



UNHCR POLICY RELATED TO THE ACCEPTANCE, DISTRIBUTION AND USE OF MILK PRODUCTS IN REFUGEE SETTINGS

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The protection, promotion and support of breastfeeding and appropriate complementary feeding are essential to the well-being of infants and young children. Inappropriate handling of milk products in refugee settings can negatively impact on infant feeding practices and directly contribute to increased morbidity and mortality in this age-group. This policy aims to assist and guide on the acceptance, distribution and use of milk products in refugee settings.

Several international instruments currently exist to emphasize our obligations to refugee children and their rights. The **UN Convention on the Rights of the Child (CRC)**^a articulates the right of all children to the highest attainable standard of health, acknowledges the mother's right to appropriate pre and post-natal care, as well as the right of all to full and unbiased access to information and education regarding child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation. Refugee children, like all children, are entitled to all other rights granted under the Convention, including the rights to life and development, adequate nutrition and adequate health care.

The Innocenti Declaration 2005^b, which took place in Florence, Italy on 21 and 22 November 2005, builds on the 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding, covering infant and young child feeding practices as a whole, as well as respect, protection, facilitation and fulfillment of accepted human rights principles. On 27 May 2006, the World Health Assembly (WHA 59.21) welcomed [11.8, (2)] "the Call for Action contained in the Innocenti Declaration 2005 on Infant and Young Child Feeding as a significant step towards achievement of the fourth Millennium Development Goal to reduce child mortality" (WHA 59.21)^c.

^a A/RES/44/25, Convention on the Rights of the Child. 61st plenary meeting, 20 November 1989. <http://www.un.org/documents/ga/res/44/a44r025.htm>

^b <http://innocenti15.net/declaration.htm>

^c WHO 59th World Health Assembly. 4 May 2006. A59/13. Provisional agenda item 11.8. WHA 59.21

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Summary of UNHCR use of milk products

1. UNHCR supports the policy of the World Health Organization (WHO) concerning safe and appropriate infant and young child feeding, in particular by protecting, promoting and supporting exclusive breastfeeding for the first six months of life and continued breastfeeding for two years or beyond, with timely and correct use of adequate complementary foods. The use of milk products in refugee settings must conform to WHO policy.
2. UNHCR recognizes the challenge of infant and young feeding in the context of HIV/AIDS. UNHCR handling of milk products in refugee settings for replacement feeding will be in accordance with current WHO policy (see section 2.8).
3. UNHCR will actively discourage the inappropriate distribution and use of breast milk substitutes (BMS) in refugee settings. UNHCR will uphold and promote the provisions of the *International Code of Marketing of Breast milk Substitutes and subsequent relevant WHA resolutions* (the International Code) (1, and annex 2).
4. UNHCR recognizes the particular challenges and risks of infant and young child feeding in emergencies (2,3). Emergency assessments need to include infant feeding¹ in order to identify and address nutritional needs of infants and young children, and the response needs to be co-ordinated with all relevant players. UNHCR endorses the *Operational Guidance for Emergency Relief Staff and Programme Managers on Infant and Young Child Feeding in Emergencies* (hereafter referred to as the Ops Guidance)(4). Many aspects of the Ops Guidance are applicable to non-emergency contexts and to refugee settings and so are specifically referred to in this policy. Key extracts are included in annexes 1-3. UNHCR recommends the full Ops Guidance is read in conjunction with this policy.
5. UNHCR will accept, source and distribute milk products only if they can be used under strict control and in hygienic conditions, either for on-the-spot consumption in a strictly supervised environment or pre-mixed centrally with cereal flour, sugar and oil to produce a dry take-away premix for cooking at household level.
6. UNHCR will accept, source and distribute milk products only when received in a dry form. UNHCR will not accept donations of liquid or semi-liquid products, including evaporated, condensed and Ultra High Temperature (UHT) milk.
7. UNHCR will accept, source and distribute dried skim milk (DSM) only if it has been fortified with vitamin A.
8. UNHCR advocates that when donations of DSM are supplied to refugee programmes, these specific donors are approached for cash contribution to be specially earmarked for operational costs of projects to ensure the safe use of this commodity.

¹ See Modules 1 and 2 for information on early needs assessment related to infant feeding practice (5,6).

9. UNHCR will not accept *unsolicited* donations of breast milk substitutes, bottles and teats and commercial 'baby' foods (see definitions). UNHCR will work with the co-ordinating agency to limit the risks of unsolicited donations that end up in circulation in refugee settings.
 10. UNHCR will only accept *solicited* donations or source infant formula when based on infant feeding needs assessment by trained personnel using established and agreed criteria², where key conditions are met (see sections 5.5-5.8), in consultation with the designated co-ordinating body, UNICEF and WHO, and after review and approval by UNHCR HQ technical units.
 11. UNHCR will discourage the distribution and use of infant-feeding bottles and artificial teats in refugee settings. In any instance where an infant or young child is not breastfed, cup feeding is encouraged.
 12. UNHCR will only accept, supply and distribute pre-formulated therapeutic milk products (see definitions) or DSM to prepare therapeutic milk for treatment of severe acute malnutrition in accordance with the current Memorandum of Understanding (MOU) with the World Food Programme (WFP), in consultation with the co-ordinating body, with UNICEF and WHO, and after review and approval by UNHCR HQ technical units.
 13. Where a population is dependent on food aid, UNHCR advocates that a micronutrient-fortified food should also be included within the general ration for older infants and young children where the regular distribution of fresh foods is not an option (5.1.4 Ops Guidance).
 14. UNHCR advocates feedback on this policy and encourages accountability within its operations. Section 6.0 lists key feedback contacts related to the content of this policy.
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² See Module 2 (6).

Issues related to the safe use of milk products in feeding programmes in refugee settings

1. Introduction

This policy aims to assist and guide the use of milk products in refugee settings. Indiscriminate distribution and use of milk products in refugee settings poses a significant risk of increased morbidity and mortality to infants and young children through the negative impact on infant feeding practices. Milk products, including DSM, Dried Whole Milk (DWM) and more recently liquid UHT milk, are handled in relief operations, often received or offered as donations. Unsolicited donations and untargeted distribution of infant formula have also featured in recent emergencies. Therapeutic milk, used in the management of severe malnutrition, typically feature in refugee settings where UNHCR operates.

The present milk policy specifically addresses the handling of these milk products, and applies to both donated milk products and those procured in the course of UNHCR programming.

Definitions are given in section 7.0 and references in section 8.0.

Key supporting materials are included in annexes 1-3.

2. Infant and young child feeding

2.1 Breastfeeding is an unequalled way of providing complete hygienic food for the healthy growth and development of infants, and forms a unique biological and emotional basis for the health of both mother and child. In addition, the anti-infective properties of breast milk help to protect infants against disease, and there is an important relationship between exclusive breast-feeding and child spacing.

2.2 Early initiation (within one hour of birth) of exclusive breastfeeding significantly reduces the risk of neonatal mortality. Infants for whom initiation of breastfeeding is delayed to more than 24 hours after birth are 2.4 times more likely to die during their first month of life. The risk of neonatal death is increased approximately fourfold if milk-based fluids or solids are provided to breastfed neonates (7).

2.3 Breast milk alone (exclusive) satisfies the nutritional requirements of an infant for the first complete six months of life. After six months, adequate and appropriate infant complementary foods become necessary to complement breast milk in order to meet the energy and other nutrient requirements of the infant (timely complementary feeding). International recommendations call for breastfeeding to continue until the child is two years of age and beyond (8).

2.4 Where difficulties with breastfeeding are reported, UNHCR advocates the focus of response should be on skilled breastfeeding support, re-lactation and supportive care of the mother, rather than the provision of infant formula (see 2.8).

2.5 Complementary feeding of children between 6 and 24 months needs close attention. A varied diet is essential, with dairy products if possible, to ensure that energy, protein, mineral and vitamin requirements are met.

Special attention should be given to the nutritional value of the food ration distributed to older infants and young children whose particular nutritional requirements are often not covered by the general ration (See Ops Guidance 5.1). Where a population is dependent on food aid, UNHCR advocates that micronutrient-fortified food should also be included within the general ration for older infants and young children) where the regular distribution of fresh foods is not an option. (See Ops Guidance 5.1.4).

2.6 Infants and young children who are not breastfed need adequate and safe solid or semi-solid food to help meet all their nutritional requirements. To ensure appropriate and safe feeding of non-breastfed infants and for the protection of breastfed infants, key conditions must be met if BMS are used for feeding non-breastfed infants (see Sections 5.5 – 5.8).

2.7 In non-breastfed infants, infant formula is not required over six months of age since the nutritional needs of the older infant can be met through appropriate complementary feeding if nutrient dense foods are available. However, the use of infant formula in non-breastfed infants aged 6-12 months is nutritionally advantageous where appropriate infant complementary feeding is lacking. Full cream animal milk (boiled or pasteurized) is safe to use for infants over six months of age (9).

2.8 Where HIV status of the mother is unknown or she is known to be HIV negative, she should be supported to exclusively breastfeed. Where a mother is HIV positive, UNHCR will support **replacement feeding** only when this option is established as acceptable, feasible, affordable, sustainable and safe (AFASS) based on individual assessment. Women who are HIV positive should be supported to make an informed decision about infant feeding, where the risk of HIV transmission through breastfeeding is weighed up against the risk of infant illness or death from not breastfeeding (10, 11, 12 and Ops Guidance 5.2.7 and 5.2.8 in annex 1).

2.9 **Early needs assessment and monitoring** of infant and young child feeding practices and co-ordinated interventions are essential to target support and to enable surveillance of the impact of milk product distribution and use (See Ops Guidance, sections 3.0 and 4.0). UNHCR will liaise with the designated infant and young child feeding co-ordinating body.

3. Nutritional value of milk

3.1 In general, milk is an excellent source of essential amino acids (proteins), calcium, vitamins B, and a number of trace elements. It is a poor source of iron and heated milk provides almost no vitamin C. Unless fortified, skimmed milk contains no vitamin A.

3.2 On a per kilogram basis, the energy requirements of young children are considerably greater than those of the adult. There are also important qualitative differences in energy and nutrient requirements that are related either to the nutritional needs of children or to their particular physiological characteristics. Milk products, such as DSM, can help to meet these requirements, if used appropriately and safely. In feeding programmes in refugee settings, the safest (see section 4) use of dried milk products is as a mix with cereal flours.

4. Summary of the health hazards associated with the use of milk products in refugee settings

Problems with contamination

4.1 Water supplies are commonly inadequate, both qualitatively and quantitatively in refugee relief settings. Insufficient water means that containers and utensils used for mixing milk are often dirty, thus making secondary contamination highly probable. DSM, DWM or infant formula that are reconstituted with contaminated water are ideal media for breeding harmful bacteria. UHT milk is also an excellent growth medium for bacteria once the packaging is open and poses a risk of accidental contamination.

4.2 The immune system of a child below two years of age is not yet fully developed and consequently, is less able to resist the effects of high bacterial food contamination. Acute diarrhoea and dehydration are the inevitable results of ingesting contaminated milk, contributing to malnutrition, and increased morbidity and mortality.

Problems with reconstitution

4.3 Feeding children over-diluted DSM or DWM as their main source of food will inevitably result in inadequate dietary intake and contribute to malnutrition. On the other hand, children who are fed under-diluted or concentrated DSM or DWM can become seriously ill due to dangerously high concentrations of sodium and protein; renal failure and death can result.

4.4 Different brands and types of infant formula carry different mixing instructions, which are rarely included on packaging in a language that is appropriate to refugee settings. Given the resources required to ensure proper instruction in, and monitoring of, reconstitution practices and use of infant formula under refugee conditions, especially during an emergency phase, UNHCR considers this is not a viable or safe option.

Risk to Infant feeding

4.5 The hazards associated with using milk products for infant feeding are considerably magnified in refugee settings. It is difficult to prevent the use of milk powder as a substitute for breast milk when it is distributed in a dry unmixed form as a part of general rations or in feeding programmes.

4.6 As well as the risk of contamination, general distribution of UHT milk also risks displacing breast milk in young infants. UNHCR considers that the nutritional benefits that the general distribution of liquid UHT milk may offer to children and adults in refugee settings are outweighed by the potential risk posed to younger infants. In the absence of evidence that demonstrates no harm in this context, UNHCR will not accept or distribute UHT milk and advocates that UHT milk be excluded from general food distributions.

4.7 The untargeted distribution of milk products undermines breastfeeding and puts all infants at risk of increased morbidity and mortality. Untargeted distribution of donated breast milk substitutes is a violation of the International Code (see sections 5.5 for conditions required for artificial feeding).

4.8 Pre-formulated therapeutic milks are not appropriate breast milk substitutes and should not be used to feed infants who are not malnourished. The standard dilution of F100 has too high a solute load for infants under six months of age. Therapeutic milks contain no iron and long-term use will lead to iron deficiency anaemia.

5. Guidelines for the safe use of milk products

Dried milk powder

5.1 Milk powder, both DSM and dried whole milk (DWM), may be used in reconstituted form **only** where it can be mixed carefully with other foods³ and hygienically in a supervised environment for on-the-spot consumption, e.g. as a therapeutic milk in a therapeutic feeding programme. On-the-spot feeding programmes, e.g. supplementary wet feeding programmes, should be conducted in enclosed areas under supervision, where the carrying away of reconstituted milk can be prevented. Unreconstituted DSM should be mixed with other foods to make it suitable for feeding older infants.

5.2 In the setting outlined in 5.1, DSM should always be mixed with oil in order to supply sufficient energy. Both DSM and DWM should be prepared with sugar to increase their energy content and improve palatability⁴. DSM and DWM must have CMV Therapeutic (combined mineral and vitamin mix) added to ensure the necessary minerals and vitamins are available for severely malnourished individuals.

5.3 In most situations, DSM or DWM may be distributed in dry take-away form for cooking *only* if they have been previously mixed with cereal flours. The possible misuse of milk powder for infant feeding is prevented if it is mixed with flour at a central point prior to its being distributed to beneficiaries.

UHT liquid milk

5.4 UHT liquid milk should not be included in general distributions in refugee settings

Breast milk substitutes (BMS)

5.5 UNHCR will only handle BMS in refugee settings when based on infant feeding needs assessment by trained personnel using established and agreed criteria⁵, where distribution can be targeted, where the supply chain is secure, where conditions for safe preparation and use can be met⁶, and in strict accordance with the International Code, in consultation with UNICEF and WHO, and after review and approval by UNHCR HQ technical units.

³ DSM, if not mixed with other foods, has a very high solute load and is not suitable for infant feeding.

⁴ See annexes of Module 2 for recipes on reconstituting milk using oil, sugar and water (6)

⁵ See Modules 1 and 2 (5, 6)

⁶ When indicated, an appropriate BMS must be regularly supplied until each infant is six months old or has established re-lactation, together with clear instructions in the local language for safe mixing and for feeding with a cup and a spoon, and conditions established for safe preparation and use.

5.6 Where a need for breast milk substitute is established, UNHCR will try to source a generically labelled infant formula, or if not available, locally purchase a formula that complies with the International Code specifications. Where infant formula is being used, UNHCR will liaise with UNICEF in training of staff and mothers/carers on how to use the formula safely.

5.7 UNHCR will only accept solicited donations or source infant formula when based on infant feeding needs assessment by trained personnel using established and agreed criteria⁷, where distribution can be targeted, where the supply chain is secure, where conditions for safe preparation and use can be met, and in strict accordance with the International Code, in consultation with UNICEF and WHO, and after review and approval by UNHCR HQ technical units.

5.8 UNHCR will not accept *unsolicited* donations of breast milk substitutes, bottles and teats and commercial baby foods (industrially produced infant complementary foods). In accordance with the Ops Guidance, UNHCR advocates that any well-meant but ill-advised donations of breast milk substitutes that have not been prevented should be collected from all ports of entry by recipient agencies and stored centrally under the control of a single agency and under the guidance of the co-ordinating body. UNHCR will work with the co-ordinating agency to formulate and effect a plan for their safe use (monitored and under supervision), or their eventual destruction, to prevent indiscriminate distribution (see Section 6.0 Ops Guidance, annex 2).

Therapeutic milk

5.9 Therapeutic milk may be pre-formulated or prepared using DSM, oil, sugar and a vitamin-mineral mix (e.g. CMV Therapeutic). When indicated (see 4.9), UNHCR will supply pre-formulated therapeutic milk products, CMV therapeutic and DSM for therapeutic feeding.

Infant feeding equipment

5.10 Use of infant feeding bottles and teats is strongly discouraged. In any instance where an infant or young child is not breastfed, cup feeding is encouraged.

6. Accountability

6.1 Any issues regarding the UNHCR policy on the acceptance, distribution and use of milk products in feeding programmes in refugee settings should be reported to UNHCR at a regional and headquarters level. **Contact:** Technical Support Service at UNHCR: HQTS01@unhcr.org

6.2 Violations of the International Code should be reported to WHO, **contact:** cah@who.int and nutrition@who.int and the International Code Documentation Center (ICDC) in Malaysia, email: ibfanpg@tm.net.my, or Fundacion LACMAT in Argentina, email: fundacion@lacmat.org.ar or Italian Code Monitoring Coalition (ICMC) in Milano, email: icmc@libero.it

⁷ See Section 6, Ops Guidance (annex 2) and Modules 1 and 2 (5, 6)

6.3 Any issues relating to infant and young child feeding should be reported to UNHCR and UNICEF at field level. For field details contact at HQ level: UNHCR: HQTS01@unhcr.org ; UNICEF: smhossain@unicef.org

6.4 To give feedback on application of the Operational Guidance on Infant and Young Child Feeding in Emergencies (2006) and share field experiences on IFE, contact the IFE Core Group c/o The Emergency Nutrition Network (ENN). **Contact:** ife@ennonline.net

7. Key Definitions

Infant: a child aged less than 12 months.

Young child: a child aged 12-<24 months (12-23 completed months). *This age group is equivalent to the definition of toddler (12-23 months) as defined in the World Health Report 2005, p.155 (<http://www.who.int/whr/2005/en/>).*

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.

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

Complementary feeding (previously called 'weaning' and more accurately referred to as '**timely complementary feeding**'): the child receives age-appropriate, adequate and safe solid or semi-solid food in addition to breast milk or a breast milk substitute.

Replacement feeding: Feeding infants who are receiving no breast milk 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 six months, replacement feeding should be with a suitable breast milk substitute. After six months the suitable breast milk substitute should be complemented with other foods.

Note: This terminology is used in the context of HIV/AIDS and infant feeding. The current UN recommendation states that "when replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended during the first months of life." If these criteria are not met, exclusive breastfeeding should be initiated, and breastfeeding should be discontinued as soon as it is feasible ('early cessation'), taking into account local circumstances, the individual woman's situation and the risks of replacement feeding (including infections other than HIV, and malnutrition).

International Code: The International Code of Marketing of Breast-Milk Substitutes, adopted by the World Health Assembly (WHA) in 1981, and subsequent relevant WHA resolutions, referred to here as 'the International Code' (4). The *aim* of the International Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast milk substitutes when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The Code sets out the *responsibilities* of the manufacturers and distributors of breast-milk substitutes, health workers, national governments and concerned organizations in relation to the marketing of breast milk substitutes, bottles and teats.

Breast milk substitute (BMS): any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.

Note: In practical terms, foods may be considered BMS depending on how they are marketed or represented. These include infant formula, other milk products, therapeutic milk, and bottle-fed complementary foods marketed for children up to 2 years of age and complementary foods, juices, teas marketed for infants under 6 months.

Infant formula: a breast milk 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.

Follow-on/follow-up formula: These are specifically formulated milk products defined as “a food intended for use as a liquid part of the weaning diet for the infant from the sixth month on and for young children” (Codex Alimentarius Standard 156-19871). Providing infants with a follow-on/follow-up formula is not necessary (See WHA Resolution 39.28 (1986) (para 3 (2))). In practice, follow-on formula may be considered a BMS depending on how they are marketed or represented for infants and children under 2 years and fall under the remit of the International Code.

Note: Acceptable milk sources include expressed breast milk (heat-treated if the mother is HIV-positive), full-cream animal milk (cow, goat, buffalo, sheep, camel), Ultra High Temperature (UHT) milk, reconstituted evaporated (but not condensed) milk, and fermented milk or yoghurt. (See ref (9)).

Home-modified animal milk: a breast milk 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 micronutrients.

Note: Acceptable milk sources include full cream animal milk (liquid or powdered), Ultra High Temperature (UHT) milk, or reconstituted evaporated (but not condensed) milk. These milks must be adapted/modified according to specific recipes, and micronutrients should also be given (22b). It is difficult to obtain nutritional adequacy with such milks, even with added micronutrients. Thus, home-modified animal milks should only be used as a last resort to feed infants when there is no alternative.

Infant complementary food: any food, whether industrially produced or locally-prepared, used as a complement to breast milk or to a breast-milk substitute.

Note 1: The term ‘infant complementary food’ is used to distinguish between complementary food referred to in infant and young child feeding and complementary food used in the context of Food Aid, which are foods (beyond the basic food aid commodities) given to an affected population to diversify their dietary intake and complement the ration, e.g. fresh fruit and vegetables, condiments or spices. Infant complementary foods should not be marketed for infants under six (completed) months.

Note 2: Supplementary foods are commodities intended to supplement a general ration and used in emergency feeding programmes for the prevention and reduction of malnutrition and mortality in vulnerable groups.

Commercial baby foods: industrially produced and marketed complementary foods, such as branded jars, packets of semi-solid or solid foods.

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. For the purpose of this UNHCR milk policy, this definition includes infant formula and therapeutic milk.

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. For the purpose of this UNHCR milk policy, the term ‘pre-formulated therapeutic milk product’ is used to describe specialized products that have been manufactured to allow for reconstitution with the addition of water only, as opposed to therapeutic milk prepared from dried skimmed milk (DSM), oil, sugar and a vitamins and minerals complex.

Note: Therapeutic milks should not be used to feed infants and young children who are not malnourished. The standard dilution of F100 has too a high a solute load for infants under six months of age. Therapeutic milks contain no iron and long-term use will lead to iron deficiency anaemia.

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

8. Key References

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14. Bull WHO, 2004. Are WHO/UNAIDS/UNICEF recommended replacement milks for infants of HIV-infected mothers appropriate in the South African context? P.C. Papathakis & N.C. Rollins <http://www.scielosp.org/pdf/bwho/v82n3/v82n3a05.pdf>

Annex 1

KEY POINTS ON INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES

1. Appropriate and timely support of infant and young child feeding in emergencies (IFE) saves lives.
2. Every agency should develop a policy on IFE. The policy should be widely disseminated to all staff, agency procedures adapted accordingly and policy implementation enforced (Section 1).
3. Agencies should ensure the training and orientation of their technical and non-technical staff in IFE, using available training materials (Section 2).
4. Within the United Nations (UN) cluster approach to humanitarian response, UNICEF is likely the UN agency responsible for co-ordination of IFE. Also, governments, NGOs, and the UNHCR in refugee settings, have key roles to play and may take the lead on IFE (Section 3).
5. Key information on infant and young child feeding needs to be integrated into routine rapid assessment procedures. If necessary, more systematic assessment using recommended methodologies can be conducted (Section 4).
6. Simple measures should be put in place to ensure the needs of mothers, infants and young children are addressed in the early stages of an emergency. Support for other caregivers and those with special needs, e.g. orphans and unaccompanied children, must also be established at the outset (Section 5).
7. Breastfeeding and infant and young child feeding support should be integrated into other services for mothers, infants and young children (Section 5).
8. Foods suitable to meet the nutrient needs of older infants and young children must be included in the general ration for food aid dependent populations (Section 5).
9. Donated (free) or subsidized supplies of breast milk substitutes (e.g. infant formula) should be avoided unless recognized strict criteria are met. Donations of bottles and teats should be refused in emergency situations. Any well-meant but ill-advised donations of breast milk substitutes, bottles and teats should be placed under the control of a single designated agency (Section 6).
10. The decision to accept, procure, use or distribute infant formula in an emergency must be made by informed, technical personnel in consultation with the co-ordinating agency, lead technical agencies and governed by strict criteria (Section 6).
11. Breast milk substitutes, other milk products, bottles or teats must never be included in a general ration distribution. These products must only be distributed according to recognized strict criteria and only provided to mothers or caregivers for those infants who need them (Section 6).

Careful attention to infant feeding and support for good practice can save lives. Preserving breastfeeding, in particular, is important not just for the duration of any emergency, but may have lifelong impacts on child health and on women's future feeding decisions. Every group of people has customs and traditions about feeding infants and young children. It is important to understand these and work with them sensitively while promoting best practice.

Source: Infant and Young Child Feeding in Emergencies, Operational Guidance for Emergency Relief Staff and Programme Managers. Interagency Working Group on Infant and Young Child Feeding in Emergencies/ Infant Feeding in Emergencies Core Group. Version 2.0, May 2006. Available from the Emergency Nutrition Network, email: ife@enonline.net, <http://www.enonline.net>.

Annex 2

Extract from: Operational Guidance on Infant and Young Child Feeding in Emergencies, Version 2.0, May 2006

Minimize the Risks of any Artificial Feeding

6.1 Targeting and use, procurement, management, and distribution of BMS, milk products, bottles and teats should be strictly controlled, based on technical advice, and comply with the International Code and all relevant WHA Resolutions (1).

6.2 Establish and implement criteria for targeting and use

6.2.1 Infant formula should only be targeted to infants requiring it, as determined from assessment by a qualified health or nutrition worker trained in breastfeeding and infant feeding issues.

6.2.2 Example criteria for temporary or longer term use of infant formula include absent or dead mother, very ill mother, relactating mother, HIV positive mother who has chosen not to breastfeed and where AFASS criteria are met, infant rejected by mother, infant artificially fed prior to the emergency, rape victim not wishing to breastfeed (*see 10 and 11*). Care should be taken that no stigma is attached to choosing to use infant formula.

6.2.3 Distribution of infant formula to an individual caregiver should always be linked to education, one-to-one demonstrations and practical training about safe preparation, and to follow-up at the distribution site and at home by skilled health workers. Follow-up should include regular monitoring of infant weight at the time of distribution (no less than twice a month).

6.2.4 When the use of infant formula is indicated, UNICEF will train, and support agencies in training, staff and mothers on how to prepare and use the infant formula safely in a given context.

6.3 Control of procurement

6.3.1 For those few infants requiring infant formula in emergencies, generic (unbranded) formula is recommended as first choice, after approval by a senior staff member and the co-ordinating body. In refugee settings and in accordance with UNHCR policy and the Operational Guidance, UNHCR will source infant formula after review and approval by its HQ technical units. UNICEF does not supply generic infant formula.

6.3.2 If generic formula is unavailable at short notice or is locally unacceptable, commercial infant formula can be purchased, ideally locally. Purchased products should be manufactured and packaged in accordance with the *Codex Alimentarius* standards and have a shelf-life of at least six months at time of arrival in country.

6.3.3 Donated (free) or subsidized breast milk substitutes (see 5.1.5) should be avoided unless all the following three conditions stipulated in WHA resolution 47.5 (1994) apply:

(a) infants have to be fed on breast-milk substitutes, as outlined in the guidelines concerning the main health and socioeconomic circumstances in which infants have to be fed on BMS (see 6.2)

(b) the supply is continued for as long as the infants concerned need it

(c) the supply is not used as a sales inducement.

Information may need to be provided to well-meaning potential donors and the media.

6.3.4 Any well-meant but ill-advised donations of BMS, bottles and teats, and commercial complementary infant foods that have not been prevented should be collected from all ports of entry by recipient agencies and stored centrally under the control of a single agency and under the guidance of the co-ordinating body. A plan for their safe use (monitored and under supervision), or their eventual destruction, will be developed by UNICEF to prevent indiscriminate distribution.

6.3.5 For those targeted infants requiring infant formula, supply should be continued for as long as the infants concerned need it (until breastfeeding is re-established or until at least 6 months and a maximum of 12 months of age (see 9 for guidance on feeding the non-breastfed child).

6.3.6 Labels should be in an appropriate language and should adhere to the specific labeling requirements of the International Code (1). These include: products should state the superiority of breastfeeding, indicate that the product should be used only on health worker advice, and warn about health hazards; there should be no pictures of infants or other pictures idealizing the use of infant formula. Purchased products may need to be relabeled prior to distribution, which will likely have considerable cost and time implications. (*An example of a generic label is available in 5*).

6.3.7 The use of bottles and teats should be actively discouraged in emergency contexts, due to the high risk of contamination and difficulty cleaning. Use of cups (without spouts) should be actively promoted. The use of supplementary feeding devices and breast pumps should only be considered where it is possible to clean them adequately.

6.4 Control of management and distribution

6.4.1 BMS, milk products, bottles and teats should never be part of a general or blanket distribution. Dried milk products should be distributed only when pre-mixed with a milled staple food and should not be given as a single commodity (see *UNHCR milk policy*).

6.4.2 Where criteria for the use of BMS are met (see 6.2), BMS *purchased* by agencies may be used within the health care system. In accordance with the International Code, donated (free) or subsidized supplies of BMS should not be supplied to the health care system.

6.4.3 To protect against the spillover of infant formula in emergency contexts, infant formula should only be distributed to caregivers who need it, through a separate and discrete distribution channel from that of general food aid and the health care system, and directly linked to the assessment by a qualified health or nutrition worker.

6.4.4 In accordance with the International Code, there should be no promotion of BMS at the point of distribution, including displays of products, or items with milk company logos.

6.4.5 Availability of fuel, water and equipment for safe preparation of BMS should always be carefully considered prior to distribution. In circumstances where these items are unavailable and where safe preparation and use of infant formula cannot be assured, an on-site 'wet' feeding programme should be initiated.

6.4.6 Therapeutic milk should only be used in the management of severe malnutrition in accordance with current international guidelines (see 13). Therapeutic milk is not an appropriate BMS (see definition in section 7.0).

6.4.7 It is difficult to obtain nutritional adequacy with home-modified animal milks, particularly regarding micronutrients (14). A micronutrient formulation to fortify home-modified milks is not available and even if developed, would likely be unfeasible in an emergency context. Work on developing a micronutrient supplement that could be given once a day to children is ongoing but a formulation has not yet been developed. Thus home-modified animal milk should be used in non-breastfed infants below six months only when there is really no other feasible alternative option, such as donated expressed breast milk, generic infant formula or commercial infant formula.

Source: Infant and Young Child Feeding in Emergencies, Operational Guidance for Emergency Relief Staff and Programme Managers. Interagency Working Group on Infant and Young Child Feeding in Emergencies/ Infant Feeding in Emergencies Core Group. Version 2.0, May 2006.

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Annex 3

Extract from Section 5.0, Operational Guidance on Infant and Young Child Feeding in Emergencies, Version 2.0, May 2006

Where HIV status of the mother is unknown or she is known to be HIV negative, she should be supported to breastfeed her infant according to optimal infant and young child feeding recommendations (see definitions).

Women who are HIV positive should be supported to make an informed decision about infant feeding. **In most emergencies**, replacement feeding or early cessation of breastfeeding (see definitions) is unlikely to be an **Acceptable, Feasible, Affordable, Sustainable and Safe (AFASS)** option. The risks of infection or malnutrition from using breast milk alternatives are likely to be greater than the risk of HIV transmission through breastfeeding. Therefore, early initiation and *exclusive* breastfeeding for the first six completed months, and the continuation of breastfeeding into the second year of life are likely to provide the best chance of survival for infants and young children in emergencies.

In all circumstances, because of the existing research and experience gaps, consult relevant senior staff for up-to-date advice (See 10, 11, 12).

For most up-to-date scientific evidence, refer to http://www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm

Source: Infant and Young Child Feeding in Emergencies, Operational Guidance for Emergency Relief Staff and Programme Managers. Interagency Working Group on Infant and Young Child Feeding in Emergencies/ Infant Feeding in Emergencies Core Group. Version 2.0, May 2006.

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