



Guidelines and Minimum Standards for the Protection, Promotion and Support of Breastfeeding and Complementary Feeding

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**Guidelines and Minimum Standards for the Protection, Promotion
and Support of Breastfeeding and Complementary Feeding**

The ASEAN Secretariat
Jakarta

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Bun, 1, is being fed complimentary foods in Mokkachok village, Bokeo province, Lao People's Democratic Republic.

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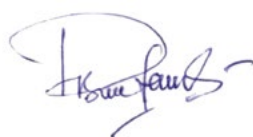
Message from the ASEAN Health Ministers Meeting Chair

First of all, I would like to acknowledge the tremendous effort of the Department of Health and National Nutrition Council of the Philippines in the development of this document as well as the leadership of the AHMM Chair Minister of Health Indonesia in the launch of the document.

The ASEAN Leaders' Declaration on Ending All Forms of Malnutrition (ALDEAFM) called on all Member States and relevant stakeholders to formulate a multisectoral regional framework and strategic plan to guide country policies, interventions and set minimum standards for service delivery, implementation and monitoring and evaluation, particularly among the most vulnerable, poor and disadvantaged groups in the ASEAN region.

The Guidelines and Minimum Standards for the Protection, Promotion and Support of Breastfeeding and Complementary Feeding, including the implementation of the International Code of Marketing of Breastmilk substitutes (ASEAN BF-CF & Code GMSs), is a set of operational guidelines, considered as a minimum standard, that presents a common approach in the ASEAN region for the programming, operation and management of breastfeeding and complementary feeding practices and the implementation of the Code as public health and socio-economic interventions.

This ASEAN BF-CF & Code GMSs shall guide ASEAN Member States and development partners in construction and implementation of strategies to achieve regional and global nutrition targets for breastfeeding and complementary feeding, and in improving regional collaboration across ASEAN pillars, among ASEAN Member States and with development partners. It shall also provide guidance in adopting measures to regulate the inappropriate marketing of food and beverages for infants and young children, casting multi-sectoral policies and programmes to ensure proper feeding practices, including in emergency situations, and the efficient use of funding for scale-up of effective strategies for the implementation of breastfeeding and complementary feeding and the Code of Marketing of Breastmilk Substitutes in ASEAN Member States. Outputs and outcomes of the use of the ASEAN BF-CF & Code GMSs shall benefit the people of the ASEAN region.



H.E. Dr. Bounfeng PHOUMMALAYSITH MSc, MMA, Ph.D.
AHMM Chair
Minister of Health of the Lao PDR

Message from UNICEF

What and how children are fed in the earliest years of life is the cornerstone of child survival, growth and development. We know that breastfeeding offers the best start in life, and that introducing high-quality complementary foods at 6 months of age is a critically important step in setting young children on the path to lifelong health, learning and prosperity.

The ten ASEAN Member States acknowledge the essential role of infant and young child feeding in achieving national nutrition targets and ending all forms of malnutrition. This commitment is reflected in this landmark publication of the *Guidelines and Minimum Standards for the Protection, Promotion and Support of Breastfeeding and Complementary Feeding*. By outlining the core policies and programmes for governments to adopt, and setting minimum standards for implementation, ASEAN Member States now have a standard by which they can benchmark their success. The coming together of all ten Member States to agree to a common vision for infant and young child feeding is a significant statement and a reflection of the importance of nutrition and diets in those first two years of life.

Families – mothers, fathers, grandparents, siblings and caregivers – all play a key role in ensuring that children receive nutritious diets to help them grow and reach their potential. At the same time, families cannot shoulder the burden of good nutrition alone: they need the support of their governments; communities; health care professionals; and food, health and social protection systems to secure the right to nutrition for every child, especially the most vulnerable. These *Guidelines and Minimum Standards* establish the supportive systems needed to achieve healthy diets for all infants and young children.

The UNICEF East Asia and Pacific Regional Office was privileged to support the efforts of the Philippines Department of Health, the Malaysia Ministry of Health, and the ASEAN Secretariat in developing these *Guidelines and Minimum Standards*. UNICEF looks forward to supporting ASEAN Member States and the ASEAN Secretariat to implement the key policies and actions to achieve their nutrition goals and secure their commitment to end all forms of malnutrition for children.



Debora Comini
Regional Director
UNICEF East Asia and Pacific Regional Office

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Glossary

1,000 days – The first 1,000 days refers to the critical developmental period between conception and a child's second birthday. Damage incurred during the first thousand days is often irreversible but good nutrition during this period can set a child up for good growth and development for life.

Breastmilk substitutes – Infant formula and any other milks (or products that could be used to replace milk) that are specifically marketed for feeding infants and young children from birth until 36 months of age, including follow-up formula and growing-up milks. They also include other foods and beverages promoted as suitable for feeding a baby during the first six months of life when exclusive breastfeeding is recommended, including baby teas, juices and waters.

Codex Alimentarius standard -- a standard adopted by the Codex Alimentarius Commission (the central part of the Joint FAO/WHO Food Standards Programme) to protect consumer health and promote fair practices in food trade.

Commercial complementary foods -- Fortified or unfortified complementary foods that are commercially processed (either locally or internationally) and available in the market.

Commercially produced foods and beverages marketed for feeding children aged 6–36 months – All commercially produced food or beverage products that are specifically marketed as suitable for feeding infants and children from 6 months to 36 months of age. This includes products that (1) are labelled with the words baby/babe/infant/toddler/young children; (2) recommend an age of introduction of younger than 3 years; (3) use an image of a child appearing 3 years of age or younger or feeding with a bottle; or (4) are in any other way presented as suitable for children under the age of 3 years.

Micronutrient deficiencies – Micronutrient deficiency is caused by inadequate (or insufficient) intake or absorption of one or more vitamins or minerals and leads to suboptimal nutrition status. The most common deficiencies for micronutrients are for iron, zinc, vitamin A, folate, vitamin B12 and iodine as these nutrients are the most difficult to acquire without diverse diets or receipt through fortification and supplementation.

Micronutrient powders (MNPs) -- Dry powder with micronutrients (vitamins and minerals) that can be added to any solid, semi-solid or soft food that is ready for consumption. MNPs are provided in sachets.

Non-communicable diseases (NCDs) and diet-related NCDs – NCDs are non-infectious chronic diseases that progress slowly, have a long duration, and are caused by a combination of modifiable and non-modifiable risk factors, including lifestyle/behavioural, environmental, physiological and genetic factors. There are four main types of NCDs: cardiovascular disease (e.g., coronary heart disease, stroke), diabetes, cancer and chronic respiratory disease. Obesity is both a chronic disease and a risk factor for other NCDs.

Nutrition-specific – Interventions, programmes or policies intended to have a direct impact on the immediate determinants of nutrition. Nutrition-specific actions include the promotion of adequate food and nutrient intake, feeding, caregiving and parenting practices; and prevention of infectious diseases. Examples are breastfeeding promotion, disease management and treatment of wasting.

Nutrition-sensitive – Interventions, programmes or policies in sectors other than nutrition that address the underlying determinants of fetal and child nutrition and development (referred to as social determinants in this report) and incorporate specific nutrition goals and actions. Sectors include agriculture, health, social

protection, early child development, education, and water and sanitation. The social determinants that nutrition-sensitive actions can address include poverty, food insecurity, scarcity of access to adequate care resources, inadequate services for health or water and sanitation.

Overweight and obesity – A form of malnutrition where children are too heavy for their height. The World Health Organization (WHO) defines childhood overweight as a weight-for-length or weight-for-height z-score of more than two standard deviations above the median; and obesity is a weight-for-height greater than three standard deviations above the median WHO Child Growth Standards. Overweight and obesity in childhood are associated with a wide range of serious health complications and an increased risk of premature onset of illness, including diabetes and heart disease.

Pre-service training – Refers to training or education designed to develop students' capacities during undergraduate courses or prior to employment.

In-service training – Refers to training or education provided to employees (including community volunteers) during the course of employment/engagement in service provision.

Systems approach – A systems approach to nutrition is one that engages multiple systems (health, agriculture, social protection, food, education and water and sanitation) to address all forms of malnutrition. A systems approach to nutrition reflects the reality that child nutrition has multiple determinants and can be improved via the shared responsibilities of multiple sectors and stakeholders, public and private.

Stunting – Stunting refers to the impaired growth and development that children experience from poor nutrition, repeated infection and inadequate psychosocial stimulation. WHO defines childhood stunting (moderate and severe) as a length-for-age or height-for-age z-score more than two standard deviations below the median of the WHO Child Growth Standards. Stunting is often associated with cognitive impairments such as delayed motor development, impaired brain function and poor school performance. Children who are stunted are also more likely to be wasted, have micronutrient deficiencies and face an increased risk of overweight later in life.

Wasting – Children who are too thin for their age because of undernutrition are 'wasted'. WHO defines childhood wasting a weight-for-length or weight-for-height z-score more than two standard deviations below the median of the WHO Child Growth Standards. Children with wasting are at a higher risk of becoming stunted.

Young child – A child aged 6–23 months, in the context of this guidance.

Acronyms

AMS	ASEAN Member States
ANC	Antenatal care
ASEAN	Association of Southeast Asian Nations
BFHI	Baby-friendly Hospital Initiative
DHS	Demographic and Health Surveys
FAO	Food and Agriculture Organization
FBDGs	Food-based dietary guidelines
HMB	Human milk bank
HMIS	Health Management Information System
IPC	Interpersonal communication
IYCF	Infant and young child feeding
IYCF-E	Infant and young child feeding in emergencies
MAM	Moderate acute malnutrition
MICS	Multi-Indicator Cluster Surveys
MNPs	Micronutrient powders
MSP	Multi-sectoral platforms
MUAC	Mid-upper arm circumference
NCD	Noncommunicable disease
NGO	Non-governmental organization
NPM	Nutrient profile model
PNC	Postnatal care
SAM	Severe acute malnutrition
SDGs	Sustainable Development Goals
SBC	Social and behaviour change
SBCC	Social and behaviour change communication
UHC	Universal health coverage
UN	United Nations
UNICEF	United Nations Children's Fund
WHA	World Health Assembly
WHO	World Health Organization



About this guidance document

01 This document outlines the essential strategies, interventions and approaches that countries should include at a minimum in a comprehensive infant and young child feeding (IYCF) strategy.

- This guidance establishes a set of minimum policies, programmes, and interventions that the Association of Southeast Asian Nations (ASEAN) Member States should use as a part of a robust nutrition strategy to improve IYCF practices from birth to age 2.
- The **purpose** of this document is to guide countries on how to protect and promote child diets and feeding practices through specific policies, actions, interventions and nutrition services that support optimal IYCF practices; and to improve implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly (WHA) resolutions in ASEAN Member States.

02 Intended audience and use

- **Intended audience:** Health, nutrition and other relevant sectoral staff in ASEAN Member State governments, programme managers and planners.
- **Intended use:** This document should guide government staff and programme managers on essential strategies, interventions and approaches as they seek to design, implement, modify and monitor the minimum set of IYCF policies, programmes and interventions. This guidance document should be used alongside other ASEAN guidance documents that have complementary sections (i.e., Integrated Management of Acute Malnutrition, Maternal Nutrition, Marketing of Unhealthy Food to Children) and with reference to the global resources and guidelines that provide more in-depth information on specific elements. The guidance is applicable at national and subnational levels but has been written with a national focus. For countries with decentralized health systems, the guidance and minimum standards can be equally applied to more local level planning.

ASEAN Leaders Declaration on Ending All Forms of Malnutrition

In 2017, ASEAN adopted the ASEAN Leaders Declaration on Ending All Forms of Malnutrition during the 31st ASEAN Summit. To realize these commitments, the ASEAN Health Ministers Meeting adopted the ASEAN Strategic Framework and Action Plan on Nutrition 2018–2030, which identifies activities and outputs. The development of the ASEAN Guidelines and Minimum Standards for the Protection, Promotion and Support of Complementary Feeding is one of these activities.



01

INTRODUCTION

1 Introduction

The first 1,000-days of a child’s life, from conception to 2 years of age, are a critical period for health, child growth and development. During this period, the nutritional needs of children are high, and poor nutrition and health can cause lifelong negative impacts on nutrition status and health outcomes and increase child mortality. Undernutrition, in the form of stunting, wasting and micronutrient deficiencies, is associated with 45 per cent of child deaths globally.¹ Overweight and obesity, which are increasing rapidly in young children, are associated with higher risk of serious health problems throughout the life course and contribute to 7.1 per cent of all adult deaths.²

IYCF practices cover the optimal feeding behaviours and practices that support good health and development from the moment a child is born until 2 years of age. There are a number of interventions that support child health and development, good nutrition status and optimal IYCF practices. These include facility- and community-based counselling on IYCF, micronutrient supplementation with vitamin A, iron, zinc and iodine, the provision of micronutrient powders and dietary supplementation.

Governments can also use legal measures and other strategies to support IYCF and protect good nutrition in early childhood, the most important of which is implementing and monitoring the *International Code of Marketing for Breast-milk Substitutes* and subsequent WHA resolutions (referred to in this document as ‘the Code’), as well as the *WHO Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children*.

These measures, combined with health system strengthening efforts and a strong enabling environment, establish the basis of a robust approach to support IYCF and eliminate all forms of malnutrition.

The appropriate IYCF practices under the scope of this guidance and minimum standards are*:

1	Early initiation of breastfeeding within one hour of birth	
2	Exclusive breastfeeding from birth until 6 months of age [†] (i.e., breastmilk only, with no other foods or liquids, including water)	
3	Timely introduction of soft, semi-soft and solid foods at 6 months of age	
4	Dietary diversity – foods from at least five food groups (including breastmilk) between the ages of 6–23 months	
5	Adequate meal frequency – feeding the minimum number of recommended times in a day between the ages of 6–23 months	
6	Continued breastfeeding from the age of 6 months to 2 years and beyond	
7	Safe preparation, storage and handling of complementary foods	

* Full definitions of IYCF indicators and practices are included in the Appendix.

† Exclusive breastfeeding is defined as breastmilk only (including expressed breastmilk or breastmilk from a wet nurse) for the first 6 months of life, with no other food or drink – not even water. Oral rehydration solutions and vitamin/mineral drops and syrups or medicines are permitted.

1.1 Consequences of inadequate IYCF

Malnutrition during the first two years of life can have lifelong consequences. Children who are malnourished as infants are more prone to illness and death and have worse educational attainment; and adults who were malnourished as children have lower productivity and earning potential.¹ With these combined impacts, economists estimate that stunting can reduce a country's gross domestic product (GDP) by 3 per cent per year.³ Globally, the total annual economic loss due to not breastfeeding according to recommendations is estimated to be between US\$257 billion and US\$341 billion.⁴

The intergenerational cycle of malnutrition is self-perpetuating. Women who were malnourished as children have a higher risk of having low birthweight children, who are then at risk of becoming stunted themselves. Further, children who are malnourished as infants have a higher risk of NCDs and being overweight as adults, while overweight infants are likely to remain overweight through childhood. Malnourished children are also more susceptible to respiratory illness as well as enteric infections that can lead to longer and more severe diarrhoeal episodes.⁵ Frequent bouts of diarrhoea also increase the risk of stunting and can impact cognitive development.⁶

Poor IYCF practices contribute to all forms of malnutrition – stunting, wasting, overweight and micronutrient deficiencies. Across East Asia and the Pacific, at least one in five children under 5 is not growing well due to all forms of malnutrition, three in five children do not eat from the minimum number of food groups and just 39% of children are exclusively breastfed.⁷ Sub-optimal feeding practices, including the inappropriate introduction of complementary foods, and lack of exclusive and continued breastfeeding can cause illness in young children through exposure to contaminated foods and water.

Infants who are exclusively breastfed are 14 times less likely to die of diarrhoea or pneumonia than those who are not breastfed.⁸ Breastfeeding is a pillar of child health, development and survival, and sub-optimal breastfeeding is linked to increased mortality, morbidity and economic losses, as well as increasing the likelihood that children do not receive their nutritional needs. Complementary foods that do not meet caloric and protein requirements are a major contributor to poor growth and development and inadequate dietary diversity with poor consumption of nutrient-rich foods can cause micronutrient deficiencies. Foods that are energy-dense and high in unhealthy types of fat, refined starches, free sugars and salt are poor sources of protein, dietary fibre and micronutrients. Excessive consumption of these energy-dense but nutrient-poor foods increase the risk of overweight and micronutrient deficiencies in children.

1.2 Current ASEAN data for IYCF and nutrition indicators

Data on key IYCF practices and the nutrition status of children under 5 years is mixed across ASEAN countries. Available data for selected indicators are included in the figures below. Overall, the data show that child malnutrition is a serious concern for all ASEAN Member States (AMS) and that very few children in the ASEAN region are receiving optimal diets and breastmilk during the first two years of life.

All forms of malnutrition are found in all ASEAN countries. The prevalence of stunting is at or above a medium threshold for 9 out of the 10 ASEAN Member States and above a very high prevalence in 4 AMS (Figure 1). Wasting is a public health concern in 8 of the 10 AMS, with 1 AMS having a high prevalence. Anaemia in children is a moderate public health problem in 7 AMS and a severe public health problem in 3 AMS, while deficiencies in zinc and B1 (thiamine) are common in many countries. The prevalence of overweight and obesity in children under 5 is also increasing: 5 out of the 10 AMS have an overweight prevalence above the medium threshold.

Figure 1. National prevalence of stunting, wasting, overweight and anaemia for children under 5 years of age in ASEAN Member States

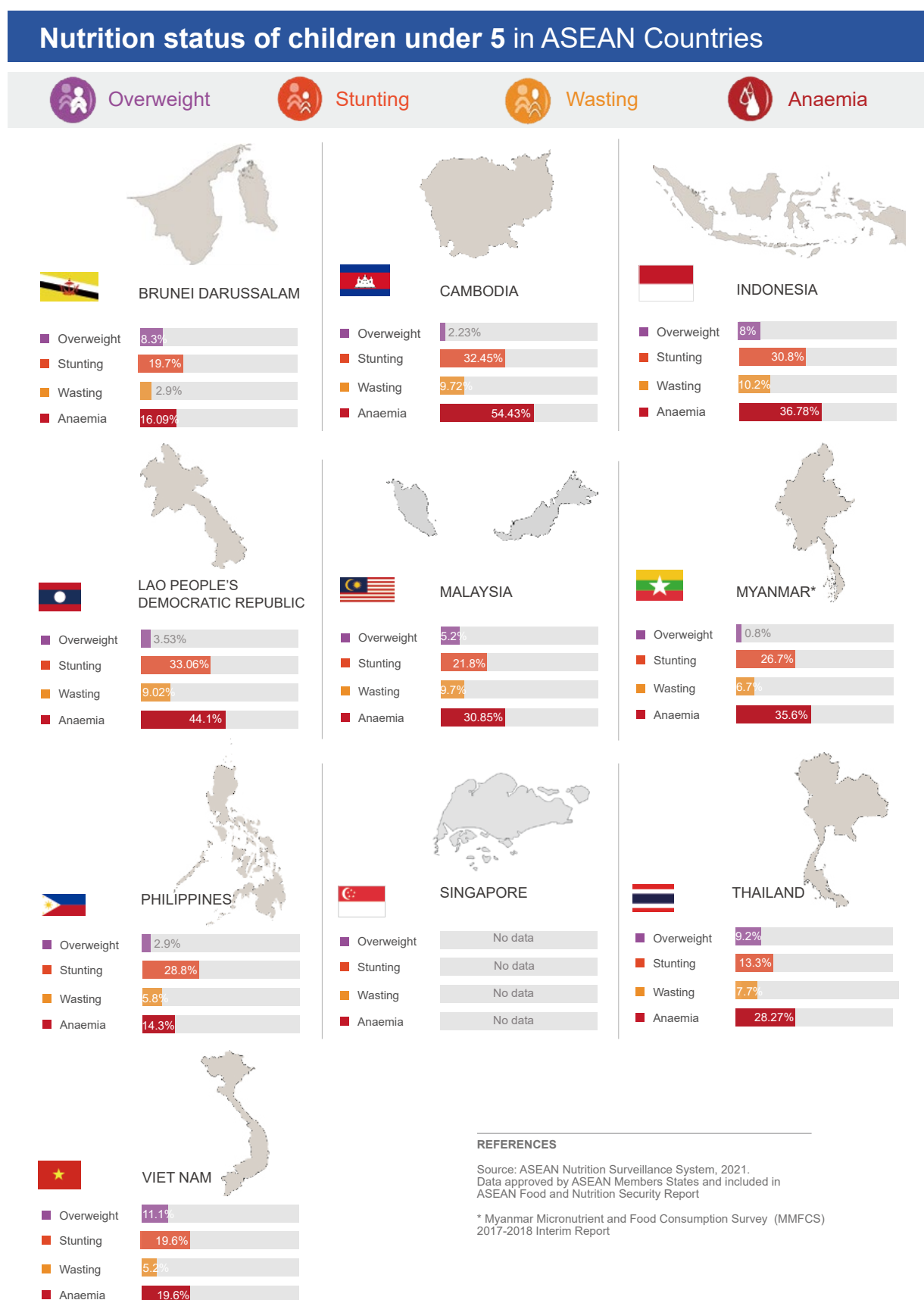
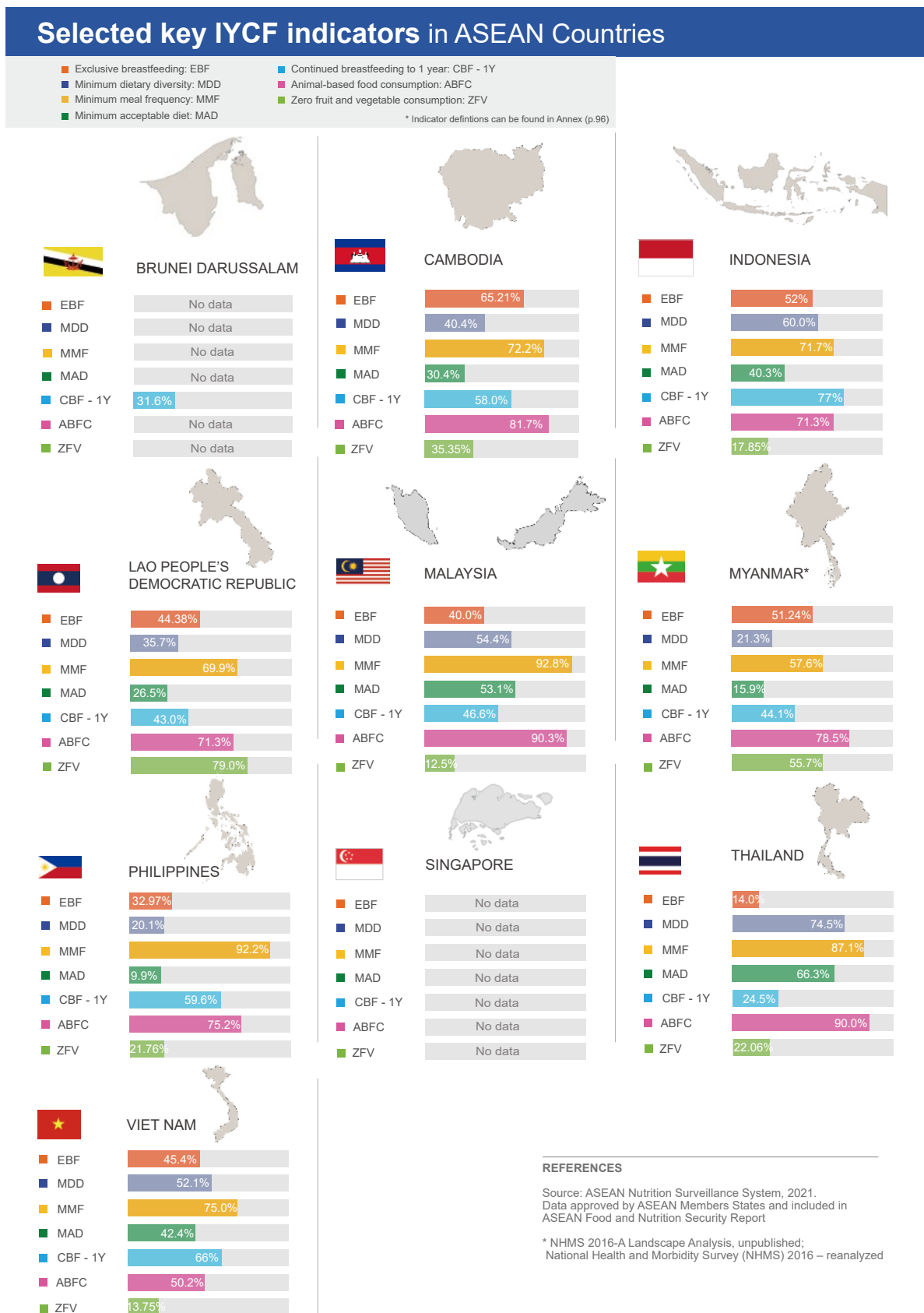


Figure 2. Selected key YCF indicators[‡]



‡ Data not available for all ASEAN countries.

Few children in the ASEAN region are receiving optimal diets and breastmilk during the first two years of life (Figure 2). Of the 8 AMS with data for IYCF practices, only 3 have exclusive breastfeeding rates exceeding the minimum threshold of 50 per cent. Continued breastfeeding practices are better with over 50 per cent of children continuing to receive breastmilk at 1 year of age in 6 of 8 AMS with data.

Complementary feeding practices in the ASEAN region indicate both poor dietary quality and inappropriate meal frequency. The proportion of children receiving the minimum dietary diversity is below 65 per cent in all AMS. While minimum meal frequency is above 80 per cent for 3 AMS, the majority of children in the ASEAN region are not receiving an adequately diverse diet at an appropriate frequency (referred to as the minimum acceptable diet). Two additional indicators of dietary quality – consumption of animal-source foods and consumption of zero fruits and vegetables – are highly variable in the ASEAN region. The proportion of children consuming animal-source foods is relatively high, with more than 50 per cent of children in all AMS with data consuming eggs or meat in the previous day. The proportion of children who were fed zero fruits and vegetables, however, is also high: more than 20 per cent of children did not consume fruit or vegetables in the previous day in 5 out of the 7 AMS with data.

Policies and strategies are in place in all ASEAN Member States to protect early childhood nutrition (Table 1).

Table 1. Mapping of policies, strategies and interventions currently in place in ASEAN Member States

	National nutrition policy/strategy in place	Specific IYCF policy/strategy	Implementing Baby-friendly Hospital Initiative (starting year)	BMS Code status or non-binding measures	Multi-sectoral Nutrition Working Group
Brunei Darussalam	Brunei Darussalam Multi-sectoral Action Plan for the Prevention and Control of Non-Communicable Diseases (2021–2025)	National Strategy for Maternal, Infant and Young Child Nutrition in Brunei Darussalam, 2014–2020	Yes (1992)	Brunei Darussalam has a 'Code of Practice for Health Workers on Ending appropriate Marketing of Foods and Related Products for Infants and Young Children (0–5 years)' (since February, 2019)	Yes (1992)
Cambodia	National Strategy for Food Security and Nutrition (2019–2023)	National Policy on IYCF (2008)	Yes (2000)	Moderately aligned with the Code	Yes
Indonesia	National Action Plan for Food and Nutrition (2020–2024)	National Guideline on IYCF	Yes (1994)	Moderately aligned with the Code	Yes
Lao People's Democratic Republic	National Strategy for Food Security and Nutrition (2019–2023) and Plan of Action (2016–2020)	No specific IYCF policy or strategy	No data	Moderately aligned with the Code	Yes
Malaysia	National Nutrition Policy of Malaysia 2.0 (NNPM 2.0) and National Plan on Action for Nutrition of Malaysia (NPANM)III, 2016–2025	National Breastfeeding Policy 2005	Yes (1992)	Malaysia has a 'Code of Ethics for the Marketing of Infant Foods and Related Products' (since 1979; last updated August 2010) [§]	Yes

§ Disciplinary actions/ penalties by the Disciplinary Committee on the Code of Ethics for the Marketing of Infant Foods and Related Products are imposed for confirm violation or non-compliance with this Code.

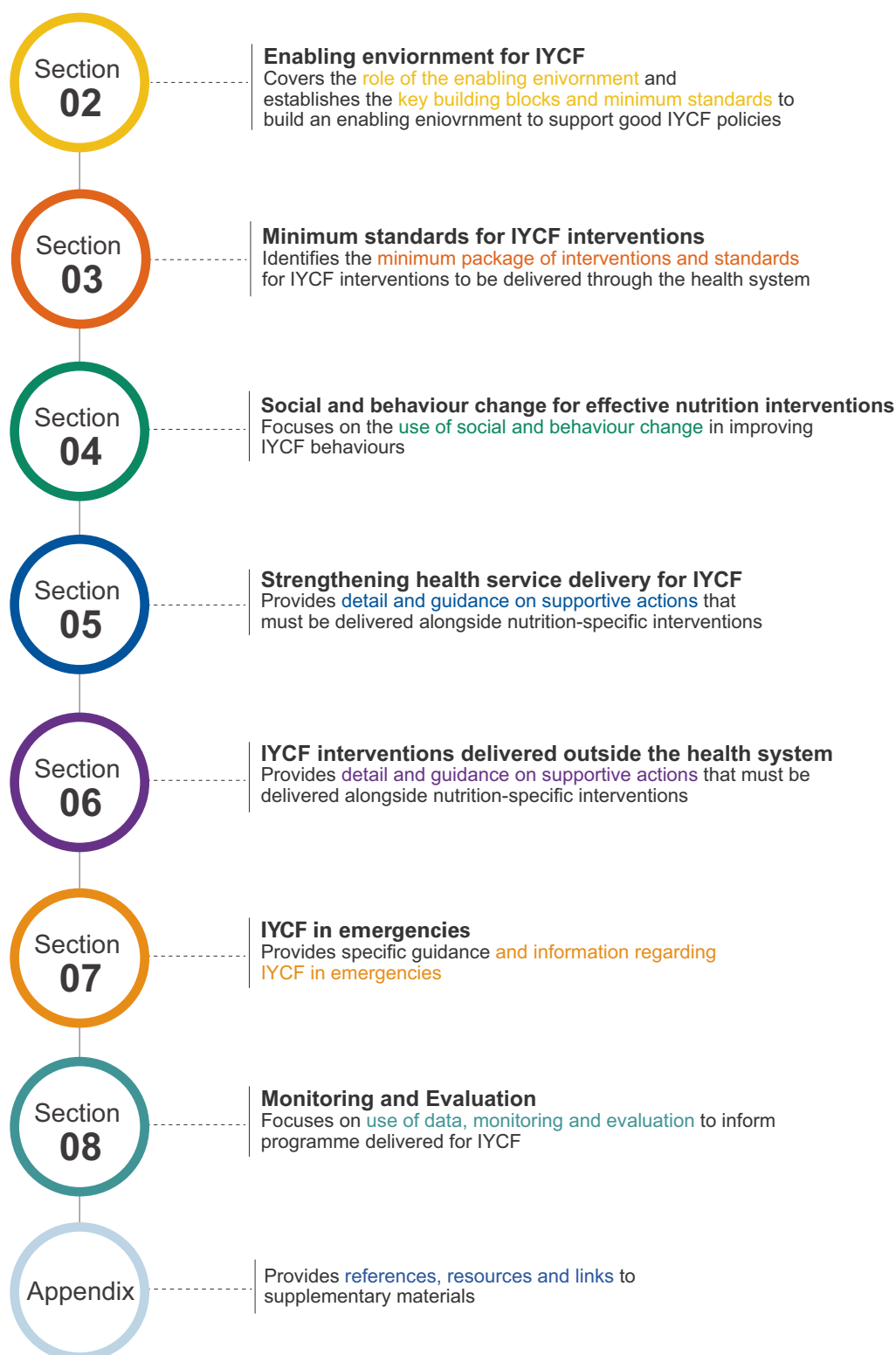
8

Myanmar	Multi-sectoral National Plan of Action on Nutrition (2018–2023)	Myanmar Maternal Infant Child Nutrition Implementation Plan 2021-2026	Yes (1998)	Moderately aligned with the Code	Yes
Philippines	Philippines Plan of Action for Nutrition (2017–2022)	No specific IYCF policy or strategy	Yes (1992)	Substantially aligned with the Code	Yes
Thailand	The 5-year National Plan for Nutrition (2019–2023)	No specific IYCF policy or strategy	Yes (1992)	Moderately aligned with the Code	Yes
Singapore	5 – Year Food Strategy 2020-2024	National Infant and Young Child Feeding Action Plan	Yes (2012)	<i>Singapore has a Code of Ethics in place on the advertising, promoting and marketing of breastmilk substitutes.[¶]</i>	
Viet Nam	National Nutrition Strategy (2011 -2020) and National Plan of Action for Nutrition to 2020	No specific IYCF policy or strategy	Yes (1992)	Moderately aligned with the Code	Yes

¶ While Singapore's Code of Ethics is not legislated, compliance to the Code is obligatory for all stakeholders. Regular monitoring and compliance checks are conducted by the Health Promotion Board and Sale of Infant Foods Ethics Committee Singapore. For companies found to be non-compliant, actions such as issuance of written warning, and publication of non-compliant companies and their violation on Health Promotion Board's website can be taken on them. Under the Code of Ethics, stakeholders need to also comply with the relevant areas under the Singapore Code of Advertising Practice, Sale of Food Act and Singapore Food Regulations, of which some of the regulations are legally binding.

1.3 Organization of document

This document is structured in eight sections to guide government staff and programme managers on essential strategies interventions and approaches as they seek to design, implement, modify and monitor the minimum set of IYCF policies, programmes and interventions.





2

ENABLING ENVIORNMENT FOR IYCF

2 Enabling environment for IYCF

► This section covers the role of the enabling environment and what can be done to strengthen support for IYCF policies, programmes and practices.

2.1 What is an enabling environment?

Child nutrition status is influenced by a wide range of immediate, underlying and enabling determinants (see Figure 3 below). Immediate determinants include the diets and practices that determine what and how frequently children eat; how they are cared for; and how healthy they are. Underlying determinants are the features that influence those practices: whether the environment is clean; whether there is food available in the household; and whether caregivers understand and can carry out optimal IYCF, health and hygiene practices. Below this, are the enabling determinants: policies, strategies, economic resources that dictate what services are available, and where; the external environment; and broader social and economic patterns and norms that influence child health and diets.

Figure 3. ASEAN Framework for Malnutrition

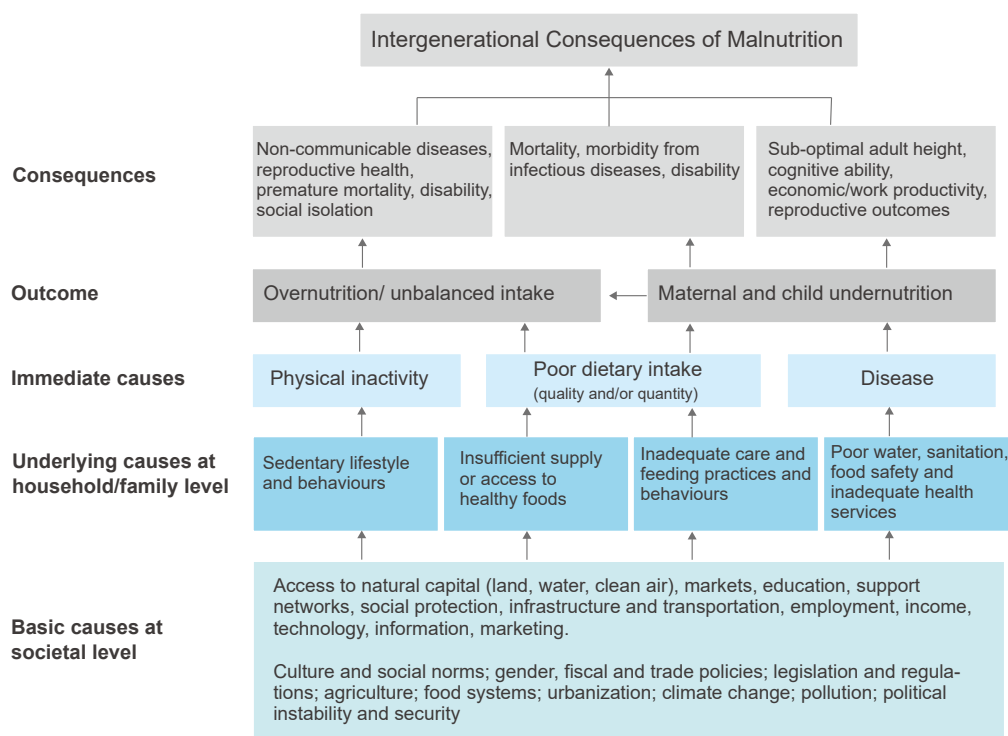


Figure adapted by ASEAN, UNICEF and WHO for publication in ASEAN/UNICEF/WHO (2016) Regional Report on Nutrition Security in ASEAN, Volume 2, from the 1997 UNICEF Conceptual Framework of Malnutrition.^{9}

** UNICEF's updated Conceptual Framework on the Determinants of Maternal and Child Nutrition is included in Appendix section 2. The Framework has been updated to reflect all forms of malnutrition and can be used in conjunction with the ASEAN Framework, as outlined in Figure 3.

A strong, supportive enabling environment is required to ensure effective, at-scale delivery of nutrition programmes, particularly for IYCF. **The enabling environment encompasses the political and policy processes that build and sustain momentum for the effective implementation of actions that reduce all forms of malnutrition.**¹⁰

This section explores the broad actions needed to create an effective **enabling environment** for IYCF in which support for breastfeeding and complementary feeding is identified as a national development priority, and policies and programmes are based on a sound understanding of the situation and aligned with global recommendations. An effective enabling environment also requires **plans** and **budgets, financial resources** and **strong coordination mechanisms** to support quality implementation at scale.

2.2 Essential components of an enabling environment to support IYCF

Effective nutrition and IYCF programmes and strategies have been introduced and scaled up in many countries. Based on global experience and evidence, **five key components** for creating an enabling environment have been identified (Figure 4).

Figure 4. Essential components of an enabling environment for optimal IYCF





2.2.1 Leadership and governance

Good nutrition governance is essential to accelerating progress in nutrition and IYCF. Countries need high-level commitment to IYCF and agreement that it is an integral part of a national strategy for eliminating all forms of malnutrition. Finding advocates, change agents and champions for IYCF and establishing cross-sectoral support for IYCF and nutrition will contribute to fostering commitment and leadership. While there is no standard way to identify and establish champions for nutrition and IYCF, having respected figures across all levels of government and civil society can contribute to building high-level commitment.

Partnerships with international organizations, non-governmental organizations (NGOs), civil society organizations and professional bodies can also support government advocacy and leadership. The private sector can also play an important role, and it should be encouraged to participate in public consultations on policies and strategies for IYCF; however, due to potential conflicts of interest, the private sector should be excluded from decision-making processes on policy and strategy, which are the domain of national governments. All organizations – public and private alike – should declare their conflicts of interest when participating in consultations relating to IYCF.

For good IYCF governance, it is essential that strong IYCF policies and strategies be embedded in each of the broader nutrition policies, plans and strategies. IYCF interventions must also be budgeted for and IYCF data should be routinely collected.

To ensure commitment at national and subnational levels and drive change in IYCF, and in turn nutrition outcomes, engagement across multiple sectors and strong leadership and coordination is required. The importance of involving multiple sectors to address malnutrition is well recognized as its root causes are complex and multifaceted; the same is true for IYCF.

Multi-sectoral coordination is usually achieved through national and subnational multi-sectoral platforms (MSPs) – working groups or coordination bodies that focus on IYCF or nutrition more broadly. Many ASEAN countries have some form of MSP, with participation from health, water, sanitation and hygiene (WASH), social affairs, agriculture, planning and other sectors. MSPs have been supported and facilitated in many ASEAN countries via the Scaling Up Nutrition (SUN) Movement. In some countries, a separate or secondary IYCF working group has been formed to address multi-sectoral programming for IYCF specifically.

MSPs are often chaired/convened by the health sector, but they can also be hosted by planning ministries or offices of Heads of State. Housing the MSPs outside the health sector helps position nutrition and IYCF as a multi-sectoral effort, encourages ownership outside the health sector and demonstrates a broader political commitment. Formal multi-sectoral engagement of stakeholders promotes collaboration and communication between sectors and ensures that accountability for nutrition and IYCF outcomes extends wider than the health sector. Multi-sectoral work should also extend to the community level where local frontline workers and decisions-makers work together to achieve IYCF and nutrition priorities.



BOX 1

Guidelines and minimum standards for leadership and governance

1. Establish an intersectoral mechanism to address nutrition, including IYCF
 - With clear definition of areas with shared IYCF responsibilities
 - Whole of government support for complementary feeding and breastfeeding as part of a national strategy for nutrition
2. Identify IYCF champions and leaders to build commitment and public support from all levels of government and civil society

Multi-sectoral coordination

1. Invite participation from cross-sectoral government partners – including agriculture, health, social welfare and education
2. Ensure a clear agenda for action with identified roles and responsibilities
3. Hold regular meetings with a set agenda, and review data and progress towards national goals and strategies for IYCF
4. Focus multi-sectoral platforms on convergence – targeting resources and actions (both nutrition-specific and nutrition-sensitive) on the regions and sub-regions most in need
5. Make all stakeholders accountable and define specific responsibilities for achieving goals



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2.2.2 Policy and legislative framework

Policy support entails **political or strategic support for appropriate IYCF practices**, as well as specific support at the sectoral and implementation levels.¹¹ Policies need to support facility- and community-level strategies, social and behaviour change and health worker training. They must also protect, promote and support breastfeeding by restricting the marketing of breastmilk substitutes through implementation and enforcement of the Code and by providing maternity leave. Minimum requirements for nutrition policies and strategies and what they should entail are outlined in **Box 2**.

In addition to these strategies, targeted policies and legislation for specific areas are essential to support breastfeeding and complementary feeding during the first 1,000 days. The SUN Movement developed a checklist that can be used to review or develop national nutrition plans and related documents (see Appendix).¹² The checklist covers nutrition as a thematic sector, but could also be used to review the adequacy of IYCF within nutrition strategies and plans.

POLICIES & LEGISLATION

BOX 2

Guidelines and minimum standards for nutrition policies and strategies to support IYCF

1. Establish a national nutrition plan or strategy that addresses IYCF in a comprehensive way, including by:
 - Prioritizing breastfeeding and complementary feeding
 - Positioning IYCF as a development priority
 - Using IYCF indicators to measure success (**see Box 9 and Section 8**)
 - Allocating adequate resources for implementation and establishing a plan for measurement (**see Box 6**)
2. Adopt a national nutrition policy that addresses IYCF in a comprehensive way, including:
 - Support for IYCF counselling, training for health workers on IYCF (**see Box 8**), strategies that include social and behaviour change communication (SBCC) for IYCF (**see Section 4**)
3. Establish national food-based dietary guidelines for children under 2 years (**see Box 3**)
4. Adopt the Code, subsequent WHA resolutions, and the WHO Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children into national legislation, with monitoring and enforcement mechanisms in place (**see Box 4 and Appendix**)
5. Develop national nutrient profile models for processed complementary foods.
6. Develop policies for maternity protection and breastfeeding workplace support for women working in private, public and informal sectors (**see Box 5**)



There are **five key pieces of policy** that are recommended for strong policy environments to support IYCF (and nutrition more broadly); each has its own set of recommendations and guidance.

- i. Regulation of the marketing of breastmilk substitutes
- ii. Regulation of inappropriate marketing of foods for children
- iii. Nutrient profile models for processed complementary foods
- iv. Maternity protections and benefits and family-friendly policies
- v. Food-based dietary guidelines

Key policy

01

Regulation of the marketing of breastmilk substitutes

Implementation of the International Code of Marketing of Breast-milk Substitutes^{††} and subsequent relevant WHA resolutions (the Code)¹³ through enactment and enforcement of robust national legal measures is essential to ensuring that parents and other caregivers are protected from inappropriate and misleading information. Implementation also ensures that health workers, their professional associations, and health facilities do not promote breastmilk substitutes or accept support from the manufacturers or distributors of breastmilk substitutes, feeding bottles or teats.

In the ASEAN region, there has been progress in implementing the Code through robust national legislation. As of October 2020, 7 out of 10 AMS have enacted legal measures with provisions for implementing the Code (Table 2). However, out of these 7 countries, only the Philippines has a law that is 'substantially aligned' with the Code.¹⁴

The remaining 6 countries have laws that are only 'moderately aligned' with the Code, while 3 countries have no binding legal measures to implement the code. This signifies that most ASEAN countries fall short of having comprehensive and robust legal and regulatory frameworks to prohibit all forms of promotion of breastmilk substitutes and work remains to be done in this area to protect mothers from inappropriate and misleading information on IYCF practices.

Table 2. Legal status of the Code in ASEAN Member States, including categorization of measures¹⁴

Country	Legal status of the Code	Total points out of 100	Year
Philippines	Substantially aligned with the Code	85	1986
Myanmar	Moderately aligned with the Code	74	2014
Viet Nam	Moderately aligned with the Code	73	2014
Thailand	Moderately aligned with the Code	68	2017
Lao People's Democratic Republic	Moderately aligned with the Code	64	2019
Cambodia	Moderately aligned with the Code	51	2005, 2007
Indonesia	Moderately aligned with the Code	50	2012, 2013
Singapore	No legal measures		
Malaysia	No legal measures		
Brunei Darussalam	No legal measures		

††See glossary

Addressing the inappropriate promotion of foods for infants and young children

Aligned with the 2016 WHO Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children, regulating the inappropriate promotion of commercially produced foods and beverages marketed for feeding children aged 6–36 months is an essential action for all AMS.¹⁵

The 2016 WHO guidance defines ‘promotion’ as the communication of messages that are designed to persuade or encourage the purchase or consumption of a product or raise awareness of a brand. This includes advertising activities and materials, non-advertising promotions (such as special displays, sales, discount coupons and rebates, loss leaders and tie-in sales), and labelling, packaging and claims. The key principles of the 2016 WHO guidance are summarized in **Box 4**.

Key policy

02

Food-based dietary guidelines

Food-based dietary guidelines (FBDGs) are a tool that governments can use to guide nutrition, health, agriculture and education policies to foster healthy eating habits and lifestyles; as such, they can be an important part of achieving nutrition and IYCF goals. Country-specific FBDGs provide advice on preferable foods, food groups and dietary patterns that are tailored to the nutrition, geographical, economic and cultural context. Complementary communication materials (graphic/pictorial guides) help make FBDGs more accessible to consumers.

FBDGs are designed for all members of society, but they should include specific guidance for children under 2 years of age and pregnant and breastfeeding women, given the specific nutrient needs of these groups.¹⁶ This includes information on appropriate foods, recommended intakes, and specific advice on complementary feeding, child diets and breastfeeding.

POLICIES & LEGISLATION

BOX 3

Minimum standards for FBDGs to support optimal child feeding practices and healthy diets

FBDGs for children should:

1. Be tailored to the specific nutritional, geographical, economic and cultural conditions within which they operate
2. Provide detail on recommended intakes and advice on continued breastfeeding
3. Be clear and specific on how much animal-source food is enough for each age group, recognizing the specific nutritional needs and available nutrient sources and balancing sustainability concerns
4. Go beyond ‘what’ and ‘how much’ to eat by providing practical guidance on how nutritious diets and healthy eating can be achieved for young children
5. Be supported by complementary communication materials intended to convey information to the public, such as pictures, food pyramids and infographics. Emphasis should be placed on suitable foods and food types for infants and children

(continued)

Topics to consider for children aged 6–23 months include:¹⁷

1. Continued breastfeeding
2. Developmental readiness and appropriate age of introduction of complementary food
3. Stages in transitioning to family food, including appropriate foods and textures and example menus and/or recipes
4. Timing of introduction of food groups (particularly animal-source foods) and animal milk
5. Practical 'how to' for feeding, including dealing with food refusal and 'picky eaters'
6. Dealing with poor appetite
7. Feeding during illness
8. Frequency of meals and snacks
9. Portions and portion sizes
10. Responsive feeding and interaction between caregiver and child
11. Other 'food parenting' issues, such as providing a role model, avoiding the use of food as reward, and creating pleasant mealtimes
12. Healthy snacks
13. Recommended beverages (including guidance on type of milk), and those to avoid
14. Guidance on sugar and salt, and on unhealthy foods high in sugar, salt and/or unhealthy fats
15. Context-specific guidance on micronutrient supplements and home fortification
16. Use of cups
17. Hygiene and safe feeding (including choking hazards)

Detailed and specific information on development, use and implementation of food-based dietary guidelines is included in reference materials on page 78.

Key policy

03

Policies on the inappropriate marketing of breastmilk substitutes and foods for infants and young children

Since the mid-1990s, the International Code Documentation Centre, in consultation with international legal experts, has promoted the use of a Model Law to give effect to the Code and subsequent WHA resolutions. Updated regularly, it was revised in 2018 to incorporate the recommendations of the WHO Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children. Recognizing that the Code and WHA resolutions form a 'minimum standard', the Model Law is intended to serve as a comprehensive legal resource and template that can be adapted to the needs of a country's legislative system. Its overarching goal is to ensure safe and adequate nutrition for infants and young children by protecting breastfeeding and by regulating the marketing of breastmilk substitutes, feeding bottles, teats, pacifiers and foods for infants and young children. The Model Law represents a recommended standard and is a useful tool for lawmakers. It contains model language that can be used to give legal effect to the provisions of the Code and is included in its entirety in the Appendix.

POLICIES & LEGISLATION

BOX 4

Guidance on the inappropriate promotion of foods for infants and young children:^{‡‡18}

1. Optimal IYCF shall be promoted based on the guiding principles of complementary feeding and feeding non-breastfed children aged 6–24 months , with an emphasis on nutrient-rich, home-prepared, and locally available foods
2. Products that function as breastmilk substitutes shall not be promoted
3. Foods for infants and young children that do not function as breastmilk substitutes should be promoted only if they meet all the relevant national, regional and global standards for composition, safety, quality, and nutrient levels, and are in line with national dietary guidelines
4. Messages used to promote foods for infants and young children should support optimal IYCF practices and should not include inappropriate messages
5. There should be no cross-promotion of breastmilk substitutes indirectly via the promotion of foods for infants and young children
6. Companies that market foods for infants and young children should not create conflicts of interest in health facilities or throughout the health system. Health workers, health systems, health professional associations and NGOs should avoid such conflicts of interest
7. Places where infants and young children gather should be free from all forms of marketing of foods high in fats, sugars, or salt

Key policy

04

Nutrient profile models for processed complementary foods

The development of policies to protect children from the inappropriate promotion of food for infants and young children requires the existence of global, regional and/or national-level standards for the composition, safety, quality and nutrient levels of processed complementary foods. To develop these standards, the WHO Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children recommends using relevant Codex Alimentarius standards and guidelines to develop a nutrient profile model (NPM). An NPM is used to classify processed complementary foods according to their nutritional and labelling composition. This classification is then used to guide decisions on which foods can and cannot be promoted for infants and young children up to 36 months(WHO/EURO 2019).

ASEAN Member States should ensure their national standards and legislation for all processed complementary foods are in line with the 2006 Codex Standard for Processed Cereal Based Foods for Infants and Young Children and the 1981 Codex Standard for Canned Baby Foods. These two standards provide specifications on the nutritional, technical, safety, and labelling requirements for defined categories of processed cereal based complementary foods and canned baby foods.

For guidance on the development of national standards and legislation on the nutritional and technical aspects for all other categories of processed complementary foods, ASEAN Member States should use the 2013 Codex Guidelines on Formulated Complementary Foods for Older Infants and Young Children. This document includes guidance to ASEAN

^{‡‡} These GMS are not committing AMS to minimum standards on this topic. These recommendations are included as a starting point for AMS, with the understanding that policies on inappropriate marketing are essential, and should be in keeping with WHO Guidance. Further discussion on the inappropriate marketing of foods to children aged 0–18 years will be discussed in the Minimum Standards and Guidelines on the Marketing of Food and Non-Alcoholic Beverages to Children, to be developed in 2020.

^{***} See information on box 10 and 11 for WHO Guidance on Breastfed and Non-Breastfed Children.

Member States on the setting of standards for macronutrients, and the selection of vitamins and minerals for nutrient addition into processed complementary foods. The guidelines note the importance of using national level data on micronutrient status and dietary intake to guide the development of standards and legislation for vitamin and mineral content and levels. A summary of recommended vitamins and minerals to include in national standards and legislation, based on national level data, is presented on [Table 7](#) on page 78). In ASEAN Member States where micronutrient deficiencies are present, the Codex guidance is consistent with the WHO/FAO Guidelines on food fortification; recommending a minimum level of 30-50 percent of the RDI in a daily ration of a processed complementary food for key nutrients including iron and zinc to ensure older infants and young children consume adequate amounts of these essential vitamins and minerals. An NPM is required in addition to national standards and legislation based on Codex to provide guidance to countries on which foods are inappropriate for promotion. To guide the development of national NPM's, the WHO Regional Office for Europe (WHO/Europe) developed a draft NPM for infants and young children aged 6–36 months (below). The draft NPM summarizes WHO/Europe's recommendations for baby food promotion and composition.

The development of national NPM's for processed complementary foods provides a basis from which countries can restrict the marketing of foods to children on the basis of inappropriate levels of sugar, protein, fat, micronutrients and use of inappropriate labelling and claims. The NPM can also define what foods can be considered appropriate for marketing. National NPM's are an essential component of regulating the inappropriate promotion of food for infants and young children and ensuring that processed complementary foods contribute to the healthy diets of older infants and young children.

Figure 5. WHO/Europe nutrient profile model for infants and young children aged 6–36 months

Recommendations for baby food promotion and composition in the draft nutrient profile model

<p>01 </p> <p>Baby foods should not be marketed as suitable for children under 6 months of age</p>	<p>02 </p> <p>Fruit drinks and juices, confectionary and sweet snacks should not be marketed as suitable for infants and young children</p>	<p>03 </p> <p>Limit total sugar content of dry savoury snack foods to ≤ 15 per cent of energy</p>
<p>04 </p> <p>Prohibit added sugars, including concentrated fruit juice, in all baby foods</p>	<p>05 </p> <p>Limit use of pureed fruit, particularly in savoury foods to ≤ 5 per cent of total weight</p>	<p>06 </p> <p>Introduce front-of-pack upper-age restrictions for heavily pureed and very smooth products intended as weaning foods (e.g. suitable for age 6-12 months)</p>
<p>07 </p> <p>Phase out pouches with spouts for pureed foods and add pack labelling instructing infants and young children should not suck from spouts</p>	<p>08 </p> <p>Improve product labelling for total sugar and total fruit contents (e.g. front-of-pack flags for high total or free sugar content, and back-of-pack ingredient information such as the total fruit content)</p>	<p>09 </p> <p>Ensure that front-of-pack product names are representative of primary ingredients</p>
<p>10 </p> <p>Ban misleading labelling and claims relating to sugar contents or product healthiness</p>	<p>11 </p> <p>Set a minimum energy density threshold of 60 kcal/100g for some soft-wet spoonable foods to ensure that complementary foods provide adequate nutrition for infants 6–12 months</p>	<p>12 </p> <p>The maximum permitted sodium content should be reduced, limiting content to 50 mg/100 kcal and 50 mg/100 g for most products</p>
<p>13 </p> <p>Industrially produced trans fatty acids should not be included in products*</p>	<p>14 </p> <p>Total fat should not exceed 4.5 g/100 kcal except in certain types of products with higher protein content</p>	<p>15 </p> <p>A minimum proportion of fish, poultry, meat or other traditional source of protein is required for products that name a protein source in the product name on the front of pack</p>

* These should be eliminated from the food supply.

* Figure adapted from WHO Regional Office for Europe (2019)¹⁹

Key policy

05

Maternity protection and workplace breastfeeding policies

In the ASEAN region, the need for mothers to return to work after childbirth is one of the most significant barriers to exclusive and continued breastfeeding. Maternity protection at the workplace is a legal and social recognition of the contribution that women make by having and nourishing babies; and maternity leave allows women the time and space they need to recover from childbirth, and to nourish and nurture their infants. The right to maternity protection is recognized by International Labour Organization Convention No. 183 (14 weeks) and Recommendation No. 191 (18 weeks). The minimum standards for maternity protection policies to support breastfeeding and complementary feeding practices are summarized in **Box 5**.^{§§}

POLICIES & LEGISLATION

BOX 5

Minimum standards for maternity protection policy to support breastfeeding and complementary feeding practices

Maternity protection policy should:

1. Cover working women in all sectors – private, public, and especially the informal sector – through innovative approaches such as cash transfers.
2. Ensure paid maternity leave of sufficient duration and level of financial benefit to enable the recommended breastfeeding practices. While the International Labour Organization Convention 183 sets a **minimum** duration of 14 weeks, five ASEAN countries meet or exceed this recommendation: Viet Nam (24 weeks); Singapore (16 weeks); Myanmar (14–24 weeks), Brunei Darussalam and the Philippines (15 weeks). Recommendation 191 promotes an optimal maternity leave duration of at least 18 weeks. Convention 183 also states that payment during maternity leave shall not be less than two-thirds of the woman's previous earnings. This may be complemented by paternity leave of at least 14 days.
3. Provide **health benefits and health protection**, including but not limited to medical care during pregnancy, confinement and recovery. This also includes protection from potentially harmful workplace conditions.
4. Ensure **job protection and non-discrimination** so that women who take maternity leave or medical leave for pregnancy reasons will regain their positions once they return to work, with the same salary and level of responsibility. Non-discrimination means that women who are pregnant or who may become pregnant should be considered for employment on an equal basis with others, both men and women.
5. Ensure a **supportive workplace** so mothers who have returned to work can continue to breastfeed. Workplace policies should provide:
 - **Time** – One or more breaks during the workday to breastfeed or express breastmilk that are considered 'working hours'; and the option of flexible working hours
 - **Space** – A dedicated space in the workplace for breastfeeding or expressing breastmilk that is clean, adequately ventilated, and includes adequate breastmilk storage facilities. In informal workplace settings, alternatives may be explored, such as shared common spaces.

§§ UNICEF, as part of the Global Breastfeeding Collective, advocates for at least 18 weeks and preferably six months. <https://www.globalbreastfeedingcollective.org/media/271/file/Breastfeeding%20and%20family-friendly%20policies.pdf>



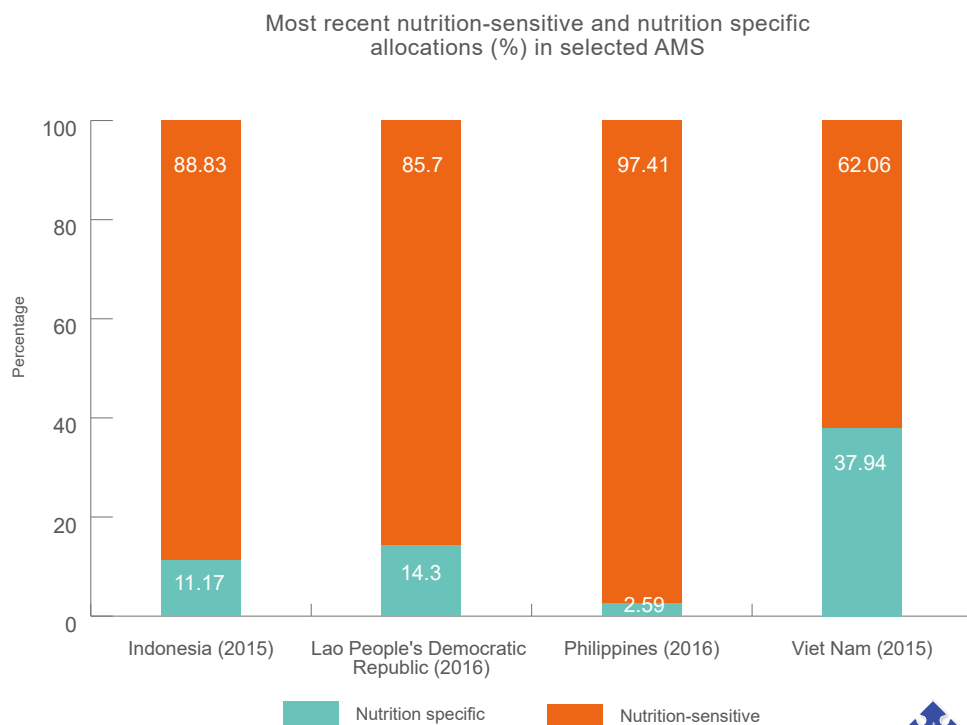
2.2.3 Financing for IYCF

Effective planning and budgeting for IYCF at scale requires political commitment for financial investments in nutrition within the national nutrition agenda. This includes ensuring adequate, effective, efficient, and equitable public financing, and the alignment of other financing streams towards national IYCF nutrition priorities and implementation plans/budgets.

In many countries, including in the ASEAN region, nutrition interventions are financed through public funds as well as by multilateral and bilateral donors, United Nations agencies, private foundations and civil society. An analysis of budget allocations to nutrition (within and outside the health system) in four ASEAN countries shows that expenditure on nutrition programmes comprises only a small proportion of total government expenditure, the Philippines allocates to 9 per cent of their total budget to nutrition and the rest of the AMS between 0 to 2.5 per cent. Of the funding allocated to nutrition, the majority is allocated to nutrition-sensitive interventions (see Figure 6 below) with social protection programmes receiving the most resources.²⁰ Budget analyses show that governments spend more on addressing the underlying determinants of nutrition than they do on the list of highly cost-effective nutrition actions recommended by WHO.¹¹

Evidence shows that nutrition interventions – particularly those relating to breastfeeding, micronutrient supplementation and complementary feeding – are very cost-effective.²¹ Despite the demonstrated cost-effectiveness, interventions are not being delivered at scale due to a number of factors, including insufficient allocation of resources.

Figure 6. Proportion of nutrition spending on nutrition-specific interventions in four AMS²²



¹¹ WHO cost effective interventions for nutrition (relevant to this guidance in bold) :Optimal timing of umbilical cord clamping, Care of low-birthweight and very low-birthweight infants, Assessment and management of wasting, Protecting, promoting, and supporting breastfeeding, Appropriate complementary feeding, Growth monitoring and assessment, Vitamin A supplementation, Iodine supplementation, Zinc supplementation in the management of diarrhoea, Iron-containing micronutrient supplementation, Nutritional care during pregnancy and postpartum.

Common resource and finance barriers related to achieving IYCF outcomes

- *Low budget priority* due to a lack of awareness among financial decision-makers around the economic case for investing in nutrition
- *Insufficient* budget allocation for implementing nutrition plans
- *Inefficient* expenditure due to delayed disbursements, leakages and procurement issues
- *Ineffective* expenditure by funding high-cost, low-impact interventions; or fragmented spending, where multi-sectoral interventions are required
- *Inequitable* allocations, resulting in lower investment and poorer services for disadvantaged areas or populations
- *Weak financial accountability* compounded by limited budget transparency or citizen participation

There is a strong case for investing in nutrition programmes from public health and economic perspectives. Studies have estimated that early nutrition programmes can lead to improved schooling completion rates and increased adult wages. In Asia, stunting reduction can lead to potential increases in GDP *per capita* by 4 per cent to 11 per cent.²³

Appropriate public financing for nutrition is a tool that can be used for this purpose. It requires an in-depth understanding of country-specific budget and planning cycles. The integration of breastfeeding and complementary feeding services into health care packages is one way to ensure adequate financing. The minimum standard guidelines on establishing appropriate public financing for IYCF are provided in **Box 6**. Further detail on public financing for nutrition, and guidance and tools for conducting analyses, can be found in the resource list on page 87.

FINANCING

BOX 6

Guidelines on appropriate public financing for IYCF to establish an enabling environment^{*}**

1. Conduct a nutrition budget analysis
2. Develop a costed plan/strategy to identify the actual costs of scale-up
3. Advocate to key line ministries for budget allocation
4. Integrate budgetary allocations for essential nutrition interventions into the policy, planning, and budget cycle; and ensure support by relevant national stakeholders at central and decentralized levels
5. Track and monitor budget allocations and expenditure for nutrition (nutrition-specific and sensitive), including at subnational levels across all sectors

^{***} Given the complex and multi-stakeholder nature of financing for nutrition, and the necessary involvement of other sectors and government departments, no recommendations for minimum standards for nutrition financing are made with regard to IYCF. The guidelines provide advice on suitable processes and actions that AMS should take.



2.2.4 Human resource capacity

A well-trained, robust, appropriately-sized and resourced workforce is an essential part of a strong enabling environment for IYCF and nutrition. A strong workforce is required to deliver on government strategies and meet national and global goals and targets.

In many ASEAN countries, the health workforce is insufficient in size, not adequately trained in IYCF, or overburdened by tasks, and cannot deliver IYCF interventions effectively. Some approaches to overcoming these barriers are beyond the scope of this guidance, and will be dependent on resources, national policies and institutional training capacity.

Guidance on the number of health workers per population has been developed to establish what is needed to achieve universal health coverage. Given that nutrition services should be fully integrated within health service packages, relevant staffing and training needs should be considered within these targets. To meet the Sustainable Development Goal (SDG) targets for universal health coverage, a threshold of 4.45 doctors, nurses and midwives per 1,000 people was identified as the minimum density needed for health workers.²⁴ Older figures had recommended the following density of nutritionists per population of 5 million: 100–500 nutritionists with bachelor degrees or licence level qualifications; 10–50 with masters degrees; and 5–25 doctorate level staff.²⁵ Meeting both of these targets requires significant increases in staffing across low and middle-income countries.

Minimum standards and guidance on actions to build capacity for nutrition are outlined in **Box 8**. More practical detail and guidance on developing human resource capacity for nutrition is included in Section 5. Governments must ensure that resources are available for training, that enough staff are hired to carry out government strategies, that training institutions are using effective and up-to-date materials and curricula, and that staff are well-trained and supported. Health worker training should never be conducted by or with members of the baby food industry (see **Box 7** for further guidance).

BOX 7

HUMAN RESOURCE CAPACITY

WHO Guidance on ending the inappropriate promotion of foods for infants and young children²⁶ highlights in **Recommendation 6** that companies that market foods for infants and young children should not create conflicts of interest in health facilities or throughout health systems. Health workers, health systems, health professional associations and NGOs should likewise avoid such conflicts of interest.

Such companies, or their representatives, should not:

1. Provide free products, samples or reduced-price foods for infants or young children to families through health workers or health facilities, except as supplies distributed through officially sanctioned health programmes. Products distributed in such programmes should not display company brands;
2. Donate or distribute equipment or services to health facilities;
3. Give gifts or incentives to health care staff;
4. Use health facilities to host events, contests or campaigns;
5. Give any gifts or coupons to parents, caregivers or families;
6. Directly or indirectly provide education to parents and other caregivers on IYCF in health facilities;
7. Provide any information to health workers other than that which is scientific and factual;
8. Sponsor meetings of health professionals and scientific meetings



BOX 8

Minimum standard and guidance on actions to build capacity for nutrition

1. Include information about the recommended IYCF practices and the Code in pre- and in-service training for facility- and community-based health and nutrition staff
2. Ensure that facility- and community-based staff are adequately supported, managed, and mentored to deliver IYCF counselling and other nutrition programmes
3. Ensure quality training and refresher training for frontline workers
4. Ensure quality materials and regular curriculum updates to training materials
5. Ensure up-to date and appropriate training modalities are used
6. Ensure government has capacity and systems to provide routine supportive supervision to facility- and community-based health and nutrition staff
7. Ensure government has capacity and systems to enforce and monitor policies and laws relating to manufacturing and advertising breastmilk substitutes and complementary foods for children under 2.

**2.2.5 Data for decision-making**

High-quality data are needed to track progress towards reducing and eliminating all forms of malnutrition and reach global and national nutrition targets, such as the WHA Global Nutrition Targets and the SDGs.²⁷ High-quality data are also essential for problem-solving, decision-making, building commitment and advocating for better IYCF policies and programmes. Strong data collection systems are an integral component to a robust enabling environment for IYCF and nutrition; these data should be regularly reviewed and used to guide programming and policy priorities. Regular data collection can be supported by research and robust evaluations of IYCF and nutrition programmes to provide contextual evidence for decision-making and support high-level advocacy efforts.

Globally, and within ASEAN, nutrition data systems are not always integrated into routine health monitoring information systems, such as health management information systems. Most ASEAN countries track national and subnational prevalence of key indicators through regular population-based surveys, such as Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), and other national surveillance surveys. These surveys provide good quality data to track national and subnational trends, but in many instances, they are only conducted every five years and do not provide an opportunity to collect monitoring data to inform programmatic modification. AMS need to invest in strengthening regular, routine data collection – often referred to as administrative data – via health facilities. Disaggregated nutrition data are needed to:

1. Identify and characterize inequities in nutritional status, dietary practices, and deficiencies;
2. Identify underlying drivers and determinants of malnutrition;
3. Design policies and interventions to address major drivers of malnutrition and inequities;
4. Monitor the implementation of interventions and programmes for accountability and to support adaptive programme management.²⁸

At a regional level, ASEAN is working to develop the ASEAN Nutrition Surveillance System designed to monitor and track progress by AMS towards a standardized core set of nutrition indicators. The ASEAN Nutrition Surveillance System indicators will allow for the routine collection of IYCF data at the outcome, intermediate and process level to ensure that target indicators are on track and that policies and programmes are in place to support targets throughout all AMS.



The collection of a standardized nutrition surveillance system by all AMS will also allow for monitoring progress in the region and will help identify best practices and lessons learned. The minimum standards and guidance for ensuring high-quality data are provided in **Box 9**. The list of indicators tracked through the ASEAN Nutrition Surveillance System, and more detail on the essential steps to ensuring data quality of nutrition surveys, are provided in Section 7.²⁹



BOX 9

Minimum standards and guidance for ensuring high-quality data

Data prioritization

- Collected data directly supports tracking and monitoring of WHA and SDG nutrition targets, and national strategies and plans.
- Ensure that IYCF practices are measured and monitored using global standardized outcome indicators at national and subnational levels at regular intervals (ideally annually).
- Invest in data collection through administrative data, in addition to surveys, to measure IYCF service delivery, intervention coverage and financial commitments.
- Ensure relevant and appropriate disaggregation is collected and tracked. At a minimum this should include gender, income, geography, disability and ethnicity.

Data curation

- Identify all systems where nutrition data are being collected (education, health, agriculture, social protection) and develop plans for data sharing, inter-operability and management.

Data dissemination and use

- Data should be regularly communicated to managers and decision-makers and program implementers/managers.
- Data should be regularly reviewed to monitor progress.
- Data should be shared in easy to understand formats using standardized indicators.

Data collection

- Build capacity of frontline health workers to collect high-quality administrative data through:
 - Developing operational guidance on collection of high-quality nutrition data.
 - Ensure nutrition data collected across other systems are collected at a central point.
 - Use automated/digitized systems (DHIS-2) and tools (RapidPro) to improve data quality.

Data analysis

- Strengthen national and sub-national capacity for data analysis to inform decision-making at all levels.
- Develop tools to enable faster/easier decision-making, ease of access (dashboards, trackers, visualization tools, infographics, ANSS etc.).





3

MINIMUM
STANDARDS
for IYCF interventions

3 Minimum standards for IYCF interventions

- ▶ This section outlines the interventions that can be adopted through the health system (nutrition-specific interventions) that **support the adoption and use of optimal IYCF practices by caregivers**. Many of the outlined interventions address some or all of the recommended feeding practices for children 0–23 months of age, particularly those intended to improve complementary feeding.

3.1 Guidance on IYCF

Aligned with the WHO and IYCF Global Guidance on IYCF released in 2003, and UNICEF's updated 2020 guidance, ASEAN recognizes the significance of nutrition in early childhood development and the critical role that optimal IYCF practices play in achieving good health and development outcomes.³⁰

The lack of breastfeeding, particularly exclusive breastfeeding during the first six months of life, is a critical risk factor for child mortality and morbidity that is then compounded by inadequate complementary feeding practices between the ages of 6–23 months.

The WHO Guiding Principles for Complementary Feeding of the Breastfed and Non-breastfed Child set standards for developing locally appropriate feeding recommendations, as well as guidance on desired feeding behaviours, and the amount, consistency and frequency of feeding. A summary of the guiding principles for complementary feeding of the breastfed child is provided in **Box 10** and for the non-breastfed child in **Box 11**.

BREASTFED CHILD

BOX 10

Guiding principles for complementary feeding of the breastfed child³¹

1. Practice early initiation and exclusive breastfeeding from birth to 6 months of age and introduce complementary foods at 6 months of age (180 days) while continuing to breastfeed.
2. Continue frequent, on-demand breastfeeding until 2 years of age or beyond.
3. Practice responsive feeding, applying the principles of psychosocial care.
4. Practice good hygiene and proper food handling.
5. Begin introducing small amounts of food at 6 months of age and increase the quantity as the child gets older, while maintaining frequent breastfeeding.
6. Gradually increase food consistency and variety as the child grows older, adapting to the his or her requirements and abilities.
7. Increase the number of times the child is fed complementary foods as he or she gets older.
 - Two meals a day of solid, semi-solid or soft foods for breastfed infants aged 6–8 months;
 - Three meals a day of solid, semi-solid or soft foods for breastfed children aged 9–23 months;¹⁸
8. Feed a variety of nutrient-rich foods to ensure that all nutrient needs are met. Breastfed children should consume food from eight food groups, including breastmilk, aiming for 5 food groups, including breastmilk each day.^{†††}

††† The eight food groups include: 1) breastmilk; 2) grains, roots and tubers; 3) legumes and nuts; 4) dairy products; 5) flesh foods; 6) eggs; 7) vitamin A-rich foods and vegetables; and 8) other fruits and vegetables. Countries should adapt advice and counselling materials to reflect locally available, appropriate complementary foods.

BREASTFED CHILD

9. Use fortified complementary foods or micronutrient supplements for the child, as needed.
10. Increase fluid intake during illness, including through more frequent breastfeeding, and encourage the child to eat soft, favourite foods. After illness, give food more often than usual and encourage the child to eat more.

BREASTFED CHILD

BOX 11

Guiding principles for the **non-breastfed child**³²

Evidence and global standards recommend that **infants be exclusively breastfed for the first six months of life, and thereafter receive appropriate complementary feeding with continued breastfeeding until 2 years of age or beyond**. However, there are a number of infants who will not be able to enjoy the benefits of breastfeeding in the early months of life or for whom breastfeeding will end before the recommended duration of two years or longer.

Guidelines for **non-breastfed children** are as follows:

1. Ensure that energy needs are met. These needs are approximately 600 kcal per day at 6–8 months of age, 700 kcal per day at 9–11 months of age, and 900 kcal per day at 12–23 months of age.
2. Gradually increase food consistency and variety as the child gets older, adapting to his or her requirements and abilities. Children can eat pureed, mashed and semi-solid foods beginning at 6 months of age.
3. For the average healthy child, meals should be provided at least 4 times per day, with additional nutritious snacks offered 1–2 times per day, as desired. The appropriate number of feedings depends on the energy density of local foods and the usual amounts consumed at each feeding. If energy density or amount of food per meal is low, more frequent meals may be required.
4. Feed a variety of foods to ensure that nutrient needs are met. Non-breastfed children should consume foods from more than 5 of 8 food groups.^{†††}
5. Use fortified foods or vitamin-mineral supplements that contain iron as needed (preferably mixed with or fed with food). If adequate amounts of animal-source foods are not consumed, these fortified foods or supplements should also contain other micronutrients, particularly zinc, calcium and vitamin B12.
6. Provide non-breastfed infants and young children older than 6 months of age with at least 400–600 mL of extra fluids per day in a temperate climate (in addition to the 200–700 mL/day of water that is estimated to come from milk and other foods), and 800–1200 mL/d in a hot climate. Plain, clean (boiled, if necessary) water should be offered several times per day to ensure that the child's thirst is satisfied.
7. Practice good hygiene and proper food handling.
8. Practice responsive feeding, applying the principles of psycho-social care.
9. Increase fluid intake during illness and encourage the child to eat soft, varied, appetizing, favourite foods. After illness, give food more often than usual and encourage the child to eat more.

††† The 8 food groups include: 1) Breastmilk 2) Grains, roots and tubers 3) Legumes and nuts 4) Dairy products 5) Flesh foods 6) Eggs 7) Vitamin A rich foods and vegetables and 8) Other fruits and vegetables.

3.2 Minimum package of health system interventions for IYCF

The health system plays a vital role in addressing nutrition gaps and influences the quality of diets during the first 1,000 days through the provision of facility- and community-level interventions that protect, promote and support optimal IYCF, adequate diets, child health and development, good sanitation and hygiene practices.³³

To support adoption of optimal IYCF practices, health systems should adopt a ‘minimum package’ of evidence-based services that includes six interventions and supportive activities described in **Table 3**. The evidence base for many of these interventions is long established, and the interventions were identified in the 2013 *Lancet* Series on Maternal and Child Nutrition³⁴ as being part of a core package of nutrition-specific interventions to address child malnutrition.

The full package of interventions delivered through the health system and communities should be based on the specific needs of populations at national and subnational levels. A situation analysis should inform the design of evidence-based strategies, policies and programmes to improve IYCF and address all forms of malnutrition.

Table 3. Core package of nutrition-specific interventions

Minimum IYCF package for ASEAN Member States	<i>Lancet</i> series core package of nutrition interventions	Relevant for IYCF	Applicable in all contexts in ASEAN
Health system-wide interventions			
1. Exclusive breastfeeding promotion and counselling	Y	Y	Y
2. Complementary feeding promotion/education and counselling	Y	Y	Y
3. Vitamin A supplementation	Y	Indirectly	N
4. Multiple micronutrient supplementation	Y	Indirectly	Y
5. Zinc supplementation in the management of diarrhoea		Indirectly	N
6. Screening for malnutrition	With management of acute malnutrition	Y	Y
Hospital/higher-level facility interventions			
1. Baby-friendly Hospital Initiative	N	Y	Y
2. Human milk banks*	N	Y	N

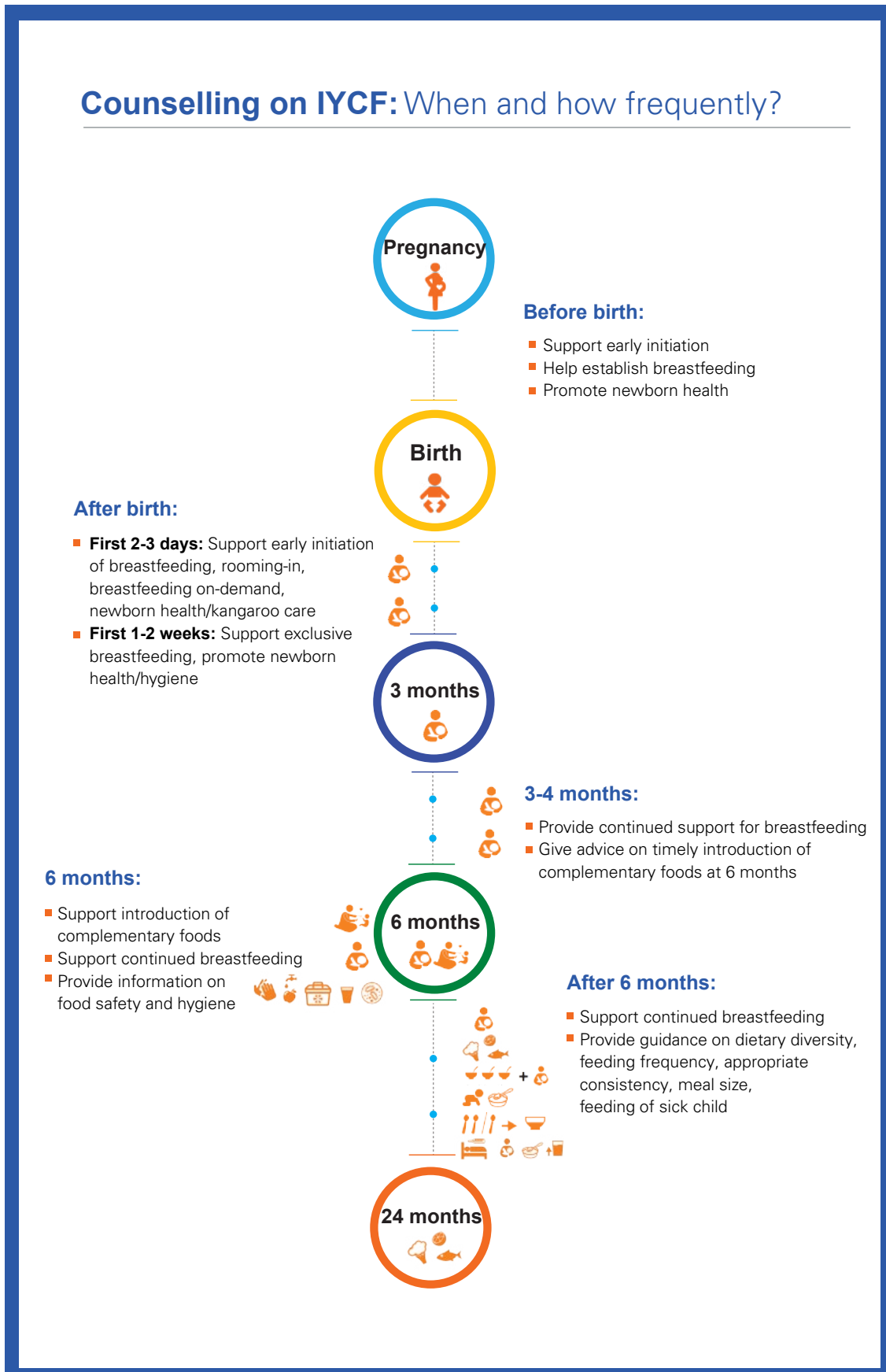
The following section outlines the **key elements for these core interventions**:

3.2.1 Counselling on IYCF

Intervention: Counselling on IYCF	
What is it?	<ul style="list-style-type: none"> • IYCF counselling is the process by which a health worker supports caregivers to implement good feeding practices (including breastfeeding and complementary feeding) and overcome feeding difficulties in a manner that is clear and feasible in their context.³⁵ • The aim of breastfeeding counselling is to empower women to breastfeed, while respecting their personal situations and wishes. Counselling should be made available and accessible to all pregnant women and mothers, particularly those who are considering or already breastfeeding.³⁶
Who delivers?	<ul style="list-style-type: none"> • Health care providers (facility- and community-based) who have regular interaction with pregnant, postpartum, and breastfeeding women are best placed to provide counselling to mothers and caregivers on early essential newborn care and IYCF throughout the 1,000-day period. • Peer educators in community-based settings can be used to support breastfeeding and complementary feeding.³⁷
When and how frequently?	<ul style="list-style-type: none"> • The WHO guidelines on newborn health and breastfeeding counselling recommend that newborn care and breastfeeding counselling be provided in the antenatal and postnatal periods and for up to 24 months or longer. Counselling should be provided face-to-face (and additionally via remote modes), six or more times throughout this period.^{37,38} • Breastfeeding and complementary feeding counselling will address the following topics at various relevant contact points during the first 1,000 days (illustrated in Figure 7): <ul style="list-style-type: none"> ○ Before birth – support for early initiation and establishing breastfeeding and promotion of newborn health ○ During and immediately after birth (within the first 2–3 days) – support for early initiation, rooming-in and establishing breastfeeding on-demand; and promotion of newborn health and kangaroo care for preterm or small babies) ○ 1–2 weeks after birth – support for exclusive breastfeeding; promotion of newborn health and hygiene ○ When the child is 3–4 months old – continued support for breastfeeding and advice on timely introduction of complementary foods) ○ At 6 months of age – support for the appropriate introduction of complementary foods, continued breastfeeding, food safety and hand hygiene ○ After 6 months of age – support for continued breastfeeding, dietary diversity, healthy diets, age-appropriate feeding frequency, age-appropriate consistency, meal size and feeding of the sick child. • Evidence also indicates that the more interaction a caregiver has with the interpersonal counselling provider – the more likely he or she is to adopt improved practices. Strategies for delivering IYCF counselling during the 1,000-day period need to consider the changing information needs of caregivers and identify contact points for providing targeted advice on diet, feeding and health during this period. • Counselling should be delivered to individual mothers and caregivers. It can also be provided in group settings if there is a trained facilitator to guide group discussions.

	<ul style="list-style-type: none"> • Facility-based and community/home-based counselling are appropriate for IYCF.^{39,40} Where active community structures are in place, home visits can provide mothers with tailored and targeted advice and information on IYCF. The IYCF counselling service provider should be determined based on the local health system and considering the existing contact points and capacity to deliver counselling. • Specific WHO guidance on counselling to breastfeeding women is included in the Annex.
<p>What supportive actions are needed for a quality intervention?</p>	<ul style="list-style-type: none"> • Quality counselling needs to be supported by training, mentoring and supervision of the counsellors (see Section 5.1.1). • The development or adaptation of specific operational guidance and guidelines on delivering counselling is recommended to support better implementation of breastfeeding and complementary feeding counselling. • The preferred mode of counselling is face-to-face; however, complementary and supplementary options (e.g., counselling via phone or other digital options) can be used where relevant or required (e.g., during COVID-19).
<p>Guidelines and resources</p>	<ul style="list-style-type: none"> • WHO Guideline: Counselling of Women to Improve Breastfeeding Practices: https://www.who.int/nutrition/publications/guidelines/counselling-women-improve-bf-practices/en/ • WHO Infant and Young Child Feeding – Model Chapter: https://www.who.int/nutrition/publications/infantfeeding/9789241597494/en/ • Alive & Thrive – Online IYCF Global E-Learning Training: http://iycfhub.org/ • UNICEF Programming Guidance: Improving Young Children’s Diets During the Complementary Feeding Period, UNICEF (2020)

Figure 7. Counselling on IYCF



3.2.2 Safe preparation, storage and use of complementary foods

Intervention: Improving access to and use of safe complementary foods and water through WASH behaviour change	
What is it?	<ul style="list-style-type: none"> Nutrition counselling and SBCC on the recommended feeding practices, together with access to basic WASH services at household level, can improve caregiver knowledge of the recommended hygiene and sanitation behaviours and decrease faecal contamination of complementary foods.⁴¹ WASH messages can be integrated into IYCF counselling to address handwashing, safe food preparation, and use of safe water to reduce food contamination, improve hygiene practices and ensure children have fewer diarrhoeal episodes. WASH messages can be integrated into other forms of counselling and community mobilization and mass media activities as outlined in Section 6.3.
Who delivers?	<ul style="list-style-type: none"> Integrated IYCF -WASH counselling can be provided by a wide range of people: facility health workers, community health workers and volunteers, WASH and agriculture sector staff, community leaders and individuals involved in community mobilization activities.
When and how frequently?	<ul style="list-style-type: none"> Messages and activities for WASH behaviour change should be delivered alongside other nutrition and health SBCC actions. Caregivers and families of children under 2 should be targeted for participation.
What supportive actions are needed?	<ul style="list-style-type: none"> Access to basic WASH services in the household, community and health facility improves hygiene and sanitation behaviours and ensures the safety of complementary foods. The availability of toilet facilities, refuse collection, safe water and other sanitation services reduces the risk of contaminating feeding utensils and complementary foods. WASH system contributions to IYCF are discussed further in Section 6.3.

3.2.3 Screening of children for malnutrition

Intervention: Screening for malnutrition	
What is it?	<ul style="list-style-type: none"> Screening of children's weight, length or height, and mid-upper arm circumference (MUAC) is an important activity to monitor child growth and development. Screening helps detect children with stunting, wasting or overweight and those at risk of these conditions. All forms of malnutrition among young children are associated with poor IYCF practices; optimal IYCF practices are critical to improve child growth and development outcomes. Screening of children should include measurement of MUAC, body weight (in kilograms) length/height (in centimetres), infant/child age (in months), sex, assessment for nutritional oedema, and follow-up counselling and information for caregivers on growth progress and diet.
Who delivers?	<ul style="list-style-type: none"> Screening should be carried out by trained health workers – either facility- or hospital-based staff, or community health workers and volunteers. Community health workers, nutritionists, midwives, doctors, nurses and all forms of frontline cadres should be trained in measuring and diagnosing malnutrition, counselling on IYCF and providing appropriate treatment for malnutrition. Where children are identified as being malnourished, they should be referred for further treatment and assessment under existing treatment and prevention protocols. ASEAN Guidance on the Integrated Management of Acute Malnutrition is under development, which will cover policy, programme and implementation in greater detail.

When and how frequently?	<ul style="list-style-type: none"> Screening can be carried out as a standalone activity, as part of ongoing growth and development monitoring and promotion activities, through sick child visits or other contacts with the health system (vaccination visits, antenatal care visits if mother brings young children, postnatal care) or through community-based activities. Screening and diagnosis of malnutrition should be delivered alongside appropriate, quality IYCF counselling (detailed in Section 3.2.1). Screening should be done when children come in contact with the health facility or health worker, rather than determined by regular screening events.
What supportive actions are needed for a quality intervention?	<ul style="list-style-type: none"> Cadres of frontline staff well-trained in measurement of malnutrition and IYCF counselling (see Section 3.2.1). Adequate staff support, management and mentoring (see Section 5.1.1). Standardized referral and treatment processes for children who are identified as being malnourished. Adequate supplies for measurement, such as tapes, scales, and height boards (see Section 5.1.2).
Guidelines and resources	<ul style="list-style-type: none"> WHO – Assessing and Managing Children at Primary Health-Care Facilities to Prevent Overweight and Obesity in the Context of the Double Burden of Malnutrition: Updates for the Integrated Management of Childhood Illness: https://www.who.int/publications/i/item/9789241550123

Micronutrient interventions

The provision of micronutrient supplements to children protects and promotes healthy growth and optimal nutrition status; it should be considered part of an essential package of IYCF interventions delivered through the health system. Use of vitamin A supplementation and micronutrient powders (MNPs) alongside other context-specific supplements (e.g., iron) should be guided, targeted and delivered within the context of national strategies for the prevention and control of micronutrient malnutrition.

3.2.4 Vitamin A supplementation

Intervention: Vitamin A supplementation	
What is it?	<ul style="list-style-type: none"> Provision of high-dose vitamin A supplementation to infants and children 6–59 months of age in settings where vitamin A deficiency is a public health problem, as recommended by WHO.⁴² Supplementation with vitamin A reduces infant/child mortality and is particularly effective in reducing mortality due to measles and diarrhoea.⁴³
Who delivers?	<ul style="list-style-type: none"> Frontline health workers, trained community volunteers, community health workers, doctors, nurses, midwives, health facility staff.
Where and how frequently is it delivered?	<ul style="list-style-type: none"> Vitamin A supplements can be delivered via campaign-based events and through regular service delivery once children are over 6 months of age. Vitamin A supplementation is once every 4-6 months apart.
What is needed to support effective delivery of vitamin A and other supplements?	<ul style="list-style-type: none"> Adequate supply and a good procurement system (see Section 5.1.2). Trained health staff (see Section 5.1.1). Regular platforms and opportunities for delivery – either through campaign-based events, child health days, regular contacts with the health system or via social protection programmes. Supportive media, awareness and social and behaviour change activities (see Section 4).

Resources and guideline	<ul style="list-style-type: none"> • WHO Guideline: Vitamin A Supplementation in Infants and Children 6–59 Months of Age: https://www.who.int/publications/i/item/9789241501767 • Global Alliance for Vitamin A: www.gava.org
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3.2.5 Micronutrient powders

Intervention: Micronutrient powders	
What are they?	<ul style="list-style-type: none"> • MNPs are nutrient powders that caregivers can use to fortify the foods they prepare for young children. MNPs can reduce anaemia, improve iron status and address other micronutrient deficiencies in areas where the prevalence of anaemia among children under 5 is higher than 20 per cent, as per WHO recommendation.⁴⁴ • The integration of MNPs into IYCF programmes should always be coupled with counselling on their use and nutrition education to improve complementary feeding practices. Integration of MNPs into IYCF programmes can incentivize participation in counselling, increase caregiver knowledge on appropriate complementary feeding, improve the consistency of complementary foods,^{146, 147} facilitate timely initiation of solid foods at 6 months of age, improve dietary diversity and improve population-based feeding indicators.^{33,45,46,47,48}
Who delivers?	<ul style="list-style-type: none"> • Frontline health workers, trained community volunteers, community health workers, doctors, nurses, midwives, health facility staff provide MNPs to caregivers to be added to home-prepared foods.
Where and how frequently are they delivered?	<ul style="list-style-type: none"> • WHO recommends providing 90 MNP sachets to be consumed by the child over a period of 6 months. WHO does not specify the optimal mode of delivery, but delivery should be free through health systems.
What is needed to support effective delivery of MNP and other supplements?	<ul style="list-style-type: none"> • Adequate supply and a good procurement system (see Section 5.1.2) • Trained health staff (see Section 5.1.1). • Regular platforms and opportunities for delivery – either through campaign-based events, child health days, regular contacts with the health system or via social protection programmes. • Supportive media, awareness and social and behaviour change activities. Evidence on successful MNP programmes shows that a combination of strong delivery platform, community involvement and supporting SBCC are essential (Section 4).
Resources and guideline	WHO Guidance on MNPs https://www.who.int/publications/i/item/9789241549943

3.2.6 Zinc supplementation in the management of diarrhoea

Intervention: Zinc supplementation for the management of diarrhoea	
What is it?	<ul style="list-style-type: none"> • Provision of 20 mg per day of zinc supplementation to children for 10–14 days (10 mg per day for infants under the age of 6 months). • The current evidence does not support the use of zinc supplementation in the following groups of children: <ul style="list-style-type: none"> ◦ children who are under 6 months of age ◦ children who are well-nourished ◦ children in settings with low risk of zinc deficiency⁴⁹

Who delivers?	<ul style="list-style-type: none"> Frontline health workers, trained community volunteers, community health workers, doctors, nurses, midwives, health facility staff
Where and how frequently is it delivered?	<ul style="list-style-type: none"> Zinc, alongside oral rehydration salts, shall be used by children whenever they have a diarrhoeal illness. Distribution to households with children under 5 during peak diarrhoea season is also an option.
What is needed to support effective delivery of zinc and oral rehydration salts?	<ul style="list-style-type: none"> Adequate supply and good procurement system (see Section 5.1.2) Trained health staff (see Section 5.1.1) Regular platforms and opportunities for delivery – either through campaign-based events, child health days, regular contacts with the health system or via social protection programmes Supportive media, awareness and SBCC activities. Evidence on successful MNP programmes shows that a combination of strong delivery platform, community involvement and supporting SBCC are essential (see Section 4)
Resources and guideline	<p>Oral Zinc for Treating Diarrhoea in Children: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD005436.pub5/full</p> <p>WHO – Zinc Supplementation in the Management of Diarrhoea: https://www.who.int/elena/titles/zinc_diarrhoea/en/</p>

Hospital-based interventions

3.2.7 Baby-friendly Hospital Initiative

Intervention: Baby-friendly Hospital Initiative	
What is it?	<ul style="list-style-type: none"> The Baby-friendly Hospital Initiative (BFHI) was launched by UNICEF and WHO to help motivate facilities providing maternity and newborn services worldwide to implement the ‘Ten Steps to Successful Breastfeeding’. The BFHI focuses on providing optimal clinical care for new mothers and their infants. In countries where institutional delivery rates are high, interventions in maternity and newborn care facilities such as the BFHI can significantly impact the rates of early initiation of breastfeeding and establish optimal infant feeding practices.⁵⁰ The WHO/UNICEF Ten Steps to Successful Breastfeeding summarizes the package of policies and procedures that facilities providing maternity and newborn services can implement to support breastfeeding.⁵¹
Who delivers?	<ul style="list-style-type: none"> Hospital administrators, nurses, midwives, doctors, staff working in BFHI facilities
What supportive actions are needed?	<ul style="list-style-type: none"> To support scale-up and adoption of BFHI, national nutrition and IYCF strategies need to set out the vision for fully integrating the principles of the Ten Steps to Successful Breastfeeding within the standard operating procedures for maternity services, including required capacities and training of staff and monitoring systems. National policy and strategy (see Section 2.2.2) Champions at the national and facility level (see Section 2.2.1) Adequate resources (see Section 2.2.3) Adequately trained staff (See Sections 2.2.4 and 5.1.1) Good national support for implementation of the Code (see Section 2.2.2 i) Regular monitoring and assessment of quality of services (see Section 8)

Guidelines and resources	<ul style="list-style-type: none"> • Implementation Guidance: Protecting, promoting and supporting Breastfeeding in facilities providing maternity and newborn services: the revised BABY-FRIENDLY HOSPITAL INITIATIVE https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf • WHO capacity-building resources on BFHI from WHO: <ul style="list-style-type: none"> ◦ BFHI Competency Verification Toolkit: Ensuring Competency of Direct Care Providers to Implement the Baby-friendly Hospital Initiative: https://www.who.int/publications/i/item/9789240008854 ◦ BFHI Training Curriculum: https://www.who.int/publications/i/item/9789240008915 • WHO – Promoting baby-friendly hospitals: 10 Steps to Successful breastfeeding: https://www.who.int/activities/promoting-baby-friendly-hospitals/ten-steps-to-successful-breastfeeding
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3.2.8 Human milk banking

Intervention: Human milk banking	
What is it?	<ul style="list-style-type: none"> • A human milk bank (HMB) is a service established to recruit breastmilk donors, collect donated milk, and then process, store, and distribute the milk to meet the needs of infants whose mothers are unable to provide their own breastmilk. • Donors are volunteer lactating mothers who have passed health screenings. After donation, milk is processed, stored and distributed following a strict procedure to provide safe, high-quality breastmilk. • Donor human milk shall not replace the mother's own milk but shall bridge the gap where the mother is still building her milk supply. • Priority recipients of donor human milk are as follows: <ul style="list-style-type: none"> ◦ Preterm/ low birthweight infants (hospital setting) ◦ Term / appropriate weight sick infants (hospital setting) ◦ Seriously unwell mother or absent mother; or a mother receiving contraindicated medication (maternal criteria)
Who delivers?	<ul style="list-style-type: none"> • Hospital administrators, nurses, midwives, neonatologists, staff working on HMB, hospital-based breastfeeding counsellors, other related departments in the hospital (e.g., laboratory department, infection control units)
What supportive actions are required?	<ul style="list-style-type: none"> • An essential first step in this process includes supporting existing policy efforts, such as the updated BFHI and the Code [1] (see Sections 2.2.2.i and ii). The foundation of a HMB includes: <ul style="list-style-type: none"> ◦ Quality assurance ◦ Auditing and tracking ◦ Breastfeeding promotion and support ◦ Guidance for the clinical provision of donor milk <p>The primary goal of an HMB is to protect, promote and support breastfeeding. For successful donations, HMBs rely on a robust donor breastfeeding population to ensure adequate supply.</p>

Guidelines and resources	<ul style="list-style-type: none"> • A regional minimum standard is being developed by the Regional Human Milk Bank Network for Southeast Asia • PATH – Resources to guide the establishment and implementation of HMBs: http://www.path.org/hmb-toolkit • Alive & Thrive – Briefing note: Ensuring every infant has access to breastmilk: Human milk banks in the ASEAN region: https://www.aliveandthrive.org/resources/briefing-note-ensuring-every-infant-has-access-to-breastmilk-human-milk-banks-in-the-asean-region/ • Alive & Thrive – Briefing note: Making space for human milk banks: Lessons learned from Viet Nam: https://www.aliveandthrive.org/resources/briefing-note-making-space-for-human-milk-banks-lessons-learned-from-viet-nam/ • Alive & Thrive: Components of human milk bank processes and services: https://www.aliveandthrive.org/resources/components-of-human-milk-bank-processes-and-services/
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3.3 Delivery of IYCF interventions within the health system

Improving breastfeeding and complementary feeding requires countries to deliver programmes grounded in evidence-based interventions at scale, with quality and equity. To achieve the desired impact, such interventions must be designed and implemented to respond to the context-specific drivers of children's diets.⁵² IYCF interventions and other nutrition interventions should be integrated into existing health packages and programmes to ensure consistent and efficient delivery of services, and to maximize health worker contacts with caregivers and children.

3.3.1 Facility-based platforms and contact points

IYCF interventions shall be delivered to mothers and caregivers throughout the 1,000-day period. Depending on existing programmes and policies, IYCF counselling and screening for malnutrition can be delivered to children through targeted visits for IYCF or via other contact points. [Table 4](#) highlights common health system contact points. This list is only illustrative; AMS may have other contact points that can be used to provide IYCF counselling.

A national and subnational mapping of existing contact points between caregivers of children under 2 and the health system can be used to identify where IYCF interventions can be added or strengthened.

3.3.2 Community-level platforms and contact points

In addition to critical IYCF services delivered at the facility level through the health system, complementary interventions should aim to reach mothers and caregivers in their communities. Families and communities are invaluable resources in localized efforts to promote and support optimal IYCF. Community-based breastfeeding and complementary feeding support can be very effective in changing behaviours and supporting caregivers.

Mother support groups, community mobilization events and the use of local change agents, community cadres and mass media can be effective opportunities to reach communities and complement facility- and community-based interpersonal communication.

Table 4. Contact points for the delivery of IYCF interventions

Intervention	Delivery platform						
	ANC	PNC	Sick child	GMP	EPI	Community	Campaign-based events
Age-appropriate IYCF counselling	•	•	•	•	•	•	•
EENC / EIB	•	•					
EBF	•	•	•		•	•	
Continued Breastfeeding	•		•	•	•	•	•
Dietary diversity		•		•		•	
Meal frequency			•	•	•	•	
Feeding size			•	•	•	•	
Responsive feeding and care		•	•	•	•	•	
Safe preparation			•	•		•	
Feeding during and after illness			•	•		•	
Hygiene and handwashing			•	•	•	•	
Screening for malnutrition		•	•	•		•	•
MNP			•	•	•	•	•
VAS			•			•	•
Zinc +ORS			•	•	•	•	•

ANC – antenatal care; **PNC** – postnatal care; **GMP** – growth monitoring and promotion; **EPI** – expanded programme on immunization; **EENC/EIB** – early essential newborn care/early initiation of breastfeeding; **EBF** – exclusive breastfeeding; **MNP** – micronutrient powders; **VAS** – vitamin A supplementation



BOX 12

Nutrition and disability

Governments have an obligation to ensure that nutrition and health services are available and accessible to children and caregivers with disabilities. The Convention on the Rights of Persons with Disabilities states that children and adolescents with disabilities have the right to receive essential nutrition services and to reach their highest attainable standard of health. Disability can lead to malnutrition and malnutrition can cause disabilities, creating a vicious cycle.⁵³ Some children with disabilities are more likely to be malnourished due to difficulties in swallowing and feeding, frequent illness, difficulties in absorbing nutrients, lack of caregiver knowledge on feeding, and neglect. Children with disabilities often need additional support and assistance to feed adequately and safely, such as special utensils and tools to allow them to eat properly.

Children with disabilities are more likely to be overlooked in mainstream programmes and services. Existing health and nutrition systems and services are often less accessible to those most in need, particularly children and families living in poverty or in remote locations. Community-based services may be underused by children with disabilities due to inaccessible or cost prohibitive transportation, inaccessible buildings or lack of service provider knowledge on how to support and treat children with disabilities and how to raise awareness among families and caregivers about appropriate interventions.

When planning programmes and interventions, any situation analysis should specifically consider the needs and rights of children with disabilities and their caregivers – with a systematic examination of the status, trends and determinants of poor diets for children with disabilities – in order to provide targeted support.⁵²

Specific actions that can be included through IYCF programmes to support children with disabilities include:

- Ensuring buildings and community events, as well as the announcements for the events and the information disseminated, are accessible.
- Providing training to health workers to support caregivers of children with disabilities/caregivers with disabilities to address the link between disability and malnutrition, attitudinal barriers with health staff and caregivers and feeding techniques. The prevention of disabilities related to nutrition during conception (e.g., iodine deficiency causing hydrocephaly, cognitive delay should also be covered).
- Involve organizations for people with disabilities in the programme design, planning, implementation, monitoring and evaluation.
- Include children with disabilities in categories of 'nutritionally vulnerable' people when implementing social protection programmes (discussed further in Section 6.2).





4

S O C I A L A N D B E H A V I O U R

change for effective nutrition interventions

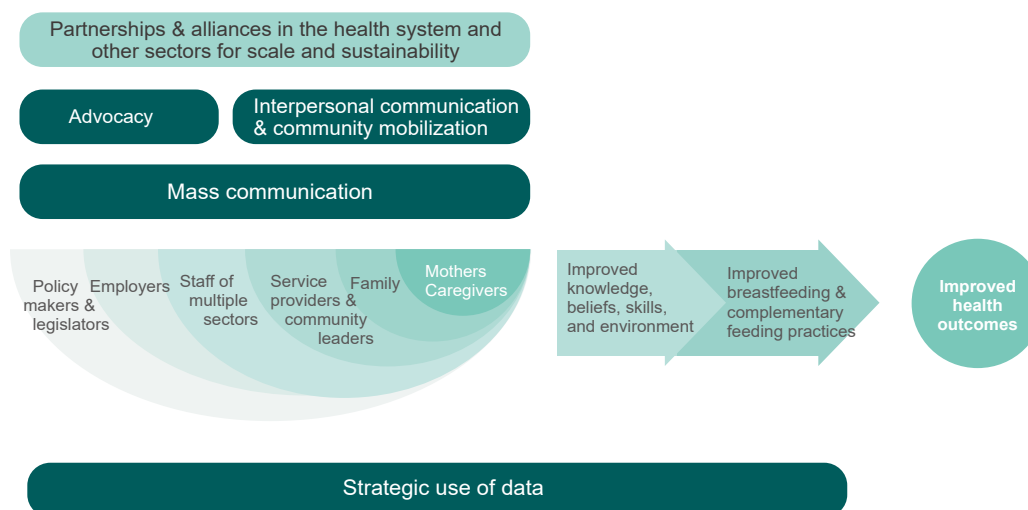
4 Social and behaviour change for effective nutrition interventions

- ▶ This section covers the development of social and behaviour change strategies to improve awareness, knowledge and practices for IYCF.

Social and behaviour change (SBC) is a process, rather than a product or standalone outcome. Some of the outputs of the SBC process include communication products and materials, such as posters, television or radio spots, flipcharts or leaflets. However, SBC is not limited to communications materials and strategies alone; the process includes other approaches and activities that foster sustained improvements in priority IYCF behaviours. In some cases, the terms SBC and social and behaviour change communication (SBCC) are used interchangeably; however, this guidance uses SBCC to make specific reference to the communications aspects and approaches of this process. This guidance considers the range of SBC considerations as they relate to interventions for improving IYCF.

Experience from around the world, including in the ASEAN region, shows that the application of an SBC framework built on evidence-based principles of behavioural science, systems approaches and social marketing can change IYCF behaviours rapidly and at-scale.^{54, 55, 56, 57, 58, 59} SBC is an essential component of an IYCF programme: evidence shows that the combination of interpersonal communication (IPC), exposure to other forms of SBC (mass media, community mobilization), in an enabling environment can have a positive impact on IYCF practices. SBC design involves a blending of art and science and allows for flexibility and adaptability to achieve true change. It is an iterative process that leverages innovative approaches, underpinned by strong data and evidence. The process outlined in [Figure 8](#) details five components for effective SBC for IYCF.

Figure 8. Proven framework for social and behaviour change



This framework consists of **five main programme components** (described further below), each addressing different audiences.

4.1 Advocacy

Advocacy is the process of educating and motivating influential audiences to take specific actions in support of an issue. This may include supporting laws, policies, financing or planning for nutrition at a large scale. Advocacy to improve the enabling environment is necessary because structural barriers may remain, even when caregivers and families are reached with messaging. For example, in the absence of policies to regulate the marketing of breastmilk substitutes, caregivers may be misled by inaccurate industry messaging about these products. To build support among decision-makers and influence change, an evidence-based advocacy process is needed, as outlined in Figure 9. A summary of steps to develop successful advocacy campaigns are listed in Box 14.

Figure 9. Evidence-based advocacy process



ADVOCACY

BOX 13

Process to develop a successful advocacy campaign:⁶⁰

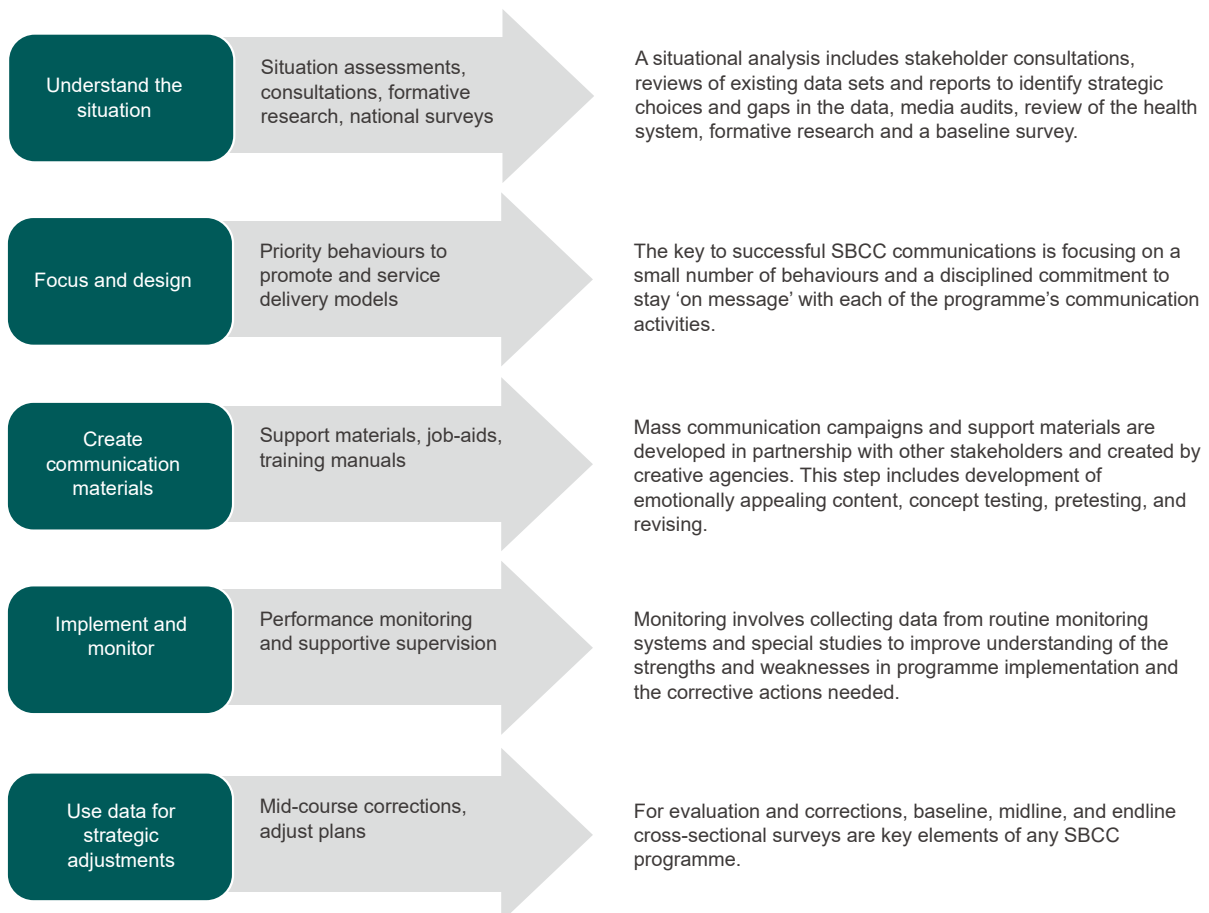
1. Define the advocacy goals
2. Plan for the advocacy strategy
3. Establish and sustain partnerships
4. Develop the evidence base
5. Create compelling messages and materials
6. Build consensus

4.2 Interpersonal communication and community mobilization

Interpersonal communication (IPC) involves face-to-face conversations and activities between frontline workers and mothers or family members. Workers personalize messages, demonstrate skills and provide encouragement during home visits, support group meetings and sessions at health centres. The personal connections built through IPC allow frontline workers to introduce recommended feeding practices, bolster confidence, and guide families to change the home environment to support these practices. Community mobilization takes place in tandem, and includes one-on-one or group meetings to elicit support for the recommended IYCF practices and for the interventions carried out by frontline workers. It aims to orient community leaders and obtain their commitment to supporting mothers, families and frontline workers. Community mobilization activities reinforce IPC with caregivers and shift social norms, lending credibility to the messages given by frontline workers and volunteers. IPC and community mobilization components can build on existing services and support mechanisms in the public and private sectors. As one expert said: “People talking to people is still how the world’s standards change.”

The required steps to effectively plan and implement the IPC component of SBC are summarized in [Figure 10](#).

Figure 10. The steps to effective planning of IPC for SBC



4.3 Mass media

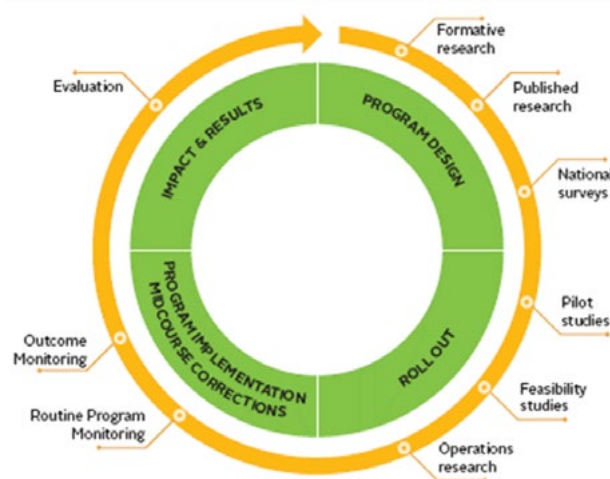
Mass communication refers to how audiences can be reached through creative media. It is the most efficient form of communication at large scale and essential to reach audiences at the national level. Mass communication campaigns (broadcast and online) reinforce the importance of key practices with caregivers and family members and work in synergy with the other programme components to maximize use of resources and achieve impact. The approach to utilizing mass media is similar to the steps outlined in Figure 10. Studies and experience in the region show that the benefit of mass media is maximized when combined with effective IPC. These also show that the intensity and scale are important to reach as many as possible, and that focused and clear messages are recalled better. Another important lesson learned is mass media is a “good buy” despite the finances required to fully utilize it for behavior change at-scale.

4.4 Strategic use of data

Data-informed decisions result in better programmes, including for SBC. Research is conducted to guide programme design, focusing on interventions proven to be effective at reducing all forms of malnutrition. Baseline data collection helps set realistic targets that are specific and relevant to the geographic areas targeted by the programme.

Data helps to develop and sustain partnerships, shape advocacy priorities and inform programme decision-making. Formative research studies, landscape analyses, media scans, surveys and stakeholder mappings can help design programmes tailored to the country context. Special studies and routinely collected data guide revisions in programme design and implementation. Internal monitoring units and external evaluation teams collect and cross-check core indicators and track programme reach. Monitoring systems help determine if the programme is on track or if corrective actions should be taken. Figure 11 presents the key steps in using data strategically to inform the SBC programme cycle.

Figure 11. Strategic use of data to inform the programme cycle



4.5 Partnerships and alliances in the health system and other sectors

IYCF challenges are unique in that nutrition is impacted by larger structural systems of policies and service delivery, the food environment, marketing and advertising of global commercial products, and societal and cultural norms, among other areas. Thus, to adequately address the critical barriers to and enablers of SBC, alliances must be built with sectors, partners and stakeholders outside of the health system. This is in addition to the important coordination and service delivery improvements within the local health system that remain critical to behaviour change and should not be overlooked. Partnerships with different sectors and actors, while identifying and avoiding conflicts of interest, are critical to successful and sustainable SBC programmes.





5

STRENGTHENING
health service delivery
for IYCF

5 Strengthening health service delivery for IYCF

- ▶ This section covers the health system strengthening inputs and actions required to support delivery of the interventions outlined in Section 3.

Quality delivery of IYCF interventions relies on a strong health system; in addition to the **core package of interventions** (Section 3) and a **strong enabling environment** (Section 2), governments at the national and regional levels need to invest in building the system's capacity to deliver the IYCF package. Health system strengthening actions improve the provision, utilization, quality and efficiency of services. This section elaborates and provides more programmatic guidance on elements outlined in Section 2.

Strong systems for IYCF requires investment and focus on:

- Human resources, capacity building and quality training
- Strengthened supply chains
- National guidelines and protocols to define service delivery processes
- Adequate monitoring and evaluation and data collection (covered in Section 7)

5.1 Human resources for health, nutrition and capacity building

To support quality IYCF service delivery, and ensure caregivers and children receive adequate information and care, health systems need a workforce that is adequate in size, well-trained and supported. Inadequate human resources, insufficient resources and lack of supportive supervision and mentoring, lack of clarity in job descriptions and outdated curricula are some of the main barriers to quality service provision. Capacity is a critical limiting factor to scale-up and sustainability of IYCF interventions.⁶¹ Building capacity requires more than just training; it involves investment in quality curricula, allocation of resources to support skills-building, adequate staff, regular review processes for trainings and programmes, and support for nutrition staff to develop skills for multidisciplinary work. To avoid conflict of interest and ensure that training is objective, evidence-based and free from commercial influence, resources for training health workers should not be accepted from companies that manufacture breastmilk substitutes or foods for infants and young children – or from their foundations or trade associations. Guidance and recommendations for strengthening the nutrition and IYCF workforce is provided in **Box 14**.

A competency-based approach for all types of nutrition training is recommended. Competency-based approaches specify the health problems to be addressed, identify the requisite competencies required of graduates for health system performance, tailor the curriculum to achieve competencies, and assess achievements and shortfalls.⁶²

STRENGTHENING CAPACITY

BOX 14

Guidance and recommendations for strengthening the nutrition and IYCF workforce

1. Train more physicians, nurses, midwives and nutritionists at the undergraduate and graduate level to implement relevant IYCF and nutrition interventions.
2. Develop a national capacity development framework for the nutrition workforce (for both the national and subnational levels) with adequate funding from governments and other relevant actors including NGOs, but not the baby food industry (see Box 16).
3. Integrate new and additional public health nutrition competencies into the curriculum of medical and nursing studies, as well as in other allied health programmes.
4. Utilize hybrid training programmes (which combine distance training and periodic in-person sessions with tutors and peers) for pre-service and in-service training, and for continuous education.
5. Develop competency standards for nutrition job descriptions, curricula and accreditation schemes, and harmonize them at the regional level, guided by international standards.
6. Distribute health workers equitably distributed across geographical areas, ensuring staff are available in remote and rural areas.⁶³

5.1.1 Health worker training

Workforce preparation (training) and continuing professional development (training, mentoring and supervision) are the central elements for establishing strong IYCF capacity for health workers delivering nutrition interventions.

At a minimum, IYCF should be included in the basic curriculum of medical and paramedical professionals. All frontline health and nutrition workers (physicians, nurses, midwives, nutritionists, community health and nutrition workers and community cadres) should be trained in IYCF either as part of pre- or in-service preparation. Training on IYCF – whether stand-alone or integrated – shall be structured according to the needs of the cadre. A comprehensive list of areas to be included for nurse training is included in the Appendix. Training packages are available to guide these efforts (see page 94). Minimum standards for robust in-service and pre-service IYCF training are summarized in **Box 15**.

HEALTH WORKER TRAINING

BOX 15

Minimum standards for robust in-service and pre-service training on IYCF

1. Competency-based and focused on skills-building for counselling
2. Include regular review and updates to curricula with best practices
3. Include content on the multi-systems nature of nutrition, and how IYCF can be influenced by the actions of other sectors
4. Supported by operational plans and guidance for roll-out and delivery of training
5. Uses appropriate modalities for context – face-to-face, online, module-based, small group
6. Allows for regular follow-up and opportunities for support and supervision

Supportive supervision, mentoring, coaching and on-the-job training

The supervision of health staff delivering IYCF interventions requires oversight from someone who is well-trained, competent in providing nutrition and IYCF services, and capable of providing this support. IYCF-specific supportive supervision and mentoring should be delivered in conjunction with other supervision and management processes. Barriers to this type of regular supervision are manager workload, insufficient time, irregular review processes/meetings and competing priorities of health staff. Further, mentoring and supervision may be absent from job descriptions and workplans for both managers and supervisees, meaning that staff often fail to make time for this activity.

Improving supportive supervision and building the capacity of frontline workers can be achieved by:

- Establishing a time, place and format for regular supportive supervision in group or individual settings
- Including supportive supervision responsibilities for IYCF (and other topics) in job descriptions for managers and supervisees
- Building management/supervision and mentoring skills for managers to ensure that supportive supervision is about identifying challenges and improving skills rather than criticism and negative feedback
- Developing tools to facilitate supportive supervision that feedback forms and planning tools.

HEALTH WORKER TRAINING

BOX 16

Role of civil society, local and international NGOs and United Nations agencies in supporting health worker capacity building

Civil society organizations, local and international NGOs and United Nations agencies are important partners who can provide support to governments for capacity building initiatives. These partners can conduct, manage and/or finance large-scale training efforts. They can also assist in follow-up training initiatives, and review and development of curriculum and materials in accordance with global standards and regional evidence.

5.1.2 Strengthen supply chains for nutrition

The availability of supplies for health facilities and communities requires strong public sector forecasting, procurement and distribution systems. Strong supply chains are an essential part of a high-functioning health system and critical for delivering nutrition commodities. For effective delivery of IYCF interventions, particularly those involving micronutrient supplements, health facilities and health workers must have access to quality products in adequate quantities, in a timely manner.

Common barriers to adequate supply of IYCF products and materials:

- Insufficient resources
- Inadequate forecasting and quantification systems
- Inadequate quality control
- Lack of timely supply and procurement processes

Supply chain management and strengthening supply systems are complex topics that are not the sole responsibility of nutrition teams; as such many actions fall outside the scope of this guidance. Minimum standards to support the supply of quality IYCF products are summarized in **Box 17**. Relevant resources with in-depth detail on strengthening supply chains are included on page 94.

BOX 17

Minimum standards to support supply of quality IYCF products include:

1. Inclusion of essential IYCF commodities (vitamin A, zinc, oral rehydration salts, MNPs, iron supplements) and supplies (anthropometric tools, MUAC tapes) in essential medicines lists
2. Development and use of operational guidance on forecasting and quantification by relevant facility staff members
3. Data-driven approach to forecasting, which can also inform budgeting and resource allocation
4. Clear guidance and allocation of responsibilities for quantification
5. Training and support for improved procurement and quantification processes for all nutrition commodities
6. Advocacy to relevant authorities on the importance of specific commodities, linked with discussions and actions on public financing

5.1.3 National guidelines, standards and protocols

Standardized protocols and guidelines for implementing interventions, along with training and data collection, can facilitate quality service delivery and ensure programme consistency across countries. Operational guidance and standards can be developed for specific interventions (e.g., delivery of vitamin A supplementation) and management tools and practices (e.g., supportive supervision and mentoring). Operational guidance should complement the technical knowledge and training provided to health staff and be supported by tools and checklists for implementation. Adaptation of international and global guidelines to local contexts, while maintaining fidelity and adherence to evidence-based practices, will support a strong health system and contribute to other capacity building efforts. Examples of relevant operational guidance are provided in the Appendix.



6

IYCF INTERVENTIONS delivered outside the health system

6 IYCF interventions delivered outside the health system

- ▶ This section provides information on actions outside the health system that can contribute to improved IYCF outcomes.

This guidance specifically focuses on health systems interventions for IYCF, but improvements in IYCF should also be supported through other systems. Specifically, the **food, water and sanitation** and **social protection** systems all have important contributions to make in improving IYCF outcomes and child nutrition status. Key actions for each system, and how they can contribute, are described below.

6.1 Food systems

The food system encompasses all elements and activities related to the production, processing, storage, distribution, marketing, preparation and consumption of food. The food system is comprised of the food supply chain; the food environment; and the behaviours of caregivers around the foods they purchase and feed their children. Key approaches and actions needed to strengthen IYCF programmes through the food system are summarized in **Box 18**.

FOOD SYSTEMS

BOX 18

Key approaches and actions to strengthen IYCF programmes through the food system

1. Ensure national policies and strategies are in place for the diversification of food production.
2. Support policies on the production, storage, fortification and biofortification of local and commercial foods.
3. Incentivize the production of nutritious, affordable, fortified complementary foods
4. Strengthen enforcement of marketing restrictions and protective legislation, such as front-of-pack labelling and taxes for unhealthy foods and beverages.

Promote improved availability and accessibility of diverse and nutritious complementary foods at household level

1. Promoting the production of locally available, nutrient-dense foods, including animal-source foods such as fish and eggs.
2. Integrating health and agriculture SBC and training, including engaging and empowering women.
3. Providing inputs to farmers and extension services to agricultural/farming households.
4. Leveraging homestead food and small livestock/aquaculture production to increase household access to nutrient-dense foods.

6.1.1 Support the improved availability of nutritious, affordable, fortified complementary foods

Fortified foods can improve the quality of complementary feeding and children's nutritional status in settings where nutrient-poor diets are common and access to diverse foods is limited.⁶⁴ Promoting access to fortified complementary foods with or without nutrition counselling can improve children's linear growth in food-insecure settings.⁶⁵

Interventions to improve access to fortified complementary foods shall be aligned with international and national regulations, including the Code and relevant WHA resolutions, and the 2016 Guidance on Ending the Inappropriate Promotion of Foods for Infants and Children (see Section 2.2.2).

6.2 Social protection systems

The social protection system refers to a set of policies and programmes aimed at protecting all people against poverty, vulnerability and social exclusion throughout the life course, with emphasis on vulnerable groups. Nutrition-sensitive social protection services, coupled with nutrition counselling and education, can improve household food security, dietary diversity and caregiver empowerment. Social protection in the form of cash or food increases household capacity to buy nutritious foods for the whole family, including the child. Complementary behaviour change activities improve caregiver knowledge on IYCF practices and have been shown to motivate caregivers to adopt the recommended practices and increase their use of services through soft or hard conditionalities.^{66,67,68}

In emergency contexts, and as demonstrated by the COVID-19 pandemic, social protection programmes allow governments to quickly respond to the urgent needs of households. During the pandemic, many ASEAN countries expanded existing social protection programmes and introduced new protections to extend benefits to families and households in need. Where programmes already target nutritionally vulnerable groups (e.g., pregnant and breastfeeding women, children under 2, households in extreme poverty, children and caregivers with disabilities) additional benefits and focus to support child diets can improve nutrition and mitigate income losses and food insecurity.

Social protection programmes targeting the nutritionally vulnerable can have an impact on improving nutrition and IYCF outcomes in young children, especially when supported by SBC initiatives (see Section 4). Key approaches and actions to address IYCF through social protection programmes are summarized in **Box 19**.

SOCIAL PROTECTION SYSTEMS

BOX 19

Key approaches and actions to address IYCF through social protection programmes include:

1. Strengthening social protection programmes to target nutritionally vulnerable populations (pregnant and breastfeeding women and children under 2) and increase access to affordable healthy foods.
2. Using social protection platforms to deliver key nutrition messages.
3. Including caregiver participation in SBC interventions on IYCF and diets as a non-mandatory component of social protection.
4. Where in-kind transfers are used, ensuring the food basket is nutrient-dense, including by using fortified complementary foods and nutritionally appropriate foods for children under 2.
5. Integrating maternity and parental leave policies (see Section 2.2.2 iii).
6. Integrating and including essential nutrition services in social health insurance and/or universal health care programmes.

6.3 Water and sanitation system

The water and sanitation system is comprised of the policies, programmes, services and actors that ensure a population's access to and use of safe drinking water and sanitation. This system is critical to protecting the diets of infants and young children, as unsafe drinking water and poor sanitation and hygiene can expose children to pathogens that cause diarrhoea and other infections, resulting in environmental enteropathy and leading to impaired structure and function of the small intestine. Improved access to basic water and sanitation services can reduce the risk of diarrhoea, helminth infections, environmental enteric dysfunction (enteropathy), and anaemia. The key approaches and actions to promote IYCF through the water and sanitation system are summarized in **Box 20**.

WASH SYSTEM

BOX 20

Key approaches and actions to promote IYCF through the water and sanitation system include:

1. Develop and implement integrated WASH and nutrition policies and programmes.
2. Support SBCC for WASH and nutrition through both sectors.
3. Prioritize baby WASH initiatives. ^{††††}
4. Ensure access to safe drinking water and improved sanitation.

^{††††} Baby-WASH is integration of WASH with maternal, newborn and child health (MNCH), nutrition, and early childhood development (ECD) programmes. Specific information on Baby WASH interventions is included in the Appendix.



7

IYCF IN
EMERGENCIES

7 IYCF in emergencies

- ▶ This section covers specific guidance and information regarding IYCF in emergencies, including a specific set of actions used to protect breastfeeding and complementary feeding during humanitarian crises.

Irrespective of the cause, humanitarian emergencies (such as natural disasters, those caused by war and pandemics) are often characterized by reduced access to nutrient-rich foods, a reduction in appropriate breastfeeding practices and an increase in poor living conditions, including reduced access to safe water and sanitation facilities. These conditions can lead to a rapid deterioration in children's nutritional status: they can increase the burden of wasting and contribute to micronutrient deficiencies and stunting in children.

During emergencies, the primary focus of nutrition-specific interventions is to prevent mortality through ensuring adequate food consumption, management of wasting and the treatment of specific nutrient deficiencies.⁶⁹ The protection, promotion and support of breastfeeding and appropriate complementary feeding, in accordance with international guidance, are also essential for appropriate emergency response. The potential to save lives through breastfeeding and appropriate complementary feeding in emergency contexts is likely even higher than under non-emergency conditions. IYCF counselling should therefore be an integral part of emergency preparedness plans, and both the initial and sustained response.⁷⁰

National IYCF strategies need to specifically address IYCF programming in emergencies because:

- Breastfeeding is safe, free and a crucial life-saving intervention for children – who face an increased risk of death during emergencies.
- Emergency situations exacerbate risks for non-breastfed children and those who are mixed feed (i.e., fed both breastmilk and breastmilk substitutes).
- Exclusive breastfeeding and continued breastfeeding are critical in reducing the risk of diarrhoea and other illnesses, which is heightened in emergencies.
- Donations of breastmilk substitutes during emergencies undermine breastfeeding and cause illness and death.
- IYCF is central to reducing the high risk of undernutrition during emergencies.
- Safe, adequate and appropriate complementary feeding, which significantly contributes to the prevention of undernutrition and mortality in children older than 6 months of age, is often jeopardized during emergencies and needs particular attention.

IYCF in emergencies (IYCF-E) concerns the protection and support of safe and appropriate feeding for infants and young children (from birth to 24 months of age) and refers to a range of nutrition and care actions that improve child survival and growth.⁷¹ A multi-agency consortium has developed official guidance on IYCF and infant feeding in emergencies, which provides operational guidelines for managing IYCF during emergencies. See appendix section 9.7 for detail on the operational guidance.

As one of the most disaster-prone regions in the world and very vulnerable to climate change, AMS need to be prepared to activate IYCF-E in the event of an emergency. Training frontline workers using the IYCF-E guidance will ensure a smooth pivot to appropriate provision of services in the wake of an emergency. In humanitarian contexts, children are particularly vulnerable.

The following actions are essential to protect children and support their caregivers in all emergency responses:

- Prioritizing mother and caregiver access to resources such as food; access to food kitchens; water and shelter; and supporting maternal and caregiver wellbeing with psychological support.
- Providing breastfeeding women with safe spaces, counselling and practical help to start, restart or continue breastfeeding and overcome any feeding difficulties.
- Providing support for early initiation of exclusive breastfeeding for all newborn infants, including via implementation of the BFHI in maternity services.
- Providing targeted support to the mothers and caregivers of non-breastfed infants, including infant formula, clean water, formula preparation and feeding implements, education and health monitoring.
- Preventing donations and uncontrolled distributions of baby foods and milk products, including infant formula, other milks and feeding bottles.
- Enabling access to appropriate complementary foods for all children aged 6–23 months and preventing donations and uncontrolled distributions of foods high in salt, sugar or fat intended for this age group.
- Providing micronutrient supplements when fortified complementary foods are not provided, in conjunction with other interventions to improve complementary foods and feeding practices.

While the Guidance on Infant Feeding in Emergencies provides detailed operational guidelines, a summarized list of the minimum standards for IYCF in emergencies is provided in **Box 21**.

EMERGENCIES

BOX 21

Minimum standards for IYCF in emergencies (IYCF-E)

Before the emergency, ensure appropriate preparedness measures are in place:

1. Assess and update national policies, implementation plans, preparedness and contingency plans to include IYCF-E standard operating procedures. Ensure appropriate complementary foods are included in emergency food baskets and food kitchens.
2. Train staff: Develop adequate national and subnational capacity for supporting IYCF during emergencies. Examples include training a pool of national IYCF-E experts that can be drawn upon during emergencies and training of frontline health workers on IYCF-E.
3. Develop an IYCF-E capacity roster and identify available staff for emergency deployment.
4. Set up communication platforms and coordination mechanisms for IYCF during emergencies, including standard operating procedures for coordination and virtual alerts systems.
5. Establish a Code violations monitoring system for emergencies and develop communication tools to discourage donations of breastmilk substitutes (e.g., a draft press statement).
6. Integrate IYCF-E into national emergency rapid assessment tools.
7. Sensitize the national emergency leadership team (national disaster management authorities) on basic IYCF-E aligned with the operational guidance.

During an emergency, focus on immediate IYCF-E response actions:

1. Deploy trained staff (e.g., from the emergency IYCF-E roster) to the emergency areas.
2. Ensure that IYCF-E is included in the emergency rapid assessments to prioritize actions for the response.
3. Actively discourage donations of breastmilk substitutes (e.g., by issuing media statements) and monitor donations, distribution and Code violations.
4. Advocate with the national emergency leadership team for the prioritization and implementation of recommended IYCF-E essential actions.
5. Develop and share contextualized messages on IYCF-E, building on the findings of emergency rapid assessments.

During the response and recovery phase:

1. Conduct detailed IYCF-E training for new staff and sensitization for other staff if needed.
2. Monitor the impact of emergency response actions on IYCF practices.
3. Uphold ongoing communications and advocacy for IYCF-E.
4. Develop an evaluation and learning plan; document lessons learned and evidence of challenges and successes in IYCF-E response.

In addition to the specifics of IYCF-E, the COVID-19 pandemic has highlighted the importance of providing social protection measures to households and individuals, particularly vulnerable groups such as young children. Social protection in the form of cash and in-kind support can alleviate the financial burden on households, allowing additional resources for food and health related expenses.

Examples of nutrition-sensitive social protection actions appropriate during emergencies include:

1. Cash or food voucher schemes to purchase nutrient-rich food and/or fortified foods that are locally available, complemented with messaging to improve dietary diversity.
2. Distribution of nutrient-rich foods or fortified foods at household level.
3. Provision of multiple micronutrient fortified foods to nutritionally vulnerable groups of children aged 6–23 months and pregnant and breastfeeding women. Examples include fortified blended foods such as SuperCereal plus and SuperCereal (or local variations of this type of fortified porridge), and lipid-based nutrient supplements.
4. Provision of micronutrient supplements, such as MNPs. Note that MNPs should not be provided when multiple micronutrient fortified foods are used.

In addition to nutrition-specific social protection actions, SBC activities should also be adapted during emergencies. For example, counselling can be delivered through alternate modalities (phone calls, messaging platforms) and mass and social media can be used to disseminate important information when face-to-face interactions are limited to support IYCF in emergency contexts.



8

MONITORING AND EVALUATION

8 Monitoring and evaluation

- ▶ This section covers the monitoring and evaluation requirements for a robust IYCF strategy.

Monitoring and evaluation of nutrition systems, programmes and interventions is needed to assess progress against national and global targets, identify problems and opportunities, and inform how programmes and interventions can be improved to reach the intended outcomes. Accountability is a critical aspect of the overarching monitoring and evaluation system, encompassing the responsibility of stakeholders to collect appropriate data on a regular basis and ensure both the quality and transparency of data.⁷² Learning and generating evidence from programme implementation are essential to inform the design of IYCF programmes and to improve service delivery and quality.

Key considerations:

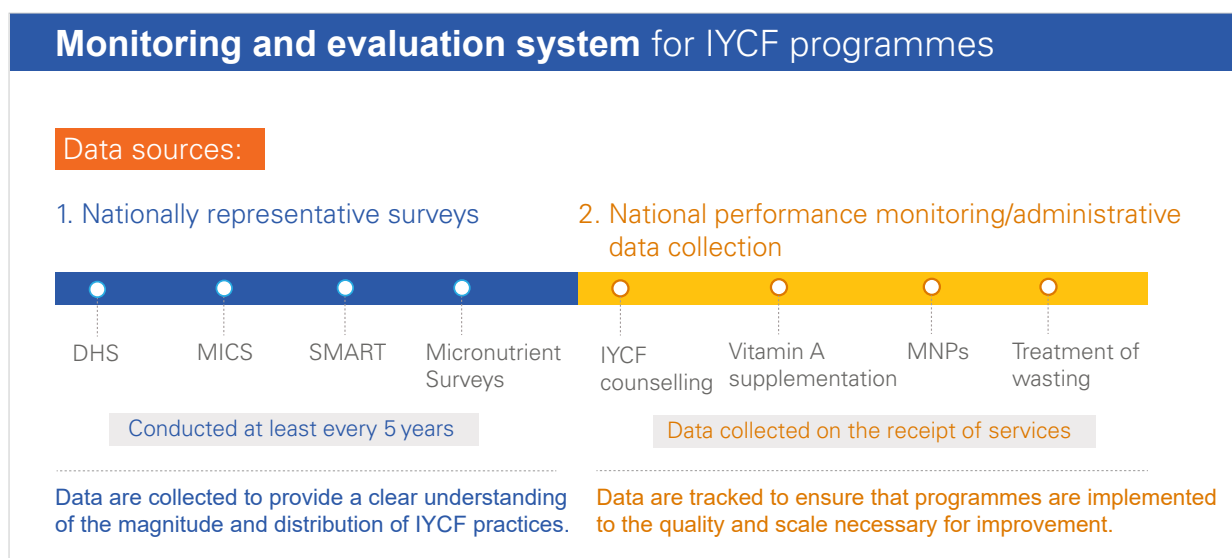
- The scope of monitoring and evaluation for IYCF programmes should reflect the determinants and drivers known to impact child diets and feeding practices, including those influenced by the health, food, social protection and water and sanitation systems.
- Regular evaluation via national surveys shall be used to assess progress against national and global targets, such as the WHA Global Nutrition Targets and the SDGs.
- Administrative data shall be used to track progress and identify problems and opportunities, while informing programmatic modification at the subnational levels.
- Timely, accurate and appropriate data from continuous monitoring at the community, subnational and national level supports adaptive programme management.

The ASEAN Nutrition Surveillance System, an approved output of the ASEAN Health Cluster 1 Work Programme 2016–2020, is the mechanism envisioned to monitor the progress of the ASEAN Strategic Framework and Action Plan on Nutrition 2018–2030. The ASEAN Nutrition Surveillance System shall include IYCF outcome indicators to reflect the progress of ASEAN Member States and provide data on underlying determinants, allowing for country analysis and presentation of trends at the regional level. These data shall be used for setting priorities, developing socially inclusive policies and prioritizing interventions for improving IYCF practices and ending of all forms of malnutrition in the region.

8.1 Data sources

A monitoring and evaluation system for IYCF programmes requires a mix of both nationally representative surveys conducted regularly every few years, and routine monitoring data collected through health and/or nutrition management information systems. [Figure 12](#) presents an overview of the sources of data for both surveys and administrative data.

Figure 12. Overview of data sources



8.1.1 Nationally representative surveys

IYCF data are collected to provide a clear understanding of the state of feeding practices and their distribution in a country. As discussed in Section 2.2.5, AMS should collect IYCF data through nationally representative surveys – such as DHS and MICS – to track progress against national and global targets and measure the impact of key determinants through the health, food, social protection and water and sanitation systems. Nationally representative survey data for IYCF and anthropometric indicators are available for the majority of AMS, with DHS, MICS or other national nutrition surveys conducted at least every five years. The minimum requirements for the collection of IYCF data through nationally representative surveys are summarized in **Box 22**.

BOX 22

SURVEYS

Minimum requirements for the collection of IYCF data through nationally representative surveys:

1. Sampling frame should be representative of all children 0–23 months of age using a household based randomized selection.
2. Sample size should ensure accurate representation at the subnational level and for identified high-risk populations.
3. Global standardized indicators should be collected using standardized questionnaires to ensure comparability across countries.

8.1.2 National performance monitoring/ administrative data collection

Collection and reporting of routine surveillance or administrative data is used to track coverage of key interventions and identify problems and opportunities to support adaptive programme management. Collecting administrative data ensures that programmes are implemented at the quality and scale necessary for improvement. The inclusion of key IYCF indicators in the health and/or nutrition management information system can help identify potential bottlenecks and facilitate performance improvement. Regular reports on the delivery of IYCF and nutrition services also provides valuable information to support

accountability and advocacy efforts. Routine monitoring of IYCF programme implementation provides timely data on successes and challenges, including whether interventions are reaching the target group in an equitable manner.⁷³

IYCF indicators collected through routine monitoring systems such as the health management information system differ from those collected in nationally representative surveys. Routine monitoring systems include data on the receipt of services, such as IYCF counselling, vitamin A supplementation, MNPs and the treatment of wasting. These systems also track progress on the determinants of IYCF practices, including percentage of health workers who received training on IYCF counselling. The minimum requirements for the collection of IYCF data through administrative systems are summarized in **Box 23**.

ADMINISTRATIVE SYSTEMS

BOX 23

Minimum requirements for collection of IYCF data through administrative systems:

1. Management Information systems should track coverage of the minimum package of IYCF interventions (outlined in Section 3).
2. Data on IYCF practices and interventions (counselling, screening) should be reviewed by subnational and national working groups to monitor progress towards goals.
3. Indicators should be standardized and aligned with those used for global and national targets, as well as those collected through nationally representative surveys.

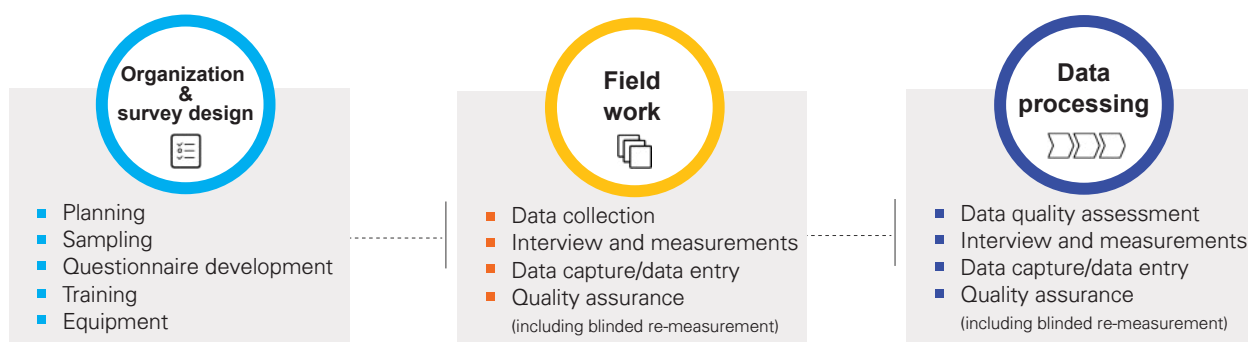
8.2 Data repository

At the national level, health management information systems (including national nutrition information systems) serve as repositories of the nationally representative IYCF survey data, as well as administrative data related to IYCF.

At the regional level, the ASEAN Nutrition Surveillance System serves as the data repository of the IYCF outcome indicators to generate data on the progress of AMS related to IYCF as well as trends in the region.

8.3 Ensuring data quality

Accurate IYCF data are critical to provide reliable information to policymakers, programme managers, researchers and advocates, especially in the nutrition field. The quality of IYCF data is also important in assessing how interventions are implemented and in guiding subsequent planning and programmatic modification. While several types of surveys and routine information systems can be used to collect data, they should all follow standard criteria for IYCF data quality and standard methods for data collection, analysis and reporting. Comparable and accurate IYCF data are essential if national governments and other stakeholders are to monitor how nutrition-specific and nutrition-sensitive programmes have been implemented and make decisions based on their progress. [Figure 13](#) provides an overview of the essential steps to ensuring high-quality data. A checklist of minimum standards for data quality is included in the Annex.

Figure 13. Improving data quality throughout the survey process

8.4 Key IYCF indicators for collection

Essential IYCF-specific and supporting indicators are identified in the WHA Global Nutrition Monitoring Framework, the UNICEF and WHO *Indicators for assessing Infant and Young Child Feeding Practices (2021)* the ASEAN Nutrition Surveillance System (ANSS). IYCF indicators are also included in the UNICEF and WHO Indicators for Assessing Infant and Young Child Feeding Practices and NutriDash^{§§§§}. Table 5 below provides an overview of all essential indicators relating to IYCF that should be collected and tracked as part of robust monitoring systems.

Table 5. Essential IYCF and nutrition status indicators

Indicator	Data source	IYCF-specific (Y/N)	Included in ANSS (Y/N)	WHA indicator
Impact indicators				
% of children under 5 who are stunted	Nationally representative surveys	N	Y	Y
% of children under 5 who are wasted	Nationally representative surveys	N	Y	Y
% of children under 5 who are overweight	Nationally representative surveys	N	Y	Y
% of children under 5 who are anaemic	Nationally representative surveys	N	N	N
% of children in previous X years who are born with a low birth weight (<2500gm)	Nationally representative surveys	N	Y	Y
Outcome indicators				
% of children born in the last two years who were put to the breast within one hour of birth	Nationally representative surveys	Y	Y	N
% of children born in the last two years who were exclusively breastfed in the first two days following birth	Nationally representative surveys	Y	N	N
% of infants 0–5 months of age who were fed exclusively with breastmilk during the previous day	Nationally representative surveys	Y	Y	Y
Proportion of mothers of children 0–23 months who received counselling, support or messages on optimal breastfeeding at least once in the previous 12 months	Administrative data	Y	N	Y

§§§§ NutriDash is a global nutrition monitoring platform, managed by UNICEF, that collects, stores, analyses and visualizes nutrition programme data from more than 120 countries.

% of infants 0–5 months of age who were fed breastmilk and formula or animal milk during the previous day	Nationally representative surveys	Y	N	N
% of children 12–23 months of age who were fed breastmilk during the previous day	Nationally representative surveys	Y	N	N
% of infants 6–8 months fed with solid, semi-solid or soft food during the previous day	Nationally representative surveys	Y	N	N
% of children 6–23 months who received foods from at least five out of eight defined food groups during the previous day	Nationally representative surveys	Y	Y	Y
% of children 6–23 months who received solid, semi-solid, or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more during the previous day	Nationally representative surveys	Y	Y	N
% of children 6–23 months who received a minimum acceptable diet during the previous day	Nationally representative surveys	Y	N	N
% of children 6–23 months who consumed egg and/or flesh foods during the previous day	Nationally representative surveys	Y	N	N
% of children 6–23 months who consumed zero fruits or vegetables in the previous day	Nationally representative surveys	Y	N	N
% of children 6–23 months who consumed sugar-sweetened beverages during the previous day	Nationally representative surveys	Y	N	N
% of children 6–23 months who consumed foods high in fat, sugar or salt in the previous day	Nationally representative surveys	Y	N	N
% of the population using safely managed drinking water services	Nationally representative surveys	N	Y	Y
% of the population using safely managed sanitation services	Nationally representative surveys	N	Y	Y
Output indicators				
% of children 6–59 months of age receiving vitamin A supplementation	Nationally representative surveys/ administrative data	Y	N	N
% of children 6–23 months of age receiving MNPs	Nationally representative surveys/ administrative data	Y	N	N
Proportion of children receiving treatment of diarrhoea with zinc and oral rehydration salts	Nationally representative surveys /administrative data	Y	N	N
Receipt of antenatal iron supplementation	Nationally representative surveys /administrative data	Y	Y	Y
Proportion of children screened for malnutrition	Administrative data	N	Y	N
Proportion of mothers with a birth in the last two years who received counselling about healthy eating and keeping physically active during pregnancy during antenatal care	Administrative data	Y	N	Y
Percentage of births that took place in facilities currently designated as baby-friendly in a calendar year	Administrative data	Y	N	Y

Percentage of health care facilities (private and public) that have been certified or re-certified as baby-friendly in the past 5 years	Administrative data	Y	N	N
Inclusion of receipt of IYCF counselling for mothers of children under 6 months in the health management information system	Administrative data	Y	Y	N
Inclusion of receipt of IYCF counselling for mothers of children 6–23 months in the health management information system	Administrative data	Y	Y	N
Other/policy indicators				
Existence of IYCF counselling and support included in pre-service curricula for medical doctors	Administrative data	Y	Y	N
Existence of IYCF counselling and support included in pre-service curricula for nurses or other health professionals	Administrative data	Y	Y	N
Number of trained nutrition professionals/100,000 population	Administrative data	N	N	Y
Legislation/regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant World Health Assembly resolutions in place	Administrative data	Y	Y	Y
Maternity protection laws or regulations in place	Administrative data	Y	Y	Y

Most indicators recommended by the UNICEF and WHO Indicators for Assessing Infant and Young Child Feeding Practices have not yet been integrated into national monitoring and evaluation frameworks. The global standardized IYCF indicators were developed in 2008 through an interagency technical consultation. In 2018, a second technical consultation was held by UNICEF and WHO to re-evaluate the standardized IYCF indicators and propose additional breastfeeding and complementary feeding indicators. Following the consultation, 16 specific IYCF indicators were recommended for inclusion in all nationally representative surveys (Table 6). Details on numerators and denominators for the indicators are included in the Appendix.

Table 6. 16 IYCF indicators recommended for inclusion in all nationally representative surveys

Indicator	Definition
1 Ever breastfeeding	Proportion of children born in the last two years who were ever put to the breast
2 Early initiation of breastfeeding	Proportion of children born in the last two years who were put to the breast within one hour of birth
3 Exclusive breastfeeding in the first two days after birth*	Percentage of children born in the last two years who were exclusively breastfed in the first two days following birth
4 Exclusive breastfeeding	Percentage of children 0-5 months who are fed exclusively with breastmilk
5 Continued breastfeeding to 1 and 2 years of age*	Percentage of children aged 12–23 months who were fed with breastmilk during the previous day
6 Mixed breastmilk and non-breastmilk feeding under 6 months of age*	Percentage of infants 0–5 months of age who were fed breastmilk and formula or animal milk during the previous day
7 Bottle feeding	Proportion of children 0–23 months of age who were fed with a bottle in the previous day
8 Introduction of solid, semi-solid, soft foods	Percentage of infants aged 6–8 months who were fed solid, semi-solid or soft food during the previous day
9 Minimum dietary diversity*	Percentage of children aged 6–23 months who received foods from at least five out of eight* defined food groups during the previous day
10 Minimum meal frequency*	Percentage of children aged 6–23 months who received solid, semi-solid, or soft foods (including milk feeds for non-breastfed children) the minimum number of times or more during the previous day
11 Minimum milk feeding frequency for non-breastfed children*	Proportion of children aged 6–23 months who received at least two milk feeds during the previous day
12 Minimum acceptable diet*	Percentage of children aged 6–23 months who received a minimum acceptable diet during the previous day
13 Animal-source food consumption *	Percentage of children aged 6–23 months who consumed egg and/or flesh foods during the previous day
14 Sugar-sweetened beverage consumption *	Children aged 6–23 months who consumed a sugar-sweetened beverage during the previous day
15 Unhealthy food consumption *	Percentage of children aged 6–23 months who consumed selected categories of unhealthy food during the previous day
16 Zero vegetable or fruit consumption*	Percentage of children aged 6–23 months who did not consume any vegetables or fruits during the previous day

* Indicates updated in 2020.

The capacity of AMS to generate data on these key IYCF indicators shall be built in cooperation with development partners and other institutions.

8.5 Monitoring and evaluating SBC interventions

In addition to regular data collection within national and other monitoring and evaluation systems, it is important to track behavioural outcomes and process indicators to ensure the activities are achieving their desired impact. SBC monitoring aims to identify gaps in the implementation of activities and the processes anticipated for the expected behavioural or social change so that early action can be taken to adjust operational activities and approaches.

Regular feedback also encourages partnership and ownership. One opportunity to ensure impact is to build in feedback loops with communities to ensure activities are meaningful and feasible. Feedback loops can help to quickly uncover issues and provide community members with a voice in their own change process. Monitoring data should then be used to make mid-course corrections. Data and feedback can be quickly analysed together and used to improve and adjust activities as necessary. This includes ensuring that communications are understood and relevant to the audience and that behaviours are indeed changing. Data can also help to uncover challenges or areas for enhanced focus for subsequent activities or campaigns.

Iterating and adjusting are key steps to any successful SBC programme or activity. Plans will seldom be perfect right away and re-planning should be an anticipated and expected part of programme design. Once necessary adjustments are identified, the next step would be to go through the necessary steps to understand, design, create, implement and monitor as necessary. The minimum standards for SBC monitoring are summarized in **Box 24**.

SBC INTERVENTIONS

BOX 24

Minimum standards for SBC monitoring

1. **Input indicators:** Number of SBC materials developed, distributed. Number of SBC channels used. These indicators could be collected through a routine monitoring system.
2. **Outcomes:** Number of target audience members who received messages (from interpersonal communication, mass media, or other channels). Proportion of target audience who received messages. Reach of target messages to key audiences. These indicators could be collected through a routine monitoring system or from media reports.
3. Changes in **process indicators**, such as strengthened systems, capacity of frontline workers, family and community support, coverage, intensity, and quality of support. These indicators could be collected through a routine monitoring system.
4. Changes in specifically-identified **determinants** of priority behaviours (e.g., knowledge, belief in benefits, self-efficacy, and perception of social norms and community/family approval). These indicators could be collected through a survey.
5. Changes in **priority behaviours**, including relevant sub-behaviours toward recommended breastfeeding and complementary feeding practices (see the list of indicators in Table 6). These indicators could be collected through a survey such as MICS or DHS.
6. Changes in community-held **social norms** and in the actions that influencers are taking to support changes in behaviours. These indicators could be collected through a survey.

9

A P P E N D I X

9 Appendix

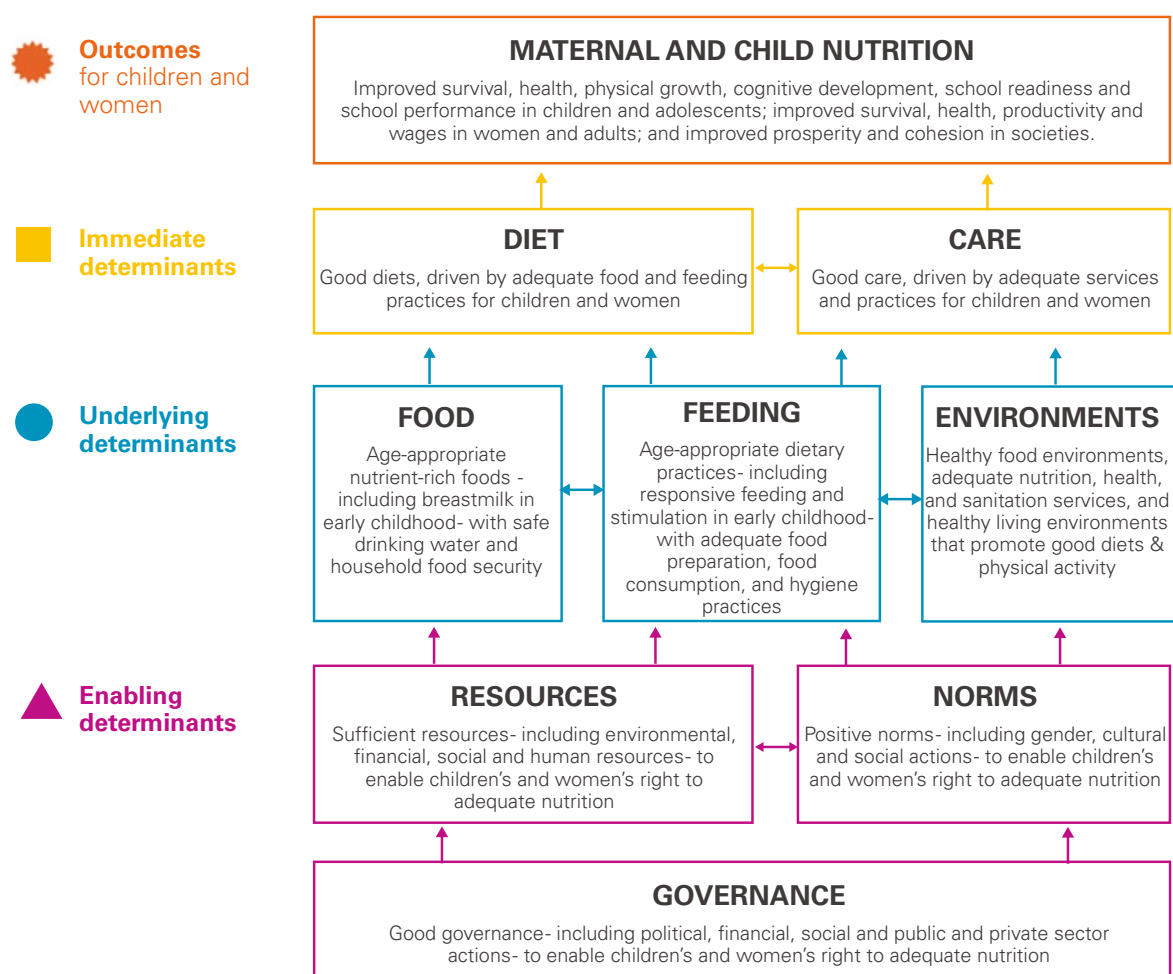
9.1 Resources, tools and useful links from Section 1: Introduction

- ASEAN Declaration on Ending All Forms of Malnutrition – https://asean.org/wp-content/uploads/2017/11/2.-ADOPTION_2017_ALD-on-Ending-All-Forms-of-Malnutrition_Endorsed-by-the-AHMM.pdf

9.2 Resources, tools and useful links from Section 2: Enabling environment for IYCF

- UNICEF Conceptual Framework on the Determinants of Maternal and Child Nutrition (updated 2020). The framework presented in [Figure 3](#) was adapted for specific use in ASEAN, and predates the updated UNICEF Framework.

Figure 14. UNICEF Conceptual Framework on the Determinants of Maternal and Child Nutrition, 2020



Summary of minimum standards and guidance for enabling environment

Checklist for enabling environment	
Enabling environment – component	Minimum standards
Leadership and governance	<ul style="list-style-type: none"> • Existence of multi-sectoral mechanisms to address nutrition • Existence and adoption of a national nutrition policy, plan and/or strategy • Identified IYCF champions and leaders to build government commitment and public support from all levels of government and civil society
Policy and legislative framework	<ul style="list-style-type: none"> • Existence of a national nutrition plan or strategy that addresses IYCF in a comprehensive way <ul style="list-style-type: none"> o That includes IYCF – with a focus on breastfeeding and complementary feeding as a development priority o That includes IYCF indicators as a measurement of success • Existence of a national nutrition policy that addresses IYCF in a comprehensive way <ul style="list-style-type: none"> o Includes support for IYCF counselling (not just breastfeeding), training for health workers on IYCF, strategies that include SBC for IYCF • Adoption of the Code into national legislation with enforcement mechanisms in place • Existence of national food-based dietary guidelines for children • Existence of national nutrient profile models for processed complementary foods • Development of maternity and breastfeeding workplace support protections policies for women working private, public and informal sectors
Financing and resources for IYCF****	<ul style="list-style-type: none"> • Nutrition budget analyses conducted • Specific budget allocation for IYCF and IYCF-related policies • Costed plans/strategies developed that identify the actual costs of scaling up interventions • Adequate resource allocation for IYCF staff and programming needs • Tracking of nutrition expenditure and allocation
Human resource capacity	<ul style="list-style-type: none"> • IYCF and the Code included in pre- and in-service training for facility- and community-based health and nutrition staff • Facility and community-based staff are adequately supported, managed and mentored to deliver IYCF and other nutrition programmes • Quality training and refresher training available for frontline workers • Quality materials available and regular curriculum updates made to training materials • Up-to date and appropriate training modalities are utilized • Government has capacity and systems to provide routine supportive supervision to facility and community-based health and nutrition staff • Government has capacity and systems to enforce and monitor policies and laws relating to manufacturing and advertising of breastmilk substitutes and complementary foods for children under 2

**** No minimum standards established for nutrition financing

Section 2.2.1 Policies and legislation

- Scaling Up Nutrition Network – Checklist on the criteria and characteristics of ‘good’ national nutrition plans <https://scalingupnutrition.org/wp-content/uploads/2016/12/Scaling-Up-Nutrition-Quality-national-plan-checklist.pdf>
- Model Law document – **provided as separate attachment**
- Family-friendly Workplaces Policies <https://www.unicef.org/sites/default/files/2019-07/UNICEF-policy-brief-family-friendly-policies-2019.pdf>
- Food-based dietary guidelines, FAO <http://www.fao.org/nutrition/education/food-dietary-guidelines/en/>
- WHO and FAO 1996 **Preparation and use of Food-based Dietary Guidelines** https://apps.who.int/iris/bitstream/handle/10665/42051/WHO_TRS_880.pdf?sequence=1
- WHO Regional Office for Europe (2019). Ending inappropriate promotion of commercially available complementary foods for infants and young children between 6 and 36 months in Europe. Copenhagen: WHO Regional Office for Europe http://www.euro.who.int/_data/assets/pdf_file/0004/406453/Ending_Final_3June2019.pdf
- WHO Regional office for Europe (2019). Improving the Nutritional Quality of commercial foods for infants and young children. Copenhagen: WHO Regional Office for Europe <https://www.euro.who.int/en/health-topics/disease-prevention/nutrition/publications/2019/improving-the-nutritional-quality-of-commercial-foods-for-infants-and-young-children-in-the-who-european-region-2019>
- European Food Safety Authority Panel on Dietetic Products, Nutrition and Allergies (2010) Scientific opinion on establishing Food-Based Dietary Guidelines <https://efsa.onlinelibrary.wiley.com/doi/pdf/10.2903/j.efsa.2010.1460>. European Food Safety Authority Journal; 8(3):1460.

Table 7. 2013 Codex Guidelines on Formulated Complementary Foods for Older Infants and Young Children ^{††††}

Vitamins and minerals	Reference nutrient intake or individual nutrient levels ⁹⁸ (INL ₉₈) ¹⁷
Vitamin A µg retinol equivalent	400
Vitamin D ¹⁸ µg	5
Vitamin E mg (α-Tocopherol)	5
Vitamin C mg	30
Thiamine mg	0.5
Riboflavin mg	0.5
Niacin mg NE	6
Vitamin B ₆ mg	0.5
Folate µg DFE	150
Vitamin B ₁₂ µg	0.9
Biotin µg	8
Pantothenic acid mg	2
Vitamin K µg	15
Calcium mg	500
Iron mg ¹⁹	11.6, 5.8, 3.9
Zinc mg ²⁰	8.3, 4.1, 2.4
Iodine µg	90
Copper mg ²¹	0.34
Selenium µg	17

†††† The reference INL₉₈ values listed in the table provide a guide for selection and amounts of vitamins and minerals to be added to a formulated complementary food. The suggested total quantity of each of these vitamins and/or minerals contained in a daily ration of the formulated complementary food is at least 50 per cent of INL₉₈.

Magnesium mg	60
Manganese mg ²¹	1.2
Phosphorus mg ²¹	460

17 Reference nutrient intake or INL98 from FAO/WHO Vitamins and Mineral requirements in Human Nutrition. 2nd Edition. FAO/WHO 2004 (for all nutrients except copper, manganese and phosphorus)

18 Vitamin D should be added if there is inadequate exposure to sunlight

19 Iron values are given for 5%, 10% and 15% dietary iron bioavailability

20 Zinc values are given for low, medium and high dietary zinc bioavailability

21 Values are dietary reference intakes. Institute of Medicine, 1997/2001 (Source for copper, manganese and phosphorus).

Section 2.2.3 Nutrition financing

- Fracassi P, Picanyol C, Knechtel W, D’Alimonte M, Gary A, Pomeroy-Stevens A, Watts R “Budget Analysis for Nutrition: guidance note for countries (update 2020)”
<https://scalingupnutrition.org/wp-content/uploads/2020/05/2020-Guidance-for-Budget-Analysis.pdf>
- World Breastfeeding Costing Initiative
<https://www.worldbreastfeedingtrends.org/resources/wbci-tool>
- An Investment Framework for Nutrition
<https://www.worldbank.org/en/topic/nutrition/publication/an-investment-framework-for-nutrition-reaching-the-global-targets-for-stunting-anemia-breastfeeding-wasting>
- The United Nations One Health Costing Tool
<https://www.who.int/choice/onehealthtool/en/>

Section 2.2.5 Data for decision-making

- Sight and Life Magazine – Data in Nutrition
https://issuu.com/sight_and_life/docs/sightandlifemagazine_2019_data_in_nutrition_full

9.3 Resources, tools and useful links from Section 3: Minimum standards for IYCF interventions

- **UNICEF Programming Guidance: Improving Young Children’s Diets During the Complementary Feeding Period**, UNICEF (2020)
<https://www.unicef.org/media/93981/file/Complementary-Feeding-Guidance-2020.pdf>
- Global strategy for infant and young child feeding. WHO/UNICEF (2003) – Global Strategy for IYCF
<https://www.who.int/nutrition/publications/infantfeeding/9241562218/en/>
- Guiding principles for complementary feeding of the breastfed child. Pan American Health Organization (2003)
https://www.who.int/nutrition/publications/guiding_principles_compfeeding_breastfed.pdf
- Guiding principles for feeding non-breastfed children 6–24 months of age. WHO (2005)
https://www.who.int/maternal_child_adolescent/documents/9241593431/en/
- Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV. WHO and UNICEF (2016)
<https://apps.who.int/iris/bitstream/handle/10665/246260/9789241549707-eng.pdf?sequence=1>

Recommended feeding practices for children aged 0–23 months

What are the key recommended feeding practices from 0–6 months?

- **Early initiation of breastfeeding:** Early and uninterrupted skin-to-skin contact between mothers and infants should be facilitated and encouraged as soon as possible after birth. Mothers should be supported to initiate breastfeeding as soon as possible after birth, within the first hour after delivery.
- **Exclusive breastfeeding:** Exclusive breastfeeding means that the infant receives only breastmilk from birth for the first 6 months of life. No other liquids or solids are given – not even water – with the exception of doctor prescribed oral rehydration solution, or drops/syrups of vitamins, minerals or medicines.

What are the key recommended feeding practices from 6–23 months?⁷⁴

- **Diverse foods:** A diverse diet should include meals comprised of foods from a minimum of five out of the eight food groups every day: breastmilk; grains, roots and tubers; legumes, nuts and seeds; dairy (milk, yoghurt, cheese); flesh foods; eggs; vitamin A-rich fruits and vegetables; and other fruits and vegetables.
- **Nutrient-dense foods, including animal-source foods, vegetables and fruits:** Young children have a limited stomach capacity and must therefore eat small, nutrient-dense meals to maximize the nutrition in each bite. Nutrient-dense local foods include meat, eggs and other animal-source foods and legumes, such as groundnuts. Daily consumption of fruits and vegetables helps ensure an adequate intake of many essential nutrients, as well as fibre and antioxidants. Caution should be taken to ensure that nutrient-dense and energy-dense foods are not fed in excessive portions, which can lead to overweight.
- **Avoidance of unhealthy foods and beverages:** This includes foods and beverages with low nutrient value and high content of saturated and trans fats, free sugars or salt, including 'junk foods' and sugar-sweetened beverages, as well as the addition of sugars to home-prepared foods and beverages.
- **Fortified complementary foods and micronutrient powders:** While nutrient-rich, home-prepared and locally available foods are always preferable, commercial fortified foods for infants and young children can also be an important source of micronutrients. MNPs are an evidence-based solution to fill micronutrient gaps in settings plagued by food insecurity or humanitarian situations, and where vegetarian diets prevail.
- **Continued breastfeeding until 2 years of age or longer:** Children should continue to receive the benefits of breastfeeding until 2 years of age or longer as breastfeeding contains essential fats, proteins and other nutrients that are important in all settings.

When?

- **Timely introduction of first foods:** At 6 months of age, children should be introduced to their first soft, semi-solid or solid foods alongside continued breastfeeding.

How?

- **Age-appropriate meal frequency:** Caregivers should increase the number of meals that children are fed throughout the day as they get older. WHO has defined the appropriate number of feedings per day according to the age of the child.
-

-
- **Age-appropriate amounts:** At 6 months, the child should be introduced to small amounts of food and the quantity should gradually increase with each meal as the child gets older, while maintaining the appropriate meal frequency. WHO has developed recommendations on age-appropriate amounts per meal for breastfed and non-breastfed children.
 - **Age-appropriate food consistency:** The consistency of food should gradually evolve with age from soft to semi-solid to solid, according to the child's requirements and abilities.
 - **Safe preparation, storage and use:** Complementary foods should be hygienically prepared, stored and fed with clean hands, dishes and utensils. Use of feeding bottles should be avoided as these are difficult to keep clean.
 - **Responsive feeding and caregiving:** Responsive feeding, where a caregiver interacts positively with the child and responds to his or her hunger and satiety cues, improves children's acceptance of food and helps to ensure adequate food intake. It also helps children develop self-regulation over food intake and their transition to independent feeding.
 - **Feeding during and after illness:** Caregivers should increase children's fluid intake during illness and encourage the child to eat. After illness, caregivers should provide meals more frequently than usual and encourage the child to eat more.
-

Minimum IYCF package for ASEAN and interventions

Minimum IYCF package for ASEAN – intervention	Resources
Health system-wide	
Exclusive breastfeeding promotion and counselling	<ul style="list-style-type: none"> WHO Guideline: counselling of women to improve breastfeeding practices https://www.who.int/nutrition/publications/guidelines/counselling-women-improve-bf-practices/en/ WHO IYCF Model Chapter https://www.who.int/nutrition/publications/infantfeeding/9789241597494/en/
Complementary feeding promotion/ education and counselling	<ul style="list-style-type: none"> Alive & Thrive – Online: IYCF Training https://www.iycfhub.org/ UNICEF Programming Guidance: Improving Young Children’s Diets During the Complementary Feeding Period https://www.unicef.org/media/93981/file/Complementary-Feeding-Guidance-2020.pdf
Vitamin A supplementation	<ul style="list-style-type: none"> WHO Guideline: Vitamin A Supplementation in Infants and Children 6–59 Months of Age https://www.who.int/publications/i/item/9789241501767 Additional resources available from the Global Alliance for Vitamin A www.gava.org
Multiple micronutrient supplementation	<ul style="list-style-type: none"> WHO Guideline on Multiple Micronutrient Supplementation⁷⁵ for point-of-use fortification of foods consumed by children 6–23 months of age https://www.who.int/elena/titles/micronutrientpowder_infants/en/ https://www.who.int/publications/i/item/9789241549943
Zinc Supplementation in the management of diarrhoea	<ul style="list-style-type: none"> Oral Zinc for Treating Diarrhoea in Children https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD005436.pub5/full WHO – Zinc supplementation in the management of diarrhoea https://www.who.int/elena/titles/zinc_diarrhoea/en/
Screening for malnutrition	<ul style="list-style-type: none"> Guideline: Assessing and Managing Children at Primary Health-Care Facilities to Prevent Overweight and Obesity in the Context of the Double Burden of Malnutrition: Updates for the Integrated Management of Childhood Illness. World Health Organization. Geneva; 2017 https://www.who.int/publications/i/item/9789241550123
Hospital/tertiary facility	
Baby-friendly Hospital Initiative	<ul style="list-style-type: none"> 10 Steps to Successful breastfeeding https://www.who.int/activities/promoting-baby-friendly-hospitals/ten-steps-to-successful-breastfeeding BFHI Implementation Guidance https://apps.who.int/iris/bitstream/handle/10665/272943/9789241513807-eng.pdf?ua=1
Human milk banks ****	<ul style="list-style-type: none"> Regional minimum standards are being developed by the Regional Human Milk Bank Network for Southeast Asia Resources to guide the establishment and implementation of HMBs (PATH) http://www.path.org/hmb-toolkit Briefing note: Ensuring every infant has access to breastmilk: Human milk banks in the ASEAN region https://www.aliveandthrive.org/resources/briefing-note-ensuring-every-infant-has-access-to-breastmilk-human-milk-banks-in-the-asean-region/ Briefing note: Making space for human milk banks: Lessons learned from Viet Nam: https://www.aliveandthrive.org/resources/briefing-note-making-space-for-human-milk-banks-lessons-learned-from-viet-nam/ Components of human milk bank processes and services https://www.aliveandthrive.org/resources/components-of-human-milk-bank-processes-and-services/

**** Human milk banks are not included as a required minimum service, but are considered relevant and appropriate for use in many contexts.

Specific breastfeeding counselling recommendations

Specific breastfeeding counselling recommendations from WHO

- Breastfeeding counselling should be provided to all pregnant women and mothers with infants and young children.
- Breastfeeding counselling should be provided in both the antenatal period and postnatally, and up to 24 months or longer.
- Breastfeeding counselling should be provided at least six times, and additionally as needed. Breastfeeding counselling should be provided through face-to-face counselling.
- Breastfeeding counselling may, in addition, be provided through telephone or other remote modes of counselling (context-specific recommendation, moderate-quality evidence).
- Breastfeeding counselling should be provided as a continuum of care, by appropriately trained health care professionals and community-based lay and peer breastfeeding counsellors.
- Breastfeeding counselling should anticipate and address important challenges and contexts for breastfeeding, in addition to establishing skills, competencies and confidence among mothers.

UNICEF Guidance: Including Children with Disabilities in Humanitarian Action – Nutrition

https://sites.unicef.org/disability/emergencies/downloads/UNICEF_Nutrition_English.pdf

9.4 Resources, tools and useful links from Section 4: Social and behaviour change

Section 4.1. Advocacy

- Alive & Thrive (A&T). A Guide for Public Health Advocacy (2018). Available from: www.AliveandThrive.org/AdvocacyGuide
- Alive & Thrive (A&T). Advocacy as a component of a comprehensive program to achieve IYCF at scale (2014). Available from: www.AliveandThrive.org/resources/advocacy-as-a-component-of-a-comprehensive-program-to-achieve-iycf-at-scale

Section 4.2 Interpersonal Communication and community mobilization

- Alive & Thrive (A&T). Interpersonal communication as a component of a comprehensive program to achieve IYCF at scale (2014). Available from: www.AliveandThrive.org/resources/interpersonal-communication-as-a-component-of-a-comprehensive-program-to-achieve-iycf-at-scale/
- Alive & Thrive (A&T). Getting strategic with interpersonal communication: Improving feeding practices in Bangladesh (2014). Available from: www.fhi360.org/resource/getting-strategic-interpersonal-communication-improving-feeding-practices-bangladesh
- Alive & Thrive (A&T). Toolkit: Infant and young child feeding counseling services: A social franchise model (2015). Available from: www.AliveandThrive.org/resources/social-franchise-toolkit/

Section 4.3 Mass Media

- Alive & Thrive (A&T). Mass communication as a component of a comprehensive program to achieve IYCF at scale (2014). Available from: www.AliveandThrive.org/resources/mass-communication-as-a-component-of-a-comprehensive-program-to-achieve-iycf-at-scale/
- Alive & Thrive (A&T). Strategic design of mass media: promoting breastfeeding in Viet Nam (2014). Available from: www.AliveandThrive.org/wp-content/uploads/2018/02/StrategicDesign.pdf
- Alayón S, Naugle D, Jimerson A, Lamarre-Vincent J, Tuan N, Hajeebhoy N, Giang N, Baume C. (2013). Using behavioral theory to evaluate the impact of mass media on breastfeeding practices in Viet Nam: Evaluation plan and baseline findings. Washington, DC: Alive & Thrive. Available from: www.AliveandThrive.org/wp-content/uploads/2019/03/Viet-Nam-Mass-Media-Baseline-Report-August-2013.pdf

Section 4.4 Strategic Use of Data

- Alive & Thrive (A&T). Strategic use of data as a component of a comprehensive program to achieve IYCF at scale (2014). Available from: www.AliveandThrive.org/resources/strategic-use-of-data-as-a-component-of-a-comprehensive-program-to-achieve-iycf-at-scale

9.5 Resources, tools and useful links from Section 5: Health service delivery for IYCF

Section 5.1 Health worker training

- **UNICEF Community and Facility-IYCF Training**
https://www.unicef.org/nutrition/index_58362.html
 - o UNICEF has developed a set of generic tools for programming and capacity development on community- and facility-based IYCF counselling.
 - o Designed for use in diverse country contexts, the package of tools guides local adaptation, design, planning and implementation of community- and facility-based IYCF counselling and support services at scale.
- **Online learning**
www.iycfhub.org
 - o To complement face-to-face training and address gaps in continuing IYCF counselling training among health workers, a multimedia e-learning training course was developed by Alive & Thrive in partnership with UNICEF, the Global Health Media Project, and IYCF counselling experts from around the world. The course is based on the latest WHO IYCF counselling training package, including stand-alone modules on IYCF counselling skills, breastfeeding, complementary feedings, and others. The content is updated to reflect the latest recommendations on IYCF and HIV as well as the updated Ten Steps to Successful Breastfeeding. The course is available in English and French.

Topics for inclusion in IYCF training for nurses

Knowledge of nutrition-specific interventions

Infant and young child feeding

Importance of IYCF and recommended practices

- Importance of skin-to-skin with newborn
- Good positioning and attachment
- Early initiation of breastfeeding (give colostrum)
- Exclusive breastfeeding from birth up to 6 months
- Breastfeeding on demand – up to 12 times day and night
- Water, sanitation and hygiene
- Physiological basis of breastfeeding
- Advantages of breastfeeding
- Disadvantages of formula/ replacement feeding

Common breast conditions

- Inverted nipple
- Breast engorgement
- Mastitis and breast abscess

Complementary feeding

- Timing, amount, frequency, consistency
- Risks of starting complementary feeding too early
- Risks of starting complementary feeding too late
- Nutritional care of infants and children with diarrhoea
- Continuing support for IYCF

Appropriate feeding in exceptionally difficult circumstances

- Low birthweight
- Wasting
- Infants of HIV-positive mothers
- Sick child <6 months of age
- Relactation

Nutritional care and support during emergencies

- Establishing safe 'corners' for mothers and infants
- One-to-one counselling
- Mother-to-mother support
- Mental and emotional support for traumatized women having difficulty responding to their infants
- Ways to breastfeed infants and young children who are separated from their mothers
- Timely registration of newborns to support early initiation and exclusive breastfeeding
- Early identification and management of infants and children with acute malnutrition to prevent serious illness and death
- Nutritional adequacy and suitability of the general food ration for older infants and young children
- Ensuring and easing access to basic water and sanitation facilities, cooking, food and non-food items
- Policies and laws relevant to the protection, promotion and support of breastfeeding

Essential nutrition actions

- Prevention of vitamin A deficiency
- Prevention of iron-deficiency anaemia

Prevention of iodine deficiency
Use of MNP by children 6–23 months of age
VA supplementation in children <5 years
VA supplementation in children with measles
Daily iron supplementation in children 6–23 months of age
Zinc supplementation for diarrhoea management
Optimal iodine nutrition in young children
Nutritional care and support of HIV-infected children aged 6 months –14 years
<i>Diagnosis and management of wasting</i>
Use of MUAC and/or weight-for-height as per WHO child growth standards
Clinical nutrition assessment
Outpatient management of severe acute malnutrition without complications (2013 Guidelines)
Inpatient care of severe acute malnutrition with medical complications (2013 Guidelines)
Individual monitoring and follow-up
Diagnosis and management of moderate acute malnutrition
<i>Food fortification</i>
Wheat / maize
Rice
Salt and condiments
Practical skills / role plays / demonstrations / exercises
<i>Communication and support skills</i>
Establishing rapport with the mother
Assessing the child's growth and breastfeeding practices
Analysing the information provided
Acting on the information provided by the caregiver
Listening and learning skills
Building confidence and giving support skills
<i>IYCF demonstration</i>
How to help a mother position and attach her baby
How to express breastmilk by hand
How to cup feed a baby
<i>Assessment of IYCF practice</i>
How to take feeding history, 0–6 months of age
How to take feeding history, 6–23 months of age
<i>Counselling</i>
Using GALIDRAA checklist
Assessing and classifying (analysing) IYCF
Measuring and assessing growth and counselling on growth and feeding
<i>Assessing the child's growth</i>
How to weigh a mother and baby using an electronic scale
How to measure baby's length or height
How to plot weight and height in a child growth chart
How to interpret the results of the child's growth using the weight-for-age growth curve

How to calculate the weight-for-height z-score

How to interpret the weight-for-height z-score

How to take MUAC

How to assess for bilateral pitting oedema (kwashiorkor)

Nutrition programme management skills for acute malnutrition, stunting, breastfeeding and other IYCF problems

Assess the burden, prevalence and distribution of acute malnutrition, stunting and other IYCF problems

Map, mobilize and consult partners and stakeholders

Perform bottleneck analysis for nutrition programmes

Develop a multi-sectoral plan to address malnutrition

Develop a monitoring and evaluation plan to track IYCF and nutrition indicators

Clinical management skills

Management and support for infant feeding in maternity facilities (early initiation and newborn care and lactation management up to three days post-partum)

Management of breast conditions and other breastfeeding difficulties

How to manage inverted nipples

How to manage breast engorgement

How to manage breast mastitis and breast abscess

Diagnosis and management of wasting

Assessment

Outpatient therapeutic care

Inpatient therapeutic care

Individual monitoring and follow-up

Management of moderate acute malnutrition

Section 5.1.2 Supply chain strengthening

- UNICEF offers procurement services and logistics expertise to governments and development partners to procure and distribute essential supplies for children. UNICEF also works with governments and key partners to strengthen supply chains and identify areas for improvement. More information about the range of services and products that are available to governments are available at:
<https://www.unicef.org/supply/what-we-do>
<https://www.unicef.org/supply>
- **UNICEF Programming Guidance: Improving Young Children’s Diets During the Complementary Feeding Period**, UNICEF (2020)
<https://www.unicef.org/media/93981/file/Complementary-Feeding-Guidance-2020.pdf>

Section 5.1.3 National guidelines, standards and protocols

- IYCF-E Operational Guidance – IFE Core Group (2017)
https://www.enonline.net/attachments/3127/Ops-G_English_04Mar2019_WEB.pdf
- Monitoring of Vitamin A Supplementation Programmes for District Level Managers
http://www.gava.org/content/user_files/2017/08/GAVA-district-vas-monitoring-guide-1.pdf
- Global nutrition monitoring framework: operational guidance for tracking progress in meeting targets for 2025
<https://www.who.int/publications/i/item/9789241513609>

9.6 Resources, tools and useful links from Section 6: Interventions outside the health system

- Baby WASH Toolkit – World Vision International 2017
<https://www.wvi.org/sites/default/files/2019-05/Baby%20WASH%20Toolkit-%20External.pdf>

9.7 Resources, tools and useful links from Section 7: IYCF in emergencies

- IYCF-E Operational Guidance – IFE Core Group (2017)
https://www.enonline.net/attachments/3127/Ops-G_English_04Mar2019_WEB.pdf
- IYCF-E Tool Kit – Save the Children (2017)
[https://resourcecentre.savethechildren.net/library/infant-and-young-child-feeding-emergencies-iycf-e-toolkit-rapid-start-emergency-nutrition#:~:text=Contact-,Infant%20and%20Young%20Child%20Feeding%20in%20Emergencies%20\(IYCF%2DE\),up%20for%20emergency%20nutrition%20personnel&text=The%20IYCF%2DE%20toolkit%20has,in%20case%20of%20an%20emergency](https://resourcecentre.savethechildren.net/library/infant-and-young-child-feeding-emergencies-iycf-e-toolkit-rapid-start-emergency-nutrition#:~:text=Contact-,Infant%20and%20Young%20Child%20Feeding%20in%20Emergencies%20(IYCF%2DE),up%20for%20emergency%20nutrition%20personnel&text=The%20IYCF%2DE%20toolkit%20has,in%20case%20of%20an%20emergency)

9.8 Resources, tools and useful links from Section 8: Monitoring and evaluation

Checklist for minimum standards for data quality

Organization and survey design

- Include an expert on IYCF for survey steering committee
- Ensure IYCF indicators are included in the scope and main survey objectives
- Leave no child behind – account for sources of exclusion bias including exclusion of informal areas and non-response in urban areas
- Ensure the level of representation is adequate – IYCF indicators can have small age ranges and require large sample sizes for subnational presentation
- Use standardized questionnaires and customize for local foods
- Pre-test all questions for clarity for both interviewer and respondent
- Include proper interview techniques, standardization exercise with pre- and post tests and piloting in enumerator training

Fieldwork

- To reduce non-response, include a minimum of two call back visits to a household when a caregiver or child is not present for the interview
- Always ask all applicable questions and do not ask leading questions to caregivers
- Computer-assisted data entry is the recommended standard to minimize transcription error
- Integrate verification checks into electronic capture of survey data; e.g., a child who was never breastfed should not have received breastmilk in the 24 hour dietary recall
- If data are collected on paper forms first, double data entry with small batch quality checks is required
- Quality assurance should be obtained through a combination of field supervision to review collection quality, spot checks of survey completeness and verification in the field and central level checks for completeness and verification

Data processing

- Conduct data quality assessment on all incoming data routinely through data collection and on the final dataset to ensure data completeness, verification and appropriate sex ratio of responses
- Use global standardized IYCF indicators and syntax for the analysis of IYCF data
<https://www.who.int/nutrition/publications/anthropometry-data-quality-report/en/>
- Unlike anthropometry, standardized thresholds are not available for the interpretation of IYCF data
- To track progress and compare trends with previous IYCF data, analysis with coefficient of variation should be used to measure significant variation
- Standardized tables should be used for presentation of data to ensure consistency between countries and surveys

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- Indicators for assessing infant and young child feeding practices – WHO (2008)
<https://www.who.int/nutrition/publications/infantfeeding/9789241596664/en/>
 - WHO Global Nutrition Monitoring Framework – Operational Guidance
<https://apps.who.int/iris/handle/10665/259904>. This includes data guides for key indicators.

Section 8.1 IYCF indicator definitions and details

Please refer to **Indicators for assessing infant and young child feeding practices: definitions and measurement methods**. World Health Organization and the United Nations Children's Fund (UNICEF), 2021 for full detail and rationale for IYCF Indicators.

Indicator name	Definition	
	Numerator	Denominator
Breastfeeding indicators		
1. Ever Breastfed	Children born in the last 24 months who were ever breastfed.	Children born in the last 24 months
2. Early initiation of breastfeeding	Children born in the last 24 months who were put to the breast within one hour of birth.	Children born in the last 24 months
3. Exclusive breastfeeding in the first two days after birth*	Children born in the last 24 months who were fed exclusively with breast milk for the first two days after birth.	Children born in the last 24 months
4. Exclusive breastfeeding	Infants 0–5 months of age who were fed exclusively during the previous day.	Infants 0–5 months of age
5. Mixed milk feeding under six months	Infants 0–5 months of age who were fed formula and/or animal milk in addition to breast milk during the previous day.	Infants 0–5 months of age
6. Continued breastfeeding 12-23 months	Children 12–23 months of age who were fed breast milk during the previous day.	Children 12–23 months of age
7. Bottle Feeding	Children 0-23 months of age who were fed from a bottle with a nipple during the previous day.	Children 0-23 months of age
Complementary feeding indicators		
8. Introduction of solid, semi-solid or soft foods	Infants 6–8 months of age who received solid, semi-solid and soft foods during the previous day.	Infants 6–8 months of age
9. Minimum dietary diversity	Children 6–23 months of age who received foods from at least five out of eight defined food groups during the previous day. § § §	Children 6–23 months of age
10. Minimum meal frequency	Breastfed children 6–23 months of age who received solid, semi-solid and soft foods the minimum number of times or more during the previous day.	Breastfed children 6–23 months of age
11. Minimum milk feeding frequency for non-breastfed children*	Non-breastfed children 6–23 months of age who consumed at least two milk feeds during the previous day.	Non-breastfed children 6–23 months of age
12. Minimum acceptable diet	Breastfed children 6–23 months of age receiving at least the minimum dietary diversity and minimum meal frequency for their age during the previous day.	Breastfed children 6–23 months of age
	Non-breastfed children 6–23 months of age receiving at least the minimum dietary diversity and minimum meal frequency for their age during the previous day as well as at least two milk feeds.	Non-breastfed children 6–23 months of age
13. Egg and/or flesh food consumption 6–23 months*	Children aged 6–23 months who consumed egg and/or flesh foods during the previous day.	Children 6-23 months of age
14. Sugar-sweetened beverage consumption *	Children 6–23 months of age who consumed a sweet beverage during the previous day.	Children 6–23 months of age
15. Unhealthy food consumption*	Percentage of children 6–23 months of age who consumed selected sentinel unhealthy foods during the previous day.	Children 6–23 months of age
16. Zero vegetable or fruit consumption*	Children 6–23 months of age who did not consume any vegetables or fruits during the previous day.	Children 6–23 months of age

§ § § § 1. breast milk; 2. grains, roots, tubers and plantains; 3. pulses (beans, peas, lentils), nuts and seeds; 4. dairy products (milk, infant formula, yogurt, cheese); 5. flesh foods (meat, fish, poultry, organ meats); 6. eggs; 7. vitamin-A rich fruits and vegetables; and 8. other fruits and vegetables.

Annex 1: Model Law

Source: IBFAN-ICDC (2018). Code Essentials 2: Guidelines for Policy Makers on Implementing the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions.
Penang: IBFAN S/B

Model Law

An Act¹ to ensure safe and adequate nutrition for infants and young children by protecting breastfeeding and by regulating the marketing of food products manufactured for infants and young children and of feeding bottles, teats and pacifiers.

It is hereby enacted as follows:

Chapter I Introductory

Section 1. Short Title and Commencement

- (1) This Act may be called the *[Marketing of Foods and Related Products for Infants and Young Children Act or Protection of Breastfeeding Act]*.²
- (2) This Act shall come into effect 60 days after the date of enactment.
- (3) This act extends to the whole of *[Anyland]*.

Section 2. Definitions

For purposes of this Act

- (1) “**Advertise**” means to make any communication or representation by any means whatsoever for the purpose of promoting the sale or use of a designated product, including but not limited to:
 - (a) written publication, television, radio, film, electronic transmission including the Internet, social media, video, telephone or mobile application;
 - (b) display of signs, billboards, or notices; or
 - (c) exhibition of pictures or models.
- (2) “**Advisory Board**” means a Board set up under Section 18.
- (3) “**Artificial feeding**” means feeding with any manufactured food product which replaces breastmilk either partially or totally.
- (4) “**Brand name**” means a name given by the manufacturer to a product or range of products.
- (5) “**Bottle feeding**” means feeding liquid or semi-solid food from a bottle with a nipple.
- (6) “**Complementary food**” means any food suitable or represented as suitable as an addition to breastmilk, infant formula or follow-up formula for infants from the age of six months (180 days) up to the age of 36 months.³
- (7) “**Complementary food product**” means a complementary food that is commercially processed.
- (8) “**Container**” means any form of packaging of a designated product for sale as a retail unit, including wrappers.
- (9) “**Cross-promotion**” means the use of similar brand names, packaging designs, labels, text, images, colour schemes, symbols or slogans or other means for the purpose of promoting another product.

1. In common law jurisdictions, a law adopted in parliament is known as an 'Act' and this is the approach taken in CE2. Each distinct article in an Act is called a 'section'. If the Code is implemented as subsidiary legislation under an existing Act, it is usually referred to as a set of 'Regulations'. In civil law jurisdictions, the terminology used and the drafting convention may differ but the substance of legal provisions should be the same.

2. Text in [] brackets can be replaced with different wording that is more appropriate to national circumstances.

3. The definition of “complementary food”, in particular its age range, will determine which complementary food product falls within the definition of “designated product”. The upper age limit for “complementary food” can be adjusted if a country chooses to limit the ban on promotion of complementary food products to say, infants or young children up to 12 or 24 months. Such discretion on age range cannot be exercised for formula products. See also Subsections 4(4) and 4(5) and footnote 6.

- (10) **“Designated product”**⁴ means
- (a) infant formula;
 - (b) any other product marketed or otherwise represented as suitable for feeding infants up to the age of six months;
 - (c) follow-up formula;
 - (d) young child formula;
 - (e) ready-to-use therapeutic food;
 - (f) complementary food product;
 - (g) feeding bottles, teats, pacifiers; and
 - (h) such other product as the Minister of Health may, by Notice in the Official Gazette, declare to be a “designated product” for the purposes of this Act.
- (11) **“Distributor”** means a person, corporation or other entity engaged in the business of marketing any designated product, whether wholesale or retail.
- (12) **“Follow-up formula”** means a milk or milk-like product of animal or vegetable origin formulated industrially in accordance with *[citation to the country’s standard for follow-up formula or, in the absence of such standard, citation to the Codex Alimentarius Standard for Follow-up Formula]* and marketed or otherwise represented as suitable for feeding infants and young children older than six months of age. It is also referred to as “follow-on formula” or “follow-on milk”. For the purposes of this Act, the term ‘follow-up formula’ includes any follow up formula for special medical purposes or dietary requirements and any follow-up therapeutic milk product for acutely malnourished infants and young children.
- (13) **“Health care facility”** means a public or private institution or organisation or private practice engaged directly or indirectly in the provision of health care or in health care education. It also includes a day-care centre, a nursery or other infant and young child-care facility.
- (14) **“Health claim”** means any representation that states, suggests, or implies that a relationship exists between a food or a constituent of that food and health. A health claim includes but is not limited to the following:
- (a) a nutrient function claim that describes the physiological role of the nutrient in growth, development and normal functions of the body;
 - (b) any other function claim concerning specific beneficial effects of the consumption of foods or their constituents that relate to a positive contribution to health or to the improvement of a function or to modifying or preserving health; and
 - (c) a reduction of disease risk claim relating to the consumption of a food or food constituent, in the context of the total diet, to the reduced risk of developing a disease or health-related condition.

In this context, health means a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity

- (15) **“Health professional”** means a health worker with a professional degree, diploma or licence, such as a medical practitioner, a registered nurse or midwife or such other person as may be specified by the Minister of Health by a Notice in the Official Gazette.
- (16) **“Health worker”** means a person providing or in training to provide health care services in a health care facility, whether professional or non-professional, including voluntary unpaid workers.
- (17) **“Infant”** means a child from birth up to the age of 12 months.
- (18) **“Infant formula”** means a milk or milk-like product of animal or vegetable origin formulated industrially in accordance with *[citation to the country’s standard for infant formula or, in the absence of such standard, citation to the Codex Alimentarius Standard for Infant Formula]* and intended to satisfy, by

4. By introducing this collective term, one can avoid the use of the term “breastmilk substitute”, the meaning of which is a subject of long drawn controversy. If a full range of products is listed as being covered by the term “designated product” like in this Model Law, there will be no room for dispute about the scope of the law. Text in the substantive parts of the law will be neater and easier to read as well.

itself, the nutritional requirements of infants from birth and/or during the first six months and includes products that continue to meet part of an infant's nutritional requirements after the first six months. For the purposes of this Act, the term 'infant formula' includes any formula for special medical purposes or dietary requirements and any therapeutic milk product for acutely malnourished children.

- (19) **“Inspector”** means an inspector appointed under Section 22.
- (20) **“Label”** means a tag, mark, pictorial or other descriptive matter, written, printed, stencilled, marked, embossed, attached or otherwise appearing on a container of a designated product. For the purposes of Sections 5(1), 5(3), 10 and 11, the term “label” includes packaging and inserts.
- (21) **“Labelling”** includes any written, printed or graphic matter that is present on the label, accompanies the food, or is displayed near the food, including that for the purpose of promoting its sale or disposal.
- (22) **“Logo”** means an emblem, picture or symbol by means of which a company or a product is identified.
- (23) **“Manufacturer”** means a person, corporation or other entity engaged in the business of manufacturing a designated product whether directly, through an agent, or through a person controlled by or under an agreement with it.
- (24) **“Market”** means to promote, distribute, sell, or advertise a designated product and includes product public relations and information services.
- (25) **“Minister”** means Minister of Health of *[Anyland]*.
- (26) **“Nutrition claim”** means any representation which states, suggests or implies that a food has particular nutritional properties including but not limited to the energy value and to the content of protein, fat and carbohydrates, as well as the content of vitamins and minerals. The following do not constitute a nutrition claim:
 - (a) the mention of substances in the list of ingredients;
 - (b) the mention of nutrients as a mandatory part of nutrition labelling;
 - (c) quantitative or qualitative declaration of certain nutrients or ingredients on the label if required by national legislation.
- (27) **“Pacifier”** means an artificial teat for babies to suck, also referred to as a “dummy”.
- (28) **“Prescribed”** or “as prescribed” means prescribed or as prescribed by rules or written decision made pursuant to this Act.
- (29) **“Promote”** means to employ any method of directly or indirectly encouraging a person, a health facility or any other entity to purchase or use a designated product whether or not there is reference to a brand name.
- (30) **“Ready-to-use therapeutic food”** means an energy-dense, vitamin- and mineral-enriched food specifically designed to treat severe acute malnutrition in children above 6 months.
- (31) **“Sample”** means a single or small quantity of a designated product provided without cost.
- (32) **“Sponsorship”** means any financial or in-kind assistance to a person or a group of persons or an entity, whether public or private, and sponsor has a corresponding meaning.
- (33) **“Young child”** means a child from the age of 12 months up to the age of three years (36 months).
- (34) **“Young child formula”** means an industrially formulated milk or milk-like product of animal or vegetable origin that is marketed or otherwise represented as suitable for feeding young children from 12 months of age. It is also referred to as “growing up milk”, “formulated milk” or “toddler milk” (note: There is as yet no international quality standard for young child formula).

Chapter II Prohibitions

Section 3. Sale of a designated product

A person shall not distribute for sale, sell, stock or exhibit for sale any designated product that

- (a) is not registered according to Section 21 of this Act or is not in accordance with the conditions of its registration; or
- (b) has exceeded its date of minimum durability.

Section 4. Promotion

(1) [Except as provided in Subsections 4(4) and 4(5)]⁵, a manufacturer or distributor shall not him or herself, or by any other person or entity on his or her behalf, promote any designated product. Prohibited promotional practices include but are not limited to:

- (a) advertising;
- (b) sales devices such as special displays, discount coupons, premiums, rebates, special sales, loss-leaders, tie-in sales, prizes or gifts;
- (c) giving of one or more samples of a designated product to any person;
- (d) donation or distribution of information or education material referring to infant or young child feeding or performance of educational functions related to infant or young child feeding, except as provided in Section 15;
- (e) the use of health or nutrition claims on labels of designated products or in any information and education materials referring to infant and young child feeding, except as provided in Section 15; and
- (f) cross-promotion of a designated product.

(2) A manufacturer or distributor shall not him or herself, or by any other person or entity on his or her behalf

- (a) donate, waive payment through any means or provide at lower than the published wholesale price where one exists, and in its absence, lower than 80 per cent of the retail price, any quantity of a designated product to a health worker or a health care facility;
- (b) donate to or distribute within a health care facility equipment, services or materials such as pens, calendars, posters, note pads, growth charts and toys or any other materials which refer to or may promote the use of a designated product;
- (c) offer or give any gift, contribution, sponsorship, benefit, financial or otherwise, of whatever value to a health worker or to an association of health workers engaged in maternal and child health, including but not limited to fellowships, research grants or funding for meetings, seminars, continuing education courses or conferences;
- (d) sponsor events, telephone counselling lines, campaigns or programmes related to reproductive health, pregnancy, childbirth, infant or young child feeding or related topics;
- (e) directly or indirectly establish relationships with parents and other caregivers through baby clubs, social media groups, child care classes, contests and any other means; or
- (f) include the volume of sales of designated products in the calculation of its employee remuneration or bonuses, nor set quotas for sales of designated products.

(3) A health worker or an association of health workers engaged in maternal and child health shall not:

- (a) accept any gift, contribution, sponsorship, benefit, financial or otherwise, of whatever value, from a manufacturer or distributor or any person on his or her behalf;
- (b) accept or give samples of designated products to any person; or
- (c) demonstrate the use of infant formula, except to individual mothers or members of their families in very special cases of need, and in such cases, shall give a clear explanation of the risks of the use of infant formula as well as the other information required by Chapter IV.

5. Delete as appropriate. See footnote 6 below.

- (4)⁶ A manufacturer or distributor may promote a complementary food product provided that:
- (a) such promotional practice does not take place in a health care facility;
 - (b) any material promoting a complementary food product must include a statement in characters *[insert particulars relating to character size, placement, appearance, etc. For example, “no less than one-third the size of the characters in the product name, and in no case less than 2mm in height”]* on:
 - i. the importance of exclusive breastfeeding for the first six months and of continued breastfeeding up to two years or beyond; and
 - ii. the recommended age of introduction which is not less than six months (180 days) and a statement that early introduction of complementary foods negatively affects breastfeeding.
- (5)⁷ Notwithstanding Subsection 4(4), a manufacturer or distributor shall not him or herself, or by any other person or entity on his or her behalf, promote a complementary food product through the use of messages in any form or media that are prohibited by Subsection 7 (1) (a) – (f).

Section 5. Prohibitions related to labelling of designated products

- (1) Except as provided in Subsection 7(1), a manufacturer or distributor shall not offer for sale or sell a designated product if the labelling thereto includes a photograph, drawing or other graphic representation other than for illustrating methods of preparation.
- (2) A manufacturer or distributor shall not offer for sale or sell a designated product, other than a feeding bottle, teat or pacifier, unless the labelling thereto indicates in a clear, conspicuous and easily readable manner, in *[insert appropriate language(s)]*, the following particulars:
- (a) instructions for appropriate preparation and use in words and in easily understood graphics;
 - (b) the age in numeric figures after which the product is recommended;
 - (c) a warning about the health risks of improper use, preparation or storage and of introducing the product prior to the recommended age;
 - (d) the list of ingredients and the declaration of nutritional value in accordance with relevant national standards or, in the absence of such standard, with the relevant Codex Alimentarius Standard;
 - (e) the required storage conditions both before and after opening, taking into account climatic conditions;
 - (f) the batch number, date of manufacture and date before which the product is to be consumed, taking into account climatic and storage conditions;
 - (g) the name and national address of the manufacturer or distributor; and
 - (h) such other particulars as may be prescribed.
- (3) A manufacturer or distributor shall not offer for sale or sell a designated product if the labelling thereto contains any health or nutrition claim or any representation that states or suggests that a relationship exists between the product or constituent thereof and health, including the physiological role of a nutrient in growth, development and normal functions of the body.

6. Subsections 4(4) and 4(5), based on the Guidance on ending the inappropriate promotion of foods for infants and young children (69/7 Add.1) and WHA resolutions, are only applicable to countries that choose to permit certain types of promotion for complementary food products f.eg, in retail outlets. Countries that choose to prohibit ALL promotion of complementary food products should delete these Subsections. Otherwise, there will be a contradiction with preceding Subsections 4(1), 4(2) and 4(3) which ban the promotion of ALL designated products. See also footnote 3.

7. Delete as appropriate; see footnote 6 above

Section 6. Prohibitions related to labelling of infant formula, follow-up formula and young child formula.

- (1) A manufacturer or distributor shall not offer for sale or sell infant formula or follow-up formula unless the container or label affixed thereto, in addition to the requirements of Section 5, conforms to the following:
 - (a) contains the words, “IMPORTANT NOTICE” in capital letters and indicated thereunder, the statement “Breastfeeding is the normal and optimal way to feed infants and young children. Breastmilk is important for the healthy growth and development of infants and young children. It protects against diarrhoea and other illnesses” in characters *[insert particulars relating to character size, placement, appearance, etc. For example, “no less than one-third the size of the characters in the product name, and in no case less than 2mm in height”]*;
 - (b) contains the word, “WARNING” and indicated thereunder, the statement, “Before deciding to supplement or replace breastfeeding with this product, seek the advice of a health professional. It is important for your baby’s health that you follow all preparation instructions carefully. If you use a feeding bottle, your baby may refuse to feed from the breast. It is more hygienic to feed from a cup” in characters *[insert particulars relating to character size, placement, appearance, etc. For example, “no less than one-third the size of the characters in the product name, and in no case less than 1.5mm in height”]*;
 - (c) has preparation instructions for infant or follow-up formula in powdered form that state that:
 - i. powdered formula is not sterile and may be contaminated with pathogenic microorganisms during the manufacturing process or may become contaminated during preparation;
 - ii. it is necessary for formula to be prepared one feed at a time using water first boiled and then cooled to not less than 70 °C; and
 - iii. any unused milk must be discarded immediately after every feed.
 - (d) includes a feeding chart in the preparation instructions;
 - (e) does not use the terms “maternalised”, “humanised” or terms similar thereto or any comparison with breastmilk;
 - (f) does not use text that may tend to discourage breastfeeding;
 - (g) specifies the source of the protein; and
 - (h) in the case of follow-up formula, states that the product shall not be used for infants less than six months old or used as the sole source of nutrition of infants in characters *[insert particulars relating to character size, placement, appearance, etc.]*
- (2) A manufacturer or distributor shall not offer for sale or sell young child formula unless the container or label affixed thereto, in addition to the requirements of Subsections 5 and 6(1)(c) – (g), states that the product shall not be used to feed infants below 12 months or used as the sole source of nutrition for young children” in characters *[insert particulars relating to character size, placement, appearance, etc.]*

Section 7. Prohibitions related to labelling of ready-to-feed therapeutic food and complementary food product.

- (1) In addition to the requirements of Subsections 5(2) and 5(3), a manufacturer or distributor shall not offer for sale or sell a ready-to-feed therapeutic food or a complementary food product if the container or label affixed thereto contains:
 - (a) any text, image or other representation that suggests the suitability of the product for infants under six months including but not limited to references to development milestones clearly reached before six months, the use of pictures of infants appearing to be younger than six months;
 - (b) any text, image or other representation that idealises the product or is likely to undermine or discourage breastfeeding or create a belief that the product is equivalent or superior to breastmilk;
 - (c) any text, image or representation that undermines or discourages appropriate complementary feeding or that may suggest that the product is inherently superior to home prepared complementary foods;
 - (d) any recommendation to feed the product in a bottle or otherwise promote the use of bottle feeding;
 - (e) any endorsement, or anything that may be conveyed or construed as an endorsement by a health

- professional, an association of health professional or other body; and
- (f) any element that allows for cross-promotion of any other designated product.
- (2) In addition to the requirements of Subsection (1), the label of a ready-to-feed therapeutic food or complementary food product shall include:
- (a) A statement in characters *[insert particulars relating to character size, placement, appearance, etc. For example, “no less than one-third the size of the characters in the product name, and in no case less than 2mm in height”]* on:
- the importance of exclusive breastfeeding for the first six months and of continued breastfeeding up to two years or beyond; and
 - the recommended age of introduction which is not less than six months (180 days) and a statement that early introduction of complementary foods negatively affects breastfeeding.
- (b) instructions for preparation, storage, handling and use; and
- (c) a feeding chart showing the appropriate ration/serving size consistent with guiding principles issued by the World Health Organization.

Section 8. Prohibitions related to labelling of skimmed or condensed milk.

A manufacturer or distributor shall not offer for sale or sell skimmed or condensed milk in powder or liquid form, unless the container or label affixed thereto contains the words, “This product should not be used to feed infants” in characters *[insert particulars relating to character size, placement, appearance, etc.]*

Section 9. Prohibitions related to labelling of low-fat and standard milk

A manufacturer or distributor shall not offer for sale or sell low-fat or standard milk in powder or liquid form, unless the container or label affixed thereto contains the words, “This product should not be used as an infant’s sole source of nourishment” in characters *[insert particulars relating to character size, placement, appearance, etc.]*

[Note: The milks in Sections 8 and 9 do not fall within the scope of this Act unless they are marketed or otherwise represented as suitable for infants. It is recommended that these labelling provisions be incorporated into the country’s food labelling laws. In addition, Sections 8 and 9 will require revision according to the types of milk products available in individual countries.]

Section 10. Prohibitions related to labelling of feeding bottles and teats

A manufacturer or distributor shall not offer for sale or sell a feeding bottle or teat unless the package or label affixed thereto, in addition to the requirements of Section 5(1), indicates in a clear, conspicuous and easily readable manner, in *[insert appropriate language(s)]*, the following particulars:

- the words, “IMPORTANT NOTICE” in capital letters and indicated thereunder, the statement, “Breastfeeding is best. Breastmilk is the ideal food for the healthy growth and development of infants and young children. It protects against diarrhoea and other illnesses” in characters *[insert particulars relating to character size, placement, appearance, etc. For example, “no less than one-third the size of the characters in the product name, and in no case less than 2mm in height”]*;
- the statement, “Warning: It is important for your baby’s health that you follow the cleaning and sterilisation instructions very carefully. If you use a feeding bottle, your baby may no longer want to feed from the breast” in characters *[insert particulars relating to character size, placement, appearance, etc. For example, “no less than one-third the size of the characters in the product name, and in no case less than 2mm in height”]*;
- instructions for cleaning and sterilisation in words and graphics;
- a statement explaining that feeding with a cup is more hygienic than bottle feeding;
- a warning that children should not be left to self-feed for long periods of time because extended contact with sweetened liquids, including infant formula, may cause severe tooth decay; and
- the name and national address of the manufacturer or the distributor.

Section 11. Prohibitions related to labelling of pacifiers (dummies)

A manufacturer or distributor shall not offer for sale or sell a pacifier unless, in addition to the requirements of Section 5(1), it is labelled with the words, "Warning: Use of a pacifier can interfere with breastfeeding" in characters *[insert particulars relating to character size, placement, appearance, etc. For example, "no less than one-third the size of the characters in the product name, and in no case less than 1.5mm in height"]*.

Chapter III Health Worker Responsibilities

Section 12. Health worker responsibilities

1. Heads of health care facilities and national and local health authorities shall take measures to encourage and protect breastfeeding and to implement this Act, and shall give information and advice to health workers regarding their responsibilities and particularly ensure that health workers are familiar with all of the information specified in Chapter IV.
2. Health workers shall encourage, support and protect breastfeeding. They are expected to know the provisions of this Act, particularly the information specified in Chapter IV.
3. Health workers shall work to eliminate practices that directly or indirectly impede the initiation and continuation of breastfeeding, such as prelacteal feeds.
4. Health workers shall make in writing a report to the head of their work place, who shall in turn report to the Advisory Board, on any offer a health worker receives for a sample or gift or other benefit from a manufacturer or distributor or on any other contravention of the provisions of this Act.

Chapter IV Information and Education

Section 13. Information and education materials about infant and young child feeding

Information and education materials, whether written, audio or visual, which refer to infant and young child feeding shall:

- (1) contain only correct and current information and shall not use any pictures or text that encourage artificial feeding, or the use of feeding bottles or that discourage breastfeeding;
- (2) be written in *[insert appropriate language(s)]*;
- (3) not give an impression or create a belief that a designated product is equivalent to, comparable with or superior to breastmilk or to breastfeeding;
- (4) not contain the brand name or logo of any designated product nor of any manufacturer or distributor of a designated product; provided that this clause shall not be applicable to information about designated products intended for health professionals as authorised by Section 15 of this Act; and
- (5) clearly and conspicuously explain each of the following points:
 - (a) the benefits and superiority of breastfeeding;
 - (b) the value of exclusive breastfeeding for six months followed by sustained breastfeeding for two years or beyond;
 - (c) how to initiate and maintain exclusive and sustained breastfeeding;
 - (d) why it is difficult to reverse a decision not to breastfeed;
 - (e) the importance of introducing complementary foods from the age of six months;
 - (f) how and why any introduction of artificial feeding, the use of a feeding bottle or the early introduction

- of complementary foods negatively affects breastfeeding; and
- (g) that complementary foods can easily be prepared at home using local ingredients.

Section 14. Information and education materials about artificial feeding or feeding bottles.

- (1) If the material referred to in Section 13 includes the topic of artificial feeding or the use of a feeding bottle, it must also include the following points:
- (a) instructions for the proper preparation, storage and use of the product including cleaning and sterilisation of feeding utensils;
 - (b) how to feed infants with a cup;
 - (c) the health risks of artificial feeding, the use of a feeding bottle and improper preparation of the product;
 - (d) explain that
 - i. powdered formula is not sterile and may be contaminated with pathogenic microorganisms during the manufacturing process or may become contaminated during preparation;
 - ii. it is necessary for powdered formula to be prepared one feed at a time using water first boiled and then cooled to not less than 70 °C; and
 - iii. any unused milk must be discarded immediately after every feed.
 - (e) the approximate financial cost of feeding an infant or a young child with such a product in the recommended quantities and
 - (f) that the practice of providing follow-up formula and young child formula is not necessary.
- (2) Except as provided in Section 15 concerning product information for health professionals, materials that include the topic of artificial feeding shall not contain any health or nutrition claims or other representation that states or suggests that a relationship exists between the product or constituent thereof and health, including the physiological role of a nutrient in growth, development or normal functions of the body.

Section 15. Product information for health professionals

Manufacturers and distributors may give materials about designated products to health professionals if such materials

- (1) are restricted to scientific and factual matters regarding the technical aspects and methods of use of the product;
- (2) provide references to published and peer-reviewed studies to support any representation or claim that states or suggests that a relationship exists between the product or a constituent thereof and health, growth or development; and
- (3) are otherwise in accordance with Sections 13 and 14 of this Act.

Section 16. Submission of materials to Advisory Board (OPTIONAL)

Any person who produces or distributes any materials referred to in this Chapter shall submit copies to the Advisory Board according to procedures as shall be prescribed.

Chapter V Administration

Section 17. Implementation

- (1) The Ministry of Health is principally responsible for the implementation of this Act.
- (2) The Minister of Health shall, when necessary, call upon other ministries to ensure the implementation of this Act.
- (3) For the purpose of implementing this Act, the Minister of Health shall have the following powers and functions:
 - (a) to promulgate such rules as are necessary or proper for the implementation of this Act and the accomplishment of its purposes and objectives;
 - (b) to call for consultations with government agencies and other interested parties to ensure implementation and strict compliance with the provisions of this Act and the rules promulgated hereunder;
 - (c) to cause the enforcement of this Act and to appoint an official within the Ministry of Health to carry out this function on his or her behalf; and
 - (d) to exercise such other powers and functions that may be necessary for or incidental to the attainment of the purposes and objectives of this Act.

Section 18. National Advisory Board for the Promotion and Protection of Breastfeeding

- (1) There shall be a National Advisory Board for the Promotion and Protection of Breastfeeding to be composed of the following members:

[In this section, list the members to be included in this inter-disciplinary committee. Countries usually include representatives of relevant ministries such as Health, Education, Communications and Trade, and representatives of organisations of health professionals, consumers, breastfeeding support groups as well as experts in relevant fields. The proviso excludes manufacturers and distributors of designated products from the committee because their involvement would create conflicts of interest. Such conflicts would compromise independence, integrity and credibility of a committee that advises the government on enforcement of the law.]

 - (a) The Minister of Health or his representative who shall be its ex officio Chairman;
 - (b)
 - (c) . . .
 - (x) Such other persons as the Minister may, by Notice in the Official Gazette, appoint as members of the Advisory Board; provided that no person shall be appointed who has any direct or indirect financial interest in any designated product.
- (2) The Minister shall appoint the members of the Advisory Board within 90 days of the date of enactment.
- (3) The members of the Advisory Board shall hold office for a term of 3 years and shall be eligible for renomination.
- (4) Any member of the Advisory Board may, at any time, resign his or her office by writing to the Minister or shall vacate his or her office if the Minister so directs. A vacancy shall be filled in the same manner as the original appointment for the balance of the unexpired term.
- (5) The Advisory Board may invite national or foreign experts to take part in the meetings as observers and may constitute committees or appoint experts for the purpose of detailed study of any matter set before it.
- (6) The Minister may, by Notice published in the Official Gazette, change the size and composition of the Advisory Board.

Section 19. Administration of the Advisory Board

- (1) The Minister shall appoint the Secretary of the Advisory Board and such other officers as he or she deems necessary to carry out the purposes of this Act.
- (2) The Advisory Board shall hire permanent staff necessary to carry out its functions, subject to the budgetary approval of the Minister.
- (3) The Advisory Board shall meet as often as it deems necessary, but not less than once every month at such time and place as the Secretary shall indicate.
- (4) The Secretary shall call meetings at the direction of the Chairman; shall maintain minutes of the meetings and shall perform such other duties as may be directed by the Advisory Board.
- (5) Two-thirds of the members of the Advisory Board shall constitute a quorum for a meeting.
- (6) A majority vote of the members present shall be sufficient to approve any business presented in a meeting of the Advisory Board.
- (7) Decisions of the Advisory Board shall be certified by the Secretary.
- (8) The Advisory Board may make such other administrative rules as may be required for its proper functioning.

Section 20. Powers and functions of the Advisory Board

- (1) The Advisory Board shall have the following powers and functions:
 - (a) to advise the *[insert Head of State]* and the Minister on national policy for the promotion and protection of breastfeeding;
 - (b) to create regional committees to carry out the functions of the Advisory Board at the regional level, as may be prescribed;
 - (c) to advise the Minister on designing a national strategy for developing communication and public education programmes for the promotion of breastfeeding; information and educational materials on the topics of infant and young child feeding; continuing education for health workers on lactation management and the requirements of this Act; curricula for students in the health professions that include lactation management and to ensure widespread distribution of and publicity concerning this Act, in a method as may be prescribed;
 - (d) to review reports of violations or other matters concerning this Act;
 - (e) to issue instructions to inspectors as to actions to be taken, or take such other actions as the case may be, against any person found to be violating the provisions of this Act or the Rules promulgated pursuant thereto;
 - (f) to scrutinize materials submitted in accordance with Section 16 and recommend appropriate actions to be taken in the case of a violation of Chapter IV; and
 - (g) such other powers and functions, including the powers of an Inspector, as are conferred by the provisions of this Act and as may be prescribed.

Section 21. Registration of designated products

- (1) The Minister of Health shall cause all designated products to be registered in accordance with such conditions and procedures as may be prescribed.
- (2) The Minister of Health shall, by notification in the Official Gazette, fix the date after which no designated product that is not registered may be imported, manufactured or sold.
- (3) A person applying for registration of a designated product shall furnish such information and samples as may be prescribed.

- (4) Once the registration of a designated product has been approved, a Certificate of Registration shall be issued.
- (5) No Certificate of Registration shall be granted unless the designated product is in accordance with the [insert applicable Food Quality Standards] and has a label which is in accordance with the requirements contained in Chapter II of this Act.

Section 22. Inspectors

The Minister shall appoint such persons as he or she sees fit having the prescribed qualifications to be Inspectors for purposes of this Act within such local limits as he or she may assign to them respectively, provided that no person who has any direct or indirect financial interest in any designated product shall be so appointed.

Section 23. Powers of inspectors

- (1) An inspector may, within the local limits for which he or she is appointed:
 - (a) inspect any premises where any designated product is imported, manufactured, sold, stocked, exhibited for sale, advertised or otherwise promoted and all relevant records;
 - (b) institute prosecution with respect to violations of this Act and the Rules made pursuant thereto; and
 - (c) exercise such other powers as may be prescribed.

Section 24. Procedure for inspectors

- (1) Inspectors shall inspect, not less than the number of times as may be prescribed, the premises as may be prescribed.
- (2) After each inspection, the inspector shall submit a report including any finding of a violation of this Act and the Rules made pursuant thereto, to the Advisory Board and seek instructions as to the action to be taken in respect of such contravention.
- (3) Institute enforcement, where applicable.

Chapter VI

Sanctions, Procedure

Section 25. Penalties

- (1) Any person who him or herself or on behalf of any other person contravenes Sections 3 and 4 shall be punishable with imprisonment for a term which shall not be less than [time] or a fine which shall not be less than [amount] or both.
- (2) Any person having been convicted of an offence under Subsection (1) and who is again convicted of an offence under that Subsection, shall be punishable with imprisonment for a term which shall not be less than [time] or with a fine that shall not be less than [amount].
- (3) Any person who contravenes any other provision of this Act or the Rules made pursuant thereto may be subject to a fine of up to [amount] or a period of imprisonment of up to [time].

Section 26. Improvement Notices, Cease and desist orders, etc.

- (1) If the Minister or any official appointed by the Minister has reasonable grounds for believing that any person is failing to comply with the provisions of this Act or the Rules promulgated thereto, he or she may, by a notice served on that person (in this Act referred to as an “improvement notice”):
 - (a) state the grounds for believing that the person is failing to comply with this Act or the Rules promulgated thereto;
 - (b) specify the matters which constitute the person’s failure so to comply;
 - (c) specify the measures which the person must take in order to secure compliance; and
 - (d) require the person to take those measures, or measures which are at least equivalent to them, within such period (not being less than 14 days) as may be specified in the notice.
- (2) In addition to the powers conferred under Subsection (1), the Minister or any official appointed by the Minister shall have the power to make cease and desist orders upon receiving a report from an inspector or the Advisory Board of a violation of the provisions of this Act or the Rules promulgated pursuant thereto.
- (3) Any person who fails to comply with an improvement notice or cease and desist order under Subsection (1) or (2) shall, after notice and an opportunity to be heard have been given, be guilty of an offence.

Section 27. Suspension or revocation of certificate of registration

Where any person has been found to have contravened any of the provisions of this Act, or the Rules pursuant thereto, the Minister, upon written recommendation of the Advisory Board, and after notice and an opportunity to be heard have been given, may suspend or revoke any Certificate of Registration that has been issued to that person pursuant to this Act.

Section 28. Suspension or revocation of professional licence

Where any health professional has been found to have contravened any provision of this Act, or the Rules pursuant thereto, the Minister may recommend to the relevant authority the suspension or revocation of any licence for the practice of that person’s profession.

Section 29. Suspension or revocation of licence, permit or authority

[Note: If a licence to manufacture, import or sell is required, give the Minister the power to suspend or revoke that licence.]

Section 30. Appeal

There shall be a right of appeal to the *[insert higher court]* within 35 days of the judgment.

Section 31. Strict liability for officers, directors, etc.

When the person guilty of an offence under this Act is a corporation, company, partnership, firm or other association, every director, officer, partner, and employee of the corporation, company, partnership, firm or other association, shall also be liable for that offence unless he or she proves that the offence was committed without his or her knowledge or consent.

Section 32. Institution of prosecution

- (1) Prosecution under this Act may be instituted only by:
 - (a) an Inspector appointed pursuant to Section 22;
 - (b) a member of the Advisory Board; or
 - (c) a representative of such voluntary organisation engaged in the field of child welfare and development or child nutrition as the Minister, by notification in the Official Gazette, may authorise in this behalf

Section 33. Public enforcement

- (1) Any person has the right to lodge a formal complaint to the Advisory Board, which may recommend that proceedings be instituted against any person relating to a violation of any provision that constitutes an offence under this Act or Rules made pursuant thereto.
- (2) Any person has the right to commence an action for damages in *[a court of law]* against any manufacturer or distributor or other person for any harm suffered as a result of a violation of any provision that constitutes an offence under this Act or Rules made pursuant thereto.

Section 34. Power to make Rules

- (1) The Ministry of Health may, by notification in the Official Gazette, make Rules for carrying out the purposes of this Act.
- (2) In particular but notwithstanding the generality of the foregoing provision, such Rules may prescribe:
 - (a) the functions of the Advisory Board;
 - (b) conditions and procedures for the registration of designated products;
 - (c) qualifications and powers of and procedures for Inspectors appointed pursuant to this Act; and
 - (d) procedures for submitting educational or informational materials to the Advisory Board.

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