can be found in Annex 2.

4.2. Criteria for eligibility to receive BMS

Infants and young children under the age of two who, after an individual assessment are determined to be classified in one of the categories below, are eligible for BMS:

1) Infants and young children who were orphaned or whose mother has been absent for a long period of time before the humanitarian situation and there is no option to wet-nurse,
2) Infants and young children who have become orphaned or whose mother is absent for a long period of time in the course of the humanitarian situation and there is no option to wet-nurse,
3) Extremely rare situations where the mother and/or infant has a medical condition during which breastfeeding is not possible and there is no option to wet-nurse. (ref. WHO and Ebola)
4) Infants and young children who were not breastfed at the time the humanitarian situation developed regardless of the reason (including infants whose mothers are in the process of relactating but whose milk supply is not yet sufficient, and for whom there is no option to be breastfed (including through relactation or wet-nursing).

If resources are limited, it is recommended that infants under six months of age be prioritised for the provision of BMS since they are the most vulnerable and cannot receive any other product. See section 5 for a description of appropriate BMS.

Selection of appropriate breastmilk substitutes

4.3. General guidance

All BMS used need to be a compliant with relevant Codex Alimentarius standards.[vii] Close liaison with Supply Division is recommended to ensure this compliance for local and off-shore procurements.

Generically labelled products are preferred, followed by commercial (branded) products. Supply Division will determine if generic products are available. Given the relatively small quantity of BMS usually required, it is not likely that a manufacturer can change the labels of a BMS for UNICEF. Also, producing different packaging will significantly increase the delivery time.

Wherever possible, products procured should be labelled in the local language. Where this is not possible, stickers should be prepared in a language that can be easily understood and stuck to packages of BMS before they are distributed. The stickers should include: (a) the words "Important Notice" or their equivalent; (b) a statement of the superiority of breastfeeding; (c) a statement that the product should be used only on the advice of a health worker as to the need for its use and the proper method of use; (d) instructions for appropriate and safe preparation, and a warning against the health hazards of inappropriate preparation.

Considering that most manufacturers of BMS are involved in marketing practices in violation of the International Code of Marketing of Breastmilk Substitutes, there is little opportunity for selection of sources that do not break the Code. Therefore, and until such sources can be identified and availability can meet demand, UNICEF will allow purchase of products manufactured by companies that break the Code. To minimize the association with such manufacturers and to work with products that are already in the supply chain, UNICEF will aim at working through distributors or traders to the extent possible.

4.4. Selection of appropriate BMS

4.4.1. Infants under 6 months

For infants under six months eligible for BMS, UNICEF, in line with the Operational Guidance, recommends the use of *ready to use infant formula* (RUIF) since it is a sterile product until it is opened, does not require reconstitution with water (like powdered infant formula (PIF)), and would therefore be the safest option.

The table below provides average suggested amounts per child, for the amount of RUIF per day, the number of feeds per day and the size of each feed.

Age in months	Average weight (kg)	Amount of RUIF per day in ml	Number of feeds per day	Size feed in ml
0-1	3	450	8	60
1-2	4	600	7	90
2-3	5	750	6	120
3-4	5	750	6	120
4-5	6	900	6	120
5-6	6	900	6	120

Table 1. Average suggested amounts of RUIF per child[3]

For forecasting purposes, it is suggested to use an amount of 750ml per child per day, which translates into 135 litres per child for a 6 month period.

At the international market, RUIF is normally packaged in Tetrapack units of 200ml. The amount of 135 litres per child for a 6 month period translates into 675 units per child. In some cases, smaller units are available as well.

The shelf life of most RUIF procured by UNICEF is 9 months. The Tetrapack packaging keeps the product very stable even in high temperatures (above 40 degrees centigrade), but direct sunlight needs to be avoided.

[3] For use at the individual level, manufacturer's instructions on the label should be followed.

Powdered infant formula (PIF) is a non-sterile product. Beside the known risks related to unsafe preparation it also carry the risk of intrinsic contamination. Therefore, PIF needs to be reconstituted with water of at least 70 degrees Celsius to avoid the growth of bacteria. Careful preparation in line with instructions is required. The distribution of PIF should be accompanied by education, WASH and one-to-one demonstrations about safe preparation of the formula as per the FAO/*WHO guidelines on safe preparation, storage and handling of powdered infant formula.* [viii] Where this is not possible, clear illustrative instructions should be provided along with the powdered infant formula. The instructions from the manufacturer should also be followed closely.

The average amount of PIF required is 3.5kg of powdered infant formula per child per month.

Concentrated liquid infant formula (which is available in some countries) is not recommended as a suitable breastmilk substitute, because of the risk of errors with diluting the product and the higher risk of contamination once a unit has been opened. Therapeutic milks like F75 and F100 are also not appropriate breastmilk substitutes.

All infants with severe acute malnutrition require urgent treatment and should be referred immediately to appropriate treatment services.

4.4.2. Infants and young children 6-23 months of age

Infants and young children older than six months who do not receive breastmilk can use RUIF, but regular liquid whole fat milk that has undergone ultra-heat treatment (UHT) can also be used for this group and will be cheaper. Children in this age group also need to receive safe and adequate complementary feeding, in line with WHO guidelines.[ix,x,xi] If there is a risk of micronutrient deficiencies, micronutrient supplements need to be provided.

5. General aspects of the management of breastmilk substitutes in humanitarian settings

5.1. Preparedness

Important preparedness actions include ensuring and providing support for the implementation of the Code through legally enforceable regulations, the adoption of policies and regulations about infant and young child feeding in emergencies, training of relevant institution and community based health and social workers and the production of relevant training and communication materials.

5.2. Communication

Communication and social mobilisation about the importance of breastfeeding and places where breastfeeding women can find support, are crucial in emergencies. Potential donors/wellwishers will need to be informed why unsolicited donations of BMS cannot be accepted. Guidance on alternative items that would promote the infant's wellbeing should be shared for consideration.

5.3. Coordination

Country offices are recommended to collaborate closely with the relevant Government entities and consider developing Programme Cooperation Agreements (PCAs) with local organisations. UNICEF has a coordinating role as the (focus on UNICEF's role as Nutrition Cluster Lead. It can be useful to set up a dedicated IYCF Working Group as a part of the Cluster for a shorter or longer period of time. Coordination with other sectors, like health, WASH and social protection is also important.

5.4. Capacity building

To the extent that this has not been done in the preparedness phase, capacity building of UNICEF staff and partners might be required to ensure optimal support for adequate infant and young child feeding practices and to ensure quality assessments of feeding practices. If BMS are distributed, it needs to be ensured that the staff involved has sufficient capacity for the assessments and counselling and support to families.

6. Procurement of BMS

6.1. Local versus off shore procurement

In principle, all food items procured by UNICEF, including BMS and RUIF, need to be procured by Supply Division. In this way, it can be guaranteed that the products are of the right quality and that batches can be traced if needed.

However, in exceptional cases, country offices can receive authorization for the local procurement of BMS (specifically powdered infant formula, UHT milk and cups). Local products already in the supply chain in the local market can be purchased after approval from Supply Division (SD) following the procedure set out in Supply Manual Chapter 6, Section 2, paragraph 4.1 - Ad hoc local procurement authorisation (LPA).[xii] Supply Division will assess that the product has been manufactured following Codex Alimentarius standards by requesting information on the product and manufacturer.

RUIF is not included in UNICEF's Supply Catalogue because it is a non –standard product. Close liaison with Supply Division about sizes and unit costs is therefore important.

6.2. Procurement and preparation of powdered infant formula (PIF)

In the absence of RUIF or until RUIF can be procured, powdered infant formula (PIF) can be purchased and distributed locally (Supply Division does not procure this), after having discussed with and received endorsement from Supply Division and the Nutrition Section (also see above under *Local versus off shore procurement*).

7. Managing supplies for artificial feeding

7.1. Storage

BMS needs to be stored in line with the guidelines. It is best to store RUIF and PIF out of direct sunlight, in a secure and supervised area. Room temperature is preferable but the product can resist temperatures up to 40 degrees Celsius. BMS might be in high demand and adequate security measures might be required to prevent theft.

7.2. Distribution of BMS

Prior to procuring BMS, the distribution system needs to be agreed upon with the government and implementing partners. The distribution system will depend on factors like access of the caregivers to the distribution point, the distance between families and the distribution point, security concerns and the level of follow up of individual families that is possible.

In general terms, it is best to distribute small amounts of BMS each time the caregiver visits the distribution point. This reduces the changes of "spill over" of BMS use to breastfed children. To reduce the risk of selling of the BMS, caregivers may be requested to return empty containers.

The distribution of BMS needs to individual children needs to be documented in a detailed manner.

8. Artificial feeding support services

8.1. Individual support services

Given the high risk of contamination of feeding bottles and teats, requiring sterilization before use, cup-feeding is the preferred feeding method. Cups can be cleaned with soap and water and do not require sterilizing. Thus, caregivers receiving BMS, also need to be provided with cups for feeding and with instructions for cup feeding (to be annexed along with an image of an appropriate cup). They need to be counselled on how to cupfeed. Regular follow up is required to monitor the child's health and growth.

8.2. Key interventions in the community

In addition to the communication about the importance of breastfeeding, it is important to promote optimal hygiene practices in the community and to promote a culture of support to breastfeeding mothers, to dispel any myths and to ensure that babies born after or during the humanitarian situation, are breastfed.

8.3. Avoiding the promotion of breastmilk substitutes and spill over

All efforts need to be made to avoid spill over of BMS to breastfed infants and pregnant women. This includes ensuring ongoing promotion and support for breastfeeding. Collaboration with government, implementing partners and Cluster partners for this is crucial. It might be needed to write down the actions each partner will undertake.

9. Managing donations and inappropriate interventions

In accordance with internationally accepted standards and guidelines, unsolicited donations of infant formula, other powdered or liquid milk and milk products, bottles and teats should not be made. Experience with past emergencies has shown that excessive quantities of poorly targeted donated products endanger infants' lives.[xiii]

According to Chapter 6 of the Operational Guidance on Infant and Young Child Feeding in Emergencies:

1) This information should be provided to potential donors (including governments and the military) and the media, both in emergency preparedness and particularly during the early phase of an emergency response.

2) Soliciting or accepting unsolicited donations of BMS should be avoided. Instead, interventions to support artificial feeding should budget for the purchase of BMS supplies along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation, staff training, and skilled personnel.

3) Any donations of BMS, milk products, bottles and teats that have not been prevented should be collected by a designated agency, preferably from points of entry to the emergency area, under the guidance of the co-ordinating body. These should be stored until UNICEF or the designated nutrition co-ordinating agency, together with the government if functional, develops a plan for their safe use or their eventual destruction.

4) An agency should only supply another agency/institution with BMS if both are working as part of the nutrition and health emergency response *(see definitions)* and the provisions of the Operational Guidance and Code are met *(see 6.2 – 6.4)*. Both the supplying agency and the implementing agency/institution are responsible for ensuring the provisions of the Operational Guidance and Code are met, and continue to be met for the duration of the intervention.

In general terms, UNICEF offices are not likely to have the conditions and expertise necessary to store and manage inappropriate donations of milk products. It is therefore recommended that the Government coordinate these tasks, or that another partner is appointed for this. UNICEF can provide coordination (in its role as the Nutrition Cluster lead agency) and technical support.

10. Monitoring & evaluation and knowledge management

The following issues are important to keep in mind when establishing monitoring and evaluation systems for infant and young child feeding interventions in emergencies, specifically in settings with relatively high numbers of non-breastfed children.

1) Monitor feeding practices regularly via community based assessments
2) Monitor any unintended consequences like increased use of breastmilk substitutes in the affected population
3) Continued monitoring for unsolicited donations of BMS
4) Document information about the recipients of BMS in as much detail possible (including age and gender of child, type and amounts of BMS provided, reason for BMS provision, morbidity)

5) Where possible, track distribution and use by individual recipients
6) For infants receiving BMS, a tracking system needs to be set up to ensure they receive the required supplies until they have reached the agreed age of discharge from this intervention
7) If possible, establish or strengthen systems for follow up of all infants and young children under two years of age, specifically aimed at identifying breastfeeding challenges as well as increased morbidity in non-breastfed infants
8) To the extent possible, document the experience in each humanitarian setting for further lesson learning and updating of guidance where relevant

List of Acronyms

BMS	Breastmilk substitute
CCC	Core Commitments for Children
IYCF	Infant and young child feeding
RUIF	Ready to use infant formula
PIF	Powdered infant formula
UNHCR	United Nations High Commission for Refugees
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organization

List of definitions

Breastmilk substitutes: any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose. This term includes but is not limited to infant formula (definition below).

Infant feeding: Feeding of children under the age of one year

Infant formula: breastmilk substitute formulated industrially in accordance with applicable Codex Alimentarius standards, to satisfy the normal nutritional requirements of infants up to six months of age, and adapted to their physiological characteristics.

Useful Reference documents

- Operational Guidance on Infant and Young Child Feeding in Emergencies: http://files.ennonline.net/attachments/1001/ops-guidance-2-1-english-010307-with-addendum.pdf
- Save the Children IYCF-E Toolkit: http://www.savethechildren.org.uk/resources/online-library/infant-and-young-child-feeding-emergencies-why-are-we-not-delivering-scale
- UNHCR – Save the Children IYCF Friendly Framework – (already on line?)
- UNHCR – Infant and young child feeding practices, Standard Operating Procedures for the Handling of Breastmilk Substitutes (BMS) in Refugee Situations for children 0-23 months, August 2015 (Version 1.0) http://www.unhcr.org/55c474859.pdf

Annex 1. Template for e-mail to request approval for procurement of BMS

Below is a template for country offices who have identified the need for the procurement of BMS by UNICEF. The template can be modified as long as key aspects from the template are included in the communication.

It is recommend to engage first with the Regional Nutrition Adviser and then the Nutrition Section in NYHQ (Nutrition in Emergencies and IYCN Unit Heads) in an informal manner, to brief colleagues about the situation and determine possible actions and alternatives before the decision to procure BMS is made.

To: [*Chief, Nutrition Section, UNICEF NYHQ*],

Cc: [*Chief, Nutrition, Supply Division*]

Cc: [*Regional Nutrition Adviser*]

In [*country*], we are facing a humanitarian situation because of [*describe the situation*]. The total population affected is estimated at [*number of population, including number of children under the age of 2 if available*].

UNICEF is undertaking the following actions to protect, promote and support breastfeeding: [*describe these actions and their coverage (if possible) as well as implementing partnerships*].

An assessment done by [*describe*] shows that a significant number of infants and young children are not breastfed and do not have the possibility to be breastfed. [*describe the findings of the assessment*]

The findings have been discussed within the Nutrition Cluster and with the Government [adjust as relevant] and it has been agreed that BMS need to be procured for children that cannot be breastfed, which includes children in the following situations: [*describe]*. The needs are estimated to be for [*xx*] children aged [*xx*] for a duration of [*xx*]. The type of BMS proposed is [*describe*].

Because of [*describe*], the Government is not able to procure the BMS and no other partner is able to procure the BMS either. UNICEF is therefore asked to procure BMS as the partner of last resort.

The following measures are/will be [*use the relevant option*] put in place to avoid spill over of the use of breastmilk substitutes are: [*describe]*

We kindly ask for your approval of this procurement.

Best regards,

[*Representative/OIC*]

Annex 2. Templates for simple rapid assessments and full assessments

Simple Rapid Assessment[4]

Mother's/Caregiver's Name: _____

Ask:

- How old is the baby? _____ months
- Are you breastfeeding him/her? ☐ yes ☐ no
- Is the baby getting anything else to drink or eat? _____ (indicate)
- Is the baby able to suckle the breast? ☐ yes ☐ no
- Have you any other difficulties with breastfeeding? _____ yes/no _____ (indicate)

Look:

- Does the baby look very thin? ☐ yes ☐ no
- Is the baby lethargic, perhaps ill? ☐ yes ☐ no

Reasons to refer for Full Assessment:

☐ Not breastfed

☐ Breastfed but feeding not age-appropriate: under 6 months not exclusively breastfed; over 6 months, and given no complementary foods

☐ Baby unable to suckle the breast

☐ Mother has other difficulties with breastfeeding

☐ Mother requests breastmilk substitutes

☐ Baby visibly thin

[4] Source: Infant Feeding in Emergencies for health and nutrition workers in emergency situations – for training, practice and reference. Module 2, Version 1.1. December 2007.

Step 1: Observing a breastfeed

Attachment at breast:

__ areola, more above

__ mouth wide open

__ lower lip turned out

__ chin close to or touching breast

__ no nipple pain or discomfort

Suckling:

__ slow, deep sucks, sometimes pausing

__ audible or visible swallowing

Mother confident:

__ enjoyment, relaxation, not shaking breast or baby

__ signs of bonding (stroking, eye contact, close gentle holding)

How the feed ends:

__ baby comes off the breast by himself (not taken off)

__ baby looks relaxed and satisfied and loses interest in breast

__ mother keeps the breast available, or offers the other breast

Step 2: Listening and learning

Breastfeeding ☐ yes ☐ no How often by day? _____ How often by night? _____

Using a pacifier? ☐ yes ☐ no

Other drinks and foods? ☐ yes ☐ no

What drinks? _____

How are they given? _____

How many times a day? _____

What soft or family foods? _____

How many times a day? _____

Beliefs and worries about feeding; how mother/caregiver decided feeding:

_____

_____

How is mother/caregiver physically and emotionally? Any worries?

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Interest in increasing breastmilk or relactation? ☐ yes ☐ no

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