MODULE 17
INFANT AND YOUNG CHILD FEEDING

Part 1: Fact sheet
Part 2: Technical notes
Part 3: Trainer’s guide
Part 4: Training resource list

Harmonised Training Package (HTP):
Acknowledgements
Numerous experts from many different organisations have been involved in writing the content of the HTP. Each module has been reviewed by a minimum of two reviewers from many of the academic institutions and operational agencies in the sector who have participated generously to ensure a high quality resource.

Module 17: Infant and young child feeding
Version 2 (Current):
Lead author: Astrid De Brabandere (Independent)
Marie McGrath (ENN)
Editorial oversight: Tamsin Walters (NutritionWorks)
Reviewers: Mary Lung’aho (CARE USA)
Rebecca Norton (IBFAN-GIFA)
Christiane Rudert (UNICEF) and Jane Lucas (UNICEF)

Version 1:
Lead author: Rebecca Norton (TDH)
Contributors: Carmel Dolan (NutritionWorks)
Marie McGrath (ENN) and Alison Maclaine (ENN)
Reviewers: Lida Lhotska (IFE Core Group)
Mary Lung’aho (CARE Advisor)

The HTP Version 2 (2011) was produced and published by the Emergency Nutrition Network (ENN) 32, Leopold Street, Oxford, OX4 1PX, UK. Tel: +44(0)1865 324996/324997, email: office@ennonline.net

The entire HTP is hosted on the UN Standing Committee on Nutrition (UNSCN) website http://www.unscn.org/en/gnc_htp/

For further information on the HTP Version 2, please write to Carmel Dolan, NutritionWorks (www.nutritionworks.org.uk) at cmadolan@aol.com


ISBN: 978-1-908182-00-5

The technical update of the HTP to produce Version 2 (2001) was made possible through the generous support of the American people through the Office for Disaster Assistance (OFDA) of the United States Agency for International Development (USAID) under the Agreement No. GHN-A-00-08-00001 to the Emergency Nutrition Network entitled Strengthening Capacity to Respond to Emergencies in the Food Security and Nutrition Sectors. The content does not necessarily reflect the views of USAID or the United States.

What is the HTP?

The Harmonised Training Package: Resource Material for Training on Nutrition in Emergencies (the HTP) is a comprehensive documentation of the latest technical aspects of Nutrition in Emergencies (NiE). The word Harmonised reflects the pulling together of the latest technical policy and guidance, the word Training refers to its main application and the word Package refers to the bringing together of the subject matter into one place. It is organised as a set of modules by subject, each containing technical information, training exercises and a resource list for use in training course development.

The HTP is an initiative of the IASC Global Nutrition Cluster (GNC) and has been endorsed by the GNC and its member’s agencies. In 2007, the IASC GNC commissioned the UK based partnership, NutritionWorks, to develop a training resource to facilitate capacity development in the NiE sector. HTP Version 1 was launched in 2008. HTP Version 2 update in 2010/11 was funded under an USAID OFDA grant to the UK based charity, the Emergency Nutrition Network (ENN). The update was undertaken in an ENN/NutritionWorks collaboration, with NutritionWorks responsible for overall coordination and editorial management, and editorial oversight and module production supported by the ENN.

What the HTP is not

The HTP is not a ready-to-use training course. It cannot be used as an ‘off the shelf’ package; rather, it should be used as a resource package during a process of course development by experienced trainers.

Who is the HTP for?

The HTP is a primarily a resource for trainers in the NiE sector and it can be used by individuals to increase their technical knowledge of the sector. It is designed to provide trainers from any implementing agency or academic institution with information from which to design and implement a training course according to the specific needs of the target audience, the length of time available for training and according to the training objectives. It is written in clear English and will be available in other languages in the future.

How is the HTP organised?

The HTP is organized into four sections containing a total of 21 modules which can be used as stand-alone modules or as combined modules depending on the training needs.

Section 1: Introduction and concepts

1. Introduction to nutrition in emergencies
2. The humanitarian system: Roles, responsibilities and coordination
3. Understanding malnutrition
4. Micronutrient malnutrition
5. Causes of malnutrition

Section 2: Nutrition needs assessment and analysis

7. Measuring malnutrition: Population assessment
8. Health assessment and the link with nutrition
9. Food security assessment and the link with nutrition
10. Nutrition information and surveillance systems
Section 3: Interventions to prevent and treat malnutrition

11. General food distribution
12. Management of moderate acute malnutrition
13. Management of severe acute malnutrition
14. Micronutrient interventions
15. Health interventions
16. Livelihoods interventions
17. Infant and young child feeding
18. HIV/AIDS and nutrition
19. Working with communities in emergencies

Section 4: Monitoring, evaluation and accountability

20. Monitoring and evaluation
21. Standards and accountability in humanitarian response

Each module contains 4 parts which have a specific purpose as follows:

Part 1: The Fact Sheet – provides an overview of the module’s topic and is designed for non-technical people to obtain a quick overview of the subject area.

Part 2: The Technical Notes – for trainers and trainees, provides detailed technical guidance on current policies and practice.

Part 3: The Trainers’ Guide – aims to help trainers develop a training course and provides tips and tools which can be adapted to the specific training context.

Part 4: Resources – lists of relevant available resources (including training materials) for the specific technical area.
How to use the HTP

The HTP should be used during a process of course development. The process of course development involves a number of steps and these are summarised in the diagram below.

1. Identify the needs of the target audience
2. Define the overall objectives of the training course to meet these needs
3. Decide on the length of the course
4. Decide on the number and content of the training sessions
5. Decide on the blend of theoretical content, practical exercises, field visits, and assessment methods
6. Select content from the HTP to build your course and adapt as appropriate
7. Implement and evaluate training course. Review effectiveness and revise course design as necessary
PART 1: FACT SHEET

The fact sheet is the first of four parts contained in this module. It provides an overview of infant and young child feeding in emergencies (IYCF-E). Detailed technical information is covered in Part 2. Words in italics are defined in the glossary.

Introduction

IYCF-E concerns the protection and support of optimal feeding for infants and young children in all emergencies, wherever they happen in the world. Sub-optimal IYCF practices increase vulnerability to undernutrition, disease and death. The risks are heightened in emergencies and the youngest are most vulnerable. Infants and young children in ‘exceptionally difficult circumstances,’ such as HIV prevalent populations, orphans, low birth weight (LBW) infants, those who are severely malnourished, and non-breastfed infants are particularly at risk.

Optimal IYCF practices

The unparalleled benefits of breastfeeding to the mother, child, and family as a whole are well documented and recognized. Optimal IYCF feeding practices in children 0-24 months are early breastfeeding initiation (within 1 hour of birth), exclusive breastfeeding for 6 complete months (no water, other liquids or solids with the exception of necessary supplements or medicines), continued breastfeeding for 24 months or beyond and introduction of adequate, appropriate and safe complementary foods at 6 months that continues for 2 years or beyond. Breastfeeding guarantees food and fluid security in infants for the first 6 months and provides active immune protection and remains a significant source of energy, nutrients and protection up to 2 years and beyond.

Why and for whom is infant and young child feeding important in emergencies?

Population displacement, overcrowding, food insecurity, poor water and sanitation, decreased availability of caregivers and an overburdened health care system all negatively impact on a mother’s and family’s capacity to feed and care for their young children. Risks of artificial feeding are heightened in emergency contexts. It is important to ensure that humanitarian assistance actively protects and supports IYCF capacity at individual, household and community level and does not undermine safe IYCF with inappropriate interventions, such as general distribution of infant formula, milk or milk products.

Key elements of IYCF response in emergencies

Policy guidance and frameworks

There are several key policy guidance documents to inform emergency programming. A national/agency policy framework to guide IYCF-E programming in an emergency is important. In preparedness, a national/agency IYCF-E policy that considers IYCF in the prevailing national/operational context and which reflects the provisions of the Operational Guidance on IYCF-E, should be developed/endorsed and shared.

Coordination

Early response to an emergency situation is critical and strong coordination is essential. Responsibility ultimately rests with government, yet external support may be needed. A lead coordinating body on IYCF-E should be assigned in every emergency. UNICEF is the UN agency responsible for co-ordination of IYCF-E, in close collaboration with the government. Other agencies also have key roles and responsibilities and expertise in IYCF that can support coordination. Effective IYCF-E interventions should be promoted; key policy guidance and tools should be issued to all cluster partners, possibly through an IYCF-E sub-group. A coordinated response should also include early needs assessment, identification of technical capacity and support needs among operational partners, implementation of basic interventions and ensuring prevention of inappropriate interventions. Coordination should engage across sectors and seek to engage a wide variety of agencies and ‘players.’
Communication

A key element of achieving a coordinated humanitarian response is timely, consistent and accurate communication on IYCF that speaks to different target audiences, such as mothers, caregivers, communities, those involved in the relief effort (government and humanitarian agencies), as well as press and media. Communication should be context-specific and address the concerns of the affected population, and those responding to their needs. It is important for agencies with IYCF expertise to directly engage with communications staff and the external media and monitor press releases to ensure appropriate media coverage on IYCF-E.

Assessment and monitoring

Early needs assessment in an emergency should always include key information on IYCF. Warning signs include reports from mothers on breastfeeding difficulties, lack of or poor quality complementary foods, artificial feeding commonly practised or donations of breastmilk substitutes during the relief effort. Non-breastfed infants need early identification and urgent support. Secondary data on IYCF practices provide an important context. In-depth assessments may be required to inform interventions. Standard indicators for IYCF practices should be used to enable comparisons over time and between programmes. Skilled analysis of IYCF information is important and should consider findings from broader data gathering.

Basic cross-sectoral interventions

In any emergency, simple measures or basic interventions are always needed to create a protective and supportive environment for safe and appropriate IYCF-E. They include:

- Prioritise mothers and caregivers of infants and young children with support to meet immediate essential needs such as household food, water, shelter and security.
- Register households with vulnerable groups to identify needs and help plan support.
- Establish secure and supportive places for mothers/caregivers of infants and young children to breastfeed and receive additional feeding support if needed. Referral to psychosocial services may be needed.
- Provide for the nutritional needs of pregnant and lactating women to prevent pregnancy complications, maternal mortality, LBW infants and decline in maternal nutritional status, and lower concentrations of certain nutrients in breastmilk.
- Provide safe and appropriate foods suitable for complementary feeding for children 6 months to 2 years and accompanying resources for safe preparation.
- Ensuring support for early initiation of breastfeeding for all newborn infants.
- Ensure access to basic frontline feeding support for individual mothers/caregivers and their children.
- Enable referral for skilled IYCF assistance.
- Implement behaviour change communication strategies on IYCF using multiple channels.

Skilled breastfeeding assistance

In an emergency, skilled breastfeeding assistance may be needed in the form of breastfeeding counselling. The nature of the support, where and how it is delivered will depend on the specific needs of mothers. Breastfeeding counselling involves practical, technical ‘know-how’ as well as communication skills to provide assistance to ensure that the fundamentals of good breastfeeding are in place and to resolve common difficulties. Breastfeeding counsellors may be health professionals, community health workers or peer counsellors (e.g. mothers and grandmothers) who have undertaken relevant training. Key actions include establishing safe ‘corners’ for mothers and infants that offer services such as one-to-one counselling, mother-to-mother support, information on allied services (e.g. family tracing, food aid provision), as well as advocating for services to families with young children and raising community awareness. Situations where experienced skilled support may be needed include support to LBW infants, infants who are growth-faltering or who are inappropriately fed, acutely malnourished infants under-6 months of age, relactation, and wet-nursing. Counsellors may also work alongside psychosocial and mental health services and link to closely allied services, e.g. reproductive health or child protection may offer opportunities to integrate breastfeeding support.

Complementary feeding support

A number of interventions across sectors may be needed to fully meet complementary feeding needs of children 6 to 24 months in an emergency. From the outset, it should be a priority to enable access of mothers and caregivers to adequate amounts of nutritious and appropriate complementary food. There are a variety of complementary food and fortification options in an emergency, depending on the context. Where a population is dependent on food aid, a suitable micronutrient fortified food or blanket provision of complementary food, including lipid nutrient supplements if appropriate and feasible, may be needed, accompanied with practical guidance, demonstration and monitoring on their preparation and hygiene. The use of micronutrient supplementation, including multiple micronutrient supplements and Vitamin A should be in accordance with the latest recommendations. Links with food security and livelihood programmes are important to develop access to adequate quality foods at household level.

Infant Feeding in the context of HIV

Maximising HIV-free child survival is a fundamental consideration for IYCF in the context of HIV. The term HIV-free survival affirms that everyone should work to ensure that children are not only HIV uninfected but should also survive. It is fundamentally important to communicate the concept of HIV-free
survival that considers not just the risk of HIV infection but other causes of death, such as diarrhoea and malnutrition. This is particularly relevant in emergencies, and any contexts where child mortality is high and health services lacking.

The risks of HIV transmission depends on a number of factors including breastfeeding pattern and ARV treatment. Poor breastfeeding practices increase the risks of both HIV transmission and illness in HIV-exposed infants. ARV drug interventions, either to the mother or infant, significantly reduce the risk of HIV transmission through breastfeeding.

The latest WHO (2010) guidance recommends that national or sub-national authorities should decide feeding recommendations, based on international recommendations and consideration of important national/sub-national circumstances. Specific IYCF recommendations include:

- Mothers of unknown or HIV-negative status should be supported to breastfeed as per global IYCF recommendations.
- Where the national recommendation for all HIV-infected mothers is to breastfeed, breastfeeding and ARVs should continue until 12 months. Breastfeeding should stop at 12 months if a nutritionally adequate diet without breastmilk can be provided, otherwise breastfeeding (and ARVs) should continue until such a diet is available.
- If there is a national decision to provide ARVs and promote and support breastfeeding for HIV-infected mothers, then the health worker should still recommend exclusive breastfeeding while waiting for ARVs to become available.
- If the national policy is to avoid all breastfeeding or if a mother opts out of exclusive breastfeeding, then mothers should avoid all breastfeeding and feed using industrially produced infant formula. In accordance with national guidance and depending on her circumstances, she may require infant formula supplies and her infant’s growth and health should be monitored.

In an emergency, important considerations include:

- Urgent artificial feeding assistance is needed for infants already established on replacement feeding.
- It may be appropriate to recommend that HIV-infected mothers breastfeed for longer than 12 months in the interests of child survival.
- Where national recommendation pre-emergency was to avoid breastfeeding, national authorities and/or the authority managing the emergency should establish whether this recommendation is still appropriate given the circumstances.

Management of artificial feeding

Artificial feeding is where an infant is fed with a breastmilk substitute (BMS). In some emergencies, management of artificial feeding is necessary, e.g. in a population where artificial feeding is common. Temporary or longer term use of a BMS for individual cases may also be needed in some circumstances, e.g. serious maternal illness. In some situations, groups of infants in a population may need feeding support, for example unaccompanied infants at a refugee camp or in institutional care, such as an orphanage.

Artificial feeding always carries risk but in an emergency these risks are heightened, therefore it should be a last resort where there is no safer alternative, e.g. maternal breastfeeding or wet nursing. Infants who are exclusively artificially fed in an emergency need early identification and targeted support and follow-up. Infants <6 months who are both breastfed and receive other liquids and foods require skilled assistance and support to move to exclusive breastfeeding.

Artificial feeding support in an emergency is a technical intervention that requires medical, nutritional and logistical expertise and capacity. Programmes need to monitor infants on an individual level and commit to supporting BMS supply for as long as the infant needs it (to at least 6 months of age). Several conditions on the hygiene, sustainability, feasibility of providing the artificial feeding to the child, as well as access to quality health care must be in place and supported. All the while it is important that breastfeeding is protected and supported in the population. Morbidity surveillance should be conducted at an individual and population level.

Procurement, management and distribution of BMS, milk products and feeding equipment should be strictly controlled, based on technical advice and should comply with the Code and the Operational Guidance on IYCF-E. There must be no distribution of donated/subsidised supplies of BMS in any part of the health care system. Where criteria for use of BMS are met, BMS supplies should be purchased and handled by agencies working as a part of the nutrition and health emergency response. Cups instead of feeding bottles should be used because of difficulties in cleaning bottles that increase risk of contamination.

Handling milk and milk products including donations

Milk and milk products should not be included in untargeted distributions. Donations of BMS, milk products, bottles and teats should not be sought or accepted in emergencies. Clear agency/national positions on the avoidance and management of donations should be reflected in IYCF policies. Preventive actions involve advocacy to Governments to avoid requesting donations of BMS on the lists of emergency supplies, issuing a joint statement advising no donations, preventing consignments from entering the country through involving customs, or removing the donations from distribution channels. Any
donations that do arrive should be placed under the control of a designated agency and their management determined by the assigned IYCF-E-coordinating body, including collection, planning for safe use and distribution or disposal. Disposal of donated BMS may include using it for target groups who could benefit from milk products, such as children 6-23 months or pregnant and lactating women by mixing with milled fortified staple foods or blended foods. Powdered milk should never be distributed as a separate commodity. Coordination is needed with WFP and its implementing partners and other food aid partners who may be preparing pre-mixes into which the powdered milk can be added.

Monitoring for Code violations and reporting them is an important contribution to accountability in humanitarian response. Key contacts to report violations are included in the Operational Guidance on IYCF-E.

**Orientation and training on IYCF-E**

Different levels of orientation and training on IYCF-E are needed. Most health professionals have little or no training in IYCF counselling and support. Identification and involvement of national and regional expertise should be a priority for emergency preparedness in IYCF-E.

Basic orientation on IYCF-E should be provided in preparedness for programme managers, donors, logisticians, water and sanitation experts and those in charge of social services. Service providers (such as health workers, community workers, lactation counsellors) need to be trained on IYCF counselling, skilled support and communication. Integrating training on IYCF-E into professional pre-service and in-service training of key medical and health staff and community workers is also an important preparedness activity.

**Key messages**

1. Early initiation of breastfeeding, exclusive breastfeeding for six months, with timely and appropriate complementary feeding from six months, and continued breastfeeding until two years of age or beyond optimises survival, health, nutrition, growth and development of children in all situations, including emergencies.

2. Infants and young children in exceptionally difficult circumstances, such as HIV prevalent populations, orphans, LBW infants, non-breastfed infants, and those severely malnourished, warrant particular attention.

3. The nutritional, physical and mental health of pregnant women and of breastfeeding mothers is central to the well-being of their children.

4. The prevailing IYCF practices of an emergency affected population and the key influences on these should inform the IYCF-E response.

5. Key policy guidance includes the Operational Guidance on IYCF-E and the Code. Both are endorsed in World Health Assembly Resolutions.

6. A timely, appropriate response on IYCF relies on policy development and implementation, coordination, strong communication and advocacy, assessment and monitoring, technical capacity and resources.

7. Emergency preparedness is essential. The presence of a comprehensive, at-scale IYCF programme with available cohorts of trained and skilled health providers and community cadres positions a country better to address IYCF in emergencies. IYCF-E should always be well reflected in a country’s emergency preparedness and response plan.

8. IYCF-E involves enabling access to basic multi-sectoral services (such as shelter, security, access to adequate household food, water, non-food items), integrating IYCF support into services that target mothers, infants and young children, providing appropriate frontline feeding assistance to mothers and caregivers with young children, and undertaking targeted technical interventions when needed.

9. Skilled breastfeeding support is an important emergency intervention.

10. Consideration of complementary feeding needs that includes enabling access to adequate amounts of appropriate complementary foods and the means to safely prepare them is always needed. Fortified foods and micronutrient supplements may be necessary to meet nutritional requirements.

11. Artificial feeding in an emergency requires skilled management to minimise the risks in accordance with provisions of the Operational Guidance on IYCF-E and the Code. Non-breastfed infants are especially at risk and need early identification.

12. Milk and milk products should not be included in untargeted distributions. Powdered milk should never be distributed as a single commodity. Donated breastmilk substitutes, bottles and teats should not be sought or accepted in emergencies.
PART 2: TECHNICAL NOTES

The technical notes are the second of four parts contained in this module. They provide information on infant and young child feeding in emergencies (IYCF-E). The technical notes are intended for people involved in nutrition programme planning and implementation as well as all other actors in emergencies. They provide recommendations, technical details, highlight challenging areas and provide clear guidance on accepted current practices. Words in italics are defined in the glossary.

Summary
This module is about infant and young child feeding in emergencies (IYCF-E). IYCF-E is concerned with emergency preparedness and a timely and appropriate humanitarian response with the goal of safeguarding the survival, nutrition, health, growth and development of infants and young children and their mothers. Policy development and implementation, coordination, communication, assessment, monitoring, and capacity development in the context of IYCF are considered. The contribution of basic interventions and multi-sectoral roles and responsibilities to protect and support optimal IYCF-E are explored. Support for breastfeeding, complementary feeding and management of artificial feeding are considered specifically. The module deals briefly with infant feeding in the HIV context and management of severe acute malnutrition in infants. The module reflects the provisions of the 2003 WHO/UNICEF Global Strategy on Infant and Young Child Feeding, the Operational Guidance on IYCF-E and the International Code of Marketing of Breastmilk Substitutes (BMS) and subsequent relevant World Health Assembly (WHA) resolutions (collectively known as the Code).

These technical notes are based on the following references and Sphere standards in the box below:


Introduction
IYCF-E response is concerned with interventions to protect, promote and support safe and appropriate (recommended) feeding practices for both breastfed and non-breastfed infants and young children in all emergencies wherever they happen in the world. Enabling recommended IYCF practices are key preparedness and response activities to maximise nutrition, health and development and minimise malnutrition, morbidity and mortality of children under 5 years in emergencies. IYCF-E centres on protecting, promoting and supporting optimal IYCF practices, and minimising the risks associated with risky practices that exist.
**Key messages**

1. Early initiation of breastfeeding, **exclusive breastfeeding** for six months, with timely and appropriate complementary feeding from six months, and **continued breastfeeding** until two years of age and beyond optimizes survival, nutrition, health, growth and development of children in all situations, including emergencies.

2. Infants and young children in exceptionally difficult circumstances, such as HIV-affected populations, orphans, low birth weight (LBW) infants, non-breastfed infants, and those severely malnourished, warrant particular attention.

3. The nutritional, physical and mental health of pregnant women and of breastfeeding mothers is central to the well-being of their children.

4. The prevailing IYCF practices of an emergency affected population should inform the IYCF-E response.

5. Relevant policy guidance includes the Operational Guidance on IYCF-E and the Code. Both are endorsed in World Health Assembly Resolutions.

6. A timely, appropriate response on IYCF relies on policy development and implementation, coordination, strong communication and advocacy, assessment and monitoring, technical capacity and resources. Emergency preparedness is essential.

7. IYCF-E involves implementing basic measures (such as providing shelter, security, access to adequate household food and water, non-food items), integrating IYFC support into services that target mothers, infants and young children and providing appropriate frontline assistance to mothers and caregivers with young children in the early response.

8. Basic breastfeeding assistance and more skilled breastfeeding counselling support may be needed as an intervention.

9. Appropriate complementary foods should be included in the general ration in food aid dependent populations, and access enabled to populations in receipt of food security/livelihood support.

10. Any artificial feeding in an emergency requires skilled management to minimize the risks in accordance with provisions of the Operational Guidance on IYCF-E and the Code. Non-breastfed infants are especially at risk and need early identification and targeted support.

---

**The burden of malnutrition and disease**

Maternal and child undernutrition accounts for 35% of child deaths worldwide. The youngest children are most vulnerable, especially children under five years. **Diarrhoea** and **pneumonia** are the most significant infections causing death, accounting for about 20% each. Nearly 70% of under five deaths occur in the first year of life and 38% of under one year deaths occur in the first months of life (see Module 15: Priority health interventions that impact nutrition status in emergencies).

**What is the impact of IYCF practices on child health?**

The way an infant or young child is fed has a large impact on their vulnerability to disease, malnutrition and death. Infants who are not breastfed are especially at risk.

- Breastfeeding could reduce child mortality in children under-5 by 12% to 20%, more than any other preventative measure.
- Complementary feeding also features the top three interventions for preventing deaths under 5 years – a further 6% of deaths could be prevented.
- Early initiation of breastfeeding significantly reduces the risk of **neonatal death** (death in the first four weeks).
- A non-breastfed infant living in disease-ridden and unhygienic conditions is between six and 25 times more likely to die of diarrhoea than a breastfed infant.

---

### Sphere standard

#### Infant and young child feeding standard 1: Policy guidance and coordination

Safe and appropriate infant and young child feeding for the population is protected through implementation of key policy guidance.

**Key actions**

- Uphold the provisions of the Operational Guidance on infant feeding in emergencies (IYCF-E) and the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions (collectively known as the Code).
- Avoid soliciting or accepting donations of BMS, other milk products, bottles, and teats.

**Key indicators**

- A national and/or agency policy is in place that addresses IYCF and reflects the Operational Guidance on IYCF-E
- A lead coordinating body on IYCF is designated in every emergency.
- A body to deal with any donations of breastmilk substitutes, milk products, bottles and teats is designated
- Code violations are monitored and reported

#### Infant and young child feeding standard 2: Basic and skilled support

Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks and optimises nutrition, health and survival outcomes.

**Key actions**

- Undertake integrated multi-sector interventions to protect and support safe and appropriate IYCF.
- Give priority to pregnant and breastfeeding women to access food/cash/voucher transfers and other supportive interventions.
- Integrate skilled breastfeeding counselling in interventions that target pregnant and breastfeeding women and children 0-24 months.
- Target mothers of all newborns with support for early initiation of exclusive breastfeeding.
- Support timely, safe, adequate and appropriate complementary feeding.
- Enable access for mothers and caregivers whose infants require artificial feeding to an adequate amount of an appropriate BMS and associated support.
- Give special consideration to feeding support of infants and young children in exceptionally difficult circumstances (orphans, acutely malnourished, LBW infants and those affected by HIV).

**Key indicators**

- Measurement of standard WHO indicators for early initiation of breastfeeding, exclusive breastfeeding rate in children <6 months, and continued breastfeeding rate at 1 and 2 years
- Caregivers have access to timely and appropriate, nutritionally adequate and safe complementary foods for children 6 to <24 months
- Breastfeeding mothers have access to skilled breastfeeding support
- There is access to Code-compliant supplies of appropriate BMS and associated support for infants that require artificial feeding


---

- A collaborative study by the World Health Organisation (WHO) showed that not being breastfed in less developed countries increases the risk of mortality (death) by six times in infants less than two months old. Even between 9 and 11 months the risk is increased by 40 per cent.¹⁰

In March 1991, 500,000 Kurds fled Iraq towards Turkey and were stranded in the mountains between the two countries. Despite the fact that the population was healthy prior to displacement, relief efforts were prompt and the acute phase of the emergency lasted only a few months, there were high mortality rates. Two thirds of all deaths occurred in children under five years and half among children under a year. An estimated 12% of all infants died during the first two months of the crisis. Most deaths were due to diarrhoea, dehydration, and resulting malnutrition. In Leda refugee camp for Burmese refugees, Bangladesh 1978-79, over a 10 month period it was estimated that 53% of children under one year and 30% of children between one and four years died. The primary cause of death was diarrhoea. During conflict in the eastern Democratic Republic of Congo, 2001 under one year mortality was an average of 26% over five regions. It was estimated that 75% of children in two of these regions had died before their second birthday. Deaths were primarily due to malnutrition, febrile illness (thought to be malaria), respiratory disease and measles. In post-conflict Guinea Bissau (1998), non-breastfed children aged 9-20 months old were 6 times more likely to have died during the first three months of the war compared with children still breastfeeding. Before the conflict, there was no difference in mortality between breastfed and non-breastfed children.

Why does infant and young child feeding need particular attention in emergencies?

In emergencies, although the causes of death remain the same as in non-emergency situations, mortality rates are often greatly elevated – up to 67 times higher than average. A significant proportion of infants may be affected; published total mortality rates for children under a year of age in emergencies range from 12% to 53%.

In many contexts, sub-optimal infant and young child feeding practices, coupled with maternal undernutrition, continue to contribute to the global burden of malnutrition, childhood illness and death and compromise child nutrition, health and development. The consequences of inappropriate infant and young child practices will be greatest in the most resource poor contexts. Unfortunately, it is also in these contexts that the most emergencies take place, placing an additional burden on already vulnerable children and caregivers.

Recommended IYCF practices

Global recommendations for infant and young child feeding practices maximise nutrition, health and development and minimise malnutrition, morbidity and mortality (see Box 1). Recommended IYCF practices are the same in emergency and non-emergency situations.

---

INFANT AND YOUNG CHILD FEEDING

Box 2: Recommended IYCF Practices

Early initiation of breastfeeding: introducing breastfeeding within one hour of birth

Exclusive breastfeeding: an infant receives only breast milk for the first 6 months of life and no other liquids or solids, not even water, with the exception of prescribed vitamins, mineral supplements or medicines.

Continued breastfeeding: sustaining breastfeeding to two years of age or beyond.

Complementary feeding: age-appropriate, adequate and safe solid or semi-solid food is provided in addition to breast-milk. The complementary feeding period extends from six months to two years of age.

Appropriate complementary foods are those that provide sufficient energy, protein and micronutrients through adequate amount, consistency and diversity to meet the child's growing nutritional needs.

From 0 up to 6 months breast milk, supplies all the 'energy needs' of a child.

From 6 up to 12 months, breast milk continues to supply about half the 'energy needs' of a child; the other half of 'energy needs' must be filled with complementary foods.

From 12 up to 24 months, breast milk continues to supply about one third of the energy needs of a child, the missing 'energy needs' must be filled with complementary foods.

Besides nutrition, breastfeeding continues to provide protection to the child against many illnesses, and provides closeness, comfort, and contact that help development.

See Annex 1 for more information on age-appropriate feeding for 0 to 2 years.

- Complementary feeding is a critical aspect of child nutrition, development and growth. This is a vulnerable time in a child's life. Prevailing complementary feeding practices may not be optimal. In an emergency, complementary foods may be lacking, breastfeeding may not be continued, a mother's time and capacity to care for her child insufficient, and the environment for food preparation and storage unsafe. The provision of adequate food for children is a complex activity being subject to political, psycho-social, cultural, economic, and commercial forces.

- It is important to ensure that humanitarian assistance does not undermine safe IYCF. Inappropriate interventions, such as general distribution of infant formula, milk or milk products, can reinforce risky practices and lead to early and unnecessary cessation or reduction of breastfeeding. It requires strong coordination and multi-sectoral cooperation to meet the obligation to infants and young children and their families to 'do no harm'.

- Good IYCF interventions can have positive longer term impact. A strong intervention in an emergency can be a catalyst for improvement and change in prevailing IYCF practices. For example, interventions around breastfeeding support in Indonesia post-earthquake were found to strengthen the national programming on breastfeeding.

Policy guidance relevant to IYCF-E

Global policy guidance and frameworks exist that are relevant to IYCF-E. Some of the key documents and considerations are:

WHO/UNICEF Global Strategy on Infant and Young Child Feeding

The WHO/UNICEF Global Strategy on Infant and Young Child Feeding, adopted by the World Health Assembly in 2002, calls for appropriate feeding support for infants and young children in exceptionally difficult circumstances including emergencies and the development of the knowledge and skills base of health workers working with caregivers and children in such situations. The Global Strategy identifies the obligations and responsibilities of governments, organisations, and other concerned parties to ensure the fulfilment of the right of children to the highest attainable standard of health and the right of women to full and unbiased information about infant feeding and adequate health and nutrition.

20 Resolution WHA54.2, 18 May 2002.
The International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions (the Code)

The International Code of Marketing of Breastmilk Substitutes was adopted by the World Health Assembly (WHA) (the governing body of the World Health Organisation) in Resolution 34.22 in 1981. The 1981 Resolution and subsequent relevant WHA Resolutions are collectively referred to as ‘the Code’. All provisions of the Code apply in emergencies and some parts are specific to emergencies, e.g. WHA 47.5 (1994).

The Code is intended to protect the mothers/caregivers of both breastfed and non-breastfed infants and young children from commercial influences on their infant feeding choices. The Code sets out the responsibilities of the infant food industry, health workers, governments and organisations in relation to the marketing of breastmilk substitutes, feeding bottles and teats. The Code does not ban the use of infant formula or bottles but controls how they are produced, packaged, promoted and provided.

Adoption of and adherence to the Code is a minimum requirement. All Member States are called upon to support the implementation of the entire provisions of the Code (WHA 34.22). Governments are strongly advised to take legislative measures to implement the Code. At least 48 countries have national legislation based on the Code. However companies have to comply with the Code independently of any other measure taken (Article 11.3 of the Code).

Worldwide, ‘typical’ violators of the Code are the companies who produce these products (see www.ibfan.org ‘Breaking the Rules’ reports). National legislation, when in place and enforced, strengthens the capacity to meet the provisions of the Code as it allows for a legal recourse when violations of the Code take place (see www.ibfan.org, State of the Code by Country reports). The Code implementation is an important emergency preparedness activity at national level. Code violations are frequent in emergency situations.

Operational Guidance on IYCF-E

The Operational Guidance on IYCF-E was developed and is managed by an interagency collaboration (IYCF-E Core Group) to help those concerned with emergency response to meet their responsibilities to infants and young children and their caregivers in emergencies. It is a practical reflection of key policy and strategies, including the WHO Guiding principles for feeding infants and young children during emergencies, the UNICEF/WHO Global Strategy and the Code. The Operational Guidance on IYCF-E was endorsed by the WHA 43.23 (2010). The provisions of the Operational Guidance on IYCF-E have informed the Sphere IYCF Standards (2011) and the content of this module. It is currently available in 13 languages.

IYCF response in emergencies

Target group of children: All children under 5 years, and especially under 2 years, require protection and support of optimal IYCF. Infants and young children in exceptionally difficult circumstances, such as HIV-affected populations, orphans, LBW infants, non-breastfed infants and those who are severely malnourished, warrant particular attention.

Target women and caregivers: Protection and support of the nutritional, physical and mental health of both pregnant and breastfeeding women is central to the well-being of the mother and child. Female single-headed households warrant particular attention. The particular needs of caregivers who are grandparents, single fathers or siblings must also be considered.

Needs assessment: Timely implementation of basic interventions on IYCF-E should be informed by early needs assessment to establish the particular IYCF characteristics of the affected population, identify urgent needs and priority areas to support. Further assessment and ongoing monitoring may be needed.

Enabling and supportive environment for safe and appropriate IYCF: Multi-sectoral collaboration, coordination and preparedness at national and agency level is needed to meet the broader nutritional and care needs of infants and young children and their mothers. Key sectors are reproductive health, child protection, water and sanitation, food security, logistics and psychosocial support. More technical IYCF interventions may be needed such as breastfeeding counselling support, artificial feeding interventions, and complementary feeding interventions.

22 Breastmilk substitutes are defined by the Code as ‘any food being marketed or otherwise represented as a partial or total replacement of breastmilk, whether or not suitable for that purpose’. In practice, this means any product promoted for use in an infant under six months of age or as a replacement for breastmilk from six months of age to 2 years or beyond.
24 www.enronline.net/IYCF-E. List members
Infant and young child feeding

MODULE 17
TECHNICAL NOTES

Box 3: Importance of Policy in IYCF-E Response

During a country situation analysis by teams from the 16 countries participating in a regional workshop on IYCF-E in Bali, lack of a policy on IYCF or poor implementation of an existing policy was ranked as a constraint to effective IYCF-E response by 11 out of 16 countries (Making it Happen Bali report, 2007). Follow-up with participants six months after the IYCF-E workshop revealed that policy development was a priority area that they took action on: half of respondents had completed or were in progress on a national IYCF-E policy, and three quarters of respondents (8/11) were working on dissemination of policy and guidance.26

Box 4: Examples of violations of the Code in Emergencies

**Indonesia**

In Java, during the tsunami response, a foreign government donated six cartons (12 tins per carton) of formula for 6-12 month olds, labelled only in a foreign language (violation article 9.2)

In Java, post-earthquake donations were received by the Provincial Health Office directly from the company manufacturer (violation article 5.2)

In Bantul, an International NGO distributed boxes including infant formula to local health workers (Violations WHA resolution 47.5)

In Pundong, boxes of food supplies including infant formula were distributed to families even with no children, as part of the general ration (violation article 6.6)

In Jedis, infant formula was distributed as incentive/reward for partaking in a measles and tetanus vaccination campaign (violation article 6.2)

**Lebanon**

Foreign governments donated formula to the Lebanese government’s aid organisation – the Higher Relief Commission (HRC) – that was not labelled in Arabic (violation article 9.2)

Tins of formula milk donated and imported by NGOs were in a foreign language (violation article 9.2)


Indirect influences on IYCF. Those who do not deal directly with infant feeding may also be confronted with issues associated with feeding infants and young children, or may take action that impacts on IYCF-E. For example, logisticians may be asked to transport unsolicited donations of infant formula or powdered milk to the emergency area. Those designing food rations may have the option of including milk powder. Those involved in camp management will influence mothers’ access to resources or availability of safe spaces for mothers and children. Communications officers may provide information to the media about what sort of aid babies and young children need. It is important that staff who may indirectly impact on IYCF are aware of the importance of considering IYCF in their programming, and that actions are appropriate.

Key considerations in IYCF-E preparedness and response are reflected in the following sections of this module.

The importance of national and agency IYCF-E policy

Governments and agencies should develop or endorse an IYCF policy that sets out what they aim to do and who is responsible for doing it in the context of an emergency. This should clearly state roles and responsibilities. Specific considerations should include breastfeeding, complementary feeding, artificial feeding management, and compliance with the Code. Integrating key elements of IYCF-E into existing policies, such as emergency preparedness plans or national IYCF policies, and into operational procedures and guidelines for emergencies, should increase the chances of implementation. A communication strategy for policy is important.

The importance of policy development in IYCF response was highlighted in a regional workshop on IYCF-E preparedness and response in Bali in 2008 (see box 3). Many countries still lack a comprehensive IYCF policy that includes infant feeding in emergencies, highlighting that IYCF-E is not a priority in many contexts.27 See Module 21 Standards and Accountability in Aid Response for indicators to monitor international policy implementation and key infant and young child feeding indicators.

Monitoring for Code violations and reporting them is an important contribution to accountability in humanitarian response. There are many examples of Code violations in emergencies (see Box 4 and sections below). Many Code violations relate to donations made to emergencies (see section “Managing artificial feeding in emergencies” on page 36). A simple Code monitoring form can be used to monitor for violations in emergencies.28 Key contacts to report violations are included in the Operational Guidance on IYCF-E.

The importance of good IYCF-E coordination

The strength of coordination on IYCF-E is a key determinant of how timely, appropriate and effective the IYCF-E response is. Good coordination during the early response is critical to protecting and supporting safe and appropriate IYCF-E. The first days and weeks of an emergency is when international response may depend on a country, donations of BMS will arrive, mothers present with feeding difficulties, infants are orphaned and press content calls for aid.

The responsibility for emergency response ultimately rests with government. Establishing IYCF coordination leads and key decision makers at national level is part of preparedness. External support to coordination may be needed, depending on the context and capacity. Reflecting UNICEF’s Core Commitments to Children29 and as lead agency for the Global Nutrition Cluster, UNICEF is the likely UN agency responsible for co-ordination of IYCF, in close collaboration with the government. Other UN agencies also have key roles and responsibilities towards IYCF. For example, the WHO’s lead role in health should facilitate integrated IYCF in health and malnutrition treatment services. WFP should prioritise the complementary food needs of target populations. In addition, many NGOs have developed specific expertise and accumulated experiences on IYCF that can support coordination as well as programming.

Coordination may involve dissemination of key policy guidance and issuing of joint statements, early needs assessment, identification of technical capacity and support needs among operational partners, implementation of basic interventions, and ensuring appropriate interventions are implemented to meet assessed needs. Plans to prevent donations of BMS, milk products, bottles and to handle any that do arrive should be in place.

Coordination should engage across sectors as well as with those who may be operating outside established humanitarian coordination mechanisms (for example, international military, the private sector, civil society groups). Coordination on IYCF-E needs also to happen within agencies. For example, agreement on how best to achieve integrated programming that involves different sectors within an agency, e.g. nutrition and child protection, or nutrition and water, sanitation and hygiene (WASH).

Joint statements on IYCF-E have been effectively used in emergencies to help coordinate response by national governments and agencies in a specific emergency context, to bring attention to specific IYCF issues, to provide official advice to agencies including donors, the general public and the media in a specific emergency context, and to point to key policies and guidance materials. Joint statements are generally issued by the coordinating agency and/or group of agencies. Endorsement of the statement by the national government can help to reinforce the contents within the country. To facilitate consistency and rapid release of joint statements in emergencies, in 2008 a model joint statement was produced by participants of a regional IYCF-E workshop in Indonesia and has been used in subsequent emergencies (see Annex 5).

The importance of timely, consistent and accurate communication

Timely, consistent and accurate communication that speaks to different target audiences and addresses the concerns of the affected population, and those responding to their needs is needed in emergencies.

Communication to mothers, caregivers, and communities

Mothers, caregivers and the community are key targets for key messages that promote optimal IYCF practices, and address any specific concerns or myths in a given context. Also consider addressing influential people in the community like grandparents, local leaders and religious leaders about safe and appropriate infant and young child feeding. The negative impact of stress on breastfeeding is a common concern in some emergency contexts. Sample messages that have been used in emergencies to address this and other concerns and myths are included in Annex 6). Translation and field testing of mes-

---

27 The IBFAN World Breastfeeding Trends Initiative (WBTI) – a participatory civil society initiative to track country progress in implementation of Global Strategy on infant and young child feeding – revealed in the 2010 33 country report that “only 8 out of the 33 countries reviewed have a comprehensive policy on IYCF that includes infant feeding in emergencies and IFE is not a priority in most countries”. The indicator for IFE in WBTI is “the country has a comprehensive policy on IYCF that includes IFE”. WBTI 33 country report. http://www.worldbreastfeedingtrends.org/

28 IBFAN Code Monitoring form (see Part 4 Resources).

29 Core Commitments to Children.
Case Example 1: Breastfeeding poster developed by and for mothers during the Indonesia 2006 earthquake response

Urgent action was needed to reduce the use of widespread donations of infant formula by breastfeeding women. UNICEF developed posters and radio/TV spots using community focus groups. Mothers gave a low score for conventional posters showing a mother and child happily breastfeeding. They said they had seen such posters all their life, including on packets of infant formula, and that they didn’t demonstrate the potential harmful effects of infant formula. The community reacted well to an image that emphasised the cost of artificial feeding. Mothers realised their reliance on donations made their breastmilk stop and once the donations stopped, they would need to buy more formula.

Source: Field Exchange 34

Engagement with the press and media

It is important to engage with the press/media to ensure IYCF-E information and calls for aid in the media are accurate and appropriate. The general press relies heavily on the press releases of UN agencies and NGOs for the content of their own communication. Agency communication/media/press departments can have a key influence on messages in the general media. Building relationships with the media – internally and externally – is a good emergency preparedness activity. Guidance exists on communication for the media on IYCF in emergencies (see Annex 12), such as what messages and stories to include in press releases and the reasons why.

The importance of assessment

In an emergency, initial or early rapid assessments are used to guide the early planning of urgent humanitarian interventions, identify needs for follow up assessments, and inform initial funding decisions. Initial rapid assessment tends to be multi-sectoral. They may be followed by more in-depth assessments and surveys (see Modules 7 and 8 on Nutrition and Health Assessment).

Initial or early rapid assessment on IYCF-E combines multi-sectoral information and specific IYCF information to enable a rapid analysis of the situation with regard to IYCF. It involves collating and analysing secondary data, background information and primary data. Specific IYCF information should always be gathered in initial rapid assessment in an emergency. Assessment teams should include at least one person who has received basic orientation on IYCF. Data should be analysed by those with expertise on IYCF to determine next steps, and results shared through the co-ordinating body.

Initial rapid assessment may indicate the need for more detailed assessment of the IYCF situation. This may be undertaken as ‘standalone’ IYCF-E assessments, or incorporated into other assessments, e.g. nutrition surveys, reproductive health surveys. It is important that standard indicators and methods of data collection and careful determination of child age are used when collecting data on IYCF practices (see resources for guidance). Expertise will be needed to guide on sampling, methodology, data analysis and to inform development of any necessary interventions.

Even if there is no immediate cause for concern, ongoing monitoring is needed to watch the IYCF situation, and to monitor the effectiveness of the emergency response and interventions. Both process or performance indicators and outcome indicators may be used.

See case example 2 for an example of IYCF assessment informing interventions in Haiti.

---

Box 5: Example IYCF Questions in Initial Rapid Assessment

Note: These questions are appropriate in a context where breastmilk substitutes may be used in the population and there is a suspicion that they may feature in the emergency response.

Q.1 Has infant formula (dried or ready to use) or other milk products (e.g., dried whole, semi-skimmed or skimmed milk powder, ready to use milk) and/or baby bottles/teats been distributed since the emergency started? If yes, by whom?

Why is this question useful? It is important to investigate if products are circulating that may be used as a BMS and expose infants to increased risk. Investigation of the spectrum of milk products (not just infant formula) that may be distributed is relevant too. If any products are marketed or represented as a breastmilk substitute, then they will fall under the scope of the Code.

Q.2 Estimate what percentage of infants 0-<6months old and 6-<12months old are not breastfed?

Compare with pre-emergency assessment.

Why is this question useful? Infants under six months are most vulnerable in an emergency if they are not breastfed. If a proportion of infants under six months are not breastfed, then they will need urgent identification and support with further more detailed assessment of the situation. Older infants are also vulnerable in an emergency, if they are not breastfed.

Q.3 Has the community/health staff/parents/caregivers identified any problems in feeding children <2 years since the crisis started? If yes, what problems have been reported?

Why is this question useful? This will help determine what are the immediate problems faced in feeding infants and young children, to inform early assistance in an emergency.

Q.4 Since the emergency, what foods are most commonly fed to children 6-24 months of age?

Why is this question useful? Inadequate complementary feeding increases the risk of malnutrition and illness in children. This information can be used to investigate whether basic food needs are being met and to inform decisions about complementary feeding interventions.

Q.5 What are the priorities expressed by parents and caregivers regarding infant and young child feeding?

Why is this question useful? Understanding what the family priorities are to meet the immediate feeding needs can be used to inform early assistance.

Secondary IYCF data and background information

Secondary data review helps build the picture of the population in the current crisis and informs the collection and interpretation of primary data. Ideally it is done in emergency-preparedness pre-crisis. Typical sources of IYCF data are large surveys and assessments carried out pre-emergency, e.g. Demographic Health Survey (DHS), Multiple Indicator Cluster Surveys (MICS). Key data to gather includes:

- Exclusive breastfeeding rates in 0-<6 month old infants in the population pre-emergency
- Pre-crisis rates of initiation of breastfeeding in newborn infants
- Proportion of infants or groups of infants that were not breastfed pre-emergency
- Proportion of infants who are mixed fed (breastfeeding combined with other fluids or foods, including breastmilk substitutes)
- Common complementary feeding practices
- Continued breastfeeding at 1 year and 2 years of age.

Background information should include:

- Resources available to support IYCF-E programming, e.g. availability of skilled breastfeeding counsellors locally or nationally who could be mobilised to support breastfeeding
- Availability of local appropriate (energy and nutrient dense) foods for complementary feeding of children 6-24 months of age.
- Institutional factors, such as legislative status of the Code or existing national IYCF policies.

Primary IYCF data collection

Primary data collection involves gathering information directly from key informants such as mothers and caregivers of children <2 years, government staff (Ministry of Health (MOH)/ Maternal and Child Health (MCH), etc.), UN/NGOs working in humanitarian response, health facility staff, and direct observations.

Box 5 gives examples of IYCF questions to include in a multi-sectoral initial rapid assessment and the rationale. IYCF assessment should be context specific. Adaptation of standard assessment tools that exist may be needed to reflect specific concerns or contexts.
Case Example 2: Initial rapid assessment informing interventions in Haiti 2010

Following the massive earthquake that struck Haiti in January 2010, there was an urgent need to understand the types and causes of malnutrition that were present before; how and among which population groups the earthquake was likely to increase vulnerability and the type of response required. This was particularly important due to the overwhelming scale, rapid onset and unique urban context of the emergency.

At the time of the earthquake, the most recent nutrition assessments available came from the 2005 DHS and an Action Contre la Faim (ACF) survey in 2008/09. There was general agreement that the prevalence of acute malnutrition could rapidly escalate given the poor food security and hygiene conditions, and as a result, services for the community-based management of acute malnutrition (CMAM) were scaled up. It was also agreed, however, that one of the greatest risks to nutritional status and child survival was poor infant feeding practices.

While breastfeeding was the norm in Haiti, exclusive breastfeeding was not widely practiced. Before the earthquake, only 40% of infants under six months were exclusively breastfed (DHS 2005) this rate was only 22% in Port-au-Prince (Enquêtes nutritionnelle 2007-2009 Action Contre la Faim).

Based on this understanding of the situation pre-earthquake and the danger posed by the deterioration in the hygiene environment post-earthquake, infant feeding support in the form of ‘baby tents’ were established across the city. Here, individual infant feeding assessment, counselling and where necessary, controlled infant formula and the necessary supports were provided.

Subsequent evaluation found that project outcomes, such as exclusive breastfeeding rates, diarrhoea, malnutrition rates and mortality rates, were very encouraging. All data suggested that positive behaviour change had taken place that will even benefit future generations.

Source: Concern Worldwide 2011

Warning signs
Early IYCF assessment information is especially looking for factors that indicate that infants and young children are at increased and significant risk, and that warrant further investigation. Here are some of the warning signs:

- General distribution of infant formula and milk products, and/or bottles and teats
- Mothers reporting difficulties in breastfeeding or stopping breastfeeding due to the crisis situation.
- Reports of infants under 6 months who are not breastfed
- Reports of increased diarrhoea in infants under 12 months
- Poor availability of food for complementary feeding in the markets/food aid provided.
- Mothers reporting difficulties feeding their children.

In secondary data and background information, be alert for:

- Low exclusive breastfeeding rates in the population pre-emergency (e.g. <25% exclusive breastfeeding)
- Low initiation of breastfeeding rates in the population pre-emergency (e.g. < 75% initiation of breastfeeding)
- Low mean duration of breastfeeding
- Low breastfeeding rates at one year
- Artificial feeding practice pre-emergency
- Risky complementary feeding practices (e.g. early or late introduction of complementary foods, poor quality complementary foods)
- Use of baby bottles for feeding infants
- Legal status of the Code in the country, and history of Code violations in the country

Common concerns around IYCF
Many people may have heard that breastfeeding is difficult, especially in emergency situations. Some of these concerns are based on experience and some are deeply held but mistaken beliefs. Some may be held by mothers or their peers, others may be preconceptions by national and international health workers. Some mothers need specialist support to reinforce their confidence and capacity to breastfeed.

Here are some important common concerns and the information to help address them:

“Stress prevents mothers from producing milk.”
Stress does not prevent milk production but it may slow the release of milk from the breasts. This can result in babies being ‘fussy’ when breastfeeding. Mothers and aid workers may think that there is not enough breastmilk. Frequent breastfeeding will help the mother and baby to get over this and ensure the baby receives enough. Reassuring support will decrease a mother’s stress and increase her confidence.
‘Malnourished mothers cannot breastfeed.’
Malnourished mothers can breastfeed. However they should be provided with extra food and fluids to rebuild their own nutrient stores and be encouraged to breastfeed the infant very frequently. Moderate malnutrition has little or no effect on milk production. In fact the mother will continue to produce milk, even to the detriment of her own wellbeing. Milk production is only likely to be reduced if a woman is severely malnourished; then the woman herself would need immediate feeding/extra food while continuing breastfeeding. “Feed the mother and let her feed the baby” is the key approach.

“The mother thinks she is not producing enough milk to feed her baby.”
A mother produces enough milk to feed her baby if she breastfeeds frequently and for as long as the baby wants at each feed. Her breasts may seem soft and ‘empty’ but they are producing milk.

“HIV-infected mothers should not breastfeed their baby”
Even though there is a chance of transmission from mother to child through the breast milk, the risk is greater during pregnancy and birth. A mother who receives ARVs and who exclusively breastfeeds in the first six months significantly reduces the risk of transmission. This risk must be balanced with the risk of disease, malnutrition and death through unsafe or inadequate use of artificial milk. If social and environmental conditions for replacement feeding are not met, breastfeeding offers a much better chance of survival for the child. See the section on HIV and infant feeding and Module 18 on HIV/AIDS and nutrition.

Basic interventions

Registration of vulnerable groups
Registration of vulnerable groups will help to identify needs and plan support. Steps to take include:

- Register mothers of all newborn infants within 2 weeks of delivery, to ensure timely access to additional household food entitlement for the breastfeeding mother, as well as for extra breastfeeding support if needed
- Register vulnerable groups such as orphans, pregnant women, single-headed households with children under 2 years, to ensure access to essential services.
- Record demographic breakdown at registration of children under 2 years with specific age categories: 0 to 6 months, 6 to 12 months, 12 to 24 months and children aged 24 to 60 months, as well as pregnant women
- Register infants who are not breastfed, who will need urgent assistance (see later).

Meeting immediate essential needs
Steps that can be taken to prioritise the basic needs of mothers and infants and young children include:

- Arrange rest stops and arrival areas, with private areas for breastfeeding if needed, for populations in transit.
- Screen for feeding problems on arrival that can be referred for skilled assistance.
- Enable access for caregivers to water and sanitation facilities, food and non-food items and shelter. For example, priority access for pregnant women and mothers/careers with children under 2 years, or separate distribution points where queues may be less, and/or seating areas/quiet areas where mothers can breastfeed while queuing
- Provide water to mothers and children while waiting. Infants less than 6 months do not need extra water and mothers should be encouraged to breastfeed them as frequently as possible to avoid dehydration in long hot queues.
- Provide a shaded area for waiting mothers and young children.
- Assist mothers to keep their infants with them, e.g. provide material to be used as a baby sling.
- Ensuring access to adequate amounts of appropriate complementary foods, the means to prepare them safely, and support for complementary feeding is an important intervention from the outset of an emergency.

Providing safe and supportive ‘corners’
Provide a ‘safe space’ where mothers and their children can come together to access information and varying levels of support (see later). A shared/multi-sectoral setting, e.g. with psychosocial support or child protection services, can help to strengthen collaboration and access to key services in other sectors. In some cultures, privacy to breastfeed may be an important issue to plan around (see Case Example 3 from Pakistan). For many other cultures, breastfeeding is well accepted.

Complementary feeding
Complementary feeding means giving other foods in addition to breast milk. (When an infant is 6 months old, breast milk alone is no longer sufficient to meet his or her nutritional needs and therefore other foods and liquids should be given along with breast milk). These other foods are called complementary foods.

Active/responsive feeding is being alert and responsive to a baby’s signs that she or he is ready to eat. It involves active encouragement, but not forcing the baby to eat. See Annex 7 for guidance on active feeding.
Case Example 3: Mother – Baby Tents/Corners in Pakistan

As a result of the Pakistan earthquake in 2006, many women lacked privacy. They were sharing shelters with distant male relatives or non-related males and were feeling uncomfortable breastfeeding in such circumstances. ‘Mothers’ corners’ were created by MOH Pakistan and UNICEF in order to overcome the problems related to lack of privacy and support. These were tents where women could meet to breastfeed, provide mutual support and exchange information and receive support and information from a female health worker.


Box 6: Complementary food options

- Nutritious complementary foods and recipes based on locally available foods.
- Fortified foods used in preparation of meals, e.g. iodised salt, vegetable oil fortified with Vitamin A.
- Fortified blended foods, e.g. Corn Soya Blend (CSB), Wheat Soya Blend (WSB) and many local versions, e.g. Unimix
- Point of use31 products that include micronutrient powders (solely micronutrients, such as Sprinkles), micronutrient powders plus plus (can include protein, milk powder and/or essential fatty acids, such as complementary nutritional sachets), and lipid based nutrient supplements (less than 20 g given per day, such as Nutributter).
- Micronutrient supplementation may be needed to fully meet the nutritional needs of young children, especially when the population is dependent on food aid.

Enabling access to complementary foods

A number of interventions across sectors may be needed to fully meet complementary food requirements in an emergency. From the outset, it should be a priority to enable access of mothers and caregivers to adequate amounts of nutritious and appropriate complementary food. It is important to remain sensitive to and support the mothers’/caregivers’ central role in feeding and caring for their children.

There are a variety of complementary food options in an emergency, depending on the context. See Annex 8 for types of foods suitable for different ages of breastfed and non-breastfed children and Box 6 for some complementary food options in an emergency.

Important nutritional considerations are:
- Use iodised salt in preparing family foods
- In countries with endemic vitamin A deficiency, provide vitamin A supplementation to infants and young children beginning at 6 months (or as per national recommendations), every six months until 5 years (see Module 14 Micronutrient interventions)
- In countries with high levels of anaemia and micronutrient deficiencies, multiple micronutrient powders may be given beginning at 6 months, according to national recommendations (see Module 14 Micronutrient interventions)
- In countries with high levels of stunting and food insecurity, special supplements may be given to children beginning at 6 months. These supplements are usually added to the usual complementary foods to enrich the diet and should not replace local foods. If such products are available through the health system or can be obtained at reasonable cost from the market, they should be recommended to caregivers as a means to improve the quality of children’s diets.

In an emergency, targeted interventions to provide micronutrient-rich complementary food to children 6 –<24 months of age may be needed, and may be provided to the 6 to 59 months age group (see Module 12 on Management of moderate acute malnutrition).

 Provision of complementary food should be accompanied by advice to mothers and caregivers on complementary food preparation, especially for unfamiliar foods, and on hygiene and energy density.

---

31 ‘Home fortification’ or ‘fortification/enrichment at the point of use’ is used to describe the addition of less than 20g per day of product to food to increase the nutritional value.
CURRENTLY, THERE ARE NO STANDARD CRITERIA FOR USING FORTIFIED FOODS AND SUPPLEMENTS IN CHILDREN OF COMPLEMENTARY FEEDING AGE. FURTHER RESEARCH IS NEEDED TO GENERATE MORE EVIDENCE ON WHICH PRODUCT IS BEST FOR WHICH CIRCUMSTANCE, HOW BEST TO PROMOTE THEIR CORRECT UTILISATION, AND THEIR CONTRIBUTION TO IMPROVING NUTRITIONAL, DEVELOPMENTAL AND HEALTH STATUS IN DIFFERENT CIRCUMSTANCES.

CASH OR VOUCHER DISTRIBUTIONS TO FAMILIES WITH CHILDREN OF COMPLEMENTARY FEEDING AGE SHOULD BE CONSIDERED WHERE MARKETS ARE FUNCTIONING AND THERE IS GOOD FOOD DIVERSITY (SEE MODULE 16 ON LIVELIHOOD INTERVENTIONS AND CASE EXAMPLE 4). LONGER TERM INITIATIVES TO STRENGTHEN COMPLEMENTARY FOOD PROVISION IN A COMMUNITY INCLUDE SUPPLYING TOOLS AND SEEDS TO ENABLE CULTIVATION OF SUITABLE COMPLEMENTARY FOODS AND STRENGTHENING LINKS BETWEEN LIVESTOCK AND NUTRITION PROGRAMMING TO ENHANCE FOOD QUALITY AVAILABLE TO CHILDREN.

COMMERICAL ‘BABY FOODS’ HAVE FEATURED IN SOME EMERGENCY CONTEXTS, OFTEN ARRIVING AS DONATED ITEMS. THEY VARY GREATLY IN NUTRIENT CONTENT, CONTRIBUTE TO PROBLEMS OF WASTE DISPOSAL AND IN GENERAL, SHOULD NOT BE INCLUDED AS A RELIEF ITEM.

SEE THE SECTION BELOW “INFANT AND YOUNG CHILD FEEDING IN THE CONTEXT OF HIV” FOR COMPLEMENTARY FEEDING CONSIDERATIONS IN THE HIV CONTEXT.

COMPLEMENTARY FOODS AND THE CODE

ANY FOODS OR PRODUCTS THAT ARE DISTRIBUTED AS COMPLEMENTARY FOODS IN EMERGENCIES SHOULD MEET INTERNATIONAL CODE PROVISIONS TO ENSURE THAT MOTHERS AND CAREGIVERS ARE CLEAR ON THEIR USE TO COMPLEMENT RATHER THAN SUBSTITUTE BREASTMILK. FOR EXAMPLE, ALL COMPLEMENTARY FOODS AND FORTIFIED FOODS SHOULD BE ADEQUATELY LABELLED IN THE APPROPRIATE LANGUAGE AND WITH CLEAR INSTRUCTIONS ON SAFE PREPARATION, USE AND STORAGE. ALSO THE CODE REQUIRES THAT THE EXPIRY DATES SHOULD ALSO BE CLEARLY INDICATED, WITH A MINIMUM OF ONE YEAR SHELF-LIFE.

Infant and young child feeding

A breastfeeding mother does not have a fixed ‘supply’ of breastmilk. She can always make more with the right technique, confidence and frequent feeding. A mother with twins can produce enough milk for both babies.

A mother can also produce enough milk even if she is moderately malnourished. In such cases, the woman needs support to continue to offer her baby the breast in order to maintain the milk-making process while she recovers herself. Some mothers need specialist support to reinforce their confidence and capacity to breastfeed.

In the case of weak or sick babies, the mother must initiate breastfeeding regularly herself as those babies might not indicate their need for milk. They will need to be fed more often than healthy babies as they can only take small quantities at a time.

For newborn infants (especially premature infants), skin-to-skin contact (Kangaroo care) is a life-saving, low-tech intervention. The naked infant is held upright between the mother’s breasts under her clothing. It stabilises blood glucose in fragile infants, helps regulate temperature and blood pressure, increases survival and helps establish breastfeeding.

Understanding how breastfeeding works can help frontline staff to have confidence in responding to mothers. See annex 9 on how breastfeeding works. For more detailed guidance on assessing and supporting breastfeeding in emergencies, (see IFE Module 2 in Part 4: Resources).

Box 7: Technical tips on breastfeeding

- A baby that is floppy or disinterested in feeding needs urgent medical attention and skilled feeding assessment.
- Encourage the mother to have ‘skin to skin contact’ with her infant – holding the infant close to the breast on her bare chest as much as possible, even when not feeding. For feeding, the baby should be turned towards his/her mother and be held closely. Baby slings can be used to help mothers/caregivers and babies stay together and feel more secure.
- The recommended practice is to feed on demand. Therefore there is no recommended time in between two feeds; the mother should feed when the healthy baby indicates that he/she wants to drink.
- It is good to feed babies at night when they ask for it, as it is an indication they need the milk at that time. In addition, feeding at night is beneficial for the mother’s milk production. The baby will indicate him/herself when he/she is ready to sleep through the night.
- In infants under six months of age, it is important to breastfeed exclusively and give no water, teas, milk, or other food to the infant.
- In infants over six months of age, encourage breastfeeding to continue as the main fluid source.
- Encourage the mother to breastfeed at night. Suckling stimulates release in the mother’s body of a hormone called prolactin. Prolactin makes the breasts produce milk and is better secreted at night.
- Some babies drink fast, other babies drink slow, therefore there is no indicated time per feed. The mother can let the baby drink from one breast until the baby releases the breast by his/herself and then offer the other breast. Taking too little time at one breast will result in incorrect emptying of the breast which can be the cause of breast problems, insufficient weight gain in the baby and reduced milk production.

Handling requests for infant formula from breastfeeding mothers

It is important to respond sensitively to mothers or other caregivers who are asking for breastmilk substitutes, such as infant formula.

If a breastfeeding mother is requesting infant formula, find out why she is requesting it:
- A mother may ask for infant formula because she has lost confidence in her capacity to feed her baby and thinks she “does not have enough milk”. You need to try and reinstall her confidence in breastfeeding (see above for simple measures). This mother may also need the support of an experienced breastfeeding counsellor to re-establish breastfeeding.
- A mother may believe that infant formula is better for her child – you can advise her that breastmilk is the most secure, safe, nutritious and protective food and drink for her infant.
- If infant formula is being distributed on request to mothers and caregivers whose babies cannot/are not breastfed, breastfeeding mothers may request infant formula because it has a monetary value and is free.
Breastfeeding counselling involves practical, technical know-how as much as strong communication skills. Listening to mothers, reinforcing their confidence and encouraging them, rather than “telling” them what to do, is an essential component. A skilled breastfeeding counsellor can provide assistance to breastfeeding women to ensure that the fundamentals of good breastfeeding are in place and to resolve common difficulties. Mothers are greatly helped to breastfeed and care for their infants if someone calm and friendly listens to them, and builds their confidence with reassurance and correct information. Breastfeeding counselling increases the success of breastfeeding. Breastfeeding counsellors may be health professionals, community health workers or peer counsellors (e.g. mothers and grandmothers) who have undertaken relevant training.

See IFE Module 2 and WHO/UNICEF breastfeeding counselling course for more detailed information.

Box 8: A guide to breastfeeding counselling

Breastfeeding counselling involves practical, technical know-how as much as strong communication skills. Listening to mothers, reinforcing their confidence and encouraging them, rather than “telling” them what to do, is an essential component. A skilled breastfeeding counsellor can provide assistance to breastfeeding women to ensure that the fundamentals of good breastfeeding are in place and to resolve common difficulties. Mothers are greatly helped to breastfeed and care for their infants if someone calm and friendly listens to them, and builds their confidence with reassurance and correct information. Breastfeeding counselling increases the success of breastfeeding. Breastfeeding counsellors may be health professionals, community health workers or peer counsellors (e.g. mothers and grandmothers) who have undertaken relevant training.

See IFE Module 2 and WHO/UNICEF breastfeeding counselling course for more detailed information.

• A mother may decide that she does not want to/ no longer wants to breastfeed. She needs accurate information on the risks of artificial feeding so that she can make an informed decision.

If a mother is feeding both artificial milk or other liquids and breastfeeding and her infant is under six months of age, she should be advised it is much safer for her to exclusively breastfeed. It is likely that the mother/baby pair will need referral for more comprehensive assessment and assistance by skilled personnel trained in breastfeeding counselling (see next section).

Frontline assistance to non-breastfed infants and their mothers/caregivers

Cases of non-breastfed infants may also present to frontline workers. These infants may have been artificially fed pre-emergency, their mothers may have stopped breastfeeding during the emergency, or they may have been orphaned. Urgent referral to health services and for skilled assessment and support will be needed (see section on artificial feeding).

In the immediate term, it is important to:

• Investigate if there is any possibility of breastfeeding the infant, e.g. is a mother who has stopped breastfeeding willing to restart or is there a wet nurse available (even as a temporary solution) who could be a family member or other community member.

• For cases where there is no immediate prospect of breastfeeding, an adequate supply of an appropriate breastmilk substitute will be needed for the infant and referral for more skilled assistance and monitoring at a health facility to enable this.

• Cases of non-breastfed infants should be reported to the designated IYCF coordinating agency. Where orphaned cases present to nutrition and health services, it will be important to refer to child protection services to ensure adequate support is provided.

Skilled breastfeeding assistance

Breastfeeding counselling as an emergency intervention

Mothers may present with a range of breastfeeding difficulties in an emergency. Some may have longstanding difficulties due to lack of earlier support or cultural practices that undermine optimal breastfeeding. Women can lose confidence and doubt the adequacy of their breastmilk. Mothers who are socially isolated find it even harder to care for their infants, and may have extra breastfeeding difficulties. New mothers may not have access to support. Traumatised and depressed women may have difficulty responding to their infants. The nature of the support, where and how it is delivered will depend on the specific needs of mothers. Skilled breastfeeding assistance in the form of breastfeeding counselling (see Box 7) and skilled psychosocial support may be needed.

Breastfeeding counsellors/lactation consultants have not been traditionally considered important members of humanitarian intervention teams. Their presence is, however, essential if an agency’s aim is to provide skilled support to mothers. Ideally, such staff are local and can speak to mothers in their own language. Humanitarian agencies can contact the International Association of Lactation Consultants ILCA, La Leche League International (association of mother to mother support), the IBFAN network and WABA (World Association of Breastfeeding

Case Example 5: Skilled support at a Baby Friendly Tent in Haiti

During the relief efforts in Haiti 2010, over 100 Baby Friendly Tents were set up by 12 NGOs in the relocation sites. Mothers and caregivers with children up to 2 years old came to receive infant and young child feeding advice and counselling. Each followed national guidelines, while adding activities within their capacity and expertise, such as psychological counselling, early childhood development activities, vaccination and growth monitoring.

This large scale programme drew major attention to the importance of IYCF and tens of thousands of mothers or caregivers with young children, as well as pregnant women were seen and followed up in this way.

Delivering skilled breastfeeding assistance

Interventions may involve establishing ‘safe corners’ for mothers and infants (see earlier), one-to-one counselling, and mother-to-mother support (see Case Example 5 example from Haiti).

More experienced skilled support will be needed in situations such as where infants under six months are malnourished (see Box 9), for newborns (see below) or low birth weight infants, for relactation or for supporting wet-nursing (see Case Example 6). Integration of IYCF support into CMAM programmes offers an opportunity for identification of inappropriate feeding practices that may have contributed to the development of malnutrition, correction of those practices during the course of treatment, and follow-up post-discharge to prevent relapse.

Case Example 6: A wet-nurse who relactated during the post-cyclone intervention in Myanmar 2008

Sa Bei is 7 weeks old – she was born only a week or two after the cyclone in Myanmar. Her foster mother, San San Min, told us that Sa Bei’s mother had given birth in her home after they were told to leave the monastery where they had sheltered from the storm. Sa Bei’s mother abandoned her to return to her own village where her 4 older children had gone with their father.

Sa Bei had gained less than 200g in six weeks since her birth. Breastfeeding counsellors had been working with San San for about 10 days and her milk was beginning to flow – a remarkable effort since the counsellors had only seen her every 2 or 3 days.


See IYCF-E Module 2 for more detailed information on relactation.

Skilled expertise can be used to lead on group support; for example, in peer to peer support led by a skilled counsellor, where breastfeeding mothers are trained to support each other. Such support has been implemented at the community-level in emergencies (see Case Example 7: Indonesia).

Breastfeeding counsellors may work alongside or integrated into psychosocial and mental health, reproductive health and child protection services (see Case Example 8). Reproductive health services, in cooperation with nutrition and health service providers, may offer a route to target micronutrient supplementation of pregnant and lactating women, and the point to initiate growth monitoring of infants and children.

Early initiation of exclusive breastfeeding

Newborn infants are a priority group to establish breastfeeding. Steps to support early initiation of breastfeeding are:

- Include early initiation of breastfeeding as a key intervention in reproductive health services and nutrition programmes that target pregnant women.

- Assess and support capacity of maternity services and traditional birth attendants to provide skilled breastfeeding support and encourage skin-to-skin contact (see later).

36 Relactation is the process by which a woman who is not breastfeeding begins to produce breastmilk in response to the suckling of a child. A woman need not have recently or in fact ever been pregnant in order to relactate. Relactation requires that an infant suckle frequently at the breast.

37 Wet nursing is where a woman who is not the mother of the child breastfeeds the child. Wet nurses may be already producing breastmilk or they may restart breastfeeding. In some communities, wet nursing is commonly practiced. It is an important practice to investigate in early needs assessment as it is a life-saving option for infants. Wet nurses may require additional emotional, social and practical assistance, and resources, as well as skilled breastfeeding support.

An investigation into the management of acute malnutrition in infants <6 months in emergency programmes (the MAMI Project Review)\(^{39}\) found that the global burden of care for infants <6m is significant and that programmes currently struggle to manage this age-group using current guidelines.

One of the MAMI Project Review proposals was to develop a community based model for acute malnutrition management in this age-group, similar to that for older children where uncomplicated cases are treated in the community and complicated cases in facilities (see Module 13, Management of severe acute malnutrition). Currently management of infants <6m is largely facility-based.

The MAMI Project Review and subsequent WHO consultation (2010)\(^{40}\) highlighted some key resources, ‘potentially better practices’, complementary initiatives and priority operational research to improve management. These include:

- Any admissions of infants <6 months to programmes should be documented.
- Admission and discharge indicators for infants <6 months should include breastfeeding status on admission and on discharge.
- Where appropriate, infants <6 months should be included in nutrition surveys to determine programme coverage and burden of disease. Note this has implications for equipment and training needs, and capacity to manage cases identified.
- For infants <6 months with access to breastmilk, case management should aim to restore exclusive breastfeeding.
- Strategies with potential to improve inpatient outcomes of ‘complicated’ cases of severe acute malnutrition in infants <6m include implementation of routine Kangaroo care, breastfeeding ‘corners’ with skilled breastfeeding support, and psychosocial stimulation/support of the infant, the mother-infant dyad and their families.
- Strategies with potential for effective outpatient-based care of infant <6m moderate acute malnutrition and ‘uncomplicated’ severe acute malnutrition (SAM) include community-based breastfeeding support, psychosocial support programmes and women’s groups programmes.
- MSF guidelines 2006, ACF Assessment and Treatment of Malnutrition, 2002, IFE Module 2 and Integration of IYCF in CMAM are good reference tools. UNICEF b-r-e-a-s-t\(^{41}\),\(^{42}\), the UNICEF 2006 breastfeeding observation aid\(^{43}\) and the aids described in IFE Module 2\(^{44}\) are good tools to assess breastfeeding in programmes managing infants <6m.
- The IYCF guidance in CMAM training\(^{45}\) should be used to strengthen the IYCF component of community services, including SFPs. IFE Module 2\(^{46}\) should be used to strengthen individual level assessment and support at facility and community support/referral services, e.g. stabilisation centres, breastfeeding ‘corners’/tents.

See Annex 10 for more details.

**Box 9: Managing acute malnutrition in infants under six months of age**

- Implement the *Baby Friendly Hospital Initiative* (BFHI) ‘ten steps to successful breastfeeding’, in whatever hospital/facility is set up in an emergency response\(^{47}\) (see annex 11)
- The *Baby Friendly Initiative* considers the extended support that is needed on discharge from maternity services into the community antenatal services to women and their infants.

---

39 http://www.ennonline.net/research/mami
40 These reflect the consensus statements agreed at the WHO consultation on management of moderate malnutrition in U5s, Geneva, March, 2010 and the recommendations of the MAMI Review, 2010.
41 Body position, Responses, Emotional Bonding, Anatomy, Suckling, Time suckling.
43 UNICEF. 2006. BABY-FRIENDLY HOSPITAL INITIATIVE. Revised, Updated and Expanded for Integrated Care. Section 3.2, p91
Infant and young child feeding

**Case Example 7: Indonesia**

Following the earthquake, there was widespread distribution of milk products and BMS, and assessment revealed increased morbidity amongst infants and young children. There were only 40-50 skilled breastfeeding counsellors in the country, not nearly enough to meet the need of thousands of mothers affected by the earthquake. A cascade method of breastfeeding support was developed by UNICEF/MOH where trainers were located in the community to train counsellors who, in turn trained mothers as peer educators. Using this approach, 4,260 families were targeted.

Follow up of fifty-four mothers who gave birth after the earthquake and who received the counselling revealed that almost all of these mothers initiated breastfeeding in the first hour after birth and that 63% were exclusively breastfeeding regardless of access to free BMS.

In November 2006, 247 mothers with babies born after the earthquake were assessed on their breastfeeding practices. All babies were under six months of age. Findings indicated a positive impact on exclusive breastfeeding rates and infant feeding knowledge amongst mothers of young infants born after the earthquake. Despite the widespread distribution of BMS to the population, the findings suggest that the intervention limited the negative impact this had—the reported use of BMS amongst those surveyed was similar to pre-earthquake levels. Feeding practices were not ‘perfect’, however better exclusive breastfeeding rates were achieved compared to pre-earthquake practice.


**Case Example 8: Providing psycho-social support to stressed and traumatised mothers in Georgia**

Local child-care experts were deployed to offer psychological support, as well as tips on breastfeeding and child-rearing. “During the fighting, most of these mothers were traumatized…,” said a director at Tbilisis Iashvili Child Clinic, Keti Nemsadze, who is a member of IBFAN and one of the experts deployed by UNICEF.

While it remains uncertain when these mothers and other displaced people will be able to return to their homes, many already seem to be recovering.

“I was already going to start artificial formula feeding for Mariam, as I had lost hope in my breast milk”, said Lia Kazarashvili, a 26-year old mother who fled the Gori region several weeks after giving birth to her daughter. “But the doctors here have explained how to restore my milk. They told me to think nice thoughts when nursing, to think about Mariam’s happy future and her future joyful life.” This method really helps. After feedings, Mariam is in a good mood and sleeps well.


Where artificial feeding was common pre-emergency, skilled breastfeeding support will be especially important for mothers of newborns. Antenatal and postnatal care staff, midwives, etc. may also need orientation and training to renew skills and capacity to support breastfeeding mothers.

**Non-counselling based interventions to support breastfeeding**

Counselling based interventions to support breastfeeding are an important intervention in emergencies (see “Skilled breastfeeding assistance”). Non-counselling based interventions may also positively impact on feeding practices. Sub-optimal IYCF practices are not necessarily a consequence of poor knowledge, but may also reflect poor coping at a household level. Failure to adequately address poor access to food and livelihood constraints is likely to limit the impact of counselling-based interventions. For example, initiatives to support livelihoods have shown a positive impact on breastfeeding rates (see Case Example 9).

**Infant and young child feeding in the context of HIV**

**Maximising HIV free child survival**

The term HIV-free survival simply affirms that everyone should work to ensure that children are not only HIV uninfected but should also survive. Maximising HIV-free child survival is the primary consideration in determining the best feeding option for infants born to HIV-infected mothers. HIV-free child survival requires a balancing of risks between the risk of an infant becoming infected with HIV through breastfeeding versus the risks of malnutrition, infectious diseases and non-HIV related death. The balance of risk to maximise HIV-free child survival is reflected strongly in the latest WHO guidance on HIV and infant feeding (2010).

The risk of HIV transmission through breastfeeding depends on a number of factors, including:
Case Example 9: Use of Cash to Improve IYCF practices

In 2010 (2011) SCUK led a review of a programme in the delta of Myanmar where cash had been given to mothers with babies under 6 months, to enable them to stay at home and breastfeed exclusively, instead of going out to work. The monitoring data returned consistently high reports of exclusive breastfeeding among the beneficiaries. To investigate further, diets of the babies of a sample of 26 mothers were assessed using 24 hour and 7 day diet recalls. These were a part of detailed semi-structured interviews with mothers and their husbands, which included assessing knowledge and understanding of key practices and access to, and uptake of, various IYCF promotion and support and other livelihoods interventions.

The review found that mothers had good knowledge and understanding of key IYCF practices and all were staying at home, not working, buying more food and nutritious foods and eating better than before. The recalls suggested a high prevalence of exclusive breastfeeding where 12 mothers fed only breastmilk, 3 gave breastmilk and multivitamins, 5 gave breastmilk, multivitamins and traditional colic medicine and 4 gave breastmilk and traditional colic medicine (1 gave breastmilk and water, 1 breastmilk and formula).

The high prevalence of exclusive breastfeeding seemed strongly related to improved knowledge and understanding of best practices and the enabling force of the cash which meant that mothers stayed at home with their babies. Although hunger had been a barrier to breastfeeding promotion during the emergency response, there was also a strong suggestion that mothers/households had spent more on food and women were eating better, and feeling that this helped their breast milk production.


Box 10: Key infant feeding definitions

**Exclusive breastfeeding:** only breast milk, no other food or drink (including water) is given to the infant.

**Replacement feeding** is the process of feeding a child who is not breastfeeding with a diet that provides all the nutrients the child needs until the child is fully fed on family food. During the first six months of life, replacement feeding should be with a suitable breast milk substitute, usually with infant formula, given exclusively (not mixed with breastmilk or other foods). After six months the suitable breast milk substitute should be complemented with other foods.

**Mixed feeding** is giving breast milk plus other foods or drinks, including ready to use therapeutic foods) before the age of 6 months of age. Giving solids or liquids to a breastfeeding child less than 6 months increases HIV transmission risk. The mother should be advised to EITHER exclusively breastfeed OR exclusively replacement feed her child up to 6 months of age. (Mixed feeding is dangerous for ALL infants less than 6 months, irrespective of knowing HIV status of mother. In an HIV prevalent area, there is even more reason to support exclusive breastfeeding.)

**Mixed feeding is dangerous for ALL infants less than 6 months, irrespective of knowing HIV status of mother. In an HIV prevalent area, there is even more reason to support exclusive breastfeeding.)

**Mixed feeding is dangerous for ALL infants less than 6 months, irrespective of knowing HIV status of mother. In an HIV prevalent area, there is even more reason to support exclusive breastfeeding.)

**Note:** A baby less than 6 months has immature intestines. Food or drinks other than breastmilk can cause damage to the baby’s stomach. This makes it easier for HIV and other diseases to pass to the baby.

Source: UNICEF IYCF Counselling Package (2010). See Part 4 of this module: resources.

- Breastfeeding pattern: Poor breastfeeding practices increase the risks of both HIV transmission and illness in HIV-exposed infants. Mixed feeding (see Box 9) before 6 months increases both the risk of HIV transmission and infections due to other causes, like diarrhoeas.

- The use or not of anti-retrovirals (ARVs): ARV interventions to the HIV-infected mother and/or HIV-exposed infant significantly reduce the risk of transmission of HIV during pregnancy, labour, delivery and post-natally through breastfeeding.

---


If a woman is HIV-infected, what is the risk of HIV passing to her baby when NO preventive actions are taken?
A baby born to an HIV-infected mother can get HIV from the mother during pregnancy, labour and delivery, and breastfeeding. In the absence of any interventions\(^\text{50}\) to prevent or reduce HIV transmission, research has shown that if 100 HIV-infected women get pregnant, deliver, and breastfeed for two years\(^\text{51}\):

- About 25 may be infected with HIV during pregnancy, labour and delivery
- About 10 may be infected with HIV through breastfeeding, if the mothers breastfeed their babies for 2 years
- About 65 of the babies will not get HIV
- The aim is to have infants who do not have HIV but still survive (HIV-free survival) Therefore the risks of getting HIV through breastfeeding have to be compared to the risks of increased morbidity and mortality associated with not breastfeeding.

If a woman is HIV-infected, what is the risk of passing HIV to her baby if both take ARVs and practise exclusive breastfeeding during the first 6 months?
Combining ARV interventions with breastfeeding can significantly reduce post-natal HIV transmission. A pregnant woman living with HIV should be given ARVs to decrease the risk of passing HIV to her infant during pregnancy, birth, or breastfeeding. Her baby may also receive ARVs to decrease the risk of getting HIV during the breastfeeding period.

To reduce HIV transmission through breastfeeding, exclusive breastfeeding in the first six months is combined with provision of ARVs for the mother and the baby. This is the best way for a mother to breastfeed her infant safely.

If 100 HIV-infected women and their babies take ARVs and practise exclusive breastfeeding during the first 6 months:
- About 2 babies are infected during pregnancy and delivery
- About 3 babies are infected during breastfeeding
- About 95 babies will not get HIV

Note: When mother takes ARVs from 14 weeks of pregnancy, the risk of transmission during pregnancy and labour is virtually non-existent. Some studies have also shown that the transmission during breastfeeding with ARVs is as low as 1 out of 100 babies.

**WHO (2010) recommendations**
The WHO (2010) guidance recommends that national or sub-national 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 to avoid breastfeeding. This national decision should be based on international recommendations and consideration of the:

- Socio-economic and cultural contexts of the populations served by maternal, newborn and child health services
- Availability and quality of health services
- Local epidemiology including HIV prevalence among pregnant women
- Main causes of maternal and child undernutrition
- Main causes of infant and child mortality.

**What are the differences between infant feeding recommendations for HIV-infected mothers versus HIV-uninfected mothers?**
Under the WHO 2010 guidelines, countries may choose to recommend breastfeeding to all mothers, regardless of whether or not they are HIV-infected. In this case, all mothers are encouraged to exclusively breastfeed during the first 6 months of their baby’s life. The two differences in the recommendations for HIV-infected mothers are i) either the HIV-infected mother or her baby should receive an ARV intervention to prevent HIV transmission and ii) how long to continue breastfeeding after 6 months, while giving in addition adequate amounts of nutritious and safe complementary foods. Women in the general population are recommended to continue breastfeeding their infants up to 2 years of age or beyond, while the recommendation for HIV-infected women is for at least 12 months and to then assess whether an alternate, adequate diet without breast milk can be safely provided. The shortened period for HIV-infected mothers is based on balancing the risk to the infant of not breastfeeding with issues of feasibility and likely adherence to ARVs over a longer time period.

\(^{50}\) Interventions to reduce mother to child transmission (MTCT)

**During pregnancy:** HIV counselling and testing; primary prevention; prevent, monitor, and treat STIs; malaria, opportunistic infections; provide essential Ante-Natal Care (ANC), including nutrition support; ARVs; counselling on safe sex; partner involvement; infant feeding options; family planning; self care; preparing for the future.

**During labour and delivery:** ARVs; keep delivery normal; minimize invasive procedures - artificial rupture of membranes (AROM), episiotomy, suctioning; minimize elective C-Section; minimize vaginal cleansing; minimize infant exposure to maternal fluids.

**During post-partum and beyond:** Early breastfeeding initiation and support for Exclusive Breast Feeding (EBF) if breastfeeding is infant feeding choice; prevent, treat breastfeeding conditions; care for thrush and oral lesions; support replacement feeding if that is infant feeding choice; ARVs for mother and infant for duration of breastfeeding period; immunizations, and growth monitoring and promotion for baby; insecticide-treated mosquito nets; address gender issues and sexuality; counsel on complementary feeding at 6 months; treat illness immediately; counsel on safe sex; and offer family planning counselling.

Box 11: IYCF recommendations in the context of HIV (from WHO (2010))

**HIV un-infected mother or mother of unknown status:**
Exclusively breastfeed for up to 6 months, add complementary foods at 6 months and continue breastfeeding for 2 years and beyond

**HIV-infected mother whose infant is HIV uninfected or of unknown HIV status:**
Mother has two main options for feeding her baby (depending on national policy).

**Option 1: Exclusively breastfeed together with ARVs for mother OR infant**
- Exclusive breastfeeding in the first six months helps to significantly reduce the baby’s risk of illness, malnutrition and death, and carries a relatively low average risk of transmission in the first six months as compared to mixed feeding.
- Same recommended breastfeeding practices that apply for HIV-negative mother and mother of unknown status (See Participant Materials 5.2: Recommended breastfeeding practices and possible counselling discussion points)
- Breastfeeding and ARVs should continue until 12 months. Breastfeeding should cease at 12 months if a nutritionally adequate diet without breast milk can be provided. Otherwise breastfeeding should continue until such time that such a diet can be provided.

**Exclusively breastfeed even when no ARVs are available**
- The 2010 WHO Guidelines on HIV and Infant Feeding, Principles and recommendations for infant feeding in the context of HIV and a summary of evidence state: When a national authority has decided to promote and support breastfeeding and ARVs, but ARVs are not yet available, mothers should be counselled to exclusively breastfeed in the first six months of life and continue breastfeeding thereafter unless environmental and social circumstances are safe for, and supportive of replacement feeding.
- In circumstances where ARVs are unlikely to be available, such as acute emergencies, breastfeeding of HIV-exposed infants is also recommended to increase survival.

**Cessation of breastfeeding at 12 months (where indicated)**
WHO recommends against early, abrupt or rapid cessation of breastfeeding. 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.

**HIV-infected mother whose infant is HIV-infected:**
Exclusively breastfeed for up to 6 months, add complementary foods at 6 months and continue breastfeeding for 2 years and beyond

**Option 2: If National Policy is Avoid All Breastfeeding OR if mother opts out of exclusive breastfeeding:**
Avoid All Breastfeeding and feed using industrially produced infant formula

*Note:* The replacement feeding option is also accompanied with provision of ARVs for the mother and the infant (the latter for six weeks after delivery)

The mother gives the baby industrially produced infant formula from birth (no breastfeeding). Maintaining the mother’s central role in feeding her baby is important for bonding and may also help to reduce the risks in preparation of replacement feeds.

There may be circumstances in specific regions or all of a country which may lead national authorities to extend the recommended period of breastfeeding beyond 12 months. Where women cannot safely provide foods to replace breast milk after 12 months, then national authorities can specify a different duration, and provide ARVs over this longer time. Health workers need to provide a consistent message and ensure that the supply chain to provide ARVs over an extended period operates effectively. Other circumstances in which it may be appropriate to recommend that HIV-infected mothers breastfeed for longer than 12 months may include an emergency, such as an earthquake, drought or conflict, or a region with very high infant mortality and/or limited health services.

**Does breastfeeding negatively affect the health of HIV-infected mothers?**
The health and survival of a mother is critical to the well-being of her child. Available evidence shows that breastfeeding does not cause any health problems for HIV-infected mothers. Evidence also shows that HIV disease progression is not more rapid in HIV-infected breastfeeding women compared with HIV-infected women who do not breastfeed. The most important
issue related to maternal health and breastfeeding is to identify those HIV-infected women who have low CD4 counts, and initiate them on ART according to current guidance. New mothers who do not know their HIV status should be offered testing in the postnatal period. Health facilities should ensure that CD4 testing is available for HIV-infected mothers during the breastfeeding period, and that referral for ARV treatment takes place. Services and support that assist mothers to remain HIV-uninfected are also essential.

If ARVs are not available immediately should health workers still recommend breastfeeding?
If there is a national decision to provide ARVs and promote and support breastfeeding for HIV-infected mothers, then the health worker should still recommend exclusive breastfeeding while waiting for ARVs to become available. However, the health worker should discuss with the mother the risks of breastfeeding without ARVs, as well as the risks of not breastfeeding. If a mother states that she would prefer to formula feed in the absence of ARVs, then the health worker should discuss her circumstances to ensure that specific conditions for replacement feeding are in place and that it is safe for her to do so. If the mother decides to formula feed, then she should be supported to practice this option. Health authorities should avoid giving different infant feeding messages in different parts of a health province or district depending on whether ARVs are currently available. Conflicting messages may confuse both mothers and health staff and compromise the quality of support mothers receive.

When a HIV-infected mother is breastfeeding, how should she feed her child from 6 up to 24 months of age?
Once an infant reaches 6 months of age, the mother should continue to breastfeed (along with ARVs for mother and child) up to 12 months. She should stop breastfeeding if an alternate, adequate diet without breastmilk can be safely provided. If such a diet is not available, she should continue breastfeeding (and ARVs) with periodic review (e.g. monthly) of the feeding situation. The same recommended complementary feeding practices that apply for HIV-negative mother and mother of unknown status should be followed.

When a HIV-infected mother is NOT breastfeeding, how should she feed her child from 6 up to 24 months of age?
• At about 6 months an infant is better able to tolerate undiluted animal milk and a variety of semi-solid foods.
• For infants 6 up to 12 months old, milk provides many essential nutrients and satisfies most liquid requirements. However, in some places, neither animal milk nor infant formula is available.
• Mother or caregiver needs to feed infant animal foods (meat, poultry, fish, eggs, or milk products), additional meals and/or specially formulated, fortified foods where suitable breast milk substitutes are not available.

• Calcium-rich foods such as papaya, orange juice, guava, green leafy vegetables, and pumpkin should be consumed daily.
• Infants not fed milk should be offered plain, clean, boiled water several times a day to satisfy thirst.
• Where neither breast milk substitutes nor animal milk or animal foods are available, nutrient requirements cannot be met unless specially formulated, fortified foods or nutrient supplements are added to the diet.

See also the related section on complementary feeding (above) and Annex 8.

Are the feeding recommendations the same for emergencies?
The balancing of risks to maximise HIV-free child survival is especially critical in emergencies. Safe water supplies, fuel to boil water and to sterilise feeding utensils are often in short supply. Sanitation and other conditions to prepare replacement feeds as safely as possible are typically non-existent. Health services to care for children who might develop diarrhoea or pneumonia are grossly over-stretched or missing.

In emergency settings, national authorities should endeavour to provide ARVs as soon as feasible. In acute emergency settings when ARVs are unlikely to be available, breastfeeding of HIV-exposed infants is recommended to increase child survival.

Deteriorating circumstances in an emergency may also have implications for implementation of national/sub-national feeding recommendations on the safest feeding option for HIV-free child survival.

• Where national/sub-national policy recommends breastfeeding pre-emergency, this becomes all the more critical in the emergency context. As described earlier, in an emergency it may be appropriate to recommend that HIV-infected mothers breastfeed for longer than 12 months in the interests of child survival.
• In a pre-emergency context where national policy was to avoid breastfeeding, the shift in the balance of risks means this is likely to no longer be the safest option in the immediate term (see Case Example 10 for example). Breastfeeding will be the safest option for HIV-exposed infants. National authorities and/or the authority managing the emergency should establish whether the recommendation for formula feeding is still appropriate given the circumstances. Urgent artificial feeding assistance will be needed for infants already established on replacement feeding (see ‘Managing artificial feeding in emergencies’). Considering how national or sub-national feeding recommendations may need to respond to an emergency situation – and the programming implications – should form part of emergency preparedness, especially in HIV-affected populations. This is a challenging area of policy and programming.
Case Example 10: Lessons from Botswana 2006

This example from Botswana precedes the WHO (2010) recommendations but reflects a context where a national recommendation to offer replacement feeding was in place.

In Botswana, replacement feeding using infant formula was offered to all HIV-infected mothers as part of a national programme to prevent transmission of HIV from mother to child (PMTCT). But flooding led to contaminated water supplies, a huge rise in diarrhoea and national under five mortality increased by at least 18% over 1 year. An investigation by the Centre for Disease Control (CDC) into admissions in one hospital found that non-breastfed infants were 50 times more likely to need hospital treatment than breastfed infants, and much more likely to die. Many of the children admitted had developed severe acute malnutrition during or after bouts of diarrhoea. Use of infant formula ‘spilled over’ to 15% of HIV-uninfected women, exposing their breastfed infants to unnecessary risk.

As a consequence, Botswana modified its national policy in line with 2006 WHO recommendations on HIV and infant feeding, strengthening breastfeeding support and ensuring that conditions to minimise the risks of replacement feeding were in place for individual mothers before embarking on this feeding option.

(Creek et al, 2006).

What are the key messages for communities to hear to help them implement the WHO 2010 guidelines?

With regard to feeding practices, where breastfeeding is the national recommendation for HIV-infected women, the WHO 2010 guidelines recommend exclusive breastfeeding for the first six months, which corresponds to feeding practices that should already be the norm for the general community.

Communities should also be alerted about the major advance that ARVs represent in terms of enabling HIV-infected mothers to breastfeed with only a small risk of transmitting HIV to their infants while providing major protection against the major illnesses that kill young children. They should be informed that all mothers need to be supported, especially during the first 6 months of an infant’s life, to exclusively breastfeed and to avoid giving other foods or fluids, such as formula milk or porridges, that can make young infants ill.

If replacement feeding with infant formula is the nationally recommended feeding practice for HIV-infected women, then communities should be helped to understand that there have always been a few women who need to practice artificial feeding for medical reasons, and HIV is one indication for this although it is not recommended for everyone.

It is fundamentally important to communicate the concept of HIV-free survival that considers not just the risk of HIV infection but other causes of death, such as diarrhoea and malnutrition. This is especially relevant for emergency affected populations, and where child mortality is high and health services lacking. Conveying this concept requires careful and simple explanations – probably many times over. It is important at all levels, including for communities, programme managers, mothers, health workers, policy makers, funders, civil society and other advocates.

See Part 4 Resources for current guidance and tools on HIV and infant feeding. For the most up to date guidance, visit www.who.int

Managing artificial feeding in emergencies

What is artificial feeding?

Artificial feeding is where an infant or young child is fed with a breast milk substitute. An infant may be exclusively or partially fed on a BMS. The terms formula feeding and replacement feeding (in the HIV context) are sometime used.

Infant formula is a typical and an appropriate BMS, as it meets a specified formulation (Codex Alimentarius). Infant formula is usually non-sterile powder, or a sterile liquid as a ready-to-use infant formula (RUIF).

When breastfeeding is not possible and breastmilk is unavailable, infants require a BMS meeting Codex Alimentarius standards until breastfeeding is re-established or until at least six months of age, and up to a maximum of 12 months. Cow’s milk is considered an appropriate BMS after 12 months.


Box 12: Risks associated with powdered infant formula: Enterobacter sakazakii.

Powdered infant formula (PIF) has been associated with serious illness and death in infants due to infections with *Enterobacter sakazakii*. During production, powdered infant formula can become contaminated with harmful bacteria, such as *Enterobacter sakazakii* and *Salmonella enterica*. This is because, using current manufacturing technology, it is not feasible to produce sterile PIF. During the preparation of PIF, inappropriate handling practices can exacerbate the problem. It is therefore important to follow the WHO/FAO guidelines on the safe preparation, storage and handling of infant formula (2007). For safe preparation, water no cooler than 70 degrees should be used to prepare feeds from PIF. This temperature will kill harmful bacteria that may be present in PIF. Any feeds that have not been consumed need to be thrown out within 2 hours, if there is no refrigeration. If there is refrigeration (less than 5 degrees), feeds should be used within 24 hours.

Indications for artificial feeding in an emergency

An emergency may affect a population where artificial feeding is common practice and many infants may be partially or exclusively artificially fed. In some situations, groups of infants in a population may need feeding support, for example where there are unaccompanied infants at a refugee camp or where there is institutional care, such as an orphanage. There are some circumstances where temporary or longer term use of a BMS for individual cases is needed.

The decision to support artificially fed infants and young children should be based on needs assessment. Interventions around artificial feeding should not be based on assumptions of feeding practices, on individual cases, emotive calls in the media for milk powder or in response to offers/receipt of donations of infant formula. Initial rapid assessment should provide key information (see earlier section).

Supporting artificial feeding in an emergency is challenging. It requires medical, nutritional and logistical expertise and capacity in programmes that can assess, target and monitor infants on an individual level. An agency should only supply another agency/institution with BMS if both are working as part of the nutrition and health emergency response and the provisions of the Operational Guidance on IYCF-E and Code are met.

Individual situations where artificial feeding is indicated include:

- The mother has died, or is absent for an unavoidable reason.
- The infant has been rejected by the mother due to having experienced rape or psychological trauma.

- The infant was dependent on artificial feeding when the emergency occurred.
- During relactation or whilst moving from mixed feeding to exclusive breastfeeding

Source: Operational Guidance on IYCF-E (Section 6.2.2) and IYCF-E Module 2.

Conditions for artificial feeding in an emergency

Key conditions that all need to be in place for artificial feeding to minimise risks are:

- Safe water and sanitation are assured at the household level and in the community
- The mother, or other caregiver, can reliably provide sufficient infant formula milk to support normal growth and development of the infant
- 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
- The mother or caregiver can, in the first six months, exclusively give infant formula
- The family is supportive of this practice
- The mother or caregiver can access health care that offers comprehensive child health services.

Cold bottled water is not sufficient for preparation of powdered infant formula, as it will not kill the potentially harmful bacteria contained in powdered infant formula (see Box 11).
Case Example 11: Artificial feeding programming in Haiti

During the relief effort for the earthquake in Haiti in 2010, it was found that the use of infant formula was needed to accommodate those children who were already using infant formula pre-crisis or who lost their mothers during the earthquake and for whom no other alternative could be found.

Criteria for the use of infant formula were designed by the Nutrition Cluster and partners and endorsed by the Haitian Ministry of Health. The choice was made to use ready-to-use infant formula, since hygiene conditions were very poor. The RUIF was entrusted to the Nutrition Cluster who provided it to agencies who fulfilled the following criteria:

- At least one senior staff member must attend the Baby Tent Training Sessions (see later)
- The agency must sign an agreement in which it engages itself to adhere to the National Protocol (conform with the Code and Operational Guidance on IYCF-E)
- The agency must attend Nutrition Cluster meetings

Monitoring of the use of the RUIF by the relevant agencies was conducted by the Nutrition Cluster. If it was found that agencies did not use the RUIF as agreed upon, their provision of RUIF was stopped.

Source: Astrid De Brabandere, Nutrition Cluster Haiti, 2010

Supplies of BMS and feeding equipment

Procurement, management and distribution of BMS and milk products should be strictly controlled, based on technical advice and must comply with the Code. Where criteria for use of BMS are met, infant formula purchased by agencies working as a part of the nutrition and health emergency response may be used in or distributed by the healthcare system. Distribution should be carried out sensitively and not as part of the general food aid, to prevent spillover. When infant formula is used, markets should be monitored to see whether the distributed formula is being sold (ûspilloverû), or whether prices of formulas change.

Some important key points from the Code include:

- Labels should be in the appropriate languages, with specified information and warnings
- No free samples to mothers or families
- No advertising or promotion to the public
- No donations of free or subsidised supplies to the health care system; normal procurement channels must be used to obtain required breastmilk substitutes
- Obligation to provide breast milk substitutes to targeted infants for as long as needed (at least six months old or until breastfeeding is re-established)

Infant formula generally comes as powdered or liquid (ready to use) product. The choice of which to use depends on resources and size of need, availability, transportation, storage and preparation facilities. Preparation of a “home made” BMS, using animal milk for example, should only be used as a last resort.

The use of bottles and teats should be actively discouraged due to the high risk of contamination and difficulty with cleaning. Use of cups without spouts should be actively promoted. In situations where bottle feeding is common and cannot be discouraged, attention must be given to the risk of contamination and the need for proper cleaning of the feeding tools.

There is a lack of detailed operational guidance to guide artificial feeding programming. However there are lessons from recent emergencies to draw upon (see Case Example 11).

Protecting breastfeeding in artificial feeding programmes

In meeting the needs of artificially fed infants, it is important that breastfeeding is protected and supported in the population. Distributing resources (e.g. infant formula, cooking equipment, soap, fuel, water) only to the caregivers of artificially fed infants has the potential to undermine breastfeeding, or may encourage breastfeeding mothers to report feeding difficulties when they have none, in order to qualify for commodities. Where a mother is mixed feeding, there should not be a disincentive to transition to exclusive breastfeeding. So securing breastfeeding mothers with an equivalent value incentive should be factored into any artificial feeding programme.

55 Nutrition and health emergency response: For an agency to be part of the nutrition and health response, they must have staff actively involved in the healthcare system (governmental, non-governmental or private institutions or organizations engaged directly or indirectly in health care for mothers, infant 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) who are responsible for targeting the BMS, monitoring the infants, and ensuring that the supply of BMS is continued for as long as the infants concern need it.

Box 13: Lactose Intolerance

Lactose intolerance is a clinical syndrome of 1 or more of the following: abdominal pain, diarrhea, nausea, flatulence, and/or bloating after the ingestion of lactose or lactose-containing food substances. Lactose is found exclusively in mammalian milk. Absorption of lactose requires activity of the enzyme lactase. Lactase is present at birth, but for many children it disappears when growing up, at various ages in different racial groups and is the most common cause of lactose malabsorption and lactose intolerance (Heyman 2006). Approximately 70% of the world’s population has primary lactase deficiency (Kretchmer 1971, Kretchmer 1968). The percentage varies according to ethnicity. In populations with a predominance of dairy foods in the diet, particularly northern European people, as few as 2% of the population has primary lactase deficiency. In contrast, the prevalence of primary lactase deficiency is 50% to 80% in Hispanic people, 60% to 80% in black and Ashkenazi Jewish people, and almost 100% in Asian and American Indian people (Paige et al. 1977, Lloyd, Olsen 1995, Sahi 1994).

Distributing cow’s milk or cow’s milk products to population groups who do not use animal milk traditionally in their diet therefore holds the risk of triggering lactose intolerance symptoms among them.


Further technical guidance is available in Module 2 on IYCF-E, Chapter 9, When infants are not breastfed, and in the online orientation package (lessons.ennonline.net)

Handling milk and milk products in emergencies

Milk is a valuable nutritious food, a source of energy, good quality protein, and calcium. As an animal source food, it can make a valuable contribution to a young child’s diet. Pastoral populations in particular rely heavily on animal milks as a nutrient source. Where used, it is important to ensure milk and milk products are safely accommodated into the diets of young children in emergencies. Milk is easily contaminated, and provides a perfect medium for bacterial growth – making it potentially deadly. In particular there are risks regarding dried milk powder and, in some contexts, liquid milk use, regarding hygienic preparation, storage, and the risk that they may be used inappropriately as a breastmilk substitute. Use of inappropriate images on packages can override the value of any written label advice. This is seen in an example from Laos (Case Example 12). Lactose intolerance may also be a consideration in some populations (see Box 12).

The Sphere Standards (2011) and the Operational Guidance on IYCF-E are clear in recommendations and specify there should be no distribution of free or subsidised milk powder or of liquid milk as a single commodity.

Managing donations of BMS and feeding equipment in emergencies

Donations of BMS, milk and milk products and infant feeding items have proved a significant problem in some emergency contexts.

What are the problems with donated milk and milk products?

Donations of milk and milk products are often made in response to emotive media appeals (see earlier section). Misconceptions about prevailing infant feeding practices amongst relief workers and using this as a basis for programming, can contribute to calls for donations in an emergency (see case example 13), and subsequent inappropriate use (see case example 14). The amount many be disproportionate to or may not be responding to the needs of the population. For example, other animal source foods, such as tinned fish or meat, may be locally available that could be included in the food basket. ‘Free’ supplies may have hidden costs – transport, storage, distribution and monitoring use. Agencies offered donations may not be equipped to deal with them. Handling donations of BMS that arrive draw staff away from delivering necessary assistance in emergencies.
Case Example 12: Example from Laos of misuse of a milk product as a breast milk substitute

An example of inappropriate use of a milk product as a breastmilk substitute comes from an investigation in Laos. Here, labelling on a coffee creamer that depicted the image of a bear holding a baby bear in a breastfeeding position meant mothers mistook the creamer as a suitable BMS and so fed it to their babies. This depiction is a violation of Article 5 of the Code (marketing a product depicting holding the baby bear in a breastfeeding position) and a twisted violation of Article 9 in using a baby bear as the label image, as pictures of infants are not allowed to appear on formula products.

Of 1098 adults surveyed, 96% believed that the can contains milk; 46% believed the Bear Brand logo indicates that the product is formulated for feeding to infants or to replace breast milk; 80% had not read the written warning on the can; and over 18% reported giving the product to their infant at a mean age of 4.7 months (95% confidence interval 4.1 to 5.3).

Of 26 paediatricians interviewed, 13 reported that parents “often” feed the Bear Brand coffee creamer to infants as a substitute for breast milk. Eleven reported that parents “sometimes” feed the product to infants. Paediatricians had encountered infants and children admitted to hospital with malnutrition who had been fed this product exclusively.

The authors concluded that: “The Bear Brand logo’s non-verbal message implies that the product contained is intended for infants. The powerful visual message is not mitigated by the addition of warning text or by the confusing symbol of the feeding bottle with a cross through it. The sale of coffee creamer with this logo places the health of infants and children at risk in a developing nation that already has extreme levels of malnutrition”.


Box 14: Donations of infant formula in emergencies

During the earthquake response in Indonesia in 2006, UNICEF conducted a survey into infant feeding practices, due to concerns over untargeted distribution of milk powder as part of relief. They found that 80% of households with children 0 to 5 months old surveyed had received donated infant formula, whereas only 32% of 0 to 5 months old children consumed infant formula before the earthquake. In addition, 76% of families received commercial porridge and 49% received powdered milk. Consumption of all types of BMS was higher among those who received donated commodities.

One week diarrhoea incidence was higher among those children who received donated infant formula (25.4%) than among those who did not (11.5%; Relative Risk = 2.12). There were strong associations between receipt of BMS and changes in feeding practices, and between receipt of infant formula and diarrhoea. Uncontrolled distribution of infant formula exacerbates the risk of diarrhoea among infants and young children in emergencies.

Case Example 13: Example of misconceptions fuelling response

Despite a strong perception amongst benefactors that BMS were already widely used in Indonesia (used to justify the wide distribution of BMS that had arrived), a UNICEF/Ministry of Health survey found only one-third (32%) of infants under six months had ever consumed infant formula before the earthquake. However, three-quarters of households with infants under six months (75%) had been given donations of infant formula and 15% had received baby bottles.

Source: Ninik et al, Field Exchange 34

Case Example 14: Technical training of NGO and government staff in Haiti 2010

In the aftermath of the earthquake in Port-Au-Prince, Haiti in 2010, the Nutrition Cluster partners identified the need for training within NGOs and government health services. A training of trainers of 3 days for NGO key personnel was designed specifically for this situation, based on the WHO/UNICEF Breastfeeding Course and IYCF-E Module 2. This was adapted to meet the implementation of “Baby Friendly Tents” as described in the national guidelines. The training consisted of basic breastfeeding information, technical breastfeeding counselling skills and how to protect breastfeeding while distributing RUIF to those in need. The training was obligatory for those NGOs distributing RUIF made available by the Nutrition Cluster and over a 100 key personnel were trained.

During a TOT to integrate CMAM into government health facilities targeting Departmental Nutrition Focal Points, planned before the emergency, a module on IYCF-E and on integration of IYCF into CMAM was added to the curriculum.

Source: Astrid De Brabandere, Nutrition Cluster Haiti, 2010

Case Example 15: Experience of Breastfeeding Counselling Training in Indonesia

During the earthquake response in Indonesia, the WHO/UNICEF 40 hours breastfeeding counselling training module was adapted to suit the context and deliver frontline breastfeeding support and counselling. Volunteers with modest formal education were successfully trained in breastfeeding counselling in an emergency. Providing hands-on practice, above and beyond the recommended numbers of practices in the WHO/UNICEF guidelines, was a key strategy in training volunteers with no prior health/nutrition training and experience. Using community volunteers was the best choice in this setting, as they were well accepted by their communities to help and support the pregnant and lactating mothers. Creative adaptation of the training was made possible by using a local implementing agency, whose mandate was to train and counsel on breastfeeding.


Informed by the experiences in emergencies, the Operational Guidance on IYCF-E advises that donated (free) or subsidised supplies of breastmilk 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 breastmilk substitutes, bottles and teats should be placed under the control of a single designated agency.

Having plans in place to handle any donations that cannot be prevented is also needed. If donations arrive they should be collected by a designated agency, preferably from point of entry into the emergency area, under the guidance of the IYCF-E co-ordinating body (as specified in Operational Guidance 6.1.3). This allows any supplies that arrive to be controlled and a plan devised for their use.

Examples of strategies to handle unwanted donations of infant formula and milk products:

- Prepare a fortified blended food for use as complementary food for infants over 6 months.
- Use in institutional nutrition support, e.g. for the elderly, orphans
- Used in animal feed.
- Use in preparation of biscuits and cakes that can be distributed.
- Destruction.
Orientation and Training on IYCF-E

Different levels of orientation and training on IYCF-E are needed for all those involved in emergency response – from governments that respond in disaster-prone countries, to country offices of NGOs and UN agencies, to donors who fund emergency programmes.

Basic orientation on IYCF-E should be provided as a preparedness activity for managers, donors, logisticians, water and sanitation experts and those in charge of social services.

Integrating training on IYCF-E into pre-service training of key personnel is an important preparedness activity and requires a longer term approach to capacity development on emergency response.

In-service training can help build and refresh skills that are directly relevant to health staff in their daily work, e.g. training on IYCF in CMAM programming, breastfeeding counselling 40 hour training with added emergency component.

In identifying and working with national capacity when an emergency strikes, it is important to appreciate that staff may also be affected themselves by an emergency and may be struggling to meet their own family needs. Breastfeeding counsellors at community level are often women, with children themselves. In planning training, these constraints should be taken into account, for example conducting part-time training, offering childcare provision and enabling access to psychosocial support if needed.

Training has often proved necessary in an emergency (see case example 14). Training carried out in an emergency can help improve national capacity in the longer term (see case example 15).
# Annex 1: Recommendations for feeding your child

## RECOMMENDATIONS FOR FEEDING YOUR CHILD

### Newborn, birth up to 1 week
- Immediately after birth, put your baby in skin to skin contact with you.
- Allow your baby to take the breast within the first hour. Give your baby colostrum, the first yellowish, thick milk. It protects the baby from many illnesses.
- Breastfeed day and night, as often as your baby wants, at least 8 times in 24 hours. Frequent feeding produces more milk.
- If your baby is small (low birth weight), feed at least every 2 to 3 hours. Wake the baby for feeding after 3 hours, if baby does not wake self.
- Do not give other foods or fluids. Breast milk is all your baby needs.

### 1 week up to 6 months
- Breastfeed as often as your child wants. Look for signs of hunger, such as beginning to fuss, sucking fingers, or moving lips.
- Breastfeed day and night, whenever your baby wants, at least 8 times in 24 hours. Frequent feeding produces more milk.
- Do not give other foods or fluids. Breast milk is all your baby needs.

### 6 months up to 9 months
- Breastfeed as often as your child wants.
- Also give thick porridge or well-mashed foods, including animal-source foods and vitamin A-rich fruits and vegetables.
- Start by giving 2 to 3 tablespoons of food. Gradually increase to 1/2 cup at each meal.
- Give 2 to 3 meals each day.
- Offer 1 or 2 snacks each day between meals when the child seems hungry.

### 9 months up to 12 months
- Breastfeed as often as your child wants.
- Also give a variety of mashed or finely chopped family foods, including animal-source foods and vitamin A-rich fruits and vegetables.
- Give 1/2 cup at each meal.
- Give 3 to 4 meals each day.
- Offer 1 or 2 snacks between meals. The child will eat if hungry.
- For snacks, give small chewable items that the child can hold. Let your child try to eat the snack, but provide help if needed.

### 12 months up to 2 years
- Breastfeed as often as your child wants.
- Also give a variety of mashed or chopped family foods, including animal-source foods and vitamin A-rich fruits and vegetables.
- Give 1/4 cup at each meal.
- Give 3 to 4 meals each day.
- Offer 1 or 2 snacks between meals.
- Continue to feed your child slowly, patiently. Encourage-but do not force-your child to eat.

### 2 years and older
- Give a variety of family foods to your child, including animal-source foods and vitamin A-rich fruits and vegetables.
- Give at least 1 full cup at each meal.
- Give 3 to 4 meals each day.
- Offer 1 or 2 snacks between meals.
- If your child refuses a new food, offer “tastes” several times. Show that you like the food. Be patient.
- Talk with your child during a meal, and keep eye contact.
Annex 2: Additional Policy Guidance and Frameworks

**Human rights**

The mandate to protect and support IYCF-E is grounded in international human rights conventions. The International Covenant on Economic, Social and Cultural Rights (1966), the Convention on the Elimination of all forms of Discrimination Against Women (1979) and the Convention on the Rights of the Child (CRC) (1989) directly commit ratifying states and indirectly, non-state actors, to promote and protect the nutritional wellbeing of women and children.

**UNICEF and Lancet conceptual frameworks**

The UNICEF conceptual framework for causes of malnutrition (1990) was developed to help understand the causes of malnutrition and has been widely applied to emergency contexts. This is elaborated upon in the Lancet conceptual framework that also considers maternal undernutrition and poverty, and both the short-term and longer term consequences of maternal and child undernutrition.

The Lancet conceptual framework for causes of malnutrition illustrates how malnutrition is the result of a complex mixture of multiple causes at various levels with a reciprocal relationship. It differentiates between the immediate causes, the underlying causes that lead to the immediate causes, which in their turn are determined by the larger political, economic and social context.

Poor maternal nutrition will contribute to poor intra-uterine growth, low birth weight and subsequent suboptimal growth and development of a child. Sub-optimal infant and young child feeding and care practices will have a major negative impact on the nutritional and health status of an infant.

Unhygienic food preparation (storage and cooking) will also increase the risk of diseases—subsequently increasing vulnerability to acute malnutrition, while unequal distribution of food within the household will also contribute to undernutrition.

Inadequate provision of water and sanitation facilities will significantly increase the risk of infection/illness. Inadequate provision of basic health services will further compromise health and nutrition status when common illnesses are not properly treated.

Emergencies directly impact the basic and underlying causes of undernutrition. Humanitarian programming will primarily focus on addressing the immediate causes of undernutrition (disease and inadequate dietary intake) and the consequences of the underlying causes of undernutrition (household food insecurity, inadequate care, unhealthy environment and lack of services). IYCF fits into this framework.

This conceptual framework is a useful starting point in understanding the links between different factors and the need for multi-sector assessment and multi-sector interventions to prevent mortality and morbidity and undernutrition in an emergency context.

**WHO guiding principles on infant and young child feeding in emergencies**

In 2004, WHO set out 10 Guiding Principles in order to help prevent increased morbidity and mortality among children in emergencies and to serve as a basis for action. They are intended to:

- Clarify that optimal practices for feeding infants and young children during emergencies are essentially the same as those that apply in other, more stable conditions
- Inform decision-makers about the key interventions required to protect and promote optimal feeding for infants and young children that should be *routinely* included in any emergency relief response
- Provide a starting point for organizing pragmatic, sustained interventions that will ensure optimal feeding and care for infants and young children during emergencies.

Since feeding infants and young children during emergencies is only one aspect of a broader survival strategy for entire populations, the guiding principles should be applied *flexibly* in conjunction with manuals, guidelines, training curricula, and other practical field-oriented documentation that treat in detail a variety of related topics.
Figure 1: Framework of the causes of maternal and child undernutrition and its short-term consequences

Annex 3: The International Code of Marketing of Breast-milk Substitutes and WHA Resolutions: Summary of portions relevant to emergencies

In 1979, WHO and UNICEF organized an international meeting on infant and young child nutrition. One of the recommendations made was that there should be an international code of marketing of infant formula and other products used as breastmilk substitutes. Member states of WHO and other groups and individuals who had attended the 1979 meeting, including representatives of the infant food industry, were then involved in a consultative process, which culminated in the production of the International Code. This Code was endorsed by the World Health Assembly in 1981 in a Resolution that stressed that the Code is a minimum requirement to be enacted in its entirety by all countries.

The Code sets out the responsibilities of the infant food industry, health workers, national governments and concerned organizations in relation to the marketing of breastmilk substitutes, feeding bottles and teats as well as information regarding the use of these products. Since 1981, subsequent WHA Resolutions have been passed which aim to strengthen and clarify the Code. These Resolutions have the same status as the Code itself and should be read with it.

The most important parts of the Code relating to infant feeding in emergencies are: 

**Aim:** “The aim of the Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when they are necessary, on the basis of adequate information and through appropriate marketing and distribution.”

**Scope:** The Code applies to any product that is marketed or otherwise represented as a partial or total replacement for breastmilk, and to feeding bottles and teats. Only certain products are suitable as breastmilk substitutes, but many other unsuitable products (such as baby cereals, fruit or sugar drinks and follow-on formulas) fall under the scope of the Code when they are marketed inappropriately.

**Advertising:** No advertising of the above products to the public.

**Samples:** No free samples to mothers, their families or health workers (‘Sample’ means ‘single or small quantities of a product provided without cost.’)

**Health care facilities (Article 6):**
- No promotion of products, i.e., no product displays, posters or distribution of promotional material.
- ‘Feeding with infant formula… should be demonstrated only by health workers, or other community workers if necessary, and only to the mothers or family members who need to use it; and the information should include a clear explanation of the hazards of improper use’ (Article 6.5).
- No use of ‘mothercraft’ nurses or similar company-paid personnel.
- ‘There should be no free or subsidized supplies of breast-milk substitutes or other products covered by the Code in any part of the health care system.’ 1994 Resolution (WHA 47.50)

**Health care workers (Article 7):**
- No gifts or samples should be given to health care workers.
- ‘Health workers should not give samples of infant formula to pregnant women, mothers of infants and young children, or members of their families.’ (Article 7.7).
- Product information must be factual and scientific.

**Supplies:** No free or low-cost supplies of breastmilk substitutes to maternity wards and hospitals (The 1994 WHA Resolution (WHA 47.50) states that they should not be in any part of the health care system)

**Information:** Governments have responsibility to ensure that ‘objective and consistent information is provided on infant and young child feeding.’ Such information should never promote or idealise the use of breastmilk substitutes and should include specified points. It should also explain the benefits and superiority of breastfeeding and the costs and hazards associated with artificial feeding. Manufacturers should provide only scientific and factual information to health workers and should never seek contact with mothers.
Infant and young child feeding

MODULE 17

TECHNICAL NOTES

Labels (Article 9):

- The label must be ‘in an appropriate language’, it should also be ‘easily readable and understandable’ (Article 9.2.)
- Must clearly state the superiority of breastfeeding, that ‘the product should only be used on the advice of a health worker as to its use and the proper method of use’ and warning about health hazards. (Article 9.2.)
- There must be no pictures of infants, nor ‘pictures or text which may idealize the use of infant formula’. The terms ‘humanized’, ‘materialized’ or similar terms should not be used.
- The label should also state the following: (a) the ingredients used; (b) the composition/analysis of the product; (c) the storage conditions required; and (d) the batch number, and the date before which the product is to be consumed, taking into account the climatic and storage conditions of the country concerned. (Article 9.4)

Products: Unsuitable products should not be promoted for infants, such as sweetened condensed milk. All products should be of high quality and take account of the climatic and storage conditions of the country where they are used. Manufacturers and distributors should comply with the Code independent of government action to implement it. NGOs have a responsibility to report any violations to governments and to manufacturers.

The WHA Resolutions most relevant to emergencies are:

- The 1981 Resolution (WHA 34.22) stresses that the Code is a ‘minimum requirement’ to be enacted ‘in its entirety’ by all countries, that it should be translated into ‘national legislation, regulation or other suitable measures’ and that compliance should be monitored.
- The 1986 Resolution (WHA 39.28) states that:
  - Any food or drink given before complementary food is required may interfere with breastfeeding (less than six months of age) and so should not be promoted or encouraged for use by infants during this period.
  - ‘Ensure the small amounts of breast-milk substitutes needed for the minority of infants who require them in maternity wards and hospitals are made available through the normal procurement process and not through free or subsidized supplies.’
  - The practice being introduced in some countries of providing ‘follow-up milks’ for older children is not necessary.
- The 1992 Resolution (WHA 45.34) reaffirms that during the first 4-6 months no other foods or fluids (even water), except breastmilk, are required.
- The 1994 Resolution (WHA 47.50) states that:
  - Mothers should be supported in their choice to breastfeed, obstacles should be removed and interference prevented in health services, the workplace or the community
  - Complementary feeding should be introduced from about six months of age
  - There should be no free or subsidized supplies of breastmilk substitutes or other products covered by the Code in any part of the health care system
  - To exercise extreme caution when planning, implementing or supporting emergency relief operations, by protecting, promoting and supporting breast-feeding for infants, and ensuring that donated supplies of breast-milk substitutes or other products covered by the scope of the International Code be given only if all the following conditions apply:
    - Infants have to be fed on breast-milk substitutes… (b) The supply is continued for as long as the infants concerned need it; (c) The supply is not used as a sales inducement’
- The 1996 Resolution (WHA 47.15) states that
  - Financial support for professionals working in infant and young child health should not create conflicts of interest.
  - Monitoring of the Code and subsequent relevant resolutions should be carried out in a transparent independent manner, free from commercial influence.
- The 2001 Resolution (WHA 55.2) states that exclusive breastfeeding should be promoted, protected and supported for six months as a global public health recommendation, and to provide safe and appropriate complementary foods, with continued breastfeeding for up to two years of age or beyond.
The 2005 Resolution (WHA 58.32) states that:

- financial support and other incentives for programmes and health professionals working in infant and young child health do not create conflicts of interest
- Member States should be aware of the risks of intrinsic contamination of powdered infant formulas and ensure this information is conveyed through label warnings

The 2010 Resolution (WHA 63.23) urges Member States "to ensure that national and international preparedness plans and emergency responses follow the evidence-based Operational Guidance for Emergency Relief Staff and Programme Managers on infant and young child feeding in emergencies, which includes the protection, promotion and support for optimal breastfeeding, and the need to minimize the risks of artificial feeding, by ensuring that any required breast-milk substitutes are purchased, distributed and used according to strict criteria";
**Annex 4: Operational Guidance on IYCF-E: 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 IYCF-E. The policy should be widely disseminated to all staff, with agency procedures adapted accordingly and policy implementation enforced.
3. Agencies should ensure the training and orientation of their technical and non-technical staff in IYCF-E, using available training materials.
4. Within the United Nations Inter-agency Standing Committee (IASC) cluster approach to humanitarian response, UNICEF will likely be the UN agency responsible for coordination of IYCF-E in the field. Other United Nations agencies and NGOs do, nonetheless, have key roles to play in close collaboration with the government.
5. Key information on infant and young child feeding needs to be integrated into routine rapid assessment procedures. If necessary, more systematic assessment using recommended methodologies could be conducted.
6. Simple measures should be put in place to ensure that the needs of mothers, infants and young children are addressed in the early stages of an emergency. Support for other caregivers and those with special needs, e.g., orphans and unaccompanied children, must also be established at the outset.
7. Breastfeeding and infant and young child feeding support should be integrated into other services for mothers, infants and young children.
8. Foods suitable to meet the nutrient needs of older infants and young children must be included in the general ration for food-aid dependent populations.
   Donated (free) or subsidized supplies of breastmilk 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 breastmilk substitutes, bottles and teats should be placed under the control of a single designated agency.
9. 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. Breastmilk substitutes, other milk products, bottles and teats must never be included in a general ration distribution. Breastmilk substitutes and other milk products must only be distributed according to recognized 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 actively avoided.


Full text including translated versions available at [www.enonline.net](http://www.enonline.net).
ANNEX 5: MODEL JOINT STATEMENT ON INFANT AND YOUNG CHILD FEEDING IN AN EMERGENCY

Note: Context-specific information required to produce a joint statement from this model is indicated by brackets.

Call for support for appropriate infant and young child feeding in emergencies

List of issuing organisations call for support for appropriate infant and young child feeding in the current emergency, and caution about unnecessary use of milk products.

INSERT OPENING LEADING LINES, CONTEXT SPECIFIC.
During emergency situations, whether manmade or natural disasters, [contexts and examples can be inserted here], disease and death rates among under-five children are generally higher than for any other age group. The younger the infant, the higher the risk. Mortality may be particularly high due to the combined impact of a greatly increased prevalence of communicable diseases and diarrhoea and soaring rates of under-nutrition. The fundamental means of preventing malnutrition and mortality among infants and young children is to ensure their appropriate feeding and care.

[List of issuing organisations] note that donations of infant formula and other powdered milk products are often made, whilst experience with past emergencies has shown that without proper assessment of needs, an excessive quantity of milk products for feeding infants and young children are often provided, endangering their lives. There should be no donations of breastmilk substitutes (BMS), such as infant formula, other milk products, bottle-fed complementary foods represented for use in children up to 2 years of age, complementary foods, juices, teas represented for use in infants under six months; and bottles and teats. Any unsolicited donations should be directed to the designated coordinating agency (see below).

[List of issuing organisations] reiterate that no food or liquid other than breast milk, not even water, is needed to meet an infant’s nutritional requirements during the first six months of life. After this period, infants should begin to receive a variety of foods, while breastfeeding continues up to two years of age or beyond. The valuable protection from infection and its consequences that breast milk confers is all the more important in environments without safe water supply and sanitation. Therefore, creation of a protective environment and provision of skilled support to breastfeeding women are essential interventions.

Any provision of BMS for feeding infants and young children should be based on careful needs assessment. Therefore, all donor agencies, non-governmental organisations (NGOs), media, individuals wishing to help and other partners, should avoid calls for and sending donations of BMS, bottles and teats and refuse any unsolicited donations of these products. BMS should be used only under strict control and monitoring and in hygienic conditions, and in accordance with the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions, as well as humanitarian agencies’ policies and guidelines. There should be no general distribution of BMS.

There is a common misconception that in emergencies, many mothers can no longer breastfeed adequately due to stress or inadequate nutrition. A desire to help may result in the inappropriate donations of infant formula and other milk products. Stress can temporarily interfere with the flow of breast milk; however, it is not likely to inhibit breast milk production, provided mothers and infants remain together and are adequately supported to initiate and continue breastfeeding. Mothers who lack food or who are malnourished can still breastfeed adequately. Adequate fluids and extra food for the mother will help to protect her health and well-being.

If supplies of infant formula and/or powdered milks are widely available, mothers who might otherwise breastfeed might needlessly start giving artificial feeds. This exposes many infants and young children to increased risk of infectious disease, malnutrition and death, especially from diarrhoea when clean water is scarce. The use of feeding bottles only adds further to the risk of infection as they are difficult to clean properly.

In exceptionally difficult circumstances, therefore, the focus needs to be on creating conditions that will facilitate breastfeeding, such as establishing safe ‘corners’ for mothers and infants, one-to-one counselling, and mother-to-mother support. Traumatised and depressed women may have difficulty responding to their infants and require particular mental and emotional support. Every effort should be made to identify ways to breastfeed infants and young children who are separated from their mothers, for example by a wet-nurse.

In addressing IYCF-E in the context of high HIV prevalence, a position reflecting the latest consensus may be stated here.
Infant and young child feeding

Treatment of severely malnourished children, whether facility or community based, should be treated in accordance with international standards and best practice and closely monitored. Standard commercial infant formulas are not meant for this purpose.

Children from the age of six months require nutrient-rich complementary foods in addition to breastfeeding. Complementary feeding should be addressed with priority for locally available, culturally acceptable, nutritionally adequate family foods.

Provision of fortified foods or micronutrient supplements such as vitamin A or zinc in supervised programmes for young children represent a much more appropriate form of assistance than sending milk products. In rations for general food distribution programmes, pulses, meat, or fish are preferable to powdered milk.

List of issuing organisations] strongly urge all who are involved in funding, planning and implementing an emergency response and in all levels of communication to refer to key policy and programme instruments to avoid unnecessary death following uncontrolled distribution of BMS. Community leaders are called upon to monitor and report any donations that may undermine breastfeeding.

We urge governments and partners to include capacity building for breastfeeding and infant and young child feeding as part of emergency preparedness and planning, and to commit financial and human resources for proper and timely implementation of breastfeeding and infant and young child feeding in emergencies.

The designated coordinating agency is Insert

Available on: http://www.ennonline.net
Direct link: http://www.ennonline.net/resources/237
Annex 6: Sample key messages on IYCF for communication to different target groups

Sample key messages on stress and breastfeeding to circulate in an emergency

• Breastfeeding can help a mother and baby or young child deal with stressful or traumatic situations.

• A traumatised mother can be helped through breastfeeding her baby.

• A frightened young child will get reassurance, as well as nourishment, from breastfeeding.

• Breastfeeding can also help in pain relief of infants and young children. So if a baby or young child is injured, breastfeeding can help – as well as supply essential food and fluid.

• If you have stopped breastfeeding, you can restart – if you breastfeed more, then you will produce more milk.

• Even if your breasts are soft, this does not mean they are empty – they will still produce enough milk.

• If you are breastfeeding your baby, encourage and support other mothers caught up in the crisis especially those who may be having difficulties, who may be traumatised or who have newborns. Help to build their confidence and reassure them of this amazing capacity they have to nourish and protect their babies in this emergency.

• If you are the father or the husband or the relative of a mother who is breastfeeding or who has breastfed and has stopped during this crisis, encourage her to continue or restart. Reassure her of the resilience of breastfeeding and how well she is equipped to nourish and protect her baby.

Sample key messages to mothers and caregivers in an emergency

Their use should be informed by the particular context and carefully translated to ensure accurate interpretation.

• Babies are very vulnerable but taking special care in feeding them can protect them. This is what you can do to protect your baby: The most effective way of protecting babies is to breastfeed them. Breastmilk gives your baby food and water and is a medicine that fights illness. Babies under 6 months should not be given anything except for breastmilk. Giving a baby under 6 months water or infant formula, milk powder or solid food under the current circumstances is dangerous. It can give them diarrhoea and this can be fatal, this is why it is so important to only breastfeed if it is at all possible. Children over 6 months should continue to be breastfed until at least 2 years.

• The youngest babies are at the greatest risk if they are not breastfed. So it is essential that newborn babies begin breastfeeding immediately after birth (within an hour) and are given only breastmilk.

• Some people think that stress or not having good food will make a mother’s milk dry up, this is not true. A hand or shoulder massage can help you to feel less stressed and will help the milk to flow more easily when you are breastfeeding. Stressful or traumatic situations can interfere with how often and when you feed your baby, so that you may produce less breastmilk. Babies and young children may be disturbed by stressful situations and become difficult to settle down to feeding.

• Whatever the reason, more frequent breastfeeds will help you make more milk if you think you don’t have enough. Keeping the baby close to you, the mother, day and night will help you to breastfeed more and make more milk.

• If you have had powdered milk given to you for your baby and you are breastfeeding, drink it yourself, nourishing yourself will help you to nourish your baby. Do not give your baby infant formula or powdered milk unless it is absolutely necessary because it is dangerous.

• If a baby does not have a mother or if their mother has stopped breastfeeding another woman can breastfeed the baby (depending on local context).

• If you have been using infant formula and breastfeeding you can increase your milk supply by reducing the amount of formula given to your baby and breastfeeding more frequently. If you have stopped breastfeeding you can start again; letting the baby suck at the breast will start the milk flowing again but this can take a few days to a couple of weeks for there to be enough milk – depending on how long it has been since you stopped.

• It is very important to take extreme care in feeding babies formula. This should only happen if there is no way that the baby can be breastfed. It is very important to make sure that everything used to feed the baby is clean. Cups are better for feeding than bottles, which are very hard to clean properly. Cleaning water and water to make up formula should be boiled. Made up formula should not be stored. Seek help from organisations supporting mothers feeding their babies. Seek medical help if your baby gets sick with diarrhoea or a chest infection.

English and French copies of this are available at www.ennonline.net or direct link http://www.ennonline.net/resources/735
Annex 7: Active/Responsive Feeding for Young Children

**Definition:** Active/responsive feeding is being alert and responsive to your baby’s signs that she or he is ready-to-eat; actively encourage, but don’t force your baby to eat.

**Importance of active feeding:**
When feeding him/herself, a child may not eat enough. He or she is easily distracted. Therefore the young child needs help. When a child does not eat enough, he or she will become malnourished.

- Let the child eat from his/her own plate (caregiver then knows how much the child is eating)
- Sit down with the child, be patient and actively encourage him/her to eat.
- Offer food the child can take and hold; the young child often wants to feed him/herself. Encourage him/her to, but make sure most of the food goes into his/her mouth.
- Mother/father/caregiver can use her fingers (after washing) to feed child.
- Feed the child as soon as he or she starts to show early signs of hunger.
- If your young child refuses to eat, encourage him/her repeatedly; try holding the child in your lap during feeding.
- Engage the child in “play”, trying to make the eating session a happy and learning experience… not just an eating experience.
- The child should eat in his/her usual setting.
- As much as possible, the child should eat with the family in order to create an atmosphere promoting his/her psycho-affective development.
- Help older children to eat.
- Do not insist if the child does not want to eat. Do not force feed.
- If the child refuses to eat, wait or put it off until later.
- Do not give child too much to drink before or during meals.
- Congratulate the child when he or she eats.

Parents, family members (older children), child caretakers can participate in active/responsive feeding.

Annex 8: Key information on complementary foods

Things to consider regarding complementary feeding are: A = Age of infant/young child, F = Frequency of foods, A = Amount of foods, T = Texture (thickness/consistency), V = Variety of foods, A = Active or responsive feeding, H = Hygiene

Energy and nutrient considerations

Energy
- From 0 up to 6 months breast milk supplies all the ‘energy needs’ of a child
- From 6 up to 12 months breast milk continues to supply about half (1/2) the ‘energy needs’ of a child; the other half of ‘energy needs’ must be filled with complementary foods
- From 12 up to 24 months breast milk continues to supply about one third (1/3) of the energy needs of a child; the missing ‘energy needs’ must be filled with complementary foods
- Besides nutrition, breastfeeding continues to:
  - provide protection to the child against many illnesses, and provides closeness, comfort, and contact that helps development.

Iron
- The iron stores present at birth are gradually used up over the first six months
- There is little iron from breast milk (although it is easily absorbed). After 6 months the baby’s ‘iron needs’ must be met by the food he or she eats.
- Best sources of iron are animal foods, such as liver, lean meats and fish. Some vegetarian foods such as legumes have iron as well. Other good sources are iron-fortified foods and iron supplements.
- Plant sources such as beans, peas, lentils and spinach are a source of iron as well.
- Eating foods rich in vitamin C together with/or soon after a meal, increases absorption of iron.
- Drinking tea and coffee with a meal reduce the absorption of iron.

Vitamin A
- Best sources of vitamin A are yellow-coloured fruits and vegetables (papaya, mangoes, passion fruit, oranges, carrots, pumpkins, yellow sweet potato); dark-green leaves, and organ foods/offal (liver) from animals; eggs, milk and foods made from milk such as butter, cheese and yoghurt; dried milk powder and other foods fortified with vitamin A.

Breastfed infants and young children requirements

At 6 months
- Babies have small stomachs and can only eat small amounts at each meal so it important to feed them frequently throughout the day
- Start with the staple cereal to make porridge (e.g. corn, wheat, rice, millet, potatoes, sorghum)
- Animal source foods are very important and can be given to babies and young children. Cook well and chop fine.
- The consistency of the porridge should be thick enough to be fed by hand
- When possible use milk instead of water to cook the porridge
- Use iodised salt to cook the porridge
- Continue breastfeeding to 24 months or older
- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhoea and other illnesses.
Infant and young child feeding

From 6 up to 9 months

- An 8-month old stomach holds about 200 ml or less than a cup
- Add colourful (variety) foods to enrich the staple including beans, peanuts, peas, lentils or seeds; orange/red fruits and vegetables (such as ripe mango, papaya, and carrots, pumpkin); dark-green leaves (such as kale, chard), avocado. Soak beans and legumes before cooking to make them more suitable for feeding children
- Add animal-source foods: meat, chicken, fish, liver; and eggs and milk, and milk products (whenever available)
- Mash and soften the added foods so your baby/child can easily chew and swallow.
- By 8 months the baby should be able to begin eating finger foods. It is important to give finger foods to children to eat by themselves only after they are able to sit upright.
- Use iodised salt
- Continue breastfeeding
- Additional nutritious snacks (such as fruit or bread or bread with nut paste) can be offered once or twice per day, as desired
- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhoea and other illnesses.

From 9 up to 12 months

- Add colourful (variety) foods to enrich the staple including beans, peanuts, peas, lentils or seeds; orange/red fruits and vegetables (such as ripe mango, papaya, and carrots, pumpkin); dark-green leaves (such as kale, chard), avocado.
- Add animal-source foods: meat, chicken, fish, liver; and eggs and milk, and milk products (whenever available)
- Give at least 1 to 2 snacks each day such as ripe mango and papaya, avocado, banana, other fruits and vegetables, fresh and fried bread products, boiled potato, sweet potato
- Use iodised salt
- Continue breastfeeding
- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhoea and other illnesses.

From 12 up to 24 months

- Add colourful (variety) foods to enrich the staple including beans, peanuts, peas, lentils or seeds; orange/red fruits and vegetables (such as ripe mango, papaya, and carrots, pumpkin); dark-green leaves (such as kale, chard), avocado.
- Add animal-source foods: meat, chicken, fish, liver; and eggs and milk, and milk products every day at least in one meal (or at least 3 times/week)
- Give at least 1 to 2 snacks each day such as ripe mango and papaya, avocado, banana, other fruits and vegetables, fresh and fried bread products, boiled potato, sweet potato
- Use iodised salt
- Continue breastfeeding to 24 months or beyond
- Foods intended to be given to the child should always be stored and prepared in hygienic conditions to avoid contamination, which can cause diarrhoea and other illnesses.
Non-breastfed infants and young children considerations

Recommended complementary feeding practices to address the need for milk products and extra fluids for a non-breastfed child

- Exclusive breast milk substitute from 0 up to 6 months
- After 6 months of age, add the following:
  - 1 to 2 extra meals and offer 1 to 2 snacks (especially ‘animal flesh’ foods), i.e. 4 meals/day of family foods
  - 1 to 2 cups of milk per day
  - About 2 cups/day of extra fluids (in addition to the 1 to 3 cups/day of water that is estimated to come from milk and other foods in a temperate climate, and 3 to 4 cups/day in a hot climate)

Hygiene

- Wash hands with soap and water before preparing food, eating, and feeding young children. Wash baby’s hands before eating.
- Wash hands with soap and water after using the toilet and washing or cleaning baby’s bottom.

Five keys to safer food

1. Keep clean (hands, working surfaces, utensils).
2. Separate raw from cooked foods including utensils and containers
3. Use fresh foods and cook thoroughly (especially meat, poultry, eggs and fish)
4. Keep food at safe temperature
5. Use clean and safe water

Feeding a sick child over 6 months of age

Encourage the child to breastfeed more and continue eating during illness and provide extra food after illness.

- Fluid and food requirements are higher during illness.
- It is easier for a sick child to eat small frequent meals. Feed the child foods he or she likes in small quantities throughout the day.
- Children who have been sick need extra food and should be breastfed more frequently to regain the strength and weight lost during the illness.
- Take advantage of the period after illness when appetite is back to make sure the child makes up for loss of appetite during sickness.

Annex 9: How breastfeeding works

Understanding how breastfeeding works can help staff to see why appropriate support is necessary and dispel common concerns and misconceptions in emergencies. During emergencies, a breastfeeding counsellor’s task is to build the mother’s confidence, provide accurate information, help the mother to ensure adequate milk production and ensure that the mother has necessary support.

There are four key components to effective breastfeeding:

- Good attachment and positioning
- Milk flow and confidence
- Adequate milk production
- Age-appropriate feeding for the infant and young child

Interventions to support breastfeeding mothers should address these.

**Good attachment**

In order to ensure effective breastfeeding a baby needs to suckle effectively, by taking enough of the breast into his or her mouth: this is called ensuring a good attachment. Signs of good attachment are:

- more areola above the baby’s mouth than below
- baby’s mouth wide open
- lower lip turned out (can be hard to see)
- chin touching the breast (or nearly touching)

In addition, the baby is well attached if breastfeeding is comfortable and painless for the mother (see IFE Module 2 for illustration of attachment).

**Good positioning**

Positioning, how a mother holds her baby, can be very important in ensuring good attachment and feeding. For good positioning, the baby’s body must be:

- straight and in line with the head so that the neck is not twisted or bent forward too far back
- facing the breast (baby’s nose facing the nipple as s/he comes to the breast)
- close to the mother’s body
- supported: a young infant needs the whole body supported, not just the head and neck; an older child may like to have his/her back supported even though s/he sits up to breastfeed
- good positioning of the baby done with different positions (mother lying down, sitting up); it is important to ensure that the baby’s wrappings do not get in the way.

**Milk flow and confidence**

There are two things that affect milk flow: the baby’s suckling (which also affects milk production) and the mother’s feelings. The breasts of a breastfeeding mother are never completely empty. Milk is produced and stored in the breast all the time. When a baby suckles, a hormone called oxytocin is released. Oxytocin makes the stored breastmilk flow through ducts towards the nipple. Good feelings, such as pleasure in touching, seeing or hearing her baby, or feeling confident that her milk is good, help her milk to flow. Bad feelings, such as worries about her milk, or rejection by the baby, may interfere with the flow of milk.

The extreme stresses and disturbances of emergencies sometimes seem to interfere with milk flow. Fortunately, any stopping of milk flow is usually temporary. Protection, shelter and a reassuring atmosphere around a woman can help her milk to flow easily again. A mother does not need perfect calm or special conditions to breastfeed. Many women breastfeed without difficulty in extremely stressful situations. Some women find that breastfeeding soothes and helps them to cope with stress.
Adequate milk production
Breasts make milk in response to the suckling of an infant. There are two processes to know about:

a) Suckling stimulates release in the mother’s body of a hormone called prolactin. Prolactin makes the breasts produce milk. The milk is stored in the breast.

b) Milk production slows down if a lot of milk is left in a breast at any time.

More suckling makes more milk
A breastfeeding mother does not have a fixed supply of breastmilk. She can always make more with the right technique, confidence and frequent feeding. A mother with twins can produce enough milk for both babies. A mother can also produce enough milk even if she is moderately malnourished. Milk production is only likely to be reduced if a woman is severely malnourished; then the woman herself would need immediate feeding/extra food (‘Feed the mother to feed the baby’). In such cases, the woman needs support to continue to offer her baby the breast in order to maintain the milk-making process while she recovers herself.

Recommended breastfeeding pattern
Frequent and unlimited breastfeeds throughout the first year of life ensures stimulation of the mother’s breasts to make the milk that the baby needs to grow and develop healthily. The baby should:

- suckle as often as s/he wants, day and night, without long periods of separation
- suckle for as long as s/he wants at each feed (getting the rich milk that comes later in the feed).
- have the breast kept available if s/he pauses or lets go for some moments (pauses do not necessarily mean that s/he has finished the feed).
- finish the first breast and then be offered the second which s/he may or may not want – it is up to the infant to decide whether s/he wants one or two breasts at each feed (there is no rule).
Step 1: Ensure effective suckling
• Observe a breastfeed for the four points of good attachment (areola, mouth, lip, chin) and effective suckling.
• If attachment is not good, or suckling not effective, improve position (straight, facing, close, supported) and help attach the baby. If necessary, also improve the position by:
  • reducing baby’s wrappings so s/he can reach the breast
  • showing the mother how to hold her breast well behind the nipple, without pinching
  • encouraging her to lie down and hold the baby under arm or across the body.
• Avoid distractions and let baby suckle at own speed.
• Avoid feeding-bottles and pacifiers.

Step 2: Build the mother’s confidence and help milk flow
• Help mother and infant until suckling is effective.
• Encourage her to enjoy skin-to-skin contact and to play with her baby face-to-face.
• Build her confidence:
  • recognize and praise what she is doing right – including signs of milk flow,
  • give relevant information in an encouraging way and correct misconceptions.
• Help her to breastfeed near trusted companions, which helps relaxation.

Step 3: Increase milk production
Encourage more frequent breastfeeds
• Ask mother to breastfeed very often, 12 times or more in 24 hours if the baby is willing.
• Tell her the value of keeping the baby with her day and night and breastfeeding at night.
• Encourage her to give the breast for comfort at any time.
• If baby is ill or unusually sleepy, encourage her to wake him/her up and offer her breast often.

Encourage longer breastfeeds
• Suggest that the mother continues each feed until baby stops him or herself and does not want more. It is best if she does not detach the baby or put her breast away quickly.
• Encourage her to offer the other breast, and let baby decide if s/he wants more or not

Ensure mother gets enough to drink (Supportive care has assured enough food).
• Help her to keep drinking water available for herself.

Remove interference
• Help the mother to reduce any milk supplements by 50 millilitres per day, monitoring weight weekly to reassure her that infant is still gaining 125 grams per week.
• Ask her to avoid separation from the baby, scheduled feeding, care of the baby by others, delaying feeds and, as above, giving bottles and pacifiers.
• Help her to prevent a new pregnancy with non-oestrogen family planning methods.

Step 4: Encourage age-appropriate feeding
• Help the mother to establish or re-establish exclusive breastfeeding until the baby is six months old.
• If supplements are needed, teach her to give them by cup, not bottle.
• Show her how to prepare and give adequate complementary foods from six months of age, as well as frequent breastfeeds.
Annex 10: Challenges in managing acute malnutrition in infants <6 months

Global burden

Secondary data analysis\(^{57}\) of demographic and health survey datasets in 21 developing countries found wasting among infants under 6 months was prevalent in many of the developing countries. Using National Centre for Health Statistics (NCHS) growth references, prevalence of wasting in infants under 6-months ranged from 1.1% to 15% (median 3.7%); this equates to around 3 million wasted infants <6 months worldwide. Prevalence was more than double using 2006 WHO growth standards: 2.0-34% (median 15%), equivalent to 8.5 million wasted infants <6 months worldwide. Prevalence differences using WHO standards are more marked for infants under 6 months than children and both moderate and especially severe wasting prevalence is increased. There are considerable implications for policy makers, programme managers and clinicians in child health and nutrition programmes.

Programme experiences

In the MAMI review\(^{58}\), infants <6m accounted for 16% of admissions,\(^ {59}\) ranging from 1.2% in Uganda to 23.1% in Tajikistan (individual level data analysis). Inpatient care was the dominant form of treatment. Overall % mortality in infants <6m was significantly higher than children aged 6 to <60 months (4.7% vs. 4.0% respectively, \(p<0.01\)). A risk ratio of 1.29 (ranging from 1.08-1.53, \(p<0.01\)) was observed.

There was little information on programme coverage of infants <6m. Many programmes did not actively seek malnourished infants <6m and not all presentations or admissions/referrals of infants <6m were recorded. Assessment of growth history of infants <6m was difficult due to use of different indicators in the community (weight-for-age) and for admission (weight-for-height, MUAC), lack of serial measures and poor quality of anthropometric measurements. Guidelines for MAMI were inconsistent and lacked information on supporting mothers/caregivers of this age group on specific issues, e.g. breastfeeding assessment tools, supplementary sucking technique. A combination of clinical judgement and/or anthropometric indicators, that varied greatly, was often used to determine admission.

Examples of good practice exist, such as the use of ‘breastfeeding corners’ to assess breastfeeding pre-admission and supplementary sucking — a core treatment in many current guidelines. Staff time and experience were important limiting factors in success rates.

Managing orphans and non-breastfed infants was identified as a major challenge, both in treatment and longer term follow-up. Follow-up was not clearly defined.

Priority research:

Key areas include:

- Develop a triage tool based on a set of clinical signs for ‘complicated’ cases in need of urgent inpatient treatment.
- Systematic review of studies of different anthropometric indicators suitable for use in the community in infants<6m, including a review of the suitability of MUAC for this age group.
- Review of the effectiveness of community-based breastfeeding support to assess its viability as a treatment option for uncomplicated cases of SAM in infants <6m.
- Review the effectiveness of breastfeeding assessment tools for use in the community to identify ‘uncomplicated’ and ‘complicated’ cases of SAM in infants <6m.
- Investigate the nature and effectiveness of skilled breastfeeding counselling and support in inpatient treatment of severely malnourished infants <6m.

See full and summary reports at: http://www.ennonline.net/research/mami


\(^{59}\) A total of 25,195 children (4,002 infants <6m) were included in the main analysis, derived from thirty-three ‘raw’ databases with individual-level data from 12 countries.
Annex 11: 10 Steps to successful breastfeeding

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Practice rooming-in – allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Annex 12: Protecting infants in emergencies: Information for the Media

This briefing was prepared by the IFE Core Group, an international collaboration of UN agencies and NGOs developing policy guidance and capacity building on IYCF-E. This briefing was prepared with the support of the UNICEF-led Inter-Agency Standing Committee (IASC) Nutrition Cluster. Available (with references and key contacts) in English, Arabic, French, Spanish, Italian and German on: http://www.ennonline.net or direct link: http://www.ennonline.net/resources/126

“Although Sri Lanka is a country with a high exclusive breastfeeding rate, there was a myth among mothers about the inability to produce enough breastmilk when under stress. A major problem was the distribution of infant formula and feeding bottles by donors and non-governmental organisations (NGOs), without the appropriate controls, to breastfeeding mothers. Donors acted emotionally without any scientific basis, disregarding the dangers of artificial feeding in disasters. Additionally the mass media was very keen on feeding babies so made a public appeal to supply artificial milk and feeding bottles. The Ministry of Health faced many challenges to ensure that breastfeeding mothers continued to do so and did not swap to unsustainable and potentially dangerous infant formula”.

Statement from the Sri Lankan Ministry of Health after the 2004 Indian Ocean Tsunami

Natural and man-made disasters – earthquakes, floods, droughts and wars – regularly put lives at risk. And babies caught in the ensuing chaos are vulnerable to malnutrition and death. Journalists have an important role in helping to protect infants in emergencies by not supporting appeals for donations of infant formula and by reminding audiences that breastmilk is a reliable and sterile food that helps to prevent illness, while artificial feeding may further add to the health risks.

Why are infants vulnerable?

Babies have specific nutritional needs and are born with an undeveloped immune system. For infants who are breastfed, breastmilk provides both food and immune support, which protects them from the worst of emergency conditions. However, the situation is very different for babies who are not breastfed. In an emergency, food supplies are disrupted, there may be no clean water with which to make up infant formula or to clean feeding implements and the health care system is stretched past breaking point. This means that babies who are not breastfed are vulnerable to infection and to developing diarrhoea. Babies with diarrhoea easily become malnourished and dehydrated and so are at real risk of death. Whenever there is an emergency, it is extremely important that babies who are already being breastfed continue to be and that babies who are not breastfed re-start breastfeeding or, if this is not possible, are given infant formula in the safest possible way.

What about young children?

It is not only babies that are vulnerable. Under five year olds, and especially children under 2 years, are at risk of increased illness and death in emergencies. Breastfeeding still protects these children and the World Health Organisation (WHO) recommends that breastfeeding be continued until at least 2 years of age. Young children also need enough nourishing food that is safely prepared – this too can be a real challenge in an emergency.

What is the problem?

Past experience has shown that when there is an emergency, massive amounts of infant formula and powdered milk are commonly donated. Some donations are a direct result of media appeals for infant formula. These may originate with aid agencies, governments or from individual efforts to help. Media coverage may generate public pressure on governments to bring in formula. In the confusion that surrounds emergencies, these products are often distributed in an uncontrolled way and used by mothers who would otherwise breastfeed their babies. This results in unnecessary illness and death for many infants. For instance, a UNICEF audit after the 2006 Yogyakarta earthquake in Indonesia found that although breastfeeding rates were initially very high, 70% of children under six months had been given donated infant formula. In another example, a Centre for Disease Classification (CDC) investigation of the post-flood deaths of more than 500 children in Botswana in 2005-06, found that nearly all of the babies who died were formula fed. Here the risk of hospitalisation for babies who were not breastfed was 50 times greater than that of breastfed infants. It is also extremely common for powdered milk to be distributed as a part of general rations. However, this is also problematic since experience has shown that about half of such milk will be given to babies.
How can journalists help?
The media has an important role to play in protecting babies in emergency situations by disseminating information that will protect breastfeeding and promote the appropriate use of infant formula and powdered milk. Members of the media can assist by including the following messages in their stories:

- Supporting mothers to continue breastfeeding is the surest way of protecting infants in emergencies.
- Breastfeeding is not fragile and women who are physically and emotionally stressed are able to make enough milk for their babies.
- The indiscriminate use of infant formula in an emergency is extremely dangerous to babies, causing illness and death.
- Emergency workers do not need large amounts of infant formula when there is an emergency and any that they do need should be procured locally. There is no need for donations of infant formula, powdered milk or baby bottles to be sent to the site of an emergency.
- Members of the public who donate funds to aid agencies should be encouraged to ask the recipients of their donations if and how they are distributing infant formula or powdered milk and encourage them to act appropriately.
- Members of the public who become aware of aid agencies distributing infant formula or powdered milk inappropriately should report these activities to the relevant authorities (see key contacts).

Sometimes representatives of aid or government agencies will seek to place an appeal for donations of infant formula via the media. This is never appropriate. Such representatives should be directed to UNICEF for clarification on how to appropriately source and supply infant formula.

How can babies and young children be protected in emergencies?
There are accepted guidelines for the management of infant feeding in emergencies.

1. Mothers who are breastfeeding their babies are to be given support and practical assistance to continue, they should never be indiscriminately given infant formula or powdered milk. Experience has found that peer support programmes can help mothers to care for their babies and keep breastfeeding.
2. Mothers who have stopped breastfeeding completely, i.e. weaned their babies, should be encouraged to restart breastfeeding (relactate) and the option of wet nursing (where another woman breastfeeds the baby) should be explored for babies without mothers.
3. If there are infants who cannot be breastfed they should be provided with infant formula and the associated necessary resources to prepare it, under close supervision. Carers should be provided with education and support and the health of the baby monitored. Baby bottles should never be used because of the risk of contamination due to the difficulty of effectively cleaning them – even young babies can be fed via cup or spoon.
4. If powdered milk is to be provided it should be mixed with the local staple cereal prior to distribution so that it cannot be used as a breastmilk substitute.
5. Efforts to protect and support breastfeeding and ensure safe artificial feeding should extend to all young children.
6. Emergencies may be used by infant formula manufacturers as a way to enter new markets and increase sales. Unethical marketing of infant formula is a problem worldwide and an international code has been developed to protect mothers and babies from such unethical marketing.

Conclusion
The messages that the media present about the needs of infants in emergencies can have a far-reaching impact on the babies who are unfortunate enough to be affected by an emergency. Members of the public, NGOs and donor agencies want to assist babies and giving them good information about infant and young child feeding in emergencies will help to prevent harmful practices and help to protect the most vulnerable from malnutrition and death.
PART 3: TRAINER’S GUIDE

The trainer's guide is the third of four parts contained in this module. It is NOT a training course. This guide provides guidance on how to design a training course by giving tips and examples of tools that the trainer can use and adapt to meet training needs. The trainer's guide should only be used by experienced trainers to help develop a training course that meets the needs of a specific audience. The trainer’s guide is linked to the technical information found in Part 2 of the module.

Module 17 is about infant and young child feeding in emergencies (IYCF-E) and covers a range of interventions from developing policy to support for individual mothers and caregivers. The module can be used to provide orientation on key elements of IYCF-E for senior managers, and to provide guidance to fieldworkers on the main considerations in their line of work.

Module 17 forms the written content of an orientation package on IYCF-E (Module 1, v2.0, 2010). This package of resources has been developed to orientate emergency relief staff, programme managers, and technical staff involved in planning and responding to emergencies at national and international level, on IYCF-E. It comprises e-learning (available online and on CD), training resources (PowerPoints and exercises) more detailed technical notes, and key resources. It supports the practical implementation of the Operational Guidance on IYCF-E and Sphere Standards (2011).

For those requiring more technical guidance on IYCF-E, key resources are included in Part 4.

Navigating your way around the guide

The trainer's guide is divided into six sections.

1. **Tips for trainers** provide pointers on how to prepare for and organise a training course.
2. **Learning objectives** set out examples of learning objectives for this module that can be adapted for a particular participant group.
3. **Testing knowledge** contains an example of a questionnaire that can be used to test participants' knowledge either at the start or at the end of a training course.
4. **Classroom exercises** provide examples of practical exercises that can be done in a classroom context by participants individually or in groups.
5. **Case studies** contain examples of case studies (one from Africa and one from another continent) that can be used to get participants to think by using real-life scenarios.
6. **Field-based exercises** outline ideas for field visits that may be conducted during a longer training course.
CONTENTS

1. Tips for trainers

2. Learning objectives

3. Testing knowledge
   Exercise 1: What are optimal infant and young child feeding practices?
   Handout 1a: What do you know about optimal infant and young child feeding practices?: Questionnaire
   Handout 1b: What do you know about optimal infant and young child feeding practices?: Answers

4. Classroom exercises
   Exercise 2: Country problem analysis
   Handout 2a: List of indicators
   Exercise 3: What are the risk factors and challenges facing mothers and caregivers in emergencies?
   Handout 3a: Setting the Scene on IYCF-E
   Handout 3b: Comments on photos of different emergencies
   Exercise 4: Basic interventions and communication on IYCF-E
   Handout 4a: Article on basic interventions and communication on IYCF-E
   Handout 4b: Follow up article
   Handout 4c: Answers
   Exercise 5: Frontline assistance to infants and their mothers/caregivers
   Handout 5a: Case Studies
   Handout 5b: Model answers
   Exercise 6: HIV and IYCF in emergencies
   Handout 6a: Questions on HIV and IYCF-E
   Handout 6b: Answers on HIV and IYCF-E
   Exercise 7: Individual risk assessment for artificial feeding
   Handout 7a: Exercise on individual risk assessment for artificial feeding
   Handout 7b: Answers on individual risk assessment for artificial feeding
   Exercise 8: Community level risk assessment regarding artificial feeding and milk and milk product use
   Handout 8a: Community level risk assessment regarding artificial feeding and milk and milk product use questions
   Handout 8b: Interventions with artificial milk: model answers
   Exercise 9: Rapid Assessments on IYCF-E
   Handout 9a: Exercise on rapid assessment
   Handout 9b: Model Answers
5. **Case studies**
   - **Exercise 10**: Support for infant and young child feeding in the Haiti 2010 earthquake
   - **Handout 10a**: Case study I: Aftermath of the Haiti 2010 earthquake
   - **Handout 10b**: Case study I: Aftermath of the Haiti 2010 earthquake: Model answers

6. **Field-based exercises**
   - **Exercise 11**: Assessing prevailing IYCF practices
   - **Handout 11a**: Community Focus Group Discussions Matrix
   - **Handout 11b**: Team Checklist for Community Outreach Focus Groups
1. Tips for trainers

Step 1: Do the reading!

- Read Parts 2 of this module.
- Familiarize yourself with the technical terms from the glossary.
- Read through the following key documents (see full references and how to access them in Part 4 of this module):
- Materials to support training can be found at:
  - *Module 2 on IYCF-E*. This is a reference document for more technical content on IYCF-E. It provides more extensive background reading/reference for those interested in learning more. It was developed for health and nutrition staff working directly with infants and young children and their caregivers in emergencies. It includes chapters on breastfeeding support, managing breastfeeding difficulties, managing artificial feeding in emergencies and managing malnourished infants under six months of age.
  - *IFE Resource Library*, www.ennonline.net/ife: Online library developed by the IFE Core Group that includes key resources and materials including presentations and media reports on IFE. Resources referred to in the exercises are located here.
  - *Field Exchange online search database*. Many of the case studies in Module 17 (and other modules) have been located in the Emergency Nutrition Network's *Field Exchange* publication, available online at [http://fex.ennonline.net](http://fex.ennonline.net). This publication can be used to source experiences from more recent emergencies and to track emerging issues.

Step 2: Know your audience!

- Find out about your participants in advance of the training:
  - How many participants will there be?
  - Are the participants ùtechnical staffú (health and nutrition workers) or ùgeneralistsú in the field of IYCF-E (managers, logisticians, other)?
  - Do any of the participants already have experience of infant and young child feeding in emergencies?
  - Are any of the participants trained breastfeeding counsellors?
  - Could participants with experience be involved in the sessions by preparing a case study or contribute through describing their practical experience?
Step 3: Design the training!

- Decide how long the training will be and what activities can be covered within the available time. In general, the following guide can be used:
  - A 60- to 120-minute classroom-based training can provide an orientation on IYCF-E.
  - A half-day classroom-based training can provide an orientation on IYCF-E and include some short group exercises (3.5-4 hours).
  - Integrate key elements of IYCF-E into other nutrition in emergencies training sessions where possible. This will be necessary if there is not a “standalone” session on IYCF-E. For example, include IYCF in a session on individual assessment or complementary feeding in a session on food security.
  - A one-day classroom-based training can provide a more in-depth understanding of IYCF-E, more technical information, and include a number of practical exercises and/or a few case studies. However, a full technical training takes more time (3 to 5 days) and should draw on more technical materials to expand on the HTP content (see resources).
  - Where IYCF-E training is part of a broader nutrition in emergencies training, look for opportunities to integrate key elements on IYCF-E in shared practical sessions on emergency response.

- Conduct a pre-training assessment of the IYCF-E context you are dealing with to inform the key content and focus to include in training sessions. The priority IYCF issues will depend on the context (see Exercise 2 that may help in preparation regarding this).

- Identify appropriate learning objectives. This will depend on your participants, their level of understanding and experience, and the aim and length of the training.

- Decide exactly which technical points to cover based on the learning objectives that you have identified.

- Divide the training into manageable sections. One session should generally not last longer than an hour.

- Ensure the training is a good combination of activities, e.g., mix PowerPoint presentations in plenary with more active participation through classroom-based exercises; mix individual work with group work.

- Practice timing.

Step 4: Get prepared!

- Prepare PowerPoint presentations with notes (if they are going to be used) in advance and do a trial run. Time yourself! Keep written content on PowerPoints to a minimum, use images to talk around rather than written text. Do not prepare PowerPoints as ‘handouts’ for a session. For existing PowerPoint presentations, consult the Module 1 orientation package at [http://www.ennonline.net/ife/orientation](http://www.ennonline.net/ife/orientation) and the online IYCF-E Resource Library on the ENN website, [www.ennonline.net/ife](http://www.ennonline.net/ife). Suggested PowerPoint presentations that can be adapted from existing sources include (see full references and how to access in Part 4 of this module):

<table>
<thead>
<tr>
<th>Author/Session</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IFE Core Group, 2009</td>
<td>Pictorial presentation on IFE</td>
</tr>
<tr>
<td>IFE Core Group, 2009</td>
<td>1 hour orientation on IFE</td>
</tr>
<tr>
<td>IFE Core Group, 2009</td>
<td>Bonus slides on IFE</td>
</tr>
<tr>
<td>ENN. Adapted from IFE Core Group, 2009</td>
<td>Orientation on IYCF-E (Lebanon, 2010)</td>
</tr>
<tr>
<td>ENN. Adapted from IFE Core Group, 2009</td>
<td>Orientation on IYCF-E (Nairobi, 2009)</td>
</tr>
<tr>
<td>ENN. Adapted from IFE Core Group, 2009</td>
<td>Orientation on IYCF-E for military</td>
</tr>
<tr>
<td>IBFAN-ICDC. <em>Making sense of the Code: training course on the Code</em> (see Part 4 for full reference)</td>
<td>Various presentations on the Code</td>
</tr>
</tbody>
</table>
• Prepare exercises and case studies. These can be based on the examples given in this trainer’s guide but should be adapted for the particular training context.

• Important note regarding the exercises: Exercises should be used that can be completed using Module 17 and the Operational Guidance on IYCF-E. The exception is the field exercise which draws on IYCF in CMAM training material for an adapted exercise.

• Prepare a ‘kit’ of materials for each participant. These should be given out at the start of the training and should include:
  ° Timetable showing break times (coffee and lunch) and individual sessions
  ° Parts 1 and 2 of this module
  ° Pens and paper

**REMEMBER**

People remember 20% of what they are told, 40% of what they are told and read, and 80% of what they find out for themselves.

People learn differently. They learn from what they read, what they hear, what they see, what they discuss with others and what they explain to others. A good training is therefore one that offers a variety of learning methods which suit the variety of individuals in any group. Such variety will also help reinforce messages and ideas so that they are more likely to be learned.
2. Learning objectives

Below are examples of learning objectives for a session on IYCF-E. Trainers may wish to develop alternative learning objectives that are appropriate to their particular participant group. The number of learning objectives should be limited; up to five per day of training is appropriate. Each exercise should be related to at least one of the learning objectives.

Examples of learning objectives

At the end of the training participants will be able to:

- Define optimal infant and young child feeding practices and their particular relevance in emergencies
- Identify risk factors and challenges to IYCF-E in a given context
- Identify key policy guidance relevant to IYCF-E
- Understand the importance of IYCF-E needs assessment
- Describe key multi-sectoral and technical interventions on IYCF-E
- Understand key aspects of coordination, communication and orientation/training in emergencies
- Understand the importance of preventing and how to manage donations of breastmilk substitutes and feeding equipment in emergencies
- Avoid Code violations and monitor/report Code violations encountered
- Identify emergency preparedness activities
- Locate sources of resources and shared experiences
3. Testing knowledge

This section contains one exercise, which is an example of a questionnaire that can be used to test participants’ knowledge of infant feeding in emergencies either at the start and/or at the end of a training session. The questionnaire can be adapted by the trainer to include questions relevant to the specific participant group.

Exercise 1: What are optimal infant and young child feeding practices?

<table>
<thead>
<tr>
<th>What is the learning objective?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To test participants’ knowledge about optimal infant and young child feeding practices including some misconceptions around IYCF practices</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When should this exercise be done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• At the start of a training session to establish knowledge level (as pre-test)</td>
</tr>
<tr>
<td>• At the end of a training session to check how much participants have learned (as post-test)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How long should the exercise take?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 20 minutes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What materials are needed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Handout 1a: What do you know about optimal infant and young child feeding practices and common beliefs on IYCF?: Questionnaire</td>
</tr>
<tr>
<td>• Handout 1b: What do you know about optimal infant and young child feeding practices and common beliefs on IYCF?: Answers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What does the trainer need to prepare?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Familiarise yourself with the questionnaire questions and answers.</td>
</tr>
<tr>
<td>• Add your own questions and answers based on your knowledge of the participants and their knowledge base.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1:</strong> Pre-training: Give each participant a copy of Handout 1a.</td>
</tr>
<tr>
<td><strong>Step 2:</strong> Ask participants to complete the questions individually.</td>
</tr>
<tr>
<td><strong>Step 3:</strong> Post training: repeat the exercise and compare pre- and post- answers.</td>
</tr>
<tr>
<td>Alternatively, if used as post-training test only:</td>
</tr>
<tr>
<td><strong>Step 1:</strong> Give each participant a copy of Handout 1a.</td>
</tr>
<tr>
<td><strong>Step 2:</strong> Go over each question, asking the group to reply orally, give quick explanation when the answer is wrong; refer back to the relevant training session.</td>
</tr>
</tbody>
</table>
Handout 1a: What do you know about optimal infant and young child feeding practices?: Questionnaire

1. According to the Lancet series on Child Survival (2003) and Maternal and Child Undernutrition (2008), which are the top three life-saving interventions for infants and young children?
   a) Zinc supplementation
   b) Exclusive and continued breastfeeding until 1 year of age
   c) Complementary feeding
   d) Vitamin A distribution
   e) Clean delivery
   f) Newborn temperature management
   g) Insecticide treated materials

2. What is the recommended time to initiate breastfeeding after birth?
   a) Within 2 hours of birth
   b) Within 12 hours of birth
   c) Within 1 hour of birth
   d) Within 24 hours of birth

3. Exclusive breastfeeding means:
   a) Breastmilk and occasional water or water-based fluids in hot weather
   b) Breastmilk is the main food for the infant, with other liquids or solids allowed if in very small quantities (e.g. given for religious reasons)
   c) Only breastmilk, no other liquids or solids, not even water, with the exception of vitamins, minerals supplement, medicines or ORS

4. What is important during breastfeeding (more than one answer is possible)?
   a. The baby must be fed every 3 hours
   b. The baby must be turned towards his/her mother and be held closely
   c. The baby must drink around 20 minutes from each breast
   d. After two months the baby should not be fed at night
   e. It is best to feed the baby whenever he/she asks for it, day or night
   f. The baby can drink from a breast as long as he/she wants

5. Complementary foods should be introduced:
   a) from 4 months.
   b) between 4 to 6 months.
   c) from 6 months.
6. What proportion of energy should breastmilk contribute to the intake of a 1-2 year old?
   a) Less than 10%
   b) 10-20%
   c) 30-40%
   d) Breastmilk does not significantly contribute to energy intake of breastfed children aged 1-2 years

7. Select the true statements from the following:
   a) In emergencies, micronutrient supplementation may be needed to fully meet the micronutrient needs of young children
   b) General distribution of milk powder is a priority in populations used to having milk
   c) Animal source foods are a valuable nutrient source during the complementary feeding period

8. Answer true or false to the following statements:
   a) A traumatised mother cannot breastfeed
   b) Moderate malnutrition in a mother reduces breastmilk production
   c) Acute stress does not affect production but can affect the release of breastmilk
   d) Providing a breastfed infant with infant formula will not affect the production of the mother’s breastmilk
   e) HIV infected mothers should be discouraged from breastfeeding
Handout 1b: What do you know about optimal infant and young child feeding practices?: Answers

1. According to the Lancet series on Child Survival (2003) and Maternal and Child Undernutrition (2008), which are the top three life-saving interventions for infants and young children?
   b) Exclusive and continued breastfeeding until 1 year of age
   c) Complementary feeding
   g) Insecticide treated materials

2. What is the recommended time to initiate breastfeeding after birth?
   c) Within 1 hour of birth: Initiating breastfeeding within one hour of birth is essential to prevent hypoglycaemia, hypothermia and jaundice in the newborn and reduce postpartum bleeding with the mother. It is also very important for mother-child bonding, optimal milk production and is beneficial for successful breastfeeding in the long run.

3. Exclusive breastfeeding means:
   c) Only breastmilk, no other liquids or solids, not even water, with the exception of vitamins, minerals supplement, medicines or ORS. This is the recommended feeding practice for infants up to 6 completed months.

4. What is important during breastfeeding (more than one answer is possible)?
   a) The baby must be fed every 3 hours
      FALSE The recommended practice is to feed on demand, therefore there is no recommended time in between two feeds; the mother should feed when the healthy baby indicates that he/she wants to drink. In the case of weak or sick babies, the mother must initiate breastfeeding regularly herself as those babies might not indicate their need for milk. They will need to be fed more often than healthy babies as they can only take small quantities at a time.
   b) The baby must be turned towards his/her mother and be held closely
      TRUE The baby must be turned towards its mother, in a straight line so his neck is not twisted or bent forward and held close and be fully supported to allow good attachment.
   c) The baby must drink around 20 minutes from each breast
      FALSE Some babies drink fast, other babies drink slow, therefore there is no indicated time per feed. The mother can let the baby drink from one breast until the baby releases the breast by his/herself and then offer the other breast. Taking too little time at one breast will result in incorrect emptying of the breast which can be the cause of breast problems, insufficient weight gain in the baby and reduced milk production.
   d) After two months the baby should not be fed at night
      FALSE It is good to feed babies at night when they ask for it, as it is an indication they need the milk at that time. In addition, feeding at night is beneficial for the mother’s milk production. The baby will indicate him/herself when he/she is ready to sleep through the night.
   e) It is best to feed the baby whenever he/she asks for it; day or night
      TRUE See answers above
   f) The baby can drink from a breast as long as he/she wants
      TRUE See answers above

5. Complementary foods should be introduced:
   c) from 6 months: Until the age of 6 months all the baby’s needs are covered by the breastfeeding. From 6 months onwards the introduction of complementary food, such as meat, fish, vegetables and fruit, is necessary. Before this age, the child’s intestines are not ready to eat complementary food and it only exposes the child to a higher risk of diarrhoea or other diseases.
6. What proportion of energy should breastmilk contribute to the intake of a 1-2 year old?
   c) 30-40%: Even for young children, breastmilk contributes significantly to the total energy requirements, and therefore remains a very important part of the diet. One should also not forget that breastmilk continues to provide protection against diseases at this age as well.

7. Select the true statements from the following:
   a) In emergencies, micronutrient supplementation may be needed to fully meet the micronutrient needs of young children since the food available might lack essential micronutrients
   c) Animal source foods are a valuable nutrient source during the complementary feeding period

8. Answer true or false to the following statements:
   a) A traumatised mother cannot breastfeed FALSE, a traumatised mother can breastfeed, since the trauma will not affect her production. She might experience difficulties letting down the milk, but this can be overcome by support, relaxation and motivation.
   b) Moderate malnutrition in a mother reduces breastmilk production FALSE, Malnourished mothers can breastfeed. However they should be provided with extra food and fluids to rebuild their own nutrient stores and should be encouraged to breastfeed the infant very frequently to stimulate milk production. Moderate malnutrition has little or no effect on milk production. In fact the mother will continue to produce milk, even to the detriment of her own wellbeing. Milk production is only likely to be reduced if a woman is severely malnourished; then the woman herself would need immediate feeding support while continuing breastfeeding. “Feed the mother and let her feed the baby” is the key approach.
   c) Acute stress does not affect production but can affect the release of breastmilk TRUE
      Stress does not prevent milk production but it may slow the release of milk from the breasts. This can result in babies being ‘fussy’ when breastfeeding. Mothers may think that there is not enough breastmilk as a result. Frequent breastfeeding will help the mother and baby to get over this and ensure the baby receives enough. Reassuring support will decrease a mother’s stress and increase her confidence.
   d) Providing a breastfed infant with infant formula will not affect the production of the mother's breastmilk FALSE, every time a child drinks infant formula instead of breast milk, the milk production of the mother will reduce.
   e) HIV infected mothers should be discouraged from breastfeeding FALSE. Even though there is a chance of HIV transmission from mother to child through the breast milk, the risk is greater during pregnancy and birth. Most mothers will not transmit HIV through breastfeeding. A mother who receives ARVs and who exclusively breastfeeds in the first six months significantly reduces the risk of transmission. This risk must be balanced with the risk of disease, malnutrition and death through unsafe or inadequate use of artificial milk. If social and environmental conditions for replacement feeding are not met, breastfeeding offers a much better chance of survival for the child.
4. Classroom exercises

This section provides examples of practical exercises that can be carried out in a classroom context by participants individually or in groups. Practical exercises are useful between plenary sessions, where the trainer has done most of the talking, as they provide an opportunity for participants to engage actively in the session. The choice of classroom exercises will depend upon the learning objectives and the time available. Trainers should adapt the exercises presented in this section to make them appropriate to the particular participant group. Ideally, trainers should use case examples with which they are familiar.

Exercise 2: Country Problem Analysis

What is the learning objective?
• To identify the main areas of concern regarding IYCF in a given situation and region or country

When should this exercise be done?
• At the start of a training session

How long should the exercise take?
• 30-45 minutes

What materials are needed?
• Handout 2a: List of indicators around IYCF in emergencies
• Module 20 on Monitoring and Evaluation

What does the trainer need to prepare?
• Prepare a list of indicators around IYCF in emergencies, based on the provisions of the Operational Guidance on IFE. Consider the pre-emergency situation and any experiences in previous/current emergency, with regard to the context you are focusing on. Examples of indicators used in training in Asia and in East Africa are included below but should be adapted to the context of the training. For example, other indicators might include low breastfeeding rate at one year in non-emergency, to reflect a specific context.
• Participants can be asked to bring secondary data on IYCF from their work area. If this is not possible, the trainer can prepare secondary data from a specific context and put this into a case study. For example, a slide showing the most recent exclusive breastfeeding rates by country for a regional training provides useful context.
• A large chart to display the indicators

Instructions
Step 1: Give each participant Handout 2a with the list of indicators

Step 2: Participants are asked to rank indicators as ‘a big problem’, ‘a medium problem’, or ‘not a problem’ at all. Red/yellow/green paper/markers are used to reflect this on the chart. A limited number of red (big problem) and yellow (no problem) markers are given, to encourage prioritisation.

Step 3: Review the different indicators as a group and discuss which are: a big problem – Red Post-It (max 8), a medium problem – Yellow Post-It (max 8), not a problem at all – Green Post-It (13)
### Handout 2a: List of indicators

Sample indicators for problem analysis

<table>
<thead>
<tr>
<th>Sample indicators from Asia (2008) and East Africa (2009)</th>
<th>Insert country 1</th>
<th>Insert country 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant Feeding Practices/Current Situation (outputs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Low exclusive breastfeeding rate in non-emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Significant artificial feeding/replacement feeding in non-emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Mother to child transmission of HIV is a big concern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 PMTCT programmes available in non-emergency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Poor nutritional status of pregnant and lactating women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Complementary feeding difficult for 6-&lt;24 month olds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Acute malnutrition prevalent in U2s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Orphans/non-parent carers common</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 2006 WHO Growth Standards roll-out</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 General perception that infant formula is as good as/better than breastfeeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current IYCF/IFE Programme (inputs)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 No government IYCF-E policy/not implemented</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 No national BMS Code/not enforced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Few government trained/knowledge on IYCF-E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 Few NGOs trained/knowledge on IYCF-E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 Few lactation specialists available during emergencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Perception mothers can’t breastfeed/great difficulties during emergencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 Donations of BMS during emergencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 No suitable complementary foods in distributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 BMS included in distributions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 Pregnant and lactating women often not targeted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 Emergency coordinators do not prioritize IYCF-E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22 NGOs act independently of national Emergency Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23 Early rapid assessments do not include IYCF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 Unclear IYCF-E indicators to use in assessments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25 Services to encourage and support BF often absent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26 Emergency/transit/reception areas not supportive for BF</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27 Early support to orphans in emergencies not clear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28 No systems to minimise artificial feeding risks in an emergency.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29 Little capacity to manage malnourished infants &lt;6m</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30 Ready-to-Use Foods use not clear in prevention of malnutrition/complementary feeding</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Exercise 3: What are the risk factors and challenges facing mothers and caregivers in emergencies?

**What is the learning objective?**
- To be able to identify risk factors and challenges to infant feeding in different emergency settings

**When should this exercise be done?**
- Use as a quick 'brainstorming' at the start of a training session

**How long should the exercise take?**
- 10 to 20 minutes

**What materials are needed?**
- **Handout 3a:** Setting the Scene on IYCF-E (or images as PowerPoints)
- **Handout 3b:** Comments on photos of different emergencies

**What does the trainer need to prepare?**
- Be familiar with the photos and the issues that may emerge or that participants are being asked to identify, so that if they miss out something, you are able to fill them in with the answers.
- PowerPoint presentation with the photos

**Instructions**

**Step 1:** Explore perceptions around IYCF-E amongst participants. Personal and professional experiences around IYCF can have a significant influence on practice.

**Step 2:** Give each participant Handout 2a or present as a PowerPoint presentation.

**Step 3:** Taking each photo in turn, ask the group what the risk factors are.

**Step 4:** The trainer adds additional key information when necessary.

**Step 5:** Give each participant Handout 2b.
**Handout 3a: Setting the scene on IYCF-E**

Photo 1 and 2: Queuing for food distribution
Photo 3: Unaccompanied children in DRC

Photo 4: Mother who lost her own child caring for an orphan
Photo 5: Malnourished Child

Photo 6: A mother in distress
Infant and young child feeding

Photo 7: An injured mother

Photo 8: People taking water from a dirty pond
Photo 9: A malnourished mother

Photo 10: Emergency workers as an IYCF risk factor
Handout 3b: Comments on photos of different emergencies

Photo 1 and 2: Queues
Long crowded queues in the hot sun are not suitable for babies, who may be left alone in shelters. Mothers cannot leave the queue to breastfeed the infant on demand or to prepare other feeds; they will lose their place. Crowds can be aggressive, one may have to struggle to get something. Mothers who also have to protect their children will get the least.

Photo 3: Unaccompanied children
Children without adult caregivers may have carried infants long distances to a camp but cannot manage artificial feeding. Infants lacking adult care may have to be brought into an organized care setting.

Photo 4: Mother who has lost all her own children caring for a sick orphan in Rwanda
The stress and sadness of a mother cannot be removed, but measures to lessen her isolation may help her to cope with her feelings and care for the orphaned infant. Seek any relatives, clan members, or women who speak her home language to be with her. If this infant is sick, partly because he/she is not getting enough breastmilk, the mother also needs encouragement and help to re-lactate if she is willing.

Photo 5: Malnourished Child
A malnourished child needs his mother’s milk even more to survive and fight against diseases. If the child is too weak to suckle the breast effectively, measures must be taken to help him by pumping the milk and feeding it to him in a different manner. If the mother does not have enough milk, a milk supplement can be given while making efforts to increase her production. Treatment with therapeutic milk should aim to complete breastfeeding, not to replace it.

Photo 6: A mother in distress
This mother is clearly stressed in the aftermath of an emergency. If she breastfeeds she needs a quiet place where she can find the peace and quiet to nurse her child. She is carrying a baby bottle, but where is she going to prepare milk in a safe and adequate way to feed her baby?

Photo 7: An injured mother
An injured mother is cradling her new born baby. She will need help, support and motivation to breastfeed her child with her difficulties. She must be allowed to keep her child with her and she needs health professionals to assist her so she can breastfeed the baby.

Photo 8: People taking water from a dirty pond
This dirty pond seems to be an important water source for these people. What would happen if this water is used to prepare the powdered milk for an infant?

Photo 9: A malnourished mother
This mother is malnourished but she is still breastfeeding, proving that she can. Instead of providing breastmilk substitutes for the baby, it is much better to treat the mother’s malnutrition and let her continue to breastfeed the baby.

Photo 10: Emergency workers as an IYCF risk factor
Here is an aid worker demonstrating artificial feeding to mothers who are breastfeeding. Preconceptions regarding IYCF practices held by workers may reflect their personal experiences and assumptions rather than the context they are working in. It also reflects a poor understanding of the risks and benefits of different practices in an emergency context.
Exercise 4: Basic interventions and communication on IYCF-E

What is the learning objective?
- To appreciate the basic interventions required to support a safe environment for IYCF
- To understand the power of the media in affecting humanitarian response

When should this exercise be done?
- *Either* at the start of a training session (to see what people know, and what they come up with themselves)
- *Or* at the end of a training session (to see what people have remembered)

How long should the exercise take?
- 30 to 45 minutes

What materials are needed?
- PowerPoint (optional)
- Handout of the article (optional)
- Media guide on IYCF-E (see Part 2 of this module, annex 12)

What does the trainer need to prepare?
- Familiarise yourself with the background and power of communication and its consequences so you are able to complete participants’ remarks
- The original article included in the newspaper is included. Depending on the participants’ proficiency in English, you may wish to summarise the article in simpler English, provide a summary on PowerPoints or simply tell the story in your own words.

Instructions
**Step 1:** Give participants Handout 4a or present in a PowerPoint presentation.
**Step 2:** Discuss the answers to the different questions.
**Step 3:** Give Handout 4b and discuss this outcome
**Step 3:** Discuss other ways of communication and appropriate interventions.
Handout 3a: Article on basic interventions and communication on IYCF-E

Behind the photograph: the human face of Pakistan’s deadly flood
Mother of the child in image that went around the world tells of her family’s struggle
Rania Abouzeid in Azakhel, Monday September 6 2010, The Guardian

It was an image that conveyed the human cost of the Pakistani floods and the failure to deliver aid to those affected more powerfully than any statistic: four young children lying on a filthy patchwork quilt, one of them sucking on an empty yellow bottle, all of them covered by flies.

The Guardian identified the child with the bottle as two-year-old Reza Khan and tracked him down to a makeshift camp at a roadside in Azakhel, some 19 miles from Peshawar, the capital of the insurgency-plagued province of Khyber Pakhtunkhwa, bordering Afghanistan.

The camp is a hotchpotch of about two dozen tents donated by various aid organisations, but it is run by none. Its residents must fend for themselves, and rely on the charity of passers-by. There are 19 families here, all of them Afghan refugees; people who were displaced once by conflict in their homeland have now been displaced again by the month-long deluge. Reza’s family is from Butkhak, near the Afghan capital, Kabul. His father fled the area as a young boy, some 30 years ago, to escape the cycle of foreign occupation and battles plaguing his homeland.

When we found him, Reza was in a tent with his mother, Fatima, who, like most Afghans, has only one name, and six of his seven siblings, all huddled on a blue blanket extended over the muddy floor. He was still clutching the same bottle. It was still empty. Fatima tried to calm the boy, who cries in a constant, low whimper, as well as his twin brother, Mahmoud. She covered three of her other children – she has eight, all under the age of nine – with a dirty mosquito net somebody in a passing car gave her, but it has several gaping holes. Her eldest child, a nine-year-old girl called Sayma, is mute and seems dissociated from her surroundings. Her green eyes stare blankly ahead, seemingly oblivious to her brothers’ wails. Flies carpet the few blankets arranged on the floor, and swarm all over the children. There is precious little in the tent, one cooking pot, a few cushions and two or three items of children’s clothing. The stench of human and animal waste is overwhelming in the hot, humid air. There is no sanitation, just shallow, open ditches of raw sewage that attract flies and mosquitoes.

“They have had nothing to eat today. I have no food,” Fatima says as she tries to swat the flies away from her children with a bamboo fan. “He’s crying with hunger,” she says, pointing to Reza. “It’s been a month since he had any milk.” On this day, Reza’s father, Aslam, was in a nearby hospital with his seven-year-old daughter, who has a skin infection caused by the unsanitary living conditions. Reza and several of his siblings also bear red spots, and appear malnourished. Their thin hair is coming out in clumps, their mother says. “We have been here for a month, a month!” Fatima says. “We are tired of these flies and of being without food. Before the waters came my husband worked. We were poor before, but we had full stomachs.”
The family of 10 used to live among the 23,000 residents of the Azakhel Afghan refugee camp, about 20 minutes’ walk from their current roadside location. Aslam sold chickens for a living, travelling from door to door on a rickety bicycle, one of the family’s prized possessions. He made about $2 a day. Their mud-brick home was small, Fatima says, but it was enough for her. They lived among her husband’s clan, about six families in all. “I had a kitchen, and there was a water tap close by,” she says as her youngest child, one-year-old Ayad, tugs on her lilac dupatta, the scarf Pakistani women drape over their heads, arms and chest, pulling it away from her hair. She quickly readjusts the worn, holed fabric. “These clothes are all that we have now,” she says, almost apologetically. The loose mud bricks of their home were no match for the raging waters of the nearby swollen Kabul River. The floodwaters gushed into the house in the morning. She and her husband snatched several of the children in their arms, while extended family members helped bundle the others out of the house. The clan of some 60 people walked toward the main road linking the town of Nowshera to Peshawar. They spent five days out in an open field, eating whatever scraps they could forage. Aslam’s older brother, Taykadar, set out on foot to find help, stopping at several of the dozen or so organized relief camps nearby. “They would ask us for our Pakistani identification cards in order to register us, but we are Afghans,” he says. “And we are too many, that’s the problem. We don’t want to be split from each other. We’ve already lost our homes, we don’t want to lose our families.” The men managed to obtain several tents from various organisations. Fatima’s, for example, was donated by the Saudi government while others bear the logos of UNHCR. The Afghans say they have nothing to return to. Taykadar says they haven’t received any help from a government he knows is overwhelmed by the destitution of its own people. The busy road that they have camped alongside is now their lifeline. Men, women and children rush out towards any car that appears to slow down alongside them. Hundreds of hands stretch out, hoping for food, water or clothing. “We have to run after the food, it isn’t given by some organisation in the tents,” Fatima says bitterly. Her children eat once a day, usually in the evenings, thanks to charity organisations that provide iftar meals during Ramadan. But Ramadan ends this week. “I just want to say to the world, isn’t there any way they can get us food?” she pleads. “Look,” she says, pointing to the twins in her lap. “Please, our children are dying of hunger.”

1. What does this article tell you about the immediate needs of this mother to enable her to care for and to feed her children?

2. What does this article tell you about infant and young child feeding practices in this emergency?

3. What message does this piece send about what aid is needed?
The headlines read: Pakistan floods: Reza Khan finally gets his milk after readers respond, The Guardian, UK, 7 Sept 2010:

A story highlighting the plight of the two-year-old and his displaced Afghan family led to worldwide donations.

Reza Khan, and his twin Mahmoud drinking their first bottle of milk since floods forced them from their refugee camp a month ago.

Fatima beamed broadly as she knelt in the mud outside her tent and filled two-year-old Reza Khan's baby bottle with milk. "Look, he’s not crying anymore" she said, as he sucked down the liquid. It had been a month since the little boy had tasted milk.

The mother of eight kept an eye on her son as she lifted the lid on a blackened aluminium pot, her only one, that was bubbling over a campfire and stirred the yellow lentils inside. "Tonight my children will sleep until dawn on full stomachs," she said. The Guardian first met the displaced Afghan family several days ago, after a photograph of Reza and several of his siblings, covered in flies, featured in the Eyewitness slot. We tracked them down to a roadside camp in Azakhel, 19 miles from Peshawar, capital of Pakistan’s insurgency-plagued Khyber Pakhtunkhwa province, bordering Afghanistan. Yesterday a story in the newspaper and on our website highlighted the family’s plight: the devastating month-long deluge had driven them from their mud brick home in the nearby Azakhel Afghan refugee camp. Fatima, her husband, Aslam, and their eight children, along with their extended family, were camped in an empty field relying on the charity of passersby. The response to the Guardian story was immediate and overwhelming. Readers from the UK, North America and Europe contacted us with offers of help. Aijaz Ahmed from the Pakistani group save-humans.org had also offered immediate assistance. The organisation, which describes itself as a group of Pakistani professionals who have “joined hands to serve humanity”, immediately set about buying relief supplies. Today three members of the group rented a truck, loaded it with 500,000 Pakistani rupees (£3,800) of goods, including flour, rice, oil, lentils and milk, and headed north from Islamabad on a two-hour trek to Azakhel. “The article compelled us to act,” said Sufyan Kakakhel, 30, one of the three. “When I read that they were Afghans, I knew that they couldn’t get rations from the government because they don’t have Pakistani citizenship, and I didn’t give a second thought about whether I should come here.” Dozens of men, women and children, many barefoot, rushed towards the vehicles as they stopped near their encampment. “We have brought you some things and are going to distribute them in a very peaceful way,” Kakakhel told the crowd. “It will be ordered.” His colleague Abu Bakr Shoaib, a 30-year-old IT professional who works in Dubai but was in Pakistan for Ramadan, went tent to tent, notebook in hand, to record the number of men, women and children in each tent. Bearded men in round, flat caps thrust their small green Afghan identity cards in Shoaib’s direction. "Don’t worry, we’re going to help everybody," he said. Some 53 Afghan families are living by the railway track and the parallel pools of stagnant water that separate this makeshift tent city from the wasteland on the other side that was once the Azakhel Afghan refugee camp, home to 23,000 people. Now, it is just a pile of muddy rubble, broken timber and straw. The two men promised to return with fumigation equipment to reduce the vast population of mosquitoes and flies. They also promised to study ways to help the family rebuild their home across the railway tracks. Fatima kept her eye on the boiling pot perched on the campfire. She was smiling. Tonight, her children would have dhal for dinner.

4. How could the donation of milk have been avoided?
Handout 4c: Answers

1. **What does it tell you about the immediate needs of this mother to enable her to care for and to feed her children?**
   
   The poorest/most vulnerable/marginalised in society will be worst affected (in this story, they are displaced refugees, and falling between the gap in terms of who is responsible for them).
   
   There are many supports needed, including enabling access to:
   
   - Shelter
   - Water and sanitation
   - Mosquito net
   - Food for the household (registration is difficult given their difficult status)
   - Access to food for her children under 2 years
   - Clothing (especially once winter sets in)
   - Food for family and for her children
   - Cooking facilities
   - Support to minimise the risks of artificial feeding (managing bottle use)
   - Restored dignity (feeling that she has regained control over her situation)
   - General support from the community to her and her family members

2. **What does this article tell you about infant and young child feeding practice?**
   
   Use of bottles and mixed feeding is common practice. It is however unclear from the article what this mother is actually feeding her younger children with, and how many times per day- all she says is that her son has not received any milk for one month. A more detailed needs assessment is needed to collect vital information.

3. **What message does this piece send about what aid is needed?**
   
   It focuses on the need to provide milk and 'fill the baby’s bottle'. It does not consider appealing for support to address the environment and support services this family needs. It is highly emotive. It may reflect it is easier to send milk than to address the more challenging reality.

4. **How could the donation of milk have been avoided?**
   
   - Better communication towards the press on optimal infant and young child feeding practices and interventions in emergencies: the article could have included facts on the benefits of breastfeeding, the dangers of milk donations and the direction of the support in this situation
   - Better communication towards humanitarian actors to avoid inappropriate milk donations and improve IYCF-E practices
   - Better policy and guidelines from the Ministry of Health, known by all actors
   - Information on the availability of IYCF-E interventions in the close surroundings of the family, enabling rapid transfer for appropriate help

   The need for stronger and more accurate information reflects the importance of journalists and press/communication teams engaging with technical staff in press releases and articles.
Exercise 5: Frontline assistance to infants and their mothers/caregivers

What is the learning objective?
• To understand the nature of frontline assistance to infants and their mothers/caregivers

When should this exercise be done?
• This is an exercise for front line staff, likely to be involved with mothers.
• Two case studies are included, you can include one or both depending on time, or one per group.

How long should the exercise take?
• 30 to 45 minutes

What materials are needed?
• Handout 5a: Case studies
• Handout 5b: Model answers

What does the trainer need to prepare?
• Familiarise yourself with Part 2 Module 17 IYCF.
  This exercise explores non-counselling based assistance that frontline workers can undertake when faced with acute IYCF situations. It involves exploring what basic assistance can be offered, and referral for more specialist help. It is not a substitute for skilled counselling or medical assistance, but it recognises that in emergency situations, many different workers will be faced with challenging situations on IYCF that they will need to respond to at the most basic level, for example during early needs assessment, at reception centres for arrivals to a camp, or while technical interventions are being established.
  Module 2 IYCF-E (see Part 4 resources) is a resource to refer to, to see the nature of individual level rapid and further assessment that should be employed when such cases are referred for assessment.

Instructions
Step 1: Give each participant a copy of Handout 5a; divide the participants in groups.
Step 2: Ask each group to discuss the case study and to list the actions they would take.
Step 3: Let the groups present their answers and discuss.
Step 4: Give each participant handout 5b.
Handout 5a: Case studies

Case study 1:
You are a social worker, registering new arrivals in a refugee camp on the lists for distributions of shelter, food and non-food items, when the mother in the picture walks up to you.

This mother has walked a long way. She says the baby is ill and has not been suckling the breast. She says she is not producing enough breastmilk since she had to flee her village.

The baby is four months old and irritable.

The mother asks whether you can give her infant formula to feed her baby.

How can you help?

Case study 2:
You work with a child protection team and come across this case on a village assessment, in the aftermath of a cyclone.

Ma Gan is a new mother who survived cyclone Nargis. She is traumatised, and has withdrawn from family activities.

Ma Gan is not breastfeeding and her baby girl of 2 months old is growing weaker. There is precious little food. The family have not accessed any health services. A grandmother has taken charge of the infant and is trying to keep her alive by feeding her drops of water from a polluted canal.

How can you help her?

Case study 3
Sophie, the aid worker in the picture, is a nurse from a western country where bottle feeding is the norm. Upon arrival in a tsunami-hit country she finds that women have problems breastfeeding. She is genuinely concerned about the health of those women’s children and organises a shipment of infant formula to arrive quickly so as to distribute them to the concerned women so that the children can be well fed. Aware of the poor hygienic conditions in which the population lives she takes care of providing bottled water to dilute the formula with and teaches good hygiene practices to prepare the formula.

What do you think motivated Sophie’s actions?

If you came across this situation, what would you do?
Handout 5b: Model answers

Case study 1:
Congratulate the mother on taking such good care of her child, coming this distance to seek help and caring for her baby all along the way.

Note: It is important to act quickly for medical assessment and referral. If the baby had been floppy, this should be considered a medical emergency and the baby in need of urgent medical attention. Assure the mother that you will refer her to the appropriate help. Keep the baby and mother under surveillance. While urgent referral/transfer is being arranged, give the mother some water and something to eat. Once the infant is stabilised, follow up with the points below.

In this case, assure the mother that you will refer her to the appropriate help. Tell her that the best thing for her child and for her is to continue to give the breast to the child, as frequently as possible, so that she will keep producing some milk if the child continues to suckle the breast. Encourage her as much as possible, telling her that her milk is the best protection for her baby in this difficult situation.

Arrange for the mother and child to get basic support and professional help:
• Give the mother water, something to eat and a place where she can rest while arrangements are made for transfer.
• Both mother and child need a medical check-up and treatment as quickly as possible; refer to a health post
• Both mother and child should be screened for malnutrition and treated accordingly as quickly as possible; refer to a screening site for feeding programmes
• The mother needs skilled breastfeeding counselling. If she is not admitted in a health facility or feeding programme where breastfeeding counselling is available, she should be referred to a baby friendly tent or other programme where she can receive counselling.
• The mother should be helped to access shelter, water, food distribution and non-food distributions. Explain to her how she can access all the help she is entitled to, and if there are priority lists that she can be added to.
• Explore her family situation and whether she needs access to any family tracing services.
• This mother needs extra rations of food for lactating women. Help her to register on any targeted food distribution programmes and explain to her how she can access this food.

Case study 2:
The priority for the health of the infant is to quickly establish exclusive breastfeeding. It is not too late to establish breastfeeding. The priority for the mother is to support her to do this and help her psychological state. The priority for the household is to enable access to shelter, warmth and food. The well-being of the mother is central to the well-being of her infant. The grandmother is well placed to care and support her daughter to feed and care for her new baby.

Use of infant formula in this situation is highly risky, especially since the baby is young and already unwell. If artificial feeding is needed temporarily while breastfeeding is established, this needs to be based on skilled assessment and conducted under close supervision.

Both the mother and infant need referral to a health clinic for assessment. The grandmother or other mothers in the community who have positive breastfeeding experiences may be able to offer support and assistance to her.
In the immediate term:

- Advise the family and mother how important the mother is to the nourishment and wellbeing of her baby.
- Encourage skin to skin contact between the mother and infant and frequent breastfeeding.
- Refer the mother to any psychosocial services support available, and for medical assessment.
- Register/ensure the family know how to access food, shelter
- Refer for more specialised assistance for breastfeeding support, if/as available.
- Be alert for donations of infant formula in general – such activities are often reported by the media, as they make a ‘good’ human interest story. Inform your superiors of the case and details on return from your field trip, and share this case with the nutrition coordination agency.

In preparation for an assessment, it is useful to prepare in advance by orientating yourself on the key cross-sectoral services and contacts available. This will help inform cases and ensure you know how and to whom to refer cases.

Case Study 3

Sophie is a concerned nurse, but her interventions are coloured by her background as a health professional in a country where artificial feeding is the norm. She has not made an objective assessment of the context she is working in and the different risks and benefits of feeding options in this situation. She does not seem to be aware of the IYCF context that she is working in where breastfeeding is the norm.

When you come across a situation like this, it is important to establish a professional relationship in which the concerned person/organisation can see you as a professional aid worker who is there to help. IYCF-E can be highly emotive. Congratulate her on her efforts to help the emergency relief. Confirm that she is right to worry about the children’s health status and that these women need help. Introduce her to the objective assessment of risks of different feeding options that are needed in this instance. Explain about the importance and the possibilities of sustaining/improving breastfeeding and the many risks of artificial feeding. Explain how her actions are a Code violation. Provide her with key information on IYCF-E resources, support and invite her to attend coordination meetings, IYCF-E training sessions or schedule more time to inform her about potential, more appropriate action.

Alert the IYCF-E coordinating agency of this case.
Exercise 6: HIV and IYCF in emergencies

What is the learning objective?
- Understand the concept of HIV-free child survival
- Understand the balance of risks regarding IYCF recommendations
- Understand IYCF in HIV recommendations (WHO, 2010)

When should this exercise be done?
- During orientation training and/or technical training of health/nutrition staff

How long should the exercise take?
- 30 to 45 minutes

What materials are needed?
- Flipchart and pens
- Handout Exercise 6a: List of multiple choice questions on HIV and IYCF-E
- Handout Exercise 6b: List of answers on multiple choice questions on HIV and IYCF-E

What does the trainer need to prepare?
- Familiarise yourself with Part 2 of this module
- WHO (2010) Guidance on HIV and infant feeding (See Part 4 Resources)
- WHO (2011) FAQs on HIV and infant feeding (forthcoming Sept 2011)

Instructions

A. Balance of Risks for Infant Feeding Options in the Context of HIV to maximise HIV-free child survival

Step 1: Draw or distribute the table in Handout 6a.
Step 2: Ask participants to define HIV-free child survival and the three feeding options given in the table.
Step 3: Ask participants to brainstorm on the risks of HIV transmission and morbidity and mortality associated with different feeding options.
Step 4: Complete the table using yes/no.
Step 5: Discuss the results.

B. IYCF in HIV recommendations  (WHO, 2010)

Step 1: Give each participant a copy of the questions Handout 6a.
Step 2: Present each question and discuss with the group, correct answers when necessary.
Step 3: Give each participant a copy of Handout 6b

Note: When asking true/false questions in a group, you can have the group sit in a circle with everyone's back to the centre of the group. Each can raise a hand for 'true', without being aware of the responses of the majority of the group. This can be a less threatening environment in which to share.
**Handout 6a: Questions on HIV and IYCF-E**

**A. Balance of Risks for Infant Feeding Options in the Context of HIV to maximise HIV-free child survival**

**Balance of risks**

<table>
<thead>
<tr>
<th>HIV-free child survival:</th>
<th>Exclusive Breastfeeding</th>
<th>Exclusive Replacement Feeding</th>
<th>Mixed Feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk of Morbidity/Mortality</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**B. IYCF and HIV recommendations (based on WHO, 2010)**

Circle whether each statement is true or false:

<table>
<thead>
<tr>
<th>Statement</th>
<th>True/False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 If a mother’s HIV status is unknown in an HIV-prevalent population, she should replacement feed until she knows her HIV status</td>
<td>True</td>
</tr>
<tr>
<td>2 An HIV-infected mother should breastfeed for 6 months only, then switch to replacement feeding</td>
<td>True</td>
</tr>
<tr>
<td>3 HIV-infected infants have a better chance of survival if breastfed</td>
<td>False</td>
</tr>
<tr>
<td>4 If there are no ARVs available, an HIV-infected mother should not breastfeed</td>
<td>False</td>
</tr>
<tr>
<td>5 Rapid cessation of breastfeeding is not recommended when switching from breastfeeding to replacement feeding, to reduce the risk of HIV transmission.</td>
<td>False</td>
</tr>
<tr>
<td>6 An HIV-infected mother should stop breastfeeding at 12 months in all circumstances</td>
<td>False</td>
</tr>
</tbody>
</table>
Handout 6b: Answers on HIV and IYCF-E

HIV-free child survival

A. Balance of Risks for Infant Feeding Options in the Context of HIV

<table>
<thead>
<tr>
<th></th>
<th>Exclusive Breastfeeding</th>
<th>Exclusive Replacement Feeding</th>
<th>Mixed Feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of HIV</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Risk of Morbidity/Mortality</td>
<td>Much lower risk, but doesn’t eliminate the risk entirely</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Note: mixed feeding is the worst option, as it increases the risk of HIV transmission as well as exposing the infant to the risks of illness from contaminated formula made with dirty water and given in dirty bottles, and contaminated foods and other liquids.

C. IYCF and HIV recommendations

1. If a mother’s HIV status is unknown in an HIV-prevalent population, she should replacement feed until she knows her HIV status FALSE

   This statement is false. If a mother’s HIV status is unknown, then she should be encouraged to breastfeed her infant in keeping with the IYCF feeding recommendations for all children. This gives the best chance of child survival.

2. HIV-infected infants have a better chance of survival if breastfed TRUE

   This statement is true. Non-breastfed HIV-infected infants have been shown to be more at risk of malnutrition, morbidity and death. So breastfeeding an HIV-infected infant gives the best chance of survival.

3. If there are no ARVs available, an HIV-infected mother should not breastfeed FALSE

   This statement is false. For HIV-infected mothers, even when ARVs are not available, mothers should be counselled to exclusively breastfeed in the first six months of life and continue breastfeeding thereafter, unless environmental and social circumstances are safe for, and supportive of replacement feeding. Every effort should be made to make ARVs available.

4. Rapid cessation of breastfeeding is not recommended when switching from breastfeeding to replacement feeding. TRUE

   This statement is true. Rapid cessation of breastfeeding increases the risk of breast conditions that leads to increased HIV transmission risk. So a gradual cessation of breastfeeding over up to 1 month is recommended.

5. An HIV-infected mother should stop breastfeeding at 12 months in all circumstances. FALSE

   This statement is false. Breastfeeding and ARVs should continue until 12 months. Breastfeeding should cease at 12 months only if a nutritionally adequate diet without breastmilk can be provided. Otherwise, breastfeeding should continue until such time that such a diet can be provided.
Exercise 7: Individual risk assessment for artificial feeding

What is the learning objective?
• Understand how to investigate key conditions for risk assessment for artificial feeding

When should this exercise be done?
• During orientation training and/or technical training of health/nutrition staff

How long should the exercise take?
• 15 minutes

What materials are needed?
• This module 17
• Handout Exercise 7a: Risk assessment exercise
• Handout Exercise 7b: Model answers

What does the trainer need to prepare?
• The Operational Guidance on IFE
• Read Part 2 of this module, particularly sections describing the conditions necessary for artificial feeding.

Instructions
Step 1: Let each participant fill out the exercise on handout 7a
Step 2: Correct together with the group
Step 3: Give each participant a copy of Handout 7b
Handout 7a: Exercise on individual risk assessment for artificial feeding

A mother with a 1 month old infant presents to your temporary clinic. She is requesting infant formula for her baby. This is her third baby. She started breastfeeding both her older children at birth, but introduced infant formula at around 2 months of age. She is currently breastfeeding but wishes to establish formula feeding like she did with her older children. She received a donation of one pack of infant formula in a general distribution and began giving this to her baby, but she has just one more day’s supply. Over the last few days the baby has had diarrhoea and is now not breastfeeding well.

Since the conflict started, she has moved in with her sister-in-law and her four children. Water supply to the house has been just cut off and they are accessing household supplies via distributions.

You are exploring what conditions are in place to support artificial feeding safely. You have recorded the information below. Are all the conditions for artificial feeding met in your opinion?

<table>
<thead>
<tr>
<th>Current situation</th>
<th>Are conditions for artificial feeding met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother familiar with artificial feeding (fed older baby), many family members familiar with it (acceptable).</td>
<td>Yes</td>
</tr>
<tr>
<td>Mother can understand and read instructions in the local language. Current available supplies are imported and in foreign language (labels being made). She has no refrigeration, storage facility and rationed fuel supply (feasible).</td>
<td>No</td>
</tr>
<tr>
<td>Normal market sources have greatly reduced. As a result prices have increased. Alternative supplies are being procured by your agency but awaiting custom clearance (affordable).</td>
<td>Maybe</td>
</tr>
<tr>
<td>Disruption in supply chain means market supplies are uncertain. Funding for a six month programme is being sought by your agency but not secured yet (sustainable).</td>
<td>Maybe</td>
</tr>
<tr>
<td>Water supply disrupted and risk of contamination. No facilities for storage of prepared formula. One stove for all family meals with little fuel. Preparation of night feeds in particularly difficult (safe).</td>
<td>Maybe</td>
</tr>
</tbody>
</table>

- What would you advise the mother regarding artificial feeding as a feeding option?
- What support does the mother need?

**Note:** An alternative/additional case you could consider is where a caregiver presented with an artificially fed infant for whom there was no option of breastfeeding, e.g. a 2 month orphaned infant with no wet nurse available. This exercise could be used to explore what interventions would be needed to meet all the conditions necessary for artificial feeding the infant.
### Handout 7b: Answers on individual risk assessment for artificial feeding

Are all the conditions for artificial feeding met in your opinion? No they are not

<table>
<thead>
<tr>
<th>Current situation</th>
<th>Is it met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother familiar with artificial feeding (fed older baby), many family members familiar with it (acceptable).</td>
<td>X</td>
</tr>
<tr>
<td>Mother can understand and read instructions in the local language. Current available supplies are imported and in foreign language (labels being made). She has no refrigeration, storage facility and rationed fuel supply (feasible).</td>
<td>X</td>
</tr>
<tr>
<td>Normal market sources have greatly reduced. As a result prices have increased. Alternative supplies are being procured by your agency but awaiting custom clearance (affordable).</td>
<td>X</td>
</tr>
<tr>
<td>Disruption in supply chain means market supplies are uncertain. Funding for a six month programme is being sought by your agency but not secured yet (sustainable).</td>
<td>X</td>
</tr>
<tr>
<td>Water supply disrupted and risk of contamination. No facilities for storage of prepared formula. One stove for all family meals with little fuel. Preparation of night feeds in particularly difficult (safe).</td>
<td>X</td>
</tr>
</tbody>
</table>

Note: Even if the conditions had all been met, it is less risky for the child to continue breastfeeding.

**What would you advise the mother regarding artificial feeding as a feeding option?**

Artificial feeding is a risky option in this environment. Her baby is more likely to get sick and become malnourished. Supplies are expensive and are uncertain.

Returning to exclusive breastfeeding is the safest and most secure way to feed her infant.

**What supports does the mother need?**

The mother may need some skilled breastfeeding support to help establish exclusive breastfeeding. She needs advice on how to manage her baby with diarrhoea and follow up at your clinic.

Refer this woman for breastfeeding counselling so as to increase her milk supply and motivate her to continue breastfeeding.

You can explore whether any of her peers, e.g. sisters, friends, mother, breastfed exclusively and could give support.
**Exercise 8: Community level risk assessment regarding artificial feeding and milk and milk product use**

**What is the learning objective?**
- Recognise the risks associated with different interventions around the use of breastmilk substitutes and milk and milk products

**When should this exercise be done?**
- During orientation training and/or technical training of health/nutrition staff

**How long should the exercise take?**
- 15 to 30 minutes

**What materials are needed?**
- The operational guidance on IYCF-E (full text).
- Handout Exercise 8a: Community level risk assessment regarding artificial feeding and milk and milk product use
- Handout Exercise 8b: Interventions with artificial milk: Model answers

**What does the trainer need to prepare?**
- Operational Guidance on IYCF-E

**Instructions**
- **Step 1:** Hand out copies of the operational guidance.
- **Step 2:** Give each participant a copy of Handout 8a.
- **Step 3:** Present each case and discuss with the group, correct answers when necessary.
- **Step 4:** Give each participant a copy of Handout 8b
Handout 8a: Community level risk assessment regarding artificial feeding and milk and milk product use

Please read the following examples of interventions with artificial milk and say whether this is a suitable intervention or not, stating why.

Are any of the proposed interventions a potential Code violation?

1. After an earthquake devastated a big city, many people are homeless and have lost all their belongings. They live in makeshift camps. Many mothers had been feeding their babies both breastmilk and artificial milk before the earthquake. They are requesting milk for their babies, as they are used to mixed feeding. Since the earthquake, there are reports that mothers are having difficulty breastfeeding, particularly those with infants under six months of age. Your team is preparing to distribute kits to the victims including tarpaulin, soap, cooking set, blankets etc. A colleague proposes to include two boxes of infant formula, together with a baby bottle in each kit to answer to the needs of those mothers. Do you agree with this proposition?

2. You are in charge of a health clinic in an emergency setting. Your expatriate head of mission says that a food manufacturer from his homeland wishes to donate 5 MT of infant formula. He proposes to accept this, so you can provide it to those infants who have lost their mothers. The staff can make a thorough assessment of whether breastfeeding is indeed not possible, and each child can be followed individually to assess its health throughout the whole period where infant formula is provided. Will you agree with this proposition?

3. You are part of a team that assesses the needs of the population in an emergency, so that you can recommend what actions need to be taken. A person from the Child Protection team informs you that the disaster has caused a lot of deaths and that many children are orphaned or separated from their parents. Among them, there are even small infants and young children, for whom they have not been able to find family to care for. She says they urgently need infant formula for the young infants. What will you recommend?

4. The food distribution team of your organisation plans to include milk cartons in a general food distribution. You tell them about the dangers of milk distribution, that it can negatively affect breastfeeding and consequently cause diseases and even death. The food distribution team says this is not an issue here, because the milk is intended for children older than 2 years old only, not for children of breastfeeding age. It clearly says on the carton in English it should not be used as a breast milk substitute. In addition, the milk cartons are ready-to-use, so no dilution with water is needed. The cartons are presented as 1 litre cartons. Do you agree?
Handout 8b: Interventions with artificial milk: model answers

1. This is not a good idea. The Operational Guidance on IYCF-E recommends that there is no untargeted distribution of breastmilk substitutes such as infant formula. Untargeted distribution of infant formula with no guarantee of supply for as long as the infant needs it is a Code violation (WHA 47.5). Giving a mother infant formula in this way will decrease her breastmilk production further, as the more the baby suckles, the more breastmilk is produced. After those two boxes you provided, she will have no access to additional milk. The hygiene, access to safe water and sanitation in the camps is likely to be poor. This means that the use of powdered infant formula poses a large threat to the health of the children, putting them at risk of diseases such as diarrhoea, pneumonia, malnutrition and even death. Baby bottles are difficult to clean and pose an additional risk of infection. Rather than infant formula supplies, these mothers need skilled breastfeeding support. Where the infant is less than six months of age, support to establish exclusive breastfeeding is the best option.

2. The Operational Guidance on IYCF-E recommends that donations of infant formula (and any other BMS, bottles and teats) are not accepted in emergencies. Donations are typically in the wrong language and are supplied disproportionate to need. It is unlikely that you will need 5 MT of infant formula for the individual cases that present to your clinic. Any supplies should be purchased, labelled in the local language and meet Codex Alimentarius requirements. Note that distribution of donated supplies through a health facility is a Code violation. The quantities of infant formula that need to be purchased should be based on the assessment of needs, taking into consideration that the children enrolled in the programme receive the formula for as long as needed. This is not a good intervention.

3. This is a situation where there is indeed a need for infant formula and all the associated supports and care, since those infants do not have the possibility to breastfeed. As reflected in the Operational Guidance on IYCF-E, there are considerable supports necessary to minimise the risks of artificial feeding. You will need to urgently notify the designated coordinating agency on IYCF-E, UNICEF and WHO. The designated agency for managing artificial feeding will need to work with Child Protection to register and manage these cases.

4. The Operational Guidance on IYCF-E recommends that there is no general distribution of milk and milk products. There is a strong risk that this milk will be used as a breast milk substitute. Mothers may not be able to read the instructions on the carton, especially if it is not in the local language. Once open, liquid milk is a rich medium for bacterial growth. It is likely that cartons will not be immediately consumed and without refrigeration, will quickly become contaminated. If such a distribution is already happening, it is better to recommend the milk is used in family cooking (e.g. to fortify porridge) with strong messaging regarding infant feeding.
Exercise 9: Rapid Assessments on IYCF-E

What is the learning objective?
- To be able to identify priority questions for IYCF-E Assessment
- To be able to make a picture of the IYCF situation from multi-sectoral assessment information

When should this exercise be done?
- During orientation training and/or technical training of health/nutrition staff

How long should the exercise take?
- 15 minutes

What materials are needed?
- The operational guidance on IFE (full text).
- Handout Exercise 9a: Exercise on rapid assessment
- Handout Exercise 9b: Model answers

What does the trainer need to prepare?
- Familiarise yourself with Part 2 of this module

Instructions

Step 1: Give Handout 9a to all participants
Step 2: Let participants discuss the different questions in groups
Step 3: Present answers and discuss
Step 4: Give Handout 9b to complete answers from presentations by groups
Handout 9a: Exercise on rapid assessment

An area you work in has just been hit by extensive flooding due to torrential rain. Many people have been displaced from their homes. Many are now housed in temporary accommodation, such as football stadiums and schools and tents on high ground. A multi-sectoral (nutrition, health, water and sanitation, food security, population data) initial rapid assessment is being planned in the next 24 hours. This will involve key informant interviews and focus group discussions in some of the affected areas that are accessible.

Pre-emergency, most mothers initiated breastfeeding, but mixed feeding was common.

You can include only 3 questions on infant and young child feeding. This assessment will help identify if infant and young child feeding risks are significant and whether further, more comprehensive assessment is needed.

1. Suggest three questions you could include in the assessment.
2. What other infant and young child information can be used to build a picture of infant and young child feeding in the population?
3. What findings from your analysis would indicate the need for further assessment?
Handout 9b: Model Answers

1. **Suggest three questions you could include in the assessment.**
   i. Have infant formula or other milk products and/or baby bottles/teats been distributed since the emergency started?
   ii. What is the estimated proportion of infants 0-<6 months and 6-<12 months who currently are not breastfed?
   iii. Has the community/health staff/parents/caregivers identified any problems in feeding children <2 years since the crisis started?

   *Note: It is important not to add lots of questions on IYCF in this context but to ask just the key questions, otherwise they will be left out, badly questioned, risk information and data overload, and hamper timely analysis.*

2. **What other infant and young child information can be used to build a picture of infant and young child feeding in the population?**
   - Pre-crisis rates of initiation of breastfeeding/Exclusive breastfeeding rates 0-<6 month pre-emergency
   - Proportion of infants not breastfed pre-emergency
   - Common complementary feeding practices
   - Continued breastfeeding at 1 year of age/2 years of age
   - Household food security indicators
   - Water and sanitation indicators
   - Check methods, use of standard indicators and age assessment

3. **What findings from your analysis would indicate the need for further assessment?**
   - Distribution of infant formula and dried milk powder to the population
   - Mothers report conflict has led to breastfeeding difficulties
   - Low exclusive breastfeeding rates (e.g. <25% exclusive breastfeeding 0-<6m)
   - More than 90% of mothers initiate breastfeeding
   - Bottle feeding and mixed feeding is common
5. Case studies

A case study from Haiti is presented in this section. Case studies are useful for getting participants to think through real-life scenarios. They also provide an opportunity for participants to work in a group and develop their analytical and decision-making skills. Trainers should develop their own case studies which are contextually appropriate to the particular participant group. Ideally, trainers should use scenarios with which they are familiar.

**Exercise 10: Support for infant and young child feeding in the Haiti 2010 earthquake**

**What are the learning objectives?**
- To know the key measures required to support IYCF-E
- To be aware of interventions to support safe IYCF-E in populations
- To be aware of the key steps required to set up a safe artificial feeding programme and suitable breastmilk substitutes that can be used
- To have a basic knowledge of the Operational Guidance on IYCF-E and the Code and to be aware of Code violations that can occur during emergencies
- To enable participants to imagine what could be done in a specific situation (and compare to what was actually done)

**When should this exercise be done?**
- During an orientation session (if time allows) or during a training of technical staff

**How long should the exercise take?**
- 30 to 60 minutes (depending on whether carried out in plenary, or done as group work)

**What materials are needed?**
- **Handout 10a:** Case study I: Aftermath of the Haiti 2010 earthquake
- **Handout 10b:** Case study I: Aftermath of the Haiti 2010 earthquake: Model answers
- Example of key messages for emergencies (see Annex 6 of Part 2)

**What does the trainer need to prepare?**
- Familiarise yourself with the case study and the possible answers

**Instructions**
- **Step 1:** Give each participant a copy of Handout 10a.
- **Step 2:** Ask participants to identify measures of support to IYCF-E.
- **Step 3:** Give each participant a copy of Handout 10b.
Handout 10a: Case study I: Aftermath of the Haiti 2010 earthquake

Read the case study and address the following question:

What actions should be taken and interventions should be put in place to protect, promote and support optimal IYCF practices?

On January 12th 2010, a severe earthquake hit Port-Au-Prince, the capital of Haiti, and surrounding towns and reduced it to rubble. More than 200,000 people were killed, around 300,000 people were wounded and approximately 1 million people made homeless. People lived in makeshift camps all over the parks and squares of the town, or in the streets in front of the remains of their houses.

There were hundreds of these ‘camps’ in and outside Port-Au-Prince, registration was difficult and time consuming, therefore there was no clear view of the affected population, the aid already provided to them and the gaps in the relief effort.

Assessments revealed a high need for intervention. The population was highly shocked, living in constant fear due to the continuous aftershocks. Living conditions were difficult with large amounts of people living together in small spaces, in makeshift tents with limited access to water and a near non-existent access to toilets or latrines.

Breastfeeding was the norm in Haiti in 2005-2006, when it was found that 98% of children until 5 months old were breastfed, however only 41% of those children received exclusive breastfeeding. Breastfeeding rates in the cities were lower than in the countryside. The Haitian people held many myths and misconceptions with regards to breastfeeding: children were not taken along when leaving the house out of fear of bad spirits possessing them; there was the very strong belief that a mother passes her shock to the baby through the breastmilk etc. Haiti, and especially Port-Au-Prince, has a high number of HIV/AIDS programmes. Many infants of HIV-infected mothers within these programmes were being replacement-fed (artificial feeding) to prevent mother-to-child transmission.

The government of the country was also severely hit, many of their offices had collapsed or were damaged, so consequently they lost employees and materials. National staff and staff of many established agencies in Haiti lost their lives or family members, devastating the immediate national response capacity even further.

A massive international intervention was mounted, providing shelter, water and sanitation, food aid, psychological care and much more. The relief was brought by UN agencies, international non-governmental organisations (NGOs), local NGOs, churches and other religious organisations, universities and many other different aid groups large or small.

Distributions of milk products were observed in different forms: infant formula given to mothers; full milk powder as part of general distribution kits to households, etc.
Handout 10b: Case study I: Aftermath of the Haiti 2010 earthquake: Model answers

What interventions should be put in place to protect, promote and support optimal infant feeding practices?

It can be useful to broadly classify responses from discussions under the following categories, to help identify any gaps in actions and to allow participants to consider the different types of action needed:

- Policy guidance, coordination and communication
- Basic interventions
- Technical interventions
- Handling milk and milk products, including donations

Below describes what was actually implemented in this scenario. Participants may come up with other valid possible responses.

Policy guidance, coordination and communication

- The Nutrition Cluster was activated at country level and within it, an Infant & Young Child Feeding Working Group. An IYCF-E expert was brought in to lead the group. All aid agencies working within the field of nutrition, IYCF or related areas were urged to attend the regular meetings.
- A joint statement, *Call for Appropriate Feeding of Babies and Infants in Haiti*, was drafted, based on the model from IFE Core Group (see Annex 5), signed by the Haitian Ministry of Health, UNICEF, the World Health Organisation (WHO) and the Pan American World Health Organisation (PAHO). It was translated into French and distributed widely. In response to concerns regarding HIV prevalence and infant feeding, a *Technical Note on HIV and Infant Feeding* was issued by WHO, UNICEF and the Haitian Ministry of Health.
- Key IYCF messages were translated into Creole (Kreyol), the local language, and distributed widely through NGOs. Means of communication included advertising cars, theatre plays in the camps and health education sessions. Messages were disseminated through local and international media. Different radio interviews on the subject were held in local language on the local radio.
- There was an intense effort to map the IYCF activities of different aid organisations by location, in order to have an overview of who was doing what and where (3 Ws). This would help in set up of referral systems, but also identify gap areas in programming.
- Nutrition Cluster partners were urged to report Code violations through a monitoring form. Organisations responsible for violations or pending violations (e.g. donation pending) were approached, given the *Call for Appropriate Feeding* and urged to change their plans.

Handling milk and milk products and donations

- The Nutrition Cluster worked together with the Logistics Cluster, who issued the following statement: ‘The Logistics Cluster will not accept milk powder or infant formula into its warehouses or deliver it as cargo with its assets (trucks, boats, planes and helicopters) if it is not part of Nutrition Cluster approved programmes. This is in line with international policy as agreed among WHO, UNICEF, UNHCR and major NGOs.’ In addition, steps were taken to reach a similar agreement with the Haitian customs.
- Milk powder that was retrieved from (potential) Code violators, was mixed with corn soy blend (CSB) for fortified porridge.
- Media watch (monitoring of press coverage) at international level was used to identify inappropriate actions, especially donations being called for and sent to Haiti. These were relayed via the global nutrition cluster to those working at country level. To support country efforts, approaches were made by government donors and by technical agencies to military and professional groups where inappropriate interventions were identified, such as calls for international supplies of donor breastmilk.
MODULE 17
Infant and young child feeding

TRAINER’S GUIDE

Frontline assistance

- Over 100 Baby Friendly Tents or Points de Conseil en Nutrition pour bébés were set up in or nearby displaced camps. The aim of the ‘baby tents’ was to protect and support optimal IYCF practices by providing a place where mothers or caregivers with children under 2 years old, as well as pregnant women, could come for privacy, advice, and IYCF counselling. Psycho-social support, growth monitoring and other activities were also provided. For this intervention, a special manual was designed together with the Ministry of Health, based on IFE Module 2 and an Action Contre la Faim Manual for Baby Friendly Tents. Operational agencies were invited to participate in a training of trainers on breastfeeding support (see below).

Skilled breastfeeding support

- A training of trainers on the basics of breastfeeding and counselling was set up in the local language, targeting NGOs and government health workers. Over 100 key personnel were trained. The training was based on WHO Breastfeeding Course and IFE Module 2.

- A module on the integration of IYCF into community based management of acute malnutrition (CMAM) was added to the CMAM training of trainers of regional Nutritional Focal Points of the Ministry of Health. The IYCF in CMAM training material was translated into French.

Complementary feeding

- Children aged 6 months to 5 years, as well as pregnant and lactating women, were targeted with a blanket supplementary feeding programme, providing them with high energy biscuits, fortified porridge or other supplementary food.

Management of artificial feeding

- Ready-to-Use Infant Formula (RUIF) was purchased through the Nutrition Cluster and provided to those NGOs who followed the training of trainers on breastfeeding and counselling AND who signed an agreement to deliver the RUIF in accordance with the set guidelines for the use of RUIF in this context (in accordance with the Code and Operational Guidance on IYCF-E).

- RUIF was to be given in a separate space from breastfeeding infants and young children, so as not to send mixed messages to breastfeeding women. It was supplied to infants under one year of age who fulfilled strict criteria:
  - Mother is dead or absent and no wet nurse can be identified
  - Infant was exclusively artificially fed prior to the emergency
  - Infants of HIV-infected mothers who were artificially fed as part of the prevention of mother to child transmission (PMTCT) programme prior to the emergency (children born to HIV-infected mothers after the emergency were encouraged to breastfeed)
  - Children enrolled in relactation programme until relactation is complete
  - Children of mothers who were raped and who did not wish to breastfeed

Organisations providing the RUIF to these infants were responsible for educating the family of the infant on hygiene, health and psycho-social matters related to IYCF, as well as for monitoring the child’s health and nutrition status. They also committed to provide the RUIF until the infant reached 6 months of age at least, but preferably until they reached 1 year of age. Initial supplies of RUIF were in English and so were relabelled locally. Subsequent supplies were non-branded and labelled in local language.
6. Field based exercises

The section outlines ideas for exercises that can be carried out as part of a field visit. Field visits require a lot of preparation. An organisation that is actively involved in programming or nutrition surveillance has to be identified to ‘host’ the visit. This could be a government agency, an international NGO or a United Nations agency. The agency needs to identify an area that can be easily and safely visited by participants. Permission has to be sought from all the relevant authorities and care taken not to disrupt or take time away from programming activities. Despite these caveats, field-based learning is probably the best way of providing information that participants will remember.

Exercise 11: Assessing prevailing IYCF practices

**What is the learning objective?**
- To enable participants to practice assessing IYCF practices through focus group discussions.

**When should this exercise be done?**
- During training of technical health/nutrition staff. It should be done only after key orientation on IYCF has taken place.
- This exercise is based on an adapted exercise in the Integration of IYCF in CMAM training material (see Part 4 resources). It can be used to reinforce optimal IYCF practices with trainees and enable them to explore the barriers to achieving them in a community. Good knowledge of prevailing IYCF practices is an important consideration in devising any IYCF intervention.

Notes: Ideally, this training session should be supervised by an IYCF counsellor with experience in assessment and focus group discussions.
- If the community has experienced an emergency situation, the discussion can consider the impact that this had on IYCF practices.
- If time allows and depending on the ability of the group, actions to take, such as key messages, counselling points and broader interventions, can be developed in the classroom discussions to address the sub-optimal IYCF practices identified. It is important that trainees understand that to effect change in practices, many types of support may be necessary.

**How long should the exercise take?**
A whole morning in the community at least (including transportation to and from the community), followed by a feedback and discussion session with the group in the classroom. Explanations to the group prior to going out to the community can be provided the day before the field trip, in order to give people time to do their reading and prepare, as well as to maximise time dedicated to the field-based exercise.

**Advance preparations**
- Collect as much secondary data on IYCF in the area as possible and share it with participants.
- Arrangements to visit community sites to conduct focus group discussions
- Choose the target group of the focus group discussions and invite those people according to local customs: pregnant women, mothers, grandmothers, fathers, community health workers, traditional healers, etc.
- Arrangements for transport

**What materials are needed?**
- Handout 11a: Community Focus Group Discussion Matrix
- Handout 11b: Team Checklist for Community Outreach practicum
- Module 19 Working with Communities:
- Handout 7a (Trainers Notes on how to conduct a FGD)
- Handout 7b (How to conduct a FGD)

---

1 Adapted from ENN, NPP, IFE Core Group, IASC (2009) Integration of IYCF Support into CMAM. ENN 2009
2 Idem
**Exercise 11: Assessing prevailing IYCF practices** (continued)

### What does the trainer need to prepare?
- This exercise has been adapted from Integration of IYCF Support into CMAM. 2009. ENN, NPP, IFE Core Group (2009) (see Part 4). Consultation with this resource would be valuable in preparation for managing this exercise.
- Ideally the trainer needs to be experienced in breastfeeding and infant and young child feeding assessment, standard indicator definitions and counselling, as well as focus group discussion methodology (length of the discussion, number of people per focus group, how to lead the questions…)
- Facilitators in each group needs to be experienced with the methodology used for focus group discussions, as well as the definitions of the standard IYCF indicators.
- Familiarise yourself with the materials to be used for the training.

### Instructions

**Step 1:** Ensure participants are familiar with focus groups discussions. Decide on the information you want to obtain and how you will obtain it. Ensure all terminology (e.g. exclusive breastfeeding) is clear to all participants.

**Step 2:** Divide participants into groups, each group will conduct a focus group discussion with a different target group (see above, as arranged), under the guidance of an experienced facilitator (see above). Explain how to proceed in the field with emphasis on polite introduction, explaining that they are in training on infant and young child feeding, explaining the purpose of the visit and what is expected from the interviewees. The aim is not to judge but to remain open and friendly, while listening and observing at the same time. One person can ask the questions, another person can note down the answers. Time available of the interviewees must be taken into consideration and they must be thanked afterwards (see handout 11b).

**Step 3:** Once the focus groups start, participants ask interviewees on each topic: what they would like that practice to be ideally and how it is done now. Ask them what motivates them to conduct recommended practices, or what holds them back (barriers). If time allows, discuss how an emergency has or could affect this community’s IYCF practices. See ‘Issues to be investigated during an IYCF Community Assessment’ and the discussion matrix (Handout 11a).

**Step 4:** Back in the classroom, each group presents its matrix and adds their recommendation to improve practices as feasible in the community, which is then discussed with all participants together. Discuss how an emergency has or could affect this community’s IYCF practices. As time allows, identify key actions to address sub-optimal practices, such as key messages (e.g. that could be disseminated to the different groups in the community), counselling discussion points (for one to one counselling with mothers), and broader interventions (e.g. food security, water and sanitation, maternal workload).

### Issues to be investigated during an IYCF Community Assessment

1. **Ideal practice:** How the community would like to practice
2. **Current Practice:** What is actually practiced by the individual or community.
3. **Recommended Practice:** practices recommended by health authorities because they support normal health, growth and development.
4. **Motivators:** What helps the individual or community perform the recommended practice.
5. **Barriers:** What prevents the individual or community from performing the recommended practice.
6. **Feasible practice:** the most realistic do-able behaviour that an individual or community agrees to and is expected to adopt. Gradual acceptance and practice of feasible behaviour could eventually lead to the adoption of recommended practice.
7. **Impact of an emergency:** discuss how IYCF practices were impacted in an emergency-affected community (as time allows and in a community with a recent history of an emergency)
8. **Identify actions:** Discuss and develop messages, key counselling discussion points, and broader actions around the recommended practice.
## Handout 11a: Community Focus Group Discussions Matrix

<table>
<thead>
<tr>
<th>Breastfeeding and complementary feeding practice</th>
<th>Ideal practice community</th>
<th>Current practice (reality)</th>
<th>Recommended practice</th>
<th>Motivators</th>
<th>Barriers</th>
<th>Feasible practice (recommendation)</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation of breastfeeding</td>
<td></td>
<td>Within one hour after birth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duration of exclusive breastfeeding</td>
<td></td>
<td>From birth until baby is 6 months old</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of breastfeeding</td>
<td></td>
<td>On demand, day and night</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Giving other fluids</td>
<td></td>
<td>No other fluids are needed until 6 months of age, only medicine or vitamins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding during illness</td>
<td></td>
<td>Breastfeed more frequently</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start complementary feeding</td>
<td></td>
<td>From 6 months onwards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of feeding complementary food per day</td>
<td></td>
<td>• 6-8m: 2-3 times/day (food)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 9-11m: 4 times/day (food and snacks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 12-23m: 5 times/day (food and snacks)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of complementary food</td>
<td></td>
<td>Vegetables, fruit, meat, fish, staples for older children in a balanced variety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop breastfeeding</td>
<td></td>
<td>At 2 years or later</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reasons for stopping breastfeeding</td>
<td></td>
<td>Very few medical conditions or medical treatments, if HIV-infected mother only if all conditions are in place</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Handout 11b: Team Checklist for Community Outreach Focus Groups

<table>
<thead>
<tr>
<th>Community Focus Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Courteous treatment of community members</td>
</tr>
<tr>
<td>Explain objectives to focus groups: the information will be used to help mothers and fathers better feed their children</td>
</tr>
<tr>
<td>Clarity of instruction</td>
</tr>
<tr>
<td>Efficient use of village time and maximum use of opportunities</td>
</tr>
<tr>
<td>Ability to employ a variety of tactics to prompt discussion</td>
</tr>
<tr>
<td>Good written record of the discussion</td>
</tr>
<tr>
<td>Thanking for participation and restating objectives</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post Focus Group Discussions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content gaps are recognised by teams</td>
</tr>
<tr>
<td>Team is able to distil useful insights from material of focus group discussions</td>
</tr>
<tr>
<td>Team can identify changes and improvements needed to matrices and undertake these</td>
</tr>
<tr>
<td>Team can draw practical and operational conclusions and insights from focus groups</td>
</tr>
<tr>
<td>Team can determine priority actions - messages, counselling discussion points, broader intervention</td>
</tr>
</tbody>
</table>
The training resource list is the fourth of four parts contained in this module. It provides a comprehensive list of reference material relevant to this module including guidelines, training courses and reference manuals. Part 4 provides background documents for trainers who are preparing training material.

What can you expect to find here?

1. An inventory of existing guidelines and manuals listed alphabetically by agency name with details about their availability.
2. A list of known training resources listed alphabetically by agency name with details about:
   - Overall content
   - Intended use
   - Target audience
   - Length of time the course session has been designed for

Note:
An online resource library of materials relevant to IYCF-E was developed by the IFE Core Group and housed at the Emergency Nutrition Network (ENN). Many of the resources listed here (and more) can be accessed at www.ennonline.net/resources or at www.ennonline.net/ife

The ENN online forum en-net (www.en-net.org.uk) is a technical forum for practitioners to ask challenging questions to peers and technical moderators (field experts). A thematic area is dedicated to infant and young child feeding interventions.

Policies and Strategies

   A do-it-yourself three-day training package on the Code (see earlier) developed by drawing on extensive experience of the International Code Documentation Centre (ICDC), the International Baby Food Action Network (IBFAN) and UNICEF. It explains the Code's background, importance and scope as well as details on specific Code provisions. There are two modules on the role of the Code in protection of optimal infant feeding practices in the context of HIV/AIDS and emergencies. For those who are keen to create Code awareness and understanding in their countries, and for those who want to make Code monitoring and implementation an integral part of their advocacy and programming, for example, government ministries, NGOs and health professionals
   Availability: Trainer’s guide, teaching modules, teaching charts, and CD-ROM.
   Contact: ICDC, PO. Box 19, 10700 Penang, Malaysia. Fax: +60-4-890 7291, e-mail: ibfanpg@tm.net.my or IBFAN-GIFA, Avenue de la Paix 11, 1202 Geneva, Switzerland. Fax: +41 22 798 44 43, e-mail: info@gifa.org

This essential guidance provides concise, practical, but mainly non-technical, guidance on how to ensure appropriate infant and young child feeding in emergencies. It is a ‘living’ document and is updated as new evidence emerges and policies change. It has informed the technical notes of Module 17, Module 1 IYCF-E Orientation Package (see later) and the Sphere IYCF Standards (2011). It was endorsed in a WHA Resolution (23.23) in 2010. An addendum was produced in 2010 to update content regarding breastmilk substitute procurement.

Target group: All response personnel, including nutrition and health workers, logisticians and programme managers to policy makers, at headquarters/field level.


Print copies in French and English available from the ENN.

Contact: ENN, 32 Leopold Street, Oxford, OX4 1TW, UK. Tel: +44 (0)1865 324996 e-mail: office@ennonline.net


This is an example of an IYCF-E policy based on the Operational Guidance on IYCF-E (2007) to inform agency policy development.

Availability: Downloadable pdf version in English

Contact: www.ennonline.net/ife


A model joint statement on IFE produced by participants at a regional IYCF-E workshop (IFE Core Group/UNICEF/Global Nutrition Cluster) in Bali in March 2008. It was developed in the interest of emergency preparedness.

Availability: Downloadable word version in English

Contact: www.ennonline.net/ife


The Sphere Project is an initiative to define and uphold the standards by which the global community responds to the plight of people affected by disasters, principally through a set of guidelines that are set out in the Humanitarian Charter and Minimum Standards in Disaster Response (commonly referred to as the Sphere Handbook). Sphere is based on two core beliefs: first, that those affected by disaster or conflict have a right to life with dignity and therefore a right to protection and assistance, and second, that all possible steps should be taken to alleviate human suffering arising out of disaster and conflict. Sphere is three things: a handbook, a broad process of collaboration, and an expression of commitment to quality and accountability.

Availability: Downloadable pdf in English, French, Spanish, Arabic, Russian

Contact: http://www.sphereproject.org


A call for action following 15 years since the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding and the 2002 Global Strategy for Infant and Young Child Feeding and in order to meet the Millennium Development Goals by 2015. It highlights issues for governments, manufacturers and distributors of products within the scope of the Code, multilateral and bilateral organizations, international financial institutions, and NGOs.

Availability: Downloadable pdf in English, French, Spanish, Arabic, Chinese, Russian

Contact: www.innocenti15.net/declaration.htm

---

   Geneva: UNHCR.
   Policy to assist and guide the use of milk products in refugee settings. This revised edition was produced in collaboration with the Emergency Nutrition Network, the IFE Core Group and the Institute of Child Health. It built on the WHO policy on safe and appropriate infant and young child feeding (supported by UNHCR), and the Operational Guidance on IYCF-E v2.0.
   Note: This policy requires updating to reflect Operational Guidance on IYCF-E, v2.1 (2007)
   Availability: Downloadable pdf version in English and French.
   Contact: www.unhcr.org or www.ennonline.net/ife

8. **WHO (2004). Guiding principles for feeding infants and young children during emergencies.**
   Geneva: WHO.
   Sets out the 10 guiding principles on feeding of infants and young children during emergencies to prevent excess morbidity and mortality in emergencies and their basis, such as clarifying optimal practices for feeding infants and young children, informing decision makers about key interventions and providing a starting point for more sustained interventions. The operational guidance assists with the practical application of the guiding principles and contains updates on IYCF-E practice since 2004.
   Available: Downloadable pdf version in English
   Contact: www.who.int

   Geneva: WHO.
   This publication sets out the challenges in improving infant and young child feeding practices, and the types of interventions governments and other stakeholders will need to undertake in order to achieve the objectives, and the obligations and responsibilities of governments and other interested parties.
   Availability: Downloadable pdf in English, French, Spanish, Arabic, Chinese, Russian
   Contact: http://www.who.int/nutrition/topics/global_strategy/en/index.html

10. **WHO (2007). Planning guide for national implementation of the global strategy for infant and young child feeding.**
    Geneva: WHO
    The purpose of this Planning Guide for national implementation is to help translate the aim, objectives and operational targets of the Global Strategy for Infant and Young Child Feeding into concrete, focused national strategy, policy and action plans. The guide is written for programme managers in governments and their partners, primarily those working in maternal and child health and nutrition. It proposes a step-wise process to develop a country-specific strategy, with plans to be implemented in support of appropriate infant and young child feeding, especially in the first two years of life.
    Availability: English as pdf and in print
    Contact: http://www.who.int/nutrition/topics/global_strategy/en/index.html

    Geneva: WHO.
    The International Code of Marketing of Breast-milk Substitutes 1981 and subsequent World Health Assembly (WHA) resolutions are known as ‘the Code’. The aim of the Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. In order to do this it has provisions for governments, the health care system and health workers, the general public and mothers, and manufacturers and distributors of products covered by the Code. The Code is the minimum requirement (WHA34.22). Everyone should be aware of the Code and is responsible to ensure that it is not violated.
    Availability: Full Code and relevant WHA resolutions in downloadable pdf versions
    Contact: www.ibfan.org and www.who.int

    Geneva
    The purpose of this document is to provide easy-to-read detailed information on specific questions related to the Code. It is intended for policy-makers and others concerned with the Code, as well as the general public.
    Availability: Downloadable pdf version in English
MODULE 17
Infant and young child feeding

TRAINING RESOURCE LIST

Advocacy

1. IBFAN-Wemos (2001). Infant feeding in emergencies. Do you know that your generous donations of breastmilk substitutes could do more harm than good? 2nd ed. Panang: IBFAN.
   Availability: Downloadable pdf version in English
   Contact: www.ibfan.org

   This contains a copy of the 1981 Code and other resolutions, has information on the background to the Code, examination of some important provisions of the Code, information for health workers on how to make the Code work and how to support breastfeeding. It contains black and white photographs, examples of marketing and cartoons. While it is for health workers (of any country), many others interested in the Code often find its style of writing very accessible.
   Availability: Downloadable.
   http://www.ibfan.org/
   Contact: IBFAN-ICDC International Code Documentation Centre, Penang, Malaysia at ibfanpg@tm.net.my or IBFAN Europe c/o GIFA, Geneva, Switzerland at info@gifa.org or IBFAN Regional Offices or WHO Child and Adolescent Health and Development (CAHD) Department, Geneva, Switzerland vallenasc@who.ch

   Produced by the International Code Documentation Centre in Penang, a specially themed issue of their publication ‘Focus,’ looked at specific issues related to the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions in the context of infant feeding in emergencies.
   Availability: English, Spanish, Portuguese, French, Arabic, Italian
   Contact: http://www.ibfan.org/code_watch-focus-emergencies.html and http://www.ennonline.net/resources

   A guide to help the general public understand their important role in protecting and supporting infants and young children caught up in crises worldwide. Focusing on infant and young child feeding, the guide includes a description of what happens on the ground in emergencies, works to dispel some myths surrounding infant feeding in emergencies and details what the general public can do to help. Sample letters are included.
   Availability: Downloadable pdf version in English
   Contact: www.ennonline.net/ife

   A two-page pamphlet outlining how the media can help protect and support appropriate and safe infant and young child feeding in emergencies
   Availability: Downloadable pdf version in English, French, Spanish, German, Italian and Arabic
   Contact: www.ennonline.net/ife
Technical guidelines and training material

Breastfeeding

This is a package of resources to help in orientation on infant and young child feeding in emergencies (IYCF-E).
These resources are targeted at emergency relief staff, programme managers, and technical staff involved in planning
and responding to emergencies, at national and international level. The package comprises:
• E-learning lessons
These can be used in self-learning, in preparation for a face-to-face training, or as a group exercise. The lessons do not
have to be completed at the one time, but ‘remember’ where you’ve stopped so that you can return and continue.
Availability: English. Online at http://lessons.ennonline.net. CD: ENN, 32 Leopold Street, Oxford, OX4 1TW, UK,
e-mail: office@ennonline.net.
It is also available integrated in UNICEF nutrition in emergencies training. This includes an assessment www.unicef.org/
training (English). French and Spanish versions are forthcoming.
Time for training: The e-learning series takes approx. 1 day to complete. Sample PowerPoints are designed for 1-3 hours.
• Training resources
These comprise PowerPoint presentations and exercises for face to face orientation sessions. The materials have been
informed by a number of pilots in training settings with different groups. PowerPoints include:
• A ‘silent’ presentation of images only (‘silent’)
• A one hour orientation series of slides
Additional PowerPoints available are:
• Orientation on IYCF-E (Lebanon, 2010), ENN/IFE Core Group.
• Orientation on IYCF-E (Nairobi, 2009) ENN/IFE Core Group.
• Orientation on IYCF-E for military. ENN/IFE Core Group.
Contact: www.ennonline.net/resources/ click ‘infant and young child feeding in emergencies’
Materials (PowerPoint, spread sheet) that support Exercise 2 in Part 3 of Module 17 are available at:
http://www.ennonline.net/ife/orientation/resources (see Country Problem Analysis)
• Technical notes
Detailed notes for facilitators and for those looking for more detail to target different groups and topics.
• Key resources
Key resources are available to support the content of this package and are referred to in lessons and training content.
These have been produced as a compilation to download as a single folder of documents.
• Evaluation guide
Pre/post assessment questions are available (an answer sheet on request) for an essential orientation on IFE.
In addition, an evaluation strategy has been developed to help locate this work in a larger evaluation process.
Availability: English. Access all four elements of the package at: http://www.ennonline.net/ife/orientation
Contact: Emergency Nutrition Network (ENN), 32 Leopold Street, Oxford, OX4 1TW, UK.
Tel: +44 (0)1865 324996, Fax: +44 (0)1865 324997, e-mail: office@ennonline.net, or visit www.ennonline.net/ife

child feeding in emergencies for health and nutrition workers in emergency situations. Four parts: Core manual
for training practice and reference; additional material; annexes; overhead figures. Version 1.1.
Module 2 aims to provide those directly involved with infants and caregivers with the basic knowledge and skills to
support safe and appropriate infant and young child feeding. It details how breastfeeding works, supportive care for
mothers, individual assessment of the mother-child pair, providing basic aid and more skilled help for breastfeeding
(including low birth weight, malnourished mother, traumatised mothers. In an additional part it contains special
chapters on re-lactation and the management of breast conditions. Additional material also covers the management of
severely malnourished infants less than six months, as well as artificial feeding (reflecting realities in the field and in the
context of a lack of guidance on these two issues). The content is supported by detailed annexes and slides. It is used
both as a training resource and a technical guidance by field staff.
Note: The information has been simplified and streamlined, so that health and nutrition workers with little time and little opportunity for study can learn and use effective interventions with the minimum of training. Module 2 was designed to specifically address emergency situations when time shortages prevent full training. The breastfeeding content is based on the WHO/UNICEF breastfeeding counselling course. It is not a substitute for a week-long training course in breastfeeding counselling.

Time for training: Module 2 consists of five core parts, which can be covered in 5 hours of group teaching. Additional parts can be studied or taught separately. If included with the core part, the entire session would take 1-1.5 days.

Availability: English, French and Arabic

Contact: www.ennonline.net/ife/module2/index.html

PowerPoint slides: http://www.ennonline.net/resources/739

Facilitator’s guide and handouts for participants on 1 1/2 day orientation on IYCF counselling in the context of community-based programmes for management of severe acute malnutrition. Availability: English, French


This Programme Guidance contains detailed programming information on IYCF, including breastfeeding, complementary feeding and infant feeding in general and in especially difficult circumstances including in the context of HIV and in emergencies. It also briefly addresses maternal nutrition. The key action areas for these components are detailed at the different levels, including national policy/strategy level, health services, and community. The document provides strategic programme recommendations for priority IYCF actions and their operationalisation that will support achievement of MDGs 1 and 4, among others, as well as UNICEF Medium Term Strategic Plan Focus Area 1 on Young Child Survival, Growth and Development.

The Programme Guidance serves as a single reference on IYCF programming – updating existing guidance where necessary (e.g. HIV and infant feeding and the Code) and adding new or more detailed guidance where little existed previously (e.g. complementary feeding, community-based programming and communication). It draws upon and builds on existing tools such as the 2007 WHO/UNICEF Planning Guide for National Implementation of the Global Strategy for IYCF, with additional detailed and practical guidance on ‘how’ to design and implement the recommended key IYCF action areas at scale in a comprehensive manner. For each component, the document describes the best practices, based on lessons learned, case studies, reviews and evidence of impact. It suggests options to implement proven effective interventions, such as institutionalising the Baby Friendly Hospital Initiative (BFHI), building skills of community health workers to counsel and support mothers on IYCF and describing improved approaches to communication for behaviour and social change. The guidance highlights that communication alone is not sufficient for improving breastfeeding and complementary feeding practices, and needs to be complemented by counselling and support by skilled workers at community and health system levels.

Availability: English


Contact: IYCN Unit, Nutrition Section, UNICEF, 3 UN Plaza, New York, NY 10017, USA. e-mail: iycn@unicef.org

The training course on “Programming for Infant and Young Child Feeding”, has been developed through a close collaboration between UNICEF Headquarters’ nutrition section, and Cornell University’s Division of Nutritional Sciences. This course aims to enhance the competencies and build capacity of UNICEF staff and counterparts who are involved in IYCF programme development, programme implementation, programme evaluation, and other related activities for improving programmes for infants and young children in developing countries. Based on an assessment of the current level of competencies in the target audience for this course, the learning objectives for the course were selected for developing the training sessions and resources.
Units cover essentials of IYCF including undernutrition basics, role of IYCF in child survival, growth and development, essentials of breastfeeding and essentials of complementary feeding; as well as programming topics including comprehensive IYCF programming, selected interventions for improving breastfeeding and selected interventions for improving complementary feeding. The course also includes special topics such as IYCF in emergencies and IYCF in the context of HIV/AIDS, and case studies. The course will be available free of charge through a basic registration and is recommended an integral part of training for health and nutrition staff, consultants, counterparts and public health practitioners and managers.

Availability: English
Contact: iycn@unicef.org for information about the course and when it will be opened.

The community IYCF training package was developed by UNICEF to meet the needs of community-based workers. It incorporates breastfeeding, complementary feeding, maternal nutrition during pregnancy and lactation (briefly), infant feeding in the context of HIV and emergencies and infant feeding in the context of acute malnutrition, for example, specific recommendations to prevent acute undernutrition for children living in settings of high levels of acute malnutrition or for children recovering from acute malnutrition. It has a strong focus on building practical skills in counselling, group facilitation/interpersonal communication, support to mothers and caregivers and problem solving. The IYCF training module contains generic content based on materials developed for a number of East African countries (e.g. Kenya, Uganda), and will be made available at global level in several languages. The materials include a set of counselling cards, reference materials for participants and a facilitator's guide. A detailed planning adaptation guide accompanies the package, containing guidance for adaptation of the graphics and technical content at country level, as well as guidance on planning and structuring a community-based IYCF programme. The package also includes three take-home brochures for caregivers on breastfeeding, complementary feeding and maternal nutrition, as well as a library of images that can be used in the adaptation process for different settings.

Available: generic version in English and French. Other language versions available from selected UNICEF country offices upon request from iycn@unicef.org
Contact: http://www.unicef.org/nutrition/index_58362.html

7. **WHO (2009). Infant and Young Child Feeding: Model Chapter for Textbooks for medical students and other allied health professionals**
The Model Chapter on Infant and Young Child Feeding is intended for use in basic training of health professionals. It describes essential knowledge and basic skills that every health professional who works with mothers and young children should master. The Model Chapter can be used by teachers and students as a complement to textbooks or as a concise reference manual.

Note that as of August 2011, the HIV and infant feeding module of this course has not yet been updated to reflect the 2010 guidelines.

Availability: English, Spanish
Contact: http://www.who.int/nutrition/publications/infantfeeding/9789241597494/en/index.html

This five-day *Infant and Young Child Feeding Counselling: An Integrated Course* is based on core content from three existing WHO/UNICEF training courses (breastfeeding counselling, HIV and infant feeding counselling and complementary feeding counselling). This course aims to give health workers basic counselling skills so that they can help mothers and caregivers more effectively. The course is based on a set of competencies which participants are expected to learn during training and follow-up. It is suitable for training lay counsellors, community health workers, primary health care nurses and doctors – especially if supervising and/or at referral level, clinicians at first referral level. Course participants are not expected to have any prior knowledge of infant feeding. Note that as of August 2011, the HIV and infant feeding module of this course has not yet been updated to reflect the 2010 guidelines. An update is due by 2012.

Time for training: 5 days.
Availability: Downloadable
Contact: http://www.who.int/nutrition/publications/infantfeeding/9789241594745/en/index.html
   A global effort to implement practices that protect, promote and support breastfeeding in health facilities.
   The revised package of BFHI materials includes five sections:
   1) Background and Implementation
   2) Strengthening and Sustaining the BFHI: A course for decision-makers
   3) Breastfeeding Promotion and Support: a 20-hour course for maternity staff
   4) Hospital Self-Appraisal and Monitoring
   5) External Assessment and Reassessment (for limited distribution, available to the regional and national UNICEF and WHO)
   Note that as of August 2011, the HIV and infant feeding module of this course has not yet been updated to reflect the 2010 guidelines.
   Availability: English

**Complementary Feeding**

   This document is intended to guide policy and programmatic action on complementary feeding up to two years of age at global, national and community levels. It sets out ten scientifically based guidelines which can be adapted to local feeding practices and conditions.
   Availability: Spanish, English, French
   Contact: [www.who.int](http://www.who.int)

   See earlier.

   There are a number of infants who will not enjoy the benefits of breastfeeding. They include children born to HIV-positive mothers who choose not to breastfeed and children whose mothers have died. To address the nutritional needs of children who are not breastfed after 6 months of age, WHO has led a process to develop Guiding principles for feeding non-breastfed children 6-24 months of age. These principles are the result of a background document that examined the feasibility of designing adequate diets using locally available foods, and are based on consensus achieved during an informal meeting of experts held in Geneva in early 2004. They are adapted from the Guiding principles for complementary feeding of the breastfed child. The publication lists the nine guiding principles, with the scientific rationale for each, and gives examples of diets from different parts of the world that can meet energy and nutrient needs of infants and young children after 6 months of age who are not breastfed. Annexes include information on developing locally appropriate feeding recommendations based on the principles, and on key issues around early breastfeeding cessation for infants and young children of HIV-positive mothers.
   Availability: French, Spanish, English

   The purpose of this course is to provide knowledge and skills for health workers who work with caregivers of young children from 6 to 24 months of age; designed for workers in primary health care services, in the community or attached to hospital health services.
   Availability: English

**Artificial Feeding**

   Chapter 9. When infants are not breastfed.
   Contacts and availability: See earlier
   - Explains the causes of diarrhoea, how breastfeeding prevents diarrhoea and how infant formula makes infants vulnerable to diarrhoea and the risks during emergencies.
   - Availability: Downloadable pdf version in English
   - Contact: www.ennonline.net/ife

   - Contact: pubdoc@unicef.org

   - Powdered infant formula (PIF) has been associated with serious illness and death in infants due to infections with Enterobacter sakazakii and Salmonella enterica. These guidelines are a generic document that will provide guidance and support for countries and governments. When adapted at the country level, conditions (e.g., climatic and socioeconomic differences, etc.) within the country should be reflected. Individual countries should outline minimum training requirements for parents, caregivers, and staff in hospitals and day care centres. Also available at same website are individual guidelines for bottle feeding, cup feeding and feeding in care facilities.
   - Availability: English, French, Spanish, Chinese, Arabic, Japanese, Russian

   - A small number of health conditions of the infant or the mother may justify recommending that she does not breastfeed temporarily or permanently. These conditions, which concern very few mothers and their infants, are listed in this document together with some health conditions of the mother that, although serious, are not medical reasons for using breastmilk substitutes.
   - Availability: English

6. **Generic label to put on tins of infant formula.**
   - A sample generic label for infant formula. Note: This is in English only. This would require translation to the target population and should be developed in consultation with lead technical agencies.
   - Availability: Downloadable in English
   - Contact: http://www.ennonline.net/resources/176

---

### HIV and infant feeding

   - The 2010 recommendations recognize the important impact of ARVs during the breastfeeding period, and recommend that national authorities in each country decide which infant feeding practice, i.e. breastfeeding with an ARV intervention to reduce transmission or avoidance of all breastfeeding, should be promoted and supported by their Maternal and Child Health services. This differs from the previous recommendations in which health workers were expected to individually counsel all HIV-infected mothers about the various infant feeding options, and it was then for mothers to decide between them.
   - Where national authorities promote breastfeeding and ARVs, mothers known to be HIV-infected are now recommended to breastfeed their infants until at least 12 months of age. The recommendation that replacement feeding should not be used unless it is acceptable, feasible, affordable, sustainable and safe (AFASS) remains, but the acronym is replaced by more common, everyday language and terms. Recognizing that ARVs will not be rolled out everywhere immediately, guidance is given on what to do in their absence.
   - Availability: English

2. **WHO (2011). Frequently asked questions on HIV and infant feeding.**
   - Contact: Due out late 2011. Check www.who.int
Monitoring and Evaluation

   A practical step by step guide to including WHO standard indicators of infant and young child feeding practices in surveys. It includes excel spread sheets for data entry and analysis, and a standard questionnaire.
   Availability: Downloadable in English
   Contact: http://www.ennonline.net/resources/743

   An assessment tool for use in rapid onset emergencies in the first 72 hours. It includes questions on IYCF-E. For multi-agency teams, including national government institutions, United Nations agencies, international NGOs and national non-governmental institutions.
   Contact: www.unicef.org/nutrition/globalnutritioncluster.html

   This document presents data on indicators for assessing infant and young child feeding practices for 46 countries, based on Demographic and Health Surveys conducted between 2002 and 2008. The indicator values were calculated using new and updated definitions published by WHO and partners in 2008; some values have not been calculated before and therefore provide a baseline for tracking progress in infant and young child nutrition in the future.
   The document is one in a series of three documents on Indicators for assessing infant and young child feeding practices issued by WHO that includes Part 1: Definitions and Part 2: Measurement.
   Availability: downloadable in English
   Contact: http://www.who.int/nutrition/publications/infantfeeding/9789241599757/en/index.html

   This tool is designed to assist countries in (a) summarizing current data with regard to infant and young child feeding practices, (b) assessing the strengths and weaknesses of their policies and programmes to promote, protect and support optimal feeding practices, and (c) determining where improvements may be needed to meet the aims and objectives of the Global Strategy for Infant and Young Child Feeding. Provides the tools to answer the question: Are appropriate policies and programmes in place to ensure that mothers, infants and children will be provided adequate protection and support for appropriate feeding during emergencies?
   Available: Downloadable
   Contact: www.who.int

Other resources

   Technical review of the current evidence, policies, practices and programme outcomes of management of acute malnutrition in infants under the age of 6 months.
   Availability: downloadable in English
   Contact: http://www.ennonline.net/research/mami

   Publication that includes field articles to contribute case study material. Online searchable archive and free print subscription available.
   Availability: English, print and online
   Contact: Search database at www.fex.ennonline.net and subscribe for print copy at www.ennonline.net.

3. IASC Nutrition Cluster.
   A toolkit for addressing nutrition in emergency situations intended as an easy-to-use field guide that outlines the key basic interventions for nutritional support to individuals and groups during an emergency situation. Provides the what, why, when, and how for different nutrition interventions, including basic monitoring benchmarks and expected standards.
   Availability: Online
   Contact: www.unicef.org/nutrition/globalnutritioncluster.html
4. **IFE Core Group.**  
An interagency collaboration that has developed policy guidance, training materials, and tools to aid programming on infant and young child feeding in emergencies since 1999. Key outputs include the Operational Guidance on IYCF-E, Module 1 Orientation Package and Module 2 (see earlier). The institutional ‘home’ is the ENN.  
Contact: www.ennonline.net/ife and resources at www.ennonline.net/resources

5. **Infant and Young Child Nutrition (IYCN) Project/USAID.**  
A collection of tools and resources for use by community-based nutrition programmes produced by the USAID funded IYCN Project. The collection includes literature reviews, social and behaviour change communication resources for reaching a wide range of community members, and monitoring and evaluation tools. Informed by IYCN’s experience implementing community approaches in eight countries, the tools fill specific programme needs but can be adapted for use in other country settings. The resources described can be used together or separately and modified based on findings from formative research.  
Availability: Downloable  
Contact: http://www.iycn.org or e-mail: info@iycn.org to request a CD with all the resources.

6. **The Linkages Project. LINKAGES. Washington: The Linkages Project.**  
Facts for Feeding:  
- Recommended Practices to Improve Infant Nutrition during the First Six Months (July 2004)  
- Guidelines for Appropriate Complementary Feeding of Breastfed Children 6-24m (April 2004)  
- Breastmilk: A Critical Source of Vitamin A for Infants and Young Children (October 2001)  
- Birth, Initiation of Breastfeeding, and the First Seven Days after Birth (July 2003)  
Frequently Asked Questions:  
- Breastmilk and Maternal Nutrition (July 2004)  
- Exclusive Breastfeeding: The Only Water Source Young Infants Need (June 2004)  
Also: Mother-to-Mother Support for Breastfeeding (April 2004)  
The Lactational Amenorrhea Method (September 2001).  
Availability: Most documents available in English, French, and Spanish (sometimes Portuguese)  
Contact: LINKAGES, Academy for Educational Development, e-mail: linkages@aed.org, www.linkagesproject.org

*Facts for Life* provides information to help save, improve and protect children’s lives, and should be shared widely with families, health workers, teachers, youth groups, women’s groups, community organisations, government officials, employers, trade unions, media, and non-governmental and faith-based organisations. It is designed to educate those who have influence over the safety and wellbeing of children through simple messages.  
Contact: http://www.factsforlifeglobal.org/resources/factsforlife-en-full.pdf

Provides the means to prepare, plan, implement and monitor behaviour change communication initiatives supporting health, hygiene and child protection efforts in emergencies, including IFE issues. For programme managers from UNICEF, United Nations agencies, NGO partners and government personnel  
Availability: Downloadable  
Contact: www.unicef.org/influenzaresources/files/BCC_in_Emerg_chap1to8_2006.pdf