Infant, and Young Child Feeding in Emergencies (IYCF-E) Standard Operating Procedures

State of Palestine, December 2023

IYCF-E programming is set of lifesaving interventions that targets pregnant and breastfeeding 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 apply across all sectors.

Important to remember: In a situation with severe food insecurity, breastfeeding is the infant and young child's food security. This is life saving in this situation.

A mother who is hungry and dehydrated can still make enough nutritious milk. Breastfeeding mothers can also feed others' babies directly or by expressing milk into a clean cup or spoon and feeding that way.

Humanitarian actors should prioritize breastfeeding mothers for food and water distribution. **Feeding the breastfeeding woman will help to feed the child.**

1. Overview

Breastfeeding should be promoted, protected, and supported in all circumstances from birth until two years of age.

Key Recommended IYCF-E 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)

  In this context it is important to achieve these as best as possible
- **Continued breastfeeding from 6 months up to 24 months and beyond.**
  - This is incredibly important in this situation.
  - Breastfeeding is the infant's food security.

State of Palestine Nutrition Cluster

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A global level and a country level joint statement has been issued to help secure immediate, coordinated, multi-sectoral action on infant and young child feeding.

Nutrition partners call for **ALL** involved in the emergency response to protect, promote, and support the feeding and care of infants and young children, their caregivers, especially pregnant and breastfeeding women.

Infant formula distribution should not take place without close coordination with the nutrition cluster. **Indiscriminate distribution of infant formula and milk products will result in diarrhea, illness, malnutrition, and death of vulnerable infants.**

For infants who are not breastfed and for whom breastfeeding is not possible either by their mother or by another women is not possible, UNICEF is the provider of the first resort to procure and distribute Ready to Use Infant Formula (RUIF) in a targeted way to address the needs of the non-breastfeed infant. UNICEF is also responsible for strengthening the monitoring system to address any breast milk substitute code violations such as donations and indiscriminate distribution of milk products, infant formula, commercial complementary foods, bottles, and teats in emergencies.

When implementing IYCF-E, activities and services will vary by setting and access to the population and should be contextualized as such by health and nutrition partners. An outline of these activities is below.

2. Background to IYCF-E SOP

This document is intended to inform all actors involved in the humanitarian response in the State of Palestine on multi-sectoral minimum standards for Infant and Young Child Feeding and the of child survival.

In all circumstances all health and humanitarian actors should:

- Promote recommended adolescent, maternal, infant and young child nutrition practices.
- Prevent separation between children and mothers/caregivers.
- Prevent donations and uncontrolled distributions of BMS and feeding bottles and monitor and report the BMS Code[1] 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.
- Prioritise privacy, food and water, and shelter for pregnant and breastfeeding women
- Provide private and supportive spaces to breastfeed.
- Communicate effectively about IYCF-E
- Mitigate the risk of Gender Based Violence

3. Key Messages

Breastfeeding Is lifesaving in an emergency

- In an emergency, breastfeeding saves lives. This is because human milk is not only the perfect nutrition for infants; it also contains antibodies that fight infection and disease, preventing bacteria and pathogens from attaching to the infant's intestines.

[1] The International Code of Marketing of Breast-milk Substitutes and Relevant Resolutions, abbreviated as "The Code", is a set of recommendations to the 194 countries that are members of the World Health Assembly aimed at eliminating inappropriate and harmful marketing of breastmilk substitutes. https://www.aliveandthrive.org/en/resources/the-code-frequently-asked-questions

- Contaminated water, poor sanitation, and the spread of germs and bacteria are widespread in emergencies, and infants and young children are at heightened risk. The safest, most sanitary food is always breastmilk.
- Breastfeeding also helps keep infants warm, lowers pain levels in infants, and lowers stress levels to calm infants and mothers.
- Encourage pregnant and postpartum women to breastfeed, or to restart breastfeeding if they have stopped.

Mothers can make enough milk, even if they have experienced stress.

- It is commonly assumed that a mother who is stressed during an emergency cannot make milk. However, this is not true.
- A woman who has experienced stress can make enough of milk, though stress can sometimes delay the flow of that milk to the baby. If the flow is delayed it requires support and patience to keep the child to the breast. Holding her baby skin-to-skin[2] will help lower stress levels in both mother and baby, and increase the hormone oxytocin, which helps the milk to flow. Creating a calm, safe space for mothers to breastfeed can also help with the flow of breastmilk.
- Remind humanitarian staff that supporting breastfeeding mothers can help them feel confident that they can continue to breastfeed. Staff should advocate for privacy, when possible, to help mothers and children relax. Encourage mothers to hold their baby skin-to-skin. A wrap, hijab, blanket, or scarf can help give mothers and babies a little privacy for skin-to-skin contact and breastfeeding.

It is possible for mothers who are hungry and dehydrated to still make enough nutritious milk.

- Mothers CAN breastfeed and make plenty of nutritious milk for their baby even when they aren't getting enough food or water themselves, except in rare, extreme situations. Mothers make milk from their own body stores, so even in an emergency, the quality and quantity of the milk will be unaffected. However, a hungry or dehydrated mother will lack strength and may find breastfeeding more difficult than usual.
- Humanitarian responders should prioritize pregnant and breastfeeding women for food and water distribution. Feed the mother so she can feed her baby.

Babies should continue to breastfeed, even if they are sick.

- Infants and young children are five times more likely to die in an emergency, primarily due to diarrhea. Breastfeeding dramatically decreases the risk of diarrhea. Human milk is quickly absorbed, and the many immune factors help fight illness and infection.
- Human milk also has important nutrients, minerals, and water to help keep the baby hydrated. Electrolyte solutions, teas, and water are a poor substitute for human milk and are not needed for an infant who is receiving breastmilk.
- If an infant is ill, encourage the mother to breastfeed as often as possible and refer her to a health or nutrition specialist if breastfeeding support is needed.

Begin introducing complementary foods only after six months in addition to breastmilk.

[2] Skin to skin is when a person, usually the mother or breastfeeding woman, holds the baby to their chest. The baby wears only a diaper, nothing at all, or possibly a hat and socks to help stay warm. The infant lays against the bare chest, allowing for skin to skin contact. A blanket can be laid on top of the mother, caregiver or baby to help remain warm.

- After six months mothers should continue to breastfeed the infant in a responsive way, as the infant requests, day and night to maintain the baby's health and strength. This should continue until the baby is two years or older.
- Mothers should breastfeed first before giving complementary foods.
- Complementary foods should be as fresh and diverse as possible and be fed at least two to three times a day.
- Mothers and caregivers should wash their hands and the baby's hands with soap and water before preparing food, feeding the baby, after using the toilet and cleaning the baby's bottom.
- Humanitarian workers should use a multisector approach to integrate counselling and social and behaviour communication change (SBCC) to improve access to diverse and nutritious foods at the household level.

Avoid Routine Distribution of Infant Formula

- Infant formula should never be routinely distributed in an emergency[3]. This is especially true of powdered formulas since they are not sterile, as well as concentrated formulas that require clean water for safe preparation. In an emergency, infant formula distribution can actually do more harm than good.
- Discourage donations of infant formula by well-meaning contributors. Any formula used should be purchased by the relief agency and used only in the strictest conditions, including situations where human milk is not an option, where infant formula can truly be prepared safely, and where its availability can be continued for as long as the infant needs it.

4. What is Breast Milk Substitute?

Breastmilk substitute (BMS) is any food or drink being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose. This includes infant formula, other milk products, therapeutic milk, and bottle-fed complementary foods marketed for children up to 2 years of age and complementary foods, juices, teas marketed for infants under 6 months.

Follow-on milk, follow-up formula, growing up milks, and infant formula stage 2 and above are milks marketed for infants over 6 months of age. They are specifically formulated milk products defined as a food intended for use as a liquid part of the weaning diet for the infant from the sixth month on and for young children[4]. Providing infants with a follow-on/follow-up formula is not necessary and against global recommendations[5]. **These milks are unnecessary and should never be distributed in any circumstances.**

5. Milk Distribution

[3] Blanket infant formula distribution is forbidden in global guidance and charters including the SPHERE, Infant Feeding in Emergencies Operational Guidance, and many humanitarian organization internal policies.
[4] Codex Alimentarius Standard 156-19871
[5] See WHA Resolution 39.28 (1986) (para 3 (2))

As per the Sphere handbook[6] DO NOT distribute dried liquid milk products and liquid milk as a single commodity. Indications for and management of artificial feeding should be in accordance with the Operational Guidance and the Code, under the guidance of the nutrition cluster.

Children under 6 months should only ever receive only breastmilk or infant formula through a controlled distribution by a nutrition team with specific and very targeted interventions based on **assessed needs**. Violations of milk distribution in the age group need to be reported to the cluster and the national reporting mechanisms when they are active (at the moment for Gaza that is just through the cluster). All milks, teas, sugar water, and alternative foods (anything other than breastmilk) in this age group would be considered breast milk substitute (BMS) and needs very close monitoring with specialist support from nutrition **It should NEVER be given out as a blanket distribution.**

Children 6 months to 2 years. Children should be supported to breastfeed up until 2 years of age. Any form of milk distribution in this age group by other sectors needs to be coordinated with nutrition and only take place when there is IYCF-E programming alongside it to support mothers to continue to breastfeed and milk used as part of an appropriate complimentary diet. **As with under six months, this should never be a blanket distribution product.**

Children over 2 years receiving milk (for example school age children through a CFS) must also be considered as they will often have younger siblings so programming should be linked up with IYCFE to support mothers with their younger children not to disrupt breastfeeding.

Acceptable milk sources after six months, alongside breastfeeding, include expressed breast milk, full-cream animal milk (cow, goat, buffalo, sheep, camel), Ultra High Temperature (UHT) milk, reconstituted evaporated (but not condensed) milk, and fermented milk or yoghurt.

Milk is useful for childhood nutrition, but it is the secondary impact on breastfeeding that must always be considered and protected, if there is doubt always refer to a nutrition team or contact the nutrition cluster to receive support to assess the risk, report as appropriate, and advise on the most appropriate way of supporting families.

6. Infant Feeding Equipment

Infant feeding equipment such as bottles, teats, and baby cups with lid or spouts should never be distributed in an emergency.

If an infant is assessed by a trained nutrition worker to be unable to breastfeed, appropriate infant feeding equipment includes syringes, spoons, medicine cups, and baby cups without lids and/or spouts.

7. Importance of skin-to-skin

[6] Sphere handbook Food security and nutrition: minimum standard 4- Infant and Young Child Feeding

Newborns who have prolonged skin-to-skin contact with their mother are more likely to breastfeed successfully. This is according to a recent World Health Organization (WHO) study[7], which found that 90 minutes of uninterrupted skin-to-skin contact, where a baby is dried and laid directly on their mother's bare chest after birth, maximizes the chance for babies to be physically ready to breastfeed.

The practice:

- calms and relaxes both mother and baby
- regulates the baby's heart rate and breathing, helping them to better adapt to life outside the womb
- stimulates digestion and an interest in feeding
- regulates temperature
- enables colonisation of the baby's skin with the mother's friendly bacteria, thus providing protection against infection
- stimulates the release of hormones to support breastfeeding and mothering.

Skin-to-skin contact also provides benefits for babies in the neonatal unit, in that it:

- improves oxygen saturation
- reduces cortisol (stress) levels, particularly following painful procedures
- encourages pre-feeding behaviour
- assists with growth
- may reduce hospital stay
- improves milk volume if the mother expresses following a period of skin-to-skin contact, with the expressed milk containing the most up-to-date antibodies.

How to support skin to skin

Maternity units can ensure that:

- all mothers have skin-to-skin contact with their baby after birth, at least until after the first feed and for as long as they wish
- all mothers are encouraged to offer the first feed in skin contact when the baby shows signs of readiness to feed
- mothers and babies who are unable to have skin contact immediately after birth are encouraged to commence skin contact as soon as they are able, whenever or wherever that may be.

Neonatal units can ensure that:

- parents have a conversation with an appropriate member of staff as soon as possible about the importance of touch, comfort and communication for their baby's health and development
- parents are actively encouraged to provide comfort and emotional support for their baby, including prolonged skin contact, comforting touch and responsiveness to their baby's behavioural cues
- mothers receive care that supports the transition to breastfeeding, including the use of skin-to-skin contact to encourage instinctive feeding behaviour.

[7] https://gh.bmj.com/content/5/8/e002581

8. Trainings

All humanitarian actors should be provided with a sensitization session and IYCF-E orientation as well as BMS violations and monitoring and reporting.

Who	Phase 0 Preparedness	Phase 1 72 hours	Phase 2 Weeks 1 and 2	Phase 3 Weeks 2 and 3	Phase 4 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[8]			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 (in service)	In-service training		Orientation (½ day)	Orientation (½ day)	Training (2 days)
IYCF-E Counsellors	Training (5 days)		Refresher Orientation (1 day)	Orientation (2 days)	Training (5 days)
National Policy & Coordination Bodies	Sensitisation (1 hour)		Sensitisation (15 minutes)		
Local Level Coordination Leaders	Sensitisation (1 hour)		Sensitisation (15 minutes)		
Local Level Coordination Personnel	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)	

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

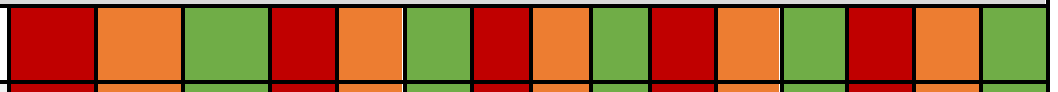
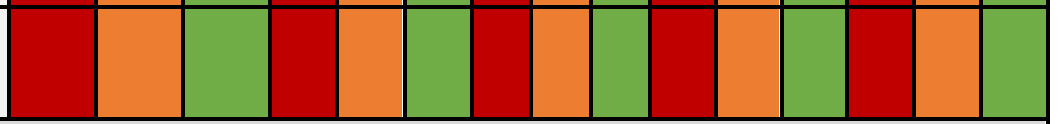
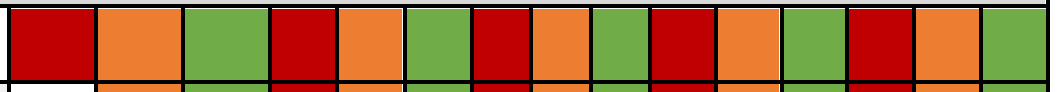
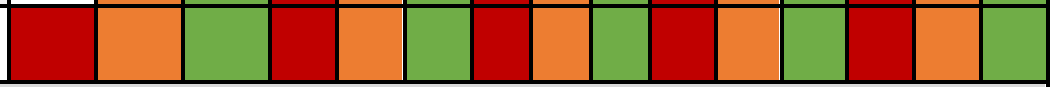
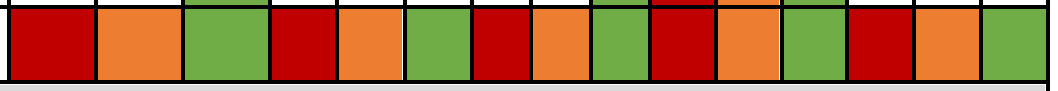
9. Minimum Package of Services

Activities and Services		Setting				
No access[9] / Limited access[10] / Full access[11]						
Where		**Community**	**Mobile medical team**	**Shelters**	**Mother and Baby Areas**	**Hospitals**
Who		All humanitarian actors including non-nutrition actors	All mobile medical team staff	Doctor, nurse, nutrition counsellor or midwife		Doctor, nurse, nutrition counsellor midwife
What	**Basic multi-sectoral actions**					
	Include IYCF indicators in assessments, including joint assessments					
	Register households with PLW, children 0-23 months and higher risk groups					
	Disaggregate data for PLW, infants and young children: number of pregnant women, number of woman with an infant less than 6 months, number of children 0-5 month, 6-11 months, 12-23 months					
	Have a clearly defined inter-sectoral referral mechanism for infants 0-5 months who are not breastfed, 0- 23 months with					

[9] No Access means movement is restricted and aid, including staff and services, are not able to reach the affected population

[10] Limited Access generally means humanitarian aid, including staff and services, are able to reach an area or a variable perimeter around the affected population but not the entire affected population.

[11] Full access means that there is no restriction to meeting the affected population

	feeding problems and with acute malnutrition	
	Protect	
	Enable priority access for pregnant and breastfeeding women to essential services	
	Prevention of separation of child and mother/caregiver	
	Provision of private, shaded, and safe spaces to breastfeed including provision of water in these spaces	
	Promote	
	Orient all staff on IYCF-E in coordination with nutrition partners	
	IYCF-E education sessions	
	Dissemination of standardized, clear, and accurate messages on IYCF-E	
	Support	
	Staffed breastfeeding corner	
	Basic frontline feeding support	
	Skilled support for relactation and wetnursing	
	Skilled support including IYCF-E counselling	
	Growth monitoring and promotion sessions	
	Peer support groups or Care groups	
	Support and counselling for complementary feeding	
	Mitigate risk of breast milk substitutes	

	Prevent donations and uncontrolled distributions of BMS and feeding bottles and teats															
	Monitor and reporting of BMS and Code violations															
	Artificial feeding support															
	BMS prescription and targeted distribution															
	Referrals to appropriate IYCF-E Support															
	GBV Risk Mitigation															
	Receive GBV disclosures as per GBV pocket guide															
	GBV support and referral according to the guidelines															
	GBV Risk mitigation measures															

10. 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.

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

10.1 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

10.2 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.

10.3 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 IYCF-E 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)

10.4 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 IYCF-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

10.5 Dissemination of standardized, clear, and accurate messages on IYCF-E

Clear and consistent IYCF-E messages 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 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.

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 IYCF-E 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.

10.6 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.

NO DONATIONS	NO GENERAL (BLANKET) DISTRIBUTIONS
Breastmilk Substitutes e.g. infant formula	Breastmilk Substitutes
Donor Human Milk[12]	Donor Human Milk
Other milk products e.g. powdered milk	Other milk products
Infant Foods	Infant Foods
Commercial Complementary Foods	Feeding Accessories*
Feeding Accessories e.g. bottles and teats	

[12] *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.*

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

10.7 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.

10.8 GBV Risk Mitigation Measures

Conflicts and natural disasters have different impacts on women, girls, boys, men, and other vulnerable people. 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, women. Nutrition projects that analyse and take into consideration the needs, priorities, and capacities of all genders to increase their potential to contribute to their own and their community's wellbeing and to enhance their security and safety.

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

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.

11. Core Essential Services

The Core IYCF-E Interventions are standard activities to be implemented as part of any Nutrition Response in the State of Palestine. These should be started as soon as possible. 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.

11.1 Staffed Breastfeeding Corner and Mother and Baby Spaces[13]

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[14]. 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 IYCF-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.

[13] Refer to the Mother and Baby Area Guidance for the State of Palestine (2023) on the State of Palestine Nutrition Cluster website: https://response.reliefweb.int/palestine/nutrition
[14] https://www.ennonline.net/supportivespacesiycfetechbrief2020

- 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 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.) 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.

11.2 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:

11.2.1 IYCF-E Simple Rapid Assessment[15]

A Simple Rapid Assessment (SRA) is used to determine the age of the child, and whether there are issues with feeding which require a full assessment by a skilled worker.

Who conductes the SRA?

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
- OTP

[15] https://resourcecentre.savethechildren.net/document/simple-rapid-assessment/

- Community outreach
- BSFP, TSFP
- Household visit Screening Awareness session
- 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 (see below). The purpose of this is to minimise the immediate risk, until the caregiver can access individual IYCF-E counselling and support. *(See Annex 1: Referral for a Full Assessment)*

This combination of activities at community level is known as Basic Frontline Feeding Support.

11.2.2 IYCF-E Full Assessment

A Full Assessment is used to determine IYCF-E practices and any difficulties faced by the caregiver, and what type of support is needed (such as IYCF-E counselling, nutrition education, provision of micronutrients or complementary feeding supplements). *(See Annex 2: One to One Full Assessment)*

11.2.3 Basic Frontline Assistance for Caregivers who request Breastmilk Substitutes

If a caregiver requests a BMS such as infant formula during a one to one assessment, it is important to sensitively handle such requests. Find out why the caregiver is requesting it and respond accordingly.

- 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 a full assessment 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.

11.3 Skilled IYCF-E support

Mothers and caregivers 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 aid breastfeeding women to ensure that the fundamentals of good breastfeeding are in place and to resolve breastfeeding difficulties. It is essential to ensure the environment where skilled IYCF-E support takes place 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.

11.4 IYCF-E Counselling[16]

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.

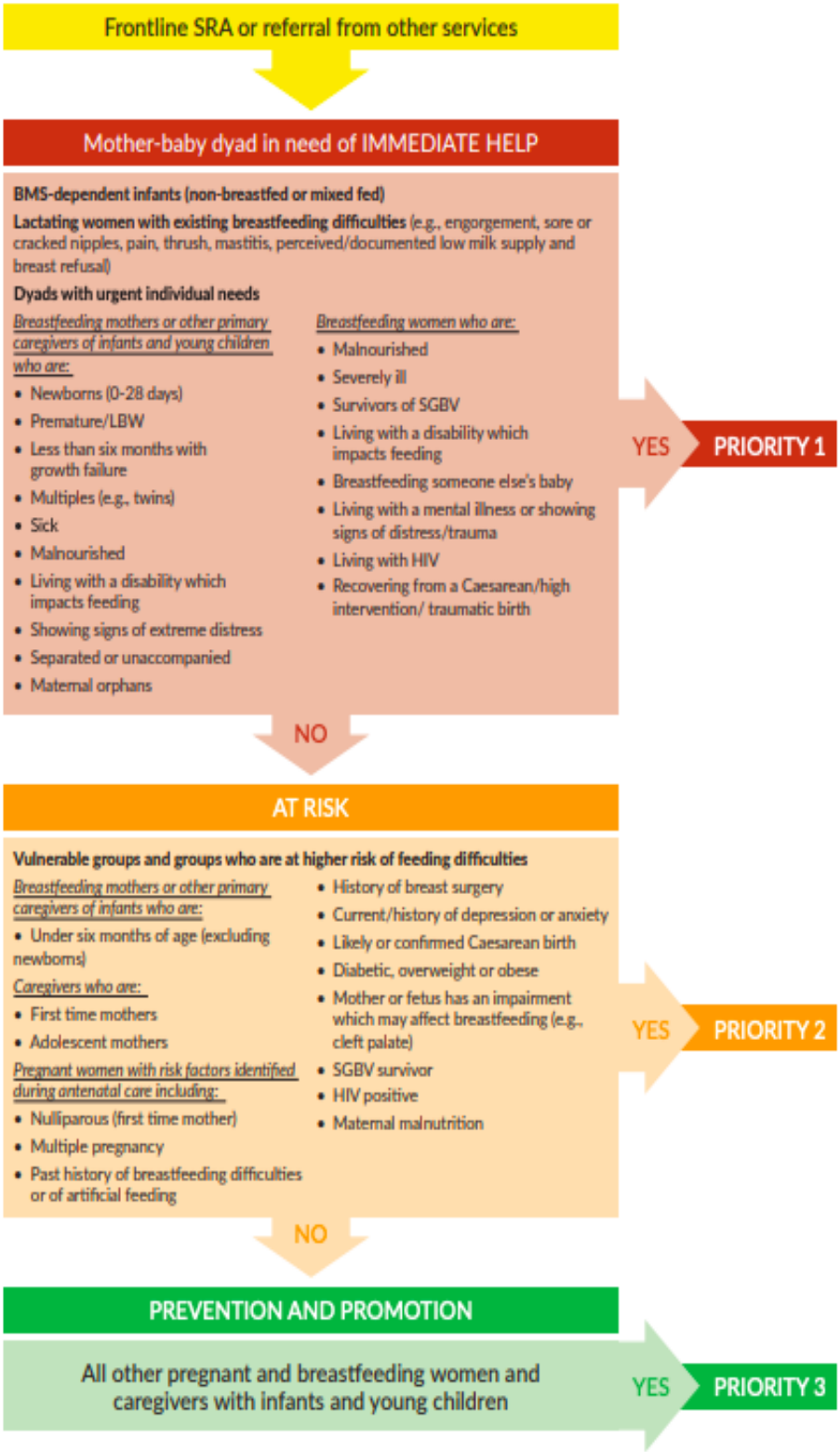
Counselling consists of assessing the mother's needs and providing individualised counselling in order to address challenges with breastfeeding. This includes observation of a breastfeed and counselling for re-lactation and increasing milk supply. Caregivers and mothers of infants and young children 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[17] 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[18]. This will likely involve education and messaging for the other adults in the household for the child to receive full and sustainable support.

[16] Operational Guidance for Breastfeeding Counselling in Emergencies: https://www.ennonline.net/breastfeedingcounsellinginemergencies
[17] https://www.unicef.org/documents/community-iycf-package
[18] See UNICEF Operational Guidance for Wet Nursing in Emergencies (2024) *in DRAFT*

Flow Chart: Prioritization for Counseling by Category[19]



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

11.5 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 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 IYCF-E and their regular meeting times, as well as their ability to identify one key member who can undergo training on IYCF-E.

11.4.1 Mother to Mother Support Groups

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
- 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

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.

11.4.3 Father to Father Support Group(s)[20]

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

[20] Save the Children *Facilitating Father to Father IYCF Support Groups Standard Operating Procedures* Found in the NE Nigeria Nutrition Sector Google Drive

- 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.

11.4 Support for complementary feeding

The context in the State of Palestine is such that it is very likely in all situations the following complementary feeding guidelines will not be able to be followed in full. It is important to consistently relay the critical message that **breastfeeding is the child's food security**, including over the age of six months. IYCF-E and nutrition staff should work with and support families as much as possible to provide appropriate complementary foods for the child in addition to micronutrient supplementation as outlines in the micronutrient supplementation guidelines.[21]

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.

[21] Contact The State of Palestine Nutrition Cluster for guidance.

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.

11.5.1 Recommended Complementary Feeding Practices[22]

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[23], and that meal frequency and feeding are suitable for age.

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

[23] 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.

Recommended Complementary Feeding Practices				
Age	Recommendations			
	Frequency (per day)	Amount of food an average child will usually eat at each meal (in addition to breastmilk)	Texture (Thickness/Consistency)	Variety
Start Complementary foods after baby reaches 6 months	2 to 3 meals, plus frequent breastfeeds	Start with 2 to 3 tablespoons Start with 'tastes' and gradually increase amount	This porridge/pap or mashed/pureed fruits/vegetables	Breastmilk (Breastfeed as often as the child wants) PLUS Staples (maize millet, sorghum pap/porridge, agidi, or other local examples) PLUS Legumes (roasted groundnuts paste or other local examples) Legumes (soft boiled beans, moi-moi, or other local examples) PLUS Fruits (banana, mango, oranges)/vegetables (ugu leaves, green leaves, okro, ewedu, or other local examples)
6 months to 9 months	2 to 3 meals plus frequent breastfeeds 1 to 2 snacks can be offered	2 to 3 tablespoons per feed Increase gradually to half (2/1) of a 250ml cup/bowl	This porridge/pap Mashed/pureed family foods and fruits/vegetables	
9 months to 12 months	3 to 4 meals plus breastfeeds 1 to 2 snacks can be offered	Half (1/2) of a 250 ml cup/bowl	Finely chopped family foods and fruits/vegetables Finger foods, including fruits/vegetables Sliced foods	
12 months to 24 months	3 to 4 meals plus breastfeeds 1 to 2 snacks can be offered	Three-quarters (3/4) to one 250ml cup/bowl	Sliced foods Family foods	

If the child is between 6 and 24 months and NOT breastfed	Add 1 to 2 extra meals 1 to 2 snacks can be offered PLUS 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		

11.6 Artificial feeding support

The State of Palestine Nutrition Cluster has developed and published **Standard Operating Procedures for Breast Milk Substitutes (BMS)**. Please refer to this document if considering implementing any BMS programming[24].

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.

[24] The State of Palestine BMS SOP can be found at: https://response.reliefweb.int/palestine/nutrition

Guiding principles for BMS[25]

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.

11.7 Monitoring and Reporting

It is essential to monitor the impact of humanitarian action or inaction on IYCF-E 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.

11.7.1 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[26].

Priority outcome indicators to measure in the State of Palestine are:

- Early initiation rate of breastfeeding in newborn infants. This is a key benchmark of the effectiveness of an emergency response.

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

[26] **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

- 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

11.7.2 Breastfeeding Indicators

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

11.7.3 Complementary Feeding Indicators

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

11.7.3 Other indicators

- Bottle feeding 0-23 months

These indicators need to be measured before[27], 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:

- Focus Group Discussions
- Transect Walks
- KAP Surveys
- Incorporation of IYCF-E indicators within SMART Surveys

11.7.4 Disseminating Results

[27] *Do not delay the start of emergency activities because baseline indicators have not yet been collected.*

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.

Annex 1: Simple Rapid Assessment Referral Form[28]

Instructions: Administer this rapid assessment whenever a caregiver with a child under 2 years is encountered and a referral is indicated. Do not ask the last 5 questions in italics under **LOOK** but note them down if observed.

If any difficulties are observed, refer the caregiver-baby pair for a Full Assessment or other support as appropriate. If anything in **RED** is circled, then refer to full assessment.

_____**Cut Here** _____
COMPLETE IF REFERRAL IS INDICATED

Caregiver Name: _____

When to attend: Immediately / date: _____ Referral to: _____

Location of facility: _____

REASON FOR REFERRAL:
A) Full IYCF Assessment needed
B) Medical care needed: (reason)_____
C) Other:_____
Referred by (name): _____ Job Title/Agency: _____

Simple Rapid Assessment Referral Form						
Name of baby:	Date of Birth/Age:		Girl		Boy	
Age of baby	0-59 months 0-28 days		6-12 months		12-24 months	
ASK						
Is the baby being breastfed?	Yes	No	Yes	No	Yes	No
Is the baby getting anything else to eat/drink?	Yes	No	Yes	No	Yes	No
Is the baby unable to suckle at the breast?	Yes	No	Yes	No	Yes	No
Are there any other difficulties in breastfeeding?	Yes	No	Yes	No	Yes	No
Does the mother or caregiver feel there are feeding concerns?	Yes	No	Yes	No	Yes	No
Did the caregiver request infant formula?	Yes	No	Yes	No	Yes	No
LOOK						

[28] Adapted from Module 2 on IFE, Core Manual, Section 3, IFE Core Group, 2007

Does the baby look very thin, lethargic or ill?	Yes	No	Yes	No	Yes	No
Is the mother or child visibly diabled?	Yes	No	Yes	No	Yes	No
Does the mother look visibly young?	Yes	No	Yes	No	Yes	No
Is the caregiver the child's mother?	Yes	No	Yes	No	Yes	No

Annex 2: Full Assessment of Mother/Caregiver - Baby Pair[29]

IYCF Full Assessment Of Mother-Baby Pair

NOTE: During the Full Assessment care must be taken to ask open questions, to listen to the mother and show respect and sensitivity to her feelings, her culture, and her experience.

Date: _____ IYCF-E Reg. No. _____

Child's name: _____ Child's sex: M / F Date of birth_____ Age/months_____

Mother's/Caregiver's name: _____ Relationship to child_____

Address:_____ Telephone:_____

Other Children in the home and ages?: _____

Does the mother/caregiver have concerns about other children in the home? Y N

(If yes, request mother/caregiver to bring in the other children to be seen after this assessment is completed)

Assessment undertaken by *(qualified nutritionist/nurse with breastfeeding expertise)*

Name_____ Job Title_____ Organisation_____ Location_____

Breastfeeding Information:

Breastfeeding? Yes / No *(If yes observe breastfeed, if no continue to the next section)*

Breastfeed observation results: *(tick relevant observations below and/or use 'B.R.E.A.S.T' tool)*
Attachment at breast:

- ☐ Areola more above
- ☐ Mouth wide open
- ☐ Lower lip turned out
- ☐ Chin close to or touching breast
- ☐ No nipple/breast pain or discomfort

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

Positioning of baby:
☐ Head & body straight ☐ Child held close to mother's body
Suckling:
☐ Slow, deep sucks, sometimes pausing ☐ Swallowing can be heard and seen
Mother is confident:
☐ She is enjoying breastfeeding, relaxed, not shaking/moving breast or baby ☐ Has a positive relationship with baby -stroking, eye contact, close gentle holding
How the feed ends:
☐ Baby comes off the breast itself (not taken off by mother) ☐ Baby looks relaxed and satisfied and no longer interested in breast ☐ Mother keeps breast available, or offers other breast

How often breastfeed a day? _____ **How often baby breastfeeds at night?** _____

Pacifier or other teat? Yes _____ No _____

Other Food and Drinks:

Note: If child is under 6 months and receiving additional foods, orif child is over six months and not receiving appropriate complementary foods then additional counselling, referral, and follow-up should take place.

Other Foods / Drinks	**Is your child getting anything else to eat?**	**What?**	**Frequency: times/day**	**Amount: How much?** *(Reference 250 ml cup)*	**Texture: How thick?** *Thin, Thick, Finely chopped, or normal family food*
Solid Foods	Staple (porridge, other local examples)				
	Legumes (beans, other local examples)				

Further Information:

Child currently sick? Yes / No

Recovering for sickness? Yes / No

How has the sickness influenced food intake? Increased / Decreased / No change

Mother's beliefs: how did she decide to feed the baby in this way?

	Vegetables/Fruits (local examples)				
	Animal: meat/fish/ offal/bird/eggs				
Liquids	**Is your child getting anything else to drink?**	**What?**	**Frequency: times/day**	**Amount: How much?** *(Reference 250 ml cup)*	**Feeding Bottle use? Yes/No**
	Other milks				
	Any other liquids (e.g. water or tea)				
Who assists the child when eating? _____ **Where does the child eat? _____**					
Hygiene	Does caregiver use a clean plate and spoon?			Yes_____ No _____	
	Does caregiver wash hands with clean, safe water and soap before preparing food, before eating, and before feeding young children?			Yes _____ No _____	
	Does caregiver wash child's hands with clean, safe water and soap before he or she eats?			Yes _____ No _____	

_____

How is the mother emotionally and physically? Does she have any worries? _____

Does she wish to increase her breastmilk supply or is she interested in relactation? Yes / No

If Artifically Fed, Assess practices in the Home:

This MUST be completed to consider providing BMS support. If the infant is fully breastfed skip to the next section.

Resources - What resources are available in the household?

[Note: Feeding with bottle and teat is very dangerous, cup or spoon feeding should be taught]

		Yes/ No	Concerns / Comments
Breastmilk	Breastmilk substitute is suitable for child's age?		
	Expiry date clearly marked, and not past		

	Instructions written in users own language		
	Preparer or another household member is able to read label's instructions		
	Caregiver is easily able to obtain sufficient formula until the child is at least 6 months of age		
	Subsequent visit: Quantity used since last distribution is appropriate		
	Quantity remaining is sufficient until next distribution		
Storage	Safe storage/tightly closed containers used for ingredients		
	Artificial feeds prepared in advance only if refrigeration is available		
	Drinking water is stored in a special container (clean, with cover)		
Preparation facilities	Adequate fuel is available for boiling water (and for cleaning feeding equipment)		
	Adequate drinking water is available for preparing several feeds per day (at least 4 litre)		
	Adequate other water and soap are available for washing utensils and hands		
	Clean surface is available to put utensils on (and a clean cover for them)		
	Suitable means of measuring milk and water (if a feeding bottle, the top and teat are removed. Or the health care worker can make a volume (mls) mark in a cup if measuring equipment not available)		
Extra time	Time to prepare 6-8 fresh feeds per day		

Procedures – how does the caretaker manage the feeding?

		Yes/ No	Concerns / Comments
Preparation	Caregiver washes hands		
	Cup washed with soap and water		
	Cup and spoon are boiled before use (*bottles should never be used)*		
	Water to prepare feed is brought to a rolling boil		

	Caregiver measures proportions of infant formula and water correctly		
	Boiled water allowed to cool for no more than 30 minutes before being added to infant formula		
Feeding technique	Infant is fed with cup, and takes most or all of the milk		
	Infant is fed with feeding bottle *(this is dangerous and mother/caregiver should be counselled to stop using the bottle and use a spoon or cup instead)*		
	Infant is fed with another method *(describe)*		
Interaction and end of feed	Infant is held throughout the feed		
	Caregiver interacts lovingly with the infant during the feed		
	Infant finishes the milk feed		
	None of this feed is kept for the infant to take later *(milk could be drunk by mother or older child – don't use after an hour)*		
Adequacy of artificial feeds	Number of feeds given per day appropriate to age and weight		
	Amount given at each feed appropriate		
Age-appropriate feeding	Under 6 months, only age-appropriate infant formula is given		
	Over 6 months, milk and complementary foods are given		

Complete IYCF Care Plan according to the findings of the Full Assessment and maintain the records together

Child < 6months ___ Child 6-23 months

SUMMARY OF INITIAL ASSESSMENT (main issues)

Support to mother: (amend below as necessary)

___ **(A) Continuing Supportive Care** (Adequate nutrition; Helpful Maternity Services; Continuing Assistance and support; Appropriate health services)

___ **(B) Basic Breastfeeding Aid**

(i)Ensure effective suckling by good attachment + positioning; *(ii) Building mother's confidence: encourage breastfeeding + skin to skin contact;* *(iii) Increase milk production: frequent feeding for as long as infant wants* *(iv) Encourage age appropriate feeding: exclusive breastfeeding for 6 months followed by continued breastfeeding and safe/appropriate complementary food*

___ **(C) Further Help Baby refusing the breast (Skilled support)**

___ **(D) Further Help Restorative care for the mother (needs emotional / extra support / referral to MHPSS support services)**

___ **(E) Further Help Wet nursing (Skilled Support)**

___ **(F) Further Help Relactation (Skilled Support from an IYCF Focal Point in the SC)**

___ **(F) Further Help Breast conditions (Skilled Support)**

___ **(H) Further Help Supported artificial feeding (BMS Referral to the SC in charge)**

___ **(I) Further Help Complementary Feeding (Additional support /referral to a complementary feeding programme or OTP)**

Referral / Specialised Support:

___ **Medical treatment/Therapeutic feeding**

___ **Other – specify** _____