Standard Operating Procedures (SOP) for Breast Milk Substitute (BMS) Management for the State of Palestine[1,2]

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Breastfeeding gives all children the healthiest start in life. In the State of Palestine, it is critical that breastfeeding is protected, promoted, and supported. Breastfeeding is the infant and young child's food security.

State of Palestine Nutrition Cluster

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Breast milk promotes cognitive development and acts as a baby's first vaccine, giving babies everywhere a critical boost. Breastfeeding also reduces the burden of childhood and maternal illness, lowering health care costs and creating healthier families.

In emergencies, targeting and use, procurement, management and distribution of breast milk substitutes (BMS), such as infant formula, other milk products, and anything that can replace breast milk should be strictly controlled based on technical advice, and comply with the Operational Guidance for Infant and Young Child Feeding in Emergencies[3], The International Code of Marketing of Breast Milk Substitutes (the Code) and all relevant World Health Assembly Resolutions[4].

Breast milk substitutes[5] (BMS), such as infant formula or animal milk, in all forms carries risk and should only be used as a **last resort** when all other options are unavailable and should be used only after rapidly exploring the viability of milk expression, relactation, breastfeeding by a woman other than the child's mother, and donor human milk. Infants, and young children under the age of 2 years are particularly vulnerable to illness, malnutrition, and death. These risks are far higher for infants who are not breastfed. Therefore, it is critical that non-breastfed infants are identified, protected, and appropriately supported.

[1] This document draws from the Whole of Syria BMS SOP (2016), the Infant Feeding in Emergencies Operational Guidance v 3 (2017), the Sphere Handbook (2017).
[2] This document was created by the Global Nutrition Cluster Technical Alliance Operations Team MIYCN-E Advisor with support of the State of Palestine IYCF-E Infant and Young Child Feeding in Emergencies (IYCF-E) and specialized supplementary food and MNs supplementation TWG for the State of Palestine Nutrition Cluster with generous support from USAID Bureau of Humanitarian Assistance (BHA). However, the contents of this document are the sole responsibility of the GNC MIYCN-E Advisor and do not necessarily reflect or represent the views or policies of BHA.
[3] IFE Core Group (2017) Operational Guidance for Infant and Young Child Feeding in Emergencies https://www.ennonline.net/operationalguidance-v3-2017
[4] WHO (2017) International Code of Marketing and Breast Milk Substitutes FAQ https://apps.who.int/iris/bitstream/handle/10665/254911/WHO-NMH-NHD-17.1-eng.pdf
[5] Breast milk substitute (BMS) are any food that reduces breast milk consumption and serve as a partial or total replacement for breast milk, whether or not suitable for that purpose. In practical terms, foods may be considered BMS depending on how they are represented if intended for infants under 6 months. BMS includes infant formula, other milk products, therapeutic milk, and bottle-fed complementary foods, juices, teas.

Bottles and teats are difficult to wash, carry bacteria, and cause illness and malnutrition. **Bottles and teats should never be used in an emergency.** Cups and spoons should be offered when required. A comprehensive support system is required when BMS programming is implemented.

This document is to be used with the Infant and Young Child Feeding in Emergencies (IYCF-E) Standard Operational Guidance for the State of Palestine[6]. The purpose of this document is to ensure that the risk of artificial feeding is minimized and that the needs of both breastfed and non-breastfed infants are protected and met.

This document provides guidance for all humanitarian organizations across all sectors. Any organization planning, procuring, or distributing BMS should coordinate with the State of Palestine Nutrition Cluster.

The Standard Operating Procedures for Breast Milk Substitute Management for the State of Palestine have been developed in consultation with the Infant and Young Child Feeding in Emergencies (IYCF-E) and specialized supplementary food and micronutrient supplementation Technical Working Group (TWG) members and are based on the Operational Guidance for Infant Feeding in Emergencies[7], adapted to the current State of Palestine context and operating environment.

Acceptance, endorsement, and support or this document by all partners is critical. It is also important to note that while this SOP focuses on the management of infants dependent on Breast milk Substitutes, breastfeeding is lifesaving in an emergency and the protection, promotion, and support for breastfeeding is critical to prevent malnutrition and death. It is critical that resources investing in, protecting, promoting, and supporting breastfeeding are a priority.

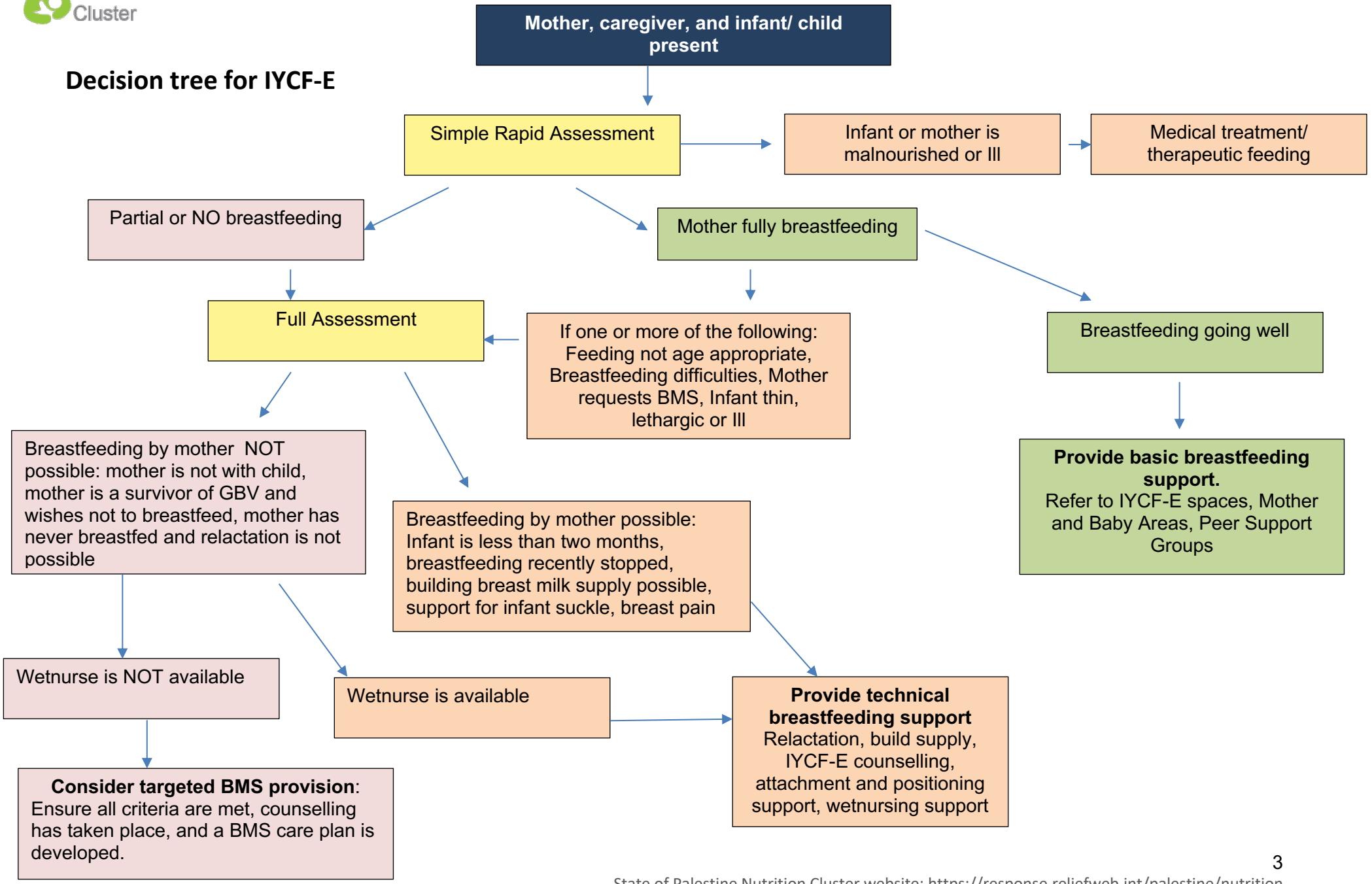
This document accompanies the IYCF-E Standard Operating Procedures for the State of Palestine as well as the Joint Statement for the State of Palestine[8].

The SOP covers the following:

1. Coordination
2. Human resources
3. Prevention and Management of BMS Donation and Supplies
4. Assessing the need for BMS Programming
5. Procurement of BMS
6. Storage and Transportation of BMS
7. Individual Criteria for Targeted BMS Distribution
8. Mitigate the risk of targeted BMS distribution
9. BMS distribution methods
10. Referrals
11. Monitoring and evaluation
12. Exit strategy

[6] Found on the State of Palestine Nutrition Cluster Website: https://response.reliefweb.int/palestine/nutrition
[7] IFE Core Group (2017) Operational Guidance for Infant and Young Child Feeding in Emergencies (OG-IFE) https://www.ennonline.net/operationalguidance-v3-2017
[8] Found on the State of Palestine Nutrition Cluster Website: https://response.reliefweb.int/palestine/nutrition

Decision tree for IYCF-E



1. Coordination

1.1 The Infant Feeding in Emergencies coordination authority for the State of Palestine is UNICEF. In accordance with mandates, WFP[9], WHO[10] and UNRWA[11] also have key responsibilities.

1.2 Close collaboration with the State of Palestine Health Cluster and the Sexual and Reproductive Health Technical Working Group is required to ensure that breastfeeding is prioritized for newborn infants and breastfeeding promotion and education is provided during pregnancy and that any infants requiring BMS at birth are referred to the nutrition cluster for ongoing provision and support.

1.3 All partners should collaborate closely with WASH sector to ensure that a hygienic space and facilities for cleaning and preparation of BMS dependent infants are available, including safe water for washing of hands and equipment.

1.4 Collaborate closely with health, nutrition, early childhood development, mental health and psychosocial support, GBV, WASH, protection, and other sectors to establish referral pathways. *(See Annex 1: Outline of the Role of Each Sector in Breast milk Substitute Management)*

2. Human Resources

2.1 All staff of the implementing organisation should be oriented on IYCF-E and be aware of this SOP.

2.2 All IYCF staff should be trained according to the standard WHO/UNICEF IYCF Integrated Counselling Course (5 days) covering all aspects of infant and young child feeding. Where rapid training is needed (e.g. if staff are over capacity, communications are not consistent, etc) a rapid training can be considered, however every effort must be made to expand the training as soon as possible.

2.3 Programmes should plan to have sufficient levels of staff to allow weekly contact with caregivers: twice monthly (or more) contact of approximately 30 minutes.

2.4 It is recommended that the majority of IYCF-E staff are female due to cultural sensitivities; however it may be helpful to also employ male IYCF-E to engage with fathers.

3. Prevention and Management of BMS Donation and Supplies

3.1 Donations of BMS are not needed and may put infants' lives at risk. Unsolicited donations of BMS should not be accepted as they are highly unlikely to be appropriate (in quantity, quality, type, labelling requirements etc.) and are likely to encourage further donations. Asking for donations of BMS should also be avoided as it encourages a demand for dangerous donations.

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[9] WFP is responsible for mobilizing food assistance in emergencies in a manner that upholds the provisions of the OG-IFE.

[10] WHO is responsible for supporting Member States to prepare for, respond to and recover from emergencies with public health consequences.

[11] UNRWA is responsible for preventive and curative health services to sustain and promote the health of Palestine refugees, from conception through pregnancy, childhood, adolescence and adulthood and active ageing.

3.2 Prevention of donations is critical. Ensure that the Joint Statement[12] has been widely disseminated to all humanitarian actors, government, and through the media. Nutrition Cluster partners should monitor online media and share any reports of calls for donations or uncontrolled distributions so that identified donors and distributors can be targeted.

3.3 Key actors should be repeatedly sensitized on the dangers of BMS donations. Sensitization should be widespread to start and then repeated every 2 months during emergency response to address high turnover of emergency responders. Topics to cover include:

- The importance of preventing donations and blanket distributions of restricted products
- The Joint Statement
- Practical guidance on actions to take, including monitoring and reporting mechanisms.

3.4 A standard online form[13] is available and to be used for reporting BMS donations and untargeted distribution by anyone working within the humanitarian response including frontline health and nutrition workers, humanitarian organizations, logistics staff, community members, and others. Humanitarian agencies should integrate donation monitoring into their daily activities. Train and support community leaders to monitor and report to the State of Palestine Nutrition Cluster if they do not have access to online reporting. Regularly analyze monitoring data and ensure it is used for action.

3.5 Any donations of BMS (such as infant formula, other milk products, foods targeted to infants under 6 months, bottles, and teats) that have not been prevented should be securely stored and immediately reported to the Nutrition Cluster.[14] In consultation with IYCF-E Technical Working Group (TWG) members, a decision will be taken by the cluster on the most suitable strategy to handle the donation. The cluster will take the decision within 2 weeks of receipt of the donation notification. Donations should remain securely stored by the receiving agency until such a decision is taken. *(See Annex 2: Handling options for donations)*

3.6 There may be a need for a limited supply of BMS. These needs should be budgeted for in IYCF-E programmes. The fact that donations are ***not*** needed should continuously be reiterated to all stakeholders, potential donors, and the media, as well as those potentially requesting donations at field level (e.g. local authorities and NGOs/CBOs) *(See Annex 3: Key messages for fundraisers, donors, and media)*

3.7 An agency should only supply another agency / institution with BMS if both are working as part of the nutrition and health emergency response, in coordination with the State of Palestine Nutrition Cluster, and in full compliance with this SoP.

4. Assessing the need for BMS Programming

4.1 Monitor for alerts in early needs and rapid assessments that may trigger the need for an in-depth assessment. Alerts that may trigger need for an in-depth assessment:

- High rate of non-breastfed, mixed fed, and other BMS-dependent children

[12] https://www.nutritioncluster.net/resources/infant-and-young-child-feeding-joint-statement-gaza-conflict
[13] The online form for the State of Palestine can be found at https://ee-eu.kobotoolbox.org/x/uDOd9izU
[14] Nutrition Cluster are under obligation to report this to UNICEF

- High risk of BMS donations (e.g. history of BMS donations, calls/offers of BMS donations, weak WHO international Code legislation enactment or enforcement)
- Requests for BMS support
- High number of separated infants/maternal orphans

4.2 The decision to implement a BMS programme should be supported by assessments which demonstrate IYCF-E practices at the time of the emergency. The type of assessment carried out and thus the level of detail produced should be appropriate for the phase of the emergency. It is recommended to use the standardized IYCF Assessment Tools,[15] available on the Nutrition Cluster website. The State of Palestine Nutrition Cluster has additionally developed contextualized IYCF-E questionnaire to be used by partners[16].

4.3 Ensure that all assessments include key information (data) to inform BMS programming[17]. Indicators on exclusive and continued breastfeeding rates and complementary feeding practices should be included in all assessments to allow for the most urgent IYCF needs to be identified and appropriately responded to as part of a complete IYCF programme**.** To inform BMS programming the following indicators should be used:

- Estimated total population
- Estimated # of infants under 6 months
- Estimated # of maternal orphans under 6 months
- Estimated % of infants under 6 months who are not breastfed[18]

4.4 An assessment of the health environment, including water, fuel, sanitation, housing, and facilities for BMS preparation should also be carried out.

4.5 Any partly or non-breastfed infants, and infants whose mothers or caregivers describe challenges for feeding under 6 months identified during assessments should be referred for a full individual feeding assessment[19] to receive appropriate feeding support as soon as possible.

4.6 The estimated quantity of infant formula needed for a population should be based on assessment information or, if not available, pre-existing data on infant feeding practices of the population. This will give an indication of the percentage of infants under 6 months requiring BMS support. The quantity[20] needed can then be calculated[21].

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[15] https://www.nutritioncluster.net/resources/guidance-conducting-iycf-e-assessment

[16] IYCF Questionnaire for Nutrition Partners: https://www.nutritioncluster.net/resources/iycf-questionnaire-nutrition-cluster-partners

[17] WHO (2021) "Indicators for assessing infant and young child feeding practices: definitions and measurement methods"
https://www.who.int/publications-detail-redirect/9789240018389

[18] During the initial phase of an emergency, this can be estimated from key informant interviews and opportunistic sampling to give an alert. In later phases, this indicator can be measured through standardised surveys.

[19] See the State of Palestine IYCF-E Standard Operating Procedures for details of one-to-one full assessment.

[20] On average, a 0–6-month-old infant needs 3.5 Kgs of powdered infant formula each month or 120 units of 200ml of RUIF per month and this should be provided for as long as the infant requires.

[21] See the Save the Children and UNHCR BMS calculator here (automatic download):
https://dylbw5db8047o.cloudfront.net/uploads/2._iycf-e_caseload_and_supply_calculator.xlsx

4.7 Infant formula should be prioritised for infants less than 6 months requiring it, as determined by a one-to-one full assessment (see inclusion criteria below in section 7 of this document).

4.8 It is important to specify appropriate BMS and priorities infants under six months. It is never necessary to procure or provide toddler milk, follow-on milk, or growing up milks. For the State of Palestine priority is to use ready-made liquid infant formula, also knowns as Ready to use Infant Formula (RUIF). Priority should be as follows:

- 0-5 months: Ready to use Infant Formula should be prioritized for this age group
- 6-11 months; Ready to use infant formula or powdered infant formula, pasturised boiled full cream animal milk, ultra-high temperature milk, reconstituted evaporated milk, fermented milk, or yogurt.
- 12-23 months pasteurized boiled, full cream animal milk, ultra-high temperature milk, reconstituted evaporated milk, fermented milk, or full fat yogurt.

4.9 Home modified animal milk for infants under 6 months of age are not recommended and should only be used as a temporary measure and as a last resort[22].

5. Procurement of BMS and BMS Kits

5.1 For the State of Palestine, UNICEF acts as the provider of first resort and procure BMS to meet UNICEF mandate.

5.2 Any organisations procuring BMS should ensure that they can meet the provisions of the IFE Operational Guidance, The Code, and this SOP and should work in close coordination with the State of Palestine Nutrition Cluster and UNICEF. BMS programming has cost implications and organisations should budget for these accordingly in all proposals. Interventions to support non-breastfed infants should always include a component to protect breastfed infants for example, through budgeting for activities which promote breastfeeding and support breastfeeding mothers.

5.3 BMS is not a stand-alone product. It requires additional resources to reduce the risk of the use of the product. A BMS Kit *(See Annex 4: BMS Kit Supplies)* should always be distributed or available to all mothers and caregivers receiving BMS.

5.4 Procured BMS should meet the following criteria:

- Manufactured and packaged in accordance with the Codex Alimentarius standards[23].
- Suitable for infants under 6 months.
- Generic (unbranded) infant formula is first choice, however, when this is not possible, a relabeled commercial infant formula is acceptable.
- BMS must have a shelf-life of at least 6 months on receipt of supply.
- Ready to use infant formula (RUIF) is a sterile product only until opened and requires refrigeration afterwards. For ready to use infant formula, small volume units (eg. 200ml) are preferred to prevent re-use and wastage. Teats are sometimes included with RUIF procurement by the supplier. It should either a) be communicated that the teats are not to

[22] See 9.12 of IFE Module 2 on Preparing Large Quantities of Feeds and 9.12 on Organising Feed Preparation https://www.ennonline.net/attachments/144/module-2-v1-1-complete-english.pdf

[23] https://www.fao.org/fao-who-codexalimentarius/thematic-areas/nutrition-labelling/tr/

be sent with the product or b) the teats are destroyed upon arrival in country. Teats should never be distributed.

5.5 Labels of any distributed infant formula should adhere to the following guidelines. Any products not meeting these requirements should be relabeled prior to distribution, and implementing agencies should take into account the cost and time implications of relabeling to fit the following:

- Labels should be written in Arabic
- Commercial infant formula branding (name / logo) should not be visible
- Labels should adhere to the specific labelling requirements of the International Code:
  - Labels should state the superiority of breastfeeding
  - Labels should indicate that the products should be used only on health worker advice
  - Labels should warn about health hazards of using infant formula
  - There should be no pictures of infants or other images idealizing the use of infant formula.

5.6 Procurement should be managed so that infant formula supply is always adequate and continued for as long as the targeted infants need it – that is, until breastfeeding is re-established or until at least 6 months of age, after which infants should be supported to transition to complementary feeding which includes some other suitable source of milk and / or animal source food.

5.7 It is recognised that infants develop at different rates and are particularly vulnerable during the transition period when complementary feeding begins. A buffer stock of 2 – 4 weeks of BMS while infants transition to complementary feeding can be considered on an individual basis, however the focus should be on strong complementary feeding counselling at this stage.

5.8 The use of bottles, teats and pacifiers should be actively discouraged due to the high risk of contamination, difficulty with cleaning and interference with breastfeeding. Cup feeding is the safest practice for artificially fed children and the use of cups (without spouts) should be actively promoted in all BMS management programmes, including through provision of cups in BMS kits and intensive counselling and support. Bottles and teats should never be distributed by a BMS programme.

5.9 However, in recognition that bottles are widely used in the State of Palestine, supporting the sterilisation of bottles may be considered as a harm reduction measure while maintaining the focus on strong cup feeding counselling and promotion. *(See Annex 5: Sterilization of Infant Feeding Equipment)*

5.10 Specialist infant formula:

- Specialist infant formulas such as those in the case of inborn errors of metabolism are rarely needed. However, the scenario of children with metabolic diseases such as Phenylketonuria, Homocystinuria, MCADD, etc. may exist. These should be referred to the Health Cluster and partners as they are specialist prescription only and are not seen in the same way as general infant formula.
- Specialist infant formulas should be given by a health partner as prescription only given under medical supervision.

6. Storage and Transportation of BMS

6.1 Ensure that storage, transportation and safeguarding of BMS are sufficiently budgeted for in project proposals and planning.

6.2 BMS stock should be carefully secured (restricted entry, locked) to ensure that there is no leakage or theft at any point during the supply chain (warehouse, health facility etc.) Storage facilities should be clean, dry, free of chemical and pest contaminants and protected from extreme temperatures.

6.3 Store unopened units at room temperature. Avoid excessive heat and prolonged exposure to light. Do not freeze.

6.4 Stocks should be managing according to FEFO (First Expired First Out) principles and clear records kept preventing misuse and leakage.

6.5 It is recommended that in areas at risk of besiegement, a sufficient quantity of BMS stock is securely pre-positioned to meet the needs of non-breastfed infants for 6 months.

7. Individual Criteria for Targeted BMS Provision

7.1 A full assessment *(See Annex 6: One to One Full Assessment)* should always be conducted by a health or nutrition worker previously trained in breastfeeding and infant feeding counselling according to a standardised curriculum[24] or an adapted training programme in situations where full training is not feasible (i.e. besiegement) with strong supervision or mentorship available. This assessment is to understand what options other than BMS are available.

7.2 If, after a full assessment and IYCF-E counselling is conducted, and BMS is the only option after bulding breastmilk supply, relactation, and wetnursing are explored, a targeted BMS provision plan can be created

7.3 The final decision to provide or not provide BMS will be taken by an IYCF-E trained health worker or IYCF-E counsellor performing the full assessment, in consultation with a clinician also trained on infant feeding issues if required (e.g. medical conditions).

7.4 Always ensure above everything else that the following is not possible, in order:

- Building mother's own milk supply
- Mother's own expressed breast milk
- Re-starting supply to return to breastfeeding (relactation)
- Breastfeeding by a woman other than the child's mother (wet nursing)
- Expressed human milk from another mother.

7.5 If the above is not possible then Infant formula (BMS) during emergencies can be provided for the following cases:

7.4.1 Short term criteria for BMS eligibility:

[24] UNICEF Integrated IYCF Counselling Course (5 days) or UNICEF Community based IYCF training programme

- Mother severely ill
- Relactation (with infant formula as the supplement)[25]
- Waiting for other, safer alternatives
- Increasing supply to return to exclusive breastfeeding (U6M)
- Short-term separation

7.4.2 Long term criteria for BMS eligibility:

- Not breastfed pre-emergency
- Replacement feeding in the case of a person living with HIV where the mother chooses not to breastfeed[26]
- Mother deceased or absent
- Rare medical condition[27]
- Mother has rejected infant[28]
- Survivor of Gender Based Violence (GBV) who does not want to breastfeed (IMPORTANT: do not document or record this to protect the survivor's identity)

7.5 Create a BMS care plan *(see Annex 7: BMS Care Plan).* The care plan includes reason for BMS provision as well as a follow up plan and exit plan for the infant to decrease and/or stop using BMS.

7.6 Ensure support services:

- Ensure that a BMS care plan is in place
- One to one counselling, education, and practical demonstration of hygienic preparation and storage of BMS and cup feeding.
- One to one counselling on IYCF-E, including appropriate complementary feeding if the child is around 6 months or over.
- Growth monitoring, if possible
- Access to health services

7.7 Follow up of artificially fed infants with no complications should include regular monitoring of infant weight and health status at a health / nutrition facility no less than twice a month. Visits to the place of shelter must also take place when staff capacity, security and movement restrictions allow. These should occur once a month to ensure risk is being mitigated in the place of shelter. Higher frequency may be necessary dependent on the level of support required and the vulnerability of the infant.

7.8 The Nutrition Cluster and identified partners will provide training and support to nutrition agencies to ensure they are able to train staff and mothers and caregivers on how to correctly

[25] For relactation, a two month supply of infant formula should be planned to allow time to re-establish exclusive breastfeeding and to allow for a safety-net. See Part 6 of IFE Module 2- Additional Materials https://www.ennonline.net/ifemodule2

[26] Note that exclusive breastfeeding is recommended by WHO: https://apps.who.int/iris/bitstream/handle/10665/246260/9789241549707-eng.pdf

[27] note that this medical decision should ideally be taken by a doctor trained on IYCF so that BMS is not unnecessarily prescribed

[28] Where possible this rejection should be confirmed by a psychologist oriented on IYCF-E. Bereavement, trauma or emotional crises do not automatically warrant cessation of breastfeeding - restorative care and psychosocial support should be the first step.

prepare and use infant formula using standardized training materials. Care should be taken that no stigma is attached to the use infant formula when required and that a mother or caregiver's informed choice is respected.

7.9 Use of infant formula by an individual caregiver should always be linked to education, one-to- one demonstrations, and practical training on the quantity (measurements) of preparing a feed, frequency feeds, hygiene practices and preparation[29], cup feeding[30].Regular follow up is also required at the distribution site and/or at the place of shelter by trained health or nutrition workers. *(See Annex 8: RUIF Education Handout)*

7.10 It is critical to determine if BMS can be used hygienically at the location where the mother or caregiver is sheltering during the emergency i.e.: home, formal shelter, tent, informal shelter *(See Annex 9: Evaluation of Artificial Feeding in the Place of Shelter)*.

- Families must have access to handwashing facilities, clean and dry storage, a heat source, and washing facilities.
- For PIF it is also mandatory for potable water to be available before distribution.
- RUIF does not require water for reconstitution it is not required but, washing facilities are required- if washing facilities are not available then disposable cups are to be used if heat source and washing facilities are not available.

7.11 If BMS cannot be prepared hygienically at the place of shelter (with or without a BMS kit[31]) then on-site feeding with 24/7 access should be provided (see Section 9, options for provision below).

8. Mitigate the Risk of Targeted BMS Provision

8.1 The right provision method for BMS will depend on the context (see section 9 of this document). Despite the distribution system, **it is critical that ALL provision must follow the guidelines in this section.**

8.2 Ensure risk mitigation measures and coordinate with partners to avoid causing harm during dissemination[32]. Ensure that partners distributing supplies and who are in-contact with affected populations are aware of Sexual Exploitation and Abuse (SEA) zero-tolerance policies; disseminate key messages on SEA; and understand reporting requirements and channels. As soon as possible, establish or reestablish community-based complaints and feedback mechanisms.

8.3 Ensure that any distributions are safe and accessible to all people caring for a non-breastfed infant, including women and girls, women headed households, persons with disabilities, etc. This includes queue management, women-only distributions where safe and feasible, considering size/weight of ration packages, timing, and locations of distributions, etc.

[29] WHO preparation and storage guidelines for PIF https://www.who.int/publications/i/item/9789241595414
[30] Cup feeding demonstration tool in multiple language can be found here https://resourcecentre.savethechildren.net/document/cup-feeding/
[31] Access to a BMS kit is required when receiving BMS. An overview and list for the kit is in Annex 5: BMS Kit Supplies
[32] See: General GBV risk mitigation messages and recommendations Gaza response October 2023 (Automatic download): https://gbvaor.net/sites/default/files/2023-10/Gaza%20RM%20messaging_%20GBV%20Guidelines.pdf

8.4 A GBV Safety Audit[33] should be carried out to ensure the safety and security of mothers and caregivers and infants using the BMS distribution point. Especially in the case of direct distribution when the mother or caregiver is returning to the place of shelter with a high value product such as BMS and where cartons of RUIF are bulky and heavy to carry.

8.5 Never distribute BMS or any milk products through general or blanket distribution[34] BMS, milk products, bottles, teats, and pacifiers should never be part of a general or untargeted distribution. Dried milk products should be distributed when pre-mixed with a milled staple food and should not be distributed as a single commodity.

8.6 Therapeutic milk[35] is not an appropriate BMS and should only be used in the management of severe malnutrition by qualified agencies in accordance with State of Palestine guidelines[36]. Any distributions or misuse of therapeutic milk should be immediately reported to the Nutrition Cluster and partners and communities sensitized on this issue.

8.7 There should be no promotion of BMS at the point of provision (e.g. Displays of products or items with company logos).

8.8 BMS should be distributed discretely and out of sight from areas dedicated for breastfeeding mothers and caregivers to protect and support breastfeeding in this context. Distributing BMS nearby is likely to undermine breastfeeding efforts.

8.9 Communicate clearly to caregivers and communities on the importance of breastfeeding and clearly communicate eligibility criteria for all BMS. Ensure targeting criteria is clear to all staff and written down in order that staff can show this to those who may be requesting BMS but do not meet the targeting criteria. It is very important to remember that targeted BMS distribution programmes and distribution points should never be publicly announced for safety and to avoid wrong admissions into the programme and to mitigate any security risks.

8.10 Be alert to unintended consequences of BMS provision, such as sale of products. Some ways to prevent resale are to open the tin upon distribution, require the return of tins for re-distribution for direct provision.

8.11 The availability of a heat source (e.g. fuel), clean water and equipment for preparation of BMS at household level should always be carefully considered prior to implementing artificial feeding programmes. Steps should be taken to ensure all these conditions are in place before implementation, including through coordination with other sectors and / or providing equipment to caregivers[37]. In circumstances where these items are unavailable and where risk of preparation and use of infant formula cannot be mitigated, on site reconstitution and

[33] GBV Safety Audit Tool for the Nutrition Cluster (automatic download): https://gbvguidelines.org/wp/wp-content/uploads/2021/06/Safety-Audit-Example-Tool-Nutrition.pdf
[34] SHPERE (2018) https://handbook.spherestandards.org/en/sphere/#ch001
[35] Example: F75 and F100
[36] Contact State of Palestine Nutrition Cluster for the latest guidelines
[37] See Annex 5: BMS Kit Supplies

consumption ("wet feeding") should be initiated. (See section 10 of this document for more information on wet feeding)

9. Targeted BMS Provision Methods

9.1 Where criteria for the use of BMS are met, infant formula purchased by agencies working as part of the nutrition and health emergency response may be used in or discretely provided by trained nutrition partners or healthcare system[38] in line with this SoP.

9.2 BMS Kits must be provided whenever BMS provision is taking place. This includes both PIF and RUIF use. If direct provision or on-site wet feeding, all equipment required to prepare, feed, and store BMS must be included[39].

9.3 Options for provision within the State of Palestine is limited. These options include direct provision and on-site wet feeding.

9.4 Direct provision is when the BMS is given to the mother or caregiver to be prepared at the place of shelter.

9.4.1 When direct, targeted provision is provided it is important that it is carried out away from areas where breastfeeding mothers programming is taking place, distribution should be carried out in a discrete manner.

9.4.2 Caregivers should be provided with a supply sufficient to meet the needs of the infant[40].

9.4.3 **No more than a week supply of BMS should be supplied to caregivers at one time. This is approximately two (2) tins of 400g or one (1) tin of 800g of powdered infant formula[41] or 24 containers (1 case) of 200ml of RUIF.[42]** BMS is a high commodity item and there is risk of selling the BMS or the security risk of carrying a large quantity and these risks should be mitigated. Additionally, RUIF is bulky and carrying long distances will be taxing on a mother or caregiver. Frequent distribution also ensures follow-up and avoids misuse.

9.4.4 If due to security reasons movement is severely restricted and frequent distribution is impossible, a longer supply can be given, however strict procedures must be put into place for follow-up, security with transport, and guidance for misuse. If this is the case, please contact the State of Palestine Nutrition Cluster for guidance and support.

9.4.5 BMS cannot be distributed alone. BMS Kits must be distributed along with BMS for any direct provision.

9.5 On-site reconstitution and consumption of powdered infant formula (PIF) or on-site consumption of RUIF, called "Wet feeding" *(See Annex 10: Wet feeding)*

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[38] Distribution of *donated* BMS in any part of the healthcare system is a violation of World Health Assembly Resolution 47.5, 1994 (follow on from The Code)

[39] See Annex 5: BMS Kit Supplies

[40] Infants require 100 kcal/kg/day. The energy value of prepared infant formula is 65-70 kcal/100 ml. An infant needs 150 ml of prepared formula per kg per day (150ml/kg/d).

[41] Approx. 6-day supply for 0-6 month old

[42] Approx. 6-day supply for 0-6 month old

9.5.1 In circumstances where preparation and use of infant formula within the place of shelter carries extreme risk or is impossible, on-site reconstitution and consumption ("wet-feeding") should be considered.

9.5.2 This is likely to be necessary during situations such as mass displacement and if the use of PIF is common.

9.5.3 Where wet feeding is implemented, it is required that all resources such as those in the BMS Kits are available for communal use.

9.5.4 Additionally, where wet-feeding is implemented 27/7 availability is required and safety to and from the location must be considered and any risks mitigated.

9.6 No matter the method of provision, all mothers and caregivers should be counselled and provided with a demonstration how to feed the child with the least amount of risk possible.

9.6.1 Counselling topics include:

- Correct, hygienic preparation of both PIF[43] and RUIF[44]. It is important to ensure to point out that over and under dilution of PIF is dangerous and that no dilution of RUIF needs to take place.
- Responsive feeding[45]
- Cup feeding 1-1 practical demo[46]
- Remember feeding bottles are not recommended.
- Where and when to seek medical care
- Storage of BMS in a clean and dry location.

9.7 Records should be kept of infants enrolled in BMS support and coordinated appropriately with other distributing agencies to avoid duplication of provision. This includes a record of individual registration[47] as well as a database of infants enrolled in the programme[48]

10. Referrals

10.1 Referral mechanisms should be in place linking caregivers and their infants to medical services, therapeutic feeding services, GBV services[49], and child protection services, where these services exist.

10.2 Upon exiting the programme (e.g. after relactation or when the infant is aged over 6 months) caregivers, and their infants should be systematically linked to breastfeeding and / or complementary feeding support services as is appropriate.

[43] How to prepare PIF at home https://www.who.int/publications/i/item/9789241595414
[44] See Annex 9: BMS Preparation Educational Tools
[45] Nurturing Care Responsive Feeding Thematic Brief: https://nurturing-care.org/nurturing-responsive-feeding
[46] How to prepare cup feeding at home https://www.ennonline.net/attachments/543/safe-prep-cup-feeding-leaflet.pdf
[47] Template registration form for infants registered in the BMS programme https://dylbw5db8047o.cloudfront.net/uploads/4.15._template_for_registration_form_for_artificially_fed_infants.xlsx
[48] Template BMS prescription database https://dylbw5db8047o.cloudfront.net/uploads/4.16._template_for_bms_prescription_database.xlsx
[49] All staff should be familiar and have a copy of the GBV pocket guidelines for GBV disclosures and referrals: https://gbvguidelines.org/en/pocketguide/

11.Monitoring and Evaluation

11.1 All BMS programmes should have a strategy that outlines its goal, has measurable objectives and monitors activities on a monthly or weekly basis:

- Artificial Feeding indicators to measure are:
  - % of infants under 6 months that are not breastfed
  - # of untargeted distributions of infant formula, dried or liquid milk
  - Health outcomes (eg. Diarrhoea incidence in infants under 6 months)

11.2 It is recommended to use standardised data collection tools to track and monitor infants enrolled in BMS support and to allow for comparable results between Nutrition Cluster partners[50].

11.3 Regular supervision of BMS programmes should monitor:

- Whether the criteria for admitting infants to a BMS support programme are being respected (e.g. checking the register, verifying reasons for prescription)
- Whether who receives the BMS is tightly controlled (e.g. is the prescription valid? Checking caregiver and infant identity).
- Whether BMS is being correctly distributed (e.g. correct quantity and frequency). This information can be checked against prescriptions and stocks to ensure there is no leakage or duplication.

11.4 Markets, where applicable, should be regularly monitored to see whether the distributed formula is being sold ('spillover'), or whether prices of formulas change. Actions (such as removing the foil cover under the plastic lid from the tin) can be taken to prevent resale.

12. Exit Strategy

12.1 **The provision of BMS should be needs led and not resource led.** The main consideration in deciding the transition strategy should be whether there are ongoing needs among a highly vulnerable population – rather than whether there are still stocks of RUIF remaining or whether a certain predetermined cut-off date has been reached.

12.2 In theory, where IYCF-E counselling and support is provided, **enrolment in the RUIF should decrease** over time as (i) those affected by the emergency and meeting the criteria will already have been admitted; (ii) almost all newborns with mothers should be exclusively breastfed; (iii) only a few with no possibility to be breastfed according to WHO criteria for acceptable medical reasons for use of breast milk substitutes[51] should be found in the population.

12.3 BMS programming and distribution is one component inside a larger programme to protect, promote and support recommended infant and young child feeding practices. The wider programme both inside health clinics, shelters, and in the community should continue to proritise the provision of protection, support, and promotion of breastfeeding.

[50] See Save the Children IYCF Toolkit Part 5: Reporting Templates https://resourcecentre.savethechildren.net/toolkits/iycf-e-toolkit/#chapter-3
[51] WHO. Acceptable medical reasons for the use of breast milk substitutes. 2009

Annex 1: Outline of the Role of Each Sector in Breast milk Substitute Management

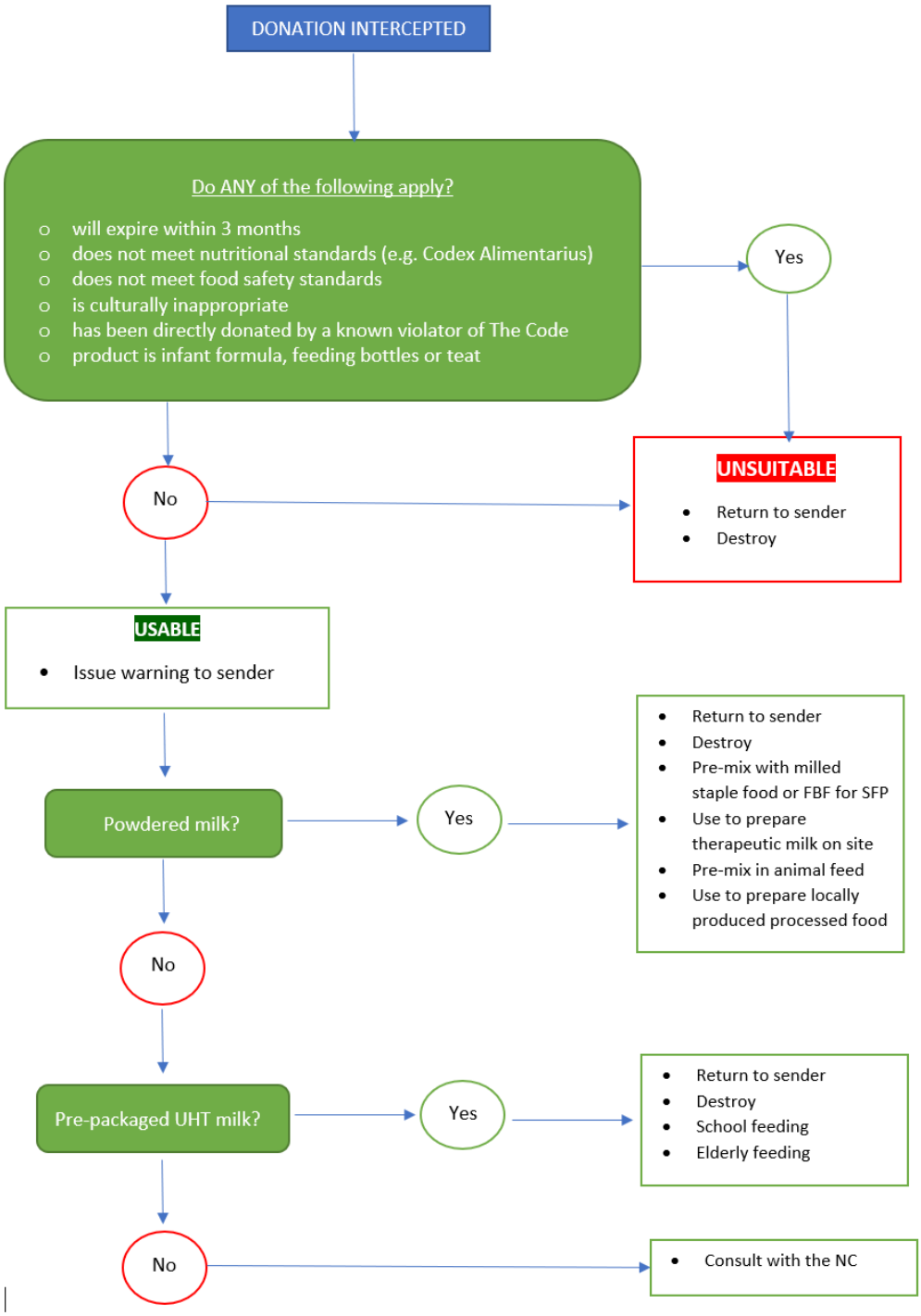
Outline of the Role of Each Sector in Breast milk Substitute Management

SECTOR	ROLE
NUTRITION	• Lead development, implementation and monitoring of this SOP, in collaboration with partners. • Liaise with relevant sectors for effective implementation of this SOP. • Mobilize partners and other sectors to collect and store the unsolicited donation of BMS once notified. • Lead the development of a plan for the safe re-use or disposal of the collected BMS. • Train/orient partners on the SOPs for BMS. • Advocate with the donors / other stakeholders to prevent unsolicited donations of BMS. • Coordinate procurement and targeted distribution of BMS together with relevant sectors.
HEALTH	• Integrate this SOP in the essential primary healthcare package. • Monitor WHO XB shipments and coordinate procurement and distribution of BMS together with OCHA, nutrition and logistics sectors when needed. • Circulate this SOP to relevant partners and health directorate and encourage its adoption. • Share any relevant documentation when available for any unsolicited/untargeted distribution through the health system and notify the nutrition working group accordingly. • Support the development of plan for the safe re-use or disposal of the collected BMS.
FOOD SECURITY	• Document any untargeted distribution of BMS through food distribution, if any to the nutrition working group. • Coordinate procurement and targeted distribution of BMS together with the nutrition sector. • Establish a mechanism to encourage the adherence of sector partners to this SOP.
WASH	• Provide support and produce guidelines on safe water and sanitation when administering artificial feeding to mitigate risk in the controlled use of BMS for non-breastfed infants. • Circulate this SOP along with relevant updates to WASH partners.

PROTECTION	• Whenever possible, provide appropriate space for women and girls to breastfeed within and near spaces where child protection activities are taking place. • Whenever possible, run joint programs with the nutrition sector in terms of community mobilization and prevention messages that include socially and culturally appropriate, technical accurate, messages on breastfeeding and nutrition. • Include child protection messages, including on prevention and response as well as referral mechanisms (where available), in activities related to nutrition, community outreach and raising awareness. • Include discussions related to protection, including psychosocial support and gender-based violence, in mother-to-mother nutrition activities. • Choose at least one trained staff member to act as a child protection focal point in nutrition programs, and make sure the focal point is trained on identifying and referring children or families in need of additional services, as well as basic psychosocial support related to, for example, coping with stress. • Ensure that those working in nutrition have signed up to and been trained in a code of conduct or other policy which covers child safeguarding.
UNOCHA	• Coordinate cross border shipments (BMS) under UNSC resolution 2165/2191/2258, in collaboration with logistic cluster, Nutrition working group and UNICEF. • Circulate this SOP to relevant OCHA staff and partners who are involved with cross border shipments. • Coordinate with Jordanian authority to encourage them to notify OCHA and the nutrition working group when informal cross border shipments containing BMS are planned / organized.

Annex 2: Handling option for donations

Handling options for donations. Note that school /elderly feeding programmes can only be implemented in controlled environments once the situation has stabilised.



The term **"handling"** should be understood to refer either to using the product in another way (which minimises the risks) or to its destruction.

Annex 3: Key messages for fundraisers, donors, and media

Key messages for fundraisers, donors, and media

The donations of infant formula and other milks in emergencies are dangerous and increase infant morbidity and mortality. However, experience in humanitarian settings has shown that as a first response, potential donors and fundraisers often assume that BMS donations are required as part of the relief efforts. THIS IS NOT THE CASE.

Therefore, it is important to remember:

- In emergencies, as in regular situations, exclusive breastfeeding is the safest way to feed infants under the age of 6 months. Breastfeeding remains a key component of children's diets from 6 months until 2 years of age or older while complementary foods should be given as well.

- In emergencies, women may experience temporary challenges with breastfeeding. The production of breast milk is not affected by stress. With adequate psychological and practical support, virtually all mothers can breastfeed.

- The nutrition status of breastfeeding women should also receive priority attention. In emergencies, prioritize support for the protection, promotion, and support for breastfeeding in its response, while also assuring that the nutritional needs of non-breastfed and other formula-dependent infants are met. Women can restart breastfeeding. Every effort should be taken to ensure that infants are breastfed because formula feeding is so risky in emergencies.

- In an emergency setting, there might be situations in which infants and young children cannot be breastfed, or are partially breastfed, for a longer or shorter period of time. These situations can be grouped into the following categories:

    - Infants and young children who were orphaned or whose mother has been absent for a long period of time either before the humanitarian situation or during the humanitarian situation and for whom, relactation or receiving donor human milk is not feasible.
    - Infants and young children whose mother is present and who were not breastfed before the time of the humanitarian situation, or in the course of the humanitarian situation, regardless of the reason, and for whom, relactation or receiving donor human milk is not feasible.
    - Situations where the mother and/or infant has a medical condition for which breastfeeding is not possible, and for whom, relactation or receiving donor human milk is not feasible.
    - Infants under the age of 6 months who are mixed fed (breastfeeding plus BMS) and whose mother is being supported to transition to exclusive breastfeeding.
    - A survivor of GBV who wishes not to breastfeed.
- Infants and young children who belong to one of the categories above need to receive BMS and BMS kits by trained practitioners and in a controlled and monitored programme. The BMS

required for an emergency response need to be procured in line with normal procurement channels and in line with global guidance on this issue. UNICEF is the provider of first resort and, as such, has responsibility in a context where BMS is required. Provision of BMS should be accompanied by other activities such as counselling and provision of BMS kits.

- The WHO Code of Conduct for BMS must be always followed, in development and emergency settings, by producers and distributers of BMS, health workers, actors in the emergency response and others.

- In response to donor enquiries, the following are suggested items for donation that benefit mothers, infants, and young children:

    - Other nutritious foods, e.g., animal-source foods such as tinned fish or meat
    - Other non-food item products, e.g., clothes, toiletries for children, baby blankets, water, nappies
    - Funds to support infant feeding programmes

DO NOT ever call for or accept donations of breast milk substitutes.
This is dangerous and will cause malnutrition in death in emergency contexts.

Annex 4: BMS Kit Supply List

The BMS Kit lists all supplies needed in order to try to minimise the risks of using breast milk substitutes.

Breast milk substitutes are never safe even in non-emergency settings. In emergencies the risks of morbidity, malnutrition and death for not-breastfed infants increase significantly. This kit has been developed in order to try and minimise the risks when feeding at home, but care must be taken not to undermine breastfeeding.

Breastfeeding is life-saving especially in emergencies. Relactation, wet nursing, donated breastmilk should always be prioritised first before undertaking an artificial feeding programme. Only after careful consideration and discussions with the Nutrition Cluster should an artificial feeding programme be developed.

The items in the BMS kit are essential when supporting caregivers to make infant formula using powder at home. Powdered infant formula needs to be made using a specified amount of formula and boiled water no less than 70 degrees centigrade and then cooled rapidly before feeding to the infant. RUIF is already reconstituted with water and does not require any preparation and so not all the items below are essential if using this ready-to-use product. However, those items in bold below will help to minimise the risks of artificial feeding.

Cup feeding is safer in an emergency. **Feeding bottles should not be used.**

Note: RUIF is already reconstituted with water and does not require any preparation and so not all the items below are essential if using this ready-to-use product. However, those items in **bold** below will help to minimise the risks of artificial feeding with both RUIF and PIF.

BMS Kit Supply List

Item	Quantity	Description
High quality thermos flask	2 per kit PIF	For hot water for PIF preparation and cleaning
Plastic feeding bib	2 per BMS kit	To provide wipeable bib during feeding and minimise infant spilling on clothes
Open feeding cups	2 per BMS kit	For feeding infants
Soap	2 per BMS kit	For handwashing and washing of feeding equipment- when it runs out it should be replaced
Paper napkins	21 a day	Approximately 2 per feed x 8 feeds a day= 16 + 5 day extra to clean preparation area= 21 a day For cleaning preparation area
Solid plastic box with lid for stable populations *Or* Backpack for people in transit	1 per BMS kit	For storage and preferable to have a smooth flat lid which can be used as a washable preparation surface. If it does not have a smooth flat lid then plastic sheeting will be needed as a preparation surface
Jug for measuring mixing	1 per kit	To mix formula and to measure amounts
Small bowl	1 per kit	To rapidly cool PIF after preparation
Fuel (wood, charcoal, electricity) for boiling water	N/A	For boiling water for PIF preparation and/ or to boil water for sterilization of equipment
Small pot/kettle	1 per kit	For boiling water for infant formula preparation
Small spoon	1 per kit	For mixing PIF or for feeding small infant instead of cup
Small basin	1 per kit	For washing equipment
Purification treatment (Aquatab) (1 tab per feed)	1 box per kit	To purify water if potable water not available
Potable water	Approx 3 liters per day	To make PIF, to wash hands, and to clean equipment
Instruction leaflet	1 per kit	For caregiver

Annex 5: Sterilisation of Infant Feeding Equipment

PROTOCOL : STERILISATION OF INFANT FEEDING EQUIPMENT

Cup feeding is **much safer** than bottle feeding and must be actively promoted. In exceptionally difficult circumstances and as a last resort, bottle sterilisation may **temporarily** be implemented during rapid response to minimise risks for caregivers who are unwilling or unable to feed their child using a cup.

It is very important that all equipment used for feeding infants and for preparing formula feeds is thoroughly cleaned AFTER each use and both cleaned and sterilised BEFORE use to remove harmful bacteria, as outlined in the below protocol.

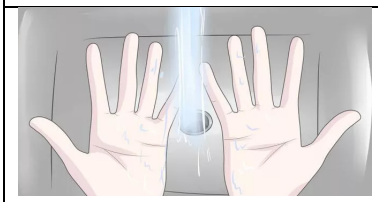
AFTER each feed: Wash bottle, teat, and feeding tools with soap and water and place in a clean, dry location and cover with a clean lid or cloth.

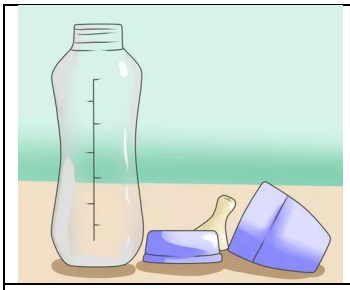
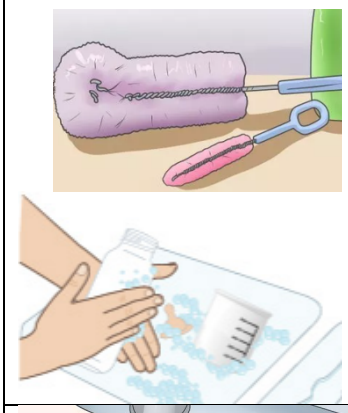
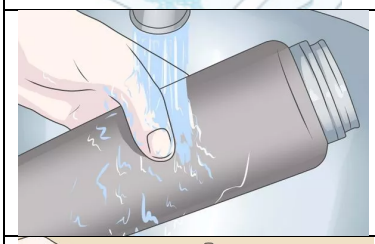
BEFORE each feed: Wash bottle, teat, and feeding and preparation tools and sterilize following the instructions below.

Mother or caregiver should always be counselled on the risks of BMS, how to mitigate those risks if breastfeeding is not an option, and counselled on the risks of bottle feeding and explained the use of cup or spoon feeding as an alternative.

Equipment

1. Safe water
2. Washing up liquid (*gentle, non-toxic)*
3. Bottle cleaning brush
4. Timer
5. Steam steriliser (or pan with lid)
6. Heat source
7. Tongs

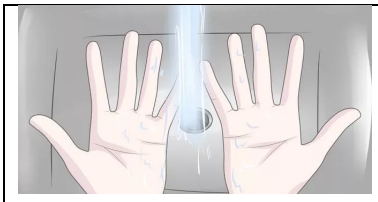
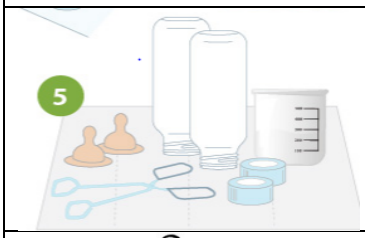
BMS TOOL STERILISATION INSTRUCTIONS	
Before moving forward with sterilisation, ALWAYS explore the possibility of using a cup instead of a bottle	
	Disinfect hands **a.** Wash hands thoroughly using warm water & soap for 30 seconds **b.** Dry hands with a single use paper towel

<table>
<tr><td>  </td><td rowspan="2">Clean equipment
a. Dismantle the bottle and wash each part separately
b. Wash feeding & preparation equipment thoroughly in hot soapy water.
c. Bottles & teats: scrub inside & outside with clean bottle brushes. Turn teats inside out.</td></tr>
<tr><td>  </td></tr>
<tr><td>  </td><td>Rinse thoroughly with safe, cold water</td></tr>
<tr><td>  </td><td>Sterilise Option 1 - Sterilisation

Option 1 is the RECOMMENDED method as not all bottles can be safely boiled

a. Carefully follow manufacturer’s instructions[52]
b. Do not use harsh cleaning agents to clean the steriliser</td></tr>
<tr><td>  </td><td>Sterilise Option 1 - Boiling
a. Fill a large pan with water
b. Place the cleaned bottle (or other feeding utensils) into the water
Make sure that all utensils are completely covered with water, utensils do not float and that no air bubbles are trapped.
c. Cover the pan with a lid and bring to a rolling boil.
d. Boil for at least 10 minutes, with sufficient water.
e. Keep the pan covered until feeding utensils are needed</td></tr>
</table>

[52] It is recommended to adapt this protocol based on the specific type of steriliser being used. Manufacturer’s sterilisation instructions should be included in the protocol which should be displayed on the wall.

	When sterilization process finished, remove sterilized bottle **a.** Wash hands thoroughly using warm water & soap for 30 seconds **b.** Dry hands with a single use paper towel Clean and disinfect surface you will use to assemble equipment.
	Remove equipment using sterilised tongs from steriliser/pan when it is needed
	Fully assemble feeding equipment (e.g. bottle & teat) to prevent the inside of the sterilised bottle and the inside & outside of the teat from becoming contaminated. Use immediately.
IMPORTANT **This process of washing the equipment MUST be completed after each feed and sterilisation of equipment must be completed before each feed** **Always counsel the mother or caregiver on usage of alternate feeding tools such as cups or spoons.**	

Additional Notes

- Do not use teats that have had the holes cut open, are badly scratched, split or cracked. Bacteria can stay in the damaged surfaces and survive the cleaning and sterilisation process.
- Always check whether bottles are suitable for boiling if using this method i.e. BPA free or glass
- Once removed from the steriliser or pan, bottles will lose their sterility if left out for too long. Re-sterilise any equipment that you've taken out and haven't used straight away.
- Sterilise *everything* that comes into contact with infant formula, which can foster the growth of particularly dangerous bacteria. It is not necessary to sterilise vacuum flasks which hold water if washed thoughtfully regularly.

Annex 6: One to One Full Assessment

One to One Full Assessment of Mother/Caregiver - Baby Pair

NOTE: During the Full Assessment care must be taken to ask open questions, to listen to the mother and show respect and sensitivity to her feelings, her culture, and her experience.

Assessment details			
Date:	**Location of assessment:**		
Interviewer Information			
Name of interviewer:	**Position:**		**Organisation:**
Contact details:			
Infant details			
Date of birth (approx. if required):	**Name of baby:**	**Male/Female**	**IYCFE registration number (if available):**
Place of shelter:			**Child MUAC:**
Caregiver details			
Name of Caregiver:	**Relationship to the child:**		**Contact:**
Place of shelter:			
Alternate caregiver name:	**Alternate caregiver details (phone/place of shelter):**		
How many other children in caregiver care:	**Ages of other children:**		

Notes

1. Mother / Caregiver Support

Mother / Caregiver mental and physical health	
ASK: **How are you emotionally and physically? Do you have any worries or concerns?** *Action: Refer to MHPSS, hospital, GBV survivor support, protection, etc as appropriate. Provide information on distributions, shelters, support hotlines, etc as appropriate.*	
Details:	
LOOK: **Does mother or caregiver look very thin; is crying, distressed or afraid; look lethargic or very sick?** *Action: Refer for support as appropriate*	□ Yes □ No
Details:	
Ask: **Do you have concerns about feeding the infant?** *Action: If yes, counsel mother/caregiver on specific concerns and refer where appropriate.*	□ Yes □ No
Details:	
Ask: **Do you have concerns about any of the other children in the place where you are sheltering?** *Action: If yes, request mother/ caregviver to bring in the other children to be seen after this assessment is completed.*	□ Yes □ No
Details:	

2. Child Visual assessment

***LOOK:* DOES THE CHILD LOOK VERY THIN?** □ Yes □ No *Action: If YES, refer to a health facility after assessment*	Details:	**Immediate referrals to health facility** □ Vomits *everything* □ Fits or convulsions □ Lack of movement /unconscious □ Fast breathing (> 50 breaths /min.) □ Chest indrawing □ Sunken eyes □ High temperature (>37.5) □ Low temperature (<35.5) □ Very small (<2.5kg)
***LOOK:* DOES THE CHILD LOOK LETHARGIC OR VERY SICK?** □ Yes □ No *Action: If YES, refer to a health facility after assessment*	Details:	

3. Current Feeding Pratices

ASK: HOW IS YOUR BABY CURRENTLY BEING FED? *If infant if being breastfeed <u>at all</u> please complete section 4 of this form*	
□ **Breast milk only**	**Say:** Please continue to breastfeed your baby, you are offering perfect nutrition and protection against disease.
	Action: Discontinue this section and **continue section 4** of this form. Refer to basic IYCFE support including mother and baby areas, peer support groups
□ **Breast milk and formula**	**Say:** Formula feeding your baby is dangerous in the current situation. This is why we do not want to give infant formula to breastfeeding women. It is safer to only breastfeed. Breastfeed before feeding formula in order to increase breast milk production. Continue to section TWO of this form.
	Action: Consider temporary BMS provision using best judgement if current breastfeeding frequency is very low. Must refer to breastfeeding counselling for building breastmilk supply. Continue to section 4 of this form.

□ **Breast milk and anything else**	**Say:** Breast milk protects your baby from infection and is all your baby needs. Giving other foods/ fluids will reduce your milk supply and increase the chances of infection. Please give only breast milk to your baby.
	Action: Consider temporary BMS provision using best judgement if current breastfeeding frequency is very low. Must refer to breastfeeding counselling for building breastmilk supply. Continue to section 4 and 5 of this form.
□ **Formula milk and anything else**	**Say:** Infant formula is the only suitable milk to use for babies less than 6 months if you are not breastfeeding. If you wish, it is possible to start breastfeeding again. Bottles and teats are extremely dangerous in this context, cup feeding is recommended. Infants can use cups from birth.
	Action: Consider registration into the BMS programme alongside IYCF-E counselling and referral to health facility if diarrhoea exists. Continue to section 5 of this form.
□ **Formula milk only**	**Say:** Infant formula is the only suitable milk to use for babies less than 6 months if you are not breastfeeding. If you wish, it is possible to start breastfeeding again. Bottles and teats are extremely dangerous in this context, cup feeding is recommended. Infants can use cups from birth.
	Action: Consider registration into the BMS programme alongside IYCF-E counselling and referral to health facility if diarrhoea exists. Continue to section 5 of this form.
For completely non-breastfed child	
Ask: When did the child stop breastfeeding and why? Reason given: _____	
IMPORTANT: Always explore whether she is willing and able to restart or if another women might be able to be identified to breastfeeding the infant or provide expressed milk at this point.	
Ask: Does you wish to increase breast milk supply or is are you interested in relactation? Yes / No **Action:** If yes, refer to IYCF-E counselling	

Ask: Do you wish to identify another woman to breastfeed the child directly or express milk for the child? Yes/No **Action:** If yes, refer to IYCF-E counselling
Medical reasons for BMS provision: ☐ Mother is dead or separated ☐ Rejection of infant ☐ Infant is currently dependent on artificial feeding and there is no possibility or breast milk provision by mother or another woman ☐ Temporary BMS provision in the case of building milk supply or relactation ☐ Medications contraindicated ☐ Mother is a GBV survivor and wishes not to breastfeed ☐ Other: _____

4. Breastfeeding Information

If infant is breastfeeding at all then ask if it is possible to observe a breastfeed. This allows for any challenges to be identified and counselling and referrals to take place where required.

How often breastfeed a day? _____ **How often baby breastfeeds at night?** _____ **Pacifier or other teat being used?** Yes _____ No _____

Breastfeed observation results: *(tick relevant observations below)*
Attachment at breast:
☐ Areola more above ☐ Mouth wide open ☐ Lower lip turned out ☐ Chin close to or touching breast ☐ No nipple/breast pain or discomfort
Positioning of baby:
☐ Head & body straight ☐ Child held close to mother's body

Suckling:
☐ Slow, deep sucks, sometimes pausing ☐ Swallowing can be heard and seen
Mother is confident:
☐ She is enjoying breastfeeding, relaxed, not shaking/moving breast or baby ☐ Has a positive relationship with baby -stroking, eye contact, close gentle holding
How the feed ends:
☐ Baby comes off the breast itself (not taken off by mother) ☐ Baby looks relaxed and satisfied and no longer interested in breast ☐ Mother keeps breast available, or offers other breast

5. Other Food and Drinks

Note: If child is under 6 months and receiving additional foods, or if child is over six months and not receiving appropriate complementary foods then additional counselling, referral, and follow-up should take place.

Other Foods / Drinks	**Is your child getting anything else to eat?**	**What?**	**Frequency: times/day**	**Amount: How much?**	**Texture: How thick?** *Thin, Thick, Finely chopped, or normal family food*
Solid Foods	Staple (porridge, other local examples)				
	Legumes (beans, other local examples)				
	Vegetables/Fruits (local examples)				
	Animal: meat/fish/ offal/bird/eggs				

Liquids	**Is your child getting anything else to drink?**	**What?**	**Frequency: times/day**	**Amount: How much?**	**Feeding Bottle use? Yes/No**
	Other milks				
	Any other liquids (e.g. water or tea)				
Who assists the child when eating? _____ **Where does the child eat? _____**					
Hygiene	Does caregiver use a clean plate and spoon?			Yes_____ No _____	
	Does caregiver wash hands with clean, safe water and soap before preparing food, before eating, and before feeding young children?			Yes _____ No _____	
	Does caregiver wash child's hands with clean, safe water and soap before he or she eats?			Yes _____ No _____	

6. Actions

REFERRAL MADE TO:	**REASON FOR REFERRAL**
□ Medical	□ Not exclusively breastfeeding
□ Nutrition	□ Breastfeeding difficulties
□ Child Protection	□ BMS Support Follow Up
□ MHPSS	□ **Other:**
□ Mother Baby Area	
□ IYCF Services	

7. BMS Distribution

Complete below before any BMS distribution.

Amount required

Age	Ready-to-use infant formula per day	Number of feeds per day	Number of units per day	Number of units per every 6 days
0 to <6 months	800 ml	6-8	4	24
6 to 11 months	600 ml	3	3	90

Amount distributed

Item	Quantities Distributed
RUIF	**200 ml containers**
0-2 months	
3 – 6 months	
BMS kit	
Disposable cups (if not in kit)	
Cups (if not in kit)	

1. **I considered the safety and security of the person carrying the RUIF and BMS kit from the distribution point to their home.** (tick if completed)
   - ☐ I have considered the weight of the RUIF and kit, the timing of the distribution, and the route the person will take. I have ensured that the distribution of the items is **DISCRETE**. If it is deemed UNSAFE for any reason I have ensured that other means of transportation of the RUIF and BMS Kit are made available.

2. **I gave the right amount of RUIF – in a plastic bag or inside the BMS kit, and I gave information on:**

Tick below if counselling completed on the following topics:

- ☐ Value of breastfeeding vs infant formula
- ☐ Exclusive breastfeeding for under 6 months children
- ☐ Initiation of complementary feeding after 6 completed months
- ☐ Cup feeding
- ☐ Hygiene recommendation (including to be used within 1 hour of opening)
- ☐ Number of feeds per day
- ☐ Ready to Use (no water to be added)
- ☐ [illegible]

Comments:

Annex 7: BMS Care Action Plan

Care Action Plan For Mother And Baby Receiving Skilled Support And BMS including temporary BMS use

Name of designated IYCF-E counsellor _____
Location: _____
IYCF-E Registration Number:_____
Child's name _____
Child's gender M/F
Child's DoB _____ **Age/months** _____
Mother/ Caregiver's name _____ **Relationship to child**_____
Address _____
Telephone:_____

Date of initial full assessment of mother-baby pair:_____
Main findings of one to one full assessment:_____
_____

Recommendations for feeding: (amend below as necessary)
___ **(**A) Continuing Supportive Care
___ (B) Basic Aid
___ (C) Further Help Baby refusing the breast
___ (D) Further Help Restorative care for the mother (needs emotional / extra support)
___ (E) Further Help Wet nursing
___ (F) Further Help Relactation
___ (G) Further Help Breast conditions
___ (H) Further Help Supported artificial feeding
___ (i) Further Help Complementary Feeding
Referral / Specialised Support:
___ Medical treatment/Therapeutic feeding
___ Other – specify _____

IYCF-E Reg. No. _____ ***Child's name:*** _____***Date of birth***_____
Mother/Caregiver's name: _____***Relationship to child***_____

FOLLOW UP / MONITORING FOR EACH CONTACT* (for artificially fed infants see checklists below):

Date						
Health & Weight of child (kg) (if part of programme)						

Date / time / place of next contact						
Notes and Agreed Actions for next visit (1 or 2)						
Progress from last visit						

** choose frequency of follow up according to each child/carer's situation, start more frequently and then aim for weekly contacts. Add new card if necessary, e.g if continuing support to an artificially fed infant.*

Checklist for counselling on BMS (ensure that information from the Full Assessment of Mother-Baby Pair is used to inform the discussions below and to highlight any additional issues):

Item to discuss (initially and to ensure on subsequent visits if needed)	**Check (date)**
What BMS will be given, when and where to receive it.	
What extra resources they will need to prepare BMS and how they will obtain these (See items in 'Safer BMS Kit')	

How much and how often to feed BMS	
How to keep feeding utensils clean and safe	
How to prepare and store the feeds	
The advantages of cup feeding and how to cup feed	
Warning of the potential hazards of using BMS.	
Demonstrate	
Care worker should demonstrate safe preparation of a feed in the home	
Check that	
The caregiver has been observed making a feed	
The caregiver has been observed cup feeding	

Checklist for follow up visits (write findings in visit notes)

Check and discuss
Infant health status and weight
Observe feed preparation: Check hygiene and it is as safe as possible
Observe a feed: Check feeding is as safe as possible – cup feeding
Find out any difficulties the caregiver may be facing and discuss practical solutions and/or refer for appropriate support
Check for warning signs of misuse of infant BMS (e.g. over concentration, over-dilution, formula being shared, etc)

Annex 8: RUIF Education Handout

This handout is adapted for the State of Palestine from the UNICEF document: How to feed your child with Ready to Eat Infant Formula

What is ready-to-use infant formula?

The milk in this container is like the brands of infant formula in the State of Palestine. It is made from dried cow's milk and is suitable for babies from birth. When offered as instructed, it will provide all the food a baby needs until about six months of age. There is no need to add other foods unless this is advised by a health worker.

If your baby is under 6 months, infant formula (labelled as suitable from birth) is the only suitable milk to use. If your baby is over 6 months of age, you can use either infant formula or other milk sources instead. Acceptable milk sources include pasteurized full-cream animal milk (cow, goat, sheep), Ultra High Temperature (UHT) milk, fermented milk or yogurt. These items may be easier to find and are less risky than using powdered milk. Condensed milk is not suitable for infant feeding. **Any animal milk given to infants <12 months of age should be boiled and left to cool before giving the milk, to prevent the risk of gastrointestinal blood loss.**

What do I need to know?

When using ready-to-use infant formula

- **Instructions vary per brand:** Always read the instructions that are printed on the container very carefully.
- The instructions on the container need to be followed exactly. Feeding too little will not get your baby enough food.
- If you run out of infant formula, you should not add more water to make it last longer.
- Unclean water, bottles, teats and cups can make your baby ill. Cleaning feeding utensils is essential to prevent sickness.
- Do not keep leftover milk. Instead, drink it yourself or give it to an older child. It will become unclean and unsafe for your baby if you try to keep it for another feed.
- Bottles are more difficult to clean than cups. A baby can cup feed from birth. During emergencies, cup feeding is much safer than bottle feeding. If cups cannot be adequately cleaned, consider using disposable cups instead. If you wish to continue to bottle feed, good hygiene (including sterilization of bottles) is essential to reduce the risk of infection.
- If your baby is over 6 months of age, you can mix infant formula into your child's food (such as porridge) rather than giving it to them as a drink.
- Feeding is a time for emotional and physical connection and comfort, regardless of what your baby is fed. This is especially important during stressful times, such as emergencies.
- When your baby is using infant formula, he/she is at higher risk of diarrhea and chest infections, especially in the current emergency conditions. Find out what medical services are available

wherever you are so that you are prepared and can get treatment quickly.
- If your baby becomes ill, continue to encourage him or her to drink and eat, offering smaller amounts more often if appetite is reduced.
- If you have any questions about feeding your baby, ask a trained health care provider for help.

How much ready-to-use infant formula will I need in a month?

If you are using 200ml containers of ready-to-use infant formula, you will require on average 4 units (800 ml) per day per infant. Older infants will need an average of 3 units (600 ml) per day alongside other foods. If the formula is provided in containers other than 200 ml, your health worker will indicate the number of units required to feed your baby.

Age	Ready-to-use infant formula per day	Number of units per day	Number of units per month
0 to <6 months	800 ml	4	120
6 to 11 months	600 ml	3	90

What steps must I follow when preparing ready-to-use infant formula?

Steps in preparing ready-to-use infant formula	
1	Wash hands thoroughly with water and soap or alcohol-based sanitizer.
2	Ensure the feeding preparation utensils and cup and other utensils are clean.
3	Pour the ready-to-use formula into a clean cup and offer it to the infant.
4	Hold your baby close to you and provide as much milk as he/she wants. Do not pour milk quickly into his/her mouth. Let the infant sip slowly.
5	Discard any leftover formula that is not used within two hours or mix with other foods or consume it yourself as the caregiver or offer to the elderly.
6	Thoroughly clean feeding and preparation equipment after use

How should I feed my baby with ready-to-use infant formula?

- Feed the baby using a clean open cup. Even a newborn baby learns quickly how to drink from a cup.
- Whenever possible, hold your baby close to your body during or between feeds. Your close presence helps your baby feel calm and safe, while skin-to-skin contact helps to regulate their body temperature.
- Hold the baby closely in an upright or semi-upright position on your lap.
- Hold the cup to the baby's mouth such that the milk just reaches the baby's lips. The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper

lip.

- Do not rush and do not pour the milk into the baby's mouth. Continue to hold the milk to the baby's lips while the baby sucks, sips or takes it with his/her tongue.
- When the baby has had enough, the baby will refuse to take any more milk.
- Whenever you can, treat feedings as a time for bonding and connection, rather than just physical nourishment. For example, you might feel like talking to or singing to your baby while feeding them.
- If the baby does not drink all of the infant formula during a feeding, discard what is left in the cup or use it to cook a meal. Or, mix it in family food or give it to an older, non-breastfed child or elderly family member. It is not safe to keep for your infant. Giving a baby leftover milk can make your baby ill.
- After use, clean the cup thoroughly using soap and hot water and store it in a clean area. Disposable cups should be discarded.

Annex 9: Evaluation of Artificial Feeding in the Place of Shelter

Evaluation of Artificial Feeding in the Place of Shelter

Resources - What resources are available?

[Note: Feeding with bottle and teat is dangerous, cup feeding is safer]

	Observations	Yes/ No	Concerns / Comments
Breast milk substitute (eg. Infant formula)	Breast milk substitute is suitable for child's age?		
	Expiry date clearly marked, and not past		
	Instructions written in users own language		
	Preparer or another household member is able to read label's instructions		
	Caregiver is easily able to obtain sufficient formula until the child is at least 6 months of age		
	Subsequent visit: Quantity used since last distribution is appropriate		
	Quantity remaining is sufficient until next distribution		
Storage	Safe storage/tightly closed containers used for ingredients		
	Milk feeds prepared in advance only if refrigeration is available		
	Drinking water is stored in a special container (clean, with cover)		
Preparation facilities	Adequate fuel is available for boiling water (and for cleaning feeding equipment)		
	Adequate drinking water is available for preparing several feeds per day (at least 1 litre)		
	Adequate other water and soap are available for washing utensils and hands		
	Clean surface is available to put utensils on (and a clean cover for them)		
	Suitable means of measuring milk and water (if a feeding bottle, the top is cut off. Or the health care worker can make a volume (mls) mark in a cup if measuring equipment not available)		
Extra time	Time to prepare 6-8 fresh feeds per day		

Procedures – how does the caretaker manage the feeding?

	Observations	Yes/ No	Concerns / Comments
Preparation	Caregiver washes hands		
	Cup washed with soap and water		

	Bottle and teat (if used) washed and boiled before use (note cup feeding is safer)		
	Water to prepare feed is brought to a rolling boil		
	Caregiver measures proportions of milk and water correctly		
	Boiled water allowed to cool for no more than 30 minutes before being added to formula		
	Prepared formula is rapidly cooled		
Feeding technique	Infant is fed with cup, and takes most or all of the milk		
	Infant is fed with feeding bottle		
	Infant is fed with another method (State)		
Interaction and end of feed	Infant is held throughout the feed		
	Caregiver interacts lovingly with the infant during the feed		
	Infant finishes the milk feed		
	None of this feed is kept for the infant to take later (milk could be drunk by mother or older child – don't use after an hour)		
Adequacy of milk feeds	Number of feeds given per day appropriate to age and weight		
	Amount given at each feed appropriate		
Age-appropriate feeding	Under 6 months, only milk is given		
	Over 6 months, milk and complementary foods are given		

Annex 10: On site wet feeding

PROTOCOL: ON SITE WET FEEDING OF INFANT FORMULA

The use of any infant formula increases the risk of illness and infection compared to breastfeeding. There are, however, instances where it is appropriate and necessary to provide an infant with a Breast milk Substitute (BMS) such as infant formula. Such children are highly vulnerable during emergencies and the BMS must be prepared and fed to them as safely as possible. **Ready To Use Infant Formula (RUIF) is preferred for these cases**, however where its use is not an option Powdered Infant Formula (PIF) may be provided. PIF is not sterile and requires reconstitution with boiled water, both of which can be a source of contamination and cause serious illness. Inappropriate handling and storage practices can increase the risk; therefore specific food hygiene measures must be taken to avoid doing harm

In circumstances where **all** resources required to prepare and feed infant formula are unavailable or cannot be transported by caregivers and where safe preparation or use of infant formula cannot be assured at household level (e.g. sanitation concerns) **on-site reconstitution and consumption** (may be referred to as '**wet' feeding**) should be initiated for formula-dependent infants 0 – 6 months. This is likely to be necessary during situations such as mass displacements, particularly if Ready To Use Infant Formula (RUIF) cannot be secured.

Required Equipment

1. A clean preparation environment
2. Handwashing station with soap
3. Heat source
4. Safe water*
5. Washing up liquid
6. Kettle OR pot with lid
7. Sterile feeding cup (preferred) OR bottle (caregiver's own)
8. Thermometer
9. Mixing spoon
10. Scaled measuring cup (for liquids)
11. Measuring scoop (for PIF)
12. Sterilisation equipment (see sterilisation protocol)
13. Cleaning materials incl. surface disinfectant
14. Shallow bowl
15. Disposable paper towels
16. *Optional:* Refrigerator / coolbox (< 5®C)
17. *Optional:* < 1 litre sterile container made of food-grade material, suitable for hot liquids
18. *Optional:* sterile ladle to transfer prepared formula from container to cup

*Follow WASH cluster protocol

General requirements:

- Written guidelines for the preparation and handling of PIF should be available.
- The implementation of guidelines should be monitored.
- Personnel preparing BMS should be fully trained according to the guidelines.
- There should be full traceability of BMS.
- There should be a clean dedicated area for preparation and storage of BMS
- Purchased, rather than donated, BMS should be used.

DISTRIBUTION FOR ON-SITE CONSUMPTION

- Ensure provision of infant formula is discrete.
- Access to onsite wet feeding sites should be restricted to caregivers who have undergone a rapid individual caregiver-baby assessment carried out by trained personnel.
- Entry should be limited to a few caregivers at a time to maintain oversight and control. The caregivers should have space to sit comfortably and to feed children after receiving the infant formula.
- Provision of infant formula should always be accompanied by strong messages on hygiene, support for cup feeding and instructions to discard any leftover infant formula.
- Caregivers are encouraged to immediately feed formula to children while still on site.
- Do not rush caregivers – encourage responsive feeding.
- No additional PIF should be provided for off-site preparation.
- Avoid scalds / burns. Keep children well away from kettles, boiling water etc.
- Do not combine with medical services, due to increased risk of contamination.

PREPARATION PROTOCOL[53]

Always prepare feeds fresh each time and to feed immediately. Wet feeding sites will be required to prepare feeds for many infants. Ideally, each feed should be prepared in an individual feeding cup. Mixing feeds within larger containers and then transferred into individual feeding cups poses a risk because BMS is more susceptible to contamination in large, open containers. Also, large volumes of feed take much longer to cool, leaving the potential for growth of harmful bacteria.

1.1. Wash hands with soap and water, and dry using a clean cloth or a single-use napkin.

1.2. Clean and sterilise all feeding and preparation equipment that will come into contact with infant formula according to the sterilisation protocol. It is best to remove feeding and preparation equipment just before it is required for use. If equipment is removed from the sterilizer and not used immediately, it should be covered and stored in a clean place, to minimize the contamination with germs.

1.3. Clean and disinfect a surface (e.g. using Isopropyl Surface70% Alcohol) on which to prepare the feed.

1.4. Boil a sufficient volume of safe water. If using an automatic kettle: wait until the kettle switches off. If using a pot with lid: make sure that the water comes to a rolling boil and boils for 2 minutes. Do not use water that has been boiled before as this increases the mineral content, which can harm

[53] WHO (2007) Safe Preparation, Storage and Handling of PIF

infants. Note: bottled water is not sterile and must be boiled before use. Microwave ovens should never be used in the preparation of PIF as uneven heating may occur and burn the infant's mouth.

1.5. Use a measuring cup to measure the correct amount of *newly* boiled water for the feed, left for no longer than 30 minutes after boiling.

1.6. Pour the appropriate amount of boiled water into a cleaned and sterilized feeding cup. The temperature of the water[54] should be checked using a sterile thermometer.

a) *If making a batch in a larger container:* the container should have been cleaned and sterilized. It should be no larger than 1 litre, be made from food-grade material and be suitable for pouring hot liquids.

1.7. Dip the formula scoop into the milk powder. Use a clean spoon or spatula to level off the scoop.

1.8. Pour the powder into the water. Add the exact amount of formula milk as instructed on the label. Adding more or less power than instructed could make the infant ill.

1.9. Use a clean mixing spoon to mix the powder into the water in the cup.

a) If using a feeding cup, mix thoroughly by stirring with a clean and sterile spoon

b) If preparing a batch in a larger container: stir formula using a cleaned and sterilized spoon to ensure even mixing. Immediately pour into individual feeding cups or bottle[55].

1.10. Cool the feed quickly by placing the cup into a shallow bowl of safe cold water. Ensure the water level is below the rim of the cup.

1.11. When the cup feels just warm, dry the outside of the cup with a paper napkin or disposable cloth.

1.12. Label with appropriate information, such as type of formula, infant's name or ID, time and date prepared, and preparer's name.

1.13. Check the temperature of the feed by dripping a little onto the inside of your wrist. It should feel lukewarm, not hot. If it still feels hot, cool some more before feeding..

1.14. Discard any feed that has not been distributed within 2 hours

PREPARING FEEDS IN ADVANCE

Note that it is strongly recommended to make PIF fresh for each distribution and to instruct caregivers to use for immediate consumption. Reconstituted PIF increases the risk of the growth of harmful bacteria. If feeds need to be prepared in advance for on-site wet feeding, **refrigeration facilities are required with the possibility to monitor the temperature.**

2.1 Follow steps above

2.2 Store in clean, sterilised jar / container with lid no larger than 1 litre

2.3 Keep in fridge / coolbox no warmer than 5 °C. Monitor temperature and record temperature checks

2.4 Rewarm feed and transfer to feeding cups as needed. Check temperature before feeding.

2.5 Discard any feed that has not been distributed within 24 hours

[54] No less than 70 degrees Celsius is recommended

[55] If caregiver is unwilling or unable to cup feed. NOT RECOMMENDED.

Annex 11: Messages BMS Feed Infants

HOW TO PROTECT YOUR FORMULA-FED BABY FROM ILLNESS AND MALNUTRITION

كيف يمكنك حماية طفلك الرضيع عن طريق الرضاعة الاصطناعية من الامراض وسوء التغذية

It is safer and healthier for your baby to be breastfed.
انه من الاكثر امانا وصحة لطفك ان يرضع من صدرك.

Formula feeding your baby is dangerous in the current situation. If you are both breastfeeding and using infant formula or other milks, it is safer to only breastfeed. Breastfeed before feeding formula in order to stimulate breastmilk production. You can gradually replace each formula feed with a breastfeed. The more the baby suckles, the more milk will be produced. This may take a few days.

تعتبر الرضاعة الاصطناعية خطيرة في مثل هكذا ظروف. إذا كنت تقومين بالرضاعة الطبيعية واستخدام قنينة الرضاعة الاصطناعية، أو اي من انواع الحليب الأخرى، فالاعتماد على الرضاعة الطبيعة فقط يكون الاكثر امانا على الاطلاق. احرصي على القيام بالرضاعة الطبيعية قبل الرضاعة الاصطناعية من اجل تحفيز انتاج حليب صدرك. يمكنك استبدال كل عملية رضاعة اصطناعية بالرضاعة الطبيعة تدريجيا. علما بأنه كلما زادت رضعات الطفل كلما زاد انتاج الحليب، هذا وقد يستغرق ذلك بضعة أيام.

If your baby is under 6 months, infant formula is the only suitable milk to use. If your baby is over 6 months, you do not need to use infant formula but can use other milk sources instead.

إذا كان عمر طفلك اقل من ستة اشهر، فإن حليب الأطفال الصناعي هو الحل الوحيد لتوفير الحليب. وإذا كان عمر طفلك اكثر من ستة اشهر، فلا يوجد داع لان تستخدمي حليب الأطفال الصناعي، بل يمكنك استخدام مصادر الحليب الاخرى.

Powdered Infant Formula is very difficult to safely and hygienically prepare in this situation. We have provided you with Ready-to-Use Formula which is safer to use. It already has pure water added: it is not necessary to add water.
ان مسحوق حليب الأطفال يكون صعب الإعداد من الناحية الصحية في مثل هكذا ظروف. ولذا فقد اعددنا لك قنينة حليب جاهزة للرضاعة امنة ومعدة للاستخدام الفوري. الماء النقي مضاف اليها مسبقا، لذا ليس من الضروري اضافة الماء اليها.

Do not keep the left-over formula milk. Left-over milk can make your baby very sick and can be life-threatening. Discard the milk container after each feed.
لا تبقي الحليب المتبقي في قنينة الرضاعة. فالحليب المتبقي في قنينة الرضاعة يمكنه ان يصيب طفلك بالمرض الشديد. ارمي قنينة الرضاعة بعد كل رضعة.

Bottles are more difficult to clean than cups. A baby can cup feed. Cleaning of feeding utensils (cups, spoons) is essential to prevent sickness. Disposable plastic or paper cups are one option to remove the need for cleaning. We have provided you with these cups to feed your baby.

تعتبر قناني الرضاعة الاصطناعية أكثر صعوبة من ناحية التنظيف من الاقداح. علما ان الطفل يمكنه من ان يرضع عن طرق القدح. ان تنظيف اواني التغذية (الأكواب والملاعق) ضروري لمنع المرض. يمكنك التخلص من عملية التنظيف بأستخدام الاقداح البلاستيكية او الورقية المعدة للاستخدام لمرة واحدة. لقد قمنا بتوفير هذه الاقداح لتغذية طفلك.

If you wish to continue to bottle feed, hygiene is essential to reduce the risk of infection. If not cleaned properly, they can cause illness, malnutrition and death.

إذا كنت ترغب في الاستمرار في قنينة الرضاعة الاصطناعية فأن النظافة تكون ضرورية للحد من خطر العدوى. إذا لم تقومين بتنظيفها بشكل صحيح، فإنها يمكن أن تسبب المرض وسوء التغذية والموت.

كيف يمكنك ارضاع طفلك عن طرق القدح

كل الاطفال يمكنهم الرضاعة بالقدح!

- تاكدي من ان طفلك مستيقضا تماما.
- احملي طفل قريبا اليك وبصورة مستقيمة.
- امسكي الاكتاف والرقبة.
- احملي القدح الى فم الرضيع بصورة يمكن للحليب من ان يصل الى شفته.
- لا تسكبي الحليب في فم الرضيع؛ ابقي القدح قريبا بما فيه الكفاية حتى يتمكن الرضيع من ان يرضع الحليب بنفسه.
- لا تستعجلي – استمري بتقريب الحليب الى فم الطفل بينما يقوم هو / هي بمصه او يأخذ رشفات بلسانه.
- ابقي القدح بوضعية مائلة.
- لا تبعدي القدح عن الطفل حين يقوم بالتوقف بل الى ان يبعد نفسه عنه تماما.
- اسمحي له بالبداء من جديد عندما يكون جاهزا.
- اتبعي اشارات وسرعة طفلك.
- استخدمي قدحا نظيفا دائما.


العمر بالاشهر	الوزن (كغم)*	عدد الرضعات باليوم (24 ساعة)	ملغ من الحليب في اليوم
1	8	3	450
2	7	4	600
3	6	5	750
4	6	5	750
5	6	6	900
6	6	6	900

HOW TO CUP FEED YOUR BABY

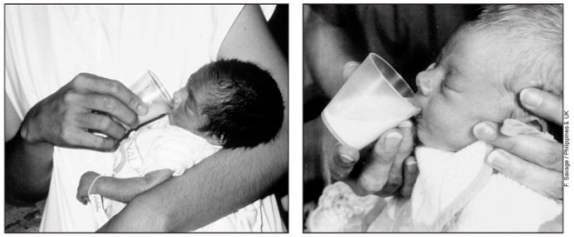
All babies can cup feed!


- Make sure the baby is fully awake
- Hold the baby closely in an upright position
- Support the shoulders and neck
- Hold the cup to the infant's mouth such that the milk just reaches the infant's lips.
- Do NOT pour the milk into the baby's mouth; tip the cup just enough so that he can lap the milk himself.
- Do not rush – continue to hold the milk to the baby's lips while the baby sucks or sips or takes it with his/her tongue.
- Keep the cup in this tilted position.
- DO NOT take the cup away when the baby pauses, unless he pulls away.
- Allow him to start again when he is ready.
- Follow your baby's signals and speed.
- Always use a clean cup!

Annex 12: How to cup feed

HOW TO CUP FEED YOUR BABY

All babies can cup feed!



- Make sure the baby is fully awake
- Hold the baby closely in an upright position
- Support the shoulders and neck
- Hold the cup to the infant's mouth such that the milk just reaches the infant's lips.
- Do NOT pour the milk into the baby's mouth; tip the cup just enough so that he can lap the milk himself.
- Do not rush – continue to hold the milk to the baby's lips while the baby sucks or sips or takes it with his/her tongue.
- Keep the cup in this tilted position.
- DO NOT take the cup away when the baby pauses, unless he pulls away.
- Allow him to start again when he is ready.
- Follow your baby's signals and speed.
- Always use a clean cup!