Infant and Young Child Feeding in Emergencies: An analysis of key factors of a strong response
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Introduction

Infant and young child feeding

Breastfeeding is the single most effective intervention to save children’s lives. Thirteen percent of all deaths among children less than five years could be averted if breastfeeding was practised optimally, while good complementary feeding could prevent another 6% of deaths. Non-breastfed infants are 14 times more likely to die from pneumonia and 10 times more likely to die of diarrhoea than breastfed children. Globally, the deaths of 823,000 children aged five and under could be prevented yearly if breastfeeding practices were scaled up to near universal level.

In both development and emergency settings, infant and young child feeding (IYCF) programming is focused on actions to promote and support safe and appropriate feeding practices which will ensure the survival, growth and development of children under two years of age.

Development programmes focus mostly on children’s growth and development while humanitarian actions focus on child survival, but the interventions are built around the same recommended practices of early initiation of breastfeeding, exclusive breastfeeding for the first full six months of life, continued breastfeeding for at least two years, complementary feeding from six months and appropriate water, sanitation and hygiene (WASH) practices. Key activities of IYCF encompass multiple bands of influence at national, health system, community and individual level.

Figure IYCF activities
Although IYCF interventions in both development and emergency settings promote, protect and support optimal feeding practices and aim to improve IYCF practices, IYCF in emergencies (IYCF-E) also includes a ‘do no harm’ component (for example, preventing and managing untargeted donation of breast-milk substitutes).

Caregivers have different needs in emergencies in relation to IYCF due to severe disruption of family life, communities, systems, and infrastructure. For example, often mothers feel they cannot produce enough breast milk due to stress, or because they are not eating as much food as they were before the emergency. Because of often dire living conditions in emergencies, mother and baby areas, where women can rest with their children and receive support, are an important component of IYCF-E. Therefore, staff working in emergencies, need a different skill set and different tools from those working in development settings, and different monitoring and evaluation systems are needed. In addition, IYCF-E needs to reach as many people as possible as quickly as possible, whereas IYCF has more time to address long-term behaviour change.

There is a need to support IYCF in all humanitarian settings. Increased risks such as poor sanitation, disease outbreaks, infant formula donations, stress and trauma mean that support for appropriate feeding is critical for child survival and the protection of infants and young children. IYCF-E must be included as one of the first activities of a response. However, despite the evidence that appropriate and timely support of IYCF-E saves lives, it is rarely prioritised or adequately supported.

In this study we explored factors that supported or inhibited a strong IYCF-E response in three emergencies: The El Niño drought in Ethiopia in 2015-2016; the earthquake in Nepal in 2015; and the ongoing Syrian crisis.

El Niño crisis, Ethiopia, 2015-2016
Over the course of 2015 and 2016, Ethiopia experienced its worst drought in 50 years, related to the El Niño phenomenon. The effects were devasting. The drought affected the North-Eastern areas especially severely. In August 2015, the government estimated that 4.5 million people were in need of emergency food assistance; this was revised to 8.2 million two months later and to 10.2 million by the end of 2015.

Acute malnutrition increased countrywide, with more than half of all districts classified as hotspots by March 2016, which triggered selective feeding interventions. This was the highest number of districts classified as hotspots since 2009. In total, 420,000 children under 5 required treatment for severe acute malnutrition and 2.5 million for moderate acute malnutrition in 2016. As per the Humanitarian Response Plan, a total of 1.1 million children aged 0-2 years and 600,000 pregnant and lactating women were targeted with IYCF-E interventions in 142 priority districts.

Nepal earthquake 2015
On 25 April 2015, a 7.8 magnitude earthquake struck Nepal, causing severe destruction in 14 out of the 75 districts in the country. Two weeks later, on 12 May, another quake of 7.3 magnitude hit, worsening the humanitarian situation. 8,891 people were confirmed dead,
605,254 houses destroyed, and 288,255 houses damaged. During the height of the emergency, some 188,900 people were temporarily displaced.

The earthquake response took place in a rugged and largely inaccessible operating environment. Hundreds of villages destroyed by the earthquakes could be reached only by helicopter or on foot, often days away from the nearest road. Monsoon rains from June to September made most of the mountain passes inaccessible due to multiple landslides, while low cloud cover suspended almost all air operations. Humanitarian assistance directly reached 3.7 million people in the 14 severely affected districts. 404,000 children aged from six months to five years and pregnant and lactating women were in need of nutrition support.

Syria crisis

The humanitarian situation in Syria has deteriorated significantly since protests erupted in March 2011. Ongoing conflict, massive population displacement, overcrowding in formal and informal settlements, breakdown in social and public services and destruction of infrastructure have significantly affected food security, livelihoods, health services and IYCF practices and subsequently nutritional status. In 2017, as the crisis entered its sixth year, 13.5 million people required humanitarian assistance, including 4.9 million people trapped in besieged and hard-to-reach areas, according to the 2017 Humanitarian Needs Overview. Children and women comprise the majority of the displaced: 2.5 million children aged six months to five years and 1.9 million pregnant and lactating women are in need of assistance.

Although the prevalence of acute malnutrition and chronic malnutrition is within acceptable range in many areas, anaemia is of concern, as well as poor feeding practices as reflected by low uptake of exclusive breastfeeding in the first six months of life and the low breastfeeding rate at one year. The majority of children are fed infant formula. The scaling-up of ongoing preventative and curative nutrition services is required, with an emphasis on serving hard-to-reach and besieged areas where data on the nutrition situation is unavailable. Nutrition actors work to promote and protect exclusive breastfeeding for infants up to months and ensure provision of adequate complementary feeding for children from six months to two years, through community-level counselling, establishment of mother- and baby-friendly spaces, bottle exchange programmes and, in a few settings, monitoring violations of the International Code of Marketing of Breast Milk Substitutes. We assessed the response in Northern Syria only

Methodology

A panel of Save the Children Nutrition in Emergency Technical Advisors determined indicators defining strong IYCF-E programming and potential key underlying factors (see Annex 1), drawing from existing indicators, such as Sphere standards and Global Nutrition Cluster indicators.

Secondary data was collected, and interviews were conducted with key stakeholders from NGOs and UN agencies, using a standard questionnaire for each country, until saturation was attained. Data collection took place in October-November 2016 for Ethiopia; May-June 2017 for Syrian; and August-September 2017 for Nepal.
Finally, data was analysed and a score of strength of the IYCF-E response in each country was attributed. Points were attributed according to responses to each indicator (Annex 1). The maximum possible score was 16. The response was considered weak if the country’s total score was less than half the maximum score; medium if it was 50-74% of the maximum and strong if it was more than 75% of the total score. This score is a way of comparing responses between countries and should not be read in isolation.

Results

Interviews

Interviews were conducted with staff from international NGOs, local NGOs, UN agencies and from the Nutrition Cluster. The following table shows the number of staff interviewed in each location:

<table>
<thead>
<tr>
<th>Location</th>
<th>International NGOs</th>
<th>Local NGOs</th>
<th>UN</th>
<th>Nutrition Cluster</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopia</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Nepal</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Northern Syria</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

Strength of IYCF-E response in each country

Out of a maximum of 16, Ethiopia scored 9, showing a medium IYCF-E response; Nepal scored 11, also medium, and Northern Syria scored 13, indicating a strong response. It has to be noted that the score for Northern Syria concerned the IYCF-E response as it was in 2017; it had evolved positively compared to the beginning of the crisis, as discussed below.

Coordination and policy

In all three countries, an IYCF-E national policy, strategy or action plan was in place, as well as a lead coordinating body. In Ethiopia, this was a working group led by the Ministry of Health (MoH), not under the nutrition cluster; in Nepal, it was a technical working group under the nutrition cluster, while in Syria, it started before the nutrition cluster was activated and has since been integrated within the nutrition cluster.

Coordination around IYCF-E within the nutrition sector was felt to be medium in Ethiopia with IYCF-E being a new concept introduced in 2015-2016.

In Nepal, it was also medium. A strong factor was the presence of community volunteers, health workers, and mothers’ groups already trained in ICYF and lactation management, because a USAID funded consortium project, Suaahara, had been implementing a large IYCF programme in 60% of the districts since 2011. Suaahara was a programme to operationalise the multisector nutrition plans from the government. It was implemented by seven partners, including local NGOs, and led by Save the Children. On the other hand, it seems that the transition from IYCF to IYCF-E was difficult as many actors did not understand the difference and were reluctant to adapt their programmes. IYCF-E priorities such as the
establishment of mother and baby areas were not always understood by longer-term actors. Coordination by the nutrition cluster was also new for them.

In Northern Syria, coordination was strong at the time of the study but was reported to have been weaker before the activation of the nutrition cluster and the creation of an IYCF-E technical working group in 2015. At the beginning of the crisis, there was a nutrition working group under the health cluster but there were few actors and people saw nutrition as community-based management of acute malnutrition (CMAM) only. When some NGOs started IYCF-E activities, IYCF-E gained momentum with UN agencies like OCHA and UNICEF and funding started to become available for IYCF-E, leading to more actors becoming involved.

Coordination with other sectors was weak in Ethiopia, although some sporadic integration with health, water, sanitation and hygiene and food security and livelihoods was mentioned. In Nepal, it was medium, being weak at the beginning and growing stronger afterwards. In Northern Syria, coordination with other sectors also improved with time; the strongest coordination was with health and food security.

Monitoring and management of breast-milk substitutes donations

Standard operating procedures on violations of the International Code of Marketing of Breast-Milk Substitutes (including unsolicited donations and distribution of breast-milk substitutes) and monitoring and reporting existed in each country, as well as bodies to deal with any donations of breast-milk substitutes (BMS), milk products, bottles and teats, but it was reported that implementation of these was not optimal. In Ethiopia, no unsolicited donations of BMS were reported, while in Nepal a lack of policy and procedures on the confiscation, storage and disposal of BMS led to delays.

In Ethiopia no joint statement was issued on IYCF and BMS. In Nepal, a statement was issued five days after the earthquake, however, the Nepalese government subsequently listed BMS as a needed item and several countries made donations of BMS as a result. In Northern Syria, a joint statement was issued in 2015.

Assessment of IYCF needs

In both Nepal and Ethiopia, there was no assessment of standard indicators of breastfeeding and complementary feeding, even at a later stage of the emergency when it becomes more feasible. In Northern Syria, IYCF indicators were included, in the latest MIRA, SMART and some KAP surveys. IYCF indicators were also included in the food security and livelihood assessment conducted by the food security cluster in 2017.

Assessment of needs was weak in Ethiopia, with no IYCF-E assessment, although some IYCF indicators were included in SMART surveys. It was medium in Nepal, where views of interviewees varied. Some felt that the response team came in with pre-conceived ideas of what they should be doing while others thought assessments soon after the earthquake were comprehensive and captured a lot of needs. However, they failed to foresee changes in the months after the earthquakes and to adapt interventions designed for densely populated displacement camps, as displaced people did not stay in the camps long. It was also
mentioned that the scale of BMS donations was not known and that no comprehensive assessment on IYCF-E in all of the response areas was conducted. In Northern Syria, assessment of needs was also medium, with poor coordination. Some IYCF assessments were conducted but their quality was questioned.

**IYCF-E interventions and indicators in Humanitarian Response Plans**

Many IYCF-E interventions were included in the Humanitarian Response Plan (HRP) in Ethiopia, which targeted 1.1 million children under two years and 600,000 pregnant and lactating women in 142 priority districts affected by the emergency. In Nepal and Northern Syria, some interventions were included, with IYCF-E being one of five nutrition pillars in Nepal and 10% of nutrition interventions being IYCF-E in the 2017 HRP in Northern Syria.

In all countries, IYCF indicators were reported in the HRP and/or cluster monitoring report.

Funding of these interventions varied. In Ethiopia, some of these interventions were funded but CMAM was usually prioritised. This was also the case in Nepal, although many IYCF-E interventions were also funded. In Northern Syria, partners struggled to find funding for IYCF-E at the beginning of the response. Thereafter, IYCF-E interventions were generally well funded.

**Capacity building**

National training events on IYCF-E took place in Ethiopia, and the training was cascaded to the regional level afterwards. Training was also conducted in Northern Syria, including for health workers, community volunteers and cluster partners. In Nepal, orientations and capacity-building activities were conducted for stakeholders including Ministry of Health and Population staff. There was also training for the Suaahara consortium, but it does not seem that national training was carried out.

**Timeliness, quality and coverage of interventions**

Timeliness of IYCF-E interventions was medium in Ethiopia, with delays in implementation of the IYCF-E response. The overall nutrition response also faced some delays.

In Nepal, timeliness was also medium. Although some people were already trained in IYCF prior to the earthquake, the shift to IYCF-E was slow, especially because of logistics and funding constraints. Shelter, food assistance and CMAM were seen as higher priorities than IYCF-E.

Timeliness was weak in Northern Syria, where a significant IYCF-E response only began three years after the onset of the crisis.

Quality of response was felt to be medium in all countries. Most respondents mentioned large-scale training of health workers in Ethiopia as an essential part of the response but questioned the overall impact of this short training without follow-up. In Nepal, some interviewees mentioned that there had been a strong response for increasing awareness, support to mothers, counselling and establishment of mother and baby areas.
In Northern Syria, availability of tools, guidelines, reporting tools and capacity increased throughout the crisis. On the other hand, the lack of access to Northern Syria might have undermined quality, as only remote training and management were allowed. It was also mentioned that scaling up was prioritised rather than quality monitoring.

In Ethiopia coverage was medium. Geographical coverage was good, with more than 80% of the priority areas covered, but coverage in terms of numbers of beneficiaries was not known. In Nepal coverage was reported to be strong, with most of the areas in need covered and thousands of frontline workers mobilised, although displacement and the rainy season hampered access. In Northern Syria access was considered medium, with IYCF-E available in more than half of health facilities. However, there were big gaps at community level and access was restricted, although some local NGOs had good access.

Factors affecting strength of response

International Code of Marketing of Breast-Milk Substitutes

In Ethiopia, there were no legal measures to enforce the International Code of Marketing of Breast-Milk Substitutes (the Code) and no monitoring of Code violations. However, at the end of 2015, the Ethiopian Food, Medicine and Healthcare Administration and Control Authority finalised a Directive for the regulation of the promotion of infant formula, follow-up formula, feeding bottles, pacifiers and teats.

Full legal provisions existed in Nepal to enforce the Code and many provisions existed in Syria but there was no information on Code monitoring for these two countries.

Pre-crisis policy, strategy and programming

All countries had an IYCF policy or strategy. These included a strong component on IYCF-E in Nepal and a weaker one in Ethiopia. In Syria, the IYCF policy did not include IYCF-E; instead, a stand-alone IYCF-E strategy was developed in 2017-2020. National policies on HIV and infant feeding were available in Nepal and Ethiopia but not in Syria. IYCF-E was included in national emergency preparedness and contingency plans in Ethiopia and Nepal but not in Syria.

In Ethiopia and Nepal, there were many pre-crisis IYCF programmes. In Ethiopia, IYCF was part of community-based nutrition while in Nepal, Suaahara covered 60% of the country and some other programmes also existed. In Syria, there were a limited number of programmes, mainly focusing on the Baby-friendly Hospital Initiative and counselling.

Level of commitment, capacity and funding during the crises

Funding availability was medium in Ethiopia, with one interviewee mentioning that IYCF-E in a slow onset emergency is difficult to differentiate from IYCF and therefore hampers attraction of emergency funds. In Nepal, funding availability for IYCF-E was also medium, with priority given to CMAM. One interviewee also mentioned that funds allocated to IYCF-E activities were underspent. In Northern Syria, funding availability was felt to be weak, although it has become stronger throughout the crisis. Funding for IYCF-E was easier to obtain through health funding channels than through nutrition funding channels. It was also
mentioned that convincing donors of the importance of IYCF-E requires significant advocacy.

The overall level of commitment from national and international NGOs, UN agencies and government was medium in Ethiopia. The level of commitment from national and international NGOs and government was strong in Nepal, while the level of commitment from UN agencies was medium, with more focus on CMAM. In Syria, the level of commitment from international NGOs and national NGOs was strong and the commitment of national NGOs increased throughout the crisis with improved capacity building. However, discrepancies between headquarters and field staff were mentioned. Commitment from UN organisations was weak at the beginning of the crisis and recently much improved.

IYCF-E champions were only present in Nepal, including in the MoH, Suaahara and international NGOs such as Save the Children and Action Against Hunger.

IYCF and IYCF-E technical capacity were felt to be medium/strong and medium/weak respectively in Ethiopia, with IYCF-E being a new concept. In Nepal, technical capacity in IYCF was strong, with many staff trained under the Suaahara programme. On the other hand, IYCF-E capacity was weak. In Northern Syria, capacity was weak at the beginning of the crisis and grew to medium.

**Pre-crisis IYCF indicators**

Data were missing for most indicators in Syria. The percentage of children aged nought to 23 months who were ever breastfed was high in Ethiopia and Nepal. The percentage of children aged up to five months who were exclusively breastfed was medium in Ethiopia and Nepal and low in Syria. The percentage of children aged up to 11 months who were bottle fed was low in Ethiopia and Nepal. While no pre-crisis national data were available in Syria, assessments during the crisis showed a high proportion of bottle feeding. The percentage of children up to 23 months receiving foods from more than four food groups was low in Ethiopia and Nepal. In general, pre-crisis data showed sub-optimal feeding practices.

**Limitations**

Due to resource constraints, we were not able to interview representatives of Health Ministries, who might have had different views.

We did not conduct field visits and were not able to assess whether IYCF-E interventions funded were appropriate and met the needs. This would have required an in-depth field evaluation that was not part of this study.

**Conclusion**

In Ethiopia and Nepal, the IYCF-E response was medium, while in Northern Syria it was weak at the beginning of the crisis but significantly improved throughout the crisis and was strong at the time of the study.

The main factors that have emerged as supportive of a good IYCF-E response are:
1. Activation of the nutrition cluster. In Northern Syria, it was only after nutrition cluster was activated that the response grew stronger. Before that, when nutrition was a working group of the health cluster, the IYCF-E response was weak.

2. Having a strong component on IYCF-E as part of the national IYCF strategy before the crisis contributed to the strength and timeliness of the response in Nepal.

3. Commitment of government and national and international NGOs is key. In Nepal, this was seen as a factor in the good and relatively timely response initiation. In Nepal, the commitment of the government also translated into the implementation of the International Code of Marketing of Breast-Milk Substitutes as well as policies and strategies including IYCF-E. In Northern Syria, commitment of international NGOs was crucial to build capacity of national NGOs and increase their commitment.

4. Assessment of IYCF practices and needs were generally weak, but improved lately in Syria, which might have helped the strengthening of the response.

5. Pre-crisis IYCF programmes and availability of trained staff were also important factors in the responses in Ethiopia and especially in Nepal. However, transition from IYCF to IYCF-E, such as the establishment of mother and baby areas, was not straightforward and capacity building and convincing stakeholders to move from IYCF to IYCF-E were major steps. Pre-crisis IYCF programmes and the availability of trained staff were weak in Northern Syria and might partly explain the slow IYCF-E response.

6. Awareness and capacity building in IYCF-E were key factors, whether pre-crisis IYCF capacity existed or not. Building capacity raised the level of commitment of stakeholders not previously aware of the importance of IYCF-E.

7. Linking IYCF-E programmes with health programmes may sometimes enable access to more funding. In Northern Syria, funding of IYCF-E within health programmes was significant.

Recommendations
To strengthen the IYCF-E response, the following should be applied:

1. Activate the nutrition cluster when IYCF needs assessment shows necessities, even if acute malnutrition prevalence is low.

2. Include IYCF-E in pre-crisis IYCF and nutrition policies, strategies and preparedness plans.

3. Ensure the presence of IYCF-E champions (such as the Ministry of Health, national and international NGOs, or UN agencies) to raise awareness about IYCF-E and advocate for implementation of interventions when needed.

4. Conduct IYCF-E assessments so that needs are clearly demonstrated.
5. Take into consideration pre-crisis IYCF interventions and coordinate with pre-crisis IYCF staff and programmes. Consider their views, experience and knowledge and orientate them on interventions and mechanisms specific to emergencies, such as mother-baby areas and the nutrition cluster coordination, so that they are fully on board when additional IYCF-E activities are developed.

6. Prioritise awareness and capacity building in IYCF-E.

7. Reinforce links between IYCF-E and other sectors, especially health.
References

Global

Ethiopia
Federal Ministry of Health, Family Health Department, Ethiopia (2004). National Strategy for Infant and Young Child Feeding

Joint Government – Humanitarian Partners National Flood Contingency Plan 2016 kiremt


Training of trainers manual for counselling on maternal, infant and young child nutrition

Ethiopia IYCF-E Plan of Action 2016

Nepal

Nepal Nutrition Cluster Bulletin, August 2015


Strategy for Infant and Young Child Feeding: Nepal 2014


Northern Syria

Standard Operating Procedures for Breast Milk Substitute management in the Syrian crisis context for infants 0-6 months - Validated by the Turkey-Syria Cross Border IYCF-E TWG – March 2016

IYCF-E Rapid Response Mechanism package guidance - Rapid BMS support for 0-6 months in transit (Addendum to Standard Operating Procedures for Breast Milk Substitute (BMS) management in the Syrian Crisis Context for Infants 0-6 Months) - Developed by the Turkey Cross Border Nutrition Cluster as part of the IYCF-E Rapid Response Mechanism Package – April 2017


Humanitarian Response Plan for Syrian Arab Republic (January-December 2017) – UNOCHA Syria - Produced on behalf of the Whole of Syria SSG and partners - March 2017

Humanitarian Needs Overview for Syrian Arab Republic 2017 – UNOCHA Syria - Produced on behalf of the SSG and humanitarian partners working under the Whole of Syria (WoS) framework - December 2016

Humanitarian Response Plan Monitoring Report for Syrian Arab Republic (January-June 2016) - Prepared by the whole of Syria ISCCG for the SSG


Syria Nutrition Cluster Bulletin (Turkey Hub) – March 2016
Annex: Indicators and scoring system

1. **Defining what is a strong IYCF-E response**

1.1. A national and/or agency policy (and/or action plan) is in place that addresses IYCF-E and reflects the Operational Guidance on IFE (yes/no) (Sphere indicators)

1.2. A lead coordinating body on IYCF-E is designated (e.g. IYCF working group in the nutrition cluster) (yes/no) (Sphere indicator)

1.3. Code violations (included unsolicited donations and distribution of BMS) are monitored and reported (yes/no) (Sphere indicator)

1.4. A body to deal with any donations of BMS, milk products, bottles and teats is designated (yes/no) (Sphere indicator)

1.5. A joint statement on IYCF and BMS issued (yes/no)

1.6. Assessment(s) of standard indicators of breastfeeding and complementary feeding (yes/no) (Sphere indicator)

1.7. IYCF-E interventions included in the Humanitarian Response Plan (HRP) (no (0% of total nutrition interventions)/some (1-25% of total nutrition interventions)/many (26%-50% of total nutrition interventions)) (based on HRP secondary data review)

1.8. IYCF-E interventions funded (no (0% of total nutrition interventions)/some (1-25% of total nutrition interventions)/many (26%-50% of total nutrition interventions)) (based on secondary data review and interviews)

1.9. IYCF-E indicators included in HRP/cluster monitoring reports (yes/no)

1.10. A national training on IYCF-E has been conducted (yes/no)

1.11. Interviewees perception of IYCF-E response

1.11.1. Coordination within the nutrition sector (weak/medium/strong)

1.11.2. Coordination with other sectors (weak/medium/strong)

1.11.3. Assessment of needs (weak/medium/strong)

1.11.4. Timeliness of response (weak/medium/strong)

1.11.5. Quality of response (weak/medium/strong)
1.11.6. Coverage of response (weak/medium/strong)

**Scoring:**

*If response = Yes, Many or Strong; 1 point is attributed.*
*If response=Some or medium; 0.5 point is attributed*
*If response = No or weak; 0 point is attributed*

The some of the points are calculated for each country.

The maximum possible score was 16. The response was considered weak if the country’s total score was less than half the maximum score; medium if it was 50-74% of the maximum and strong if it was more than 75% of the total score. This score is a way of comparing responses between countries and should not be read in isolation.

2. Defining supportive or inhibitive factors

**Proposed indicators**

4.1 BMS code into law (full/many/few)
4.2 Key provisions of national legal measures (full/many/few)
4.3 Code is monitored & enforced (yes/no)
4.4 National IYCF policy (yes/no);  
4.5 IYCF policy includes IYCF-E (yes/no);  
4.6 National HIV & Infant Feeding policy (yes/no)  
4.7 IYCF-E included in national emergency preparedness & contingency plans (yes/no)  
4.8 IYCF indicators  
   % of 0-23-month-old children ever breastfed (low/medium/high);  
   % of 0-5-month-old children exclusively breastfed (low/medium/high);  
   % children 0-11 months bottle fed (low/medium/high);  
   % children 0-23 months who received foods from more than 4 food groups (low/medium/high);  
4.9 Pre-crisis IYCF programmes (no/some/many);  
4.10 Presence of IYCF champions during the crisis (yes/no);  
4.11 Level of commitment from nutrition partners, e.g. government, UN, international NGOs, national NGOs (weak/medium/strong);  
4.12 In-country IYCF and IYCF-E technical capacity (weak/medium/strong);  
4.13 Funding availability (strong/medium/weak).