Sudan Infant and Young Child Feeding in Emergencies (IYCF-E)

Operational Guidance

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Sudan NUTRITION Sector

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[1] https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/b_iycf_strategy_23_4_15.pdf

[2] https://resourcecentre.savethechildren.net/library/infant-and-young-child-feeding-emergencies-iycf-e-toolkit-rapid-start-emergency-nutrition

[3] https://sites.unicef.org/nutrition/index_58362.html

[4] https://www.nutritioncluster.net/node/19161

[5] https://www.unicef.org/documents/infant-and-young-child-feeding-context-covid-19

[6] https://www.advancingnutrition.org/what-we-do/social-and-behavior-change/iycf-recommendations-covid-19

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Glossary

Acute malnutrition: Also known as 'wasting', acute malnutrition is characterized by a rapid deterioration in nutritional status over a short period of time. In children, it can be measured using the weight-for-height nutritional index or mid-upper arm circumference (MUAC). There are different levels of severity of acute malnutrition: Moderate Acute Malnutrition (MAM) and Severe Acute Malnutrition (SAM).

Adolescent: defined by the United Nations as all human beings ages 10-19 are a population group profoundly affected by any crisis, at tremendous risk of death, injury, and nonfulfillment of their rights to protection, education, and participation.

Basic Nutrition Package: Basic nutrition services package: Measures to treat and prevent malnutrition as well as to promote optimal nutrition behaviors and practices, including acute malnutrition management, micronutrient support, immunization, and deworming.

Body mass index (BMI): Defined as an individual's body mass (in kilograms) divided by height (in meters squared): BMI units = kg/m2. Acute malnutrition in adults is measured by using BMI.

Breastmilk substitutes (BMS): Any food marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.

Chronic malnutrition: Chronic malnutrition, also known as 'stunting', is a form of growth failure which develops over a long period of time. Inadequate nutrition over long periods of time (including poor maternal nutrition and poor infant and young child feeding practices) and/or repeated infections can lead to stunting. In children, it can be measured using the height-for-age nutritional index.

The Code: The International Code of Marketing of Breastmilk Substitutes adopted by the World Health Assembly (WHA) in 1981, and subsequent WHA resolutions.

Community Outreach: A community outreach team comprises two skilled people (one CMAM provider and one nutrition screener) for the identification and treatment of SAM children in densely populated areas, mainly in host communities.

Complementary feeding: The use of timely age-appropriate, adequate, and safe solid or semi-solid food in addition to breast milk or a breast milk substitute. The process starts at 6 months of age when breast milk or infant formula alone is no longer sufficient to meet the nutritional requirements of an infant. The target range for complementary feeding is generally considered to be 6–23 months.

Complications: Symptoms associated with acute malnutrition that require specialized in-patient treatment. These include swelling (Oedema), fever, lower respiratory tract infection, severe

dehydration, anemia, lack of alertness and lack of appetite for the products used for out-patient treatment.

Early initiation of breastfeeding: Provision of mother's breastmilk to infants within one hour of birth is referred to as "early initiation of breastfeeding" and ensures that the infant receives the colostrum, or "first milk", which is rich in protective factors.

Exclusive breastfeeding: An infant receives only breastmilk and no other liquids or solids, not even water, with the exception of oral rehydration salts (ORS) or drops or syrups consisting of vitamins, mineral supplements or medicines. UNICEF recommends exclusive breastfeeding for infants aged 0-6 months.

Fixed health facilities (FHFs): FHFs are part of the government routine health system in host communities before the crisis. Nutrition services, including Stabilization Centers and Outpatient Therapeutic Programmes, are integrated into FHFs as a component of the primary healthcare package.

Follow-on/follow-up formula: Breastmilk substitute formulated for infants aged 6 months or older.

Food fortification: The addition of micronutrients to a food during or after processing to amounts greater than were present in the original food product. This is also known as 'enrichment'.

Food security: Access by all people at all times to sufficient, safe and nutritious food needed for a healthy and active life. (1996 World Food Summit definition).

General food distribution (GFD): The free distribution of a mixed basket of food, usually including grains, pulses, and vegetable oil, to a particular population that lacks access to normal food sources because of a crisis. GFD is designed to meet immediate food needs and protect livelihoods.

Global acute malnutrition (GAM): The total number of children aged between 6 and 59 months in a given population who have moderate acute malnutrition, plus those who have severe acute malnutrition. (The word 'global' has no geographic meaning.) When GAM is equal to or greater than 15 % of the population, then the nutrition situation is defined as 'critical' by the World Health Organization (WHO). In emergency situations, the nutritional status of children between 6 and 59 months old is also used as a proxy to assess the health of the whole population.

Growth monitoring and promotion: Individual-level assessment where the growth of infants and young children are monitored over time in order to identify and address growth faltering and growth failure.

Health workers: Doctors, nurses, midwives, and nutritionists.

Humanitarian Development Nexus: The transition or overlap between the delivery of humanitarian assistance and the provision of long-term development assistance

IDP or Refugee Camp Facilities: These are set up temporarily in Internally Displaced People (IDP) or Refugee camps to provide basic health and nutrition services to Refugees and IDPs after they have arrived in a safe and secure location.

Infant and Young Child Feeding (IYCF): Term used to describe the feeding of infants (less than 12 months old) and young children (12–23 months old). IYCF programs focus on the protection, promotion, and support of exclusive breastfeeding for the first six months, timely introduction of complementary feeding at six months and continued breastfeeding for two years or beyond. Issues of policy and legislation around the regulation of the marketing of infant formula and other breast milk substitutes are also addressed by these programs.

Infant and Young Child Feeding in Emergencies (IYCF-E): Both IYCF and IYCF-E aim to promote, protect and support optimal IYCF and aim to improve IYCF practices. However, IYCF-E goes beyond this to ensure two key principles: 1) DO NO HARM meaning the prevention of untargeted, unregulated donation of Breastmilk Substitutes and 2) Immediately save lives. IYCF-E takes the Public Health approach and reach as many people as possible as quickly as possible, whereas IYCF has the time to reach caretakers multiple times and achieve long-term behaviour change more easily as a result. IYCF-E thrives on a strong IYCF background.

Infant Formula (IF): A breast milk substitute formulated industrially in accordance with applicable Codex Alimentarius standards. The Codex Alimentarius Commission was established in 1963 by the Food and Agriculture Organization (FAO) and WHO to protect the health of consumers and to ensure fair practices in the international food trade.

Malnutrition: A broad term commonly used as an alternative to 'undernutrition' (stunting, wasting, micronutrient deficiencies), but which technically also refers to over-nutrition (overweight and obesity). People are malnourished if their diet does not provide adequate nutrients for growth and maintenance or if they are unable to fully utilize the food they eat due to illness (undernutrition). They are also malnourished if they consume too many calories (over-nutrition).

Micronutrients: Essential vitamins and minerals required by the body in miniscule amounts throughout the life cycle.

Mid-upper-arm circumference (MUAC): The circumference of the mid-upper arm is measured on a straight left arm (in right-handed people) midway between the tip of the shoulder (acromion) and the tip of the elbow (olecranon). It measures acute malnutrition or wasting in children aged 6–59 months. The mid-upper arm circumference (MUAC) tape is a plastic strip, marked with measurements in millimeters. MUAC < 115mm indicates that the child is severely malnourished; MUAC < 125mm indicates that the child is moderately malnourished.

Mixed feeding: Giving other liquids or foods as well as breastmilk to infants under 6 months of age.

Minimum Dietary Diversity (MDD): Percentage of children 6–23 months of age who consumed foods and beverages from at least five out of eight defined food groups during the previous day. Dietary diversity refers to the child receiving 5+ of the following food groups: 1. breastmilk; 2. grains, roots, tubers and plantains; 3. pulses (beans, peas, lentils), nuts and seeds; 4. dairy products (milk, infant formula, yogurt, cheese); 5. flesh foods (meat, fish, poultry, organ meats); 6. eggs; 7. vitamin-A rich fruits and vegetables; and 8. other fruits and vegetables.

Moderate Acute Malnutrition (MAM): Also known as moderate wasting. Indicated when WFH is less than 80 percent of the median, or between minus two and minus three Z-scores from the median WFH of the standard reference population.

Multiple Micronutrient Powder (MNP): Powder containing most of the daily nutrients required that is sprinkled on food. It is used for children aged 6–23 or 59 months or to pregnant mothers to improve the quality of complementary food.

Nutrition Surveillance: The regular collection of nutrition information that is used for making decisions about actions or policies that will affect nutrition. In emergency situations, nutritional surveillance is part of early warning systems to measure changes in nutritional status of populations over time to mobilize appropriate preparation and/or response.

Oedema: Bilateral oedema (fluid retention on both sides of the body) is caused by increased fluid retention in extracellular spaces and is a clinical sign of severe acute malnutrition. There are different clinical grades of oedema: mild, moderate, and severe.

Outreach: The word “outreach” is used to describe a wide range of activities, from actual delivery of services to dissemination of information. As a tool to help expand access to health services, practices or products, outreach is most often designed to accomplish one of the following (or some combination):

- Directly deliver healthy services or products
- Educate or inform the target population, increasing their knowledge and/or skills
- Educate or inform people who interact with the target population (often called community health promoters)
- Establish beneficial connections between people and/or organizations

Ready-to-Use Infant Formula (RUIF): A type of breastmilk substitute that is formulated industrially in accordance with applicable Codex Alimentarius standards and is in a form that is pre-made and ready to use for infants who do not have the option of being breastfed.

Relactation: The process of resuming breastfeeding after a period of no breastfeeding or very little breastfeeding for the purpose of feeding a child, including the child of another woman. A woman who has stopped breastfeeding, recently or in the past, can resume the production of

breastmilk. Many women who relactate can produce enough milk to breastfeed an infant exclusively, per WHO recommendations.

Social Mobilization: Social mobilization is a process that raises awareness and motivates people to demand change or a particular development. It is mostly used by social movements in grassroots groups, governments, and political organizations to achieve a particular goal.

Severe acute malnutrition (SAM): A result of recent (short term) deficiency of protein, energy, and minerals and vitamins leading to loss of body fat and muscle tissue. Acute malnutrition presents with wasting (low weight-for-height) and/or the presence of oedema (i.e. retention of water in body tissues). Defined for children aged 6–59 months as a 1) weight-for-height below -3 standard deviations (SD) from the median weight-for-height for the standard reference population, 2) a mid-upper arm circumference of less than 115 mm or, 3) the presence of nutritional oedema or marasmic-kwashiorkor.

Stunting: Also known as 'chronic malnutrition', is a form of growth failure which develops over a long period of time. Inadequate nutrition over long periods of time (including poor maternal nutrition and poor infant and young child feeding practices) and/or repeated infections can lead to stunting. In children, it can be measured using the height-for-age nutritional index.

Volunteer: Members of a community who are chosen by community members or organizations to provide basic health and nutrition services to their communities

Vulnerable Population: Populations affected by the crisis, priority for interventions are pregnant and lactating women, those living with disability, infants, and children under 5 years of age, adolescents, and the elderly. Vulnerable populations, defined as those at greater risk for poor health status and healthcare access, experience significant disparities in life expectancy, access to and use of healthcare services, morbidity, and mortality. Their health needs are complex, intersecting with social and economic conditions they experience. This population is also likely to have one or more physical and/or mental health conditions.

Wasting: Also known as 'acute malnutrition'. Acute malnutrition is characterized by a rapid deterioration in nutritional status over a short period of time. In children, it can be measured using the weight-for-height nutritional index or mid-upper arm circumference (MUAC). There are different levels of severity of acute malnutrition: moderate acute malnutrition (MAM) and severe acute malnutrition (SAM).

Wet nursing: When a woman breastfeeds a baby that is not her own.

Weight for Age: Used as a Nutritional Index, as a measure of being underweight (or wasting and stunting combined).

Weight for Height: Used as a Nutritional index, as a measure of acute malnutrition or wasting.

Acronyms

ANC: Antenatal Care
ARI: Acute Respiratory Infection
CFS: Child Friendly Space
CMAM: Community-based Management of Acute Malnutrition
COVID-19: Novel Coronavirus
EBF: Exclusive Breastfeeding
FMOH: Federal Ministry of Health
GAM: Global Acute Malnutrition
GNC: Global Nutrition Cluster
HAZ: Height-for-Age Z-score
IYCF: Infant and Young Child Feeding
KAP: Knowledge, Attitudes and Practice
KII: Key Informant Interviews
MAM: Moderate Acute Malnutrition
MUAC: Mid-Upper Arm Circumference
NIS: Nutrition Information System
ORS: Oral Rehydration Salts
ORT: Oral Rehydration Therapy
PHC: Primary Health Care
PLHIV: People Living with HIV
PLW: Pregnant and Lactating Women
S3M II survey: Simple Spatial Surveying Method
SAM: Severe Acute Malnutrition
TBA: Traditional Birth Attendant
UNHCR: United Nations High Commission for Refugees
UNICEF: United Nations Children's Fund
USAID: United States Agency for International Development
VAD: Vitamin A Deficiency
WASH: Water, Sanitation and Hygiene
WAZ: Weight-for-Age Z-score
WHZ: Weight for Height Z-score
WFP: World Food Program
WFS: Women Friendly Space
WHO: World Health Organization

Chapter 1: Overview and Introduction to the Guidance

1.1 Humanitarian Situation Overview of Sudan

Sudan faces a complex and protracted humanitarian situation characterized by conflict-related displacement, flooding, epidemics, malnutrition, food insecurity, and a deteriorating economic situation. The COVID-19 pandemic only added a burden on the already dire nutrition situation and exhausted health system.

The deteriorating macroeconomic situation is worsening economic conditions for all Sudanese people, especially vulnerable families, infants, and children under five. Approximately half of the population are at or below the poverty line and food insecurity remains alarmingly high. An estimated 13.4 million people are in needs for humanitarian assistance.[7] An estimated 7.1 million people face crisis or worse levels of food insecurity (IPC Phase 3 and above) and require urgent assistance.[8]

The rate of malnutrition has changed little in three decades, with an estimated 52 per cent of cases living in non-conflict states.[9] Around 3 million children under five suffer from acute malnutrition out of which an estimated 570,000 have Severe Acute Malnutrition (SAM). Sudan have more malnourished girls and boys U5 than 30 years ago, due to an increase in prevalence in the past 2 decades from 20 to 32 per cent underweight and from 32 to 35 per cent underweight combined with population growth[10].

Over one in three children U5 (2.3 million) are too short for their age (stunted) with rates above 30 per cent in 128 out of 188 localities, making Sudan one of the 14 countries where 80 per cent of the world's stunted children live.[11]

According to the Simple Spatial Surveying Method (S3M II survey) results, the national prevalence of global acute malnutrition (GAM) is 13.6 per cent, reaching above 15 per cent threshold in 7 out of 18 states in Sudan, indicating a very high level of acute malnutrition.[12] Around 3.8 million children and women are suffering from GAM and over 574,000 children require treatment for severe acute malnutrition (SAM).[13] It is anticipated that current malnutrition levels and vulnerabilities among children and women will further be exacerbated by the ongoing COVID-19 pandemic mainly due to loss of livelihood, disrupted access to food value chain and restricted access to health care services.

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[7] 2021 Humanitarian Response Plan Sudan https://reliefweb.int/sites/reliefweb.int/files/resources/SDN_2021HRP.pdf

[8] IPC Acute Food Insecurity Analysis April 2021- Feb 2022 https://reliefweb.int/sites/reliefweb.int/files/resources/IPC_Sudan_AcuteFoodInsecurity_2021Apr2022Feb_report.pdf

[9] 2021 Humanitarian Response Plan Sudan https://reliefweb.int/sites/reliefweb.int/files/resources/SDN_2021HRP.pdf

[10] UNICEF https://www.unicef.org/sudan/health-nutrition

[11] Ibid

[12] Simple, Spatial, Survey Method (S3M II) for Sudan 2018 https://data.humdata.org/dataset/simple-spatial-survey-method-s3m-ii-for-sudan-2018

[13] Humanitarian Needs Overview Sudan 2021 https://fscluster.org/sudan/document/sudan-humanitarian-needs-overview-hno

The rate of exclusive breastfeeding under six months is 62.4 per cent reaching its lowest (20 per cent) in Central Darfur (Um Dukhun locality).[14] With regards to complementary feeding, only 24 per cent of the children receiving age-appropriate diet diverse meal and 63 per cent receiving adequate meal frequencies.[15] The low continued breastfeeding and lack of appropriate complementary feeding levels reflect suboptimal infant feeding practices, which is harmful to all age groups with children 6-23 months old particularly vulnerable, who are at the stage of rapid growth and have high nutritional requirements. The nutrition situation is further aggravated by low coverage of WASH services, where less than one-third of the population has access to improved water sources, and only about a quarter have improved sanitation facilities with rates of open defecation practiced by about one-third of the population leading to disease outbreak including diarrheal related diseases.[16]

The deterioration of the socioeconomic and political situation is making the situation worse and more complex and timely response is critical.

Factors Driving Malnutrition in Sudan

Malnutrition is more than having too little food, it is a combination of various factors including insufficient protein, energy and micronutrients, frequent infections or disease, poor feeding practices, inadequate health services and unsafe water and sanitation. Children who are well nourished have a better chance of being healthy, and are more able to develop, learn and be productive members of their community.

In Sudan, where stunting rates are above 30%, stunting is well above emergency thresholds and is at a critical level of public health significance. Stunting increases a child's risk of dying, although it is often mistakenly not considered a life-threatening condition and therefore often deprioritized within humanitarian operations. The over 30% of children who are stunted in Sudan are at high risk of dying as they become stuck in a vicious cycle of worsening nutritional status and increasing susceptibility to infection.

Stunting has devastating, long-lasting effects across multiple sectoral outcomes. Its impact on individuals, families and communities has been well documented. Factors contributing to malnutrition in Sudan are frequent infections or disease compounded with unprecedented high levels of food insecurity leading to insufficient protein, energy and micronutrients, coupled with inadequate health services, widespread conflict and insecurity, population displacement, poor access to services, extremely poor diet (in terms of both quality and quantity), low coverage of sanitation facilities and poor hygiene practices.

[14] Simple, Spatial, Survey Method (S3M II) for Sudan 2018 https://data.humdata.org/dataset/simple-spatial-survey-method-s3m-ii-for-sudan-2018

[15] Ibid

[16] Ibid

The population of Sudan mainly relies on farming, fishing or herding for their livelihoods, but displacement due to conflict has forced people to abandon their source of income and food. Displacement also puts a strain on the resources available in areas hosting those displaced and the forced migration of cattle herders leads to the spread of bovine diseases, the loss of cattle and less production of milk. The return of people to their areas of origin puts a strain on food resources as food production does not match the population numbers. The conflict and resulting insecurity make it difficult to deliver aid to much of the country and restricts access to safe water and basic sanitation facilities leading to malnutrition. Whilst structural constraints connected to historic poor governance, corruption, the lack of investment in infrastructure, and striking inequality across the country also drive food insecurity. Sudan's health system is in dire condition because of the protracted armed conflict, economic crisis and massive displacements which means children under five years and PLWs are not being treated at the early stages of malnutrition or for diseases that exacerbate malnutrition, such as cholera.

While the causes of stunting are numerous and complex, we know that IYCF practices play a significant role. Given the poor practices evidenced by assessments in Sudan, it is reasonable to assume that a major driver behind the high stunting levels seen in Sudan today are suboptimal IYCF practices. Interventions to strengthen these practices should therefore be a critical component of a multisectoral effort to reduce the rate of stunting in Sudan.

IYCF Challenges due to Infectious Disease Outbreak in Sudan

Both human and animal infectious disease outbreaks influence IYCF, such as interrupted access to health and feeding support services; deterioration in household food security and livelihoods, spread of rumours and unreliable information transmission risks via breastfeeding; inappropriate advice from health workers on breastfeeding, separation of the mother and infant pair, donations and uncontrolled distributions of BMS, and maternal illness and death. In Sudan, COVID-19 affected all states, with Khartoum being the epicenter. Although Khartoum state accounts for the majority reported cases in the country, over 60 per cent of all COVID-19-related deaths have been reported from outside the capital, reflecting the low capacity of the health system and testing in peripheral states. Several diseases are endemic in Sudan such as malaria, cholera, dengue fever, and chikungunya with a tendency to cause annual outbreaks across several states.

It is important in Sudan for partners to mitigate risks. Consultation with WHO and the development of interim guidance may be necessary to address unanticipated IYCF consequences in outbreaks.

1.2 Overview of Relevant Strategy and Policy Documents

The *National Infant and Young Child Feeding Strategy 2015*-2024[17] has been developed as part of *National Nutrition Program Strategy 2014-2018*.[18]

[17] https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/b_iycf_strategy_23_4_15.pdf

[18] https://scalingupnutrition.org/wp-content/uploads/2016/08/4.-Sudan-National_nutrition_strategic_Plan.pdf

The *National Infant and Young Child Feeding Strategy 2015- 2024* is intended as a guide for action and is based on accumulated evidence of the significance of the early months and years of life for child growth and development. It identifies interventions with a proven positive impact during this period. Implementing the strategy thus calls for increased political will, public investment, awareness among health workers, involvement of families and communities, and collaboration between governments, international organizations and other concerned parties that will ultimately ensure all necessary action is taken.

The strategy identifies the crucial and important role of IYCF-E in protecting, promoting, and supporting breastfeeding and ensuring timely, safe and appropriate complementary feeding. Every effort should be made to keep breastfeeding mothers and children together, to re-establish breastfeeding among mothers who have stopped, and to identify alternative ways to breastfeed infants whose biological mothers are unavailable, including the provision of a healthy wet-nurse.

The IYCF Strategy components are guided by relevant national documents regarding nutrition, health, and food security:

- The National Health Policy (2006)
- The National Child Health Policy (2006)
- The National Reproductive Health Policy (2006)
- The Rural Development, Food Security and Poverty Alleviation Act (2005)
- The Sudan New Nutrition Policy and Plan of Action 2004-2010 (2004)
- 25 Years Strategic Plan for the Health Sector (2005)
- The National Policy on HIV/AIDS (2004)
- 10 Year Strategic Plan for Human Resource
- National Nutrition Strategy (2014)
- National Nutrition Policy (2021)
- Nutrition Policy Brief (2013)
- MCH Acceleration Plan (2014)
- Child Health Strategy (2016)
- Sudan National Health Sector Policy 2021-2024

1.3 Introduction to the IYCF-E Operational Guidelines

The *Sudan Infant and Young Child Feeding in Emergencies (IYCF-E) Operational Guidance* was developed as a practical tool to provide standards and tools for implementation of IYCF-E activities in line with the *Sudan Infant and Young Child Nutrition (IYCF) National Strategy for 2015-2022*. The Operational Guidelines outline the key IYCF-E activities set within the Basic Nutrition Package and wider Nutrition Sector Strategy.

1.4 Aim of the IYCF-E Operational Guidance

The overall aim of the *Sudan Infant and Young Child Feeding in Emergencies (IYCF-E) Operational Guidance* is to provide standardized guidance for Sudan Nutrition Sector partners who are implementing programs specifically focused on or relevant for IYCF-E thereby enhancing

harmonization of IYCF programs between all partners and ensure a more timely, efficient, consistent and effective response.

1.5 Scope of the IYCF-E Operational Guidance

The *Sudan Infant and Young Child Feeding in Emergencies (IYCF-E) Operational* applies to emergency preparedness, response, and recovery nationally to minimize maternal and infant and young child morbidity and/or mortality risks associated with feeding practices and to maximize child nutrition, health, and development.

1.6 Development of the Guidelines

The *Sudan Infant and Young Child Feeding in Emergencies (IYCF-E) Operational Guidance* were developed by Nutrition Sector Partners in coordination with the Federal Ministry of Health with support from the Global Nutrition Cluster Technical Alliance.

This is a "live document", which will be amended regularly by the Sudan Nutrition Sector and Partners, at least once a year or on an ad hoc basis when/if change in the humanitarian response requires to ensure the document remains in line with the context as well as to national and international guidance.

1.7 Target Audience

The target populations for interventions outlined in this guidance are infants and young children aged under two years old (0-23 months) and pregnant and lactating women (PLW).

The target audience of this guidance are programme planners and decision makers, front-line workers, program managers, and implementers.

It is designed for:

- National and Sub-national government
- Government health and nutrition professionals
- Nutrition Sector and Partners
- Emergency responders working for sectors other than health or nutrition
- Health workers, social workers, community leaders, community health and nutrition volunteers and mobilizers
- Donor community
- Civil society and Community Based Organizations
- Volunteer Groups
- The private sector

Chapter 2: Policy Endorsement, Development and Preparedness

Strategy number one within the *National Infant and Young Child Feeding Strategy 2015*-2024 outlines the need for national development policies and plans, major health initiatives and other projects to incorporate IYCF interventions into them to advocate for its importance and mobilize resources.

Strategy 8, Sub Strategy 8b in the *National Infant and Young Child Feeding Strategy 2015-2024* calls for inclusion of key interventions to protect promote and support optimal feeding for infants and young children in the response to any emergency that affects women and children, provides guidelines on coordination, capacity strengthening, advocacy and increasing awareness and knowledge on IYCF-E.

The *National Infant and Young Child Feeding Strategy 2015-2024* revitalizes the important place infant and young child feeding plays within the broad national development agenda in all relevant sectors, such as agriculture, livestock, education, environment water and sanitation etc. and major health initiatives such as the Global funds for HIV/AIDS, Malaria and Tuberculosis. As such, relevant existing policy documents should be reviewed and IYCF incorporated.

2.1 Endorse Existing Policies

In Sudan the existing relevant policies outlined in section 1.2 should be reviewed and where relevant, infant, and young child feeding interventions should be included.

2.2 Policy Development

The International Code of Marketing of Breastmilk Substitutes[19]

There is a need to strengthen the implementation, monitoring and enforcement of the Breast milk Substitutes (Regulation of Marketing) Ordinance and amendments in Sudan. A draft policy for the National Regulation to Promote Breastfeeding (2020) has been developed and is awaiting national implementation. This regulation outlines the provision of safe and adequate nutrition for those infants for whom breastmilk may not be an option by ensuring appropriate marketing and distribution of breast milk substitutes and prohibition of its promotion and advertisement for the general population. This regulation ensures that all products intended for consumption by infants and young children are appropriately marketed and distributed.

There is need to strengthen the monitoring and enforcement procedures of the National Code so that code violations are more effectively detected and swift legal action is taken. (See Section 14 of this document)

[19] https://www.who.int/nutrition/publications/code_english.pdf

Once implemented, the awareness of policy-makers, infant-food manufacturers, wholesalers/ marketers, health service providers and the general public about the Sudan National Regulation to Promote Breastfeeding Code needs to be raised through awareness activities, broad messaging, and orientation sessions.

2.3 IYCF-E preparedness

Emergency preparedness should remain a core element of the IYCF-E response. It is critical that during the ongoing response and within any new and emerging conflicts that key conditions such as movement and resource planning, humanitarian access approvals, and other preparedness activities are met so that a rapid response can take place including displacements, outbreaks, or movement restrictions.

Due to movement restrictions related to security or inaccessibility to areas, changes in response due to a lack of humanitarian access by key staff and programs in locations of acute conflict, localized response plans will remain a key element to the Humanitarian Response in Sudan. Having localized response plans in place will allow for ongoing and harmonized response, especially when access is limited.

To ensure that a location specific response is possible, the following is needed:

1. Design a basic response plan specific to the location and local context. The development of these should be supported by the Sudan Nutrition Sector and should have a specific focal point agency in the location and be updated once a year or on an ad hoc basis when/if based on changes in the context.
2. Building IYCF-E capacity at the local level, for example through strengthening peer counselling capacity.
3. Disseminate to local authorities, agencies, and groups the key IYCF-E guidance and disseminate key messages to actors across all sectors.
4. Send communication updates to specific media targets, as well as to members' internal teams (such as messages on BMS) and send updates according to a new response (See Annex 1: Infant and Young Child Feeding in Emergencies (IYCF-E) Communications Guidance)
5. Build partnerships and maintain communication with key local government partners and local community leaders.
6. Prepare in advance the key messages for Nutrition in Emergencies in Sudan, and then update with context specific messages on the first day of the response.
7. Conduct basic IYCF-E training for local communities and partners in selected areas and sensitize all actors across sectors in the selected area
8. Pre-position essential supplies, materials, tools
9. Strengthen roles, responsibility, and accountability mechanism among staff, teams and local partners
10. Assign partners clear roles and responsibilities, in case of limited or no access to the areas

Chapter 3: Coordinate Operations and Responsibilities

Coordination of activities is a key component to IYCF in humanitarian response. Advocacy to all stakeholders to ensure that understanding of IYCF and relevant policies and guidance to lead to the reduction of any harmful practices that may take place is necessary.

3.1 Advocacy and Communication

Advocacy for IYCF-E involves the process of educating and influencing stakeholders and audiences with the objective of galvanizing support for the buy-in and implementation of IYCF-E activities. This will target audiences in both nutrition and non-nutrition sectors.

Understanding what stakeholders to target with what information and advocacy points can be conducted through Stakeholder Mapping (below).

3.2 Stakeholder Mapping

Stakeholders at the national level

- Policy and decision makers at national level
- Director of Nutrition at the Federal Ministry of Health
- Administrators, heads of departments, heads of divisions, heads of units
- Program managers/officers
- Health workforce

Stakeholders at the Federal State level

- Chief officer of health at state level
- Health workforce

Stakeholders outside the state level

- Media–national and local (newspapers, radio, and television)
- Leaders of government agencies, various government bodies, and top leadership in ministries such as the Ministry of Education, Ministry of Agriculture, Livestock and Fisheries, Ministry of Devolution & Planning, Ministry of Labour, Social Security and Services etc.
- Legislators – senators, members of parliament, Women representatives, relevant parliamentary committees
- Key donors and developmental partners
- Academia – heads of schools, universities, training institutes
- Civil society organization– international, national, and local civil society organisations
- County level leaders – governors, members of county assemblies, county executive committee members, administrators
- Religious leaders of all denominations at national, county, and local levels
- Administrative – commissioners, chiefs, administrators
- Opinion holders – village elders

- CBOs – women, youth
- Individuals in the community

3.3 Channels for Communication and advocacy

Different channels will be used to advocate for and communicate IYCF care and stimulation messages. These are:

- Print – policy briefs, advocacy packs, SBCC materials Electronic – TV, radio, social media, video/tele-conferencing
- Interpersonal communication – advocacy workshops, community dialogues, personalized counseling, Community barazas, and Engagement meetings
- Traditional media -songs, drama, artefacts

3.4 Audiences for targeted IYCF Communications

The audiences being targeted in IYCF are categorized into primary, secondary and tertiary. The actions to achieve the outlined outcome entail what is done to the target audience to achieve the stated communication outcomes.

Audience segmentation:

a) Primary Audience
    a. Pregnant and lactating women
    b. Immediate caregivers
    c. Other women of reproductive age

b) Secondary audience
    a. Spouse and partners
    b. Mother and fathers in law
    c. Grandmothers
    d. Health professionals
    e. Community health workers and volunteers
    f. Media- National and local media
    g. Community opinion leaders and influencers
    h. Social support groups

c) Tertiary
    a. Policy and decision-makers
    b. Legislators
    c. Country level leaders

Table 1: Target audience, communication goals, and proposed actions

Objective: Improve access and uptake of accurate IYCF care and stimulation messages			
Category	**Target Audience**	**Communication outcomes**	**Actions to achieve the Outcomes**
Primary audience	Pregnant & lactating women, immediate caregivers (spouses/partners, siblings, households, daycare attendants) and other Women of reproductive age	a) Increased and improved knowledge and practice of IYCF, care and stimulation b) Improved IYCF practices c) Increased and sustained uptake of good nutrition practices including the uptake of health services d) Increased number of champions practicing and advocating forappropriate IYCF, care and stimulation	a) Raise awareness and sensitize communities on good nutrition, care and stimulation practices, using clear messages disseminated through M2MSG, baby friendly meetings, targeted home visits, and other health promotion activities through community outreach, community dialogues, campaigns, nutrition days, and health fairs b) Provision of communication content materials such as fliers
Secondary audience	Spouse/partners, mothers-in-laws, and grandmothers	a) Improved family and social support system for best IYCF, care and stimulation practices b) Increased family resources allocated for optimal IYCF, care and stimulation c) Increased knowledge translating to support of optimal IYCF practices d) Increased number of nutrition role models at community level supporting positive behavior change and more citizen engagement	a) Use participatory community engagement through photo voice, and digital media with key nutrition messages and the right to good nutrition for communities b) Raise awareness and sensitization of communities on good nutrition practices, using clear messages disseminated through CMSG, baby friendly meetings, targeted home visits and other health promotion activities through community outreach, community dialogues, campaigns, nutrition days, health fairs, chiefs barazas c) Provision of take-home fliers

	Health professionals	Increased and improved knowledge and understanding of IYCF/IYCF-E Improved services including counselling, interpersonal communication	a) Capacity building of health workers on IYCF/IYCF-E b) Provision of Job Aids and IEC materials c) Provision and monitoring of adherence to the guidelines
	Community Health and Nutrition Workers/Volunteers	a) Increased and improved knowledge and understanding of IYCF/IYCF-E b) Effective and accessible feedback and participation CHVs to engage in and influence IYCF activities c) Improved uptake of health and nutrition services in the community d) Create and increase demand for Health and nutrition services	a) Capacity building of CHVs b) Provision of Job aids and IEC materials c) Monthly reporting of community activities

	Media – National and local media	Increased frequency and improved quality (diversity, profile, technical accuracy) of IYCF care and stimulation messaging by the media	a) Building and maintaining stronger relationships with media through advocacy (media breakfast, joint field visits, media briefing, media package) b) Build the capacity of media professionals on IYCF/IYCF-E c) Broadening the scope and type of media channels used to advocate for and communicate IYCF messages d) Building the communication and media skills of nutrition professionals for effective media engagement on IYCF issues e) Develop appropriate IYCF media content
	Community opinion leaders and influencers (e.g. birth companion, religious leaders, based on community profiling) a) Social support groups (e.g. peer groups, women's groups, "*chama**", farmer groups)	a) Improved knowledge and understanding of IYCF b) Increased number of leaders and champions advocating for positive behaviour change in IYCF	a) Orientation and sensitization of opinion leaders and influencers through barazas, formal meetings and dissemination of IYCF Social, Behaviour Change Communication (SBCC) materials b) Support the establishment of IYCF role models/champions (traditional/religious/local/media leaders) to be spokespeople for communities in advocating for IYCF
Tertiary Audience	a) Policy and decision makers b) Legislators c) County level leaders	a) conducive legal/legislative framework for IYCF at national and county level	a) Sensitization on the value and impact of prioritizing IYCF at all levels of the health system b) Identify national and county BFCI champions and empower

3.5 Roles and Responsibilities of IYCF Committees and Groups

Table 2. Role and responsibilities of IYCF committees and groups

Group	Focal Point	Roles and Responsibilities
Maternal Infant Young Child Feeding (MIYCF) Task force/ Nutrition Sector Coordination Team	FMOH (Undersecretary, PHC directorate, emergency unit directorate, MCH directorate, health promotion directorate.) Humanitarian aid commission coordination unit.	• Formulate policy and guidelines for implementation of IYCF • Develop and disseminate IYCF package to the states • Oversee the implementation of IYCF activities • Facilitate the timely and regular meetings of the National MIYCF taskforce/steering committee • Facilitate capacity development on IYCF activities at national and state level • Conduct sensitization of state health workforce, partners, and stakeholders on IYCF/IYCF-E • Facilitate advocacy and resource mobilization in support of IYCF/IYCF-E • Facilitate the coordination of partners involved in IYCF activities implementation • Coordinate the monitoring and evaluation of IYCF implementation
State level Health Management Team	Nutrition directorate, emergency coordinator, IYCF coordinator, sector coordinator.	• Adopt and implement IYCF/IYCF-E guidelines • Coordinate implementation of IYCF activities • Provide regular IYCF supportive supervision in the state • Coordinate sensitization of the district level health management team, partners, and other stakeholders on IYCF • Coordinate selection and capacity building of TOTs • Coordinate the monitoring and evaluation of IYCF activities • Facilitate advocacy and resource mobilization in support of IYCF activities • Coordinate the orientation of state level health workforce, key line ministries and other stakeholders • Ensure that cross-sectoral programmes (ie. Livelihood and agriculture, WASH) promote optimal IYCF/IYCF-E practices

Health Facility Management Committee (HFMC)	Nutrition officer (IYCF-E focal person) or emergency focal person	• Advise community on matters related to the promotion of IYCF/IYCF-E • Represent and articulate community interests on IYCF matters in local development forums • Facilitate a feedback process to the community pertaining to the operations and management of the health facility • Document all the IYCF activities • Oversee referral of mothers to the community from the facility • Execute community decisions in the facility pertaining to IYCF/IYCF-E implementation • Mobilize community resources towards IYCF activities within the area
Nutritionist and Nutrition Practitioners	Nutritionist at facility, community level, community volunteer team leader	• Facilitating CHV training on IYCF module • Support the CHVs in assigned tasks and mentor them on IYCF I to ensure achievement of desired outputs and outcomes • Compiling IYCF reports from CHVs • Ensure that feedback is passed on to the CHVs through dialogue and planning is done to address issues raised • Advocate for IYCF community awareness at all levels • Supervise M2MSG activities • Ensure IYCF is incorporated during education sessions at maternal and child welfare clinics • Provide refresher trainings and updates to CHVs • Facilitate the implementation of IYCF activities at all levels • Coordinate and facilitate the training of health workers, partners and other stakeholders on IYCF package • Conduct regular supervision, mentorship, documentation and reporting of IYCF activities • Facilitate and coordinate advocacy and resource mobilization for IYCF activities from local leaders and state government • Conduct mentorship for CHVs • Monitoring of the implementation process
Community Health and Nutrition Volunteers (CNV/CHVs)		• Facilitate formation of mother to mother support groups (M2MSGs) and father to father support groups (F2FSGs) • Conduct targeted home visits • Conduct education and counselling on IYCF/IYCF-E, care and stimulation including addressing any problems mothers face • Conduct community mobilization for uptake of IYCF practices • Mobilize the identified influencers on IYCF • Participating in baby friendly community meetings

		• Mapping the primary audience within their area of operation • Reporting to the nutritionist on the activities they have been involved in and keeping records • Participate in resource mobilization for community IYCF meetings • Referral of cases to the nearest health facility • Promoting care seeking and uptake of optimal IYCF practices • Participate in CHVs monthly meetings
Lead Mothers and Lead Fathers		• Convene monthly M2MSG and F2FSG meetings • Deliver key messages for IYCF, care and stimulation and discuss with mothers how to address any problems • A link between the M2MSG/F2FSG and the health facility • Models the health and nutrition behaviors in M2MSG/F2FSG and community • Support the CHV in collecting IYCF data • Referral of mothers and fathers to CNVs/CHVs, other peer support groups

3.6 Roles of Partners in IYCF-E Promotion

Table 3. Roles of Partners in Optimal IYCF Promotion

Development and implementing partners	• Provide technical and financial support in the development and review of IYCF Policies and Guidelines. • Provide technical and financial support to national government, state government and community efforts in capacity building, advocacy, and social mobilization for successful promotion of optimal IYCF activities. • Monitor marketing practices of private sector according to Breast Milk Substitutes Regulations and Control and report violations when observed
Line ministries: • Ministry of Social Welfare and Women and Children Affairs • Ministry of Industry • Ministry of Agriculture and Forestry • Ministry of Justice • Ministry of Education • Ministry of Higher Education and Scientific Research • Ministry of Irrigation and	• Collaborate, communicate, and synergize activities at all levels with the Ministry of Health with the aim of improving IYCF, care and stimulation ensuring that improving IYCF is incorporated in strategies, policies, and other relevant documents • Monitor the marketing practices of private sector, industries, and enterprises according to Breast Milk Substitutes Regulations and Control and take action as needed

Water Resources • Ministry of Environment and Physical Development • HAC • SSMO • Ministry of Finance • Ministry of trade • Ministry of Information & Culture • Ministry of Labour	
Private sector, industries and enterprises	• Support promotion of optimal IYCF practices • Ensure that their conduct at every level conforms to the Breast Milk Substitutes Regulations and Controls • Monitor their marketing practices according to Breast Milk Substitutes Regulations and Control
Media agencies	• Support IYCF advocacy, communications components and social mobilization using TV, radio, social media and other relevant media outlets • Disseminate correct information on optimal IYCF, care and stimulation • Highlight needs of infants and young children during emergencies
Universities and research institutions	• Provide technical support to relevant agencies and organizations in conducting research on various components IYCF • Evidence Generation for IYCF • Ensure institutional standards, curriculum and related mechanisms for students and staff adhere to IYCF/IYCF-E policy and related national standards • Review their training curricula periodically to include new guidelines from IYCF/IYCF-E research. • Provide technical support to relevant agencies and organizations in conducting research on various components of maternal, infant and young child feeding.
Professional Associations	• Regulate their professional members and practice in accordance with national IYCF/IYCF-E standards and law. • Facilitate harmonization of pre-service training curricula of learning institutions offering nutrition and dietetics courses to include IYCF/IYCF-E package necessary to implement this policy. • Provide technical support on training and capacity building to agencies and organizations involved in the implementation of this policy. • Recognize achievements and promote the maintenance of standards in the implementation of various components of this policy.
Communities/Affected Populations	• Adhere to policy directives and support mothers and their infants to ensure optimal IYCF/IYCF-E. • Deliver user friendly messages on maternal and child nutrition and health, including infant feeding, positive hygiene and sanitation and health services seeking behaviors. • Promote the establishment of “emergency” community social support groups. • Work in collaboration with the public and private sectors, partners, NGOs and other stakeholders to mobilize resources to support nutrition and health programmes in the communities.

3.7 IYCF Package by Context

When implementing IYCF-E services activities and services will vary by setting and access to the population.

Box 1: Optimal Infant and Young Child Feeding Practices

Optimal Infant and Young Child Feeding Practices

1. Initiate breastfeeding immediately after birth
2. Exclusive breastfeeding for 6 months
3. Complementary feeding:
   - Timely (introduced at 6 months- 180 days)
   - Adequate (appropriate energy and nutrients)
   - Safe (hygienically prepared, stored, and used)
   - Appropriate (frequency, feeding method, responsive feeding)
4. Continued breastfeeding from 6 months up to 24 months and beyond

The following are minimum activities that should be implemented when full access to the affected population is possible:

Basic Nutrition Package Activities and Services

- IYCF/E message dissemination
- Nutrition Screening, growth monitoring, and referral
- Rapid and full assessment of IYCF/E practices
- Nutrition Counselling for pregnant and lactating mothers
- IYCF one to one counselling for mothers and caregivers with children 0-23 months
- Mother to Mother and Father to Father support groups
- IYCF/E Supportive Spaces
- Care groups
- Complementary food supplementation with MNP
- Vitamin A supplementation for children and pregnant adolescents and women
- Iron and folic acid supplementation for pregnant adolescents and women
- Care of children in special circumstances; Support for the non-breastfed child, LBW, HIV and Infant Feeding
- Artificial Feeding Support
- Implementation, monitoring, and control of the International Code of Marketing of Breastmilk Substitutes

In areas where access is limited or where access is not possible, priority activities must be adapted rather than discontinued all-together if at all possible[20].

Within Sudan the context varies extensively with regards to culture, geography, security, and access. All of these must be considered when creating context specific response plans. All nutrition

[20] The MISP is a priority set of lifesaving activities to be implemented at the onset of every emergency (within 48 hours wherever possible). To prevent morbidity and mortality, essential services for all newborns (essential newborn care) include support for skin-to-skin contact, immediate and exclusive breastfeeding and not discarding colostrum.

partners will have to review their capacity to ensure implementation of the most comprehensive and appropriate services.

The following table outlines activities and services outlined within this guidance by their setting and access. The table provides an overview of basic IYCF services within low emergency, medium emergency and full emergency contexts with respect to access and resources.

Table 2: IYCF/E Activities and Services by Setting and Access

Activities and Services	**Setting**											
Full Access, low or no emergency context / Limited Access, medium emergency context / No Access, full emergency context	Community			Camps			OTP			SC			PHC			Hospital		
Nutrition screening and/or growth monitoring																		
IYCF/E Message Dissemination																		
Linkage with the CMAM progamme																		
Rapid and full assessment of IYCF/E practices																		
Nutrition counselling of the pregnant and lactating mother																		
IYCF counselling																		
Mother Support Groups																		
Father Support Groups																		
Supportive Spaces																		
Care Groups																		
Implementation of the ten steps for successful breastfeeding (BFHI)																		
Regulation of the marketing of BMS																		
Monitoring and control of donations of breastmilk substitutes																		
Care for Children in Special Circumstances																		
Artificial Feeding Support																		
BMS Prescription and targeted distribution																		
Deworming/vitamin A supplementation																		
Iron-folic acid supplementation																		
Complementary food supplementation (MNP)																		

Chapter 4: IYCF and Gender Based Violence Risk Mitigation

More than 2.3 million people—IDPs, members of the host communities, and returnees—need GBV prevention, mitigation, and response services across Sudan[21].

Gender-integrated programs assume that gender norms, unequal power relations and differences in access to resources influence development outcomes. They, therefore, examine and address possible gender-related issues throughout the project cycle, aiming to achieve desired outcomes while simultaneously being "gender aware" and moving towards greater gender equality. At a minimum, they are "gender accommodating" (i.e., they recognize and work around gender inequalities and norms) and at best, they are "gender transformative" (i.e., they seek to reduce gender inequality and modify norms). In keeping with the fundamental principle of "Do No Harm" gender integrated programs should strive to never be "gender exploitative," wherein they intentionally reinforce or take advantage of gender inequalities.

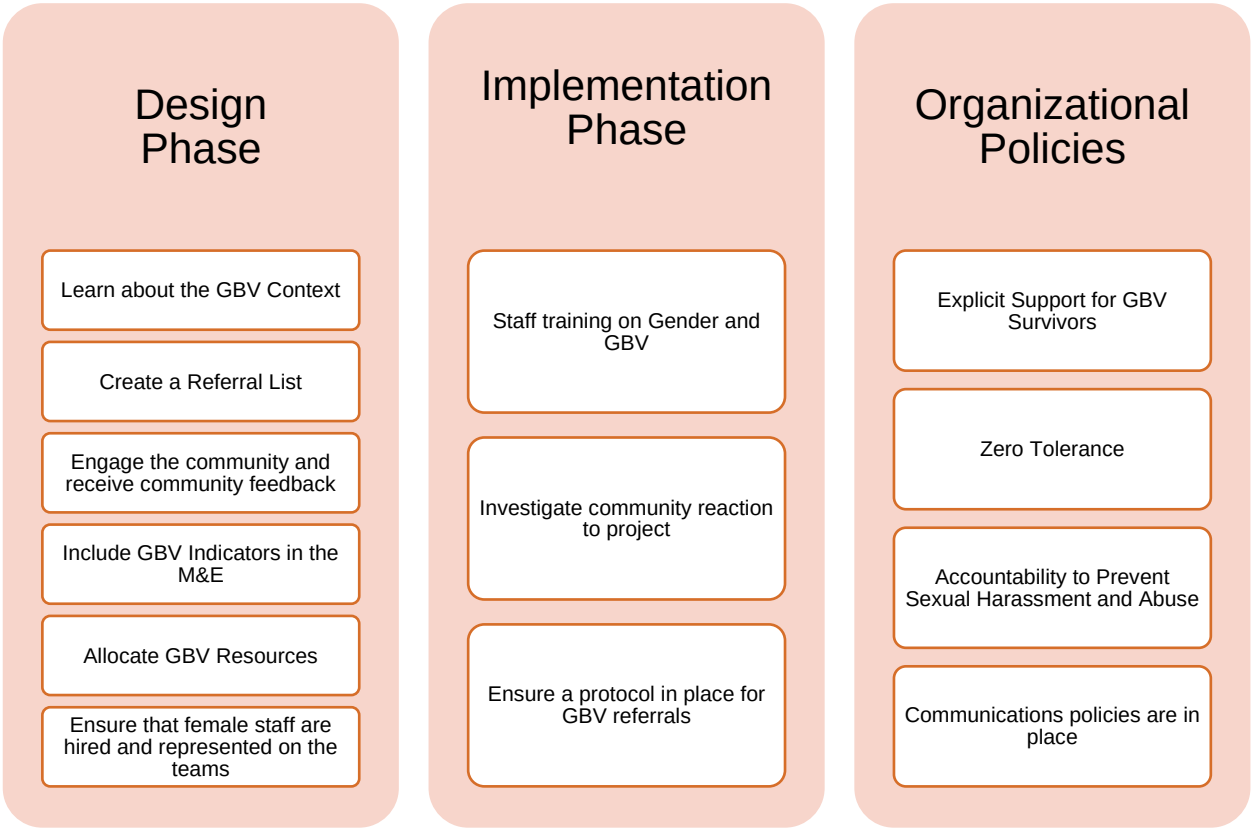
Nutrition, gender inequality and gender-based violence (GBV) are interrelated. Evidence shows that higher levels of both acute and chronic malnutrition for women and girls is directly related to gender-inequitable access to nutritious foods, quality health care, and water, sanitation and hygiene (WASH) services. Gender-inequitable access to food and services is a form a GBV that can, in turn, contribute to other forms of GBV. Women, girls and other at-risk groups face a heightened risk of GBV in humanitarian settings. The links between nutrition, gender inequality and the risks of GBV may also become particularly pronounced in these settings, where food and other basic needs are in short supply.

For example:

- Families may try to ensure the nutritional needs of their daughters are met by arranging child marriages.
- Underfed women and girls may be at heightened risk of exchanging sex for food.
- Disagreements about how to manage limited household food supplies or assign food rations may contribute to intimate partner violence and other forms of domestic violence.
- Emergencies may result in large numbers of children becoming orphaned, displaced, or separated from their families - separation of children from their families makes them particularly vulnerable to abuse and exploitation especially when they have to depend on others for security and basic needs

Figure 1: Examples of areas to include GBV risk mitigations measures in the Humanitarian Program Cycle

[21] Sudan Humanitarian Needs Overview https://reliefweb.int/report/sudan/sudan-humanitarian-needs-overview-2021-december-2020



Failure to incorporate GBV prevention into nutrition programmes can result in families trying to ensure the nutritional needs of their daughters are met through child and/or forced marriages or sacrificing female children's nutrition to meet the needs of male children. Mothers weakened by poor nutritional status might also be less able to protect their children from GBV and other forms of violence.

Examples of GBV Risk Mitigation measures in Nutrition:[22]

- Infant and young child feeding programmes can ensure privacy for breastfeeding mothers and help decrease the risk of harassment or violence against female participants.
- Mother to Mother Support Groups and peer support groups, Therapeutic Feeding Centers or Stabilization Centers can provide a supportive and confidential environment for women, girls and other at-risk groups seeking information about where to report risk or access care for exposure to GBV.
- Community based nutrition programmes can monitor households resource scarcity and any resulting conflicts at the family and community levels; they can share this information with GBV specialists so that preventative action can be taken at the earliest possible stage.

The Nutrition Sector can work close coordination with the Gender and GBV Technical Working Group and actors working in other humanitarian sectors such as Mental Health and Psychosocial Support (MHPSS), HIV, health, and protection.

[22] Further guidance including a pocket guide for non-GBV actors can be found at: https://gbvguidelines.org/en/

Chapter 5: Workforce and Capacity Strengthening

Building health and nutrition workforce capacity requires major barriers to be overcome to achieve the objectives of this operational guidance and the IYCF strategy in Sudan. There is an emphasis on the need for workforce strengthening through lifelong learning opportunities.

5.1 Gender and Staffing

It is vitally important within humanitarian response that women are included in both the planning and implementation of IYCF-E interventions including the hiring of women as humanitarian staff. When discussing sensitive or female specific topics like menstrual health, maternity care, sexual and reproductive health, IYCF including breastfeeding or supporting survivors of Gender Based Violence it is vital to have female staff within the workforce.

In Sudan, while women make up nearly 80 per cent of the regional healthcare workforce, they only represent 25 percent of the senior roles[23]. With increasing greater responsibilities at home and a high rate of Gender Based Violence, exacerbated by the recent COVID-19 pandemic lockdown, many women and young girls were isolated from the workforce, essential health, and nutrition services, and GBV support.

It is important that within the Nutrition Sector partners barriers and potential bridges to involving women and other at-risk groups as staff and leaders in the planning, design, implementation and monitoring of nutrition activities are identified, understood, and addressed. It is recommended that at least 50 per cent representation of women within nutrition program staff is achieved, including in leadership roles[24]. To achieve this, it may be necessary to engage in dialogue with male community members to ensure their support. Once hired they should be provided with formal and on-the-job training as well as targeted support to assume leadership and training positions. It is important to ensure that strategies are in place that increase the safety and security of all staff, especially female staff.

Potential Barriers[25]:

- Personal Safety and Security
- Confidence and Skills
- Personal hygiene including access to sanitary products for menstruation and access to safe toilets
- Wellbeing and support including professional wellness support from a female advisor
- Family, childcare, and personal relationships
- Perceptions and stereotypes. (roles)
- Hostile environment (patronizing or sexist behaviors)
- Living arrangements or distance to job location

[23] UNFPA, CVAW Voices of Sudan 2020 https://reliefweb.int/sites/reliefweb.int/files/resources/UNFPA_16th.pdf

[24] IASC Gender Marker Tip Sheet https://www.humanitarianresponse.info/en/operations/somalia/document/iasc-gender-marker-tip-sheet-nutrition

[25] Actionaid, Care How can Humanitarian Organisations Encourage More Women in Surge? 2017 https://reliefweb.int/sites/reliefweb.int/files/resources/action_aid_aw_v4_-_final.pdf

Examples of Good Practices[26]:

- Strive for 50 per cent of nutrition programme staff to be women, including health workers at therapeutic feeding centres at facility and community levels
- Family and breastfeeding friendly policies – such as paid maternity leave, access to childcare, breastfeeding breaks and dedicated breastfeeding/breastmilk expression spaces – promote gender equality and support women's participation in the workforce.
- Ensure that women, girls, men, and boys participate meaningfully in nutrition sector programmes and are able to provide confidential feedback and access complaint mechanisms by managing safe and accessible two-way communication channels
- Ensure that women at heightened risk have a mechanism to raise their concerns and participate in decisions, while guaranteeing confidentiality regarding their personal situations and without exposing them to further harm or trauma. Some mechanisms such as confidential hotlines run outside the community, are more effective.
- Be proactive about informing women about forthcoming meetings, training sessions, etc. and support them in preparing well in advance for the topics.
- Ensure access to childcare to enable the participation of women and girls, who often carry responsibility for care, throughout the programme cycle.
- Increase the number and impact of women in leadership and decision-making structures for the response at all levels.
- Address social norms and engage males in change efforts and in the advancement of gender equality and the empowerment of women and girls.
- Recognize and amplify the voices and impact of women-led and youth organizations in community education and engagement.
- Humanitarian actors to engage community members – including women, youth (both boys and girls), and traditional and religious leaders – equally in analysis and problem solving in addressing IYCF-E issues.
- Identify local women's rights groups, networks and social collectives — in particular informal networks of women, youth, people with disabilities— and support their participation in programme design, delivery and monitoring, and ensure they have a role in coordination.
- Nutrition education programme for school children (in curriculum) in collaboration with Ministry of education and higher education and related to gender issues.
- IYCF-E services should anticipate and accept that a proportion of female staff will require maternity leave and that some may not return to work after marriage or childbirth and plan accordingly.

5.2 Capacity Building and Service Strengthening

Skilled support for IYCF-E as well as general IYCF promotion should be available at all levels of the health system and especially within communities. This will ensure women and caregivers will receive current advice and support on feeding their infants and young children. It will also provide a mechanism to identify issues as they emerge and to provide appropriate support and referral.

[26] IASC *Gender Handbook for Humanitarian Action* 2017 https://interagencystandingcommittee.org/iasc-reference-group-gender-and-humanitarian-action/iasc-gender-handbook-humanitarian-action-2017

To achieve adequate geographical and quality coverage of IYCF-E services capacity building and services strengthening must take place. A workforce skilled on IYCF-E must include not only health and nutrition workers within the formal system but also community level workers, volunteers, and mothers/fathers/caregivers and community members themselves.

Key Objectives:

- Capacity building is not a one-off event and should begin with capacity mapping at both an institutional and individual level[27]. *See Additional References for Capacity Mapping tools.*
- Capacity building should not be limited to training but will also include other learning opportunities such as supportive supervision, mentoring, on-the-job training.

Essential Competencies

It is recommended that training programs and packages aim to ensure that the right competencies are in place for all IYFE-E staff and key focal points[28]. Table 3 provides an overview of an essential set of basic competencies, that key focal points should have in order to fully implement IYCF-E programmes and activities.

When to conduct Capacity Building Activities

IYCF-E programming is a vital part of any emergency response, but it is difficult to implement if skills do not already exist in-country or if proper planning is not in place. Ideally, trainings should take place throughout the Humanitarian Program Cycle and should be incorporated into any Emergency Preparedness and Response Plans that are created.

Trainings

Formal training programs for priority staff are necessary to build essential skills and knowledge. Trainings should mainly draw from the existing FMOH Community and Facility IYCF training packages. Ad hoc and specialized trainings will be required for more technically specific interventions example, management of the non-breastfed child, BMS prescription guidelines and children at risk.

Trainings can be conducted in-person or virtual. Trainings that involve a lot of role play, one to one demonstrations, and counselling demonstrations are examples of trainings that would benefit from in-person training. Introduction to tools and protocols are examples of trainings that would be more appropriate for virtual training.

IYCF-E related trainings should focus on developing the necessary competencies of the different Government nutrition officers, nutritionists, dietitian, technical nutritionist, and IYCF Project Managers, Stabilization Center and Outpatient Therapeutic Program (OTP) staff, Community Nutrition Mobilizers, Peer support group and Care group lead mothers and fathers as well as community members including mother, fathers, primary and secondary caregivers and community members such as religious leaders, key community focal points, market managers, and shopkeepers, etc.

[27] Save the Children, Tech RRT *IYCF-E individual capacity assessment tool for Health and Nutrition Service Providers* 2020 https://s16947.pcdn.co/wp-content/uploads/2020/12/IYCF-E-Ind-Cap-Assess-Tool_Nov20.pdf

[28] UNICEF The Community Infant and Young Child Feeding Package: Facilitators Guide 2012

Formal training programs, with demonstration and practicum sessions, should prioritize the following:

- National Nutrition Programme Officers
- Health Care Providers
- IYCF Project Managers
- CMAM staff
- Community health and nutrition mobilizers

Examples of Training Programmes

Examples of training programmes, including core modules, that address the essential competencies are outlined in the table below.

Table 3: Required Skills and Competencies

#	Skills and Knowledge Required	Target								
		Health Care Progessionals (HCPs)	IYCF Project Managers	Stabilization Center Staff	OTP Staff	CNM	Lead mothers and fathers	Mothers and primary caregivers	Fathers and secondary caregivers	Community
	Development of Localized Emergency Response Plans									
	Conduct MUAC screening for pregnant and lactating women and children 6 to 59 months									
	Referral of identified SAM and MAM cases									
	Impact of birth practices on nutrition									
	Growth monitoring									
	Conduct Simple Rapid Assessment									
	Full assessment and development of care action plan									
	Monitor and follow-up of SAM and MAM cases for compliance to care action plan									
	Identify women, infants, and young children who are nutritionally at-risk									
	Nutrition Counselling for pregnant and lactating mothers or caregivers									
	Nutrition counselling for adolescent girls									
	IYCF/E Counselling									
	Orient and mobilize volunteers/mother support groups on IYCFE									
	Nutrition education through weekly group session and community sessions									

	Assist the IYCF/E focal point on the day-to-day operation of supportive spaces and care groups									
	Monitor, Reporting and Compliance with the International Code for BMS									
	Help collect data and information									
	Report any IYCF/E issues that need to be addressed									
	Vitamin A supplementation									
	Iron-Folic acid supplementation									
	Administration of MNP and/or other relevant supplementation to children 6-23 months									
	Assist mother/caregivers with appropriate complementary feeding practices for children 6-23 months									
	Support early initiation of breastfeeding									
	Implementation of BFHI and 10 steps to breastfeeding									
	Basic breastfeeding support									
	Address breastfeeding complications and challenges									
	Counsel and refer on the feeding of children in special circumstances									
	Provide Care for children in special circumstances									
	Identification and referral for the non-breastfed child									
	Artificial feeding support									
	Relactation Support									
	Provide Prescription for BMS									

	Support the feeding of pre-term babies									
	GBV risk mitigation, support and referral									

5.3 Supportive supervision, on the job training and mentoring

To assess and support the ability of training participants to appropriately apply the knowledge and counselling skills including those gained in trainings to the post-training work in the community supportive supervision, on the job training, and mentoring should take place. The training facilitators, those trained on supportive supervision and monitoring[29] or trained programme managers[30] should observe and evaluate participants at their workplace as appropriate both before, during, or following the completion of training and within at least three months after training[31].

Regular supportive supervision, as described in the Operational Guidance for Breastfeeding Counselling in Emergencies[32], is particularly important during emergency responses as new counsellors may quickly be given significant responsibility following rapid training. Supervisors play a vital role in supporting and monitoring the quality of counselling service provision and evaluating the effectiveness of in-service training and other capacity building activities.

Post-training follow-up will allow a facilitator/supervisor/mentor to determine the need for reinforcement of specific participant's knowledge and skills through additional or refresher training or ongoing supportive supervision.

Mentoring[33] is an ongoing and collaborative effort between the mentor (mentor-supervisor) and IYCF staff member to help the staff member improve his/her performance and confidence. Together, the staff member and mentor-supervisor define objectives. The mentor-supervisor observes the staff member's interactions with mothers/caregivers and provides constructive feedback. The mentor-supervisor and staff member work together, discussing and problem-solving in order to identify areas of strength and address any areas of difficulty. The staff member should feel motivated by the process and be encouraged to continue improving his/her skills, resulting in more skilled judgment and increased independence and self-confidence.

Mentoring is an ongoing process (not a one-time event) that can be applied to helping a staff member improve the quality of his/her performance of different tasks (e.g., counselling around IYCF or women's and adolescent nutrition and anemia; support group facilitation; and growth monitoring and promotion). It is task focused, as opposed to the supervision that occurs when a supervisor visits and assesses an entire facility and its workforce. Ideally, the mentor (mentor-supervisor) and staff member develop a personal relationship of mutual trust.

Objectives of Supportive Supervision, on the job training, and mentoring

Supportive Supervision, on the job training, and mentoring is used to:

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[29] UNICEF Community Infant and Young Child Feeding (IYCF) Counselling Package: Supportive Supervision/Mentoring and Monitoring 2013 https://sites.unicef.org/nutrition/files/Supervision_mentoring_monitoring_module_Oct_2013(1).pdf

[30] Also see Training Supervisors to Mentor Health Workers Who Provide Counselling on Infant and Young Child Feeding A Three-Day Course for Kyrgyz Mentor-Supervisors Facilitator's Guide (USAID and Spring Nutrition; 2017) for an example of a training package: https://www.spring-nutrition.org/sites/default/files/publications/trainingmaterials/spring_eng_training_supervisors_mentoring.pdf

[31] UNICEF The Community Infant and Young Child Feeding Package: Facilitators Guide 2012

[32] Operational Guidance for Breastfeeding Counselling in Emergencies

[33] 'Mentoring-supervision' is sometimes called 'supportive supervision,' although 'supportive supervision' does not always include 'mentoring.'

- Monitor and promote quality standardized services
- Assess performance in relation to quantity (i.e. reach- coverage, volume, service utilization)
- See the use of knowledge and skills used to counsel mothers/caregivers with accurate information and facilitate group work
- Ability to use the recording and reporting tools
- Identification of difficulties and support to resolve the issue(s).
- Sharing of best practices, experiences and lessons learnt

Timing for Supportive Supervision
All newly trained Community Mobilizers should receive at least one supervisory visit within 6 weeks to 2 months following training.

Ideally, supportive supervision/mentoring is part of routine and ongoing monitoring activities.

If a system of ongoing supervision or mentoring is not yet in place, all newly trained IYCF CWs should receive a minimum of 2-3 visits and then participate in regular meetings with other IYCF CWs for sharing experiences, mutual support and on-going or refresher training.

More frequent supervisory contacts are likely to be needed where training of new counsellors has been shortened due to the emergency. Criteria used for selecting priority areas for supportive supervision visits can include poor breastfeeding practices, low counselling coverage rates, poor reports from previous supervision visits, low post-training test results, areas with recent reports of disease outbreaks, uncontrolled BMS distributions or other threats to breastfeeding.

Where to hold supportive supervision, on the job support or mentoring

Ideally, facilitators/supervisors should provide on-the-job support or mentoring and assist with problem solving in work situations that include:

- a counselling interaction with a mother/father/caregiver and child in a community or home setting
- during group education (action-oriented groups)
- during support group facilitation.

Chapter 6: Nutrition Screening

Infants and young children should undergo nutrition screening every month. This can be through health and nutrition workers or by the families themselves through Mother and Family MUAC programs. By conducting nutrition screening, parents, caregivers, and health and nutrition workers can monitor the nutritional status and well-being of the child. Additionally, when screening is conducted by health and nutrition workers, targeted messages can be provided to the mother or caregiver and, when necessary, referrals can be made to additional services.

Early detection of acutely malnourished children is essential for the success of their treatment and should be done at community level including events, religious events, of through Community Health Nutrition Workers and Volunteers. Mother and Family MUAC at a community level is also an important

method for screening, especially during COVID-19 or other emergency situations where access might be limited. Screening can also be done at formal nutrition services and in health facilities.

6.1 MUAC and Bilateral Pitting Oedema

MUAC Measurement

Mid Upper Arm Circumference (MUAC) is a measure of wasting. It is used for children 6-59 months of age and Pregnant and Lactating Women. Children younger than 6 months or older than 59 months will have different thresholds for malnutrition. However, these thresholds have not yet been standardized by the international community and are not recommended in Sudan.

The measurement procedure for MUAC is:

- Straighten child's arm (the mother or other caregiver can hold the child's hand to keep it straight)
- Visually estimate the midpoint of the upper arm between the tip of the shoulder and elbow
- With relaxed arm– and straight, wrap tape around the midpoint and measure.

Note: Tape should be snug against the skin without pinching or leaving gaps.

Table 4: MUAC reading interpretation

Color coding	Measurement	Indicator
RED	<11.5cm	Severe acute Malnutrition
YELLOW	11.5 - < 12.5 cm	Moderate acute Malnutrition
GREEN	≥ 12.5 cm	No acute Malnutrition

Bilateral Pitting Pedal Oedema and Grading

Bilateral pitting oedema is the cardinal physical sign of the oedematous form of SAM (previously called kwashiorkor). These children are associated with a high risk of mortality. In order to determine the presence of oedema, apply pressure on the top of both feet for three seconds and observe for a pit (indentation) on the foot when the thumb is lifted.

Photo 1: Bilateral Pitting Oedema Identification[34]

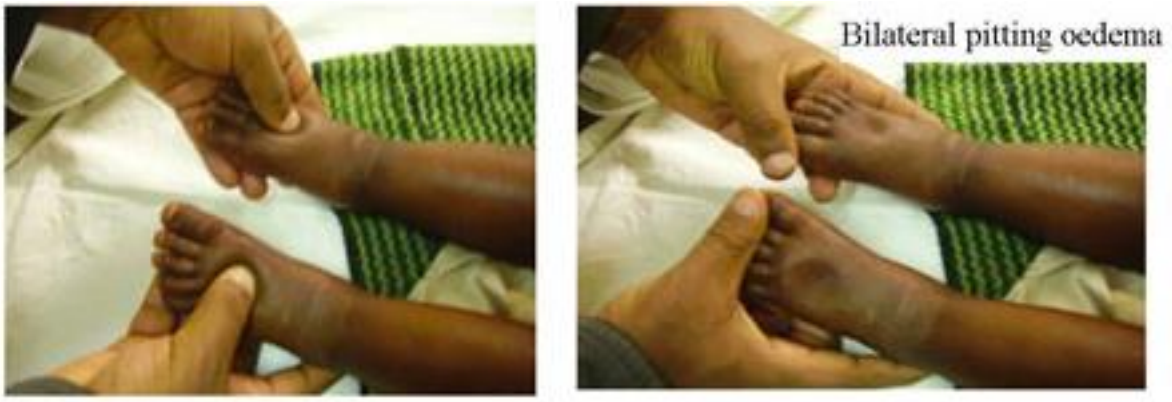


Table 5: Grading of Oedema

Grade of Oedema	Definition
Grade 1 (+)	Mild: both feet/ankles
Grade 2 (++)	Moderate: more than feet/ankles but not generalized to the whole body
Grade 3 (+++)	Severe: generalized oedema including feet, legs, hands, arms and face.

6.2 Mother and Family MUAC

The 'Family MUAC' approach, also known as MUAC for mothers or Mother-MUAC (although the term Family MUAC is preferred as it puts responsibility for the nutrition screnning and support on the wider family, not only the mother), trains mothers and other caregivers to identify early signs of malnutrition in their children using a simple to use Mid-Upper Arm Circumference (MUAC) tape. By moving this task to mothers and other family members, who are able to do it as effectively as Community Health and Nutrition Workers and Volunteers (CHWs/CHVs), the cases are detected earlier, leading to less hospitalizations.

Mother and Family MUAC training should be implemented at nutrition contact points, health facilities, OTPs, and SCs.

Mother-Family MUAC Training Topics[35]

1. Welcome and explain objectives of Mother-Family MUAC
2. What is Malnutrition
3. How to recognize the early signs of malnutrition
4. What is the difference between wasting and edematous malnutrition
5. Advantages of Mother-Family MUAD
6. How to check MUAC in three steps followed by practical demonstration

[34] Photo Credit: UNICEF/Dr Tewoldeberhan Daniel

[35] ALMA Mother-MUAC: Guidelines for Training of Trainers https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/mother-muac_-_guidelines_for_tot.pdf

7. How to read MUAC tape according to colour
8. How to check for edema in two steps followed by a practical demonstration
9. When to check MUAC and check for edema
10. When, where, and how to self-refer

It is **important** to remind mothers and caregivers that they can always visit the health center or nutrition point if they think their child is, or for whatever reason, regardless of MUAC or edema status and without a referral.

6.3 Nutrition Screening Children U6 Months

NOTE: All non-breastfed infants should be referred immediately to a SC (for those under six months), an OTP, or Health Center for full assessment. They are at high risk, especially in an emergency setting.

Children under six months are often overlooked as MUAC is not designed or approved for this age group in Sudan. During active case finding, health and nutrition workers should identify children through visible wasting as well as speaking to the mother about breastfeeding and illness through a Simple Rapid Assessment. See Box 8 for the Simple Rapid Assessment guidance.

Active Case Finding

At community level, active case identification of acute malnutrition can be done by trained CVs: Village Health Committees, Community IMCI, members from community groups and other community-based services providers (TBAs/VHWs/Breastfeeding Support Groups including traditional health practitioners), religious leaders, teachers, social workers etc. This should be completed once a month.

Measurements by a trained case finder at the community level can take place during house-to-house outreach or performed during scheduled outreach activities and in an opportunistic way at community events and gatherings where children are present, should the situation.

Additionally parents and caregivers for children under six months should also be taught on identifying malnutrition at a household level and self-referral by the family can take place at any time.

Referral Guidance

All children < 6 months with any of the signs below must be referred to stabilisation care as RUTF is not suitable for children of this age:

- WFH < -3 Z scores (if child is > 45 cm in length)
- Visible severe wasting
- Bilateral pitting oedema
- Infant is not gaining adequate weight on breast milk (despite counselling the caregiver on proper positioning & attachment)
- Infant is too weak to suckle effectively

- Infant is not breastfed or partially breastfed (eg. Breastfeeding is supplemented by inappropriate complementary foods or other milks)
- The child is lethargic / unresponsive

Procedure for Nutrition Screening for children under six months

- Unwrap and physically look at the child
- Conduct a Simple Rapid Assessment (See SectionXXX: Simple Rapid Assessment)
- Engage with the mother, father, or caregiver and listen to their concerns (See XXX IYCF-E Counselling)

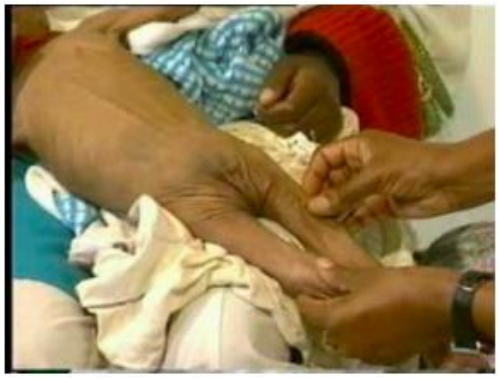
The screening should consist of a physical assessment of children 0-5 months, in addition to identification of nutritional oedema, a Simple Rapid Assessment (SRA), and IYCF counselling.

Visual Assessment

The child **MUST** be unwrapped and physically looked at.

Signs of visible wasting in infants include “baggy pants” (reduced or absent buttocks), prominent ribs, scapulae and spine, thin appearance and “old man’s face”

Photo 2: ‘Baggy Pants’ and thin appearance



6.4 IYCF Assessments

All children receive the Simple Rapid Assessment (SRA) at Health Facilities, Stabilization Centers, Outpatient Therapeutic Programs, Community including via Family MUAC and at all nutrition service points. SRAs can also be conducted at multi-sectoral contact points where implementers have been taught in SRA.

See below for a flow chart of IYCF assessments. This should be printed out and visible at locations where IYCF assessments are conducted.

WHO recommends that individual IYCF counselling should be provided to all pregnant women and women with children less than 2 years of age[36]. During emergencies IYCF individual counselling should be provided as a primary intervention to all pregnant women and caregivers of children 0-23 months who present to health or nutrition workers.

When unable to provide counselling to all, consider prioritising specific groups for counselling. Through rapid screening and triage, those requiring immediate support or who are at high risk of developing breastfeeding problems can be identified and referred for further assessment and counselling, as discussed below. Mothers not experiencing difficulties can be provided with less intensive forms of breastfeeding support (e.g., education, enabling environment) that can help to prevent breastfeeding problems and reduce the need for counselling in the future.

Priority 1: Dyads in need of immediate help

- Description: BMS-dependent, breastfeeding difficulties, urgent individual needs including malnutrition
- Timing: Immediate
- Frequency: As often as needed

Priority 2: Dyads at high risk

- Description: Vulnerable groups at higher risk of feeding difficulties, including infants under 6 months
- Timing: Counselling should take place as soon as possible after counselling needs are identified to prevent potential problems from developing
- Frequency: As often as needed

Priority 3: All pregnant and breastfeeding women

- Note: In settings where activities can be scheduled (e.g., established camps) but human resources are limited, organising group counselling by cohort (e.g., pregnancy/0-5 months/6-23 months) can facilitate the delivery of relevant and timely counselling content and appropriate activities (e.g., play and stimulation) for large numbers of caregivers
- Timing: As per the Operational Guidance for Breastfeeding Counselling[37], counselling can take place during planned contacts (e.g., during a scheduled antenatal visit or group counselling session). Counselling may also be spontaneous or ad hoc (e.g., when a caregiver is admitted to hospital). Regardless of whether counselling takes place at suggested time-points or not, content relevant to the dyad's life stage is covered. Counselling around the time of birth is prioritised.

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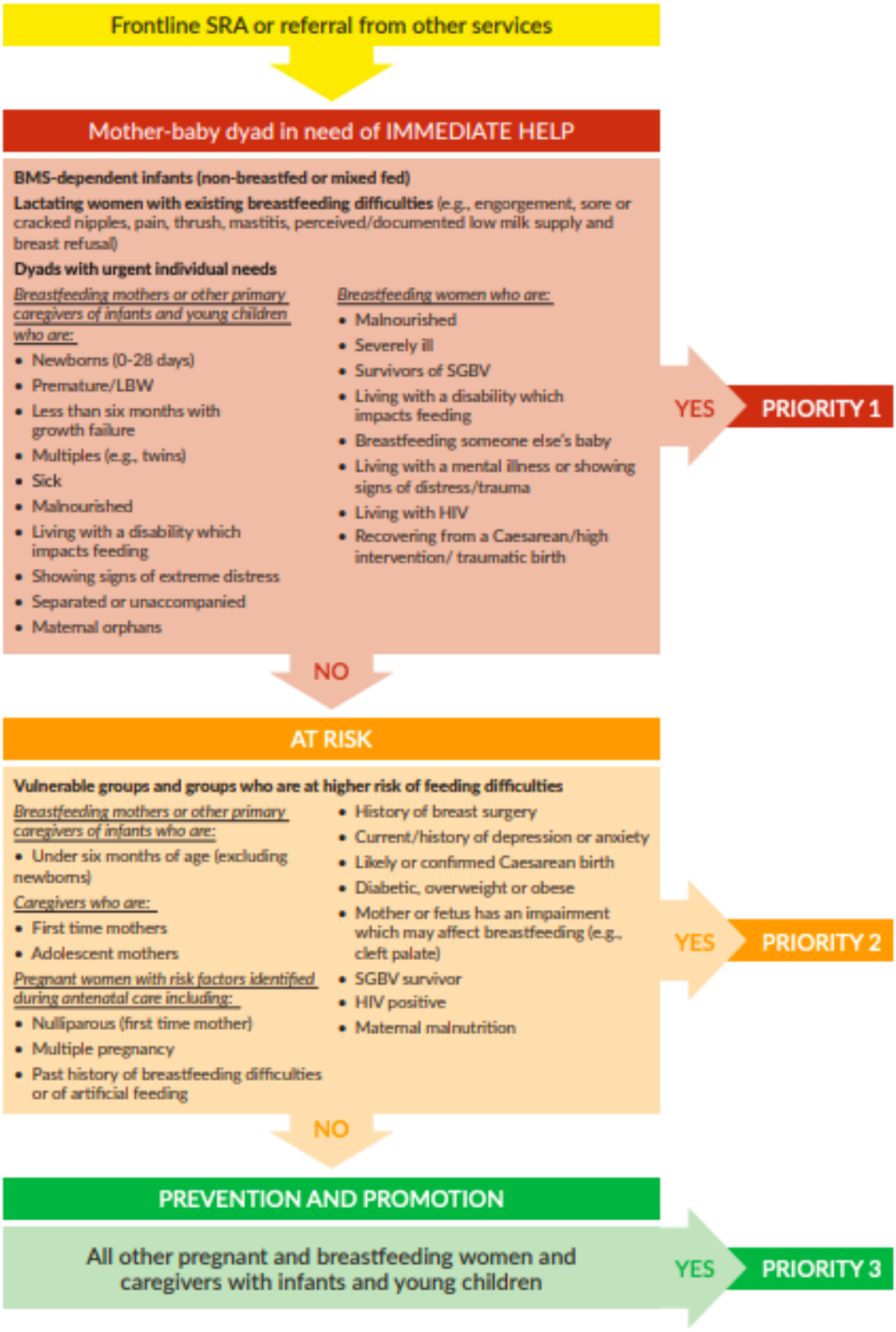
[36] WHO, UNICF Infant young child feeding counseling: An integrated course
https://www.who.int/nutrition/publications/infantfeeding/9789241594745/en/

[37] WHO (2018) *Guideline: Counselling of women to improve breastfeeding practices*
https://www.ennonline.net/attachments/4088/Operational-Guidance-on-Breastfeeding-Counselling-in-Emergencies.pdf

Flow Chart: Prioritization for Counseling by Category[38]



Types of Assessment

A Simple Rapid Assessment is first conducted when the mother or caregiver and child present to the Health or Nutrition focal point and the second, a Full Assessment, is conducted either by that same focal point if they are trained, or the mother and child are referred to receive the full assessment.

Any referrals made should be documented in an IYCF Referral Register for follow-up and monitoring and reporting purposes. (See Annex 4: IYCF Referral Register Example)

6.5 Simple Rapid Assessment

Simple rapid assessment (SRA) is a verbal assessment and observation of the baby that does not require observation of breastfeeding, or medical and nutrition training and can be done at all stages of IYCF programming.

It covers:

- Age-appropriate feeding
- Breastfeeding practices
- The baby's condition

What is the SRA

It is a set of simple questions to be asked from memory and is usually conducted without the use of a form. The SRA does not require in-depth medical or nutrition training and does not require observation of a breastfeed. Not all groups requiring urgent help and high risk groups can be identified with the SRA. For example, it may not be possible or appropriate for a layperson to identify low birth weight (LBW) infants or infants with growth failure, breastfeeding survivors of SGBV or breastfeeding women who are HIV positive. It may also not be possible to rapidly reach all breastfeeding women with an SRA (e.g., when a refugee population is dispersed within a host community). Therefore, alongside screening using the SRA, it is important to put in place different routes through which caregivers can access counselling including self-presentation[39]. Ideally, counselling is directly integrated into services used by vulnerable groups who may be missed by the SRA. Priority services include maternity, those that support small and nutritionally at risk infants including malnutrition treatment programmes, MHPSS, HIV (especially PMTCT) and adolescent services (see the prioritization flow chart above). If it is not possible for these service providers to directly provide counselling, at a minimum ensure that these service providers are trained to identify and refer caregivers who may require counselling

Please see Annex 5 for an example of a Simple Rapid Assessment.

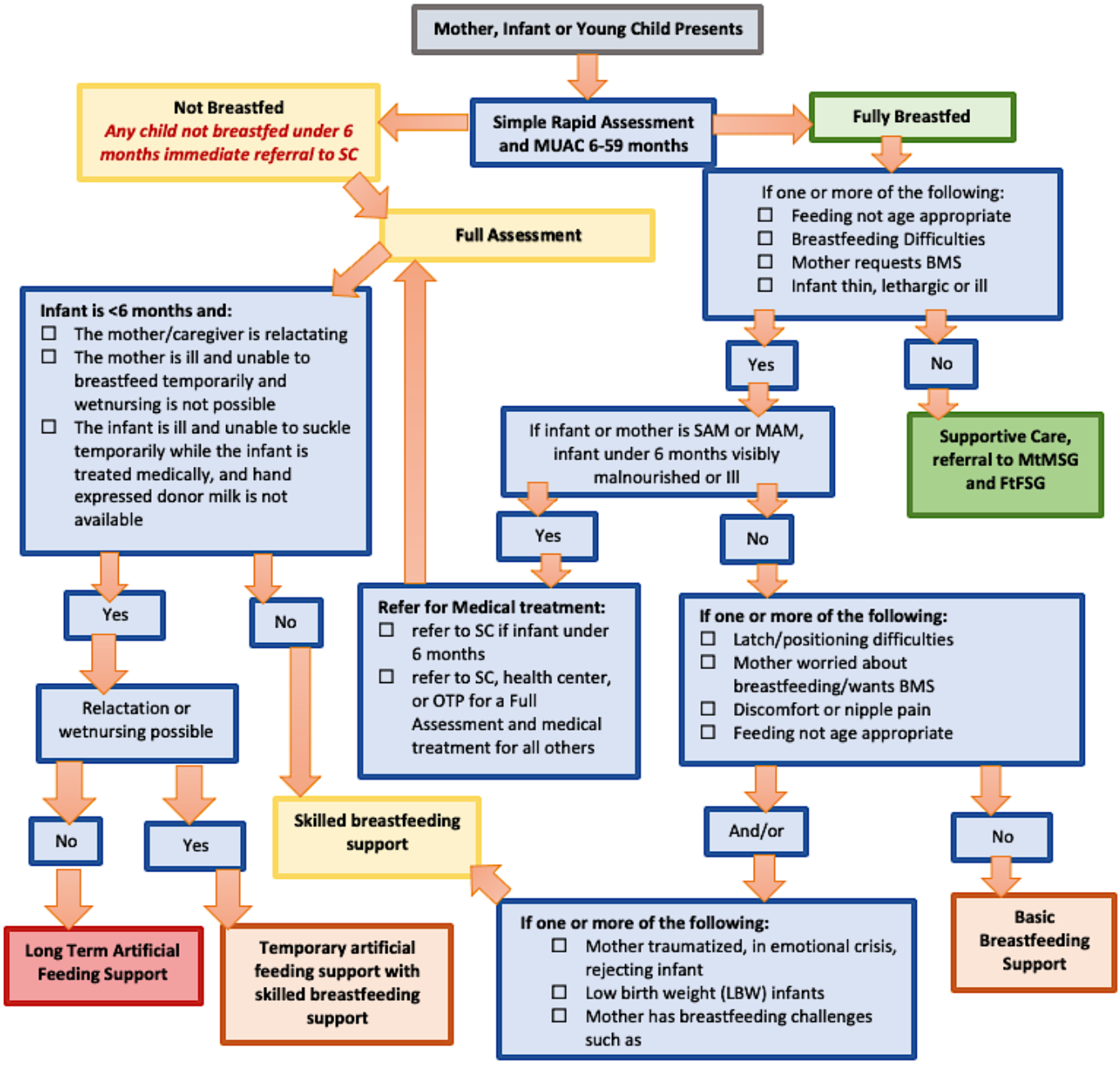
When to Conduct the SRA

The SRA is conducted whenever a mother or caregiver and child presents to the health or nutrition worker.

[38] ENN, IFE CG, Irish Aid (2021) Operational Guidance for Breastfeeding Counselling in Emergencies

[39] Ibid

Flow chart for the process of an Individual IYCF Assessment[40]



[40] Adapted from Save the Children International, 2016

Who conducts the SRA

The SRA is performed by frontline health or nutrition workers, IYCF Project Managers, Stabilization Center Staff, OTP staff, and lead mothers and lead fathers working at a community or facility level.

Where to conduct the SRA

The SRA can be conducted at the household level, community level or within PHCs. It is best to question each mother or caregiver privately, away from other mothers, as the responses may be affected if others can hear.

Referral after SRA

For referral, an SRA referral form can be completed when a mother or caregiver and child are referred for a full assessment (See Annex 5: Simple Rapid Assessment Referral Form).

For infants 0-6 months who are not breastfed, not exclusively breastfed, mixed fed, having breastfeeding difficulties, mothers requesting infant formula, infant or mother is lethargic or ill, or it is the mother's first child will be referred for **Full Assessment** (see below for guidelines for a Full Assessment).

For infants 6-24 months who don't have age-appropriate feeding habits (i.e. are breastfed and receive complementary foods), mothers requesting infant formula, infant or mother is lethargic or ill will also be referred to have a **Full Assessment.**

If there are no identified concerns, then refer to Mother to Mother Support Groups, care groups, as well as complementary feeding support as appropriate.

6.6 Full Assessment

The priority for individual, one to one, IYCF counselling are women and caregivers that are shown to have problems, signs, or symptoms that indicate a need for a **Full Assessment,** a Care Action Plan, and skilled support in the form of one-on-one counselling.

If the simple rapid screening indicates problems, a full mother-child assessment will be conducted by a trained health or nutrition worker, IYCF programme staff, or midwife including observation of breastfeeding. The full assessment should be conducted on infants referred after conducting the Simple Rapid Assessment.

What is a Full Assessment

A full assessment is a series of questions and observations within a form that is completed one to one with the mother or caregiver. (See Annex 6: Full Assessment of Mother/Caregiver and Baby pair)

The objective of a full assessment is to discover if:

- Relactation and/or wetnursing are possible and the best plan and resources for either
- Whether a BMS prescription is truly indicated or not
- If BMS is **not** indicated, where to refer the infant for the most appropriate IYCF support

- If BMS is truly indicated, whether BMS use is likely to be temporary or long term (until six months of age) and the best plan for the infant including additional resources required at the household level.

Who conducts the Full Assessment

Trained Health and nutrition workers with direct responsibility for the mothers' and babies' health and nutrition provide the full assessment and one to one counselling. It is preferred that this focal point is female to maintain the sensitivity of the situation.

This person should have full training on IYCF, IYCF Counselling, referral systems, and methods for follow-up.

Where to conduct the Full Assessment

The Full Assessment should be conducted by a trained IYCF focal point at the Primary Health Facility, Stabilization Center, or OTP. The full assessment can also be conducted at home visits and during outreach for mothers accessing a facility who are at risk (e.g. a mother recovering from a difficult birth, someone who is anxious or depressed, a person living with a disability).

Reasons for Referral After Full Assessment

Based on the Full Assessment, infants will be referred to either skilled IYCF support or artificial feeding support. (See Annex 7: IYCF Referral Form)

Next Step

After the Full Assessment is completed, one to one counselling should take place after which a Care Action Plan should be developed.

6.7 Care Action Plans

Once a full IYCF Assessment has been conducted and one to one counselling has taken place a Care Action Plan should be put in place. Two types of Care Action Plans will be applicable. These care plans should be filed with the Full Assessment and taken to all follow-up visits, including home visits.

Care Action Plan for Mother/Caregiver and Baby Receiving Skilled Support

For the child who it is found that BMS support is not required and the child can be exclusively breastfed (0-6 months) or breastfed with the addition of complementary feeding (6-23 months) but who require ongoing skilled support, the **Care Action Plan for Mother/Caregiver and Baby Receiving Skilled Support** (See Annex 10: Care Action Plan for Mother/Caregiver and Baby Receiving Skilled Support) should be completed and information input in each follow up session.

Care Action Plan for Mother/Caregiver and Baby Receiving Skilled Support and BMS

Note: This is created only after a BMS Prescription referral has been completed and all due diligence and BMS Prescription Process has been completed. See Section 13.4 BMS Prescription Process for further information on BMS prescription procedures.

If it is determined that relactation, wetnursing, or donated human milk is not possible only then can a **Care Action Plan for Mother/Caregiver and Baby Receiving Skilled Support and BMS** (See Annex 11: Care Action Plan for Mother/Caregiver and Baby Receiving Skilled Support and BMS) be put into place. Skilled support MUST be in place whenever a child is prescribed BMS. This Care Action Plan includes follow-up in the child's home, ongoing regular visits, and continuous skilled support and monitoring to ensure that the BMS is appropriately used, that the child is not becoming malnourished on the care plan, and that the mother/caregiver has ongoing support.

Chapter 7. Basic IYCF Support

7.1 Basic Breastfeeding Support

Mothers who are breastfeeding should be provided with education and peer support via existing community-based mother support groups as well as remote and social media platforms as appropriate when movement is restricted.

Basic messaging on IYCF including exclusive breastfeeding and complementary feeding can be used in mass messaging campaigns. Messaging and support should be done at all levels, including the primary health facility, at the community, or at the household level.

Sensitization and messaging among Fathers, Grandmothers, and other immediate family members as well as engaging Traditional Birth Attendants for sensitization should be a key program area[41]. Involvement of grandmothers and husbands can have a great influence on feeding practices, especially with regards to exclusive breastfeeding as they are main influencers in the community[42].

Priority should be given equally to sensitizing community and religious leaders because they have influence on the main secondary participants of IYCF. These sensitization sessions can take place at ward community meetings or other community meetings. The local Imam can also provide support and sensitization in the mosque or community gatherings.

7.2 IYCF Support for 0-5 Completed Months

Breast milk is an ideal food for the healthy growth and development of the infants; it is an integral part of the reproductive process with beneficial implications for the infant and maternal health. The Sudan Ministry of Health, in line with global recommendations, state that breastfeeding should be initiated within the first 30 minutes to 1 hour following birth and no prelacteal feeds should be given.

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[41] See the experience in South Central Somalia: *The Strengthening Nutrition Security in South Central Somalia (SNS) Consortium1 Learning Brief Learning from Four Years of SNS Consortium IYCF Experience* November 2017 https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/sns-iycf_learning_brief-nov_2017.pdf

[42] World Vision International (2016) Grandmother Inclusive Approach https://www.wvi.org/nutrition/publication/grandmother-inclusive-approach-overview

Early initiation of breastfeeding is associated with lowering neonatal mortality and successful establishment of the bonding between the mother and her baby. Infants should be exclusively breastfed up to 6 months, that is, no other fluids or food given to achieve optimal growth, development and health. Children 0-5 completed months of age should be breastfed responsively, that is, they should be given to suckle whenever they or their mother want to, night and day, at least 8-10 times a day. Exclusive breastfeeding from birth to 6 months is possible except in very few circumstances where artificial feeding support might be indicated by a Full Assessment[43].

Early introduction of foods and other liquids, reduces breast milk production by the mother and in consequence, breast milk intake by the child, thereby increasing the risk of malnutrition. Additionally and particularly relevant for emergencies, non-exclusively breastfed infants under six months are at increased risk of infection and illness. Breast milk at this age range (0-6 months) is enough for the infant; it contains ideal and balanced nutrients that the infant can digest easily and needs to optimally grow. After that point in time, to meet their evolving nutritional requirements, infants should be fed adequately available local and safe complementary foods while continuing to be breastfed up to two years of age and beyond.

Even though breastfeeding is a natural act, it is a complicated behavior that needs to be learned. Generally, almost all the mothers can breastfeed their babies provided they learn how to do it and have the support from their husbands, families, communities and from the health care system. Malnourished and stressed mothers can breastfeed. They should also have access to skilled practical help from, for example, trained health workers and nutritionists. Also, grandmothers, counsellors etc. can help build mothers‟ confidence, improve feeding techniques, and prevent or resolve breastfeeding problems provided they are knowledgeable of recommended breastfeeding practices.

Continued Integration of the Ten Steps to Successful Breastfeeding of the WHO/UNICEF Baby-friendly Hospital Initiative in maternity services is essential to IYCF services. BFHI, implemented in Sudan, aims to give every baby the best start in life by creating a health care environment where breastfeeding is the norm. The Ten Steps for Successful Breastfeeding (Box 3) include having a breastfeeding policy in the hospital, not promoting infant formula products, pacifiers, or bottles, while counselling and educating mothers on how to initiate, support, and maintain breastfeeding.

Key newborn health interventions within the BFHI framework include skin-to skin contact, kangaroo mother care, ‘rooming in’ (keeping mothers and infants together), and delayed umbilical cord clamping, limiting supplementation with BMS to only when medically necessary, and target support to mothers of premature and LBW infants, adolescent mothers and first-time mothers[44].

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[43] 1) Infants and young children who were orphaned or whose mother has been absent for a long period of time either before the humanitarian situation or in the course of the humanitarian situation and for whom wet-nursing, relactation or receiving donor human milk is not feasible 2) Infants and young children whose mother is present and who were not breastfed before the time the humanitarian situation or in the course of the humanitarian situation, regardless of the reason, and for whom wet-nursing, relactation or receiving donor human milk is not feasible 3) Situations where the mother and/or infant has a medical condition for which breastfeeding is not possible, and for whom wet-nursing, relactation or receiving donor human milk is not feasible 4) Infants under 6 months of age who are mixed fed (breastfeeding plus BMS) and whose mother is being supported to transition to exclusive breastfeeding

[44] UNICEF, WHO *Protecting, promoting and supporting Breastfeeding in facilities providing maternity and newborn services: the revised BABY-FRIENDLY HOSPITAL INITIATIVE* 2018
https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf

Box 3: Ten Steps for Successful Breastfeeding

Ten steps for successful breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the necessary skills 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 breast milk 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.

Early Initiation of Breastfeeding within the First Hour of Life and Early Exclusive Breastfeeding[45]

Early initiation of breastfeeding refers to the provision of breastmilk within one hour of birth. It is a high impact intervention that ensures that the infant receives colostrum, which is rich in protective factors and gives newborns a higher chance of survival.

There is a growing body of evidence that shows that skin-to-skin contact between mother and infant shortly after birth is highly important and supports early initiation early breastfeeding, increases the overall duration of breastfeeding, as well as likelihood of exclusive breastfeeding in addition to helping the mother develop a close, loving relationship with their child[46]. Infants placed in early skin-to-skin contact with their mother also appear to interact more with their mothers and cry less[47].

Babies should be placed skin-to-skin, where the baby is laid directly on the mother's bare chest, both covered in a warm blanket immediately following birth for at least an hour during which baby should receive continuous, uninterrupted skin to skin contact. In this time, the mother should be offered skilled breastfeeding help if/when needed.

Delay bathing for the first few days and avoid bottles and pacifiers or giving any foods and fluids other than breastmilk. During emergencies, mothers may be more stressed than usual, and their confidence

[45] Refer to the IFE Core Group infographic on Early Initiation for Breastfeeding in Emergencies for further instruction https://www.ennonline.net/ifecoregroupinfographicseries

[46] UNICEF *Research on Skin to Skin Contact* https://www.unicef.org.uk/babyfriendly/news-and-research/baby-friendly-research/research-supporting-breastfeeding/skin-to-skin-contact/

[47] UNICEF *Skin to Skin Contact* https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/implementing-standards-resources/skin-to-skin-contact/

may be shaken. This may delay the onset of plentiful milk production or slow down milk flow. You can support a mother's milk to flow by helping her to feel safe and supported:

- Listen to mothers
- Provide respectful medical care
- Share praise and encouragement
- Protect privacy and dignity
- Support skin to skin
- Ask for consent before any necessary touch or procedure

There are risks and danger of separation of the mother and infant and mothers and their infants should always be kept together unless there are exceptional circumstances that require temporary separation. When temporary separation is unavoidable, support mother to express breastmilk every 2-3 hours into a clean container for cup feeding.

Exclusive Breastfeeding

Exclusive breastfeeding (EBF) means that the child receives only breast milk for the first six months of life and is the most effective preventive intervention to reduce early-childhood mortality under the age of five globally by 13%[48].

Exclusive breastfeeding means nothing is given except breastmilk. This includes examples like water, tea, powder milk, cows or camel milk, porridge, solid or semi-solid foods, or any other liquids, foods, or milks. Medications and vitamins recommended by a health professional are excluded and are allowed when exclusively breastfeeding. Six months of EBF is recommended for improved infant, child, and maternal health and unrestricted EBF, including responsive feeding and feeding on cue, results in ample milk production and should be a part of every intervention targeting mothers and babies under six months of age.

7.3 IYCF support for Children 6 to 59 Months

Breastmilk remains a vital source of nutrition after 6 months of age, however at this time introduction to solid food is required to meet the baby's growing needs. Introduction of complementary foods in addition to continued breastfeeding at this time is essential.

Continued Breastfeeding from 6 months and beyond

Breastfeeding continues to be nutritionally vital well beyond the first year of life. It is an important source of energy and nutrients even after six months when complementary foods have been introduced. Breastmilk provides half or more of a child's energy needs between the ages of 6 and 12 months, and one third of energy needs between 12 and 24 months. It is also a critical source of energy and nutrients during illness and reduces mortality among children who are malnourished[49] and continued and frequent breastfeeding also protects maternal health by delaying maternal fertility in the postpartum period.

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[48] The Lancet Breastfeeding Series 2016: http://www.thelancet.com/series/breastfeeding

[49] WHO *Infant and Young Child Feeding Factsheet* 2020 https://www.who.int/en/news-room/fact-sheets/detail/infant-and-young-child-feeding

All IYCF-E programming should promote, protect, and support continued breastfeeding after six months.

7.4 Complementary Feeding

Box 4: Breastfeeding During Complementary Feeding Recommendation

Continued breastfeeding is an important component of optimal complementary feeding and all complementary feeding programs should include breastfeeding messaging and support.

Complementary Feeding is the process of giving other foods and liquids in addition to breastmilk (or an appropriate BMS for non-breastfed infants), when these alone are no longer sufficient to meet the nutritional needs of infants and young children. In breastfed infants, the objective of complementary feeding is to complement ongoing breastfeeding, neither displacing nor replacing breastmilk. Complementary feeding typically covers the period from 6 months to 2 years of age, and due to the potential for inappropriate feeding practices and risk of malnutrition, this is a very vulnerable period for infants and young children.

Growth faltering is most evident between 6 and 11 months, when foods of low nutrient density begin to replace breast milk, and the rates of diarrheal illness caused by food contamination are at their highest.

The transition from exclusive breastfeeding to the introduction of complementary foods can be difficult to navigate without skilled support. The primary components of appropriate complementary feeding including the correct preparation of foods and the introduction of a diverse group of foods are important, but additionally, secondary components of complementary feeding are equally as important and often overlooked, such as responsive feeding and hygienic preparation and handling of foods.

Inappropriate complementary feeding practices include late initiation of breastfeeding, a lack of exclusive breastfeeding in the first 6 months, complementary feeding starting too early or too late with foods that are often nutritionally inadequate and unsafe, and discontinued breastfeeding. In terms of intervention, influencing appropriate feeding practices is as critical as influencing the availability and use of adequate foods; a complex activity being subject to political, psycho-social, cultural, economic, and commercial forces.

The nutritional principles governing infant and young child feeding will be the same in an emergency as for any other situation, however the increased burdens placed on populations and the unique challenges of emergencies may necessitate more flexible and innovative approaches.

To help avert such devastating impacts in emergencies, caregivers will need access to adequate amounts of nutritious, appropriate and safe complementary foods. And while there is no reason for CF to start earlier in emergencies, there may be situations where it is preferable to delay it for slightly longer than 6 months; for example if sanitation is extremely poor and/or there are no quality foods immediately available to meet the most acute nutrient requirements for iron and zinc. To help meet these requirements, international guidance on micronutrient supplementation of mothers, infants and

young children in emergencies should be followed41 and the common practice of early clamping of the umbilical cord should be prevented to enable a significant transfer of blood (and therefore iron) to the baby. Further, the prevailing nutritional status of the population prior to the emergency will present specific challenges and have some bearing on the most appropriate response; for example, in chronically undernourished populations where the micronutrient status of mothers may be poor and infants are more likely not to be exclusively breastfed (due to recurrent illness).

Appropriate complementary feeding interventions should support the nutritional status of the mother, support breastfeeding (encouraging optimal breastmilk intake for the complementary feeding period), and introduce energy and nutrient dense foods for complementary feeding in amounts that do not undermine breastfeeding. Food and nutrition agencies must ensure that nutritious and appropriate complementary feeding options are always included as standard in food rations and in cases where the general food ration is lacking in quality, targeted interventions to provide culturally acceptable micronutrient-rich (fortified) complementary food to children 6 months to 2 years of age will be required. This is quite a challenge, and in any CF intervention, it is imperative to also support and reinforce the caregiver's central role in feeding and caring for their children.

The Code and Complementary Feeding in Emergencies[50]

The Code, and Sudan's national commitments to the Code, are intended to protect against any activity which undermines breastfeeding. BMS are any foods which are marketed or otherwise represented as total or partial replacements for breastmilk, whether or not suitable and with or without modification for that purpose. This means that any food targeted to infants less than 6 months of age constitutes a BMS; any actions to market or otherwise represent a food as a BMS to children aged 6 months to 2 years or beyond will also fall under the jurisdiction of the Code.

Thus, to ensure the provisions of the Code and Sudan national guidelines are upheld, it is important that any commodities are represented for the suitable age group, with appropriate information and support for continued breastfeeding throughout the complementary feeding period, and with attention to established guidance, management, and provisions for their correct use.

Recommended Complementary Feeding Practices[51]

In order to meet the nutritional needs of the infant complementary foods should be:

- **Timely** – introduced at 6 months when the need for energy and nutrients exceeds what can be provided through exclusive breastfeeding;
- **Adequate** –provide sufficient energy, protein and micronutrients to meet a growing child's nutritional needs;
- **Safe** – hygienically stored and prepared, and fed with clean hands using clean utensils and never using bottles and teats;

[50] See also the WHO Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children https://apps.who.int/iris/bitstream/handle/10665/260137/9789241513470-eng.pdf?sequence=1&isAllowed=y

[51] WHO Complementary Feeding Practices https://www.who.int/health-topics/complementary-feeding#tab=tab_2

- **Properly fed** – given consistent with a child's signals of appetite and satiety[52], and that meal frequency and feeding are suitable for age.

See Table 4 for recommended complementary feeding practices for each age group.

WHO recommends that infants start receiving complementary foods at 6 months of age in addition to breastmilk. Between 6-8 months infants should receive complementary foods 2–3 times a day and increase to 3–4 times daily between 9–11 months and 3-4 times per day with snacks offered 1-2 times a day between 12–24 months.

Gradually increase food consistency and variety as the infant gets older, adapting to the infant's requirements and abilities. Infants can eat pureed, mashed and semi-solid foods beginning at 6 months. By 8 months most infants can also eat foods that can be picked up and eaten by children themselves.

By 12 months, most children can eat the same types of foods as consumed by the rest of the family, while keeping in mind the need for nutrient-dense foods, including animal-sourced foods like meat, poultry, fish, eggs and dairy products.

Avoid foods in a form that may cause choking, such as whole grapes or raw carrots. Avoid giving drinks with low nutrient value, such as tea, coffee and sugary soft drinks. Limit the amount of juice offered, to avoid displacing more nutrient-rich foods.

Complementary Feeding Interventions During an Emergency[53]

The concepts of complementary feeding in emergencies are not only food focused, but encompass a much wider array of interrelated feeding practices and caring behaviours that are instrumental in child development. The challenges posed by emergency situations will make caring for and feeding children harder, and it is therefore crucial to have effective practical guidance for carers, practitioners, and agencies in the field to not only ensure that the nutrition components of complementary feeding are met, but help promote, support, and sustain the social and psychosocial elements which may be very much undermined during emergency conditions. As such, a number of interventions across sectors may be needed to fully meet complementary requirements in an emergency;

- Counselling and advice to support appropriate CF practices
- Advice on complementary food preparation (especially for unfamiliar foods)
- Supporting maternal nutrition
- Support for continued breastfeeding during the 6 months to 2 years period
- Ensuring food rations distributed to emergency affected populations always include provision for (culturally) appropriate complementary foods
- Use of fortified foods e.g. fortified blended foods, 'point of use' fortificants, and micronutrient powders

[52] Caregivers should take active care in the feeding of infants by being responsive to the child's clues for hunger and also encouraging the child to eat.

[53] ENN and IFE (2009) Core Group Complementary Feeding of Infants and Young Children in Emergencies https://www.ennonline.net/attachments/965/cfe-review-enn-ife-core-group-oct-2009.pdf

- Micronutrient supplementation
- Resources, such as fuel and cooking equipment
- Voucher and complementary foods distribution schemes
- Education to ensure that meals are prepared hygienically and to an adequate nutrient and energy density (i.e. not too dilute)
- Supplying tools and seeds to enable cultivation of suitable complementary foods
- Strengthening links between livestock and nutrition programming to enhance food quality available to children

Table 4: Recommended Complementary Feeding Practices

Recommended Complementary Feeding Practices				
Age	**Recommendations**			
	Frequency (per day)	**Amount of food an average child will usually eat at each meal** (in addition to breastmilk)	**Texture** (Thickness/Consistency)	**Variety**
Start Complementary foods after baby reaches 6 months	2 to 3 meals, plus frequent breastfeeds	Start with 2 to 3 tablespoons Start with 'tastes' and gradually increase amount	This porridge/pap or mashed/pureed fruits/vegetables	Breastmilk (Breastfeed as often as the child wants) PLUS Staples (maize millet, sorghum pap/porridge, agidi, or other local examples) PLUS Legumes (roasted groundnuts paste or other local examples) Legumes (soft boiled beans, moi-moi, or other local examples) PLUS Fruits (banana, mango, oranges)/vegetables (ugu leaves, green leaves, okro, ewedu, or other local examples)
6 months to 9 months	2 to 3 meals plus frequent breastfeeds 1 to 2 snacks can be offered	2 to 3 tablespoons per feed Increase gradually to half (2/1) of a 250ml cup/bowl	This porridge/pap Mashed/pureed family foods and fruits/vegetables	
9 months to 12 months	3 to 4 meals plus breastfeeds 1 to 2 snacks can be offered	Half (1/2) of a 250 ml cup/bowl	Finely chopped family foods and fruits/vegetables Finger foods, including fruits/vegetables Sliced foods	
12 months to 24 months	3 to 4 meals plus breastfeeds 1 to 2 snacks can be offered	Three-quarters (3/4) to one 250ml cup/bowl	Sliced foods Family foods	
If the child is between 6 and 24 months and NOT breastfed	Add 1 to 2 extra meals 1 to 2 snacks can be offered	Same as above, according to age group		Same as above

	PLUS 2 to 3 cups of extra fluid, especially in hot climates		
Active/responsive feeding (alert and responsive to signs that the baby is ready to eat; actively encourage but do not force the baby to eat)	● Be patient and actively encourage your baby to eat more food. ● If your young child refuses to eat, encourage him/her repeatedly; try holding the child in your lap during feeding, or face him/her while he or she is sitting on someone else's lap. ● Offer new foods several times, children may not like (or accept) new foods in the first few tries. ● Feeding times are periods of learning and love. Interact and minimize distraction during feeding. ● Do not force-feed. ● Help your older child feed him- or herself.		
Hygiene	● Feed your baby using a clean cup/bowl and spoon; never use a bottle because it is difficult to clean and may cause your baby to get diarrhoea. ● Wash your hands with soap and water before preparing food, before eating, and before feeding young children. ● Wash your child's hands and face with soap before and after he or she eats		

Provision of Complementary Foods and Vitamin Sources

Ideally, complementary foods should be made from locally available, affordable, nutritious foods. In settings where markets were functioning and foods are available and affordable, it is important to prioritise the promotion and use of locally available foods in the response. Where foods were not available and affordable, the importation of products suitable for use in feeding children aged 6-23 months, such as SuperCereal, may be a necessary temporary intervention until locally produced/used foods became available again on the markets which the population could afford, or the cash/voucher programmes could assist them in accessing these products.

When foods are introduced, they should be soft, semi-solid and given a little at a time for the infant to become accustomed to the flavor and texture of the food.

Table 5: Locally available complementary foods in Sudan

Types of Locally Available Complementary Foods in Sudan		
Staples	Grains such as maize, wheat, rice, millet, and sorghum; roots and tubers, such as cassava and potatoes.	
Legumes	Beans, lentils, and peas. Groundnuts and seeds, such as sesame and benniseed.	
Vitamin A-rich foods	Vegetables: dark-green leaves, carrots, orange-flesh sweet potato, and pumpkin. Eggplant, garden egg, and cabbage.	
	Fruits: Mango, pawpaw, passion fruit, oranges, banana, pineapple, avocado, watermelon, tomatoes,	
Animal-source foods	Flesh foods such as meat, chicken, fish, liver, cheese, and eggs. Milk and milk products	
Oil and fat	Oil seeds, margarine, and butter added to vegetables and other foods will improve the absorption of some vitamins and will provide extra energy. Infants only need a very small amount of this type of food- no more than half a teaspoon per day.	

Iron

Iron is important for a child's development. Iron is stored within the body and is present in breastmilk in small quantities, however this iron is easily absorbed. Iron stores present at birth are gradually used up over the first six months. After six months, the baby's iron needs must be met by complementary foods.

Good sources of iron are:

- Animal foods: liver, lean meats, and fish
- Plant Sources: legumes, beans, peas, lentils, and spinach.

Vitamin C

- Eating foods rich in vitamin C with/or soon after a meal, increases the absorption of iron.
- Drinking tea and coffee with a meal **reduces** the absorption of iron and should be avoided.

Iodine

A small portion of Iodized salt can also be used in preparing family foods to ensure iodine is present.

Artificial Flavors

Flavor enhancers, including flavouring stock cubes such as Maggi or Royco, etc., are not recommended in complementary foods. Even though they are commonly used in the household, they do not have any nutritional value and they add ingredients that are unhealthy and can increase the risk of diseases in the long term. In addition, an essential part in the introduction to new foods is for the infant to learn and accept new flavors, those naturally found in the food, which would be otherwise masked by artificial flavors.

Integration of Complementary Feeding Guidance in IYCF Areas

Complementary feeding messaging and support should be in place wherever IYCF-E activities take place, including IYCF corners, OTPs, and mother to mother and father to father support groups.

In emergencies, food demonstrations (see below) can be modified to be held at an individual level within IYCF-E corners or where IYCF messaging takes place. In this situation, rather than cooking the food itself, it is limited to sharing messaging, showing ingredients including portions, providing recipes.

7.5 Food Demonstrations

Box 5: Food Demonstrations Overview

Participatory Food demonstrations are a practical way of showing mothers and caregivers how to prepare improved dishes for young children, using readily available local ingredients.

The purpose of conducting participatory cooking demonstrations is to convey complementary feeding messages as well as provide mothers and caregivers with new food preparation skills and to develop their confidence in preparing improved or new dishes that incorporate locally affordable and available foods. It is also designed to create awareness of underutilized nutritious

food ingredients readily available at home or in the area, particularly important for populations who have recently been displaced as available foods and cooking supplies might be changed. Relevant messages and instructions on how to prepare nutritious meals through hands-on participation in meal preparation, e.g. washing or cutting ingredients are also key to Food Demonstrations. And finally, it provides them an opportunity to taste prepared dishes and give feedback on the color and appearance, aroma/smell, and taste of the improved dish to provide feedback to the facilitators of the Food Demonstration implementation to continually work with the community to ensure that food recommendations remain relevant, accepted, affordable, and appropriate.

Timing and Location

Timing and location of Food Demonstrations should take place at a venue agreed upon by the mothers and caregivers participating in the demonstration. The venue should be accessible and within close proximity to other nutrition activities. The timing should be appropriate for the mothers and caregivers and, as much as possible, avoid days/times when distributions take place or when other household chores such as preparing larger family meals within the home would take place. As foods are to be purchased from the local market, the timing of the demonstrations can take place one or two days after market days.

Procurement of Food Demonstration Ingredients

Ingredients should be purchased in the community and, as much as possible, within the local market. Foods should be seasonably appropriate, available, and affordable.

Proposed Agenda

Food Demonstrations should take approximately 120 minutes or around 2 hours total. A demonstration table should show the ingredients for cooking displayed and stored in transparent containers and should, in all cases, represent the various stages of food preparation.

Agenda:

- Welcome and Introduction
- Key Messages on Complementary Feeding
- Hand washing demonstration
- Introduction to the Recipes
- Preparation of ORS
- Preparation of complementary meals for infants 6-8 months
- Preparation of complementary meals for 9-11 months
- Preparation of complementary meals for 12-23 months
- Closing and goodbye

Monitoring, Evaluation, Accountability, and Learning (MEAL)

A feedback mechanism should be put into place that allows for feedback on the flavour and ease of the recipes used as well as applicability to the recipes use within the household.

Box 6: 10 Steps to a Successful Food Demonstration

10 Steps to a Successful Food Demonstration

1. Identify your target group- identify knowledge on types of food in the locality and what food does in the body
2. Create a concise message on nutrition
3. Be organized, confident, and courteous
4. Use relevant recipes with affordable, locally available ingredients.
5. Be sure the demonstration area is clean and will capture the attention of the audience
6. Emphasize nutrition messages and hygienic practices while demonstrating
7. Ensure active participation of the group members in the food preparation tasks
8. Allow all participants to taste the prepared food
9. Observe good food safety and handling habits and practices
10. Obtain feedback through questions and answers for future improvement of the food demonstration

7.6 IYCF Counselling[54]

Breastfeeding counselling is a lifesaving intervention as it helps to mitigate the impact of an emergency and ensure that breastfeeding is started and continued. Failure to protect breastfeeding during emergencies has detrimental consequences such as low breastfeeding rates and increased malnutrition and death. Providing skilled support for breastfeeding is therefore a priority action during emergencies as outlined in the Sphere Humanitarian Charter and Minimum Standards in Disaster Response[55].

Mothers or caregivers who are not breastfeeding, partially breastfeeding, or in need of breastfeeding support should be provided with counselling by a trained IYCF focal point. Breastfeeding counselling is conducted on a one-one basis with the mother/caregiver at any level where IYCF Support is provided and staff are trained to counsel including the primary health facility, SC, OTP, BSFP, TSFP, or at the household level. Counseling should take place in all contexts, including emergencies, however, service delivery may need to be adapted to meet the constraints of the emergency.

Counselling consists of listening to concerns, discussing questions, teaching about breastfeeding and observing and assisting with the normal process of breastfeeding and breastfeeding challenges. The aim of breastfeeding counselling is to empower women to breastfeed and to strengthen responsive caregiving practices while respecting their personal situations and wishes. This includes observation of a breastfeed and counselling for relactation and increasing milk supply. Caregivers and mothers of infants and young children 6-23 months should be provided with counselling and education on both breastfeeding and complementary feeding.

[54] For more information refer to the Operational Guidance for Breastfeeding Counselling in Emergencies (2021) https://www.ennonline.net/attachments/4088/Operational-Guidance-on-Breastfeeding-Counselling-in-Emergencies.pdf

[55] SPHERE https://spherestandards.org/

Breastfeeding counselling includes support for relactation, cup feeding and increasing milk supply which are actions that are carried out with infants who may be breastfed or fully or partially artificially fed. Caregivers may transition between artificial feeding and breastfeeding or practice both (mixed feeding). Therefore, counselling to reduce the risks of artificial feeding and ensure it is carried out hygienically and responsively should not be seen as separate from breastfeeding counselling and adequate support should be provided for both breastfed and non-breastfed children as part of any emergency response.

Possible entry points for counselling within health and nutrition services include reproductive health including essential newborn care (ENC), sexual and gender based violence (SGBV), prevention of mother-to-child transmission (PMTCT), family planning, antenatal care (ANC) and postnatal care (PNC); child health including paediatric services treating wasted infants, immunisation services, well-baby clinics, integrated community case management (iCCM), integrated management of childhood illness (IMCI) and growth monitoring; mental health and psychosocial support (MHPSS); communicable disease outbreak response interventions including clinical care and case management, nutritional care and infant feeding support; community health; infant and young child feeding in emergencies (IYCF-E) and wasting treatment including community based management of acute malnutrition (CMAM) and MAMI services.

The IYCF counselling cards are tools that can be used to provide key messages on continued breastfeeding and complementary feeding and address any challenges. Counseling cards should be adapted to each context and translated into the appropriate languages. In Sudan, counseling cards are available in English, Arabic, and Tigray languages. Nutrition partners should ensure that these cards are available to their health and nutrition workers everywhere where counseling should take place.

For situations where wet nursing or expressed human milk from another woman is acceptable and possible, the counselor should also provide support to the wet nurse or human milk donors. Education and counselling for the other adults in the household are also important for the child to receive full and sustainable support. (See Section XXX for more information on Wetnursing Guidelines)

7.7 Observing a Breastfeed

If it is discovered from the full assessment that a mother or caregiver is having challenges with breastfeeding it is important to observe as they breastfeed the child to identify if there are any issues with positioning and attachment. Observation is also important to improve confidence and provide key messages during counselling as the child is being breastfed.

The B-R-E-A-S-T Feeding Observation Form (See Annex 8: B-R-E-A-S-T Feeding Observation Form) is a tool that can support a community nutrition mobilizer, health staff, or other nutrition staff as they observe a breastfeed during a full assessment.

Note: Always Ask permission before observing a mother or caregiver as they breastfeed.

Before observing a breastfeed:

- Introduce yourself to the mother, begin with opening questions about how she feels breastfeeding is going, if there is any pain or discomfort, and listen to any concerns she has.
- Ask permission to watch her baby feed. If the baby is heavily wrapped in a blanket, ask the mother to unwrap the blankets so the baby is clearly seen.
- If the baby is feeding, ask the mother to continue as she is doing. If the baby is not feeding, ask the mother to offer a feed in the normal way at any time that her baby seems ready. If the baby is willing to feed at this time, ask the mother's permission to watch the feed. If the baby is not interested in feeding, be patient and try a bit later if needed.
- Find a chair or stool to sit on or sit near her on the ground. When you are at the same level as the mother or caregiver this breaks down boundaries and allows for clearer communication.
- Before or after the breastfeed, ask the mother or caregiver some open questions about how she is, how her baby is, and how feeding is going, to start the conversation. Encourage the mother to talk about herself and her baby.
- With the mother or caregiver identify what they feel is going well with the breastfeed. Some examples could be to notice that the baby is suckling strongly, that milk is pooling around the infant's mouth, that the infant becomes more relaxed as the feed continues, etc. Where relevant offer a small amount of information when it is appropriate.

While observing the breastfeed:

- Continue to watch and engage with the mother or caregiver as she is able as the feed continues.
- The B-R-E-A-S-T feed Observation Aid can be used as the breastfeed is observed. When using the aid explain to the mother what the observation aid is and why it is being used.
- When using the aid mark a tick beside each sign that you observe.

If it is identified that the mother or caregiver requires further support conduct or refer them to a full IYCF assessment or continue or refer for IYCF Counselling as appropriate.

7.8 Three-Step Counselling

There are three important steps that take place during IYCF Counselling. Assess, Analyse, and Act, there are times where more than one step is happening at the same time, for example during a breastfeeding observation where counselling and messaging can take place at the same time as counselling and messaging. See Annex 9: Three Step Counselling for more details on each step.

1. **ASSESS**:
   - Ask, listen, and observe.
   - Simple Rapid Assessment (SRA)
   - Full Assessment if the SRA indicates the need
   - B-R-E-A-S-T Feeding Observation Form if the Full Assessment indicates the need

2. **ANALYZE**:
   - Identify the difficulty and if there is more than one, prioritize the difficulties.
   - Follow the guidelines for Basic Breastfeeding Support (Section XXX: Basic Breastfeeding Support) and Skilled Breastfeeding Support as difficulties are identified (See Section XXX: Skilled Breastfeeding Support),

3. **ACT**:
   - Discuss, suggest a small amount of relevant information, and agree on a possible plan of action.
   - Create a Care Action Plan (See Section XXX: Care Action Plans)
   - Provide Referrals if required (See Section XXX: IYCF-E Referral Systems)

7.9 IYCF Supportive Spaces

An IYCF 'Supportive Space' is a general term that describes the different kinds of safe spaces where pregnant women, mothers and other caregivers of infants and young children can access support in feeding and caring for their children and themselves during emergencies.

Supportive Spaces can include Mother Baby Areas, Baby Friendly Spaces, Mother Baby Areas, or IYCF Corners. They are physical spaces, usually staffed (although not always in the case of IYCF Corners) with skilled focal points who can provide services that protect, promote, and support appropriate IYCF practices. Some services might be as basic as providing a private area to breastfeed or may be more comprehensive including scheduled activities including Simple Rapid Assessments, one to one counselling, or psychosocial or hygiene activities.

Sessions targeted specifically at men/fathers or grandmothers, depending on the context, can also be included in Supportive Spaces. At a minimum staff should be trained on IYCF, basic breastfeeding support, Simple Rapid Assessments, and be oriented on protection issues, including gender-based violence, regardless which services are offered at the supportive space.

Box 9: Examples of Services and Activities within Supportive Spaces[56]

[56] GTAM Supportive Spaces for Infant and Young Child Feeding in Emergencies: Technical Brief 2020 https://reliefweb.int/sites/reliefweb.int/files/resources/Suppotive%20Spaces_16Sept2020%20%28004%29.pdf

Services and Activities within supportive spaces
Examples include: Baby Friendly Spaces, Baby Friendly Tents, Mother Baby Areas, IYCF Corners and other supportive spaces
Core Services and Activities
● Provision of a welcoming space for caregivers to relax and spend time with their children ● Provision of space to breastfeed comfortably and privately ● Provision of safe drinking water and handwashing facilities ● Assessment of the individual mother-baby pair's needs (e.g., IYCF, psychosocial, protection) ● Provision of information about/referral to relevant services (e.g., vaccination, antenatal care, etc.) ● Skilled one-to-one IYCF counselling/breastfeeding counselling ● Early childhood development (ECD)/early learning/play sessions ● Activities for pregnant women (e.g., preparing for birth and the postpartum period) ● Referral for survivors of gender-based violence
Possible additional services and activities to consider
● Psychosocial support ● Psychological support ● Relaxation and mindfulness exercises ● Group discussions and/or peer-support groups ● Education on nutrition/hygiene/care practices ● Skilled support for relactation and/or wet nursing ● Management of breastmilk substitute (BMS)-dependent infants (or referral to BMS management services) ● Baby massage ● Baby bath/hygiene activities ● Complementary feeding activities; e.g., cooking demonstrations ● Screening and referral for child/maternal malnutrition ● Family planning and emergency contraception ● Information and support around protection issues (beyond referral only) ● Support for survivors of gender-based violence (beyond referral only) ● Provision of nutritious snacks for pregnant and lactating women

7.10 IYCF Corners

IYCF Corners are an important component to providing supportive IYCF care in an emergency. For example, an IYCF corner with dedicated staff in a busy health center reminds midwives to refer women for IYCF counselling as part of their antenatal and postnatal care. They can be placed in any facility or distribution point and while there are no interagency minimum standards for IYCF corners, they should meet the general requirements set out in these Operational

Guidance for Infant Feeding in Emergencies[57], the International Code on the Marketing of Breastmilk Substitutes[58], Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children[59]. They should also meet relevant SPHERE Standards regarding IYCF, Water, sanitation and hygiene (WASH), Protection and Mental Health minimum standards.

IYCF Corners provide a private space for breastfeeding and skilled IYCF counselling within a nutrition or health facility. They ensure a welcoming, respectful, friendly and positive atmosphere where mothers and caregivers can feel respected and valued. They are generally bright with positive decorations instead of an abundance information, education and communication (IEC) materials. Hand washing stations and safe drinking water should be provided and, if available, snacks for mothers and caregivers. IYCF Corners should provide some privacy, in case it is wanted and should be fitted with comfortable seating where a woman or caregiver can breastfeed comfortably.

IYCF Corners are not limited to only health and nutrition centers, however. They can also provide private space for breastfeeding within a child-friendly space, distribution site, or other site where women attend regularly. Depending on the availability of counselling staff, an IYCF corner in a site outside of a health or nutrition facility may not provide skilled support or may provide skilled support on a rotational basis.

Core services and activities for IYCF Corners are[60]:

- Provision of a welcoming space for caregivers to relax and spend time with their children
- Provision of space to breastfeed comfortably and privately
- Provision of safe drinking water and handwashing facilities
- Assessment of the individual mother-baby pair's needs (e.g., IYCF, psychosocial, protection)
- Provision of information about/referral to relevant services (e.g., vaccination, antenatal care, etc.)
- Skilled one-to-one IYCF counselling/breastfeeding counselling
- Skilled support for relactation and/or wet nursing
- Complementary feeding activities, e.g., cooking demonstrations
- Screening and referral for child/maternal malnutrition

[57] IFE Core Group *Operational Guidance on Infant Feeding in Emergencies (OG-IFE) version 3.0* 2017 https://www.ennonline.net/operationalguidance-v3-2017

[58] The International Code on the Marketing of Breastmilk Substitutes. WHO 1981 and sub- sequent World Health Assembly (WHA) Resolutions https://www.who.int/nutrition/publications/code_english.pdf

[59] WHA Resolution: Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children. 69th WHA A69/7 Add.1. 2016 https://apps.who.int/iris/bitstream/handle/10665/260137/9789241513470-eng.pdf

[60] Adapted from: GTAM *Supportive Spaces for Infant and Young Child Feeding in Emergencies* 2020 https://reliefweb.int/sites/reliefweb.int/files/resources/Suppotive%20Spaces_16Sept2020%20%28004%29.pdf

- Referrals for survivors of gender-based violence

7.11 Mother Baby Areas (MBA)[61]

Mother Baby Areas (MBA) are safe, low-stress spaces where mothers can breastfeed, rest, have snacks and water, and receive skilled individual and group counselling about breastfeeding and nutrition. MBAs provide holistic support for pregnant, lactating women and their children in emergency situations.[62]

The Mother Baby Area objectives are:

- Prevent the increase of malnutrition, morbidity and mortality rates,
- Help the family to adapt care practices to the emergency and post-emergency context,
- Improve the wellbeing of pregnant women, infants, young children and their mothers/caretakers, taking into account life experiences, past and present difficulties,
- Help families to facilitate child development and survival,
- Prevent or reduce the negative effects of unsolicited and unmonitored distributions of breast milk substitutes,
- Provide appropriate and sustainable solutions for infants for whom breastfeeding is not an option.
- Provide information and training on appropriate complementary feeding, and infant and newborn care
- Skilled assessment of the potential to breastfeed and referral to health facilities for alternative sources to breastmilk

The MBAs offer:

- Waiting area – area to welcome arrivals, explain to the mothers what will happen, offer drinks or snacks to mother, and direct mothers to activities
- A breastfeeding area – quiet, private and relaxing space for mothers to breastfeed and provide mother-to-mother support, as well as group counselling sessions
- Hygiene station for use by all caregivers as needed, including nappy changing, baby bathing, and other hygiene practices to minimize infection
- Child play area – provides mother-baby play sessions and play sessions for older children if mothers come with them (includes art supplies, blocks, and toys)
- Counselling area – for pregnant and lactating women and caregivers to receive individual counselling and support, including an assessment of mother-baby pairs, counselling on breastfeeding and relactation, counselling for non-breastfed infants, complementary feeding, and referrals if additional issues are identified.

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[61] Adapted from: GTAM *Supportive Spaces for Infant and Young Child Feeding in Emergencies* 2020 https://reliefweb.int/sites/reliefweb.int/files/resources/Suppotive%20Spaces_16Sept2020%20%28004%29.pdf

[62] ACF *Baby Friendly Spaces - Holistic Approach for Pregnant, Lactating Women and their very young children in Emergency* 2014 https://www.ennonline.net/attachments/2305/ACF_BFSManuel.2014.gb.pdf

The Mother Baby Area's main objective and line is to take care of the mother and caregiver, in order to support the care of the child. Mother Baby Areas do not only focus on breastfeeding and child feeding, although these issues are given a particular importance, considering their impact on children's survival. It is a holistic psychosocial program that aims at providing comprehensive support to children and their caregivers who face emergency situations.

MBAs can be located in a shelter or tent where appropriate space is available.

7.12 Implementation of Supportive Spaces

In an emergency context where assessments show that IYCF practices and/or maternal wellbeing are at risk and where women lack space to breastfeed comfortable or privately, where there is a disruption of health services, a lack of safe and clean playing spaces for infants and young children, reduced access to education and information, or where IYCF is deprioritized due to heavy workloads or competing priorities the implementation of supportive spaces should be considered.

It is likely NOT to be appropriate to set up new Supportive Spaces where the population is widespread or of low density or during an infectious disease outbreak such as COVID-19[63]. However existing spaces in place prior to disease outbreaks should follow public health recommendations specific to the disease, such as the strengthening of infection prevention control (IPC) measures.

Staffing

The number of staff will depend on the range of activities offered, the size of the space, number of expected users, and mobility restrictions due to security or COVID-19 guidelines. In general, 1 staff member to 15 mothers or caregivers is the maximum acceptable ratio[64].

Materials and Equipment

The materials and equipment required will be context and activity-dependent, informed by an assessment of the needs of the emergency-affected population and the cultural context[65]. Selected materials should aim to create a welcoming and familiar environment (e.g., in terms of sitting arrangements). As a preparedness measure, the pre-positioning of kits containing essential materials is recommended.

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[63] UNICEF, GNC, GTAM Infant and Young Child Feeding in the Context of COVID-19 2020 https://www.unicef.org/media/68281/file/IYCF-Programming-COVID19-Brief.pdf

[64] World Vision Women, Adolescent and Young Child-friendly Spaces (WAYCS) in Emergencies Guideline 2014 https://www.wvi.org/health/publication/women-adolescent-and-young-child-spaces

[65] Save the Children IYCF Toolkit: *MBA Checklist* https://resourcecentre.savethechildren.net/library/iycf-e-toolkit-chapter-four-annexes

Site Selection

When deciding on the number of spaces and their size, it is important to consider the size of the population, the geographical spread, safety and security. Location and opening hours should be safe and accessible with latrines located within 50 meters. Supportive Spaces should also be co-located near nutrition points, health facilities, or other relevant services. Coordination with community members and site managers is critical to ensure that the location is safe and a GBV safety audit should be completed[66].

7.13 Care Groups and Peer Support Groups

Care Groups and Peer Support Groups are volunteer, community-based groups, who regularly meet together to exchange information, provide support, and develop a sense of community.

Community level support groups are often disrupted by an emergency. It is important to re-establish community level support and build on existing community structures after the onset of an emergency. Depending on the emergency phase considerations should be taken to re-starting or establishing support groups.

Care Groups

The Care Group (CG) approach[67], a specific peer support group model and behavior change promotion approach, has proven instrumental in addressing issues of food insecurity and nutrition within many development contexts.

A Care Group is a group of 10-15 volunteer, community-based health educators who regularly meet together with project staff for training and supervision. They are different from typical peer support groups in that each volunteer is responsible for regularly visiting 10-15 of her neighbors, sharing what she has learned and facilitating behavior change at the household level. Care Groups create a multiplying effect to equitably reach every beneficiary household with interpersonal behavior change communication. They also provide the structure for a community health information system that provides nutrition screening including MUAC as well as reports on new pregnancies, births and deaths detected during home visits[68].

Care Group Gender Considerations

Both men and women should be included within the Care Group model, especially in areas where father peer to peer support groups exist and have been shown to benefit IYCF outcomes.

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[66] UNICEF GBViE Help Desk Mapping of Safety Audit Tools and Reports 2018 https://gbvguidelines.org/en/documents/safety-audits-a-how-to-guide/

[67] World Relief *A Guide to Mobilizing Community-Based Volunteer Health Educators: The Care Group Difference* 2004 https://www.mchip.net/sites/default/files/Care_Group_Manual_ENGLISH.pdf

[68] Care Groups Info Definition and Criteria. http://caregroups.info/?page_ id=35

While the Care Group Model, including trainings and guidance rely on women led care groups, evidence from other contexts have shown beneficial behaviour change when men have also been included either within the Care Group Model[69] or using a similar model such as the Father's Club model[70] using a Men's Health Group approach[71].

Therefore, implementing adapted Care Groups with male leaders who target fathers or male caregivers in the Neighbor Groups will likely have a positive impact on behaviour change in the community and once implemented this should be assessed, reviewed, and revised if required.

Care Group Delivery

Implementing partners who implement programmes based on the Care Group model have specific staff to work within the programme. A coordinator is responsible for the overall implementation of the programme and the supervisors are staff members who oversee the community level implementation including supervising four to six promoters. Promoters are community members hired by the NGO to facilitate and supervise the Care Group volunteers. The Care Group volunteers are the core of the CG model and disseminate important messages to their specific neighbourhood groups (See Figure 4 for a Typical Care Group Delivery Model).

Health Promoters

Health Promoters should be taught essential IYCF-E practices including hygiene and basic child development.

Care Group Volunteers (CGV) Selection

CGVs should be key community members who are elected by the programme participants or key community leaders. This ensures that they are in a position to share and influence social behaviour change.

CGV Training

CGVs should be trained on IYCF-E alongside hygiene and infant care practices by the health promoters who supervise and support them. Every two weeks the CGV meets with the Health Promoter to learn a new set of nutrition or health-related messages and activities.

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[69] GOAL Ethiopia *Evaluation of the "Building on Community Strengths: Identifying and Addressing the Social and Cultural Aspects of Maternal, Infant and Young Child Nutrition" Project in West Hararghe Zone of Oromiya Region, Ethiopia* https://www.fsnnetwork.org/sites/default/files/Evaluation%20of%20the%20Building%20on%20Community%20Strengths%20Project.pdf

[70] Promundo and Plan International Canada *Father's Club Manual* 2020 http://men-care.org/wp-content/uploads/sites/3/2020/04/SHOW-Fathers-Club-Manual-Jul-2020.pdf

[71] GOAL Ethiopia *Evaluation of the "Building on Community Strengths: Identifying and Addressing the Social and Cultural Aspects of Maternal, Infant and Young Child Nutrition" Project in West Hararghe Zone of Oromiya Region, Ethiopia* https://www.fsnnetwork.org/sites/default/files/Evaluation%20of%20the%20Building%20on%20Community%20Strengths%20Project.pdf

Care Group Development

Each CGV is tasked with forming 5-10 care groups in their area where each Care Group, depending on the adaptation for men's groups, has 10-16 men or women who will then relay the information in their respective social networks.

Table 10: Care Group Criteria[72]

Care Group Criteria	
Care Group Volunteer Selection	CGVs should be elected by families or caregivers within the group of households they will serve or by the leadership in the village, rather than appointed by program staff.
Care Group Size	The size of CGs, in which CGVs are trained, is between 6 and 16 CGVs to allow for participatory learning. Attendance is monitored, as low attendance rates at CG meetings is a sign that something is wrong and the organization should identify potential problems.
Frequency of Contact	CGV contact with assigned beneficiary mothers or fathers and CG meeting frequency is at least once a month (preferably twice a month) and is monitored, in order to establish trust and rapport. Meeting frequency also correlates with behavior change.
Coverage	Coverage is monitored. The plan is to reach 100% of households in the targeted group at least once monthly and the project achieves a minimum of 80% monthly coverage of targeted households. This is important as behavior change is more likely when contact is regular and when many mothers adopt the promoted practices.
Target Behaviours	The majority of what is promoted through CGs is directed towards reduction of mortality and malnutrition – this criterion was established for advocacy purposes, in order to establish the effectiveness of CGs in reducing child and maternal mortality, morbidity and malnutrition. The structure of CGs can then be adapted for other settings and topics with a different name.
Teaching Tools	CGVs use visual teaching tools, such as flipcharts and IYCF Counseling Cards
Participatory Methods of Social Behavior Change (SBC)	These are used with CGVs and by CGVs in community, as they are proven to be more effective than more formal methods when teaching adults.
Instructional Time	CG meeting time is limited to 1-2 hours, to respect CGVs' time and to limit requests for financial compensation

[72] Adapted from Davis TP, Wetzel C. Establishing Care Group Criteria. 2009 http://caregroupinfo.org/docs/Care_Group_Criteria_November_12_2010.pdf

Supervision	Supervision of Promoters and at least one CGV (data collection, observation of skills) occurs at least monthly, to receive feedback and support
Distance	All beneficiaries live within a distance that facilitates frequent home visitation by their CGV. This is to facilitate household visits and to increase the likelihood that the CGV has a prior relationship with the people she is serving. All CGVs should also live less than an hour walk from the location of CG training meetings with the Promoter.
Program Culture	The program culture should convey respect for the beneficiaries and CGVs, especially women, as an important part of the model is fostering the empowerment of women.

Peer Support groups

Peer Support Groups including Mother Support Groups, Mother to mother support groups (MtMsg) and Father to Father support groups (FtFsg) are groups that gather to support families to discuss good childcare practices and to promote improved behaviours with regards to breastfeeding, complementary feeding, diet diversity and other IYCF behaviours.

Mother to Mother Support Groups (MtMSG)

A mother-to-mother support group is a meeting where pregnant women and mothers with young children, as well as other people with similar interests, come together in a safe place to exchange ideas, share experiences, give and receive information, and at the same time, offer and receive support in breastfeeding, child rearing, and women's health. Within the group mothers and caregivers support each other as they care for children ages 0–2 years. One member of each group acts as a facilitator, called a Lead Mother, and is trained on IYCF, as well as on basic group facilitation techniques. The group facilitator is generally a mother from the community itself and is responsible for engaging group members in discussion about IYCF and providing basic health education in an interactive, participatory manner.

To maximize the effectiveness and sustainability of such groups, mobilization efforts should focus on identifying and recruiting existing community groups with women members instead of forming entirely new groups. For example, this can be groups that regularly gather in a Women's Friendly Space (WFS). Groups should be recruited based on their interest in IYCF and their regular meeting times, as well as their ability to identify one key member who can undergo training on IYCF.

Possible groups for mobilization include:
- Women's groups
- Church groups
- Married adolescent groups
- Breastfeeding groups
- Groups for preventing mother-to-child transmission (PMTCT) of HIV

• Groups for people living with HIV/AIDS (PLHA)
• Youth groups
• School clubs

Using the *Guidelines for Facilitating Community- based Support Group Meetings on Infant and Young Child Feeding*[73] and relevant counselling cards, the facilitator conducts a series of 12 meetings on specific topics where registered mothers attend each meeting until they graduate the group at the end of the series.

Father to Father Support Group(s)

Men and women have a shared responsibility to prevent child undernutrition. As head of the household, men play an important role in ensuring that pregnant women have access to the right foods. After a child is born, to ensure proper growth, men can ensure that young children are fed properly, which includes frequent meals, adequate quantity and density of food, diverse foods, and continued breastfeeding.

FtFSGs are designed in the same way as MtMSGs. They are community based and have a trained, lead father who is the father of a breastfed infant. Fathers are recruited then trained to give breastfeeding and parenting information to other fathers.

Table: Peer support Group Criteria

Mother to Mother and Father to Father Support Group Criteria	
Lead mothers and lead fathers	Lead mother and lead fathers should be trained in facilitation of peer support groups. They should be mothers and fathers of breastfed children themselves. The responsibilities of the lead mother and father are to (1) identify future participants, (2) prepare for the topic of the meeting (3) invite participants to the meeting.
Group Size and composition	Groups to have 8 to 15 participants who are mother or fathers of infants or children 0-2 years old or who are pregnant or who have a pregnant wife and other interested people. The group is open, allowing for new members. Group is monitored, as low attendance rates is a sign that something is wrong and the organization should identify potential problems. It is important that MtMSGs and FtFSGs are based on a sense of trust, acceptance, self-worth, value, and respect. When the group members feel respected and valued then information is easier to share, it is easier to learn new skills, and a feeling of connection is developed amongst the participants.

[73] https://www.aliveandthrive.org/sites/default/files/attachments/Guidelines-for-facilitating-a-community-based-support-group-meeting-on-IYCF.pdf

Frequency of Contact	Meeting is at least once a month (preferably twice a month) and is monitored, in order to establish trust and rapport. Meeting frequency also correlates with behavior change.
Coverage	Coverage is monitored. The plan is to reach 100% of households in the targeted group at least once monthly and the project achieves a minimum of 80% monthly coverage of targeted households. This is important as behavior change is more likely when contact is regular and when many mothers and fathers adopt the promoted practices.
Target Behaviours	The majority of what is promoted through peer support groups is directed towards increasing optimal IYCF practices. The group can be open, where the participants discuss topics meaningful to them or there can be a meeting rotation where a topic is focused on in each session for example: (1) maternal nutrition and pregnancy, (2) early initiation of and exclusive breastfeeding, (3) complementary feeding, (4) family planning and birth spacing.
Teaching Tools	Lead mothers and fathers use visual teaching tools, such as flipcharts and IYCF Counseling Cards
Participatory Methods of Social Behavior Change (SBC)	It is important for the group to be participatory and engaging, as this method proven to be more effective than more formal methods when teaching adults. Is not a LECTURE or CLASS. All participants play an active role. It is important to focus on peer communication. In this way all participants can express their ideas, knowledge, and doubts, share experiences and receive and give support to the other mothers or fathers who make up the group.
Instructional Time	Timing of the FtFSGs should not interfere with the primary activities of the members (market days, distribution, work schedules, etc.). Meeting time is limited to 1-2 hours.
Supervision	Supervision of Promoters and at least one lead mother or father (data collection, observation of skills) occurs at least monthly, to receive feedback and support
Location and Distance	If it is a home, it should not be more than 15– 25 minutes walking distance from the homes of members. If the community is spread out, community areas, Child Friendly Space (CFS) or school could be a good alternative. The place should be private and safe so that members can bring their children.
Program Culture	The program culture should convey respect for the participants, especially women, as an important part of the model is fostering the empowerment of women.

8. Technical Breastfeeding Support

Initial breastfeeding support and counselling can help prevent breastfeeding challenges and create an environment where challenges are caught early to prevent the development of infections and other challenges.

Initial counselling on early and exclusive breastfeeding, myths and misconceptions, hunger cues, positioning and attachment and mother's concerns should take place as soon as initial contact with the mother or caregiver is made, most preferably during ANC appointments in pregnancy. Ensure that anytime a child comes in with a feeding challenge that the IYCF Focal point also follows up with the mother's health, including breast health, as often the focus is on the child and further breastfeeding challenges might not be identified.

The IYCF Focal point who is trained to conduct a Full Assessment in the SC or OTP should be trained using the WHO and UNICEF *Infant and Young Child Feeding Counselling: An Integrated Course*[74]. It should be within their job description to be able to provide counselling and support for breastfeeding challenges and should know and understand referral pathways in case of further medical support.

Further information on specific breastfeeding challenges can be found in the WHO and UNICEF *Infant and Young Child Feeding Counselling: An Integrated Course*[75] IYCF Counselling for Breastfeeding Challenges is taught in Session 20, Breast Conditions.

8.1 How Breastfeeding Practices Change in an Emergency

Emergency situations can seriously threaten breastfeeding practices and consequently child nutrition, health and survival. Misconceptions of mothers, community members and those involved in the relief effort about the effects of trauma, stress and maternal malnutrition on breast milk may reduce a mother's confidence in her ability to breastfeed. Though a woman's ability to produce breast milk is not affected by a stressful situation, her body's capacity to 'let down' milk can be impaired by stress. The inability of the mother to let down can interfere with effective suckling and further reduce her confidence. A lack of privacy in shelters or camp settings may restrict a mother's ability to comfortably breastfeed and heighten her stress level. As well, post-traumatic stress, illness, sexual violence and severe depression – all potentially elevated during emergency settings – may cause mothers, to reject their infants or the act of breastfeeding.

Time constraints may also be heightened during emergency settings and undermine breastfeeding. Women who must travel long distances, queue in long lines for food, water and fuel rations, and carry rations back to communities may be unable to travel with their infants. This interferes with on-demand and frequent feeding necessary to maintain breast milk supply. These activities also restrict the time the mothers can dedicate to appropriate breastfeeding and care of their children. Lastly, the unregulated distribution of breast milk substitutes (BMS), which

[74] WHO and UNICEF *Infant and Young Child Feeding Counselling: An Integrated Course* 2006 https://www.who.int/nutrition/publications/IYCF_Participants_Manual.pdf
[75] Ibid

includes powdered milk provided in food rations, may also undermine women's efforts to breastfeed.

Mothers have the right to specialist support to reinforce and restore their confidence and capacity to breastfeed their children. Given the unique challenges and heightened risks in emergency situations, specific and extra efforts must be taken to ensure that breastfeeding is protected and promoted.

8.2 Cracked Nipples

Sore or cracked nipples is the most common breastfeeding challenge, especially with the first breastfeeding child or soon after birth. While sore or cracked nipples can be common it is not necessarily normal and shows signs that additional support is required.

The most common signs of sore or cracked nipples are breast and nipple pain often with cracks across top of nipple or around base of the nipple. The nipples may bleed or show signs of infection. There is no reason to avoid or decrease breastfeeding. If one nipple is too sore for the mother to breastfeed from that particular breast she can breastfeed from other unaffected breast and hand express into a boiled, clean cup and feed it to the child after the child is finished feeding from the unaffected breast.

Early detection and support for sore or cracked nipples is key to preventing additional challenges like engorgement, mastitis or malnutrition. One to one counselling by an IYCF Focal point should take place.

To prevent sore or cracked nipples counsel on what good positioning and attachment looks like and encourage the mother not to use soap or creams on the nipples or to use teats with the infant. Not only are teats unhygienic and can lead to malnutrition but they can also cause the infant to attach to the breast differently than if they were exclusively breastfed, which may cause sore or cracked nipples.

When counselling a mother or caregiver on sore or cracked nipples encourage them to continue to breastfeed. Stopping breastfeeding or reducing the number of feeds can cause engorgement and mastitis. Observe the breastfeed using the B-R-E-A-S-T Feeding Observation Form (See Section 7.1: Observing a Breastfeed).

Identify potential challenges with positioning and attachment.

- Ensure that the child is facing toward the mother, the mother brings the child to the breast rather than the breast to the child and that the child attaches to the nipple with a wide, open mouth with the chin touching the breast. When counselling a mother on positioning and attachment provide encouragement and support. If the child needs to be

repositioned show the mother how to release the suction by putting a clean finger into the side of the child's mouth before removing the child from the breast.

- Ensure that the mother is in a comfortable position before beginning the breastfeed. If the mother brings the child to the breast and then moves herself into a comfortable position this can change the baby's attachment at the breast and can cause sore or cracked nipples.
- Suggest to the mother not to wash her breasts more than once a day and not to use soap or rub hard with a towel. Washing removes natural oils from the skin and makes soreness more likely. Do not recommend medicated lotions and ointments because these can irritate the skin.
- Suggest that after feeding she rubs a little expressed breast milk over the nipple and areola with her finger. This promotes healing.

8.3 Candida Infection (Thrush)

The second commonest cause of sore nipples is infection with candida, also known as 'thrush'. Candida infection can make the skin sore and itchy.

Candida infections often follow the use of antibiotics to treat mastitis and other infections.

Symptoms

Some mothers describe a burning or stinging which continues after a feed. Sometimes the pain shoots deep into the breast. A mother may say that it feels as though needles are being driven into her breast.

Candida should be suspected if sore nipples persist even when the baby's attachment is good.

Candida will usually affect both mother and infant at the same time. Check the baby for thrush. He may have white patches inside his cheeks or on his tongue that does not go away or bleeds when wiped with a cloth. The infant may have a rash on his bottom that is red and bumpy and has a smell similar to yeast.

It is important to treat both the mother and the baby with nystatin in all cases of suspected thrush even if only one is showing symptoms. Treatment of one without the other may allow for the infection to pass back and forth even after treatment.

For women who are living with HIV and AIDS it is particularly important to treat breast thrush and oral thrush in the infant promptly.

Table 11: Treatment of Candida of the Breast[76]

Treatment of Candida	
Mother or Caregiver	Nystatin cream 100,000 IU/g: Apply to nipples 4 times daily after breastfeeds. Continue to apply for 7 days after lesions have healed.
Infant	Nystatin suspension 100,000 IU/ml: Apply 1 ml by dropper to child's mouth 4 times daily after breastfeeds for 7 days, or as long as mother is being treated.

8.4 Engorgement

Breasts may become engorged if:

- There has been a delay in starting breastfeeding after birth.
- There is poor attachment to the breast, so breastmilk is not removed effectively.
- There is infrequent removal of milk, for example if breastfeeding is not on demand.
- The length of breastfeeds are restricted

Engorgement may be prevented by letting babies feed as soon as possible after delivery, making sure the baby is well positioned and attached to the breast and encouraging unrestricted breastfeeding. Milk does not then build up in the breast.

Engorgement is caused by a build-up of milk, blood, and other fluids in the breast tissue. Soon after the infant is born a mother may find that her breasts become larger and feel heavy, warmer, and uncomfortable when as the more mature breastmilk is produced. This is commonly usually about 2–6 days after the infant is born. This is a normal occurrence, and it does not affect milk-flow, but it may affect the ability of the baby to attach to the breast. With engorgement a mother's breasts can become very hard, swollen, tender, and her nipples become flattened and taut if she is very engorged. It can be painful for the mother and may make it difficult for a baby to attach to the breast if the breast is very engorged.

If a mother comes to the IYCF focal point, there are ways to support her through engorgement with counselling and practical support.

There are methods of prevention of engorgement and ways to minimize the effects if engorgement does happen:

- Early initiation of breastfeeding. Breastfeeding as soon after the birth as possible, and as often as possible after that. Ideally 8-12 times in 24 hours including through the night.
- Ensure that the baby is positioned and attached well.

[76] WHO and UNICEF *Infant and Young Child Feeding Counselling: An Integrated Course* 2006 https://www.who.int/nutrition/publications/IYCF_Participants_Manual.pdf

- Encourage the mother to breastfeed as soon as the infant shows signs of hunger. Remind the mother that crying is a late hunger cue. If the baby sleeps more than two to three hours during the day, or four hours at night, wake the infant to breastfeed.
- Remind the mother or caregiver to allowing the baby to complete breastfeeding before switching to the alternative breast. Allow the infant to fall asleep or come off the breast on their own. There is no need to limit the baby's time for breastfeeding.

There is no reason to stop breastfeeding during engorgement, frequent nursing should be encouraged. If breastfeeding is too painful for the mother encourage her to breastfeed on the least painful breast and hand express breastmilk from the affected breast. This milk can be expressed into a boiled, clean cup and given to the infant.

If the breast is very engorged and the infant is having difficulty attaching to the breast teach the mother how to hand express to soften the breast to allow the infant to attach. The hand expressed milk can be given to the infant after the breastfeed.

Additional suggestions for dealing with the discomfort of engorgement include:

Gentle breast massages
With the palm of your hand, start from the top of your chest (just below your collar bone) and gently stroke the breast downward in a circular motion toward the nipple. This may be more effective when done in the shower or while leaning over a basin of warm water and splashing water over the breasts.

Warm compresses and massage
Some mothers find that applying a warm, moist compress, and expressing some milk just before feeding helps to relieve engorgement. Using heat for too long will increase swelling and inflammation, so it is best to keep it brief.

Request the mother to return to the IYCF Focal Point if:
- Engorgement is not relieved by any of the above comfort measures.
- The mother begins experiencing symptoms of mastitis: fever of greater than 100.6°F (38.1°C), red/painful/swollen breast(s), chills, "flu-like" symptoms.
- The baby is unable to attach to the breast or is unable to or refusing to breastfeed.
- The infant is losing weight or showing signs of dehydration, for example not having enough wet and soiled diapers in a day

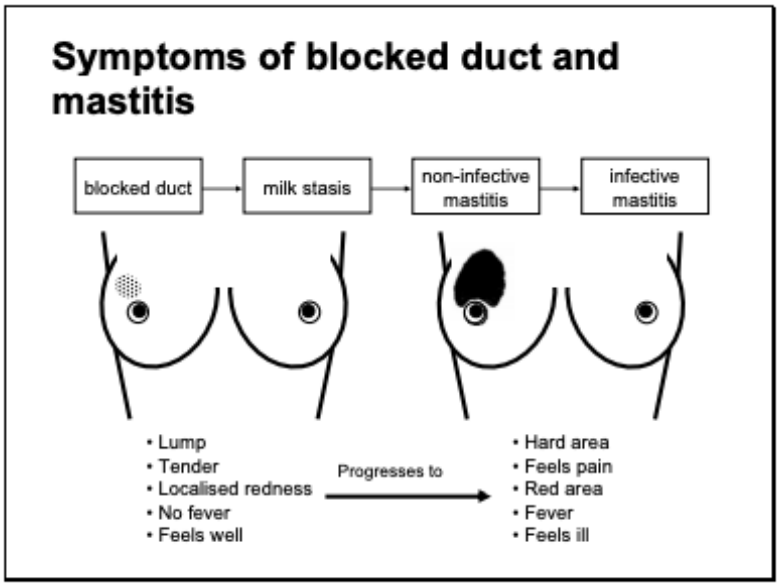
8.5 Blocked ducts

- Sore or cracked nipples and subsequent reduction of feeding may cause the milk ducts to become blocked or clogged. This will feel like a sore or bruise on the breast and it may be possible to feel a small lump in the breast where the clog is located. Support the

mother to use a warm compress and hand expression to remove the clog. Show the mother various positions to feed the baby, this can also help to remove the clog.

- Encourage the mother to follow-up with the Health Worker if the situation doesn't improve in 24 hours or if it becomes worse. The IYCF Focal Point should ensure follow-up to avoid worsening of the situation.

Figure 4: Symptoms of Blocked Duct and Mastitis[77]



8.6 Mastitis

Mastitis is a painful infection of the breast tissue that is often accompanied by fever and flu-like symptoms. The possible causes are a blocked milk duct or bacteria entering the breast. It most commonly occurs within the first three months of breast-feeding but can happen at anytime. Symptoms include breast pain, swelling, warmth, fever and chills. For treatment antibiotics are commonly required and mild pain relievers can help with discomfort. See Box 12 for Mastitis Treatment Protocol.

The most important part of treatment is to improve the drainage of milk from the affected part of the breast. Stopping breastfeeding is not recommended unless the mother is HIV positive.[78] See section 11.5.1 for guidance on Mastitis for Women Living with HIV.

Look for a cause of poor drainage, and correct it:

- Look for poor attachment

[77] WHO and UNICEF *Infant and Young Child Feeding Counselling: An Integrated Course* 2006 https://www.who.int/nutrition/publications/IYCF_Participants_Manual.pdf

[78] WHO and UNICEF *Infant and Young Child Feeding Counselling: An Integrated Course* 2006 https://www.who.int/nutrition/publications/IYCF_Participants_Manual.pdf

- Look for pressure from clothes, usually a tight bra
- Notice what the mother does with her fingers as she breastfeeds. Does she hold the areola, and possibly block milk flow?

Whether or not you find a cause, advise the mother to do these things:

- Breastfeed frequently. The best way is to rest with her baby, so that she can respond to the infant and breastfeed when the infant wants.
- Gently massage the breast while the baby is suckling.
- During counselling, show the mother how to massage over the blocked area, and over the duct that leads from the blocked area, right down to the nipple. This helps to remove the block from the duct.
- There may be a plug of thick material that comes out with her milk. *(It is safe for the baby to swallow the plug, this is the plug of milk and other tissue from the clogged duct)*.
- Apply warm compresses to her breast between feeds.

Sometimes it is helpful to do the following:

- Start the feed on the unaffected breast. This may help if pain seems to be preventing the oxytocin reflex. Change to the affected breast after the reflex starts working.
- Breastfeed the baby in different positions at different feeds. This helps to remove milk from different parts of the breast more equally. Show the mother how to hold her baby in the underarm position, or how to lie down to feed him, instead of holding him across the front at every feed. However, do not make her breastfeed in a position that is uncomfortable for her.
- Sometimes a mother is unwilling to feed her baby from the affected breast, especially if it is very painful. Sometimes a baby refuses to feed from an infected breast, possibly because the taste of the milk changes. In these situations, it is necessary to express the milk. If the milk stays in the breast, an abscess is more likely.

Usually, blocked duct or mastitis improves within a day when drainage to that part of the breast improves. However, a mother needs additional treatment if there are any of the following:

- Severe symptoms when you first see her

And/Or

- A fissure, through which bacteria can enter

And/Or

- No improvement after 24 hours of improved drainage.

If any of the above are observed, refer her for antibiotic, analgesics, and rest. See Table 12: Antibiotic Treatment for Infective Mastitis.

Table 12: Antibiotic Treatment for Infective Mastitis[79]

Antibiotic Treatment for Infective Mastitis		
The commonest bacterium found in breast abscess is Staphylococcus aureus. Therefore, it is necessary to treat breast infections with a penicillinase-resistant antibiotic such as either flucloxacillin or erythromycin.		
Drug	**Dose**	**Instructions**
Flucloxacillin	250 mg orally 6 hourly for 7-10 days	Take dose at least 30 minutes before food
Erythromycin	250-500 mg orally 6 hourly for 7-10 days	Take dose 2 hours after food

Treatment of mastitis in a woman living with HIV or AIDS[80]

For a woman who is living with HIV or AIDS, mastitis or nipple fissure (especially if bleeding or oozing) may increase the risk of HIV transmission. Therefore, the recommendation to increase the frequency and duration of feeds in mastitis is not appropriate.

She should avoid breastfeeding from the affected side while the condition persists. It is the same if she develops an abscess. She must express milk from the affected breast, to ensure adequate removal of milk. This is essential to prevent the condition becoming worse, to help the breast recover and to maintain milk production.

The health worker should help her to ensure she is able to express milk effectively. If only one breast is affected, the infant can feed from the unaffected side, and feeding more often and for longer increases milk production. Most infants get enough milk from one breast. The infant can feed from the affected breast again when it has recovered.

If both breasts are affected, she will not be able to feed from either side. The mother will need to express her milk from both breasts. Breastfeeding can resume when the breasts have recovered. The health worker may need to discuss other feeding options for her to use in the meantime.

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[79] WHO and UNICEF *Infant and Young Child Feeding Counselling: An Integrated Course* 2006 https://www.who.int/nutrition/publications/IYCF_Participants_Manual.pdf

[80] WHO BFHI *Baby-friendly Hospital Initiative training course for maternity staff* https://www.who.int/publications/i/item/9789240008915

The mother can feed the baby with her expressed breast milk, if she is able to heat-treat the milk or she can give commercial formula. Please refer her to an appropriate health-care provider for antibiotic treatment and pain relief, and counselling about alternative methods of feeding. Sometimes a woman may decide to stop breastfeeding, if she is able to give another form of milk safely. She should continue to express enough milk to allow her breasts to recover and stay healthy until milk production ceases.

If the mother is unable to breastfeed from both breasts, the IYCF Focal Point will need to discuss other feeding options for her to give meanwhile including a wetnurse or temporary use of BMS *(See Section 1.9.3 for further information on temporary use of BMS).* When temporary BMS is used, ensure that the mother continues to hand express to remove breastmilk and maintain breastmilk supply. Once the infant is able to begin breastfeeding again relactation support may be required *(See Section 1.9.2 for further information on Relactation).*

The infant should be fed by cup, bottles should always be avoided. Give antibiotics for 10-14 days to avoid relapse. Give pain relief and suggest rest, the same treatment for all women irregardless of their HIV status. Sometimes a woman may decide to stop breastfeeding at this time, if she is able to give another form of milk safely. She should continue to express enough milk to allow her breasts to recover and to keep them healthy, until milk production ceases.

8.7 Flat, Dimpled and Inverted Nipples

Flat, dimpled, or inverted nipples are nipples that aren't raised or may dimple or retract into the areola. Most commonly a person who has flat, dimpled, or inverted nipples were born with it and it may be on one breast or both. While there may be challenges, most mothers with flat or inverted nipples can and do breastfeed successfully with counselling and support.

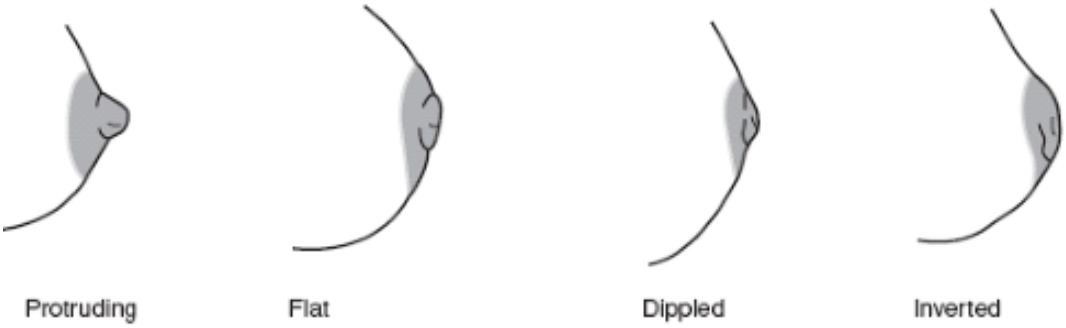
Some types of nipples can be more challenging that others and might be difficult for a baby to latch on to at first. In most cases, with counselling and support from an IYCF Focal Point, a mother will be able to breastfeed successfully. Counselling should focus on positioning and attachment rather than an 'inadequate nipple'.

When counselling a mother who has inverted or flat nipples it is important to remind her that infants breastfeed from the breast, not only the nipple itself. The infant's mouth and gums should bypass the nipple entirely and latch on to the areola.

Observation and Assessment

Figure 5: Nipple Types[81]

[81] Adapted from Huggins, K. *The nursing mother's companion* 2007



There are a variety of nipple appearances and inversions. Some nipples appear to protrude but will invert when compressed, whereas others will appear to invert but will protrude when compressed. Neither visual assessment nor self-reporting of flat nipples is adequate to determine how the nipple protracts.

The best test to identify if the nipple is able to protract is by assessing the infant at the mother's breast. **If the baby is breastfeeding well there is no need for further intervention.**

Treatment and support for breastfeeding with Flat, Dimpled or Inverted Nipples

Antenatal treatment

Antenatal treatment is not recommended. For example, stretching nipples, or wearing nipple shells or shields does not help. Most nipples improve around the time of delivery without any treatment.

At Delivery

Help is most important soon after delivery, when the baby starts breastfeeding.

- Build the mother's confidence. Explain that while it may be difficult at the beginning but the mother has access to skilled IYCF support and that with patience and support she will succeed.
- Explain that her breasts will improve and become softer in the week or two after delivery.
- Explain that a baby suckles from the breast - not from the nipple. Her baby needs to take a large mouthful of breast.
- Explain also that as her baby breastfeeds the nipple will stretch out.
- Encourage her to give plenty of skin-to-skin contact, and to let her baby explore her breasts.
- Let the baby try to attach to the breast on his own, whenever the baby is interested. Some babies learn best by themselves.
- Help the mother to position her baby If a baby does not attach well, help his mother to position the baby so that better attachment can be achieved. Give her this help early, in the first day soon after the birth.

- Sometimes putting a baby to the breast in a different position makes it easier for the baby to attach. For example, some mothers find that the underarm position or using the V-hold or C-hold during feeding helpful (see Deep Attachment Techniques below).
- Sometimes making the nipple stand out before breastfeeding through nipple stimulation or massage also helps a baby to attach. Often with inverted nipples this is enough for the infant to attach to the breast.

If a baby has difficulty suckling effectively in the first week or two, the mother can try the following:

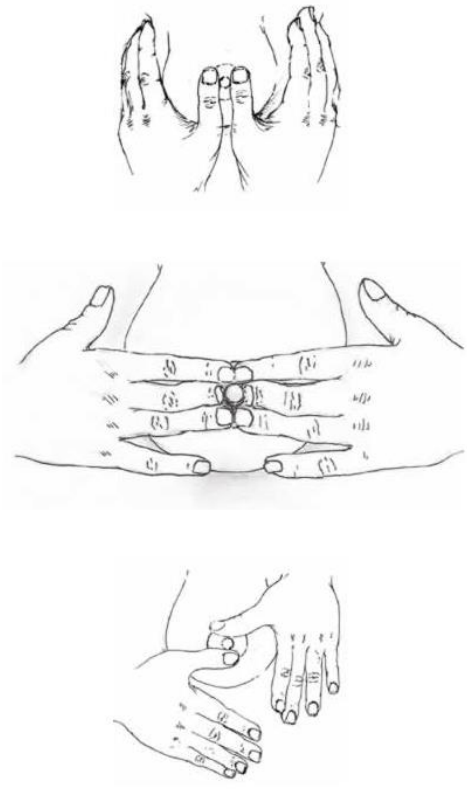
- Express her milk and feed it to her baby with a cup. Expressing milk helps to keep breasts soft, so that it is easier for the baby to attach to the breast; and it helps to keep up the supply of breast milk.
- Alternatively, she could express a little milk directly into her baby's mouth. Some mothers find that this is helpful as it can create interest for the child. The baby gets some milk straight away, so the reward is fast and the infant may be more willing to try to suckle.

Nipple massage

If the mother's nipple can be pulled out, grasp and roll the nipple between the thumb and index finger for a couple of minutes before breastfeeding to encourage the nipple to remain erect.

Reverse Pressure Softening[82]

Figure 7: Reverse Pressure Softening



For most women, gentle massage and expression are enough to soften a swollen areola to encourage the nipple to protrude further. If massage and hand expression do not soften the areola reverse pressure softening may help. Reverse Pressure Softening is often helpful in the first few weeks postpartum. Apply gentle pressure by placing the fingertips around the base of the nipple for sixty seconds to create a ring of 'dimples'. This can reduce swelling temporarily, enough to permit effective latching. It is best done immediately before breastfeeding.

Reverse pressure softening technique:

- Firmly but gently press steadily on the areola, right at the nipple base.
- Press inward toward the chest wall for a full 60 seconds or longer
- A variety of finger combinations may be used. See Figure XXX.

Deep Attachment Techniques

Shaping the breast to create more definition to the nipple may assist the baby with attachment. The mother can compress her breast and areola between two fingers and the thump to provide as much nipple as possible. Placing the hand in a C shape, V shape, or U shape (left to right in Figure 8 below), depending on the position of the baby, and pulling back toward the chest can also help the nipple to protrude.

Figure 8: Deep Attachment Techniques[83]

[82] Figure credit: Kellymom.com Kyle Cotterman *Reverse Pressure Softening*

[83] Image Credit: Boba *Nursing in a Baby Carrier* 2018

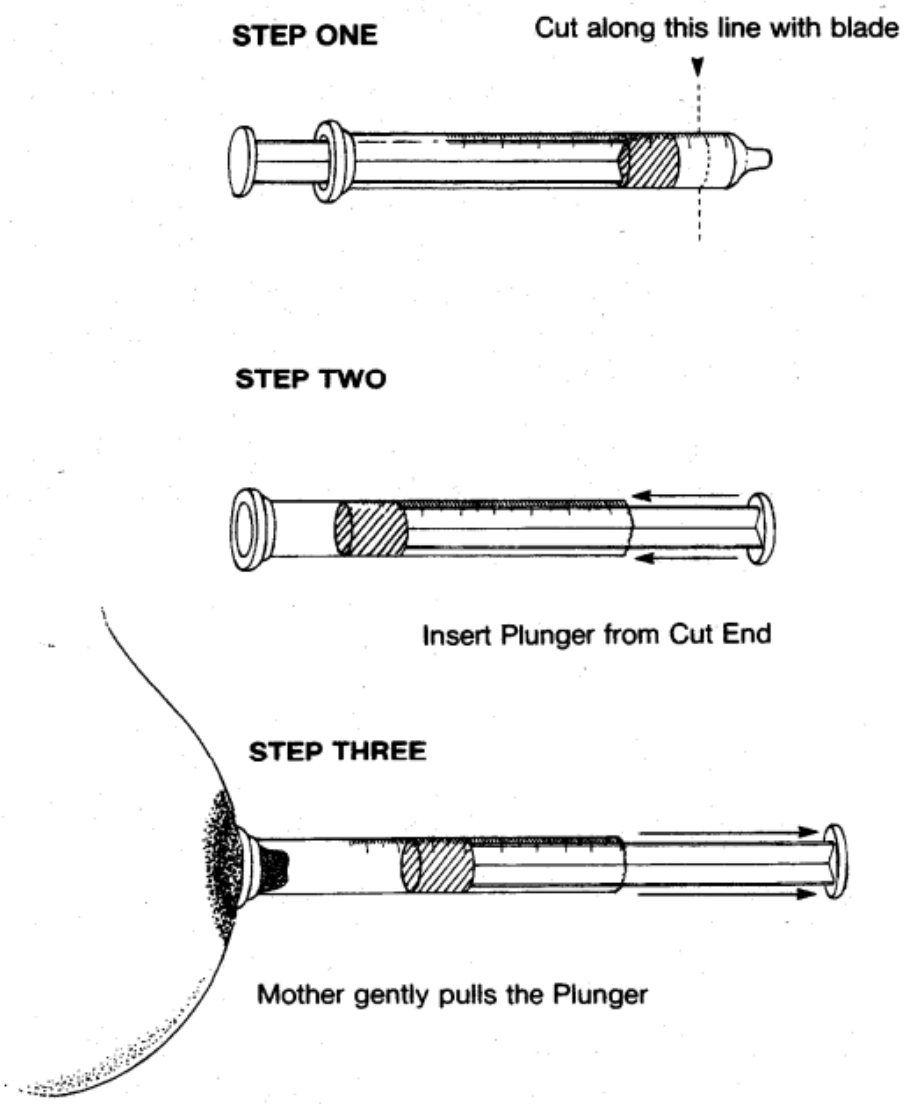
Syringe Method

In addition to massage, it is possible to syringe to assist in pulling the nipples outward. With this method, a plastic, disposable syringe is used and suction is applied. The mother can repeat this method before each breastfeed following up with the IYCF Focal Point if there is pain or no improvement.

To use a syringe on inverted nipples:

- Use a 10 ml or 20ml (in the case of larger nipples) disposable plastic syringe. Ensure that when the nipple is in the syringe there is enough room around the edge of the syringe that the nipple is not pinched or rubbing against the sides.
- Remove the plunger from the syringe and cut through the barrel of the syringe 1 mm from the nozzle (see figure 9 below).
- Turn the syringe around and insert the plunger through the cut end of the nozzle. The smooth end of the syringe should be toward the inverted nipple.
- Wet the nipple before using the syringe and place the smooth end on the inverted nipple.
- Next, gently pull the plunger out for 30 seconds to one minute to create a suction which will draw the nipple out.
- If the mother experiences pain then push the plunger inside to lessen the pressure.

Figure 9: Syringe Method[84]



[84] WHO and UNICEF *Infant and Young Child Feeding Counselling: An Integrated Course* 2006 https://www.who.int/nutrition/publications/IYCF_Participants_Manual.pdf

Chapter 9. Special Circumstances

9.1 Wetnursing

Wetnursing, or cross nursing, is when woman breastfeeds a baby to whom she did not give birth. Wet nursing is recommended in the World Health Organization/UNICEF Global Strategy on Infant and Young Child Feeding[85] and the Operational Guidance for Infant and Young Child Feeding in Emergencies[86], in situations where maternal breastfeeding is not possible and where it is culturally accepted, as is the case in parts of Sudan. It can be an essential practice that allows for infant survival if the infant is orphaned, unaccompanied, or if the mother is unable to breast feed for any reason. Even if/when a wetnurse is identified support the mother or caregiver to play with the baby, hold the baby skin to skin, bath the infant, to promote emotional bonding.

It is important to provide full counselling to the infant's family, potential wetnurse, and wetnurse's family where appropriate.

Investigate the cultural acceptability of wet nursing and availability of wet nurses in preparedness and as part of early needs assessment. Wet nursing and relactation can work together where the wet nurse provides supplemental milk until the mother has sufficient milk. Prioritize wet nurses for the youngest infants.

The wetnurse should receive the same food supplements or micronutrient supplements as other lactating women, for example, wetnurses should be included in BSFP distribution where appropriate.

Often a wetnurse:

- Is woman who is already feeding her own child
- Is known to the family, either they are a relative or neighbor

If a wetnurse is concerned about not having enough milk to feed her child and another child at the same time similar protocols to relactation can be implemented (See: Relactation 1.9.2).

- Her weight and the growth of both infants can be monitored
- She can use a supplementary suckling technique to increase her milk supply (See Relactation).

[85] World Health Organization and UNICEF *Global Strategy on Infant and Young Child Feeding* 2003: https://www.who.int/nutrition/publications/infantfeeding/9241562218/en/

[86] IFE Core Group *Operational Guidance on Infant Feeding in Emergencies (OG-IFE) version 3.0* 2017 https://www.ennonline.net/operationalguidance-v3-2017

HIV Testing and Counselling[87]

Prospective wet nurses should undergo HIV counselling and rapid testing where available. In the absence of testing, if feasible undertake HIV risk assessment (See below). If HIV risk assessment/counselling is not possible, facilitate and support wet nursing. Provide counselling on avoiding HIV infection during breastfeeding.

HIV risk assessment[88]

An HIV Risk Assessment is a process (usually a set of questions) which provides insight into the likelihood that a prospective wetnurse has been exposed to the HIV virus. A standard HIV risk assessment or score does not exist for appraisal of a prospective wetnurse. An assessment will consider HIV status of current or previous partners, practice of unprotected sex, history of sexually transmitted disease and if the woman appears to be in good health. However, even if these questions are asked, there is presently no agreed guidance on how to quantify the risk of HIV infection and what feeding practice to suggest. The decision on infant feeding practice requires a balance of risk factors that influence HIV free survival of the child. This will include consideration of the prevalence of HIV, the likely duration of wet nursing, whether the wet nurse is in good health, HIV test history (e.g. during previous pregnancy) and other factors such as the risks of not breastfeeding and the feasibility and safety of artificial feeding in this circumstance.

In Sudan the HIV Epidemic is classified as low epidemic with adult HIV prevalence of around 0.2 per cent with an incidence rate of 0.16[89] per cent in women attending antenatal clinics. An infant being wet nursed by a woman of unknown HIV status would be at low risk of HIV transmission since:

- In most settings, including Sudan, most women are HIV uninfected. This is especially true in low prevalence settings and if the woman does not engage with high-risk behaviours e.g. intravenous drug use;
- The overall duration of breastfeeding is likely to be short, weeks or a few months, and therefore the proportional risk of HIV infection is likely to be low – the risk of transmission is about 0.8 per cent/ per month of breastfeeding in the absence of all antiretroviral drugs;
- HIV-infected women who have higher risks of transmission are those with high viral load and low CD4 count. These women are likely to have been unwell and to have already presented with symptoms, and perhaps they are not even well enough to breastfeed;

[87] IFE Core Group *Operational Guidance on Infant Feeding in Emergencies (OG-IFE) version 3.0* 2017 https://www.ennonline.net/operationalguidance-v3-2017

[88] WHO *HIV and Infant Feeding in Emergencies: Operational Guidance* 2018 https://apps.who.int/iris/bitstream/handle/10665/272862/9789241550321-eng.pdf?ua=1

[89] UNAIDS Sudan Country Report 2020 https://www.unaids.org/sites/default/files/country/documents/SDN_2020_countryreport.pdf

- In most high prevalence settings (and ideally in low prevalence settings as well), pregnant women will have had an HIV test. A mother who is volunteering to wet nurse an infant in an emergency setting may know her status from some years back.

9.2 Relactation

It is possible for a woman who has previously breastfed a child, even years in the past, to relactate to exclusively breastfeed a child. This should **ALWAYS** be explored before considering a prescription for BMS.

WHO recommends exclusive breastfeeding for at least the first six months of an infant's life and continued breastfeeding with adequate complementary foods for up to two years or more. However, many infants stop breastfeeding in the first few weeks or months of life and, as a result, are at increased risk of illness, malnutrition, and death.

There are many reasons why breastfeeding might stop including cultural beliefs (e.g., Breastmilk has gone 'bad'), personal beliefs (e.g., perceived low milk supply), the death of a mother, separation of the child, temporary stopping of breastfeeding due to medication or illness, etc. In these, and other, circumstances breastfeeding it is possible for breastfeeding to re-establish or, as in the case of the death of the mother, another woman may be able to establish breastfeeding. Restarting breastfeeding after having stopped, even in the far past, is possible for a woman's own child or a child born to another mother even without further pregnancy. This is called Relactation.

Many women who relactate can produce enough milk to breastfeed an infant exclusively. It does take patience, motivation of the mother or caregiver, and trained staff for relactation to be successful.

Factors that affect the success of relactation[90]

Factors related to the infant:
The main requirement for relactation is that the infant should suckle. This can be affected by:

- The infant's willingness to suckle
- The infant's age
- The infant's breastfeeding gap (the time since the infant stopped breastfeeding)
- The infant's feeding experience during the gap
- Infant-related reasons for interrupting breastfeeding
- Gestational age (low birth weight babies)
- Infant's nutritional status (for example an infant with SAM might be less willing to suckle)

Factors related to the mother or caregiver

[90] Adapted from: WHO *Relactation Review of Experience and Recommendations for Practice* 1998 https://apps.who.int/iris/bitstream/handle/10665/65020/WHO_CHS_CAH_98.14.pdf?sequence=1

- Personal motivation
- Her lactation gap (the time since she stopped breastfeeding)
- Support from her family, community, and health workers,
- Access to a skilled and trained IYCF focal point and tools

Time it takes to relactate

The time required for breastmilk production to start can vary. It may be a few days (for example, if breastfeeding has recently stopped) or a few weeks (for example if breastfeeding was in the past with another child). But these timelines are not always the case. However, in any case there should be patience and skilled support offered for as long as the mother or caregiver desires to relactate. The more frequently the infant suckles at the breast and the more frequently the woman.

Relactation Referrals

Any infant under six months who is not exclusively breastfed should be referred to the Stabilization Center in Charge for a full assessment and possible relactation support. Any child over six months who is not breastfed should be referred to a full assessment and relactation should be explored. If relactation is recommended and/or if the mother or caregiver is motivated to relactate they should be given or referred for relactation support.

Skilled Relactation Support

All staff in the SC should be trained on relactation protocols and one IYCF Focal Point should be placed within the SC to work directly with women who are relactating.

Relactation Protocol[91]

It is essential to counsel the mother, caregiver, and other family members as appropriate to ensure that the woman relactating receives support at the household level.

Steps:

- Explain why breastmilk is the safest and best way to feed her baby and what she needs to do to start breastfeeding again. Explain that it will take patience and perseverance but that skilled support is available for her and express confidence in her ability to relactate

- Educate and describe how relactation works
    - That milk supply is based on supply and demand, the more the child feeds or suckles the more the body will create
    - Skin to skin and allowing the baby to suckle even if milk production hasn't started yet can help to promote the hormones required for making breastmilk

[91] Adapted from: WHO *Relactation Review of Experience and Recommendations for Practice* 1998 https://apps.who.int/iris/bitstream/handle/10665/65020/WHO_CHS_CAH_98.14.pdf?sequence=1 and Save the Children IYCFE Toolkit https://resourcecentre.savethechildren.net/node/12652/pdf/table_of_contents_0.pdf

- Teach relaxation techniques such a deep breathing, back massage, visualisation, and breast massage. These should only be done with consent from the mother and, especially with back massage and other physical touching, can be done with a female staff member, female family member, or husband as culturally appropriate.
    - Deep breathing: guide the mother or caregiver to take deep breaths to create a sense of calm. Breathe in for four seconds, hold for four seconds, breathe out for four seconds and hold for four seconds and repeat. This is called Box Breathing and can reduce anxiety, fear, and stress.
    - Back Massage: Massaging the upper back, shoulders and neck can release tension and create calm. Gently rub directly on the skin or over the clothes as the mother is comfortable. Continue for around 5 to 10 minutes, or for as long as the mother is comfortable.
    - Visualisation: Guide the mother or caregiver through visualisation exercises. Can she visualise the child going to school, getting married, playing, etc. Visualising peaceful and happy times can help to create a sense of calm and confidence.
    - Breast massage: This is something the mother can do for herself or, as with back massage, a female family member or staff member. Gently massage the breasts from chest to nipple. This is different from hand expression where milk is expressed from the nipple. With breast massage the intention is to stimulate the breast tissue, not to express milk. Continue this for 5 to 10 minutes, or for as long as the mother is comfortable, for both breasts.

- It is important to build confidence. Help her feel like she can produce enough breastmilk for the baby. **She should be seen by the IYCF focal point at least twice a day.** Any concerns or worries should be addressed though counselling.

- Ensure she has enough to eat and drink. Many breastfeeding women, even those who are not relactating, worry about their diet. Ensuring that she has at least one supplemental meal a day can help to build her confidence.
    - In many contexts there is a belief that certain foods like oats, grains, etc. can help build breastmilk supply. While this is not proven it is thought that the feelings of confidence a woman has by consuming these foods may create a sense of relaxation and therefore her supply may increase. These foods, however, should not be promoted as creating more breastmilk but feeding the mother does help to feed the child.

- Relactation takes time. Encourage the mother to keep the baby near her and give skin to skin contact. Counsel the family to support the mother or caregiver with household duties and chores to ensure she can rest and focus on the relactation.

- Explain to the mother or caregiver to put the child to the breast whenever the child is

fussy, unsettled, seems hungry, etc. even at night. The child should aim to suckle at the breast at least 10 to 12 times during the day for as long as the child desires.

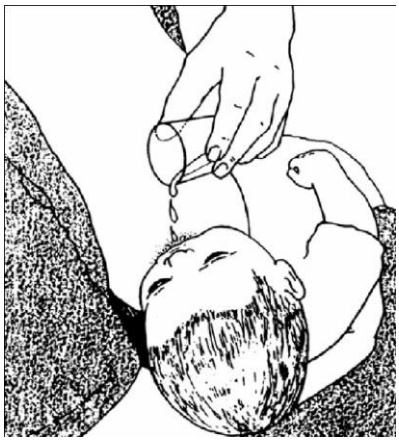
- She can offer her breast every two hours
  - She should let him suckle whenever he seems interested
  - She should let him suckle longer than before at each breast
  - She should keep him with her and breastfeed at night
  - Sometimes it is easiest to get a baby to suckle when he is sleepy
  - Ensure attachment and positioning is optimum to encourage milk production.

Providing other milk until relactation is established

If an infant is admitted for acute malnutrition and the mother or caregiver is still producing breastmilk, is motivated to relactate, must give other milks including F75 or F100 in the case of acute malnutrition or Donated breastmilk from a wetnurse, or a BMS prescription if it is provided. The Drip Drop method or a Supplemental Suckling Technique can be used to ensure the breastmilk supply does not decrease, that the child still gets the benefits of breastmilk while also receiving the therapeutic milk, donor milk, or BMS. The IYCF Focal Point should be trained and educated on the use of this technique.

- Discuss how to give other milk feeds, while she waits for her breastmilk to flow, and how to reduce the other milk as her milk increases.
- Show her how to give the other feeds from a cup, not from a bottle. She should not use a pacifier.

Figure 10: Drip – drop Method



Drip Drop method (See Figure 10)
As the baby is attached to the breast, with a syringe or cup milk is dropped on to the breast dripping down to the nipple to encourage the baby to suckle

The drip drop method may be most appropriate for home settings as it doesn't require sterilization of specialist equipment

Supplemental Suckling Technique (See Box 11)
One end of a nasogastric tube, gauze 5 or 8 is taped next to the nipple, while other end is in a cup with milk supplement.

As baby suckles the child will receive the milk from the cup as well as any milk being produced. Even if no breastmilk is being produced suckling with the supplemental suckling technique can stimulate breastmilk production

SUPPLEMENTARY SUCKLING TECHNIQUE (SST)

• Explain to the mother what you propose to do. If she is not motivated, explain more, let her speak to other mothers who have used this technique and ask her if you can show her once to let her see
• Wash your hands and ask the mother to wash her breasts and hands
• Tape an NG Tube n°5 or n°8, the tip cut off, with the tip next to the nipple of the mother
• Put the right quantity of F-100 Diluted in a cup, and place the other end of the NGT (open) in the cup
• First an assistant holds the cup about 10 cm lower than the breast, and the child is offered the breast. When the child suckles, the milk is sucked from the cup. When the mother is used to the technique, she can hold the cup herself
• It may take the child 1 or 2 days to adjust to feeding by the tube. Sometimes the child notices the difference between the taste of the breast milk and the F-100 and rejects the tub feeding initially, however it is important to persevere.
• After use, the tube is cleaned with clean water & a syringe, then spun to dry

Box 11: Supplementary Suckling Technique

Relactating for an acutely malnourished child

If a mother or caregiver is relactating for an infant receiving inpatient treatment for acute malnutrition. Continue to use F75 or F100 according to clinical protocols. Once the child is able to be discharged only then begin to reduce supplementary feeds, always adhere to clinical protocols for inpatient treatment.

Relactating using expressed milk or donated breastmilk

If the mother or caregiver is relactating using expressed milk or donated breastmilk breastfeed on demand for the child using the supplemental suckling technique or drip drop method and monitor child's weight gain and urine output.

Relactating using BMS

If the infant is not getting enough and expressed breastmilk is not available it may be necessary for temporary use of BMS to be prescribed. If BMS is prescribed prepare an entire feed according to the directions on the container as directed by the IYCF Focal Point who provided the prescription.

Allow the infant to suckle in between feeds to encourage relactation. If it is noticed that milk has begun to be produced through hand expression or by the baby being satisfied with just breastmilk alone, then a decrease of 10ml per feed can begin.

Throughout the day, with each BMS feed that is prepared decrease by 10ml, ensuring appropriate preparation of the feed- the correct BMS to water ratio.

If the infant seems satisfied with this then decrease by 10ml per feed again after a few days. Continue to observe the child.

If the child seems satisfied after each meal, shows no signs of hunger and/or gains weight of more than 125 g/week; If the infant remains satisfied, decrease again by 10ml per feed again after a few days.

Keep reducing the supplement until it can be stopped completely. Follow the mother/caretaker and child closely once supplements are stopped to ensure the child remains in good health.

If you can see that the infant is not getting enough then do not reduce the BMS feed for a few days and, if necessary, increase the amount of BMS for a few days. Continue to hand express, massage the breasts and using relaxation techniques.

If more than eight weeks goes by without success or if the mother or caregiver decides to stop relactating, then other alternatives must be considered such as finding a wetnurse or, as a very last option, a long term BMS prescription.

9.3 Infant Feeding in the Context of HIV[92]

There can be specific challenges associated with HIV in emergency setting. Crises change risk profiles, and the relative risks and acceptability of various feeding practices among mothers and communities therefore need to be re-evaluated. For example, replacement feeding may become much more dangerous. Infants established on replacement feeding pre-crisis will need urgent identification and support to minimize risks.

Additionally, Girls and women may be especially vulnerable and at additional risk of HIV infection, with the implication that there may be more new infections and thus the potential for increased mother-to-child transmission (MTCT), especially if testing is unavailable or unacceptable.

• The fear of HIV transmission among families and health staff may result in inappropriate responses, including avoiding breastfeeding in the absence of testing, and demand for, or offers of, infant formula milk, with implications for child health.

Guiding Principles for Infant Feeding in the Context of HIV

[92] UNICEF and WHO (2018) *HIV and Infant Feeding in Emergencies: Operational Guidance* https://apps.who.int/iris/bitstream/handle/10665/272862/9789241550321-eng.pdf?ua=1

Start antiretroviral (ARV) treatment during pregnancy. Mothers known to be HIV positive should be provided with lifelong ART if eligible or ARV prophylaxis to reduce HIV transmission through pregnancy, labour, delivery and breastfeeding.

Health workers should counsel women during pregnancy as to their infant feeding options, the benefits and management of breastfeeding, MTCT and the importance of adhering to ARV regimen.

- **Mothers living with HIV** (and whose infants are HIV uninfected or of unknown HIV status) should exclusively breastfeed their infants for the first 6 months of life, introducing appropriate complementary foods thereafter, and continue breastfeeding for at least 12 months and up to 24 months or longer, while being fully supported for ART adherence. Breastfeeding should then only stop once a nutritionally adequate and safe diet without breast milk can be provided.
- **Start breastfeeding within 1 hour of birth for all infants**. Pay particular attention to the positioning and attachment to prevent conditions such as cracked nipples and mastitis which increases the risk of HIV transmissions.
- **Start the baby on Nevirapine (NVP) prophylaxis from birth**. For infants born to HIV positive mothers who received ARV prophylaxis and are breastfeeding, NVP prophylaxis should be given from birth until 1 week after cessation of breastfeeding. For infants born to HIV positive mother who are on ART during the entire period of breastfeeding NVP prophylaxis should be given until 6 weeks of age.
- **Test the infant for HIV infection by 6 weeks of age.** All infants who are HIV positive should be referred to ART clinic and started on ARV's. If the test result is Negative and the child breastfed in 6 weeks of the test, a 2nd DNA PCR test should be done 6 weeks after cessation of breastfeeding.
- **Breastfeed exclusively all infants from 0– 5 months.**
- **Give complementary foods to all children starting at 6 months of age**.
- For **HIV- negative infants**, continue breastfeeding for 2 years or beyond.
- For **infants living with HIV** continue BF until the infant is 12 months old. After 12 months, BF should be stopped only if nutritionally adequate and safe diet, which includes source of milk can be provided.

What to feed infants when mothers stop breastfeeding

When mothers known to be living with HIV decide to stop breastfeeding at any time, infants should be provided with safe and adequate replacement feeds to enable normal growth and development.

Alternatives to breastfeeding include:

For infants less than 6 months of age:

- commercial infant formula milk, as long as the home conditions outlined next are fulfilled;
- expressed, heat-treated breast milk.

Home-modified animal milk is not recommended as a replacement food in the first 6 months of life.

Conditions needed to safely formula feed

In previous global recommendations the acronym AFASS[93] was used, however, current guidance explicitly defines the conditions, using common everyday language, rather than referring to the acronym. By more carefully defining the environmental conditions that make replacement feeds a safe (or unsafe) option for HIV-exposed infants will improve HIV-free survival of infants. Such language, as that below, will likely better guide health workers regarding what to assess, and to communicate this to mothers who were considering if their home conditions would support safe replacement feeding. However, using these descriptions does not invalidate the concepts represented by AFASS.

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

- 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 the infant formula milk 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 6 months of life, exclusively give infant formula milk;
- the family is supportive of this practice;
- the mother or caregiver can access health care that offers comprehensive child health services

[93] Acceptable, Feasible, Affordable, Sustainable, Safe

9.4 Infectious Disease and Outbreak[94]

Important: During any emergency, including an outbreak, it is important that the primary objective is to **DO NO HARM** and to continue to prioritize continued breastfeeding and avoid separating the mother and child unless evidence proves otherwise.

In every emergency, including infectious disease outbreaks including Ebola, Cholera, COVID-19, it is important to assess and act to protect the nutrition needs and care of both breastfed and non-breastfed children.

It is important to ensure that appropriate infant feeding recommendations are in place. If WHO has up to date infant feeding recommendations for the infectious disease it is important to align existing national recommendations or develop new recommendations that are aligned and disseminate rapidly to all sectors.

If there is not updated infant feeding recommendations for the infectious disease it is important to develop interim infant feeding recommendations based on the best available evidence and disseminate widely to all sectors.

Practice relevant and appropriate infection prevention and control (IPC) measures including hand hygiene, facemasks, preventing nipple damage. It is important to remember that some IPC measures that might be appropriate for the general population, like physical distancing, may not be appropriate for mothers and their infants. Only interrupt breastfeeding or separate mothers and infants if there is good reason to believe that withholding breastfeeding and/or depriving infants of close contact with their mothers is justifiable. It is important to remember that breastfeeding transfers antibodies and immune protection from mother to infant that reduces the severity and duration of most infectious diseases.

Separation causes severe stress, harms mental health, impairs development, weakens breastmilk's protection against infectious diseases, carries a high risk of breastfeeding failure and places a high burden on healthcare systems. If there is evidence that separation is justifiable temporary alternatives are (1) mothers expressed breastmilk, (2) donor human milk, (3) wetnursing, and as a very last resort (4) breastmilk substitute fed by cup or spoon.

A strong multi-sectoral response is critical during all emergencies, including outbreaks[95].

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[94] IFE Core Group (2021) *Infographic Infant Feeding During Infectious Disease Outbreak* https://www.ennonline.net/ifecoregroupinfographicseries

[95] For further guidance on multi-sectoral actions see: IFE CG infographic on *Infant Feeding during Infectious Disease Outbreaks 2: A guide for decision makers and programmers working in outbreak preparedness and response* https://www.ennonline.net/ifecoregroupinfographicseries

Step 1: Anticipate and assess the impact of the outbreak on IYCF practices.

- Consider that there may be inappropriate advice from healthcare providers on breastfeeding and separation; IYCF counselling services may be disrupted; donations and uncontrolled distributions of BMS may occur; romours and unreliable information may be spread about transmission; and there may be disrupted access to healthcare

Step 2: Take action to mitigate these risks

- All sectors have a responsibility to mitigate risks
    - All actors: ensure multi-sector collaboration; actively avoid any general distributions and donations of BMS, other milk products, bottles, and teats; protect, promote and support breastfeeding in the general population

9.5 Feeding the Sick Child

It is important to continue to feed nutrition foods and to offer more fluids, including breastmilk, to a child when the child is sick.

Appropriate infant feeding during sickness is especially important as a sick child loses a lot of body fluids through increased body temperature, sweating and sometimes diarrhoea thus will need increased fluid intake. A sick child also loses a lot of energy through increased body temperature and poor appetite due to the disease itself. With specific illness such as diarrhoea, measles or pheumonia, the appetite of the child often decreases, and their body uses food less effectively.

It is also important to give a sick child more food than usual to replace the lost energy. Therefore, parents/caretakers must continue to feed and offer more fluids, including breast milk to sick children. During an illness, children need additional fluids and encouragement to eat regular meals, and breastfeeding infants need to breastfeed more often. Never force a sick child to eat. After an illness, children need to be offered more food than usual to replenish the energy and nourishment lost due to the illness.

Chapter 10. Targeted and Controlled Artificial Feeding using BMS

In emergency settings protecting, promoting, and supporting breastfeeding is a lifesaving intervention for the following reasons:

- Risks of infections are higher during emergencies: breastfeeding protects against the increased risks of infection and illness among infants during emergencies.
- Breastfeeding counselling and mother-to-mother support reinforces and renews a mother's confidence and resolve to breastfeed.

- There is a strong association between the receipt of infant milk formula donations, a change in feeding practices, and diarrhea.
- Providing infants with BMS in an emergency increases the risk of illness and mortality, as hygiene and sanitation conditions are often poor, and access to clean water and fuel are usually limited.

Only after ALL options for breastfeeding by the mother, caregiver, or through a wet nurse have been exhausted, including increasing the proportion of the diet from locally available complementary solids if the child is over six months, etc., shall the provision of BMS (e.g. infant formula) be considered.

Most mothers and children can and will breastfeed if conducive supportive environments, correct information, skilled support and positive messages are provided. However, there are cases where, for certain mothers, caregivers, and children breastfeeding is not feasible or possible at all and the health and nutritional status of these children must be safeguarded A BMS is never 'safe'; even in developed countries infants get ill and die due to not being breastfed. In emergencies where conditions are much worse the risks are even higher. It should be remembered that unlike other emergency commodities IYCF programming is endeavoring to reduce the number of infants requiring the use of a Breastmilk Substitute. Relactation, wet nursing, or using donor human milk , should all be priority solutions to feeding the non-breastfed child and programming should be in place to support this.

The aim of a BMS program is to ensure that assessed and targeted infants receive the supplies and support that they need while not undermining breastfeeding in the general community.

Box 12: Guiding principles for BMS[96]

Guiding principles for BMS

A general distribution should NEVER include breast-milk substitutes or any other milk products.

Distributions, including baby kits or neonatal kits, should never contain infant formula or bottles or teats

Organizations must NEVER accept unsolicited donations of ANY milk products (infant formula or other powdered milk products, long life milk, dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed milk, soya milks, evaporated or condensed milk, fermented milk or yogurt.)

Instead, interventions to support artificial feeding should budget for the purchase of BMS supplies along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation, staff training, and skilled personnel.

Infant formula prescriptions will only be accepted if based on a full infant feeding needs assessment by trained health personnel using established and agreed criteria and the prescription of infant formula supplementation is supported through the appropriate approval chains

10.1 Assessing the Need

The decision to implement a BMS programme should be supported by needs assessments which demonstrate IYCF practices at the time of the emergency. The type of assessment carried out and thus the level of detail produced should be appropriate for the phase of the emergency. It is recommended to use the standardised IYCF Assessment Tools, available on the Nutrition Cluster website.

Initial rapid assessments (e.g. following sudden displacement) should look for "alerts" indicating risk to infant & young child feeding practices (e.g. reports of mothers stopping breastfeeding, malnourished infants < 6 months presenting to clinics, uncontrolled BMS distributions) and include key information (data) to inform BMS programming, such as:

- Estimated total population
- Estimated # of infants under 6 months
- Estimated # of maternal orphans under 6 months
- Estimated % of infants under 6 months who are not breastfed[97]

[96] IFE Core Group *Operational Guidance on Infant Feeding in Emergencies (OG-IFE) version 3.0* 2017 https://www.ennonline.net/operationalguidance-v3-2017

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

Note that indicators on exclusive and continued breastfeeding rates and complementary feeding practices should also be included in the assessment to allow for the most urgent IYCF needs to be identified and appropriately responded to as part of a complete IYCF programme.

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

Any non-breastfed infants under 6 months identified during assessments should be referred for a full individual feeding assessment in order to receive appropriate artificial feeding support as soon as possible.

The estimated quantity of infant formula needed for a population should be based on assessment information or, if not available, pre-existing data on infant feeding practices of the population. This will give an indication of the percentage of infants under 6 months requiring BMS support. On average, an infant needs 3.5 Kgs of powdered infant formula each month and should be provided for as long as the infant needs it.

10.2 BMS Procurement Process

Table 14: Checklist for an appropriate infant formula

Checklist for an appropriate infant formula	
Criteria	**Check**
Manufactured and packaged in accordance with the Codex Alimentarius standards	
Suitable for infants under 6 months ('Follow on' milks and milks advertised as being suitable for infants over 6 months are not suitable)	
Labels should be in an appropriate language for the refugee population	
Labels should adhere to the specific labelling requirements of the International Code:	
● Labels should state the superiority of breastfeeding	
● Labels should indicate that the products should be used only on health worker advice	
● Labels should warn about health hazards of using infant formula	
● There should be no pictures of infants or other pictures idealizing the use of infant formula	
Generic (unbranded) infant formula is first choice, however, when this is not possible, a commercial infant formula is acceptable.	
Have a shelf-life of at least 6 months on receipt of supply.	
Infant formula is purchased (not donated)	

UNICEF or another agency identified by the Sudan Nutrition Sector will be responsible for procurement at the Sector level.

Agencies who are identified as SCs in Charge and have implemented BMS programmes will then apply to the Identified Agency to request BMS. An Agency Agreement for BMS Substitutes should be put into place. (See Annex 12 for an example of an Agency Agreement for BMS Substitutes)

Procuring BMS should ensure that they can meet the provisions of the global IFE Operational Guidance for Infant Feeding in Emergencies, The Code and this Operational Guidance. If this has cost implications, they should budget for these accordingly in their proposals. Interventions to support non-breastfed infants should always include a component to protect breastfed infants for example, through budgeting for activities which promote breastfeeding and support breastfeeding mothers.

Procured BMS should meet the following criteria:

- Manufactured and packaged in accordance with the Codex Alimentarius standards[98]
- Suitable for infants under 6 months[99]
- Generic (unbranded) infant formula is first choice, however, when this is not possible, a re-labelled commercial infant formula is acceptable.
- Have a shelf-life of at least 6 months on receipt of supply.

Labels of any distributed infant formula should:

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

Any products not meeting these requirements should be re-labelled prior to distribution and implementing agencies should take into account the cost and time implications of this.

[98] http://www.codexalimentarius.org/standards/list-of-standards/en/?no_cache=1

[99] ('Follow on/up' milks and milks advertised as being suitable for infants over 6 months are not suitable. 'Growing up milks', often marketed for children over the age of 12 months, are also not necessary. Baby teas or juices they have little nutrient value and are not necessary.

10.4 Storage and Transportation of BMS

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

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

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

It is recommended that in areas that are insecure or where security may cause limited movement, a sufficient quantity of BMS stock is securely pre-positioned to meet the needs of non-breastfed infants for 6 months.

10.5 Handling BMS Donations and Supplies[100]

Donations of BMS are not needed and may put infants' lives at risk. Unsolicited donations of BMS should not be accepted[101] as they are highly unlikely to be appropriate (in quantity, quality, type, labelling requirements etc.) and are likely to encourage further donations. Asking for donations of BMS should also be avoided – it sets up a demand for donated formula that may be hard to control[102]

Any donations of BMS (such as infant formula, other milk products, bottles and teats) that have not been prevented should be securely stored and immediately reported to the Nutrition Sector[103] In consultation with Sudan Nutrition Sector and/or IYCF-E TWG Members, a decision will be taken by the Sector on the most suitable strategy to handle the donation. Donations should remain securely stored by the receiving agency until such a decision is taken.

While a need for a limited supply of BMS may exist, these needs should be budgeted for in IYCFE programmes. The fact that donations are not needed should continuously be reiterated to all stakeholders, potential donors, and the media, as well as those potentially requesting donations at field level (e.g. local authorities and NGOs/CBOs).

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[100] For additional information on handling BMS donations and supplies see: IFE Core Group (2021) *Infographic on Preventing and Managing Inappropriate Donations* https://www.ennonline.net/ifecoregroupinfographicseries

[101] Operational Guidance on IYCF-E; Section 6 Sphere Standards

[102] The Code states free (donated) supplies of infant formula should not be in any part of the health care system (WHA resolution 47.5) meaning that it cannot be used or distributed through this means without violation.

[103] Nutrition Sector is under obligation to report this to UNICEF and the Ministry if applicable

11. BMS Prescription Process

Note: BMS should be provided for as long as the targeted infants require it. Providing just few tins is forbidden by The Code and the Operational Guidance for Infant and Young Child Feeding in Emergencies.

Breastmilk substitutes or infant formula should only be provided discretely to infants 0-5 months of age[104] who require it, on a case-by-case basis and in accordance with the Sudan National Regulation to Promote Breastfeeding (2020, Draft), the IFE Core Group Operational Guidance[105], the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions[106] and the SPHERE Standards Handbook[107]. Interventions to support non-breastfed infants should always include a component to protect breastfed infants for example, through budgeting for activities which promote breastfeeding and support breastfeeding mothers.

Always review the WHO *Acceptable Medical Reasons for use of Breastmilk Substitutes*[108] to understand the appropriate medical reasons for prescribing BMS on a case-by-case basis.

BMS requirement may be temporary in the case of relactation or if the mother and infant are temporarily separated or longer term in the case of an absent mother and relactation or wetnursing from another woman or caregiver is not possible.

Box 13: Indications for BMS Prescription

Indications for BMS Prescription

Temporary BMS indications include[109]

- During relactation
- Transition from mixed feeding to exclusive breastfeeding
- Short-term separation of infant and mother
- Short-term waiting period until wet nurse or donor human milk is available

Longer-term BMS indications include[110]

- Infant not breastfed pre-crisis

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[104] IFE Core Group *Operational Guidance on Infant Feeding in Emergencies (OG-IFE) version 3.0* 2017 https://www.ennonline.net/operationalguidance-v3-2017

[105] IFE Core Group *Operational Guidance on Infant Feeding in Emergencies (OG-IFE) version 3.0* 2017 https://www.ennonline.net/operationalguidance-v3-2017

[106] WHO International Code of Marketing of Breast-milk Substitutes 1981 https://www.who.int/nutrition/publications/code_english.pdf

[107] SPHERE *Sphere Handbook* 2018 https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf

[108] WHO Acc*eptable Medical Reasons for use of Breastmilk Substitutes* 2009 https://www.who.int/nutrition/publications/infantfeeding/WHO_NMH_NHD_09.01/en/

[109] IFE Core Group *Operational Guidance on Infant Feeding in Emergencies (OG-IFE) version 3.0* 2017 https://www.ennonline.net/operationalguidance-v3-2017

[110] Ibid

- Mother not wishing or unable to relactate
- Infant established on replacement feeding in the context of HIV
- Orphaned infant
- Infant whose mother is absent long-term
- Specific infant or maternal medical conditions[111]
- Very ill mother
- Infant rejected by mother
- A survivor of Gender Based Violence not wishing to breastfeed.

Only once all of the following have been completed can a BMS prescription be created. Once these are completed the exact need for the BMS prescription can be determined.

Required Steps

- An individual-level Full Assessment by a Trained Health Worker
- In-depth IYCF counselling has taken place
- All options have been considered including wetnursing and Relactation
- Referral to the Stabilization Center in-charge is made
- Non-Breastfed Child Care Action Plan is developed and implemented
- A home visit to determine household capacity and resources for a BMS prescription.

[111] WHO Acc*eptable Medical Reasons for use of Breastmilk Substitutes* 2009 https://www.who.int/nutrition/publications/infantfeeding/WHO_NMH_NHD_09.01/en/

11.1 BMS Approval Process

After the full assessment has been completed and all options have been exhausted then a referral must be created and sent to the Trained Health Worker at the SC in charge using the BMS Referral Form (See Annex 13 for an example of a BMS Prescription Referral Form)

Home Visit Assessment

Within the Non-Breastfed Child Care Action Plan (Annex 11) there is a home visit assessment section this must be completed by the Health Worker at the SC in charge before a BMS prescription can be considered.

This home visit assessment includes the following:

- A Checklist for Counselling on BMS where discussion topics
- Demonstrations on preparation of BMS feeding in the home
- Identification of additional resources needed
- Observation on appropriate preparation of BMS feeds

Additional Resources Required

It must be ensured that all artificial feeding resources are either available in the home or are provided by the SC in charge. A list of required additional resources for appropriate BMS Preparation is included in Annex 14 BMS Resource Kit.

BMS Prescription Form

A BMS Prescription Form that has been authorized by the SC Manager or Nutrition Manger must be completed and included in the patient file. (See Annex 15 for an example of a BMS Prescription Card.)

11.2 BMS Provision Guidelines

Artificial feeding support should be administered discretely and in line with the IYCF Operational Guidance on Infant Feeding in Emergencies[112]. Infant formula should be provided discretely to families and conjunction with education as well as the necessary equipment needed to feed the infant.

Provide individual-level education, one-to-one demonstrations and practical training on BMS preparation to the caregiver. Additionally, all the necessary feeding equipment should also be

[112] IFE Core Group *Operational Guidance on Infant Feeding in Emergencies (OG-IFE) version 3.0* 2017 https://www.ennonline.net/operationalguidance-v3-2017

included when prescribing BMS, not only the BMS itself. The mother or caregiver must have access to all the necessary equipment.

Infant formula should be provided discretely to families and conjunction with education as well as the necessary equipment needed to feed the infant

Distribution should be discrete and away from others. Distribution should not be held around the same time or place as mother-to-mother support groups. Distribution to be from pharmacy and in discrete packaging like a non-transparent bag or box so that the tin is not able to be seen by others. There should be no promotional materials on artificial feeding distributed or displayed anywhere in the distribution side.

The use of bottles and teats should be actively discouraged due to the high risk of contamination and difficulty with cleaning. Bottles and teats **MUST NOT** be distributed with infant formula. Use of open cups, without spouts, should be promoted and demonstrated during education on BMS preparation and use.

Tins should be labeled with generic labeling and in the local language for the caregiver.

A one-week supply of BMS should be given at a time. This is generally one tin of formula given weekly. This ensures close follow-up and will prevent the misuse of the formula such as re-selling the formula.

When the BMS is given the IYCF focal point should point out the expiry date and write their name, the mother or caregivers name and the IYCF program ID on the tin. The BMS tin has a safety seal under the plastic lid and this should be opened in front of the mother or caregiver and the safety seal removed. A system where the mother or caregiver returns the empty tin to receive the new tin should be put into place. This will allow for closer monitoring of the infant.

Box 14: BMS Distribution Guidelines

BMS Distribution Guidelines

Always include education and messaging before distribution
Distribute discretely and away from others
Distribute one week's provision at a time
Note the expiry date to the mother or caregiver
Open the safety foil in front of the mother or caregiver before distributing
Distribute in discrete packaging so that the BMS is not able to be seen by others
The IYCF Focal point writes the date, their name, the name of the mother or caregiver and the IYCF registration ID on the tin

11.3 Education on BMS Preparation and Use

In line with the guidance on artificial feeding support, families receiving artificial feeding support should be provided with education on the use of infant formula in order to minimise risk. IYCF focal points must have received training on providing one to one BMS messaging and education before prescribing BMS.

Tools are available that can support one to one BMS educational sessions.

- See Annex 16 for an example of a generic BMS label and educational tool that can be used when providing messaging and education when BMS is prescribed.
- The following counselling cards may be useful:
  - IYCF counselling cards: https://www.unicef.org/nutrition/index_58362.html
  - IYCF counselling cards in the context of COVID-19: https://www.advancingnutrition.org/what-we-do/social-and-behavior-change/iycf-recommendations-covid-19

It is important to note that powdered infant formula (PIF) is not sterile and requires reconstitution with water that has been heated to at least 70 degrees Celsius. As a guide, for 1 litre, boiled and left standing for no more than 30 minutes.

Therapeutic milks (F75, F100) are not appropriate BMS in non-malnourished infants; this should be particularly emphasized with introduction of therapeutic milk in tins as of 2017 (previously in sachets), to avoid confusion with infant formula.

11.4 BMS Prescription Follow-up Procedures

Follow up should take place once a week in the SC when the new tin of BMS is distributed by the Trained Health Worker. This should include an assessment that is included into the Full Assessment file. All follow-up must be monitored.

Once a month or if a weekly assessment highlights issues or concerns an in-home visit should take place. See Annex 17 for an example of a Home Visit Follow-up Form.

11.5 Length of Provision

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

It is recognized that infants develop at different rates and are particularly vulnerable during the transition period when complementary feeding begins. A buffer stock of 2 – 4 weeks of BMS

while infants transition to complementary feeding can be considered on an individual basis, however the focus should be on strong complementary feeding counselling at this stage.

11.6 Avoiding Wrong Admissions

While it is important to take great care to avoid wrong admissions care must also be taken to avoid stigma for those mothers or families who are prescribed BMS.

It is very important to ensure the appropriate targeting of BMS through a Full Assessment and the creation of a Care Action Plan, however there may be times when a mother or caregiver and their infant may be wrongfully admitted into the BMS prescription program. It is common, especially in a diverse emergency context like Sudan, for people to request infant formula and milk products often due to a belief that artificial milk is better than breastmilk and/or because they believe the common myths and misconceptions commonly believed in emergencies that stress or trauma makes breastmilk bad or can decrease supply, both of which are not true. Once people know that infant formula is available then the requests for infant formula can increase, which can become extremely challenging especially if the IYCF workers come from the same communities and have the same myths/misunderstandings and/or may be put under pressure to include caregivers as beneficiaries of the program.

Actions that should be taken to reduce the risk of wrong admissions[113]:

- Locate the BMS program in an alternative site or at least a separate area in the IYCF space
- Ensure there are no visible references to the BMS program e.g. posters, leaflets, BMS supplies in view of the public
- IYCF workers should only discuss the BMS program away from beneficiaries
- Ensure that the targeting criteria is clear to the IYCF staff and written down in order that staff can show this to those who may be requesting the BMS but do not meet the targeting criteria.
- Conduct thorough intake interviews with the beneficiaries to establish a relation of confidence between the counsellor and the beneficiary (eg. Ask questions such as “Who fed the child this morning?” “Who bathed the child yesterday?”)
- Conduct a home visit to the family, in order to verify if the home situation is consistent with the details given in the interview; questions could also be diplomatically asked to the neighbors
- Link up with protection agencies, who might have lists of orphaned children for each site
- Observe the behavior of the infant when on a woman’s lap. If he turns his head towards the breast, rubs it, wants to take it; this might be an indicator he is still breastfeeding. If you suspect that the caregiver is the mother, you can tactfully ask if you can examine the breast to see if milk comes out

[113] *Adapted from Save the Children: IYCF-E Toolkit 2017: https://resourcecentre.savethechildren.net/iycf-e*

- If there is suspicion that the child could be breastfed, the risks of artificial feeding as opposed to breastfeeding must be thoroughly explained

Any action to cross check the actual impossibility of the child to receive breast milk must be done with diplomacy and tact. This will ensure that there is no loss of confidence of the mother or caregiver and will not put additional stresses on the mother or caregiver.

12. Adolescent Girls and Maternal Nutrition

Special considerations for adolescents: During emergencies, there are many situations that make adolescent girls vulnerable to early pregnancy. Sexually active adolescents may not have access to information about reproduction or access to family planning services and they may engage in unprotected sex. Married adolescents may be expected to become pregnant right away in order to demonstrate their fertility. Adolescent girls are at risk of rape, SEA, or they may be compelled to engage in sex work in order to meet their own needs or the needs of their families. In any situation, young pregnant women are a high-risk group; this is particularly true in the emergency context, when family and social support systems are disrupted and health services may be less accessible than during normal times.

It is important to raise awareness among staff from all sectors that adolescent pregnancies are a high risk for both the mother and the unborn child and identify ways to link pregnant adolescents with maternal and newborn health and nutrition services. If necessary, health workers should link pregnant adolescents to other sectors, such as protection, for additional support.

12.1 Counseling during Adolescence and Pregnancy

At all times when working with mothers, especially adolescents, health and nutrition workers should be non-judgmental and should protect the privacy and dignity of the mother and her child.

A nutrient-rich maternal diet before and during pregnancy is associated with improved fetal health, more appropriate birth weight, and increased rates of maternal and infant survival. Nutritional counselling before and during pregnancy is a critical intervention in maternal and child health. Pregnancy is also an important time to counsel the mother on birth practices, early initiation of breastfeeding, and exclusive breastfeeding. If the mother has support and is prepared before and during pregnancy, their ability to practice early initiation and exclusive breastfeeding is enhanced. It is important that all actors who have contact with pregnant adolescents and women are skilled and trained on providing nutrition counselling and support to pregnant women.

Nutrition counselling should focus on the following:

- Attend antenatal care at least four times during pregnancy. These check-ups are important for you to learn about your health and how your baby is growing.
- Know your HIV status, attend all the clinic appointments, and take your medicines as advised by your health provider.
- During your pregnancy, eat one extra small meal or "snack" (extra food between meals) each day to provide energy and nutrients for you and your growing baby.
- During pregnancy and breastfeeding, special nutrients will help your baby grow well and be healthy.
- Take iron-folate tablets to prevent anemia during pregnancy and for at least three months after the birth of your baby.
- Take de-worming tablets to help prevent anemia, as prescribed.
- To prevent malaria, sleep under a long-lasting, insecticide-treated mosquito net and take anti-malarial tablets as prescribed.
- Avoid drinking coffee, tea, and sugary drinks during pregnancy. Drink clean water when you are thirsty.
- You need to eat the best locally available foods, including milk, fresh fruit and vegetables, meat, fish, eggs, grains, peas, and beans.
- Take vitamin-A tablets immediately after delivery or within six weeks so that your baby receives the vitamin A in your breastmilk to help prevent illness.
- Use iodised salt to help your baby's brain and body develop well.

Adolescent mothers:

- You need extra care, more food, and more rest than an older mother.
- You need to nourish your own body, which is still growing, as well as your growing baby's.
- During breastfeeding, you need to eat two extra small meals or "snacks" (extra food between meals) each day to provide energy and nutrients for you and your growing baby.

16.2 Weight Gain in Pregnancy

Most normal gestational weight gain occurs after 20 weeks of gestation and the definition of "normal" is subject to regional variations, but should take into consideration pre-pregnant body mass index (BMI). According to the Institute of Medicine classification[114], women who are underweight at the start of pregnancy (i.e. BMI < 18.5 kg/m2) should aim to gain 12.5–18 kg, women who are normal weight at the start of pregnancy (i.e. BMI 18.5–24.9 kg/m2) should aim to gain 11.5–16 kg, overweight women (i.e. BMI 25–29.9 kg/m2) should aim to gain 7–11.5 kg, and obese women(i.e. BMI > 30 kg/m2) should aim to gain 5–9 kg.

[114] Rasmussen KM, Yaktine AL, editors; Institute of Medicine and National Research Council. Weight gain during pregnancy: re-examining the guidelines. 2009 http://www.nationalacademies.org/hmd/Reports/2009/Weight-Gain-During-Pregnancy-Reexaminingthe-Guidelines.aspx

12.2 MUAC Screening of Pregnant Adolescents and Women[115]

MUAC may be used as a screening tool for pregnant women, for example as a criterion for entry into a feeding programme[116]. Given their additional nutritional needs, pregnant women may be at greater risk than other groups in the population.

A MUAC of less than 20.7 centimetres indicates a severe risk of foetal growth retardation, and less than 23 centimetres indicates a moderate risk.

Table 15: MUAC Measurement for Pregnant women

Measurement for MUAC Screening of Pregnant Adolescents and Women		
Target group	MUAC Measurement	Level of Malnutrition
Pregnant Adolescent and Women	>23cm	Normal
	>/=18 to <23cm	Moderate
	<18cm	Severe

At the health facility or within community programmes, in addition to the routine antenatal and post-natal checks for pregnant and lactating women, all pregnant women should be systematically screened for acute malnutrition and those whose MUAC is less than 21 cm are referred to further nutritional support.

Table 16: TSFP Admission criteria for Pregnant and Lactating Women

Measurement for MUAC Screening of Pregnant Adolescents and Women	
Target group	MUAC Measurement
Pregnant Women (from the second trimester)	<21cm
Lactating women whose child is under 6 months.	

12.3 Supplementation with Iron and Folic Acid (IFA)

Daily or weekly oral iron and folic acid supplementation is recommended as part of antenatal care or delivered within the school programmes to reduce the risk of low birth weight, maternal anemia, iron deficiency, and death as a result of anaemia in pregnancy and during delivery.

[115] SPHERE Handbook: Appendix 4 https://spherestandards.org/wp-content/uploads/Sphere-Handbook-2018-EN.pdf

[116] Mija-tesse. V et al *Which Anthropometric Indicators Identify a Pregnant Woman as Acutely Malnourished and Predict Adverse Birth Outcomes in the Humanitarian Context?* https://www.ennonline.net/fex/47/anthropometric

Antenatal Supplementation

Prophylaxis IFA supplementation is an important option to prevent iron deficiency anemia in pregnant women. IFA supplementation is part of Antenatal Care (ANC) to reduce the risk of low birth weight, maternal anemia, and iron deficiency.

In settings where anemia in pregnant women is a severe public health problem (40% of higher), a daily dose of 60 mg of elemental iron is preferred over a lower dose.

Table 17: Suggested scheme for daily iron and folic acid supplementation in pregnant women[117]

Suggested scheme for daily iron and folic acid supplementation in pregnant women	
Supplement Composition	Iron: 30-60mg of elemental iron[118] Folic Acid: 400 µg (0.4mg)
Target Group	All pregnant adolescents and women
Frequency	One supplement Daily
Duration	Throughout pregnancy, starting as early as possible
Settings	All Settings

The World Health Organization (WHO) recommends[119] intermittent (once a week) IFA supplementation (see Table 18) as a public health intervention in menstruating women living in settings where the prevalence of anaemia is 20% or higher, to improve their haemoglobin concentrations and iron status and reduce their risk of anaemia. For menstruating women and adolescent girls living in settings where anaemia is highly prevalent (40% or higher), daily iron supplementation is recommended for the prevention of anaemia and iron deficiency

Table 18: Suggested scheme for intermittent iron and folic acid supplementation in menstruating women[120]

Suggested scheme for daily iron and folic acid supplementation in menstruating women	
Supplement Composition	Iron: 360mg of elemental iron[121] Folic Acid: 2800 µg (2.8mg)
Target Group	All menstruating adolescent girls and adult women
Frequency	One supplement per week
Duration	3 months of supplementation followed by 3 months of no supplementation after which the provision of supplements should

[117] http://apps.who.int/iris/bitstream/handle/10665/77770/9789241501996_eng.pdf;jsessionid=E12A2AF138B426E85B793978BF7705B5?sequence=1

[118] 30 mg of elemental iron equals 150 mg of ferrous sulfate heptahydrate, 90 mg of ferrous fumarate or 250 mg of ferrous gluconate

[119] Guideline. Intermittent iron and folic acid supplementation in menstruating women. Geneva: World Health Organization; 2011 (http://apps.who.int/iris/ bitstream/10665/44649/1/9789241502023_eng.pdf, a

[120] http://apps.who.int/iris/bitstream/handle/10665/77770/9789241501996_eng.pdf;jsessionid=E12A2AF138B426E85B793978BF7705B5?sequence=1

[121] 60 mg of elemental iron equals 300 mg of ferrous sulfate heptahydrate, 180 mg of ferrous fumarate or 500 mg of ferrous gluconate.

	restart. If feasible, intermittend supplements could be given throughout the school or calendar year.
Settings	Populations where the prevalence of anaemia among nonpregnant women of reproductive age is 20% or higher

Weekly Iron and Folic Acid Supplementation (WFIS)

Weekly iron and folic acid supplementation (WFIS) is among the eight key effective actions for improving adolescent nutrition included by the WHO in the 2018 guidelines.[122] A Weekly Iron and Folic Acid Supplementation (WIFS) Programme can be introduced to meet the challenge of high prevalence and incidence of anaemia amongst adolescent girls and boys. WIFS is evidence based programmatic response to the prevailing anaemia situation amongst adolescent girls and boys through supervised weekly ingestion of IFA supplementation and biannual helminthic control.

Features of WIFS:

- Objective of Weekly Iron Folic acid Supplementation (WIFS) To reduce the prevalence and severity of anaemia in adolescent population (10-19 years).

Target groups

- School going adolescent girls and boys ages 10-19 years enrolled in schools
- Out of school adolescent girls.

Intervention

- Administration of supervised Weekly Iron-folic Acid Supplements of 60mg elemental iron and 2.8mg Folic acid.
- A fixed day approach should be used where having one day as "WIFS Day" in order to reduce the risk of forgetfulness.
- Screening of target groups for moderate/severe anaemia and referring these cases to an appropriate health facility.
- Biannual de-worming (Albendazole 400mg), six months apart, for control of helminthic infestation.
- Information and counselling for improving dietary intake of iron rich foods and for taking actions for prevention of intestinal worm infestation.

[122] WHO *Weekly Iron and Folic Acid Supplementation as an Anaemia-Prevention Strategy in Women and Adolescent Girls* http://apps.who.int/iris/bitstream/handle/10665/274581/WHO-NMH-NHD-18.8-eng.pdf?ua=1

Table 19: WHO WIFS recommendations[123]

Suggested scheme for daily iron and folic acid supplementation in adolescent girls and boys	
Supplement Composition	Iron: 60mg of elemental iron Folic Acid: 2.8mg
Target Group	School going adolescent girls and boys ages 10-19 years and out of school adolescent girls.
Frequency	One supplement per week
Duration	3 months of supplementation followed by 3 months of no supplementation after which the provision of supplements should restart. If feasible, intermittend supplements could be given throughout the school or calendar year.
Settings	Populations where the prevalence of anaemia among nonpregnant women of reproductive age is 20% or higher

12.4 Vitamin A Supplementation

According to WHO guideline 2011[124] , routine Vitamin A supplementation in pregnant or postpartum women is **no longer recommended** as a public health intervention for the prevention of maternal and infant morbidity and mortality.

Rather than routine supplementation, counselling should take place:

- Postpartum women should be encouraged to receive adequate nutrition, which is best achieved through consumption of a balanced healthy diet, and to refer to guidelines on healthy eating during lactation.
- Advise all pregnant women to eat a piece of liver once a week as a preventive measure.

Vitamin A supplementation for pregnant women is only recommended for pregnant women in areas where vitamin A deficiency is a severe public health problem where ≥5% of women in a population have a history of night blindness in their most recent pregnancy in the previous 3–5 years that ended in a live birth, or if ≥20% of pregnant women have a serum retinol level <0.70 µmol/L[125].

[123] WHO *Weekly Iron and Folic Acid Supplementation as an Anaemia-Prevention Strategy in Women and Adolescent Girls* http://apps.who.int/iris/bitstream/handle/10665/274581/WHO-NMH-NHD-18.8-eng.pdf?ua=1

[124] WHO *Guideline: Vitamin A supplementation in postpartum women*. 2011 https://www.who.int/elena/titles/vitamina_postpartum/en/#:~:text=Current%20evidence%20suggests%20however%2C%20that,of%20a%20balanced%20healthy%20diet.

[125] WHO eLENA Vitamin A Supplementation During Pregnancy 2019 https://www.who.int/elena/titles/vitamina_pregnancy/en/

In areas where supplementation is indicated for vitamin A deficiency, it can be given daily or weekly. Existing WHO guidance suggests a dose of up to 10 000 IU vitamin A per day, or a weekly dose of up to 25 000 IU[126].

A single dose of a vitamin A supplement greater than 25 000 IU is not recommended as its safety is uncertain. Furthermore, a single dose of a vitamin A supplement greater than 25 000 IU might be teratogenic if consumed between day 15 and day 60 from conception[127].

12.5 Deworming Administration

It is recommended to periodically treat all at-risk people living in endemic areas, without previous individual diagnosis, with anthelminthic (deworming) medicines. This includes pregnant women after the first trimester.

Treatments should be given once a year when the prevalence of soil-transmitted helminth infections in the community is over 20%, and twice a year when the prevalence of soil-transmitted helminth infections in the community exceeds 50%. By lessening the worm burden this intervention reduces morbidity.

Preventive chemotherapy (deworming), using single-dose albendazole (400 mg) or mebendazole (500 mg), is recommended as a public health intervention for pregnant women, after the first trimester, living in areas where both: (i) the baseline prevalence of hookworm and/or *T. trichiura* infection is 20% or more among pregnant women, and (ii) where anaemia is a severe public health problem, with a prevalence of 40% or higher among pregnant women[a], in order to reduce the worm burden of hookworm and *T. trichiura* infection

12.6 Recommended Care Practices for People Living with HIV (PLHIV)

1. Support PLHIV to increase their food intake because their body requires more than the usual amount of food.
2. Support PLHIV to eat small but frequent meals throughout the day.
3. Support PLHIV to modify their diet to include nutrient- rich foods like meat, fish, egg, cowpea and dairy products.
4. Support the use of fortified foods like iodised salt, vitamin A fortified oil, sugar, and flour.
5. Support PLHIV to promptly seek care from trained counsellors.

[126] WHO *Guideline: Vitamin A supplementation in postpartum women*. 2011 https://www.who.int/elena/titles/vitamina_postpartum/en/#:~:text=Current%20evidence%20suggests%20however%2C%20that,of%20a%20balanced%20healthy%20diet.

[127] WHO eLENA Vitamin A Supplementation During Pregnancy 2019 https://www.who.int/elena/titles/vitamina_pregnancy/en/

13. IYCF Referral systems

A complete referral list should be created that all partners can access and share. This list should be shared across all sectors to ensure that referral pathways are clear. The use of referral forms as well as a referral register will make follow-up possible.

It is important to not only refer one way, upon discharge of the patient the community support mechanisms should be put into place for household level follow-up and support

13.1 Reproductive Health Referrals

Reproductive health services: for families with pregnant and lactating women and infants and young children in need of health services, these should be referred to the nearest primary health care facility

13.2 Additional Food Aid Referrals

Supplementary feeding support for pregnant and lactating women: families identified with pregnant and lactating women and children 0-2 years of age are vulnerable households and should be prioritized for food assistance. Families should be referred to relevant food aid distribution services or the nearest BSFP or TSFP as appropriate.

13.3 Mental Health and Psychosocial Services

Mothers and children identified in need for mental health and psychosocial support should be referred to the nearest hospital or closest relevant services in close coordination with the MHPSS Sector. Nutrition partners should be trained on Psychological First Aid and care should be made to support referrals appropriately and not to attempt to provide care above appropriate roles or responsibilities.

13.4 Referrals for Survivors of Gender Based Violence

Survivors of Gender Based Violence, Sexual Exploitation and Abuse including children have a right to safety and dignity and it is important that all care is survivor led and referrals are held in a confidential manner.

People who experience gender-based violence (such as rape, sexual assault, domestic violence, exploitation, stalking, verbal abuse, etc.) should be referred for appropriate assistance, for their safety, health, and psychological wellbeing. Children (under age 18) who are survivors of violence or at risk of harm should be referred to actors who are trained to handle the special needs of child survivors of sexual abuse, and who are familiar with local procedures relating to the protection of children.

14. IYCF-E Multi-sectoral Integration

14.1 Integration of IYCF-E into CMAM Services

The WHO Essential Nutrition Actions[128] state that integration of breastfeeding and IYCF support in all levels of healthcare is a key action to improving IYCF practices. Linkages with IYCF and CMAM activities is essential in combating malnutrition. To do this, staff working at nutrition centers and health facilities offering CMAM services need additional training to enhance their effectiveness of providing support.

The following services should be considered as part of the job description of the health and nutrition workers and others providing IYCF and CMAM services:

- SC, OTP, BSFP, TSFP: IYCF information, assessments and support should take place during admission, discharge, and follow-up to ensure that good IYCF practices are reestablished, and age-appropriate feeding practices are being maintained, ensuring that appropriate, diverse complementary foods are incorporated into the diet if the child is over six months.

- All community outreach activities can include a brief rapid assessment to establish any child specific IYCF issues.

- Upon discharge for SAM/MAM cases a referral to community level support should take place to ensure ongoing IYCF counseling services and follow-up take place, during both treatment and upon discharge.

- IYCF assessments and counseling during MUAC screening(s) sessions, both in the community and health facilities to ensure that appropriate messaging is disseminated to all at-risk households.

CMAM with IYCF Training Modules

The *Integration of IYCF Support in CMAM Facilitators Guide*[129] provides guidance for training CMAM staff in IYCF and should be included in all CMAM trainings at all levels.

General overview of the guide is to train on integration of IYCF support into CMAM.

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[128] WHO Essential Nutrition Actions 2019 https://www.who.int/publications/i/item/9789241515856

[129] ENN, IASG, IFE Core Group *Integration of IYCF Support in CMAM Facilitators* Guide 2009 https://www.ennonline.net/attachments/998/iycf-cmam-facilitators-a4large-final(1).pdf

14.2 Multi-Sectoral Integration of IYCF-E

For an IYCF-E strategy to be implemented successfully, IYCF must be mainstreamed across sectors for IYCF strategies and interventions to be implemented successfully. Stakeholders across sectors must have a basic understanding of IYCF, even if they do not specifically work in health or nutrition.

Table 20: Examples of opportunities for integrated programming[130]

Examples of opportunities for integrated programmming	
Child Protection	Extend community outreach by engaging members of existing community-based mechanisms to identify and refer PLW and children aged 0-23 months in need of case management and/or IYCF support. Coordinate to ensure that there is appropriate IYCF support in place for maternal orphans (eg. Small scale artificial feeding programme)
Education	Engage students through community-mobilisation opportunities and provision of key messages and information on IYCF through poems, drama, songs, stories and other methods; consider drama competitions related to IYCF. Prioritize and povide Early Childhood (ECD) interventions for families with infants and young children. Support sensitive caregiving and attachment upon reunification in the case of separation
FSL	Coordinate in the design of rations and non-food items to ensure the needs of 0-23 month-olds and pregnant and lactating women (PLW) are considered and protected. For example, ensure rations include appropriate complementary foods for young children and sufficient food for at least one PLW; complement ration with fresh foods if necessary; and consider unintended consequences of food aid on feeding practices. Provide safe, nutritionally adequate complementary foods for children 6 months to two years of age and support maternal nutrition
Health	Consider ways of incorporating IYCF indicators in the Health Information System (HIS) and UNHCR's reporting system (TWINE) to collect, analyse and utilise information related to IYCF. Train staff on IYCF and psychological first aid. Foster the establishment of mother-to-mother support groups through delivery/postnatal care services. Integrate IYCF into case management, vaccination and risk communication protocols Ensure adequate workplace support for breastfeeding health workers tackle rumors and unreliable information about breastfeeding and promote how important breastfeeding is to infants

[130] UNHCR and Save the Children *Infant and Young Child Feeding in Refugee Situations* 2018 https://www.unhcr.org/5c0643d74.pdf

	Make provisions for breastfed infants to stay with hospilized mothers Provide breastfeeding support to mothers who are incapacited by severe illness
WASH	Provide hygiene promotion and related non-food items at Mother-Baby Friendly Spaces, to allow complementary nutrition education, particularly around IYCF and care practices. Provide Hygiene promotion of key practices during IYCF counselling at CMAM centres. Additionally, distribute non-food items including WASH kits and water storage containers to caregivers of children 0-23 month-old and PLWs. Support hygiene and access to safe water for caregivers of children under two months of age.
Settlement and Shelter	Collaborate in planning discussions on minimising environmental and health risks in Mother-Baby Friendly Spaces related to food storage facilities, food preparation (ventilation, water access, etc.) and vector control.
Social protection/ cash transfer programmes	Work with social protection to ensure the inclusion of caregivers of children 0-23 months and PLWs in cash transfer programmes.

15. Monitoring and Reporting

Measuring progress and tracking results is a critical element of IYCF programing. A minimum set of indicators is proposed to help assess the effectiveness and reach of the IYCF-E activities outlined in this guidance and to measure and track progress at both the facility and community level (See Annex 20: Proposed IYCF Indicators).

Reporting, monitoring, and evaluation are key functions that should be carried out as the MIYCN guideline is being implemented. Monitoring and evaluation of MIYCN activities will be guided by the Sudan National Monitoring and Evaluation framework and will be integrated in the existing infrastructure that collects, and analyses surveillance and service delivery data from various Service Delivery Points in the country.

Data collection, reporting, management and use All the MIYCN programs/activities should have a record of basic information done at the service delivery point based on how often the service is offered e.g. daily. Reporting of service delivery MIYCN activities will be monthly from the facility, locality, State, and county levels. The reports are sent to the higher level through the DHIS. Each level (facility, locality, state, and national level) is required to analyze and consume the information at their level for decision making and to guide public health action. Data should be analyzed by comparing achievement against the set targets.

The routine data that will be collected by the health worker and community worker and will be used to track MIYCN Program. Monitoring data will be collected through the Health Information System (HIS). The HIS is the routine source of health facility service statistics. The HIS will rely on

HWs at facility level to collect patient data and HIS staff to aggregate the data and report it on standardized forms.

The routine data that will be collected through HIS for monitoring of activities will be:
exclusive breastfeeding, early initiation of breastfeeding, introduce adequate, safe complementary food at 6-month, Introduction of solid, semi-solid or soft food, bottle feeding, pregnant receiving counselling, mother receiving counselling, number of mother support groups, number of men groups.

The data have register book and report format for each MIYCN activities.

The assessment indicator will be collected through surveys (MICS, S3M, Standardized Expanded Nutrition Survey (SENS), base line and close line, and SMART). Additionally, integration of IYCF indicators should be included in multi-sectoral rapid assessments.

The role of the FMoH is critical in monitoring and reporting and including IYCF-E indicators in national data collection and monitoring and reporting.

Targeting

Organizations should be able to target at coverage level even if they are reporting using numbers, reach is very key.

15.1 Emergency Assessments and MEAL[131]

Pre-Emergency or as soon as possible

- Gather and organize pre-crisis situation background data
- Collect information from observations and key informants if applicable

Within 72 Hours

- Gauge government and partners IYCF-E response capacity
- Map stakeholders and coordinate with them as required
- Conduct multi-sectoral (including Child Protection, Education, Food Security and Livelihoods, Health, HIV, Shelter, WASH, etc.) initial rapid assessment (MS-IRA) in coordination with other sectors incorporating IYCF-E.
- Define relevant indicators

Week 1

- Develop and implement monitoring and supervision framework

Week 2-4

[131] Tech RRT and Save The Children (2020) *IYCF-E Standard Operating Procedures for Emergency Response Teams* https://www.ennonline.net/attachments/3713/IYCF_E-SOP-for-emergency-teams_Oct20.pdf

- Analyse MS-IRA data and prepare the assessment report
- Disseminate MS-IRA assessment results
- Develop evaluation and learning plan
- Begin evidence building
- Develop IYCF-E database

Weeks 5-8

- Support/undertake detailed IYCF-E assessments including baseline surveys, SMART surveys, Focus Group Discussions, or Key Informant Interviews

Multisectoral Assessments

Assessment of IYCF practices should be included in multi-sectoral rapid assessments.
Indicators to include are:

- Exclusive and age-appropriate breastfeeding
- Introduction of solid and semi solid food
- Meal frequency for children 6-59 months
- Distributions and donations of BMS
- Care for non-breastfed infants
- Care for pregnant women and lactating mothers
- Adolescent girls nutrition

Bottleneck Analysis

In order to fully understand the IYCF service delivery performance, behaviors, practices, and barriers to optimal practices a bottle-neck analysis on an annual basis should be conducted.

4Ws Activity Mapping Matrix

The 4W mapping exercise allows nutrition actors to:

- Gain a clear understanding of the nutrition interventions carried out by organizations working in different locations, as well as the calculation of target group for IYCF activities.
- It provides the structure for a common and systematic information sharing process.
- Provides real time analysis of the nutrition response for effective planning and monitoring.

The 4Ws should be submitted by partners monthly and collated by the nutrition sector on a quarterly basis and then shared with partners.

Indicators include:

- Active case finding
- OTP Admission
- <6 months SC Admission

- 6-59 months SC admission
- BSFP Programme 24- 59 months
- BSFP Programme PLW
- Targeted Supplementary Feeding Programme
- C4D
- MNP Distribution
- Infant and Young Child Feeding counselling
- Pregnant counselling
- M2MSG/F2FSG, care groups, peer support groups

15.2 Package of indicators

Table 21 presents the list of indicators that the members of the Nutrition Sector should collect and report on, according to the type of activities and settings where they are operating and/or implementing. The data will be reported to the respective agencies (by implementation agency). Consolidation at the agency level should be facilitated.

A revised package of indicators was released by WHO and UNICEF in 2021.[132] This document presents a set of new and updated indicators to assess infant and young child feeding (IYCF) practices at household level. It is a follow-up to the 2008 document "Indicators for assessing infant and young child feeding practices – Part I & II".
In total, there are 17 recommended IYCF indicators in the 2021 edition. Seven are new, and four of the 2008 indicators have been excluded from the 2021 list of IYCF indicators. In addition, three indicators of unhealthy food and beverage consumption are included. Unlike in 2008, no distinction is made between core and optional indicators in this set of recommendations. It is important to assess data using the full set of indicators for any given population and to report all findings.

Table 21: Proposed Minimum IYCF Indicators[133]

	Indicato	Short	Age	Definitio
	Breastfeeding indicators			
1	Ever breastfed	EvBF	Children born in the last 24 months	Percentage of children born in the last 24 months who were ever breastfed
2	Early initiation of breastfeeding	EIBF	Children born	Percentage of children born in the last 24 months who

[132] WHO and UNICEF 2021 *Indicators for Assessing Infant and Young Child Feeding Practices* https://www.who.int/publications/i/item/9789240018389
[133] WHO and UNICEF IYCF Indicators https://www.who.int/publications/i/item/9789240018389

			in the last 24 months	were put to the breast within one hour of birth
3	Exclusively breastfed for the first two days after birth	EBF2D	Children born in the last 24 months	Percentage of children born in the last 24 months who were fed exclusively with breast milk for the first two days after birth
4	Exclusive breastfeeding under six months	EBF	Infants 0–5 months of age	Percentage of infants 0–5 months of age who were fed exclusively with breast milk during the previous day
5	Mixed milk feeding under six months	MixMF	Infants 0–5 months of age	Percentage of infants 0–5 months of age who were fed formula and/or animal milk in addition to breast milk during the previous day
6	Continued breastfeeding 12–23 months	CBF	Children 12–23 months of age	Percentage of children 12–23 months of age who were fed breast milk during the previous day

	Indicato	Shor t	Age	Definitio
	Complementary feeding indicators			
7	Introduction of solid, semi-solid or soft foods 6–8 months	ISSSF	Infants 6–8 months of age	Percentage of infants 6–8 months of age who consumed solid, semi-solid or soft foods during the previous day
8	Minimum dietary diversity 6–23 months	MDD	Children 6–23 months of age	Percentage of children 6–23 months of age who consumed foods and beverages from at least five out of eight defined food groups during the previous day
9	Minimum meal frequency 6–23 months	MMF	Children 6–23 months of age	Percentage of children 6–23 months of age who consumed solid, semi-solid or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more during the previous day
10	Minimum milk feeding frequency for non-breastfed children 6–23 months	MMFF	Children 6–23 months of age	Percentage of non-breastfed children 6–23 months of age who consumed at least two milk feeds during the previous day
11	Minimum acceptable diet 6–23 months	MAD	Children 6–23 months of age	Percentage of children 6–23 months of age who consumed a minimum acceptable diet during the previous day
12	Egg and/or flesh food consumption 6–23 months	EFF	Children 6–23 months of age	Percentage of children 6–23 months of age who consumed egg and/or flesh food during the previous day
13	Sweet beverage consumption 6–23 months	SwB	Children 6–23 months of age	Percentage of children 6–23 months of age who consumed a sweet beverage during the previous day
14	Unhealthy food consumption 6–23 months	UFC	Children 6–23 months of age	Percentage of children 6–23 months of age who consumed selected sentinel unhealthy foods during the previous day

15	Zero vegetable or fruit consumption 6–23 months	ZVF	Children 6–23 months of age	Percentage of children 6–23 months of age who did not consume any vegetables or fruits during the previous day

Other indicators

Bottle Feeding 0-23 motths	BoF	Children 0–23 months of age	Percentage of children 0-23 months of age who were fed from a bottle with a nipple during the previous day
Zero vegetable or fruit	AG	Infants 0-5 months of ag	Percentage of infants 0-5 months of age who were fed exclusively with breastmilk and water only, breastmilk and non-milk liquids, breastmilk and animal milk/formula, breastmilk and complementary foods, and not breastfeed during the previous day

15.3 BMS Monitoring and Reporting

The aggressive marketing of breastmilk substitutes is a major barrier to improving newborn and child health, especially when donations or marketing is conducted through health and nutrition workers or within humanitarian response where nutrition and health advice is trusted.

The Code bans all forms of promotion of breast-milk substitutes, including advertising, gifts to health workers and distribution of free samples. Labels cannot make nutritional and health claims or include images that idealize infant formula. Instead, labels must carry messages about the superiority of breastfeeding over formula and the risks of not breastfeeding.

In Sudan, not only does strong policy need to be developed but government, humanitarian, and civil society organizations should also not seek or accept donations of breast-milk substitutes in emergency situations.

Monitoring and enforcement of the Code is critical in Sudan, especially during times of emergency.

All violations should be reported to the FMoH and Nutrition Sector through a channel consisting of two parts.

1) MS Word form for tracking of violation of the International Code of Marketing of Breastmilk Substitutes which has been adapted for the Sudan context
    a. This document should be shared in the pdf format with partners.
    b. In addition, the Nutrition Sector may wish to develop an online form (such as through surveymonkey.com) to facilitate reporting of the Code violations
2) MS Excel database, which is an internal document for the Nutrition Sector and FMoH to compile code violations for further consolidation, analysis and follow up. *Note: It should not be shared widely as it contains sensitive information, such as who reported the Code violation.*

List of Anexes

Annex 1: Infant and Young Child Feeding in Emergencies (IYCF-E) Communications Guidance

INFANT & YOUNG CHILD FEEDING in EMERGENCIES (IYCF-E) COMMUNICATIONS GUIDANCE[134]

The purpose of this document is to provide guidance for anyone delivering humanitarian assistance in Sudan who may be involved in communications on behalf of their agency (e.g. social media) or engage with the media (e.g. interviews) to ensure we meet our responsibility to provide accurate information that highlights the needs of infants, young children and their caregivers and prevents harmful aid from occurring.

DO's and DON'Ts when talking/writing about IYCF-E

DO remember that children are at increased risk of malnutrition, illness and death in emergencies. The younger the child, the more vulnerable they are. When children start their lives malnourished, the negative effects are largely irreversible. We include pregnant and lactating women in our interventions to support them in giving their children a healthy start to life. **DO** advocate for pregnant and breastfeeding women to be prioritised, including for access to food aid.

DO remember that breastfeeding saves lives in emergencies. Infants who are ***NOT*** breastfed are far more likely to get sick and die. Supporting mothers to breastfeed is the surest way of protecting infants from malnutrition, disease and death in emergencies. Highlight this.

DO remember that the National Policy on IYCF in Sudan recommends that all children should initiate breastfeeding within 30 minutes of birth, exclusively breastfeed for the first 6 months of life. **(*Do not give any other liquids, including water, or foods during this time*)** and continue to breastfeed thereafter with the introduction of safe, appropriate and timely complementary foods from 6 months to 24 months and beyond. Our communications should always protect, promote and support these IYCF practices.

[134] How to Write and Talk About Infant and Young Child Feeding in Emergencies https://www.ennonline.net/attachments/2872/IFE-HowTo-Guide.pdf

DO remember that there are often donations of breastmilk substitutes (BMS[135]) such as infant formula, milk products and infant feeding bottles/teats during emergencies. Uncontrolled donations and indiscriminate use of infant formula not only displace breastfeeding, a life-saving practice, but are extremely dangerous for infants, causing illness and death. **DO talk about the risks associated with such donations in order to prevent harmful aid. State clearly that donations of BMS are not needed.** Refer to the IYCF-E Toolkit[136] (*Minimising the Risks of Artificial Feeding*) for details on the dangers of infant formula donations and how to manage them.

DO share stories of mothers who continue to breastfeed despite difficult circumstances, emphasising their bravery, strength, and resilience. When a family has lost everything in a crisis, a breastfeeding mother can provide all the nourishment her baby needs as well as warmth, comfort and protection against disease. Portray the mother as the hero of the story, with your organisation as her partner to support her.

DO remember that, as agencies working in IYCF-E, YOU have an important role to play in protecting infants in emergencies by presenting accurate information to the public and the media about what sort of aid helps or does not help. The media in turn also has a crucial role to play by, for example, not supporting appeals for donations of infant formula or spreading disaster myths.

DO remember to advocate for access to appropriate and nutritionally adequate complementary foods for children aged 6 – 23 months. These should be provided alongside breastfeeding which continues to play a very important role. Introducing complementary foods too early (before six months) puts the child at risk. Delaying the introduction of complementary foods means that the infant's nutritional needs are not being met. Children are vulnerable during this transition phase and caregivers are likely to need support in continuing breastfeeding and accessing safe, adequate and appropriate complementary foods during a food crisis. Talk about the dangers associated with donations of inappropriate complementary foods and the need to support hygienic feeding practices if sanitation is poor.

DON'T – RED FLAGS

DON'T inadvertently spread disaster myths and misconceptions

- Malnourished mothers CAN breastfeed (but may need nutritional support)
- Stress does NOT dry up breastmilk
- Breastfeeding is NOT an "additional burden" to mothers
- Mothers CAN breastfeed during pregnancy and most illnesses
- Infants less than 6 months do NOT need extra food or water if they are breastfed

[135] Any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose

[136] https://sites.google.com/site/stcehn/documents/iycf-e-toolkit

Be aware that these are common misconceptions that can lead to harmful aid and proactively prevent them from being published. Women who are physically and emotionally stressed are able to make enough milk for their babies. However, they need support. Stress the importance of supporting maternal nutrition and access to safe drinking water – as well as reducing energy expenditure and providing breastfeeding and psychosocial support. We need to ensure the mental and physical well- being of the mother AND baby, so we need to care for and feed the mother and let her breastfeed her child. DO refer to Section 8 of Save the Children's IYCF-E Toolkit to check for further explanations and other common myths and misconceptions during disaster.

DON'T praise donations of 'baby milk' or other BMS, highlight artificial feeding programmes or use images of babies being bottle-fed. We must support the non-breastfed child in accordance with strict national and international guidelines, which include giving *discrete* support so as not to undermine breastfeeding practices.

DON'T use imagery such as feeding bottles or pacifiers (dummies) to represent infants and young children. The preferred image is of a mother holding / breastfeeding her child.

DON'T *assume* that an infant is crying because they are hungry when describing a case. There are many reasons babies cry, especially during an emergency, when the family is in turmoil. Breastfeeding and skin-to-skin contact with the mother can help calm the baby.

PHOTOGRAPHY

Inappropriate use of photography can endanger children and their caregivers, contribute to the spread of disaster myths and misconceptions and create a perceived need for harmful aid such as donations of infant formula, bottles, teats etc. However, photography can be a powerful tool for highlighting needs and sharing best practices.

DO publish pictures of	Do NOT publish pictures of…
Mothers receiving breastfeeding support	Children receiving infant formula, bottles, teats, pacifiers etc. as a form of aid
Mothers continuing to breastfeed despite difficult circumstances	Any brands or commercial labels of BMS
Children who have become ill or malnourished due to inappropriate formula use, BMS distributions or because they were not exclusively breastfed	Pictures of feeding support for mothers living with HIV, where this is potentially stigmatising, breaches their confidentiality or privacy. Ensure you follow agency guidelines on obtaining consent, protecting identity etc.
Showing breastfeeding mothers as the central hero of the story, with agencies as her partner to support her	Photographs depicting aid workers as the heroes of the story e.g. through providing infant formula

IYCF-E interventions which are protecting, promoting and supporting appropriate IYCF practices e.g. cooking demonstrations, IYCF counselling sessions, early skin to skin contact after delivery, IYCF corners	Mothers with her breast fully exposed, where this is culturally sensitive
Cup Feeding (0 – 23 months) and Wet Nursing	
Mother and father support groups / Breastfeeding Corners	
Secondary caregivers supporting breastfeeding or supporting a mother to breastfeed	
Situations demonstrating the difficulties pregnant and lactating women face in emergencies	
Any situation or effort where breastfeeding practices are protected, promoted and supported	

Annex 2: Food Demonstration Evaluation[137]

Food Demonstration Evaluation

Recipe Name:	
Date:	
Demonstrator:	

S/N	Questions	Yes	No
1.	I liked the sample I tasted at this demonstration		
2.	I plan to use this recipe at home		
3.	This demonstration taught me the skills I need to make this recipe at home		
4.	I learnt new ways to help my children eat healthier with the foods locally available and affordable to me		
5.	The ingredients used in this demonstration are items that I use at home		
6.	The ingredients used in this demonstration are items that I am able to buy		
7.	I have participated in food demonstration before		
Suggestion/Comment if any:			

Thank you for your time.

Note: This applies at the end of the demonstration and should be completed by all the target group who attended the food demonstration. This form is anonymous and there is no need to identify the respondent. The administrator of the evaluation can ask verbally the questions or, where possible, the evaluation can be translated into the appropriate local language and filled out individually where literacy levels are able to support. Where possible, the person other than the moderator and demonstrator should handle this tool.

Name of Administrator:

Signature:

[137] Adapted from USAID and SPRING Nigeria: Complementary Feeding and Food Demonstration Training 2016 https://www.spring-nutrition.org/sites/default/files/training_materials/files/nigeria_complementary_feeding_manual.pdf

Annex 3: Frequently Asked Questions on Micronutrient Powders

Frequently Asked Questions on MNP Use

1. **How is Micronutrient Powder (MNP) used? Does it need cooking?**
   - Micronutrient Powder (MNP) does not need cooking. It must be sprinkled and mixed with a small portion of ready to be consumed regular homebased food on the basis of one sachet per child per day.
   - MNP cannot be mixed into the meal while cooking.
   - The child must consume the whole portion of the food mixed with the MNP to get the full benefit.

2. **Can MNP be provided in combination with other fortified products and supplements, such as:**

   a. High-dose vitamin A capsules (VAC)
      - **YES**

   b. Iodized salt
      - **YES**

   c. General food fortification of flour, oil, salt etc
      - **YES**

   d. Specially formulated products (LNS, RUTF, CSB+/++, WSB+/++, RUSF etc)
      - **NO**, wait until discharged from OTP/TSFP

3. **Can the same amount of one sachet/d with the 15-micronutrient formulation be used by all 6-59-month-old children, or should younger children use smaller portions?**
   - All children as of six months of age can consume the full sachet once per day, because the RNI is designed to provide one RNI for children 6-59 months old.

4. **Can the micronutrient cause toxicity if intake exceeds the recommended levels? E.g 2 sachets per day.**
   - Thus, there is no immediate safety risk when an individual's intake occasionally exceeds the recommended levels.
   - Furthermore, consuming more than the recommended levels is very unlikely to occur for most micronutrients.

5. **Have adverse events been reported from the use of MNP?**
   - Diarrhea is sometimes reported by caregivers when children start using MNP. (this is could be mostly due to poor hygiene).
   - Because of the iron content in Micronutrient Powder (MNP), a child's stool may be darker than normal. Unabsorbed iron makes the child's stool darker which is not of concern.

6. **Can Micronutrient Powder (MNP) be given to children without mixing it to food?**
   - It is not recommended to use Micronutrient Powder (MNP) without mixing it into food first because the child may not like the taste and will be difficult to swallow.

7. **Can Micronutrient Powder (MNP) be used by Muslims who follow traditional food practices?**
   - Yes, it can be used by the Muslims. Neither alcohol nor pork products are used in the production of Micronutrient Powder (MNP). They have Halal Certification.

8. **Can Micronutrient Powder (MNP) be used in fluid drinks like milk, tea or juice?**
   - If Micronutrient Powder (MNP) is mixed into liquids, the micronutrients will float to the top of the liquids and tend to stick to the side of the cup or glass and therefore some will be lost in the process. It is therefore recommended not to add Micronutrient Powder (MNP) to liquids.

9. **Is Micronutrient Powder (MNP) a medicine?**
    - No, Micronutrient Powder (MNP) is not a medicine but it is a powdered nutrient supplement for children 6-59 months that contains 15 essential vitamins and minerals that promote optimum growth and development in children.

10. **Is there a possibility of Zinc overdosing if separate Zinc is given during diarrhea as well as in Micronutrient Powder?**
    - Zinc supplementation is given especially for diarrhea. Zinc present in Micronutrient Powder (MNP) is based on the recommended dietary allowance (RDA), so there is no chance of overdosing.

11. **Should Micronutrient Powder (MNP) be continued even if a child is sick?**
    - Micronutrient Powder (MNP) can be continued even if the child is sick.
    - The child needs extra vitamins and minerals to recover from the illness, so it should be continued.

12. **What are the benefits of Micronutrient Powder (MNP)?**
    - Prevent micronutrient deficiencies specially anemia
    - Improve the body's immune system
    - Improve a child's appetite
    - Improve a child's ability to learn and develop
    - Makes a child clever, strong and active

13. **Will the Micronutrient Powder (MNP) change the taste of food?**
    - MNPs will not change the taste of food if added immediately the food is ready
    - Sometime the taste of food may change if the portion of food with MNP is kept for more than 30 minutes.

Annex 4: IYCF Referral Register Example[138]

IYCF Referral Register

Date	IYCF-E beneficiary number	Mother's name	Address (area house number, landmarks)	Child's name	Child's age (months)	Sex (M/F)	Reason for referral	Referral returned (Yes/No)	Treatment provided at the centre	Follow-up Recommended	Follow-up Given

Name:	Organisation:	Position:
Facility:	Location:	LGA:

[138] *Adapted from Save the Children: IYCF-E Toolkit 2017: https://resourcecentre.savethechildren.net/iycf-e*

Annex 5: Simple Rapid Assessment Referral Form[139]

Instructions: Administer this rapid assessment whenever a caregiver with a child under 2 years is encountered and a referral is indicated. Do not ask the last 5 questions in italics under **LOOK** but note them down if observed.

If any difficulties are observed, refer the caregiver-baby pair for a Full Assessment or other support as appropriate. If anything in **RED** or **Yellow** is circled, then refer to full assessment. If no red or yellow are circled there is no need to refer, instead provide praise and encouragement.

_____**Cut Here** _____

COMPLETE IF REFERRAL IS INDICATED

Caregiver Name: _____

When to attend: Immediately / date: _____ Referral to: _____

Location of facility: _____

REASON FOR REFERRAL:
A) Full IYCF Assessment needed
B) Medical care needed: (reason)_____
C) Other:_____
Referred by (name): _____ Job Title/Agency: _____

Simple Rapid Assessment Referral Form						
Name of baby:	Date of Birth/Age:		Girl		Boy	
Age of baby	**0-5 months** 0-28 days (Newborn)		6-12 months		12-24 months	
ASK						
Is the baby being breastfed?	Yes	No	Yes	No	Yes	No
Is the baby getting anything else to eat/drink?	Yes	No	Yes	No	Yes	No
Is the baby unable to suckle at the breast?	Yes	No	Yes	No	Yes	No
Are there any other difficulties in breastfeeding?	Yes	No	Yes	No	Yes	No
Does the mother or caregiver feel there are feeding concerns?	Yes	No	Yes	No	Yes	No
Did the caregiver request infant formula?	Yes	No	Yes	No	Yes	No
LOOK						
Does the baby look very thin, lethargic or ill?	Yes	No	Yes	No	Yes	No
Is the mother or child visibly diabled?	Yes	No	Yes	No	Yes	No
Does the mother look visibly young?	Yes	No	Yes	No	Yes	No
Is the caregiver the child's mother?	Yes	No	Yes	No	Yes	No

[139] Adapted from Module 2 on IFE, Core Manual, Section 3, IFE Core Group, 2007 and the Operational Guidance for Breastfeeding Counselling in Emergencies 20201

Annex 6: Full Assessment of Mother/Caregiver - Baby Pair[140]

IYCF Full Assessment Of Mother-Baby Pair

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

Date: _____ IYCF-E Reg. No. _____

Child's name: _____ Child's sex: M / F Date of birth_____ Age/months_____

Mother's/Caregiver's name: _____ Relationship to child_____

Address:_____ Telephone:_____

Other Children in the home and ages?: _____

Does the mother/caregiver have concerns about other children in the home? Y N

(If yes, request mother/caregiver to bring in the other children to be seen after this assessment is completed)

Assessment undertaken by *(qualified nutritionist/nurse with breastfeeding expertise)*

Name_____ Job Title_____ Organisation_____ Location_____

Breastfeeding Information:

Breastfeeding? Yes / No *(If yes observe breastfeed, if no continue to the next section)*

Breastfeed observation results: *(tick relevant observations below and/or use 'B.R.E.A.S.T' tool)*
Attachment at breast:
☐ Areola more above ☐ Mouth wide open ☐ Lower lip turned out ☐ Chin close to or touching breast ☐ No nipple/breast pain or discomfort
Positioning of baby:
☐ Head & body straight ☐ Child held close to mother's body
Suckling:
☐ Slow, deep sucks, sometimes pausing ☐ Swallowing can be heard and seen
Mother is confident:
☐ She is enjoying breastfeeding, relaxed, not shaking/moving breast or baby ☐ Has a positive relationship with baby -stroking, eye contact, close gentle holding
How the feed ends:
☐ Baby comes off the breast itself (not taken off by mother) ☐ Baby looks relaxed and satisfied and no longer interested in breast ☐ Mother keeps breast available, or offers other breast

[140] Adapted from Save the Children: IYCF-E Toolkit 2017: *https://resourcecentre.savethechildren.net/iycf-e*

How often breastfeed a day? _____ **How often baby breastfeeds at night?** _____

Pacifier or other teat? Yes _____ No _____

Other Food and Drinks:

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

Other Foods / Drinks	**Is your child getting anything else to eat?**	**What?**	**Frequency: times/day**	**Amount: How much?** *(Reference 250 ml cup)*	**Texture: How thick?** *Thin, Thick, Finely chopped, or normal family food*
Solid Foods	Staple (porridge, other local examples)				
	Legumes (beans, other local examples)				
	Vegetables/Fruits (local examples)				
	Animal: meat/fish/ offal/bird/eggs				
Liquids	**Is your child getting anything else to drink?**	**What?**	**Frequency: times/day**	**Amount: How much?** *(Reference 250 ml cup)*	**Feeding Bottle use? Yes/No**
	Other milks				
	Any other liquids (e.g. water or tea)				
Who assists the child when eating? _____ **Where does the child eat?** _____					
Hygiene	Does caregiver use a clean plate and spoon?			Yes_____ No _____	
	Does caregiver wash hands with clean, safe water and soap before preparing food, before eating, and before feeding young children?			Yes _____ No _____	
	Does caregiver wash child's hands with clean, safe water and soap before he or she eats?			Yes _____ No _____	

Further Information:

Child currently sick? Yes / No **Recovering for sickness?** Yes / No

How has the sickness influenced food intake? Increased / Decreased / No change

Mother's beliefs: how did she decide to feed the baby in this way? _____

How is the mother emotionally and physically? Does she have any worries? _____

Does she wish to increase her breastmilk supply or is she interested in relactation? Yes / No

If Artifically Fed, Assess practices in the Home:

This MUST be completed to consider providing BMS support. If the infant is fully breastfed skip to the next section.

Resources - What resources are available in the household?

[Note: Feeding with bottle and teat is very dangerous, cup or spoon feeding should be taught]

		Yes/ No	Concerns / Comments
Breastmilk substitute (eg. Infant formula)	Breastmilk substitute is suitable for child's age?		
	Expiry date clearly marked, and not past		
	Instructions written in users own language		
	Preparer or another household member is able to read label's instructions		
	Caregiver is easily able to obtain sufficient formula until the child is at least 6 months of age		
	Subsequent visit: Quantity used since last distribution is appropriate		
	Quantity remaining is sufficient until next distribution		
Storage	Safe storage/tightly closed containers used for ingredients		
	Artificial feeds prepared in advance only if refrigeration is available		
	Drinking water is stored in a special container (clean, with cover)		
Preparation facilities	Adequate fuel is available for boiling water (and for cleaning feeding equipment)		
	Adequate drinking water is available for preparing several feeds per day (at least 4 litre)		
	Adequate other water and soap are available for washing utensils and hands		
	Clean surface is available to put utensils on (and a clean cover for them)		
	Suitable means of measuring milk and water (if a feeding bottle, the top and teat are removed. Or the health care worker can make a volume (mls) mark in a cup if measuring equipment not available)		
Extra time	Time to prepare 6-8 fresh feeds per day		

Procedures – how does the caretaker manage the feeding?

		Yes/ No	Concerns / Comments
Preparation	Caregiver washes hands		
	Cup washed with soap and water		
	Cup and spoon are boiled before use (*bottles should never be used)*		
	Water to prepare feed is brought to a rolling boil		
	Caregiver measures proportions of infant formula and water correctly		
	Boiled water allowed to cool for no more than 30 minutes before being added to infant formula		
Feeding technique	Infant is fed with cup, and takes most or all of the milk		
	Infant is fed with feeding bottle *(this is dangerous and mother/caregiver should be counselled to stop using the bottle and use a spoon or cup instead)*		
	Infant is fed with another method *(describe)*		
	Infant is held throughout the feed		

Interaction and end of feed	Caregiver interacts lovingly with the infant during the feed		
	Infant finishes the milk feed		
	None of this feed is kept for the infant to take later *(milk could be drunk by mother or older child – don't use after an hour)*		
Adequacy of artificial feeds	Number of feeds given per day appropriate to age and weight		
	Amount given at each feed appropriate		
Age-appropriate feeding	Under 6 months, only age-appropriate infant formula is given		
	Over 6 months, milk and complementary foods are given		

Complete IYCF Care Plan according to the findings of the Full Assessment and maintain the records together

Child < 6months ___ Child 6-23 months

SUMMARY OF INITIAL ASSESSMENT (main issues)

Support to mother: (amend below as necessary)

___ (A) Continuing Supportive Care (Adequate nutrition; Helpful Maternity Services; Continuing Assistance and support; Appropriate health services)

___ (B) Basic Breastfeeding Aid

(*i)Ensure effective suckling by good attachment + positioning;*
(ii) Building mother's confidence: encourage breastfeeding + skin to skin contact;
(iii) Increase milk production: frequent feeding for as long as infant wants
(iv) Encourage age appropriate feeding: exclusive breastfeeding for 6 months followed by continued breastfeeding and safe/appropriate complementary food

___ (C) Further Help Baby refusing the breast (Skilled support)

___ (D) Further Help Restorative care for the mother (needs emotional / extra support / referral to MHPSS support services)

___ (E) Further Help Wet nursing (Skilled Support)

___ (F) Further Help Relactation (Skilled Support from an IYCF Focal Point in the SC)

___ (F) Further Help Breast conditions (Skilled Support)

___ (H) Further Help Supported artificial feeding (BMS Referral to the SC in charge)

___ (I) Further Help Complementary Feeding (Additional support /referral to a complementary feeding programme or OTP)

Referral / Specialised Support:
___ Medical treatment/Therapeutic feeding

___ Other – specify ____

Annex 7: IYCF in Emergencies Referral Form[141]

IYCF in Emergencies Referral Form

CHILDS NAME_____ CAREGIVER NAME_____
DATE OF BIRTH_____ AGE (completed months)_____
Gender of Child (circle) F M
Name of household location:_____
Address:_____ Telephone number _____

Date_____
Reason for referral (state a, b, c, d, e or f):_____

a) Full mother-baby assessment needed

Full mother-baby assessment needed as:

_ Baby Not Breastfed
_ Breastfed but feeding not age appropriate
  Under 6 months not exclusively breastfed
  Over 6 months given no complementary foods or not safe or appropriate complementary foods
_ Baby unable to suckle the breast
_ Mother has other difficulties with breastfeeding
_ Mother requests breastmilk substitute (e.g. infant formula)
_ Baby visibly thin
_ Baby lethargic, perhaps ill

b) Medical care needed (State reason_____)
c) Mother pregnant
d) Child Malnourished (circle) <6 months / 6-59m: **MUAC <11.5cm** / 6-59m: **MUAC <12.5cm** / Oedema
e) Pregnant and lactating mother malnourished MUAC <22cm
f) Other (state reason_____)

Referred to (facility/service)_____ Location of facility/service_____
When to attend (circle): immediately / date_____
Referred by:_____ Job title/Organisation_____

----------Cut here ----------

Part Two: To be completed at referral site and given to caretaker (as record of next steps and to show the person who referred them)

Child's Name_____ Caretaker Name:_____ Referred by:_____

Reason for the referral: (state a,b,c,d,e,f)

a) Full mother-baby assessment needed
b) Medical care needed (State reason_____)
c) Mother pregnant
d) Child Malnourished
e) Pregnant and lactating mother malnourished
f) Other (state reason_____)

Name of the facility:
Date:
Service/treatment provided:

Recommendations for follow-up:

[141] Adapted from Save the Children: IYCF-E Toolkit 2017: *https://resourcecentre.savethechildren.net/iycf-e*

Annex 8: B-R-E-A-S-T Feed Observation Form

B-r-e-a-s-t Feed Observation Form

Mother's name: **Date:**
Baby's name: **Age of baby:**

(The signs in brackets below apply only to newborns and not to older children)

Signs of a correct way of breastfeeding	Signs of difficulties
(BODY) POSITION OF THE BODY	
□ Mother relaxed and comfortable	□ Shoulders strained, leaning forward
□ Baby near the body facing the breast	□ Body of the child away from the mother
□ Head of the baby and body straight	□ Neck of the child 'twisted'
□ Chin of the baby touching the breast	□ Chin is not touching the breast
□ [Hand supporting the buttocks of the baby]	□ [Supporting shoulder or head]
RESPONSE	
□ The baby goes towards the breast if hungry	□ No response to the breast
□ [The baby cries for the breast]	□ [No cry observed]
□ Baby explores the breast with his tongue	□ No interest of the child for the breast
□ The baby is calm and alert when suckling	□ The baby is agitated or crying
□ The baby remains attached to the breast	□ No signs of milk ejection
□ Signs of milk ejection	□ [The milk flows, pain at the end]
(LINK) EMOTIONAL	
□ Firm and confident support	□ Nervous or loose support
□ Exchange of looks	□ No exchange of looks
□ Mother touches the child	□ The mother shakes and wakes the child
ANATOMY	
□ Breast soft after suckling	□ Engorged breasts
□ Nipples erectile and protractile	□ Flat or inverted nipples
□ The skin looks healthy	□ Redness or skin abrasions
□ The breasts are round during the suction	□ The breasts appear elongated
SUCTION	
□ Mouth wide open	□ Mouth slightly open, 'pointed'
□ Lower lip turned backwards	□ Lower lip facing forward
□ Round cheeks	□ Baby's tongue non visible
□ Biggest part of the areola above the mouth	□ Biggest part of the areola below the mouth
□ Suction slow and deep, with breaks	□ Only fast suctions
□ Swallowing visible and audible	□ Slap or rattling audible
TIME OF SUCTION	
□ The baby leaves the breast by himself	□ The mother takes the baby from the breast
□ The baby has suckled for minutes	

Annex 9: Three Step Counselling

Three Step Counselling

The following, Three-Step Counselling will help you to counsel, problem-solve and reach an agreement with mothers or caregivers about infant and young child feeding.

Step 1: Assess

1. Greet the mother/ caregiver
2. Engage with the mother and/or caregiver to create conversation
    - Use listening and learning skills
    - Use helpful verbal communication
        - Ask open questions
        - Use responses and gestures that show interest
        - Reflect back what the mother (or caregiver) says
        - Avoid using "judgmental" words ("that's wrong", "you are doing the wrong thing")
    - Use helpful non-verbal communication
        - Keep your head level with the mother or caregiver
        - Pay attention
        - Reduce physical barriers
        - Take your time
        - Touch appropriately
    - Use building confidence and giving support skills
    - Accept what a mother (or caregiver) thinks and feels.
    - Listen carefully to the mother's (or caregiver's) concerns.
    - Recognize and praise what a mother (or caregiver) and child are doing correctly.
    - Give practical help.
    - Give little, relevant information at a time.
    - Use plain language that the mother or caregiver will understand.
    - Make one or two suggestions, not commands.
3. Ask some of the following questions
    - What are your name and your child's name?
    - What is the age of the child?
    - How has your child been feeling lately? Has your child been recently sick? If presently sick, refer to health facility
    - Ask mother/ father/ caregiver if you can check the child's growth chart. Is growth curve increasing? Is it decreasing? Is it leveling off? Does the mother or caregiver know how their child is growing?
    - Ask the mother or caregiver how the child is doing, whether the child is gaining weight (do not just rely on the plots on the growth chart)
    - If there is no growth chart, ask mother/ father/caregiver how he or she thinks or feels the child is growing
    - Ask about the child's usual food intake
    - Ask about breastfeeding. Are you breastfeeding? How is that going for you and the baby?
    - Observe the mother's and the baby's general conditions
    - Observe the baby's position and attachment when breastfeeding
    - Ask about complementary feeding

- What type/kinds of foods are given?
- How often are foods given?
- How much food is given along with breastfeeding?
- Texture (thickness/consistency: mashed, sliced, chunks)
- Ask about other milks
- Ask about other liquids
- Does your child use a cup?
- Who assists child during meals?
- Are there other challenges that mother/caregiver faces in feeding the child?

Step 2: Analyze

1. Ask some of the following questions:
    - Is feeding age-appropriate? Identify feeding difficulties
    - If there is more than one difficulty, prioritize difficulties
    - Answer the mother's questions and address any concerns

Step 3: Act

1. Depending on the analysis and age of the baby, select a small amount of information relevant to the mother or caregiver's situation
2. Praise the mother
3. For any difficulty, discuss with mother/father/caregiver how to overcome the difficulty
4. Present options/small doable actions and help mother to select one that she can try to overcome the difficulty
5. Share with mother/father/caregiver appropriate counselling card and discuss
6. Ensure the mother understands what is being presented to her
7. Let mother know that you will follow-up with her at the next weekly visit
8. Suggest where mother can find additional support
9. Refer, as necessary, to the nearby health facility
10. Thank the mother for her time

Annex 10: Care Action Plan for Mother/Caregiver and Baby Receiving Skilled Support[142]

Care Action Plan For Mother/Caregiver And Baby Receiving Skilled Support

This form is for infants NOT using BMS, this will be the MOST COMMONLY used form

Name of designated IYCF-E counsellor

_____

Location:

_____

IYCF-E Registration Number:

_____

Child's name _____

Child's Sex M/F

Child's DoB _____ Age/months _____

Mother/ Caregiver's name _____

Relationship to child_____

Address_____

Telephone:_____

Date of initial full assessment of mother-baby pair:_____

Main findings of assessment:

Recommendations for feeding: (amend below as necessary)

- ☐ **(A) Continuing Supportive Care**
- ☐ **(B) Basic Aid**
- ☐ **(C) Further Help Baby refusing the breast**
- ☐ **(D) Further Help Restorative care for the mother (needs emotional / extra support)**
- ☐ **(E) Further Help Wet nursing**
- ☐ **(F) Further Help Relactation**
- ☐ **(G) Further Help Breast conditions**
- ☐ **(H) Further Help Complementary Feeding**

Referral / Specialised Support:

- ☐ **Medical treatment/Therapeutic feeding**

IYCF-E Reg. No. _____ Child's name: _____Date of birth_____

[142] Adapted from Save the Children: IYCF-E Toolkit 2017: *https://resourcecentre.savethechildren.net/iycf-e*

Mother/Caregiver's name: _____Relationship to child_____
FOLLOW UP / MONITORING FOR EACH CONTACT:

Choose frequency of follow up according to each child/carer's situation, start more frequently and then aim for weekly contacts. Add new card if necessary, e.g if continuing support for relactation or other ongoing support.

Date						
Health & Weight of child (kg) (if part of programme)						
Date / time / place of next contact						
Notes and Agreed Actions for next visit (1 or 2)						
Progress from last visit						

Annex 11: Care Action Plan for Mother/Caregiver and Baby Receiving Skilled Support and BMS[143]

Care Action Plan For Mother/Caregiver And Baby Receiving Skilled Support And BMS

(Note: This form is to be completed after a Full Assessment. This care plan may be used for temporary BMS use as well as full BMS use)

Name of designated IYCF-E counsellor _____

Location: _____

IYCF-E Registration Number:_____

Child's name _____

Child's Sex M/F

Child's DoB _____ Age/months _____

Mother/ Caregiver's name _____

Relationship to child_____

Address_____

Telephone:_____

Date of initial full assessment of mother-baby pair:_____

Main findings of assessment:

Recommendations for feeding: (amend below as necessary)

- ☐ **(A) Continuing Supportive Care**
- ☐ **(B) Basic Aid**
- ☐ **(C) Further Help Baby refusing the breast**
- ☐ **(D) Further Help Restorative care for the mother (needs emotional / extra support)**
- ☐ **(E) Further Help Wet nursing**
- ☐ **(F) Further Help Relactation**
- ☐ **(G) Further Help Breast conditions**
- ☐ **(H) Further Help Supported artificial feeding**
- ☐ **(i) Further Help Complementary Feeding**

Referral / Specialised Support:

- ☐ **Medical treatment/Therapeutic feeding**
- ☐ **Other – specify _____**

[143] Adapted from Save the Children: IYCF-E Toolkit 2017: *https://resourcecentre.savethechildren.net/iycf-e*

IYCF-E Reg. No. _____ Child's name: _____Date of birth_____
Mother/Caregiver's name: _____Relationship to child_____
FOLLOW UP / MONITORING FOR EACH CONTACT:

Choose frequency of follow up according to each child/carer's situation, start more frequently and then aim for weekly contacts. Add new card if necessary, e.g if continuing support to an artificially fed infant. For a fully artificially fed child this form MUST be used until BMS support is completed, until relactation or wet nursing is fully established or until the child graduates from the BMS prescription programme (at 6 months of age).

Date						
Health & Weight of child (kg) (if part of programme)						
Date / time / place of next contact						
Notes and Agreed Actions for next visit (1 or 2)						
Progress from last visit						

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

Item to discuss (initially and to ensure on subsequent visits if needed)	**Check (date)**
What BMS will be given, when and where to receive it.	
What extra resources they will need to prepare BMS and how they will obtain these ***(Always ensure a plan is in place for ALL resources required for artificial feeding use)***	
How much and how often to feed BMS	
How to keep feeding utensils clean and safe	
How to prepare and store the feeds	
The advantages of cup feeding and how to cup feed	
Warning of the potential hazards of using BMS.	
Demonstrate	
Care worker should demonstrate appropriate preparation of a BMS feed in the home	
Check that	
The caregiver has been observed making a feed	
The caregiver has been observed cup feeding	

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

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

(Return to Section 13.4 BMS Prescription Procedures)

Annex 12: Agency Agreement for Breastmilk Substitutes[144]

Agency Agreement For Breastmilk Substitutes

Programme Agreement

(insert emergency name) **emergency response** *(insert date):* **Programme Agreement between** *(insert coordinating agency name)* **for UNICEF and in collaboration with (***insert government department)* **and the BMS receiving agency: _____ represented by _____**

1. Beneficiaries of Breastmilk Substitute

The above named agency confirms that use of the breastmilk substitute *(state if Ready to Use Infant Formula (RUIF) and/or Powdered Infant Formula (PIF)*) received from *(insert name of coordinating agency)* will be in accordance with the IYCF-E programming guidance outlined in the agreed guidelines *(state name of guideline)* on use and distribution of infant formula as developed by the Nutrition Cluster. The guidelines have been developed to support application of both the International Code of Marketing of Breastmilk Substitutes and the Operational Guidance on Infant and Young Child Feeding in Emergencies. This is an emergency programme and hence it is understood that the infant formula will only be provided to those infants the meet the agreed criteria *(state)* and are affected by the emergency. Hence it is understood that the programme will not continue indefinitely.

2. Receiving agency obligations

a. On receipt of the BMS and other items from the *(insert coordinating agency name)* warehouse, the receiving agency will be responsible for transporting, storing and handling and secondary transport to distribution locations and for distribution to beneficiaries in accordance with the guidelines. The receiving agency shall be responsible for any damage and losses after the BMS and other items coming under its physical control, custody or possession

b. Ensure suitably qualified and trained personnel and adequate means necessary for the implementation and supervision of the programming using the BMS, in line with the guidelines.

c. Be fully and solely responsible for acts and omissions of its personnel.

d. Respect the confidentiality of any information pertaining to any beneficiaries who receive BMS under this agreement

e. Ensure that all humanitarian assistance is to be provided free of charge, fees or services and with impartiality, and according to need, in accordance with good humanitarian practice and generally greed principles.

3. Monitoring

The agency will allow monitoring of activities in the IYCF-E counselling sites as determined by the government *(name the department)* and the rest of the Nutrition Cluster and agrees to comply with the findings.

4. Reporting

a. In accepting the BMS and other items, the receiving agency agrees to provide reporting to *(insert coordinating agency name)* on the programming of the BMS by location of programme and number of beneficiaries, as outlined in the guidelines.

b. The agency also agrees to undertake reporting activities in relation to all the IYCF-E counselling sites activities for the Nutrition Cluster as requested by the government *(name the department)* and the Nutrition Cluster Information Manager. Specifically reporting on all open and proposed IYCF-E counselling sites *(Insert e-mail address of Nutrition Cluster information manager)* and completing the monthly IYCF-E counselling sites reporting format and stock reports returning this on time to the Nutrition Cluster: *(Insert e-mail address of Nutrition Cluster IYCF-E lead or information manager)*. The agency also agrees to undertake any further reporting as determined necessary by the government (*(name the department*, the Nutrition Cluster, UNICEF and/or *insert coordinating agency name)*. The agency also agrees to attend the Nutrition Cluster meetings.

c. The agency understands that the BMS will not be provided if reports are not provided in a timely manner and in these circumstances that stocks of BMS will have to be returned immediately on request.

[144] Adapted from Save the Children 2016

d. *(insert coordinating agency name)* undertakes to report to UNICEF and the government *(name the department)* on BMS supply as outlined in the guidelines.

Signed for *(insert coordinating agency name)*	Signed for receiving agency
Name	Name
Title	Title
Date	Date

Annex 13: BMS Prescription Referral Form

BMS Prescription Referral Form

Part One: To be completed at referring site and sent to the referral agency (SC in charge) as well as kept in referring agency records for follow-up

Referral Information

Referral Date: _____/_____/_____ Referral Follow-up Completed: Yes / No

Referring Agency: _____	Referral to Service/ Facility: _____
Referred by (name): _____	Location: _____
Job Title/Designation: _____	Contact Information/ Phone Number: _____
Location: _____	
Contact Information/Phone Number: _____	

When to Attend: Immediately/ Date: _____

Referral Transportation Plan: Self/ Referring Agency Supported Transport.

Person of Concern Details

Child Name: _____	Mother/Caregiver Name: _____	Mother/Caregiver location/address: _____ _____ _____
Sex: ☐ Male ☐ Female	Contact Details/Telephone Number: _____	
Child Age in Months:_____		

IYCFE/OTP/SC or Health Facility Identification Number#:_____

Is the Full Assessment form Included with this referral form? Yes / No

Always ensure that the Full Assessment is sent along with this form and follow-up in completed between the referring and receiving agencies and that a transportation is in place for the referral.

REFERRAL CRITERIA

☐ **Temporary BMS indication:** ☐ During relactation ☐ Transition from mixed feeding to exclusive breastfeeding ☐ Short-term separation of infant and mother ☐ Short-term waiting period until wet nurse or donor human milk is available	☐ **Longer-term BMS indication:** ☐ Infant not breastfed pre-crisis ☐ Mother not wishing or unable to relactate ☐ Infant established on replacement feeding in the context of HIV ☐ Orphaned infant ☐ Infant whose mother is absent long-term ☐ Specific infant or maternal medical conditions[145] ☐ Very ill mother ☐ Infant rejected by mother

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	☐ A survivor of Gender Based Violence not wishing to breastfeed.

----------Cut here ----------

Part Two: To be completed at referring site and given to caretaker (as record of next steps and to show the referral facility)

Child's Name_____ Caregiver Name:_____

Referring Agency:_____ Referring Agency Contact Details: _____

Name of Referral Facility: _____ Location: _____

Contact Details: _____

When to Attend: Immediately/ Date: _____

Referral Transportation Plan: Self / Referring Agency Supported Transport.

Reason for Referral:

- ☐ **Temporary BMS indication:**
  - ☐ During relactation
  - ☐ Transition from mixed feeding to exclusive breastfeeding
  - ☐ Short-term separation of infant and mother
  - ☐ Short-term waiting period until wet nurse or donor human milk is available
- ☐ **Longer-term BMS indication:**
  - ☐ Infant not breastfed pre-crisis
  - ☐ Mother not wishing or unable to relactate
  - ☐ Infant established on replacement feeding in the context of HIV
  - ☐ Orphaned infant
  - ☐ Infant whose mother is absent long-term
  - ☐ Specific infant or maternal medical conditions[146]
  - ☐ Very ill mother
  - ☐ Infant rejected by mother
  - ☐ A survivor of Gender Based Violence not wishing to breastfeed.

Recommendations for Follow-up:

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Annex 14: BMS Resource Kit[147]

How to use a BMS Resource Kit

The items in the BMS Resource Kit are essential when supporting caregivers to make infant formula using powder at home. Powdered infant formula needs to be made using a specified amount of formula and boiled water no less than 70 degrees centigrade and then cooled rapidly before feeding to the infant.

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

Things to avoid

Breastfeeding saves lives, especially in emergencies and therefore any activities that may undermine breastfeeding such as providing a BMS Resource Kit must be undertaken sensitively and in a way that minimises this risk e.g. discretely. Providing breastfeeding mothers with something of equivalent or greater value to support breastfeeding should be seriously considered (see below).

Care should be taken when cup feeding – this can take time to learn but is very successful. Using the spoon to feed the baby can also be successful but is slower and the spoon should NOT be used to force open the babies mouth and may hurt the baby. Cup feeding following the guidelines is recommended.

Consider purchasing at the same time

Provision of powdered infant formula (PIF) should be carefully considered**.** PIF should be provided with the scoop from the manufacturer.

In order to ensure that breastfeeding is not undermined in emergencies by providing PIF to support caregivers of infants that have no possibility to be breastfed, then breastfeeding mothers should receive something of greater or equal value. The nature of this will depend on programming and what is valued by mothers in that context but may be vouchers, food, clothes.

BMS Resource Kit Items

Item Description	Unit	QTY
General Equipment & Supplies		
High quality thermos flask (Optional – depending on the situation)	Pce	2
Large cup (or jar with wide opening) for infant formula	Pce	1
Measuring scoop for water (Note: This can be a steel cup or glass with a line etched on it to indicate the exact amount of water to be mixed with one scoop of formula powder, as indicated by the manufacturer.)	Pce	1
Paper napkins (approximately 2 per feed x 8 feeds a day =16 + 5 extra a day to clean preparation area = 21 a day)	Pce	21 paper napkins a day
Water Purification Treatment (Aquatab) if necessary	Tablet	N/A

[147] Adapted from Save the Children 2016

Shallow bowl (to contain safe cold water for cooling the feed)	Pce	1
Small pot/kettle (for boiling water)	Pce	1
Small spoon	Pce	1
Small cup/medicine cup for cup feeding infant	Pce	1
Small basin (for washing equipment)	Pce	1
Soap (for washing hands and equipment) – when runs out it should be replaced.	Pce	2
Solid plastic box with lid (for storage. Preferably with a smooth flat lid which can be used as a washable preparation surface. If it does not have a smooth flat lid then plastic sheeting will be needed as a preparation surface)	Pce	1
Jerry can (20L)	Pce	1
Water (approx. 3 litres per day if using PIF)	Pce	N/A
Fuel (wood, charcoal, electricity) for boiling water	Pce	N/A
Guidelines for caregivers on using infant formula (BMS)	Pce	1

Annex 15: BMS Prescription Card

Prescription Card for infant milk formula[148]

Date: ____/____/_____

POC INFORMATION		
Child Name: _____ _____ First Name Last Name Sex: ☐ Male ☐ Female	Mother Name: _____ _____ First Name Last Name Address: _____	DOB: ____/____/_____ DD MM YYYY Tel. No. _____ Programme #:_____

REFERRAL CRITERIA	
☐ Social – No need for breast examination: For permanent infant condition no breast examination is needed (Only prescription).	☐ Medical – Breast examination (For temporary infant conditions and mother conditions).

PRESCRIPTION CRITERIA	
NON-MEDICAL – NO breast EXAMINATION	MEDICAL – *(To Be Filled by Health Provider, Midwife or Pediatrician)*
☐ Child is orphaned - wet-nursing is not possible. ☐ Child is temporarily or permanently separated from mother. ☐ Mother has stopped breastfeeding and re-lactation is: ☐ ongoing or ☐ failed. ☐ Infant rejected by mother ☐ Infant refuse breast milk	**Infant conditions (permanent – special formula needed):** ☐ Galactosemia ☐ Maple syrup urine disease ☐ Phenylketonuria ☐a syndrome or an inborn error in metabolism **Infant conditions (Temporary):** ☐ low birth weight (1.5 < gm) ☐ pre-term infant (< 32 weeks of gestational age) ☐ Newborn at risk of hypoglycemia **Mother conditions - with Breast Feeding (Temporary):** ☐ Breast abscess ☐ Hepatitis B ☐ Hepatitis C ☐ Mastitis ☐ TB ☐ Substance use ☐Engorged breast, flat/inverted nipples **Mother conditions- No Breast Feeding (Temporary):** ☐ Severe illness ☐ Medication contra indication[149] ☐ Herpes simplex virus type 1 (HSV-1)

Prescription (to Pharmacy)

Date of Prescription: ____/____/_____
DD MM YYYY

Child Name : _____ _____ DOB: ____/____/_____ Sex: ☐ Male UNHCR #:_____
First Name Last Name DD MM YYYY ☐ Female

Qty in Ml/ Day: ____ Number of Days: ____ Total Qty (tin): _____

Date of follow up: ____/____/_____
DD MM YYYY

IYCF counselor name: _____ Staff Name: _____(pediatrician/midwife)
Signature: _____ Signature: _____

SC Manager or LGA Nutrition Manager Approval

[148] Adapted from IMC Jordan

[149] Sedating psychotherapeutic drugs, anti-epileptic drugs and opioids; Radioactive iodine-131 is better avoided given that safer alternatives are available; excessive use of topical iodine or iodophors

Official Stamp

Date: _____

Name: _____

Organisation:_____

Job Title: _____

Annex 16: Generic BMS Label and Educational Tools[150]

Example of a Generic Label for Powdered Infant Formula

The details will need to be changed according to the size of the powdered infant formula tin and the manufacturer's details. The label MUST be in the local language.

INFANT FORMULA
Suitable from birth

IMPORTANT NOTICE – WARNING!
A mother's breastmilk is always the best food for her infant.
Only use this milk if there is a medical reason to do so or if it is not possible for the baby to have breastmilk.

The milk in this tin is similar to all the brands of infant formula on sale. It is made from dried cow's milk and is suitable for babies from birth. When mixed with clean boiled drinking water it will provide all the food a baby needs until about six months of age. There is no need to add other foods unless this is advised by a health worker. However, like all artificial formulas it does not contain the living antibodies which are in mother's milk. It will not protect your baby against infections (such as diarrhoea, coughs or colds).

using this milk it might not be easy to start breastfeeding again. (*People working for baby food and feeding bottle companies should not give you advice on how to feed your baby)

This product must not be used after date printed at the bottom of the tin/pack. Keep in a cool, dry place with the lid (or seal) tightly closed. (Production date, batch no, etc.)
[*Address of factory manufacturing and packing this product, in 6 point type, no logo*]

500

IMPORTANT WARNING

USE THIS MILK ONLY IF YOU CAN SAY YES TO ALL THESE QUESTIONS:

✓ Is there a medical reason why you should not breastfeed?

✓ Can you understand all the instructions on this tin?

✓ Do you have everything you need to make this milk up properly? For example, it will be very difficult if you do not have a water supply to your home.

✓ Will you be able to get enough powder to last your baby until she/he is about six months old? You will need about forty 500 gram tins for six months.

· **UNBOILED WATER AND UNCLEAN CUPS CAN MAKE YOUR BABY ILL.**

· **DO NOT KEEP LEFTOVER MILK** – Drink it yourself or give it to an older child. It will become unclean and unsafe for your baby if you try to keep it for another feed.

[150] Adapted from Save the Children: IYCF-E Toolkit 2017: *https://resourcecentre.savethechildren.net/iycf-e*

· If you use **TOO MUCH** powder your baby could become dehydrated and sick. If you do not use **ENOUGH** your baby will not get enough food.

NUTRITIONAL INFORMATION

INGREDIENTS: dried cow's milk, lactose, vegetable oil, whey, calcium citrate, potassium citrate, sodium chloride, calcium carbonate, potassium carbonate, vitamin C, L-arginine, calcium chloride, magnesium carbonate, ferrous lactate, vitamin E, niacin, zinc sulphate, pantothenate, copper sulphate, vitamin A, vitamin B6, vitamin B1, follacin, potassium iodide, vitamin K1, biotin (vitamin H), vitamin D3, vitamin B12.

Analysis per 100 ml prepared feed [*details to be added by manufacturers*]

ENERGY
PROTEIN
CARBOHYDRATE
FAT
FIBRE
SODIUM

FEEDING GUIDE

Age of baby	No of tins needed for the month	No of **large scoops** of water per feed	No of **small scoops** of powder per feed	No of feeds per day
1st month	4	2	2	8
2nd month	6	3	3	7
3rd month	7	4	4	6
4th month	7	4	4	6
5th month	8	5	5	6
6th month	8	5	5	6

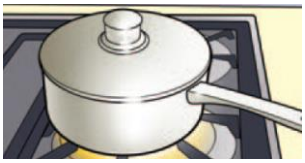
The guide above shows how much milk your baby might need. Some babies need more. If you are anxious, ask for your baby's weight to be checked

HOW TO FEED A BABY WITH A CUP

- Hold your baby sitting or half sitting on your lap.
- Keep a small cup of milk near the baby's lips. Tilt the cup until the milk touches his lips. The cup should rest gently on the baby's lower lip and the edges of the cup should rest on the outer edge of the upper lip of the baby.
- This will alert the baby, who will open his mouth and eyes. A baby born too small will begin to lick the milk with his tongue. A baby born at term or older will suck up the milk, but a little milk will fall from his lips.
- Do not pour the milk into the baby's mouth. Continue to hold the cup near the lip of the baby, allowing him/her to drink.
- When the baby has had enough, he/she closes his mouth and refuses to take more. A baby who has not drunk enough during a meal may take more the next, or you can increase the frequency of meals.
- Measure the consumption of the baby per day rather than per meal

POWDERED INFANT FORMULA PREPARATION INSTRUCTIONS: *Follow these carefully*

1. Wash your hands with soap and water



2. Boil safe water until it reaches a rolling boil. Allow it to boil for 2 Minutes

3. Pour boiling water over mixing cup, smaller feeding cup and mixing spoon. Do not use a feeding bottle.

4. Pour the correct amount of boiled water into the cup. This water should not be less than 70°C so do not leave it for more than 30 minutes after boiling

5. Fill the small scoop with powder. Add to the water. Mix thoroughly.

6. Cool the feed quickly by placing the cup into a shallow bowl of safe cold water. Ensure the water level is below the rim of the cup. When the cup feels just warm, dry the outside of the cup

7. Check the temperature of the feed before giving it to the child

8. Hold your baby close to you and give as much milk as he/she wants. Do not pour milk quickly into his/her mouth – let him/her sip slowly.

Annex 17: BMS Home Visit Follow Up Form[151]

BMS Home Visit Follow-up Form

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

Home Visit Information		
Date: _____/_____/_____	Referral Follow-up in SC Required: Yes / No	
Health Worker (name): _____ Job Title/Designation: _____ Location: _____ Contact Information/Phone Number: _____		
Referral to SC for Further Follow-up When to Attend: Immediately/ Date: _____ Referral Transportation Plan: Self/ Referring Agency Supported Transport.		
Person of Concern Details		
Child Name: _____ Sex: ☐ Male ☐ Female Child Age in Months:_____	Mother/Caregiver Name: _____ Contact Details/Telephone Number: _____	Mother/Caregiver location/address: _____ _____ _____

	Observations	**Yes/ No**	**Concerns / Comments**
Breastmilk substitute (eg. Infant formula)	Breastmilk substitute is suitable for child's age?		
	Expiry date clearly marked, and not past		
	Instructions written in users own language		
	Preparer or another household member is able to read label's instructions		
	Caregiver is easily able to obtain sufficient formula until the child is at least 6 months of age		
	Subsequent visit: Quantity used since last distribution is appropriate		
	Quantity remaining is sufficient until next distribution		
Storage	Safe storage/tightly closed containers used for ingredients		
	BMS feeds prepared in advance only if refrigeration is available		
	Drinking water is stored in a special container (clean, with cover)		

[151] Adapted from Save the Children 2016 and IMC Jordan BMS Programme Guidance

Preparation facilities	Adequate fuel is available for boiling water (and for cleaning feeding equipment)		
	Adequate drinking water is available for preparing several feeds per day (at least 1 litre)		
	Adequate other water and soap are available for washing utensils and hands		
	Clean surface is available to put utensils on (and a clean cover for them)		
	Suitable means of measuring milk and water		
Extra time	Time to prepare 6-8 fresh feeds per day		

Procedures – how does the caretaker manage the feeding?

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

Annex 18: Draft Joint Statement on IYCF

[LOGOS of GOVT, WHO, UNICEF in Header]

Infant and Young Child Feeding in Sudan
A JOINT STATEMENT
[DATE]

In Sudan, the persistent food insecurity is a key driver of malnutrition among children under five years and pregnant and lactating women. The other drivers of malnutrition are multi-factorial including conflict, displacement, poverty, poor WASH, limited access to health services and poor dietary diversity. This is further exacerbated by annual flooding and disease outbreaks. Amidst this, to protect the health and wellbeing of the people of Sudan and based on the **Infant and Young Child Feeding Strategy 2015-2024** and relevant national policies and guidance, the Ministry of Health and partners remind everyone of:

- ✓ The importance of promoting and supporting breastfeeding and protecting the right of children to be breastfed and of mothers to breastfeed to ensure appropriate care for infants and young children.
- ✓ The **importance of abiding by Law** and the protection against unethical marketing of products that replace breastfeeding.

Rationale

Protecting and supporting exclusive breastfeeding in normal situations and particularly in crises is key, as breastfeeding provides a protective measure against the increased risks of illness among infants, ensures safe and available nutrition for the baby and provides a comforting environment for both the mother and baby.

Recommendations

Exclusive breastfeeding of infants during the first six months, with no introduction of other food or drinks even water, is the ideal natural nutrition, as it meets the nutritional requirements of the infant and provides valuable protection from disease and infection. After 6 months, the infants' requirements increase beyond what is provided by breast milk alone, and therefore infants should receive complementary foods in addition to breast milk up to two years and beyond.

What can you do to support and protect breastfeeding?

Support exclusive breastfeeding for the first 6 months of life and continued breastfeeding up to 2 years or beyond

- ✓ Prioritize access to food and safe water to mothers with infants less than 2 years of age
- ✓ Encourage and support mothers to continue breastfeeding. Mothers may be stressed; therefore, it is important to provide assurance and safe havens for them to exclusively breastfeeding.
- ✓ Identify and refer mothers and babies who need more support with breastfeeding to the closest health or nutrition center.

Support complementary feeding and ensure that it is age appropriate, nutritionally adequate, and safely prepared.

Protect breastfeeding and abide by Law based on the International Code of Marketing of Breast- Milk Substitutes including:

- ☒ Never include infant formula or any other milk products including powdered or Ultra High Temperature milk in the general distribution of food or food baskets.
- ☒ Never accept unsolicited donations of any milk products or distribute donations to the general population.

What can you do to help families with infants less than one year who are not breastfed?

- ✓ Refer to a health care center or to the nearest nutrition focal point

For more information please contact:

Annex 19: BMS Code Monitoring Form

BMS Code Monitoring in Emergency Situations

The form should be submitted to [Country] Nutrition Cluster at xxx.

Add here in-country contact details (name, email and phone number of person responsible for Code Monitoring data collection. It can be someone from the Cluster Coordination team or designated lead agency (usually UNICEF)

The International Code of Marketing of Breastmilk Substitutes (BMS Code) and relevant World Health Assembly resolutions are operational in all situations. Communities that have been struck by emergency situations like war or natural disasters may encounter influxes of unsolicited supplies of breastmilk substitutes and other products that run counter to international guidelines. Usual marketing activities may take on different dimensions as companies try to reposition themselves in destabilised markets. Sometimes, it is non-governmental organisations or others involved in the humanitarian response, even governments that are directly violating the International Code rather than companies. Reports of Code violations in emergency situations will enable the right responses to be taken by policy makers and aid agencies.

Name: _____ Address: _____

Organisation: _____ Email: _____

The above information is necessary to enable Nutrition Cluster to double-check the information you have given, if necessary.
Your identity will be kept confidential

* *

Type of emergency: *(please answer all questions, especially the when, where, who, what and how)*

---

1. Short description of violation *(name of emergency relief programme, heading or slogan found on company/campaign materials)*

---

2. **When** was the violation observed? (dd/mm/yyyy) _____
3. **Where?** (place, city and country) _____
4. **Who** is violating the Code and **how**? _____

Company/organisation	*Brand*	*Type of product*[1]	*Type of violation*[2]

[1] **Type of product**

A. Infant formula including special formula
B. Follow-up formula
C. Growing-up milk
D. Cereal
E. Fruit/vegetables/meat puree
F. Juice/tea/mineral water
G. Bottle
H. Teat
I. Other:_____

[2] **Type of violation**

A. Donations of the BMS/bottles/teats from agencies, government, donors, etc;
B. Accepting unsolicited donations of BMS/bottles/teats;
C. Blanket distribution of unsolicited or free supplies of BMS/bottles/teats;
D. Distribution of formula that has been properly procured other than to mothers and babies that have been professionally assessed as requiring formula
E. Donations of complementary food to children 0-5 months;
F. Distribution of milk products (incl. dried) that can be potentially used as BMS to general population;
G. Distribution of infant formula with less than 6 months shelf life;
H. Inadequate labelling (no health hazard warning, inappropriate language, no statement on BF superiority, no info on safe preparation, etc.)
I. Promotion of BMS at the distribution point (displays, logos, etc,);
J. Other (specify)

5. Details: For e.g. describe how products are distributed to affected communities/nature of the relief programme
(please use another sheet of paper if necessary)

If specimen or picture is attached to this form, tick here ☐

The tool was developed by the Global Nutrition Cluster with support from IBFAN, IFE Core group and UNICEF

Annex 20: Proposed IYCF Indicators[152]

(Return to Section)

Nutrition Information System and DHIS Output Indicators

SL	Indicator	Definition	Source	Formula	Frequency
1	# (%) of pregnant women counselled on MIYCN (individual counselling) first time	The number of pregnant women that received one on one counselling (Individual counselling) first time ONLY	MIYCN Facility Reporting Tool; MIYCN Community Reporting Tool	Numerator: Total # of pregnant women counselled individually for the first time Denominator: Total estimated # of pregnant women	Monthly
2	# (%) of pregnant women counselled on MIYCN (individual counselling) more than one time (follow-up)	The number of pregnant women that received one on one counselling (Individual counselling) more than one time (follow-up ONLY)	MIYCN Facility Reporting Tool; MIYCN Community Reporting Tool	Numerator: Total # of pregnant women counselled individually for more than one time Denominator: Total estimated # of pregnant women	Monthly
3	# (%) mothers/ caregivers of children 0-6 months counselled on MIYCN (individual counselling) first time	The number of mothers/caregivers of children 0-6months that received one on one counselling (Individual counselling) first time ONLY	MIYCN Facility Reporting Tool; MIYCN Community Reporting Tool	Total # of mothers/ caregivers of children 0-6 months counselled individually for the first time; Denominator: Total estimated # of pregnant women	Monthly

[152] Adapted from OCHA Indicator Registry https://ir.hpc.tools/indicators/global_clusters/9/sub_domain/n2-infant-and-young-child-feeding-673?s=&page=1

4	# (%) mothers/ caregivers of children 0-6 months counselled on MIYCN (individual counselling) more than one time	The number of mothers/caregivers of children 0-6months that received one on one counselling (Individual counselling) more than time (follow-up ONLY)	MIYCN Facility Reporting Tool; MIYCN Community Reporting Tool	Numerator: Total # of mothers/ caregivers of children 0-6 months counselled individually for more than one time; Denominator: Total estimated # of pregnant women	Monthly
5	# (%) mothers/ caregivers of children 6-23 months counselled on MIYCN (individual counselling) first time	The number of mothers/caregivers of children 6-23 months that received one on one counselling (Individual counselling) first time ONLY	MIYCN Facility Reporting Tool; MIYCN Community Reporting Tool	Numerator: Total # of mothers/primary caregivers of children 6-23 months counselled individually for the first time; Denominator: Total estimated # of pregnant women	Monthly
6	# (%) mothers/ caregivers of children 6-23 months counselled on MIYCN (individual counselling) more than one time	The number of mothers/caregivers of children 6-23 months that received one on one counselling (Individual counselling) more than one time (follow-up ONLY)	MIYCN Facility Reporting Tool; MIYCN Community Reporting Tool	Numerator: Total # of mothers/primary caregivers of children 6-23 months counselled individually for more than one time; Denominator: Total estimated # of pregnant women	Monthly

7	# (%) of pregnant mothers/caregivers of children 0-23 months attending mother support groups first time	Total number of pregnant and mothers/caregivers attending mother support groups for the first time	MIYCN Community Reporting Tool for Mother Support Group	Not needed	Monthly
8	# (%) of pregnant mothers/caregivers of children 0-23 months attending mother support groups more than one time	Total number of pregnant and mothers/caregivers attending mother support groups more than one time	MIYCN Community Reporting Tool for Mother Support Group	Not needed	Monthly
9	# of men attending father support groups first time	Total number of men of pregnant and mothers of children 0-23 months attending Father support groups first time	MIYCN Community Reporting Tool for Father Support Group	Not needed	Monthly
10	# of men attending father support groups more than one time	Total number of men of pregnant and mothers of children 0-23 months attending Father support groups more than one time	MIYCN Community Reporting Tool for Father Support Group	Not needed	Monthly

11	# mother support groups operational	Mother Support Groups that met at least once during the reporting period	MIYCN Facility Reporting Tool; MIYCN Community Reporting Tool	Numerator: Total # of Mother Support Groups that reported; Denominator: Total # of Mother Support Groups established	Monthly
12	# father support groups operational	Father Support Groups that met at least once during the reporting period	MIYCN Facility Reporting Tool; MIYCN Community Reporting Tool	Numerator: Total # of Father Support Groups that reported; Denominator: Total # of Father Support Groups established	Monthly
13	# (%) of Health and Nutrition facilities with a dedicated MIYCN corner with MIYCN counsellor	Health facilities (Hospital/PHCC /PHCU) and separate CMAM (OTP/TSFP) sites that have a dedicated MIYCN corner with MIYCN counsellor	MIYCN Facility Reporting Tool; MIYCN Community Reporting Tool	Numerator: Total # of Health and Nutrition facilities that have a dedicated MIYCN corner with counsellor Denominator: Total # of Health and Nutrition facilities	Monthly
14	# (%) of mothers/caregivers of non-breastfeed children 0-23 months received counselling and BMS support (1st time and Follow Up)	Mothers/caregivers of non-breastfeed children 0-23 that received BMS support	MIYCN Facility Reporting Tool	Numerator: Total # of primary caregivers of non-breastfeed children 0-23 months counselled that received BMS support Denominator: Total # of mothers/caregivers of non-breastfeed children 0-23 months	Monthly
15	# (%) of code violation reports that received feedback from the	The total number (proportion) of the reported donations, where	BMS Monitoring register	Numerator: Total # of violations reports with a feedback	Quarterly

mandated authority (sector/cluster/MOH)	the agency received a feedback from the mandated authority (sector/cluster/MOH)	Denominator: Total # of reports submitted during the period

Assessment Indicators for MIYCN Baseline and Outcome Survey[153]

SL	Indicator	Baseline	Target	Definition	Source	Formula
1	Ever breastfed (EvBF)	X	≥80%	Proportion of children born in the last 24 months who were ever breastfed.	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Number of children born in the last 24 months who were ever breastfed. Denominator: Children born in the last 24 months.
2	Early initiation of Breastfeeding (EIBF)	X	≥80%	Percentage of children born in the last 24 months who were put to the breast within one hour of birth.	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children born in the last 24 months who were put to the breast within one hour of birth. Denominator: Children born in the last 24 months.
3	Exclusively breastfed for the first two days after birth (EBF2D)	X	XX	Proportion of children born in the last 24 months who were fed exclusively with breastmilk for the first two days after birth.	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children born in the last 24 months who fed exclusively with breastmilk for the first two days after birth. Denominator: Children born in the last 24 months.

[153] NOTE: The newly updated April 2021 WHO IYCF Indicators have not been updated in the OCHA Indicator Registry and therefore no baseline or target is currently included in this document. It is recommended that this is updated once the Indicator Register is updated.

4	Exclusive breastfeeding under six months (EBF)	X	XX	Proportion of children 0-5 months of age who were fed exclusively with breastmilk during the previous day	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Infants 0-5 months of age who were fed only breastmilk during the previous day Denominator: Infants 0-5 months of age
5	Mixed milk feeding under six months (MixMF)	X	XX	Percentage of infants 0-5 months of age who were fed formula and/or animal milk in addition to breastmilk during the previous day	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Infants 0-5 months of age who were fed formula and/or animal milk in addition to breastmilk during the previous day Denominator: Infants 0-5 months of age
6	Continued breastfeeding 12-23 months (CBF)	X	XX	Percentage of children 12-23 months of age who were fed breastmilk during the previous day	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children 12-23 months of age who were fed breastmilk during the previous day; Denominator: Children 12-23 months of age
7	Introduction of solid, semi-solid or soft food 6-8 months (ISSSF)	X	No standard; <80% generally a priority	Percentage of infatns 6-8 months of age who received solid, semi-solid or soft foods during the previous day	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Infants 6-8 months who received solid, semi-solid or soft foods during the previous day; Denominator: Infants 6-8 months of age

8	Minimum dietary diversity 6-23 months (MDD)	X	No standard; <80% generally a priority	Percentage of children 6-23 months of age who consumed foods and beverages from at least five out of the eight defined food groups during the previous day.	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children 6-23 months of age who consumed foods and beverages from at least five out of eight food groups during the previous day;[154] Denominator: Children 6-23 months of age
9	Minimum Meal Frequency 6-23 months (MMF)	X	No standard; <80% generally a priority	Percentage of children 6-23 months of age who consumed, solid, semi-solid or soft foods (also including milk feeds for non-breastfed children) at least the minimum number of times during the previous day.	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children 6-23 months of age who consumed solid, semi-solid, or soft foods at least the minimum number of times during the previous day.[155] Denominator: Children 6-23 months of age
10	Minimum milk feeding frequency for non-breastfed children 6-23 months (MMFF)	X	XX	Percentage on non-breastfed children 6-23 months of age who consumed at least two milk feeds during the previous day.	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Non-breastfed children 6-23 months of age who consumed at least two milk feeds during the previous day. Denominator: Non-breastfed children 6-23 months of age

[154] The eight food groups used for tabulation of this indicator are: 1) breastmilk, 2) grains, roots, tubers and plaintains, 3) pulses (beans, peas, lentils), nuts and seeds, 4) dairy products (milk, infant formula, yogurt, cheese), 5) flesh foods (meat, fish, poultry, organ meats), 6) eggs, 7) vitamin-A rich fruits and vegetables, 8) other fruits and vegetables.

[155] The minimum number of times is defined as: 1) two feedings of solid, semi-solid, or soft foods for breastfed children aged 6-8 months, 2) three feedings of solid, semi-solid, or soft foods for breastfed children aged 0-23 months, 3) four feedings of solid, semi-solid, or soft foods or milk feeds for non-breastfed children aged 6-23 months whereby at least one of the four feeds must be a solid, semi-solid, or soft feed.

11	Minimum acceptable diet 6-23 months (MAD)	X	No standard; <80% generally a priority	Percentage of children 6-23 months of age who consumed a minimum acceptable diet during the previous day.	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children 6-23 months of age who consumed a minimum acceptable diet during the previous day.[156] Denominator: Children 6-23 months of age
12	Egg and/or flesh food consumption 6-23 months (EFF)	X	XX	Percentage of children 6-23 months of age who consumed egg and/or flesh food during the previous day	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children 6-23 months of age who consumed egg and/or flesh food during the previous day Denominator: Children 6-23 months of age
13	Sweet Beverage Consumption 6-23 months (SwB)	X	XX	Percentage of children 6-23 months of age who consumed a sweet beverage during the previous day.	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children 6-23 months of age who consumed a sweet beverage during the previous day. Denominator: Children 6-23 months of age

[156] The Minimum acceptable diet is defined as: 1) for breastfed children: receiving at least the minimum dietary diversity and minimum meal frequency for their age during the previous day, 2) for non-breastfed children: receiving at least the minimum dietary diversity and minimum meal frequency for their age during the previous day as well as at least two milk feeds.

14	Unhealthy food consumption 6-23 months (UFC)	X	XX	Percentage of children 6-23 months of age who consumed selected sentinel unhealthy foods during the previous day	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children 6-23 months of age who consumed selected sentinel unhealthy foods during the previous day[157] Denominator: Children 6-23 months of age
15	Zero vegetable of fruit consumption 6-23 months (ZVF)	X	XX	Percentage of children 6-23 months of age who did not consume any vegetables or fruits during the previous day	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children 6-23 months of age who did not consume any vegetables or fruits during the previous day Denominator: Children 6-23 months of age
16	Bottle Feeding 0-23 months (BoF)	X	XX	Percentage of children 0-23 months of age who were fed from a bottle with a nipple during the previous day	National: DHIS2; Subnational: Baseline or Outcome survey	Numerator: Children 0-23 months of age who were fed from a bottle with a nipple during the previous day Denominator: Children 0-3 months of age
17	Infant feeding area graphs (AG)	X	XX	While the indicators recommended above are useful for comparing population groups, targeting programmes, and evaluating progress over time, they provide a limited understanding of how population-level feeding patterns change with the age of the infant. In addition to calculating numerical indicators, we also recommend presenting graphic displays of how IYC are fed.		

[157] Selected sentinel unhealthy foods examples (not an exhaustive list and foods might change country to country): Candies, chocolate, ice cream, cakes, pastries, sweet biscuits, chips, cheese puffs, french fries, instant noodles; including commercially produced, street vendors, or in home production.

	The standard recommended area graph classifies IYC into one of six categories: exclusively breastfed; breastfed and plain water only; breastfed and non-milk liquids (no solid or semi-solid foods and no animal milk-based liquids or infant formula); breastfed and animal milk or formula (no solid or semi-solid foods); breastfed and solid or semi-solid foods; or not breastfed.