Nutrition Wing
Ministry of National Health Services,
Regulations & Coordination
Government of Pakistan

unicef

IYCF in Emergencies Guidelines

2017

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ABOUT THE GUIDELINES

IYCF-E should be a priority in every emergency as it is both a preventive and life-saving activity, as well as promoting longer-term growth and development.

Infants and young children are among the most vulnerable groups in emergencies. Interruption of breastfeeding and inappropriate complementary feeding increase the risks of malnutrition, illness and mortality. In the context of emergencies the responsibility for protecting, promoting and supporting beneficial infant and young child feeding practices and minimizing harmful practices should be shared by the emergency-affected host country and all those involved in the emergency response.

The aim of the Pakistan IYCF-E Guidelines document is to provide clear, concise, easily adaptable, practical guidance for organizing strategic, efficient, coordinated responses to protect, promote and support appropriate infant and young child feeding in any natural hazard or conflict-induced emergencies that may occur in Pakistan.

Serving as a basis for action the document:

- Clarifies the optimal IYCF practices, and the challenges faced during emergencies
- Informs stakeholders about key interventions required to protect, promote and support optimal feeding for infants and young children that should be routinely included in emergency responses – and which extend to non-emergency situations, particularly in the interest of emergency preparedness and recovery
- Provides a set of minimum reporting standards

The Guidelines are not prescriptive. Responses need to be adaptive and flexible considering the diverse nature of emergency contexts -the type, impact, stage, and setting of the hazard – and the nature of the population – their vulnerability and exposure to risk.

The document does not provide complete guidance. It is intended to complement and be used in conjunction with other manuals, guidelines, training curricula, and other practical field-oriented documentation relevant to IYCF-E, for example: national and provincial emergency and non-emergency guidelines and strategy documents, including those of other sectors, and national and international documents that define best practices for IYCF-E.

The IYCF-E Guidelines are intended for use by all actors/ agencies throughout Pakistan who are involved, either directly or indirectly, with planning and implementing IYCF emergency preparedness, response, and recovery activities. This includes national and provincial governments, United Nations (UN) agencies, national and international non-governmental organisations (NGOs), and donors.

The Guidelines were developed through a participatory process involving consultations with key representatives from national, provincial and district government, national and international NGOs, academia and technical experts in Islamabad, Baluchistan, Khyber Pakhtunkhwa, Punjab and Sindh and mothers and fathers affected by chronic and acute crises. They have been developed with consideration of national policies, strategies and programmes and the emergency context and are based on international and nationally agreed IYCF best practice standards and lessons learned from addressing IYCF-E globally and within Pakistan.

An effective IYCF response to emergencies will contribute longer-term strategies directed at achieving the Pakistan Sustainable Development Goal targets 2030, the Provincial Multi-sectoral Nutrition Strategies under the Government's Vision 2025 and the National Vision for Maternal, Neo-natal, Child, Adolescent Heath and Nutrition 2016-2025.

The term 'emergency' used in these guidelines refers to “humanitarian emergency”.

FORWARD

Suboptimal IYCF practices increase vulnerability to undernutrition, illness and death. They are a strong contributor to the endemically high rates of malnutrition, stunting, wasting and micronutrient deficiencies, suffered by young children in Pakistan. The 2011 National Nutrition Survey (NNS 2011)3 based on 24-hour recall, found that 40.5% of mothers of children under 24 months of age had initiated breast feeding within one hour of birth, 12.9% of mothers exclusively breastfed and 63.5% predominantly breastfed their children under-6 months, and 77.3% continued breast feeding up to 12- 15 months. More than half (51.3%) of mothers across Pakistan reported that they had started giving semi solid foods to their children at 6 -8 months; the age-appropriate breastfeeding rate was 63.6%. Overall, only 3.0% of children received a diet that met the recommended dietary diversity, as the proportion of children 6-23.9 months of age who received foods from 4 or more food groups and 56.4% of mothers provided foods to their children at a minimally acceptable meal frequency.

Infants and young children under the age of two years are among the most vulnerable victims of natural or human-induced emergencies due to their age-specific nutrition needs and risk of infection and their complete dependency on others for their care. Conditions that arise during emergencies can greatly affect the appropriate and safe feeding of infants and young children; with the impact of sub-optimal IYCF practices exemplified. Emergency response to protect and support infant and young child feeding is often characterised in practice by poor management of artificial feeding, lack of attention to breastfeeding, inadequate skilled breastfeeding support and lack of support and attention to appropriate and timely complementary feeding. All the above can contribute to increasing the risk of morbidity and mortality of infants and young children, both during the emergency, especially through diarrhoeal diseases, as well as after the emergency, through optimal IYCF practices having been undermined.

Infant and young child feeding in emergencies (IYCF-E) concerns the protection and support of appropriate, adequate and safe feeding for infants and young children under the age of 24 months in emergency situations, with the goal of safeguarding their survival, health, growth and development. Lessons learned from various country contexts globally show that to effectively protect, promote and support infant and young child feeding in emergency contexts, IYCF-E needs to be represented in emergency preparedness and response and coordination guidelines. The Pakistan IYCF-E Guidelines will support strategic responses for infant and young child feeding in emergency situations in Pakistan.

The role and contribution of different stakeholders and partners in developing this strategy is highly appreciated. These include Provincial & Regional Departments of Health, UN organization, International and National Organizations, Academia and Research Institutions especially AFPGMI, PIMS & HSA, Line Federal Ministries and Civil Society. I would like to acknowledge the hard work put in by Dr. Khawaja Masuood Ahmed from MoNHSR&C and Dr. Saba Shuja from UNICEF for development, review and finalization of the National IYCF Strategy for Pakistan.

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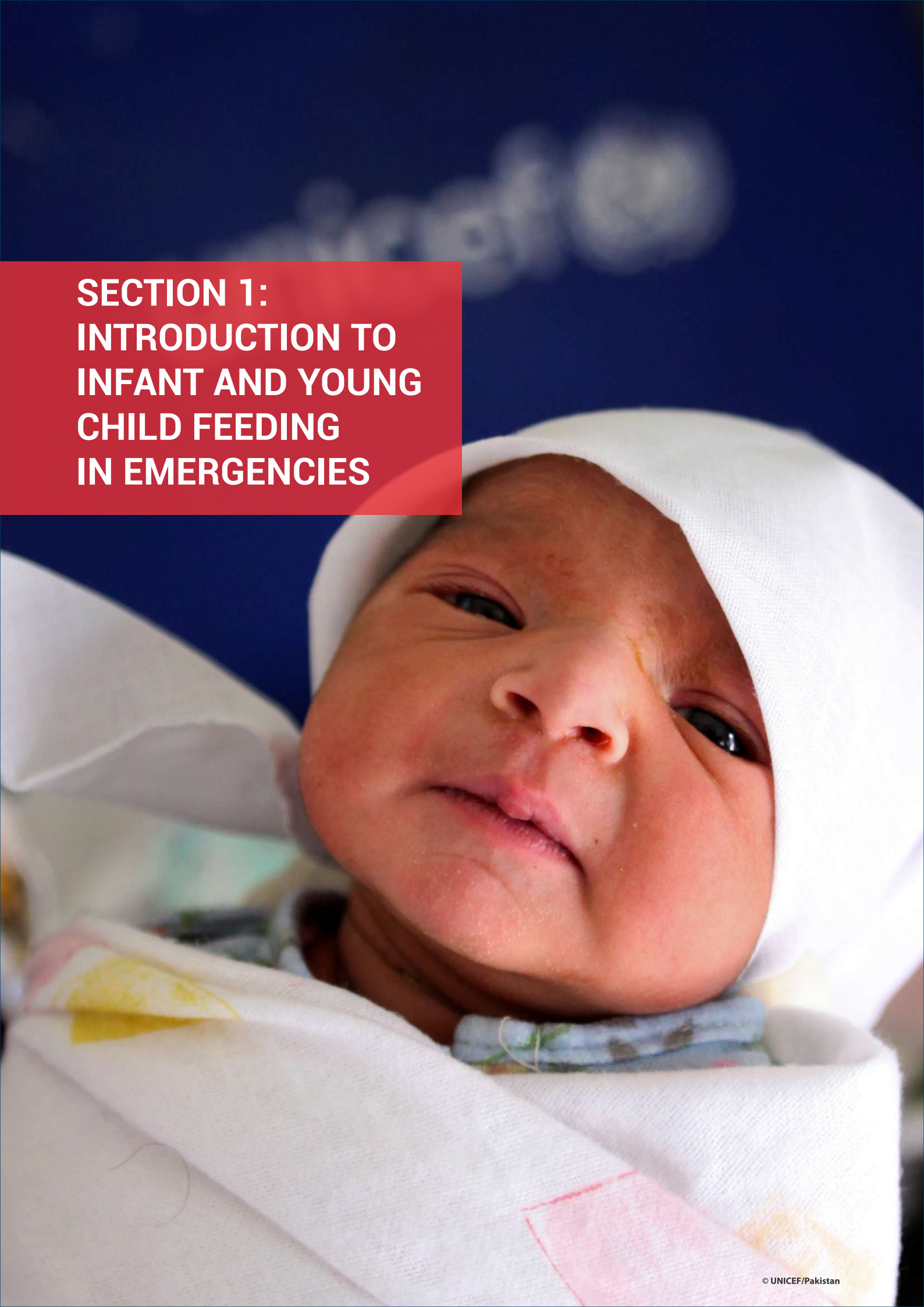
GLOSSARY

ABBREVIATIONS AND ACRONYMS

BMS	Breast Milk Substitute
CMAM	Community-based Management of Acute Malnutrition
CMW	Community Mid-Wives
DDMA	District Disaster Management Authority
DoH	Department of Health
FAO	Food and Agriculture Organization, of the United Nations
FSL	Food Security and Livelihoods
HIV / AIDS	Human Immuno-deficiency Virus / Acquired Immuno-Deficiency Syndrome
INGO	International Non-Government Organization
IRA	Initial Rapid Assessment
IYCF	Infant and Young Child Feeding
IYCF-E	Infant and Young Child Feeding in Emergencies
IYCF TAG	Infant and Young Child Feeding Technical Advisory group
LHV	Lady Health Visitor
LHW	Lady Health Worker
MIRA	Multi-sectoral Initial Rapid Assessment
MNCH	Maternal, Neo-natal and Child Health
MoH	Ministry of Health
MoNHSR&C	Ministry of National Health Services, Regulation & Coordination
NDMA	National Disaster Management Authority
NGO	Non-Government Organization
PDMA	Provincial Disaster Management Authority
PLW	Pregnant and Lactating Women
TBA	Traditional Birth Attendant
The Code	The International Code of Marketing of Breast Milk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
WASH	Water, Sanitation And Hygiene
WFP	World Food Programme
WHO	World Health Organization

SECTION 1: INTRODUCTION TO INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES



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INTRODUCTION

Introduction to Infant and Young Child Feeding in the Emergency Context

Children who get the right nutrition during the first 1000 days from conception until two years of age, have an increased chance of survival and optimal cognitive, motor-skill, physical, social and emotional development, laying a foundation for their life time. Any deficits acquired by age two years are difficult to reverse later.

The fundamental means of preventing poor nutrition and maximizing the health, growth and development for infants and young children is to ensure their optimal feeding and care.

Optimal feeding practices from age 0-2 years, known collectively as infant and young child feeding (IYCF) practices, include:

- Early initiation of breastfeeding (within an hour from birth);
- Exclusive breastfeeding for the first 6 months of life;
- Age-appropriate, nutritionally adequate and safe complementary foods starting at 6 months;
- Continued breastfeeding for 24 months or beyond.

Infants (defined as children <1 year) and young children (aged 1-2 years) are among the most vulnerable victims of natural and human-induced emergencies. The disease and death rates among children under two years are generally higher than for any other age group, primarily because of the combined impact of an increased incidence of communicable diseases, especially diarrhea, and possible increased rates of undernutrition and lack of appropriate health care.

Individual factors combined with conditions than arise during emergencies increase the vulnerability of infants and young children.

Infants and young children have: high nutrient requirements for growth and development; undeveloped immune systems and therefore a high risk (compared to other population groups) of contracting infections, which can further increase nutrient requirements, impede nutrient use and reduce appetite; complete dependence on others for their care, including feeding.

Conditions that arise during emergencies can greatly compromise the appropriate and safe feeding of infants and young children. These can include: inadequate shelter; lack of privacy; overcrowding; time and psychosocial constraints on caring capacity; weakened family and community social support structures; poor sanitation; compromised water quality and availability; breakdown of health structures and constrained availability of and access to quality services; disrupted or reduced availability, affordability and accessibility to food/liquids and non-food items.

The adverse effects of emergencies last long after the emergency, through optimal IYCF practices having been undermined.

What is the difference between IYCF and IYCF-E?

In emergency situations the principles and recommendations for optimal IYCF are the same as those that apply in non-emergency conditions, however the changed conditions create different needs and priorities that require a reorientation of service delivery.

IYCF-E	IYCF
Priority target groups: children under age 2 years, their caregivers, especially lactating women, and pregnant women	Priority target groups: children under age 5 years, their caregivers, especially lactating women, and pregnant women
Activities principally directed at reaching as many people and as quickly as possible, to save lives and mitigate the impact of the emergency. Behaviour change activities implemented after the initial phase.	Activities principally directed at individual and social long-term behaviour change and longer term development outcomes
Specialized responses/ services activated which have a life span limited to the duration of the emergency which during recovery are transitioned into non-emergency activities with longer-term development goals	Continuous services integrated with longer-term development goals

Appropriate and timely support of infant and young child feeding should be prioritized in all emergencies. It is both a preventive and life-saving intervention -while also promoting infant and young children's longer-term growth and development.

IYCF programming in emergencies needs to be prioritized because:

- Breastfeeding is safe, free and a crucial life-saving intervention for infants and young children, whose risk of illness and death increases markedly in emergencies;
- Emergencies exacerbate the risks of not breastfeeding and of feeding non-breast milk drinks and foods to children under age 6 months;
- Continued breastfeeding to 2 years is crucial to reduce the increased risk of illness, such as diarrhea;
- There may be indiscriminate distributions of breast milk substitutes; use of breast milk substitutes increases the risk of illness and death for infants;
- Optimal infant and young child feeding is central to reducing the high risk of undernutrition;
- Safe, nutritionally adequate, and appropriate complementary feeding, which significantly contributes to prevention of undernutrition and death in children after 6 months, is often jeopardized during emergencies and needs particular attention;
- Capacity of caregivers to feed and care for their children may be constrained as a result of the changed (emergency) environment.

The Pakistan IYCF-E Emergency Context

Pakistan is prone to monsoon floods, earthquakes, droughts, cyclones, extreme temperatures; it is rated among the ten countries in the world most vulnerable to the impact of climate change.

Pakistan also has a history of human-induced conflict and civil unrest. Conflict and floods experienced have created major displacements of populations.

Emergencies exacerbate the underlying nutrition crisis in Pakistan, as shown by previous emergencies (such as the monsoon floods of 2010, 2011 and 2012), which intensified malnutrition for populations who were already suffering from pre-emergency levels of malnutrition.

Several assessments have reported the adverse effects of emergencies on optimal IYCF practices, including: reduction in frequency and rates of breastfeeding (exclusive, predominant and continued); increased demand for infant formula and full-cream milk powder; donations of infant formula have not been controlled; strategies that adversely affect complementary feeding practices; early introduction of complementary foods; reduction in quantity, quality and frequency of complementary foods given.

Pakistan's concerning nutrition and IYCF context

Sub-optimal IYCF practices and acute infections are critical contributors to the endemically high rates of malnutrition (wasting, stunting, underweight and micronutrient deficiencies), exceeding emergency levels in areas across Pakistan.

According to several surveys Pakistan has low rates of early initiation of breastfeeding and exclusive breastfeeding for the first six months, and continued breastfeeding until the age of two years; rates of early introduction of complementary food before age 6-8 months are high; the traditional use of pre-lacteals is common practice; delayed introduction until 10 months is also reported. Use of bottles and teats is common. Few children receive a diet that meets the recommended minimum dietary diversity, and rates of complementary feeding at the minimum acceptable meal frequency are low. Consistency of first foods is typically of low energy density and young children's diets lack protein from animal foods. Children with low birth weight are particularly vulnerable to the effects of inadequate infant and young child feeding practices; in Pakistan approximately one-third of children are born with low birth weight.

Responding to emergencies in Pakistan

Humanitarian response in Pakistan is led by the Government Disaster Management Authorities, at national, provincial/ regional and district levels (NDMA; PDMA, DDMA), with the support of the security forces (who are often the first-line responders), district coordinators, civil society, and the international humanitarian community at the request of the Government. NDMA leads the role of regulating and directing employment and coordination of organizations (e.g. UN; INGOs, NGOs) to respond to an emergency. In the event of a declared emergency, the Cluster Coordination system is likely to be activated, co-chaired by the NDMA with UNICEF as the lead agency for the Nutrition Cluster. In the case of Nutrition Working Groups, the most likely co-lead will be UNICEF and Health Ministry or Health Departments.

IYCF PRIORITY AREAS

The priority IYCF areas to address in emergencies are:

- Protecting, promoting and supporting early initiation and exclusive breastfeeding of infants;
- Supporting the timely, safe, nutritionally adequate and appropriate complementary feeding;
- Minimizing the risks of artificial feeding;
- Supporting safe and adequate feeding for non-breastfed infants;
- Providing for the needs of pregnant and lactating women.

These are discussed below.

Protect, Promote and Support Early Initiation of Exclusive Breastfeeding of Infants

Infants should be exclusively breastfed from birth to 6 months of age, and breastfeeding continued until two years of age.

- Breastfeeding should be initiated within the first hour of birth so the newborn receives colostrum, which is the rich creamy-coloured milk produced in the first few days after delivery. Colostrum is highly nutritious and contains antibodies and other factors that provide children with natural protection against illness. It also benefits the mother, through stimulating contraction of the uterus and reducing postpartum blood loss.
- Infants should be exclusively breastfed for the first 6 months - meaning that the infant receives only breast milk - no other food or drink with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines. Breast milk provides all the food and water a baby needs, and should have, for the first complete six months of life.
- Breastfeeding should continue up to two years of age, or beyond, while also giving adequate complementary foods, starting from 6 months of age. For children 6-23 months breast milk still remains an important source of energy, high quality protein, vitamin A, anti-infective nutrients and emotional comfort.
- Breastfeeding from birth is possible for virtually every mother, except a few with rare conditions,
- Even though breastfeeding is a natural act, it is a complicated behaviour. Mothers need to learn how to breastfeed, and have support for breastfeeding from their husbands, families, communities and from the health care system.
- Factors that affect mothers' successful initiation and establishment of breastfeeding, and thus the prospects for continued breastfeeding up to 2 years include the attitude, technique, confidence and frequency.

Breast milk production works on a hormone-controlled demand-supply basis – the more breast milk a child suckles the more breast milk is made. To ensure ample milk supply, ensure the infant is correctly positioned and attached to the breast, and breastfed on demand (which means the infant suckles as often and as long as desired, day and night).

Breastfeeding in the Emergency Context

The benefits of exclusive breastfeeding to 6 months of age, and then continuing to receive breast milk in addition to complementary foods are even more important in the context of an emergency, which are typically characterized by a combination of food insecurity, lack of safe water, unsanitary conditions and stress.

- Breastfeeding, particularly exclusive breastfeeding, provides critical protection for infants from infection and may be an infant and young child's only safe and secure quality source of food.
- Breastfeeding also enhances bonding, physical warmth and care, and helps calm the child – and mother.
- However, mothers commonly face challenges to breastfeeding during emergencies.

Challenges to Breastfeeding in Emergency Contexts:

- Lack of confidence in their ability to provide adequate quality and quantity of breast milk, due to myths and misconceptions that mothers stress and poor diet reduce breast milk production and quality;
- Culturally-specific customs and beliefs, which may or may not be affected by the emergency context;
- Changes or breakdown in the community and family structure or health care system may reduce support available to the mothers, such as for early initiation, breastfeeding difficulties and continued breastfeeding;
- High demands placed on women's time and energy may interfere with frequency of breastfeeding;
- Post-traumatic stress, illness, and severe depression may cause mothers to stop breastfeeding;
- Breast milk substitutes donated and indiscriminately distributed may undermine women's efforts to breastfeed;
- Lack of privacy may restrict a mother's ability to comfortably breastfeed.

- Infants and young children who are not exclusively breastfed experience an increased risk of illness and death, due to diarrhea and other infections; the younger the child the more vulnerable. The increased risk applies to infants who are either partially breastfed (e.g. fed breast milk and infant formula or other food or fluid) or who are not breastfed at all. The risk is exemplified in emergency contexts.
- Special encouragement may be needed for women to sustain breastfeeding.
- Those infants under 6 months who are mixed fed (given both breast milk and infant formula) should be supported to move to exclusive breastfeeding.
- Mothers of non-breastfed infants need to be supported to breastfeed or, to use the most appropriate and safest alternative.

Support Timely, Safe, Nutritionally Adequate and Appropriate Complementary Feeding

To meet their requirements for healthy growth, development and activity, infants from 6 months onwards and young children need hygienically prepared, and easy-to-eat and digest foods with sufficient energy and nutrients to 'complement' that provided by breast milk.

Complementary feeding is the process of giving other - solid, semi-solid and soft- foods and liquids in addition to breast milk (or an appropriate BMS in the case of non-breastfed infants).

Breast milk remains an important source of energy, nutrients and anti-infection substances during the complementary feeding period from 6-23 months.

Ensuring that nutritional needs are met requires that complementary foods be:

- Timely: introduced at 6 months, when the need for energy and nutrients exceeds what can be provided through exclusive breastfeeding, and that the foods provided are age-appropriate;

- Adequate: provide sufficient energy, protein and micronutrients to meet a growing child's nutritional needs. This requires a variety/diversity of foods that they are fed frequently, as children have small stomachs;
- Appropriate: culturally acceptable, appealing to the child, and easily chewed and digested;
- Safe: hygienically stored, prepared, and fed with clean hands or utensils or cups – not bottles;
- Responsively fed: given consistent with a child's signals of appetite, and actively encouraging the child, even during illness, to consume sufficient food – are suitable for the child's age.

Complementary Feeding in the Emergency Context

Recommended complementary feeding practices are the same as in non-crisis contexts.

However, ensuring infants and young children receive safely prepared complementary foods that are rich in energy, protein and vitamins and minerals to meet the infants' changing nutritional requirements can be a significant challenge during emergencies, since constraints often exist.

Challenges to complementary feeding in emergency contexts:

- Continued breastfeeding practices may have been interrupted as a result of the emergency;
- Mother's time and capacity to access food, care for and frequently and responsively feed her child may be constrained;
- Breakdown in social support may reduce transfer of complementary feeding knowledge to mothers;
- Foods may be difficult to prepare into a soft, semi-solid form, due to lack of appropriate equipment;
- Traditional ingredients normally used to prepare complementary foods may not be accessible;
- Foods that are available may be unfamiliar;
- Environmental conditions (e.g. lack of safe water) may compromise safe food preparation and feeding;
- A child's appetite can be reduced, or lead to a refusal to eat, due to stress of the child or caregiver, illness, change from usual foods.

Poor pre-emergency complementary feeding practices further compound the challenges of ensuring appropriate complementary feeding during emergencies.

Appropriate, nutritionally adequate and safe complementary feeding should be a priority in emergencies. The practical, nutritional, and functional elements of complementary feeding need to be addressed:

1) The practical element comprises the preparation of complementary foods;
2) The nutritional element addresses the nutrient and energy density of the food;
3) The functional element concerns defining the use, role and appropriateness of food.

- Appropriate, adequate and safe complementary feeding should be a priority in emergencies.
- The emergency context may challenge the safety, quantity and quality of complementary foods but also the associated care practices that influence how, when and where caregivers provide food.
- The practical, nutritional and functional elements of complementary feeding need to be addressed.
- A non-prescriptive approach with multi-sectoral interventions targeted to the specific context is required to meet complementary feeding needs, due to the diverse nature and impact of emergencies, the environmental differences between regions, and the various influences on feeding practices.

Minimize the Risks of Breast Milk Substitutes

Breast milk substitutes - infant formula (otherwise termed 'artificial milk') and other milk products which replace breast milk when used - and bottles and teats must be tightly controlled in emergencies, because of the hazards associated with their use.

Use of breast milk substitutes (BMS), bottles and teats in emergency situations significantly increases the risk of morbidity and mortality to infants and young children, especially from diarrhea and malnutrition. Even in contexts where BMS use was prevalent before the emergency, the change in resulting circumstances may take away the conditions and the caregivers' ability to produce infant formula safely. Additionally, in emergencies caregivers are very vulnerable to having their confidence and ability to care for their children being reduced, particularly related to their capacity and ability to breastfeed, thereby increasing the risk that they may use BMSs.

Hazards Associated with the Use of Infant Formula and other Milk Products in Emergency Contexts

Problems with contamination

- Infant formula is intrinsically not sterile and once opened further provides risk of contamination;
- Water access can be constrained, making it difficult to clean equipment used for preparation;
- Fuel, cleaning equipment and cooking pots can be scarce, making it difficult to safely prepare infant formula;
- Use of bottles and teats is likely to increase with use of breast milk substitutes. They cannot be cleaned free of contamination.

Problems with reconstitution

- Over-dilution (done to reduce the cost of supplies) leads to malnutrition
- Under-dilution (done to conserve water) can cause renal failure, due to the high sodium and protein concentration
- Different brands and types of infant formula carry different mixing instructions, and may not be understood because they are in a foreign language or because caregivers are illiterate

Supply constraints

- A continuous supply of infant formula, or appropriate formula, is not always available or affordable

Risks to Infant feeding

- Easy access to infant formula can lead to an early and unnecessary reduction or cessation of breastfeeding, thereby disrupting the important nutritional and anti-infection benefits of breast milk.
- Feeding an infant from a bottle with a teat may cause “nipple confusion”, making it difficult for an infant to attach well to the breast.

Guidelines on the Use and Distribution of BMSs in Emergencies Contexts

The use and distribution of BMS in emergencies should be tightly controlled to protect infants and caregivers from inappropriate marketing of BMS and to control unsolicited donations and distribution of unsuitable products, according to national and international guidance:

The WHO 1981 international code of Marketing of Breast milk substitutes and subsequent relevant World Health Assembly Resolutions (collectively known as 'The Code'), the Pakistan Ordinance 2002 and Provincial Acts, in which the principles of The Code are imbedded. (See Annex: 1)

- Provision of breast milk substitutes should only be distributed when targeted to infants who have no possibility to receive breast milk, when there are no other viable breast milk options available, and provision should be governed by strict criteria (See section on Non-breastfed child)

- Unsolicited donations or subsidized supplies of breast milk substitutes and bottles and teats should be refused in emergency situations. Agencies should advocate against unsolicited or subsidized donations of BMS, bottle and teats. Any unsolicited or subsidized donations of breast milk substitutes, bottles and teats should be placed under the control of a lead coordinating body – the Nutrition Cluster.
- Dry and liquid milk products (including condensed milk and UHT milk) must never be provided as a single commodity, to prevent their use by children under 12 months
- Milk powder can be pre-mixed with a staple food (eg cereal flour or blended food), used as an ingredient in the local production of biscuits or cakes or in animal feeds – or destroyed.

Many Code violations relate to donations made in response to emergencies. They may occur as a result of infant formula and milk companies viewing the emergency situation as an 'opportunity' to enter or strengthen markets; humanitarian organizations, donors or government officials lacking awareness of the Code provisions; well-meaning members of society may donate infant formula, sometimes due to ill-advised media highlighting a need.

- Use of BMSs, bottles and teats in emergency situations significantly increases the risk of illness and death to infants and young children.
- Hazards associated with the use of BMS relate to contamination, inappropriate reconstitution, supply-access constraints and interference with breastfeeding.
- The use and distribution of BMS in emergencies must be tightly controlled, according to national and international guidance, to protect the lives of infants and young children. This must be widely communicated nationally and internationally.

Support Safe and Adequate Feeding for Non-breastfed Infants

Appropriate feeding for children with no possibility to be breastfed should be assured.

In addition to protecting, promoting and supporting breastfeeding in emergencies, it is fundamental to ensure that the needs of infants who are not breastfed or cannot be breastfed are met, as their vulnerability to illness and death increases during emergencies.

Infants less than six months old who are not breastfed in non-emergency situations are more than 14 times more likely to die from all causes than exclusively breastfed children. In emergency situations the risk is further elevated.

- Non-breastfed infants need early identification and targeted skilled feeding support, as their health and nutrition status can quickly deteriorate in emergency contexts.
- Special psychosocial counseling and peer support to the caregiver should be provided when the non-breastfed child's mother has died or is unable to breastfeed as a result of the emergency.

Breastfeeding from birth is possible for virtually every mother except a few rare conditions.

Breast milk feeding options for feeding non-breastfed children

Infants whose biological mothers are unavailable as well as those who have never been breastfed, should still have breast milk in their diets if at all possible. The possibility of re-lactation or wet-nursing should be investigated as the first options.

Re-lactation

- If breastfeeding is interrupted – for example due to temporary separation – mothers with children under age 12 months should be encouraged and supported to re-establish breastfeeding.
- To build mothers confidence in her ability to produce adequate amounts of milk, counseling and provision of food supplements may be helpful, especially if her nutritional status is poor.
- Breast pump "supplementer" devices, that allow supplementation during suckling, should only be used where culturally acceptable and hygiene for cleaning the equipment can be assured.

Wet nursing

- In the absence of a biological mother, pairing an infant with a healthy wet-nurse can be facilitated, if culturally and personally acceptable.
- Until a wet nurse has been identified, a child under six months of age should be fed with a suitable breast milk substitute.

Breast milk substitutes

BMSs should only be used when all options for accessing breast milk have been exhausted.

Infant formula

Feeding infant formula should be used as a last resort for infants under age 6 months - and for children aged 6-12 months if appropriate nutritious complementary foods are lacking.

The many disadvantages of using infant formula are exemplified in emergency contexts:

- Lacks breast milk's precise infant-specific balance of nutrients & appropriate temperature;
- Does not contain antibodies to protect against illness;
- Increases an infant's risk of infection, via bacteria & parasites that can contaminate the infant formula, water supplies & feeding equipment during storage, preparation & use;
- Can be incorrectly prepared;
- More difficult to digest, than breast milk;
- Requires access to resources (fuel, water, and equipment), which can be limited in emergencies.

(See previous section: Minimize the risks of breast milk substitutes)

Home-modified animal milk

Home-made breast milk substitutes of modified animal milk should only be given to non-breastfed infants below six months when there is no other feasible alternative option, such as re-lactation, wet nursing or infant formula. It lacks nutritional adequacy, particularly micronutrients, and it is difficult to ensure it's safe preparation.

Unmodified animal milk should not be introduced as a drink until the age of 12 months. Introduction of unmodified cow's milk and milk products before this age is an important nutritional risk factor for the development of iron deficiency anaemia and gastrointestinal bleeding.

- In addition to protecting, promoting and supporting breastfeeding in emergencies, it is fundamental to ensure that the needs of infants who are not breastfed or who cannot be breastfed are met.
- The possibility of re-lactation or wet nursing should be investigated as the first options for supporting non-breastfed infants.
- BMSs should only be used when all options for accessing breast milk have been exhausted.
- If an agency is considering providing infant formula to non-breastfed children an appropriate infant formula should be purchased, distributed and used according to the defined strict criteria, to ensure appropriate and safe feeding of the non-breastfed infants and the protection of breastfed infants.

Provide for the Needs of Mothers of Children aged 0-23 Months and Pregnant Women

It is important to respond to the special needs of caregivers, in particular pregnant and lactating women, recognizing that the health and caring capacity of the mother is an instrumental and inseparable determinant of appropriate infant and young child feeding practices.

The protection and support for the nutritional, physical and psychosocial dimensions of pregnant and lactating women, and other primary caregivers, is central to their health and well-being, and that of their children, directly through conception, pregnancy and lactation and indirectly through their child caring and feeding practices.

- Pregnant and lactating women have special nutritional needs. During pregnancy and lactation, women's needs for energy, protein, micronutrients and drinking water increase. Pregnant women require an additional 285 kcals/day, and lactating women require an additional 500 kcals/day. Adequate intake of iron, folate, vitamin A and iodine are particularly important for the health of both women and their infants.
- In addition to effects on maternal health, deficits in pregnant women's diets can contribute to restricted growth and development of the foetus and lack of stores of some micronutrients in the newborn child. The nutritional status and nutrient intakes of the mother also affects the concentration of some nutrients in breast milk.

A moderately malnourished woman can still successfully breastfed her baby but needs nutritional support to rehabilitate and protect her own nutritional status, and protect the micronutrient content of her breast milk. A guiding principle is: "Feed the mother for her to feed her child".

Women's Vulnerability in the Emergency C

Women, particularly pregnant and lactating women, are at greater risk from the impact and effects of humanitarian emergencies than men. Their vulnerability is related to their biological make-up and specific needs, context-specific sociocultural and economic aspects related to the role of gender in the society and the additional challenges they face in the context of an emergency. These impact on their capacity to care for and feed themselves and their children.

Women's time, knowledge and awareness, and empowerment are important determinants of child feeding and caring practices in both emergency - and non-emergency - contexts.

Challenges related to IYCF mothers may face in emergency contexts:

- Women may have low visibility and therefore their needs and concerns may not be identified.
- Women may face constraints accessing essential humanitarian services and resources as a result

of insecurity, limited access to information or limited decision-making power. Women heads of households may find it especially difficult to access resources and services.

- Distribution point queues may be long, no shelters provided for lactation, or aid packages too heavy to carry when also carrying a child.
- Emotional trauma may adversely impact on women's ability to appropriately feed and care for their children.
- Pregnant and lactating women are at particular risk of undernutrition due to their increased physiological requirements.
- Women may reduce their food intake, or intake of nutritious foods, to preferentially feed other family members.
- The traditional family and community support systems may not be available, to pass on information and provide support for optimal IYCF to pregnant women and caregivers.
- Lack of privacy for lactating women may disrupt appropriate breastfeeding practices.
- A mother's ability to care for and feed herself and her child may be compromised when overburdened with tasks, particularly when women elders and male heads of households are absent.
- Female health care providers may not be readily available, due to their own family commitments or lack of human resources capacity.

- The health and caring capacity of the mother is an instrumental and inseparable determinant of appropriate infant and young child nutrition, feeding and caring practices.
- Women are at greater risk from the impact of emergencies than men. Their vulnerability is related to their biological make-up and needs and sociocultural and economic status.
- Women's nutritional status, dignity, safety, time, knowledge and awareness, participation and decision-making must be supported in emergency contexts, to enable them to appropriately feed and care for their children.

SECTION 1 RESOURCES

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SECTION 2: ACTION PLANNING FOR INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES

IYCF-E OBJECTIVES, ENABLERS AND KEY ELEMENTS

PREPAREDNESS	RESPONSE	RECOVERY
General Objective: To develop national and provincial capacity to efficiently respond to any emergency so IYCF is protected and supported	**General Objective:** To provide timely and effective response actions during an emergency to protect, promote and support IYCF practices	**General Objective:** To build back a stronger, quality comprehensive system for the protection, promotion and support of IYCF practices in emergency-affected areas

ENABLERS

Policy, Standards and Guidelines
Leadership, Coordination Information Management

KEY ELEMENTS

Contingency planning and building Resilience

- Policy and Leadership
- Coordination
- Information management
- Communication
- Capacity development
- Building strong routine IYCF

Needs assessment

- Multi-sectoral Initial Rapid Assessment
- IYCF-E or Nutrition Initial Rapid Assessment
- Comprehensive IYCF-E Survey and Multi-sectoral Survey

Response interventions

- Basic and Specialized
- Integrated multi-sectoral

Monitoring, Evaluation, Learning, Accountability

Recovery planning

Identify recovery needs and capacities

Develop community resilience

Assess and strengthen capacity

Communicate priority needs

ENABLERS

Implementation of key policy and best practice guidance and strong coordination, supported by collaborative and timely information management, is critical. They are 'enablers' (or 'glue' components) to support the successful implementation of all emergency preparedness, response and recovery actions.

Policies, Standards and Guidelines

Policies, standards and guidelines guide best practice in humanitarian responses. Several instruments provide guidance for protecting, promoting and supporting appropriate infant and young child feeding. All agencies involved in humanitarian response should be informed on and adhere to nationally respected policies, guidelines and international standards of best practice. These include:

- The International Code of Marketing of Breast Milk Substitutes (1981) - with subsequent WHA resolutions (known as 'The Code')
- Operational Guidance on Infant and Young Child Feeding in Emergencies (2007)
- Sphere Handbook: Sphere Minimum Standards (2011)
- Pakistan Protection of Breast-Feeding and Child Nutrition Ordinance n. XC111 2002, and Rule (2009)
- Pakistan provincial Breast Feeding and Child Nutrition Acts
- Principles of Conduct for The International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programmes' (1994)
- Numerous 'best practice' technical and operational guidance tools produced by the Government, UN, NGOs and donor agencies.

ACTIONS:

- Ensure humanitarian stakeholders are informed on and adhere to policies and best practice operational and technical guidance
- Monitor, report and enforce violations to the Ordinance/The Code and best practice standards

Leadership and Coordination

Strong coordination of agencies and actors, who work together in a cohesive manner for collective outcomes, fosters a humanitarian response that is efficient, needs based, appropriate and effective.

Coordination is also required to ensure connectedness, through a joined up approach to humanitarian and development actions.

The Pakistan Government has the obligation to establish, lead and maintain mechanisms for coordination in humanitarian contexts.

Two major humanitarian coordination mechanisms can be activated to support the government in emergencies: UNHCR-led responses for refugee concerns and cluster-led responses for non-refugee situations. Within the cluster coordination system UNICEF is responsible for co-ordination of Nutrition and IYCF in the field, in collaboration with the leadership of the MoNHSR&C.

The core priorities for IYCF-E coordination are to: support a common approach based on best practices and adherence to policies; inform decision-making; support inter-sectoral coordination; reduce gaps and duplications in coverage; disseminate key guiding documents and tools; provide capacity development and technical support; support service delivery; monitor, evaluate and report on the IYCF-E response.

ACTIONS:

Ensure a lead IYCF-E coordination body is appointed and active, co-led by the Government

Information Management

Information management is the foundation of effective coordination and for ensuring awareness and monitoring of policies, standards and best practice. Accurate and timely information enables the government and partners to identify and prioritise needs, and to take evidence-based strategic and operational decisions to fill gaps and avoid duplication of efforts.

ACTIONS:

- Widely disseminate policy and best practices guidance documents
- Establish and maintain routine IYCF-E context monitoring and information sharing systems
- Use standardised indicators and reporting formats, with gender and age disaggregated data
- Represent IYCF-E data within the wider humanitarian reporting systems

KEY ELEMENTS

Emergency Preparedness

General objective: To develop national and provincial capacity to efficiently respond to any emergency so IYCF is protected and supported

Strong humanitarian preparedness is critical for a timely, coordinated, targeted and effective – and in some cases more cost-effective – IYCF-E response at local, provincial and national levels.

Emergency preparedness involves actions taken in anticipation of an emergency. Emergency preparedness can help make a response more efficient and effective, thereby lessoning the impact of the emergency within the affected population. Preparedness activities and measures also play a vital part in ensuring the connectivity between the fields of development and humanitarian actions.

Strong investment in ongoing emergency preparedness in Pakistan is required due to the frequency, magnitude and scale of disasters in Pakistan. Building a strong at scale 'routine' IYCF programme is an imperative part of preparedness, as a strong non-emergency IYCF programme better positions a country to effectively address IYCF in the situation when an emergency occurs.

PREPAREDNESS ACTION	LEAD
POLICY AND LEADERSHIP	
Enforce policies to protect optimal IYCF	
Develop an action plan with clear mechanisms to monitor, report and deal with violations to the National Ordinance and The Code	Provincial and District level MoH; Federal & Provincial Infant Feeding Boards
Advocate to infant formula companies to fulfill their Corporate Social Responsibilities, through actions that protect and promote optimal IYCF	Government (MoNHSR&C; P&D); UNICEF and Nutrition partners
Legislate Baby-friendly Hospital Initiative standards	
Develop legislation requiring temporary health facilities and services established for emergency response to conform to the BFHI standards	National and Provincial MoH; NDMA; PDMA
Reflect the protection, promotion and support of IYCF-E in policies and operational guidance plans and documents	
Ensure all emergency preparedness, response and recovery policies, strategies and action plans, and MOUs as applicable, of government and operational partners reflect consideration of how actions contribute to, or affect, the optimal feeding and caring of infants and young children. Disseminate widely for procedures to be adapted accordingly.	NDMA; PDMA Clusters/Working Groups. All humanitarian agencies

COORDINATION	
Maintain nutrition cluster performance for IYCF-E	
Conduct annual Nutrition Cluster performance monitoring of the IYCF-E component to ensure performance benchmarks are maintained	Global Nutrition Cluster
Create an IYCF-E coordination body	
Form provincial IYCF-E Task Forces, as sub-groups of the IYCF-E TAG, to lead on IYCF-E coordination and technical support. Members should include selected IYCF TAG members and Nutrition Cluster or Working Groups plus representatives from multiple sectors; ensure representation of at least 50% women.	Federal and Provincial IYCF TAGs. One representative from each cluster/working group: Nutrition; WASH; Health; Food security; Child Protection
Formulate and share provincial interagency mandates and responsibilities	
Determine who will do what, when and where in case of emergency, coordinating responsibilities to reduce gaps, avoid duplication and ensure coverage in reach and service provision and reflect in operational plans.	MoH. NDMA. DDMA. Federal and Provincial IYCF-E Task Force
Ensure commodities for IYCF are available for use in an emergency	
Pre-position contingency emergency stock and materials or establish a mechanism for procurement and distribution of items necessary for IYCF-E interventions (e.g. cups; spoons; communication materials; IYCF-E structures)	MoNHSR&C. Nutrition Cluster/Working Group. Humanitarian agencies
Develop referral mechanisms for non-breastfed children	
Develop protocols and referral mechanisms within the government health system for non-breastfed infants aged 0-5 months to receive specialist skilled assessment and follow-up support in the context of an emergency	MoNHSR&C
INFORMATION MANAGEMENT	
Ensure availability of IYCF-E baseline data	
Establish an IYCF-E knowledge management platform for sharing experiences and lessons learned from emergency responses	MoNHSR&C; Nutrition partners
Ensure survey and assessment data and population data related to IYCF (gender and age disaggregated to 0-5 mo, 6-11 mo and 12-23 mo) are entered regularly into the main information systems, and provided to PDMA and NDMA, so secondary data is available to guide emergency responses	MoNHSR&C; Nutrition partners
Establish agreed IYCF-E monitoring indicators and tools, ensuring uniformity between provinces and regions, to enable comparison of data	MoNHSR&C. IYCF-E Task Force

COMMUNICATION	
Mobilize stakeholders to consider the protection, and support of IYCF-E as a priority	
Advocate to government and donors for emergency response funding pools for IYCF-E	OCHA; UNICEF
Conduct an advocacy, awareness campaign on The Code and Ordinance, Pakistan IYCF-E Guidelines, informing of the issues and impact of violations on infant survival in emergency contexts. Target government, humanitarian agencies, healthcare service managers, senior level medical doctors, and lead business community members	MoNHSR&C. Provincial DoH; UNICEF
Widely disseminate key policy, technical and coordination guidance documents related to IYCF-E to agencies/ actors involved in development and humanitarian work, including Government departments, agency staff, health care workers (including military hospital doctors, nurses, mid-wives), donors, civil society and business networks	MoNHSR&C. Provincial DoH. IYCF-E Task Force
Provide briefings to the media on IYCF-E on the broadcasting of messages in emergency contexts directed at highlighting appropriate IYCF and reducing harmful practices or actions (such as the untargeted distribution of infant formula and other milk products)	MoNHSR&C. IYCF Task Force. Provincial DoH; UNICEF
Develop an IYCF-E communication package	
Develop 7-10 key thematic messages directed at priority audiences that reflect the specific knowledge, attitudes and practices, the intended target audience groups need to develop, perform or reinforce, and sustain Collaborate with multiple sectors to develop relevant cross-sectoral messaging. (See Annex 3: Key IYCF-E messages)	MoNHSR&C. IYCF-E Task Force. UNICEF.
Develop pamphlets/flyers to convey key IYCF-E messages in Urdu and English, with pictorial representation understood by those not literate, ready to insert into hygiene kits, food aid ration kits, newborn baby kits. Collaborate with IYCF-E related sectors to develop multi-sectoral messaging pamphlets.	MoNHSR&C. Provincial DoH; IYCF-E Task Force
Develop a draft Interagency Joint Statement on IYCF in the emergency context, directed at the media, donors and organizations involved in the humanitarian response. Finalise and disseminate within 3 days of the onset of an emergency	MoNHSR&C. UN and humanitarian partner nutrition agencies
Develop community media videos that present recommended priority IYCF-E key messages and actions (contingency and response) for families and communities. Present to communities.	MoNHSR&C UNICEF. WFP. WHO. FAO. Humanitarian partners. LHWs.
Advocate to the NDMA and PDMA for IYCF-E to be included into the NDMA emergency response communication system allocated free mobile messages and air time.	MoNHSR&C. UNICEF and humanitarian partners.

Investigate innovative methodologies and media channels	
Pilot possible strategies for IYCF-E mass media communication, for example (local FM) radio (talkback; messages; education); mobile voice messaging. Identify a national IYCF Celebrity Role Model to feature in conveying IYCF-E messaging	UNICEF; NDMA; PMRA.
CAPACITY DEVELOPMENT	
Maintain an up-to-date database of provincial and national capacity for IYCF-E	
Identify and map available IYCF-E resources and capacities available to support programming: Provincial coverage of personnel trained and experienced on IYCF-E (including Master Trainers); Specific IYCF, nutrition and other health-related programmes, and their coverage areas; Materials available for use in emergency contexts; Funding available for IYCF-E.	MoNHSR&C. Provincial DoH; National Nutrition Cluster
Integrate IYCF-E into MoH institutional capacity building plans	
Integrate IYCF-E into existing pre-service and in-service training curriculums for health care workers (community and facility-based)	MoNHSR&C; Provincial DoH.
Facilitate harmonized trainings and orientations on IYCF-E using a cascaded approach	
Develop IYCF-E (incorporating psychosocial support and responsive stimulation components; communication skills) modules and curriculums and provide trainings for: health care facility staff (including pre- and post-natal), LHWs, LHSs, LHVs, LHCs; Community Mid-wives (CMWs); Traditional Birth Attendants (TBAs); Military paediatricians, gynaecologists and nurses (Armed Force Post-Graduate Medical Institute; Armed Medical College.). Follow-up with post-training mentoring/ supervision.	MoNHSR&C; Provincial DoH; UNICEF in partnership with a training institution. Utilize Master Trainers.
Provide orientations on IYCF-E for key community decision-makers and influential people, targeted appropriately to their roles: Religious leaders: the role they can play in emergencies. Pharmacy staff: the key IYCF-E messages and the risks of and 'safer' use of infant formula. NDMA and PDMA key decision-makers: highlighting basic needs to protect, promote and support IYCF-E and "do no harm" IYCF emergency responses and IYCF-E interventions. Members of business associations and philanthropic groups: on optimal IYCF-E practices, risks of use of BMSs and The Ordinance, and ways they can best support IYCF needs in emergency contexts. Students at academic institutions (schools; universities): on key messages directed at household and community actions. Teachers: on key IYCF-E messages and how they can best support IYCF in the context of an emergency)	MoNHSR&C; Provincial DoH

Provide orientation workshops or presentations on IYCF-E sensitive programming to multiple sectoral Cluster or Working Groups, in particular WASH, FSL, Health and Child Protection, highlighting the IYCF-E linkages with their sectors. Provide follow-up support to the sectors for integrating IYCF-E into their emergency preparedness and response strategies and action plans	IYCF-E Task Force
Develop IYCF-E rapid response cadres	
Train national cadres of health and nutrition students from academic institutions who can be rapidly deployed to lead on IYCF-E assessments and surveys in an emergency	MoNHSR&C. Provincial DoH. Training institutes. UNICEF
Develop a pool of IYCF-E Master Trainers, ready to deploy to emergency locations to provide capacity building for IYCF-E, when required. Maintain an updated database of Master Trainers.	MoNHSR&C. Provincial DoH. Training institutes. UNICEF
Develop cadres of personnel trained in IYCF-E, with experience in emergency response, who can be available to relocate temporarily to emergency locations to provide surge coordination and technical support	MoNHSR&C. Provincial DoH. Training institutes. UNICEF

RECOMMENDATIONS FOR STRENGTHENING THE 'ROUTINE' IYCF PROGRAMME FOR IYCF-E	
ACTION	**LEAD**
Integrate IYCF-E into expanded services for mother and child health	
Strengthen the LHW programme for IYCF: expand the LHW coverage area; enhance the LHW curriculum for nutrition/ IYCF, and incorporate IYCF-E; expand the training package to incorporate IYCF-E issues and needs, including peer support groups and IYCF Spaces management; Incorporate IYCF-E into the IYCF counseling package	MoNHSR&C. Provincial DoH
Integrate IYCF and IYCF-E into PHC programmes (MNCH programme; EPI Programme; ENAP (Every Newborn Action Plan)); SUN Strategy and Plan of Action	MoNHSR&C; Provincial DOH
Integrate key information on IYCF into routine individual rapid assessment procedures at mother and child health and nutrition service contact points at facility and community levels	MoNHSR&C; Provincial DoH
Evidence-based initiatives for complementary feeding	
Develop Positive Deviance Inquiry-Hearth (PDI-Hearth) pilot programmes, particularly in high disaster risk areas. During Hearth sessions formulate recipes/food mixes that can be used for complementary feeding in emergency situations	MoNHSR&C; PDMA; DDMA
Train communities on crop diversification, 'household nutrient gardens and small animal husbandry' supported by education on complementary feeding	FAO and partners

Maintain the BFHI standard in all hospitals	
Achieve and maintain the global BFHI criteria as a mandatory minimum standard for all hospitals, extending to their community outreach activities	MoNHSR&C; WHO.

Emergency Response

General objective: To provide timely and effective response actions during an emergency, to protect, promote and support infant and young child feeding practices.

Needs Assessment

Invest in timely, quality IYCF-E assessments to strengthen the evidence base for intervening.

- Situation and needs assessments and analyses of the specific emergency context within the wider (pre-emergency socio-cultural, economic and environmental) context should form the basis for determining the design of the IYCF-E intervention and it's components. Assessments need to be ongoing, to capture the evolving emergency context and the implications for IYCF-E.
- Obtain demographic data disaggregated by gender and age categories 0-5mo, 6-11mo, 12-23mo, at the very minimum, as recommended feeding practices are age-specific.
- Include IYCF-E in multi-sectoral, joint or interagency assessments wherever possible, as well as in sector-specific assessments, so infants and young children and their needs are visible.

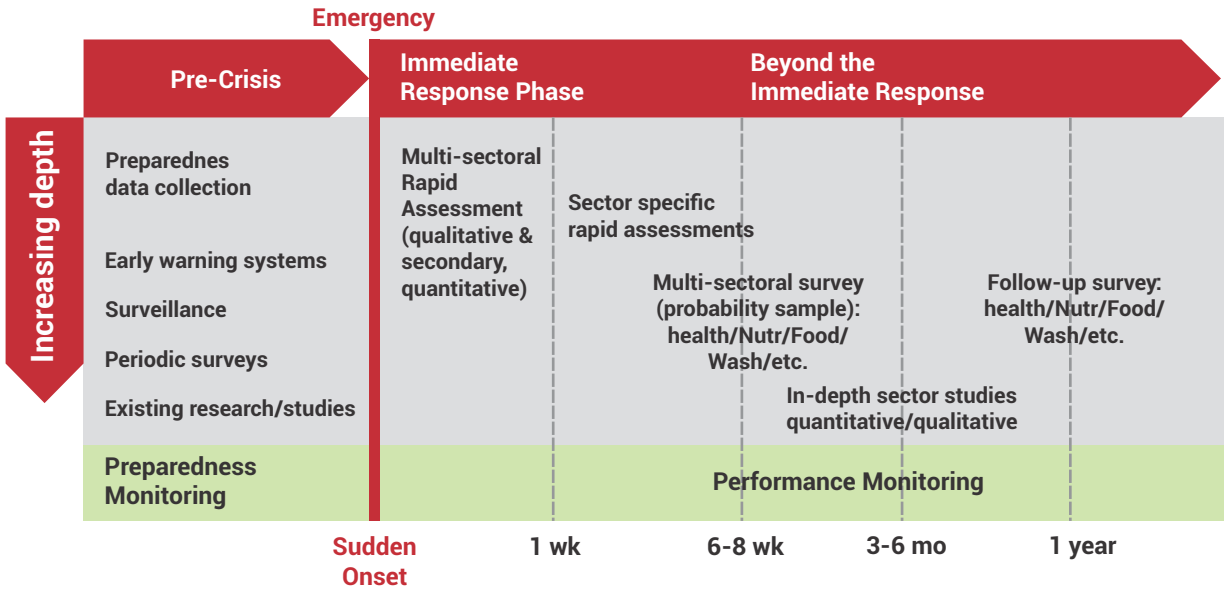
The 3 main 'types' of assessments

Type 1: Multi-sectoral Initial Rapid Assessment

Type 2: IYCF-E or Nutrition Sector-specific Rapid assessment

Type 3: Comprehensive Assessment in the form of an IYCF-E Survey, SMART and Multi-sector survey

(Source: Save the Children IYCF-E Toolkit)



Type 1: Multi-sectoral Initial Rapid Assessment

- Conduct in the initial emergency phase of sudden onset emergencies
- Use the Multi-Cluster Initial Rapid Assessment (MIRA) methodology, to identify initial humanitarian priorities including: the scale and extent of the disaster; gaps in response; priority needs to assist in the planning and deployment of resources.
- The MIRA initial secondary data analysis should be completed within 72 hours and the MIRA finalized within 14 days, to inform the humanitarian response plan and initial funding requirements
- The MOH should advocate for an IYCF-E Nutrition specialist to be on the MIRA analysis team

- The Pakistan MIRA currently incorporates three key informant interview questions nutrition-specific questions related to IYCF:
- *No 24: a) What is the approximate number of children below one year in the community?*
- *No 24: b) What is the state of lactating mothers?*
- *No 25: What type of milk/food supplement distributed for children?*

Type 2: IYCF-E or Nutrition-specific Initial Rapid Assessment (IRA)

- Due to limitations of the MIRA with identifying IYCF-specific information, an IYCF-E Initial Rapid Assessment (IRA) should be facilitated, as a stand-alone assessment or as part of a Nutrition IRA
- Conduct within 15 days of the onset of a sudden emergency
- Use initial findings from the MIRA to identify priorities for the design of the IYCF-E/Nutrition IRA
- The IRA includes the analysis of per- and in-crisis secondary data combined with primary (or community level) data collection and analysis.

I) Secondary information review and analysis on IYCF and background information

Collect and analyse secondary information on both the pre-crisis and 'current-crisis context, to develop a scenario (or 'picture') of the likely risks to IYCF and impact of the crisis on IYCF, nutrition and health, and to inform the collection and interpretation of primary data.

(See Annex 4: IYCF-E assessments- Pre-crisis secondary information; In-crisis secondary information)

Routine pre-crisis data collection and consolidation should be an emergency preparedness activity.

Pre-crisis IYCF warning signs of increased vulnerability in an emergency context to be alert for:

- Low exclusive breastfeeding rates in the population pre- emergency (e.g. <25%)
- Low initiation of breastfeeding rates in the population pre-emergency (e.g. < 75%)
- Low mean duration of breastfeeding
- Low breastfeeding rates at one year
- Artificial feeding practices pre-emergency (not-breastfed and mixed breastfed infants)
- Use of baby bottles, teats and pacifiers
- Risky complementary feeding practices (e.g. early or late introduction of complementary foods; low dietary diversity and feeding frequency; inadequate calorie/energy content)

Note: Knowledge, attitudes and beliefs components are not commonly included in primary data collection for initial assessments. However they should be analyzed from pre-emergency data and be included in later comprehensive IYCF-E surveys, particularly in chronic/ prolonged emergency response, to add crucial qualitative information on the reasons behind feeding patterns.

ii) Primary data collection

Community level data collection, using observation, key informant interviews, and focus group discussion with affected mothers, fathers, women elders and other community members where possible.

(See Annex 4: IYCF-E assessments- Primary data collection)

Type 3: Comprehensive Assessment

3a. Comprehensive IYCF-E OR Nutrition Survey

Where more detailed information is required to inform the IYCF-E response, and access allows, conduct a household-level IYCF assessment, using a simplified IYCF-E questionnaire, which incorporates the standard IYCF indicators, relevant WASH indicators, and qualitative indicators.

Alternatively, if a SMART nutrition survey is undertaken, questions on IYCF and WASH may be included in the questionnaire.

(See Annex 4: Core and optional IYCF indicators)

3b. Comprehensive Multi-sectoral Survey

Seek opportunities to integrate IYCF into multi-sectoral surveys and scheduled assessments of other sectors, such as a tri-cluster (Health, Nutrition, and Water, Sanitation and Hygiene (WASH) survey.

Collaborating closely with other clusters in the planning and implementation of assessments provides a for a more comprehensive understanding of the emergency context as it affects IYCF, encourages multi-sectoral response planning, promotes resource sharing, and reduces assessment overlaps and thereby assessment fatigue for the affected population.

RESPONSE INTERVENTIONS

"Mothers and other caregivers of infants and young children need access to timely and appropriate feeding support that minimizes risks and optimizes nutrition, health and survival outcomes" (Sphere 2011)

IYCF-E Response Guidance Notes

1. It is essential to ensure that in the early stages of an emergency core measures are put in place in all sectors to ensure the specific needs of infants and young children and pregnant and lactating women, and other caregivers are addressed.
2. Priority areas to address are:
   - Protect, support and promote early initiation and exclusive breastfeeding of infants
   - Support timely, safe, nutritionally adequate and appropriate complementary feeding
   - Support safe and adequate feeding for non-breastfed infants less than 6 months old
   - Minimize the risks of artificial feeding
   - Provide for the needs of pregnant and lactating women
3. Determine required interventions based on initial and ongoing situational analyses and needs assessments and monitoring.
4. Interventions should address the gap between people's needs and their own or the government's, capacity to meet them and prioritized based on their ability to reach the most vulnerable populations and have the greatest coverage and impact.
5. Involve the active participation of community members in setting priorities and identifying solutions, as much as is feasible.
6. Ensure that humanitarian assistance does not undermine safe IYCF practices with inappropriate interventions, and that the longer-term impact of interventions is considered.
7. Activities should build upon existing health and nutrition programmes to the extent possible, rather than creating new and separate or parallel structures.
8. At the start of an acute emergency prioritise life-saving IYCF activities and ensure caregivers can access basic needs. Thereafter, as soon as possible, focus on IYCF activities that promote behaviour change – as behaviour change supports lifesaving interventions.

Core Interventions

Core interventions can be defined as:

1. **Basic and Specialized IYCF-E support interventions**
2. **Integrated multi-sectoral interventions**

These interventions are described below.

Death among infants and children is usually highest at the onset of an emergency when conditions are the most threatening.

During the first days and weeks, strong enforcement of policies and effective leadership and coordination, supported by timely and efficient information management and sharing, is particularly critical.

This is when the impact of the emergency needs to be assessed and response plans formulated, there may be an influx of humanitarian actors arriving, media reports will be highlighting the context and aid needs, donated supplies (including BMS) may arrive, and when mothers most commonly present with feeding difficulties.

Wide dissemination and enforcement of policies and best practice guidelines is crucial.

Ongoing coordination between and within humanitarian response stakeholders is imperative to ensure needs are identified and responded to and gaps and duplications in reach and coverage are reduced.

Basic Support and Specialized IYCF-E Support Interventions

Basic interventions that create a protective and supportive environment for mothers/ caregivers of children <2 years and pregnant and lactating women should be put in place as soon as possible after the onset of the emergency. They provide the backbone to an effective IYCF-E response and should be implemented in all emergencies.

Basic measures encompass multi-sectoral interventions (such as provision of shelter, security, access to adequate household food and water, non-food items), communication directed at highlighting priority practices and needs and prevention of harm from inappropriate actions, integration of IYCF into health services that target women, infants and young children, and ensuring frontline assistance to support women and young children.

Basic interventions should be put in place as soon as possible after the onset of the emergency:

- Prioritise mothers of children aged 0-23 months and pregnant women for immediate essential needs
- Register children 0-23 months and pregnant and lactating women
- Establish support for mothers of children 0-23 months to optimally breastfeed
- Provide for the nutritional needs of pregnant and lactating women
- Support safe and adequate feeding for non-breastfed infants
- Support timely, safe, nutritionally adequate and appropriate complementary feeding
- Ensure consistent and appropriate communication on IYCF-E

Prioritise Mothers/Caregivers of Children 0-23 Months of age and Pregnant Women for their Immediate Essential Needs

In the planning and provision of all services, prioritize mothers/caregivers of children <2 years and pregnant women for essential basic needs for survival, protection and dignity, considering their particular vulnerabilities and requirements, to enable them to care for themselves and their children.

Actions to take	Lead
Initiate in the early phase of the response	
• Ensure the planning and analysis of initial and ongoing needs assessments incorporate considerations of children under 2 years, their caregivers and pregnant women. Obtain demographic data disaggregated by gender and age categories 0-5mo, 6-11mo, 12-23mo, as a minimum requirement.	NDMA; OCHA; Implementing agencies
• Consider – and consult with as much as feasible – pregnant women and caregivers of children <2 years in planning the location, frequency and timing of distributions and the collection modalities (e.g. queuing arrangements; package sizes)	DDMA.
• Enable priority, and secure easy access for mothers/primary caregivers' with children under 2 years and pregnant women to services and basic commodities such as drinking water, sanitation facilities, food and non-food items (such as shelters; fabric for screening breastfeeding areas within private dwellings; coverings/blankets' clothes). • Provide priority queues for mothers and pregnant women to access distributions. • Provide drinking water to queuing breastfeeding and lactating women.	DDMA. Clusters/Working Groups; Camp management.
• Facilitate access to basic needs and key services for mothers and pregnant women, infants and young children, through being informed of registration processes, aid eligibility criteria, available services and focal points, and referral pathways to access support.	Frontline workers
• Ensure pregnant women and caregivers of children <2 years are informed of distributions and their entitlements, in a form suitable for those not literate.	DDMA.

Ensure access to basic frontline support for mothers of children 0-23 months and pregnant women

Basic frontline support is the provision of basic assistance, such as providing support or essential information. Frontline workers do not have specialist training to provide skilled support for IYCF but play important roles in supporting IYCF-E throughout the emergency response, especially in the early response phase when services are being set up and skilled staff and formal referral systems may be limited. Frontline workers include the Military, field staff from multiple sectors, particularly WASH and Health in the first phase of an emergency. Community members, especially religious leaders and teachers, can also provide important basic frontline support.

Register Children 0-23 Months and Pregnant and Lactating Women

Ensure children 0-23 months of age and pregnant and lactating women are registered. Registration enables those affected by the emergency to be visible and their needs identified, so relief support can be appropriately planned and responded to.

Actions to initiate in the early phase of the response	Lead
• Advocate to all registration services (overall and of specific services) for registration data to be disaggregated into gender and the specific age categories of 0-5 months, 6-11 months, 12-23 months and registration forms to include names of both the female/wife and male/husband as the heads of the household, to enable mothers to access distributions.	DDMA. Military.
• Identify and register pregnant women, their location and expected delivery date, to ensure timely access to additional food entitlements and provision of targeted breastfeeding promotion for immediate, exclusive breastfeeding.	DoH (LHWs. CHWs. IYCF-E surge staff)
• Register mothers of all newborn infants within 2 weeks of delivery, to ensure timely access to additional household food entitlements for lactating mothers and provision of support for exclusive breastfeeding.	DoH (CMWs; LHWs; Facility health staff; IYCF-E surge staff)
• Register/ identify highly vulnerable groups, such as infants and young children who are orphans or temporarily without their mother, single-headed households with children under 2 years, to support referral for access to essential services and support.	Sector: Child Protection. Frontline workers
• If possible, at the site of registration provide skilled health care IYCF counselors to assess the mother–infant/child pairs for feeding problems, assess children's growth, and to refer cases of concern to appropriate services.	DoH (LHWs. CMWs. Facility health staff; CMAM site). IYCF-E surge staff

Provide Support for Mothers of Children 0-23 Months to Optimally Breastfeed

Create and sustain an environment that encourages early initiation of breastfeeding, exclusive breastfeeding for 6 months and continued breastfeeding for children up to two years, through providing culturally appropriate and supportive places for breastfeeding.

Actions to take	Lead
Initiate in the early phase of the response	
• Identify breastfeeding support needs in initial and ongoing assessments	DDMA. OCHA.
• Provide private shaded rest areas for women to breastfeed at registration and service points (e.g. distribution). • For refugees and displaced populations in transit, ensure availability of secluded sheltered areas for women to breastfeed along their route.	DDMA. OCHA. Camp management
• Integrate breastfeeding support within key health services, such as primary health care, including reproductive health and psychosocial services. • Ensure availability of female doctors and nurses for skilled breastfeeding and psychosocial support.	DoH (LHV; LHWs. CMWs; reproductive health services; psychosocial services)
• Ensure established IYCF Corners in health facilities are functional, with staff skilled in breastfeeding and psychosocial support counseling.	DoH
• Ensure mandatory application of the Baby Friendly Hospital Initiative 'Ten steps to successful breastfeeding' in all health facilities set up in the emergency response, including mobile units	MoNHSR&C/ DoH
• At community level, ensure availability of skilled breastfeeding support. Deploy surge staff to provide additional skilled breastfeeding counselling, if required. *If available, experienced women in the community who model positive breastfeeding practices can provide encouragement and practical assistance in the initial phase.*	DoH (LHWs; CMWs; Surge teams)
As soon as possible after the initial phase of the emergency	
• Establish or re-activate specialized IYCF-E support services supported by trained health care workers, including: • IYCF Corners in health facilities where not previously established • Mother support groups (e.g. held in tent, health house; school or other building) • IYCF-E spaces in relief camps Provide separate group sessions for infants with no possibility to breastfeed. *(See Annex 5: Specialized IYCF-E Support Services)*	DoH (LHWs; CMWs; Surge teams)

Specialized IYCF-E Support Interventions

Establish specialized interventions as soon as possible after the onset of the emergency.

Considering the high risk to disruption of infant and young child feeding and care practices in emergency contexts specialized interventions should be standard activities, even if the malnutrition rate is low.

Specialized support interventions include:

- IYCF corners
- IYCF Spaces
- Mother IYCF Support Groups

- One-to-one skilled IYCF and psychosocial counselling is particularly important in emergency situations, especially to provide support for: mothers with breastfeeding difficulties or concerns; for infants under 6 months who are malnourished; re-lactation; supporting wet nursing; newborn feeding, especially low birth weight infants; moving from mixed feeding to exclusive breastfeeding. IYCF corners and IYCF Spaces provide private areas and skilled staff for the provision of one-to-one counselling.
- IYCF Spaces and Mother IYCF support groups provide important peer support during emergencies, as the changed (emergency) conditions make safe and appropriate IYCF more important while caring for themselves and their children is more challenging.
- The magnitude of the crisis and whether it is a slow or sudden onset or protracted crisis can influence the type of intervention and specialized services provided:
  - When there are major threats or problems with breastfeeding, large numbers of orphaned or unaccompanied infants and many displaced people, destruction of existing health facilities or disruption of services, then stand-alone temporary specialized services such as IYCF-E Spaces are likely needed.
  - When the emergency is slow-onset, such as a drought, or in protracted crisis where there is no major destruction of existing services, no significant displacement of populations and no major concentration of people into relief camps, IYCF-E services can be integrated within other nutrition and health services, such as CMAM or maternal and child health services – or through standalone specialized IYCF services
- Activities should be linked to a referral system for caregivers to access basic services (such as food and non-food aid programmes) and to refer cases of concern for example to specialized psychological support services, child protection services.

(See Annex 5: Specialized IYCF-E Support Interventions)

Provide for the Nutritional Needs of Pregnant and Lactating Women

"Feed the mother so she can feed and care for her baby". Pregnant and lactating women need additional food, to provide for their and their baby's nutritional needs. Pregnant women need an additional 285kcal/day, or if malnourished, they need an additional 500kcal/day. Lactating women need an additional 500kcal/day, or if malnourished, need an additional 500kcal/day.

Actions to take	Lead
Initiate in the early phase of the response	
• Include consideration of pregnant and lactating women in initial, and ongoing, food security and nutrition assessments, to identify their needs and ability to access nutritious local foods and the means to safely and appropriately prepare them	OCHA (Nutrition Cluster/Working group; IYCF-E Task Force)
• Prioritise pregnant and lactating women (from the second trimester or pregnancy until 6 months after delivery) for: - Provision of nutrient-rich local foods or fortified targeted supplementary foods additional to receiving the general ration - Extra one litre (minimum) of drinking water/day, with requirements adjusted based on consideration of activity and temperature.	OCHA (Nutrition; FSL; WASH implementers
• Inform the family and community of the special nutritional needs of pregnant and lactating women, why they are being provided with extra/ supplementary food and water, and that it is intended exclusively for them, to enhance their health, feeding and caring capacity.	OCHA (Nutrition; FSL; WASH Cluster/Working group)
Later in the response	
• If the markets are functioning consider, in consultation with the community, cash or voucher schemes to enable pregnant and lactating women to purchase nutrient-rich foods.	Sector: FSL

ENHANCE WOMEN'S CARING CAPACITY THROUGH GENDER-RESPONSIVE PROGRAMMING

The impact of emergencies are not neutral, but are influenced by the distinct needs, vulnerability and capacities of women, men, boys and girls to respond. These are directly related to the differential roles and responsibilities, capabilities, opportunities and challenges women and men had prior to it. Also, humanitarian response activities, are not neutral and can increase, reinforce, or reduce existing inequalities.

Women's vulnerabilities are exemplified in emergencies. A gender perspective needs to be integrated throughout the planning, response and recovery phases of humanitarian actions, being sensitive to and responsive to the challenges faced by women, their needs, and the influence of gender on IYCF.

Gender-responsive actions to take include, but are not limited to:

- Promote participation of women in all phases of emergencies –from planning through recovery;
- Ensure collection and availability of gender and age disaggregated data, so women's needs are visible;
- Ensure services are safely and easily accessible and appropriate for women;
- Ensure women have access to information, in a form that is able to be understood by them;
- Strengthen humanitarian workers knowledge of the association between gender and women's capacity to feed and care for themselves and their children.

ADAPT & ACT-Collectively Framework

Use the ADAPT & ACT-Collectively Framework tool to guide consideration of gender throughout the humanitarian project cycle. The elements of the framework are: Analyse gender differences; Design services to meet needs of all; Access ensured for all; Participate equally; Train women and men equally; & Address GBV in all sector programmes; Collect, analyse and report sex- and age-disaggregated data; Target actions based on a gender analysis; Coordinate actions with all partners.

Support Safe and Adequate Feeding for Non-breastfed Infants

From the early phases of the emergency, cases of non-breastfed infants may present to frontline workers. These infants may have been fed BMSs pre-emergency, their mothers may have stopped breastfeeding due to the emergency, or the infants may have been orphaned. Urgent referral to health services and for skilled assessment and support will be needed.

Actions to take	Lead
Initiate in the early phase of the response	
• Conduct a simple breastfeeding assessment, investigating if there is any possibility of breastfeeding the infant, for example if the mother has previously breastfed and is willing to restart/re-lactate or is there a wet nurse available. • Seek skilled support for conducting a full breastfeeding assessment. Investigate re-lactation or wet nursing options as required.	CMW. LHW. Surge staff. Other female frontline workers.
• Report cases of non-breastfed infants to the MoH and designated IYCF-E Task Force	DoH; Frontline workers

• For cases where there is no immediate prospect of breastfeeding or wet nursing, refer to a health facility for skilled support to assess the need, *and if no other option is deemed possible according to the defined strict criteria (for these few cases) inform the IYCF-E Task Force so an adequate supply of infant formula on prescription can be arranged*, and ensure clear instructions and demonstrations on it's 'safer' preparation and use, including the importance of correct dilution. • Exchange cups and spoons for bottles. • Refer the mother to services to ensure ongoing monitoring of the infant's growth and health. • Refer orphans to child protection services to ensure adequate care support is provided. (See Box below)	MoH. Paediatrician. MNCH.
Later in the response	
• Inform retail outlets selling infant formula on the benefits of breastfeeding, the risks of using BMS (BMS alone or 'mixed' feeding BMS and breastfeeding), and guidance on the 'safer' preparation and use of infant formula. • Provide a Memo, pamphlets and/or posters for display in the retail outlets.	DoH. IYCF-E Task Force

Programming for the provision of infant formula to non-breastfed infants:

If an agency is considering providing infant formula to non-breastfed children an appropriate product should be purchased, distributed and used according to strict criteria, to ensure appropriate and safe feeding of the non-breastfed infants and the protection of breastfed infants.

- Provision of free (donated) or subsidized breast milk substitutes should ONLY be provided when targeted to infants who have no possibility to receive breast milk, after safer breast milk feeding options (including re-lactation and wet nursing) have been fully explored. This should be based on a full breastfeeding and needs assessment of the mother-child pair carried out by health professionals trained in lactation management and counseling

  Eligibility for use of infant formula, as defined by the MoH, includes:

  - Mother has died or is absent for an acceptable reason
  - Feeding of the infant has been rejected by the mother, for example due to psychological trauma
  - Acceptable maternal or infant medical condition, assessed by a paediatrician
  - Infant was exclusively fed on artificial milk prior to the emergency
- An agency should only supply infant formula if the provisions of the Pakistan Ordinance, The Code and defined by the MoH are met and approved by the IYCF-E Task Force. (See Annex 1)
- A generically (unbranded) infant formula is recommended as the first choice, or if not available, a locally purchased formula that complies with the requirements set out in The Code and Codex Alimentarius and has a shelf-life of at least 6 months on receipt of supply.
- Infant formula is manufactured as a powdered or liquid (ready to use) product. Ready-to-Use Infant Formula is the preferred choice, as it is a pre-mixed liquid infant formula, ready to be consumed

directly from the container or from a cup. However it is more difficult to transport, store and dispose of than powdered infant formula.

- The infant formula should be appropriate for the infant, with consideration of their age.
- The infant formula must be supplied for as long as the infant needs it -at least 6 months though preferably 12 months, or until breastfeeding is re-established
- The infant formula should be regularly supplied to the caregiver (no less than twice a month), concurrently with assessment of the child's health and growth and measures taken to adequately inform and equip caregivers for its safe preparation and use:
  - Assessment of the individual conditions to determine what supports are required to meet the AFASS (Acceptable, Feasible, Affordable, Sustainable, Safe) criteria;
  - One-to-one demonstrations on how to prepare and feed the infant formula safely, including use of an open cup rather than a bottle;
  - Caregiver education about the health hazards of inappropriate preparation and unsafe feeding;
  - Ensure access to adequate amounts of clean water, preparation equipment and cooking fuel for frequent preparation;
- To prevent use of infant formula interfering with protecting and promoting breastfeeding for the majority the following measures should be taken:
  - Infant formula distribution should not be done directly through general food aid distribution channels;
  - Care should be taken to not publically display containers of infant formula;
  - Provision of infant formula should not be advertised;
  - Caregiver education related to its use should be facilitated privately, away from breastfeeding mothers and children.

Interventions to support non-breastfed infants should include components directed at protecting and supporting breastfed infants, to ensure that support for artificial feeding does not undermine breastfeeding or that it does not encourage breastfeeding mothers to report feeding difficulties when they have none, in order to qualify for commodities.

Support Timely, Safe, Nutritionally Adequate and Appropriate Complementary Feeding

Caregivers need access to timely, appropriate, nutritionally adequate complementary foods for children aged 6 to 23 months, and the knowledge and equipment to prepare them safely.

Actions to take	Lead
Initiate in the early phase of the response	
• Determine required complementary feeding interventions based on consideration of complementary feeding in initial and ongoing situation and needs assessments and analyses	Clusters/Working groups: FSL; Nutrition. IYCF-E Task Force
• Ensure the nutritional needs of the general population are met, giving special attention to the inclusion of commodities suitable as complementary foods. • Nutritious complementary foods and recipes based on locally available nutrient-dense foods should be considered as the first option.	Cluster/Working group: FSL
• In situations where nutritional needs are not met by locally available foods, advocate for/provide a general ration and supplements of inexpensive locally available nutrient-rich foods and a micronutrient fortified blended food (e.g. wheat soya blend) as part of general ration, blanket or supplementary feeding, and micronutrient supplementation (eg micronutrient powders), if required.	IYCF-E Task Force. Cluster/Working groups: FSL; Nutrition; Health
• Ensure caregivers have the equipment (such as cooking containers; plates, spoons and cups) and access to adequate amounts of clean water and fuel to prepare and cook complementary foods appropriately and safely.	Cluster/Working groups: FSL; WASH; Nutrition; Shelter-NFIs
• Accompany food distributions with information on the purpose and safe and appropriate use of all foods and supplements, including verbal and written messaging for continued breastfeeding until age two years and exclusive breastfeeding for infants aged 0-5 months, so food aid is not re-directed to infants aged 0-6 months.	Cluster/Working groups: FSL; Nutrition; Health; WASH. IYCF-E Task Force
As soon as possible after the initial phase of the emergency	
• Cooking demonstrations on the use of foods, especially unfamiliar foods, and how to increase the energy value of foods and viscosity of porridges, by adding oil. • Accompany food aid with information on the commodities' special value, the quantity required to meet nutritional needs, and any nutritional gaps and how to fill the gaps using local foods.	Cluster/Working group: FSL; Nutrition
• Continue supplementary feeding activities at least until the emergency context has stabilized and caregivers have access to available, affordable, appropriate and nutritionally adequate complementary foods, and the ability to prepare them, safely.	Cluster/Working group: FSL; Nutrition

Interventions for complementary feeding should consider the following

Three elements to complementary feeding need to be addressed -practical, nutritional, and functional:

Practical: foods are easy and quick to cook and able to be fed frequently, using minimal fuel; hygienically stored, prepared, and fed.

Functional: easy to chew and digest; liked by the child; culturally appropriate.

Nutritional: age-appropriate foods of adequate nutrient density to provide for the growing child's needs.

Decisions on the type of foods and the source, duration, targeting and delivery mechanisms of any food support programmes will depend on the local context and the situation.

Initial and ongoing situational analyses and needs assessments and monitoring should be used to inform the best interventions to support complementary feeding, considering, for example: the type of emergency (eg natural hazard or human-induced disaster); the ambient temperature; food security situation; nutritional status of the population and complementary feeding practices pre-crisis; availability, affordability and accessibility to quality, appropriate and acceptable locally available foods – as well as the availability of suitable food aid commodities and partners.

A number of interventions across sectors may be needed to meet complementary food requirements:

1. Food and nutritional support:

- Nutritious complementary foods and recipes based on locally available nutrient-dense foods should be considered as the first option.
- Promote use of methods that improve the nutritional quality of complementary foods, based on consideration of their feasibility. For example: adding oil to provide energy and viscosity; addition of a small amount of sugar to increase palatability; use of dried blended food mixes (for example ground nuts and dahl blend); inclusion of animal products; use of traditional processing methods, such as roasting, to enhance flavor, reduce anti-nutritional factors and reduce cooking time.
- Fortified commodities used in the preparation of meals (e.g. flour; iodized salt; vegetable oil).
- Provision of a general ration that includes foods suitable to meet the nutrient needs of older infants and young children, for food aid dependent populations. Additional foods that could be provided as a temporary safety net when a general ration does not enable nutritional needs to be met include:
  - Inexpensive locally available foods that provide nutrients missing from the general ration
  - Fortified blended foods, e.g. Wheat Soya Blend (WSB), provided as part of general ration, blanket or supplementary feeding
  - Food supplementation products for example point-of-use lipid-based, nutrient-dense, ready-to-use foods (such as Wawa Mum) and multiple micronutrient tablets or powders. High Energy Biscuits can be used until other resources become available, typically in the first days of a response
- .Planning of the food ration should be carried out with the participation of the affected community. In particular, consult mothers of children aged 6-23 months.
- The frequency of provision will depend on various factors such as the ease of access to distribution sites, size of ration and type of food commodities being distributed.
- Milk products should not be distributed as single commodities.

- Wet feeding, or the provision of pre-prepared foods, can be considered as a temporary measure at the outset of the emergency when no other foods or cooking facilities are available (e.g. for populations in transit). Food preparation should ideally remain with the family unit, to encourage food preparation according to local dietary habits and support family cohesion and other social functions and customs.

2. Cash or voucher distributions targeted to families with children of complementary feeding age should be considered where markets are functioning and there is good food diversity. They can be conditional, for example on attendance at IYCF and growth monitoring educational activities.

- Distribution of vouchers or micronutrient supplements or vouchers for complementary foods can be linked to IYCF activity, for example to distributed from an IYCF Space, thereby serving as an incentive for mothers to attend the programme.

Note: Any foods or products distributed as complementary foods in emergencies should meet the Codex Alimentarius standards and the International Code provisions. This includes commercial 'baby foods'.

Commercial 'baby foods' have featured in some emergency contexts, often arriving as donated items. Before distributing commercial baby foods in an emergency the following should be considered: their nutrient value; cultural appropriateness and acceptability; the cost compared to local foods of similar nutritional value; methods for waste disposal; the risk of undermining traditional complementary feeding practices. In general, commercial baby foods should not be included as a relief item.

Giving food baskets for children aged 6-23 months?

Do give:	**Do NOT give:**
Vegetables esp orange, yellow and dark green coloured - Fruit eg banana, guava, mango, dates - Eggs - Meat - Dahl - Cereals (eg ground rice, suji, yellow maize, millet) - Fortified cereal mixes - Ghee/Oil	Powder or liquid milk - Infant formula - Biscuits or cakes - Sweets - Chips and similar salty snack foods - Sweetened drinks

Ensure Consistent and Appropriate Communication on IYCF-E

Timely, clear, consistent and appropriate communication, to increase awareness and knowledge among all stakeholders to the emergency of how to prevent illness and death through protecting and supporting optimal infant and young child feeding practices and to provide awareness of the support available for caregivers and young children, can have a critical influence on the effectiveness of the response.

Key messages targeted to the priority IYCF-E concerns and needs should speak to priority audiences and be directed through a variety of channels and methodologies (interpersonal, mass media, traditional media, and print) to provide multiple exposure.

Actions to take	Lead
Initiate in the early phase of the response	
• Disseminate key policy and best practice guidance documents to all agencies involved in the humanitarian response	IYCF-E Task Force
• Issue an inter-government and agency Joint Statement on IYCF-E, to promote optimal practices and protect against harmful actions (highlighting the inappropriate distribution and use of breast milk substitutes) directed to the media, agencies, government departments, community leaders and business associations. • Widely disseminate, publicize, and accompany with tailored press releases and advertisements. • Conduct media briefings to elaborate on the recommended practices, and priority needs and concerns for IYCF in the emergency context, as defined in the Joint Statement. *(See Annex 2: Sample Joint Statement)*	MoNHSR&C. IYCF-E Task Force
• As soon as possible after the onset of the emergency, building on the orientations and trainings provided as part of preparedness, provide orientation to frontline workers on registration processes, aid eligibility criteria, available services and focal points, IYCF-E priority needs and actions, the key IYCF messages and the referral pathways between programmes or activities for pregnant and lactating women and other caregivers of children 0-23mo to access informed and skilled support	OCHA. IYCF-E Task Force
• Monitor and report (to the IYCF-E coordinating body, local government or camp manager) donations or distributions of infant formula	Frontline workers. Community members. IYCF-E Task Force
• Inform the wider public (provincial, national) of foods suitable for children aged 6-23 months in the current emergency context. Ensure this information is included in statements to the media. (See section 'Support timely, safe, nutritionally adequate and appropriate complementary feeding': Giving food baskets for children aged 6-23 mo)	IYCF-E Task Force.
• Advocate to different levels of decision makers (national, provincial, and district government levels, donors, business leaders, and others) to motivate them to take action and commit appropriate resources to support priority IYCF-E needs	OCHA
• Widely disseminate key targeted IYCF-E messages to the wider community members (including religious leaders; teachers) and frontline workers to promote optimal infant and young child feeding, raise awareness of the risks of infants formula use within the current emergency context, and information on services and commodities (food and non-food items) available to infants and young child aged 0-23 mo, their caregivers, and pregnant and lactating women.	IYCF-E Task Force.
• Widely disseminate key targeted messages to pregnant women and mothers and fathers of children aged 0-23mo, to promote optimal infant and young child feeding, raise awareness of the risks of early introduction of non-breast milk foods and fluids before age 6 months, especially in the	IYCF-E Task Force. Frontline workers.

conditions of the current emergency, myths and truths about breastfeeding and information on services and commodities (food and non-food items) available to them. • Prioritise IYCF key messaging in the initial and ongoing WASH response. • Incorporate flyers with key multi-sectoral messages (including IYCF) in hygiene kits and food aid ration kits. *(See Annex 3: Key IYCF-E Messages)*	
• Actively participate in IYCF-E coordination forums, to be informed on IYCF concerns and needs and to coordinate activities, so gaps and duplications in reach and coverage are reduced.	Humanitarian stakeholders
• Designate a selected representative from the IYCF-E Task Force to attend all Cluster/Sectoral Working Group meetings to ensure IYCF-E issues are addressed in the respective clusters/sectors and that actions of the sector are reported back to the IYCF Task Force (and Nutrition Cluster/Working Groups).	IYCF-E Task Force
As soon as possible after the initial phase of the emergency	
• Provide pamphlets in new-born kits with verbal and pictorial messaging on recommended IYCF practices and contacts for accessing support	DoH. Cluster/ Working group: Reproductive
• Provide messaging directed at fathers, women elders and religious leaders on optimal IYCF-E and the support mothers need related to the changed (emergency) context	DoH (LHWs; CHWs)
• Integrate key messaging on IYCF recommended practices (the importance of continued breastfeeding and guidance on complementary feeding) in sensitization campaigns for micronutrient distributions (e.g. micronutrient powders to children aged 6-23 months and provision of fortified foods) and immunization campaigns.	IYCF-E Task Force.

Ensure a strong focus on communication

Ensure a strong focus on communication from the early stages and throughout the response, to provide awareness and to mobilize the affected target populations, humanitarian response stakeholders and other influential actors to take recommended actions.

Communication activities that span beyond the initial response should build upon those implemented pre-emergency and during the initial relief phase.

Integrated Multi-sectoral Interventions

Actions that foster integration and synergy for responsibility and engagement across sectors to create an enabling and supportive environment for IYCF-E are required, to enhance the reach, effectiveness and impact of IYCF-E interventions.

IYCF-E does not just concern the IYCF/nutrition domain.

- Vulnerabilities and risks that influence IYCF practices cut across many other sectors
- Actions of many actors, and interventions, associated with the emergency response can impact on the feeding and care of infants and young children

- Integrated multi-sectoral actions are required to enhance the reach, effectiveness and impact of IYCF-E interventions.
- All actors involved in emergency response need to consider how their actions affect the specific needs of infants and young children.
- Pre-crisis and initial and ongoing in-crisis assessments and monitoring should be used to inform the required multi-sectoral interventions.
- Plan multi-sectorally - Implement sectorally - Evaluate inter-sectorally.
- Priority sectors for integration include: Nutrition; WASH; FSL; Health and HIV; Child Protection; Education; Shelter and Non-food items; Camp or General Coordination + Logistics

Potential opportunities for integration between IYCF-E and other specific sectors include both IYCF-E specific and IYCF-E-sensitive actions that protect, promote and support IYCF. Examples include:

- Development of sectoral policies and action plans based on consideration of IYCF-E;
- Joint communication initiatives, such as advocacy and messaging;
- Integrated trainings and education;
- Integrated service delivery;
- Joint and coordinated assessments and monitoring, with harmonized indicators and tools;
- Information sharing;
- Representation of IYCF-E at multiple sectoral forums;
- Coordinated referral pathways for cases on concern.

(See Annex 6: Integrated multi-sectoral opportunities for IYCF-E action)

Monitoring, Evaluation, Accountability and Learning

All agencies involved in humanitarian response have a responsibility, to the humanitarian community and affected populations, to access and share information relevant to understanding the situation and the response.

Monitoring and Evaluation

Systematic but simple, timely and participatory mechanisms should be established to monitor the response, to ensure the appropriateness of the intervention and assess progress of how infant and young child feeding needs are being addressed and outcomes improved. Revise interventions, as required, to reflect changes in the context, risks and people's needs and capacities.

- Develop and use simple standard reporting formats, harmonized within and between agencies and provinces, to monitor implementation against targets for the population reach, coverage and input, output, process and outcome
- Use simple recording tools at service delivery points (such as attendance sheets; simple and full IYCF assessment forms; activities log forms; personal data sheets)
- Ensure IYCF-E is represented within the wider humanitarian reporting systems including: NDMA database, Pakistan Bureau of Statistics database, OCHA Humanitarian Coordination Team (HCT) database, and the HumanitarianResponseInfo website
- Evaluate the effectiveness of the response, using the OECD-DAC criteria (Relevance/ appropriateness; Connectedness; Coherence; Coverage; Efficiency; Effectiveness; Impact) to guide planning future initiatives, in collaboration with the government (DoH, DDMA, PDMA), implementing agencies and the affected target population (including mothers of children aged <24 months, pregnant women).

(See Annex: Proposed Indicators)

Accountability

Actors working in emergencies are accountable to those they wish to assist – including pregnant women and caregivers of children aged <2 years

Actions of accountability to put in place include:

- Listen to, involve and communicate with the target beneficiaries populations – during emergency preparedness, response and recovery;
- Encourage the population to actively participate in analyzing and expressing their specific needs and priorities, planning activities and judging the effectiveness of assistance;
- Communicate to the population information appropriate to their needs. For example: objectives and details of the interventions; staff roles and responsibilities; eligibility for inclusion in services; monitoring information;
- Disaggregate data by gender and ages (for infants and young children: 0-5 months; 6-11 months; 12-24 months) to ensure visibility of the populations and enable targeting of their needs;
- Set up formal two-way feedback systems for beneficiaries and other stakeholders to raise issues, make complaints and provide general feedback -and for these to be replied to. Ensure the systems are tailored to the literacy levels of the population; and
- Conduct lessons learned exercises on implemented activities.

Learning

Documenting and sharing experiences and lessons learned from activities are important for creating an evidence base on the appropriateness and effectiveness of interventions. This evidence base can be used to continue or modify current interventions, plan new interventions, or as a tool for advocating to decision makers (such as management and donors) for priority IYCF-E activities.

Learning activities that can be taken include:

- Document and share case studies of IYCF-E programming and examples of integrated activities;
- Conduct regular reflection and learning exercises throughout implementation of the IYCF-E responses;
- Consult with a variety of people (including mothers of children aged 0-23mo) to obtain a diversity of opinions and experiences;
- Carry out objective learning reviews of programmes, for example final programme evaluations;
- Share findings from learning activities with other stakeholders in the IYCF-E response, such as the Government (MoH; DoH; MoNHSR&C, NDMA, PDMA), Nutrition Cluster or IYCF-E Task Force, and more widely through national and global information-sharing forums.

RECOVERY

General objective: To build back a stronger, quality, comprehensive system for the protection, promotion and support of infant and young child feeding in emergency-affected areas

Recovery involves decisions and actions taken with a view to restoring or improving the pre-emergency conditions of the affected populations, while encouraging and facilitating necessary adjustments to reduce vulnerability to the effects of future emergencies. The Government has the primary role and responsibility to provide support for the recovery of those affected by an emergency.

When to transition IYCF-E response activities to longer-term development focus depends on many things, among others: the severity and length of the emergency; pre-crisis and post-crisis evolving IYCF related practices and needs identified; the availability and capacity of services to provide health care and IYCF support; household access to nutritionally adequate, appropriate food and the ability to safely prepare and cook it.

Actions Required

- Connecting emergency response actions with long-term development IYCF programming
- Reflect IYCF-E programme transition strategies in emergency response action plans and proposals;
- Ensure IYCF-E is reflected in transition plans of other Clusters/Sectors;
- Raise awareness of, and advocate to, donors and governments for IYCF-E recovery funding and policies;
- Involve the active participation of community members, in IYCF-E preparedness planning, and, as much as feasible, throughout the response and recovery phases, in identifying needs, setting priorities and implementing activities.
- Plan activities based on sound analysis of the context, addressing root causes of risks and vulnerabilities as well as the impact of the emergency on IYCF practices;
- Build on/ support existing systems (services, initiatives and networks) for IYCF support, reinforcing and enhancing them with use of existing in-country human resources.
- Plan IYCF-E services with consideration of routine services that should be maintained beyond the emergency period. Facilitate linkages between IYCF-E services and routine services;
- Involve the provincial/ regional and/or district authorities in all planning, assessment and reporting of activities, to promote appropriate planning for transitioning activities into provincial/ regional systems and district government ownership and sustainability of activities.
- Share information on assessments, monitoring, evaluation and lesson learning, through national, provincial and community information systems;
- Build and maintain strong IYCF-E coordination structures led through an IYCF-E coordination body, with representatives from the IYCF coordination body. Avoid a sudden gap in IYCF-E coordination mechanism that may undermine the transition;
- Develop the capacity of staff for IYCF and IYCF-E;
- Keep affected populations and other stakeholders informed of any changes in activities and the reasons why.
- Gradually transition IYCF-E programmes through integrating activities into other longer-term community LHW and public health facility-based programmes, and other services, in agreement with concerned parties.

Transitioning from Humanitarian Response

Actions to take	Lead
Identify recovery needs and capacities	
Assess current and future potential vulnerabilities and risks to IYCF, in geographic areas directly affected as well as those indirectly affected by the emergency for example: IYCF-E practices; food security and livelihoods; morbidity (esp acute diarrhea; acute respiratory tract infection; malnutrition) and mortality rates; coping strategies; displacement status; community support; shelter; malnutrition prevalence; water quality and supply; sanitation; other environmental conditions; availability and capacity of, and accessibility to, functioning health services (including CMAM) and other support services for IYCF-E and basic health care. Incorporate risk reduction into the transition strategy.	IYCF-E Task Force. Nutrition Cluster. Implementing agencies.
Conduct evaluations of response actions, using the OECD-DAC criteria, to guide planning future initiatives, in collaboration with the government and the affected target population (including mothers of children aged <24 months, pregnant women)	DoH. DDMA. PDMA. Implementing agencies
Analyse lessons learned from the emergency response and revisit the preparedness plan to identify measures required to mitigate the impact of future emergencies. Ensure consideration of the quality, coverage, access and safety of routine IYCF services through the health system.	DoH. IYCF-E Task Force. Nutrition Cluster/Working Groups
Strengthen community resilience	
Strengthen social safety networks eg skill-based initiatives; financial assistance through Government-led initiatives	MoNHSR&C. NDMA.
Support activities required to provide for household food security and livelihoods, to support access to complementary foods and health care services	Cluster/Working group: Food security
Assess and strengthen capacity	
Conduct a capacity assessment, including a needs and gap analysis, of district, provincial/regional and national support capacities for IYCF-E	IYCF-E Task Force. DoH. DDMA.
Strengthen human resource capacity for IYCF, through conducting refresher training of health care providers and community workers on IYCF-E, based on needs identified in the capacity assessment	MoH; DoH.
Scale up, re-activate or re-energise community-based support systems and services for IYCF in emergency affected areas, including IYCF activities within in the LHW programme and mother support groups (encompassing psychosocial support activities)	DoH
Scale up integration of IYCF into facility-based Primary Health Care Services Package	DoH

Ensure all health facilities have functional IYCF Corners supported by skilled breastfeeding and psychosocial support counsellors	DoH
Develop or strengthen the mental health and psychosocial support system to scale up treatment coverage or referral mechanisms, considering the effect of trauma on IYCF practices	DoH
Communicate priority needs	
Adapt the IYCF-E communications strategy, IYCF-E promotion activities, within health facilities and outreach to reflect priority IYCF behaviour change, social mobilization and advocacy messaging, based on needs identified	IYCF-E Task Force; DoH
Promote awareness among government and other policy-makers around the critical role of IYCF in development and long-term recovery, as part of wider advocacy for resource mobilization to support transition needs, e.g. institutional capacity development, based on lessons learned from the emergency.	IYCF-E Task Force

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SECTION 3:
ANNEX

ANNEX

ANNEX 1: POLICIES

1. Pakistan Protection of Breast-Feeding and Child Nutrition Ordinance, 2002, ORDINANCE NO. XCIII

To provide protection of breast-feeding and nutrition for infants and young children

Whereas it is expedient to ensure safe and adequate nutrition for infants and young children by promoting and protecting breast-feeding, and by regulating the marketing and promotion of designated products including breast milk substitutes, and of feeding bottles, valves for feeding bottles, nipple shields, teats and pacifier and to provide for matters connected therewith or ancillary thereto;

The specific practices which are prohibited include:

- No person shall, in any form whatsoever, promote any designated products except as provided for under this Ordinance.
- No person shall in any manner assert that any designated product is a substitute for mother s milk, or that it is equivalent to or comparable with or superior to mothers milk.
- No manufacture or distributor shall offer, or make gift or contributions of any kind, or pay to any extent for any reason whatsoever, or give any kind of benefit, to a health worker or his family, or any personnel employed directly or indirectly, in a health care facility, or any member of the Board or a Provincial Committee, as the case may be, or the employees thereof.
- No manufacturer or distributor shall donate any designated product and equipment or services related to a designated product free of charge or at low cost to a health care facility, or offer or give any benefit to a professional association of medical practitioners for this purpose.
- No person other than a health worker who is not engaged by a manufacturer or distributor shall instruct any user on the need and proper preparation and use of any designated product: Provided that a manufacturer or distributor may instruct any user on the need and proper preparation and use of any designated product in accordance with the provisions of section 8.
- No distributor or manufacturer shall in furtherance of or for the purposes of its business have contact, directly or indirectly, with general public within a health care facility.
- No manufacturer, distributor or any person engaged by them shall produce or distribute any educational or informational material relating to infant and young child feeding: Provided that any educational or informational material relating to a designated product may be provided by a manufacturer or distributor to a health professional subject to the prescribed conditions, and that the same shall be restricted to scientific and factual matters, and shall not imply or create a belief that bottle-feeding is equivalent or superior to breast-feeding.
- No designated product shall be marketed or sold in Pakistan unless its label is in accordance with the provisions of this Ordinance and the rules, and approved in the manner as may be prescribed by the Federal Government: Provided that for any designated product already being sold in Pakistan, a manufacturer or distributor shall provide for the label of such product within one hundred and eighty days of its approval in the manner as may be prescribed.

(Reference: Government of Pakistan. 2002. Protection of breastfeeding and child nutrition ordinance 2002)

2. The International Code of Marketing of Breast milk Substitutes, and subsequent relevant World Health Assembly resolutions

The International Code of Marketing of Breast milk Substitutes (known as 'The Code') is an international health policy instrument for the protection and promotion of breastfeeding and to ensure the proper use of breast milk substitutes (BMS) when necessary, through adequate information and appropriate marketing and distribution.

All provisions of the Code apply in emergencies and some parts are specific to emergencies, e.g. WHA 47.5 (1994). The International Code provides a required minimum standard that applies to the marketing, and related practices, of the following products: BMSs, including infant formula; other milk products, foods and beverages, including bottle-fed complementary foods, when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast milk; feeding bottles and teats. It also applies to their quality and availability, and to information concerning their use, including how they are produced, packaged, promoted and provided, to ensure that mothers are not discouraged from breastfeeding and that BMSs are used safely if needed. Acts of non-compliance to The International Code are termed 'violations'.

(Reference: WHO. 1981. International Code of Marketing of Breast milk Substitutes

http://www.who.int/nutrition/publications/code_english.pdf)

ANNEX 2: SAMPLE JOINT STATEMENT

Joint Statement from [State names of supporting agencies]

Call for support of infant and young child feeding in Pakistan

[State names of supporting agencies] call for support of appropriate infant and young child feeding in the current emergency, and caution against the unnecessary and potentially harmful donations and use of breast milk substitutes.

During emergency situations, such as [specify the natural or man-made emergency context], disease and death rates among under-two children are generally higher than for any other age group. The younger the child the higher the risk. Mortality may be particularly high due to the combined impact of a greatly increased prevalence of communicable diseases and diarrhoea and soaring rates of undernutrition.

Ensuring the appropriate feeding and care is the fundamental means of preventing malnutrition and death among infants and young children.

In accordance with internationally agreed guidelines, general distributions and donations of infant formula, and other powdered or liquid milk and milk products, complementary foods or drinks represented for use by infants under six months, and bottles and teats, should not be made. Experience with past emergencies has shown poorly targeted distribution and unsupported use of these products, which has endangered young children's lives.

If supplies of infant formula and/or powdered milks are widely available, mothers who might otherwise breastfeed might needlessly start giving artificial feeds, thereby increasing the child's risk of infection and not getting the important nutrients and protective factors breast milk provides. The use of feeding bottles, teats and pacifiers, adds further to the risk of infection as they are difficult to clean properly.

If powdered milk is to be provided it should be mixed with the local staple cereal prior to distribution so that it cannot be used as a breast milk substitute.

Feeding breast milk substitutes carries high risks of malnutrition, illness and death and is a last resort only when safer options have been ruled out.

For the protection of infants and young children, any provision of breast milk substitutes for feeding infants and young children must be based on a careful needs assessment, and targeted only to those children under age 6 months requiring it, when all options for receiving breast milk have been exhausted. Breast milk substitutes should be used only under strict control and monitoring and in hygienic conditions, and in accordance with the International Code of Marketing of Breast Milk Substitutes and subsequent relevant World Health Assembly resolutions, as well as humanitarian agencies' policies and guidelines, and adhere to the Codex Alimentarius Standards. The preferred type of breast milk substitute is ready-to-use infant formula.

All donor agencies, non-governmental organisations (NGOs), the military, media, individuals wishing to help and other partners, should avoid calls for donations of breast milk substitutes, bottles and teats and refuse any unsolicited donations of these products. The Logistics Cluster is requested not to move these items unless approved by the [state IYCF-E coordination body]. Any unsolicited donations should be directed to the designated coordinating agency [state IYCF-E coordination body] (see below).

Misconception: in emergencies many mothers can no longer breastfeed adequately due to stress or inadequate nutrition. Stress can temporarily interfere with the flow of breast milk; however, it is not likely to inhibit breast milk production, provided mothers and infants remain together and are adequately supported to initiate and continue breastfeeding. Mothers who lack food or who are malnourished can still

breastfeed adequately. Extra fluids and food and provision of psychosocial support for the mother will help to protect the health and well-being of the mother and child.

Feeding infants under six months of age

It is critical to encourage and support mothers to initiate breastfeeding immediately after delivery, exclusive breastfeed for up to six months, and for infants under 6 months who are 'mixed feeding (breast milk and another liquid or food) to revert back to exclusive breastfeeding. Non-breastfed infants need early identification and targeted support, with re-establishing breastfeeding (re-lactation) or wet nursing being the preferable feeding options. No food or liquid other than breast milk, not even ghutti or water, is needed to meet an infant's nutritional and fluid requirements for the first six months of life.

For non-breastfed infants for whom it is deemed receiving breast milk is not possible, as assessed by a skilled breastfeeding health professional, use of infant formula must be accompanied by training on it's appropriate and safe preparation and use -including how to feed the infant using a cup- to minimize the risks of it's use. The infant's growth and health should be monitored a minimum of every two weeks.

Feeding children above six months of age

Children from the age of 6 to 24 months require nutrient-rich, safe and age-appropriate complementary foods, in addition to breast milk. Priority should be placed on locally available, culturally acceptable, nutritionally adequate foods. When availability of local foods is limited, fortified ready-to-use, fortified blended foods and micronutrient powders should be considered; the most preferable option should be based on a contextual assessment.

[State names of supporting agencies] strongly urge all who are involved in funding, planning and implementing the emergency response and in all levels of communication to avoid unnecessary illness and death, by protecting, promoting and supporting appropriate and safe breastfeeding and complementary feeding and to prevent and report harmful actions, including donations and uncontrolled distributions of BMSs.

The designated coordinating agency is [Insert]

References:

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http://www.who.int/nutrition/publications/code_english.pdf

ANNEX 3: KEY IYCF-E MESSAGES

Annex 3a. Message Characteristics

Key messages should have the following characteristics:

- Maximum 10 key messages to consistently convey to priority audiences (primary caregivers/ mothers; women elders; fathers) across a variety of communication channels (materials, trainings, community activities). Ensure the messages are:
- Targeted, appropriate, clear, concise, feasible, action-oriented, reflect a positive voice;
- Based on an understanding of the pre-emergency knowledge, attitudes and practices of the affected population and experience of previous emergency contexts;
- Address the critical influences, motivators, challenges and enablers to optimal IYCF and risks of sub-optimal feeding within the current emergency context, as identified from the situation assessment;
- Identify the rationale for the recommended action;
- Pre-test the messages with the intended audiences;
- Ensure all messages and communication materials are assessed and approved by the IYCF TAG, IYCF-E Task Force, and the Communication Task Force if established;
- Translate messages directed for individual household and community levels into the Urdu or regional language, as appropriate;
- Provide pictorial messages, understood by those who are not literate

Annex 3b. Sample IYCF-E Messages

Sample IYCF-E Messages

1. Breastfeeding gives babies the best start in life, providing strong protection for your baby's health and nutrition. During the first 6 months babies should be exclusively breast-fed -this means ONLY giving breast milk and no other fluid or food, even during hot and cold weather. Breast milk provides all the food and water your baby needs and should have during the first 6 months. It is made to perfectly meet each individual baby's nutrient, fat and water needs and to help protect against infection; there is no substitute that can replicate it.
2. Giving non-breast milk foods and fluids to a baby aged under-6 months can cause the baby to drink less breast milk and to get sick from diarrhoea and other illness, particularly in the current emergency environment context where there is lack of clean water and increased risk of getting infections.
3. Newborn babies are especially at risk in this crisis. It is essential that newborn babies begin breastfeeding within one hour after birth. The milk (colostrum) is baby's first "immunization", containing factors that strengthen baby's protection from illness. Feeding ghutti can make baby get sick, as baby's body is not strong enough to fight the increased risk of infections in this emergency environment.
4. Newborns whose mothers are "weak" following delivery can still breastfeed immediately after birth.

5. Breastfeed as often as baby demands milk, allowing baby to feed until satisfied. Babies can regulate the amount of breast milk they need to meet their thirst and nutrient needs. The more baby suckles the more milk mother makes.

6. Use of bottle, teats and pacifiers increase the risk of diarrhea and other infections, as they are difficult to clean and easy for baby to drop and get dirty. Do not use bottles and teats; use cups instead.

7. Stress does not stop mother from producing milk. For a few mothers stress or anxiety may temporarily interrupt milk flow and can interfere with how often and when the baby is fed. Frequent suckling by baby at the breast promotes milk flow - the act of breastfeeding also helps calm both mother and baby. Support from family and friends are important for helping mother to breastfeed.

8. Babies can get fussy or cry for many reasons, especially during an emergency when their environment has changed. Breastfeeding and holding baby skin-to-skin will keep baby warm and help calm baby. If concerned seek medical assistance.

9. A woman can produce a good quantity of breast milk even if her diet has been poor for some time. Quantity of breast milk only reduces when a small baby is receiving other foods and therefore demands less breast milk. Even very thin women can produce enough breast milk. Feed the mother so that she can feed her infant. All mothers need extra fluids and food to maintain their strength and prevent getting undernourished.

10. Infant formula should only be used when absolutely necessary, based on assessment by a health professional and support for it's safer preparation and use. Use of infant formula increases the risk of illness and death in the current context, where there is lack of clean water and conditions to prepare and use it safely. If used, it should only be fed by teaspoon or cup.

11. If you have had powdered milk given to you for your baby and you are breastfeeding, drink it yourself, nourishing yourself will help you to nourish your baby. Do not give it to your baby.

12. If you have been breastfeeding and giving infant formula you can increase your milk supply by gradually reducing the amount of formula given to your baby and breastfeeding more frequently. Breast milk provides protection from illness; infant formula does not.

13. If you have stopped breastfeeding you can start again; letting the baby suck at the breast often will start the milk flowing again. It can take a few days to a couple of weeks for there to be enough milk – the time will depend on how long it has been since you stopped. Keep confident and persevere.

14. At 6 months, introduce other foods in addition to breast milk. Give a variety of nutritious foods - cereals, meats, egg, fruits and vegetables. Feeding non-breast milk foods and liquids before 6 months reduces the amount of breast milk baby drinks; breast milk provides important nutrients and protection from illness. Starting foods too late can cause baby's growth to falter.

15. Continue breastfeeding up to 2 years, or beyond. Breast milk continues to provide older babies with nutrients and energy important for their healthy growth and development.

16. If you are breastfeeding your baby, share your skills and knowledge and encourage and give support to other mothers – especially those who may be having difficulties, are traumatized or who have newborn babies. Help to build their confidence and reassure them they have ability to nourish and protect their babies in this emergency.

Annex 3c: Communication Channels

Use a variety of communication channels

Interpersonal communication, involves face-to-face dialogue between individuals or groups, facilitated informally or through formal discussions at specific contact points. Interpersonal communication provides opportunities to ask questions, to discuss constraints and challenges, and to develop solutions. Interpersonal communication should be prioritized in emergency communication strategies when possible. Promotional activities should include, where possible, interactive methods, rather than focusing on the mass dissemination of messages.

Mass media (e.g. mobile messaging; radio; television) can reach large numbers of people to introduce and reinforce information, promote desired behaviours, and lead to social change.

Community or traditional media, such as radio programmes and videos, are in-between' an interpersonal and a mass audience approach.

Print materials, such as posters, flip charts and counseling cards, can be used to support interpersonal communication; but should not be used as the main delivery method.

How can journalists help?

The media has an important role to play in protecting infants and young children in emergency situations by disseminating information that promotes appropriate breastfeeding and complementary feeding practices and highlights the harm caused from inappropriate use of infant formula and powdered milk. Members of the media can assist by including the following messages in their stories:

- Supporting mothers to continue breastfeeding is the surest way of protecting babies in emergencies.
- Breastfeeding is not fragile. Women who are physically and emotionally stressed are able to make enough milk for their babies. Breastfeeding will also calm mother and baby. Be patient and continue to put baby to the breast.
- Emergency workers do not need large amounts of infant formula when there is an emergency and any that they do need should be procured locally, in coordination with the [state IYCF-E coordination body]. Donations of infant formula, powdered milk or baby bottles should not be sent to the site of an emergency.
- The indiscriminate use of infant formula or other milk products in an emergency is extremely dangerous to babies, causing illness and death.
- Members of the public who donate funds to aid agencies should be encouraged to ask the recipients of their donations if and how they are distributing infant formula or other milk products, and to encourage them to act appropriately so their actions do no harm to infants and young children.
- Agencies and individuals wishing to support infants and young children in the current emergency can help by [specify current IYCF needs]
- Members of the public who become aware of aid agencies distributing infant formula or powdered milk inappropriately should report these activities to the relevant authorities (see key contacts).

ANNEX 4: IYCF-E ASSESSMENTS

Annex 4a. Core and Optional IYCF Feeding Indicators

Core feeding indicators	
Breastfeeding	
Early initiation of breastfeeding	Proportion of children 0-23 months old who were put to the breast within one hour of birth
Exclusive breastfeeding rate	Proportion of infants 0-5 months old who were fed exclusively with breast milk in the past 24 hours
Continued breastfeeding rate at one year and two years	Proportion of children 12-15 months of age and 20-23 months of age who were fed breast milk in the past 24 hours
Complementary feeding	
Introduction of solid, semi-solid and soft food	Proportion of infants 6-8 months old who received solid, semi-solid or soft foods in the past 24 hours
Minimum dietary diversity	Proportion of children 6-23 months of age who receive foods from 4 or more food groups during the past 24 hours
Minimum meal frequency	1. Proportion of breastfed and children 6-23 months of age who receive solid, semi-solid, or soft foods (also including milk feeds for non-breastfed children) the minimum number of times or more during the past 24 hours 2. Proportion of non-breastfed and children 6-23 months of age who receive solid, semi-solid, or soft foods (including milk feeds) the minimum number of times or more during the past 24 hours
Minimum acceptable diet	1. Proportion of breastfed children 6-23 months of age who had at least the minimum meal frequency and minimum dietary diversity during the previous day 2. Proportion of non-breastfed children 6–23 months of age who received at least 2 milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day
Consumption of iron-rich foods	Proportion of children 6-23 months old who in the past 24 hours received an iron-rich food or iron fortified food that is specially designed for infants and young children or that is fortified in the home
Optional feeding indicators	
Children ever breastfed	Proportion of children born in the last 24 months who were ever breastfed
Age-appropriate breastfeeding	1. Proportion of infants 0–5 months of age who received only breast milk during the past 24 hours. 2. Proportion of children 6–23 months of age who received breast milk, as well as solid, semi-solid or soft foods, during the past 24 hours

Predominant breastfeeding	Proportion of infants 0-5 months of age who received breast milk as the predominant source of nourishment in the past 24 hours
Milk feeding for non-breast milk-fed infants	1. Proportion of children 0-6 months of age who were not fed breast milk in the past 24 hours 2. Proportion of non-breastfed children 6–23 months of age who received at least 2 milk feedings during the past 24 hours
Bottle feeding	Proportion of children 0–23 months of age who were fed with a bottle during the past 24 hours

Reference: WHO. 2010. Indicators for assessing infant and young child feeding practices: Part 2 -measurement

Annex 4b. Initial Rapid Assessment

Pre-crisis secondary information.

Some factors about the affected population and context to review:

- What was the demographic profile of the population stratified by age for 0-5 months, 6-11 months, 12-24 months), and women of reproductive age, parity and pregnancy spacing?
- What were the IYCF practices based on the standard (WHO) IYCF indicators (see below),
- What are the knowledge, attitudes and beliefs related to IYCF?
- What methods were used to feed orphans? Are re-lactation, expressing breast milk or wet nursing culturally acceptable?
- Who are the key people at household, community and health facility level that influence IYCF practices?
- How could gender affect the vulnerability of women and girls? Do women have access to economic resources, information, decision making? What are the maternal education and literacy levels? Who makes, or influences, decisions about infant and young child feeding and health care?
- What were the pre-emergency nature, scale and causes of undernutrition among the pregnant and lactating women and children aged <2 years? How is undernutrition related to IYCF?
- What activities were in place pre-crisis to protect, promote and support IYCF? (such as those organized by local communities, individuals, NGOs, government organizations, UN agencies, religious) organizations, etc.? What are the IYCF strategies being implemented or planned to be implemented?
- What social protection mechanisms are in place for families with infants and young children?
- What is the legislative and enforcement status of policies, such as The Pakistan Ordinance 2002 and provincial IYCF policies?
- What are the lessons learned from previous emergencies?
- What are the national and provincial emergency response plans?
- What IYCF-E emergency preparedness activities have been undertaken?

In-crisis secondary information.

Some factors to consider:

- ***Emergency context***

  What is the type of emergency and how has it affected the population?

  What are the current and potential safety and security concerns for the population, and specifically for infants and young children and women and humanitarian workers?

  Is the affected population safely accessible?

  Is the population in relief camps or among the host population? Are they internally displaced persons or are they refugees?

  Are there reports of large numbers of unaccompanied women and children?

- ***IYCF practices, risks and vulnerabilities***

  - What are the initial reports of the effect of the emergency on IYCF practices?
  - What are the initial WASH, health, food security and child protection reports? How could they influence appropriate and safe IYCF?
  - What are the media reports related to IYCF? Are they promoting appropriate IYCF practices and response actions?

- ***Stakeholders***

  Who are the stakeholders in IYCF? (government and non-government workers; existing or new community networks (mother to mother support groups; religious leaders etc). What is their role, their experience with IYCF and IYCF-E, their plans for supporting the emergency response?

- ***Service availability***

  What services are available (including all sectors and other formal and informal service providers) which can support IYCF interventions? What is the capacity of health facilities? Community structures?

  What communication channels are available –what is their coverage and population reach?

- ***Resource analysis***

  What human resources are available at district and provincial level with the capacity to support IYCF-E programming? –What is the capacity and availability of the health care facility (LHV; female nurses, doctors and paediatricians) and community workers (LHWs; CMWs), religious leaders, community support groups, I/NGOs? What is the availability of skilled breastfeeding and psychosocial support counsellors provincially or nationally who could be mobilised to support the IYCF-E response?; What tools are available for facilitating IYCF-E interventions such as trainings, community education; etc

- ***Leadership and coordination***

  Who is in charge of coordination of IYCF-E? Is the Cluster system activated, or going to be activated?–Does the Cluster have the capacity to coordinate IYCF, or is does a sub-group need to be formed eg IYCF-E Task Force?

  Who are the lead agencies for different sectors? What are their initially planned responses?

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1. *WHO. 2010. Indicators for assessing infant and young child feeding practices: Part 2 -measurement*
2. *https://www.humanitarianresponse.info/en/applications/ir/indicators/global-clusters/9?search=&page=3*

Primary data collection.

Some factors to consider:

- What is the demographic profile of those affected? How many pregnant and lactating women and children aged 0-23 months are estimated to be affected?
- How has the normal care and health environment been disrupted (e.g. through displacement, affecting access to secondary caregivers, access to foods for children, access to water, etc. Do pregnant and lactating women and infants and young children <2 years have access to basic needs eg shelter, health care services, sanitation facilities, water (in quantity and quality), food and facilities for preparation and cooking?
- What support for IYCF is being provided by health facilities providing antenatal, delivery, postnatal and child care? What is the capacity of other potential support providers?
- Is there a reported increase in diarrhea or other morbidity among children <2 years?
- What is the estimated percentage of infants 0-<6months old and 6-<12months old who are not breastfed? Is infant formula accessible? What support is available for non-breastfed infants?
- Has there been any evidence or suspicion of a change in infant feeding practices since the onset of the emergency? (such as a decline in breastfeeding initiation or exclusive breastfeeding rates, an increase in artificial feeding rates and/or an increase in proportion of infants not breastfed?)
- Has the community/health staff/parents/caregivers identified any difficulties or concerns with feeding children <2 years since the crisis started? If yes, what difficulties or concerns have been reported?
- What foods are most commonly being fed to children 6-24 months of age?
- Are age-appropriate, nutritionally adequate, safe complementary foods and the means to safely prepare them accessible? –either locally or through the provision of food aid commodities.
- Is infant formula being requested? Have there been any reported distributions of infant formula?
- Is there any evidence or suspicion of untargeted distributions of infant formula, other milk products bottles and teats, either donated or purchased? If yes, by whom?
- What are the priorities expressed by parents and caregivers regarding infant and young child feeding?

ANNEX 5: MONTHLY REPORT FORMAT – IYCF

Province	District	Tehsil/Taluka	Union Council
Village	Nutrition Site/ Health Facility	Site Type	IP Name
From Date	To Date		Reporting Date
Community Based IYCF Counselling			
# of pregnant women counselled for early initiation & exclusive breast feeding	Total Pregnant women	# of mothers with Children < 6 months counselled for exclusive breast feeding.	Mothers of Boys Mothers of Girls Total Mothers
# of mothers with Children 6- 23 months counselled for age appropriate complementary feeding	Mothers of Boys Mothers of Girls Total Mothers	# of mothers of children < 24 months who are part of mother support groups.	Mothers of Boys Mothers of Girls Total Mothers
Health Facility Level Data Reporting Section			
# of mother's/caregivers of children < 2 years who received IYCF counselling.	Mothers of Boys Mothers of Girls Total Mothers	# of Health facilities with assigned HR for IYCF counselling	Male Staff Female Staff Total Staff

Reported By:

Name: _____

Signatures: _____

ANNEX 6: SPECIALIZED SUPPORT INTERVENTIONS

IYCF Corners

An IYCF Corner is a small private area, within a room, used for one-to-one breastfeeding and complementary feeding counseling.

Components	Skilled breastfeeding and complementary feeding and psychosocial counseling. Growth assessment.
Who for	All mothers of children aged 0 – 12 months requiring on-one breastfeeding or complementary feeding counselling
Staffing requirement	Skilled female staff, trained on breastfeeding and complementary feeding and psychosocial support counselling.
When to establish	As soon as possible after the emergency onset OR continue or re-activate IYCF Corners that existed prior to the onset of the emergency.
Where to locate	Small private area, within a room in all health facilities in emergency affected area, in MNCH, maternity and CMAM sites. Optional: Community Health House if privacy for counseling at houses not feasible.
How often to hold	Daily, or often as required for the needs of the affected population.
Possible linkages with other activities	Provide referral to mother support groups. Refer unwell infants or mothers to medical treatment & therapeutic or targeted feeding. Identify caregiver and infant and young child needs and refer to relevant sector leads (eg FSL; WASH; Health; Child Protection *(See Annex 5: Integrated multi-sectoral activities)*

IYCF Spaces

An IYCF Space is a room or tent where women can informally gather together during the day to safely and comfortably breastfeed, share experiences and knowledge and provide mutual psychosocial support, receive one-to-one skilled breastfeeding and complementary feeding counselling and participate in structured education or peer support group activities.

Components	1. Skilled breastfeeding and complementary feeding and psychosocial counseling. 2. Informally share knowledge and experience. 3. Mothers peer support group meetings and action oriented activities: Education and discussion: Topics could include: the six care practices (care for women (including pregnant and lactating women), breastfeeding and feeding practices (including overcoming challenges to IYCF, IYCF myths and misconceptions), psychosocial care, food preparation, hygiene practices and home health practices); responsive stimulation; stress reduction techniques; registration of newborns; Action-oriented activities: demonstrations on the safe and appropriate preparation and use of complementary foods and micronutrient supplements; making water safer

	at household level; responsive stimulation; hygiene practices; life skills; income generation activities. Provide information on support services available; identifying and reporting cases of feeding, nutrition and caring concern. 3. Optional: Baby washing facilities; Children's growth assessment; Peer support and educational group sessions for fathers.
Who for	All mothers of children aged 0-23 months, and pregnant women. Grandmothers could also be included, given their influence on decisions about IYCF at household level. Separate sessions for non-breastfed infants should be facilitated from those of breastfed infants. Separate sessions for pregnant women could be held. Attendance is optional. The aim is to support the highest number of beneficiaries, while always ensuring a good quality of intervention.
Staffing requirement	Skilled female staff, trained on breastfeeding and complementary feeding and psychosocial support counselling and education. Trained mother volunteers could facilitate support group activities.
When to establish	As soon as possible after the emergency onset. Continue or re-activate when the IYCF Space existed prior to the onset of the emergency.
Where to locate	In a tent or room in a permanent structure, typically in a relief camp or at health facility. Ideally establish near a complementary activity (for example CMAM site; Child-friendly Space; general distribution site) to facilitate collaboration and referral. Could be mobile -the skilled counselor moving from village to village or the venue for the IYCF Space moving locations.
How often to hold	Daily, or often as required for the needs of the affected population, and staff or volunteers are available.
Possible linkages with other activities	Provide referral to mothers attending ante-natal and post-natal health services and registered in targeted feeding programmes to participate in IYCF Spaces activities. Identify caregiver and infant and young child needs and refer to relevant sector leads (e.g. FSL; WASH; Health; Child Protection) For example: refer unwell infants or mothers to medical treatment & therapeutic or targeted feeding. *(See Annex 5: Integrated multi-sectoral activities)*

Mother IYCF Support Groups

An IYCF support group comprises a group of people who share their own experiences and knowledge, and provide basic mutual psychosocial support. Mother IYCF support groups may also facilitate structured education or peer group activities.

Components	*Education and discussion:* Topics could include: the six care practices (care for women (including pregnant and lactating women), breastfeeding and feeding practices (including overcoming challenges to IYCF, IYCF myths and misconceptions), psychosocial care, food preparation, hygiene practices and home health practices); responsive stimulation; stress reduction techniques; registration of newborns. Action-oriented activities: demonstrations on the safe and appropriate preparation and use of complementary foods and micronutrient supplements; making water safer

	at household level; responsive stimulation; hygiene practices; life skills; income generation activities. Provide information on support services available; identifying and reporting cases of feeding, nutrition and caring concern *Optional:* Fathers peer support and educational group sessions.
Who for	All mothers of children aged 0-23 months, and pregnant women. Generally, group participants should be as similar as possible e.g. breastfeeding mothers with infants <6m; mothers with children aged 6-23 months, but this depends on the time, space, etc. Grandmothers could also be included, given their influence on decisions about IYCF at household level. Separate support groups for non-breastfed infants should be facilitated from those of breastfed infants. Separate sessions for pregnant women could be held. Attendance is optional. The aim is to support the highest number of beneficiaries, while always ensuring a good quality of intervention.
Staffing requirement	Best led by peers, who have been selected by the community, who model appropriate IYCF practices, are respected by the community and are trained on support group facilitation. Where trained peers are not available deploy external trained staff (eg surge team) to establish and lead the groups.
When to establish	As soon as possible after the emergency onset. Continue or re-activate support groups that existed prior to the onset of the emergency. Establish new Support Groups where they did not exist before the emergency
Where to locate	In 'safe' quiet sheltered location, within a temporary or permanent stand-alone unit (such as in a room or tent), where women feel comfortable meeting, in health facility, community or relief camp locations. Where external trained staff are deployed to lead the support groups, they could be mobile, facilitating support groups in different communities on different days
How often held	As often as required for the needs of the affected population, and availability of support group facilitators.
Possible linkages with other activities	Provide referral to mothers attending ante-natal and post-natal health services, including IYCF corners and registered in CMAM or targeted feeding programmes, to participate in to participate in mother support groups. Identify caregiver and infant and young child needs and refer to relevant sector lead (eg FSL; WASH; Health; Child Protection *(See Annex 5: Integrated multi-sectoral activities)*

ANNEX 7: INTEGRATED MULTI-SECTORAL OPPORTUNITIES FOR IYCF-E ACTION

a. Nutrition – CMAM

A. Common strategic objectives:

- Contribute to the prevention and treatment of acute malnutrition and micronutrient deficiencies in children aged 0-23 months

The goal of the Nutrition sector in emergency contexts is the prevention and treatment of undernutrition, with an emphasis on acute malnutrition as a life-saving intervention in emergency contexts.

Integration of IYCF support into CMAM programmes offers an opportunity for identification of inappropriate feeding practices that may have contributed to the development of malnutrition, correction of those practices during the course of treatment, and follow-up post-discharge to prevent relapse.

Opportunities for action

- Provide or advocate for nutritional support to lactating mothers of acutely malnourished children to support their own nutritional status and increase the potential for successful breastfeeding
- IYCF-E programmes refer cases of malnutrition concern to CMAM focal persons
- On admission to the CMAM programme, complete a full IYCF Assessment for every child aged 0-23 months, discuss any difficulties, and encourage the mother to continue breastfeeding or refer for appropriate skilled breastfeeding support
- Before discharge from the CMAM programme, initiate IYCF counseling and education to the mother (and grandmother and father if possible) on optimal IYCF practices and the risks of inappropriate practices
- At discharge record breastfeeding status; encourage maintenance of appropriate IYCF practices; refer to community-based support programmes eg Mother Support Groups; IYCF Spaces, eligible food distributions
- Provide IYCF corners at CMAM sites
- Ensure staff trained and skilled in breastfeeding and psychosocial counseling and communication skills are available at CMAM sites (or other facility providing rehabilitation for children aged <2 years with severe acute malnutrition)
- Provide complementary food preparation and hygiene demonstrations for groups of caregivers attending CMAM programmes
- Ensure all health care staff working in acute malnutrition rehabilitation programmes are informed on policies and protocols on the distribution and use of infant formula, and monitor and report violations
- Micronutrient supplementation interventions incorporate sensitization on their appropriate use and awareness of IYCF practices that contribute to achieving good micronutrient status

b. Water, Sanitation and Hygiene (WASH)

Common strategic objectives:

To promote good personal and environmental hygiene in order to protect health

The goal for the WASH sector is to reduce morbidity and mortality due to faeco-oral transmission and disease-bearing vectors, through promoting good hygiene, providing sufficient drinking water, increasing availability of appropriate sanitation and decreasing environmental health risks.

WASH and IYCF-E activities have several possible linkages and can achieve common outcomes, especially by selecting common target groups/beneficiaries For example: Improper sanitation facilities and waste disposal often lead to food contamination; unsafe drinking water and poor hygiene practices can make the use of infant formula and complementary foods unsafe, increasing the risk of diarrheal diseases; alterations in the intestinal flora, due to poor WASH conditions, may consequently decrease appetite; lack of water makes the preparation of foods and drinks and hygiene difficult.

Opportunities for action

- IYCF-E Task Force representative provide an orientation at WASH sector meeting on IYCF-E and WASH linkages
- Obtain demographic data disaggregated by gender, age categories 0-5mo, 6-11mo, 12-23mo for assessments, monitoring, reporting and registration and identify pregnant women.
- WASH situation and needs assessments identify non-breastfed infants and infants using bottles and teats
- IYCF and WASH select common target beneficiaries
- Prioritise households with children <24 months and pregnant women for access to safe water
- WASH collaborate with IYCF staff to ensure caregivers of non-breastfed infants obtain targeted support and information on how to prepare safer infant formula
- Households with children <24 months are prioritized for receipt of hygiene kits, which include cups and spoons information on the risks of using bottles and teats, in locations where bottle use is common
- WASH and IYCF actors develop and disseminate joint IYCF messaging and education
- Hygiene kits distributions are accompanied by messaging promoting exclusive breastfeeding from 0-5 months and the safe storage, preparation and feeding of food
- WASH hygiene promotion and education topics include hygiene related to IYCF
- Education on IYCF is included in WASH trainings and new staff orientations
- WASH staff are informed on the referral pathways, & refer, IYCF cases of concern, for targeted support
- WASH sector has a policy on IYCF and action plans that reflect support for optimal IYCF practices
- WASH actors monitor and report untargeted/indiscriminate distributions of infant formula, powdered milk or liquid milk products as single commodities, and bottles and teats
- WASH ensure drinking water and sanitation facilities are available near distribution and registration points, IYCF Corners and other IYCF-E activity services
- Hygiene items (eg soap) are provided to mothers attending IYCF-E education or support group sessions

c. Food Security and Livelihoods (FSL)

Common strategic objectives:

- Contribute to minimizing the risk of malnutrition, through improving the availability, access to and utilization of food
- Support optimal feeding practices of infants and young children and pregnant and lactating women

The right to food is enshrined in human rights treaties. Nutrition is explicitly linked to food security, with the 'right to food' enshrined in human rights treaties. "Food security exists when all people, at all times, have physical, social and economic access to sufficient and nutritious food to meet their dietary needs and food preferences for a healthy life" and details the three components of food security as being: availability, access and utilization (The Sphere Project)

Opportunities for action

- IYCF-E Task Force representative provide an orientation at FSL sectoral meeting on IYCF-E and the linkages with FSL
- Obtain demographic data disaggregated by gender, age categories 0-5mo, 6-11mo, 12-23mo for assessments, monitoring, reporting and registration and identify pregnant women.
- Conduct causal analyses on food security and poor feeding practices, & how FSL interventions might better promote and facilitate optimal IYCF-E practices for improved nutrition outcomes
- Integrate IYCF-E into staff trainings and new staff orientations
- Prioritise the availability of safe and appropriate foods for young children aged 6-23 months and pregnant and breastfeeding women. Collaborate with the IYCF-E Task Force, and consult with women, to plan appropriate and adequate rations
- Plan and implement food security and livelihoods interventions using a gender-sensitive lens" and considering "do no harm" to optimal infant and young child feeding and care practices –include mothers of children aged 0-23mo in activities that do not take them away from their caregiving roles
- Ensure availability of private shaded shelters for breastfeeding women at centralized distribution points. Provide priority access or separate queues for pregnant women or mothers of children aged 0-23 months.
- Accompany food distributions with messaging promoting exclusive breastfeeding from 0-6 months, continued breastfeeding until 24 months of age, and timely, safe & nutritious complementary feeding, and education or information on the use of items given particularly unfamiliar foods
- Collaborate with the IYCF-E Task Force to develop and disseminate joint IYCF and food security messaging, to provide IYCF-E education at distribution points and practical guidance on the preparation of complementary foods
- Ensure caregivers have the equipment and fuel to be able to prepare food available to them
- Do not provide bottles and teats or infant formula, powdered or liquid milk products as single commodities in untargeted food assistance
- FSL staff monitor and report untargeted distributions or donations of BMS to the IYCF-E coordination body
- Ensure cash and voucher programmes do not enable access to infant formula, unless as a targeted conditional intervention directed at eligible non-breastfed children according to the criteria defined by the IYCF Task Force
- Ensure staff are informed on the referral pathways for IYCF cases of concern to receive targeted support

d. Health

Common strategic objectives:

- Prevent and reduce morbidity and mortality linked to feeding practices of infants and young children aged <24 months

Mothers and caregivers of infants and young children need access to timely and appropriate support that minimises risks and optimizes nutrition, health and survival outcomes. The importance of coordination of health across agencies and sectors is specified in Sphere health systems standard 6: "People have access to health services that are coordinated across agencies and sectors to achieve maximum impact.

In emergency contexts, access to and delivery of health services and supportive medical supplies can be disrupted, health facility services overburdened, while there is concurrently increased risk of stress-related conditions, infection and other illnesses.

Health professionals are influential figures in a society, and the messages, counselling and advice they provide play a crucial role in influencing infant and young child feeding practices. Senior health advisors and managers influence health care providers, during trainings, supervision and advising on and enforcing policies and protocols.

Opportunities for action

- IYCF-E Task Force representative provide an orientation on IYCF and the linkages with health at Health sectoral and sub-group meetings.
- Health sector obtain demographic data disaggregated by gender, age categories 0-5mo, 6-11mo, 12-23mo for assessments, monitoring, reporting and registration and identify pregnant women.
- Ensure all frontline health care staff receive training on IYCF and care practices, psychosocial support and communication skills, and the risks of inappropriate IYCF and caring practices in the emergency context.
- IYCF-E Task Force advocate to senior health advisors and managers on the importance of protecting and supporting optimal IYCF-E, and the controlled use and distribution of breast milk substitutes.
- Enforce health staff monitoring and reporting of violations to the Pakistan Ordinance and The Code.
- Ensure IYCF-E key interventions are well reflected in the minimum package of services for health facility and community (Lady Health) workers.
- Include skilled breastfeeding and psychosocial assessment and support and education on optimal IYCF practices at all health care delivery points for children aged 0-23 months, including mobile clinic services.
- Provide IYCF Corners in health facilities, with skilled support for breastfeeding and psychosocial counselling.
- Where artificial feeding is required, according to the strict eligibility criteria, ensure support is provided for it's 'safer' use and routine monitoring of the infants growth and health.
- Register pregnant women, and follow up on their date of delivery so newborns are supported with early initiation of exclusive breastfeeding.
- Integrate education on IYCF into vitamin A supplementation, vaccination and deworming campaigns for young children
- Ensure health care staff (including the reproductive health team, and other field staff (are aware of the importance of the optimal IYCF and caring practices in the emergency context, and the referral pathways for cases of concern to receive the appropriate specialized support
- Design disease outbreak response measures with consideration of mitigating the impact on

pregnant and lactating women, infants and young children

- Include IYCF-E messaging materials in Reproductive Health (Newborn Baby) Kits
- MoH legislate for every health facility set up in an emergency response to practice the 'ten steps to successful breastfeeding' as defined in the Baby-friendly Hospital Initiative.

e. HIV

Common strategic objectives:

- Prevent mother to child transmission of HIV
- Increase child survival

IYCF and HIV are closely linked. HIV can be transmitted through the breast milk of HIV-positive women. However, infants who are not breast-fed may be exposed to higher risk of morbidity and mortality associated with malnutrition and infectious diseases other than HIV. Combining anti-retroviral (ARV) interventions with breastfeeding can significantly reduce post-natal HIV transmission.

Early initiation and exclusive breastfeeding for the first 6 months, and the continuation of breastfeeding for at least 12 months offers the greatest likelihood of survival for infants born to HIV-infected mothers and for survival of HIV-infected infants, while mothers are taking ARVs. Mixed feeding carries a higher risk of transmission than exclusive breastfeeding, therefore should be avoided. It is important for HIV-positive pregnant and lactating women to take ARVs, and infants to take ARV prophylaxis for the first 6 weeks post-partum, according to recommendations. Replacement feeding or early cessation of breastfeeding is unlikely to be an Acceptable, Feasible, Affordable, Sustainable and Safe (AFASS) option and therefore the risks of infection or malnutrition from using breast milk substitutes are likely to be greater than the risk of HIV transmission through breastfeeding.

To support the capacity to care for herself and her child's well-being. HIV positive mothers need to be supported to access adequate and appropriate food and health services. However in the context of humanitarian crises food security and livelihoods systems and access to pre-existing health services are disrupted increasing the risk of appropriate support for HIV-exposed infants and HIV-positive primary caregivers.

Opportunities for action

- Obtain demographic data disaggregated by gender, age categories 0-5mo, 6-11mo, 12-23mo for assessments, monitoring, reporting and registration
- HIV/AIDS and IYCF-E specialists collaborate on the provision of targeted support for the 'safer' use of infant formula and regular monitoring of the growth and health of infants whose HIV-positive mothers choose not to breastfeed.
- Prioritise access to and use of ARVs by HIV positive pregnant and lactating women and newborns of HIV-positive mothers
- Ensure health and nutrition staff are trained on the national protocols and latest WHO guidance on HIV and infant feeding, as relevant to their roles.
- IYCF-E staff train HIV/AIDS staff on the provision of specialized IYCF and psychosocial support
- Ensure staff are informed on the referral pathways, & refer cases of concern, to receive targeted support
- Support women who are HIV positive to make an informed decision about infant feeding, and with the support needed based on her decision: 1. Breastfeeding support (recommended option) or 2. Supported to meet the AFASS criteria for use of artificial milk.
- Prioritise HIV positive mothers for access to food rations and WASH and health services
- Provide guidance on infant feeding in HIV messages and education, reflecting the emergency context

f. Child Protection (CP)

Common strategic objectives:

- Contribute to the right to life, survival, development and protection of children from age 0-23 months.
- Protection of adolescents from harmful traditional practices in an emergency context strengthened –considering the correlation between early/child marriage and negative health (including mental health) outcomes for mother and child

The Core Strategies for Child Protection in Emergencies include:

Support all relevant line agencies for the effective and coordinated delivery of child protection, case management and referral services in an emergency – humanitarian context.

In addition, technically support the governmental provision of protection/ relief services for children and women in an emergency context primarily through the PLACES modality (Child friendly Space providing access or referral to child and women protective services and to the child protection system wherever established).

Opportunities for action

- IYCF-E Task Force representative/s provide an orientation at CP sub-cluster, as appropriate or PDMA Gender and Child Cell meetings on IYCF and the linkages with CP.
- IYCF-E support the enhanced design of CPMIS in each province to obtain demographic data disaggregated by gender, age categories 0-5mo, 6-11mo, 12-23mo, orphans and unaccompanied children, single or child-headed households, caregivers of infants and young children, and/or pregnant and lactating adolescents in support of strengthened assessments, monitoring, reporting and registration
- IYCF sectors input into the development of multi-sectoral two-way referral pathways, for cases of protection and feeding concern, including referral to psychosocial services for caregivers with potential mental health issues
- Through the CP sub-cluster IYCF provides training to members on identifying and referring children with feeding problems
- CP field staff monitor and report indiscriminate distributions or donations of infant formula to the IYCF-E Task Force
- IYCF and CP services coordinate activities, so mothers of infants can attend IYCF activities while their older children attend Child-friendly Spaces
- Child-friendly Spaces provide private areas for women to breastfeed
- IYCF-E Task Force & CP sub-group or Gender and Child Cell collaborate on developing and disseminating joint messages & educational materials
- Child protection advocacy initiatives highlight the importance of appropriate IYCF
- Child-friendly Space staff provide parenting skills education to participants at Mother Support Groups or IYCF-E Spaces
- IYCF-E staff provide education and practical demonstrations at Child-friendly Spaces parenting classes, on timely, safe and appropriate IYCF
- Integrate IYCF education into life skills-based education programmes, for both women and men.

g. Education

Common strategic objectives:

- Build children's developmental capacity
- Develop positive parenting practices, through enhancing caregivers knowledge and skills

Key messaging provided through the education system can reach caregivers of young children, directly through interaction with the caregivers or indirectly though messages relayed to the house by children. Teachers are often respected members of the community, who are informed on and interact with the wider community and can support the promotion of written messaging to the illiterate. Additionally, education facilities (classrooms or temporary learning spaces) often have available areas that can be used for other non-school activities.

Opportunities for action

- IYCF-E staff train teachers on IYCF-E
- IYCF-E staff provide orientation sessions on IYCF-E to school management committees and at Education sectoral meetings
- Education leads ensure education staff are informed on the warning signs of feeding and caring concern (such as reduced mental health and caring capacity of the mother, malnutrition of infants and young children) and know the procedures for referring cases of concern to receive skilled support
- Teachers inform mothers of children <2 years of IYCF-E activities
- Teachers provide education and informational materials to school children on recommended IYCF-E and caring practices (including play)
- Teachers provide education and informational materials to caregivers on IYCF-E and caring practices (including play, hygiene, and responsive feeding)
- Education facilities share educational spaces with IYCF activities (such as Mother Support Groups) –alternating timing of activities
- Education facilities provide private spaces for mothers to breastfeed
- Education facilities place pictures on classroom walls of recommended IYCF-E practices
- Life-skills initiatives for adolescents include targeted education on IYCF-E

h. Shelter and Non-food Items (NFI)

Common strategic objectives:

- Contribute to providing for the basic human need for security, dignity and protection from environmental conditions of pregnant and lactating women and children aged 0-23 months.
- Provide mothers of children aged 6-23 months with tools that support their capacity to feed and care for their children

"Shelter is a critical determinant for survival in the initial stages of a disaster. Beyond survival, shelter is necessary to provide security, personal safety and protection from the climate and to promote resistance to ill health and disease. It is also Important for human dignity, to sustain family and community life and to enable affected populations to recover from the impact of disaster. Shelter and non-food item responses should support existing coping strategies and provide self-sufficiency and self-management by those affected by the disaster." (Sphere 2011)

Opportunities for action

- IYCF-E Task Force representative provide an orientation at the Shelter & NFI sectoral meeting on IYCF and the linkages with Shelter and NFIs
- Obtain demographic data disaggregated by gender, age categories 0-5mo, 6-11mo, 12-23mo for assessments, monitoring, reporting and registration and identify pregnant women.
- Prioritise shelters for pregnant and lactating women and children aged 0-23 months, taking into account their specific needs and vulnerabilities
- Provide shelters for families in preference to communal shelters, considering the privacy needs of women for breastfeeding and personal dignity
- Provide private shaded shelters for women to breastfeed, at distribution and registration points, rest areas at transit sites and health facilities.
- Provide shelters for IYCF programme activities eg IYCF Spaces, Mother Support Groups. Consider ease of access, safety and appropriateness when determining placement and design
- Consider the specific needs of pregnant women and mothers of children aged 0-23 months when defining the content of NFI kits (such as coverings/blankets and clothing; fabric screens; food preparation equipment and fuel) and the modalities and location for distribution
- Ensure pregnant women and mothers of children aged 0-23 months are aware of their eligibility to receive NFIs
- Provide cups for aged 6-23 months, accompanied by information to discourage the use of bottles and teats and to promote breastfeeding. Consider establishing a bottle-for-cup exchange system.

I. Camp or General EMERGENCY COORDINATION

Common strategic objectives:

- Provide a safe and supportive environment that supports the well-being of pregnant and lactating women and infants aged 0-23 months

Coordination of emergencies includes actions related to the organization of relief camps and communities

Opportunities for action

- IYCF-E Task Force representative provide an orientation to the Disaster Management Authority and to Camp Coordination sectoral meetings on IYCF and the linkages with the planning and provision of services and structures in camps and host communities
- Ensure that all planning considers the safety, appropriateness and needs of pregnant and lactating women and infants and young children aged 0-23 months, so that their feeding and nutrition is protected, promoted and supported. Consult with caregivers to identify their vulnerabilities and needs.
- Assist with settlement of populations into familiar groups, so that women can access support from their family and communities
- Ensure distributions consider pregnant women and mothers of children aged 0-23 months who may be unable or unwilling to leave their homes

j. Logistics

Common strategic objectives:

The provision of life-saving supplies and services in order to ensure an effective and efficient response.

The logistics cluster helps various agencies with shipment and importation of their goods in emergencies.

Opportunities for action

- IYCF Task Force representative provide a sensitization session at the Logistics Cluster meeting about IYCF, the Ordinance and The Code, and the procedures to monitor and report violations of the legislations.
- Logistics Cluster ensure their Standard Operating Procedure documents includes wording on the shipment and storage of breast milk substitutes, and all staff are informed, so any unsolicited, untargeted donations are prevented, returned or dealt with so they are used in a responsible way, before or as soon as they enter the country.
- Logistics Cluster put out a press release to the effect that it will not store or transport any milk products or any infant feeding products unless they are part of a programme that has received prior approval from the IYCF-E coordinating body,

ANNEX 8: PROPOSED INDICATORS

Activities indicators

Input and output indicators

Proportion of registration, distribution and transit points with secure private spaces for breastfeeding

IYCF corners established and operational with trained staff

IYCF-Spaces established and functional with trained staff

Mother Support Groups established and functional with trained female facilitators

Health care facility and community female and male workers (including surge personnel) trained in IYCF-E

Frontline female and male workers oriented the recommended IYCF practices, the Ordinance and the referral procedures for cases of IYCF concern

Dedicated trained female breastfeeding counsellors

Materials with key IYCF-E messages produced

Government, agencies and clusters/working groups who are stakeholders to the humanitarian response who develop strategies and action plans that reflect consideration of IYCF-E

Process and activity indicators

Surveys/ Assessments with IYCF-E components conducted

Sessions (Mother Support Group or IYCF Spaces) activities held

Mothers (with an infant or young child) admitted to the activity

Pregnant women admitted to the activity Frequency of individual women's participation to activities

Beneficiary mothers and girls and boys <2 years referred for psychosocial or other support

One-to-one skilled breastfeeding/ complementary feeding consultations

Newborn girls and boys supported to breastfeed within 24 hours of delivery

Infant girls and boys assessed by a health professional as requiring infant formula who have access to Code-compliant supplies of appropriate BMS and support for it's 'safer' use

Proportion of girls and boys aged 6-24 months whose caregivers have access to timely, appropriate, nutritionally adequate and safe complementary foods, and the facilities or equipment to prepare it

Proportion of pregnant and lactating women who have access to appropriate, nutritionally adequate food

Educational sessions held on complementary feeding

Female and male health care facility, community and surge workers trained in IYCF mobilized

#/ Proportion of mothers/ primary caregivers who can cite five key IYCF-E messages

#/ Proportion of confirmed distributions of infant formula, dried or liquid milk to children <2 years which were followed up

IYCF-E activities with FSL/ WASH/ Health/ Education/ Child Protection sector components implemented

Outcome and impact indicators

% Mothers of infants 0-5 mo who reported to have changed from mixed feeding to exclusive breastfeeding

% Girls and boys being exclusively breastfed at 4/5/6/7/8 months

% Girls and boys aged 0-5mo predominantly breastfed

% Women who managed to relactate% Infant girls and boys 0-5mo who were supported to feed from a wet-nurse

% Women who show an improvement in knowledge on breastfeeding/ complementary feeding

% Infant girls and boys born since the onset of the emergency who after birth, initiated exclusive breastfeeding within 1 hour after birth

% Girls and boys breastfeeding at 1 year and 2 years

Proportion of girls and boys who commenced complementary feeding at 6-8 months

Proportion of girls and boys who received the minimum dietary diversity*

Proportion of girls and boys with the minimum meal frequency

Proportion of girls and boys under age 6 months mixed fed

Proportion of girls and boys not breastfed

Proportion of girls and boys bottle fed

** These are based on 7 food groups: Grains, roots and tubers; Legumes and nuts; Dairy products (milk, yoghurt, cheese); Flesh foods (meat, fish, poultry, and liver/organ meats); Eggs; Vitamin A rich fruits and vegetables; Other fruits and vegetables. Each of the 7 food groups has each been identified as critically important in the complementary feeding diet; foods specified within the groups should be adapted to local diets.*

GLOSSARY

Baby-friendly Hospital Initiative (BFHI): An approach to transforming hospital practices, an initiative launched in 1991 by UNICEF and WHO to protect, promote and support breastfeeding: the special role of maternity services (1989). Baby-friendly hospitals practice the ten steps to successful breastfeeding (part of the joint statement) and observe the principles and aim of the International Code of Marketing of Breast milk Substitutes, including not accepting free or low-cost supplies of breast milk substitutes, feeding bottles, teats and pacifiers. To acquire the "baby-friendly" designation, a hospital must be externally assessed according to an agreed procedure using the global criteria

Breast Milk Substitute (BMS): any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not it is suitable for that purpose. These include infant formula, other milk products (eg modified liquid animal milks and modified evaporated milk), therapeutic milk, and bottle-fed complementary foods marketed for children up to 2 years of age and complementary foods, juices, teas marketed for infants under 6 months

Cluster: In the context of the Humanitarian Reform, a cluster is a group of agencies, organizations and/or institutions interconnected by their respective mandates that work together towards common objectives. The purpose of the clusters is to foster timeliness, effectiveness and predictability while improving accountability and leadership

Commercial baby foods: industrially produced and marketed infant complementary foods, such as branded jars or packets of dried, semi- solid or solid foods

Complementary food: Any food, whether industrially produced or locally prepared, used as a complement to breast milk or to a breast milk substitute

Contingency planning: The process of establishing programme objectives, approaches and procedures to respond to situations or events that are likely to occur, including identifying those events and developing likely scenarios and appropriate plans to prepare and respond to them in an appropriate manner

Disaster: A situation or event causing serious disruption to the functioning of a community or a society, such as widespread human, material, economic or environmental losses, which exceed the ability of the affected community or society to cope using its own resources. It implies the interaction of an external stressor with a human community and it carries the implicit concept of non-manageability

Emergency preparedness: Actions taken in anticipation of an emergency to facilitate rapid, effective and appropriate response to the situation

Home-modified animal milk: a breast milk substitute for infants up to six months prepared at home from fresh or processed animal milk, suitably diluted with water and with the addition of sugar and micronutrients

Humanitarian emergency: an event or series of events which represents a critical threat to the health, safety, security or wellbeing of a community or other large group of people. A humanitarian crisis can have natural or manmade causes, can have a rapid or slow onset and can be of short or protracted duration

Infant formula: an animal or vegetable-based breast milk substitute formulated industrially in accordance with applicable Codex Alimentarius standards (developed by the joint FAO/WHO Food Standards Programme). Generic infant formula is unbranded and is not available on the open market, thus requiring a separate supply chain

Milk products: dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed

milk, soya milks, evaporated or condensed milk, fermented milk or yogurt

Minimum acceptable diet: a composite indicator of the adequacy of complementary feeding practices. It is the proportion of children 6–23 months of age who received a minimum acceptable diet (apart from breast milk)

Minimum dietary diversity: estimated as the proportion of children 6–24 months of age who received foods of 4 or more food groups out of a total number of 7 food groups defined

Minimal meal frequency: estimated as the minimum number of times solid, semi-solid or soft foods (including milk for children who are not breastfed) are given to breastfed and non-breastfed children who are 6-7 months of age. "Minimum is defined as 2 times for breastfed infants 6-9 months, 3 times for breastfed children 9-24 months and 4 times for non-breastfed children 6-24 months. "

Mixed feeding: breastfeeding a child while also giving non-human milk and/or fluid or solid food

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

Resilience activities: directed at boosting the capacity to absorb, prepare for, and prevent humanitarian disasters, crises, and long-term stresses

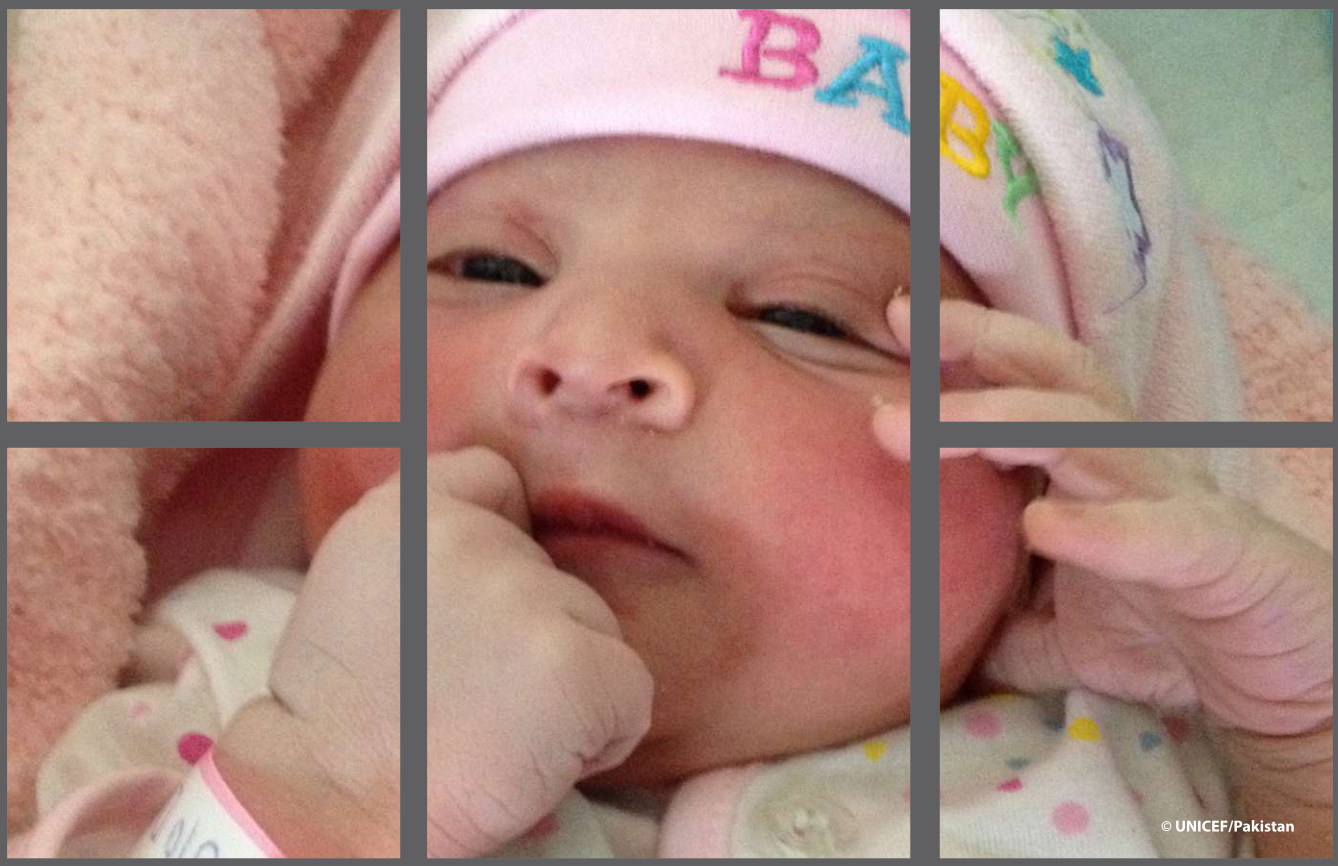
Risk: An evaluation of the probability of occurrence and the magnitude of the consequences of any given disaster or hazard, i.e. how likely is a hazard and what consequences will it have. The evaluation of a risk includes vulnerability assessment and impact prediction taking into account thresholds that define acceptable risk for a given society

Supplementary foods: Commodities intended to supplement a general ration and used in emergency feeding programmes for the prevention and reduction of malnutrition and mortality in vulnerable groups

Supplementation: The process of supplying nutrients –in the form of bars, capsules or powders- that are missing or not consumed adequately in a persons diet. Typical supplements for mothers and young children include micronutrient mixes, Vitamin A, iron and zinc

Vulnerability: The degree to which a system or person is either susceptible or resilient to the impact of natural hazards and human-induced disasters. The degree of vulnerability is determined by a combination of several factors including hazard awareness and preparedness and condition of the environment, society or person

Wet nursing: where a woman who is not the birth mother of the child breastfeeds the child. In Urdu language termed "razi". The woman who breastfeeds another's child is called a 'wet nurse'. Wet nurses may be already producing breast milk or they may restart breastfeeding



Nutrition Wing
Ministry of National Health Services,
Regulations & Coordination
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