



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

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TABLE OF CONTENTS

ACRONYMS.....	4
KEY DEFINITIONS	6
BACKGROUND.....	9
UNHCR responsibilities regarding artificial feeding in refugee contexts	9
Rationale and scope of these SOP.....	10
PART 1: GUIDING PRINCIPLES FOR ARTIFICIAL FEEDING PROVISIONS.....	12
Key UNHCR provisions regarding artificial feeding in refugee situations.....	12
PART 2: OVERALL MANAGEMENT OF ARTIFICIAL FEEDING IN REFUGEE SETTINGS ...	14
Preparedness	14
Coordination	14
Capacity.....	15
PART 3: ASSESSMENT	16
Community assessment of artificial feeding needs	16
Individual assessment of artificial feeding needs	18
PART 4: ARTIFICIAL FEEDING SUPPORT SERVICES	19
Criteria for BMS use	19
Individual support services	20
PART 5: MANAGING BMS SUPPLIES	22
BMS type	22
Feeding equipment and other non-food items.....	23
Procurement procedures	24
Distribution of BMS.....	25

PART 6: SPECIAL CONSIDERATIONS FOR INFANTS.....	26
Infants over 6 months	26
Pastoral communities.....	27
HIV and Infant Feeding	27
Maternal death	30
PART 7: MANAGING DONATIONS AND OTHER INAPPROPRIATE INTERVENTIONS	31
PART 8: EXPERIENCE EXCHANGE & LEARNING	34
CASE STUDIES	35
Case Study 1: IYCF assessment and affirmative action by a UNHCR Health Officer ..	36
Case Study 2: Individual cases alert UNHCR of critical gaps in IYCF system	38
Case Study 3: Artificial feeding scenarios in UNHCR operations	39
Case study 4: Baby tents in Haiti.....	40
Case Study 5: The challenges of artificial feeding in unhygienic conditions.....	41
Case Study 6: The challenge of security in the follow up of infants.....	41
Case Study 7: Bottle amnesty in Jordan	42
Case Study 8: Implementing controls around the distribution of infant formula in Jordan.....	42
Case Study 9: Meeting milk needs of non-breastfed infants over 6 months in a refugee pastoral community in Burkina Faso	43
Case Study 10: Preventing donations of BMS in Kenya and Jordan.....	43
Case Study 11: Use of donated BMS in Jordan	44

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral Drug
BMS	Breastmilk Substitute
DHS	Demographic and Health Surveys
EMTCT	Elimination of Mother-to-Child Transmission (of HIV)
FA	Full Assessment
HIV	Human Immunodeficiency Virus
IDP	Internally Displaced Person
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies
MOH	Ministry of Health
MUAC	Mid-Upper Arm Circumference
NGO	Non-Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
PIF	Powdered Infant Formula
PLW	Pregnant and Lactating Women
POC	People of Concern
RUIF	Ready-to-use Infant Formula
SAM	Severe Acute Malnutrition
SENS	Standardised Expanded Nutritional Survey
SFP	Supplementary Feeding Programme
SOP	Standard Operating Procedure
SRA	Simple Rapid Assessment
TFP	Therapeutic Feeding Programme
TOR	Terms of Reference
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water Sanitation and Hygiene
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation



KEY DEFINITIONS

Artificial feeding: the use of a BMS, such as infant formula, to feed an infant or child. This term includes both non-breastfed infants *and* infants who are mixed feeding.

Artificial feeding support services: this involves individual level assessment and targeted support including breastfeeding assessment and support, provision of BMS and equipment supplies, individual assessment and training on feed preparation, and health and nutritional monitoring of infants and young children.

Breastmilk substitute (BMS): any food or liquid being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose. Appropriate BMS include infant formula (unbranded or branded) or for temporary use, modified liquid animal milks and modified evaporated milk. Inappropriate BMS include condensed milk, therapeutic milks, and bottle-fed complementary foods marketed for children up to two years of age and complementary foods, juices and teas marketed for infants under 6 months.

Complementary feeding: the child receives age-appropriate, adequate and safe solid or semi-solid food in addition to breastmilk or a breastmilk substitute.

Complementary food: any food, whether industrially produced or locally-prepared, used as a complement to breastmilk or to a breastmilk substitute and that should be introduced after six months of age.

Exclusive breastfeeding: an infant receives only breastmilk and no other liquids or solids, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

Home-modified animal milk: a breastmilk substitute for infants up to six months prepared at home from fresh or processed animal milk, suitably diluted with water and with the addition of sugar and micronutrients¹.

¹ Home-prepared formula must be fortified with many micronutrients. Micronutrients needed to fortify home-prepared formula - 150ml: manganese 7.5µg, iron 1.5mg, copper 100µg, zinc 205µg, iodine 5.6µg, vit A 300IU, vit D 50 IU, vit E 1 IU, vit C 10mg, vit B1 50 µg, vit B2 80µg, niacin 300µg, vit B6 40µg, folic acid 5µg, pantothenic acid 400µg, vit B12 0.2µg, vit K 5µg, Biotin 2µg. However appropriate formulations are often not available in the field. If micronutrients are not added, home preparations should be used only for a short time.

Infant: a child aged between 0 and <12 months (sometimes referred to as 0-11 months) that is 12 completed months of life. A **young infant** is defined as an infant aged between 0 and <6 months (sometimes referred to as 0-5 months) that is six completed months of life. A **very young infant** is defined as an infant aged between 0 and <2 months (sometimes referred to as 0-1 months) that is two completed months of life.

Infant feeding equipment: bottles, teats, syringes and baby cups with or without lids and/or spouts.

Infant formula: a breastmilk substitute formulated industrially in accordance with applicable Codex Alimentarius standards (developed by the joint FAO/WHO Food Standards Programme). Commercial infant formula is infant formula manufactured for sale, branded by a manufacturer and may be available for purchase in local markets. Generic infant formula is unbranded and is not available on the open market, thus requiring a separate supply chain.

Milk products: dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed milk; soya milks; evaporated or condensed milk; fermented milk or yogurt.

Mixed feeding: feeding infants with both breastmilk *and* a breastmilk substitute.

Non-breastfed infant: the infant receives no breastmilk.

Optimal infant and young child feeding: early initiation (within one hour of birth) of exclusive breastfeeding, exclusive breastfeeding for the first six months of life, followed by nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.

Replacement feeding: term used for feeding non-breastfed infants in the context of HIV. It involves feeding infants who are receiving no breastmilk with a diet that provides the nutrients infants need until the age at which they can be fully fed on family foods. During the first 6 months, replacement feeding should be with an appropriate BMS that is likely to be infant formula. After 6 months, the necessity for and type of BMS will depend on what complementary foods are available.

Therapeutic milk: term commonly used to describe formula diets for severely malnourished children, e.g. F75 and F100. Strictly speaking, these are not milks – F100 comprises only 42% milk product, and F75 less so. Therapeutic milk may be pre-formulated or prepared from dried skimmed milk (DSM), oil and sugar, with the addition of a vitamins and minerals complex.

Young child: a child aged between 12 and <24 months (sometimes referred to as 12-23 months).



C. Wilkinson/November 2008

BACKGROUND

UNHCR RESPONSIBILITIES REGARDING ARTIFICIAL FEEDING IN REFUGEE CONTEXTS

UNHCR is mandated to protect and support refugee adults, children and infants under the 1951 Convention Relating to the Status of Refugees². While Internally Displaced Persons (IDPs) remain under the official protection of their own governments, UNHCR also plays a lead role in providing them with protection and assistance. Under the UN Convention of the Rights of the Child (CRC) refugee children and children who have been internally displaced are entitled to all of the same rights laid out in the CRC, including the rights to life and development and adequate nutrition and health care³.

Under The Innocenti Declaration 2005 Call to action⁴, the UNICEF/WHO Global Strategy for Infant and Young Child Feeding (2003)⁵ and the Operational Guidance on Infant and Young Child Feeding in Emergencies (IYCF-E) (2007)⁶ and to uphold the provisions and spirit of the International Code of Marketing of Breastmilk Substitutes (BMS) and subsequent relevant World Health Assembly Resolutions (collectively known as the Code)⁷, UNHCR is required and is strongly committed to protect, promote and support optimal Infant and Young Child Feeding (IYCF) in refugee situations.

UNHCR is also required and is committed to protecting the interests of artificially fed infants who may or may not be breastfed. This protection has two components: minimising the risks associated with artificial feeding while maximising the nutrition, health and development of non-breastfed children in refugee settings.

Particularly in refugee situations, the risks of malnutrition, illness and death are significant and heightened in children under two years of age who are not breastfed and in infants under six months of age who are not exclusively breastfed. These standard operational procedures (SOP) have been developed to help put policy commitment into practice. These SOP comply with the International Code and relevant World Health Assembly (WHA) Resolutions⁸, the

2 "Convention relating to the Status of Refugees", Geneva, 28th July, 1951.

3 "Convention on the Rights of the Child", New York, 20th November, 1989.

4 "Innocenti Declaration, 2005", Florence, Italy, 22nd November, 2004.

5 WHO and UNICEF (2003) Global Strategy for Infant and Young Child Feeding. Geneva, WHO.

6 IFE Core Group (2007) Infant and Young Child Feeding in Emergencies: Operational Guidance for Emergency Relief Staff and Programme Managers, v. 2.1, February 2007. Endorsed in WHA Resolution 63.23.

7 WHO (1981) International Code of Marketing of Breast-milk Substitutes. Geneva.

8 World Health Assembly Resolution 63.23, 21st May, 2010.

Operational Guidance on IYCF-E (2007), the UNHCR's own Milk Policy (2006)⁹ and the WHO Guidelines on HIV and Infant Feeding (2010)¹⁰.

RATIONALE AND SCOPE OF THESE SOP

UNHCR operates in contexts where it may be necessary to provide support for artificial feeding to protect infants and young children. Any artificial feeding carries risks for both breastfed and non-breastfed infants and young children and these are heightened in emergency contexts. There are significant economic and logistical challenges to artificial feeding programming. UNHCR need to plan for and provide artificial feeding support services programming in all refugee contexts.

These SOP on artificial feeding should be located within a wider framework of IYCF in refugee programmes. It assumes and will rely on other direct interventions to support breastfeeding, complementary feeding, and the nutrition of mothers, as well as nutrition sensitive interventions including health, food security, livelihoods, shelter, water sanitation and hygiene and animal welfare.

These SOP provide guidance on how staff of UNHCR and UNHCR partners should manage artificial feeding in refugee contexts¹¹ to protect both breastfed and non-breastfed children. Particular consideration is given to emergency contexts; to high burden, resource poor settings; and to pastoral communities. Emergency context is considered specifically due to the particular vulnerability in overcrowded unstable situations. The issue is however also of concern in protracted refugee situations.

Children under 2 years of age (0 - <24 months) and their mothers/caregivers are the population of concern, especially infants 0 - <6 months. Since pastoral communities comprise a significant proportion of refugees under UNHCR protection, management of milk in infants over 6 months in this population group is considered specifically. The SOP do not cover the handling of therapeutic milks for the treatment of severe acute malnutrition.

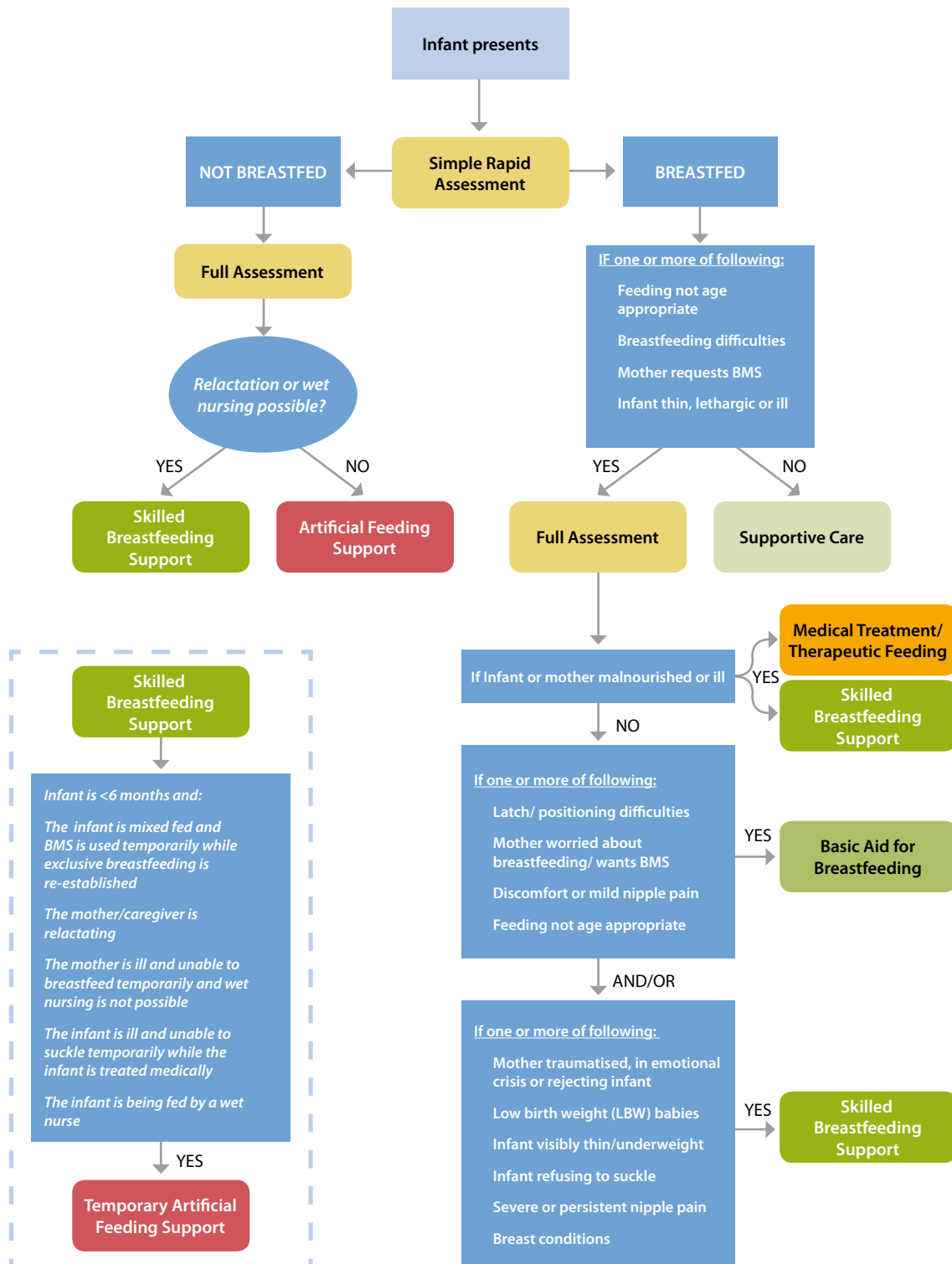
These SOP comprise core recommendations and case studies (laid out in this document) and annexes (in a separate document). The case studies were collected from UNHCR country programmes and have informed the scope and content of these SOP. The annexes include further details to inform programming. Further resources are displayed in Annex 1.

9 UNHCR Policy related to the acceptance, distribution and use of milk products in refugee settings, first edition produced in 1989, and revised edition in 2006.

10 WHO Guidelines on HIV and Infant Feeding (2010): principles and recommendations for infant feeding in the context of HIV and a summary of evidence.

11 This includes internally displaced populations where UNHCR has a lead role in protection and assistance.

Figure 1: Flow chart for process of individual assessment of an infant



PART 1: GUIDING PRINCIPLES FOR ARTIFICIAL FEEDING PROVISIONS

KEY UNHCR PROVISIONS REGARDING ARTIFICIAL FEEDING IN REFUGEE SITUATIONS

UNHCR will seek to support and establish optimal IYCF practices in all operations.

UNHCR will adhere to the principle of 'do no harm' related to IYCF practices. In the hierarchy of actions first breastfeeding by the mother will be supported and relactation wherever possible, the second solution that will be sought is wet nursing for the infant followed as a last resort to provision of breastmilk substitutes (BMS) for the individual infant.

The use of BMS in refugee contexts is a last resort and will be used only when the following key conditions are met:

- Infants using BMS are <6 months of age.
- The BMS used is an infant formula that is Codex compliant and meets the provisions of the Code. Generic formula is preferred, followed by commercial (branded) infant formula. Modified animal milks are a temporary 'stop gap' option.
- BMS supply is targeted to individual infants 0 - <6 months of age where the need has been established using skilled individual level assessment.

UNHCR will not support the provision of BMS to infants >6 months; exceptions will require approval from UNHCR HQ technical unit or regional nutrition and food security technical unit. For infants >6 months who are not breastfed, programme focus should be on complementary feeding support that does not include BMS provision.

UNHCR will undertake preparedness planning for artificial feeding in every refugee 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.

UNHCR will advocate for and enable the assessment, targeted support and supervision of infants who are not breastfed and/or who are artificially fed in refugee contexts.

UNHCR will supply BMS and support the management of appropriate artificial feeding with partners in accordance with the provisions of these SOP.

UNHCR will act to prevent and limit risks of inappropriate BMS use. This includes acting to prevent donations of BMS, managing donations that do arrive and intervening to act on inappropriate, untargeted distributions of BMS in refugee contexts.

UNHCR will act to meet the needs and protect the well-being of mothers of both breastfed and non-breastfed infants, in the interests of both women and their children. This includes enabling access to adequate food, health services and social and household support that will empower a mother to care for her infant, as well as help protect her own rights to food, shelter and health.

UNHCR will prioritise protection of infants who have lost their mother, recognising they are especially at risk.

UNHCR seeks to respect and enable cultural practice and good nutrition using milk while protecting breastfeeding and enabling safe use. Pastoral communities comprise a significant proportion of UNHCR refugee operations and are a particular consideration.

UNHCR will provide a clear agency position for staff and partners on IYCF in refugee contexts where HIV is a concern. UNHCR will enable the necessary support services for breastfed and non-breastfed infants in HIV contexts.

UNHCR will document and share lessons from artificial feeding programming to inform policy guidance development and practice.

PART 2: OVERALL MANAGEMENT OF ARTIFICIAL FEEDING IN REFUGEE SETTINGS

PREPAREDNESS

UNHCR Public Health and Nutrition/ Food Security Officers should undertake preparedness planning regarding artificial feeding. Key considerations are assessing the potential burden of care in a given context, identifying resources for support and response (in emergencies), establishing BMS type and supplies, identifying and helping to build capacity on skilled assessment and support, developing standardised monitoring systems for BMS supplies (country and global levels), and risk reduction (such as supporting implementation of the Code and optimal IYCF practice). UNHCR operations should use the recommendations throughout these SOP to inform preparedness actions.

Where artificial feeding is being considered or managed in UNHCR operations, a focal point within the UNHCR country office should be designated. This is likely to be the UNHCR country Nutrition/ Food Security Officer or Public Health Officer. If necessary, an experienced partner agency and focal point should be identified to support the technical aspects of the UNHCR's management role in a given operation.

The preparedness plan should be a short document including who is responsible for what, relevant sources to procure BMS, and setting out conditions for artificial feeding.

COORDINATION

All involved parties should be familiar with key agency and international policy guidance, specifically the Operational Guidance on IYCF-E, the UNHCR milk policy and the Code. Key policy guidance is listed in Annex 1 and summarised in Annex 2.

Relevant policy guidance at national and sub-national levels should be identified and appraised. Implementation and where necessary, the development of relevant policy guidance, should be supported. UNHCR and partners should advocate to national policy-makers on the Operational Guidance on IYCF-E and the Code as key reference policies that are endorsed in WHA Resolutions.

All parties should act to ensure that any efforts around artificial feeding within the refugee population are coordinated and managed. This should be located within or work closely with existing IYCF coordination systems and also be linked to health, protection, and water sanitation and hygiene coordination mechanisms and programmes. Engagement should include government ministries, other UN agencies (particularly UNICEF), NGOs, the cluster system, donors and expert groups.

CAPACITY

UNHCR has a role to establish what services are needed and which partners are best placed to deliver them. An assessment of agency capacity will help to identify the best partners to provide artificial feeding services in a refugee operation. UNHCR staff should request evidence of agency capacity when appraising possible partners for IYCF roles.

Clear TOR for partners should be developed so that expectations for service delivery are clear and monitoring of activities and outcomes to ensure expectations are met. Key considerations regarding partner capacity appraisal are included in Annex 3.



PART 3: ASSESSMENT

COMMUNITY ASSESSMENT OF ARTIFICIAL FEEDING NEEDS

Timely and appropriate community assessment of artificial feeding must be ensured in all refugee contexts. Nutrition or public health staff should engage with other sectors (such as health, protection, food security) and should join forces with other relevant agencies, such as UNICEF, WHO and experienced NGOs, relevant authorities, technical fora and donors at country level, and seek support from UNHCR HQ or regional nutrition and food security technical units where necessary.

Nutrition or public health staff should be alert to risky IYCF practices. UNHCR should assess and periodically review the operational situation regarding artificial feeding at community-level. The type of assessment will depend on the context and may involve **scenario definition** (using background information, programming data), **rapid assessment** (initial rapid assessment, opportunistic assessment) and more **detailed surveys**. In summary:

There are a number of **'alerts'** regarding feeding practices in a community that indicate risk. Examples of alerts are: a history of artificial feeding in a population, a history of donations of BMS in previous emergencies, reports of artificial feeding in a population, reports of mothers stopping breastfeeding, malnourished infants <6 months presenting to clinics, individual cases of artificial feeding presenting to clinics. *Case Studies 1 and 2 give examples of UNHCR staff members responding to 'alerts' to IYCF problems.*



Scenario definition should be done in every operation to determine whether there are infants and young children who require artificial feeding and therefore UNHCR protection. Possible community scenarios are: breastfeeding is the norm and artificial feeding is rare; mixed feeding is common; artificial feeding is the norm and breastfeeding is not common; or infant sub-groups are artificially fed (e.g. as part of elimination of mother to child transmission (EMTCT) of HIV). Sources of information for the scenario definition should include secondary data, such as recent DHS surveys, Initial Rapid Assessment data, staff observations and clinic and programme data. More information on conducting a scenario definition is provided in Annex 4. *Case Study 3 gives 'examples of artificial feeding scenarios in different refugee situations'.*

In communities where mixed feeding is common or breastfeeding is not common, one can assume that there are infants and young children who require artificial feeding. In scenarios where breastfeeding is common but there are still sub-groups or individuals who require artificial feeding, individual assessment and targeted assistance must be provided for these individuals.

Rapid assessment involves measuring minimal key indicators on targeted IYCF issues in response to concerns or 'alerts'. IYCF should be included in initial (early) rapid assessments in emergencies as well as regular nutrition surveys in protracted situations. Other opportunities for collecting IYCF data include at UNHCR refugee reception centres, at vaccination/registration stations of NGO agencies, in MUAC screenings, at health centres, in supplementary feeding programmes (SFPs) targeting pregnant and lactating women (PLW)¹², by community health workers, at mother-baby tents/child friendly spaces, in WFP household food security assessments, and through allied staff, such as community service staff and psychosocial support staff. More information on conducting a rapid assessment is provided in Annex 5.

Wherever possible, standard indicators and methodologies should be used in assessment. Adapted IYCF indicators are needed in rapid assessments due to limitations in sampling and capacity at this level. Recommended IYCF indicators for assessment are included in Annex 6.

Where rapid assessments indicate an IYCF risk, **detailed surveys** will be needed to more clearly define and monitor the situation and response. The UNHCR Standardised Expanded Nutrition Survey (SENS) IYCF module should be included in scheduled surveys. How to calculate a non-breastfed indicator using the SENS IYCF module data is included in Annex 7. In addition, qualitative methods can be used to answer questions specific to the context in order to gain a deeper understanding of IYCF issues in a particular community.

12 In general, SFPs that target PLW do not confirm breastfeeding status of enrolled mothers; mothers may be mixed feeding.



INDIVIDUAL ASSESSMENT OF ARTIFICIAL FEEDING NEEDS

All nutrition programmes in refugee contexts should systematically assess individual infants who are identified as potentially needing artificial feeding support. Ways to identify such infants include: active screening in the community; presentation to community teams such as protection staff or community health workers or survey staff; presentation of mothers/caregivers to clinics with feeding difficulties; requests by caregivers for BMS. Skilled assessment of cases is needed by a trained health or nutrition worker. On assessment, referral to appropriate services is needed. More details on individual assessment and referral are given in Annex 8. An individual assessment system should include both **simple rapid assessment (SRA)** of infants and **full assessment (FA)**, summarised as follows:

Simple Rapid Assessment (SRA) of infant mother (or caregiver) pairs is a non-specialist task. It can be undertaken at arrival or registration by non-nutrition staff (such as health, community service or vaccination workers, or at an early contact point with an appropriately orientated staff member). SRA should identify any immediate risk of inadequate feeding. If there is a risk, the mother and infant should be referred for a full assessment.

Full Assessment (FA) of the infant mother (or caregiver) pair should take place in a health care setting accessible to the refugee population and should be carried out by a trained health or nutrition worker. FA should involve observing a breastfeed (or artificial feed if the baby is not breastfed) and listening to the mother to find out what her concerns are and what support is required.

PART 4: ARTIFICIAL FEEDING SUPPORT SERVICES

CRITERIA FOR BMS USE

In general and as stated earlier, UNHCR will only supply BMS for infants <6 months of age as a last resort and only when key conditions are met as determined by a trained health or nutrition worker. Where mothers experience difficulties breastfeeding, the priority response is skilled breastfeeding support. Where infants <6 months are mixed fed, the focus of response should be to support the mother to return to exclusive breastfeeding. Most women can relactate if they are motivated and have adequate information and support. If the mother is not present or if she is unable to breastfeed, breastfeeding the infant through a wet nurse¹³ is the second best option. Where artificial feeding is indicated, an infant will require referral to MCH clinic.

Target groups and conditions for the use of BMS are:

- Infants 0 - <6 months who are not breastfed and for whom relactation or wet nursing is not possible. This may include orphaned or abandoned infants or infants who have never been breastfed.
- Infants 0 - <6 months who are mixed fed whilst being supported to transition to exclusive breastfeeding. In this case, BMS is used temporarily (for a maximum of 2 months) while the mother/ caregiver is relactating or re-establishing exclusive breastfeeding.
- In exceptional situations where the mother and/or infant has a medical condition that makes them unable to breastfeeding for a period and wet nursing is not possible.¹⁴

Support for BMS supply to infants over 6 months of age will only be considered in exceptional cases, e.g. where an infant over 6 months has been established on replacement feeding in the context of HIV or other medical condition. This will need prior discussion with UNHCR HQ or regional nutrition and food security technical unit.

13 Wet nursing means a women breastfeeding another women's baby.

14 Refer to 'WHO (2009) acceptable medical reasons for the use of Breastmilk Substitutes' for further definition of acceptable medical conditions.

INDIVIDUAL SUPPORT SERVICES

Adequate **breastfeeding support services** should be accessible and provided to infants under 6 months and their mothers/caregivers. This is necessary in the artificial feeding context for individual level assessment of the indication for artificial feeding (see page 18 on individual assessments) and to support those infants who may re-establish exclusive breastfeeding. **Basic aid for breastfeeding, skilled breastfeeding support and supportive care** for the mother are needed. For more details on support see Annex 8. *Case Study 4 gives an example of how 'baby tents' were used to provide IYCF services in Haiti.*

Adequate **artificial feeding support services** should be accessible and provided when needed to infants under 6 months and their mothers/caregivers. Artificial feeding support services encompass nutrition and health assessment and monitoring and supplies management (e.g. appropriate BMS supply and associated equipment including availability of fuel, water, feeding cups and equipment for safe preparation of BMS, and safe storage). BMS supplies and associated equipment is covered in Part 5. For more information on supporting artificially fed infants, see Annex 9. *Case Study 5 gives an example of the difficulty of safe feed preparation in unsanitary environments.*

Where resources and capacity are limiting factors, UNHCR may need to prioritise which infants are targeted with different services. Amongst artificially fed infants, there are sub-groups who are particularly at risk. Infants who are not breastfed, especially the youngest infants (0 - <2 months), are priorities to identify and support. Country operations should seek technical guidance from UNHCR HQ or regional nutrition and food security technical unit where necessary.

Examples of service prioritisation are:

- *Support service for relactation:* Prioritise non-breastfed infants 0 - <6 months whose mother/wet nurse is willing to relactate. If further prioritisation is needed, target infants 0 - <2 months whose mother/wet nurse is willing to relactate.
- *Support service to re-establish exclusive breastfeeding:* prioritise infants aged 0 - <2 months (including newborns) always, infants 0 - <4 months as a priority, and infants 0 - <6 months in the ideal situation.
- *Provision of BMS and associated support services:* prioritise infants <6 months who are not breastfed.

Where refugees are located in urban or other non-camp settings, this may complicate identification, provision of skilled support, and follow up of artificially fed infants. UNHCR will need to work closely with relevant national ministries and service providers in such contexts and innovate to protect infants in these settings.

As stated, BMS should only be used on the basis of a full assessment by a trained health or nutrition worker. Once supply is indicated, it is necessary for the health worker to assess the type, quantity and source of BMS to be used and to set up a management and monitoring plan for the infant's nutrition and health. Initial setup should include a household visit to assess the home environment and support safe home feed preparation. Information on calculating individual BMS needs is included in Annex 9.

All infants in receipt of BMS must receive regular follow up and active support by health/nutrition staff. Ideally, a named health worker should be assigned to the family. A minimum monthly follow up is required, with encouragement of the mother/caregiver to present at clinic between scheduled visits if there are feeding problems or if the infant is unwell. Where home visits are not possible, particular emphasis should be placed on what to do if the infant is unwell, practical sessions on preparation of infant formula, and 'spot checks' during clinic follow up visits on how BMS is prepared. A checklist for initial counselling and follow up visits is included in Annex 9. *Case Study 6 gives an example of issues to do with providing regular follow up in insecure environments.*

Clear referral systems from IYCF assessment and support services to medical and/or therapeutic feeding services should be established.

Priority access to safe water and hygienic feeding conditions must be ensured for infants that are artificially fed.

Breastfeeding and complementary feeding support services should be provided to children over 6 months of age (see page 26 on infants over 6 months). There should be continued follow up for infants who are not breastfed after 6 months of age. This may require referral between programmes and partner agencies, in which case partner responsibilities and the care pathways should be made clear to all staff and mothers/caregivers involved.

PART 5: MANAGING BMS SUPPLIES

BMS TYPE

Where artificial feeding support is indicated in a refugee operation, UNHCR should ensure that adequate amounts of appropriate BMS are available to infants under UNHCR protection. Where indicated, UNHCR will source and if necessary supply BMS (see page 24 on procurement procedures).

The recommended BMS type for use in refugee contexts for infants <6 months is infant formula that meets the Codex standard¹⁵ and is Code compliant. Where infant formula is not immediately available, it may be necessary to modify animal milk for temporary use as a BMS. Details on BMS types and modifications needed are given in Annex 10.

Generic (unbranded) infant formula is the preferred type of infant formula for use in UNHCR operations. Key considerations include: is it available via another organisation (e.g. UNICEF?); is it available in the local language?; urgency of the supply (how long will it take to procure?); and, how much will it cost relative to an alternative locally available branded supply? Where generic supply is not feasible, local procurement of commercial (branded) infant formula is the next preferred option, followed by international supply of the same.

Infant formula may take two forms: Powdered Infant Formula (PIF) and Ready-to-Use Infant Formula (RUIF). In general, UNHCR operations should use PIF. RUIF may be used in specific situations as a short term measure. More details on considerations are included in Annex 11. In summary:

- PIF is a non-sterile product that requires reconstitution with water that is at 70 degrees Celsius. It is the preferred form of infant formula in UNHCR operations in the interests of cost, storage, waste and, in most populations, product familiarity. Individual support services and additional equipment supply will be needed.
- RUIF is liquid infant formula that is ready to use. It is sterile until opened. It may present in tins or cartons in various volumes (single feed or 24 hour volume). It is expensive, costly to transport, requires significant storage, is unlikely to be locally available in refugee settings and generates considerable waste. It may be considered as a short term measure in extreme situations where there is an urgent need to support non-breastfed infants <6 months in a context of extremely poor water and sanitation conditions and cooking facilities e.g. in flooded or severely overcrowded refugee camps or transit sites.

15 Infants Codex 72/1981. Standard for Infant Formula and Formulas for Special Medical Purposes Intended for Infants.
<http://www.codexalimentarius.org>

In exceptional circumstances, where household conditions for PIF preparation are not available and RUIF is not feasible, as a temporary measure UNHCR operations should consider the central preparation of infant formula ('wet feeding') for provision to non-breastfed infants. This is likely most feasible in a camp setting however it is resource intensive.

Therapeutic milks are not an appropriate BMS. They should only be used in the inpatient treatment of severely malnourished infants and young children as defined by and according to WHO guidelines¹⁶. All other infants and young children in refugee situations for whom artificial feeding is indicated, including those who were severely malnourished who have recovered (defined by reaching ≥ -2 Z-score weight for height and no oedema for at least 2 weeks, or by reaching ≥ 125 mm Mid-Upper Arm Circumference (MUAC) and no oedema for at least 2 weeks¹⁷) should receive artificial feeding support as laid out in these SOP.

FEEDING EQUIPMENT AND OTHER NON-FOOD ITEMS

In addition to a sustainable supply of BMS and feeding utensils, households preparing BMS for an infant will need a safe and secure water source, a preparation area, a sufficient heat source (e.g. adequate fuel and an area to boil water) and preparation (measuring) and cooking (boiling) equipment. If necessary, UNHCR should source and supply fuel, water, feeding cups and preparation equipment for vulnerable families in the context of artificial feeding. Official requests should be submitted and standard UNHCR procurement procedures followed.

UNHCR should promote and support cup feeding for all artificially fed infants including 0 - <6 months. More information on cup feeding support is included in Annex 9. UNHCR operations should actively discourage the use of bottles and teats for feeding infants and young children, due to the high risk of contamination and difficulty with cleaning. The use of supplementary suckling feeding devices and breast pumps should only be considered where it is possible to clean them adequately.

In refugee populations where feeding bottle use is common, it may be difficult to enforce a 'no bottles' policy immediately. In such cases, UNHCR operations can consider a bottle exchange scheme (swapping new, clean bottles in exchange for old ones but retaining the option to exchange to a cup) together with individual advice and equipment supply for household sterilisation and bottle cleaning/cup feeding as appropriate. *Case Study 7 describes experiences of a 'bottle amnesty' in Jordan.*

16 WHO (2003) Guidelines for the inpatient management of severely malnourished children

17 WHO (2013). Guideline: updates on the management of severe acute malnutrition in infants and children.

PROCUREMENT PROCEDURES

UNHCR operations may directly procure supplies, provide funding for supply procurement to a partner agency or negotiate a supply source from another, such as UNICEF, pre-qualified NGO partners or government ministry. In some situations, it may be appropriate that caregivers purchase supplies directly resourced through a cash/voucher scheme. UNHCR operations can procure BMS supplies directly at local or international level. A guide for calculation of community level supply of BMS is given in Annex 12.

The UNHCR country office must **notify** UNHCR HQ or regional nutrition and food security technical units of all **local BMS procurement** and indirect sourcing (e.g. via partner agencies or providing funding for supplies). UNHCR HQ or regional nutrition and food security technical unit may seek further clarification from country operations in response to notifications.

The UNHCR country office must **seek approval** from UNHCR HQ or regional nutrition and food security technical units for **all international BMS procurement**. All international supplies of BMS should be sought using the appropriate supplies requisition (via UNHCR HQ Procurement Management and Contracting Service).

Where supplies are sourced directly from local or international suppliers, UNHCR operations should favour companies that are not violators of The Code.

UNHCR should only use purchased supplies of BMS in refugee programmes. Donated supplies of BMS should not be sought or used in UNHCR programmes (see page 31 under Managing Donations).

UNHCR and partners must plan so that adequate supplies of BMS are procured and supply can be sustained for as long as the infant needs it (to around 6 months of age). It may be required to allow a 2-4 week 'buffer' supply to allow a transition to non-BMS feeding. Supply needs should be calculated for the whole community and supplies procured accordingly.

Where UNHCR or partners are supplying infant formula, resources for storage and logistics must be factored into budgets and guidelines for safe storage followed. See Annex 13 for storage considerations.

In some contexts, cash or voucher schemes may be used to enable BMS supply purchase by the caregivers of targeted infants. This will require a market assessment of supply and sustainability. This may be suited to non-camp settings, where the target population is dispersed and infant formula is widely available.

For procurement of non-food items, see page 23 on feeding equipment and other non-food items.

DISTRIBUTION OF BMS

When a BMS such as infant formula is made available in a refugee context, there is a risk that there is 'spill over' into the community. Strong distribution mechanisms for BMS must be established and post distribution monitoring must be practiced to help prevent spill over. Partner reports should include details of targeting, monitoring findings and corrective actions taken when problems are identified. UNHCR HQ or regional nutrition and food security technical unit should be notified of any instances of reported spill over of BMS in operations. *Case Study 8 describes experiences of targeting BMS to avoid 'spill over' in Jordan.*

BMS should be supplied on an individual basis to targeted infants, for example, by prescription as a 'medical product' in short intervals within the health care system or allied to it (e.g. via pharmacy). BMS supplies should never be distributed through untargeted, blanket distributions or as part of general aid packages.

Distribution should be monitored closely to ensure that the right infants receive and use the right amount of BMS, based on proper needs assessment. All infants receiving BMS should receive regular follow up (see page 20 under individual support services).

BMS should be distributed discretely, not in view of breastfeeding mothers, and there should be no promotion of BMS at the point of distribution, nor any materials displaying BMS or bottle feeding within refugee operations.

On-site reconstitution and consumption ('wet feeding') may be an option in exceptional circumstances (see page 22 under BMS type).

PART 6: SPECIAL CONSIDERATIONS FOR INFANTS

INFANTS OVER 6 MONTHS

In general and as stated earlier, UNHCR will not provide infant formula to infants over 6 months of age. The emphasis of UNHCR support for infants over 6 months of age is safe, appropriate complementary feeding that includes breastfeeding support for breastfed infants, access to a wide range of appropriate and nutritious complementary foods for all infants and young children; access to the facilities, equipment and sanitation for safe preparation; a hygienic household environment; and where indicated and in accordance with UNHCR operational guidance¹⁸, targeted micronutrient supplementation. See Annex 14 for summary guidance on feeding non-breastfed children 6 - <24 months of age.

Support for complementary feeding may include direct provision of specialised nutritious foods, such as fortified blended foods (SuperCereal+ being the most appropriate choice for infants age 6-23 months) or lipid-based nutrient supplements (also called Ready-to-use supplementary foods), voucher or cash schemes to exchange for specified foods, use of micronutrient powders or nutrient supplements, or support to household gardens and agriculture/livestock interventions.

UNHCR has a critical role in advocating for and realising access to safe and appropriate complementary foods for infants and young children over 6 months. UNHCR staff should coordinate efforts and communicate with other UN agencies, NGOs and government partners who provide food, in-kind (e.g. voucher or cash schemes) and health and nutrition services to promote a multi-sector approach.

For non-breastfed infants over 6 months of age, UNHCR country operations should consider that:

- Staff and caregivers are clear that infant formula supplies will not continue after 6 months of age. It may be required to allow a 2-4 week 'buffer' supply to allow a **transition** to non-BMS feeding. This should be considered at the planning stage with the partner and a clear process established for transition.
- There should be continued follow up for infants who are not breastfed after 6 months of age, This may require referral between programmes in which case the care pathways should be made clear to all staff involved.

18 UNHCR Operational Guidance on the use of special nutritional products to reduce micronutrient deficiencies and malnutrition in refugee populations. UNHCR 2011

PASTORAL COMMUNITIES

The **use of milk and milk products** in UNHCR operations is governed by the UNHCR milk policy.¹⁹ Milk and milk products are not distributed by UNHCR on a routine basis. Milk products should only be used under strict supervision and in controlled environments, such as on-the-spot feeding or premixed in food rations. Country operations should seek technical guidance from UNHCR HQ or regional nutrition and food security technical unit where necessary.

In some refugee contexts, such as **pastoral communities**, milk represents a significant source of nutrition for infants and young children over six months. In such contexts it may be appropriate to provide suitable milk (such as animal milk) and milk products (such as yoghurt) to infants over 6 months of age, as part of a complementary diet. In these cases, milk products will only be distributed under strict supervision and in controlled environments such as on-the-spot feeding. A list of suitable and unsuitable milks for infants over 6 months is included in Annex 14. Where 'on the spot' consumption is used that includes the caregivers of infants <6 months, the liquid milk should be targeted to the mothers of breastfeeding infants rather than the infants. Pre-mixed rations that incorporate milk are suitable for all infants >6 months of age. *Case Study 9 shares an example of a milk programme to meet the needs of a refugee pastoral community in Burkina Faso.*

HIV AND INFANT FEEDING

Coordination in HIV and Infant Feeding

The current WHO guidance on HIV and infant feeding (2010) reflects a public health approach to infant feeding. WHO (2010) recommends that national or sub-national authorities should decide on the best option for HIV infected mothers: to breastfeed and receive ARV treatment *or* to avoid breastfeeding and provide replacement feeding (artificial feeding in the context of HIV). Breastfed infants should be exclusively breastfed for the first six months of life, introducing appropriate complementary foods thereafter and continue to breastfeed for the first 12 months of life. The WHO guidance further recommends that **in circumstances where ARVs are unlikely to be available, such as acute emergencies, breastfeeding of HIV-exposed infants is also recommended to increase survival.** Even when ARVs are not available, mothers should be counselled to exclusively breastfeed in the first six months of life and continue breastfeeding thereafter unless environmental and social circumstances are safe for, and supportive of, replacement feeding.

¹⁹ UNHCR Policy related to the acceptance, distribution and use of milk products in refugee settings, first edition produced in 1989, and revised edition in 2006.

This directive approach is similar to other health interventions. This means that national or sub-national health authorities should promote and support a single infant feeding practice as standard. In refugee settings, UNHCR may be the authority to designate and support the standard feeding practice for a given context. UNHCR is only obliged to provide the support for the practice that has been designated the chosen one for a given setting. Key guidance and FAQs on HIV and infant feeding are included in Annexes 1 and 15 respectively. Important applications of WHO (2010) to UNHCR operations are included below.

IYCF practice in the HIV context should be in accordance with the latest WHO recommendations (2010) and existing, appropriate national or sub-national guidance (where they exist). UNHCR should work with the appropriate authorities and WHO to support implementation of existing recommendations and/or to support their update/development to respond to new circumstances, e.g. emergency, population movement.

UNHCR must designate and support the feeding practice (breastfeeding or replacement feeding) that will give the best chance of child survival in a given context. Such a position should be informed by consultation with WHO, UNICEF, government health ministry and partners and should be clearly communicated to programme staff. UNHCR country operation should consult with relevant UNHCR technical units for support.

UNHCR's decision about the safest feeding option in the context of HIV should be based on a balance of risks in a given context. This considers the risks of HIV transmission versus the risks of death from other diseases, such as diarrhoea and respiratory infection. Factors to consider include the causes of infection in a given population; the socio-economic circumstances; what health services are available to manage sick children; and the HIV prevalence. In emergency contexts and refugee situations, the overall balance of risks for HIV-free survival of infant/child is very likely to be in favour of breastfeeding by a mother or a wet nurse, even if their HIV status is unknown and even in the absence of ARVs. Further considerations are included in Annex 15.

UNHCR should have a clear agency position on IYCF in refugee contexts where there is significant HIV prevalence²⁰ or where HIV infection is a concern amongst caregivers or staff and/or where replacement feeding is practiced. UNHCR staff and partners should have a clear understanding of this position. A short brief should be prepared that clearly states the situation regarding HIV and infant feeding and UNHCRs position, which should be approved by the UNHCR Regional Reproductive Health and HIV Officer and HQ Public Health Section.

20 'Significant' HIV prevalence is where HIV prevalence is consistently over 5% in at least one defined population but below one percent in pregnant women in urban areas (concentrated epidemic) or HIV prevalence consistently over 1% in pregnant women nationwide. Most Asian, North Africa, Middle East and Latin America countries would be classified as either low-level (HIV prevalence has not consistently exceeded 5% in any defined sub-population) or concentrated. Sub-Saharan Africa will be classified as a generalised epidemic. Source: UNIADS/WHO

A sample brief on the situation regarding HIV and infant feeding is included in Annex 16.

Individual level considerations in HIV and infant feeding

Mother is HIV negative or of unknown HIV status: UNHCR should provide support for optimal IYCF as per the general population. Even in contexts where HIV is prevalent, this recommendation stands; the majority of women will not be HIV infected and breastfeeding is in the best interests of child survival. Consideration of a recommendation to replacement feed requires that the HIV status of the mother is known.

Mother is HIV infected (infant uninfected or unknown status) and needs guidance on feeding option: The individual mother should be advised and supported on the feeding option that has been designated as in the best interests of child survival (see page 27 on coordination in HIV and infant feeding). In refugee contexts, it is most likely that a mother will be supported to breastfeed as this will give the greatest chance of child survival, even in the absence of ARVs.

Mother is HIV infected (infant uninfected or unknown status) and is breastfeeding: Current WHO (2010) guidelines recommend exclusive breastfeeding for 6 months, introduction of complementary foods at 6 months, while continuing to breastfeed until 12 months of age. At 12 months, the feasibility and safety of stopping breastfeeding should be assessed. Only if the environmental and social circumstances are safe for, and supportive of, replacement feeding should breastfeeding cease, otherwise the mother should be supported to continue breastfeeding until conditions are in place.

Of note to operations:

- The decision on whether to recommend breastfeeding for a longer period before consideration of cessation, e.g. continued breastfeeding to 15 months or 18 months, should be taken in accordance with WHO (2010).
- The potential for population movement (e.g. return to original country) and the ability to monitor and track child health are all factors to consider in the sustainability of supply provision and associated resources.

Mother is HIV infected (infant under 6 months is uninfected or unknown status) and mother is mixed feeding: The mother should be supported to establish exclusive breastfeeding and ensure access to ARVs in accordance with relevant national protocols.

Mother is HIV infected (infant uninfected or unknown status) and is replacement feeding: Where an infant <6 months is already established on replacement feeding and is

not breastfed, then the necessary artificial feeding support must be provided (see part 4). Where an infant is >6 months and established on replacement feeding, then guidance from the UNHCR technical unit should be sought as an exceptional case.

Mother is HIV infected and infant is HIV infected: If a mother and her infant are HIV infected, then exclusive and continued breastfeeding support is the option that gives the best chance of child survival. Malnourished HIV infected children require the same nutrition and medical management as malnourished infants without HIV, but tend to have more serious infections.

MATERNAL DEATH

Where an infant has lost his/her mother, a **wet nurse**²¹ is the preferred option of feeding support. The wet nurse should receive similar support for breastfeeding as breastfeeding mothers.

Where HIV is a concern, a wet nurse should undergo HIV testing and be supported with ARV treatment if indicated. In situations where HIV testing and counselling is available and linked to care and treatment services, but prioritized to pregnant women among other special groups, the same should be accorded to wet nurses as a priority from the point of view of elimination of mother to child transmission. Where the HIV status of a wet nurse is unknown and HIV testing is unavailable, the balance of risks applied to a mother should be applied to a wet nurse (see page 29). An infant being wet nursed by a woman of unknown HIV status is at low risk of HIV transmission, especially in low prevalence settings. Actions can be taken to minimise risks such as developing a screening tool for potential wet nurses about HIV risk behaviour and symptoms.

Case Study 2 deals with some of the issues around HIV programming, including wet nursing, in a programme in Sudan.

21 Wet-nursing means a woman breastfeeding another woman's baby and may be considered in communities where this option is accepted. Possible wet nurses include: a grandmother or other female relative, a woman who has recently lost her own infant, or a woman who is breastfeeding her own infant. Relactation is possible even years after the relative breastfed her own children, and even after the menopause. See more in Module 2 on IFE, Section 5.7.

PART 7: MANAGING DONATIONS AND OTHER INAPPROPRIATE INTERVENTIONS

UNHCR does not accept donations of breastmilk substitutes, bottles and teats and commercial 'baby' foods for its refugee operations. Experiences with donated BMS supplies in refugee situations have found that they are generally not Code compliant (especially regarding language), inappropriate (different age group formulations), poor quality (close to expiry), disproportionate to need (too little or too much) and unpredictable.

Collaboration and coordination with the nominated health and nutrition co-ordinating authority will limit the risks of unsolicited donations that end up in circulation in refugee settings. *Case study 10 describes experiences of prevention donations of BMS in Kenya and Jordan.*

The distribution of *donated* BMS in any part of the healthcare system, including in emergencies, is a Code violation. *Purchased* supplies of BMS can be distributed within the healthcare system. Relevant sections of the Code are included in Annex 2.

The UNHCR position regarding donations must be clearly communicated, particularly in the early stages of an emergency in contexts where donations have occurred previously or are considered likely to arrive.

Communications should:

- State that donations of BMS, commercial complementary foods and bottles and teats are not needed and expose infants and young children to risk of illness and death.
- State what the actual need for BMS is in the community and what is being done within the UNHCR operations to meet this need.
- Include information on who to report offers of donations to, and what to do with donations that do arrive.

Information should target key stakeholders that will depend on the context, for example government, camp management, military and donor governments. UNHCR operations must be alert to donations arriving from less traditional sources (e.g. via the military or private donors) or from agencies not operating within the main coordinating system.

Sometimes it is not possible to prevent the arrival of donations; they may be fuelled by political rather than child nutrition objectives. Donations may arrive unannounced to an emergency context. UNHCR operations should have a plan in place to manage any commodities that do arrive.

Preparedness steps regarding handling donations that may arrive should be established.

Examples of steps are:

- Identify where donations of BMS, feeding equipment, etc. could be stored safely should they arrive (e.g. UNHCR storage, another UN agency, technical NGO)
- Advise other UN agencies, authorities, NGOs, other sectors (WASH, food distribution, protection) to be alert to the arrival of donations and who to contact in this instance
- Alert logistics/administrators at borders/freight handling/airport for the arrival of donations of BMS and feeding equipment, etc. and who to contact in this instance

When donated supplies of BMS arrive, immediate actions must be taken to manage supplies.

Examples of actions are:

- Call a meeting with health and nutrition partners and the host government to plan what to do with the supplies (see below)
- Collect or arrange collection, ideally from the point of entry to the emergency area as soon as it arrives
- Record the source, product, amount, expiry dates
- Store in a central, secure location to ensure there is no leakage
- Place supplies under the control of a designated body
- Review donation prevention strategies and assess whether this could have been avoided. Document in lessons learned

Examples of uses for donated supplies of BMS that are not expired are:

- Return of BMS donations to the source (at the donors cost); in practice this has proved difficult (unknown source, too much cost)
- Mixing BMS at source into blended complementary foods for infants over 6 months (do not supply as milk powder to families for home mixing)
- Mixing BMS into blended foods for the elderly or other vulnerable target groups, such as hospital inpatients (do not supply as milk powder to families for home mixing)
- Use BMS as an ingredient in bread making when bread is part of the blanket distribution
- Use BMS as an animal food (liaise with animal health and welfare organisations)

Case Study 11 describes a way in which donated BMS was used in Jordan.

If a safe use for donated supplies cannot be found or supplies are expired, supplies should be buried or burned. Baby bottles, teats and soothers should also be destroyed except in

exceptional cases, e.g. where a bottle exchange programme is in place (see page 23 under feeding equipment and other non-food items).

As stated earlier, UNHCR should only use purchased supplies of BMS in refugee programmes. A UNHCR country request to use donated BMS supplies to meet a defined need in programmes indicates a problem with planning or official procurement procedures. The UNHCR HQ technical unit should be notified and investigate any indication or use of donated supplies in country operations.

Actions must be taken to minimise the impact of any misuse of BMS irrespective of whether they are donated or purchased. Examples of alerts to inappropriate use of BMS include severely malnourished infants under 6 months and/or infants with diarrhoea presenting to clinics, infant formula being included in the general food ration, or infant formula included in aid packages.

UNHCR staff should document violations of the Code and report them immediately to the WHO at the country/regional level. For field contact details, contact WHO at the HQ level, email: cah@who.int and nutrition@who.int. Violations can also be reported to the International Code Documentation Centre (ICDC) in Malaysia, email: ibfanpg@tm.net.my, or Fundación LACMAT in Argentina, email: fundacion@lacmat.org.ar or Italian Code Monitoring Coalition (ICMC) in Milan, email: icmc@ibfanitalia.ie. A code violation monitoring form is available at: <http://ibfan.org/code-watch-form>.



PART 8: EXPERIENCE EXCHANGE & LEARNING

UNHCR encourage staff to use the en-net online forum (www.en-net.org.uk) to seek peer and expert support for programming challenges and to help respond to other programme questions. A thematic area is dedicated to IYCF-E.

UNHCR encourages regional and country operations to document and share programming experiences related to implementation of these procedures. Examples from urban programming contexts are especially needed. Feedback on implementing these SOP should be submitted to UNHCR HQ or regional nutrition and food security technical unit.

It is recommended that all UNHCR staff complete the IFE Core Group Module 1 orientation on IFE, an online training available at: <http://lessons.enonline.net/>.

CASE STUDIES

- Case Study 1:** IYCF assessment and affirmative action by a UNHCR Health Officer
- Case Study 2:** Individual cases alert UNHCR of critical gaps in IYCF system
- Case study 3:** Artificial feeding scenarios in UNHCR operations
- Case study 4:** Baby tents in Haiti
- Case Study 5:** The challenges of artificial feeding in unhygienic conditions
- Case Study 6:** The challenge of security in the follow up of infants
- Case Study 7:** Bottle amnesty in Jordan
- Case Study 8:** Implementing controls around the distribution of infant formula in Jordan
- Case Study 9:** Meeting milk needs of non-breastfed infants over 6 months in a refugee pastoral community in Burkina Faso
- Case Study 10:** Preventing donations of BMS in Kenya and Jordan
- Case Study 11:** Use of donated BMS in Jordan

CASE STUDY 1: IYCF ASSESSMENT AND AFFIRMATIVE ACTION BY A UNHCR HEALTH OFFICER

This case study demonstrates the role that UNHCR staff can play in identifying IYCF issues and coordinating a response.

Assessment

Last weekend I conducted a rapid assessment in the General Hospital after receiving reports that a number of refugee children were admitted with signs and symptoms of malnutrition.

We observed 2 children above 6 months old whose weight, MUAC and clinical findings demonstrated that they were severely malnourished and four infants less than 6 months who had signs and symptoms of failure to thrive. For instance, a young boy was born on 23 May 2013 with a birth weight of 4 kg. On 3rd August 2013 the child was 3.7 kg. These infants were admitted with diarrhoea and vomiting and treated for dehydration with intravenous fluids, which we know is dangerous for children with severe malnutrition.

The use and promotion of BMS was widespread in the hospital. Several refugee women reported that doctors were advising them to stop breastfeeding, telling them breastfeeding was not safe or they did not have sufficient milk. We observed three refugee women who had not breastfed at all. At birth, most of the newborns are separated from their mothers and, once in the neonatal intensive care unit, BMS were started.

It was clear to us that we had an emerging public health problem with misdiagnosis and inappropriate treatment of severe malnutrition, inappropriate infant feeding practices and indiscriminate use of BMS.

Immediate action

To ensure cases of severe malnutrition were managed properly, we notified all partners that, with immediate effect, infants and children with severe malnutrition should be referred to another hospital for treatment, where the paediatrician had been trained by a strong local NGO and where there were supplies of F75, F100 and RUTF. We also agreed that children with severe malnutrition would be treated at no cost to the parents and that UNHCR would be notified of every new case.

We immediately commissioned an NGO to initiate a rapid community based assessment in all refugee communities where cases of acute malnutrition were reported or suspected, with results in 5 days. This was to include an assessment of IYCF practices.

I also immediately briefed the Director General of the Ministry of Public Health (MOPH) and all key partners of my findings at the General Hospital.

Actions in coming days and weeks

Along with the MOPH and key partners, we agreed to do the following:

NGO to train a core group of first line staff (paediatrician and nurses) to identify cases of acute malnutrition.

UNHCR to second a consultant to the MOPH for 6 months to monitor and advise the General Hospital and other hospitals on the use of BMS. We are open to all options including cancelling UNHCR/ partner contracts in hospitals that refuse to adjust their policy on the use of BMS.

UNICEF to assist with the active promotion of breastfeeding and appropriate IYCF practices in the community and to promote the use of oral rehydration in hospitals and in the community.

UNICEF to carry out a nutrition survey in September 2013, which will include IYCF assessment.

WHO/MOPH to review the early warning system and review why the deaths reported as dehydration in the general hospital were not picked up and investigated by EWARN.

UNICEF/MOPH to facilitate/ensure that all refugee children are provided with child health record cards (not all refugee children identified had them) and UNICEF to assist and intensify countrywide growth monitoring.

Source: UNHCR Health Officer, Lebanon (2013)

CASE STUDY 2: INDIVIDUAL CASES ALERT UNHCR OF CRITICAL GAPS IN IYCF SYSTEM

This case study gives an example of how individual cases with infant feeding issues can alert UNHCR of critical gaps in the IYCF system.

I was notified of an individual case that presented in the refugee community here in South Sudan of a 5 month old infant whose mother had died of Hepatitis E 10 days previously. The infant's grandmother was requesting help to feed the infant. This is normally a breastfeeding population. Wet nursing was advised as a first option, but a wet nurse could not be identified. There were concerns regarding supporting wet nursing as HIV testing was not available. The individual case alerted my colleagues and I to an infant feeding problem in the community related to maternal morbidity and mortality. There were a number of maternal deaths from Hepatitis that had implications for infant nutrition, care and survival in this community. We knew we needed to investigate further to find out how widespread the problem was.

We also realised that we didn't have a good enough system in place to support non-breastfed infants. There was a medical NGO on the ground dealing with health issues and another NGO dealing with child protection issues in the community, but neither was equipped to assess individual infants with complex feeding issues. There were also no proper and standardized systems in place to support artificial feeding in Maban camps. We immediately initiated discussions with our NGO partners and agreed on a set of roles and responsibilities to ensure that this gap was filled. In this case we felt it was best that the medical NGO oversee the assessment, prescription and management of individual cases, while the community-based NGO help to identify cases in the community and manage follow-up. It was difficult to agree on who should supply infant formula. In our case it was decided that the community-based NGO should source the formula for the medical agency with UNHCR funding. A guidance document was drafted accordingly.

After a similar case in Doro Camp, where the mother of a 4 month old infant died from Hepatitis E where a wet nurse could not be identified, UNHCR initiated another meeting with all NGO partners. Roles and responsibilities were agreed to manage artificial feeding and the draft guidance document was finalized and shared. UNHCR now oversees the management of artificial feeding in both camps and roles and responsibilities of NGO partners are clear. A buffer stock of artificial milk is also forecast to cover any other cases such as these that may arise.

In this situation, identifying a wet nurse for this infant, such as a close relative, remains the best option for child survival. The risk of transmission is low; about 0.79% per month of breastfeeding in the absence of all antiretroviral drugs. For more considerations regarding the HIV context including wet nursing, see Annex 15.

Source: UNHCR Community Services Officer, South Sudan (2013)

CASE STUDY 3: ARTIFICIAL FEEDING SCENARIOS IN UNHCR OPERATIONS

These case studies provide examples of different artificial feeding scenarios faced in UNHCR operations.

Scenario 1: Somali refugees in Dadaab refugee camp, Kenya

Breastfeeding prevalence is high in this population, although exclusive breastfeeding rates are low. There is an IYCF programme running that includes mother support groups and mothers are aware of the importance of breastfeeding. There is low usage of BMS and bottles. In a camp of 30,000, 19 children are on BMS.

Scenario 2: Syrian refugee camp, Iraq

Mixed feeding and artificial feeding prevalence are high in this population. A recent nutrition survey (2013) of the refugee population showed that 46% of infants under 2 years are using infant formula. Usage of bottles is high. The actual number of infants using BMS in this camp of 15,000 is not yet known.

Scenario 3: Sudanese refugee camp, South Sudan

Breastfeeding prevalence is high in this population. There is an IYCF programme running and breastfeeding is well accepted in the community. There is low usage of BMS and bottles. There is high prevalence of HIV, but low access to testing, and fear around mother-to-child transmission through breastfeeding.

CASE STUDY 4: BABY TENTS IN HAITI

This case study describes the establishment and running of baby tents in an emergency.

It became clear that infant feeding had to be facilitated through the creation of spaces where mothers could receive antenatal and postnatal counselling and safely breastfeed their infants, and where infants who could not be breastfed (e.g. orphans and infants separated from their mothers) could be given ready-to-use infant formula. This led to the establishment of the baby tent programme.

The goal of the baby tent programme was to promote and sustain optimal infant feeding practices while reducing the health risks associated with the unregulated use of infant formula. Baby tents were relaxed, friendly and stimulating spaces where mothers could breastfeed comfortably and be supported by a trained counsellor and their own peers. The tents were spacious, light, clean, attractive and, in places with electric power, equipped with fans. Safe drinking water was available and there were mats and mattresses for sitting and relaxing. The tents were often decorated with balloons and posters and children's songs about child feeding were played in some of them between other activities.

The tents operated 6 to 7 days a week, as prescribed by the national guidelines developed by the health ministry and Haiti's nutrition cluster partners. Activities included registration and assessment of the feeding and nutritional status of new mother–infant pairs and pregnant women; individual nutrition counselling of pregnant and breastfeeding women; counselling of caretakers of non-breastfed infants on ready-to-use infant formula; infant growth monitoring; and group education sessions on health and nutrition, childcare and the caretaker–child relationship. Children with acute malnutrition were transferred to the closest government-run or NGO-run nutrition programme, as appropriate; those with other severe medical conditions, such as dehydration or pneumonia, were transferred to the closest health centre.

The staff of a baby tent included a social worker, a guard and a nurse in charge. The nurse had overall responsibility for the tent, performed all the nutritional and health assessments and saw to it that all reports were written and correct. Tents providing psychosocial support had a psychologist on the staff. One individual routinely supervised four baby tents.

Women came and went with their children throughout the day. Every morning and sometimes in the early afternoons, nutrition staff members conducted community awareness and participation activities in the camps with the use of megaphones. They also paid home visits, sometimes assisted by the psychologist. Home visits were conducted to encourage

absentee mothers or caretakers to return to the tents; to counsel mothers experiencing breastfeeding difficulties; to see if the caretakers of infants who could not be breastfed were using ready-to-use infant formula and to investigate why some infants were losing weight.

Source: Ayoya, A. M. et al (2013) Protecting and improving breastfeeding practices during a major emergency: lessons learnt from the baby tents in Haiti. Bulletin World Health Organisation 2013; 91: 612-617. Available from: <http://www.who.int/bulletin/volumes/91/8/12-113936.pdf>

CASE STUDY 5: THE CHALLENGES OF ARTIFICIAL FEEDING IN UNHYGIENIC CONDITIONS

This case study highlights the practical difficulties of safe preparation of BMS in refugee situations and how these can be overcome.

Conditions for preparing BMS are not ideal for many Syrian refugee families in Jordan. Conditions inside tents and caravans are often unhygienic. In response to this we encourage the caregivers to use the communal kitchens when they prepare infant formula. Some do and some don't. In addition, midwives regularly educate caregivers on the safe preparation of feeds. Infants using BMS are routinely monitored and where there are health issues or weight gain problems, we use this as an alert that there may be problems.

Source: UNHCR Health Officer, Jordan (2013)

CASE STUDY 6: THE CHALLENGE OF SECURITY IN THE FOLLOW UP OF INFANTS

This case study highlights the security challenges that are sometimes faced by staff in the field during the follow up of infants.

There is a level of insecurity here in Dadaab at the moment and so staff movement is sometimes limited. It isn't always safe for our staff to move around and visit people in their homes. This is difficult when it comes to the follow up of infants using BMS. What we say to our staff is: if the child is doing well, then monitor them at the clinic on a weekly basis and continue to counsel and encourage caretakers to continue the best practices. Only if the child's growth velocity is reducing or is not doing well do we insist on home visits and only if it safe to do so. This isn't what our guidelines say, but we have to adapt and do the best that we can in our situation.

Source: UNHCR Health Officer, Dadaab, Kenya (2013)

CASE STUDY 7: BOTTLE AMNESTY IN JORDAN

This case study describes an initiative which successfully resulted in a reduction in the use of feeding bottles in Jordan.

In Jordan we have a situation where the use of bottles is extremely high. Our partner agencies have bought cups and set up a bottle amnesty. If mothers return a bottle, they are given a cup. To make this work, we have worked hard to prevent the donation of bottles. Originally, one of the military hospitals was distributing packages of feeding bottles and infant formula to newborns. After much work, this has stopped. Mothers are also educated on the importance of using cups not bottles and gradually more and more women are switching to cups.

Source: UNHCR Health Officer, Jordan (2013)

CASE STUDY 8: IMPLEMENTING CONTROLS AROUND THE DISTRIBUTION OF INFANT FORMULA IN JORDAN

This case study demonstrates the kinds of challenges that can be faced by staff in artificial feeding programming in refugee situations and provides examples of controls that can be put in place to prevent 'spill over' of infant formula.

At the beginning of the crisis there was huge demand for infant formula from the Syrian refugee population. Prescriptions for infant formula and distribution were poorly monitored at that time. As infant formula is highly sought after there were several security incidents over it. Staff responsible for prescribing infant formula were attacked and staff transporting BMS were mobbed and the milk was taken. We had to put tight controls in place to stop this kind of thing happening.

Midwives at the public health clinic assess individual infants and give prescriptions for infant formula only when strict criteria are met. However, now, the actual distribution of the prescribed infant formula takes place at one of the military hospitals in the camp. This makes the security much easier to control. We also now hold a database of mothers receiving milk. We use the mother's ration card for identification and we mark the baby's fingers with ink to stop substitute babies being brought in. Previously mothers would borrow a child to try to be eligible for the programme so that they could sell the milk on the market. These controls stop this kind of thing happening.

Source: UNHCR Health Officer, Jordan (2013)

CASE STUDY 9: MEETING MILK NEEDS OF NON-BREASTFED INFANTS OVER 6 MONTHS IN A REFUGEE PASTORAL COMMUNITY IN BURKINA FASO

This case study gives an example of an alternative method of providing milk to non-breastfed infants in a pastoral community.

The Malian population living in Burkina Faso refugee camps is primarily composed of nomadic pastoralist and agro-pastoralists. Livestock remains important for socio-economic transactions and for covering food needs. The main species of livestock are camels, cattle, sheep and goats. Milk makes up 68 percent of caloric consumption of these communities in north-eastern Mali. The refugee population receive food assistance in the form of a full food ration consisting of cereals, pulses, oil, CSB, and salt. However, the refugee population has often expressed the need to include more culturally preferred food items in the basket, especially milk.

In order to improve the diet of children among Malian refugees in Burkina Faso and prevent malnutrition, UNHCR is planning a pilot project to serve ready-to-drink milk to children in a 'milk kitchen' for on the spot consumption hosted in child friendly spaces in the camp. The aim is to ensure adequate milk consumption of children 6-36 months of age in a controlled and safe environment and to improve knowledge of mothers/caregivers regarding IYCF and hygiene practices.

The milk kitchen would be open three to five days per week (depending on the number of targeted children and capacity of health/nutrition workers). Milk will be supplied as cow's or goat's milk purchased from host and refugee livestock owners. Many of these livestock owners are included in livelihood programmes, thus the milk kitchens will potentially support both the local economy and refugees included in livelihoods programmes. In the context of this programme, infants over 6 months who are not breastfed will be supplied with milk to support complementary feeding, thus avoiding risk practices associated with the reconstitution of infant formula.

Source: UNHCR HQ Technical Unit

CASE STUDY 10: PREVENTING DONATIONS OF BMS IN KENYA AND JORDAN

These case studies provide examples of how UNHCR staff can draw partners together and coordinate a response to help prevent and manage donations of BMS in refugee situations. Both examples also show the value of having a policy in place that has the buy-in of national authorities.

Here in Dadaab Refugee camp, the government received donations of BMS and started distributing them in the camp. Our team at UNHCR stopped them and raised awareness as to why this is dangerous. The next time donations were received, the government stopped the distribution itself. This was in Dollo Ado, Ethiopia, while I was working there during the emergency in 2011. In Kenya, there is a policy in place at country level and practitioners are very aware of it. Sessions have also been held by government counterparts for health practitioners in Dadaab.

Source: UNHCR Food and Nutrition Officer, Dadaab, Kenya, Somali refugees

Here in Jordan and within this region people are not aware of the importance of breastfeeding. Lots of organisations offered BMS at the start of the emergency and the NGO responsible for camp management would receive it and distribute it through the clinics, hospitals, or sometimes through other distributions. We had to sit with all partners in the camp and with the MOH to make them understand the dangers of BMS donations and to come up with an IYCF/ BMS strategy. The MoH now has its own statement to the effect that they will not accept donations of BMS. The military hospitals are on board too. A lot of work went into this but now there is agreement that donations will not be accepted in future.

Source: UNHCR Health Officer, Jordan

CASE STUDY 11: USE OF DONATED BMS IN JORDAN

This case study reflects the scale of donations and how they are difficult to control.

It was very difficult to find a way to use unsolicited donations of infant formula in Jordan. Overall, 60,000 tins of branded infant formula arrived and we couldn't find a way to use it. In the end the donated formula was actually used as part of the milk prescription programme in the camp. This was because despite extensive consultation no other safe use could be found for it. The brand name was covered with tape and it was only distributed on prescription of a midwife.

Source: UNHCR Health Officer, Jordan (2013)

