**Standard Operating Procedures and Minimum Package of Essential Maternal Infant and Young Child Nutrition Services NW Syria**

**V 1 November 2022**

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| MIYCN programming is set of lifesaving interventions that targets pregnant and lactating women, adolescents, and girls, infants, and young children, some of the most vulnerable groups during humanitarian crisis. The prioritization and standardization of policies and guidelines must be underpinned by evidence and implemented across all sectors. |

# Background

Syria has been faced with nearly twelve years of protracted crisis, that has seen the worsening of nutritional status of vulnerable groups, including children and women. The ongoing conflict has aggravated pre-existing nutritional concerns in Syria, as food security and water, sanitation, and health care services have deteriorated, and inappropriate MIYCN practices have increased. These factors potentially predispose the population to the risk of diarrhea, insufficient micronutrient intake, and under-nutrition. Poor nutritional status was present in Idleb and Aleppo governorates before the current crisis according to the Syrian health ministry reports; sub-optimal infant and young child feeding (MIYCN) and micronutrient deficiencies (vitamin A, iron, and iodine) also existed. A series of SMART surveys conducted in NWS by PAC and UNICEF from 2014 to 2021 showed a highest Global Acute Malnutrition (GAM) rate by MUAC of 4.7% in June 2021 SMART survey and 0.8 % Severe Acute Malnutrition (SAM). Stunting has been a major problem in Syria and especially in NWS, the previous SMART surveys conducted in the area between 2014 and 2021 showed a stunting rate between 14.20% in 2017 and 24.5% in 2021, and this prevalence considered as a serious/severe according to the global nutrition severity ranking.

As such, the NW Syria Nutrition Cluster, with the support of the Global Nutrition Cluster Technical Alliance Technical Support Team (GNC Alliance TST), alongside the MIYCN-E Technical Working Group (MIYCNE TWG) have identified the need to develop a national Standard Operating Procedures and Minimum Package of Essential Infant and Young Child Nutrition in Emergencies for standardized and harmonized implementation and institutionalization of MIYCN programming across the country.

MIYCN-E programmes and interventions aim to protect, promote and support feeding practices for pregnant and lactating women and girls and children from birth to two years old as recommended by the WHO and incorporated into national policy and guidance by XXX.

General MIYCN-E activities require specific consideration during an emergency to ensure the inclusion within emergency specific policies, capacity needs, monitoring and evaluation tools and information systems. Most specifically, MIYCN-E requires strong regulation prior to an emergency for capacity development of staff and specific consideration for non-breastfed children and the adherence to the International Code of Marketing for Breast Milk Substitutes (BMS)[[1]](#footnote-1) and subsequent related WHA resolutions, including the donation and distribution of BMS and commercial complementary feeding, bottles, and teats in emergencies.[[2]](#footnote-2)

*Box 1: Recommended Infant and Young Child Feeding Practices*

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| **Recommended Infant and Young Child Feeding Practices*** Initiate breastfeeding immediately after birth
* Exclusive breastfeeding for 6 months
* Complementary feeding:
* Timely (introduced at 6 months)
* Adequate (appropriate energy and nutrients)
* Safe (hygienically prepared, stored, and used)
* Appropriate (frequency, feeding method, responsive feeding)
* Continued breastfeeding from 6 months up to 24 months and beyond
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1. **Minimum Package of Essential MIYCN-E Services by Context in NW Syria**

When implementing MIYCN-E activities and services will vary by setting and access to the population and should be contextualized as such by health and nutrition partners.

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 MIYCN-E

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

1. Establishment of supportive spaces (MIYCN-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 breastfeeding and infant feeding Counselling (one-to-one)
7. Further support for particularly vulnerable children including disability
8. Access to safe, adequate and appropriate complementary foods
9. Management of non-breastfed infants

The activities include:

* Promote good adolescent, maternal, infant and young child nutrition practices
* Provide practical support to pregnant women and primary caregivers of children aged under-2 years
* Encourage the family to assist in household responsibilities to support the mother or primary caregiver to feed and care for herself and her young children
* Mobilize community members to adopt societal norms and values that protect, promote and support optimal maternal, infant and young child nutrition practices.

The Minimum Package (table XXX) outlines minimum activities that should be implemented when full access to the affected population is possible. In areas where access is limited or where access is not possible, priority activities must be adapted rather than discontinued all-together if at all possible[[3]](#footnote-3). The following section, (Priority Activities) outlines all activities that must be undertaken no matter the context.

Within NW Syria, the context varies with regards to culture, geography, security, and access.  All of these must be considered when creating context specific response plans.  All nutrition partners will have to review and adapt their capacity to ensure implementation of the most comprehensive and appropriate services.

**Priority Activities**

**In all circumstances all health and humanitarian actors should:**

* Prevent harm by prevention of separation from children and mothers/caregivers. Prevent donations and uncontrolled distributions of BMS and feeding bottles and monitor and report Code violations.
* Advocate, plan for and roll out basic multi-sector breastfeeding support and protection, enable priority access for pregnant and breastfeeding women to essential services, define and register households with pregnant women, children under two years of age and at risk groups. Provide supportive spaces to breastfeed.
* Communicate effectively about MIYCN-E
* Mitigate the risk of Gender Based Violence

All Health and Humanitarian partners should implement the following priority activities in all circumstances, including during an emergency context. These activities are also highlighted in the table of essential services in **BOLD**:

* Enable priority access for pregnant and breastfeeding women to priority services
* Prevention of separation of child and mother/caregiver
* Provision of private and safe spaces to breastfeed
* Dissemination of standardized, clear, and accurate messages on MIYCN-E
* Prevent donations and uncontrolled distributions of BMS and feeding bottles
* Monitor and reporting of BMS and Code violations
* GBV Risk mitigation measures
* GBV support and referral according to the guidelines

**Trainings**

All humanitarian actors should be provided with a sensitization session and orientation on MIYCN as well as BMS violations and monitoring and reporting.

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

**Support Location and Referral**

**Basic MIYCN support** is provided at the following locations:

* Community
* Health Post (HP)
* Rapid Response Teams (RRT)

Staff located in the locations that provides basic MIYCN support should be trained in the following activities: Basic MIYCN Counselling, simple rapid assessment, care of the non-breastfed child, complementary feeding support, referral to skilled support, GBV support, referrals, and risk mitigation

**Skilled MIYCN support** is provided at the following locations

* Basic Health Center (BHC)
* Outpatient Therapeutic Feeding Programme (OTP)
* Stabilization Center (SC)
* Comprehensive Health Center (CHC)
* District, Provincial, regional, national, and specialty hospitals

Staff working in locations where skilled support is provided should be trained in the following areas: Basic MIYCN Counselling, simple rapid assessment, Skilled MIYCN counselling, full assessment, care of breast conditions, care of the non-breastfed child, relactation, artificial feeding, BMS programme management and prescription, complementary feeding support, GBV support, referrals, and risk mitigation.

**Gender Based Violence, support, referrals and risk mitigation**

Conflicts and natural disasters have different impacts on women, girls, boys and men; access to services and resources is different for each and also influenced by other aspects including age, disability, and family dynamics and composition; they face different risks and, accordingly, may experience different vulnerabilities where, in most contexts women and girls are generally affected more by gender inequalities; level of power, roles and responsibilities within society can also change. Conflict and disaster tend to increase existing gender inequalities and exposure to Gender Based Violence (GBV). Humanitarian actors should understand these differences and aim to ensure equity in services and support to all segments of the population while mitigating risk. Beyond the obvious importance of meeting basic needs, access to adequate, safe, and appropriate services and facilities plays an important role in the protection and dignity of the displaced population, particularly girls and women. Nutrition projects that analyse and take into consideration the needs, priorities and capacities of both the female and male population increase their potential to contribute to their own and their community’s wellbeing and to enhance their security and safety.

GBV is an umbrella term for any harmful act that is perpetrated against a person’s will and is based on socially-ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such actions, coercion and other deprivations of liberty. GBV exists in every context worldwide and is particularly exacerbated in emergencies. Humanitarian actors – particularly colleagues working in non-GBV specialized sectors - may not be able to tackle all the various root causes of GBV during acute emergency response. However, ALL humanitarian actors, regardless of mandate or sector, have a responsibility to mitigate GBV risk in their work.

GBV risk mitigation comprises a range of activities within humanitarian response that aim to first identify GBV risks and then take specific actions to reduce those risks.

GBV-related risks can exist in the general environment, within families and communities, and in humanitarian service provision. In practical terms, GBV risk mitigation means taking actions to:

* Avoid causing or increasing the risk of GBV associated with humanitarian programming
* Facilitate and monitor vulnerable populations’ safe access to and use of humanitarian services
* Identify and actively reduce the risks of GBV in the environment and programming/service delivery

**Minimum Package of MIYCN Services[[6]](#footnote-6)**

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|  | **Basic MIYCN Support** | **Skilled MIYCN Support** |
| Where | All levels | Community | Health Post (HP)  | Health Sub-centers (HSC) | Rapid Response Team (RRT) | Basic Health Center (BHC) | Outpatient Therapeutic Feeding Programme (OTP) | Stabilization Center (SC) | District, Provincial, regional, national, and specialty hospitals |
| Who | All humanitarian actors including non-nutrition actors | 10 -1 5 volunteer women from the community | Male and Female Community Health Worker (CHW) | Nurse, Nutrtion counsellor and midwife | Doctor, nurse, or midwife | Doctor, nurse, nutrition counsellor or midwife |  | Doctor, nurse, nutrition counsellor midwife | Doctor, nurse, nutrition counsellor midwife |
| What | **Enable priority access for pregnant and breastfeeding women to essential services** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| **Prevention of separation of child and mother/caregiver** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| **Register households with PLW, children 0-23 months and higher risk groups** |  |  |  |  |  |  |  |  |  |
| **Provision of private and safe spaces to breastfeed** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| **Dissemination of standardized, clear, and accurate messages on MIYCN-E** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| **Prevent donations and uncontrolled distributions of BMS and feeding bottles and teats** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| **Monitor and reporting of BMS and Code violations** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| **Referrals to appropriate MIYCN Support**  | **Ö** |  |  |  |  |  |  |  |  |
| **GBV Risk mitigation measures** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| **GBV support and referral according to the guidelines** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| Staffed breastfeeding corner |  |  |  |  |  |  |  |  |  |
| Mother and Baby Spaces |  |  |  |  |  |  |  |  |  |
| Basic frontline feeding support |  | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| Skilled MIYCN support |  |  |  |  |  |  | **Ö** | **Ö** | **Ö** |
| Growth monitoring and promotion sessions |  | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| Referral of wasting  |  | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| Treatment of MAM and SAM |  |  |  |  |  |  |  |  |  |
| Peer support groups or Care groups |  | **Ö** | **Ö** | **Ö** |  |  |  |  |  |
| Support for complementary feeding |  | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| Artificial feeding support |  |  |  |  | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| BMS prescription and targeted distribution |  |  |  |  |  |  |  | **Ö** | **Ö** |
| MAMI |  |  |  |  |  |  | **Ö** | **Ö** | **Ö** |
| Clinical diagnosis and management of anemia among adults including PLWs, children 6 to 59 months and adolescents |  |  |  |  |  |  | **Ö** | **Ö** | **Ö** |
| Vitamin A supplementation for children and pregnant adolescents and women |  |  |  | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| Iron and folic acid supplementation for pregnant adolescents and women  |  |  | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** | **Ö** |
| Monitoring and Reporting |  |  |  |  |  |  |  |  |  |
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**Details of Services**

**Basic Multi-sectoral Actions**

**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.**

**Enable priority access for pregnant and breastfeeding women and mother/caregivers of children 0-23 months 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 MIYCN-E teams to provide all services. The responsibilities for MIYCNE teams are:

* Advocate for adequate services to be in place and for PLWs/caregivers to be prioritised for resources, distributions, etc
* Provide information and support (e.g., referrals) to help women access relevant services such as GBV support, health services, MHPSS, Early Childhood Development or nurturing care support, etc
	+ To conduct effective referrals in which MIYCN-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 for **ALL HUMANITARIAN PARTNERS** to prioritise PLWs, mothers, and caregivers of young children and to support them to access services include:

* Consideration of timing of services/distributions/interventions
* 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 PLWs and their children
* Provide security and crowd control so that PLW and their children are not at risk of physical harm
	+ Conduct security assessments and GBV risk analysis
* Provide basic structures that offer women a private space to breastfeed nearby

**Prevention of separation of child and mother/caregiver**

Separation of mother and child is a known barrier to breastfeeding and cause of malnutrition. It is important that children stay with their mothers not only for breastfeeding but also for bonding, safety, and security.

If physical separation of mother and child is unavoidable: ensuring that frequent contact between mother and child is facilitated, during which time breastfeeding is encouraged; counselling on hand expression and the provision of storage containers to the mother; providing breastfeeding counslling to the mother; enabling transport of breastmilk to the child; education of the secondary caregiver on the importance of breastfeeding, the storage and feeding of expressed breastmilk and the behaviour of breastfed infants.

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

Registration enables people to be visible and assists in identifying the size and location of 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 MIYCN 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)
* Ensure registration of vulnerable groups (i.e., orphans, pregnant women, women headed households, single-headed households with children)

**Provision of private and safe spaces 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) which can later be developed into more comprehensive supportive spaces offering MIYCN-E services later on.

* Ensure shaded / sheltered areas which offer privacy for breastfeeding e.g., near queues
* Provide breastfeeding corners within services e.g., health facilities
	+ Place IEC materials within the corners
	+ Not all spaces must be staffed but information on support available should be provided in all cases

**Dissemination of standardized, clear, and accurate messages on MIYCN-E**

Clear and consistent MIYCN-E messages that reinforce safe and appropriate MIYCN-E and address any specific concerns can have a large impact due to their potential reach. Mothers, caregivers and the community are key targets that can address any specific concerns. Informing and engaging influential people in the community like grandparents, local leaders and religious leaders will help broaden the scope of support to mothers and caregivers. Generally, it has to be standardised, agreed upon messages and communicate them consistently, keep simple and short, one message at a time, positive in tone, field testing, highlighting the positive consequences (motivation), using a trusted source, customised for culture, language, environment, target group. These messages are in the following frontline feeding support.

Dissemination channels could include registration and distribution points, community/religious meetings, safe spaces, at health/child-protection service sites or during household assessments. 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.

Messages to support effective breastfeeding:

* Your breast milk 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. Look at the baby and engage as they are feeding
* Breastfeed frequently, as the baby wishes, day and night
	+ It may feel like the baby wants to feed all the time, especially when newly born, or especially during illness- this is OK and normal. If you feel like something is wrong please see an MIYCN provider.
* Husbands and other household members should help around the house and support the mother or caregiver as they feed and care for themselves and the child
* Hold baby close to your breast against your skin, even when not feeding
* 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 breast milk 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 breast milk as the main source of fluid as you introduce other foods to the baby’s diet
* Let baby finish one breast, then offer the other breast
* Avoid giving baby feeding bottles or pacifiers

**Prevent donations and uncontrolled distributions of BMS and feeding bottles and teats**

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 XXX** explain why there should be no donations or uncontrolled distributions respectively.

|  |  |
| --- | --- |
| **NO DONATIONS** | **NO GENERAL (BLANKET) DISTRIBUTIONS** |
| Breastmilk Substitutes *e.g. infant formula*Donor Human Milk[[7]](#footnote-7) Other milk products *e.g. powdered milk*Infant FoodsCommercial Complementary Foods Feeding Accessories *e.g. bottles and teats*  | Breastmilk SubstitutesDonor Human MilkOther milk products Infant Foods Feeding Accessories\*  |

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

**Monitor and reporting of BMS and Code violations**

A standard online form 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 Nutrition Cluster if they do not have access to online reporting. Regularly analyse monitoring data and ensure it is used for action.

**GBV Risk Mitigation Measures**

Female headed households, displaced women and girls, adolescent girls, those with disabilities are among the most vulnerable to Gender Based Violence (GBV) and younger women are more likely to experience physical violence. Limited availability of health services for GBV, insecurity and weak humanitarian access further exacerbate the situation. It is important that all nutrition actors incorporate GBV risk mitigation measures into their programmes.

GBV risk mitigation interventions aim to reduce exposure to GBV and ensure that humanitarian response actions and services themselves do not cause harm or increase risk of violence.

Conducting gender and risk analyses of response efforts is a key first step. Consultations with women and girls and groups at increased risk (eg, persons with disabilities) must be prioritised. Existing guidance can help safely navigate such issues. In addition, women’s organisations have context-specific expertise and deep understanding of women’s and girls’ specific risks and needs. These organisations should be engaged in a meaningful way at all stages of response efforts. Unintended consequences of response efforts must be considered, measured and addressed to ensure response actions are not causing harm or increasing risk of violence.

Assessment to be done by implementers while programming/Planning

1) What types of GBV are prevalent in your settings?

2) What are the risks in this setting that contribute to GBV

* Pre-existing - exists independent of, or prior to emergency or conflict (culture, policy, etc.)
* Emergency-related - specific to/resulting from the disaster or conflict
* Humanitarian-related - caused directly or indirectly by humanitarian environment

3) What can your organisation do to prevent and mitigate GBV risks?

* Pre-existing risk mitigation activity
* Emergency-related risk mitigation activity
* Humanitarian-related risk mitigation activity

Examples of integrations at the Service Point

* Integrated messages and education sessions at the health facilities or/and during the outreach/mobile team
* Training all the health providers to all cadres to identify GBV/IPV cases and know the referral pathways
* Strengthen referrals within the services within the facilities and to other service the survivors needs such as protection or health cluster

**Core Essential Services**

The **Core MIYCN-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 MIYCN-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.

**Staffed Breastfeeding Corner and Mother and Baby Spaces**

During emergencies, women often lack a space to comfortably and privately breastfeed due to displacement from their homes or overcrowding in temporary settlements. Registration and distributions often involve standing in queues for long 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 and violent, putting infants and young children at risk of physical harm and very stressful for caregivers. Therefore, it is important to create safe and low-stress spaces where mothers can breastfeed, rest and receive support. Types of Space Breastfeeding 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 MIYCN-E services. They are space 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.

Factors indicating need of supportive spaces are as follow.

* Physical safety and access to services
* Plan for the appropriate number of spaces and size based on target population size, geographical spread and access e.g., large population need higher number of smaller spaces.
* Coordinate with other actors to ensure an even distribution of services.
* Ensure proximity to segregated latrines (no more than 50 metres) and hand washing with soap facilities.
* 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 MIYCN-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.) Target Population NC partners will agree upon targeting criteria at the start of the response and communicate clearly to the community and emergency responders. Caregivers will come directly or referred.

Criteria are:

* Lactating women (with children 0 – 23 months)
* Children 0 – 23 months
* Pregnant women (referral criteria may vary depending on expected caseload and available resources e.g., only after the 1st or 2nd trimester)

**Basic frontline feeding support**

Basic Frontline Feeding Support means staff who can use a Simple Rapid Assessment (SRA) and provide practical help and information sharing including referrals.

Active measures are needed to identify infants, children and mothers in need of special attention so that their condition can be identified and treated. Two methods can be used for feeding of children 0 – 23 months:

1. MIYCN Simple Rapid Assessment to determine the age of the child, and whether there are issues with feeding which require a full assessment by a skilled worker.

2. MIYCN Full Assessment to determine MIYCN practices and any difficulties faced by the caregiver, and what type of support is needed (such as MIYCN counselling, nutrition education, provision of micronutrients or complementary feeding supplements).

Who: Frontline workers who frequently interact with children 0 – 23 months and their caregivers should be prioritized for training and instructed to carry out 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 check ups
* as part of the case management process for child protection services
* upon presentation at a health care facility
* front-line workers are those who interact directly with the disaster-affected population e.g., community health workers, volunteers, midwives, birth attendants, nutrition and health service providers and child protection case workers.

Location:

* Mother Baby Area Breastfeeding Corner
* SC
* OTP
* Community outreach
* BSFP, TSFP
* Household visit Screening Awareness session
* Rural Health Centers, Sub Rural Health Centers
* Child Protection case management
* Women and Children Friendly Spaces

If a problem is detected through the SRA, the frontline worker will provide relevant key messages and practical help as interim support and make a referral for a Full Assessment. The purpose of this is to minimise the immediate risk, until the caregiver can access individual MIYCN counselling and support. This combination of activities at community level is known as Basic Frontline Feeding Support.

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.

* Basic Frontline Assistance for Caregivers who request Breastmilk Substitutes.
* Reason for request:
	+ Lost confidence in her ability to breastfeed her baby
	+ Worried she does not have enough milk
	+ Believes infant formula is better for her child
	+ Mixed feeding (breastmilk and infant formula) infant under 6 months
	+ Infant is < 12 months and is not breastfed (mother has no milk)
* Response:
	+ Reinstall confidence in breastfeeding
	+ Refer for FA and skilled individual counselling
	+ 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
	+ Advise that it is much safer and better for her baby to be exclusively breastfed
	+ Refer to services supporting non-breastfed infants.

**Skilled MIYCN support**

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. 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 anenvironment that is conducive to counselling and that offers sufficient privacy for the counsellor to directly observe a breastfeed and to monitor the quality of counselling provided.

|  |  |  |  |
| --- | --- | --- | --- |
| **Intervention**  | **When**  | **Who**  | **Where**  |
|  **Support for Early Initiation of Exclusive Breastfeeding**  |  * Within the postnatal period (first 6 weeks after birth) with an emphasis on the 1st hour

  |  Birth Attendant108 / Newborn Attendant  |  Maternity Services     |
|  Birth Attendant/ Newborn Attendant  |  Community   |
|        **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, mastitis109
* 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     |

**MIYCN Counselling**

Mothers or caregivers who are not breastfeeding, partially breastfeeding, or in need of breastfeeding support should be provided with counselling by a trained IYCF focal point. Breastfeeding counselling is conducted on a one-one basis with the mother/caregiver at any level where IYCF Support is provided and staff are trained to counsel including the primary health facility, SC, OTP, BSFP, TSFP, or at the household level while respecting distancing and other guidance for prevention of transmission of COVID-19.

Counselling consists of assessing the mother’s needs and providing individualised counselling in order to address challenges with breastfeeding. This includes observation of a breastfeed and counselling for re-lactation and increasing milk supply. Caregivers and mothers of infants and young children 6-23 months should be provided with counselling and education on both breastfeeding and complementary feeding. Complementary feeding counselling will consist of provision of tailored messages on complementary feeding based on caregiver’s needs. IYCF counsellors should be trained on providing adapted counselling on complementary feeding.

The IYCF counselling cards are tools that can be used to provide key messages on continued breastfeeding and complementary feeding and address any challenges.

For situations where wet nursing or expressed human milk from another woman is acceptable and possible, the IYCF specialist should also provide support to link with the wet nurse or human milk donors. This will likely involve education and messaging for the other adults in the household for the child to receive full and sustainable support.

**Peer support groups or Care groups**

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

**Important Aspects of Peer Support Groups**

• Safe environment

• Sense of respect

• Sharing information

• Availability of practical help

• Sharing responsibility

• Acceptance

• Learning together and from each other

• Emotional connection

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

Possible groups for mobilization include:

• Women’s groups

• Church groups

• Married adolescent groups

• Breastfeeding groups

• Groups for preventing mother-to-child transmission (PMTCT) of HIV

• Groups for people living with HIV/AIDS (PLHA)

• Youth groups

• School clubs

**MtMSG groups composition**

It is important that MtMSGs are based on a sense of trust, acceptance, self-worth, value, and respect. When the group members feel respected and valued then information is easier to share, it is easier to learn new skills, and a feeling of connection is developed amongst the participants.

Before Identification and formation of Lead persons and support groups respectively, there is a need for sensitization and awareness creation to the Key stakeholders (community leaders, religious leaders).

**Mother-to-mother support groups have the following characteristics:**

• Groups between 8 to 15 participants, adapted during times such as COVID-19

• Members support each other through sharing experiences and information.

• The group is made up of pregnant and lactating women and other interested people

• Facilitation is by a trained lead mother

• The group is open, allowing for new members.

**Facilitator responsibilities include:**

• Identifying future participants.

• Preparing for the topic.

• Inviting participants to the meeting

• Referral to onward services when the need arises

• Registration of participants and data collection for Monitoring and Evaluation

Using the *Guidelines for Facilitating Community- based Support Group Meetings on*

*Infant and Young Child Feeding in Emergencies* and relevant counselling cards, the facilitator conducts a series of 12 meetings on specific topics where registered mothers attend each meeting until they graduate the group at the end of the series.

**Timing**

Timing of the MtMSGs should not interfere with the primary activities of the members (preparation of meals, washing, market days, distribution, work schedules, etc.). The group should meet once a month for a regular session and every two months for a cooking demonstration, which is carried out after the regular MtMSG meetings.

Meetings should last an average of 40 minutes, and never more than one hour.

**Location**

If it is a home, it should not be more than 15– 25 minutes walking distance from the homes of members. If the community is spread out, the Women’s Friendly Space, community areas, Child Friendly Space (CFS)or school could be a good alternative. The place should be private and safe so that members can bring their children. Security risk mapping should take place and a GBV safety audit should also be conducted.

**Father to Father Support Group(s)[[8]](#footnote-8)**

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

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

**FtFSG groups composition**

Just as it is with MtMSGs, it is important that FtFSGs are based on a sense of trust, acceptance, self-worth, value, and respect. When the group members feel respected and valued then information is easier to share, it is easier to learn new skills, and a feeling of connection is developed amongst the participants.

**Father to Father support groups have the following characteristics:**

* Groups to have 8 to 15 participants, adapted during times such as COVID-19
* Members support each other through sharing experiences and information
* The group is made up of fathers of infants and children or who have a pregnant wife or partner and other interested people
* Facilitation is by a trained lead father
* The group is open, allowing for new members.

**Facilitator responsibilities include:**

• Identifying future participants.

• Preparing for the topic.

• Inviting participants to the meeting

• Referral to onward services when the need arises

• Registration of participants and data collection for Monitoring and Evaluation

**Time**

Timing of the FtFSGs should not interfere with the primary activities of the members (market days, distribution, work schedules, etc.).

**Location**

If it is a home, it should not be more than 15– 25 minutes walking distance from the homes of members. If the community is spread out, community areas, Child Friendly Space (CFS) or school could be a good alternative. The place should be private and safe so that members can bring their children. Security risk mapping should take place before any final decisions are made on location.

**Support for complementary feeding**

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

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

**Recommended Complementary Feeding Practices[[9]](#footnote-9)**
In order to meet the nutritional needs of the infant complementary foods should be:

* **Timely** – introduced at 6 months when the need for energy and nutrients exceeds what can be provided through exclusive breastfeeding;
* **Adequate** –provide sufficient energy, protein and micronutrients to meet a growing child’s nutritional needs;
* **Safe** – hygienically stored and prepared, and fed with clean hands using clean utensils and never using bottles and teats;
* **Properly fed** – given consistent with a child’s signals of appetite and satiety[[10]](#footnote-10), and that meal frequency and feeding are suitable for age.

|  |
| --- |
| **Recommended Complementary Feeding Practices** |
| **Age** | **Recommendations** |
| **Frequency** (per day) | **Amount of food an average child will usually eat at each meal** (in addition to breastmilk)  | **Texture** (Thickness/Consistency) | **Variety** |
| **Start Complementary foods after baby reaches 6 months**  | 2 to 3 meals, plus frequent breastfeeds | Start with 2 to 3 tablespoonsStart with ‘tastes’ and gradually increase amount | This porridge/pap or mashed/pureed fruits/vegetables | Breastmilk (Breastfeed as often as the child wants) PLUS Staples (maize millet, sorghum pap/porridge, agidi, or other local examples) PLUS Legumes (roasted groundnuts paste or other local examples) Legumes (soft boiled beans, moi-moi, or other local examples) PLUS Fruits (banana, mango, oranges)/vegetables (ugu leaves, green leaves, okro, ewedu, or other local examples) |
| **6 months to 9 months** | 2 to 3 meals plus frequent breastfeeds1 to 2 snacks can be offered | 2 to 3 tablespoons per feedIncrease gradually to half (2/1) of a 250ml cup/bowl | This porridge/papMashed/pureed family foods and fruits/vegetables |
| **9 months to 12 months** | 3 to 4 meals plus breastfeeds1 to 2 snacks can be offered | Half (1/2) of a 250 ml cup/bowl | Finely chopped family foods and fruits/vegetablesFinger foods, including fruits/vegetablesSliced foods |
| **12 months to 24 months** | 3 to 4 meals plus breastfeeds1 to 2 snacks can be offered | Three-quarters (3/4) to one 250ml cup/bowl | Sliced foodsFamily foods |
| **If the child is between 6 and 24 months and NOT breastfed** | Add 1 to 2 extra meals1 to 2 snacks can be offeredPLUS 2 to 3 cups of extra fluid, especially in hot climates | Same as above, according to age group | Same as above |
| **Active/responsive feeding** (alert and responsive to signs that the baby is ready to eat; actively encourage but do not force the baby to eat) | * Be patient and actively encourage your baby to eat more food.
* If your young child refuses to eat, encourage him/her repeatedly; try holding the child in your lap during feeding, or face him/her while he or she is sitting on someone else’s lap.
* Offer new foods several times, children may not like (or accept) new foods in the first few tries.
* Feeding times are periods of learning and love. Interact and minimize distraction during feeding.
* Do not force-feed.
* Help your older child feed him- or herself.
 |
| **Hygiene** | * Feed your baby using a clean cup/bowl and spoon; never use a bottle because it is difficult to clean and may cause your baby to get diarrhoea.
* Wash your hands with soap and water before preparing food, before eating, and before feeding young children.
* Wash your child’s hands and face with soap before and after he or she eats
 |

**Artificial feeding support**

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

* Risks of infections are higher during emergencies: breastfeeding protects against the increased risks of infection and illness among infants during emergencies.
* Breastfeeding counselling and mother-to-mother support reinforces and renews a mother’s confidence and resolve to breastfeed.
* There is a strong association between the receipt of infant milk formula donations, a change in feeding practices, and diarrhea.
* Providing infants with milk formula in an emergency increases the risk of illness and mortality, as hygiene and sanitation conditions are often poor, and access to clean water and fuel are usually limited.

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

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

The aim of a BMS program is to ensure that assessed and targeted infants receive the supplies and support that they need, as such while stocks of BMS are required, if according to program needs, they are no longer needed (which may be due to the success of the relactation, wet nursing, etc. program) they must be disposed of carefully as care must be taken not to undermine breastfeeding.

**Guiding principles for BMS**

* A general distribution should NEVER include breast-milk substitutes or any other milk products.
* Neonatal or baby kits should never contain infant formula or bottles or teats
* Organizations must NEVER accept unsolicited donations of ANY milk products (infant formula or other powdered milk products, long life milk, dried whole, semi-skimmed or skimmed milk; liquid whole, semi-skimmed or skimmed milk, soya milks, evaporated or condensed milk, fermented milk or yogurt.)
* Instead, interventions to support artificial feeding should budget for the purchase of BMS supplies along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation, staff training, and skilled personnel.
* Infant formula prescriptions will only be accepted if based on a full infant feeding needs assessment by trained health personnel using established and agreed criteria and the prescription of infant formula supplementation is supported through the appropriate approval chains.

**Box 12: Guiding principles for BMS[[11]](#footnote-11)**

**Monitoring and Reporting**

It is essential to monitor the impact of humanitarian action or inaction on MIYCN 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.**

Disaggregate the data:

* Disaggregate data by sex and age: 0-5 months, 6 – 8 months, 9-11 months, 12-23 months, pregnant, lactating, pregnant and lactating women. Depending on the context, further disaggregation by other relevant factors e.g., ethnicity or geographic location are needed.

**Outcome indicators** which reflect the effect of interventions should be measured using **standard indicators and definitions[[12]](#footnote-12).**

Priority outcome indicators to measure in NW Syria are:

* Early initiation rate of breastfeeding in newborn infants. This is a key benchmark of the effectiveness of an emergency response.
* The proportion of infants under six months that are exclusively breastfed compared to pre-crisis rate; this should not go down.
* Non-breastfed infants have access to an adequate amount of an appropriate breast milk substitute, and are provided with the supportive conditions and access to healthcare needed to reduce the risks from artificial feeding.
* Incidence of watery diarrhea in infants 0-6m, 6-12m, 12-24m.
* Proportion of children aged 6-24 months with access to nutritious, energy dense complementary foods

Breastfeeding Indicators

1. Ever Breastfed
2. Early initiation of breastfeeding
3. Exclusively breastfed for the first two days after birth
4. Exclusive Breastfeeding under 6 months
5. Mixed milk feeding under six months
6. Continued breastfeeding up to 12- 23 months

Complementary Feeding Indicators

1. Introduction of solid, semi-solid or soft foods 6-8 months
2. Minimum dietary diversity 6-23 months
3. Minimum meal frequency 6-23 months
4. Egg and/or flesh food consumption 6-23 months
5. Sweet beverage consumption 6-23 months
6. Unhealthy food consumption 6-23 months
7. Zero vegetable or fruit consumption 6-23 months

Other indicators

1. Bottle feeding 0-23 months

These indicators need to be measured before[[13]](#footnote-13), 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 MIYCN indicators within SMART Surveys
* **<cluster reporting mechanisms>.**

Disseminating Results: Share the methodology used and any assumptions, biases, limitations or gaps while adhering to data-sharing principles. The results should be shared with the NC / Sector Information Management Officer, other relevant clusters and assessed communities.

1. [WHO (1981) International Code of Marketing of Breast-milk Substitutes](https://www.who.int/nutrition/publications/infantfeeding/9241541601/en/) [↑](#footnote-ref-1)
2. The Code applies to the marketing and practices related to the following products: breast milk substitutes including infant formula; other milk products, foods, and beverages, including commercial complementary foods when marketed or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breastmilk, feeding bottles and teats. It also applies to their quality and availability and to information concerning their use (Article 2. Scope of the Code, WHO, [1981](https://onlinelibrary.wiley.com/doi/full/10.1111/mcn.12730#mcn12730-bib-0044)). [↑](#footnote-ref-2)
3. The Minimum Package of Services is a priority set of lifesaving activities to be implemented at the onset of every emergency (within 48 hours wherever possible). To prevent morbidity and mortality, essential services for all newborns (essential newborn care) include support for skin-to-skin contact, immediate and exclusive breastfeeding and not discarding colostrum. [↑](#footnote-ref-3)
4. *MIYCN-E topics should be integrated into existing education curricula wherever possible, rather than as standalone training.*  [↑](#footnote-ref-4)
5. *See:* **National Strategy on MIYCN in Bangladesh (2007) Box 6** (p. 39) *for examples of community-based health workers and volunteers to target – including Family Welfare Agents, Health Assistants, Skilled Birth Attendants, Community Nutrition Promoters and Village Health Volunteers.*  [↑](#footnote-ref-5)
6. Priority activities outlined in the table are highlighted in **BOLD** [↑](#footnote-ref-6)
7. *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.*  [↑](#footnote-ref-7)
8. Save the Children *Facilitating Father to Father IYCF Support Groups Standard Operating Procedures* Found in the NE Nigeria Nutrition Sector Google Drive [↑](#footnote-ref-8)
9. WHO Complementary Feeding Practices https://www.who.int/health-topics/complementary-feeding#tab=tab\_2 [↑](#footnote-ref-9)
10. Caregivers should take active care in the feeding of infants by being responsive to the child’s clues for hunger and also encouraging the child to eat.  [↑](#footnote-ref-10)
11. IFE Core Group *Operational Guidance on Infant Feeding in Emergencies (OG-IFE) version 3.0* 2017 https://www.ennonline.net/operationalguidance-v3-2017 [↑](#footnote-ref-11)
12. **Indicators for Assessing Infant and Young Child Feeding Practices**: **Part 1: Definitions and measurement methods**. WHO, UNICEF (2021) https://www.who.int/publications/i/item/9789240018389 [↑](#footnote-ref-12)
13. *Do not delay the start of emergency activities because baseline indicators have not yet been collected.*  [↑](#footnote-ref-13)