Anti-racism & Localisation Community of Practice

Theme 9 - Discriminatory Supply Chains

April 2026

*We can think of **discriminatory supply chains** as the systems - from policy and manufacturing to procurement and distribution - that lead to the production, direction, and delivery of inferior or insufficient products to last-mile users in the Global South.*

Resources:

Nestlé adds sugar to infant milk sold in poorer countries. The investigation, conducted through label examination and laboratory testing, revealed that sugar and honey were added to infant milk and cereal products sold to consumers in Africa, Asia, and Latin America.

In the past, WHO research has demonstrated that **1 in 10 medical products in developing countries is substandard or falsified**. Many of these products, such as antibiotics and antimalarials, are vital for people's survival and wellbeing - especially the most vulnerable.

The article **Covid vaccine figures lay bare global inequality as global target missed** reflects on the COVID-19 pandemic as a case study in discriminatory supply chains. Despite global targets, by mid-2022, nearly three in four people (75%) in high-income nations had been fully vaccinated, while just one in seven people (14%) in low-income countries were fully vaccinated.

Key takeaways:

Below is a collection of key takeaways from community of practice (CoP) members discussing this theme in the Nutrition in Emergencies (NiE) sector, along with practical strategies to navigate these challenges. Please note, they do not necessarily represent the views of any specific organisation or the Global Nutrition Cluster. Further, we acknowledge that the resources shared and CoP discussions are currently held in English, which we acknowledge is a limitation.

1 We have known about the problem of discriminatory supply chains for a very long time. Codex and international standards exist, but some companies disregard them and take advantage of weaker legislation and consumer protections in countries in the Global South to maximise profits.

2 Members shared their experiences of COVID-19 vaccine supply chain discrimination:

- Witnessing severe delays in vaccines arriving in South Sudan. When travel resumed the "expat" staff could return home for rest and recuperation and get vaccinate, but national staff in South Sudan had to wait over a year for vaccination. Even then, insufficient quantities and short expiry dates made vaccination campaigns challenging.
- In Yemen, by 2021 COVID-19 vaccines had been administered to only 1.5% of the country. One member remarked that among humanitarian organisations these were exclusively provided for UN agency staff.

3 Ethically, countries with weak health infrastructures should have been prioritised for vaccination support during the COVID-19 pandemic – but the opposite happened.

4 Members shared their experiences with substandard or falsified medical products:

- While working in Madagascar, a member was told by another international staff member that they shouldn't stock up on anti-malarials for future work trips while in-country, because there was a higher likelihood the medicine would be ineffective; suggesting this was a known problem.
- A member recalled a conversation with a colleague who previously worked in the pharmaceutical industry in an East African country. When she placed an order for a specific medication from Europe, and there was a mix-up with the quantity ordered, the European supplier was upset because "they could only send that medication to Africa", inferring that it wasn't of sufficiently good quality to be distributed within Europe.
- Reflection on the consequences of long term eroding of confidence in health systems when medications from pharmacies and hospitals may be ineffective.
- A member shared that in the Ugandan context, people often prefer to buy the expensive European-made products, followed by products manufactured in India, before purchasing the medications produced in-country, due to issues of trust. Although it would be interesting to see if studies had been done to see if this trust is warranted.

5 A member recalled working on debris removal in the Philippines following Typhoon Yolanda/Haiyan in 2014. Their team was ordered to stop working on a site because broken asbestos[1] tiles had been detected, and removing it would be too costly (involving hazmat suits, sealing the asbestos in specialized containers, and burying them deeply at specific sites). However, they were also told that brand new asbestos tiles could be found at the local stores. At the time, Canada was the largest exporter of asbestos to the Philippines. Due to public outcry and organised campaigns, Canada banned all asbestos exports by 2018.

6 From an infant and young child feeding in emergencies perspective, in accordance with the Infant Feeding in Emergencies Operational Guidance, we aim to ensure that infants requiring infant formula have the necessary supply and support for safe feeding, while protecting and supporting breastfeeding in humanitarian settings. It is well known that infant formula manufacturers use emergencies to expand their markets.

- Nestlé intentionally adding sugar and honey to infant formula and cereal products is concerning. What is the motive for this? To get kids accustomed to sugar-sweetened foods from infancy, setting up a consumers of processed foods for life? Is it cheaper to manufacture with added sweeteners?
- The statement by Nestlé in the article made it seem like the company was hiding behind local and national policies to justify their actions.

7 Historically there have been barriers to producing medicines and nutrition products in countries in the Global South. Arguments around limited infrastructure, aflatoxin contamination, and a reliance on milk-based formulations have slowed progress towards manufacturing therapeutic nutrition products closer to affected populations. We are still working to overcome some of these barriers.

8 As a case study, here is a brief timeline of progress towards more Ready-to-use therapeutic food (RUTF) production closer to end users:

- 1996-2004 - production of RUTF was limited to France.
- 2005-2008 - first local factories opened as part of the PlumpyField Network in Ethiopia, Haiti, Niger, Malawi, and Sudan.
- 2008-2012 - continued scale-up RUTF production in India, Kenya, Ghana, USA, and the Dominican Republic.
- 2013-2016 - expansion of production to Nigeria, Bangladesh, Pakistan, Madagascar, and Burkina Faso.
- 2017-today- more than 20 countries produce RUTF.

9 Today, RUTF is considered an example of successful public private-collaboration. UNICEF is the largest purchaser of RUTF and procures RUTF from 21 suppliers globally, 18 of which are in, or near, countries with high levels of child wasting. Further, UNICEF reports that 70% of RUTF they purchase comes from countries where there are UNICEF programmes.

[1]Asbestos is a naturally-occurring resistant material that has been used widely in manufacturing and construction. However, asbestos is also considered a major global public health crisis. Globally, inhalation of asbestos fibres is causing over 200,000 deaths annually from diseases like lung cancer, mesothelioma, and asbestosis.

10 However, humanitarian organisations only receive nutrition commodities from UNICEF if they are a formal implementing partner with UNICEF. As INGOs are often favoured as implementing partners, by default local and national organisations are less likely to have access to nutrition products.

- Are we saying that local and national actors don't have the capacity to implement nutrition programming without UNICEF? Does this lead to a sort of discrimination for the affected population based on who is supporting them?

11 The WHO recommends standard RUTF (with at least 50% of protein from milk products), and does not endorse plant-based RUTF beyond research settings. Critics have advocated for the adoption of other formulations, as milk powder requires importation in many settings making local production more difficult, and can double the cost of the end product. Evidence on alternative RUTFs is expanding but remains limited, especially for milk-free formulations.

12 One member shared about their experience In South Sudan, where a group of INGOs were exploring whether RUTF could be produced in-country. The necessary infrastructure did not exist, but they wanted to learn from neighboring countries and eventually produce RUTF domestically. This has not yet been achieved, and most RUTF for South Sudan is still sourced from other countries, including neighboring Kenya.

13 We have strong evidence that RUTF works, and we want to invest in prevention to reduce children falling into SAM, but more local production and local formulations are required to reduce cost and accessibility.

14 One member shared their experience in Madagascar, where malnourished children in remote/enclaved areas were not receiving life-saving nutrition products, despite having funding for helicopter or drone transport. Some reflection on if this is a sort of geographic discrimination and how this relates to equity in NiE programming.

15 Currently, members are hearing about increased limitations on US funding. For example, that at least half of US funding must be spent on American-grown commodities including RUTF and Corn Soy Blend (CSB). This feels like moving back towards historic restrictions on only buying US-products for US-funding humanitarian operations (vehicles, electronics etc.).

16 In public health generally, we need to call out and push back on these double standards and discriminatory practices when we witness them.

17 What are our avenues for influencing and affecting change? Will it take boycotting and shaming companies, taking lessons from the strong campaigns against Apartheid South Africa?