Standard Operating Procedures on Donations, Distribution and Procurement of Infant Formula and Infant Feeding Equipment

Jordan Emergency Updated April 2014

Past experience has shown that when there is an emergency, massive amounts of infant formula and powdered milk are commonly donated. In emergencies, donations of BMS are not needed and may put infants' lives at risk. In the confusion that surrounds emergencies, these products are often distributed in an uncontrolled way and used by mothers who would otherwise breastfeed their babies. This results in unnecessary illness and even death for infants.

Guiding principles

- A general distribution should NEVER include breast-milk substitutes or any other milk products.
- Neonatal or baby kits should never contain infant formula or bottles or teats
- Organizations should not accept unsolicited donations of ANY milk products (infant formula or other powdered milk products, long life milk, dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed milk, soya milks, evaporated or condensed milk or fermented milk)
- Instead, interventions to support artificial feeding should budget for the purchase of BMS supplies along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation, staff training, and skilled personnel.
- Solicited donations or sourcing of infant formula will only be accepted if based on infant feeding needs assessment by trained personnel using established and agreed criteria.

1. Management of unsolicited donations

In the context of the current refugee emergency in Jordan the following steps should be taken to avert unnecessary illness and death in infants.

1. Any unsolicited donation of infant formula or bottles and teats should be reported to UNHCR (Rana Tannous tannous@unhcr.org), UNICEF (ButhyanaBalkhatib balkhatib@unicef.org , Save the Children Jordan (Sura Alsamman SAlsamman@Savethechildren.org.jo).
2. All unsolicited donations should be collected and stored under the control of either UNICEF or UNHCR.
3. In such cases a plan will be developed by the Nutrition Working Group in coordination with the Ministry of Health for the safe use or disposal of the product in order to prevent indiscriminate distribution.

2. Distribution of breast milk substitutes

1. An agency should only supply another agency with BMS if both are working as part of the nutrition and health emergency response and the provisions of the Operational Guidance and Code are met (see below)
   Infant formula should only be targeted to infants requiring it, as determined from assessment by a qualified health worker at a clinic trained in breastfeeding and infant feeding issues and based on established medically acceptable criteria (Annex 1).
2. Use of infant formula by an individual caregiver will 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 clinic at the time of prescription (no less than twice a month).
3. Distribution will be carried out in a discrete manner through a clinic setting. There will be no promotional materials on artificial feeding distributed or displayed.
4. The use of bottles and teats will be actively discouraged due to the high risk of contamination and difficulty with cleaning. Bottles and teats will not be distributed with infant formula. Use of cups (without spouts) will be actively promoted and accompanied by demonstration.

3. Control of procurement

1. UNHCR will be the agency responsible for procuring breast milk substitutes in Za'atri and Azraq Camps
2. Generic (unbranded) infant formula will be the first choice, followed by locally purchased infant formula.
3. Infant formula should be manufactured and packaged in accordance with the Codex Alimentarius standards and have a shelf-life of at least 6 months on receipt of supply.
4. Labels of procured infant formula should be in an appropriate language and should adhere to the specific labeling requirements of the International Code (21). 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.
5. Procurement will be managed so that infant formula supply is always adequate and continued for as long as the targeted infants need it – until breastfeeding is re-established or until at least 12 months of age, and formula or some other source of milk and/or animal source food after that during the complementary feeding period (6-24 months of age).

For further information please contact: Sura Al Samman, Save the Children Jordan (salsamman@savethechildren.org.jo), Rana Tannous UNHCR (tannous@unhcr.org); Buthyana Al-Khalib UNICEF (balkhatib@unicef.org)Farah El-Zubi at farah.elzubi@wfp.org

Annex 1

Acceptable medical reasons for use of breast-milk substitutes[1]:

Infant conditions

1. Infants who should only receive specialized milk formula:

- Infants with classic galactosemia: a special galactose-free formula is needed.
- Infants with maple syrup urine disease: a special formula free of leucine, isoleucine and valine is needed.
- Infants with phenylketonuria: a special phenylalanine-free formula is needed (some breastfeeding is possible, under careful monitoring).

2. Infants who may need other food in addition to breast milk for a limited period:

- Infants born weighing less than 1500 g (very low birth weight).
- Infants born at less than 32 weeks of gestational age (very pre-term).
- Newborn infants who are at risk of hypoglycaemia by virtue of impaired metabolic adaptation or increased glucose demand, if their blood sugar fails to respond to optimal breastfeeding or breast-milk feeding.

Maternal conditions

1. Conditions justifying permanent avoidance of breastfeeding:
   - HIV infection[2]: if replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS)

2. Conditions justifying temporary avoidance of breastfeeding:
   - Severe illness that prevents a mother from caring for her infant, for example sepsis.
   - Herpes simplex virus type 1 (HSV-1): direct contact between lesions on the mother's breasts and the infant's mouth should be avoided until all active lesions have resolved.
   - Relactating mother until lactation is re-established.

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[1] With reference to **Acceptable Medical Reasons** for use of Breast-Milk Substitutes. World Health Organization/UNICEF 2009 http://www.who.int/nutrition/publications/infantfeeding/WHO_NMH_NHD_09.01/en/index.html

[2] The most appropriate infant feeding option for an HIV-infected mother depends on her and her infant's individual circumstances, including her health status, but should take consideration of the health services available and the counselling and support she is likely to receive. Exclusive breastfeeding is recommended for the first six months of life unless replacement feeding is AFASS. When replacement feeding is AFASS, avoidance of all breastfeeding by HIV-infected women is recommended. Mixed feeding in the first 6 months of life (that is, breastfeeding while also giving other fluids, formula or foods) should always be avoided by HIV-infected mothers.

- Maternal medication:
  - Sedating psychotherapeutic drugs, anti-epileptic drugs and opioids and their combinations may cause side effects such as drowsiness and respiratory depression and are better avoided if a safer alternative is available.
  - Radioactive iodine-131 is better avoided given that safer alternatives are available - a mother can resume breastfeeding about two months after receiving this substance.
  - excessive use of topical iodine or iodophors (e.g., povidone-iodine), especially on open wounds or mucous membranes, can result in thyroid suppression or electrolyte abnormalities in the breastfed infant and should be avoided. Cytotoxic chemotherapy requires that a mother stops breastfeeding during therapy.

3. Maternal conditions during which breastfeeding can still continue, although health problems may be of concern

- Breast abscess: breastfeeding should continue on the unaffected breast; feeding from the affected breast can resume once treatment has started.
- Hepatitis B: infants should be given hepatitis B vaccine, within the first 48 hours or as soon as possible thereafter.
- Hepatitis C.
- Mastitis: if breastfeeding is very painful, milk must be removed by expression to prevent progression of the condition.
- Tuberculosis: mother and baby should be managed according to national tuberculosis guidelines.
- Substance use[3]:
  - Maternal use of nicotine, alcohol, ecstasy, amphetamines, cocaine and related stimulants has been demonstrated to have harmful effects on breastfed babies.
  - Alcohol, opioids, benzodiazepines and cannabis can cause sedation in both the mother and the baby.

  Mothers should be encouraged not to use these substances, and given opportunities and support to abstain.

Other:

1. Absent or dead mother.
2. Infant rejected by mother.
3. Mother who was artificially feeding her infant prior to the emergency for any of the above reasons.
4. Rape victim not wishing to breastfeed.

[3] Mothers who choose not to cease their use of these substances or who are unable to do so should seek individual advice on the risks and benefits of breastfeeding depending on their individual circumstances. For mothers who use these substances in short episodes, consideration may be given to avoiding breastfeeding temporarily during this time.