WORLD VISION POLICY GOVERNING THE PROCUREMENT AND
USE OF MILK PRODUCTS IN FIELD PROGRAMMES

PREAMBLE:

Goal: To ensure the fulfillment of the highest attainable standards of health including the right to adequate nutrition as stated in the Convention on the Rights of the Child by all children in World Vision programme areas.

To ensure effective infant feeding practices and avoidance of harm to children, World Vision has set an internal policy regarding the procurement and use of milk and milk derived products in field programmes, in both emergency and non-emergency contexts. This policy is reviewed on a periodic basis to ensure alignment with the latest technical findings and standards. The 2007 version of World Vision’s Milk Policy was updated in 2011 to include the recommendations in the World Health Organization’s (WHO) 2010 Guidelines on HIV and Infant Feeding.

World Vision will uphold and promote the principles embodied in the International Code of Marketing of Breast Milk Substitutes, and subsequent relevant World Health Assembly (WHA) resolutions (Annex 2) in protecting, promoting and supporting breastfeeding and safe and appropriate infant and young child feeding practices.

POLICY:

1. World Vision will support, protect and promote immediate and exclusive breastfeeding of infants for the first six months of their lives and continued breastfeeding for two years or beyond, with timely and correct use of adequate complementary foods starting at six months of age in all programming, advocacy, internal policies and practices and marketing.

2. World Vision will uphold and promote the provisions of the International Code of Marketing of Breast Milk Substitutes (the International Code) and subsequent World Health Assembly resolutions (Annex 2). World Vision will not accept unsolicited donations of breast milk substitutes and commercial baby foods.

3. World Vision endorses the Operational Guidance for Emergency Relief Staff and Programme Managers on Infant and Young Child Feeding in Emergencies, version 2.1, February 2007 (key points attached in Annex 3). World Vision recommends that the full operational guidance is referenced and implemented in conjunction with this policy.

4. World Vision’s handling of milk products in refugee settings will be in accordance with the United Nations High Commissioner for Refugees’ (UNHCR) policy for Acceptance, Distribution and Use of Milk Products in Refugee settings (UNHCR 2006).
EXCEPTIONAL SITUATION FOR TEMPORARY OR LONGER-TERM USE OF INFANT FORMULA

5. World Vision will only source and distribute infant formula in an exceptional situation where the infant cannot or should not be breastfed. The exceptional situation must be identified by an infant and young child feeding needs assessment using established and agreed criteria (Annex 4) and conducted by personnel who have received training on infant and young child feeding in consultation with health and nutrition personnel. Examples of exceptional situations include: absent or dead mother, very ill mother, relactating mother, infant rejected by mother, infant artificially fed prior to the emergency or rape victim not wishing to breastfeed. Another exceptional situation is an HIV-positive mother who is replacement (e.g. infant formula) feeding in accordance with the country’s infant feeding strategy and where breast milk substitute is considered safe (based on 2010 WHO recommendations, Annex 4).

6. When the use of infant formula is indicated, World Vision will only distribute to the infants requiring it and will ensure that the supply is continued for as long as the infants concerned require it. Training on how to use the formula will be given to those mothers and none other. World Vision will not source and distribute infant formula in areas without access to adequate clean water, without resources to provide sufficient infant formula and to prepare formula safely, without family support and without access to comprehensive health services (as per WHO 2010 guidance on conditions needed to safely formula feed, Annex 4).

7. In such exceptional circumstances confirmed by health or nutrition personnel, World Vision will purchase or solicit generic (unbranded) formula after approval by senior health and nutrition staff. If and when generically labelled infant formula is unavailable, World Vision will purchase or solicit branded infant formula, manufactured and packaged in accordance with Codex Alimentarius standards, that has a shelf-life of at least six months of local receipt of supply, labelled in the appropriate language and compliant to the labelling requirements of the International Code, on the open market and used carefully in ways that reduce the risk of World Vision being associated with or implying endorsement of the formula.

8. World Vision will assess the availability of fuel, water and equipment for safe preparation and use of breast milk substitute and milk products prior to distribution. Interventions to support artificially fed infants should budget for the purchase of breast milk substitute supplies along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation and staff training.

HANDLING BREAST MILK SUBSTITUTE DONATIONS AND SUPPLIES

9. World Vision will not accept unsolicited donations of breast milk substitute and milk products.

10. World Vision will not accept donations of infant formula for use in the health care system in accordance with the International Code, or for general distribution to pregnant women and lactating mothers. Where criteria for the use of breast milk substitute are met (point 5 above), breast milk substitute supplies that have been purchased or solicited by World Vision may be used within the health care system. The health care system refers to governmental, non-governmental or private institutions or organisations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries
or childcare institutions. It also includes health workers in private practice. It does not include pharmacies or other established sales outlets.

11. World Vision will not accept or supply bottles and teats (nipples) and will take all possible steps to actively discourage the distribution and use of infant feeding bottles and artificial teats in all its programmes and projects. World Vision will not use pictures of bottles and teats in their training materials or media communications that would promote or condone their use. In the exceptional situation where an infant or young child is not breastfed, World Vision encourages use of cups (without spouts) and spoons for feeding.

12. World Vision will accept, source and distribute dried milk products only if they can be used under strict control in hygienic conditions either for on-the-spot consumption in a strictly supervised environment, such as therapeutic feeding programmes and wet supplementary feeding programmes, or pre-mixed centrally with cereal flour, sugar and oil to produce a dry take-away premix for cooking at household level. Dried milk should not be distributed as a single commodity.

13. World Vision will accept, source and distribute milk products received in dry form (for use as specified in point 12). World Vision will not accept donations of liquid or semi-liquid milk, including evaporated, condensed and Ultra High Temperature milk. Exceptions are made only for Ready-to-use infant formula (RUIF) when it is acceptable in the country context and where sanitation and storage conditions are guaranteed and with prior approval of the Operations Director, as for any breast milk substitute.

14. World Vision will accept, source and distribute dried skim milk (for use as specified in point 12) only if it has been fortified with vitamin A. In this case, staff involved should be made aware that it is NEVER appropriate to feed dried skim milk on its own to infants. When given in calorically adequate amounts it can cause dehydration and death due to its excessive protein and mineral content.

15. World Vision will accept, source and distribute pre-formulated therapeutic milk or dried skim milk to prepare therapeutic milk only for treatment of severe malnutrition in accordance with current international guidelines.

16. All milk products must have a shelf life of at least six months at time of arrival to World Vision in-country.

HIV SPECIFIC CONTEXT

17. World Vision recognises the challenges regarding infant and young child feeding in the context of HIV infection. World Vision promotes, supports and advocates for the accessibility of HIV diagnosis for pregnant women as part of primary health services.

18. Wherever HIV status of the mother is unknown or known to be HIV negative, World Vision encourages and supports the mother to exclusively breastfeed her infant for the first six months of life with continued breastfeeding for two years or beyond, with timely and correct use of adequate complementary foods.

19. The 2010 WHO guidelines on infant feeding in the context of HIV (Annex 5) urge national or sub-national health authorities to establish one recommendation for infant feeding (that is, either breastfeeding plus anti-retroviral (ARV) prophylaxis or total avoidance of breastfeeding) as the strategy that will most likely give infants the greatest chance of HIV-free survival. World Vision supports the 2010 WHO Guidelines on HIV and Infant Feeding and encourages mothers
who are HIV positive to feed their infants in accordance with their country’s national or sub-national Infant Feeding Strategy based on these guidelines. World Vision promotes, supports and advocates for availability and accessibility to timely and regular ARV prophylaxis provision for HIV-positive women who choose to breastfeeding.

20. If the mother is HIV positive and conditions needed to safely formula feed (see Annex 4) are not met (whether or not ARV drugs are available), then World Vision promotes:
   - Exclusive breastfeeding in the first six months of life.
   - After six months, continued breastfeeding with appropriate and adequate complementary foods unless environmental, economic and social circumstances are safe for and supportive of replacement feeding.

21. In all circumstances, decisions about infant feeding options for women who are HIV positive will be made in consultation with senior health and nutrition technical staff (refer to Annex 5).

STAFF TRAINING

22. World Vision will provide training, or access to training where it is available, to technical and non-technical staff to promote, protect and support optimal infant and young child feeding practices (including breastfeeding management and relactation, assessment and targeting needs for breast milk substitutes).

23. World Vision Health, HIV, Nutrition, Food Programming, Gifts-in-Kind (GIK) and Water, Sanitation and Hygiene (WASH) staff working in communities will be trained to understand the evidence around the negative impact (that is, much higher risk of death) of using infant formula when conditions are not met to safely formula feed, even when mothers are HIV positive.

COORDINATION

24. World Vision will work with the coordinating agencies for infant feeding in the field on dissemination and implementation of the milk policy to ensure that solicited donations or specific distributions are in compliance with the International Code and in respect to principles endorsed by World Vision.

ACCOUNTABILITY

25. Acceptance of donations and procurements of all milk products, infant formula and breast milk substitutes must be approved by the Operations Director (National Office) or Emergency Response Manager consistent with the above policy. The National Health/Nutrition Advisor is responsible for advising the National Operations Director and/or Emergency Response Manager of the Milk Policy.

26. Any issues regarding the World Vision policy on the procurement and use of milk products in field programmes should be reported to the National Office and Regional Office Health/Nutrition Advisors, and where necessary, reported to the Global Centre Emergency Nutrition and Emergency Health Advisors.

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<th>DEFINITIONS:</th>
<th>Milk Products</th>
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<td>Dried whole, semi skimmed or skimmed milk; liquid whole, semi skimmed or skimmed milk; soya milk; evaporated or condensed milk; fermented milk or yogurt.</td>
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### Infant Formula
A breast milk substitute formulated industrially in accordance with applicable Codex Alimentarius Standards (developed by the joint FAO/WHO Food Standards Program) to satisfy the normal nutritional requirements of infants to six months of age and adapted to their physiological characteristics. Commercial infant formula is infant formula manufactured for sale, branded by a manufacturer and may be available for purchase in local markets. Generic infant formula is unbranded and is not available on the open market, thus requiring a separate supply chain.

### Breast Milk Substitute
Any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not it is suitable for that purpose.

**Note:** In practical terms, foods may be considered breast milk substitutes depending on how they are marketed or represented. These include infant formula, other milk products, therapeutic milk and bottle-fed complementary foods marketed for children up to two years of age and complementary foods, juices and teas marketed for infants less than six months. In some markets, products not suitable as the sole food of infants are perceived or used as such. One of the more common examples is commercial cereals which can be over-diluted and fed by bottle.

### SCOPE:
This World Vision International Management Policy applies to all World Vision corporate entities (which includes all WVI branch offices; Global Centre offices; Regional offices; National Office branches, and programme/project offices). It supersedes and replaces the World Vision International Policy Governing the Procurement and Use of Milk Products in Field Programmes written in 1991 and revised in 2007.

### BACKGROUND:
World Vision protects, promotes and supports immediate and exclusive breastfeeding until six months of age and continued breastfeeding with appropriate complementary feeding until two years as priority interventions essential to the well-being of infants and young children (See Annex 1).

There are only very few specific situations as described in this policy where breast milk substitutes may be necessary. Inappropriate handling of milk products can negatively impact infant feeding practices and directly contribute to increased morbidity and mortality in infants and young children.

World Vision recognises the challenges posed by the HIV pandemic and emergencies on infant feeding. Fully aware of these challenges and in alignment with the International Code of Marketing of Breast-milk Substitutes, the Innocenti Declaration, the Baby-friendly Hospital Initiative, the WHO 2010 guidelines on HIV and Infant Feeding and SPHERE standards, World Vision is committed to promote appropriate infant and young children feeding practices.
ANNEX I

CRITICAL IMPORTANCE OF BREASTFEEDING TO CHILD HEALTH

World Vision interventions seek to provide the maximum benefit for children using internationally recognised standards and context-appropriate approaches. The interventions target underlying causes of mortality and morbidity of children and avoid harm.

Thirty-five per cent of under-five deaths are due to the presence of undernutrition (Black et al, Lancet 2008). Many of these deaths occur during the first year of life and are often associated with inappropriate feeding practices.

The protection, promotion and support of immediate and exclusive breastfeeding and appropriate complementary feeding are essential to the well-being of infants and young children. WHO/UNICEF recommendations are clear in the first two years of life: Infants should be put to the breast within an hour of birth and exclusively breastfed on demand for the first six months. Children six to 24 months of age need more food to grow and, in addition to breastmilk, should be fed nutritionally adequate and safe (hygienically prepared, stored and fed with clean hands and clean utensils) complementary foods. Breastfeeding is recommended to continue up to two years of age or beyond.

1. Infants from birth to five months of age who are not breastfed have a seven-fold and five-fold increased risk of death from diarrhoea and pneumonia, respectively, compared with infants who are exclusively breastfed (Black et al, 2003).

2. If all babies were fed only on breast milk for the first six months of life, an estimated one million would be saved every year. This figure is based on estimates from Lancet 2008 of 13 per cent of under-five child deaths that could be prevented through immediate and exclusive breastfeeding, applied to latest UNICEF figures of 7.6 million total under-five child deaths in 2010.

3. Breast milk provides all the energy and nutrients that the infant needs for the first months of life and it continues to provide up to half or more of a child's nutritional needs during the second half of the first year, and up to one-third during the second year of life.

4. Breast milk promotes sensory and cognitive development and protects the infant against infectious and chronic diseases since it contains high levels of immune substances found in the colostrum.

5. Exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhoea or pneumonia and helps for a quicker recovery during illness (Kramer et al, 2001).

6. Breastfeeding contributes to the emotional stability of the infant and bonding between the infant and the mother.

7. Breastfeeding contributes to the health and well-being of mothers. It helps to space children and reduces the risk of ovarian cancer and breast cancer.

8. Breastfeeding increases family resources; it is free and is safe for the environment.

Replacing breastmilk with other milk products (e.g. infant formula) can result in serious problems in many contexts, such as contamination of milk products and incorrect reconstitution of milk, which in turn, can lead to malnutrition and even death. Milk products may be contaminated by use of unsafe drinking water, and lack of sterilisation of bottles and cups. If over-diluted milk is fed to children, the resulting inadequate dietary intake will lead to malnutrition. Conversely, the consumption of concentrated milk products such as dried-skim milk or dried-whole milk by young children can result in renal failure or even death due to high concentrations of sodium and protein.
ANNEX 2

THE INTERNATIONAL CODE


KEY PROVISIONS OF THE CODE

1. Promote and support immediate (within one hour of delivery) and exclusive breastfeeding for six months as a global public health recommendation with continued breastfeeding for up to two years of age or beyond.

2. Foster appropriate complementary feeding from the age of six months recognising that any food or drink given before or in larger amounts than nutritionally required may interfere with breastfeeding or displace breast milk in the infant diet.

3. No advertising of products under the scope of the Code to the public.

4. No free samples to mothers.

5. No promotion of products in health care facilities, including the distribution of free or low-cost supplies.

6. No company representatives to advise mothers.

7. No gifts or personal samples to health workers.

8. No words or pictures idealising artificial feeding, including pictures of infants and/or women, on the labels of the products.

9. Health workers should be trained on how to support mothers to immediately and exclusively breastfeed for six months. Information to health workers should be scientific and factual. Health claims on labels are inappropriate.

10. All information on artificial feeding, including the labels, should explain the benefits of breastfeeding and all costs and hazards associated with artificial feeding.

11. Unsuitable products such as sweetened condensed milk should not be promoted for babies.

12. All products should be of a high quality and take account of the climatic and storage conditions of the country where they are used.

13. Complementary foods are not to be marketed in ways to undermine exclusive and sustained breastfeeding.

14. Financial assistance from the infant feeding industry may interfere with professionals’ unequivocal support for breastfeeding. Using free gifts (even something as seemingly harmless as a pen) results in associating oneself with and unintentionally endorsing the product.
ANNEX 3

INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES

from Operational Guidance for Emergency Relief Staff and Programme Managers on Infant and Young Child Feeding in Emergencies, Version 2.1, February 2007

KEY POINTS

1. Appropriate and timely support of infant and young child feeding in emergencies (IFE) saves lives.

2. Every agency should endorse or develop a policy on IFE. The policy should be widely disseminated to all staff, agency procedures adapted accordingly and policy implementation enforced (Section 1).

3. Within the United Nations (UN) Inter-agency Standing Committee (IASC) cluster approach to humanitarian response, UNICEF is likely the UN agency responsible for coordination of IFE in the field. Also, other UN agencies and NGOs have key roles to play in close collaboration with the government (Section 3).

4. Breastfeeding and infant and young child feeding support should be integrated into other services for mothers, infants and young children (Section 5).

5. Donated (free) or subsidised supplies of breast-milk substitutes (e.g. infant formula) should be avoided. Donations of bottles and teats should be refused in emergency situations. Any well-meant but ill-advised donations of breast milk substitutes, bottles and teats should be placed under the control of a single designated agency (Section 6).

6. The decision to accept, procure, use or distribute infant formula in an emergency must be made by informed, technical personnel in consultation with the coordinating agency, lead technical agencies and governed by strict criteria (Section 6).

7. Breast milk substitutes, other milk products, bottles or teats must never be included in a general ration distribution. Breast milk substitutes and other milk products must only be distributed according to recognised strict criteria and only provided to mothers or caregivers for those infants who need them. The use of bottles and teats in emergency contexts should be strictly avoided (Section 6).

8. No information, education or communication IEC materials promoting and condoning mothers using bottles should be utilised in training or health promotion.
ANNEX 4

CONDITIONS NEEDED TO SAFELY FORMULA FEED
(Extracted from WHO 2010 Guidelines on HIV and Infant feeding)

Mothers known to be HIV-infected should only give commercial infant formula milk as a replacement feed to their HIV-uninfected infants or infants who are of unknown HIV status when specific conditions are met:

a. safe water and sanitation are assured at the household level and in the community; and

b. the mother, or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant; and

c. the mother or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition; and

d. the mother or caregiver can, in the first six months, exclusively give infant formula milk; and

e. the family is supportive of this practice; and

f. the mother or caregiver can access health care that offers comprehensive child health services.

Example criteria for temporary or longer-term use of infant formula:
Absent or dead mother, very ill mother, relactating mother, HIV positive mother who is not breastfeeding in accordance with the country national or sub-national strategy and where breast milk substitute is considered safe (based on 2010 WHO recommendations), infant rejected by mother, infant artificially fed prior to the emergency or rape victim not wishing to breastfeed. Care should be taken that no stigma is attached to choosing to use infant formula, and that adequate resources are available to families to ensure that the conditions needed to safely formula feed for six months and as long as needed after that period (see above ‘Conditions needed to safely formula feed’). Formula should only be supported if the conditions exist for safely formula feeding.
ANNEX 5

WHO GUIDELINES ON HIV AND INFANT FEEDING, 2010

(Principles and recommendations for infant feeding in the context of HIV and a summary of evidence)

KEY POINTS

1. Infant feeding practices recommended to mothers known to be HIV-infected should support the greatest likelihood of HIV-free survival of their children and not harm the health of mothers. To achieve this, prioritisation of prevention of HIV transmission needs to be balanced with meeting the nutritional requirements and protection of infants against non-HIV morbidity and mortality.

2. National or sub-national health authorities should decide whether health services will principally counsel and support mothers known to be HIV-infected to either:
   - breastfeed and receive ARV interventions,
   or,
   - avoid all breastfeeding,

as the strategy that will most likely give infants the greatest chance of HIV-free survival. This decision should be based on international recommendations and consideration of the:
   - socio-economic and cultural contexts of the populations served by maternal and child health services;
   - availability and quality of health services;
   - local epidemiology including HIV prevalence among pregnant women; and,
   - main causes of maternal and child under-nutrition and infant and child mortality

KEY RECOMMENDATIONS

1. Mothers known to be HIV-infected should be provided with lifelong ART or ARV prophylaxis interventions to reduce HIV transmission through breastfeeding according to WHO recommendations.

2. In settings where national or sub-national authorities have decided that maternal, newborn and child health services will principally promote and support breastfeeding and ARV interventions the following recommendations apply:
   a. Mothers known to be HIV-infected (and whose infants are HIV uninfected or of unknown HIV status) should:
      - exclusively breastfeed their infants for the first six months of life,
      - introduce appropriate complementary foods thereafter, and
      - continue breastfeeding for the first 12 months of life. Breastfeeding should then only stop once a nutritionally adequate and safe diet without breast milk can be provided.
   b. Mothers known to be HIV-infected who decide to stop breastfeeding at any time should stop gradually within one month. Mothers or infants who have been receiving ARV prophylaxis should continue prophylaxis for one week after breastfeeding is fully stopped. **Stopping breastfeeding abruptly is not advisable.**
   c. When mothers known to be HIV-infected decide to stop breastfeeding at any time, infants should be provided with safe and adequate replacement feeds to enable normal growth and development.
3. Mothers known to be HIV-infected should only give commercial infant formula milk as a replacement feed to their HIV-uninfected infants or infants who are of unknown HIV status, when all the following conditions are met:
   a. safe water and sanitation are assured at the household level and in the community; and
   b. the mother, or other caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant; the mother should have no expectation that current income could reasonably be expected to decline within the coming months and
   c. the mother or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhoea and malnutrition; and
   d. the mother or caregiver can, in the first six months, exclusively give infant formula milk; and
   e. the family is supportive of this practice; and
   f. the family has reason to expect that their source of infant formula is unlikely to be disrupted during the coming months; and
   g. the mother or caregiver can access health care that offers comprehensive child health services

4. If infants and young children are known to be HIV-infected; mothers are strongly encouraged to exclusively breastfeed for the first six months of life and continue breastfeeding as per the recommendations for the general population, that is, up to two years or beyond.

5. When antiretroviral drugs (ARVs) are not (immediately) available and in contexts where the conditions for safe formula feeding (i.e. #3 above) are not all met; breastfeeding is recommended and will provide infants born to HIV-infected mothers with a greater chance of HIV-free survival. In circumstances where ARVs are unlikely to be available, such as acute emergencies, breastfeeding of HIV-exposed infants is also recommended to increase survival.
KEY REFERENCES


ACKNOWLEDGEMENTS

World Vision’s 1991 Milk Policy was revised in 2007 by Colleen Emary (then WV Canada Emergency Nutrition Advisor) and Mesfin Teklu (then WV Global Rapid Response Team), internally reviewed by Carolyn MacDonald (then WV Canada Nutrition and Health Team Leader) and Anne Peterson (then WV International Senior Health Advisor) and externally by the Interagency Infant Feeding in Emergencies Core Group chaired by Emergency Nutrition Network.

The WV Policy Governing the Procurement and Use of Milk Products in Field Programmes was updated in 2011 by Magalie Nelson, WV International (WVI) Nutrition Centre of Expertise (NCOE) Emergency Nutrition Advisor, with external contributions from Ted Greiner, Professor of Nutrition at Hanyang University, Seoul, South Korea, and internal contributions from the following WV staff:

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