OPERATIONAL GUIDELINE FOR INFANT AND YOUNG CHILD FEEDING IN EMERGENCIES for BANGLADESH

FOREWORD

<Foreword>

ACKNOWLEDGEMENTS

The majority of this guideline has been adopted and adapted from: the Baby Friendly Spaces Manual (ACF, 2014), Harmonised Training Package (HTP): Resource Material for Training on Nutrition in Emergencies (Nutrition Works, ENN, GNC, 2011), The IYCF Framework (UNHCR and Save the Children, 2017), The National Strategy on IYCF in Bangladesh (MOHFW, 2007), The Operational Guidance on Infant and Young Child Feeding in Emergencies (IFE Core Group 2017), and Standard Operating Procedures for the Handling of Breastmilk Substitutes in Refugee Situations (UNHCR, 2015). A full reference list is provided at the end of this guideline.

The development of this document was led by the Institute for Public Health Nutrition (IPHN) and UNICEF Bangladesh. The author would like to thank the Technical Advisory Group who provided strategic guidance and technical support to the development of the guideline. TAG members were composed of experts from the National Nutrition Service, Action Against Hunger, Concern, the Hellen Keller Initiative, Save the Children, WHO, UNICEF, and WFP. Contributions were provided by numerous Nutrition Cluster partners. A full list can be found under the reviewers and contributors section of this guideline.

This guideline was reviewed and validated by a Technical Committee <insert details once completed>
EXECUTIVE SUMMARY

Bangladesh recognises that Infant and Young Child Feeding (IYCF) practices are a cornerstone of child survival and child health, and that protecting, promoting and supporting recommended practices is key to curbing the country’s high malnutrition rates. Whilst the lifesaving practice of breastfeeding is almost universal in Bangladesh, a concerted effort remains necessary to improve overall IYCF practices. According to the 2014 Demographic and Health Survey, almost half of all newborns were put to the breast too late, just 55% of infants were exclusively breastfed for the first 6 months of life and a mere 23% of children aged 6 – 23 months received a minimum acceptable diet. The country has thus aligned itself with global commitments in support of IYCF, and embraced various national initiatives including the development of the National Strategy on IYCF in Bangladesh in 2007.

A priority identified by the national strategy was to increase attention and support for families in exceptionally difficult circumstances, including those affected by emergencies. Bangladesh is one of the most disaster-prone countries in the world. During emergencies, infants and young children are particularly vulnerable to malnutrition, illness and death. IYCF practices are often negatively impacted by emergencies, and inappropriate practices become even more dangerous. The fundamental means of protecting and saving infant and young children’s lives during emergencies is to ensure their appropriate feeding and care. This is done through Infant and Young Child Feeding in Emergencies (IYCF-E), a lifesaving intervention which must be a priority during the first phase on any emergency response in Bangladesh.

This Operational Guideline on IYCF-E in Bangladesh is the result of the national strategy’s 2007 recommendations. It seeks to provide policy-makers, decision-makers, programme planners and managers working in emergency preparedness and response in Bangladesh with practical guidance on how to ensure appropriate infant and young child feeding in the event of a humanitarian emergency in Bangladesh.

The guideline strives to meet the provisions of international humanitarian standards (such as The Sphere Standards) and to assist with the practical application of Bangladesh’s national policy and guidance on IYCF, including the Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and Accessories Thereof (Regulation of Marketing) Act 2013. It aims to assist decision-makers and planners to meet their responsibilities as set out in conventions ratified by Bangladesh, and is closely aligned with the most up-to-date, globally recognised guidance on IYCF-E.

A Framework for Action outlined in Chapter 2 describes nine priority actions to be collectively undertaken by the Government of Bangladesh (GoB) and its partners in preparedness and during response to support the creation of an Infant and Young Child Friendly Environment i.e. an environment which enables caregivers to follow recommended IYCF practices despite finding themselves in difficult circumstances. The key actions are:

1. **Adhere to key policies and operational standards** – key provisions regarding IYCF-E should be reflected in government, multi-sector and agency policies and should guide emergency responses.
2. **Coordinate** – The GoB is the lead coordination authority on IYCF-E in Bangladesh; capacity to coordinate IYCF-E should be established within coordination mechanisms for every response.
3. **Assess the situation** – Timely, harmonized needs assessments using agreed upon methodologies should ensure that communities affected by emergencies receive assistance that is appropriate to their needs.
4. **Select and implement appropriate IYCF-E interventions** – The response should ensure that mothers and other caregivers of infants and young children have access to timely and appropriate feeding support that minimizes risks, is culturally sensitive and optimizes nutrition, health and survival outcomes. Immediate action to protect recommended IYCF practices and minimize risks is necessary in the early stages of an emergency, with targeted support to higher risk infants and young children.
5. **Advocate and communicate** – Timely, harmonized and accurate communication to the affected population, emergency responders and the media is essential.

6. **Prevent inappropriate donations and unsafe distributions** – Any donations of breastmilk substitutes, other milk products, infant foods, commercially manufactured complementary foods or accessories thereof are a blatant violation of the Bangladesh BMS Act 2013 and can put children’s lives at risk. Blanket (general) distributions should never be used as a platform to supply breastmilk substitutes or other products which may be used as a breastmilk replacement, such as powdered milk.

7. **Build capacity** – Sensitisation and training on IYCF-E is necessary at multiple levels and across sectors.

8. **Monitor, Evaluate and Be Accountable** - The performance of the GoB and its partners should be continually examined and communicated to stakeholders. It is essential to monitor the impact of humanitarian action 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.

9. **Collaborate and integrate with other sectors** – In line with Bangladesh’s National Nutrition Policy (2015) objectives to strengthen nutrition-sensitive, or indirect, nutrition interventions and to strengthen multisectoral programmes and increase coordination among sectors, it is imperative that opportunities are identified, and activities are put in place in collaboration with other sectors to facilitate and complement direct IYCF-E interventions. Annexe C provides sector-specific guidance on the implementation of an IYCF-E sensitive response.

The final chapter of this operational guideline provides programmatic guidance on the implementation of the **Bangladesh Minimum IYCF-E Response Package** i.e. the standard activities to be implemented as part of any emergency response in Bangladesh. It includes five basic multisectoral action to be undertaken by all sectors, as well as core (direct) IYCF-E interventions to be implemented by health, nutrition and food security actors.

The five **basic multisectoral actions** are:

1. Enable priority access for pregnant and lactating women (PLW) to essential services
2. Prevent the separation of children from their caregivers
3. Register households with PLW, children under 2 years of age and higher risks groups
4. Provide privacy and space to breastfeed
5. Disseminate standardised, clear and accurate messages on IYCF-E

The **Core (direct) IYCF-E interventions** to be implemented as soon as possible are:

1. Establishment of supportive spaces (IYCF-E Corners and / or Mother Baby Areas)
2. Basic Frontline Feeding Support (rapid assessment, practical support and referrals)
3. Group Education and Information Sharing
4. Nutrition Care and Counselling for PLWs
5. Support for Early Initiation of Exclusive Breastfeeding
6. Skilled IYCF Counselling (one-to-one)
7. Further support for particularly vulnerable children
8. Access to safe, adequate and appropriate complementary foods
9. Management of non-breastfed infants

The guideline also specifies which **additional IYCF-E interventions** can be implemented, based on the specific emergency context and the needs of the affected population. While not considered an essential requirement, the integration of Psychosocial Support and Early Childhood Development within IYCF-E interventions is strongly encouraged.
# ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>BMS</td>
<td>Breastmilk Substitute</td>
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<tr>
<td>ECD</td>
<td>Early Childhood Development</td>
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<tr>
<td>C/JNA</td>
<td>Coordinated/Joint Needs Assessment</td>
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<tr>
<td>FBF</td>
<td>Fortified Blended Food</td>
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<td>GoB</td>
<td>Government of Bangladesh</td>
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<td>HCTT</td>
<td>Humanitarian Coordination Task Team</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>IMO</td>
<td>Information Management Officer</td>
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<tr>
<td>IPHN</td>
<td>Institute of Public Health Nutrition</td>
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<tr>
<td>IYCF-E</td>
<td>Infant and Young Child Feeding in Emergencies (also referred to as IFE)</td>
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<tr>
<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
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<tr>
<td>KAP</td>
<td>Knowledge, Attitudes, Practices</td>
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<td>LBW</td>
<td>Low Birth Weight</td>
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<td>MHPSS</td>
<td>Mental Health and Psychosocial Support</td>
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<tr>
<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
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<td>MNP</td>
<td>Micronutrient Powder</td>
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<td>MODMR</td>
<td>Ministry of Disaster Management and Relief</td>
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<td>MOHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>NC</td>
<td>Nutrition Cluster</td>
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<td>NCC</td>
<td>Nutrition Cluster Coordinator</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>PLW</td>
<td>Pregnant and lactating women</td>
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<td>SFP</td>
<td>Supplementary Feeding Programme</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<td>UNICEF</td>
<td>United Nations International Children’s Fund</td>
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<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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<td>WFP</td>
<td>World Food Programme</td>
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<td>WHA</td>
<td>World Health Assembly</td>
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CHAPTER 1: INTRODUCTION

1.1 Infant and Young Child Feeding Recommendations

The Government of Bangladesh recommends the following IYCF practices:\footnote{National Strategy for Infant and Young Child Feeding in Bangladesh. MOHFW, 2007.}

- Early initiation of breastfeeding (putting baby to the breast within 1 hour of birth)
- Exclusive breastfeeding for the first 6 months (no food or liquid other than breastmilk, not even water)
- Introduction of safe and nutritionally adequate complementary foods from 6 months of age
- Continued breastfeeding for 2 years and beyond

1.2 Infant and Young Child Feeding in Bangladesh

Bangladesh has made significant progress in reducing poverty and malnutrition. However, malnutrition rates remain amongst the highest in the world, especially among children. Micronutrient deficiencies are also widespread. Inappropriate IYCF practices are among the most serious obstacles to maintaining adequate nutrition status (National Strategy on IYCF, 2007). Despite Bangladesh’s strong breastfeeding culture, children are often not breastfed according to recommended practices. For example, almost half of all newborns born in Bangladesh are put to the breast too late and 27% receive a prelacteal feed (BDHS 2014\footnote{Bangladesh Demographic and Health Survey. 2014} ). Complementary
feeding practices are also often inappropriate, as reflected by the sharp increase in malnutrition rates commonly seen in Bangladesh between 6 and 12 months of age.

A wealth of evidence exists demonstrating that IYCF practices are a cornerstone of child survival and child health. Breastfeeding is the single most effective intervention to save children’s lives; 823,000 child deaths could be prevented each year through scaling up recommended breastfeeding practices globally\(^3\). About half of all diarrhoea episodes and a third of respiratory infections (major killers resulting in the loss of 2 million young lives each year\(^4\)) could be avoided through breastfeeding\(^5\). Appropriate complementary feeding could prevent another 6% of deaths\(^6\).

Bangladesh recognises the vital importance of improving IYCF practices as an effective strategy to curbing infectious diseases and malnutrition, thereby improving child survival. It has aligned itself with global commitments (see Section 1.5) and embraced various initiatives, beginning with the development of the National Strategy on IYCF in Bangladesh in 2007, and including the adoption of supportive policies (such maternity protection legislation and nationalisation of The Code), health system support, implementation of the Baby Friendly Hospital Initiative and development of national IYCF training curricula. The development of this guideline is the next step in supporting IYCF efforts in Bangladesh.

1.3 Rationale for the Guideline

Bangladesh is one of the most disaster-prone countries in the world, exposed to a variety of hazards including floods, droughts, cyclones and earthquakes. Its high population density exacerbates the impact of disasters. Continuing population growth and environmental degradation may further aggravate the intensity of disasters in the future, contributing to a significant increase in humanitarian needs\(^7\).

Events such as floods or earthquakes often lead to humanitarian emergencies, which can be defined as an event 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 “emergency” used in this guideline encompasses natural disasters, man-made emergencies and complex emergencies.

Infants and young children are particularly vulnerable to malnutrition, illness and death during emergencies. IYCF practices are often negatively impacted by emergencies, and risk undoing progress made in Bangladesh over the years. As explained in the National Strategy for IYCF in Bangladesh: “The challenging conditions typically faced by women and families during emergencies can undermine breastfeeding practices and interfere with crucial support for breastfeeding women. The shortage and often unsuitability of food resources during emergencies make essential aspects of feeding and care still more difficult.” Interrupted breastfeeding, inappropriate complementary feeding and unsafe use of breastmilk substitutes all put children at risk. The fundamental means of protecting infants and young children during emergencies is to ensure their appropriate feeding and care.

Infant and Young Child Feeding in Emergencies (IYCF-E) is a lifesaving intervention for children in the vulnerable life stage of infancy and up to two years. IYCF-E encompasses a range of multisectoral actions to support safe and appropriate feeding practices during emergencies. The activities focus on infants, children

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\(^3\) Breastfeeding in the 21\(^{st}\) Century: epidemiology, mechanisms and lifelong effect. The Lancet. Victora at al., 2016.


\(^7\) Bangladesh Fact Sheet. ECHO, 2017.
up to 2 years of age, pregnant and breastfeeding women, and other caregivers of young children in a humanitarian setting, and must be a priority intervention during the first phase of an emergency response.

The National Strategy on IYCF in Bangladesh (2007) identifies IYCF in Exceptionally Difficult Circumstances as one of the national strategy’s key pillars (9b), including the need to increase attention and support to families affected by emergencies. This guideline is the direct result of the national strategy’s recommendation to develop a guidance document to aid the implementation of Bangladesh’s national strategy.

1.4 About the Guideline

Target users
This operational guideline is intended for policy-makers, decision-makers and programme planners and managers working in emergency preparedness and response in Bangladesh, including government agencies and authorities, United Nations (UN) agencies, national and international non-governmental organisations (NGOs) and donors.

Recommended actions are directed at IPHN and UNICEF as agencies responsible for coordinating Nutrition in Emergencies (NIE) and at those implementing activities to protect, promote and support appropriate IYCF during emergencies i.e. the Government of Bangladesh (GoB) in collaboration with its partners. While this guideline speaks particularly to Nutrition Cluster (NC) partners, it is relevant across sectors and disciplines.

Aim
To provide practical guidance on how to ensure appropriate infant and young child feeding in the event of an emergency in Bangladesh.

Overall goal:
To protect the nutrition status, growth and development, health, and survival of infants and young children affected by emergencies in Bangladesh through appropriate infant and young child feeding practices.

Overview of this Guideline

Text underlined in blue is hyperlinked. When using a soft copy of this guideline, click on the blue text to jump to a referenced section in the guideline, or an external weblink. The green boxes highlight the minimum standards for an IYCF-E response in Bangladesh. The blue boxes contain key actions for emergency responders to take. The yellow boxes provide additional information and specific examples.

Chapter 1 provides background information to the guideline and can be used by readers to understand the Bangladesh context within which this guidance was produced and the rationale behind it.

Chapter 2 provides a Framework for Action, comprised of actions which should be implemented by the GoB and its partners in preparedness and during emergency response in Bangladesh to ensure that an Infant and Young Child Friendly Environment is created i.e. an environment which enables caregivers to follow recommended IYCF practices during an emergency. Implementing these actions will ensure that Sphere Standard 3.1 “Policy guidance and coordination ensures safe, timely and appropriate IYCF” is met.

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8 National Strategy on IYCF in Bangladesh (2007) overall goal: “To improve the nutrition status, growth and development, health, and survival of infants and young children in Bangladesh through optimal infant and young child feeding practices.”
Use Chapter 2 to identify the priority actions that need to take place during the early warning phase or at the onset of an emergency, in order to develop an emergency-specific action plan for implementation by the GoB with support from its partners.

Chapter 3 describes technical IYCF-E interventions to be undertaken by GoB health and nutrition agencies and its partners during an emergency in Bangladesh.

Use Chapter 3 to understand the Standard Minimum IYCF-E Package to be automatically implemented as part of any NiE Response in Bangladesh, and to identify additional technical IYCF-E interventions which may be implemented in addition to the minimum package depending on the emergency context and the needs of the affected population.

1.5 Policy and Guidance Framework

Those involved in humanitarian responses are expected uphold the human rights of the affected population and to abide by international and national guidance. This section provides an overview of the various endorsed, relevant international instruments which exist in support of infant and young child feeding.

Global Policy and Guidance


The Code and subsequent World Health Assembly (WHA) resolutions represents an expression of the collective will of member states to ensure the protection and promotion of appropriate feeding of infants and young children. The Code aims to contribute “to the provision of safe and adequate nutrition for infants, by ensuring the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes (BMS), when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.” The Code aims to stop the aggressive and inappropriate marketing of products covered by the Code and sets out the responsibilities of the infant food industry, health workers, governments and organisations. The Code does not restrict the availability of BMS, feeding bottles or teats or prohibit the use of BMS during emergencies. In emergency situations, the Code is especially important for controlling donations, preventing the distribution of unsuitable products and preventing companies from using emergencies to increase market share or for public relations.

The 34th session of the WHA adopted The Code in 1981 as a minimum requirement. Just 4 years after its release, Bangladesh was one of the first countries in the world to adopt the Code when it released the 1984 Ordinance XXXIII on Regulation of Breastmilk Substitutes. Since then, the government has enacted the Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and Accessories Thereof (Regulation of Marketing) Act, 2013 which replaces the 1984 ordinance.


CEDAW states in article 12 (2) that parties must ensure “appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as as adequate nutrition during pregnancy and lactation.” This convention has been ratified by Bangladesh in 1984.


This convention states in Article 24 that parties recognise “the right of the child to the enjoyment of the highest attainable standard of health” and that “states shall take appropriate measures to ensure that... all segments

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\(^9\) [http://www.who.int/nutrition/publications/code_english.pdf](http://www.who.int/nutrition/publications/code_english.pdf)
\(^11\) [https://www.unicef.org/crc/](https://www.unicef.org/crc/)
of society, in particular parents and children, are informed, and have access to education and are supported in the use of basic knowledge of children’s health and nutrition, the advantages of breastfeeding....” This convention has also been ratified by Bangladesh (1990).

The Baby Friendly Hospital Initiative\textsuperscript{12} (1991)
The initiative was launched by WHO and UNICEF in 1991, following the Innocenti Declaration of 1990, as a global effort to give every baby the best start in life by creating a health care environment where breastfeeding is the norm.

In 1992, the Bangladesh Breastfeeding Foundation took on the task of initiating the implementation of the BFHI in Bangladesh. Besides the global Ten Steps to Successful Breastfeeding, an additional 5 steps were added to a policy which was endorsed by government and disseminated to hospitals to base their own policies upon. Since 2012, a revitalisation process has been underway.

WHO/UNICEF Global Strategy on Infant and Young Child Feeding\textsuperscript{13} (2002)
Adopted by the WHA in 2002 (Resolution 55.25), this strategy calls for appropriate feeding and support for infants and young children in exceptionally difficult circumstances including emergencies and the development of a knowledge and skills base of health care providers working with caregivers and children in such situations. The Global Strategy identifies the obligations and responsibilities of governments, organisations, and other concerned parties to ensure the fulfilment of the right of children to the highest attainable standard of health and the right of women to full and unbiased information about infant feeding and adequate health and nutrition. Its publication created a strong impetus to develop the National Strategy for IYCF in Bangladesh (2007).

WHO Guiding Principles for Feeding of Infants and Young Children During Emergencies\textsuperscript{14} (2004)
10 guiding principles are set out in order to prevent excess child morbidity and mortality in emergencies, which cover breastfeeding, BMS, complementary feeding, food aid, food security, caring for caregivers, assessment and evaluation. The Operational Guidance on IYCF-E assists with the practical application of these principles and contains updates that have occurred after 2004.

UNICEF Innocenti Declaration 2005 on IYCF\textsuperscript{15} (2005)
The declaration is a call for action following 15 years since the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (which was ratified by Bangladesh) as well as to apply the 2003 Global Strategy on IYCF and meet the Millennium Development Goals by 2015.

Regarding emergencies, it states “Protect breastfeeding in emergencies, including by supporting uninterrupted breastfeeding and appropriate complementary feeding, and avoiding general distribution of breastmilk substitutes.”

The Sphere Project: Humanitarian Charter and Minimum Standards in Disaster Response\textsuperscript{16} (2011)
The Sphere Project is a unique agreement amongst humanitarian actors, international agencies, NGOs and donor institutions to improve the quality of assistance provided to people affected by disasters and the accountability of the humanitarian system in their disaster. The Sphere Handbook outlines minimum standards that describe conditions that must be achieved in any humanitarian response in order for disaster-affected populations to survive and recover in stable conditions and with dignity. This operational guideline is in line with Sphere Standards.

\textsuperscript{12} http://www.who.int/nutrition/topics/bfhi/en/
\textsuperscript{13} http://apps.who.int/iris/bitstream/10665/42590/1/9241562218.pdf
\textsuperscript{14} http://www.who.int/nutrition/publications/emergencies/9241546069/en/
\textsuperscript{15} https://www.unicef-irc.org/publications/435/
\textsuperscript{16} http://www.sphereproject.org/
The Core Humanitarian Standards of Quality and Accountability\textsuperscript{17} (CHS) (2015)

The CHS is a voluntary code that describes essential elements of principled, accountable and quality humanitarian action. It sets out nine commitments which this guideline urges agencies involved in humanitarian response in Bangladesh to use to improve the quality and effectiveness of the assistance they provide. Communities and people affected by emergencies may use these commitments to hold agencies to account.

The Sustainable Development Goals\textsuperscript{18} (2016)

These global calls are a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. IYCF-E programmes contribute in particular to the achievement of Goal 2 (end hunger, achieve food security and improved nutrition and promote sustainable agriculture), Goal 3 (ensure health lives and promote wellbeing for all at all ages) and Goal 6 (Ensure access to water and sanitation for all).

Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children\textsuperscript{19} (2017)

In May 2016, Member States adopted a new WHA resolution (WHA 69.9) that calls on countries to implement WHO’s latest guidance to further protect breastfeeding, prevent obesity and chronic disease, promote a healthy diet, and ensure that caregivers receive clear and accurate information on feeding. It encourages Member States to develop stronger national policies that protect children under the age of 36 months from marketing practices that could be detrimental to their health.

The Operational Guidance on Infant Feeding in Emergencies\textsuperscript{20} (2017)

The guidance was first developed in 2001 to help those involved with emergency response to meet their responsibilities to infants and young children and their caregivers during times of crisis, with an updated version released in 2007 and an addendum in 2010. Version 3.0 was released in 2017 to reflect operational experiences, needs and guidance updates. The Operational Guidance on IYCF-E (OG-IFE) was endorsed by the WHA 43.23 in 2010. It seeks to meet the provisions of international emergency standards including The CHS and Sphere Standards. It is a practical reflection of global policies such as the Guiding Principles of Feeding Infants and Young Children in Emergencies, The International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA resolutions and assists planners, donors and decision makers to meet their responsibilities as set out in WHO/UNICEF Global Strategy on IYCF, in Article 24 of the Convention of the Rights of the Child and the Call for Action contained in the Innocenti Declaration 2005 on IYCF. It contributes to the achievement of the Sustainable Development Goal (SDG) targets and the work programme of the United Nations Decade of Nutrition (2016 – 2025). This guideline is based on the OG-IFE.

National Policy and Guidance

Extensive policy and guidance is in place in Bangladesh (See Box 1). Three key documents to refer to are:

The National Strategy for IYCF in Bangladesh\textsuperscript{21} (2007)

Bangladesh’s national strategy is consistent with the Global Strategy on IYCF and outlines 9 priority strategies in the main areas of legislation, policy and standards, health system support, community-based support and IYCF in exceptionally difficult circumstances. The latter includes infant feeding in the context of HIV, emergencies and for malnourished and low-birthweight infants. This guideline, the Operational Guidance on IYCF-E for Bangladesh, aims to provide detailed guidance on the practical application of the national strategy’s objective of supporting IYCF in difficult circumstances.

\textsuperscript{17} https://corehumanitarianstandard.org/the-standard
\textsuperscript{18} http://www.un.org/sustainabledevelopment/
\textsuperscript{19} http://www.who.int/nutrition/publications/infantfeeding/manual-ending-inappropriate-promotion-food/en/
\textsuperscript{20} http://www.ennonline.net/operationalguidance-v3-2017
\textsuperscript{21} https://www.unicef.org/bangladesh/IYCF_Strategy.pdf
The Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and
Accessories Thereof (Regulation of Marketing)22 Act (2013)

The Bangladesh BMS Act has 24 sections describing different restrictions and directions covering breastmilk
substitutes, infant foods, commercially manufactured complementary foods and accessories thereof. It
specifically prohibits the donation or (blanket) distribution of these items to disaster-affected communities.

The National Nutrition Policy 2015 has been designed to strategically address the multiple causality of
malnutrition through specific and sensitive nutrition actions, including provisions during emergencies. This
policy has been translated into action through the endorsed, costed National Plan of Action for Nutrition

Box 1 KEY NATIONAL POLICIES AND STRATEGIES

- The Baby Friendly Hospital Initiative
- The National Food Policy (2006)
- The National Strategy for IYCF in Bangladesh (2007)
- The National Neonatal Health Strategy and Guidelines for Bangladesh (2009)
- The Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and
Accessories Thereof (Regulation of Marketing) Act (2013)
- The Food Safety Act (2013)
- National Guidelines for Community Based Management of Acute Malnutrition in Bangladesh (2017)
- National Guidelines for the Facility Based Management of Children with Severe Acute Malnutrition in
Bangladesh (2017)

Box 1 - Key National Policies and Strategies

This document, the Operational Guidance on IYCF-E in Bangladesh, is based on the above global guidance
and strives to meet the provisions of international humanitarian standards as well as Bangladesh’s national
policy and guidance. It provides practical guidance on the application of the above instruments during
humanitarian emergencies in Bangladesh and assists decision-makers and planners to meet their
responsibilities as set out in the conventions ratified by Bangladesh.

22 XXX
CHAPTER 2: FRAMEWORK FOR ACTION

This chapter outlines actions to implement in preparedness and during emergency response to ensure that an Infant and Young Child Friendly Environment\textsuperscript{24} is created i.e. an environment which enables caregivers to follow recommended IYCF practices during an emergency through supportive policies, communication, coordination and multi-sector collaboration.

Overall goal: To protect the nutrition status, growth and development, health, and survival of infants and young children affected by emergencies in Bangladesh

Specific objective: Safe, timely and appropriate IYCF is ensured during emergencies through policy guidance and coordination\textsuperscript{25}

Target Population: Infants and Young Children (0 – 23 months) and their caregivers
Pregnant and Lactating Women (PLW)

How to use this chapter
The Framework lists 9 Key Actions to be undertaken by GoB and its partners for all IYCF-E responses in Bangladesh. Each key action has:

- A performance target for the Nutrition Cluster (NC) to monitor whether the necessary actions are being achieved within the specified timeframe
- Suggested activities that can be carried out as part of the key action. (Which activities are most relevant and important to undertake in order to achieve each action will depend on the context of the particular emergency.
- A timeframe indicating when to do each activity\textsuperscript{26}

➢ During early warning or at the onset of an emergency, IPHN and NC partners to develop an Action Plan (Annexe A1) indicating what the priority activities are and who will undertake them. Activities should be allocated amongst GoB agencies and NC partners.

Table 1 below provides an overview of the key actions, activities and timeframe. The remainder of the chapter provides detailed guidance on each activity.

| Table 1 - Framework for Action on IYCF-E |
|-----------------|---------------------|
| **1** | **Adhere to Key Policies and Operational Standards** |
| Performance Target: | 1 interagency joint statement on IYCF-E released within the 1\textsuperscript{st} week |
| Week 1 | Consult preparedness plans, policies and procedures and identify gaps that need to be addressed |
| Week 1 | Integrate IYCF policies into agreements with partners and implementing agencies |
| Week 1 | Release a joint statement on IYCF-E |
| **2** | **Coordinate** |
| Performance Target: | Lead coordinating body on IYCF-E designated within 72 hours |
| 72 hours | Confirm the IYCF-E coordination authority within the emergency coordination mechanism |
| 72 hours | (Re-) sensitisre partners on IYCF-E coordination mechanism ways of working |
| Week 2 - 8 | Identify the need for an IYCF-E TWG and establish one if necessary |
| Week 2 - 8 | Identify relevant coordination structures and fora for widely sharing information related to infants, young children and PLWs and advocating for a streamlined IYCF-E response |


\textsuperscript{25} Sphere Standard 3.1: Policy guidance and coordination ensures safe, timely and appropriate IYCF

\textsuperscript{26} The suggested timeline is for a rapid onset emergency. Actions can also be undertaken earlier than indicated. The timeline can be used to flag actions that need to be completed at a particular time if they have not been carried out already. When there is strong emergency preparedness, many actions indicated for the first 72 hours or first week will not have to be carried out because they have already been completed during the emergency preparedness phase.
<table>
<thead>
<tr>
<th>Week 2 - 8</th>
<th>Identify IYCF champions in strategic coordination mechanisms beyond the NC to ensure IYCF-E is taken into consideration in decision making processes for an IYCF-E sensitive response</th>
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<td><strong>Assess the situation</strong></td>
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<td><strong>Performance Target:</strong></td>
<td><strong>IYCF-E included in early joint needs assessments</strong></td>
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<td>Prep/ASAP</td>
<td>Prepare for the assessment</td>
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<td>Collect secondary data</td>
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<tr>
<td>Ongoing</td>
<td>Collect primary data</td>
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<td>Ongoing</td>
<td>Analyse and disseminate</td>
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<td><strong>Performance Target:</strong></td>
<td><strong>Select and implement harmonised technical IYCF-E interventions</strong></td>
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<td>Week 1</td>
<td><strong>Put basic multi-sectoral actions in place</strong></td>
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<tr>
<td>Week 1</td>
<td>a) Prioritise PLW for access to essential</td>
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<tr>
<td>Week 1</td>
<td>b) Keep children with their mothers, fathers, family or other caregivers</td>
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<td>Week 1</td>
<td>c) Register households with PLW, children 0–23 months and higher risk groups</td>
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<td>Week 1</td>
<td>d) Provide privacy and space to breastfeed</td>
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<td>Week 1</td>
<td>e) Disseminate consistent, clear and accurate information on IYCF-E</td>
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<tr>
<td>Week 2 - 8</td>
<td>Select and implement harmonised technical IYCF-E interventions</td>
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<td>5</td>
<td><strong>Advocate and Communicate</strong></td>
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<td><strong>Performance Target:</strong></td>
<td><strong>3 key advocacy asks on IYCF-E included in the NiE response advocacy strategy</strong></td>
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<td>Week 2 - 8</td>
<td>Ensure relevant sectors and coordination mechanisms have IYCF Champions</td>
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<td>Week 2 - 8</td>
<td>Advocate to other sectors to implement and IYCF-E Friendly Response</td>
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<td>Week 2 - 8</td>
<td>Advocate to the military, local and national authorities to support IYCF-E</td>
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<td>Week 2 - 8</td>
<td>Support communities to advocate for the needs of infants and young children</td>
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<tr>
<td>Week 2 - 8</td>
<td>Engage with the media to improve the quantity and quality of reporting on issues impacting infants, young children and their caregivers.</td>
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<td>6</td>
<td><strong>Prevent inappropriate donations and unsafe distributions</strong></td>
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<tr>
<td><strong>Performance Target:</strong></td>
<td><strong>A body is designated for reporting on BMS Act violations and dealing with donations of BMS, commercial complementary foods, other milk products, bottles and teats within 72 hours</strong></td>
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<tr>
<td>Week 1</td>
<td><strong>Prevent inappropriate donations from arriving</strong></td>
</tr>
<tr>
<td>Prep/ASAP</td>
<td>a) Communicate the position of the GoB on donations to donors and potential distributors</td>
</tr>
<tr>
<td>Prep/ASAP</td>
<td>b) Put in place customs and importation control measures</td>
</tr>
<tr>
<td>Week 2 - 8</td>
<td>c) Engage with donors and distributors and raise awareness on the dangers of breastmilk substitutes in emergencies</td>
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<tr>
<td>Week 2 - 8</td>
<td>d) Repeatedly sensitise key actors including other sectors</td>
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<tr>
<td>Week 1</td>
<td><strong>Prevent inappropriate products from being distributed in an uncontrolled manner</strong></td>
</tr>
<tr>
<td>Prep/ASAP</td>
<td>a) Collaborate with the Logistics Cluster (NC partners) and Site/Camp Management</td>
</tr>
<tr>
<td>Prep/ASAP</td>
<td>b) Collaborate with the Deputy Commissioner</td>
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<tr>
<td>Prep/ASAP</td>
<td>c) Collaborate with the military</td>
</tr>
<tr>
<td>Week 1</td>
<td><strong>Manage products which have arrived</strong></td>
</tr>
<tr>
<td>Week 1</td>
<td>a) Monitor and report donations and inappropriate distributions</td>
</tr>
<tr>
<td>Week 2 – 8</td>
<td>b) Establish a local taskforce to handle donated and inappropriate relief items</td>
</tr>
<tr>
<td>Week 2 – 8</td>
<td>c) Agree upon a management plan for confiscated items</td>
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<tr>
<td>Week 2 – 8</td>
<td>d) Document and learn</td>
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<td>7</td>
<td><strong>Build Capacity</strong></td>
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<tr>
<td><strong>Performance Target:</strong></td>
<td><strong>IYCF-E capacity building plan is drafted within 1st month</strong></td>
</tr>
<tr>
<td>Prep</td>
<td>Roll out formal training in preparedness</td>
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<tr>
<td>Week 2 – 8</td>
<td>Carry out a gap analysis and develop a capacity building plan</td>
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<tr>
<td>Week 2 – 8</td>
<td>Implement short term capacity building activities (orientation, info sharing, supportive supervision)</td>
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<tr>
<td>Month 3 - 6</td>
<td>Implement medium term capacity building activities (formal training)</td>
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<td>8</td>
<td><strong>Monitor, Evaluate, Be Accountable and Learn</strong></td>
</tr>
<tr>
<td><strong>Performance Target:</strong></td>
<td><strong>Complaints mechanisms are in place within IYCF-E programmes within 1st month</strong></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Monitor IYCF-E activities using harmonised indicators within existing monitoring systems</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Involve the affected population at all stages of the emergency response</td>
</tr>
</tbody>
</table>
2.1 ACTION: Adhere to key policies and operational standards

STANDARD: Safe and appropriate IYCF for the population is protected through implementation of key policy guidance.

Policies define the operating environment for agencies, who are all expected to commit to, and comply with, national policy. Policies provide guidance, a common understanding and can offer protection to PLWs, infants and young children. For example, by respecting the provisions of the Bangladesh BMS Act 2013, mothers and caregivers are protected from receiving misleading messages regarding the feeding needs of their children through inappropriate marketing or the uncontrolled distribution of breastmilk substitutes.

IYCF-E Activities for Action 2.1

1. Consult preparedness plans, policies and procedures and identify critical gaps
2. Integrate IYCF policies into agreements with partners and implementing agencies
3. Release a joint statement on IYCF-E
4. Widely disseminate policies that are most relevant and advocate for them to be upheld
5. Activate a clear mechanism to detect, report and act upon violations of the Bangladesh BMS Act 2013

1. Consult preparedness plans, policies and procedures and identify critical gaps

At the start of the emergency, assess which policies and plans are in place at a national and agency-level. (As part of Context Analysis – Action 2.3) If existing policy is outdated, absent or is found not to adequately address the new emergency context, it may be necessary to develop interim guidance. This shall be done under the leadership of IPHN in consultation with Nutrition Cluster Partners and technical groups such as the IYCF Alliance.

BE PREPARED: Ensure that national and agency policies are up-to-date and address all of the following elements in the context of an emergency, in line with the guidance issued in this document:

- Protection, promotion and support of breastfeeding
- Minimising the risk associated with artificial feeding
- Appropriate complementary feeding
- The nutrition needs of pregnant and lactating women
- Compliance with The Bangladesh BMS Act 2013
- Prevention of donations and blanket distributions of breastmilk substitutes
- Infant feeding in the context of public health emergencies and infectious disease outbreaks

2. Integrate IYCF policies into agreements with partners and implementing agencies

Organisations who are authorised by the GoB to operate in Bangladesh are expected to design and implement IYCF-E activities in compliance with national guidance, policy and the minimum standards of this guideline.

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27 Operational standards include this document, as well as broader GoB and Nutrition Cluster operational standards.
➢ To ensure this is upheld, put accountability mechanisms in place.

For example, funders of humanitarian response activities should include requirements to demonstrate how partners will comply with The Bangladesh BMS Act 2013 within proposals.

3. Release a joint statement on IYCF-E

➢ Release an inter-agency joint statement (JS) within the first week of an emergency.

The JS is an advocacy tool which clarifies the government’s position on donations and distributions, highlights relevant policy and provides context-specific guidance, harmonises communication and calls for action from stakeholders. Timely development and release during the first phase of emergency response is crucial.\(^{28}\)

The process will be led by the Nutrition Cluster Coordinators (NCCs) as follows:

a) Identify and agree upon who will be the immediate issuing agencies and 3–5 named signatories\(^{29}\) for the joint statement. This will usually be IPHN/NNS and relevant UN agencies.

b) Using the JS Template (Annex A2) contextualise the Joint Statement for the current emergency

c) Share the Joint Statement with NC partners for rapid review and consensus building (48 hours)

d) Issue the statement and disseminate as widely as possible

➢ Main signatories and NC partners to widely share the Joint Statement beyond the nutrition sector, including to government agencies, local authorities, the military, community leaders, civil society and voluntary organisations, local and international NGOs, academic institutions, potential donors (both institutional and the private sector) and responders across all sectors, amongst others.

**BE PREPARED:** Secure preliminary approval for a draft joint statement and a plan for its dissemination

4. Widely disseminate policies that are most relevant and advocate for them to be upheld

During the context analysis at the start of the emergency, assess which policies are in place at a national level and decide which ones should be prioritised for advocacy and monitoring of adherence (consider relevance to the emergency context, the potential lifesaving impact and level of implementation required). For example, it might not be possible to attain the high standards required for Baby Friendly Hospital Initiative (BFHI) accreditation in an emergency, but it should be possible to meet a number of important steps which ensure that the principles of the BFHI policy are complied with and its main goal is worked towards i.e. that all newborns initiate breastfeeding within 1 hour after birth, even during an emergency.

➢ XXX to disseminate the policies which have been identified as a priority to all relevant responders across sectors, including media groups, the private sector, donors, the military and volunteer groups, and advocate for them to be upheld.

\(^{28}\) During protracted crises, the joint statement should be reissued on a yearly basis and at key moments e.g. significant change in context, guidance or during key advocacy opportunities e.g. World Breastfeeding Week.

\(^{29}\) It is beneficial if additional agencies endorse the Joint Statement i.e. are added to the original signatories. However, do not wait for these endorsements to come through before releasing the initial statement as agencies’ varying approval processes can result in delays. The initial focus should be on rapid issuance; a statement endorsed by further agencies can be circulated later on.
## 2.2 ACTION: Coordinate

**STANDARD:** Coordination ensures safe, timely and appropriate infant and young child feeding is protected during emergencies

### IYCF-E Activities for Action 2.2

1. **MOHFW** to confirm the IYCF-E coordination authority (72 hours)
2. **NC Team** to (re-)sensitise partners on IYCF-E coordination mechanism ways of working
3. **NC Team and members** to identify the need for an IYCF-E TWG and establish one if necessary
4. **NC Team** to identify relevant coordination structures and fora for widely sharing information related to infants, young children and PLWs and advocating for a streamlined IYCF-E response
5. **XXX** to identify IYCF champions (See Action 2.5) in strategic coordination mechanisms beyond the NC to ensure IYCF-E is taken into consideration in decision making processes for an IYCF-E sensitive response

During complex or large-scale emergencies, the needs of the affected population are often too large to be met by a single entity. Effective coordination is therefore needed among stakeholders planning and delivering assistance to the affected population. This is done through bringing humanitarian actors together, strategic planning, gathering data and managing information, mobilising resources, ensuring accountability, orchestrating a functional division of labour, negotiating and maintaining a serviceable framework and providing leadership. The goal of alleviating suffering and saving lives is shared by many stakeholders responding to emergencies. However, government authorities, non-governmental agencies (both national and international), donors, development partners and the affected population in emergencies have different expectations and interests as well as different roles and responsibilities in coordinating humanitarian assistance.

### 2.2.1 Coordination Structure in Bangladesh

The Cluster Approach has been adopted by the Government of Bangladesh (GoB) to coordinate emergency preparedness and response in Bangladesh. The approach is not formally supported by the Inter-Agency Standing Committee (IASC) approved cluster, however in the event of a large-scale emergency the decision may be taken by the IASC to formally activate the cluster approach. Country-wide humanitarian nutrition activities are coordinated by the National Nutrition Cluster (NC). The NC functions under the overall coordination of the Humanitarian Coordination Task Team (HCTT), as outlined in Figure 1 below.

![Figure 1 - Disaster Coordination Bangladesh](https://interagencystandingcommittee.org/)

30 [https://interagencystandingcommittee.org/](https://interagencystandingcommittee.org/)
2.2.2 The National Nutrition Cluster
The National Nutrition Cluster (NC) was initially activated in Bangladesh in 2012. The NC is jointly led by UNICEF and Institute for Public Health Nutrition (IPHN) under the Ministry of Health and Family Welfare (MOHFW). Both actors share equal responsibilities and work together in partnership as co-leads. The aim of the NC in Bangladesh is to support the Government of Bangladesh (GoB) in the coordination of effective nutrition emergency preparedness and response to humanitarian crises that meets core commitments and standards through strengthening the collective capacity of humanitarian actors working in the area of nutrition in Bangladesh. At sub-national level, the civil surgeon leads the district-level nutrition coordination, while UNICEF’s District Nutrition Support Officers (DNSO) act as facilitators and co-lead.

2.2.3 IYCF-E Coordination Roles

| IPHN | • lead coordination authority on IYCF-E in Bangladesh |
| UNICEF | • supports IPHN with the coordination of IYCF-E in Bangladesh  
  • mandated at a global level to coordinate IYCF-E in humanitarian situations |
| UNHCR | • mandated at a global level to coordinate IYCF-E responses in refugee response |
| WFP | • responsible for mobilising food assistance in emergencies in a manner that upholds the provisions of the Operational Guidance on IYCF-E (2017) |
| WHO | • responsible for supporting Bangladesh’s MOHFW to prepare for, respond to and recover from emergencies with public health consequences |
| Nutrition Cluster Partners | • expected to actively participate in relevant cluster coordination meetings and activities as stipulated in the NC Terms of Reference (TOR). |

2.2.4 IYCF-E Coordination Structure
Coordination responsibilities and roles should be identified, made clear and agreed by all stakeholders during emergency preparedness or early response.

In Bangladesh, IYCF-E activities are coordinated by the Nutrition Cluster. It is the Nutrition Cluster’s responsibility to ensure that adequate IYCF-E coordination mechanisms are in place. This involves country-wide mapping of existing capacity (technical, human resource, financial and operational). The NC may undertake activities to address identified gaps from results of the mapping exercise such as organizing of relevant IYCF-E training, advocating for funding for identified gaps, recruitment or secondment of additional staff or collaboration / partnership with another agency. Where a partner agency is identified to undertake coordination activities, the Nutrition Cluster remains accountable for ensuring an adequate, appropriate and timely IYCF-E response.
The level of coordination, including whether a dedicated IYCF E Coordinator is necessary, will depend on the nature and scale of the emergency. Whenever possible, IPHN should be supported to fulfil their coordination role and existing country-level structures and mechanisms should be respected.

During a large-scale or complex emergency, it may be necessary to establish an IYCF-E Technical Working Group (TWG). The need for this will be identified by the Nutrition Cluster Coordination team and members. TWGs develop and agree upon minimum standards and formulate the most appropriate technical practices with which to attain those standards\(^{31}\). Because TWGs are put in place to meet specific needs, they should be dissolved once those needs have been met. Nutrition cluster partners will self-select who is best placed to participate in the TWG, based on organisations’ thematic focus, available technical skills, interests and capacities. There should be no more than 12 – 15 members in the IYCF-E TWG. The IYCF-E TWG is co-chaired by a competent Nutrition Cluster partner and IPHN. Establish a clear Terms of Reference for the TWG – ideally drafted in preparedness. (Annexe A3) The IYCF-E TWG provides regular updates to the Nutrition Cluster during coordination meetings.

In line with the Bangladesh National Nutrition Policy 2015, it is also important to coordinate with other sectors to identify opportunities for multi-sector collaboration in needs assessment and programming and to inform sector policies, action plans and risk management regarding IYCF-E. Those working independently of mainstream coordination mechanisms, such as the military or volunteer groups, should also be identified and engaged with.

2.2.5 Nutrition Cluster Responsibilities

Coordination provides context-specific, technically informed direction on IYCF-E to all responders, identifies critical vulnerabilities and response gaps and acts to ensure these are quickly addressed and monitors the adequacy of response. In close collaboration with government and sector / cluster partners, IYCF-E coordination authority responsibilities include:

- Undertake contextual analysis of existing baseline data, including pre-emergency secondary data.
- Map and continually update country-wide existing IYCF-E capacity to immediately inform actions.
- Ensure IYCF-E is included in early/multi-sector/rapid needs assessment; advise on standard and context-specific indicator use; provide IYCF-E situational analysis; ascertain need for and direct further needs assessments.
- Ensure IYCF-E interventions are included and accurately reflected in emergency funding calls and flash appeals.
- Appraise the adequacy of existing policy guidance and direct, as necessary, policy updates, stop-gap guidance development and joint statements.
- Develop and oversee implementation of a communication and advocacy strategy.
- Develop a context-specific action plan, drawing on preparedness plans where they exist and in collaboration with other sectors.

• Determine and actively seek the necessary resources and partner capacity to support action plan implementation.
• Coordinate breastfeeding support and complementary feeding interventions.
• Coordinate the management of artificial feeding, as necessary.
• Mitigate and manage risks regarding the humanitarian response, including prevention and management of donations of BMS, infant foods, milk products, complementary foods, donor human milk and feeding equipment.
• Provide adapted guidance where IYCF-E programming response is compromised.
• Be alert to, avoid and manage conflicts of interest, such as when cooperating with the private sector and when securing funding for IYCF-E interventions. Develop interim guidance as necessary to ensure adequate safeguards.
• Monitor the IYCF-E response effort.

The Nutrition Cluster is accountable for the implementation of relevant international and national standards and benchmarks, including the provisions of this guideline, the Sphere Standards, the Bangladesh National Nutrition Policy 2015 and the Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and Accessories Thereof (Regulation of Marketing) Act, 2013.

Where it is not possible to meet all the provisions of this guideline immediately, such as where access to those affected is limited or impossible, critical analysis by the Nutrition Cluster, IPHN, UNICEF, WHO and, where applicable, UNHCR will be essential to provide context-specific guidance on appropriate actions and acceptable compromises. In this event, partners should consult with the Nutrition Cluster.

2.3 ACTION: Assess the Situation

Coordinated assessments ensure that communities and people affected by crisis receive assistance that is appropriate to their needs.

Critical analysis and needs assessments should inform the development of a response which is appropriate for the context and the emergency and designed to effectively meet the needs of the disaster-affected population. Assessments provide an understanding of a hazard situation and a clear analysis of threats to life, dignity, health and livelihoods. They involve systematically gathering and analysing information relating to the needs, conditions, and capacities of persons of concern – infants, young children and their caregivers – in order to determine gaps between a current situation and agreed standards. Through an assessment it can be determined, in consultation with relevant authorities and communities, whether assistance is required and, if so, the kind of assistance needed. Responders should invest in gathering reliable, accurate, systematic and coordinated information.

In Bangladesh, the Humanitarian Coordination Task Team (HCT) strives to conduct Coordinated / Joint Needs Assessments (C/JNA) in the first phases of emergency response. C/JNAs involve multiple organisations working alongside each other to identify top shared priorities for the whole humanitarian community. It is critical to ensure that the needs of infants, young children and their caregivers are considered during early assessments.

This section provides guidance on using assessments as a tool to design an IYCF-E response, through providing an overview of appropriate methodologies and types of information to collect for each phase.

Regardless of the phase of the response, all assessments are composed of the following steps:

32 How to Conduct a Food Security Assessment. IFRC, 2006.
1. Prepare for the assessment

All assessments require a certain amount of preparation, including selecting appropriate methodologies and standard tools, budgeting adequately\(^3\), selecting and training assessment teams, informing and coordinating with local authorities, informing communities and making logistics arrangements.

Regardless of who is leading on preparations (e.g. HCTT for early joint needs assessments), NC partners should ensure that the needs of infants and young children are considered to a level that is adequate for the type of assessment. For example, **ensure that multi-sector rapid assessment teams always have at least 1 person oriented on IYCF-E**.

Defining the objectives of the assessment

A key preparatory step is to clearly define the **objectives** of the assessment so that the necessary information is gathered in a focused manner and to ensure that resources and people’s time are not wasted collecting or sharing unnecessary information. Determining the **purpose** of the information collected (i.e. why it should be

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\(^3\) For example - staff costs, translation costs, transportation, communication, security, stationary, IT equipment, printing of questionnaires/tablets, voice recorders.
collected and how it will be used) is one of the best ways to clarify the specific goals of an assessment. Collect and analyse only the data that is required for the specified decision-making task.

For example, during early rapid needs assessments the objective should be to obtain critical information which is necessary to save and sustain the lives of infants and young children. Assessment of acute needs and difficulties that expose children to the greatest risk should be prioritised. Objectives can include:

i) To understand the scale and severity of the crisis
ii) To estimate the number of infants and young children in need
iii) To establish key priorities
iv) To define access constraints

Early assessments should also aim to detect ALERTS (Box 2) which indicate that infants and young children may be at risk. Alerts should prompt the Bangladesh Minimum IYCF-E Response Package to be initiated. Alerts also indicate which areas future in-depth IYCF-E assessments should focus on.

**Box 2 - ALERTS THAT INDICATE INFANTS AND YOUNG CHILDREN ARE AT RISK**

- Poor pre-emergency IYCF practices
  - Exclusive breastfeeding prevalence < 50%
  - Continued breastfeeding at 1-year prevalence <70%
- Reports of infant or maternal illness / death
- Mothers reporting difficulties / stopping breastfeeding
- Reports of non-breastfed infants under 6 months of age
- Requests for infant formula from the affected community
- Poor accessibility/ availability of safe and nutritionally adequate complementary foods
- Infants under 6 months of age presenting with acute malnutrition
- Infants 6 – 23 months of age and mothers presenting with acute malnutrition
- Visibly thin infants / infants who are too weak or feeble to suckle
- Reports of separated or orphaned infants
- Reports of donations / untargeted distributions of infant formula and other milk products
- Lack of cooking / feeding utensils, fuel or space for safe food preparation
- Caregivers voicing concerns regarding feeding their infants and young children
- Reports of increased rates of diarrhoea in children 0 – 23 months of age
- Global Acute Malnutrition prevalence above 5%

The objectives of sector-led, in-depth IYCF-E assessments later on in the response could be:

- to understand how the crisis has impacted infant and young child feeding practices
- to obtain detailed and statistically representative data on IYCF practices
- to define and quantify needs in terms of IYCF-E programming and operations
- to capture representative views of the affected population through joint consultation

The purpose of such in-depth assessments is usually to inform detailed programmatic and operational planning and design of the IYCF-E response, or to adjust the ongoing response so that it is better suited to meet the needs of the affected population.

2. Collect secondary data

Maximum use should be made of available secondary data. Collecting secondary data means accessing existing information which has already been collected for other purposes. This includes information collected
before the crisis and during the crisis. Review the best available background information (secondary data) to obtain general information about the situation and to avoid unnecessarily collecting primary data.

**BE PREPARED:** Develop an IYCF situation profile in preparedness to inform early decision making and immediate action (to be updated at emergency onset).

**HOW is secondary data collected?**
Secondary data is collected through a desk review using the best available sources. These include:

- Demographic Health Survey (DHS)
- Multiple Indicator Cluster Surveys (MICS)
- State of Food Security and Nutrition in Bangladesh (FSNSP)
- KAP studies
- World Breastfeeding Trends Initiative (WBTi): Bangladesh Country Profile
- WHO and UNICEF databases
- Assessments implemented by clusters and partners
- Post-emergency evaluations (from previous emergencies) – lessons learned
- Previous flash appeals and Humanitarian Response Plans (HRP)
- Comprehensive Food Security and Vulnerability Analysis (CFSVA)
- Secondary data reviews and briefing notes

**WHAT information should be collected?**
Collecting **pre-crisis secondary IYCF data** at the start of a response tells us about the realities facing infants and young children before the onset of the disaster, which allows anticipation of the likely challenges that will be encountered and type of response needed. It is important that **sub-optimal feeding practices** are identified, as these become riskier in emergency settings. It is equally important to identify **optimal feeding practices**, so that they can be protected. Collect secondary data on:

- **Pre-emergency feeding practices**: breastfeeding initiation in newborns; exclusive breastfeeding in infants under six months; non-breastfed infants under six months; continued breastfeeding at one year and at two years; timely initiation of complementary feeding; minimum acceptable diet; bottle feeding (at any age);
- Population **knowledge and attitudes** regarding IYCF.
- Common complementary foods used and their sources.
- Local acceptability of **relactation and wet nursing**
- Local perceptions of child **disability** and associated feeding and care practices.

Other contextual information which is relevant to IYCF includes secondary data on:

35 District level IYCF situation profiles can be developed for high-risk districts which are vulnerable to emergencies
36 https://dhsprogram.com/Publications/Publication-Search.cfm?ctry_id=1&country=Bangladesh
37 http://mics.unicef.org/surveys
38 http://sph.bracu.ac.bd/index.php/publications/fsnspreport
39 http://worldbreastfeedingtrends.org/country-report-wbti/
40 UNICEF Research and Reports: www.unicef.org/reports
WHO Global Database on Malnutrition: www.who.int/nutgrowthdb/en/
UNICEF Data: https://data.unicef.org/topic/nutrition/infant-and-young-child-feeding/
WHO Global Databank on IYCF: http://www.who.int/nutrition/databases/infantfeeding/en/
Nutrition Landscape Information System (NLis): http://www.who.int/nutrition/nlis/en/
41 Assessment registry: https://www.humanitarianresponse.info/en/operations/bangladesh/assessments
42 ACAPS: https://www.acaps.org/country/bangladesh
Start Network: https://reliefweb.int/country/bgd?source=14437#content
44 Exclusive breastfeeding rate of less than 50% is an alert indicating infants and young children are at risk in an emergency
• **Policy environment**, including relevant national guidance and preparedness plans; policies and protocols on public health emergencies and national food and drug legislation that affects the procurement of commodities.

• **Pre-emergency child nutritional status** including prevalence of acute malnutrition\(^{45}\), stunting and anaemia; and maternal nutritional status, including anaemia prevalence.

• Population **security and access** difficulties, including prevalence of violence against women and girls.

• **Estimated number**\(^{46}\) of children under two years of age and PLW.

• Prevalence/reports of **higher risk** infants, young children and mothers.

• Household **food security**, including access to appropriate complementary foods.

• **WASH environment**, including access to safe water and sanitation, infant faeces disposal practices and social norms on hygiene.

• **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\(^{47}\) (CMR), infant mortality rate\(^{48}\) (IMR) and under-five mortality rate\(^{49}\) (U5MR); coverage of antiretroviral treatment (ART) and support for survivors of Sexual and Gender Based Violence (SGBV)

• **Lessons learned** from previous responses.

3. **Collect primary data**

**HOW is primary data collected?**

**Primary data collection** involves collecting new information using various methods, for the specific purpose of the IYCF-E assessment. **Standardised methodologies** which have been agreed upon by the Nutrition Cluster should be used to allow for standardisation, comparability and quality assurance Table 2 shows which methods to use at which phase of the response.

<table>
<thead>
<tr>
<th>PRIMARY DATA COLLECTION METHODOLOGY</th>
<th>PHASE 1</th>
<th>PHASE 2</th>
<th>PHASE 3</th>
<th>PHASE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>72 hours</td>
<td>Week 1 and 2</td>
<td>Week 2 and 3</td>
<td>Remaining Time</td>
</tr>
<tr>
<td></td>
<td>C/JNA Phase I</td>
<td>C/JNA Phase II</td>
<td>Cluster Led Phase III / Coordinated In-Depth</td>
<td>Cluster Led Phase III / Coordinated In-Depth</td>
</tr>
<tr>
<td>Direct Observation</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Key Informant Interview</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Community Group Assessment (FGD)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Service availability assessment</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Quantitative Survey</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Barrier Analysis</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>+ SECONDARY DATA COLLECTION</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

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\(^{45}\) Global Acute Malnutrition (GAM) prevalence of over 5% is an alert indicating infants and young children are at risk

\(^{46}\) Use the proportion of PLWs and children 0 – 23 months from the latest demographic survey or nutrition survey.

\(^{47}\) Mortality rate among all age groups and due to all causes; typically expressed in units of deaths /1,000 individuals/year

\(^{48}\) The number of deaths of children under one year of age / 1,000 live births.

\(^{49}\) The number of children under five years of age dying / 1,000 live births in a given year
Direct Observation

Direct observation provides a snapshot picture of an affected location. The tools for recording direct observation remind assessment teams what to look for and enable them to make critical sense of those observations. Observations can be used to inform assessment teams what they should ask key informants and community groups, or to confirm what they have been told.

For Phase I and II, standardised multisectoral direct observation tools are available for Bangladesh. Ensure that IYCF-E topics are included; Box 3 includes key observations which can inform IYCF-E programming. An IYCF-E specific Direct Observation Tool for later phases is included in Annexe A4.

Box 3 - KEY DIRECT OBSERVATION QUESTIONS WHICH CAN INFORM THE IYCF-E

1. Does the community have physical access to functioning markets?
2. Can a sufficient quantity and variety of food be observed available at the market?
3. Do people appear to have access to adequate space to hygienically cook/prepare food?
4. Are water points easily and safely accessible to women and children?
5. Are functional handwashing facilities available?
6. Is there adequate privacy for breastfeeding women?
7. Are there any ongoing distributions of milk products, infant formula or feeding bottles?
8. Are there any visibly thin young children or women?

Key Informant Interviews

A key informant interview is when a person with prior knowledge of the affected community is questioned to gather key information on the impact of the disaster and on priority community needs. Key informants may be chosen because of their professional background, leadership role or personal experience. Examples of key informants to interview for an IYCF-E assessment include: community leaders, Imams, health workers, birth attendants, leaders of CBOs working on MNCH.

For Phase I and II, standardised multisectoral key informant interview tools are available for Bangladesh. Always ensure that questions relevant to IYCF-E are included. IYCF-E assessment teams may also approach key informants specific to IYCF-E, who are not likely to be approached by multisectoral assessment teams. An example of a key interview questionnaire is included in Annexe A5. It is recommended to use a semi-structured interview method whereby some important topics to cover and open-ended questions to ask are prepared in advance to aid the assessment team. During Phase III and IV, a structured interview method can be used if the necessary technical expertise and resources are in place to do so.

Community Group Assessment (Focus Group Discussions)

Community group discussions (focus groups) interview groups of 6 – 12 people to discuss a specific subject of common interest or knowledge. These discussions help identify a range of information, because different opinions, views and experiences will be shared. Focus group discussions (FGD) mainly aim at gathering qualitative information.

For Phase II, a standard “Community Group Assessment” questionnaire exists, to be asked to 2 groups of different (heterogenous) men and women. Always ensure that questions relevant to IYCF-E are included, such as:

1. Are mothers facing any difficulties in breastfeeding their children? If yes, what difficulties?

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50 For further guidance: Technical Brief: Direct Observation and Key Informant Interview Techniques for Primary Data Collection during Rapid Assessments. ACAPS, 2015.
51 For further guidance: Guidelines for Conducting Focus Group Discussions. Belfrage and Wigley.
2. Are there difficulties in feeding young children? If yes, what difficulties?
3. Have there been any distributions of milk powder or baby milk (infant formula)? If yes, where and by whom?

During Phase III and IV, more structured FGDs focused on IYCF-E on can be held with homogenous (similar) groups, such as groups of mothers from a similar background. It can be of interest to conduct FGDs among different groups, such as mothers, fathers, other family members, health workers, and community leaders, to see any differences and levels of influence. At this stage, FGDs should be conducted until no new information is gathered (i.e. saturation has been reached). FGDs can be used before a survey to understand the IYCF environment and better define the indicators to be assessed. They can also be used during and after to better understand the findings. A sample FGD questionnaire is available in Annexe A6.

Service Availability Assessment
During Phase II, the assessment team will obtain information on service availability through the Community Group Assessment and through meetings with Upazila officials. During Phase III and IV, the NC Information Management Officer (IMO) will support the mapping of available services for children 0–23 months and their caregivers (across sectors) to enable the identification of gaps in service provision and opportunities to integrate and mainstream IYCF, using the Who, What, Where (When) 3W/4W data collection method. It is imperative that NC partners contribute to this process by sharing information in a timely manner.

Examples of services to map include: CMAM services, Women & Girl Friendly Spaces, Supplementary Feeding Programmes, Reproductive Health Services, Sick Child Consultations and Immunisation Services.

Quantitative Survey
During Phase III, a short, quantitative questionnaire can be administered to a convenient sample of caregivers of children 0–23 months i.e. easy accessible populations such as those gathering at distribution points, collective centres or health facilities if it is necessary to obtain quantitative information to inform lifesaving programming (e.g. estimated number of non-breastfed children). An example can be found in Annexe A7.

During Phase III and IV, the following representative survey methods can be used:

1. Inclusion of relevant IYCF indicators within surveys by other sectors
2. Inclusion of IYCF indicators within SMART surveys
3. IYCF-E Knowledge Attitudes Practices (KAP) Survey

Whenever possible, it is recommended to conduct a household survey (interviewing caregivers of children 0-23 months) that is representative of the population of concern because it gives more robust data on the situation and allows comparison with subsequent surveys and surveys conducted in other locations or by other partners.

52 Groups can be identified by starting with a heterogenous group
53 The same sample size calculation can be used as for random sampling, however there might be a large bias due to the convenient sampling, so it is better not to spend resources and time assessing large numbers. See: IYCF Practices: Collecting and Using Data – Chapter 3 (Care, 2010) for guidance on calculating sample size.
54 Remember that IYCF is a multisectoral issue. Take every opportunity to include relevant IYCF questions. For example, WASH surveys can collect information on infant faeces disposal practices whilst, the Health sector can collect data on Early Initiation of Breastfeeding and the Food Security Sector is well placed to collect data related to Complementary Feeding. Further suggestions in Annexe A9.
55 Note that there are a few limitations when incorporating IYCF within SMART surveys due to the difference in target groups and required sample sizes. This should not be attempted without the necessary technical expertise. Further guidance can be found at: Standard Expanded Nutrition Survey. UNHCR. http://sens.unhcr.org/
57 Exhaustive or random-sampled
➢ Ensure design and planning is done by staff with the necessary experience and technical expertise to design a representative survey (e.g. choose correct sampling methods and calculate an appropriate sample size). Where such capacity is limited at local level, seek regional or global-level specialist support through the NC.

BE PREPARED: GoB and NC partners to identify key personnel who will work on IYCF-E assessments and work toward building assessment capacity.

➢ NC partners to agree upon a harmonised questionnaire which uses standard questions such as those used for the BDHS, MICS and FSNSP in Bangladesh. These questions have been validated and should not be changed without a strong justification as to why it is necessary. Questionnaires which have been adapted to the foods and liquids commonly consumed in Bangladesh may need to be adapted further to the specific survey area or target population. If additional questions need to be developed, the Assessment TWG will lead on their development in consultation with the IYCF-E TWG / Nutrition Cluster.

➢ NC partners to measure standard IYCF indicators developed by WHO/UNICEF\(^{58}\) which have been validated and allow for comparison.

➢ NC partners carrying out surveys to ensure that teams are adequately trained\(^{59}\) on: survey teams, roles & responsibilities, code of conduct, obtaining informed consent, questionnaire, event calendar to determine age, field procedures, segmentation and random number table (if required for assessment), household selection method, special cases and field testing. It is especially important for teams to be trained to determine age with accuracy as age will determine which children are included in the survey and whose data are used to calculate specific indicators\(^{60}\).

Barrier Analysis Survey

Barrier Analyses\(^{61}\) further explore the facilitators and barriers to key IYCF behaviours and help to inform behaviour change interventions. They are typically carried out after a KAP Survey. Agencies planning to carry out a barrier analysis should ensure the necessary technical expertise and resources are available for this type of activity.

WHAT information should be collected?

Collect only what is not already available through secondary data. Primary data collection should focus on determining what has changed and validating data.

During Phase I and II, collect essential information which is required in order to implement lifesaving IYCF-E activities, and to obtain a rough indication of IYCF practices\(^{62}\). For example:

i) Estimated number of children 0 – 23 months affected (0-5, 6 – 23 months)

ii) Estimated number of children 0 – 6 months affected who are not breastfed\(^{63}\)

iii) Estimated number of pregnant and lactating women affected

iv) Location of most vulnerable / most affected groups

v) Current availability of services to support infants, young children and their caregivers

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\(^{58}\) Indicators for assessing infant and young child feeding practices. WHO, 2010.

\(^{59}\) A typical training for a representative IYCF-E survey takes 3 – 4 days (including field testing) and up to 6 days if SMART anthropometry is included.

\(^{60}\) Guidelines for estimating the Month and Year of Birth of Young Children. FAO, 2008.


\(^{62}\) For further guidance on rapid IYCF-E assessments: Fact Sheet on IYCF practices assessment in emergencies, Tech RRT 2016.

\(^{63}\) Priority information to collect because these children are highly vulnerable and need urgent lifesaving support.
vi) Presence of alerts indicating infants and young children are at risk (Box 2) – including whether distributions of infant formula or other milk products have occurred.

During Phase III and IV, information collected during Phase I and II can be verified, adjusted, determined with greater precision and collected in greater depth. New information can also be collected to better inform and adapt the design of the response, and to determine which additional activities should be implemented in addition to the Bangladesh Minimum IYCF-E Package. (See: Action 2.4) A list of relevant topics to include in IYCF-E Needs Assessments is included in Annexe A8.

At this stage, indicators can start to be measured through representative surveys. Priority indicators of interest during an emergency response in Bangladesh are likely to include those that measure the following feeding practices:

1. Children ever breastfed
2. Early initiation of breastfeeding
3. Exclusive breastfeeding under 6 months
4. Continued breastfeeding at two years
5. Timely introduction of complementary feeding
6. Minimum Acceptable Diet
7. Bottle Feeding
8. Not Breastfed
9. Frequency of breastfeeding

Data Disaggregation
Disaggregate data for children under two years old by sex and age as follows: 0-5 months, 6-8 months, 9-11 months, 12-23 months, pregnant, lactating. Depending on the context, it may be necessary to disaggregate further by other relevant factors such as ethnicity or geographic location.

Interpreting Results
Take into account special circumstances, such as seasonality, that might affect availability and affordability of some foods as well as care practices. Use relevant multi-sector data, such as WASH and health reports.

➢ Hold a joint analysis session during which findings can be validated, interpreted and complemented by experts from other sectors and disciplines.

Results can be compared with results from other surveys conducted in Bangladesh (e.g. DHS surveys) or results of previous surveys, if available. IYCF assessment results form just one part of the research required to inform programme design. While important, data from assessments should be complemented with additional information such as availability, affordability and price of nutrient-dense foods.

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65 The choice of indicators to measure should be based on the objectives of the survey, analysis of the situation (including pre-crisis data), potential impact of the emergency on specific IYCF practices, the gaps in information and resources available.
66 An adapted indicator should be used where the denominator should be infants born since onset of the emergency.
67 Composite indicators (Minimum Dietary Diversity, Minimum Meal Frequency)
68 IYCF Practices. Collecting and Using Data: A Step-by-Step Guide. Care, 2010
Disseminating Results
Share the methodology used as well as any assumptions, biases, limitations or gaps while adhering to data-sharing principles. Assessment results should be shared with:

- The Nutrition Cluster / Sector Information Management Officer
- Other relevant clusters
- Upazila officials
- Assessed communities

2.4 ACTION: Select and Implement appropriate Interventions

**STANDARD:** Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks, is culturally sensitive and optimises nutrition, health and survival outcomes

IYCF-E Activities for Action 2.4

1. Put basic multi-sectoral actions in place
2. Select and implement harmonised technical IYCF-E interventions

The Bangladesh Minimum IYCF-E Package is composed of Basic Multi-sectoral Actions and Core IYCF-E Interventions.

1. Put basic multi-sectoral actions in place

Basic interventions involve non-specialised support which can be undertaken by any sector in support of infant and young children, and their caregivers. They are a minimum response in every emergency.

- Prioritise PLW for access to essential services
- Keep children with their mothers, fathers, family or other caregivers
- Register households with PLW, children 0 – 23 months and higher risk groups
- Provide privacy and space to breastfeed
- Disseminate standardised, clear and accurate messages on IYCF-E
- Adopt an MHPSS approach

2. Select and implement harmonised IYCF-E interventions

The Core IYCF-E Interventions are standard activities to be implemented as part of any Nutrition Response in Bangladesh (Table 3). These should be started as soon as the Joint Needs Assessment findings indicate that a humanitarian response is necessary. In addition to the Core IYCF-E Interventions, select additional activities as necessary. The type and design of these additional interventions is based on an analysis of the context and needs assessments. Prioritise lifesaving interventions.
### Table 3 - Core Interventions of the Bangladesh Minimum IYCF-E Package

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Chapter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education and Information Sharing</td>
<td>Chapter 3.1</td>
</tr>
<tr>
<td>Basic Frontline Feeding Support</td>
<td>Chapter 3.3</td>
</tr>
<tr>
<td>Establishment of supportive spaces</td>
<td>Chapter 3.4</td>
</tr>
<tr>
<td>Support for early initiation of exclusive breastfeeding</td>
<td>Chapter 3.5</td>
</tr>
<tr>
<td>Skilled IYCF counselling for pregnant and breastfeeding mothers</td>
<td>Chapter 3.5</td>
</tr>
<tr>
<td>Further feeding support to particularly vulnerable infants and young children</td>
<td>Chapters 3.6, 3.7, and 3.13</td>
</tr>
<tr>
<td>Management of infants who are not breastfed</td>
<td>Chapter 3.7</td>
</tr>
<tr>
<td>Timely, safe, adequate and appropriate complementary feeding</td>
<td>Chapter 3.8</td>
</tr>
<tr>
<td>Nutrition Care and Counselling for PLWs</td>
<td>Chapter 3.9</td>
</tr>
</tbody>
</table>

➔ **See:** [Chapter 3](#) for guidance on implementation of the above activities.

### 2.5 ACTION: Advocate and Communicate

**KEY ACTION:** Support timely, harmonised and accurate communication on IYCF-E to the affected population, emergency responders and the media

Advocacy educates and motivates policy makers, decision makers and other stakeholders to act and support measures that will create an enabling environment for caregivers to implement recommended IYCF practices despite being affected by an emergency and to minimize feeding related risks during emergencies.

**IYCF-E Activities for Action 2.5**

1. Ensure IYCF-E is included in the nutrition response’s advocacy strategy
2. Ensure relevant sectors and coordination mechanisms have IYCF Champions
3. Advocate to other sectors to implement and IYCF-E Friendly Response
4. Advocate to the military, local and national authorities to support IYCF-E
5. Support communities to advocate for the needs of infants and young children
6. Engage with the media to improve the quantity and quality of reporting on issues impacting infants, young children and their caregivers.

1. **Ensure IYCF-E is included in the nutrition response’s advocacy strategy**

Referring back to the stakeholder mapping carried out as part of the context analysis (See: Action 2.3), identify the main stakeholders who should be targeted, or be involved with, advocacy activities concerning Nutrition in Emergencies, and IYCF-E in particular. Identify existing networks, such as the IYCF Alliance. Examples of who to target with advocacy include donors, higher level coordination structures and the general public.

**Who are they? What do they do? What are their plans? What are their resources? What are their priorities?**

**The Nutrition Cluster** is the lead on ensuring the needs of infants, young children and their caregivers are adequately represented within the sector’s advocacy efforts.

➔ **NC partners** to produce a brief document which outlines priority advocacy actions for the Nutrition Cluster (NC). Within the strategy, answer the following questions:
**What do we want? Who can make it happen? What do they need to hear? Who do they need to hear it from? How can we make sure they hear it? How can we tell if it is working?**

Examples of delivery mechanisms include humanitarian coordination meetings, media briefs and donor briefing notes. Messages should be compelling, targeted, tested and backed up by evidence whenever possible. Consider what type of emergency you are dealing with and how much time, human resources and/or funding stakeholders have available to allocate for IYCF-E. Consistent messages used by all partners make them more memorable and credible. NC partners should agree on a limited number of priorities and advocate for these in a unified manner. For example, advocate for...

- Government to adequately include IYCF-E within emergency preparedness plans and actions
- Donors to increase funding and support for IYCF-E programmes, including preparedness
- Responders to improve availability of complementary foods children 6 – 23 months
- Site managers to allocate sufficient space to enable women to comfortably breastfeed in privacy
- All sectors to consider the needs of infants and young children within the overall response
- The private sector not to send donations of infant formula or milk powder

**Example advocacy message:**

Funding skilled breastfeeding counsellors to support mothers to continue breastfeeding is a critical means of preventing malnutrition, illness and death amongst babies.

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### 2. Ensure relevant sectors and coordination mechanisms have IYCF Champions

It is important that, from the beginning of an emergency, someone advocates for the needs of infants and young children to be taken into account. Without such a person, IYCF-E is often overlooked during emergencies. **An IYCF Champion** is an individual who is willing to strongly support and advocate for IYCF, especially during coordination at the early stages of an emergency.

- **XXX** to ensure all sectors working with children under 2 and their caregivers have at least 1 IYCF Champion at both national and local level.
- **NC partners** to identify promising IYCF Champions during capacity building activities and to provide them with ongoing support in becoming IYCF Champions

**Who should be an IYCF Champion?**

- Someone who is passionate about the needs of infants, young children and their caregivers
- Someone with good interpersonal and communication skills
- Someone who is listened to and is able to influence decisions
- From any sector - no previous experience of IYCF-E or background in nutrition is required

**What should an IYCF Champion do?**

- Participate in coordination mechanisms and advocate for IYCF-E to be taken into account
- Speak out against inappropriate donations or distributions within their sector
- Advocate for funds to be allocated to IYCF-E in multi-sector strategies and proposals
- Advocate for IYCF-E to be considered during needs assessments
- Identify opportunities for integration of IYCF-E within their sector and suggest integrated activities
3. Advocate to other sectors to implement an IYCF-E Friendly Response

All sectors have a responsibility to protect, promote and support appropriate IYCF practices during emergencies; this cannot be achieved by the nutrition sector alone. Sensitise other sectors on IYCF-E as early in the response as possible, and at all levels of coordination, so that the needs of infants and young children are kept in mind during needs assessments and various sectors’ response design and planning activities.

➢ At an inter-cluster /sector coordination meeting, XXX to provide a brief sensitisation session on the importance of IYCF-E and the responsibilities that other sectors have in ensuring that appropriate IYCF practices are protected, promoted and supported during emergencies. Agree on plans to sensitise various sectors.

➢ At various cluster / sector coordination meetings, NC partners to provide a brief, targeted sensitisation session on the importance of IYCF-E, the common objectives that IYCF-E shares with the relevant sector and what the priority integrated activities are. (See Action 2.9) Invite those who are interested to attend the IYCF-E TWG or other relevant coordination fora, and agree on plans to hold orientation workshops. (See ACTION 2.7: Build Capacity)

4. Advocate to the military, national and local authorities to support IYCF-E

➢ IPHN in collaboration with NC partners to provide targeted orientation for military personnel and relevant authorities involved with emergency response, with particular attention given to creating an enabling environment for IYCF-E, supporting basic multisectoral actions and preventing inappropriate donations from entering the affected area and preventing inappropriate distributions from occurring. (See ACTION 2.7: Build Capacity)

5. Support communities to advocate for the needs of infants and young children

Community ownership is essential. Involving disaster-affected communities in preparing and sharing advocacy messages is a vital way to gain credibility and bring added strength to advocacy efforts. Start by engaging with community leaders and representatives, influential community members and caregivers.

Communicate with them about the risks to infants and young children in the given situation, available services, IYCF practices, as well as feedback and complaints mechanisms. Support them advocate for themselves whenever possible. Regularly discuss and agree with the community what the priority needs are. Ensure these discussions are reflected in wider advocacy messages.

6. Engage with the media to improve the quantity and quality of reporting on issues impacting infants, young children and their caregivers.

Agencies working on IYCF-E have an important role to play in protecting infants in emergencies by presenting accurate information to the public and the media and to prevent harmful aid from occurring. The media in turn also has a crucial role to play by, for example, not supporting appeals for donations of infant formula or spreading unhelpful disaster myths. Broadcast and print media has a very strong reach in Bangladesh, especially among policy makers and opinion leaders (Alive and Thrive, 2013). Media advocacy can be an effective means of raising awareness and increasing support for disaster affected communities.

Possible activities to effectively engage the media can include:

- Orientation sessions, briefings, press releases and site visits for journalists. (Annexe A10)
- Provision of guidance on how to communicate about IYCF-E (Annexe A11) to agency spokespersons.
• Release of communications guidance and key talking points for harmonised used by responders.

**2.6 ACTION: Prevent Inappropriate donations and unsafe distributions**

Stakeholders should not call for, support, accept or distribute donations of Breastmilk Substitutes (BMS), other milk products, infant foods, commercially manufactured complementary foods or feeding equipment.

Blanket (i.e. general, untargeted) distributions should never be used as a platform to supply Breastmilk Substitutes or products which may be used as a breastmilk replacement, such as powdered or liquid milk.

Box 4 and Box 5 explain why there should be no donations or uncontrolled distributions respectively.

<table>
<thead>
<tr>
<th>NO DONATIONS</th>
<th>NO GENERAL (BLANKET) DISTRIBUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breastmilk Substitutes <em>e.g. infant formula</em></td>
<td>Breastmilk Substitutes</td>
</tr>
<tr>
<td>Donor Human Milk</td>
<td>Donor Human Milk</td>
</tr>
<tr>
<td>Other milk products <em>e.g. powdered milk</em></td>
<td>Other milk products</td>
</tr>
<tr>
<td>Infant Foods</td>
<td>Infant Foods</td>
</tr>
<tr>
<td>Commercial Complementary Foods</td>
<td></td>
</tr>
<tr>
<td>Feeding Accessories <em>e.g. bottles and teats</em></td>
<td>Feeding Accessories*</td>
</tr>
</tbody>
</table>

*Note that distribution of open cups, cooking utensils and feeding utensils such as cutlery and plates are permitted.

**Key Activities for Action 2.7**

**Prevent inappropriate donations from arriving**

• Communicate the position of the GoB on donations to donors and potential distributors
• Put in place customs and importation control measures
• Engage with donors and distributors and raise awareness on the dangers of BMS
• Repeatedly sensitise key actors including other sectors

**Prevent inappropriate products from being distributed in an uncontrolled manner**

• Collaborate with the Logistics Cluster and Site/Camp Management
• Collaborate with the Deputy Commissioner
• Collaborate with the Military

**Manage products which have arrived**

• Monitor and report donations and inappropriate distributions
• Establish a local taskforce to handle donated and inappropriate relief items
• Agree upon a management plan for confiscated items
• Document and learn

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69 To date, there is little experience with the use of formal donor human milk in emergency settings. The use of donor human milk in an emergency is likely to be a more viable option where there are existing human milk banks in the emergency-affected area, that are integrated into broader infant feeding programmes, and where key conditions are met. The key conditions that need to be in place for 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 pasteurization, and the establishment and maintenance of a cold chain to preserve quality and safety. Until and unless these conditions can be met, the use of formal donor human milk is not currently recommended as an appropriate intervention for emergency responses in Bangladesh.
1. Prevent inappropriate donations from arriving

Communicate the position of the GoB on donations to donors and potential distributors

➢ GoB to lead on ensuring its position on donations and distributions is made clear, including which items will and will not be accepted.
➢ IPHN/NNS to ensure relevant authorities and coordination mechanisms receive a copy of the GoB position on donations for inclusion in various GoB response documents and directives being issued.
➢ Nutrition Cluster to identify potential donors and distributors who should be reached with information. Identification should be started in preparedness and include a review of past responses. Use this information to develop a dissemination plan which various NC partners will contribute to.
➢ Nutrition Cluster to ensure this information is included as part of the Joint Statement (See: Action 2.1)

Put in place customs and importation control measures

➢ MoDMR to (re-)issue directives to customs officials detailing which items are restricted and what actions to take upon receiving restricted items.
➢ XXX to sensitise customs officials and others assigned to dealing with the entry of humanitarian cargo into Bangladesh on the Bangladesh BMS Act 2013, MoDMR directives and the importance of preventing donations of unwanted and inappropriate items.

These actions should ideally be done in preparedness, with a refresher provided early on in the response. Breastmilk substitutes, other milk products, commercially manufactured complementary foods, bottles and teats should be included in customs procedures for humanitarian organisations. Incoming shipments without clear packing lists detailing contents should not be accepted. Items that are restricted, not prohibited, should be allowed to enter if they have obtained proper approvals. For example, infant formula that has been purchased by a registered agency (under the Bangladesh BMS Act 2013) for use in approved BMS activities (See: Support for infants who are not breastfed) should be cleared for entry.

➢ Customs to keep clear records (source, type, quantity) and to communicate on a fortnightly basis to XXX who will share information with the Nutrition Cluster and <agency responsible for enforcing BMS Act>

Engage with donors and distributors

➢ NC partners to monitor online media and share any reports of donations or uncontrolled distributions so that identified donors and distributors can be targeted.

Upon identification, the Nutrition Cluster (or IYCF-E TWG if operational) should rapidly identify an agency who is best suited to engage with the particular donor or distributor and provide guidance on what actions are most appropriate. It is important to understand why the donation was made (e.g. news reports) to inform messaging and future prevention efforts. Such discussions should be supported by standardised messages and materials which have been agreed upon by the Nutrition Cluster. Communications should:

- State that donations of BMS, infant foods, commercially manufactured complementary foods, bottles and teats are not needed and expose infants and young children to malnutrition, illness and death
- Raise awareness on relevant authorities, legislation and the consequences of violations
- State what the actual need for BMS is in the disaster affected community (usually far lower than perceived) and what is being done to meet this need (See: Support for Non-Breastfed Infants)

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70 To include those who are responsible for receiving or pre-positioning relief items e.g. the Ministry of Disaster Management and Relief, The Ministry of Women and Child Affairs, The LCG-DER, XXXXX

71 Examples include: country embassies, the private sector, donors, development partners or civil society groups.
o Provide guidance on appropriate alternative items or ways to support the health and wellbeing of disaster-affected children and their caregivers.

Where there have been requests for donations, investigate the reasons behind those requests and determine whether further action is necessary (for example, community messaging or a BMS programme).

**BOX 4: WHY SHOULD DONATIONS NOT BE ACCEPTED?**

Donations of breastmilk substitutes, infant foods, commercially manufactured complementary foods and accessories therefor a violations of the Bangladesh BMS Act 2013.

During emergencies, donations of breastmilk substitutes (such as infant formula) may occur. This is dangerous and unnecessary. Such donations are often of variable quality, of the wrong type, supplied disproportionate to need, near or past their expiry date, labelled in the wrong language, not accompanied by an essential package of care (See: Support for Non-Breastfed Infants), distributed indiscriminately, not targeted to those who need them, do not provide a sustained supply and take excessive time and resources to manage in order to mitigate associated risks. Donations and blanket distributions of breastmilk substitutes can negatively impact breastfeeding practices for many years, well beyond the end of an emergency.

Donations and general distributions of other milk products (such as powdered milk) are also dangerous during emergencies. There are food handling and safety concerns in emergency settings, and powdered milk products may be mixed with unsafe water leading to high levels of bacterial contamination, diarrhoea and potentially, mortality. UHT milk is a growth medium for bacteria once the packaging is opened. There is also a high risk that such milk products will be used as a replacement for breastmilk, even if they are not provided for that purpose. This is known as spill over risk. The nutritional benefits of a general distribution of milk to emergency-affected children and adults are outweighed by the risk posed to younger children and infants.

Donations of commercially manufactured complementary foods also carry risks, including that they may not meet nutritional and safety standards\(^1\), BMS Act 2013 labelling requirements, or global guidelines\(^1\). They may also be culturally inappropriate and undermine local food use or recommended IYCF practices. Note that safe, nutritionally adequate non-commercial complementary foods which have been purchased by an implementing agency may be distributed.

For donated foods that are not designed as complementary foods but could be used for feeding children 6 – 23 months old, 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 of such foods are being considered or have been received, consult with the Nutrition Cluster regarding their appropriateness and/or management.

Feeding equipment\(^1\), with the exception of open cups or spoon used for cup- or spoon-feeding, should also not be donated or distributed. Feeding bottles and artificial teats are unsafe to use during emergencies. Breastfeeding supplementary feeding devices and breast pumps are difficult to keep clean in most emergency settings; if their use is vital they may be purchased by those who are part of the emergency health or nutrition response for use in a facility where it is possible to clean them adequately, such as in a clinical setting overseen by a registered medical practitioner.
Repeatedly sensitise key actors
➢ IPHN/NSS in collaboration with NC Partners to sensitise key actors

Sensitisation should ideally begin in preparedness and be repeated every 2 months during emergency response to address high turnover of emergency responders. Topics to cover include:

i) The importance of preventing donations and blanket distributions of restricted products
ii) The provisions of the Bangladesh BMS Act 2013 and the Joint Statement
iii) Practical guidance on actions to take, including monitoring and reporting mechanisms

Key target groups for sensitisation include: GoB agencies receiving foreign donations e.g. XXX, government agencies responsible for prepositioning or receiving relief items at national and sub-national level e.g. MWCA, XXX, local authorities e.g. District Disaster Management Committees, the military, community leaders, Civil Society Organisations, volunteer groups and local NGOs, the private sector, the media and various clusters – prioritising logistics, nutrition, health, child protection and food security clusters.

2. Prevent inappropriate products from being distributed

STANDARD: There is NO general distribution of powdered or liquid milk as a single commodity

BOX 5: WHY SHOULD SOME ITEMS NOT BE DISTRIBUTED IN A BLANKET MANNER?

It is common for donations to be distributed in a blanket manner. Products which have been purchased may also be distributed in a blanket manner by those who are unaware of global and national guidance and legislation, including by sectors other than nutrition. Blanket distributions are a violation of Clause 4 (g) of the Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and Accessories Thereof (Regulation of Marketing) Act, 2013 and Clause 3 of the Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and Accessories Thereof (Regulation of Marketing) Rules 2018.

It is important that blanket distributions of breastmilk substitutes are prevented because they place children at risk. This is because they may be fed to children who would otherwise be breastfed, because they cannot be accompanied by adequate levels of information and education, because they do not provide a sustained supply and because it is unlikely that all recipients will have sufficient equipment, fuel and water for safe preparation.

Any reports of donations or blanket distributions must be actively managed by the Nutrition Cluster.

Note that this section addresses general distributions (See: definitions). This is different from the targeted provision of appropriate breastmilk substitutes to infants who need them. (See: Support for Non-Breastfed Infants)

Collaborate with the Logistics Cluster and Site / Camp Management
➢ NC Team to approach the logistics cluster as well as site/camp managers, ideally in preparedness, to help prevent an influx of unwanted and unsuitable donations. Wording on the shipment and storage of restricted products can be included in the operational procedures for the Logistics Cluster. (Annexe A12)
Collaborate with the Deputy Commissioner

In anticipation of an emergency, the Deputy Commissioner (DC) will request the Director General, DRR, for relief items to be prepositioned. Furthermore, all incoming donations must be screened at Deputy Commissioner (DC) level and can only be distributed once written approval has been granted. It is therefore imperative that the Nutrition Cluster engages with the DC’s office on this issue.

- **IPHN/NNS** to ensure that the DC office is aware which products should not be cleared for distribution
- **NC partners** to ensure that that DC office personnel are included in relevant sensitisation activities
- **XXX** and the DC to establish ways of working to handle (confiscate, store, dispose of) inappropriate products

Collaborate with the military

The national military is an arm of the GoB tasked to respond to emergencies in Bangladesh.

- **MOHFW** to ensure that military is aware which products should not be cleared for distribution. Note that Officers-in-Charge (OIC) are rotated regularly so repeat sensitisation is likely to be necessary.
- **XXX** to establish clear communication lines for handling inappropriate products, where the military is involved with receiving/distributing items.
- **NC Team** to raise awareness of the issue and address operational issues through **Coordination Cell Meetings**, when activated

### 3. Manage products which have arrived

Monitor for and report donations and inappropriate distributions

- **NC cluster** to activate the monitoring mechanism (**Distribution Alert System – DAS**) to detect and report planned or ongoing uncontrolled distributions or other BMS Act 2013 violations (Table 4)
- Sensitise stakeholders on legislation
- **NC cluster** to systematically share information, including reports of violations, with **IPHN** and the **Bangladesh Breastfeeding Foundation** for action (e.g. enforcement) at national level.

A standard online form (**Annexe A13**) can be used for reporting by frontline health and nutrition workers, local authorities, NGO staff and others. Frontline workers should integrate monitoring into their daily activities. Train and support community leaders to monitor and report to the **Civil Surgeon** if they do not have access to online reporting. Regularly analyse monitoring data and ensure it is used for action.

Emergency responders should support any ongoing national efforts to monitor and enforce the **Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and Accessories Thereof (Regulation of Marketing) Act, 2013 (BMS Act 2013) & BMS Rule 2018**.

| Table 4 - Actions to undertake to activate the Distribution Alert System |
|---|---|---|
| Action | Responsible | When |
| Train frontline nutrition actors on the DAS | NC Partners | Preparedness |
| Circulate link to form and reporting instructions | NC Team | Early Warning Immediate (Wk. 1) |
| Orient other frontline actors (authorities, other sectors) and community leaders on the DAS | NC Partners | Short Term (Wk. 2 – 8) |
| Analyse overall data and share with NC / IYCF-E TWG / Taskforce to inform prevention efforts | Taskforce / NC IMO | Every month |
Establish a local taskforce to handle donated and inappropriate relief items

- **NC Team** to lead on rapidly setting up a local **Donations Task Force** that will address donations, inappropriate distributions and other violations of the BMS Act 2013 & BMS Rule 2018. The taskforce will be comprised of approximately 4-6 members, including:
  1. Representative of Institute for Public Health Nutrition (IPHN)
  2. Representative from the Deputy Commissioner’s Office
  3. Representative of UNICEF or UNHCR (See: Coordination)
  4. Representative from the Logistics Cluster (WFP)
  5. Representative of agency designated to handle donations and other confiscated items

The task force is responsible for: developing the emergency-specific management plan, guiding the designated management agency and ensuring information is fed into national monitoring and enforcement mechanisms.

Agree upon a management plan for confiscated items

- **The Task Force** to finalise a **context-specific management plan** (Template – **Annexe A14**) to deal with donated and other inappropriate relief items and other BMS Act 2013 violations and seek approval from the IPHN Director / National Advisory Committee. The following elements should be included in the management plan:
  i) Identification of designated management agency
  ii) Means of receiving alerts / reports
  iii) Collection and transportation
  iv) Storage
  v) Sorting
  vi) Handling
  vii) Security
  viii) Communication

- **The designated management agency** (identified by IPHN) is assigned to:
  i) Collect and store donations and inappropriate relief items
  ii) Handle donations
  iii) Keep accurate records of the donations (source, type, quantity, condition etc.)
  iv) Provide weekly reports to the Taskforce

The default management agency is <government agency/authority>. Day to day management activities may be delegated to / supported by a suitable NC partner in the event of a large-scale emergency. Ensure that all essential components (Table 5) are in place so the designated management agency can carry out their duties.

| Table 5- Components required for successful implementation of management plan |
|-------------------------------|-----------------------------|
| Funding                       | BMS Act 2013, & BMS Rule 2018, Stock Management, Waste Management |
| Human Resources               | One focal person to manage  |

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72 as constituted under Rule 7 of the BMS Rules 2018
Teams for sorting and handling

<table>
<thead>
<tr>
<th>Teams for sorting and handling</th>
<th>Storage Facilities</th>
<th>For storage of confiscated items until they are dealt with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>For transportation of staff and confiscated items</td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td>For lifting, storage, destruction</td>
<td></td>
</tr>
<tr>
<td>Materials</td>
<td>Reporting Forms, Health &amp; Safety incl. gloves, masks, boots</td>
<td></td>
</tr>
</tbody>
</table>

*Figure 5 - Handling options for donations. Note that school/elderly feeding programmes can only be implemented in controlled environments once the situation has stabilised. Further guidance on the various options to handle donations can be found in Annexe A14.*
The term “handling” should be understood to refer either to using the product in another way (which minimises the risks) or to its destruction. Figure 5 outlines how products can be handled. Further details can be found in Annexe A14.

Document and learn
To document learning and improve the effectiveness of future actions taken in response to donations and distributions, a database should be maintained. (Annexe B5). This information should be regularly analysed to better understand how to prevent and effectively manage future violations.

2.7 ACTION: Build Capacity

STANDARD: Emergency-affected PLWs have access to skilled IYCF counselling.

Building the capacity of individuals, communities, agencies and the health system to support or implement IYCF-E activities is necessary at multiple levels and across sectors.

The quality of an IYCF-E response relies on sensitised decision makers from relevant sectors and the availability of trained staff. There are different competencies required for different aspects of the IYCF-E response, ranging from basic awareness to specialised technical capacity. The majority of capacity building activities should be carried out in preparedness, with IYCF-E integrated into national capacity building efforts for longer term IYCF programming. Despite these efforts, it is likely that some capacity building activities will need to take place during an emergency. For example, program planners may not be aware about IYCF-E, the workforce itself may have been affected by the emergency, the demand for services may have greatly increased or service providers may need support in adjusting to a new context and new ways of working.

IYCF-E Activities for Action 2.7

1. Roll out formal sensitisation and training activities in preparedness
2. Carry out a gap analysis and develop a capacity building plan at the start of the response
3. Implement short and medium-term capacity building activities

KEY TERMINOLOGY

Sensitisation – short session aimed at raising basic awareness on IYCF-E, preventing harm and increasing support for collaboration and integration. Sensitisation is usually targeted at decision- and policy makers and programme planners (Preparedness and Short Term).

Orientation – condensed action-oriented, skills-focused training activity aimed at sharing information and /or instructions to rapidly improve awareness and understanding of IYCF-E programming (including key policies, resources and actions) and to equip participants with the basic resources, knowledge and skills required to support or implement priority IYCF-E activities. (Short Term)

Training – in-depth activity aimed at sharing comprehensive information and / or instructions to strengthen specialized technical capacity for IYCF-E programming and to equip participants with a thorough set of resources, knowledge and skills required to support or implement IYCF-E activities. Topics are covered in greater detail than during orientation. (Preparedness and Medium Term)

73 The ability of individuals and agencies to perform functions, solve problems and achieve objectives
74 National Strategy on IYCF in Bangladesh (2007) – Strategy 7: Knowledge and skills of health service providers
Table 6 - Priority target groups of sensitisation, orientation and training

<table>
<thead>
<tr>
<th>WHO</th>
<th>PHASE 0</th>
<th>PHASE 1</th>
<th>PHASE 2</th>
<th>PHASE 3</th>
<th>PHASE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preparedness</td>
<td>72 hours</td>
<td>Week 1 and 2</td>
<td>Week 2 and 3</td>
<td>Remaining Time</td>
</tr>
<tr>
<td>Health and Nutrition programme managers, coordinators and advisers</td>
<td>Training (5 days)</td>
<td>Sensitisation (15 minutes)</td>
<td>Orientation (1 day)</td>
<td>Training (5 days)</td>
<td></td>
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<tr>
<td>(government and NGO)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Health service providers (in training)</td>
<td>Pre-service education (25 hours)</td>
<td>Orientation (1 day)</td>
<td>Training (3 days)</td>
<td></td>
<td></td>
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<tr>
<td>Health service providers (in service)</td>
<td>In-service training</td>
<td>Orientation (1 day)</td>
<td>Training (3 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Based Health Workers and Volunteers (in service)</td>
<td>In-service training</td>
<td>Orientation (30 minutes)</td>
<td>Training (2 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IYCF Counsellors</td>
<td>Training (5 days)</td>
<td>Refresher Orientation (1 day)</td>
<td>Orientation (2 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Policy &amp; Coordination Bodies</td>
<td>Sensitisation (1 hour)</td>
<td>Sensitisation (15 minutes)</td>
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<tr>
<td>E.g. National Disaster Management Advisory Committee, Co-ordination Committee of NGOs relating to Disaster Management</td>
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<tr>
<td>Local Level Coordination Leaders E.g. District Commissioner</td>
<td>Sensitisation (1 hour)</td>
<td>Sensitisation (15 minutes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Level Coordination Personnel E.g. District Disaster Management Committee</td>
<td>Training (1 day)</td>
<td>Sensitisation (15 minutes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local NGOs / CSOs / Volunteer Organisations</td>
<td>Training (1 – 2 days)</td>
<td>Orientation (½ day)</td>
<td>Training (1 – 2 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Humanitarian Coordination Task Team</td>
<td>Sensitisation (1 hour)</td>
<td>Sensitisation (15 minutes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Programme managers, coordinators and advisers from sectors other than nutrition</td>
<td>Training (1 – 2 days)</td>
<td>Sensitisation (15 minutes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Customs, military, logistics personnel</td>
<td>Training (½ day)</td>
<td>Sensitisation (30 minutes)</td>
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<tr>
<td>Media</td>
<td>Training (1 day)</td>
<td>Orientation (2 hours)</td>
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</tbody>
</table>

75 IYCF-E topics should be integrated into existing education curricula wherever possible, rather than as standalone training.

1. **Roll out formal sensitisation and training activities in preparedness**

   1. Training of trainers: national and district level GoB and NGO representatives
   2. Roll out of trainings to priority target groups (Table X)
   3. Implement follow up plan (and, where relevant, supportive supervision/mentoring)
   4. Refresher training (every 2 years) to address staff turnover and revitalise / update knowledge and skills

As part of wider capacity development efforts, MOHFW in collaboration with NC partners will **roll out formal sensitisation and training** of priority target groups (Table 6) in **preparedness** through a **pool of expert trainers** to ensure the necessary knowledge, skills and attitudes (*See Annexe A15 and A16 for required competencies*) are in places to implement an appropriate and effective IYCF-E response in a timely manner. **Standardised** national sensitisation and training curricula will be used for this purpose.

2. **Carry out a gap analysis and develop a capacity building plan**

   Significant capacity to implement IYCF programmes already exists in Bangladesh. At the start of the emergency, NC partners will contribute to a **rapid capacity mapping** at local level to identify gaps in coordination, trainers, staffing levels, knowledge and skills necessary to implement an IYCF-E response. (*Annexes A15 and 16*)

   The IYCF-E TWG will take responsibility for:
   
   a. Assessing existing capacity and identifying IYCF-E capacity building needs among NC partners
   b. Identifying IYCF-E training and capacity building opportunities for emergency responders
   c. Collecting the information required to develop a feasible capacity building plan

   Based on the results from the capacity mapping exercise, NC partners should ensure that appropriate short and medium-term IYCF-E capacity building activities are included in the **Nutrition Cluster’s capacity building plan**. NC partners will contribute operational and / or technical resources for the implementation of this plan (e.g. hosting orientation and training or loaning technical experts to facilitate sessions). Collaboration with national trainers and experts with prior IYCF-E experience and knowledge of the affected population is preferred when possible.

   Each capacity building activity should have a clear set of objectives to meet specific gaps in planning and coordination, IYCF-E service provision or performance, and use **standardised materials** which have been reviewed and agreed upon by the NC/IYCF-E TWG. Use **existing** national IYCF/IYCF-E training materials.

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77 Standardised training curricula used for training during emergencies should be adapted to the specific emergency context
78 Periodic formal capacity mapping should be carried out by IPHN during normal times (See Action 2.3 – Service availability assessment and capacity mapping) to inform nationwide capacity building activities.
80 It is recommended that a database of trained personnel (by topic) is maintained. In MOHFW, this can be integrated into existing HRIS of DGHS/DGFP.
81 DIPSHIKA – Competency Based Training on Nutrition (2016) and National Training Manual on IYCF (2011)
wherever possible. The NC/IYCF-E TWG will agree on how to adapt and prioritise existing materials and whether additional topics / capacity building activities (See Box 6) are needed based on the context (e.g. type of emergency), gaps in knowledge and skills, and time available given the phase of the emergency. Prioritise training on essential activities to meet minimum standards at the start of the response.

**Box 6 - Technical topics to consider for capacity building during emergencies**

- The importance of supporting IYCF in Emergencies
- IYCF-E Response Strategy / Overview of IYCF-E Interventions
- Contextual information (impact of the emergency, sociocultural considerations etc.)
- Available services and referral pathway
- Complementary feeding and maternal nutrition in the context of food insecurity
- Monitoring and reporting blanket distributions and other BMS Act violations (See 2.6)
- Setting up and running Supportive Spaces (See 3.2)
- Breastfeeding in emergencies (including stress and malnutrition) (See 3.7)
- Feeding support for vulnerable infants and young children (See 3.4)
- IYCF in the context of infectious disease outbreaks (See 3.9)
- Mental Health and Psychosocial Support (MHPSS) in Emergencies (See 3.8)
- Early Childhood Development (ECD) in Emergencies (See 3.8)

**3. Implement short and medium-term capacity building activities**

NC partners should ensure that capacity building activities do not limit the human resources available on the ground to deliver the IYCF-E response.

In the short term, implement the following 3 capacity building activities:

1. Sensitisation and Orientation
2. Sharing of information, best practices, experiences and learning
3. Supportive supervision and mentoring

Where training of trainers (TOT) has not been carried out in preparedness, it will be necessary to first train GoB and NGO staff on the necessary skills (including supportive supervision) to roll out the above activities.

In the medium term, roll out formal training activities (see 1.) to scale up and expand services and strengthen quality. Formal training activities can be started earlier if necessary (e.g. to train newly recruited staff), provided they do not remove much needed human resources from the response for extended periods of time. It is preferable to roll out formal training in preparedness, with action oriented, skills-focused orientation sessions targeting and response-specific priorities and gaps at the start of the response.

**Orientation**

NC partners should prioritise target groups who have not undergone sensitisation or training in preparedness for rapid sensitisation and/or orientation at the start of an emergency.
Standardised national sensitisation and orientation curricula\(^{82}\) will be used for this purpose, and will be delivered by a group of master trainers\(^{83}\) composed of national level and district level GoB and NGO representatives.

Accompany orientation sessions with written guidance notes\(^{84}\) and visual training materials\(^{85}\) for participants to refer back to. Close follow up and guidance should be provided following orientation.

It is important to organise regular opportunities (e.g. brief orientation workshops, refresher sessions) where problems that have been observed can be addressed or where new information can be offered.

Sharing of information, best practices, experiences and learning

Chairs of relevant fora will routinely allocate time for implementing partners, local authorities and other emergency responders to share new developments, experiences, innovations, best practices and lessons learned with other partners and colleagues in appropriate fora such as Nutrition Cluster, Health Cluster and Food Cluster meetings.

Supportive Supervision and Mentoring

Supportive supervision / mentoring is a collaborative effort between a supervisor and a health worker to help the health worker improve his/her knowledge, confidence and skills and thereby to improve the quality of services. The HW should feel motivated by the process and encouraged to continue improving their skills. The visit aims to:

   a. Promote and support quality, standardised services
   b. Monitor activity level and coverage

Up to 12 health workers should be supported by 1 supervisor\(^{86}\). Supportive supervision and mentoring should be intensified during an emergency, particularly when new staff have been recruited or staff have not undergone full formal training (in preparedness) prior to commencing activities. The first supportive supervision visit for each trainee should be within 4 weeks following orientation and / or training, after which staff should be visited according to a regular schedule (monthly or more).

If access to facilities is difficult to the emergency, ensure that remote support measures\(^{87}\) are put in place, such as regularly scheduled telephone support.

Supervisors should take into account that locally recruited staff may themselves have been affected by the emergency; therefore supervisors should be sensitive to the psychosocial wellbeing of their staff.

- Records\(^{88}\) of trained individuals must be kept as part of supportive supervision to assess how many trainees are in service, in order to track turnover of trained staff and to plan new trainings.
- Standardised supportive supervision/mentoring tools should be used by all responders\(^{89}\).
- Monthly team meetings should be held to provide feedback on team performance, share experiences and problems for joint problem solving, discuss results and share information and skills addressing common or new issues.

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\(^{82}\) Standardised training curricula used for training during emergencies should be adapted to the specific emergency context

\(^{83}\) It is recommended that a database of national trainers and experts is maintained by IPHN and regularly updated.

\(^{84}\) Guidance notes should refer participants to further resources as well as contact details for further support

\(^{85}\) Alive and Thrive [http://www.healthphone.org/aliveandthrive/bangladesh.htm](http://www.healthphone.org/aliveandthrive/bangladesh.htm)

\(^{86}\) National Training Manual on IYCF.

\(^{87}\) For further learning: [www.disasterready.org](http://www.disasterready.org) (Remote Management as an Operational Mode Online Learning)

\(^{88}\) DIPSISHIKA Competency Based Training in Nutrition – Module II (2016) Tool 7A and 7B

\(^{89}\) DIPSISHIKA Competency Based Training in Nutrition – Module II (2016) Tool 3A and 6A
2.8 ACTION: Monitor, Evaluate, Be Accountable and Learn

STANDARD: The performance of humanitarian agencies is continually examined and communicated to stakeholders; projects are adapted in response to performance.

Key Activities for Action 2.8

1. Monitor IYCF-E activities using harmonised indicators within existing monitoring systems
2. Involve the affected population at all stages of the emergency response
3. Document experiences to inform preparedness and future response

1. Monitor IYCF-E activities using harmonised indicators within existing monitoring systems

It is essential to monitor the impact of humanitarian action or inaction on IYCF practices, child nutrition and health. Monitoring is undertaken at Nutrition Cluster Level to track the implementation of the NC’s response strategy, and NC partners’ collective contribution to the overall response, through feeding standardised indicators into the Nutrition Cluster monitoring and reporting system.

IYCF-E support should be delivered as part of the NC’s response strategy which has a clearly defined goal and objectives (Table 7) and includes outcome indicators and process/output indicators.

<table>
<thead>
<tr>
<th>Table 7 - Goals and Objectives of the IYCF-E Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall goal:</td>
</tr>
<tr>
<td>Specific objectives:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Target Population:</td>
</tr>
</tbody>
</table>

Outcome indicators (Annexe B2) which reflect the effect of interventions should be measured using standard indicators and definitions. Priority outcome indicators to measure during emergencies are:

1. Early initiation of breastfeeding
2. Exclusive Breastfeeding under 6 months
3. Continued breastfeeding up to 2 years of age
4. Timely introduction of complementary foods
5. Minimum Acceptable Diet (6-23 months)
6. Minimum Dietary Diversity for women

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91 Composite indicator calculated from Minimum Dietary Diversity and Minimum Meal Frequency.
These indicators need to be measured before92, during and after an intervention to show progress and impact. Data on outcome indicators may be collected periodically, starting during an emergency, with ongoing follow-up in subsequent months or years. Methodologies to measure outcome indicators during longer-term emergencies include:
- KAP Surveys
- Incorporation of IYCF indicators within SMART Surveys
- <cluster reporting mechanisms>.

Ensure that key IYCF indicators are also captured within the Health Information System (HIS)

**Harmonised output/process indicators** (e.g. number of staff trained. *Annexe B3*) will be used across agencies / partners to measure the quality, quantity, coverage93 and utilisation of services and programmes. NC partners are expected to report on a minimum list of IYCF indicators (*Annexe B4*), according to the type of activity they are implementing, on a monthly94 basis. **Targets** for indicators will be defined at the start of the emergency response, based on the local emergency context. Monitoring will be done using standardised recording and reporting forms (*Annexes B7 and B8*) for Core IYCF-E Interventions.

**Disaggregate data**, at a minimum, by age (0 – 5m, 6 – 8m, 9 – 11m, 12- 24m) and gender. As soon as possible, disaggregate by vulnerable groups, including disability.

The NC will also track its collective progress towards implementing the Framework for Action against the performance targets listed at the start of this chapter (*Annexe B1*).

2. **Involve the affected population at all stages of the emergency response (be accountable)**

Those implementing IYCF-E activities are accountable to those they seek to reach i.e. children pregnant women, children 0 – 23 months and their caregivers. GoB partners granted permission to operate in Bangladesh are also accountable for respecting and upholding the polices and norms put in place by the GoB to protect its people.

Monitoring and evaluation activities should regularly involve affected communities, including during planning and during discussion of assessment results and their implications. Key conclusions from M&E activities should be distributed to all relevant stakeholders, including MOHFW, NC partners and the target population.

Aim to actively seek the views of the affected population, including through implementing safe and responsive95 feedback and complaints mechanisms96,97 (for example – XXXX). Consult PLWs and caregivers on children 0 – 23 months what type of mechanism would be accessible to them and what barriers they may face in complaining. When appropriate, arrange feedback sessions with the community in order to (confidentially) share the feedback and discuss the actions being taken to address it.

3. **Document experiences to inform preparedness and future response (learn)**

Agencies are encouraged to systematically capture lessons learned from responses, in order to strengthen and adjust these guidelines as needed. Once such example is The Framework for Action Performance Tracker (*Annexe B1*) within which reasons why performance targets were not achieved should be noted. An analysis of these reasons, as well as the NC’s successes, should be part of evaluations led by the Nutrition Cluster.

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92 Do not delay the start of emergency activities because baseline indicators have not yet been collected.
93 Coverage of services should be measured using existing coverage survey methods such as SQUEAC.
94 During the first phase of an emergency, weekly reporting may be required.
95 Communicate, receive, process, respond, learn from
96 CHS: Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.
97 http://feedbackmechanisms.org/resources/. For further learning: www.disasterready.org (Beneficiary Feedback Mechanisms)
Similarly, the BMS Act Violation Database (**Annexe BS**) records actions taken in response to violations and their outcomes; these should be analysed to inform future prevention efforts.

Any individual agencies implementing interventions which are relatively new to Bangladesh are encouraged to carefully document their experiences and to evaluate the performance and impact of their intervention, ensuring to systematically involve emergency affected girls, boys, women and men.

### 2.9 ACTION: Collaborate and Integrate with Other Sectors

**STANDARD:** Opportunities are identified and activities are put in place in collaboration with other sectors and the community to facilitate and complement direct IYCF-E interventions

The NC in Bangladesh leads on IYCF-E interventions. However, activities by other sectors/clusters can have a direct impact on IYCF outcomes. For an IYCF-E response to be implemented successfully, IYCF-E has to be mainstreamed and integrated with all other sectors operating in the context. For that to happen, all stakeholders need to have a basic understanding of IYCF-E, even if they are not nutritionists or public health experts, and strong multi-sectoral collaboration needs to be in place. Integration and coordination with other sectors are key enabling factors to ensuring the success of IYCF-E programming and, more broadly, the protection of PLW and their children. **Multisector collaboration is essential in an emergency to facilitate and complement direct IYCF-E interventions.**

IYCF shares **common strategic objectives** with other sectors. Through working together, a greater proportion of the affected population can potentially be reached and greater outcomes achieved than when we work alone. Integration can result in more efficient and cost-effective use of resources, and allows responders to holistically address the multi-sectoral needs of mother-baby pairs.

Common **examples** of integration include IYCF in newborn care or partnership with protection programmes to identify and refer infants that are separated from their mothers and therefore need feeding support.

In line with the **Bangladesh National Nutrition Policy 2015** Objective 5.4 (*strengthen nutrition-sensitive, or indirect, nutrition interventions*) and Objective 5.5 (*strengthen multisectoral programmes and increase coordination among sectors to ensure improved nutrition*), it is therefore imperative that the IYCF-E coordination mechanisms collaborate with other operational clusters/sectors at all levels during emergencies. This chapter provides guidance on possible integrated activities during emergencies, per sector. Which activities are relevant will depend on the phase and type of emergency. In line with section 6.4.5 of the National Nutrition Policy (**Engage all relevant Ministries, Divisions, institutions, civil society and NGOs in nutrition interventions**) IPHN will ensure coordination with relevant ministries and government agencies.

### KEY TERMINOLOGY

- **IYCF-friendly environment:** an environment enabling adequate IYCF practices by protecting and supporting PLW, infants and young children (e.g. giving priority to PLWs)

- **IYCF-sensitive activities:** consider the impact of their actions on IYCF; they are applied in other sectors who work with PLW, infants and young children. (e.g. ensuring the GFD contains foods rich in Vitamin A).

- **IYCF-specific activities:** Activities that directly protect, promote and support adequate IYCF practices; often applied within the nutrition or health sector. (e.g. IYCF counselling)
**Integrated IYCF-E Activities for Action 2.9**

**Government agencies involved in emergency response**

- Respective ministries actively encourage and ensure that mechanisms for linking/coordination between health, nutrition and food security clusters are in place (NPAN 2016 – 2025)

**Nutrition Cluster / Sector Co-Leads**

- Ensure IYCF-E is adequately reflected in **preparedness plans and activities** for ALL relevant sectors
- **Formalise information sharing** relevant to the wellbeing of PLWs and infants and young children between sectors (e.g. debrief following assessments) and set aside time to discuss the implications.
- **Map existing services and community based mechanisms** for PLW and children 0 – 23 months e.g. hold a workshop to bring together all relevant service providers for this target group for information sharing around available services

**Nutrition Cluster Partners**

- Hold **orientation sessions** on IYCF-E for other sectors within the 8 weeks of a response
- Brief all sectors on **donations and items which are prohibited for general distribution**, as well as monitoring and reporting mechanisms for BMS Act 2013 violations
- Encourage IYCF-E staff to participate in **sectoral coordination mechanisms** and working group
- Ensure **IYCF Champions** are in place in various sectoral coordination mechanisms (See: Advocacy)

**All Cluster / Sector partners**

- Develop clear procedures for **identification and referral** between sectors and train staff on referral.
- **Disaggregate assessment and monitoring data** for pregnant women, lactating women, children 0 – 5, 6 – 8, 9 – 11 and 12 – 23 months.
- **Cross-train** teams with a focus on the needs of children 0 – 23 months. Training topics can include:
  - Objectives, activities and ways for working each sector’s programmes
  - Key recommended practices for feeding and caring for children 0 – 23 months
  - Key aspects of other sectoral programmes
  - Joint, contextualised messages
  - Appropriate targeting criteria for both programmes and how to refer
  - Monitoring for and reporting donations and uncontrolled distributions

**Refer to ANNEXE C for sector specific IYCF-E-Sensitive Interventions**
CHAPTER 3: IYCF-E INTERVENTIONS

3.1 Overview

This section (3.1) provides an overview of the IYCF-E Interventions that can be included as part of an emergency nutrition response in Bangladesh. The following sections of this chapter provides further guidance on these interventions, and key considerations and strategies to consider for their implementation.

<table>
<thead>
<tr>
<th>Overall goal:</th>
<th>To protect the nutrition status, growth and development, health, and survival of infants and young children affected by emergencies in Bangladesh</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific objective:</td>
<td>Appropriate infant and young child feeding practices are protected, promoted and supported during emergencies through the provision of timely and appropriate IYCF-E support⁹⁸</td>
</tr>
<tr>
<td>Target Population:</td>
<td>Infants and Young Children (0 – 23 months) and their caregivers Pregnant and Lactating Women (PLW)</td>
</tr>
</tbody>
</table>

⁹⁸ Sphere Standard 3.2: Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks and optimises nutrition, health and survival outcomes.
Table 8 summarises the Bangladesh Minimum IYCF-E Response Package i.e. the standard activities to be implemented as part of any Nutrition Response in Bangladesh. It includes both basic multi-sectoral actions to be applied across all sectors, and core (direct) IYCF-E Interventions to protect promote and support infant and young child feeding during an emergency. These activities are mainly undertaken by nutrition, health and food security actors. Activities indicated in the right-hand column can be implemented in addition to the minimum package based on the emergency context and the needs of the affected population.

Table 8 - Overview of IYCF-E Response Options

<table>
<thead>
<tr>
<th>BANGLADESH MINIMUM IYCF-E PACKAGE</th>
<th>IYCF-E PACKAGE ADDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard activities to be implemented as part of any Nutrition Response</td>
<td>Additional activities to be implemented based on the emergency context and the needs of the affected population</td>
</tr>
<tr>
<td>Basic multi-sectoral actions</td>
<td></td>
</tr>
<tr>
<td>a) Priority access for PLWs to essential services</td>
<td>1. Means to prepare complementary foods</td>
</tr>
<tr>
<td>b) Prevention of separation of children from their caregivers</td>
<td>2. Mental Health and Psychosocial Support</td>
</tr>
<tr>
<td>c) Registration of households with PLW, children 0 – 23 m and higher risk groups</td>
<td>3. Mother Support Groups</td>
</tr>
<tr>
<td>d) Private and safe spaces to breastfeed</td>
<td>4. Mother-Baby Kit Distribution</td>
</tr>
<tr>
<td>e) Standardised, clear and accurate messages on IYCF-E</td>
<td>5. Support and follow up of MNP/BSFP products</td>
</tr>
<tr>
<td>IYCF-E Core Interventions</td>
<td>6. IYCF support during public health emergencies</td>
</tr>
<tr>
<td>1. Establishment of Supportive Spaces (IYCF Corner and/or Mother Baby Area)</td>
<td></td>
</tr>
<tr>
<td>2. Basic Frontline Feeding Support</td>
<td></td>
</tr>
<tr>
<td>3. Group Education &amp; Information sharing</td>
<td></td>
</tr>
<tr>
<td>4. Nutrition care and counselling for PLWs</td>
<td></td>
</tr>
<tr>
<td>5. Support for Early Initiation of Exclusive Breastfeeding</td>
<td></td>
</tr>
<tr>
<td>6. Skilled IYCF Counselling (One-on-one)</td>
<td></td>
</tr>
<tr>
<td>7. Further IYCF support for particularly vulnerable children</td>
<td></td>
</tr>
<tr>
<td>8. Access to safe, adequate and appropriate complementary foods</td>
<td></td>
</tr>
<tr>
<td>9. Management of non-breastfed infants</td>
<td></td>
</tr>
</tbody>
</table>
### Table 9 - Summary Description of IYCF-E Interventions

*Activities in **bold** are core interventions (part of Minimum IYCF-E Package for Bangladesh)*

<table>
<thead>
<tr>
<th>IYCF-E Interventions</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>IYCF Simple Rapid Assessment</td>
<td>A means for frontline workers to rapidly evaluate the IYCF practices of children 0 – 23 months (at individual level) and to identify and refer those who have problems in their feeding practices. Part of Basic Frontline Feeding Support. (Go to Chapter 3.2 - Basic Frontline Feeding Support)</td>
</tr>
<tr>
<td>IYCF Full Assessment</td>
<td>A means for providers trained on IYCF Counselling to gain an in-depth understanding of the IYCF practices of a child 0 – 23 months found to have problems in their feeding practices, in order to determine what type of IYCF support is needed. Part of IYCF Counselling. (Go to Chapter 3.2 - Basic Frontline Feeding Support)</td>
</tr>
<tr>
<td>Supportive Space – IYCF Corner</td>
<td>Spaces which are <em>integrated</em> into other services, such as health facilities, child or women friendly spaces or therapeutic feeding sites. They are spaces where women can quietly and privately breastfeed and receive basic / skilled IYCF support. (Go to Chapter 3.3 – Supportive Spaces)</td>
</tr>
<tr>
<td>Supportive Space – Mother Baby Area</td>
<td>Alone standing spaces within the community that are dedicated to IYCF-E services. They are spaces where caregivers and pregnant women can come with their children to find a supportive space to share experiences with other women, spend time with and care for their baby, receive information, support and guidance and to breastfeed. It is a space where a team of trained professionals can detect nutritional, health and psychosocial issues and provide them with care and skilled support. (Go to Chapter 3.3 – Supportive Spaces)</td>
</tr>
<tr>
<td>Basic Frontline Feeding Support</td>
<td>Assistance provided by trained frontline workers, comprised of Simple Rapid Assessment, Education and Information Sharing (e.g. key messages to support effective breastfeeding), and referral. (Go to Chapter 3.2 - Basic Frontline Feeding Support)</td>
</tr>
<tr>
<td>Group Education &amp; Information Sharing</td>
<td>Any activities during which IYCF information or skills are shared in a manner designed to enhance the ability and motivation of caregivers to voluntarily adopt nutrition-related behaviours conducive to health and wellbeing. This includes family visits, courtyard meetings, mother support groups, community dialogues or caregiver classes where IYCF related topics are discussed or messages are shared.</td>
</tr>
<tr>
<td>Mother Baby Kit Distribution</td>
<td>Kits which safeguard infant and maternal survival and support wellbeing. This intervention may be necessary before caregivers can be receptive to behaviour change activities such as counselling. Examples of kit contents include: soap, reusable diapers, baby vest, baby blanket, breastfeeding scarves, menstrual hygiene items and items to promote mother-baby bonding (such as rattles or baby massage oil).</td>
</tr>
<tr>
<td>Support for Early Initiation</td>
<td>Trained frontline health workers and non-formal providers (such as village doctors) support mothers to put their newborn to the breast within 1 hour after birth. Support includes counselling pregnant women on breastfeeding, facilitating uninterrupted skin-to-skin contact for at least the first hour of life and helping mothers to initiate breastfeeding. (Go to Chapter 3.5 Breastfeeding Support)</td>
</tr>
<tr>
<td>Skilled IYCF Counselling</td>
<td>A conversation between a health or nutrition worker trained on IYCF counselling and a 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</td>
</tr>
</tbody>
</table>
in their particular situation. Counselling is different from education and messaging, and is provided for caregivers who are experiencing difficulties in feeding their children 0–23 months.

<table>
<thead>
<tr>
<th><strong>Further support for particularly vulnerable children</strong></th>
<th>Skilled IYCF support to children in particularly difficult circumstances (e.g. HIV-exposed infants or non-breastfed infants) which requires additional skills and knowledge beyond what is required for regular skilled IYCF counselling activities (<a href="#">Chapter 3.5 - Further support for particularly vulnerable children</a>)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother Support Groups</strong></td>
<td>Mother support groups are groups of women who come together to learn about and discuss issues on IYCF. They hold meetings where PLWs, as well as other people with similar interests, come together in a safe place to exchange ideas, share experiences, give and receive information, and at the same time, offer and receive support in infant and young child feeding and care, and women’s health. Part of Education and Information Sharing.</td>
</tr>
<tr>
<td><strong>Management of non-breastfed infants</strong></td>
<td>Identification, assessment and support for infants who are not breastfed. This includes the exploration of safer feeding options first (i.e. relactation, wet nursing). As a last resort, a breastmilk substitute is provided alongside a package of essential support (including sustained BMS supply, equipment supplies for safe preparation, individual-level, context specific advice, practical training on safe preparation and regular follow up). (<a href="#">Go to Chapter 3.7</a>)</td>
</tr>
<tr>
<td><strong>Access to complementary foods</strong></td>
<td>A range of activities which improve access to safe, nutritious and appropriate complementary foods, such as provision of multiple micronutrient fortified foods through BSFP; home fortification with micronutrient supplements; fresh food vouchers; provision of nutrient rich foods for children 6–23 m in addition to the GFD. (<a href="#">Chapter 3.8</a>)</td>
</tr>
<tr>
<td><strong>Means to prepare complementary foods</strong></td>
<td>A range of activities to ensure caregivers have the means (equipment, fuel, hygienic space etc.) to safely prepare age-appropriate complementary foods e.g. distribution of cooking utensils/feeding equipment; creation of protected eating and playing spaces; communal food preparation areas. Supports both complementary feeding and maternal nutrition. (<a href="#">Chapter 3.8</a>)</td>
</tr>
<tr>
<td><strong>Support and follow up MNP/BSFP products</strong></td>
<td>Trained frontline workers / volunteers verify correct preparation, monitor actual usage of products at household level and provide guidance and practical support when needed. (<a href="#">Chapter 3.8</a>)</td>
</tr>
<tr>
<td><strong>Nutrition care and counselling for PLWs</strong></td>
<td>Activities to support maternal nutrition such as BSFP; vouchers modified to meet PLW nutritional needs; micronutrient supplementation; 1-1 counselling; maternal nutrition screening and referral to treatment. (<a href="#">Chapter 3.9</a>)</td>
</tr>
<tr>
<td><strong>Mental Health and Psychosocial Support</strong></td>
<td>The 2 main activities are: integration of Early Childhood Development into IYCF-E activities; provision of care for caregivers (psychosocial interventions), including support targeted at pregnant women. Responses should also adopt an MHPSS Approach. (<a href="#">Chapter 3.10</a>)</td>
</tr>
<tr>
<td><strong>Public Health Emergencies</strong></td>
<td>Actions to anticipate and mitigate the impact of infectious disease outbreaks on IYCF, including incorporation of feeding recommendations within treatment protocols; standardisation of joint messages; IYCF Corners in treatment facilities. (<a href="#">Chapter 3.12</a>)</td>
</tr>
</tbody>
</table>
Chapter 3.0 is arranged by key IYCF area (such as breastfeeding or complementary feeding). However, several IYCF-E interventions address multiple areas at the same time. For example, both complementary feeding and breastfeeding difficulties can be addressed through IYCF Counselling. These interventions are therefore repeated in each relevant chapter. Table 10 provides an overview of which intervention addresses which area and can be used to identify appropriate interventions to address a certain area. For example, if needs assessment results reflect there are challenges with maternal wellbeing then this table can be used to identify which possible interventions can be implemented to address maternal wellbeing.

<table>
<thead>
<tr>
<th>KEY IYCF-E INTERVENTIONS</th>
<th>Breastfeeding</th>
<th>Complementary Feeding</th>
<th>Artificial Feeding</th>
<th>Maternal Wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Frontline Feeding Support (Includes Simple Rapid Assessment)</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Supportive Space – IYCF Corner</td>
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<tr>
<td>Supportive Space – Mother Baby Area</td>
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<tr>
<td>Group Education and Information Sharing</td>
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<tr>
<td>Mother Baby Kit Distribution</td>
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<tr>
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<tr>
<td>Skilled IYCF Counselling (Includes IYCF Full Assessment)</td>
<td>✔️</td>
<td>✔️</td>
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<td>✔️</td>
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<tr>
<td>Further support for particularly vulnerable children</td>
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<tr>
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<td>Support and follow up MNP/BSFP products</td>
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<tr>
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<td>✔️</td>
</tr>
<tr>
<td>IYCF-E INTERVENTIONS</td>
<td>Health/Nut Facility*</td>
<td>Community</td>
<td>Site/Camp</td>
<td>Outreach/Mobile</td>
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<td>-----------------------------------------------------------</td>
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<tr>
<td>Basic Frontline Feeding Support (Incl. IYCF Simple Rapid Assessment)</td>
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<tr>
<td>Supportive Space – IYCF Corner</td>
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<tr>
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<tr>
<td>Support for Early Initiation</td>
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<tr>
<td>Skilled IYCF Counselling (Incl. IYCF Full Assessment)</td>
<td>✓</td>
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<tr>
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<td>✓</td>
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</tbody>
</table>

= Standard minimum package  = Expanded package (adapted to emergency context and needs)

* Prioritise IYCF support within nutrition services addressing acute malnutrition (e.g. inpatient SAM units and OTPs). Other contact points within which to integrate IYCF-E Activities include growth monitoring and promotion services, antenatal, delivery, and postnatal care services, family planning services, immunisation services and sick child consultations.
Further IYCF-E Support

IYCF-E Support

Basic Multisectoral Actions

IYCF Friendly Environment

- Skilled IYCF Counselling
- Further support for particularly vulnerable children
- Management of non-breastfed infants
- Nutrition care and counselling for PLWs

- Supportive spaces
- Basic Frontline Feeding Support
- Education and information sharing
- Support for Early Initiation of Exclusive Breastfeeding
- Access to safe, adequate and appropriate complementary foods

- Priority access for PLWs to essential services
- Prevention of separation of children from their caregivers
- Registration of households with PLW, children 0 – 23 m and higher risk groups
- Private and safe spaces to breastfeed
- Standardised, clear and accurate messages on IYCF-E

- Policy
- Coordination
- Communication
- Advocacy
- Prevention of inappropriate donations and distributions
3.2 Basic Multisectoral Actions

This section provides guidance on the implementation of basic multisectoral actions which are a standard part of any emergency response in Bangladesh and applicable across sectors.

Prioritise PLW for access to essential services – such as food, water, shelter, healthcare, protection, psychosocial support and other interventions to meet critical needs.

It is not the responsibility of IYCF-E teams to provide all services. It is however their responsibility to:
- Advocate for adequate services to be in place and for PLWs to be prioritised when resources are scare
- Provide information and support (e.g. referrals) to help women access relevant services

To conduct effective referrals, IYCF-E staff should have the following up-to-date, written information:
- Know the precise activity of each referral place, and admission criteria
- Know the exact location
- Know the opening hours and days for new admissions
- Know whether any costs (e.g. fees) are involved

Examples of ways to prioritise PLW and to support them to access services include:
- Enabling priority access or separate queues for PLW to services and commodities
- Provide potable water to PLWs and children (>6months) while waiting in queues
- Prioritise targeted food supplementation and micronutrient supplements for PLW and their children
- Provide security and crowd control so that PLW and their children are not at risk of physical harm
- Provide basic structures that offer women a private space to breastfeed nearby

Keep children with their mothers, fathers, family or other caregivers

- Be mindful of how interventions may cause separation (e.g. livelihood programmes, unsafe queues)
- Do not unnecessarily separate breastfeeding mothers and their children during illness
- Provide mothers in transit with means to keep their babies close (e.g. baby sling)\(^99\)
- Support separated children to access agencies responsible for reunification
- Keep mothers and their newborns together 24/7 within maternity services\(^100\)

Register households with PLW, children 0 – 23 months and higher risk groups

Registration enables people to be visible and assists with programme planning by identifying the size and location of potential beneficiary groups. In an emergency, those who are most vulnerable may have difficulty accessing services that are available. They may not know what they are entitled to or there can be practical difficulties for those with infants and young children. Demographic age breakdown is important as IYCF practices and support services are highly age-dependent.
- Ensure demographic breakdown during registration and assessment (pregnant women, lactating women, 0 – 6 months, 6 – 11 months, 12 – 23 months and 24 – 59 months)
- Register vulnerable groups (i.e. orphans, pregnant women, single-headed households with children <2 years, non-breastfed infants) to ensure targeted access to essential humanitarian support services.
- Register newborns within 2 weeks of delivery to enable priority targeting with skilled breastfeeding support and to ensure timely access to additional household food entitlement for the breastfeeding mother.

\(^99\) More appropriate in areas where this is already a common practice
\(^100\) Baby Friendly Hospital Initiative – Ten Steps to Successful Breastfeeding
Provide privacy and space to breastfeed

It is important to establish spaces at the onset of emergencies where mothers can privately breastfeed. These can be very basic structures within existing structures (e.g. reception centres) and services (e.g. health facilities, distribution points) at the onset of the emergency, which can later be developed into more comprehensive supportive spaces offering IYCF-E services later on (See Chapter 3.4)

- Ensure shaded / sheltered rest areas which offer privacy for breastfeeding for PLW e.g. near queues
- Provide breastfeeding corners within services e.g. health facilities
- If privacy is an issue due to displacement, overcrowding or long queues, consider distributing breastfeeding scarves to enable mothers to breastfeed more comfortably.

Disseminate standardised, clear and accurate messages on IYCF-E

Clear and consistent IYCF-E messages (Annexe D1) that reinforce safe and appropriate IYCF-E and address any specific concerns can have a large impact due to their potential reach. Mothers, caregivers and the community are key targets for communication and key messages on IYCF-E that reinforce safe and appropriate infant and young child feeding will help broaden the scope of support to mothers and caregivers.

Dissemination channels could include: The Shongjog Multi-Stakeholder Platform (MSP)\(^1\), registration and distribution points, community/religious meetings, safe spaces, at health/child-protection service sites or during household assessments:

- Use standardised, agreed upon messages and communicate them consistently
- Keel it simple – one message at a time
- Field test communication materials (FGD) to ensure comprehension, appropriateness and relevance
- Use short sentences.
- Use plain simple language (Translate & back translate)
- Be positive in tone
- Highlight the positive consequences of heeding the message (motivation)
- Use a trusted source
- Customise for culture, language, environment, target group
- Coordinate within and across sectors to ensure consistency and joint messaging

The same messages can be used to inform IEC materials e.g. leaflets, posters, mobile messages, and included in content for Basic Frontline Feeding Support (See Chapter 3.2), IYCF Counselling and Education.

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\(^1\) [http://www.shongjog.org.bd/about-the-msp/](http://www.shongjog.org.bd/about-the-msp/)
### 3.3 Basic Frontline Feeding Support
(Deciding who needs help)

Active measures are needed to identify infants, children and mothers in need of special attention so that their condition can be identified and treated.\(^{102}\)

Two methods can be used to assess the feeding of children 0 – 23 months:

1. **IYCF Simple Rapid Assessment (SRA – Annexe D2)**
2. **IYCF Full Assessment (FA – Annexe D3)**

<table>
<thead>
<tr>
<th>Type</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>SRA</td>
<td>To determine the age of the child(^{103}), and whether there are issues with feeding which require a full assessment by a skilled worker.</td>
</tr>
<tr>
<td>FA</td>
<td>To determine IYCF practices and any difficulties faced by the caregiver, and what type of support is needed (such as IYCF counselling, nutrition education, provision of micronutrients or complementary foods supplements).</td>
</tr>
</tbody>
</table>

Frontline workers\(^{104}\) who frequently interact with children 0 – 23 months (Table 13) and their caregivers should be prioritized for training and instructed to carry out a SRA whenever the opportunity arises, such as:

- as part of a household survey (active screening)
- as part of home based delivery service and postnatal care checkups
- as part of the case management process for child protection services
- upon presentation at a health care facility

<table>
<thead>
<tr>
<th>SERVICES</th>
<th>CMAM</th>
<th>SFP</th>
<th>Community</th>
<th>Health/Protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOCATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother Baby Area</td>
<td>SC</td>
<td>BSFP</td>
<td>Household visit</td>
<td>Child Protection case management</td>
</tr>
<tr>
<td>IYCF-E Corner</td>
<td>OTP</td>
<td>TSFP</td>
<td>Screening</td>
<td>Primary Health Care Centre</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Community outreach</td>
<td>Awareness session</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Women and Children Friendly Spaces</td>
</tr>
</tbody>
</table>

**Table 13 - Priority service locations to capacitate to carry out Simple Rapid Assessment**

**IF a problem is detected through the SRA,** the frontline worker will:

1. provide relevant key messages (Box 7) and practical help as interim support.
2. make a referral for a FA.

The purpose of this is to minimise the immediate risk, until the caregiver can access skilled one-to-one IYCF counselling and support. This combination of activities at community level is known as **Basic Frontline Feeding Support.** (Figure 7)

---


\(^{103}\) Ensure frontline workers are trained to accurately determine and talk about age: Guidelines for Estimating the Month and Year of Birth of Young Children. FAO, 2008 and Talking About IYCF and Child Age: A Briefing. ENN, 2014.

\(^{104}\) Frontline workers are those who interact directly with the disaster-affected population. Examples include community health workers, volunteers, midwives, birth attendants, child protection case workers and nutrition and health service providers.
Clear action-oriented messages on appropriate practices should be given at points of contact\textsuperscript{105}.

**IF a caregiver requests a BMS such as infant formula during the SRA**, it is important to sensitively handle such requests. Find out why the caregiver is requesting it and respond accordingly as outlined in Table 14.

### Box 7 - Messages to support effective breastfeeding

- Your breastmilk is providing essential food and protecting your baby against illness
- When feeding, hold baby closely and keep baby’s head, neck and body in a straight line.
- Breastfeed frequently, day and night (at least 8 times a day if baby is less than 6 months)
- Hold baby close to your breast against your skin, even when not feeding, as often as possible
- Using a baby sling/wrap can help keep your baby close and will help baby feel secure (local context dependent – assess whether practiced in the area or not)
- Feed your baby whenever he/she shows you they want to drink, including at night
- If baby is less than 6 months, they need only breastmilk and nothing else. Do not give water, tea, other milk or any other food to the baby before they are 6 months old.
- If baby is more than 6 months, continue to provide breastmilk as the main source of fluid
- Let baby finish one breast, then offer the other breast
- Avoid giving baby feeding bottles or pacifiers

### Table 14 - Basic Frontline Assistance for Caregivers who request Breastmilk Substitutes

<table>
<thead>
<tr>
<th>Reason for request</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost confidence in her ability to breastfeed her baby</td>
<td>Reinstall confidence in breastfeeding (Box 2)</td>
</tr>
<tr>
<td>Worried she does not have enough milk</td>
<td>Refer for FA and skilled 1-1 counselling.</td>
</tr>
<tr>
<td>Believes infant formula is better for her child</td>
<td>Advise that breastmilk is the most safe, secure, nutritious and protective food and drink for her infant and that using infant formula is not safe. Refer to nutrition education and information sharing activities.</td>
</tr>
<tr>
<td>Mixed feeding (breastmilk and infant formula) infant under 6 months</td>
<td>Advise that it is much safer and better for her baby to be exclusively breastfed. Refer for FA and 1-1 counselling.</td>
</tr>
<tr>
<td>Infant is &lt; 12 months and is not breastfed (mother has no milk)</td>
<td>Refer for FA / Refer to services supporting non-breastfed infants.</td>
</tr>
</tbody>
</table>

Figure 7 - Basic Frontline Feeding Support

Check for danger signs
PLW, 6 – 23 m: Check MUAC
0 – 5m: Visibly thin, wasted or not gaining weight at home

Caregiver or infant malnourished or ill?

Yes

Refer for: Medical / Nutrition Services including IYCF Support at referral point

No

Simple Rapid Assessment

Breastfeeding?

No

Refer to: Medical/Nutrition Services
See: Support for Non-Breastfed Infants

Yes

ANY of the following detected?
- Mother missing/ill/dead
- Feeding not age appropriate
- Not able to suckle
- Difficulty with breastfeeding
- Caregiver requests BMS
- Child looks very thin
- Child is lethargic, perhaps sick

No

- Praise the mother
- Share relevant key messages
- Inform her where she can access IYCF support
- Link her to other relevant services e.g. mother support groups

Yes

Provide: Referral for FA, key messages and practical help
3.4 Supportive Spaces

During emergencies, women often lack a space to comfortably and privately breastfeed for reasons such as displacement from their homes or overcrowding in temporary settlements. Registration and distributions during emergencies often involve standing in queues for long periods of time. This can be physically exhausting and dangerous for pregnant women or caregivers with young children, especially in very hot weather, or if there is no shelter, food or water. Emergency settings can be chaotic, over even violent, putting infants and young children at risk of physical harm. Emergency settings can be very stressful for caregivers. For all of these reasons, it is important to create safe and low-stress spaces where mothers can breastfeed, rest and receive support.

3.3.1 Types of supportive spaces

**KEY TERMINOLOGY**

**IYCF-E Corners** are spaces which are *integrated* into other services, such as health facilities, child or women friendly spaces or therapeutic feeding sites. They are spaces where women can quietly and privately breastfeed and receive basic support.

**Mother Baby Areas** are larger, alone standing spaces that are dedicated to IYCF-E services. They are spaces where caregivers and pregnant women can come with their children to find a supportive space to share experiences with other women, spend time with their baby, receive information, support and guidance and to breastfeed. It is a space where a team of trained professionals can detect nutritional, health and psychosocial issues and provide them with care and support.

3.3.2 Objective

To provide a safe and supportive space to for caregivers of infants and young children to enable them to practice appropriate infant and young child feeding and care practices, including breastfeeding

3.3.3 When are they needed?

<table>
<thead>
<tr>
<th>Table 15 - FACTORS INDICATING SUPPORTIVE SPACES ARE NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IYCF-E Corner</strong> (Additional space within service)</td>
</tr>
<tr>
<td>IYCF practices are at risk</td>
</tr>
<tr>
<td>Overcrowding at service point</td>
</tr>
<tr>
<td>Lack of privacy at service point</td>
</tr>
<tr>
<td>Long queues at service point</td>
</tr>
<tr>
<td>Service providers are very busy and may deprioritise</td>
</tr>
<tr>
<td>IYCF if dedicated space/staff are not provided</td>
</tr>
<tr>
<td>Risk of physical harm to mothers and children</td>
</tr>
</tbody>
</table>

*Mother Baby Areas are not appropriate for rural locations where the population is widespread at low density. In this case, it is better to integrate IYCF-E Corners into other available services.*

Planning for supportive spaces should be done in preparedness or in the immediate phase of an emergency in coordination with IPHN, Civil Surgeon Office and MODMR District Focal Points in each emergency affected.
Based on needs assessment results, IPHN in consultation will NC partners will confirm whether supportive spaces are needed or not and what type is most appropriate (i.e. IYCF Corners or Mother Baby Areas). IPHN will liaise with service providers to ensure that adequate space is allocated for IYCF-E Corners within relevant services, such as women friendly spaces and health facilities. XXX will liaise with camp/site coordination and camp/site management to ensure that adequate space is allocated for Mother Baby Areas during site planning. NC partners play an important advocacy role.

3.3.4 Setting up the space

<table>
<thead>
<tr>
<th>Table 16 - Supportive Space Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Size*</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>IYCF-E Corner</td>
</tr>
<tr>
<td>Capacity: 3 adults</td>
</tr>
<tr>
<td>Mother Baby Area</td>
</tr>
<tr>
<td>Capacity: 18 adults</td>
</tr>
</tbody>
</table>

* Spaces can be larger depending on expected number of caregivers, planned activities and space available

- Note that spaces can be mobile – for example, add an IYCF-E Corner to mobile health units.
- Ensure that all essential materials and equipment (Annexe D4 and D5) are available in the space.

Physical safely and access to services

- Plan for the appropriate number of spaces and size based on target population size, geographical spread and access. For example, if the target population is in a large camp, it is better to have a higher number of smaller spaces than one big space.
- Coordinate with other actors to ensure an even distribution of services.
- Ensure proximity to segregated latrines (no more than 50 metres)
- Consider locating MBAs near shelters allocated to vulnerable households and / or near to Child or Women Friendly Spaces
- Consider locating MBAs near relevant services to facilitate referral and follow-up care
- Ensure the locations and times of IYCF-E services are safe and accessible for PLWs (consider route, distance, travel times etc.)
- Ensure services are accessible for persons with disabilities
- Coordinate with community members and site managers to ensure spaces are not located near areas that present security risks (e.g. security checkpoints, site perimeters etc.)

3.3.5 Target population

Nutrition Cluster partners will agree upon targeting criteria at the start of the response and communicate these clearly to the community and emergency responders. Caregivers will be welcomed if they come directly to the MBA, or they may be referred. Criteria can include:

- Lactating women (with children 0 – 23 months)
- Children 0 – 23 months
- Pregnant women (referral criteria may vary depending on expected caseload and available resources. For example, only after the 1st or 2nd trimester)
Once the child is older than 2 years, sensitively refer to relevant services such as Child Friendly Spaces. Do not prevent caregivers whose child has died from accessing the programme for continued psychosocial support, if they wish to do so.

If the caseload is too high, NC partners will agree to adjust targeting criteria as a last resort. Always first explore whether new spaces can be added, the current space can be expanded, or the schedule can be changed.

- Upon arrival, trained volunteers or IYCF counsellors will carry out a Simple Rapid Assessment (SRA) to identify IYCF difficulties that need to be addressed, or assessed further.
- Once resources allow, aim for all caregivers attending the MBA to undergo a Full Assessment by a skilled IYCF counsellor to identify any difficulties (for example, breastfeeding or complementary feeding difficulties), determine what type of support is needed and discuss what type of activities would be most appropriate for the caregiver to attend. As part of the full assessment, caregivers will be registered so that their attendance can be monitored.

**Note:** Full assessment and registration is not carried out for all caregivers when MBAs are temporary (< 1 month) or populations are in transit and will not attend regular activities.

---

### 3.3.6 Activities within the space

The priority is the provision of a safe and supportive environment for mothers and their children. This means that the presence of skilled and empathetic staff is critical. Informal discussions between staff and caregivers are an important activity.

➢ **MBA Team** to define a weekly schedule of MBA activities and communicate this to communities

---

For detailed information about these activities, refer to *Baby Friendly Spaces Manual*, ACF 2014. Chapter 3.
This allows busy caregivers to attend activities of their choice, and can provide stability and structure to caregivers and children. Repeat the same session at least twice each week, to accommodate caregivers’ workloads and availability. (See example timetable in Annexe D6)

Some activities can run over several weeks. For example, mothers may meet as a group for several weeks to cover a set number of topics. Communicate this clearly, so that women can enrol for at the start of an activity.

Consult the target population when planning the schedule so that times are convenient and safe for them.

Table 17 - Overview of Supportive Space Activities, per type of space

<table>
<thead>
<tr>
<th>IYCF-E Corners are spaces where women can quietly and privately breastfeed and receive basic support.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimum activities</strong></td>
</tr>
<tr>
<td>• Provision of space to comfortably and privately breastfeed</td>
</tr>
<tr>
<td>• Simple Rapid Assessment and referral for Full Assessment if needed</td>
</tr>
<tr>
<td>• Provision of information about / referral to nearby Mother Baby Areas and other relevant services</td>
</tr>
<tr>
<td><strong>Additional activities (if the space is staffed with an IYCF Counsellor)</strong></td>
</tr>
<tr>
<td>• Full Assessment and Skilled IYCF Counselling (1-1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mother Baby Areas are spaces where caregivers and pregnant women can come with their children to find a supportive space to share experiences with other women, spend time with their baby, receive information, support and guidance and to breastfeed. It is a space where a team of trained professionals (such as health and nutrition workers or psychosocial workers) can detect nutritional, health and psychosocial issues and provide them with care and support.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimum activities</strong></td>
</tr>
<tr>
<td>• Provision of a welcoming space for caregivers to relax and spend time with their babies</td>
</tr>
<tr>
<td>• Provision of space to comfortably and privately breastfeed</td>
</tr>
<tr>
<td>• Simple Rapid Assessment and/or Full Assessment and registration</td>
</tr>
<tr>
<td>• Skilled 1-1 IYCF Counselling</td>
</tr>
<tr>
<td>• Provision of information about / referral to relevant services (e.g. for children who are ill)</td>
</tr>
<tr>
<td>• Psychosocial Interventions - Early Childhood Development (ECD) activities (See: MHPSS)</td>
</tr>
<tr>
<td><strong>Additional activities</strong> – Many different activities are possible. The choice of activities to implement in the Mother Baby Area will depend on needs identified during assessments, the stage of the emergency, caregiver availability and daily activities, availability of qualified/trained staff and space.</td>
</tr>
<tr>
<td>• Psychosocial Interventions – Care for Caregivers (See: MHPSS)</td>
</tr>
<tr>
<td>• Psychological support (See: MHPSS)</td>
</tr>
<tr>
<td>• Infant and Young Child Growth Monitoring and Promotion</td>
</tr>
<tr>
<td>• Group activities such as:</td>
</tr>
<tr>
<td>o Information sharing and education (nutrition and /or hygiene practices)</td>
</tr>
<tr>
<td>o Relaxation exercises</td>
</tr>
<tr>
<td>o Baby Massage107</td>
</tr>
<tr>
<td>o Baby Bath / Hygiene Activities</td>
</tr>
<tr>
<td>o Complementary Feeding Activities e.g. group discussions, cooking demonstrations, recipes</td>
</tr>
<tr>
<td>o Mother Support Groups</td>
</tr>
</tbody>
</table>

3.3.7 Activities outside the space

Most women do not live alone with their children, but live with family members who play an important role in making decisions about how children are fed or cared for. Family members may need further information before they are supportive of women attending a MBA. Pregnant women who were attending MBA activities

107 For baby bath and massage instructions, refer to Manual for the Integration of Child Care Practices and Mental Health into Nutrition Programmes. ACF, 2013. Chapter IV.
may not be able to visit soon after their baby is born. Caregivers experiencing depression or other difficulties may struggle to attend the MBA. Therefore, activities within supportive spaces should not be contained to the space:

- **Hold community awareness sessions** to provide information and encourage attendance.
- Consider organising **site visits** for family members (e.g. family decision makers) and community leaders.
- Carry out **home visits** in order to better understand caregiver situations, provide support at household level, engage with family members (including decision makers) and follow up with caregivers who have stopped attending (i.e. not visited for 2 weeks or more).

### 3.3.8 Staffing the Space

It is recommended that follow up appointments are scheduled in a way that allow caregivers to see the same staff member whenever possible.

**Table 18 - Staffing requirements for supportive spaces**

<table>
<thead>
<tr>
<th>Space</th>
<th>Location</th>
<th>Minimum Staffing (per shift)</th>
<th>Possible Additions</th>
</tr>
</thead>
<tbody>
<tr>
<td>IYCF-E Corner</td>
<td>Child Friendly Space, Women Friendly Space, Distribution Site, Transit Centre</td>
<td>1 x IYCF Volunteer OR 1 x IYCF Counsellor</td>
<td></td>
</tr>
<tr>
<td>IYCF-E Corner</td>
<td>CMAM, Health Facility incl. inpatient SAM and Cholera Treatment Centre</td>
<td>1 x IYCF Counsellor</td>
<td></td>
</tr>
<tr>
<td>Mother Baby Area</td>
<td>Community</td>
<td>2 x IYCF Counsellor 1 x IYCF Volunteer 1 x Cleaner</td>
<td>1 x Psychosocial workers (or: social worker, child protection worker, educator or psychologist) Guards – as necessary</td>
</tr>
</tbody>
</table>


### Do’s and Don’ts

| **DO** | Ensure that caregivers always feel welcome when they arrive by being friendly, respectful, introducing yourself and providing information about the services available. |
| **DO** | Ensure that spaces are culturally appropriate and resemble the usual home environment. |
| **DO** | Use decorations, such as children’s drawings and bright colours, to create a friendly and positive atmosphere. |
| **DO** | Limit admission to children 0 – 23 months of age. Older children need different types of support and their presence can be disruptive to MBA activities. However, take care that this does not cause separation or prohibit caregivers who also have older children from accessing the MBA through referring older children to nearby Child Friendly Spaces. If no such space exists, consider organising basic developmental activities for children aged 2 – 5 nearby to the MBA. |
| **DO** | Ensure sustainable water supply for the space (e.g. water truck access). |
| **DO** | Ensure there are handwashing facilities outside the space and encourage handwashing. |
| **DO** | Provide safe drinking water. |
| **DO** | Regulate temperature inside the space. Temperatures inside tents can rise quickly when it is hot. Consider placing additional sheeting over the tent or adding an electric fan. |
| **DO** | Ensure that activities are compliant with the **Bangladesh BMS Act 2013**. |
| **DO** | Schedule activities at times that are convenient and safe for caregivers. |
| **DO** | Ensure that adequate child safeguarding measures are in place, including through staff training. |
| **DO** | Ensure privacy; both through establishing private corners within the space and through taking measures to ensure that passers-by cannot look in. |
| **DO** | Train staff to recognise needs and ensure that they have the information required to be helpful (e.g. location, cost, admission criteria and opening hours of other services). |
| **DO** | Involve men – for example, by asking them to safeguard the space. |

### Box 8 - Early Childhood Development

Around 80% of brain growth occurs in the first 3 years of life. The brain needs nutrition and health inputs as well as responsive care and stimulation in order to grow and develop to its full potential. During emergencies, caregivers may need extra support to connect with and stimulate their children.

- No more than 7 children plus their caregivers per session
- Arrange the space so that caregivers can comfortably sit in a circle
- Sessions can be 20 – 40 minutes long depending on children’s age and attention span
- Ensure that participation is spontaneous and free; no one is forced to play
- Use simple materials which the caregivers can replicate or obtain for playing at home

**Organise the session as follows:**

1. Welcome participants and introduce the activity
2. If participant have already participated in a previous session, discuss if they are able to play with their children at home more, if they have found play materials and any difficulties encountered
3. Play (e.g. songs, body movements, rhythm, games)
4. Participant sharing time at the end of the session, including sharing feelings of feelings, difficulties or caregiver observations on their child’s development or relationship with them
5. Facilitator feedback, such as pointing out developmental milestones

For more information, see: Early Childhood Development in Emergencies Integrated Programming Guide (UNICEF, 2014)
DO NOT put up large quantities of health education posters. Any IEC materials should deal with relevant issues, be pleasant to look at and promote positive behaviour.

DO NOT use the space for multiple other purposes

DO NOT provide unsafe toys (e.g. cuddly toys, choking hazards)

DO NOT allow men to enter the space if this means women will not feel comfortable breastfeeding. Consider assigning specific times of the day for sessions with fathers.

DO NOT allow bottles, teats and breastmilk substitutes within the space.

3.3.10 Monitoring

Monitor the number of beneficiaries attending to the IYCF-E Corner or Mother Baby Area. Do not record attendance for each separate activity within the space, except for group education, skilled one-to-one counselling and psychosocial support. The following should be monitored:

- **Drop Out** – If an individual has not visited the MBA for over 2 weeks, there is a need to follow-up. A community health or nutrition worker will conduct a home visit to understand what has happened and whether they need additional support.
- **Coverage and access** - during registration, record the caregiver’s location (e.g. within a camp or community) to monitor coverage and how far caregivers are travelling to attend the space.
- **Quality** – conduct monthly supervision visits using the Quality Checklist (Annexe D7) and Client Exit Interviews (Annexe D8).

3.5 Breastfeeding Support

3.5.1 Breastfeeding in Emergencies

Emergency responders across ALL sectors should protect, promote and support breastfeeding, including early initiation of breastfeeding (putting newborn to the breast within 1 hour of birth), exclusive breastfeeding for the first 6 months of life (only breastmilk and nothing else, not even water) and continued breastfeeding for 2 years and beyond.

Breastfeeding is a lifesaving practice during emergencies. However, breastfeeding mothers may face a range of difficulties during emergencies. These include:

- Stress, trauma, depression, illness
- Competing priorities and lack of time
- Loss of maternal confidence in the adequacy of their breastmilk
- Spread of disaster myths and misconceptions (See Box 9)
- Loss of social support structures (family, community)
- Lack of food and/or water intake for the mother
- Increased rates of illness
- Lack of privacy (overcrowding, displacement)
- Poor access to skilled breastfeeding support
- Uncontrolled / blanket distributions of breastmilk substitutes
Due to difficulties such as these, mothers may breastfeed less or stop breastfeeding if they are not adequately supported, particularly if breastfeeding practices were already poor prior to the onset of the emergency. It is critical to remember that while virtually all mothers can breastfeed, many will need support in order to do so—especially during emergencies.

**BOX 9: EXAMPLES OF DISASTER MYTHS AND MISCONCEPTIONS**

During emergencies, it is common for unfounded myths to spread about women’s inability to breastfeed due to the emergency situation. Such myths can reduce a mother’s confidence and result in donations of breastmilk substitutes. Remember:

- **Stress does NOT stop mothers from making breastmilk.** Women who are physically and emotionally stressed are able to make enough milk, but stress can understandably make breastfeeding challenging. Stress can temporarily interfere with the let-down (release) of breastmilk. To help the milk to flow, it is important to create conditions for the mother that reduce stress as much as possible, and to provide psychosocial support. Stress may cause mothers to put their child to the breast less often. This can gradually reduce milk production. Mother should be counselling to put the baby to the breast often.

- **Malnourished mothers CAN breastfeed.** Moderate malnutrition has little to no effect on the quantity of breastmilk produced. Malnourished mothers need nutritional support to protect and rehabilitate their own nutritional status, as well as skilled breastfeeding support to restart or continue breastfeeding. We need to ensure the mental and physical well-being of the mother AND baby, so we need to care for and feed the mother and let her breastfeed her child. It is important to provide reassurance that a poor diet does not mean a woman cannot breastfeed and that breastmilk continues to provide valuable nutrition and protection even when she feels weak. Provide undernourished mothers with unlimited access to safe drinking water, a supportive presence and nutritional support.

**3.5.2 Interventions to support breastfeeding**

**Target Group:** Pregnant women, children 0 – 23 months and their caregivers

**Most vulnerable:** newborns, adolescent mothers, first time mothers, caregivers/children with heightened needs.

Breastfeeding support is a cornerstone of Bangladesh’s IYCF-E response. The identification of any alerts during early coordinated/joint needs assessments is sufficient to indicate that Core IYCF Activities (e.g. Skilled IYCF Counselling) must be implemented to meet the needs of breastfed children. Table 19 indicates which other factors to look for during needs assessments to determine which additional activities are appropriate and necessary to protect the lifesaving practice of breastfeeding.

- Ensure that **basic multisectoral actions** are carried out to create an environment that is supportive of breastfeeding. ([See: Action 2.4](#))
- Ensure that **supportive spaces** are established for mothers to comfortably and privately breastfeed ([See: Chapter 3.3](#))
Table 19 - Breastfeeding Support Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>When to consider implementation (One or more conditions present)</th>
<th>When to start (Timeframe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Frontline Feeding Support (See Chapter 3.2)</td>
<td>• Always – standard component</td>
<td>Short Term</td>
</tr>
<tr>
<td>Information Sharing &amp; Education</td>
<td>• Always – standard component</td>
<td>Short Term</td>
</tr>
<tr>
<td>Support for Early Initiation of Exclusive Breastfeeding</td>
<td>• Always – standard component</td>
<td>Short Term</td>
</tr>
<tr>
<td>Skilled IYCF Counselling (One-to-One)</td>
<td>• Always – standard component</td>
<td>Short Term</td>
</tr>
<tr>
<td>Mother &amp; Baby Kit Distribution</td>
<td>• Loss or destruction of possessions</td>
<td>Short Term</td>
</tr>
<tr>
<td></td>
<td>• Caregivers expressing difficulties keeping infants clean or clothed</td>
<td></td>
</tr>
<tr>
<td>Skilled IYCF Counselling (Further/Specialised support)</td>
<td>• Acute malnutrition is prevalent in infants &lt; 6 m</td>
<td>Short Term</td>
</tr>
<tr>
<td>(See 3.4)</td>
<td>• Maternal malnutrition is prevalent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reports of mothers stopping breastfeeding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Reports of violence against women and girls</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Infectious disease outbreaks (e.g. AWD)</td>
<td></td>
</tr>
<tr>
<td>Mother Support Groups (See 3.0 – Overview of Interventions)</td>
<td>• Poor IYCF practices</td>
<td>Medium Term</td>
</tr>
<tr>
<td></td>
<td>• Low caregiver knowledge on IYCF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stabilised; no frequent population movement</td>
<td></td>
</tr>
</tbody>
</table>
### 3.5.3 Skilled Breastfeeding Support Interventions

<table>
<thead>
<tr>
<th>Intervention</th>
<th>When</th>
<th>Who</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Support for Early Initiation of Exclusive Breastfeeding</strong></td>
<td>• Within the postnatal period (first 6 weeks after birth) with an emphasis on the 1st hour</td>
<td>Birth Attendant(^{108}) / Newborn Attendant</td>
<td>Maternity Services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Birth Attendant/ Newborn Attendant</td>
<td>Community</td>
</tr>
</tbody>
</table>
| **Skilled IYCF Counselling (One-to-One)** | • Feeding not age appropriate  
• Mother lacks confidence  
• Misconceptions, worries about breastfeeding  
• Doubts about having enough milk  
• Request for infant formula to supplement  
• Poor attachment, ineffective suckling  
• Breast conditions e.g. cracked nipples, mastitis\(^{109}\)  
• Breastfeeding difficulties e.g. breast refusal  
• Wet Nursing support  
• Mother / Child is sick or in recovery  
• Mother malnourished or very ill  
• Mother traumatised or highly stressed (See: MHPSS) | Trained health worker | Health Facility |
| | | Trained nutrition worker | CMAM Site |
| | | Trained IYCF Counsellor | IYCF-E Corner OR Mother Baby Area |
| | | Trained MHPSS Counsellor | MHPSS Services Mother Baby Area |
| | | Trained Peer Counsellors | Community |
| **Skilled IYCF Counselling (One-to-One) and further support for Infants with Heightened Needs** | • Low Birth Weight or Premature  
• Disabilities that affect feeding  
• Acutely malnourished infant < 6 m  
• Acutely malnourished child 6 – 23 m or mother  
• Re-lactation  
• HIV exposed Infant (See: HIV & Infant Feeding)  
• TB exposed infant  
• Survivor of sexual violence  
• Orphans  
• Twins  
• Mothers/children who are sick or recovering | IYCF-E Counsellor with additional training and /or support from Nutritionist or IYCF-E Manager | IYCF-E Corner Mother Baby Area Maternity Services C-MAMI Services Health Facility |

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\(^{108}\) A 'birth attendant': a skilled or unskilled worker, representing whoever usually attends childbirth (e.g. CSBA, FWA, CHW, or others)  
\(^{109}\) Conditions requiring medication need to be addressed together with a clinical health worker
Support for Early Initiation of Breastfeeding

Key Action: Target mothers of all newborns with support for early initiation of exclusive breastfeeding.

It is essential to protect, promote and support early initiation of exclusive breastfeeding in all newborn infants as part of the standard package of Essential Newborn Care\(^{110}\).

- Maternity services\(^{111}\) will implement/maintain the 10 Steps to Successful Breastfeeding\(^{112}\) (BFHI):
  1. Have a routinely communicated, written breastfeeding policy visible at the facility
  2. Train all relevant health workers in skills needed to implement this policy
  3. Inform all pregnant women about the benefits and management of breastfeeding\(^{113}\)
  4. Help mothers to initiate breastfeeding within 1 hour of birth
  5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants
  6. Give newborn infants no food or drink other than breastmilk, unless medically indicated
  7. Practice rooming-in (keeping mothers and their newborns together 24/7)
  8. Encourage breastfeeding on demand
  9. Give no artificial teats or pacifiers to breastfeeding infants
  10. Foster the situation allows:

For further newborn health interventions which support the health and nutrition of infants, See: IYCF-E & Health (Annex)

In line with the Bangladesh National Neonatal Health Strategy and Guidelines (2009)

- Train health workers to implement the 10 Steps to Successful Breastfeeding\(^{114}\)
- Provide a basic training to non-formal providers (such as TBAs and village doctors) who can support immediate neonatal care and facilitate referrals in the absence of skilled providers.
- Support community health workers to orient “newborn caregivers” – one family member of volunteer from the community, oriented to take care of the newborn.

One on One Skilled IYCF Counselling

Key Action: Enable access to skilled IYCF counselling for PLWs

Mothers are greatly helped to breastfeed and care for their infants if someone calm and friendly listen to them and builds their confidence with reassurance and correct information. Skilled breastfeeding support is provided in the form of counselling by a provider or volunteer who been trained on IYCF Counselling (Box 10). A skilled IYCF counsellor can provide assistance to lactating women to ensure that the fundamentals of good breastfeeding are in place and to resolve breastfeeding difficulties. It is essential to ensure an

\(^{111}\) At facility level and at community/home level e.g. home ANC services
\(^{112}\) Baby Friendly Hospital Initiative – Bangladesh Programme. http://bbf-bangladesh.org/bfhi
\(^{113}\) During the 3\(^{rd}\) (32 weeks) and 4\(^{th}\) (38 weeks) antenatal care visit – Bangladesh Neonatal Health Guidelines (2009)
\(^{114}\) Using a simplified curriculum from BFHI Bangladesh. Training should not focus on accreditation requirements during emergencies, but should focus on the 10 steps.
environment that is conducive to counselling and that offers sufficient privacy for the counsellor to directly observe a breastfeed (Annexe D9) and to monitor the quality of counselling provided.

- Integrate IYCF counselling into interventions that target pregnant and lactating women and their children 0 – 23 months through:
  - Training and supporting MNCH providers to integrate IYCF Counselling into their existing roles
  - Training a cadre of IYCF Counsellors to work in IYCF-E Corners within existing services and within Mother Baby Areas. Effective counselling requires time. Therefore, this option is recommended if the number of women requiring skilled IYCF support is expected to be high, so that mothers with breastfeeding difficulties can receive adequate support during emergencies.

Services addressing acute malnutrition (e.g. inpatient SAM units, OTP sites) should be prioritised for integration of IYCF counselling with the service. (See Chapter 3.11 - IYCF and Malnutrition)

### BOX 10: CAPACITY BUILDING FOR IYCF COUNSELLING

It is essential that training on IYCF Counselling includes practical (hands-on) learning sessions and follow up. Supportive supervision visits should be carried out at least once per month. Monitoring should include regular verification that the 10 Steps to Successful Breastfeeding (BFHI) are adhered to.

See DIPSHIKA – Competency Based Training Module 1 Facilitator Guide P.7 for the Competencies, Knowledge and Skills required for IYCF Counselling.

### 3.6 Further support for particularly vulnerable children

**KEY ACTION: Provide feeding support to particularly vulnerable infants and young children**

Families in difficult situations require special attention and practical support to be able to feed their children adequately. Infants and young children with heightened needs, or those with caregivers who are particularly vulnerable, are at higher risk of illness, malnutrition and death during an emergency. These include:

- Premature and low birth weight infants
- Twins
- Infants who are not breastfed (including orphans/infants whose mother has died)
- Mothers and children who are severely ill or recovering from severe illness
- Acutely malnourished infants < 6 months
- Acutely malnourished children 6 – 23 (SAM and MAM)
- Acutely malnourished mothers of children 0 – 23 months
- Children with disabilities that affect feeding or whose caregivers are disabled
- HIV-exposed and TB-exposed infants
- Children whose mothers are survivors of sexual violence

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115 DIPSHIKA Competency Based Training Module II – Supportive Supervision Tool 3A
116 Health and nutrition services and beyond – such as women and girl friendly spaces and child protection services.
117 Support is considered to be adequate when 50% of mothers experiencing breastfeeding difficulties and who require one-to-one skilled breastfeeding counselling can access an average of one 20-minute counselling session on a weekly basis until their difficulty has been resolved. Actual frequency and duration of counselling is decided on a case by case basis.
Children whose caregivers are experiencing mental health difficulties

The number of particularly vulnerable children may increase during an emergency, thereby creating a greater need for skilled (specialist) IYCF support. For example, the incidence of preterm and low birth weight infants often increases during emergencies\textsuperscript{119}. It is important to ensure adequate care and support is available for these vulnerable children.

### 3.5.1 Interventions to support particularly vulnerable children

Supporting these vulnerable groups requires further time, skills and attention. Due to the additional time required for training and the smaller number of caregivers who are likely to require this type of support, it is not necessary to train all health and nutrition workers delivering IYCF services on these skills during an emergency, however it is important to ensure that:

- Health and nutrition workers are able to recognise and refer caregivers requiring further support
- A cadre of health and nutrition workers exist who are trained to provide further support, and themselves receive mentoring support from a trained supervisor/manager.
- A functional referral pathway is in place for caregivers to access further support when needed

<table>
<thead>
<tr>
<th>SKILLED IYCF COUNSELLING + PRACTICAL SUPPORT + CLOSE FOLLOW UP = FURTHER IYCF SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ <strong>Train</strong> health and nutrition workers and their supervisors / managers on the provision of further support in line with national guidance (See Table 20). This can be done through integrating relevant topics into existing IYCF and MNCH training curricula based on who is being targeted for training (Table 21). During an emergency, prioritise topics that are most relevant to the context and prioritise training those who are most frequently in contact with particularly vulnerable caregivers and their children.</td>
</tr>
<tr>
<td>➢ <strong>Supportive supervision / mentoring</strong> should be intensified for IYCF Counsellors providing further support to particularly vulnerable children. For example – ensure IYCF counsellors have a means (e.g. phone credit) to contact their mentor for technical guidance and that regular meetings are held to discuss difficult cases.</td>
</tr>
</tbody>
</table>

#### Table 20 - Where to find further guidance to inform training content

<table>
<thead>
<tr>
<th>VULNERABILITY</th>
<th>FURTHER GUIDANCE</th>
</tr>
</thead>
</table>
| Low Birth Weight\textsuperscript{120} or Premature\textsuperscript{121} | National Strategy on IYCF in Bangladesh (2007)  
National Neonatal Health Strategy and Guidelines for Bangladesh (2009)  
Bangladesh Baby Friendly Hospital Initiative Training Manual |
| Twins | Clinical Guidelines on IYCF (2014) |
| Infants who are not breastfed\textsuperscript{122} | Chapter 3.7 - Support for infants who are not breastfed |
| Severe Illness / Recovery | Clinical Guidelines on IYCF (2014)  
Integrated Management of Clinical Illness (IMCI)  
Chapter 3.12 - IYCF in the context of public health emergencies |
| Acutely malnourished < 6 m | National Guidelines for the Facility-based Management of Children with Severe Acute Malnutrition in Bangladesh – Annexe 9 (2017) and National Guidelines for Community Based Management of Acute Malnutrition in

\textsuperscript{119} Guiding Principles for Feeding Infants and Young Children during Emergencies. WHO, 2004  
\textsuperscript{120} < 2500 grams at birth  
\textsuperscript{121} <37 weeks gestation at birth  
\textsuperscript{122} National Strategy on IYCF in Bangladesh. MOHW, 2007. “Infants who are not breastfed should receive special attention from the health and social welfare system as they constitute a special risk group.”
Bangladesh (2017) and Community Based Management of Acute Malnutrition in Infants Tool (2017)

See Chapter 3.11 - IYCF and Malnutrition

Acute malnourished 6 – 23 months


See Chapter 3.11 - IYCF and Malnutrition

Acutely malnourished mothers of children 0 – 23 months

See Box 9 (page X)

Feeding disability

Clinical Guidelines on IYCF (2014)

HIV exposed Infant

Chapter 3.13 - IYCF in the Context of HIV


TB exposed infant

National Guidelines for the Management of Tuberculosis in Children (2012)

Survivor of sexual violence

BOX 11

Mental Health Difficulties

Chapter 3.10 - Psychosocial Support

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Table 21 - Priority Providers to Target with Training on Further Support, by topic and level

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>TRAINING CONTENT</th>
<th>PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home/Community</td>
<td>Low Birth Weight or Premature</td>
<td>Frontline (community) health and nutrition workers e.g. birth attendants - consider daily role and who they commonly interact with when prioritising training topics</td>
</tr>
<tr>
<td></td>
<td>Twins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe Illness/ recovery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acutely malnourished children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acutely malnourished mothers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Survivors of sexual violence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental health difficulties</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Breastfed (Follow up on BMS Management + Relactation using Drip and Drop technique)</td>
<td></td>
</tr>
<tr>
<td>Outreach centre, satellite clinic, community level clinic, union level facility, Mother Baby Area</td>
<td>Same as above PLUS</td>
<td>Midwives</td>
</tr>
<tr>
<td></td>
<td>Non-Breastfed (BMS Prescription)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HIV-Exposed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TB-Exposed</td>
<td></td>
</tr>
<tr>
<td>Upazila level upwards</td>
<td>Same as above PLUS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Very Low Birth Weight&lt;1800 grams at birth</td>
<td></td>
</tr>
<tr>
<td>Inpatient SAM Unit in GoB HF</td>
<td>AM children 6 – 23 m with complications / AM children &lt; 6 m Relactation using Supplementary Suckling Technique</td>
<td></td>
</tr>
</tbody>
</table>

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123 C-MAMI Tool: [http://www.ennonline.net/c-mami](http://www.ennonline.net/c-mami)

124 < 1800 grams at birth
3.7 Support for Infants who are not breastfed

In every emergency, it is necessary to act to protect and support the nutrition needs and care of both breastfed and non-breastfed infants and young children\textsuperscript{125}.

Breastfeeding is the safest way to feed an infant, especially during an emergency. The vast majority of mothers can and should breastfeed, just as the vast majority of infants can and should be breastfed\textsuperscript{126}. All efforts must be made to protect, promote and support breastfeeding during emergencies. Despite these best efforts, a small proportion of emergency-affected infants will not be breastfed. Such infants are highly vulnerable in emergency settings, which amplify the risks associated with artificial feeding (the feeding of infants with a breastmilk substitute, such as infant formula). Increased communicable disease rates, interrupted supply chains, lack of fuel or safe water, loss of household items, restricted access to health services and poor sanitation all make artificial feeding even riskier than in normal settings. It is therefore necessary to urgently identify and protect non-breastfed infants and provide them with appropriate support in order to meet their nutritional needs and minimise risks in a manner that protects the best interests of both breastfed and non-breastfed infants.

3.7.1 Assessing the Need for an Artificial Feeding Intervention

The NC will collectively decide whether to implement an emergency response programme to support non-breastfed infants based on a needs assessment and critical analysis of the situation, informed by technical guidance. The analysis should include whether a demand for products such as infant formula 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

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\textsuperscript{125} Operational Guidance on Infant and Young Child Feeding in Emergencies. Version 3.0. IFE Core Group, 2017.

\textsuperscript{126} National Strategy on IYCF, MOHFW 2007.
the level of intervention and coordination required. As breastfeeding is commonly practiced in Bangladesh, it is expected that the scale of intervention required will be relatively small.

Immediate action to protect recommended IYCF practices and minimise risk is necessary in the early stages of an emergency, with targeted support to higher risk infants and children. When necessary, artificial feeding programmes should be rapidly implemented in order to save lives. Early needs assessments should therefore gather the essential information needed to launch programmes, such as the estimated number of non-breastfed infants.

An assessment of the health and home environment, including water, fuel, sanitation, hygiene, shelter, availability of health and nutrition service providers and facilities for BMS preparation should also be carried out.

3.7.2 Deciding who needs artificial feeding support

Individual-level assessment

Frontline workers should be sensitized to the fact that some infants may not be breastfed. Such infants may be passively identified at services where mothers and their infants present or identified through Simple Rapid Assessment activities as per Chapter 3.3. Once identified, any non-breastfed infants should be promptly referred to the nearest specialized IYCF-E centre for a Full Assessment (FA).

Best available feeding options will then be identified as per Figure 8. The safest option for non-breastfed infants is to establish breastfeeding, either through re-lactation or through wet nursing. Therefore, these feeding options must be explored first, taking into consideration the cultural context, capacity to provide skilled support and current acceptability. If safer options are not available, as a last resort, infant formula accompanied by an essential package of support (described below) should be prescribed if it is considered life saving to do so.

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128 Note that information on breastfeeding and complementary feeding practices should also be included in needs assessment to allow for the most urgent IYCF needs to be identified and appropriately responded to as part of a comprehensive IYCF programme.

129 By a registered medical practitioner under the Bangladesh Medical and Dental Council Act, 2010 (Act No. 61 of 2010)
Figure 8 – Decision tree to explore safer feeding options first
3.7.3 Relactation

Relactation means restarting breastmilk production (lactation) in a woman who has stopped lactating, recently or in the past in order to breastfeed her own or another infant. It is the best way of providing milk feeds for infants who are not breastfeeding, especially in emergency settings. Preferably the infant’s own mother will re-lactate. If this is not possible, re-lactation may be supported in another woman who is willing to be a wet nurse, such as a grandmother or close family friend, if this is acceptable to the mother. A woman who wishes to relactate will require skilled, regular breastfeeding support and frequent encouragement until breastfeeding is re-established. Success will depend on the mother’s wellbeing and motivation, the age of the infant, how long the mother has ceased breastfeeding, family support, technique used and her access to sustained skilled support. Infants less than 6 months will benefit most and should be prioritised if resources are limited.

- A moderately malnourished woman should be assisted to start the process of relactation immediately, alongside the provision of support for her own wellbeing [Chapter 3.9 - Maternal Wellbeing].
- A woman who is ill or severely malnourished should first receive treatment to improve her own condition, using breastfeeding-friendly medicines. The child should receive temporary feeding support.
- If the infant is too weak or feeble to suckle effectively (irrespective of his/her weight-for-length, weight-for-age or other anthropometry) OR the infant is not gaining weight at home (by serial measurement of weight during growth monitoring) OR Weight-for-Length is less than <-3 Z OR there is presence of bilateral pitting oedema, then the infant should be admitted into a Stabilisation Centre and the Supplementary Suckling Technique\textsuperscript{130} used for re-lactation.
- If the infant is able and willing to suckle at the breast, relactation can be attempted at home/community level using the Drip-and-Drop method.

Do not implement re-lactation activities within IYCF-E programmes without adequately training providers on a relactation protocol (Annexe D10) and ensuring that close follow up and monitoring is possible.

While the woman is starting to produce breastmilk, her infant should receive the best available milk until she is able to establish a full supply. This should ideally be expressed breastmilk from a wet nurse but may also be infant formula. Infants over 6 months of age also need nutritious complementary foods.

3.7.4 Wet Nursing

Wet nursing is a woman breastfeeding another woman’s baby. Every effort should be made to provide children who cannot be breastfed by their biological mother with a healthy wet-nurse as the first option\textsuperscript{131}. Wet nursing and re-lactation can work together where the wet nurse provides supplemental milk until the re-lactating woman has sufficient milk.

\textsuperscript{130} During emergencies, the use of tools such as breastfeeding supplementary feeding devices should only be considered when their use is vital and where it is possible to clean them adequately, such as in a clinical setting.

\textsuperscript{131} National Strategy on IYCF in Bangladesh, 2007.
• Community health workers or IYCF counsellors, in discussion with the infant’s family, should identify a wet nurse who meets criteria described in Box 12. Once a suitable wet nurse is identified, separate discussions should be with the infant’s family and the wet nurse’s family to confirm agreement.

<table>
<thead>
<tr>
<th>Box 12 - Wet Nurse Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Willing to wet nurse the infant until they are at least 6 months old</td>
</tr>
<tr>
<td>• Ideally a family member or other women with a close relationship to the family</td>
</tr>
<tr>
<td>• Lives in close proximity to the infant’s household</td>
</tr>
<tr>
<td>• Her own child should be healthy, gaining weight well free from infections</td>
</tr>
<tr>
<td>• No illness / not taking medication that may put the infant at risk</td>
</tr>
<tr>
<td>• Accepted by the infant’s family</td>
</tr>
<tr>
<td>• Accepted by the wet nurse’s family</td>
</tr>
</tbody>
</table>

• Wet nurses should undergo counselling and voluntary testing for HIV or a HIV risk assessment where testing is unavailable. (See: Chapter 3.13 - HIV and Infant Feeding).

• A wet nurse will benefit from skilled counselling to support the process. An IYCF counsellor will manage the initiation of wet nursing, observe the first feed and provide breastfeeding counselling and regular follow-up as required.

• Provide the wet nurse / caregiver with plenty of lidded storage containers to store expressed breastmilk for night time cup/spoon feeds by the infant’s caregiver. Expressed breastmilk can be kept at room temperature for 6 – 8 hours.

• Ensure the wellbeing of wet nurses (Chapter 3.9) and that they receive any additional food and other resources that PLWs are entitled to. Incentives for the Wet Nurse should be considered to motivate the wet nurse, support her nutritional requirements and minimize drop-out.

• Frontline health and nutrition workers should conduct fortnightly home visits to assess progress, monitor the child’s health and nutrition status, check-in with both families that they are still in agreement for the arrangement and to identify and manage any difficulties.

• If the mother of the child is present, support her to bond with her child (e.g. encourage her to bathe and carry her child, sing to him or play with him, or feed them complementary foods). If the mother is absent, support fathers, grandmothers or other caregivers to take on this role.

### 3.7.5 Artificial Feeding Support

**Age range for artificial feeding support**

Artificial feeding programmes will automatically target infants 0 – 5 months. These infants are fully dependent on breastmilk or a breastmilk substitute (BMS) and will be prioritised. Up to 12 months of age, the majority of a child’s nutrient needs are still met by breastmilk or a BMS. The NC under leadership of IPHN may decide to extend the age range up to 11 months depending on pre-emergency practices in the local area, available

132 Note that the risk of transmission of HIV from an infant to a wet nurse of unknown HIV status is low
133 Of both the wet nurses own breastfed child, and the child she is wet nursing. (If applicable)
resources, the context (e.g. food insecurity), sources of safe alternative milks and adequacy of complementary foods. Figure 9 demonstrates the decision-making process.

If an age range of 0 – 5 months is chosen for enrollment into artificial feeding support programmes, a buffer supply of infant formula for 2 additional months should be provided to infants being discharged from the artificial feeding support programme at 6 months to allow for transition to complementary feeding.

Eligibility (Targeting) Criteria for Infant Formula

The decision to prescribe infant formula can only be made on a case-by-case basis by a registered medical practitioner who has been trained on IYCF issues, on the basis of a Full Assessment of the caregiver-baby pair. All agencies will provide infant formula according to the same, agreed upon, eligibility criteria.

If relevant, the practitioner will consult with protection, nutrition and / or mental health and psychosocial staff. Children of mothers who do not breastfeed in order to go out for work, breastfeeding difficulties and

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134 Operational Guidance on Infant and Young Child Feeding in Emergencies 5.15. IFE Core Group, 2017.
135 Under the Bangladesh Medical and Dental Council Act, 2010
inappropriate feeding practices (such as mixed feeding) are not considered eligible criteria for the provision of BMS; the priority response for these mothers is the provision of skilled breastfeeding support. Criteria should be clearly communicated to caregivers, communities and emergency responders.

Table 22 - Targeting criteria for artificial feeding support

<table>
<thead>
<tr>
<th>Temporary provision of infant formula</th>
<th>Longer term provision of infant formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>• During relactation (no expressed breastmilk available)</td>
<td>• Relactation / wet nursing unsuccessful/not possible</td>
</tr>
<tr>
<td>• While waiting for a wet nurse to be identified</td>
<td>• Mother has died</td>
</tr>
<tr>
<td>• Mother is critically ill (e.g. unconscious, sepsis)</td>
<td>• Mother is living with HIV and child is already established on replacement feeding</td>
</tr>
<tr>
<td>• Mother and child unavoidably separated</td>
<td>• Infant medical condition: classic galactosemia, maple syrup urine disease, phenylketonuria,</td>
</tr>
<tr>
<td>• Infant has been rejected by the mother</td>
<td></td>
</tr>
<tr>
<td>• Mother is rape survivor not wishing to breastfeed</td>
<td></td>
</tr>
<tr>
<td>• Maternal medical condition: Herpes Simplex Virus Type 1 (HSV-1) active lesion on mother’s breast</td>
<td></td>
</tr>
<tr>
<td>• Maternal cytotoxic chemotherapy</td>
<td></td>
</tr>
<tr>
<td>• Where safer (breastfeeding friendly) alternatives are NOT available for psychotherapeutic drugs, anti-epileptic drugs, opioids.</td>
<td></td>
</tr>
<tr>
<td>• Relactation / wet nursing un成功的/not possible</td>
<td></td>
</tr>
<tr>
<td>• Mother has died</td>
<td></td>
</tr>
<tr>
<td>• Mother is living with HIV and child is already established on replacement feeding</td>
<td></td>
</tr>
<tr>
<td>• Infant medical condition: classic galactosemia, maple syrup urine disease, phenylketonuria,</td>
<td></td>
</tr>
</tbody>
</table>

Case Management of the non-breastfed child

Support services for the non-breastfed child encompass health and nutrition assessment, close monitoring, regular follow-up, health and nutrition education, supply management and multi-sectoral collaboration. Appropriate supplies and coordinated, targeted, skilled and consistent support should be provided to those infants who need it, based on agreed upon strict targeting criteria (Table 22), and through coordinated mechanisms for identification and support. Use of infant formula by an individual caregiver should always be linked to education, one-to-one demonstrations and practical training for the caregiver.

The use of feeding bottles and teats should be actively discouraged at all times due to the high risk of contamination, difficulty with cleaning and interference with breastfeeding. The use of clean cups (without spouts) or spoons is the safest practice for artificially fed children and should be actively supported through provision and promotion. The use of cups with lids or disposable cups may be temporary advisable in transit situations. If a caregiver has difficulties immediately transitioning from bottle- to cup-feeding, advise on sterilisation at household level and provide strong hygiene messaging. Bottles and teats, including pacifiers, should never be distributed.

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136 “Temporary” means until breastfeeding is re-established, or a nutritionally adequate and safe diet without breastmilk or a breastmilk substitute can be guaranteed. Regularly reassess the situation e.g. after providing counselling and support.

137 Note this rejection should be confirmed by a psychologist oriented on IYCF-E. Bereavement, trauma or emotional crises do not automatically warrant cessation of breastfeeding - restorative care and psychosocial support should be the first step.

138 Note that while breastfeeding is recommended as this is the safest way to feed the child and will encourage mother-baby bonding, it is recognised and respected that for some mothers this is too difficult.

139 During emergencies, breastfeeding may be in the best interests of HIV-free child survival. A mother living with HIV may choose to switch to breastfeeding. See Chapter 3.13 IYCF-E in the Context of HIV.

140 It is important to note that only a small number of infant and maternal medical conditions are contraindications for breastfeeding. For the majority of conditions, it is in the best interests of both mother and child to support the continuation of breastfeeding. Acceptable medical reasons for the use of breastmilk substitutes. WHO and UNICEF, 2009.

141 In accordance with National Strategy on IYCF in Bangladesh, MOHFW, 2007.

142 It is important to liaise with WASH agencies to secure priority access of families with infants using infant formula to WASH services. See: Annex C – IYCF-E Sensitive WASH Programming.

143 National Strategy on IYCF in Bangladesh, MOHFW 2007.

144 For example, a caregiver who is highly stressed due to the emergency situation may be resistant to changing practices.
### 1. Household Assessment

<table>
<thead>
<tr>
<th>Where:</th>
<th>Community</th>
<th>Frequency:</th>
<th>Once</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Verify that there is access to safe water, storage facilities, a sufficient heat source to boil water and a clean preparation area - either at household level or nearby the household[^145] (Annexe D11)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Discuss what support is available to the primary caregiver (e.g. family members, neighbours)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• If hygienic preparation cannot be assured, the feeds will need to be prepared at the Nutrition/Health Centre (24/7) until these provisions can be put in place[^146].</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[^145]: Coordinate with other sectors and/or provide equipment and supplies

### 2. Initial Counselling & Practical Training

<table>
<thead>
<tr>
<th>Where:</th>
<th>Stabilisation Centre Nutrition Facility</th>
<th>Frequency:</th>
<th>Once</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information provided by Health or Nutrition Worker trained on IYCF Counselling:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explain what, where, how and when supplies will be provided</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explain how often (frequency) and how much (volume) to feed (Annexe D12)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide a warning on the potential hazards of using infant formula</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Caution against sharing BMS with other household members or using it to prepare food</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explain the shelf life of the infant formula provided: before opening, once opened/prepared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Explain the hazards of bottle feeding and introduce the concept of cup feeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Agree on a monitoring and follow up plan with the caregiver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Record all information in the infant’s care plan (Annexe D13)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practical Demonstration by Health or Nutrition Worker trained on IYCF Counselling:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide a one-to-one demonstration on safe and hygienic preparation of infant formula. (Annexe D14 and D15)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Demonstrate the cleaning and safe storage of feeding and preparation utensils (Annexe D16)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Practice with the caregiver and family members how to cup feed their infant (Annexe D17)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Observe the caregiver managing an infant formula feed and correct any problems</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. Provision of Supplies

<table>
<thead>
<tr>
<th>Where:</th>
<th>Stabilisation Centre Nutrition Facility</th>
<th>Frequency:</th>
<th>Fortnightly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription by Registered medical practitioner trained on IYCF-E:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1st visit: Provide a kit containing preparation, feeding and storage utensils and equipment (Annexe D18)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Calculate the quantity of infant formula required by the infant until the next follow up[^147],[^148]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide appropriate infant formula on a prescription basis (Annexe D19)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Advise the caregiver on when, where and how to refill the prescription</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Record the details of the case and supplies given</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[^147]: Quantity required will be decreased if relactation is progressing with success.

### 4. Follow Up

<table>
<thead>
<tr>
<th>Where:</th>
<th>Community Clinic Nutrition Facility</th>
<th>Frequency:</th>
<th>Weekly Monthly – when no health, nutrition or feeding issues have been detected for 1 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Record the infant’s health and weight using a growth monitoring chart or phone app.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Refer the child if medical issues or malnutrition identified.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Find out any difficulties the caregiver may be facing and discuss practical solutions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inform the caregiver when to return.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Advise the caregiver to visit sooner if there are feeding problems or the infant is unwell.

### 5. Household Monitoring

<table>
<thead>
<tr>
<th>Where</th>
<th>Community</th>
<th>Frequency:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Fortnightly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monthly – once confident in caregiver’s ability to safely prepare and provide feeds</td>
</tr>
</tbody>
</table>

- Enquire after the infant’s and caregiver’s wellbeing and refer as appropriate
- Verify that conditions for safe preparation and storage are still in place and take action as appropriate
- Carry out “spot-checks” on how the caregiver manages feeds; provide support as needed
- Check for warning signs of misuse

#### Control of Provision

Infant formula should ONLY be given to the caregiver if they are able to hygienically able to prepare and use it at home. This means:

1. Understanding all the steps in preparation
2. Having all the resources needed for hygienic preparation and safe storage
3. Having shown their ability to correctly prepare and manage a feed

If the caregiver cannot prepare and use infant formula correctly at home then the caregiver should come to a central area for on-site reconstitution and consumption (wet feeding) until this can be done at home. Ensure that such central areas are safely and realistically accessible for the caregiver 24/7.

A sustainable provision of BMS must be provided to all children who are enrolled until the agreed upon cut-off age (6 or 12 months).

The quantity, distribution and use of breastmilk substitutes (such as infant formula) should be strictly controlled to prevent any “spillover effect” of artificial feeding into the general population. Provision should be carried out in a discrete manner and away from any general food aid distributions and breastfeeding support activities. Activities should comply with the provisions of the Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and Accessories Thereof (Regulation of Marketing) Act, 2013. There should be no promotion of infant formula at the point of distribution, including displays of products or items with company logos. Securely store products out of view of the target population.

**General distributions should never be used as a platform to supply infant formula or other milk products.**

Where unrestricted cash transfer programmes are implemented and infant formula is available, it should not be excluded as an option for purchase. 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. Report and act upon any violations of the Bangladesh BMS Act 2013 and monitor the price of products.

#### Referrals

Referral mechanisms should be in place linking caregivers and their infants to relevant services (e.g. medical services, mental health and psychosocial support services, therapeutic feeding services and child protection

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149 Signs of misuse include: not finishing supply on time/finishing supply too quickly, child not gaining weight, evidence of other children consuming infant formula, visible bottles, formula issued more than 1 month ago still present


152 Bangladesh BMS Act 2013.
services). Upon exiting the programme (e.g. after successful re-lactation or when the age threshold has been passed) caregivers and their infants should be systematically linked to relevant IYCF-E services.

### 3.7.6 Control of implementing organisations

It is probable that only a small proportion of emergency-affected infants will require specialised artificial feeding support. While it is therefore important that all health and nutrition agencies are aware what provisions are in place to support non-breastfed infants, it is not necessary or appropriate for large numbers of agencies to intervene. For every emergency, the Nutrition Cluster will determine if and where capacity to manage artificial feeding exists among government agencies and their partners and assign responsibility. In the event that multiple agencies are required to respond (for example, due to geographic spread or the scale of the emergency) IPHN will assign a central agency to coordinate activities and supplies. Providers should be working as part of the nutrition and health emergency response and have a demonstrable capacity to uphold the provisions outlined in this guideline and of the Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and Accessories Thereof (Regulation of Marketing) Act, 2013. Identified providers should be given terms of references so that expectations for service delivery are clear, as well as technical support and close oversight of procurement, monitoring and use. Responders should not implement artificial feeding interventions without first consulting with IPHN/NNS.

Any IYCF-E programme providing support to non-breastfed infants should always include a component in support of breastfeeding. Where BMS kits are provided, consider distributing items of equivalent value, such as food or hygiene products, to breastfeeding mothers.

### 3.7.8 Supplies & Equipment for Artificial Feeding

Appropriate procurement, distribution, targeting and use of BMS and associated support should be strictly controlled and planned in close consultation with IPHN/NNS, UNICEF and the Nutrition Cluster.

**Infant Formula**

Generic (unbranded) infant formula is the preferred option. If this is not available, commercial infant formula may be used. Any infant formula that is used as part of the emergency response must comply with the following specifications:

- Labelled in the language of the target population (or pictorials where literacy is an issue).
- Manufactured in accordance with the Codex Alimentarius Standards, CODEX STAN 72-1981
- Shelf-life of at least 6 months of receipt of supply
- Suitable for infants < 6 months of age
- Purchased (not donated).

Where labels of infant formula supplies do not conform to requirements, consider relabelling. This will have cost and time implications and is therefore best done in preparedness. Where this is not possible, provide the specified information to users verbally and in a leaflet. *(Annexe D20)*

Infant formula is available as **powdered infant formula** (PIF) or as liquid, **ready-to-use infant formula** (RUIF).

- **PIF** is not sterile, is time consuming to prepare and requires reconstitution with water that has been heated to at least 70 degrees Celsius. PIF can usually be procured more rapidly than RUIF.

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153 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.

154 As a guide: 1 litre should be boiled and left standing for no more than 30 minutes
• **RUIF** is a sterile product until opened, does not require fuel or water for reconstitution and requires less equipment. RUIF is more expensive, creates more waste and is bulky to transport and store. Its use is recommended in settings where sanitation is a concern, where caregivers have limited access to safe water and fuel, for caregivers who are in transit and during communicable disease outbreaks.

Appropriate use, careful storage and hygiene of feeding utensils remains essential to minimise risks regardless of which type is used. The following products should **not** be used:

- concentrated liquid formula
- therapeutic milks (for infants who are not acutely malnourished)
- home-modified animal milk (for infants less than 6 months)

### Quantification of infant formula supplies

Artificial feeding support programmes should commit to providing infant formula for as long as the infant needs it, i.e. until breastfeeding is re-established or until **at least** 6 months of age. When calculating supplies, take into account the agreed upon age inclusion criteria, duration of the programme (remember all children who are admitted must be followed until at least 6 months of age), estimated total population who will be covered by the programme, estimated number of infants who will be enrolled for BMS support and estimated number of new admissions in the following months.

**Table 24 - Average Infant Formula Needs 0 - 5 months**

<table>
<thead>
<tr>
<th></th>
<th>Day</th>
<th>Month</th>
<th>6 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ready to Use Infant Formula (RUIF)</td>
<td>750ml/day</td>
<td>22.5L/month</td>
<td>135L/6 months</td>
</tr>
<tr>
<td>Powdered Infant Formula (PIF)</td>
<td>116g/day</td>
<td>3.5kg/month</td>
<td>21kg/6 months</td>
</tr>
</tbody>
</table>

### Alternative products for infants older than 6 months

Alternative milks (instead of infant formula) may be provided for 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. Follow-on milks, growing-up milks, and toddler milks marketed to children aged six months (“infant foods”) should **not** be provided.

### Additional supplies

The provision of infant formula **must** be accompanied by the provision of appropriate equipment for safe household preparation (cleaning, sterilisation, reconstitution, storage) and feeding as specified in **Annexe D18**. Funding applications should include, and funders should accept, costs for associated supplies and hygiene measures.

### Control of procurement

Necessary supplies should be **purchased**, not accepted as donations. Any agency planning to import or distribute BMS must be registered under the **Bangladesh Breastmilk Substitutes, Infant Foods, Commercially Manufactured Complementary Foods and Accessories Thereof (Regulation of Marketing) Act**, 2013. A list or registered agencies should be maintained by the Nutrition Cluster. Registration can take up to sixty (60) days and should therefore be carried out as a preparedness action to avoid delays. Organisations should consult IPHN/NNS and UNICEF for guidance on the identification of appropriate BMS providers, including a BMS supply chain.

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155 YCF-E Toolkit: Caseload and Supply Calculator. [https://drive.google.com/file/d/0B5uBNDhhrtqbQk5lb2VncWl5Q0U/view](https://drive.google.com/file/d/0B5uBNDhhrtqbQk5lb2VncWl5Q0U/view)


Control of storage

IPHN, UNICEF and XXX will agree on a suitable and safe storage space. IPHN and/or its identified government counterpart will be responsible for the stored supplies and distribution to implementing partners. The same protocol and procedures will be used as those for the storage and release of F100 and F75 to implementers.

Implementing agencies should ensure that storage, transportation and safeguarding of BMS are sufficiently budgeted for in project proposals and planning. BMS stock should be carefully secured (restricted entry, locked) to ensure that there is no leakage or theft at any point during the supply chain (including warehouse, transportation, health facility etc.). Storage facilities should be clean, dry, free of chemical and pest contaminants and protected from extreme temperatures. Tight stock management controls should be in place to control against stock misuse and loss. A First Expired First Out (FEFO) methodology should be used to manage stocks.

3.7.9 Monitoring

Regular supportive supervision should monitor:

- Whether the criteria for admitting infants to a BMS support programme are being respected (e.g. checking the register, verifying reasons for prescription, verifying that the same story is not repeated by several caregivers requesting BMS).
- Whether who receives the BMS is tightly controlled (e.g. verifying that the prescription is valid and that caregiver and infant identity is also verified)
- Whether BMS is being correctly distributed (e.g. correct quantity and frequency). This information can be checked against prescriptions and stocks to ensure there is no leakage or duplication

Markets should be monitored to see whether the provided BMS is being sold (‘spillover’) and whether prices of infant formula on the market change.

External monitoring and compliance checks will be conducted by IPHN and <BMS Act monitoring/enforcement agency>.

3.8 Complementary Feeding

**KEY ACTION: Support timely, safe, appropriate and nutritionally adequate complementary feeding for children 6 – 23 months**

When an infant has completed 6 months of age, breastmilk alone is no longer sufficient to meet his or her nutritional needs and therefore other foods and liquids should be given along with breastmilk. This is known as complementary feeding. The same feeding principles apply during normal times and emergencies.

In every emergency, it is important to ensure the caregivers have consistent access to adequate amounts of appropriate, safe and nutritious complementary foods and associated support for children 6 – 23 months.

According to Article 6.1.3.2 of Bangladesh’s National Nutrition Policy (2015), the adequate nutrition of populations affected by emergencies should be ensured. Complementary feeding is a critical aspect of child nutrition, development and growth. 6-23 months is a vulnerable time in a child’s life, with sharp increases in malnutrition rates commonly observed between 6 and 12 months of age due to inappropriate feeding practices. It is a time which must be adequately supported, particularly in times of crisis. Poor pre-emergency

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158 Actions (such as removing the foil cover under the plastic lid from the tin) can be taken to prevent resale.
complementary feeding practices may be exacerbated by the emergency, or the setting may disrupt recommended practices, resulting in malnutrition, morbidity and mortality. For example:

- **Food may be introduced too early** because the General Food Distribution (GFD), donations or unfamiliar products may be perceived by caregivers as important to give to infants, or mothers may feel their breastmilk is not enough or not good quality.
- **Food may be introduced too late** because the family is in on the move, because there is a lack of familiar (trusted) food or there is a lack of suitable complementary foods.
- **Unhygienic practices** may occur due to environmental conditions, water contamination or scarcity, a lack of hygiene and sanitation facilities, or lack of food preparation and storage equipment.
- **Feeding frequency may be reduced** due to poor availability of foods or cooking fuel, caregiver stress and fatigue or lack of caregiver time and availability.
- **Inadequate quantities of food** may be given due to lack of access to, or availability of food (e.g. after breakdown of markets, disruption to local production or trade).
- **The nutritional adequacy (diversity and density) of the child’s diet may be reduced** due to poor access or availability of food, or reduced purchasing power resulting in families buying less nutritious/staple foods. Distributed food may be of poor quality or not meet the nutritional needs of infants and young children.
- **Unsuitable foods may be given to the child** if there is lack of availability of appropriate foods, cooking utensils or fuel to cook suitable foods. Unfamiliar foods may be given without adequate information. Caregivers may over-dilute foods when they are scarce, resulting in an inappropriate consistency.
- **Breastfeeding may be reduced or discontinued** due to the spread of emergency myths and misconceptions, breastfeeding difficulties, illness, uncontrolled distributions of breastmilk substitutes or the inappropriate promotion of commercial complementary foods.
- **Children may not be responsively fed** if caregivers are busy, stressed, traumatised or unwell.

### 3.8.2 Recommended Complementary Feeding Practices

The same complementary feeding principles apply as during normal times\(^{159}\). This includes recommendations on hygiene and on what frequency, amount, texture, variety, feeding style are appropriate at different ages and depending on whether the child is breastfed or not.

- **Adapt messaging and counselling** to the emergency context and ensure it is sensitively delivered. *For example, counsellors should be aware of the impact food insecurity has on a caregiver’s ability to practice recommendations and seek to find solutions together with the caregiver.*

Key topics to address are:

- When to introduce complementary foods
- Continued breastfeeding
- Responsive feeding
- Hygiene (preparation, serving, feeding, storage, avoidance of bottles)
- Selecting appropriate complementary foods from what is available and affordable
- Quantity, consistency, frequency, diversity (age-appropriate)
- Nutrient content of complementary food
- Feeding a child with poor appetite
- Feeding during illness and recovery

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\(^{159}\) For details on recommended practices, refer to the [National Training Manual on IYCF (2011)](https://example.com) and [DIPSHIKA: Competency Based Training Manual Module 1 (2016), National Drug Policy 2016](https://example.com)
Use of vitamin or mineral-supplements or fortified products
• Importance of anthelminthics

Complementary feeding interventions should always protect, promote and support continued breastfeeding. Health and nutrition workers must make it clear to caregivers that foods are intended to complement, not replace, breastmilk. Breastmilk continues to provide numerous benefits to mothers, babies, families and communities beyond the first 6 months of life. Breastmilk should remain the main food for infants during the first year of life, particularly when available complementary foods are less nutritious.

Bottle feeding of liquid or semi-liquid complementary foods should be strongly discouraged – these foods should be fed to the child using a spoon or open cup.

3.8.3 Interventions to support complementary feeding

Target Group: 6 – 23 months

The Nutrition Cluster will provide clear direction on appropriate complementary feeding needs and interventions specific to the emergency context.

During emergencies, special consideration should be given to older infants and young children whose particular nutritional requirements may not be met by the household food basket or may not be covered by general food rations. Given the vulnerability of infants and young children in emergencies and the narrow window in which to intervene, it should be a priority to enable access to adequate amounts of nutritious and appropriate complementary food within the first phase of emergency response.

A number of interventions across different sectors (e.g. WASH, Food Security) may be necessary to fully meet the complementary feeding needs of emergency-affected children. Table 25 provides an overview of possible interventions which may be implemented during emergencies in Bangladesh. Which interventions are selected will depend on the context, objectives and timeframe of the response.

Responses should ensure that:

1. Caregivers have secure, uninterrupted access to adequate amounts of safe, nutritious, appropriate complementary foods
2. Caregivers have the means to safely prepare (cook, mash etc.) age-appropriate complementary foods
3. Caregivers have the necessary knowledge and skills to implement recommended IYCF practices

Table 25: Possible Interventions to Meet Complementary Feeding Needs in Emergencies

<table>
<thead>
<tr>
<th>Intervention</th>
<th>When to consider implementation (One or more conditions present)</th>
<th>When to start (Timeframe) &amp; Which Cluster</th>
</tr>
</thead>
</table>
| 1. Improve access to safe, nutritious and appropriate complementary foods | • Food insecurity - poor availability of / access to appropriate complementary foods  
• Prevalence of acute malnutrition ≥ 15% in 6 – 59 month age group | Short Term  
Food Security |


161 For example – lentils, <nutrient rich foods which can be used for CF in Bangladesh>
Prevalence of acute malnutrition 10 – 14% in 6 – 59 month age group AND presence of aggravating factors

- Under 5 Mortality Rate ≥ 2 deaths/10,000/day

### Provision of multiple-micronutrient fortified foods through blanket supplementary feeding (BSFP) – take home dry ration

- Population dependant on food aid
- GFD system not yet adequately in place (start of crisis) and/or does not meet CF needs
- Prevalence of acute malnutrition ≥ 15% in 6 – 59 month age group
- Prevalence of acute malnutrition 10 – 14% in presence of aggravating factors in 6 – 59 month age group
- High stunting (>30%)
- Anticipated increase in rates of malnutrition due to seasonality / seasonally induced epidemics (e.g. acute watery diarrhoea outbreak)
- Micronutrient deficiency outbreak

<table>
<thead>
<tr>
<th>Short Term</th>
<th>Food Security</th>
<th>Nutrition</th>
</tr>
</thead>
</table>

### Provision of multiple-micronutrient fortified foods through blanket supplementary feeding (BSFP) - on site feeding (wet ration)

- Same as above PLUS one or more:
  - Take home (dry) ration is not an option
  - Household food supply is limited so sharing is likely
  - Lack of fuel and / or cooking utensils at household level
  - Poor security situation; carrying home food ration puts recipients at risk

<table>
<thead>
<tr>
<th>Short Term</th>
<th>Food Security</th>
<th>Nutrition</th>
</tr>
</thead>
</table>

### Home (point-of-use) fortification with micronutrient supplements

- NO ongoing blanket distribution of multiple-micronutrient fortified foods
- Food available and possibility of food preparation at HH level
- Dietary diversity is low
- Complementary foods prepared for the small child have insufficient nutrient content and density
- The bioavailability of micronutrients is poor due to absorption inhibitors in the diet
- High anaemia (≥ 20%) with medium – low levels of GAM and stunting
- In malaria-endemic area, if considering provision of iron: malaria prevention & treatment is in place

<table>
<thead>
<tr>
<th>Short Term</th>
<th>Food Security</th>
<th>Health</th>
<th>Nutrition</th>
</tr>
</thead>
</table>

### Cash / voucher scheme to purchase nutrient-rich and / or fortified foods (e.g. fresh food vouchers)

- Poor access: lack of means to purchase CF
- Appropriate CF are locally available
- There is good food diversity
- Markets are functioning and accessible
- Acceptable price stability is forecasted
- A viable cash delivery modality exists

<table>
<thead>
<tr>
<th>Short Term - Medium Term</th>
<th>Food Security</th>
<th>Nutrition</th>
</tr>
</thead>
</table>

### Livelihood programmes and safety net programmes for families with children < 2 yrs.

- Loss of livelihoods
- Complementary Foods are locally available

<table>
<thead>
<tr>
<th>Medium Term</th>
<th>Food Security</th>
</tr>
</thead>
</table>

### Nutrition Sensitive Homestead Gardening (e.g. provision of seeds and...

- Situation has stabilised; no frequent population movement

<table>
<thead>
<tr>
<th>Medium Term</th>
<th>Food Security</th>
</tr>
</thead>
</table>

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162 **Aggravating factors** are normally defined as inadequate general food ration, crude mortality rate above 1/10,000/day, epidemics measles or whooping cough, and high prevalence of respiratory or diarrhoeal diseases.

163 For example, watery porridges and foods with too low micronutrient content

164 E.g. fibre, phytate, tannin - especially the case in plant-source based meals.
tools) and small-scale livestock and poultry rearing

<table>
<thead>
<tr>
<th>2. Ensure caregivers have the means to prepare age appropriate complementary foods</th>
</tr>
</thead>
</table>
| **Provision of cooking equipment and feeding utensils, and/or fuel** | Widespread loss / destruction of household items | Short Term
|  | Shelter/NFI Food Security |
| **Access to communal food preparation areas** | No household facilities  
|  | Hygiene cannot be ensured at HH level | Short Term |
|  | Food Security Nutrition Site Management |
| **Protected eating and playing spaces** | Overcrowding (e.g. camp setting)  
|  | Children at risk of physical harm  
|  | Lack of space at household level  
|  | Poor hygiene at household level | Short Term |
|  | Food Security Nutrition Child Protection |

<table>
<thead>
<tr>
<th>3. Improve caregiver knowledge and skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information Sharing &amp; Education</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Skilled IYCF Counselling (1-1)</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
| **Mother Support Groups** | Malnutrition prevalent in 6 – 23-months  
|  | Poor complementary feeding practices  
|  | Low caregiver knowledge  
|  | Stabilised; no frequent population movement | Medium Term |
|  | Nutrition |
| **Support and follow up on MNP / BSFP products** | MNP / BSFP products targeted to 6 – 23 months are being distributed | Short Term |
|  | Nutrition Food Security |

Improve access to safe, nutritious and appropriate complementary foods

Considering that the majority of children 6 – 23 months in Bangladesh do not consume an acceptable diet (in terms of frequency and diversity), it is imperative that a further deterioration is prevented during emergencies.

- In accordance with the National Strategy on IYCF (2007) and the National Nutrition Policy (2015) Article 6.2.7, supplementary food shall be supplied to affected populations during emergencies and times of severe food insecurity. (See Annexe D21 – suggested complementary food baskets).

- In food assistance programmes, GoB and WFP and partners distributing food commodities have a responsibility to provide or enable access to culturally appropriate nutrient-rich complementary foods for children aged 6 – 23 months when significant food and nutrient gaps are identified.

- In accordance with the National Nutrition Policy (2015) Article 6.2.8, a food fortification programme will be initiated (e.g. iodised salt, Vitamin A enriched oil, enriched main food for children, cooked at home with mixed micronutrients).
• **Provision of multiple micronutrient fortified foods through Blanket Supplementary Feeding Programmes (BSFP)** allows for targeting with fortified blended foods which are more appropriate for the target group. BSFP programmes can target PLWs and children 6 – 23 months or 6 – 59 months. Food must be energy dense and rich in micronutrients, culturally acceptable, easily digestible and palatable. Examples include fortified blended foods (FBF) and lipid-based nutrient supplements (small – medium quantity). FBF are blends of partially precooked and milled cereals, soya, beans, pulses fortified with micronutrients and used in addition to good-quality traditional local foods and instead of poor-quality porridges. Example: distribution of Super Cereal Plus (e.g. WSB ++) at a ration of 200 grams / person / day or 6 kg per month for children 6 – 23 months of age.

• **Responders distributing food commodities should accompany provision of complementary food** (including through cash or vouchers) with harmonised messaging, practical guidance (e.g. recipes), demonstration (e.g. on hygienic preparation) and monitoring. It is necessary to contextualise advice and support, including how to adapt available foods to feed different age groups and on hygienic food preparation and storage in the current conditions. Encourage complementary food preparation using family foods. See **Annexe C** for further guidance on IYCF-E Sensitive Food Security interventions.

• **Micronutrient supplements** (e.g. Vitamin A for children 6 – 59 months) are required to prevent mineral and vitamin deficiencies during emergencies. **Home (point-of-use) fortification with micronutrient supplements** includes uses of micronutrient powders (MNP) or other supplements. MNPS are home fortificants containing only vitamins and minerals that are used to fortify the food consumed by the child. The National Strategy on Prevention and Control of Micronutrient Deficiencies in Bangladesh (2015 – 2024) recommends the integration of MNP programming within emergency responses. It is recommended to closely link MNP provision with IYCF-E programming through using contact points which bring caregivers together to discuss health, nutrition and IYCF as distribution points. Note that MNPs should not be provided where there is blanket distribution of multiple-micronutrient fortified foods. MNP use should be followed up (see next section).

• **Cash/vouchers** can be implemented to purchase nutrient-rich foods and/or fortified foods that are locally available. To enhance the nutritional benefit of cash distribution, a campaign may include key messages on the cultivation of fresh fruit and vegetables, the consumption of micronutrient-fortified foods or the purchase of micronutrient-rich foods from functional markets.

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165 Note that while this guideline is concerned with complementary feeding, children older than 23 months (e.g. children 6 – 59) months are commonly also included in BSFP programmes when there is severe food insecurity. Priority is given to children 6 – 23 months due to their heightened vulnerability when food variety and quantity are limited.


168 The National Strategy on Prevention and Control of Micronutrient Deficiencies in Bangladesh recommends that where anaemia prevalence in children under 2 is over 20%, one sachet of MNP containing 12.5 mg of elemental iron (preferably as encapsulated ferrous fumarate), 300 μg of retinol (vitamin A) and 5 mg of elemental zinc (preferably as zinc gluconate) is recommended daily.


170 Note: MNPs may still be appropriate if fortified complementary foods are not effective and being shared between whole family. If fortified complementary foods are being provided, consider the effectiveness of the programme, including quantities provided, the target age group (blanket? 6 to 23 months only?) and sharing of ration within household. Balance this against whether there is a risk of exceeding the intakes of any micronutrients if MNPs are introduced. National dosage recommendations may need to be adjusted. MNPs are still safe in the context of biannual vitamin A supplementation and when iodised salt is provided in the general food ration. Combining it with other specially formulated products (such as FBF) is not appropriate because those products already contain a similar or higher amount of micronutrients. In this case, keep MNP for later the other products are no longer used. Source: Committed to Nutrition – Toolkit for Action. UNICEF, 2017.
Animal milk (cow / goat’s milk) is a significant feature in many children’s diets in Bangladesh. Where milk consumption is a common local practice, and only once the situation has stabilised, it may therefore be relevant to establish how to safely include milk products as part of the complementary diet without undermining breastfeeding practices. Milk products should never be included in the general distribution. Milk products can be used to prepare complementary foods (such as porridge) for all children over 6 months of age. Breastfeeding mothers must be recommended not to displace or substitute breastmilk with animal milk. Pasteurized or boiled animal milk may only be provided to non-breastfed children over 6 months of age and to breastfeeding mothers to drink in controlled environments, where its consumption can be monitored. Animal milk should not be distributed outside of such controlled environments.

Improve caregiver knowledge and skills

- The WASH Cluster plays an essential role in promoting hygienic food preparation practices. See Annexe C for further guidance on how the WASH sector can support CFE.

- Education and information sharing should include advice on safe food handling and food / cooking demonstrations. Prioritise advice on safe food handling where WASH conditions are poor, food handling practices are sub-optimal, unfamiliar food products are being introduced or there is a risk of an infectious disease outbreak.

- Skilled IYCF Counselling will be provided to caregivers who are experiencing complementary feeding difficulties.171

- Mother Support Groups can be implemented once the situation has stabilised as a means of discussing and learning about IYCF topics, including complementary feeding.

- Support and follow up on MNP / BSFP products is carried out by trained frontline workers / volunteers to verify correct preparation, monitor actual usage of products at household level and provide guidance and practical support when needed. As the primary aim of home fortification with MNP is to improve nutrient intake from complementary foods, it is important that MNPs are delivered alongside IYCF Counselling and provision of harmonised messages on what MNPs are, why they are important, and how to appropriately use them. It is important to have an effective monitoring system especially if there is a change in ration or situation such as the population becomes more reliant on fortified foods.

- Health, nutrition and psychosocial workers should provide practical guidance for caregivers to help promote and support the psychosocial elements of feeding. Complementary feeding does not just concern food, but also a much wider array of feeding and caring behaviours that are important in child development. Emergencies make it harder to feed and care for children. Ensure interventions support the caregiver’s central role in feeding and caring for their children, and promote responsive feeding and care practices.

3.8.4 Selecting Appropriate Complementary Foods

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171 National Training Manual on IYCF. Job Aid and Supervision Checklist for Complementary Feeding.
The aim is to ensure that the diet (i.e. complementary food and breastmilk combined) meets the nutrient needs of children 6 – 23 months\textsuperscript{173} during emergencies.

**Appropriate, locally available, culturally acceptable complementary foods are the preferred option,** if these are available. Appropriate complementary foods are those that provide sufficient energy, protein and micronutrients through adequate amount, consistency and diversity to meet the child’s growing nutritional needs. Recipes\textsuperscript{174} are available for the preparation of energy- and nutrient-dense local foods such as khichuri and halwa.

Considering the relatively low energy required from complementary foods (Table 26), **nutrient density** is important when selecting appropriate complementary foods. It is recommended to avoid adding calories (e.g. oil, sugar) which can lower nutrient density of the diet and lessen appetite for more nutrient dense foods, including breastmilk.

**Table 26: Energy needed from complementary foods for breastfed and non-breastfed older infants and young children in developing countries and estimated gastric capacity\textsuperscript{175}**

<table>
<thead>
<tr>
<th>Age of child (mo.)</th>
<th>Recommended daily feeding frequency (meals/snacks)</th>
<th>Energy needs from complementary foods</th>
<th>Gastric capacity\textsuperscript{g} (ml)\textsuperscript{i}</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Breastfed</td>
<td>Not breastfed</td>
<td>Breastfed\textsuperscript{b} (kcal/day)</td>
</tr>
<tr>
<td>6-8</td>
<td>2-3</td>
<td>4-5</td>
<td>200</td>
</tr>
<tr>
<td>9-11</td>
<td>3-4</td>
<td>4-5</td>
<td>300</td>
</tr>
<tr>
<td>12-23</td>
<td>3-4</td>
<td>4-5</td>
<td>550</td>
</tr>
</tbody>
</table>

\textsuperscript{i} Assumes body weight of 8.3kg, 0.5 kg and 11.5 kg for well-nourished children and 6.4kg, 7.6kg and 9.1 kg for growth retarded children in the 3 age groups respectively. Gastric capacity of 30g/kg body weight.

\textsuperscript{ii} Assumes average breastmilk intake

**Additional (imported / new) products should only be considered if they can fill a critical gap in nutrients, as a complement to continued breastfeeding and the local diet, not as a replacement.**

The Bangladesh BMS Act 2013 prohibits the distribution of **commercially manufactured complementary foods**\textsuperscript{176} during emergencies. In the event that safe, nutritionally adequate local complementary foods are not available due to the emergency context, acceptable alternatives are XXXXXXXX.

The Bangladesh BMS Act regulations do **not** prohibit distribution of **fortified blended foods** (e.g. Super Cereal Plus) and **complementary food supplements**\textsuperscript{177} (e.g. Rice & Lentil Based Supplement / Chickpea Based Food Products to be added to other foods or eaten alone to improve intakes of macronutrients, micronutrients and essential fats.)


\textsuperscript{174} National Guidelines for Community Based Management of Acute Malnutrition in Bangladesh. IPHN, 2017. Note that these recipes may not be acceptable to refugee populations or other populations for whom these foods are not familiar.

\textsuperscript{175} Source: Nutritional Guidelines for Complementary Foods and Complementary Food Supplements. GAIN.

\textsuperscript{176} Defined in the Bangladesh BMS Act 2013 as “any food, by whatever name called, for requirement of a child from 6 months of age to 5 years of age manufactured commercially with appropriate nutrients.”

\textsuperscript{177} For details on fortified food-based products to be added to other foods or eaten alone to improve intakes of macronutrients, micronutrients and essential fats.
Supplement Wawa Mum) from being distributed to children 6–23 months in the event of an emergency. To ensure the provisions of the BMS Act 3013 are upheld, it is important that any commodities are represented for the suitable age group, with appropriate information and support for continued breastfeeding throughout the complementary feeding period, and with attention to established guidance, management and provision for their correct use.

Complementary foods should be purchased based on a calculation of need, not accepted as donations.

Ensure complementary feeding interventions and products comply with the Guidance on ending inappropriate promotion of foods for infants and young children178. 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 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 any breastmilk substitutes (BMS) to avoid cross-promotion.

### 3.9 Maternal Wellbeing

**STANDARD:** Pregnant and lactating women have access to a nutritionally adequate diet

#### 3.9.1 Maternal wellbeing in emergencies

The physical and mental wellbeing of a women is an important determinant in her ability to feed and care for her children. Women, including those who have been affected by emergencies, have a right to nutrition and health. Supporting IYCF means caring for the mother as well as for her infant – including during pregnancy. If a mother is feeling physically or emotionally unwell during pregnancy or early parenthood, this can have a significant impact on her child’s health, development and nutritional status. Emergencies can have a devastating impact on people’s lives; both mentally and physically. For example, mothers may lose confidence in their ability to breastfeed or become malnourished. Maternal malnutrition during pregnancy can have serious consequences for the health of both the mother and her unborn child.

During emergencies, maternal wellbeing may be at risk for multiple reasons, such as:

- Poor availability of, or access to, food
- Reduction of food and fluid intake by women and girls in favour of other household members when food, fuel or water is in short supply. This is particularly detrimental for pregnant adolescent girls.
- Disruption of family and social support networks
- Increased time and energy expenditure for activities such as collection of food and water. Women may also undertake additional work when men are absent.
- Fortified foods provided as part of food rations may not fully meet the nutritional needs of PLWs
- Nutritional requirements may increase due to malabsorption and nutrient losses causes by diarrhoeal and infectious diseases.
- Women are at increased risk of psychological problems in emergency settings (IASC, 2007)
- Women are at increased risk of Gender Based Violence (GBV) during emergencies

178WHA 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.
Breastfeeding practices are at increased risk of being disrupted during emergencies
Routine essential services for women (e.g. antenatal and postnatal care services) may be disrupted
Access to health care may be constrained (e.g. less access to emergency services)
Women may face constraints in accessing essential humanitarian services as a result of insecurity, discrimination or limited mobility
Poor hygiene and sanitation may lead to infections such as Urinary Tract Infections

If these factors are not addressed and women are not adequately supported, IYCF practices may consequently also be at risk. In all exceptionally difficult circumstances it is therefore important to create conditions that will support the mother, for example, by provision of appropriate maternity care, extra food rations and drinking-water for pregnant and lactating women179.

### 3.9.2 Interventions to support maternal wellbeing

**Target Group:** Pregnant women and primary caregivers of infants 0 – 23 months

**Most vulnerable:** Adolescent mothers, first time mothers, mothers living with HIV or TB, female headed households, survivors of sexual violence, mothers living with disabilities or with mental health issues.

#### Table 27 - Interventions to Support Maternal Wellbeing in Emergencies

<table>
<thead>
<tr>
<th>Intervention</th>
<th>When to consider implementation (One or more conditions present)</th>
<th>When to start (Timeframe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition Care and Counselling</td>
<td>Always – standard component</td>
<td>Short Term</td>
</tr>
<tr>
<td>Information Sharing &amp; Education</td>
<td>Always – standard component</td>
<td>Short Term</td>
</tr>
<tr>
<td>Supportive Spaces</td>
<td>Always – standard component</td>
<td>Short Term</td>
</tr>
<tr>
<td>Mother &amp; Baby Kit Distribution</td>
<td>• Loss or destruction of possessions</td>
<td>Short Term</td>
</tr>
<tr>
<td></td>
<td>• Menstrual hygiene challenges</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Caregivers expressing difficulties keeping infants clean and clothed</td>
<td></td>
</tr>
<tr>
<td>Mother Support Groups</td>
<td>• Poor IYCF practices</td>
<td>Medium Term</td>
</tr>
<tr>
<td></td>
<td>• Low caregiver knowledge on IYCF</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Stabilised; no frequent population movement</td>
<td></td>
</tr>
<tr>
<td>Psychosocial support</td>
<td>See: Chapter 3.10</td>
<td>Short Term</td>
</tr>
</tbody>
</table>

#### Nutrition Care and Counselling for PLWs

A major activity of Bangladesh’s National Nutrition Plan of Action (NPAN) 2016 – 2025 is to provide appropriate nutrition for vulnerable groups, including PLW. Pregnancy and lactation are Physiologically demanding times, when a woman's nutritional needs become greater than at other times in her life, as outlined in Table 28.

#### Table 28 - ADDITIONAL nutritional requirements (per day) for PLWs

<table>
<thead>
<tr>
<th></th>
<th>Pregnant</th>
<th>Lactating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy (kcal)</td>
<td>285</td>
<td>500*</td>
</tr>
<tr>
<td>Macronutrients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protein (g) Mixed Cereal / Pulse Diet</td>
<td>7.1</td>
<td>18.9 (1st 6 months)</td>
</tr>
<tr>
<td>Energy from fat</td>
<td>20 – 25%</td>
<td>20 – 25%</td>
</tr>
<tr>
<td>Micronutrients</td>
<td>Increased need for iron, folate, Vitamin A180, iodine</td>
<td></td>
</tr>
</tbody>
</table>

180 Vitamin A supplementation is not part of routine antenatal care. It should only be provided in situations where Vitamin A deficiency is a severe public health problem. Enable access to Vitamin A rich fruits and vegetables for PLW.
Undernourished women and those whose babies are low birth weight have an increased energy requirement of 675 kcal/day during the first six months of lactation (FAO/WHO/UNU 2004).

In accordance with NPAN 2016 – 2025, nutritionally enriched supplementary foods should be supplied to affected populations during disasters and in times of severe food insecurity. The increased energy requirements of PLWs are incorporated into the 2,100-kcal GFD planning figures. However, the increased micronutrient needs of PLWs may not be met through this ration.

➢ Work with the Food Security and Health Sector to select and implement appropriate activities such as:

- Mapping of households with PLWs (i.e. for screening, detection, referral and inclusion in services)
- Maternal nutrition screening and referral to treatment (e.g. by community volunteers)
- Enabling access to adequate nutrition (e.g. BSFP, cash, vouchers modified to meet PLW needs)
- Micronutrient Supplementation (e.g. during ANC and PNC) – provide Calcium, Iron and Folic Acid or multiple micronutrient supplementation in accordance with national guidance.
- Nutrition education and information sharing
- Skilled 1-1 counselling
- Community and family discussions and/or counselling on intra-family food distribution
- Tracking weight gain/MUAC during pregnancy

Pregnant women and lactating women with infants under 6 months of age are included in Blanket Supplementary Feeding Programmes. Many other complementary feeding interventions (see Table 25) are also applicable when supporting maternal nutrition.

➢ When designing interventions, consider whether both PLWs and children 6 – 23 months can be targeted by the same intervention (e.g. distributing of cooking equipment, BSFP).

Establishment of mother support groups / revival of community support structures

➢ Take steps to reduce isolation of PLWs through facilitating frequent opportunities for PLWs to meet e.g. through establishing mother support groups or reviving existing community support structures.

Mother support groups are groups of women who come together to learn about and discuss issues on IYCF and maternal wellbeing. During group meetings, caregivers reflect on recommended feeding practices, share their own experiences, doubts or difficulties and provide mutual support at community level. In this safe environment the mother builds the knowledge and confidence needed to decide to either strengthen or modify her IYCF practices. It is not a lecture or a class. Other community or family members who are key influencers of decision makers, such as fathers and mothers-in-law, are also important to include. Provide pregnant women with particular attention, as they represent a group who is especially exposed to risks in an emergency context.

➢ Identify whether support groups were active in the area pre-emergency and restart activities.
➢ Focus on identifying and recruiting existing community groups with women members, instead of forming entirely new groups.
➢ Prioritise establishment of community-based support in areas which is hard to reach and where health care is less accessible.

181 Provide foods that consume minimal time, energy and fuel to prepare (e.g. eggs)
182 National Strategy on Prevention and Control of Micronutrient Deficiencies in Bangladesh 2015 – 2024
183 National Training Manual on IYCF: Session 07 and DIPSHIKA Competency Based Training in Nutrition Session 6 – and Nutrition of Pregnant and Postpartum Mothers Job Aid adapted to the emergency context including available services and foods.
185 Due to the time, skill and level of oversight required to set up activities of an acceptable standard, start support groups once the situation has stabilised and adequate resources are available.
➢ Where possible, integrate with the health system and involve partnerships with various sectors and groups\textsuperscript{186}. For example – PNC services should link newly delivered mothers to existing support groups.

➢ Put in place mechanisms to refer caregivers and children with problems to relevant services.

➢ Arrange home visits for those for whom it is difficult to meet in a group.

➢ Monitor the quality of mother support groups (Annexe D26).

### 3.10 Psychosocial Support within IYCF-E

#### 3.10.1 Essential elements for child development

The following elements\textsuperscript{187} are essential in ensuring a child’s proper development:

1. The care and attention that a child receives, particularly during the first 3 years, is crucial and can impact their future.
2. In order to grow and develop, babies need affection, attention and stimulation as well as good nutrition and appropriate health care.
3. Children need to play and explore in order to develop well. Caregivers should provide their children with opportunities to play and explore, and encourage them to do so.
4. Children learn behavior by imitating the behavior of those closest to them.
5. Parents and those who take care of children must be capable of noticing the signs signifying a slowdown of growth and development.

#### 3.10.2 Psychosocial Impact of Humanitarian Crises

Humanitarian crises affect people individually, as families and as communities. The psychological impact of a disaster will vary according to many factors, such as the type and severity of the crisis and what internal and external resources are available to the affected population. Following a disaster, increases in the following may be observed:

- Social problems e.g. family separation
- Psychological distress e.g. grief
- Mental health issues e.g. depression
- Individual difficulties in conducting daily activities

Pregnant women, mothers and infants have all been identified to be at increased risk of such problems in an emergency\textsuperscript{188}. Young children depend to a large extent on their family. During emergencies, family structures can be seriously damaged – for example, if family members are injured or killed. When caregivers are overwhelmed, exhausted or depressed they may be physically or emotionally unable to meet their child’s needs. Children with depressed mothers face a greater risk of malnutrition, delayed growth and mortality. Hunger also leads to psychological changes and behaviours that handicap individuals in their ability to adapt to day-to-day life and care for their children. While survivors can usually reconnect with their psychological resources and survival abilities and can develop collective and individual psychosocial resilience when they are

\textsuperscript{186} National Strategy on IYCF in Bangladesh. MOHFW 2007.

\textsuperscript{187} Facts for Life. UNICEF Bangladesh, 2011.

\textsuperscript{188} Guidelines for Mental Health and Psychosocial Support in Emergencies, Interagency Standing Committee 2007
provided with appropriate psychosocial support, without such support infants and young children are at risk. *It is therefore critical that the psychosocial wellbeing of caregivers is protected and supported as part of the IYCF-E response.*

Humanitarian aid itself can also lead to social and psychological problems. For example, interventions can undermine existing community structures or a lack of information about available services can cause anxiety. *It is therefore also critical that IYCF-E responses are designed and implemented in a way that takes the psychosocial wellbeing of the affected community into consideration (MHPSS approach).*

### 3.10.3 Assessments and information sharing

Understanding the psychosocial changes and social dimensions of disaster-affected populations at the start of a crisis is necessary to ensure a quality intervention that is respectful of, and better adapted to, actual needs.

- **The Nutrition Cluster** to ensure that it engages with the <<MHPSS coordination mechanism>> in order to formalise information sharing and ensure that MHPSS assessment findings inform IYCF-E programmes.
- **The Nutrition Cluster** to collaborate with MHPSS partners to integrate MHPSS questions into IYCF-E needs assessments whenever possible. Examples of relevant topics/questions to include are:
  - Mental health related problems faced by children and their caregivers
  - Coping methods and community sources of support and resources
  - Culture specific beliefs, practices, and expressions of distress
  - Beliefs on mother and childcare practices and healthcare seeking behaviours
  - Early childhood care and stimulation activities
- **NC partners** to regularly share relevant information with MHPSS partners (*for example – information on access to key micronutrients known to influence child psychological development*).

Ensure that assessments are *participatory*, and that caregivers with MHPSS difficulties are consulted on the design of IYCF-E programmes.

### 3.10.4 Mental Health and Psychosocial Support within IYCF-E programmes

**STANDARD:** Staff in contact with caregivers and children under 2 years are trained to be sensitive to psychosocial issues and on referral pathways to more specialist support.

<table>
<thead>
<tr>
<th>Table 29 - Key Interventions to Support MHPSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Keep children with their mothers, fathers, family or other caregivers</strong></td>
</tr>
<tr>
<td>See: Action 2.4 - Basic Multisectoral Actions</td>
</tr>
<tr>
<td>2. <strong>Protect, promote and support continuation of breastfeeding</strong></td>
</tr>
<tr>
<td>Breastfeeding supports the child’s cognitive development, comforts the child and is likely to strengthen the mother-child bond. Physical and emotional stress can reduce women’s confidence in their ability to breastfeed and diminish the capacity of other family members to support her. Stress, exhaustion, trauma and grief may reduce a mother’s ability to see what her baby needs. She may put her baby to</td>
</tr>
</tbody>
</table>

the breast less often, which can gradually reduce milk production. Misconceptions about stress are common, such as that it causes breastmilk to “dry up” or that negative emotions are transmitted through breastfeeding. These are untrue. Stress does not stop breastmilk production, but can temporarily interfere with the let-down (release) of breastmilk. To help the milk to flow, it is important to create conditions for the mother that reduce stress as much as possible (such as through providing Supportive Spaces) and to provide psychosocial support. Mothers experiencing depression are also more likely to stop breastfeeding; therefore mothers experiencing symptoms of depression should receive skilled one-to-one breastfeeding counselling as well as mental health support. It is important to ensure good quality care; both breastfeeding problems AND poor-quality support can have a negative impact on the mother’s wellbeing.

➔ See: Chapter 3.5 - Breastfeeding Support
➔ See: Box 13 - IYCF Support during mental health difficulties

3 Establish Supportive Spaces

Supportive spaces are directly aimed at improving caregivers’ psychosocial wellbeing to improve feeding practices.

➔ See: Chapter 3.4 – Supportive Spaces

4 Adopt an MHPSS approach for all IYCF-E services

This means providing humanitarian assistance in ways that support the mental health and psychosocial wellbeing of the affected communities. Many interventions and actions by actors in the humanitarian response can have an effect on the mental health and psychosocial wellbeing of the disaster affected community. MHPSS is a cross cutting issue that is everyone’s responsibility.

➔ See: MHPSS approach (below)

5 Integrate MHPSS interventions in IYCF-E services: Early Childhood Development

Evidence reveals that first three years of a child’s life, physical and mental growth takes place at a rapid pace. This is critical stage for them where adequate care, stimulation and nutrition are needed. Programmes that combine improve parenting and infant stimuli with better nutrition improve children’s growth and development in the long term. Stunted young children who receive stimulation show enduring cognitive benefits, compared to children who received food alone.190

➔ See: Early Childhood Development (below)

6 Integrate MHPSS interventions in IYCF-E services: Provide care for caregivers

It is important to organize opportunities at which caregivers of infants and young children can discuss the past, present and future, share problem-solving and support one another in caring effectively for their children.

➔ See: Psychosocial Interventions (below)

MHPSS Approach

IYCF-E responses should aim to adopt an MHPSS approach from the start of the response:

➢ Coordinate with MHPSS teams to include MHPSS issues in IYCF-E needs assessments
➢ Ensure that IYCF-E services are delivered in a participatory, safe and socially appropriate manner
➢ Strengthen local social supports and mobilise community networks
➢ Include activities directly aimed at improving the psychosocial wellbeing of caregivers and their children 0 – 23 months within IYCF-E services (see next 2 sections for specific actions).
➢ Collaborate with MHPSS teams to train IYCF-E teams on MHPSS issues. Training topics can include:
  ▪ Understanding and responding to how caregivers might be feeling

- Referral pathways for further MHPSS support
- Psychological First Aid

➢ Train teams on **effective communication (Annexe D2)** and **active listening skills** and on the importance of being calm, compassionate, respectful and non-judgmental
➢ Ensure that caregivers feel **welcomed and supported** when arriving at IYCF-E services

### Box 13 - IYCF Support during Mental Health Difficulties

There are **exceptional** circumstances during which it may not be possible, or in the best interests of the mother or child, for a mother to breastfeed. In this case, it may be necessary to provide temporary or longer term feeding support as per these guidelines (See: [Support for Non-Breastfed Infants](#)). Decisions will be made on a case-by-case basis in consultation and coordination with clinical, mental health, IYCF-E and other relevant personnel. These conditions include:

- Psychiatric drugs which are a contraindication to breastfeeding are necessary
- The mother is experiencing acute mental distress
- The mother has rejected the child
- The mother is a survivor of rape who does not feel able to breastfeed
- There are child protection concerns regarding the mother’s ability to safely care for her child

### Early Childhood Development

ECD spans from the moment of conception until the beginning of primary school, and includes physical well-being, and cognitive, linguistic and socio-emotional development. ECD includes elements from education, child protection, sanitation, mental health and nutrition; the best outcomes are achieved by integrating programmes in these sectors. IYCF-E activities should provide stimulation, facilitate basic nutrition, enable protection and promote bonding between infants and caregivers. Activities should aim to support the care of infants and young children by their families and other caregivers. Supportive spaces such as Mother Baby Areas provide a safe space for babies to interact with their caregivers, for caregivers to learn from each other and for babies to interact with one another.

➢ **ECD Teams to train** frontline health and nutrition workers engaging with children 0 – 23 months and their caregivers on ECD principles, the stages of child development and basic ECD activities that can be implemented within IYCF-E programmes.

**Examples of integrated activities:**

- Include key facts on infant stimulation and ECD in IYCF-E materials and messages, and vice versa
- Include counselling on care practices and child development in IYCF counselling (See Box 14)
- Include play activities ([Annexe D23](#)) regularly in caregiver-baby activities and spaces
- Monitor ([Annexe D24](#)) and encourage caregiver-child interaction within IYCF-E services.
- Conduct home visits which combine IYCF and age specific early stimulation support.

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192 The importance of ECD. Global Education
193 In collaboration with the Bangladesh ECD Network (BEN)
Staff should be aware of the different developmental phases of infants and young children, and to adapt activities, materials and expectations accordingly (Annexe D25).

### Box 14 - Positive Care Interactions 0 - 3 Years

- Support the baby’s head when holding the baby upright
- Support the child physically when they start turning on their side or trying to crawl
- Look into the child’s eyes while breastfeeding, talking and playing with the child
- Maintain skin-to-skin contact with the child (e.g. massage, cuddling, kangaroo mother care)
- Communicate lovingly with the child (e.g. smiling, saying the child’s name, singing)
- Provide ways for the child to see, hear, feel and reach out for toys
- Provide children with safe objects to hold and explore as ways of supporting motor skill development
- Be aware of warning signs to watch out for as the child develops (e.g. crying for long periods of time without a reason, stiffness of the limbs, unresponsiveness to sounds etc.)

### Psychosocial Interventions

- **NC partners** to facilitate the training of IYCF-E teams on MHPSS principles and basic MHPSS interventions
- **NC partners** to arrange for supportive supervision visits by MHPSS teams for capacity building
- **NC partners** to create opportunities for MHPSS teams to directly deliver additional services requiring more specialist skills (such as 1-1 counselling or psychotherapy) within IYCF-E Services (e.g. Mother Baby Areas).

The following are examples of psychosocial activities that can be carried out as part of IYCF-E services, such as during Group Activities in Mother Baby Areas or during one-to-one IYCF counselling, following adequate staff training:

- **Strengthen individual and collective resources.** Activities can be carried out with caregivers to identify actions that are beneficial to them, resources that are available to them, and to aid relaxation.
- **Support in adjusting to daily life in new living conditions.** Group discussions can be held on what participants needs, and how participants can support each other in meeting these needs.
- **Strengthen and support the parent-child relationship and child development.** For example, when positive parent-child interaction occurs during small group activities, point this out and encourage other parents to interact with their own children in a similar manner.
- **Use mother-to-mother support groups** as a means of strengthening community self-help and social support initiatives that promote maternal mental health, including MHPSS, parenting skills and SGBV
- **Conduct home visits** combining IYCF, ECD and MHPSS activities
- **Teach caregivers how to carry out baby massage** as a tool for contact, communication and connection and for strengthening caregiver-baby bonding and supporting baby wellbeing.
- **Help parents and caregivers to understand** the changes they see in their children following a crisis. Explain that behavior such as increased fear of strangers, increased crying and withdrawal are common reactions to stress and reflect no failure on the caregiver’s part.
- **Identify harmful responses** to a young child’s stress (such as anger or physical punishment) and suggest alternative strategies to parents and community leaders
- **Provide psychosocial, emotional and practical support for pregnant women** (See Box 15)
- **Recognize when caregivers need further support and support referrals**

194 In collaboration with the Clinical Psychology Department of Dhaka University and key MHPSS in Emergencies partners
195 Manual for the Integration of Child Care Practices and Mental Health into Nutrition Programmes. ACF, 2012. See page 29 for detailed information on why and how to massage babies.
• Build community awareness and strengthen community based structures
• Use of the Thinking Healthy Approach for the psychosocial management of perinatal depression

Remember: psychosocial counselling services are also a key programme entry point for IYCF-E. Where MHPSS services are active, NC partners should orient MHPSS teams on IYCF-E topics and referrals.

Box 15 - Support for Pregnant Women

IYCF and MHPSS counsellors can suggest the following to help mothers connect with their unborn baby:

- Taking time out to stroke “bump” and think about baby
- Singing/talking to baby
- Encouraging siblings and other family members to talk to the baby
- Noticing times when baby is particularly active

IYCF and MHPSS counsellors can support close and loving relationships by:

- Talking about the importance of taking time to connect
- Discussing baby’s developmental stages
- Talking about baby positively, give a (nick)name
- Encouraging mother to imagine what baby might look like
- Discussing strategies to obtain support and rest

IYCF-E and MHPSS teams can arrange activities to support pregnant women such as:

- Sharing information and education on pregnancy and birth (e.g. danger signs)
- Group/family discussion on ways to decrease workload and ensure adequate rest
- Family discussions/counselling to plan for safe birth and prepare for the arrival of a new baby*
- Group relaxation and stress reduction activities (e.g. in Mother Baby Areas)
- Mother support groups to discuss caring for and breastfeeding a newborn

3.11 IYCF and Malnutrition

It is well established that the appropriate feeding and care of infants during an emergency is essential to prevent childhood malnutrition. Stunting and wasting can start early in childhood; growth faltering begins at about 3 months of age with a rapid decline in growth rates until about 12 months of age. Young children who are starting on solid foods (at 6 months) have specific feeding needs and are vulnerable to malnutrition during this phase.

The window of opportunity to ensure good nutrition for healthy growth and cognitive development is small – from before pregnancy through the first 2 years of life. Young children’s bodies and brains depend on good nutrition for healthy growth and development. It may be difficult for parents to find the time or resources required to feed their children a suitable diet during an emergency. An episode of acute malnutrition has both immediate and longterm effects on a child’s potential to survive and thrive. Prevention is critical.

Integration of IYCF support into CMAM programmes offers an opportunity for identification of inappropriate feeding practices that may have contributed to the development of malnutrition, correction of those practices during the course of treatment, and follow-up post discharge to prevent relapse. Continued frequent breastfeeding and, when necessary, re-lactation are important to ensure the best possible nutrition for the child as well as ensuring access to nutritionally adequate and safe complementary foods and nutritional supplements as required.197

IYCF interventions are one of the most important prevention measures in emergency setting. Directly addressing inappropriate IYCF practices within programmes addressing the treatment of acute malnutrition is likely to improve programme outcomes, including the prevention of readmission. Thus, IYCF should always be part of a CMAM response as it is key for adequate treatment and improving programme outcomes.

**Key Activities to support IYCF within malnutrition treatment services**

The *National Guidelines for the Community Based Management of Acute Malnutrition in Bangladesh* contains instructions on activities to promote and support appropriate IYCF practices. These are as follows:

➢ Promote appropriate IYCF practices during screening and follow up visits at household level
➢ Engage in discussion with the community to talk about existing IYCF practices, the problem of malnutrition, causes and possible solutions

*For Community Based Management of SAM*

➢ During enrolment, provide guidance on appropriate IYCF practices (Enrolment - Step 5)
➢ During follow up visits, provide guidance on appropriate IYCF practices (Follow up - Step 4)
➢ Provide key messages on the prevention of malnutrition, including recommended IYCF practices

*For Community Based Management of MAM*

➢ During enrolment, counsel on home based diet to support catch up growth. Provide specific messages on home based diet following standard IYCF protocols.
➢ During follow up visits and in the community, provide prevention messages which include IYCF
➢ Provide key messages on the prevention of malnutrition, including recommended IYCF practices

**Additional integrated activities**

Once the above activities are adequately implemented and where resources and the situation allow, consider the following additional activities to further strengthen the integration of IYCF within CMAM activities.

➢ Train CMAM staff on IYCF-E, SRA and referral, available services, recommended and lifesaving IYCF practices and communication skills.

➢ At outpatient and community outreach sites, ensure there is a place where mothers can privately and comfortable breastfeed (See: IYCF Corners)

➢ At outpatient and community outreach waiting areas, hold awareness / education sessions which cover: feeding needs for PLWs, infants and young children, recommended IYCF and care practices and early childhood development information and stimulation activities.

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➢ At outpatient and community outreach waiting areas, display context specific Information Education Communication (IEC) materials which promote recommended IYCF practices.

➢ During case finding, systematically screen all children under 2 years of age for IYCF difficulties, using the SRA. Note IYCF difficulties on referral slips. Ensure that any cases who do not need to be referred for SAM or MAM treatment but who do need IYCF support are referred to IYCF services.

➢ During enrollment, screen all children under 2 years of age for IYCF difficulties using the SRA:
  o If no IYCF issues are detected, praise the caregiver and encourage them to continue with the recommended IYCF practices, such as breastfeeding and giving appropriate family foods.
  o If IYCF difficulties are detected during screening, carry out a Full Assessment (FA) of the caregiver-baby pair. Depending on caseload and service provider availability, this task should either be carried out by the CMAM service provider or by a dedicated IYCF counsellor who is part of the CMAM team. As part of the FA, directly observe and assess all breastfeeding women using the Breastfeeding Observation Tool. Provide breastfeeding counselling if needed. Note down any IYCF difficulties on the Child Monitoring Card so they can be addressed at follow up. Enroll the caregiver for IYCF support if available.
  o If the caregiver is pregnant, provide key messages on early initiation of exclusive breastfeeding and information on accessing Antenatal Care (ANC)

➢ During follow up visits, any existing IYCF issues should be systematically followed up and any new issues should be identified.
  o Ask the caregiver if there are any new difficulties with regards to feeding their child. If yes, ensure a Full Assessment is carried out and they are enrolled for IYCF support if needed.
  o If IYCF difficulties are already noted on the Child Monitoring Card, enquire whether the difficulty has been resolved and verify that the caregiver is receiving adequate IYCF support.
  o If the caregiver is pregnant, provide key messages on early initiation of exclusive breastfeeding
  o Encourage all breastfeeding mothers to continue breastfeeding

➢ Before discharge, ensure that caregivers have the knowledge and support they need to implement recommend IYCF practices. Activities should include:
  o Checking the caregiver’s understanding of key IYCF messages
  o Encouraging breastfeeding mothers to continue breastfeeding up to 2 years and beyond
  o Encouraging pregnant women to initiate early, exclusive breastfeeding and to access ANC
  o Ensure that the caregiver knows where to access IYCF support and refer if needed
  o Refer caregivers to IYCF mother support groups, if operational
  o Encourage caregivers to attend Growth Monitoring sessions

➢ When reporting, include IYCF activities and indicators in the CMAM monthly report

➢ Record IYCF practices and analyse them against the nutritional status of children under 2 years of age

➢ Conduct a comprehensive assessment on the causes of malnutrition and feeding and care practices to identify the causes of current malnutrition, identify barriers to optimal feeding practices and to mitigate the effects of the crisis on the nutrition status of PLWs, infants and young children.
3.12 IYCF in the context of Public Health Emergencies

3.12.1 Impact of public health emergencies on IYCF

**KEY ACTION: Anticipate and assess the impact of human and animal infectious disease outbreaks**

During public health emergencies, IYCF practices may be negatively impacted by factors such as:

- Interrupted access to health and IYCF support services
- Decreased household food security and livelihoods
- Maternal illness and death
- Low caregiver awareness leading to inappropriate feeding practices
- Low health service provider awareness leading to inappropriate feeding recommendations

It is essential that the Nutrition Cluster is involved in public health emergency response from the start so that steps can be taken to mitigate and limit risks to infants and young children. It is crucial that breastfeeding is not unnecessarily disrupted by disease outbreaks or illness affecting mothers or children and that IYCF support for breastfed and non-breastfed children is integrated within disease management protocols. Myths and misconceptions about breastfeeding and illness (such as that a mother should stop breastfeeding her child when she is sick, stressed or taking medication) can lead to harmful recommendations and unsafe feeding.
practices. It is rarely in the best interests of the mother or the child to cease breastfeeding or to separate breastfed children from mothers who are ill; instead mothers should be adequately supported to access treatment and to continue breastfeeding. Where breastfeeding needs to be interrupted, it is also essential that IYCF is integrated within treatment protocols from the start to ensure that appropriate support can be provided by adequately trained health service providers.

### 3.1.2.2 Key actions to take during a public health emergency

The Nutrition Cluster and Health Cluster should work together to:

- Ensure that IYCF is included in guidelines, treatment protocols and response strategies
- Collaborate on designing of feeding protocols for PLW and children 0 – 23 (treatment, recovery)
- Procure and distribute appropriate necessary nutritional supplies for 0 – 23 months old
- Standardise relevant IYCF and public health messages across the health and nutrition clusters
- Develop clear procedures for identification and referral between health and IYCF-E services
- Build capacity of health workers to counsel caregivers on recommended IYCF practices (Box 2)
- Where relevant, co-locate health and nutrition services to provide a comprehensive service
- Monitor the progress of the coordinated work

### 3.1.2.3 General guidance for feeding during illness

It is common for morbidity rates to increase during an emergency. The WHO/UNICEF guidelines on the Integrated Management of Childhood Illness (IMCI) highlights the importance of appropriate infant and young child feeding practices during illness to facilitate a fast recovery. Health and nutrition service providers should promote appropriate feeding recommendations (See Box 17) amongst caregivers and health service providers.

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199 For example - Complementary Foods for treatment centres

200 Specifically include referral criteria for infants and young children who have been particularly impacted by the public health emergency (e.g. quarantine, maternal death).
Breastfeeding protects children against cholera infection. Exclusive breastfeeding is the most effective way to prevent cholera in infants under 6 months. Infants with diarrhoeal illness who are NOT breastfed are at higher risk of dehydration and malnutrition, and are likely to be more severely sick and for a longer duration. Mothers who experience difficulties with breastfeeding should be referred to a skilled breastfeeding counsellor for support.

- Cholera is NOT transmitted in breastmilk
- Breastmilk is ALWAYS the safest source of nutrition for infants and young children
- Breastfeeding helps to PREVENT infection with cholera
- Breastmilk helps to PREVENT dehydration and malnutrition during illness
- A mother with cholera should CONTINUE to breastfeed
- HYGIENIC PREPARATION of complementary foods is preventing infection
- Formula feeding is dangerous and should ONLY be used as a last resort
- Babies who are not breastfed are highly VULNERABLE and should be prioritized for special care

201 Adapted from Save the Children’s guidance tools on IYCF and Cholera, 2017.
Feeding bottles and teats should NEVER be used

Key NC actions during a cholera outbreak (in addition to actions in 3.10.2)

➢ Strongly discourage bottle feeding, and promote the use of open cups and spoons.
➢ Strongly discourage the use of breastmilk substitutes such as infant formula
➢ Promote exclusive breastfeeding under 6 months and continued breastfeeding thereafter
➢ Promote and support hygienic preparation of complementary foods for children > 6 months
➢ Collaborate with health partners to ensure that IYCF is adequately incorporated into treatment protocols (See Box 18 and Box 19 for recommendations)

Box 18 - Recommendations for Infants < 6 Months with Cholera

<table>
<thead>
<tr>
<th>Infant is exclusively breastfed NO signs of dehydration</th>
<th>Infant is exclusively breastfed Some dehydration*</th>
<th>Infant is not breastfed NO signs of dehydration</th>
<th>Infant is not breastfed Some dehydration</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Breastfeed frequently for as long as possible</td>
<td>• Mother should breastfeed more frequently and for as long as possible</td>
<td>• Infant should be fed infant formula at least every 3 hours**</td>
<td>• Infant should be fed infant formula at least every 3 hours and after each watery stool</td>
</tr>
<tr>
<td>• If needed, give expressed breastmilk with a clean cup /spoon</td>
<td>• If needed, give expressed breastmilk with a clean cup /spoon</td>
<td>• Provide IYCF-E support (focusing on re-lactation)</td>
<td>• Provide IYCF-E support (focusing on re-lactation)</td>
</tr>
</tbody>
</table>

* ORS should usually only be given to infants > 6 months. On a case by case basis, and following assessment by a skilled health service provider, ORS can be given to infants < 6 months. In the first 4 hours of rehydration, give ORS and breastmilk or infant formula. After 4 hours, reassess infant. If no longer dehydrated, give 50 – 100 mls of ORS after each watery/loose stool.

** Use of infant formula is dangerous and should only be provided as a last resort in accordance with these guidelines. All other options must be explored first. Infant formula should be fed with a cup or spoon. Use of bottles and teats should be actively avoided and discouraged.

Children with severe dehydration should be urgently referred to a treatment centre to be treated with IV fluids. Within 1 hour of giving IV fluids, give ORS and zinc (if able to tolerate). The child should be breastfed as soon as he/she is strong enough to suckle.
Box 19 - Recommendations for when a mother has cholera

When a mother has cholera and is breastfeeding

- A mother with cholera should continue breastfeeding as long as she is conscious, even while receiving intravenous fluids. Mother and baby should remain together to enable the mother to breastfeed her baby on demand.
- It is important that the mother receives rehydration with intravenous fluids and/or ORS. Severe dehydration in the mother can reduce breastmilk volume, rehydrating the mother can correct this quickly (within an hour).
- Antibiotics should be given only to the infected mother, not to an uninfected healthy baby.
- Before each breastfeed wash the mother’s hands and breasts with soap and water or 0.05% chlorine solution. Clean the nipples and surrounding area with a small amount of breastmilk to remove the taste of soap or chlorine.
- Do not separate mothers from their breastfed children, but separate the pair from other patients to prevent cross-infection if possible. Someone who is not sick can care for the baby between each breastfeed e.g. outside the treatment centre.
- If possible, wrap the baby in a clean cloth for each feed and make sure to wash the baby’s clothes/cloth thoroughly in 0.05% chlorine solution and dry in direct sunlight.
- Provide breastfeeding mothers with continuous encouragement and skilled breastfeeding support (e.g. place an IYCF counsellor within the treatment centre).

When a mother has cholera and breastfeeding is NOT possible

There are exceptional circumstances during which infants are not breastfed. For example, the mother may have already stopped breastfeeding before her illness or the mother may be too unwell or have died. Non-breastfed infants are highly vulnerable during a cholera outbreak because:

- Contaminated utensils or unsafe water may act as a source of infection
- Infant formula does not provide active protection against infection
- Infant formula disrupts the child’s gut, making them more susceptible to infection.

It is important to ensure that provisions are in place for supporting infants who have no possibility to be breastfed. (All safer options should be explored first – including wet nursing and relactation). Refer to Chapter 3.6 for further guidance on the provision of appropriate support to non-breastfed infants.

3.12.5 Feeding recommendations during unanticipated outbreaks

In the event of a public health emergency for which feeding recommendations are not unclear or may be out of date (e.g. Ebola), the Nutrition Cluster will work with WHO, MOHFW and ICDDR,B and XXXX to rapidly develop and roll out interim guidance.
3.13 IYCF in the context of HIV

3.13.1 Background

The *National Strategy on IYCF in Bangladesh (2007)* calls for special attention to support IYCF in circumstances where the child’s mother or father has HIV. While HIV prevalence in the general population is low in Bangladesh, HIV-exposed infants and their caregivers are highly vulnerable in an emergency setting and need to be appropriately supported in a timely manner.

Emergency settings can increase HIV transmission rates due to factors such as increased levels of sexual violence, food insecurity leading to risky behaviours, disruptions to ongoing treatment or difficulties accessing healthcare. Girls and women may be especially vulnerable and at additional risk of HIV infection. Population displacement may complicate identification and follow-up of mothers living with HIV, and the relative risks associated with not breastfeeding (such as the likelihood of developing diarrhoeal disease) are likely to be higher than in a stable setting. Access to services (such as HIV testing and counselling and IYCF counselling) and supplies (such as ARVs and infant formula) may be disrupted or reduced. National guidance for the

**Box 20: Key principles on HIV and IYCF in Emergencies**

1. Health and nutrition sectors in government and partner agencies must work together.

2. The aim of interventions on HIV and infant feeding in emergencies is to prioritize the *HIV-free survival* of children, by balancing HIV prevention with protection from other causes of child mortality.

3. To minimize an emergency’s negative impact on infant feeding practices and ensure nutrition needs are met, preparedness is critical and interventions should begin during the first phase of emergency response.

4. Interventions should focus on supporting caregivers and channelling resources to meet the nutritional needs of the HIV-exposed infants and young children in their charge, and to provide or re-establish supplies of anti-retroviral (ARV) drugs to avoid disruption of treatment. Mothers living with HIV and their infants should have their health and nutrition needs prioritized.

5. The aim of the emergency response is to create and sustain an environment that encourages breastfeeding according to national recommendations. For infants and young children who have no possibility of breastfeeding, replacement feeding needs to be provided in line with national guidance.

6. Where replacement feeding is indicated, infant formula supplies should only be provided in line with the provisions outlined in this guideline’s section on *Support for Non-Breastfed Infants*.

7. Whatever the recommendation on HIV and infant feeding promoted during the emergency response, maternal decisions regarding infant feeding should be respected.

8. Preparedness and response need to build on existing systems and national capacity related to HIV and infant feeding.

9. Infants who are not breastfed in an emergency need early identification, and then targeted support and follow up to minimize risks and maximize their nutrition and health.

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prevention of mother to child transmission (PMTCT) is in place and should be followed. Here additional considerations with regards to HIV & Infant Feeding in an emergency context are highlighted.

### 3.13.2 Key Activities to Support HIV and Infant Feeding in Emergencies
At the onset of an emergency, health and nutrition emergency actors need to update information:

- Clarify who is the designated coordination authority on HIV & Infant Feeding
- Clarify roles and responsibilities, including which actors are assigned for action on HIV and IYCF-E
- Establish whether there are any modifications of high risk groups due to the emergency
- Identify possible IYCF challenges related to the emergency
- Check whether there is sustained availability of safe water, hygiene and sanitation facilities
- Verify availability of, and access to, services related to HIV and IYCF
- Confirm that relevant policies are being implemented in the affected areas, and whether they have been impacted by the emergency
- Evaluate the quality of services related to HIV and IYCF
- Assess the quality of supply chain management for HIV test kits, ARVs and, if applicable, for replacement feeding (i.e. infant formula and associated equipment)
- Establish which communication channels and networks on HIV and IYCF are functional.

The nutrition sector should 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 difficult to access or 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; IYCF counselling; and perinatal prophylaxis for HIV-exposed infants. 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.

- Clearly communicate with emergency responders, health providers and HIV-exposed mothers regarding applicable HIV and infant feeding recommendations in a timely manner.

### 3.13.3 HIV and Infant Feeding Recommendations in the Context of Emergencies

This guidance should be used in conjunction with the latest National Guidelines for the Prevention of Vertical Transmission of HIV which provide clear recommendations on how HIV-exposed infants should be fed.

**Breastfeeding** is life-saving in settings where diarrhoea, pneumonia and under-nutrition are common causes of mortality among infants and young children. Breastfeeding, along with antiretroviral drugs (ARVs) for both mother and new-born, is part of the strategy for HIV-free survival of children exposed to HIV.

**Replacement Feeding** is the feeding of a child exclusively with infant formula instead of breast milk for the first six months of age, followed by continued provision alongside appropriate complementary foods until they can be fully fed on nutritionally adequate family foods. It is likely that replacement feeding will become much more dangerous in an emergency setting due to factors such as unhygienic conditions and disrupted supply chains. It is not appropriate for replacement feeding to be recommended for infants born during an emergency, unless the following conditions are in place to minimise risk:

- the mother or caregiver can, in the first six months, exclusively give infant formula milk; and
- the mother, or other caregiver can reliably provide sufficient infant formula to support normal growth and development of the infant; and
- safe water and sanitation are assured at the household level and in the community, and
Nutrition and health support of HIV-exposed infants in emergency settings

➢ Assess nutrition and health status of HIV-exposed infants, and address any issues as per national protocol

Close assessment and surveillance of nutritional (e.g. anthropometric assessment, screening for bilateral oedema) and health status (managing common childhood illnesses e.g. fever, pneumonia, diarrhoea and early infant diagnosis) should be conducted as the situation allows, and ideally not just for HIV-exposed infants. Any issues suspected or identified (e.g., prolonged diarrhoea, moderate or severe malnutrition, tuberculosis, pneumonia) should be managed using national treatment protocols. Where possible, cotrimoxazole\textsuperscript{204} should be provided to HIV-exposed infants who are breastfeeding.

When ARVs are not available

When ARVs are not (immediately) available due to the emergency, breastfeeding may still provide infants born to mothers living with HIV with a greater chance of HIV-free survival. Health providers should not be deterred from recommending mothers living with HIV to exclusively breastfeed in the first six months of life and continue breastfeeding thereafter as the most appropriate infant feeding practice to increase survival in an emergency setting, unless environmental and social circumstances are safe for, and supportive of, replacement feeding.

➢ Counsel mothers of HIV-exposed infants on appropriate breastfeeding practices
➢ Accelerate access to ARVs for both maternal health and to prevent HIV transmission to infants.

If stopping breastfeeding is being considered due to unavailability of ARVs, a decision on stopping will depend on the child's general health, age, the availability of and access to a nutritionally safe and adequate diet, and the risk of other infectious diseases, malnutrition and death if breastfeeding ceases. The dangers of not breastfeeding are greater among infants less than 6 months of age; the younger the infant, the more vulnerable.

Support in the absence of ARVs

➢ Provide intensified counselling on how to make breastfeeding safer and on maintaining mother’s health.
➢ Screen and treat for opportunistic infections, provide prophylactic cotrimoxazole
➢ Consider provision of supplementary foods for the mother\textsuperscript{205}
➢ Provide mental health screening and psychosocial support if resources are available
➢ Regularly assess nutritional status of PLWs known to be living with HIV and link to services as needed.

Whether ARVs are available or not, mothers with infants under 6 months of age need support to exclusively breastfeed. This support is especially critical in the immediate postpartum period. Mothers living with HIV may have additional needs to maintain confidence in the importance of breastfeeding for child survival. Conditions of the breast or of the child’s mouth are factors which can affect mother-to-child transmission of HIV. Nipple fissure (particularly if bleeding), mastitis, or breast abscess may increase the risk of HIV transmission. Therefore, breastfeeding support by skilled provider is particularly important.

An assessment of whether a woman should continue breastfeeding may be carried out if her overall health condition starts deteriorating. Progression in clinical staging is correlated with increased HIV transmission to the infant, and thus would indicate a higher priority for introducing replacement feeding if the situation allows.

\textsuperscript{204} Cotrimoxazole is recommended for children under five who are HIV positive or HIV-exposed until diagnosis is established as uninfected.

\textsuperscript{205} To meet the extra metabolic demands of both breastfeeding and HIV
When testing is not available
➢ Advise all new mothers whose HIV status is not known to breastfeed
➢ Prioritise mothers identified as at high risk of being HIV infection for testing, if resources are limited

Wet nursing should not be prevented due to unavailability of testing. Wet nursing in emergencies can be lifesaving, providing an immediate source of breast milk for infants, and is likely to carry a very small risk of HIV transmission. In the absence of testing, if feasible undertake HIV risk assessment of the wet nurse.

DEFINITIONS

For definitions of IYCF Interventions, go to: Chapter 3.1 - Overview

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

Artificial Feeding: The feeding of infants with a breast milk 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.

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 3 years. Note that as per the Bangladesh BMS Act 2013, a breastmilk substitute is understood to be a product for infants up to the age of 6 months after which they are called “infant foods”.


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.

Commercial Manufactured Complementary Food: any food, by whatever name called, for requirement of a child from 6 months to 5 years of age manufactured commercially with appropriate nutrients (Bangladesh BMS Act 2013).

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

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.

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

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206 An assessment should consider HIV status of current or previous partners, practice of unprotected sex, history of sexually transmitted disease and injecting drug use behaviour of her or her partner. 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 replacement feeding in this circumstance.
and complex emergencies. Emergencies can be slow- or rapid-onset, chronic or acute.

**Exclusive Breastfeeding:** The infant receives only breast milk 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 accessories:** Bottles; teats; syringes; feeding cups with spouts, straws or other feeding add-ons; and breast pumps.

**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)

**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.

**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.

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

**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

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

**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.

**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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