



# **Infant and Young Child Feeding in Emergencies**

**Operational  
Guidance for  
Emergency Relief  
Staff and  
Programme  
Managers**

**Developed by the  
IFE Core Group**

**Version 3.0 – October 2017**

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## Background

The Operational Guidance on Infant and Young Child Feeding in Emergencies (OG-IFE) was first produced by the Interagency Working Group on Infant and Young Child Feeding in Emergencies in 2001. This Working Group included members of the IFE Core Group; an inter-agency collaboration concerned with the development of training materials and related policy guidance on infant and young child feeding in emergencies (IFE/IYCF-E, hereon referred to as IFE).

Version 2.0 was produced in May 2006; version 2.1 in February 2007 (with addendum in 2010); and version 3.0 in October 2017 to reflect operational experiences and needs and guidance updates. Version 3.0 update was undertaken by the IFE Core Group in consultation with international, regional and country informants, co-led by the Emergency Nutrition Network (ENN) and UNICEF and coordinated by ENN. The IFE Core Group gratefully acknowledges all those who advised on and contributed to this and earlier editions.

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## Mandate

The OG-IFE seeks to meet the provisions of international emergency standards, including Core Humanitarian Standards on Quality and Accountability (CHS) and Sphere Standards<sup>1</sup>, among many others<sup>2</sup>. It assists with the practical application of the Guiding Principles for Feeding Infants and Young Children in Emergencies<sup>3</sup> and the International Code of Marketing of Breastmilk Substitutes ("*the Code*")<sup>4</sup> and subsequent relevant World Health Assembly (WHA) resolutions. It assists decision-makers, planners and donors to meet their responsibilities set out in the UNICEF/WHO Global Strategy on Infant and Young Child Feeding<sup>5</sup> in Article 24 of the Convention of the Rights of the Child<sup>6</sup> and the Call for Action contained in the Innocenti Declaration 2005 on Infant and Young Child Feeding<sup>7</sup>, welcomed unanimously by the 2006 WHA. It contributes to the achievement of Sustainable Development Goal<sup>c</sup> targets (Goals 2,3 and 6) and the work programme of the United Nations (UN) Decade of Nutrition (2016-2025)<sup>d</sup>.

## Aim

The OG-IFE aims to provide concise, practical guidance on how to ensure appropriate infant and young child feeding in emergencies.

## Scope

The OG-IFE applies to emergency preparedness, response and recovery worldwide to minimise infant and young child morbidity and/or mortality risks associated with feeding practices and to maximise child nutrition, health and development.

## Target populations

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

## Target users of this guidance

The OG-IFE is intended for policy-makers, decision-makers and programmers working in emergency preparedness and response, including governments, United Nations (UN) agencies, national and international non-governmental organisations (NGOs), donors, volunteer groups and the private/business sector.

Recommended actions are directed at those with IFE coordination authority and mandated responsibilities, and those undertaking activities directly or indirectly affecting IFE who also have key responsibilities and roles. Actions will be required at multiple levels and to varying degrees according to the context.

The OG-IFE is relevant across sectors and disciplines, particularly nutrition, but also health (including reproductive health, maternal, newborn and child health (MNCH), curative services, mental health and psychosocial support services (MHPSS); HIV; infectious disease management); adolescent services; water, sanitation and hygiene (WASH); food security and livelihoods (FSL); child protection; early childhood development (ECD); disability; shelter; cash transfer programmes; social protection; agriculture; camp coordination and camp management; and logistics.

## Layout

Beginning with a summary of **key points**, this document is organised into six sections of **practical steps**, followed by **key contacts** (Section 7), a **reference** section with key resources (Section 8), and **definitions** (Section 9). References are included as **footnotes** that link to Section 8, where numbered resources are listed. Supporting information is alphabetically indexed in the **notes** that follow Section 7. Emergency preparedness is a cross-cutting theme; key actions are summarised in **Box 1** and sections listed in **Annex 1**. **Multi-sector collaboration** is addressed in **Section 5** but also in other sections; a guide to content by sector/speciality is included in **Annex 1**.

## Feedback and support

The IFE Core Group welcomes feedback on this document and implementation experiences. Contact the IFE Core Group c/o UNICEF Programme Division, New York, USA: [nutrition@unicef.org](mailto:nutrition@unicef.org), or c/o ENN, Oxford, UK: [office@ennonline.net](mailto:office@ennonline.net). Include 'OG-IFE feedback' in the subject line.

The OG-IFE is available online at [www.ennonline.net/operationalguidance-v3-2017](http://www.ennonline.net/operationalguidance-v3-2017)

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<sup>1</sup> See 23-25 in References Section 8.2 Policy – Minimum Standards

<sup>2</sup> See References Section 8.2 Policy – Minimum Standards

<sup>3</sup> See 4 in References Section 8.2 Policy – Global and National Strategy

<sup>4</sup> See 9 and 10 in References Section 8.2 Policy – Global Policy

<sup>5</sup> See 5 in References Section 8.2 Policy – Global and National Strategy

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## KEY POINTS

1. Appropriate and timely support of infant and young child feeding in emergencies (IFE) saves lives; protects child nutrition, health and development; and benefits mothers.
2. Emergency preparedness is critical to a timely, efficient and appropriate IFE response (*Box 1*).
3. Key provisions regarding IFE should be reflected in government, multi-sector and agency policies and should guide emergency responses (*Section 1*).
4. Sensitisation and training on IFE is necessary at multiple levels and across sectors (*Section 2*).
5. Capacity to coordinate IFE should be established in the coordination mechanism for every emergency response. Government is the lead IFE coordination authority. Where this is not possible or support is needed, IFE coordination is the mandated responsibility of UNICEF or UNHCR, depending on context, in close collaboration with government, other UN agencies and operational partners (*Section 3*).
6. Timely, accurate and harmonised communication to the affected population, emergency responders and the media is essential (*Section 3*).
7. Needs assessment and critical analysis should inform a context specific IFE response (*Section 4*).
8. Immediate action to protect recommended infant and young child feeding (IYCF) practices and minimise risks is necessary in the early stages of an emergency, with targeted support to higher risk infants and children (*Section 5*).
9. In every emergency, it is necessary to assess and act to protect and support the nutrition needs and care of both breastfed and non-breastfed infants and young children. It is important to consider prevalent practices, the infectious disease environment, cultural sensitivities and expressed needs and concerns of mothers and caregivers when determining interventions (*Section 5*).
10. Multi-sector collaboration is essential in an emergency to facilitate and complement direct IYCF interventions (*Section 5*).
11. In every emergency, it is important to ensure access to adequate amounts of appropriate, safe, complementary foods and associated support for children and to guarantee nutritional adequacy for pregnant and lactating women (PLW) (*Section 5*).
12. In emergencies, the use of breastmilk substitutes (BMS) requires a context-specific, coordinated package of care and skilled support to ensure the nutritional needs of non-breastfed children are met and to minimise risks to all children through inappropriate BMS use (*Sections 5 and 6*).
13. Donations of BMS, complementary foods and feeding equipment should not be sought or accepted in emergencies; supplies should be purchased based on assessed need. Do not send supplies of donor human milk to an emergency that is not based on identified need and part of a coordinated, managed intervention. BMS, other milk products, bottles and teats should not be included in a general or blanket distribution (*Sections 5 and 6*).
14. It is essential to monitor the impact of humanitarian actions and inaction on IYCF practices, child nutrition and health; to consult with the affected population in planning and implementation; and to document experiences to inform preparedness and future response (*Section 4*).

# PRACTICAL STEPS

## 1 Endorse or develop policies

- 1.1** Governments and agencies should have **up-to-date policies** which adequately address all of the following elements in the context of an emergency: protection, promotion and support of breastfeeding; the management of artificial feeding; complementary feeding; the nutrition needs of PLW; compliance with the *International Code of Marketing of Breastmilk Substitutes (BMS)* and subsequent relevant *World Health Assembly (WHA) Resolutions (the Code)*<sup>6</sup>; prevention and management of donations of BMS; and infant feeding in the context of public health emergencies and infectious disease outbreaks (see Section 9 Definitions for recommended IYCF practices). Additional context-specific provisions may be necessary, such as for refugees or internally displaced persons (IDP). Provisions may exist as a standalone policy and/or may be integrated into other relevant policies. UNICEF and WHO have key responsibilities in supporting national/sub-national policy preparedness (see Box 1 for key preparedness actions).
- 1.2** In early response, consult **national/sub-national preparedness plans, policies and procedures** and uphold relevant legislation and international standards. In an emergency, where existing policy guidance is absent, outdated or does not adequately address the context, rapid policy guidance updates or 'stop-gap' guidance development may be necessary, led by the IFE coordination authority and in consultation with WHO, other relevant UN agencies and national/regional/global technical groups (see 3.1; 3.3).
- 1.3** Develop missing and update existing policy guidance in close collaboration with government authorities and seek to strengthen relevant national/sub-national policies. Develop and update policies and associated procedures in preparedness.
- 1.4** **Disseminate** key policy guidance to all relevant responders across sectors, including media groups, private sector, donors, military and volunteer groups (see 3.7).
- 1.5** An **inter-agency joint statement**, issued and endorsed by relevant authorities, may be used to highlight relevant guidance, provide context-specific rapid guidance, and harmonise communication. Development of the statement should be led by the IFE coordination authority (see 3.1); UNICEF and WHO have key roles to catalyse and support development. In preparedness, develop a draft joint statement and secure preliminary approval with relevant authorities. A model joint statement is available<sup>7</sup>.
- 1.6** **The Code** expresses the collective will of governments regarding the marketing of BMS and sets out the responsibilities of the manufacturers and distributors of products covered by *the Code*, health workers, national governments and concerned organisations (see 9). Enact *the Code* into national legislation in preparedness and enforce at all times, including during emergency response. Ensure that existing legislation is fully in line with *the Code*. Report Code violations (see 4.16 and 7.1).
- 1.7** Enact legislation and adopt policies in line with the WHO Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children<sup>8</sup> (see 5.27). In preparedness, UN, civil society and government policy-makers should develop national legally binding policies regarding private sector engagement in emergency response to enable constructive collaboration and avoid undue influence and conflicts of interest<sup>9</sup>.

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<sup>6</sup> See 9 and 10 in References Section 8.2 Policy – Global Policy

<sup>7</sup> See 13 in References Section 8.2 Policy – Organisational Policy

<sup>8</sup> See 11 and 12 in References Section 8.2 Policy – Global Policy

<sup>9</sup> See 7 in References Section 8.2 Policy – Global and National Strategy

## 2 Train staff

- 2.1** **Sensitise** relevant personnel **across sectors** to support IFE, including those dealing directly with affected women and children; those in decision-making positions; those whose operations affect IYCF; those handling any donations; and those mobilising resources for the response. Target groups for sensitisation include government staff, sector/cluster leads, donors, rapid-response personnel, camp managers, communications teams, logisticians, the media, volunteers, among others.
- 2.2** **Train** personnel on IFE in **preparedness** and during emergency response, as necessary. Target personnel may include government staff; NGO staff and volunteers delivering health and nutrition services and support at facility or community level; and frontline staff in other sectors.
- 2.3** Adapt and prioritise **training content** to address identified needs, cultural expectations and personal experiences of mothers and staff; capacity gaps; the target audience; and time available. More specialist capacity to counsel mothers and infants with heightened needs, such as stressed or traumatised mothers, malnourished infants and mothers, low birth weight (LBW) infants and disabled infants with feeding difficulties, may be needed. At a minimum, staff in contact with mothers and children aged under two years should be trained to be sensitive to psychosocial issues, on nutrition screening, and on referral pathways to more specialist support<sup>10</sup>.
- 2.4** Undertake sensitisation and training in **preparedness**. Integrate IFE components into existing curricula and trainings and collaborate with national and regional academic and training institutions on content development and delivery. Include basic concepts around IFE and *the Code* in pre-service training of relevant health professionals. Integrate lessons from previous emergency response into training packages. Document who is trained and how to access them in an emergency.
- 2.5** Identify and use existing **national expertise and networks**, such as on breastfeeding counselling and support. Sources of national contacts include: Ministry of Health; UNICEF and WHO country offices; World Alliance for Breastfeeding Action (WABA)<sup>6</sup>; La Leche League<sup>7</sup> and other mother-to-mother breastfeeding support organisations; International Lactation Consultant Association (ILCA)<sup>8</sup> and national ILCA affiliates; and International Baby Food Action Network (IBFAN)<sup>9</sup> national groups (see 7 for contacts).

## 3 Coordinate operations

- 3.1** Government is the **lead coordination authority on IFE**. Where this is not possible or support is needed, among UN agencies and in accordance with mandates, IFE coordination is the responsibility of UNICEF or UNHCR, whereby:
- UNICEF's coordination authority may be as cluster lead agency within the Inter Agency Standing Committee (IASC) cluster approach to humanitarian response<sup>1</sup> where a country cluster is activated, or as the UN agency with mandated responsibility for infant and young child feeding in humanitarian situations<sup>11</sup>.
  - In IDP responses, UNICEF is responsible for IFE coordination<sup>12</sup>.
  - In refugee responses, UNHCR is the UN agency responsible for IFE coordination<sup>1</sup>.
  - In all settings, UNICEF and UNHCR will maximise synergies between their respective technical and management capacities, availability of resources and response capacities.

<sup>10</sup> See References Section 8.3 Training

<sup>11</sup> See 14 in References Section 8.2 Policy – Organisational Policy

<sup>12</sup> See 14 in References Section 8.2 Policy – Organisational Policy

WFP is responsible for mobilising food assistance in emergencies in a manner that upholds the provisions of the OG-IFE. WHO is responsible for supporting Member States to prepare for, respond to and recover from emergencies with public health consequences.

- 3.2** Ensure there is capacity to coordinate IFE within **coordination mechanisms** in an emergency response. Assess and support development of government coordination capacity as necessary. Determine or clarify coordination responsibilities and roles in preparedness and in early response. UNICEF country offices have a key responsibility to prepare for coordination needs in an emergency and as necessary, to **support government capacity** and skills development in this regard.
- 3.3** The IFE coordination authority must directly coordinate the IFE response or **ensure adequate coordination mechanisms and capacity** are in place<sup>13</sup>. This may involve recruitment or secondment of additional staff or collaboration/partnership with another agency or agencies. Country/regional/global technical support mechanisms or working groups may be identified or formed to support coordination. Where a partner agency is identified to undertake coordination activities, the IFE coordination authority remains accountable for ensuring an adequate, appropriate, timely IFE response.
- 3.4** The level of coordination, including whether a dedicated IFE coordinator is necessary, will depend on the **context**. Wherever possible, support government to fulfil their IFE coordination responsibility and work with existing country-level structures and mechanisms. Identify or locate IFE coordination capacity within the most relevant sector coordination mechanism, such as nutrition, health or food security.
- 3.5** Coordination provides context-specific, technically informed direction on IFE to all responders; identifies critical vulnerabilities and response gaps and actions to ensure these are quickly addressed; and monitors the adequacy of response. In close collaboration with government, sector or cluster partners, **IFE coordination authority responsibilities** include:
- i. Undertake contextual analysis of existing baseline data to immediately inform actions.
  - ii. Ensure IFE is included in early/multi-sector/rapid needs assessment; advise on standard and context-specific indicator use; provide IFE situational analysis; and ascertain need for and direct further needs assessment (see 4).
  - iii. Ensure IFE interventions are included and accurately reflected in emergency funding calls and flash appeals.
  - iv. Appraise the adequacy of existing policy guidance and direct, as necessary, policy updates, stop-gap guidance development and joint statements (see 1).
  - v. Develop and oversee implementation of a communication strategy (see 3.7).
  - vi. Develop a context-specific action plan, drawing on preparedness plans where they exist (see 1.1) and in collaboration with other sectors (see 5.6, 5.30-5.32, Annex 1).
  - vii. Determine and actively seek the necessary resources and partner capacity to support action plan implementation.
  - viii. Coordinate breastfeeding support and complementary feeding interventions (see 5).
  - ix. Coordinate the management of artificial feeding, as necessary (see 6.7-6.10).
  - x. Mitigate and manage risks regarding the humanitarian response, including prevention and management of donations of BMS, milk products, complementary foods, donor human milk and feeding equipment (see 6.1-6.6).
  - xi. Provide adapted guidance where IFE programming response is compromised (see 3.8).
  - xii. Be alert to, avoid and manage conflicts of interest, such as when cooperating with the private sector and when securing funding for IFE interventions (see 1.7). Develop interim guidance as necessary to ensure adequate safeguards.
  - xiii. Monitor the IFE response effort (see 4.12-4.18).

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<sup>13</sup> See References Section 8.4 Coordination – Humanitarian Response Planning and Coordination



- 3.6** Coordinate with other sectors to identify opportunities for **multi-sector collaboration**<sup>14</sup> in needs assessment and programming and to inform sector policies, actions plans and risk management regarding IFE. Actively participate in relevant sector or cluster co-ordination meetings. Identify and engage with those working independently of mainstream coordination structures, e.g. military, volunteer groups and civil society groups.
- 3.7** Ensure coordinated, timely, accurate and harmonised communication to the affected population, responders and the media. A **communication strategy** should provide a framework<sup>15</sup> with accompanying implementation plan. Key considerations include policy guidance dissemination; messaging to the affected population on services available and on IYCF practices; adapted messaging for target groups in the relief effort (e.g. military, volunteer groups and civil society groups); press releases; monitoring media coverage; and adapted messaging for different media (e.g. radio, mobile phone, social media). A media guide on IFE is included in Section 8<sup>16</sup>
- 3.8** In some emergencies, it may not be possible to meet all the provisions of the OG-IFE immediately, such as where access to those affected is limited or impossible, or capacity is lacking to deliver necessary support. In such circumstances, critical analysis by the IFE coordination authority, government, UNICEF, WHO and, where applicable, UNHCR (see 3.1) is essential to provide context-specific guidance on **appropriate actions** and **acceptable compromises**. Adapted programming may fall short of OG-IFE recommendations and should be temporary. The unmet needs and risks of compromised programming should be used to inform proactive advocacy for humanitarian access, resourcing and capacity. Decision-making should be recorded and lessons learned should be documented and shared.
- 3.9** The IFE coordination authority is accountable for **implementation of international and relevant national standards** and benchmarks, including the provisions of this OG-IFE, Sphere Standards and *the Code*. Shortfalls in guidance should be addressed (see 1.2-1.3).
- 3.10** **Gaps in IFE coordination** capacity in an emergency response should be reported to UNICEF or UNHCR country or regional office and to agency headquarters as necessary (see 7).

## 4 Assess and monitor

### General

- 4.1** Assess the **needs and priorities** for IFE response and monitor the impact of interventions, humanitarian action and inaction. Prioritise assessment of acute needs and difficulties that expose children to the greatest risk. Gather qualitative and quantitative data in preparedness, early needs assessment and representative surveys. Invest in gathering reliable, accurate, systematic and coordinated information. Triangulate information sources. The level and type of IFE assessment that is possible in a given emergency will depend on a balance of factors including population access, capacity, type of emergency (e.g. acute, chronic) and resources.
- 4.2** Explore **opportunities** to include IYCF questions in other sector needs assessments and draw on relevant **multi-sector** data, such as water, sanitation and hygiene (WASH) and health reports. In multi-sector assessment teams, ensure one person has received basic orientation on IFE. For needs assessment planning and analysis, involve personnel experienced in IYCF, ideally IFE. Where such **capacity** is limited at local level, seek regional and/or global-level specialist

<sup>14</sup> See References Section 8.6 Multi-sector Interventions – Integration

<sup>15</sup> See References Section 8.4 Coordination – Communications and Advocacy

<sup>16</sup> See 65 in References Section 8.4 Coordination – Communications and Advocacy; Media Guide on IYCF-E. IFE Core Group, 2007

support (see 7). Consult with sectoral specialists to support analysis of multi-sectoral data as necessary.

- 4.3 Disaggregate** data for children under two years old by gender and by age as follows: 0-5 months<sup>6</sup>, 6-11 months, 12-23 months, and proportion of PLW<sup>7</sup>. Informed by the context, disaggregate key information by ethnicity, location, etc. to enable equity analysis.

## Pre-crisis data and early needs assessment

- 4.4** Use pre-crisis **background information** (secondary data) to develop an IYCF situation profile to inform early decision-making and immediate actions. Collate key information in preparedness or as necessary, in early response.

- 4.5** Pre-crisis **information sources** include existing government, NGO and UN country programmes; Multiple Indicator Cluster Surveys (MICS)<sup>8</sup> and Demographic Health Surveys (DHS)<sup>9</sup>; sub-national surveys; national institutions (ministries, local offices for emergency preparedness, drugs and food standards authorities); Knowledge, Attitudes and Practices (KAP) studies; World Breastfeeding Trends Initiative (WBTi) country profiles<sup>10</sup>; WHO and UNICEF databases<sup>11</sup>; Nutrition Landscape Information System<sup>12</sup>; post-emergency evaluations<sup>13</sup>; previous flash appeals and Humanitarian Response Plans (HRP). Nutrition information may also be obtained through joint nutrition and food security assessments such as Joint Approach to Nutrition and Food Security Assessment (JANFSA); Comprehensive Food Security and Vulnerability Analysis (CFSVA); and Food Security and Nutrition Monitoring Systems (FSNMS).

- 4.6** Key information to consider includes:

### 4.6.1 Contextual data<sup>14</sup>

- i. **Policy environment**, including relevant national guidance and preparedness plans<sup>15</sup>; legal status of the *Code*; policies and protocols on HIV and infant feeding and other public health emergencies/infectious disease outbreaks (see 5.33-5.40); national food and drug legislation that affects the procurement of commodities.
- ii. Pre-emergency **child nutritional status** including prevalence of acute malnutrition, stunting and anaemia; and maternal nutritional status, including anaemia prevalence.
- iii. Population security and **access** difficulties, such as in conflict-affected areas.
- iv. Estimated caseloads of children under two years of age (disaggregated data; see 4.3) and PLW.
- v. Prevalence/reports of **higher risk** infants, young children and mothers (see 5.4).
- vi. Household **food security**, including access to appropriate complementary foods (see 5.23).
- vii. **WASH environment**, including access to safe water and sanitation, and social norms on hygiene (see 5.32.viii).
- viii. **Health environment**, including support offered by providers of antenatal, delivery and postnatal services; age and morbidity profile of admissions to acute malnutrition treatment programmes; infectious disease morbidity rates; crude mortality rate<sup>16</sup> (CMR), infant mortality rate<sup>17</sup> (IMR) and under-five mortality rate<sup>18</sup> (U5MR); coverage of antiretroviral treatment (ART); and support offered by social services and social protection mechanisms.
- ix. Capacity and availability of **potential support** givers, such as breastfeeding mothers, trained health workers, trained counsellors, experienced women from the community, community outreach worker networks, translators and interpreters.

### 4.6.2 IYCF data

- Pre-emergency feeding practices**, including prevalence of: breastfeeding initiation in newborns; early and exclusive breastfeeding in infants under six months; non-breastfed infants under six months; continued breastfeeding at one year and at two years; minimum acceptable diet; bottle feeding (at any age); BMS use, including infant formula, by age group<sup>17</sup>.
- i. Population **knowledge and attitudes** regarding IYCF.

- ii. Prevalent **complementary feeding** practices, common complementary foods used and their sources.
- iii. Acceptability and feasibility of **relactation, wet nursing**, use of donor human milk, availability of human milk banks (see 5.11-5.14).
- iv. Local perceptions of child **disability** and associated feeding and care practices. Reports and observations regarding children and caregivers with disabilities and any feeding or care related issues.
- v. **Reports of feeding difficulties** or requests for feeding support (including requests for BMS) from mothers, families, communities and/or in the media.
- vi. Requests or reports of **untargeted distribution or donations** of BMS, complementary foods, or feeding equipment.

**4.7** Conduct early needs (rapid) assessment<sup>18</sup> to inform **strategic decisions** (e.g. target population, geography, type of problem, scale of problem, number of individuals affected, indication for further needs assessment) and operational decisions (e.g. budget, equipment, skills and staff needs) on response. Wherever possible, link or integrate with multi-sector needs assessment. Critical analysis of quantitative and qualitative data is needed to determine appropriate interventions.

**4.8** Where a representative survey is not feasible, use alternative, **opportunistic** means to gather relevant data on the current situation. Approaches to gather data include focus group discussions, individual interviews, transect walks and market visits. Conduct at household or community level, including where population gathers, such as registration centres, food distributions and health centres. In transit populations, rapidly screen for PLW, especially mothers with young infants. Take account of methodological limitations in analysis.

**4.9** Gather information for different population groups (by geography, ethnicity, etc.) to the extent possible. Use **standard indicators**<sup>19</sup> and develop **context-specific indicators** as necessary, in consultation with the IFE coordination authority. Additional sources of information include humanitarian situation reports, sector needs assessment reports, media reports, funding appeals and social media.

**4.10 Alerts in early needs assessment** requiring further investigation include: elevated CMR, IMR and/or USMR; reports of infant or maternal deaths; global acute malnutrition prevalence above 5%; artificial feeding practiced pre-emergency; low (<50%) exclusive breastfeeding prevalence pre-emergency; mothers reporting difficulties breastfeeding; low (<70%) continued breastfeeding prevalence at one year; reports of non-breastfed infants under six months of age; requests for infant formula; poor availability of appropriate complementary foods; infants under six months of age presenting with acute malnutrition; orphaned infants; reports of BMS donations or untargeted distributions of BMS<sup>x</sup>.

## In-depth assessment

**4.11** Where more in-depth assessment is indicated and feasible, conduct a **representative survey** (i.e. random sampling, systematic sampling or cluster sampling)<sup>20</sup>. This may involve a standalone IYCF survey or IYCF assessment integrated within another, such as an anthropometric or reproductive health survey. Integration will affect survey sampling size, sample age group and questionnaire size. Standard indicators should be used (see 4.9). Accurately determine age<sup>21</sup>. Knowledge and attitudes on IYCF may also be assessed.

<sup>17</sup> See References Section 8.5 Assessment and Monitoring

<sup>18</sup> See 76 in References Section 8.5 Assessment and Monitoring – Collecting Data (Assessment)

<sup>19</sup> See References Section 8.5 Assessment and Monitoring – Indicators

<sup>20</sup> See References Section 8.5 Assessment and Monitoring – In-depth Assessment

<sup>21</sup> See References Section 8.5 Assessment and Monitoring

## Monitoring

- 4.12** Intervention strategies should include objectives, target population, expected outputs and outcomes. Include **process/output indicators** to measure the quality, quantity, coverage and utilisation of services and programmes and **outcome indicators** to describe the effect of the intervention. Define benchmarks to determine progress and achievement considering intervention timeframes.
- 4.13** Use quantitative and qualitative indicators to determine impact of behaviour change activities; these are most likely associated with longer-term programming in chronic emergency contexts. Assess geographical or population **coverage** of services using appropriate coverage assessment methods<sup>22</sup>. Use periodic surveys to determine impacts. Assessments (or parts of a baseline assessment, for example) can be repeated as part of monitoring.
- 4.14** Monitor IFE activities and interventions using **standard indicators**<sup>22</sup> that are built into monitoring, evaluation, accountability and learning systems where they exist. Harmonise indicator use across implementing partners and in surveys. Disaggregate data by age, gender, vulnerable groups and equity indicators as appropriate to the context (see 4.3).
- 4.15** Monitor IFE response against higher-level **global indicators**, e.g. Sphere Standards. Include IYCF in humanitarian response evaluations.
- 4.16** Monitor for **Code violations** and report them to national authorities, the IFE coordination authority, and international monitors<sup>2</sup> (see 7.1 for contacts and reporting templates). Support government to develop policies and procedures to monitor for and act on Code violations; WHO and UNICEF country offices have key responsibilities in this regard. Typical Code violations in emergencies relate to infant formula labelling, supply management, and donations (see 6.1; 6.15; 6.25-6.26).
- 4.17** Ensure that **gender equality**<sup>23</sup> and **equity** are integrated consistently in disaster prevention, humanitarian response and recovery programmes.
- 4.18** Use **participatory approaches** to engage target population groups, including in programme planning and design, feedback sessions and dissemination of findings<sup>24</sup>. Confidential complaint mechanisms on IYCF activities and interventions should be available. Learn from and adapt programming/activities as necessary. Document experiences for wider sharing.<sup>25</sup>

## 5 Protect, promote and support optimal infant and young child feeding with integrated multi-sector interventions

### General

- 5.1** At national level, **UNICEF** has a key responsibility to define, advocate for and provide guidance on essential IYCF interventions in close collaboration with government and other stakeholders<sup>26</sup>. This responsibility extends to both **preparedness** and **recovery**, using and building on existing capacities, networks, policies, systems and requires multi-sector engagement. In refugee settings, **UNHCR** holds this responsibility (see 3.1). **WFP** has a responsibility to ensure that the nutrition of infants and young children and PLW is considered in food assistance response and that necessary data are gathered to inform related programming.

<sup>22</sup> See References Section 8.5 Assessment and Monitoring – Indicators

<sup>23</sup> See References Section 8.6 Multi-sector Interventions – Gender

<sup>24</sup> See References Section 8.5 Assessment and Monitoring – Participation

<sup>25</sup> See References Section 8.5 Assessment and Monitoring – Learning

<sup>26</sup> See 14 in Section 8.2 Policy – Organisational Policy

- 5.2** Disaggregate programme data for children under five years old by **gender and by age** as follows: 0-5 months, 6-11 months, 12-23 months and 24-59 months. Informed by the context, disaggregate key information by ethnicity, location, etc. to enable equity analysis.
- 5.3** Act to ensure that the **nutritional needs** of the general population are met, giving special attention to access to suitable complementary foods for children<sup>27</sup> and nutritional adequacy for PLW<sup>28</sup>.
- 5.4** Establish accessible IYCF support services to provide for **higher risk** infants, young children and mothers, such as orphans, unaccompanied children, infants who are not breastfed; children with disabilities that affect feeding or whose caregivers are disabled<sup>29</sup>; mothers in detention; children whose mothers are ill; adolescent mothers; premature infants; LBW infants; and children and/or mothers who are acutely malnourished.
- 5.5** Encourage mothers/caretakers to present to health services when their child is sick or if they have health or feeding concerns. Ensure **sick and/or malnourished** children receive nutritional support and follow-up.
- 5.6** Collaborate across **multiple sectors** to maximise synergies and opportunities to support recommended IYCF practices and minimise risks<sup>30</sup>.

## Breastfeeding support

- 5.7** Protect, promote and support **early initiation of exclusive breastfeeding** in all **newborn** infants. Integrate the Ten Steps to Successful Breastfeeding of the WHO/UNICEF Baby-friendly Hospital Initiative<sup>31</sup> in maternity services. Key newborn health interventions<sup>32</sup> include skin-to-skin contact, kangaroo mother care<sup>33</sup>, 'rooming in' (keeping mothers and infants together), and delayed umbilical cord clamping<sup>34</sup>. Limit supplementation with BMS to medical needs<sup>35</sup>. Target support to mothers of premature<sup>36</sup> and LBW infants<sup>34</sup>, adolescent mothers and first-time mothers. Ensure access to HIV services as appropriate, including nutritional support when indicated (see 5.33-5.39). Ensure birth registration of newborns within two weeks of delivery and coordinate with other sectors (such as health, food security and social protection) to facilitate access to support services. Use and build existing capacity (such as traditional birth attendants, midwives and peers) to provide skilled breastfeeding support<sup>35</sup>.
- 5.8** Protect, promote and support **exclusive breastfeeding** in infants less than six months of age and **continued breastfeeding** in children aged six months to two years or beyond. Design interventions that are culturally sensitive and that minimise risks of prevalent non-recommended IYCF practices. Where mixed feeding is practiced in infants less than six months of age, sensitively support mothers to transition to exclusive breastfeeding (see 5.33-5.36 for breastfeeding in the context of HIV).
- 5.9** The use of breastfeeding supplementary feeding devices and breast pumps should only be considered when their use is vital and where it is possible to clean them adequately, such as in a clinical setting<sup>36</sup>.

<sup>27</sup> See Section 8.6 Multi-sector Interventions – Complementary Feeding

<sup>28</sup> See Section 8.6 Multi-sector Interventions – Maternal Nutrition

<sup>29</sup> See Section 8.6 Multi-sector Interventions – Disability

<sup>30</sup> See Section 8.6 Multi-sector Interventions – Integration

<sup>31</sup> See 182 in Section 8.6 – Multi-sector Interventions

<sup>32</sup> See 185 in Section 8.6 – Multi-sector Interventions

<sup>33</sup> See 109 in Section 8.6 – Multi-sector Interventions

<sup>34</sup> See 112 in Section 8.6 – Multi-sector Interventions

<sup>35</sup> See References Section 8.3 Training – Counselling

<sup>36</sup> See 107 in References Section 8.6 Multi-sector Interventions – Breastfeeding

## Infants who are not breastfed

- 5.10** In all emergencies, intervene to protect and support infants and children who are not breastfed to **meet nutritional needs and minimise risks**. The consequences of not breastfeeding are influenced by the age of the child (the youngest are most vulnerable); the infectious disease environment; access to assured supplies of appropriate BMS, fuel and feeding/cooking equipment; and WASH conditions.
- 5.11** Where an infant is not breastfed by his/her mother, quickly explore, in priority order, the viability of relactation, wet nursing and donor human milk, informed by cultural context, current acceptability to mothers and service availability. If these options are not acceptable to mothers/caregivers or feasible to deliver, enable access to an assured supply of an appropriate BMS, accompanied by an essential package of support (see 6).
- 5.12** A non-breastfeeding mother who wishes to **relactate** will require skilled breastfeeding support until breastfeeding is re-established<sup>37</sup>. Success will depend on the mother's wellbeing and motivation; the age of the infant; how long the mother has ceased breastfeeding; and her access to sustained skilled support. Infants less than six months will benefit the most.
- 5.13** Investigate the cultural acceptability of **wet nursing** and availability of wet nurses in preparedness and as part of early needs assessment. Wet nursing and relactation can work together where the wet nurse provides supplemental milk until the mother has sufficient milk. Prioritise wet nurses for the youngest infants (see 5.33-5.39 for HIV considerations).
- 5.14** To date, there is little experience with the use of formal and informal **donor human milk** in emergency settings. Donor human milk is likely a more viable option where there are existing human milk banks in an emergency-affected area, that are integrated into broader newborn/infant feeding programmes<sup>dd</sup>, and where key conditions are met<sup>ee</sup>. Where donor human milk is available, it may be in short supply; vulnerable infants (such as LBW, premature, and sick newborns) should be prioritised<sup>38</sup>. Caregivers of infants receiving donor human milk need counselling and support to ensure appropriate and safe use (see 6.3 regarding donations in emergencies).
- 5.15** **Infant formula** is the appropriate **BMS for infants less than six months of age**<sup>39</sup> (see 6.15 for specifications). Alternative milks may be used as a **BMS in children aged six months and older**, such as pasteurised or boiled full-cream animal milk (cow, goat, buffalo, sheep, camel), ultra-high temperature (UHT) milk, reconstituted evaporated (but not condensed) milk, fermented milk or yogurt<sup>40</sup>. Use of **infant formula in children over six months of age** will depend on pre-emergency practices, resources available, sources of safe alternative milks, adequacy of complementary foods, and government and agency policies. Follow-on milks, growing-up milks, and toddler milks marketed to children aged six months or over are not necessary (standard infant formula is adequate) and should not be provided. Where infant formula is needed but supplies are limited, non-breastfed infants under six months of age should be prioritised for provision. **Home-modified animal milk** is not recommended for

<sup>31</sup> See 182 in Section 8.6 – Multi-sector Interventions

<sup>32</sup> See 185 in Section 8.6 – Multi-sector Interventions

<sup>33</sup> See 109 in Section 8.6 – Multi-sector Interventions

<sup>34</sup> See 112 in Section 8.6 – Multi-sector Interventions

<sup>35</sup> See References Section 8.3 Training – Counselling

<sup>36</sup> See 107 in References Section 8.6 Multi-sector Interventions – Breastfeeding

<sup>37</sup> See 108 in References Section 8.6 Multi-sector Interventions – Breastfeeding

<sup>38</sup> See 111 in References Section 8.6 Multi-sector Interventions – Special Circumstances

<sup>39</sup> See 202 in References Section 8.7 Artificial Feeding – BMS Specification

<sup>40</sup> See 117 in References Section 8.6 Multi-sector Interventions – Complementary Feeding

infants less than six months of age due to significant nutritional inadequacy and should only be used as a last-resort, stop-gap measure. (See 9 for information on BMS that fall under the scope of *the Code*).

- 5.16** BMS requirement may be temporary or longer term. **Temporary BMS indications** include: during relactation; transition from mixed feeding to exclusive breastfeeding; short-term separation of infant and mother; short-term waiting period until wet nurse or donor human milk is available. **Longer-term BMS indications** include: infant not breastfed pre-crisis; mother not wishing or unable to lactate; infant established on replacement feeding in the context of HIV; orphaned infant; infant whose mother is absent long-term; specific infant or maternal medical conditions<sup>41</sup>; very ill mother; infant rejected by mother; a rape survivor not wishing to breastfeed.
- 5.17** Determine infant formula need through **individual-level assessment**<sup>42</sup> by a qualified health or nutrition worker trained in breastfeeding and infant feeding issues. Provide individual-level education, one-to-one demonstrations and practical training on safe preparation to the caregiver. Ensure follow-up (at least twice a month) and trace defaulters.
- 5.18** Provide infant formula for **as long as the infant needs it**, i.e. until breastfeeding is re-established or until at least six months of age.
- 5.19** In circumstances where individual-level assessment, support and follow-up are not possible, such as where population access is compromised<sup>43</sup>, consult with the IFE coordination authority for advice on **adapted** assessment and targeting criteria and programming options (see 3.8)<sup>43</sup>.

## Complementary feeding

- 5.20** The designated **IFE coordination authority** should provide clear direction on complementary feeding needs and interventions<sup>44</sup>. Government is the lead coordination authority to guide the response on complementary feeding. Where this is not possible or support is needed, coordination on complementary feeding is the mandated responsibility of UNICEF or UNHCR, depending on context, in close collaboration with government, other UN agencies and operational partners. In all contexts, **UNICEF** has a key responsibility to provide guidance on appropriate complementary foods and feeding practices and to help define essential interventions. In food assistance programmes, **WFP** has a responsibility to provide or enable access to appropriate nutrient-rich food for children aged 6-23 months and PLW when significant food and nutrient gaps are identified.
- 5.21** Complementary feeding interventions will depend on the context, objectives and timeframe of the response. **Short-term** actions to meet immediate needs and fill identified nutrient gaps may be necessary, with planned transition to longer-term options. Tools are available to help nutrient gap analysis<sup>99</sup>.
- 5.22** **Key considerations** in determining complementary feeding response include pre-existing and existing nutrient gaps; seasonality; socio-cultural beliefs; food security; current access to appropriate foods; quality of locally available complementary foods, including commercial products; compliance to *the Code* and with *WHO Guidance on ending inappropriate promotion of foods for infants and young children* of available products; cost; proportion of non-breastfed infants and children<sup>hh</sup>; reports of children with disability-associated feeding difficulties; maternal

<sup>41</sup> See 109 in References Section 8.6 Multi-sector Interventions – Artificial Feeding

<sup>42</sup> See References Section 8.6 Multi-sector Interventions – IYCF Counselling

<sup>43</sup> See 133 in References Section 8.6 Multi-sector Interventions – IYCF-E Programming for an example of minimum screening for populations in transit

<sup>44</sup> See References Section 8.6 Multi-sector Interventions – Complementary Feeding



nutrition; WASH conditions; the nature and capacity of existing markets and delivery systems; national legislation related to food and drugs, particularly importation; and evidence of impact of different approaches in a given or similar contexts.

### 5.23 Complementary food support options/considerations include:

- i. Cash or voucher schemes to purchase nutrient-rich foods and/or fortified foods that are locally available.
- ii. Distribution of nutrient-rich foods or fortified foods at household level.
- iii. Provision of multiple-micronutrient fortified foods to children aged 6-23 months and PLW through blanket supplementary feeding. Examples include fortified blended foods such as SuperCereal plus and SuperCereal (or local variations of this type of fortified porridge), and lipid-based nutrient supplements (small to medium quantity) (see 9).
- iv. Home fortification with micronutrient supplements, such as micronutrient powders (MNPs) or other supplements. Note that MNPs should not be provided where there is blanket distribution of multiple-micronutrient fortified foods (see 5.29).
- v. Livelihood programmes and safety net programmes for families with children under two years of age and/or PLW.
- vi. Use of animal milk and products (see 5.25).
- vii. Provision of non-food items and cooking supplies (including domestic energy); access to communal food preparation areas where household facilities are lacking; advice on safe food handling; and protected eating and playing spaces.

**5.24 Commercially produced complementary foods** must meet minimum standards. Refer to international guidelines on the formulation of complementary foods<sup>45</sup>, minimum standards for nutritional profile of complementary foods<sup>46</sup> and country-specific standards as necessary. Prioritise in-country, familiar, quality complementary foods over importing new products (see 5.22 for key considerations). Ready-to-use therapeutic foods (RUTF) are not appropriate complementary foods.

**5.25** Where **animal milk** is a significant feature of child diets, such as in pastoral communities, it is important to establish how to safely include milk products as part of a complementary diet. Milk products can be used to prepare complementary foods for all children over six months of age. Recommend to breastfeeding mothers not to displace or substitute breastmilk with animal milk. Pasteurised or boiled animal milk may be provided to non-breastfed children over six months of age and to breastfeeding mothers to drink in **controlled environments** (such as where milk is provided and consumed on site (wet feeding)). Animal milk should not be distributed outside of such controlled environments (see 5.15 and 6.25).

**5.26** Ensure all complementary feeding interventions protect and support appropriate practices<sup>47</sup> by providing **context-specific advice and support**, including how to adapt foods available to feed different age groups and hygienic food preparation and storage.

**5.27** Ensure complementary feeding interventions comply with the WHO *Guidance on ending inappropriate promotion of foods for infants and young children*<sup>48</sup>. This requires that all information or messages concerning the use of complementary food products should include a statement on the importance of breastfeeding for up to two years or beyond, the importance of not introducing complementary feeding before six months of age and the appropriate age of introduction of this food (this must not be less than six months); and be easily understood by parents and other caregivers, with all required label information being

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<sup>45</sup> See 120 in References Section 8.6 Multi-sector Interventions – Complementary Feeding

<sup>46</sup> See 117 in References Section 8.6 Multi-sector Interventions – Complementary Feeding

<sup>47</sup> See 118 and 119 in References Section 8.6 Multi-sector Interventions – Complementary Feeding

<sup>48</sup> See References Section 8.2 Policy – Global Policy



visible and legible. Provide clear instructions on safe preparation, use and storage. Labels and designs of complementary food packaging need to be distinct from those used on BMS to avoid cross-promotion.

**5.28 Do not send or accept donations of complementary foods in an emergency.** Risks include donated complementary foods may not meet nutritional and safety standards, Code labelling requirements, or recommendations of WHO *Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children*; may be culturally inappropriate; and may undermine local food use and recommended IYCF practices. For donated foods that are not designed as complementary foods but can be used for complementary feeding, it is important to prevent the emergency response from being used to create a potential market for specific foods; to ensure interventions are needs based rather than donor-driven; and to guarantee adequate quality and safety of the diet. Where any donations are being considered or have been received, consult with the designated IFE coordination authority regarding their appropriateness and/or management (see 6.6).

## Micronutrient supplementation

**5.29** For children aged 6-59 months, **multiple-micronutrient supplements** may be necessary to meet nutrition requirements where fortified foods are not being provided, in conjunction with other interventions to improve complementary foods and feeding practices<sup>49</sup>. In malaria-endemic areas, the provision of iron in any form, including MNPs, should be implemented in conjunction with measures to prevent, diagnose and treat malaria. Provision of iron through these interventions should not be made to children who do not have access to malaria prevention strategies (e.g. provision of insecticide-treated bed nets and vector-control programmes); prompt diagnosis of malaria illness; and treatment with effective antimalarial drug therapy<sup>50</sup>. Vitamin A supplementation is recommended for children aged 6-59 months<sup>51</sup>. For PLW, iron and folic acid or multiple-micronutrient supplementation should be provided in accordance with the latest guidance<sup>52,53</sup>.

## Multi-sector collaboration

**5.30 Key sectors and disciplines** to sensitise and work with on IYCF include health (reproductive health; MNCH; MHPSS; HIV; infectious disease management); adolescent services; WASH; FSL; child protection; ECD; disability; shelter; cash transfer programmes; social protection; agriculture; camp coordination and camp management; and logistics.

**5.31** Sector **programme entry points** for IYCF include: antenatal and postnatal care; immunisation; growth monitoring; prevention of mother-to-child transmission (PMTCT) programmes; HIV prevention and treatment services, acute malnutrition treatment; community health; psychosocial counselling services; hygiene promotion; child protection screening; ECD activities; places of employment; and agriculture extension work.

**5.32** Examples<sup>54</sup> of **two-way multi-sector collaboration** include:

- Enable access of pregnant women to skilled **antenatal care**<sup>55</sup> and other necessary health services, including **MHPSS**<sup>56</sup>.

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<sup>49</sup> See References Section 8.6 Multi-sector Interventions – Micronutrients

<sup>50</sup> See 126 in References Section 8.6 Multi-sector Interventions – Micronutrients

<sup>51</sup> See 127 in References Section 8.6 Multi-sector Interventions – Micronutrients

<sup>52</sup> See 128 in References Section 8.6 Multi-sector Interventions – Maternal Nutrition

<sup>53</sup> See 186 in References Section 8.6 Multi-sector Interventions – Maternal, Newborn and Child Health

<sup>54</sup> See 158 in References Section 8.6 Multi-sector Interventions – Integration

<sup>55</sup> See References Section 8.6 Multi-sector Interventions – Maternal Newborn and Child Health

<sup>56</sup> See References Section 8.6 Multi-sector Interventions – Mental Health and Psychosocial Support

- ii. Integrate IYCF support and/or establish **referral systems** with reproductive, MNCH and adolescent health services; curative health services; acute malnutrition treatment; HIV; and child protection services. Include minimum/initial service packages offered by different sectors.
- iii. Integrate breastfeeding support into community-based and inpatient services treating **acute malnutrition**<sup>57</sup> and **sick children**<sup>58</sup> and into community health worker networks. Integrate skilled complementary feeding support into acute malnutrition treatment services.
- iv. Work with **HIV** prevention and treatment services to support access and adherence to ART<sup>59</sup> (see 5.38).
- v. Integrate **ECD** into IYCF support at facility and community levels and explore opportunities to incorporate IYCF elements into ECD<sup>60</sup>.
- vi. Collaborate with the **disability** focal point on identified issues regarding feeding and care of disabled children and children whose caregivers are disabled<sup>61</sup>.
- vii. Where fresh animal milk is used by a population, collaborate with **animal welfare** to facilitate access to safe animal milk supplies and with **WASH/FSL** providers regarding hygienic milk product processing and storage. Ensure initiatives act to protect recommended IYCF practices.
- viii. Ensure mother/child friendly spaces meet minimum **WASH** standards<sup>62</sup>. Agree common WASH and IYCF messaging. Advocate with WASH providers to target families with children under two years with adequate WASH support to meet minimum WASH/FSL standards for food preparation. Enable access to WASH services by families of infants who are artificially fed (see 6.21, 6.22).
- ix. Integrate **child protection**<sup>62</sup> in IYCF services with clear procedures, referral pathways and staff codes of conduct. Integrate IYCF messages in child protection communication and collaborate to help identify nutritionally vulnerable children.
- x. In IYCF programmes, identify women who are traumatised for referral to **protection services**. Embed IYCF support/referral systems within services provided to women/girls exposed to violence.
- xi. Accompany **cash transfer programmes** that include mothers in targeting with context-specific IYCF and maternal nutrition messaging.
- xii. Work with **shelter** providers to ensure minimum shelter and settlement standards are met for families with children under two years and PLW that includes adequate living conditions to support safe food preparation, feeding practices and care.
- xiii. Work with **camp coordination and camp management** providers to protect and assist families with children under two years and PLW, such as enabling access to key services and adequate living conditions for families with children under two years and PLW; and providing disaggregated population data.
- xiv. Ensure **livelihood programmes** are child friendly; e.g. providing day care arrangements and feeding breaks. Include IYCF questions in post-distribution monitoring. Consider complementary foods in crop selection of **agriculture** programmes.

## HIV and infant feeding

**5.33** Check **national/sub-national policies on HIV** and infant feeding. Assess whether they are in line with the latest WHO recommendations<sup>62</sup>; address emergency situations, including refugee

<sup>57</sup> See References Section 8.6 Multi-sector Interventions – Mainstreaming within Nutrition

<sup>58</sup> See 183 in References Section 8.6 Multi-sector Interventions – Maternal Newborn and Child Health

<sup>59</sup> See References Section 8.6 Multi-sector Interventions – HIV

<sup>60</sup> See References Section 8.6 Multi-sector Interventions – Early Childhood Development

<sup>61</sup> See References Section 8.6 Multi-sector Interventions – Disability

<sup>62</sup> See References Section 8.6 Multi-sector Interventions – Child Protection

and IDP contexts where applicable; and if necessary, support update as part of preparedness. Rapid issue of updated interim guidance may be necessary in a response where policy is outdated or to address unforeseen issues. Key emergency considerations include change in risk exposure to non-HIV infectious disease and malnutrition; likely duration of the emergency; access of refugee populations to antiretroviral drugs (ARVs) and health services; whether the conditions for safe formula feeding are available; and the availability of ARVs<sup>63</sup>.

- 5.34** In accordance with global guidance, support **breastfeeding mothers living with HIV** to breastfeed for at least 12 months (early initiation and exclusive breastfeeding for the first six months) and to continue breastfeeding for up to 24 months or longer while being fully supported for adherence to ART (see 5.38). Where ARV drugs are unlikely to be available (such as interrupted supply in an emergency<sup>64</sup>), breastfeeding of HIV-exposed infants is recommended in the interests of child survival. Breastfeeding should only stop once a nutritionally adequate and safe diet without breastmilk can be provided.
- 5.35** Support breastfeeding women who are known to be HIV uninfected or whose **HIV status is unknown** to exclusively breastfeed for the first six months of life and to continue breastfeeding for 24 months or beyond, in accordance with recommended IYCF practices.
- 5.36** Prospective **wet nurses** should undergo HIV counselling and rapid testing where available (see 5.38). In the absence of testing, if feasible undertake HIV risk assessment (see 9). If HIV risk assessment/counselling is not possible, facilitate and support wet nursing. Provide counselling on avoiding HIV infection during breastfeeding.
- 5.37** Urgently identify and provide support to infants established on **replacement feeding** (see 5.10-5.19).
- 5.38** Work with the health sector to identify HIV-positive mothers on ART to promote and **support ART adherence and retention in treatment**; to facilitate alternative distribution mechanisms for ARVs where usual systems are disrupted; and to advocate that PLW remain a priority group for ARV distribution. A minimum HIV response requires assured, continued ARV supply for PLW known to be HIV positive and on ARVs; access to safe and clean deliveries; infant feeding counselling; and perinatal prophylaxis for HIV-exposed infants<sup>64</sup>. Provide links to existing care and support services; and access to contraceptives, malnutrition treatment services, and food or livelihood support where indicated. Treatment options should be expanded to include HIV rapid testing and counselling and initiation of ART as soon as possible<sup>65</sup>. HIV test kits should be prioritised (low-cost, robust regarding storage and temperature stability, and easy to use).
- 5.39** Clearly **communicate** with emergency responders, health providers and HIV-exposed mothers regarding applicable HIV and infant feeding recommendations, such as in joint statements issued (see 1.5).

## Infectious disease outbreaks

- 5.40** Anticipate and assess the impact of human and animal infectious disease outbreaks on IYCF, such as interrupted access to health and feeding support services; deterioration in household food security and livelihoods; transmission risks via breastfeeding; and maternal illness and death. Take actions to mitigate risks. Interim guidance may be necessary to address unanticipated IYCF consequences in outbreaks, such as Ebola virus and Zika virus<sup>66</sup>. Consult **WHO** for up-to-date advice.

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<sup>63</sup> See 13 in References Section 8.6 Multi-sector Interventions – Special Circumstances

<sup>64</sup> See 188 in References Section 8.6 Multi-sector Interventions – HIV

<sup>65</sup> See 187 in References Section 8.6 Multi-sector Interventions – HIV

<sup>66</sup> See References Section 8.6 Multi-sector Interventions – Infectious Disease

## 6 Minimise the risks of artificial feeding

### Donations in emergencies

- 6.1 Do not donate or accept donations of BMS, other milk products or feeding equipment (including bottles, teats and breast pumps) in emergencies.** Donated BMS are typically of variable quality; of the wrong type; supplied disproportionate to need; labelled in the wrong language; not accompanied by an essential package of care; distributed indiscriminately; not targeted to those who need them; do not provide a sustained supply; and take excessive time and resources to manage to mitigate risks.
- 6.2** For considerations regarding complementary food donations, see 5.28.
- 6.3 Do not send supplies of donor human milk to emergencies that are not based on identified need and a part of a coordinated, managed intervention.** Safe use of donor human milk requires needs assessment, targeting, a cold chain and strong management systems (see 5.14).
- 6.4** Communicate a **clear position on donations** in preparedness and in early emergency response, such as in a joint statement<sup>67</sup>. Investigate reasons for donation requests to inform messaging and assessment. Target key actors, including donors, development partners and civil society groups, among others. Target groups that may not be engaged in official coordination mechanisms, e.g. media, the military and voluntary groups.
- 6.5** Identify and inform potential **donors and distributors** regarding the risks associated with donated supplies in emergencies. Provide information on how the nutritional needs of non-breastfed infants are being met. Give guidance on appropriate alternative items or support.
- 6.6 Report** offers or donations of BMS, donor human milk, complementary foods and feeding equipment to UNICEF or UNHCR as appropriate (see 3.1), and to the IFE coordination authority, who will determine and oversee a context-specific **management plan** to minimise risks. Donations involving WFP food assistance should also be reported to WFP (see 7 for contacts).

### Artificial feeding management

- 6.7** Plan appropriate procurement<sup>68</sup>, distribution, targeting and use of BMS and associated support (artificial feeding management) in close consultation with the **IFE coordination authority and UNICEF** (where UNICEF is not acting as the IFE coordination authority). In accordance with mandates, **WHO** and **UNHCR** also have key responsibilities. Establish terms of reference, responsibilities and roles for artificial feeding management for use by the IFE coordination authority, in preparedness.
- 6.8 Artificial feeding management** requires needs and risk assessment and critical situational analysis, informed by technical guidance. Analysis should include whether a demand for BMS constitutes an actual need and/or whether other interventions, including improved support for breastfeeding, are indicated to ensure infant nutrition and health. The scale of artificial feeding support needed will determine the level of intervention and coordination required.
- 6.9** The IFE coordination authority and/or UNICEF should determine if and where **capacity to manage artificial feeding** exists in government and among humanitarian providers. Where capacity is limited, the IFE coordination authority and/or UNICEF should identify appropriate

<sup>67</sup> See 13 in References Section 8.2 Policy – Organisation Policy

<sup>68</sup> See References Section 8.7 Artificial Feeding – BMS Supplies and Feeding Equipment

BMS provider(s), including a BMS supply chain and associated support services. In the absence of an appropriate provider, the IFE coordination authority and/or UNICEF will ensure coordinated provision of BMS supplies. The IFE coordination authority and/or UNICEF will provide clear terms of reference, technical support and close oversight of procurement, monitoring and use.

- 6.10** Establish clear **eligibility for BMS use** in agreement with the IFE coordination authority (see 5.16). If criteria are already in place, review and revise as needed. Communicate these criteria to caregivers, communities and emergency responders.

## BMS supplies

- 6.11** In refugee settings and in accordance with UNHCR policy, UNHCR will only source infant formula after review and approval by its HQ technical units<sup>69</sup>.
- 6.12** In non-refugee settings and in accordance with **UNICEF** policy<sup>70</sup>, UNICEF will only procure infant formula as the provider of last resort and at the request of the host government and/or the national humanitarian coordination structure. Country offices must seek agreement from UNICEF HQ (Nutrition Section and Supply Division), in line with UNICEF internal guidance.
- 6.13** **Funders** of BMS and milk products should ensure that all the provisions of the OG-IFE and *the Code* can be met by the implementing agency. Include compliance indicators in funding agreements. Grant applications should include, and funders should accept, costs for associated supplies, such as feeding and cooking equipment, and hygiene measures.
- 6.14** An agency should only directly supply another agency with BMS if both are working as part of the **nutrition and health emergency response** (see 9). Both the supplier and the implementer are responsible for ensuring the provisions of the OG-IFE and *the Code* are met and continue to be met for the duration of the intervention.

## BMS specification

- 6.15** BMS labels must comply with *the Code*. **Labels** should be in the language understood by the end users and service providers and include: (a) the words “Important Notice” or their equivalent; (b) a statement on the superiority of breastfeeding; (c) a statement that the product should only be used on the advice of a health worker (this includes community workers and volunteers) as to the need for its use and the proper method of use; (d) instructions for appropriate and safe preparation and storage and a warning on the health hazards of inappropriate preparation and storage. Where labels of infant formula supplies do not conform to Code requirements, consider relabelling (this will have cost and time implications) or, where not possible, provide the specified information to users. Infant formula must be compliant with relevant Codex Alimentarius standards<sup>71</sup>.
- 6.16** Infant formula is available as **powdered infant formula** (PIF) or as liquid, **ready-to-use infant formula** (RUIF). PIF is not sterile and requires reconstitution with water that has been heated to at least 70 degrees Celsius (as a guide, for 1 litre, boiled and left standing for no more than 30 minutes)<sup>72</sup>. RUIF is a sterile product until opened and does not require reconstitution; appropriate use, careful storage and hygiene of feeding utensils remains essential to minimise risks. RUIF is more expensive and bulky to transport and store. Concentrated liquid formula is not recommended due to risk of dilution errors and contamination. Therapeutic milks (F75,

<sup>69</sup> See 22 in References Section 8.2 Policy – Organisational Policy

<sup>70</sup> See 199 in References Section 8.2 Policy – Roles and Responsibilities

<sup>71</sup> See 202 in References Section 8.7 Artificial Feeding – BMS Specification

<sup>72</sup> See 196 in References Section 8.7 Artificial Feeding – Minimising the Risk

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

- 6.17** Average **infant formula needs** for an infant less than six months of age are RUIF: 750ml/day; 22.5L/month; 135L/6 months, and PIF: 116g/day; 3.5kg/month; 21kg/6 months<sup>73</sup>. Supplies should have a six-month shelf-life from point of delivery.

## Procurement of BMS supplies, feeding equipment and support

- 6.18** Where direct procurement of BMS is necessary, **purchase** necessary supplies. Considerations regarding local versus international procurement include: Codex Alimentarius and Code compliance of available product, stocks available in-country, cost, importation legislation, appropriate language of labels and instruction, and safeguarding against creating new markets for products.
- 6.19** Where BMS is provided indirectly, such as through **restricted voucher schemes**, determine if Code-compliant products are available at designated vendors. Provide supporting information if necessary to address labelling shortfalls and report such Code violations (see 4.16 and 6.15). Monitor the price of products. Advise mothers and caregivers on appropriate and inappropriate BMS for different age groups.
- 6.20** Where unrestricted **cash transfer programmes** are implemented and BMS is available, BMS should not be excluded as an option for purchase by households support (see 5.25 and 6.25). In such instances, accompany cash transfer programmes with strong messaging on the value of breastfeeding, on recommended IYCF practices, and provide information on where all infants can access IYCF support (where milk powder is commonly available, see 6.25).
- 6.21** Determine availability of **fuel, water and equipment** for safe household preparation of BMS (cleaning, sterilisation, reconstitution). If necessary, provide or enable access to the necessary additional items<sup>74</sup> and support, including training on hygienic feed preparation. In circumstances where safe preparation and use of infant formula cannot be assured, consider on-site reconstitution and consumption or provision of communal preparation and sterilisation facilities. Where access to the population is limited or absent, consult with the IFE coordination authority and technical agencies on how best to minimise risk while meeting the nutritional needs of non-breastfed infants (see 3.8).
- 6.22** **Liaise with WASH provider agencies** to secure priority access of families with infants using BMS to WASH services and meet minimum standards. Enable access to cleaning equipment and advice on hygienic preparation and storage of supplies. Where cleaning facilities are limited or not available at a household level, provide central cleaning facilities.
- 6.23** Discourage use of **feeding bottles and teats** due to high risk of contamination and difficulty with cleaning. Support use of cups (without spouts) from birth. **Cups** with lids and disposable cups may be necessary in transit situations. Immediate transition to cup feeding for bottle-fed infants may not be feasible or acceptable to mothers/caretakers. In such circumstances, to minimise risks, advise on bottle sterilisation at household level or through on-site sterilisation services, accompanied with hygiene messaging. Where cleaning facilities are limited, or in transit situations, consider exchanging used bottles for new ones as an exceptional and temporary action, taking account of waste management implications and in consultation with the IFE coordination authority.

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<sup>73</sup> See 204 in References Section 8.7 Artificial Feeding – BMS Supplies and Equipment

## Distribution of BMS

- 6.24** The **distribution system** for BMS will depend on the context, including: scale of intervention; access points to mothers/caregivers; contact frequency; transportation; waste management; and storage capacity of the provider. Options include direct supply, individual prescription and purchase (e.g. cash transfer programmes). Distribution should be carried out in a discrete manner so as not to discourage breastfeeding mothers. At community level, be alert to unintended consequences of BMS use, such as sale of products.
- 6.25** **Do not use general or blanket distributions as a platform to supply BMS** (see 6.24). Dried milk products and liquid milk should not be distributed as a single commodity in general or blanket distributions as they may be used as a BMS, exposing both breastfed and non-breastfed infants to risks. Dried milk products can be pre-mixed with a milled staple food for distribution to use as a complementary food in children over six months of age. Where milk powder is commonly used or widely available in a population, recommend and provide practical guidance to incorporate into cooked family meals and advise against use as a BMS (see 5.15). Dried milk powder may be supplied as a single commodity to prepare therapeutic milk for on-site therapeutic feeding. WFP in consultation with UNICEF and UNHCR is responsible for controlling the distribution of milk powders and BMS in general rations<sup>74</sup> in accordance with the provisions of the OG-IFE (see 5.25 for additional considerations regarding animal milk use).
- 6.26** In accordance with *the Code*, there should be **no promotion** of infant formula at the point of distribution, including displays of products or items with company logos or logos on vouchers. Storage of infant formula should not be in view of beneficiaries.
- 6.27** When BMS are distributed, ensure there is adequate **breastfeeding** counselling and support for breastfeeding mothers. Consider distributing specific items of value to breastfeeding mothers, such as food or hygiene products.

## 7 KEY CONTACTS

- 7.1** Report Code violations to relevant national authorities; to the IFE coordination authority; and to UNICEF and WHO at the country/regional level. If necessary, source WHO contacts from WHO HQ: **cah@who.int** and **nutrition@who.int**. For UNICEF contacts, see: 7.3. Code violations should also be reported for catalogue to the International Code Documentation Centre (ICDC) in Malaysia: **code@ibfan-icdc.org**. To request training on *the Code*, contact ICDC Malaysia. Visit: [www.ibfan-icdc.org/report/](http://www.ibfan-icdc.org/report/) for online submission of violations (a template is provided) or to download the Kobo Collect app (Android phone users via Google play) to submit violations. A BMS Code violations tracking tool, including a template to monitor Code violations in emergencies, is available at: [www.nutritioncluster.net/resources/bms-code-violations-tracking-tool-nutrition-cluster/](http://www.nutritioncluster.net/resources/bms-code-violations-tracking-tool-nutrition-cluster/)
- 7.2** Contacts to source expertise on breastfeeding counselling and support or on training for infant feeding counselling include: UNICEF: **nutrition@unicef.org**; WHO: **nutrition@who.int**; International Lactation Consultant Association (ILCA): **ilca@erols.com**; World Alliance for Breastfeeding Action (WABA): **waba@waba.org.my**; Geneva Infant Feeding Association – International Baby Food Action Network (IBFAN-GIFA): **info@gifa.org**
- 7.3** Technical or coordination issues relating to IFE should be addressed to the appropriate UNICEF regional or country office. Where necessary, contact UNICEF at HQ level: **nutrition@unicef.org**

<sup>74</sup> See 202 in References Section 8.7 Artificial Feeding – Roles and Responsibilities



- 7.4** Technical or coordination issues regarding IFE in the context of UNHCR operations should be addressed to the appropriate UNHCR regional or country office. Where necessary, contact the Public Health Section at UNHCR HQ: **hqphn@unhcr.org**
- 7.5** Issues regarding IFE specific to cluster coordination should be addressed to the nutrition country cluster coordinator. Where necessary, contact the Global Nutrition Cluster: **gnc@unicef.org**
- 7.6** Issues regarding IFE related to WFP food assistance programmes should be addressed to the appropriate WFP regional or country office. Where necessary, contact the WFP HQ Nutrition Advisory Office: **nutrition@wfp.org**
- 7.7** Send feedback on the OG-IFE c/o UNICEF Programme Division, New York, USA: **nutrition@unicef.org** or c/o ENN, Oxford, UK, email: **office@ennonline.net** with 'OG-IFE feedback' in the subject line.

## Box 1: Emergency preparedness actions

*This is a summary of preparedness actions contained in Sections 1-6 of the OG-IFE. Specific sections are noted in Annex 1.*

### Endorse or develop policies

1. Ensure IFE is adequately reflected in relevant national policies, guidelines and procedures.
2. Ensure there is adequate policy provision for IFE regarding IDPs and refugees.
3. Develop national/sub-national preparedness plans on IFE.
4. Draft context-specific joint statements on IFE to enable rapid release.
5. Develop legally enforceable national regulations on *the Code*. Monitor and report Code violations.
6. Enact legislation and adopt policies in line with the WHO Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children.
7. Develop national legally binding policies regarding private sector engagement in emergency response by UN, civil society and government policy-makers to enable constructive collaboration and avoid undue influence and conflicts of interest.
8. Update policies, guidelines and procedures based on lessons learned from previous emergencies.

### Train staff

1. Identify and sensitise key personnel involved in planning and delivering emergency response regarding IFE.
2. Forecast capacity needs based on emergency scenarios.
3. Identify national capacity development needs on IYCF. Integrate context-specific training content into existing curricula and delivery mechanisms.
4. Orientate and train relevant staff on IYCF support. Include key components of IFE and the Code in pre-service training of health professionals.
5. Map existing capacities for key areas, e.g. skilled breastfeeding support and translators, and develop key contact lists of existing national expertise.
6. Prepare orientation material for use in early emergency response.
7. Update training content based on lessons learned from emergency response.

### Coordinate operations

1. Identify government leadership and coordination authority on IFE and support capacity development to strengthen this responsibility as necessary.
2. Where government capacity is constrained, identify options for coordinated IFE response and leadership.
3. Develop terms of reference for IFE coordination in a response.
4. Raise public and professional awareness regarding recommended IYCF practices and benefits. Develop an IFE communication strategy and plan for rapid implementation in an emergency.



Prepare easily adapted media briefs.

5. Engage development agencies and donors in preparedness planning that includes adaptation of existing programmes to meet emergency needs, negotiating funder flexibility to meet new needs and priming sources of surge funding to accommodate increased demands.
6. Allocate funding to support monitoring, evaluation and learning.
7. Establish links with other sector focal points and coordination mechanisms, especially food security, health and WASH.

### **Assess and monitor**

1. Develop a profile on IYCF practices and maternal and child nutrition to inform early decision-making in an emergency.
2. Ensure disaggregated data and recent reports are readily accessible.
3. Calculate the prevalence of non-breastfed infants less than six months old and at one year and two years old from existing data.
4. Prepare key questions to include in early needs assessment.
5. Identify existing and/or potential national/sub-national capacity to undertake IYCF assessment and surveys.
6. Support government to develop policies and procedures to monitor for and act on Code violations. Monitor and report Code violations to relevant authorities.
7. Identify what existing monitoring and evaluation tools and systems can be applied in an emergency context and agree any necessary adaptations.

### **Protect, promote and support optimal infant and young child feeding with integrated multi-sector interventions**

1. Actively promote and support recommended IYCF practices in the population.
2. Integrate the Ten Steps to Successful Breastfeeding of the WHO/UNICEF Baby-friendly Hospital Initiative into maternity services.
3. Develop preparedness plans for interventions on breastfeeding support, complementary feeding, artificial feeding and identification and management of particularly vulnerable children.
4. Identify key sector focal points in ministries and agencies to engage on programming.
5. Profile complementary foods and feeding practices, including existing nutrient gaps and culturally-sensitive response options, and mechanisms for scale-up and response in an emergency context.
6. Identify supply chain for an appropriate BMS (if needed) and complementary foods.
7. Work to ensure that local/commercially produced complementary foods meet minimum standards.
8. Examine national legislation related to food and drugs, particularly importation.
9. Anticipate likely need for and mechanisms to provide micronutrient supplementation to PLW and children.
10. Develop plans for response and for transition post-emergency regarding IYCF interventions.
11. Identify existing or potential public health issues of nutrition concern and plan accordingly.

### **Minimise the risks of artificial feeding**

1. Develop plans for prevention and management of donations of BMS, other milk products and feeding equipment in an emergency.
2. Communicate government position on not seeking or accepting donations to key actors, including country embassies, donors, development partners and civil society groups, among others.
3. Use scenarios to forecast potential artificial feeding needs in an emergency-affected population and develop preparedness plans accordingly.
4. Establish systems for management of artificial feeding, including coordination authority (or at least terms of reference), BMS supply chain and monitoring mechanisms.

*Note: Programme preparedness actions (as well as response and recovery) are detailed in UNICEF Core Commitments for Children in Humanitarian Action. UNICEF 2010. See 14 in References Section 8.2 Policy - Organisational Policy.*

## Notes

- a A/RES/44/25, **Convention on the Rights of the Child**. 61st plenary meeting, 20 November 1989. [www.un.org/documents/ga/res/44/a44r025.htm](http://www.un.org/documents/ga/res/44/a44r025.htm)
- b WHO 59th World Health Assembly. 4 May 2006. A59/13. **Provisional agenda item 11.8**. WHA 59.21. <http://innocenti15.net/declaration.htm>.
- c <https://sustainabledevelopment.un.org/>
- d [www.who.int/nutrition/decade-of-action/en/](http://www.who.int/nutrition/decade-of-action/en/)
- e [waba.org.my](http://waba.org.my)
- f [www.lli.org](http://www.lli.org)
- g [www.ilca.org](http://www.ilca.org)
- h [www.ibfan.org](http://www.ibfan.org)
- i [www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach](http://www.humanitarianresponse.info/en/about-clusters/what-is-the-cluster-approach)
- j **UNHCR Refugee Coordination Model**. [www.unhcr.org/excom/icm/53679e2c9/unhcr-refugee-coordination-model.html](http://www.unhcr.org/excom/icm/53679e2c9/unhcr-refugee-coordination-model.html)
- k *For data purposes, the period 0-5 months is read as 0 through 5 months, meaning birth through 5.9 months, or 'up to' 6 months; it is a period of 6 completed months. In programming terms, this is referred to as infants less than 6 months of age (see References Section 8.5 [75]).*
- l *As a guide, in a developing country population with a high birth rate the expected proportions are: infants 0-5 months: 1.35%; 6-11 months: 1.25%; children 12-23 months: 2.5%; children 0-59 months: 12.5%; pregnant and lactating women: 5-7%, depending on the average duration of breastfeeding. N.B. These figures are approximations and will depend on birth rate, infant mortality rate and under-five mortality rate.*
- m <http://mics.unicef.org/surveys>
- n <http://dhsprogram.com/>
- o <http://worldbreastfeedingtrends.org/>
- p **UNICEF Research and Reports:** [www.unicef.org/reports/](http://www.unicef.org/reports/); **WHO Global Database on Malnutrition:** [www.who.int/nutgrowthdb/en/](http://www.who.int/nutgrowthdb/en/); **UNICEF Data:** <https://data.unicef.org/>
- q [www.who.int/nutrition/nlis/en/](http://www.who.int/nutrition/nlis/en/)
- r [www.alnap.org/resources/](http://www.alnap.org/resources/)
- s **ACAPS Global Emergency Overview:** [www.acaps.org/countries/](http://www.acaps.org/countries/); **Relief Web:** <http://reliefweb.int/countries/>; **Humanitarian Response Info:** [www.humanitarianresponse.info/en/](http://www.humanitarianresponse.info/en/); **Humanitarian Data Exchange:** <https://data.humdata.org/>; **RefWorld:** [www.refworld.org/type,COUNTRYPROF,,,,,0.html](http://www.refworld.org/type,COUNTRYPROF,,,,,0.html)
- t **Prevention Web:** [www.preventionweb.net/risk](http://www.preventionweb.net/risk)
- u Mortality rate among all age groups and due to all causes; typically expressed in units of deaths per 1,000 individuals per year.
- v The number of deaths of children under one year of age per 1,000 live births.
- w The number of children under five years of age dying per 1,000 live births in a given year.
- x *There are no globally accepted benchmarks for exclusive breastfeeding and continued breastfeeding alerts in an emergency. In their absence, the WHO 2025 Global Nutrition Target for*

*exclusive breastfeeding was used. For continued breastfeeding, there is no such target. A 2016 UNICEF data review from low and middle-income countries identified a global average of 74% continued breastfeeding at one year; therefore a benchmark of 70% was selected (see References Section 8.5 [70]).*

**For example, Semi-Quantitative Evaluation of Access and Coverage:**

[www.fantaproject.org/monitoring-and-evaluation/squeac-sleac](http://www.fantaproject.org/monitoring-and-evaluation/squeac-sleac) and footnote 40.

**Nutrition Cluster BMS Code Violations Tracking Tool:**

[www.nutritioncluster.net/resources/bms-code-violations-tracking-tool-nutrition-cluster/](http://www.nutritioncluster.net/resources/bms-code-violations-tracking-tool-nutrition-cluster/)  
IBFAN-ICDC Reporting Form: <https://vnhih.enketo.kobotoolbox.org/webform>

**Kangaroo Mother Care Toolkit:** [www.healthynewbornnetwork.org/kangaroo-mother-care-toolkit/](http://www.healthynewbornnetwork.org/kangaroo-mother-care-toolkit/)

**Delayed umbilical cord clamping for improved maternal and infant health and nutrition outcomes. WHO, 2014.** [www.who.int/nutrition/publications/guidelines/cord\\_clamping/en/](http://www.who.int/nutrition/publications/guidelines/cord_clamping/en/)

**WHO recommendations on interventions to improve preterm birth outcomes. WHO, 2015.** [www.who.int/reproductivehealth/publications/maternal\\_perinatal\\_health/preterm-birth-guideline/en/](http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/preterm-birth-guideline/en/)

**Establishing an integrated human milk banking approach to strengthen newborn care.** DeMarchis A, Israel-Ballard K, Amundson Mansen K and Engmann C, 2016. Journal of Perinatology. [www.ncbi.nlm.nih.gov/pubmed/27831549](http://www.ncbi.nlm.nih.gov/pubmed/27831549)

**Strengthening Human Milk Banking: A Global Implementation Framework. Version 1.** PATH, 2013. [www.path.org/publications/files/MCNH\\_haccp\\_training\\_workbook.pdf](http://www.path.org/publications/files/MCNH_haccp_training_workbook.pdf)

*Key conditions that need to be in place for **the safe use of donor human milk in an emergency** are: government policy (preparedness) or, in the absence of policy, agreement between authorities on its use; an estimate of need, defined eligibility criteria and duration of provision; adequacy of supply for the response; quality assurance including donor screening and pasteurisation; and the establishment and maintenance of a cold chain to preserve quality and safety.*

For an example of **minimum screening** for populations **in transit**, see References Section 8.6 [133].

**NutVal.** [www.nutval.net](http://www.nutval.net)

Non-breastfed children have heightened nutrient needs (see References Section 8.6 [119]).

Clean with access to safe drinking water, handwashing facilities, safe faeces management, accessible toilets, use of improved toilets and treated drinking water safely stored (see References Section 8.6 [160-166]).

*Global guidance advises that national/sub-national authorities should decide the feeding practice that gives infants and young children the greatest chance of **HIV-free survival** and support mothers and caregivers accordingly. **Recommended feeding practices** to select in the **context of HIV** are: a) breastfeed and receive anti-retroviral (ARV) drug interventions, or b) avoid all breastfeeding and replacement feed. To make this decision, the appropriate authority should balance HIV transmission risk versus other causes of child mortality. Considerations include: the socioeconomic and cultural context; availability and quality of health services; HIV prevalence among pregnant women; and main causes of maternal and child undernutrition and infant and child mortality in the affected population (see References Section 8.6 [113-115]).*

*Perinatal prophylaxis and post-partum ARV drugs for infants (see definitions) should be considered where **ARV supply to mothers is disrupted**. This is a research gap area (see References Section 8.6 [115]).*

**Safer BMS Kit.** Save the Children, 2017.

<https://drive.google.com/file/d/0B5uBNDhrtqbamMyMFg2cldrM1U/view>

## 8 References

This selection of key references and resources is organised per the most relevant section of the OG-IFE. Note that many are applicable to more than one section.

<b>8.1 General</b>	[1]
<b>8.2 Policy</b>	[1]
<i>Global and National Strategy</i>	[2]–[7]
<i>Global Policy</i>	[8]–[12]
<i>Organisational Policy</i>	[13]–[22]
<i>Minimum Standards</i>	[23]–[25]
<b>8.3 Training</b>	[26]
<i>Counselling</i>	[27]–[34]
<i>Programming</i>	[35]–[40]
<i>Community</i>	[41]–[48]
<i>Assessment and Research</i>	[49]–[50]
<i>General Humanitarian Response</i>	[51]–[54]
<b>8.4 Coordination</b>	[55]
<i>Humanitarian Response Planning and Coordination</i>	[56]–[57]
<i>Communications and Advocacy</i>	[58]–[67]
<b>8.5 Assessment and Monitoring</b>	[68]
<i>Indicators</i>	[69]–[73]
<i>Age</i>	[74]–[75]
<i>Collecting Data (Assessment)</i>	[76]–[80]
<i>In-depth Assessment</i>	[81]–[87]
<i>Monitoring</i>	[88]–[92]
<i>Participation</i>	[93]–[94]
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<b>8.6 Multi-sector Interventions</b>	[97]
<i>IYCF Counselling</i>	[98]–[101]
<i>Breastfeeding</i>	[102]–[108]
<i>Artificial Feeding</i>	[109]–[110]
<i>Special Circumstances</i>	[111]–[116]
<i>Complementary Feeding</i>	[117]–[120]
<i>Maternal Nutrition</i>	[121]–[122]
<i>Micronutrients</i>	[123]–[128]
<i>Preparedness</i>	[129]–[130]
<i>IYCF-E Programming</i>	[131]–[136]
<i>Behaviour Change</i>	[137]–[140]
<i>Mainstreaming within Nutrition</i>	[141]–[149]
<i>Disability</i>	[150]–[153]
<i>Gender</i>	[154]–[156]
<i>Integration</i>	[157]–[159]
<i>WASH</i>	[160]–[166]
<i>Protection</i>	[167]–[169]
<i>Food Security and Livelihoods</i>	[170]
<i>Early Childhood Development</i>	[171]–[174]

<i>Adolescents</i>	[175]
<i>Mental Health and Psychosocial Support</i>	[176]–[181]
<i>Maternal, Newborn and Child Health</i>	[182]–[186]
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<b>8.7 Artificial Feeding</b>	[193]–[194]
<i>Minimising the Risk</i>	[195]–[197]
<i>Roles and Responsibilities</i>	[198]–[201]
<i>BMS Specification</i>	[202]–[203]
<i>BMS Supplies and Feeding Equipment</i>	0[204]

## 8.1 General

1. **IYCF-E Toolkit. Version 3. Save the Children**, 2017. English, with core documents in French and Arabic. A collection of information and practical resources to enable rapid start-up and implementation of IYCF-E programmes in an emergency. This is a general resource which spans all sections below; however particularly relevant resources are highlighted within each section. <https://sites.google.com/site/stcehn/documents/iycf-e-toolkit-v3>

## 8.2 Policy

### Global and National Strategy

2. **IYCF-E Toolkit. Version 3. Section A: Policy**. Save the Children, 2017. <https://sites.google.com/site/stcehn/documents/iycf-e-toolkit-v3>
3. **Comprehensive implementation plan on maternal, infant and young child nutrition**. *Action plan illustrating priority actions that should be jointly implemented by member states and international partners to achieve six global nutrition targets by 2025*. WHO, 2014. Arabic, Chinese, English, French, Russian, Spanish. [www.who.int/nutrition/publications/CIP\\_document/en/](http://www.who.int/nutrition/publications/CIP_document/en/)
4. **Guiding Principles for Feeding Infants and Young Children During Emergencies**. World Health Organization, 2004. English. <http://whqlibdoc.who.int/hq/2004/9241546069.pdf>
5. **Global Strategy for IYCF**. WHO and UNICEF, 2003. Arabic, Chinese, English, French, German, Italian, Japanese, Russian, Spanish. *Provides the main framework for WHO's actions to promote breastfeeding and complementary feeding*. [www.who.int/nutrition/publications/infantfeeding/9241562218/en/](http://www.who.int/nutrition/publications/infantfeeding/9241562218/en/)
6. **Planning Guide for National Implementation of the Global Strategy for IYCF**. WHO and UNICEF, 2007. English. *Proposes a step-wise process to develop a country-specific strategy*. [www.who.int/maternal\\_child\\_adolescent/documents/9789241595193/en/](http://www.who.int/maternal_child_adolescent/documents/9789241595193/en/)
7. **Safeguarding against possible conflicts of interest in nutrition programmes: Approach for the prevention and management of conflicts of interest in the policy development and implementation of nutrition programmes at country level**. [www.who.int/nutrition/publications/COI-report/en/](http://www.who.int/nutrition/publications/COI-report/en/)

### Global Policy

8. **Policy Guidance: Priority Nutrition Interventions and Cross-Cutting Approaches in Latin America and the Caribbean**. *The World Bank*, 2011. English. *Working paper describing priority nutrition interventions and cross-cutting approaches that are essential to promote and protect nutritional status of mothers and children as well as a country's human capital in the short, medium and long terms*. <https://openknowledge.worldbank.org/bitstream/handle/10986/23711/NonAsciiFileName0.pdf?sequence=1&isAllowed=y>
9. **The International Code of Marketing of Breast-milk Substitutes. WHO, 1981 and subsequent relevant World Health Assembly Resolutions (the Code – see definition)**. Arabic, English, French, Spanish and many others. <http://ibfan.org/the-full-code>

10. **The International Code of Marketing of Breast-milk Substitutes – 2017 Update. Frequently Asked Questions.** WHO, 2017. Chinese, English, Russian, Spanish. *Easy-to-read detailed information on specific questions related to the Code.* [www.who.int/nutrition/publications/infantfeeding/breastmilk-substitutes-FAQ2017/en/](http://www.who.int/nutrition/publications/infantfeeding/breastmilk-substitutes-FAQ2017/en/)
11. **WHA Resolution: Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children.** 69th WHA A69/7 Add.1. 2016. English. *Covers commercially produced foods and beverages, including complementary foods marketed as suitable for feeding children up to 36 months of age.* [http://apps.who.int/gb/ebwha/pdf\\_files/WHA69/A69\\_7Add1-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_7Add1-en.pdf)
12. **WHA Resolution on the Inappropriate Promotion of Foods for Infants and Young Children: Policy Brief.** World Health Organization, UNICEF, Save the Children, IBFAN, & Helen Keller International, 2016. English. [http://archnutrition.org/wp-content/uploads/2016/12/011917\\_HKI\\_WHABrief\\_v3-with-date-1.pdf](http://archnutrition.org/wp-content/uploads/2016/12/011917_HKI_WHABrief_v3-with-date-1.pdf)

## Organisational Policy

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14. **Core Commitments for Children in Humanitarian Action.** UNICEF, 2010. *Global framework for humanitarian action for children undertaken by UNICEF and its partners.* [www.unicef.org/publications/files/CCC\\_042010.pdf](http://www.unicef.org/publications/files/CCC_042010.pdf)
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## General Humanitarian Response

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203. **See also: 10 and 11 (The Code).**

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## 9 Definitions

**Agency:** A generic term that may apply to UN, NGO or government bodies, organisations or departments.

**Antiretroviral drug (ARV):** The medicine used to treat HIV infection. (WHO, 2016)

**Antiretroviral therapy (ART):** The use of a combination of three or more ARV drugs for treating HIV infection. ART involves lifelong treatment. (WHO, 2016)

**Artificial feeding:** The feeding of infants with a breastmilk substitute. (UNICEF, 2012)

**Blanket distributions:** (general, untargeted) Provision of a supply to an entire population such as a camp community or a geographic area, or to individuals fulfilling an easily defined criteria, such as age.

**Blanket feeding:** The feeding of an affected population without targeting specific groups. (UNICEF, 2012)

**Blanket supplementary feeding:** Blanket supplementary feeding programmes target a food supplement to all members of a specified at-risk group, regardless whether they have moderate acute malnutrition or not.

**Bottle feeding rate:** The proportion of children 0-23 months of age fed with a bottle. Included are children less than 24 months of age who received any food or drink from a bottle with a nipple/teat during the previous day (including breastmilk). (WHO, 2007)

**Breast pump:** A device for extracting and collecting milk from the breast during lactation.

**Breastfeeding:** The provision of breastmilk, either directly from the breast or expressed.

**Breastmilk substitute (BMS):** Any food (solid or liquid) being marketed, otherwise represented or used as a partial or total replacement for breastmilk, whether or not suitable for that purpose. In terms of milk products, recent WHO guidance has clarified that a BMS includes any milks that are specifically marketed for feeding infants and young children up to the age of three years. See *The Code* definition for more details. Guidance on appropriate and inappropriate BMS for different age groups is included in 5.15.

**Cash transfer programming:** The use of cash or vouchers to enable households to meet basic needs for food and non-food items or services or to buy essential assets. This includes government social protection programmes.

**Cluster (sector group):** Clusters are groups of humanitarian organisations, both UN and non-UN, in each of the main sectors of humanitarian action, e.g. nutrition. The cluster approach is a mechanism that helps to address identified gaps in response and enhance the quality of humanitarian action by ensuring greater predictability and accountability and strengthening partnerships between NGOs, international organisations, the International Red Cross and Red Crescent Movement, UN agencies and the government. Interagency standing committee (IASC) clusters are formally activated clusters created when existing coordination mechanisms are overwhelmed or constrained in their ability to respond to identified needs in line with humanitarian principles. A formally activated cluster has specific characteristics and accountabilities. It is accountable to the Humanitarian Coordinator (HC) through the Cluster Lead Agency (CLA), as well as to national authorities and to people affected by the crisis. IASC clusters are a temporary coordination solution and efforts should be made as soon as appropriate and possible to hand over coordination to the relevant authorities.

**Cluster lead agency (CLA):** An agency or organisation that has been designated by the Resident and/or Humanitarian Coordinator (RC/HC) as cluster lead agency for a particular sector at country level, following consultations with the Humanitarian Country Team. At global level, CLAs are pre-identified by the IASC: UNICEF is the CLA for the Nutrition Cluster at global level. At country level, the CLA role

can be delegated to another agency where the global level lead agency does not have capacity or country presence to perform this function.

**Code, the:** see International Code of Marketing of Breast-Milk Substitutes

**Codex Alimentarius:** A collection of internationally recognised standards, guidelines and codes of practice relating to food safety and quality, adopted by the Codex Alimentarius Commission. (FAO). Note standard on formulated complementary foods and standard on infant formula.

**Complementary feeding:** The use of age-appropriate, adequate and safe solid or semi-solid food in addition to breastmilk or a breastmilk substitute in children aged 6-23 months.

**Complementary food:** Any food, whether industrially produced or locally prepared, suitable as a complement to breastmilk or to a BMS, that is used to feed children 6-23 months of age. Note this term is also used to describe foods that complement those included in a general ration for populations receiving food assistance.

**Conflict of interest:** A situation where there is the risk that a secondary interest of an organisation or individual unduly influences, or is perceived to unduly influence, the independence or objectivity of professional judgment or actions regarding a primary interest (ensuring the best interests of the child in IFE operations) or undermine public trust in those operations.

**Continued breastfeeding:** The provision of breastmilk beyond the first 6 months of life.

**Counselling:** A conversation between a counsellor and caregiver, based on a three-step process that includes assessment, analysis and action to help the caregiver decide on what is best for herself and her child in their situation. Counselling is different from education and messaging.

**Disability:** The term “persons with disabilities” applies to all persons with disabilities including but not limited to those who have long-term physical, mental, intellectual or sensory impairments which hinder their full and effective participation in society on an equal basis with others.

**Donor human milk:** Expressed breastmilk voluntarily provided by a lactating woman to feed a child other than her own. Informal donor human milk involves informal milk sharing (e.g. peer-to-peer, community-based) to breastmilk-feed a child with unprocessed, expressed breastmilk. Formal donor human milk is sourced from a human milk bank (see definition) to breastmilk-feed a child with screened and processed, expressed breastmilk.

**Early initiation of breastfeeding:** Provision of mother’s breastmilk to infants within one hour of birth (includes living and deceased children). Timely initiation of breastfeeding indicator is calculated on living children only.

**Education:** In the context of IYCF, education encompasses activities designed to enhance the ability and motivation of caregivers to voluntarily adopt nutrition-related behaviours conducive to health and wellbeing.

**Emergency:** (crisis, disaster) An event or series of events involving widespread human, material, economic or environmental losses and impacts that exceed the ability of the affected community or society to cope using its own resources and therefore requires urgent action to save lives and prevent additional mortality and morbidity. The term encompasses natural disasters, man-made emergencies and complex emergencies. Emergencies can be slow- or rapid-onset, chronic or acute.

**Exclusive breastfeeding:** The infant receives only breastmilk without any other liquids or solids, not even water, except for oral rehydration solution or drops or syrups of vitamins, minerals or medicines. (WHO, 2016)

**Feeding equipment:** Bottles; teats; syringes; feeding cups with spouts, straws or other feeding additions; and breast pumps.

**Follow-on/follow-up milk/formula:** A milk or milk-like product of animal or vegetable origin formulated industrially in accordance with the Codex Alimentarius Standard for Follow-up Formula and marketed or otherwise represented as suitable for feeding infants and young children 6-36 months of age. These products are not necessary for child nutrition and fall under the remit of *the Code*.

**Food security:** The situation when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life. (FAO, 2000)

**Fortified foods:** Foods which have undergone a process to deliberately increase the content of an essential micronutrient (e.g. vitamins and minerals) to improve the nutritional quality of the food.

**Growing-up milk:** Milk product marketed for children between one and three years of age. These products are not necessary for child nutrition and fall under the remit of *the Code*.

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

**HIV-exposed infant/child:** An infant or child born to a mother living with HIV until they are reliably excluded from being HIV infected. (WHO, 2016)

**Home-modified animal milk:** a breastmilk substitute for infants up to six months old prepared at home from fresh or processed animal milk, suitably diluted with water and with the addition of sugar, micronutrients and vegetable oil. (WHO, 2006)

**Human milk bank (HMB):** A service established to recruit breastmilk donors, collect donated milk, and then process, screen, store and distribute the milk to meet infants' specific needs for optimal health. (PATH, 2013)

**Individual-level assessment:** A process to evaluate a caregiver-baby pair, establish infant feeding practice and needs, and decide what type of support may be necessary. There are two levels of assessment: simple rapid assessment and full assessment.

**Infant:** A child aged 0-11 completed months (may be referred to as 0-<12 m or 0-<1 year). An *older infant* means a child from the age of 6 months up to 11 completed months of age.

**Infant formula:** A breastmilk substitute formulated industrially in accordance with applicable Codex Alimentarius standards for infants. *Commercial infant formula* is infant formula manufactured for sale, branded by a manufacturer. *Generic infant formula* is unbranded. *Powdered Infant Formula (PIF)* is an infant formula product which needs to be reconstituted with safe water before feeding. *Ready-to-use infant formula (RUIF)* is a type of infant formula product that is packaged as a ready-to-feed liquid and does not need to be reconstituted with water.

**International Code of Marketing of Breast-Milk Substitutes (*the Code*):** *The Code* intends to ensure BMS will be used as safely as possible when they are necessary based on impartial, accurate information. *The Code* does not restrict the availability of BMS, feeding bottles or teats or prohibit the use of BMS during emergencies. In the context of *the Code*, BMS means any food being marketed or

otherwise represented as a partial or total replacement for breastmilk, whether suitable for that purpose or not.

*The Code* applies to the marketing and related practices, quality, availability and information on use, including but not limited to: breastmilk substitutes (including infant formula, follow-on/follow-up milk, growing-up milk, other milk products, including bottle-fed complementary foods ) specifically marketed for feeding children up to three years of age; foods and beverages (baby teas, waters and juices) when marketed for use as a partial or total replacement of breastmilk during the first six months of life; feeding bottles and teats.

Note that the promotion of foods for infant and young children over six months is covered by 69th WHA Provisional Agenda Item 21.1 A69/7 Add.1.

**Kangaroo mother care (KMC):** Care of LBW and preterm infants carried skin-to-skin with the mother (or substitute). Key features include early, continuous and prolonged skin-to-skin contact and (ideally) exclusive breastfeeding, or feeding with breastmilk. (WHO, 2015)

**Lipid-based nutrient supplement (LNS):** A range of lipid-based products that provide vitamins and minerals, energy, protein and essential fatty acids. According to strict specifications, they are classified as medium or small quantity LNS (MQ- LNS, SQ- LNS), for use in specific target groups/interventions. MQ-LNS provide macro- and micronutrient supplementation; SQ-LNS primarily provide essential (micro) nutrients.

**Low birth weight (LBW):** Newborns with a weight of less than 2,500 grams, irrespective of gestational age.

**Micronutrient supplement:** A product which provides specific micronutrients that are not available as part of the regular diet.

**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 standard indicator for children 6-23 months of age, measuring both the minimum feeding frequency and minimum dietary diversity as appropriate for various age groups. If a child meets the minimum feeding frequency and minimum dietary diversity for their age group and breastfeeding status, they are considered to receive a minimum acceptable diet.

**Mixed feeding:** Feeding an infant younger than six months of age other liquids and/or foods together with breastmilk, i.e. they are not exclusively breastfed. (WHO, 2016)

**Newborn (neonate):** A child under 28 days of age.

**Non-breastfed:** A child who does not receive any breastmilk.

**Nutrient gap:** The difference between nutrient requirements and nutrient intake, considering both energy and nutrient adequacy

**Nutrition and health emergency response:** A formal response framework, guided by a cluster or sector group and in-country technical capacity, aimed at directly meeting the health and nutrition needs of a disaster-affected population through the delivery of humanitarian health and nutrition interventions in a coordinated and principled manner and in line with agreed international and national standards and guidance.

**Optimal (recommended) infant and young child feeding:** Early initiation (within one hour of birth) of exclusive breastfeeding, exclusive breastfeeding for the first six months of life, followed by nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond. "Recommended" rather than optimal feeding practices are referred to in the OG-IFE.

**Perinatal prophylaxis:** In the context of HIV-exposed infants, postpartum ARV drugs given to a newborn in the first three months of life to reduce the risk of perinatal and early postnatal HIV transmission from mother to child. Postpartum ARV drugs may also be given to infants beyond the first three months of life to reduce the risk of postnatal HIV transmission from mother to child, for example through continued breastfeeding.

**Preparedness:** The capacities and knowledge developed by governments, professional response organisations, communities and individuals to anticipate and respond effectively to the impact of likely, imminent or current hazard events or conditions.

**Prevention of mother-to-child transmission of HIV (PMTCT):** Programmes and interventions designed to reduce the risk of mother-to-child (vertical) transmission of HIV.

**Qualified health or nutrition worker:** In the context of IYCF, a health or nutrition worker or lay IYCF counsellor who has undergone training on relevant, contextually appropriate health and/or nutrition matters.

**Ready-to-use supplementary food (RUSF):** Specialised ready-to-eat, portable, shelf-stable products, available as pastes, spreads or biscuits, that meet the supplementary nutrient needs of those who are not severely malnourished. (UNICEF, 2012).

**Ready-to-use therapeutic food (RUTF):** Specialised ready-to-eat, portable, shelf-stable products, available as pastes, spreads or biscuits that are used in a prescribed manner to treat children with severe acute malnutrition. (UNICEF, 2012).

**Ready-to-use food (RUF):** Specialised ready-to-eat, portable, shelf-stable products that are designed to be eaten straight from the packet, without the need for cooking, dilution or other preparation. RUF is an umbrella term that includes RUTF and RUSF (Marie-Pierre Duclercq, 2014; adapted)

**Recommended infant and young child feeding:** See *Optimal (recommended) IYCF*.

**Relactation:** The resumption of breastmilk production (lactation) in a woman who has stopped lactating, recently or in the past, in order to breastfeed her own or another infant, even without a further pregnancy. *Inducted lactation* is the stimulation of breastmilk production in a woman who has not previously lactated.

**Replacement feeding:** Feeding a child who is not receiving any breastmilk with a nutritionally adequate diet until the age at which they can be fully fed on family foods. This term is used in the context of HIV.

**Skilled support:** In the context of breastfeeding, complementary feeding or feeding support, provision of technical assistance to a caregiver experiencing difficulties with breastfeeding, complementary feeding or artificial feeding by a qualified health or nutrition worker (*see definition*).

**Supplementary feeding device:** (supplementary nursing system) A lactation aid which allows for supplementary feeding (with expressed breastmilk, donor breastmilk or infant formula) at the breast.

**Targeted supplementary feeding:** Programmes that provide nutritional support to individuals with moderate acute malnutrition.

**Teat:** An artificial nipple by which an infant can drink milk from a bottle.

**Therapeutic milk:** Specialised product for the management of severe malnutrition in inpatient settings, e.g. F75 and F100. Therapeutic milk may be pre-formulated or prepared from dried skimmed milk (DSM), oil and sugar, with the addition of a vitamins and minerals complex. Note that from third quarter of 2017, packaging will transition from sachets to 400g tins (UNICEF, WHO, 2017).

**Toddler milk:** See *Growing-up milk*



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**Untargeted distribution:** See *Blanket distribution*

**Wet nursing:** Breastfeeding of a child by someone other than the child's biological mother.

**Young child:** A child from the age of 12 months up to the age of 23 completed months (may also be referred to as 12-<24m or 1-<2 years).

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## Annex 1: Guide to content by sector/speciality and preparedness

Sector/Speciality	Sections
All sectors (general)	3.6, 4.2, 4.3, 5.6
Adolescent services	5.4, 5.7, 5.30, 5.32
Agriculture	5.30-5.32
Cash (including social protection)	4.6.1, 5.23, 5.30, 5.32, 6.19, 6.20, 6.24
Child protection	5.4, 5.16, 5.30-5.32
Disability	2.3, 4.6.2, 5.4, 5.22, 5.30, 5.32
Early Childhood Development	5.30-5.32
Food Security and Livelihoods	3.4, 4.6.1, 5.22, 5.23, 5.30, 5.32, 5.7, 5.40
Health:	
<i>Reproductive, maternal, newborn and child health</i>	3.4, 3.6, 4.5, 4.6.1, 5.22, 5.23, 5.25, 5.30, 5.31, 5.32, 5.7, 5.40
<i>Curative services</i>	5.4, 5.16, 5.30, 5.32
<i>Mental health and psychosocial support services</i>	2.3, 5.16, 5.30-5.32
<i>HIV</i>	4.6.1, 5.6.1, 5.7, 5.16, 5.30-5.32, 5.33-5.39
<i>Infectious disease management</i>	1.1, 4.6.1, 5.4, 5.10, 5.30, 5.33, 5.40
Logistics	2.1, 5.22, 5.24, 5.28, 5.30, 6.1-6.6, 6.11-6.18, 6.24-6.25
Shelter	5.30, 5.32
WASH	5.10, 5.22, 5.30-5.32, 6.22
Preparedness	1.1-1.7, 2.2, 2.4, 3.2, 3.5, 4.1, 4.4-4.5, 4.6.1, 5.1, 5.13, 5.33, 6.4, 6.7

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## ACRONYMS

<b>ART</b>	Antiretroviral treatment
<b>ARV</b>	Antiretroviral (drug)
<b>BMS</b>	Breastmilk substitute
<b>CFSVA</b>	Comprehensive Crop and Food Security and Vulnerability Analysis
<b>CMR</b>	Crude mortality rate
<b>DHS</b>	Demographic Health Survey
<b>ECD</b>	Early childhood development
<b>ENN</b>	Emergency Nutrition Network
<b>FAO</b>	Food and Agriculture Organization of the United Nations
<b>FSL</b>	Food security and livelihoods
<b>FSNMS</b>	Food Security and Nutrition Monitoring System
<b>HIV</b>	Human immunodeficiency virus
<b>HRP</b>	Humanitarian Response Plan
<b>GIFA</b>	Geneva Infant Feeding Association
<b>IBFAN</b>	International Baby Food Action Network
<b>ICDC</b>	International Code Documentation Centre
<b>IDP</b>	Internally displaced persons
<b>IFE</b>	Infant and young child feeding in emergencies (also referred to as IYCF-E)
<b>IMR</b>	Infant mortality rate
<b>IYCF</b>	Infant and young child feeding
<b>JANFSA</b>	Joint Approach to Nutrition and Food Security Assessment
<b>KAP</b>	Knowledge, attitudes, practices
<b>LBW</b>	Low birth weight
<b>MHPSS</b>	Mental health and psychosocial support
<b>MICS</b>	Multiple Indicator Cluster Survey
<b>MNCH</b>	Maternal, newborn and child health
<b>MNP</b>	Micronutrient powder
<b>NGO</b>	Non-governmental organisation
<b>OG-IFE</b>	Operational Guidance for emergency relief staff and programme managers on Infant and Young Child Feeding in Emergencies
<b>PIF</b>	Powdered infant formula
<b>PLW</b>	Pregnant and lactating women
<b>PMTCT</b>	Prevention of mother-to-child transmission
<b>RUIF</b>	Ready-to-use infant formula
<b>RUSF</b>	Ready-to-use supplementary food
<b>RUTF</b>	Ready-to-use therapeutic food
<b>UHT</b>	Ultra-high temperature
<b>UN</b>	United Nations
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNICEF</b>	United Nations International Children's Fund
<b>USMR</b>	Under-five mortality rate
<b>WASH</b>	Water, sanitation and hygiene
<b>WBTi</b>	World Breastfeeding Trends Initiative
<b>WFP</b>	World Food Programme
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization

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# Notes

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