Infant and Young Child Feeding in Emergencies

Making it Happen

Bali, Indonesia, 10 – 13 March 2008

Proceedings of a regional strategy workshop

Organised by the Infant and Young Child Feeding in Emergencies (IFE) Core Group in co-operation with UNICEF East Asia and Pacific Regional Office, UNICEF South Asia Regional Office, UNICEF Indonesia Office and the Ministry of Health, Indonesia.
Funded by the Inter-Agency Standing Committee (IASC) Nutrition Cluster and IBFAN-GIFA

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Infant and Young Child Feeding in Emergencies (IFE)

The IFE Core Group

The IFE Core Group is an interagency collaboration committed to developing policy guidance and capacity building on Infant and Young Child Feeding in Emergencies (IFE). Members currently comprise UNICEF, WHO, UNHCR, WFP, International Baby Food Action Network-Geneva Infant Feeding Association (IBFAN-GIFA), CARE USA, Action Contre la Faim (ACF) and the Emergency Nutrition Network (ENN), coordinated by the ENN since 2004. Associate members are save the Children UK (SC UK) and the International Federation of the Red Cross and Red Crescent Societies (IFRC).

Scope of work

The IFE Core Group's work in policy guidance is reflected in the Operational Guidance on Infant and Young Child Feeding in Emergencies for programme and emergency relief staff (Operational Guidance on IFE). The Group's work in capacity building is reflected in two training modules (IFE Modules 1 and 2).

The **Operational Guidance on IFE** aims to provide concise, practical guidance on how to ensure appropriate infant and young child feeding in emergencies. It is intended for emergency relief staff and programme managers of all agencies working in emergency programmes, including national governments, United Nations (UN) agencies, national and international non-governmental organisations (NGOs), and donors. It applies in emergency situations in all countries. It is supported by an increasing number of UN agencies, NGOs, academic institutions and bilateral donors[1]. The Operational Guidance on IFE was first produced in 2001 by the Interagency Working Group on Infant and Young Child Feeding in Emergencies. An updated version 2.1 was produced in February, 2007 by the IFE Core Group. It is available in English, French, Spanish, Portuguese, Russian, Arabic, Bahasa (Indonesia), Bangladeshi (Bangla), Japanese, Chinese and Kiswahilli.

IFE Module 1 is intended for emergency relief staff and was developed to orientate users on key IFE issues and assist in the practical application of the Operational Guidance on IFE. Version 1.0 was produced in 2001, in a collaboration between WFP, UNICEF, the LINKAGES project, IBFAN and ENN, with many other contributors. An update is underway by the IFE Core Group in 2008, funded by the UNICEF led Inter-Agency Standing Committee (IASC) Nutrition Cluster.

IFE Module 2 targets health and nutrition workers directly involved with infants and carers in emergencies. It aims to equip them with the basic knowledge and skills to support safe and appropriate infant feeding support. Version 1.0 was produced in November 2004, as a collaborative work between ENN, IBFAN-GIFA, Fondation Terre des hommes (Fondation Tdh), UNICEF, UNHCR, WHO, and WFP, with external technical support and field contributions. An updated version 2.1 (December 2007) was produced by the IFE Core Group, coordinated by the ENN and funded by the IASC Nutrition Cluster. IFE Module 2, v2.1, is available in English, French and Bahasa (Indonesia).

Source of materials

These and other IFE resources are available on the ENN website http://www.ennonline.net/ife, which includes a searchable IFE Resource Library. For print copies (where available) or to give feedback (always welcome), contact:

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[1] Most up to date list of supporters available at www.ennonline.net/ife

Contents

Abbreviations

ACF	Action Contre la Faim
AFASS	Acceptable, feasible, affordable, sustainable and safe
ARI	Acute respiratory infection
BMS	Breastmilk substitutes
BF	Breastfeed(ing)
BFC	WHO/UNICEF Breastfeeding Counselling: A Training Course (the 40-hour course)
BMS	Breastmilk substitute
CF	Complementary feeding
CFE	Complementary feeding in emergencies
CIHD	Centre for International Health and Development
CREATE	Communication Resources Essentials and Tools for Emergencies
DHS	Demographic and Health Survey
DOH	Department of Health
DPRK	Democratic People's Republic of Korea
ENN	Emergency Nutrition Network
FG	Focus group
HH	Household
HQ	Headquarters
HIV/AIDS	Human immuno-deficiency virus/acquired Immuno-deficiency syndrome
IASC	Inter-Agency Standing Committee
IBFAN-GIFA	International Baby Food Action Network – Geneva Infant Feeding Association
ICRC	International Federation of the Red Cross and Red Crescent Societies
IFE	Infant and young child feeding in emergencies
IRA	Initial rapid assessment
IRR	Implementing Rules and Regulations
IYCF	Infant and young child feeding
MICS	Multiple indicator cluster survey
NGO	Non-governmental organisation
PHAP	Pharmaceutical and Health Care Association of the Philippines
RIRR	Revised Implementing Rules and Regulations
RUSF	Ready to use Supplementary Food
RUTF	Read to use Therapeutic Food
SAM	Severe acute malnutrition
SC-UK	Save the Child, United Kingdom
TOR	Terms of reference
TRO	Temporary Restraining Order
UCL	University College, London
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WABA	World Alliance for Breastfeeding Action
WASH	Water, sanitation and hygiene
WFP	World Food Programme
WHA	World Health Assembly
WHO	World Health Organisation
WHO SEARO	World Health Organisation, South East Asia Regional Office

1 Summary

One hundred and eleven participants from 16 countries and special territories, together with regional and international representatives of United Nations (UN) agencies, non-governmental organisations (NGOs) and infant and young child feeding experts, met in Bali, Indonesia from 10-13 March 2008 to reach consensus on how to protect and support Infant and Young Child Feeding in Emergencies (IFE) in the region. The particular focus was on emergency preparedness and the early humanitarian response on IFE.

The workshop was organised by the Emergency Nutrition Network (ENN) as coordinator of the IFE Core Group – an established interagency collaboration developing policy guidance and building capacity on IFE since 1999[i]. At an ENN/IFE Core Group hosted international strategy meeting on IFE in late 2006, a regional workshop was identified as a key step to help improve coordination, policy guidance, implementation and response capacity in the region – this was the first such workshop to be held. The workshop was funded by the Inter-Agency Standing Committee (IASC) Nutrition Cluster in recognition that infant and young child feeding in emergencies is often poorly managed and supported, yet is a crucial component of an adequate emergency response and an important intervention to save lives and prevent malnutrition. Delegate attendance was also supported by IBFAN-GIFA and many country delegates were funded by UNICEF or the delegate's agency.

The aims of the workshop were to orientate participants on relevant policy, guidance, key issues and initiatives in IFE, to identify key constraints to appropriate IFE, and to establish strategic directions and practical steps to address these, at country, regional and international levels. The agenda (Annex 1) and proceedings were guided by the provisions of the Operational Guidance on IFE, a key practical guidance for all levels of emergency relief staff, developed by the IFE Core Group and supported by a range of UN agencies, NGOs, academic institutions and bilateral donors.

The four day workshop comprised two days of presentations and discussions that culminated on Day 3 in a series of thematic and country working groups. This was followed by a capacity building workshop on Day 4 that focused upon training needs of frontline workers in a variety of scenarios. This report briefly summarises the presentations[ii] and key discussion points and then details the agreements and conclusions of the thematic groups and the country working group discussions – reflected in the country action plans (Annex 2) and a series of global and regional action plans (Annex 3). An overview of the capacity building workshop on Day 4 is followed by feedback from participants and organisers.

Roles and responsibilties

The workshop opened with a reminder of our responsibilities towards infants and young children in emergencies as clearly set out in the *UNICEF/WHO Global Strategy on Infant and Young Child Feeding*[iii], *in Article 24 of the Convention on the Rights of the Child*[iv] and the Call for Action contained in the *Innocenti Declaration 2005* on Infant and Young Child Feeding[v]. The subsequent presentations highlighted global efforts on IFE to improve capacity for a timely and appropriate response. This included the importance of the International Code on Marketing of Breastmilk Substitutes in protecting infants and caregivers from inappropriate marketing of breastmilk substitutes *including during emergencies*, an orientation on key provisions of the Operational Guidance on IFE, and the work of the IASC Nutrition Cluster to improve coordination as well as timely and appropriate interventions in IFE.

Country Situations

A participatory country situation analysis and country presentations clearly indicated that the current situation with regards to IFE in the region is far from optimal. Most countries reported poor coordination of the emergency response on IFE, lack of national policies that specifically deal with IFE, and low capacity. These issues all contribute to a general lack of services to protect and support breastfeeding, to manage artificial feeding and to have appropriate complementary feeding in emergencies.

IFE often reflects poor infant and young child feeding (IYCF) in non-emergencies. Correcting IYCF during emergencies is therefore doubly hard because of the difficult conditions resulting from the emergency and the lack of understanding, awareness and capacity within the community and government of the importance of optimal IYCF practices even in non-emergency conditions. Much work, therefore, needs to be done to improve IYCF in general (in preparedness). It was noted that emergencies may actually provide an opportunity to redouble, and even accelerate, country efforts to improve optimal IYCF practices.

The way forward

Each *thematic working group* covered one of the six main components of the Operational Guidance on IFE – (i) Policies, ii) Capacity Building, iii) Coordination, iv) Assessment and Monitoring, v) Protection, Promotion and Support of Optimal IYCF and vi) Minimising the Risks of Artificial Feeding. Working groups and plenary discussions helped identify ways forward in three particularly challenging areas in IFE response – assessment of infant and young child feeding, artificial feeding in emergencies, and complementary feeding in emergencies. The enthusiastic work of the assessment group, in particular, provided a good basis from which to develop thinking on the process of IFE assessment post-workshop. The AFASS[vi] criteria (developed in the context of HIV and infant feeding) were considered relevant to any artificial feeding in an emergency context and their application was explored. However there is a lack of guidance and programmatic experience on interventions to support artificial feeding in emergencies, in particular on integrated programming that supports both breastfed and non-breastfed infants in an emergency context. Complementary feeding in emergencies was emphasised as an area of great concern - the increasing use of Ready to Use Therapeutic Foods (RUTF) in the prevention as well as treatment of acute malnutrition raised issues over sustainability, their appropriateness for use as a complementary food, and the need to balance these innovations with more food based/holistic approaches to feeding infants and young children.

Many misconceptions around infant feeding in emergencies are perpetuated by the media, which often highlights or initiates calls for donations and often report mothers cannot breastfeed due to stress. An analysis of media coverage during the Bangladesh emergency highlighted the nature of such coverage and the importance of good communications in emergencies. Discussions explored how to improve engagement with the media, communicate key IFE messages and in particular, the risks associated with artificial feeding.

Based on their priority problems identified on Day 1 and thematic group work, country working groups produced country action plans (Annex 2). *The regional/global working group* highlighted the poor attendance by invited international or regional bilateral donors at the workshop, which was reflected in the Global Action Points (Annex 3). Key actions were reflected in a Pledge for Action by participants (see inside back cover), and a model Joint Statement on IFE to call for appropriate IYCF support during an emergency, collectively produced by the end of Day 3 (Annex 4).

This workshop was well-received and well-attended and the result of strong collaboration between many UN and NGO partners and their national counterparts. The organisers hope the workshop will prove to be a significant contribution to timely and informed interventions on IFE and furthermore, assist key country players to establish and enhance overall infant and young child feeding policies and practices in the interests of preparedness. Critically, country and regional level contributions have reinforced where actions are needed at a global level, particularly with regard to devising early breastfeeding interventions, complementary feeding, artificial feeding and communication strategies on IFE. It is hoped that this workshop will be the first in a series of regional workshops to raise awareness and build capacity on IFE.

Nina Berry/SC UK, Myanmar 2008

Seven week old, Sa Bei, with her foster mother, San San Min.

[i] Current members are: UNICEF, WHO, UNHCR, WFP, International Baby Food Action Network-Geneva Infant Feeding Association (IBFAN-GIFA), CARE USA, Action Contre la Faim (ACF) and the Emergency Nutrition Network (ENN). Associate members include Save the Children (UK) and International Federation of the Red Cross and Red Crescent Societies (IFRC).

[ii] Presentations from the Bali conference are available in the IFE Resource library at www.ennonline.net/ife, search 'Presentations'

[iii] Global Strategy for Infant and Young Child Feeding, UNICEF/WHO, WHO, 2003

[iv] A/RES/44/25, Convention on the Rights of the Child. 61st plenary meeting, 20 November 1989. http://www.un.org/documents/ga/res/44/a44r025.htm

[v] http://innocenti15.net/declaration.htm Welcomed unanimously by the WHO 59th World Health Assembly. 4 May 2006. A59/13. Provisional agenda item 11.8. WHA 59.21.

[vi] Acceptable, Feasible, Affordable, Sustainable, Safe

2 Introduction

Since 1999, an interagency collaboration that has become known as the Infant and Young Child Feeding in Emergencies Core Group (IFE Core Group), has been working to improve policy guidance and capacity building on infant and young child feeding in emergencies (IFE). This collaborative effort emerged from an International Meeting on Infant and Young Child Feeding in Emergency Situations hosted by the International Baby Food Action Network (IBFAN) in Croatia in 1998, which highlighted the poor management and support of infant feeding in emergencies.

Current members of the IFE Core Group are UNICEF, WHO, UNHCR, WFP, IBFAN-GIFA (Geneva Infant and young child Feeding in emergencies Association), CARE USA, Action Contre la Faim (ACF) and the Emergency Nutrition Network (ENN). Associate members include Save the Children UK (SC UK) and the International Federation of the Red Cross and Red Crescent Societies (IFRC). The ENN is currently the coordinating agency for the group. The IFE Core Group's work to date has been in two main areas: development of policy guidance in the form of the Operational Guidance on Infant and Young Child Feeding in Emergencies (Operational Guidance on IFE[2]) and capacity building in the form of two training modules (IFE Module 1 and IFE Module 2[3]).

In 2006, IFE Core Group activities were marked by an international strategy meeting on IFE that was held by the IFE Core Group on 1-2 November, 2006 in Oxford, UK, organised by the ENN[4]. The meeting was called due to concerns regarding an apparent failure to implement the Operational Guidance on IFE – reflected in poor co-ordination, poor policy awareness and limited technical know-how in IFE in recent emergency responses. The meeting identified both constraints and opportunities to support and protect appropriate infant feeding practices in emergencies, and generated specific strategy directions and practical steps to meet these needs. One of the specific recommendations of the meeting was to "hold regional orientation workshops on IFE" – identified as critical to improve on coordination, policy guidance implementation and response capacity. Having significantly contributed to the experiences shared at the Oxford meeting, Indonesia was selected as the location for the first regional orientation workshop.

The regional IFE workshop was held 10-13th March, 2008, organised by the ENN and IFE Core Group members. It was funded by the Inter-Agency Standing Committee (IASC) Nutrition Cluster and IBFAN-GIFA. In addition, many country delegates were funded by UNICEF or the delegate's agency.

The focus of the workshop was on emergency preparedness and improving the early response to protect and support infant and young child feeding in emergencies. The objectives of the workshop were to:

- Increase awareness of the importance of IFE in the region, including orientation on relevant policy and guidance, particularly the Operational Guidance on IFE
- Highlight key regional issues in IFE
- Identify key constraints to providing early support and protection for appropriate infant and young child feeding practices in emergencies, and
- Identify strategic directions and practical steps to address these at country and regional levels.

One hundred and eleven people attended from 16 countries and territories throughout Asia, with representatives from various organisations including IBFAN-GIFA, UNICEF, WHO, Care, University College London (UCL) Centre for International Health and Development (CIHD), Infant Feeding Consortium at UCL CIHD[5], Save the Children UK, Action Contre la Faim (ACF), IFRC and UNHCR (see the page facing the back cover for the full list of participants).

The agenda is included in Annex 1 and key points from all the presentations are integrated in this report[6].

[2] Operational Guidance on Infant and Young Child Feeding in Emergencies. Version 2.1, 2007. See online: http://www.ennonline.net/ife/category.aspx?catid=4

[3] Module 1 Infant Feeding in Emergencies for emergency relief staff. WHO, UNICEF, LINKAGES, IBFAN, ENN (2001) and Module 2 Infant Feeding in Emergencies for health and nutrition workers in emergency situations. ENN, IBFAN-GIFA, Fondation Terre des hommes, CARE USA, Action Contre la Faim, UNICEF, UNHCR, WHO, WFP, Linkages (version 1.1, Dec 2007), online: http://www.ennonline.net/ife/category.aspx?catid=5

[4] Infant and Young Child Feeding in Emergencies Making it Matter Report. IFE Core Group, February 2007. Available in print from ENN or online at http://www.ennonline.net

[5] The Infant Feeding Consortium (IFC) is based at the UCL Centre for nternational Health and Development (CIHD) in London. It provides specialists in training, curricula development, formative research, health information and writing, programme review and policy development on infant and young child feeding. E-mail: bfeed@ich.ucl.ac.uk

[6] The full presentations are available online at http://www.ennonline.net/ife in the IFE Resource Library (select 'Presentations')

3 Setting the Scene on Infant and Young Child Feeding in Emergencies (Day 1)

3.1 Overview

Day 1 comprised a series of presentations and plenary discussions intended to set the scene in relation to the policy guidance that exists for IFE, the extent of the problem of IFE and to share information on some initiatives that are being implemented which should contribute to improved support for IFE. Attention was drawn to the Operational Guidance on IFE that formed the basis for and structure of the meeting.

3.2 Opening comments

The workshop was opened by Bruce Cogill as the Global Nutrition Cluster Coordinator, Dr. Ina Hernawati, Director of Community Nutrition of the Ministry of Health (Indonesia), Dr. Gianfranco Rotigliano, Representative of UNICEF Indonesia, and Dr. Nugroho Abikusno, Regional Advisor for Nutrition of WHO South-East Asia Regional Office (SEARO). All the speakers emphasised the importance of IFE as an essential component of an adequate humanitarian response. They also, however, lamented the fact that to date, the response of national governments and international agencies has seldom been optimal. Dr. Hernawati and Dr. Rotigliano both cited the experiences of Indonesia following the tsunami in 2005 and the Yogjakarta earthquake, when large amounts of unsolicited donations of infant formula and baby milks were sent in and distributed, with negative results on child health and nutrition.

3.3 Session 1: Policy guidance and coordination

The first session focused on policy guidance and coordination in emergencies. Karen Codling, an independent consultant working for the ENN, gave an introductory presentation on the importance of IFE and how this is reflected in several global declarations and strategies. She then went on to provide an overview of the Operational Guidance on IFE, which provides the best available guidance on what to do and not do on IFE. Flora Sibanda-Mulder, UNICEF Senior Advisor for Nutrition in Emergencies, then reviewed the experiences to date on infant and young child feeding in emergencies and in particular, laid out the responsibilities of UNICEF, as lead agency for the Nutrition Cluster, on IFE.

A key issue that was raised by both presentations was the linkage between infant and young child feeding in emergencies and 'non-emergencies'. IFE often reflects poor infant and young child feeding (IYCF) in non-emergencies. Correcting IYCF during emergencies is therefore doubly hard because of the difficult conditions resulting from the emergency and the lack of understanding, awareness and capacity within the community and government, for example, to adequately protect, promote and support breastfeeding that existed even pre-emergency. Much work, therefore, needs to be done to improve IYCF in general, not only in emergencies. The point was made however, that the IFE response can often raise awareness and political commitment of the need to do more during non-emergencies – and may even strengthen national IYCF programming as a result. On a related issue, it was agreed that while policies on IFE are needed, it was preferable for them to be integrated into national IYCF policy or emergency response policy, or both.

3.4 Session 2: Regional challenges regarding donations in emergencies

The second session addressed the important issue of dealing with donations of infant formula and other milk products during the emergency. David Clark, Legal Advisor in the Nutrition Section in UNICEF Headquarters (HQ), provided information on the International Code of Marketing of Breastmilk Substitutes (BMS) and subsequent relevant World Health Assembly (WHA) Resolutions (The International Code)[7]. The International Code is important for protecting infants and caregivers from inappropriate marketing of breastmilk substitutes (BMS) and, in emergency situations, is especially important for controlling unsolicited donations and preventing distribution of unsuitable products. The International Code has been integrated and built upon in the Operational Guidance on IFE.

Sri Sukotjo from UNICEF Indonesia provided valuable quantitative data on the extent and impact of uncontrolled distribution of infant milk in Yogjakarta after the 2006 earthquake. She showed clear correlations between receipt

[7] The International Code of Marketing of Breast-milk Substitutes. WHO,1981. Full Code and relevant WHA resolutions are at: http://www.ibfan.org/English/resource/who/fullcode.html http://www.who.int/nut/documents/code_english.PDF

of donations of formula and milk products, its use and diarrhoea incidence. This is the first time such concrete data on the extent and impact of donations has been available; more often there are only anecdotal reports.

Finally, Karleen Gribble, Research Fellow at the University of Western Sydney, Australia gave a presentation that provided an indication of the extent of donations of BMS, such as infant formula and milk powder, by a wide variety of organisations, as reported by the media. She went on to show how infant feeding during emergencies is portrayed in the media. Her presentation demonstrated that donations of BMS in emergencies are very widespread and are made or requested by a very large number of organisations, including national governments and Red Cross societies. Her presentation also reflected the wide extent of misconceptions about IFE – misconceptions that are perpetuated by the media – and the fact that women seldom get the kind of support they need.

Discussions after the presentations raised the issue of how to stop such donations. The IFE Core Group proposed that it was the responsibility of all at the workshop to educate others on why milk powder and infant formula should not be donated[8]. It was agreed that some donations are made or requested because of poor understanding of the dangers of artificial feeding. However some donations are also made by organisations, such as formula companies, in order to encourage use of their products and therefore expand their market. It is also important to acknowledge that donations may well be the result of mothers with infants and young children in emergencies crying out for help and for food for their children. The public, the media and all involved parties respond to this be sending BMS, whereas what mothers really need is appropriate support in the early phases of an emergency that is assessment rather than just demand driven.

A 'Call for Action on IFE' was proposed in this session and stemming from this, a 'Pledge for Action' was drawn up and agreed to by all participants on Day 3 (See inside back cover).

3.5 Session 3: Country situation analysis

In this session, country teams undertook an exercise to map their current situation with regards to IFE and identify key areas of concern. Countries indicated on a matrix which issues were a big problem, a small/medium problem or not a problem at all (see Figure 1). The list of issues was taken from each component of the Operational Guidance on IFE. Each country only had a limited number of 'big problem' and 'small/medium problem' cards, in order to prioritise the areas of main concern.

Figure 1: Country situation analysis

	Australia*	Afghanistan	Bangladesh	Cambodia	China	DPRK	India	Indonesia	Myanmar	Nepal	Pakistan	PNG	Philippines	Sri Lanka	Thailand	Taiwan	Viet Nam
Infant Feeding Practices/Current Situation (outputs)																	
1. Low EBF rates in non-emergency times																	
2. High rates of bottle/formula feeding in non-emergency times																	
3. General perception that formula is as good as or better than breastmilk																	
4. MTCT of HIV an important cause of child mortality																	
Current IYCF/IFE Programme (inputs)																	
5. No national Code of Marketing of BMS or existing Code is not enforced																	
6. No government policy on IFE or policy is not implemented																	
7. Few government staffed trained on or knowledgeable about IFE																	
8. Few NGOs trained on or knowledgeable about IFE																	
9. Few lactation consultants during emergencies																	
10. Perception that women cannot breastfeeding during emergencies																	
11. Unsolicited donations of formula/milk powder received																	
12. Emergency food distributions do not contain suitable foods for CF																	
13. Emergency foods distributions often include formula or powdered milk																	
14. People in charge of emergency coordination do not prioritise IFE																	
15. NGOs operate independently of the national emergency response																	
16. Rapid assessments seldom include information about IF																	
17. Poor understanding on indicators for IFE assessments																	
18. BF support services often not provided during emergencies																	
19. Emergency areas seldom have places suitable for women to BF																	
20. There are no systems to minimise risks of formula feeding																	

EBF: exclusive breastfeeding rate; BMS: breastmilk substitute; MTCT:Mother to child transmission; CF: complementary feeding
* Australia was added during the exercise out of interest, as a significant donor country in the region.

Many countries reported high rates of artificial feeding during non-emergency times – this, of course, creates a high demand for BMS during emergencies. Meanwhile, on the programme side, the most widespread problem was poor coordination on IFE – ranked as a big problem by 11 out of 16 countries. A majority of countries also reported lack of a policy on IFE or poor implementation of an existing policy as a big problem. Low capacity (i.e. insufficient training) of government staff and non-governmental organisations (NGOs) was also common and many reported inadequate access to quality lactation counselling expertise in countries. Insufficient support services for breastfeeding and insufficient systems to minimize risks of artificial feeding during emergencies were also mentioned by many countries. Some of the larger, more developed countries, such as Thailand, Philippines, Indonesia and Sri Lanka, also reported a lot of unsolicited donations.

This 'mapping' exercise further helped to set the scene and enable participants and facilitators to see the main areas of concern in the region. It also created an opportunity to discuss some of the things that countries felt they are doing well.

Completed country grid reflected in Figure 1

3.6 Session 4: Initiatives to support IFE

This session included a series of presentations on initiatives to support implementation of IFE. Lida Lhotska of IBFAN-GIFA informed the workshop about the preparation of a model Joint Statement[9] on IFE by the IFE Core Group. An existing Joint Statement, issued by UNICEF, WHO and IFRC during the Yogjakarta earthquake response in Indonesia was shared. The participants were invited to contribute any suggestions for improvement through Days 1 and 2. Based on this feedback, a model joint statement for the region would be presented on Day 3 (if concensus reflected in feedback).

Bruce Cogill started the session by presenting a review of the cluster approach, highlighting what the goals of the Nutrition Cluster are at national and global level. This was followed by a review of what the Nutrition Cluster has achieved globally to date.

Marco Kerac, UCL CIHD, then introduced the management of acute malnutrition in infants (MAMI) Project. Funded by the Nutrition Cluster, the MAMI Project is led by ENN in collaboration between ENN, UCL CIHD and ACF. The aim of the MAMI Project is to investigate the management of acutely (moderately and severely) malnourished infants under six months age (0-5.9m) in emergency programmes, in order to establish consensus on (interim) good practice guidelines. Marko explained how this is a long-standing gap area identified through the work of the IFE Core Group and collaborators and outlined some of the issues the project is considering, e.g. development of a conceptual framework on causes of malnutrition in this age group. The main methodology of this project is to review what is currently happening in the field for 0-5.9 month old infants, including quantitative and qualitative data collation and any associated outcomes, to instigate development of good practice guidelines, a research agenda and improved collaboration and linkages within this area[10].

This session finished with Dr. Nugroho Abikusno describing a vulnerability mapping system that is being used by the SEARO office of WHO that ranks countries by vulnerability to emergencies (man-made and natural) and also ranks the disaster management structure. At present IFE is not considered in this analysis but he concluded it should be and shall follow this up.

The discussion that followed these presentations reflected a lot of interest in the MAMI project and some countries, e.g. Afghanistan, reported a significant proportion of acutely malnourished infants below 6 months. Clarifications were also sought on the roles of governments vis-a-vis the cluster approach and roles and responsibilities of different organisations on different aspects of the emergency response. There was a lot of interest and discussion around Ready to Use Therapeutic Foods (RUTF) – what is their role, what is the potential for cheaper versions or local production, how to strengthen national programmes, etc. Some felt a constraint to their sustainable use was their cost. A key issue, however, was that improved IFE in general, in particular complementary feeding, would reduce malnutrition and hence the need for treatment of severe acute malnutrition (SAM) and consequently RUTF. The point was also made that continued breastfeeding forms a key component of appropriate management of SAM and that RUTF is not, and should not be treated as, a breastmilk substitute.

[8] A defined need should be met through purchased supplies of BMS and handled by an experienced agency with nutritional and medical expertise (see Operational Guidance on IFE).

[9] A Joint Statement sets out the position of the signatories on a particular issue. The statement may set out or refer to relevant policies of the organisation(s) in question. Joint statements are generally used to inform others, including operational agencies, the government, media, and the general public about an issue, and often call for action to be taken. Development of a model Joint Statement was identified as an action point at the Oxford Strategy Meeting in 2006.

[10] A side meeting on this project was held on the evening of Day 2 where the methodology was expanded on, with strong participant feedback. The evening session presentation is available online at http://www.ennonline.net/ife in the IFE Resource Library (select 'Presentations') For more information on the MAMI Project, visit: http://www.ennonline.net/research or contact: marie@ennonline.net

4 Challenges Related to Implementation (Day 2)

4.1 Overview

Having set the scene on Day 1, the second day of the workshop focused on challenges related to implementation. Sessions were planned around various components of the Operational Guidance on IFE that form the basis of a good IFE strategy. The topics included policies, capacity building, assessment and monitoring, protection and support of optimal IYCF and minimising the risks of artificial feeding. The agenda items were very much guided by interests of the delegates attending and what they felt were the key issues[11].

4.2 Session 5: Avoiding unsolicited donations

The opening session reinforced that the Operational Guidance on IFE recommends that donations of BMS, milk products, bottles and teats should be avoided in emergencies. This builds on the minimum requirements laid down in the International Code and is informed by experiences from emergencies over the past seven years.

Florinda Panilo of the Department of Health of the Philippines and Sawsan Rawas of UNICEF Democratic People's Republic of Korea (DPRK) both presented on the various ways their two organisations have been trying to prevent unsolicited donations of BMS during emergencies[12].

Florinda's presentation illustrated the high number of emergencies that the Philippines experiences, the large volume of BMS that are donated and distributed with little monitoring or control and the lack of breastfeeding support services that are provided to women. Recognition of this situation led to a decision to develop a policy for managing humanitarian aid and strengthening capacity to prepare for and manage relief supplies. She described the process by which the policy was developed and several supportive events that took place. The relevant 'Administrative Order 2007 – 0017: Guidelines on the Acceptance and Processing of Foreign and Local Donations during Emergency and Disaster Situations' has now been approved. It articulates a rational and systematic procedure for the acceptance, processing, and distribution of foreign and local donations of supplies during emergencies and specifically notes "'Infant formula, breast-milk substitutes, feeding bottles, artificial nipples, and teats shall not be items for donation. No acceptance of donations shall be issued for any of the enumerated items." Florinda described how the new administrative order was being disseminated, including informing the media and disseminating the policy within the health emergency management system in the Philippines. In questions for clarification, Florinda also shared how the Administrative Order has been communicated to all foreign embassies in the Philippines.

Sawsan's presentation recounted efforts made by UNICEF to stop unsolicited donations to the DPRK during extensive flooding in mid-2007. Her presentation highlighted the difficulty of even identifying donations and tracing them back to their source. In this case, UNICEF used diplomatic channels to try to inform foreign governments of the global policies and recommendations against the use of infant formula/milk powder in emergencies and the problems presented by donations. UNICEF headquarters in New York sent letters and met with UN missions to the countries in question – South Korea and Russia. In the end it was not possible to stop the donations but it is hoped that the experience and advocacy that took place will influence future potential donations.

In the discussion of the two presentations, participants proposed to suggest IFE as a theme for World Breastfeeding Week to the World Alliance for Breastfeeding Action (WABA)[13]. This would build upon the 2008 theme of mother support. David Clark reiterated that the International Code does not condone or call for donations of BMS.

4.3 Session 6: Breastfeeding, complementary feeding and artificial feeding in emergencies

This session addressed breastfeeding, complementary feeding and artificial feeding in emergencies. Dr. Roesli

[11] Delegates had been asked to complete a form pre-meeting, which asked what topics they most wanted to discuss.

[12] Field articles detailing the Philippines and DPRK's experiences is scheduled for inclusion in ENN's publication, Field Exchange 34 (due out October 2008). Available at www.ennonline.net

[13] IFE was also proposed as a theme at the Oxford Strategy Meeting and a justification was submitted to the WABA secretariat by IFE Core Group members, IBFAN-GIFA, ENN and UNHCR, led by IBFAN-GIFA. Feedback was that it was a close contender. The 2008 proposition will be followed up by IBFAN-GIFA.

Utami, Chairman of the Sentra Laktasi (Breastfeeding Centre) Indonesia, described the cascade breastfeeding support used as part of the post 2006 Yogjakarta earthquake response in two districts of Indonesia. Through a system of facilitator-counsellor-motivator, the programme has already succeeded in reaching large number of mothers at family level, quickly. Follow-up found that 63% of mothers targeted in the programme were exclusively breastfeeding, regardless of having received donations of infant formula. Initial costs of training and materials development were covered by UNICEF. However the motivators, in particular, were empowered and continued assisting breastfeeding mothers without remuneration. In the discussion, it was clarified by the presenter – and other experiences from Pakistan emergencies – that such a response could not be mounted immediately, but could be set up within 6 – 10 weeks after the onset of an acute emergency.

The following presentation gave the perspective of Vicky Sibson, HQ Nutrition Advisor, SC UK, on complementary feeding in emergencies (CFE). She detailed how SC UK, as one of the supporters[14] of the Operational Guidance on IFE, is working to implement and build on its provisions with regard to complementary feeding. This includes building it into initial assessment and standard operating procedures, advocacy between departments within the agency, as well as in their technical interventions on the ground. She emphasised training as key. She outlined the 'typical' CFE interventions available (e.g. using 'real' complementary foods, fortified foods, 'Sprinkles', supplements), some regional experiences in using them, and the challenges. She went on to describe how in SC UK, CFE is not considered as a 'stand alone' intervention but a fundamental part of their livelihoods approach. This supports the overlap between their emergency and development programming. Other approaches that are being considered are complementary food vouchers, cash schemes and Ready to Use Supplementary Foods (RUSF). In response to questions from the floor, she emphasised the need to ensure the distinction between complementary feeding and supplementary feeding. Plenary discussion also raised questions regarding how sustainable the use of Ready to Use Therapeutic/ Supplementary Foods are (especially if used to 'prevent' rather than just treat malnutrition), their appropriateness for use as a complementary food, and the need to balance these innovations with more food based/holistic approaches to feeding infants and young children.

The next series of presentations introduced the topic of supporting artificial feeding of non-breastfeed infants. The extreme challenges were demonstrated using the context of HIV, beginning with a global policy and technical overview by Zita Weise Prinoz, Technical Officer, Emergencies, at WHO Geneva. This was followed by key considerations and principles in applying the global consensus at agency level, given by Kathy Macias of UNHCR HQ, and then to the practical realities and dilemmas of implementation at local level by Yara Sfeir from UNHCR Bangladesh[15]. An important question was raised of how to deal with situations where infants may be established on replacement feeding when a crisis strikes and what was an acceptable, feasible, affordable, sustainable and safe (AFASS) situation before, may now no longer be the reality. The participants agreed that many of the key challenges around replacement feeding in the HIV context are applicable to artificial feeding in emergencies in general. It was emphasised that AFASS criteria could be used in any process of considering artificial feeding as an option, especially in emergencies, and not just restricted to the context of HIV. Given the evidence base behind the latest HIV and Infant Feeding Consensus Statement (2006), the creation of a facilitating environment for early, exclusive and continued breastfeeding has become an imperative. The session reinforced the importance of skilled infant feeding counselling and support in emergencies that takes into account both the individual mother-baby situation, and existing services and their capacity to support caregivers in their infant feeding decision. It also highlighted how wet nursing could be a very successful way of feeding infants in emergency situations.

4.4 Session 7: Challenges to IFE assessment

This session was opened by Mary Lung'aho, Care USA, who presented a schematic[16] to explore what kind of IFE assessment[17] to do and when, in the context of an emergency (see Figure 2). Bruce Cogill then described a tri-cluster initiative (Health, Nutrition, and Water, Sanitation and Hygiene (WASH) to develop a standard, multi-sectoral rapid assessment tool, called the Initial Rapid Assessment (IRA) Tool. Ali Maclaine (Independent/ ENN) gave a personal overview of issues related to undertaking sector-specific rapid assessments on IFE drawing on her recent experiences in Bangladesh. Dr. Nugroho Abikusno, WHO, described experiences in IFE assessment in South-East Asia. Marko Kerac, UCL CIHD, described some considerations and lessons learned in integrating infant feeding into routine (30x30 cluster) nutrition surveys[18] and Mary Lung'aho introduced a step-by-step guide to monitoring of infant and young feeding behaviours in emergencies using standard indicators, being developed by CARE USA.

[14] An increasing number of agencies have signed up to support the Operational Guidance on IFE – defined as reflecting the position on IFE within an agency, and/or the thinking within an agency and a position they are working towards. See latest list of supporting agencies at http://www.ennonline.net/ife

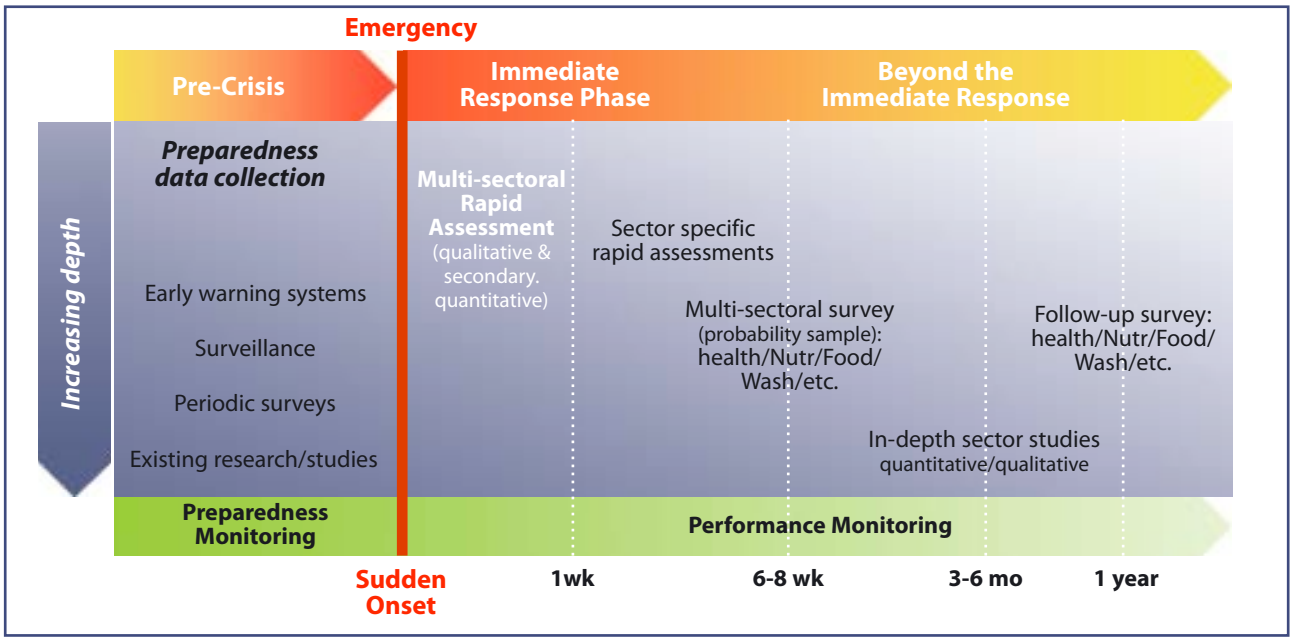
[15] Yara Sfeir's experiences featured in Field Exchange 32 (January 2008). Wet-nursing for refugee orphans in Bangladesh. Yara Sfeir. P26. Postscript by UNHCR, p27. Available online at: www.ennonline.net

[16] Adapted from a scheme used in the development of an Initial Rapid Assessment (IRA) Tool by the IASC Nutrition Cluster.

[17] The term assessment was used in this session to describe the process of critically looking and gathering information. It therefore encompasses all types of data (quantitative and qualitative) and methods of collection, including surveys, at any stage of an emergency response.

[18] This presentation shared the main findings and recommendations of a paper currently in preparation for publication by CIHD, ENN and UNHCR, provisionally titled: 'Assessing infant feeding as a component of emergency nutrition surveys: Feasibility studies from Algeria, Bangladesh and Ethiopia' A final draft be available by June 2008. For more details, contact: marie@ennonline.net

Figure 2: Assessment in the context of emergency preparedness and response



The presentations generated a lot of discussion and clearly more opportunity to compare experiences and reach conclusions on the best way to do IFE assessments is needed. However some conclusions and lessons learned from the session include:

- The schematic (Figure 2) of what kind of assessment to do and when in the context of an emergency was judged to be useful by most participants, by introducing useful common terminology and in considering what type of assessment activities should happen when.
- Different kinds of assessment are needed and are feasible at different times and there is no hard and fast rule on exactly what to do and when. However things to keep in mind are:
  - To be clear on the objectives of the assessment/ survey
  - Methodology adopted should depend on the objective, the way the information will be used and conisder logistics, feasiblity, resources, etc.
  - To collect only the most necessary information for programme planning – less is often more. The temptation is often to use the 'opportunity' to collect a lot of IYCF data, but much of this may not be relevant for programme planning in the immediate situation and thus wastes time and resources.
  - Wherever possible, standard IYCF indicators and methodologies should be used to facilitate comparison with pre-emergency data and other surveys/assessments.
  - At any stage of the assessment process, consideration of adequate sample size is important – this has implications for cost and feasibility but also for what can eventually be done with the data collected (e.g. will the precision be adequate for the objectives of the survey?)
  - Undertaking assessments is often hampered by access to the area, availability of data collectors, status of potential respondents, time for preparation, resources – this affects timing of the assessments, what can be done and when.
  - A balance is needed between spending time and resources on assessments vs. implementing interventions. However, some amount of data can greatly improve the quality of interventions and also provide monitoring and evaluation of data for programme managers, donors, etc.

4.5 Session 8: Challenge of communication in emergencies

Karleen Gribble (University of Western Sydney) presented a case study from Bangladesh after Cyclone Sidr in 2007 and Anton Susanto of UNICEF Indonesia described the process of developing communications materials after the Yogjakarta earthquake in 2006.

Karleen reported on the large number of media reports on government or military donations of BMS or requests for BMS. She also showed that some aid agencies had provided or requested BMS. Meanwhile, situation reports lamented the lack of infant formula/'baby foods' and talked about mothers' inability to breastfeed. There were no reports, however, on the fact that breastfeeding supports child survival, that infant formula and powdered milks need to be carefully targeted, or the risks of artificial feeding. Karleen then emphasised that while the media is currently contributing to calls for donations and perpetuating misconceptions about IFE, there is a big potential to use the media to improve IFE. But critically, the message we send out to the media needs to emphasise the risks of artificial feeding in emergencies, rather than just extolling on the benefits of breastfeeding.

Anton Susanto described an initiative called CREATE (Communication Resources Essentials and Tools for

Emergencies)[19], which aims to develop and bring together materials for communications in emergencies. These materials can then be adapted in emergencies in order to rapidly develop appropriate materials without having to take the time to start from scratch. In the Yogjakarta experience, community focus groups gave feedback on draft messages and images and they explained what they understood from sample materials. They preferred the unconventional approach, wittiness, "straight to the point" messages and more "urban" images. They felt that the image of a mother breastfeeding her baby was "too common [routine]". The most popular material consisted of a picture of a bottle stuffed with money. One of the images developed is shown in Picture 1, where the text in Bahasa says "In this difficult time, you have got to be smart. Why would you spend on expensive items? Breastmilk, a smart choice for mothers". The focus group reported that they liked it because it was funny, attention grabbing and was relevant to their current situation.

Both examples provided important lessons, including:

- The potential of the media in informing and educating the public about IFE.
- The need to move away from 'traditional messages' such as 'Breast is Best' and images of breastfeeding women, to find more targeted and 'relevant' messages and images. This includes informing the public of the risks of artificial feeding.

Picture 1: An example pf the CREATE materials produced in the Indonesia earthquake response. The text translates "In this difficult time you have got to be smart. Why ould you spend on expensive items? Bresatmilk,a smart choice for mothers."

- The opportunity of CREATE to prepare, gather and archive materials, messages and tools for communication on IFE in emergencies and pre-emergencies – such that appropriate and innovative communication materials can be quickly developed at the time of emergencies.

4.6 The Code/Milk Code in the Philippines (evening session)

In the evening, an optional session was arranged to share information with interested participants on recent happenings with the Code in the Philippines. The turnout was very good for this session and many people indicated in their evaluation forms that this was one of the most useful sessions of the meeting.

Sally Panje of the Department of Health (DOH) of the Philippines and David Clark, Legal Advisor in the Nutrition Section in UNICEF HQ, explained what had happened. In 1986 the Philippines adopted legislation to control the marketing of BMS - called the Milk Code. Then, in 2006, it was decided to update the Implementing Rules and Regulations (IRR) of the Milk Code, in recognition of more aggressive marketing of BMS and weaknesses in the existing implementing rules. The Revised Implementing Rules and Regulations (RIRR) were issued in May 2006, however, in June 2006, the Pharmaceutical and Health Care Association of the Philippines (PHAP) petitioned the Supreme Court to apply a Temporary Restraining Order (TRO) on the RIRR because they disputed the authority of the DOH to issue the RIRR and the validity of a number of provisions. The Supreme Court refused to sanction the TRO in July 2006, but in August they reversed their decision and applied the TRO. In June 2007, the Supreme Court heard oral arguments from both sides and, they issued their decision in October 2007. Their decision agreed partially with PHAP in relation to a total ban on advertising of all products under the scope of Milk Code and that administrative sanctions exceeded the power conferred upon DOH by the Milk Code. However, they ruled in favour of the DOH and lifted the TRO because other parts of the RIRR were consistent with the objective, purpose and intent of the Milk Code and it constituted reasonable regulation of an industry whose activities affect public health.

The experience from the Philippines is significant because the ruling very much supports the principles and implementation of the International Code and has relevance to other countries. David Clark's presentation detailed some of the specific elements that are of importance for global implementation. Meanwhile, Sally's presentation emphasised the second unique and significant lesson about the Code fight in the Philippines; despite the size, power and resources behind the PHAP case, the DOH, with the support of UNICEF, WHO and many national and international NGOs, was able to develop a massive, powerful lobby for breastfeeding that has been sustained.

[19] See at http://www.createforchildren.org

5 Strategic Directions and Country Action Plans (Day 3)

5.1 Overview

The third day of the workshop was a day of working groups, designed to help consolidate some of the presentations and discussions from the previous days. In the morning of Day 3 (Session 9), participants divided themselves into thematic working groups, with one working group for each of the components of the Operational Guidance on IFE – Policies, Capacity Building, Coordination, Assessment and Monitoring, Protection, Promotion and Support of Optimal IYCF and Minimising the Risks of Artificial Feeding. These working groups then reported back to plenary. In the afternoon (Session 10), the participants divided into country working groups to develop action plans that looked back at what they had indicated were their priority problems and considered whether they needed to take action in any of the six components of the Operational Guidance on IFE. They took into account the consolidated ideas of the thematic working groups from the morning.

5.2 Session 9: Strengthening IFE planning and implementation

Policies working group: The group agreed on the need for a policy on IFE that must both stress protection, promotion and support of breastfeeding and address procurement, distribution and use of BMS, milk products, commercial baby food and infant feeding equipment in compliance with the International Code. The group felt, however, that it was not beneficial to have 'stand alone' IFE policies – rather that IFE concerns should be addressed in national disaster management and general IYCF policies. The group recognised the need for high level endorsement and multi-sectoral agreement and buy-in for such policies. The policy should also guide coordination. The group listed out the various sections of the IFE policy and also which ministries/sectors should be included in it.

Capacity building working group: Recognising that there are many elements to achieving 'good' IFE, the group considered capacity building in the broader sense, not simply as training. Participants pointed out the importance of including IFE issues such as policy, implementation guidelines, coordination plans, and orientation and advocacy of key staff (decision-makers, in particular) as part of capacity building for emergency preparedness. Training of front line health/nutrition staff and community workers on IFE issues was also mentioned, but only after much discussion on first the need for policies and essential orientation of decision-makers. Participants identified the need for national databases of staff trained in IYCF and breastfeeding generally, as well as on specific IFE issues, that could be called on during emergencies.

The group developed several 'strategic directions' for improved capacity building that included:

- Development, approval and implementation of government policies on IYCF in general and specifically in emergencies
- Incorporation and/or development of general guidelines for emergencies, including nutrition and IYCF
- Identification of focal persons (national, state level and district level) in different departments
- Global guidelines on 'do's and don'ts' of what to include in a food box or typical package/kit to be sent out in an emergency
- Formation of a national/state/district disaster management core group into which IYCF is integrated
- Advocacy and key messages on IFE to decision-makers
- Conducting training workshop for health and non health personnel, follow up training, and supportive supervision on IFE – using IFE Modules 1 and 2
- Maintenance of a large database of trained IFE staff ready to be deployed that is regularly updated
- Creating national level trainers focusing on IFE
- Awareness to the media and awareness through the media on IFE
- Ensure the availability of appropriate communication materials for use in emergencies that can be quickly produced or adapted
- Assignment of an IFE focal person with a support group that can operate during an emergency but can also advocate, train and fundraise
- Maintenance of a roster of community trained people likely present in emergencies
- Monitoring and evaluation of training activities by district/state/national/ core group members
- Re-orientation/reinforcement of rapid response teams on IFE practices and requirements
- Documentation, reporting, sharing information and lessons learned post emergency.

Coordination working group: This group recognised that constraints and solutions around coordination vary between the preparedness phase and the early response. As a result, they had a list of solutions for each phase.

Preparedness Solutions

- Appropriately implement the cluster approach with clearly defined Terms of Reference (TORs), e.g., food vis-a-vis nutrition
- Government leadership and involvement from the beginning
- Advocacy and technical support for Government commitment to IYCF
- Advocacy for placing nutrition and IFE high on Government agenda
- Technical and managerial support to ensure effective implementation of IYCF actions
- Media briefing and press conferences on key issues on IYCF
- Develop standardised messages for the media[20]
- Ensure availability of IFE baseline data before emergency strikes
- Ensure harmonised and coordinated training of health workers and breastfeeding counsellors
- Adoption of Operational Guidance on IFE

Early Response Solutions

- IFE to be included in initial assessments
- IFE to be included in joint appeals
- Registration of children 0-5 years to identify separated/ orphaned children
- Coordinated decision making on the food basket for emergencies
- Provision of multiple micronutrients for pregnant and lactating women and children 6-59 months
- Coordination with WASH agencies to ensure secure access to safe water and sanitation facilities
- Coordination with the military and other sectors to protect against inappropriate IFE responses
- Coordination in support to non-breastfed infants
- Coordination in monitoring of use of BMS

Assessment and monitoring working group: Recommendations on IFE assessment and monitoring are included in various sections of the Operational Guidance on IFE. The assessment and monitoring working group pulled these key recommendations together and expanded on them, including using the terminology 'Initial Rapid Assessment (IRA)' for consistency with the Cluster IRA Tool development, and with reference to the schematic on assessment presented earlier in the workshop (see Figure 3).

Overall the working group concentrated on the role of three 'types' of IFE assessment, (noted on schematic in Figure 3):

Type 1: Initial rapid assessment (IRA) or multi-sectoral rapid assessment. This would generally use secondary data and qualitative assessment and may entail use of many methods e.g. key informant interviews, focus groups.

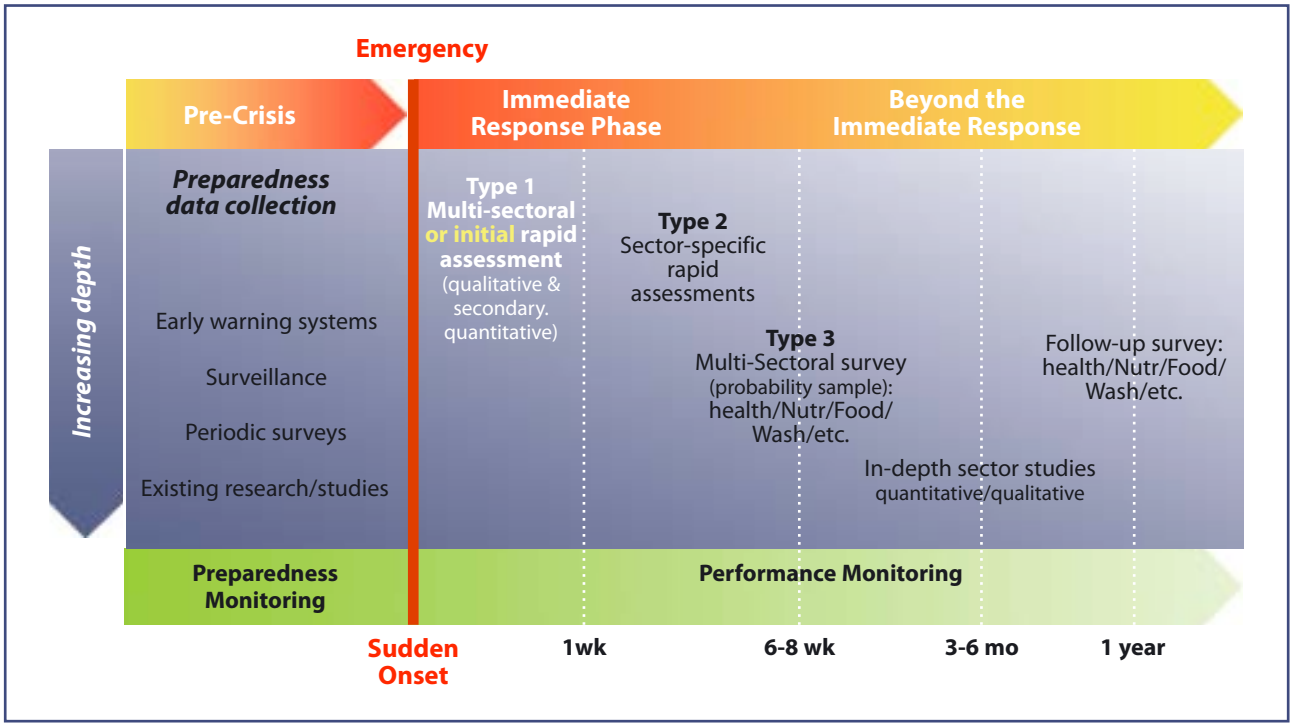
Type 2: Comprehensive assessment in the form of a sector-specific rapid assessment.

Type 3: Comprehensive assessment in the form of multi-sector surveys.

For the multi-sectoral surveys (Type 3), they discussed two potential approaches; one would be to undertake the

[20] A briefing for the media on IFE has been developed by the IFE Core Group, funded by the IASC Nutrition Cluster as part of a package of IFE activities. Available in Resource Library at http;//www.ennonline.net/ife

Figure 3: Different types of IFE assessment, reflected on assessment schematic



survey with WHO methodology, in terms of full sampling and use of standard questionnaires commonly used in Demographic and Health Surveys (DHS) and UNICEF Multiple Indicator Cluster Surveys (MICS)[21]. However there was recognition that this may not be feasible in a given situation, or there may be information needed particular to an emergency context that is not captured in the standard questionnaires. Therefore some form of rapid or 'Dip-Stick Approach' was needed to capture key (and possibly unique) IFE information to understand possible gaps in practice and make recommendations for programming. This approach could utilise multi-stage cluster sampling and modified, simplified questions on breastfeeding and complementary feeding. Suggested useful 'dip-stick' questions for an emergency situation (that could be added to the usual DHS/MICS questionnaire, for example) included: Why did you stop breastfeeding? Is the child separated from mother? Are you feeding your child more, less or the same amounts than before the emergency? Questions on bottle availability/use.

This working group went into considerable detail exploring the actual information that could be gathered and questions asked at various stages of the assessment process[22]. The 'brainstorming' in this working group produced a good basis from which to develop thinking on IFE assessment post-meeting.

Protecting, promoting and supporting optimal IYCF working group: This group recapped the constraints to adequate protection, promotion and support of IYCF as had been discussed on the previous two days, highlighting lack of pre-emergency preparedness, including policies, plans and a coordination system. They also pointed out the constraints of negative media messages and staff turnover or 'non-institutionalisation' of IFE into organisations. They saw the solution as to improve 'normal' pre-emergency preparedness through institutionalisation of IFE and the development of policies for IFE. They also mentioned the need to control BMS distribution, strengthen education and formulate key messages relevant to emergency challenges, develop a coordination plan within the Nutrition Cluster and strengthen support services such as clean, safe water, nutrition for women and 'spaces' for breastfeeding. On the communication side they proposed the key messages of:

- "Formula is dangerous"
- "You can breastfeed with support"
- "Exclusive breastfeeding for 6 months"
- "You can increase your [breast]milk supply".

The group also highlighted the need for locally appropriate messages about complementary feeding and relevant elaborations to the above, for example around continued breastfeeding for 24 months or beyond. They emphasised the need for all messages to be appropriate and sensitive.

The group clarified that protection entails control of BMS distribution and advocacy to government, donors, health workers and the disaster response team. Promotion entails education to the community and media on IYCF and support entails peer counsellors, community support groups, spaces for breastfeeding and adequate food for mothers to eat and feed their older infants/ children.

Minimising the risks of artificial feeding working group: Artificial feeding may be necessary in emergencies because, for example, the mother has died or is absent, is very ill/injured, is HIV positive and has chosen not to breastfeed, has stopped breastfeeding and relactation is not possible/desired, the infant is rejected by the mother or is an orphan and wet nursing is not yet established or not possible. Yet artificial feeding is often a dangerous option, particularly in emergencies when water supplies may be contaminated and/or limited and where it is difficult to make the formula safely. This group therefore aimed to identify the key constraints and the strategic directions to address them.

The main constraints include:

- Lack of knowledge of all stakeholders about the risks, what to do to minimize the risks and what is needed. Overall there is little understanding amongst the many emergency 'players' of the dangers of artificial feeding and the need to minimize the risks.
- The importance of minimizing the risks of artificial feeding is a difficult message to communicate and often it is not being made.
- Many emergencies experience a flow of unsolicited donations which undermines management of the situation and is hard to control. There is also little agreement on how to practically manage unsolicited donations.
- There is often lack of political commitment to prevent flows of donations and little commitment to ensure necessary resources to minimize the risks of artificial feeding.
- Criteria for which infants need artificial feeding in an emergency and the provisions needed for their support are included in the Operational Guidance on IFE. Guidance on management of artificially fed infants (developed originally as an interim measure due to the identified lack of guidance) is included in IFE Module 2. However, in practice, the criteria are not applied and further investigation is needed to determine what the limiting factors to implementation are. Discussions suggested that lack of detailed and integrated guidance on artificial feeding in emergencies (e.g. there is no agency-led guidance on the subject, such as the MSF Nutrition Guidelines), lack of experience in programming to support non-breastfed infants, difficulties in sourcing funds for skills-based approaches, (e.g. to support breastfeeding) and lack of confidence to implement such programming may all be factors. Also, the routine failure to include artificially fed infants in

[22] Detailed in the working group presentation, available in the IFE Resource Library at www.ennonline.net/ife (select 'Presentations')

[21] Typical sources of standard questions and analyses approaches are WHO, DHS, UNICEF MICS, Child Survival Knowledge Practice

early needs assessments means it is difficult to quantify numbers to target.
- Because it is considered difficult and 'messy' to appropriately support artificial feeding, there are few agencies willing to take it on and deal with all the elements of support needed. Although the target group may be small, significant resources and particular skills are required. A lack of agencies with the necessary knowledge, skills and resources can lead to a void that other less-knowledgeable groups fill and may even be a factor that contributes to inappropriate donations/distributions of BMS.
- Any agency handling artificial feeding will also need to provide for the protection and support for breastfed infants – to ensure that there is no 'spillover' effect and to support exclusive breastfeeding in infants under six months. The working group emphasised that exclusive breastfeeding would remain the safest option for all newborn infants in any population in an emergency. However there is no working model or field example of this type of integrated of programming that supports breastfed and non-breastfed infants.

Strategic directions identified by the working group were:
- Develop a communication strategy that (i) advocates with all stakeholders, (ii) develops tools on key messages e.g. CREATE, (iii) ensures internal agency understanding, e.g. through communications department, (iv) builds relationships with media pre-emergency and (v) includes preparedness communications, e.g. ensuring key people understand why donations of infant formula are not needed.
- Develop guidance on managing unsolicited donations. This might include alternate ways to use donated supplies, ways of returning supplies, and opportunities for engaging with media and other stakeholders to improve understanding.
- Develop implementing guidelines for artificial feeding which should involve a lead operational agency that would field test strategies, materials and guidelines developed to ensure they were appropriate and feasible.
- Work on HIV/AIDS has developed the concept of establishing replacement feeding only when AFASS criteria can be met. The same concept and criteria can be applied to initiating artificial feeding in emergency situations, hence the working group also considered how best to apply the AFASS concept where infants are already artificially fed when an emergency hits. It considered that the 'acceptable' condition in an emergency could be determined through predefined criteria that ensured targeting of infants that require BMS. The working group then described making artificial feeding in emergencies as FASS as possible for these infants, with reference to each of the remaining four criteria. They considered the AFASS definitions may need to be expanded to reflect the emergency context.

5.3 Session 10: Strengthening IFE planning and implementation at country level

In session 10, each country working group developed detailed work plans for the next 12 months. They aimed to identify 1-2 activities under each component of the Operational Guidance on IFE. A summary of all the country activities is given in Annex 2. Some key things to note in looking at the summary are:
- All countries except Myanmar and Sri Lanka are planning on working on the ***national IFE policy***. Most are planning on incorporating an IFE policy into an existing nutrition or IYCF strategy or an emergency policy. Most of these countries will then go on to ensure ***dissemination and the development of guidelines*** on the policy. A smaller number of countries are planning on developing a policy on donations.
- Almost all countries are going to ***train technical staff on IFE***, sometimes by integration into existing trainings, e.g. on IYCF. Many are also going to ***orient national decision-makers.***
- About half of all countries are planning on identifying an ***IFE coordinator*** through existing national systems for emergency response. Afghanistan, Indonesia, the Philippines and Sri Lanka are all planning on implementing the ***cluster approach*** as a way of improving coordination.
- ***IFE will be integrated into existing rapid assessment tools*** in about half of all the countries. Many of these countries expressed a wish to adapt existing materials and as such, completion and official release of the IRA Tool by the Nutrition/Health/WASH Global Clusters will be important. A few countries are planning on developing their own tools.
- The majority of countries are planning to improve ***services for supporting breastfeeding and complementary feeding*** through a variety of methods including breastfeeding campaigns, establishing community support and creating behaviour change communication materials. A few countries are also planning on creating ***places for breastfeeding*** during emergency situations.
- Relatively few countries appear to be planning on implementing activities to ***minimise the risk of artificial feeding***. DPRK and Pakistan are planning to do the most, including preventing and managing donations, applying criteria for when artificial feeding is needed and applying AFASS criteria.
- Several ***'cross-cutting' activities*** were identified by countries, including developing a media/communication strategy, educating donors, improving pre-emergency preparedness and strengthening implementation of the International Code. For the education of donors, many countries are planning to adopt the Philippines strategy of writing to embassies and nine countries saw the need to improve or strengthen their national Code of Marketing of BMS to control donations of infant formula and manage their arrival.

- A few countries expressed a need to have ***more information on the IFE situation*** in their countries. Such data will be used to advocate greater action and resources for IFE. Some countries also expressed interest in have a decision on ***what foods to include in food baskets*** for families affected by emergencies. Viet Nam is planning on ***producing a fortified food*** that can be used to support IFE in emergencies.

5.4 Regional/Global Actions

While the country teams were meeting, representatives from UN agencies and NGOs, at the regional and global level, met to discuss their planned actions. These included the following:

- Explore with WHO and some member states the potential for a specific resolution on IFE to be adopted by the World Health Assembly
- UNICEF to review the UNHCR milk policy and see if it can be adapted for UNICEF programme guidance
- Evaluate the use of IFE Module 2 in emergency preparedness in Indonesia (had been translated into Bahasa in preparation for this meeting)
- Establish web-based forum to lobby pressure from the general public to support appropriate IFE
- Continue to solicit support for and implementation of the Operational Guidance on IFE
- Identify a lead agency on Complementary Feeding in Emergencies in the IFE Core Group
- Advocate that the IRA tool developed in the Cluster Initiative is used in the next emergency, and is then evaluated and shared, as appropriate
- Access resources to develop indicators and guidance on assessment and monitoring on IFE, to build on work 'kick-started' at the Bali meeting
- Engage with DARA (Development Assistance Research Associates) on their Humanitarian Response Index[23] that ranks donor response, to explore incorporating indicators on the Operational Guidance on IFE
- Explore ranking on the quality of IFE response in emergencies
- Explore resources, capacity and support for a second regional IFE workshop modelled on Bali in Africa in 2009
- Investigate potential partner agency and access resources to develop a communication/media portfolio around IFE (to include CREATE developed materials, template press release, flash appeals containing calls for appropriate support)
- Explore capacity and resources to develop Artificial Feeding Chapter and related annexes of Module 2 into Guidance on Artificial Feeding. This would include applying AFASS criteria to the emergency context. This should form part of an integrated approach to supporting IFE that also included skilled breastfeeding support for breastfed infants
- Pursue IFE as a theme for WABA World Breastfeeding Week in 2009[24].

The schedule of action points with suggested timeframes and nominated responsible person/group/agency is included in Annex 3.

5.5 Model Joint Statement on IFE

Comments and suggestions for changes to the Joint Statement on IFE (presented on Day 1) were incorporated over the course of the workshop and the revised draft was presented, reviewed and agreed on the third day in the plenary. The result is included in Annex 4.

5.6 Pledge for Action

In response to a call from the floor for the workshop to lead to action and not just talk on the need for improved action on IFE, a Pledge for Action was developed by the organisers based on presentations and discussions at the meeting. The participants then reviewed the draft and made additions and comments. The final Pledge for Action by all participants on Day 3, agreed as individuals attending the meeting, is included at the end of this proceedings (see inside back cover).

Nina Berry/SC UK, 2008.

Highlighting the risks of artificial feeding in emergencies was one of the identifed actions for communications in emergencies. Pictured is a feeding bottle being used by the mother of a breastfed infant in Myanmar post-cyclone.

[23] Humanitarian Response Index ranks 23 countries in the Organisation for Economic Co-operation (OECD) according to their effectiveness in humanitarian donorship. Humanitarian Response Index aims to make donors more accountable by ranking them according to 57 indicators that reflect the principles and good practices that govern humanitarian action. The Indicators are focused around five themes—responding to humanitarian needs, integrating relief and development, working with humanitarian partners, implementing international guiding principles, and promoting learning and accountability. The outcomes are based on hard data and the views of various humanitarian agencies working on the ground in eight countries.

[24] A global recommendation made on Day 2 of the meeting.

6 Planning and Designing Capacity Building in IFE (Day 4)

6.1 Overview

Day 4 of the workshop centred on capacity building and was run largely as interactive working groups assessing capacity building needs in different scenarios[25]. The focus was on how to plan and undertake training of front line workers to enable them to provide appropriate IYCF support to mothers/caregivers and their children in emergencies. The day was faciltiated by Felicity Savage (IFC) and Rebecca Norton (Independent/IFE Core Group).

Building upon the capacity building working group of Day 3, Day 4 started out with agreement that capacity building was about systems and structures as well as training. Training has to be properly planned and integrated within existing systems and supervision and motivation of staff is an integral component. As discussed on Day 3, policy, guidelines, coordination, advocacy and orientation of decision makers has to be underway before effective training of front line workers can take place.

The session was introduced with a sketch performed with the aim of highlighting the importance of infant and young child feeding counselling. The facilitators pointed out the need to provide quality counselling during emergencies. Too often 'counselling' consists of 'messages' on infant feeding, with the result that health workers overload mothers with information and tell them what to do, rather than listening, building confidence, and negotiating behaviour change.

6.2 Training materials/resources

Two main training courses were presented and proposed for consideration. These were:

1. WHO/UNICEF Breastfeeding Counselling: A Training Course (1993) (BFC)[26]. This is sometimes called the 40-hour course and is available in a number of local languages, and several adapted forms. Some participants had been trained using the course, but others were not familiar with it.

2. Module 2 Infant Feeding in Emergencies for health and nutrition workers in emergencies (version 1.1, December 2007), developed by the IFE Core Group (referred to as IFE Module 2).

BFC is the generic training course on breastfeeding counselling, which is conducted over 5-6 days and is appropriate for health workers both in health facilities and the community. It aims to provide both clinical and counselling skills. It includes structured exercises and practical sessions, and has been shown to be effective in increasing health worker skills. It has also been shown that health workers using these skills to counsel mothers increase exclusive breastfeeding rates. The course includes a component of training of trainers.

IFE Module 2 was developed with the needs of emergency relief workers in mind. It is a resource of essential information for orientation and for training, particularly when workers need to learn what to do quickly. It is based on the BFC materials, and so complements them, and applies the latest UN policy guidance to emergency settings (e.g. WHO guidance on infant feeding and HIV). IFE Module 2 also includes additional sections that are especially relevant to situations seen in emergencies but where there are gaps in 'official' guidance (e.g. artificial feeding in emergencies, and managing malnourished infants under six months of age). It does not include structured exercises or practical counselling sessions but does include practical emergency scenarios to work through, case studies and presentation overheads.

Other relevant materials

IFE Module 1 for Emergency Relief Staff was also introduced, but hard copies were not distributed to participants because it is outdated (2001), and is due to be updated by the IFE Core Group in 2008. However, updated IFE Module 1 overhead slides were included on the participants CD Rom and are also available on the ENN website[27]. IFE Module 1 was developed as a resource for advocacy and orientation of decision makers and to support implementation of the Operational Guidance on IFE.

A module on infant feeding in emergencies is being finalised by the Capacity Development Working Group of the IASC Nutrition Cluster, as part of a harmonised training package on nutrition in emergencies. The IFE Cluster module has been authored by IFE Core Group collaborators with technical review by a number of IFE Core Group members. A draft was not ready for inclusion in Day 4 of the Bali workshop but was highlighted as a key

[25] To help in planning Day 4, a one day training on IFE had been piloted at the Breastfeeding: Policy and Practice course run at the Institute of Child Health London in July 2007.
[26] Available online at: http://www.who.int/child_adolescent_health/documents/who_cdr_93_3/en/
[27] Available at http://www.ennonline.net/ife
[28] Since the workshop, Module 17 Infant and Young Child Feeding is now available at http://www.humanitarianreform.org

resource[28].

The Baby Friendly Hospital Initiative (BFHI) revised 20-hour training course[29] was not included as it is institution-based training, not designed to be 'cascaded' to the community, and was not particularly relevant to the emergency scenarios being explored in the sessions[30]. The Integrated WHO course on infant and young child feeding[31] was also mentioned in discussions as a course that could be used for training; it combines breastfeeding, complementary feeding and HIV and infant feeding.

6.3 Procedure of working groups on capacity development for IFE

Participants were divided into eight groups of 7-8 participants and each group was given one of four emergency scenarios and working group guidelines. Each of the four scenarios reflected a population with different IFE needs: breastfeeding population with early complementary feeding/introduction of bottle feeds (A), breastfeeding with mixed feeding (B), artificial feeding common (C), breastfeeding culture with little infant formula (D). Participants were asked to have their copies of the Operational Guidance on IFE and IFE Module 2 available, and BFC materials were shown to the groups. During the morning session, groups were required to develop plans for training infant feeding counsellors appropriate for their scenarios. During the afternoon, each group presented and discussed their conclusions. Enough time was allowed to enable extensive discussion and sharing of experiences. Two groups per scenario also allowed for discussion on different approaches taken.

6.4 Issues reflected in the presentations and plenary discussions

Emergency preparedness

- Master trainers need to be available to lead training on breastfeeding counselling. A major issue was "where do we find these master trainers?" There is a need to identify nationals with expertise in breastfeeding and IYCF counselling, particularly those who are experienced trainers, as part of emergency preparedness. There is a need to develop national databases of these resource people, and it is important to know how to contact them when need arises. UNICEF offices could develop lists of such resource persons that can be called upon on emergencies.
- The IYCF/breastfeeding resource persons also need training on IFE issues as part of emergency preparedness. IFE Modules 1 and 2 are useful for this purpose and their application was suggested as a practical action that countries could explore.
- In-country experts (when available) are more appropriate than external experts as they are more culturally aware. National experts and organisations are often overlooked during international responses and there tends to be an over-reliance on external consultants. Partnerships between international agencies on the ground and local agencies are particularly useful in IYCF.
- Pre-emergency, it is important to explore what resources (e.g. funding, national expertise) may be accessed to train different people, so that training can more easily be planned and implemented in an emergency.
- As part of emergency preparedness, the need to translate IFE Module 2 was identified.

Training resources

- Different groups listed different resources as first option for training of front line workers. Some groups chose IFE Module 2 (short), others chose the BFC 40 hour course spread over time. Some mentioned using both resources (BFC as well as IFE Module 2) spread over time.
- It was, however, clear that in the acute emergency it is difficult to introduce a BFC course due to limited time and capacity. IFE Module 2 can be used more effectively to start the process, while the BFC course can be introduced at a later stage, to develop skills further. Supervision is essential, and with time, people's skills can be increased.

Experience of training materials adapted for community counsellors

- Mary Lungaho (CARE USA) presented materials used in the Dadaab refugee camps in Kenya by CARE for training low literacy community infant feeding counsellors. An adapted version of the BFC course – to which the IFE Module 2 was appended – was used. CARE is in the process of finalising the materials, which contain pictures in a flip chart, which could be adapted to different settings. Most important was the use of the triple A approach (assessment, analysis, action), to help counsellors prioritise what is most important to mothers. At the start, it was found that community counsellors had the tendency to overload the mothers with knowledge and messages. This is a common difficulty. Supervision is an essential component of the programme, and Mary pointed out that the training was a process, not a 'one-off' exercise. In Dadaab, there are a certain number of more highly trained staff members for supervision and referrals. Mother support groups are also part of the programme. It was noted that this programme has been going for quite some time, and it is not an acute emergency situation.
- Community counsellors usually refer more difficult cases (artificial feeding, relactation, and specific breast conditions) to a higher level. Hence some key staff, such as doctors and other senior health workers, need to be more highly trained, e.g. completing the full BFC 40 hour course.

[29] BFHI 20 hour course (2006) available online at: http://www.unicef.org/nutrition/index_24850.html

[30] The BFHI is of relevance to, for example, reproductive health interventions in an emergency, e.g. supporting or provision of a maternity services where establishing exclusive breastfeeding in the newborn population is a critical early intervention.

[31] Infant and young child feeding – An integrated course. Available online at: www.who.int/nutrition/iycf_intergrated_course/en/index.html

- One half-day is not sufficient to train community counsellors adequately. They need a number of training sessions, spread over time (to take into account the acute emergency and their availability).
- The cascade system used in Indonesia and presented on Day 2 of the workshopwas referred to, as a useful model to introduce.

Observations on handling of artificial feeding in emergencies

The feedback of the scenario plans showed that the majority of groups had focused on training to support breastfeeding infants, even in the group whose scenario included a significant proportion of non-breastfed infants. Attention may have automatically focused on breastfeeding because artificial feeding in emergencies is not considered a country 'problem area' by participants - as reflected in the Country Grid on Day 1. Moreover, the considerable problems with unsolicited donations of BMS in emergencies in the region and the surrounding discussions on avoiding them and protecting breastfed infants may have distracted delegates from the fact that in their countries, there are infants who are not breastfed and who, in an emergency, also need protection and support.

7 Evaluation and 'Post-Mortem' of the Workshop

An evaluation of Days 1-3 of the workshop was undertaken at the end of the third day through a questionnaire to all participants[32]. Given the different objectives and format of Day 4, a separate evaluation was carried out at the end of Day 4.

7.1 Evaluation Days 1-3

The majority of participants attending on the third day completed the evaluation and the comments were generally very positive. For example, 38 out of 43 respondents felt that the workshop "built awareness of the importance of IFE and promoted implementation of the Operational Guidance on IFE" and 40 said they felt their work on IFE would definitely or partially be improved as a result of the workshop.

Just over half of the respondents had read the Operational Guidance on IFE before coming to the workshop and about the same number said they had used it to guide their work in emergencies. In response to the question "Are there any issues which are not covered by the Operational Guidance on IFE?" respondents wanted more on complementary feeding, food diversity and maternal/caregiver feeding, reference to financial resources needed and estimations of cost for different interventions. Participants also wanted more on how to handle the media, how to incorporate IFE into pre-service curriculum of health care providers, matrices for assessment and monitoring, and a template for reporting and recording.

Participants seem to have found all of the sessions of the workshop useful or would have liked to have more detailed discussion. In particular, participants found the policy guidance and coordination session useful and many people would have liked to have had more time to discus challenges of IFE assessment. Participants indicated they would have liked to have sessions included in the workshop on the following: more on complementary feeding, budgeting for IFE and cost-saved/cost-benefit analyses, management of severe acute malnutrition, non-breastfed infants, management of HIV-negative infants, and IFE integration with other sectors.

In terms of actual presentations, many people found the presentations on the International Code and the Philippines Code experience useful. The Philippines presentation on how to avoid donations was also very much appreciated, as was the presentation on 'Where IFE sits in international policies', the communications presentations, field experiences of IFE assessment and regional experiences.

The working groups of Day 3 also appear to have been helpful; most respondents felt the morning thematic working group helped consolidate ideas on the themes and also used the conclusions of the thematic working groups in their Country working groups in the afternoon. Half of the respondents felt their country working group plans were "good and believed it would be implemented" while the other half felt the "plans were good but were not sure they would be implemented" or were "good but needed to be developed further with other stakeholders".

[32] The Indonesian representation of 40 participants for Days 1 and 2 was reduced to 23 delegates on Day 3 to facilitate the working groups and to three participants on Day 4, by prior agreement with participants.

Finally participants almost unanimously approved of Bali as the venue of the workshop because of the Indonesian experiences with IFE during recent emergencies and the easy flight connections.

7.2 Evaluation of Day 4

Overall, two thirds of those attending Day 4 were satisfied with the day, and one-third was "partially satisfied". Participants pointed out that it would have been helpful to have led people through both IFE Module 2 and the BFC materials before the session, and to have explained their structure and their differences as there was no time to look at the training materials in detail during the group work. Facilitators pointed people to sections of the Operational Guidance on IFE but not sufficiently to the much larger IFE Module 2. There were not enough copies of the BFC materials to distribute to each group, so not everyone was familiar with that course either. In retrospect, it would have been more helpful to have given people an overview of existing training resources in a presentation.

The evaluation also reflected that support required for managing artificial feeding was discussed, but probably not enough. While there is a chapter in IFE Module 2 on artificial feeding that was referred to in the afternoon discussions, many people had not had time to look at IFE Module 2 in any great detail during the morning session.

Another comment in the evaluation was about the answers to group work questions. Participants were given handouts with suggested answers to the group work questions to take home. The answers were, however, not presented in plenary. Some participants said that it would have been more instructive to spend more time plenary discussing the prepared answers to the exercise, and less time listening to groups giving feedback.

Finally participants comment that even though the timing was arranged with the intention of including a lot of expert input into the afternoon plenary session, there was not as much as had been hoped.

From the organisers point of view it was felt that the type of capacity building session held on Day 4 would work better if presented and developed as a much more integral part of the workshop. That it was less integrated in the Bali workshop is largely a reflection of its evolution. Day 4 of the workshop was originally planned as a separate day on capacity building, in which delegates from Days 1-3 could attend along with additional external candidates. However as the workshopplans evolved and given the interest of the workshop delegates in attending Day 4, this was changed into a four day workshop, where only those participating in Days 1-3 also could enrol in Day 4. Regarding the content of the day, it would have been preferable to have more country presentations and presentations by country participants, as opposed to international participants. It may have also been more constructive to have a smaller number of scenarios to work on and so more scope to explore planning and prepared answers in the plenary session. However, overall the inclusion of a Capacity Building session was very positive and practical and should feature in any future workshops.

8 Follow up

In addition to the global action points generated on Day 3, two more areas for action were identified from consideration of the evaluation feedback: (i) development of a list of available materials and training resources, sorted by stage of the emergency that they are applicable to and (ii) the development of a thematic/matrix of what assessment/intervention needs to happen and when. The IFE Core Group will explore how best to address these, most likely incorporating these into the update of IFE Module 1 in 2008.

Recognising UNICEF's key responsibility towards IFE, UNICEF HQ will follow-up with country offices to assess progress on country action plans generated at the workshop.

The ENN, as coordinating agency of the IFE Core Group, will follow-up on assigned action points and invites participants to share progress and achievements that emerge from their follow-up activities, so that we can learn how they have 'made it happen'.

Annex 1 Workshop agenda

Infant and Young Child Feeding in Emergencies:
Regional Experiences and Challenges in Achieving Optimal Early Response
Bali, Indonesia, 10–13th March 2008

Monday 10th March 2008
DAY 1: Setting the Scene on Infant and Young Child Feeding in Emergencies (IFE)

Time	Session	Speaker	Country
08.00 – 08.45	Registration		
08.00 – 08.45	Background slide show: Setting the Scene on IFE		
am	**Overall Meeting Coordinator: Karen Codling, ENN**		
08.45 – 09.25	Official Meeting Opening • Global IASC Nutrition Cluster • MOH Indonesia • UNICEF EAPRO/ROSA • WHO SEARO	Bruce Cogill, Global Nutrition Cluster Cordinator Ministry of Social Affairs, Indonesia Dr Gianfranco Rotigliano, UNICEF Indonesia Dr. Nugroho Abikusno, WHO SEARO	
09.25 – 09.40	Introductions (15 mins)	Karen Codling	
09.40 – 09.50	Housekeeping (10 mins)	Karen Codling/ Ninik Sri Sukotjo, UNICEF Indonesia	
09.50 – 10.00	**Session 1: Policy guidance and coordination. Facilitator: David Clark**		
10.00 – 10.30	Where IFE sits in international policies and strategies	Karen Codling	Global
10.30 – 11.00	Regional challenges in IFE – Emergency preparedness and early response	Flora Sibanda-Mulder, UNICEF NY	Regional
11.00 – 11.30	**Coffee**		
	Session 2: Regional challenges regarding donations in emergencies. Facilitator: David Clark		
11.30 – 12.00	The Code in Emergencies – a minimum standard	David Clark, Legal Officer, UNICEF NY	Global
12.00 – 12.30	Donations – does it matter? Evidence of impact from Indonesia post-earthquake	Ninik Sri Sukotjo, UNICEF Indonesia	Indonesia
12.30 – 13.00	Regional profile of donations	Karleen Gribble, University of Western Sydney	Regional
13.00 – 14.00	**Lunch**		
pm	**Session 3: Country Situation Analysis. Facilitator: Karen Codling**		
14.00 – 15.00	Country Problem Statement Grid Exercise • Introduce Country Problem Statement Grid (15 mins) • Interactive Session to complete the GRID (45 mins)	Karen Codling	All countries
15.00 – 15.30	Country Problem Statement Grid Feedback	Karen Codling	All countries
15.30 – 16.00	**Coffee**		
	Session 4: Initiatives to support IFE. Facilitator: Karen Codling		
16.00 – 16.15	Draft Joint Statement on IFE	Lida Lhotska/Marie McGrath (IFE Core Group)	Regional
16.15 – 16.30	The role of the Cluster Approach in IFE	Bruce Cogill Global Nutrition Cluster Coordinator	Global/country
16.30 – 16.45	The Management of Acute Malnutrition in Infants (MAMI) Project	Marko Kerac CIHD/ENN	Global
16.45 – 17.00	Disaster Vulnerability Mapping	Dr Nugroho Abikusno, WHO SEARO	Regional
17.00 – 17.30	Discussion from Day 1	Karen Codling	
17.30	**GROUP PHOTO IN BALLROOM**		
19.00	**WELCOME DINNER Patio Lounge**		

Annex 1

Tuesday 11th March 2008
DAY 2: Challenges related to implementation

Time	Session	Speaker	Country
	Overall Meeting Coordinator: Karen Codling		
08.30 – 08.50	Opening Day 2 Summary Key Points Day 1	Karen Codling	
08.50 – 0900	**Session 5: Avoiding unsolicited donations. Facilitators: Lida Lhotska & Marie McGrath**		
09.00 – 09.20	Recent floods and efforts to prevent donations in emergencies	Sawsan Rawas, Nutrition Officer, UNICEF DPRK	DPRK
09.20 – 09.40	Philippines – embassy note on donations	Ms Florinda Panlilo, DOH	
09.40 – 09.50	Conclusions/Recommendations	Lida Lhotska, Marie McGrath (IFE Core Group)	Global
09.50 – 10.00	**Session 6: Breastfeeding, complementary feeding and artificial feeding in emergencies. Facilitators: Lida Lhotska & Marie McGrath**		
10.00 – 10.30	Breastfeeding support in early emergency response	Dr. Utami Roesli, Indonesian Breastfeeding Centre, Indonesia	Indonesia
10.30 – 11.00	**Coffee**		
11.00 – 11.30	Complementary feeding in emergencies – Save the Children UK's perspective	Vicky Sibson, SC UK	Regional
11.30 – 11.50	HIV and infant feeding– technical consensus, practical application and challenges in emergencies	Zita Weise Prinzo, WHO Geneva	Global
11.50 – 12.10	Wet nursing in the context of HIV – experiences from Bangladesh	Yara Sfeir, UNHCR Bangladesh	Bangladesh
12.10 – 12.20	Key challenges regarding infant feeding and HIV	Kathy Macias, UNHCR Geneva	Global
12.20 – 12.45	Discussion Session 6 Conclusions/Recommendations	Lida Lhotska, Marie McGrath (IFE Core Group)	
12.45 – 13.45	**Lunch**		
13.45 – 13.50	**Session 7: Challenges of IFE assessment. Facilitators: Mary Lung'aho & Flora Sibanda-Mulder**		
13.50 – 14.00	Nutrition Cluster Initiative on assessment in emergencies	Bruce Cogill Global Nutrition Cluster Coordinator	Global
14.00 – 14.10	Experiences in assessment	Dr Nugroho Abikusno, WHO SEARO	Regional
14.10 – 14.30	Field experiences of IFE assessment post-cyclone	Ali Maclaine, Independent/ENN	Bangladesh
14.30 – 14.50	IFE assessment: shared field experiences	Experiences from the floor	All
14.50 – 15.10	*Responding to the challenges:* Step by step guide to monitoring of infant feeding behaviours in emergencies	Mary Lung'aho, CARE USA	Global
15.10 – 15.30	*Responding to the challenges:* Integrating standardised infant feeding assessments into emergency nutrition surveys	Marko Kerac, CIHD/ENN	Global
15.30 – 16.00	**Coffee**		
16.00 – 16.20	Discussion on assessment Conclusions/Recommendations	Mary Lung'aho, Flora Sibanda-Mulder	
16.20 – 16.25	**Session 8: Challenge of communication in emergencies. Facilitator: Karen Codling**		
16.25 – 16.45	Regional communications on IFE – key observations	Karleen Gribble, Uni of Western Sydney	Regional
16.45 – 17.00	CREATE approach to breastfeeding materials	UNICEF	Indonesia
17.00 – 17.20	Discussion	Karen Codling	
17.20 – 17.30	Close Day 2 Introduce Working Groups for Day 3	Karen Codling	
	Optional evening session		
19.00 – 20.00	*The Code in the Philippines – recent experiences*	Ms Florinda Panlilo, DOH David Clark, UNICEF NY	Philippines Regional/Global

Wednesday 12th March 2008
DAY 3: Strategic Directions and Country Action Plan

Time	Session	Speaker	Country
08.30 – 08.50	Housekeeping Summary Key Points Day 2	Karen Codling	
08.50 – 09.00	**Session 9: Strengthening IFE Planning and Implementation. Facilitators: Karen Codling & Lida Lhotska**		
09.00 – 10.30	Thematic Working Groups (group facilitator): 1. Policies (Lida Lhotska) 2. Capacity Building (Rebecca Norton) 3. Coordination (Flora Sibanda-Mulder) 4. Assessment and Monitoring (Mary Lung'aho) 5. Protection, promotion and support of optimal IYCF (Felicity Savage) 6. Minimisation of the risk of artificial feeding (Ali Maclaine/Marie McGrath)	Group working session	
10.30 – 11.00	**Coffee**		
11.00 – 12.30	Thematic Working Groups Feedback	Working Group Representatives	
12.30 – 13.30	**Lunch**		
	Session 10: Strengthening IFE Planning and Implementation at Country Level. Facilitators: Karen Codling & David Clark		
13.30 – 15.00	Country Action Plan Working Groups: 1. Country Teams (16) 2. Regional/Global Team	Groups working session	
15.00 – 15.30	**Coffee**		
15.30 – 15.50	Country Action Plan GRID – Country Feedback	Karen Codling	
15.50 – 16.10	Joint Statement Feedback	Marie McGrath & Lida Lhotska	
16.10 – 16.30	Next Steps at Regional level	Regional Working Group Rep	
16.30 – 16.50	Next Steps at Global level	Flora Sibanda-Mulder, UNICEF	
16.50 – 17.00	Official Closing (Days 1-3)		
17.00 – 17.10	Outline plans Day 4	Karen Codling	
	Optional evening session (Paradiso Ballroom)		
19.00 – 20.00	*The MAMI Project – more detailed discussion*	Marko Kerac, CIHD	Global

Thursday 13th March 2008
Day 4: Planning and Designing Capacity Building in IFE

Overall Facilitator: Karen Codling			
Session 11: Planning and designing capacity building in IFE. Facilitators: Felicity Savage and Rebecca Norton Support Facilitators: David Clark, Lida Lhotska, Ali Maclaine, Mary Lung'aho, Marie McGrath, Dr Utami Roesli, Flora Sibanda-Mulder			
Overview	This day is a workshop for those with organisational and management responsibilities, who have to plan and organise training on infant feeding and mother support for field workers. It is not a technical training, and is not designed to give field workers knowledge and skills: it is to help delegates to learn how to decide what capacity building is needed, who should be trained, what the trainees should be able to do, and how to organise their training, in order to optimise the feeding of infants in emergency situations.		
Format	**Day comprised of Group Work and interactive sessions based on 4-5 emergency scenarios.**		
Time	**Session**	**Speaker**	
08.30 – 09.30	Introduction	Felicity Savage, Rebecca Norton	Aim of the workshop. Presentation of group work (distribution of scenarios and guidelines)
09.30 – 10.00	Group Work		
10.00 – 10.30	**Coffee**		
10.30 – 12.30	Group Workk		
12.30 – 13.30	**Lunch**		
13.30 – 15.00	Plenary		
15.00 – 15.30	**Coffee**		
15.30 – 16.30	Plenary		
16.30 – 17.00	Summary and conclusions	Felicity Savage, Rebecca Norton	
17.00	**Workshop Closing**	Karen Codling	

Annex 2 Matrix of country/territory actions

Country/ Territory	Policies			Capacity Building		Coordination		A&M*	
	National IFE Policy	Policy on donations	Policy dissemination & guidelines	Orient decision-makers	Train technical staff	Identify IFE co-ordinator	Implement cluster approach	Integrate IFE into existing rapid assessment	Develop guidelines & indicators on A&M
Afghanistan	X – nutrition policy			X	X		X and at regional level	adopt tools	
Bangladesh	national IYCF strategy		action plan			thru DMC and regular meetings			
China	add to IYCF strategy			X – translate OG	X	X – national co-ordination body		translate existing A&M tools	
Cambodia	X		X incl action plan		X	X			
Democratic People's Republic of Korea	X	X	X		X				
India	X			X – national consultation	X				
Indonesia	X share and finalise		X	X – each agency	X		juni-08	harmonisation of tools	
Myanmar			X	X	X	X			X – develop RA tool
Nepal	integrate into IYCF & national disaster plan	X – council of ministers			X		X		X
Pakistan	X		X	X	X	X and core group			define R&R & develop tools & training
Papua New Guinea	X		X		X – intergrate into existing	disaster management team		X	
Philippines	Nutrition action plan at LGU & regional	enforce policy			existing IYCF modules		X	X	X
Sri Lanka			X	X	X	national co-ordination committee	X		
Taiwan	X	X – UNHCR	X	X	integrate into current course			X	
Thailand	integrate national emergency plan	X	X	X		X		X	
Viet Nam	X		X		X	set up co-ordination agency			

*Assessment and monitoring

Annex 2

Matrix of country/territory actions continued

Country/ Territory	Support IYCF		Artificial Feeding			Cross Cutting Actions				Other ideas
	Ensure services to support BF and CF	Ensure places for BF	Prevent & manage donations	Apply criteria for when artificial feeding is needed (A)	Apply FASS in all instances	Media/ Communi-cation Strategy	Educate donors	Pre-Emergency Preparation	International Code	
Afghanistan	BF campaign		message to stakeholder				letter to embassies		Finalise Code and monitor	
Bangladesh						X and standard messages		Advocacy in prepared-ness plans		
China	BF community					X			X	
Cambodia	BF community and MS group					X - BCC			X	baseline and report
Democratic People's Republic of Korea	X	X	guidelines		apply cup feeding					
India	BCC materials & MS groups	X								collect data for advocacy
Indonesia						harmonis-ation 5 messages	letter to embassies			food basket for families with young children
Myanmar						X	X	X - IYCF training	X	
Nepal	community HW training					X			X	
Pakistan	mothers counselling and CF		advocacy and restrict	X	X					decision on food basket
Papua New Guinea	training community			assess current situation		X				
Philippines		X				X	letter to embassies		IRR implement-ation	
Sri Lanka	operational procedures for BF and CF			policy existing		key messages			X	
Taiwan						X				
Thailand						X		X - communic-ation	revision	
Viet Nam	counselling	X							X	Produce MN fortified food

X = action; BF = breastfeeding; CF = complementary feeding; IYCF = infant and young child feeding; MS = mother support; (A) = acceptable; FASS = feasible, affordable, sustainable, safe; MN = micronutrient; OG = Operational Guidance on IFE; HW = health worker; RA = rapid assessment; R&R = ; BCC = Behaviour Change Communication; LGU = local government unit; DMC = developing member countries; IRR = Implmenting Rules and Regulations.

Annex 3 Matrix of regional/global action plan

	Activity 1	Responsible agency & timeline	Activity 2	Responsible agency & timeline
Policy	Explore with WHO and some member states the potential for a specific resolution on IFE to be adopted by the World Health Assembly.	IFE Core Group In time for WHA May 2009.	UNICEF to review the UNHCR milk policy and see if it can be adapted for UNICEF programme guidance.	UNICEF. *Within next 6 months*
Capacity Building	Use Module 2 on IFE in Indonesia as part of emergency preparedness (has been translated into Bahasa).	CARE Indonesia 2008.	Establish web-based forum to lobby pressure from the general public to support appropriate IFE.	Karleen Gribble, University of Western Sydney/IFE Core Group Collaborator.
Coordination	Continue to solicit support for the Operational Guidance on IFE.	IFE Core Group, list maintained by ENN Immediately.	Establish a lead agency on Complementary Feeding in Emergencies within the IFE Core Group.	UNICEF to investigate capacity for UNICEF to take lead. *Within next 6 months*
Assessment & Monitoring	Advocate that the Initial Rapid Assessment Tool developed by the Nutrition Cluster is used in the next emergency, evaluated and shared.	UNICEF, UNHCR, WFP, WHO 2008.	Access resources to develop indicators and guidance on infant and young child feeding assessment and monitoring, to build on work 'kick-started' at Bali meeting.	IFE Core Group (CARE?). *Within next 6 months*
Support for IYCF	Engage with DARA on their Humanitarian Response Index* that ranks donor response, to reflect the Operational Guidance on IFE. Explore ranking on IFE response in emergencies.	IFE Core Group (ENN). *Within next 6 months* *No timeline established*	Explore resources, capacity and support for a second regional IFE workshop modelled on Bali in Africa in 2009. *In 2008.*	IFE Core Group.
Minimise risks of artificial feeding	Investigate potential partner agency and access resources to develop a communication /media portfolio around IFE (to include CREATE developed materials, template press release, flash appeals contain calls for appropriate support).	SC UK, ENN/IFE Core Group and collaborators (Karleen Gribble).	Explore capacity and resources to review potential to develop Artificial Feeding Chapter and related annexes of Module 2 into Guidance on Artificial Feeding, that includes FASS criteria and is reflected as part of an integrated approach to supporting IFE that includes skilled breastfeeding support.	IFE Core Group.

* Humanitarian Response Index ranks 23 countries in the Organisation for Economic Co-operation (OECD) according to their effectiveness in humanitarian donorship. Humanitarian Response Index aims to make donors more accountable by ranking them according to 57 indicators that reflect the principles and good practices that govern humanitarian action. The Indicators are focused around five themes – responding to humanitarian needs, integrating relief and development, working with humanitarian partners, implementing international guiding principles, and promoting learning and accountability. The outcomes are based on hard data and the views of various humanitarian agencies working on the ground in eight countries.
Italicised represents additional clarification post-meeting

Annex 4 Model Joint Statement agreed by participants

Call for support for appropriate infant and young child feeding in emergencies

[List of issuing organisations] call for support for appropriate infant and young child feeding in the current emergency, and caution about unnecessary use of milk products.

[Insert opening leading lines, context specific.]

During emergency situations, whether manmade or natural disasters, [contexts and examples can be inserted here], disease and death rates among under-five children are generally higher than for any other age group. The younger the infant, the higher the risk. Mortality may be particularly high due to the combined impact of a greatly increased prevalence of communicable diseases and diarrhoea and soaring rates of under-nutrition. The fundamental means of preventing malnutrition and mortality among infants and young children is to ensure their appropriate feeding and care.

[List of issuing organisations] note that donations of infant formula and other powdered milk products are often made, whilst experience with past emergencies has shown that without proper assessment of needs, an excessive quantity of milk products for feeding infants and young children are often provided, endangering their lives. There should be no donations of breastmilk substitutes (BMS), such as infant formula, other milk products, bottle-fed complementary foods represented for use in children up to 2 years of age, complementary foods, juices, teas represented for use in infants under six months; and bottles and teats. Any unsolicited donations should be directed to the designated coordinating agency (see below).

[List of issuing organisations] reiterate that no food or liquid other than breastmilk, not even water, is needed to meet an infant's nutritional requirements during the first six months of life. After this period, infants should begin to receive a variety of foods, while breastfeeding continues up to two years of age or beyond. The valuable protection from infection and its consequences that breastmilk confers is all the more important in environments without safe water supply and sanitation. Therefore, creation of a protective environment and provision of skilled support to breastfeeding women are essential interventions.

Any provision of BMS for feeding infants and young children should be based on careful needs assessment. Therefore, all donor agencies, non-governmental organisations (NGOs), media, individuals wishing to help and other partners, should avoid calls for and sending donations of BMS, bottles and teats and refuse any unsolicited donations of these products. BMS should be used only under strict control and monitoring and in hygienic conditions, and in accordance with the International Code of Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions, as well as humanitarian agencies' policies and guidelines. There should be no general distribution of BMS.

There is a common misconception that in emergencies, many mothers can no longer breastfeed adequately due to stress or inadequate nutrition. A desire to help may result in the inappropriate donations of infant formula and other milk products. Stress can temporarily interfere with the flow of breast milk; however, it is not likely to inhibit breast-milk production, provided mothers and infants remain together and are adequately supported to initiate and continue breastfeeding. Mothers who lack food or who are malnourished can still breastfeed adequately. Adequate fluids and extra food for the mother will help to protect their health and well-being.

If supplies of infant formula and/or powdered milks are widely available, mothers who might otherwise breastfeed might needlessly start giving artificial feeds. This exposes many infants and young children to increased risk of infectious disease, malnutrition and death, especially from diarrhoea when clean water is scarce. The use of feeding bottles only adds further to the risk of infection as they are difficult to clean properly.

In exceptionally difficult circumstances, therefore, the focus needs to be on creating conditions that will facilitate breastfeeding, such as establishing safe 'corners' for mothers and infants, one-to-one counselling, and mother-to-mother support. Traumatised and depressed women may have difficulty responding to their infants and require particular mental and emotional support. Every effort should be made to identify ways to breastfeed infants and young children who are separated from their mothers, for example by a wet-nurse.

[In addressing IFE in the context of high HIV prevalence, a position reflecting the latest consensus may be stated here].

Treatment of severely malnourished children, whether facility or community based, should be treated in accordance with international standards and best practice and closely monitored. Standard commercial infant formulas are not meant for this purpose.

Children from the age of six months require nutrient-rich complementary foods in addition to breastfeeding. Complementary feeding should be addressed with priority for locally available, culturally acceptable, nutritionally adequate family foods.
Provision of fortified foods or micronutrient supplements such as vitamin A or zinc in supervised programmes for young children represent a much more appropriate form of assistance than sending milk products. In rations for general food distribution programmes, pulses, meat, or fish are preferable to powdered milk.

[List of issuing organisations] strongly urge all who are involved in funding, planning and implementing an emergency response and in all levels of communication to refer to key policy and programme instruments to avoid unnecessary death following uncontrolled distribution of BMS. Community leaders are called upon to monitor and report any donations that may undermine breastfeeding.

We urge governments and partners to include capacity building for breastfeeding and infant and young child feeding as part of emergency preparedness and planning, and to commit financial and human resources for proper and timely implementation of breastfeeding and infant and young child feeding in emergencies.

The designated coordinating agency is [Insert]

Source: This 'working' statement is available in the online Resource Library at www.ennonline.net/ife or on request from the ENN.

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Infant and Young Child Feeding in Emergencies Workshop
Bali, Indonesia, 10 –13th March 2008
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Pledge for Action

Steps to Improve Infant and Young Child Feeding in Emergencies

111 participants from 16 countries and special territories together with regional and international representatives of United Nations agencies, non-governmental organisations and infant and young child feeding experts, met in Bali, Indonesia from 10-13 March 2008. We agree on the following:

The protection, promotion and support of Infant and Young Child Feeding in Emergencies are inadequate. Inappropriate use of breastmilk substitutes in emergencies, often received as unsolicited donations, endangers the lives of infants and young children. Creation of a protective environment and provision of skilled support to breastfeeding women and caregivers of infants and young children is a life-saving intervention in all emergencies. Equally, non-breastfed infants require appropriate care and follow up to reduce the significant risks they are exposed to through artificial feeding.

As participants and individuals committed to safeguarding public health and well-being, we pledge to implement the Operational Guidance on Infant and Young Child Feeding in Emergencies to our full capacity. In particular we pledge to:

1. Ensure Infant and Young Child Feeding in Emergencies (IFE) is integrated into national policies on emergencies and Infant and Young Child Feeding/nutrition.

2. Develop a policy on donations, including a designated agency responsible for managing unsolicited donations.

3. Act to strengthen implementation of the International Code.

4. Identify ways to strengthen coordination for IFE.

5. Build capacity to support breastfeeding mothers through breastfeeding counselling by health and community workers, and other measures.

6. Improve capacity and systems to improve complementary feeding.

7. Improve capacity to provide support for non-breastfed infants and minimise the risks of artificial feeding.

8. Educate and advise donors on how best to support IFE, including by not donating breastmilk substitutes.

9. Engage the media to improve how IFE is presented to the public.

10. Document and share experiences on the impact of our country's emergency response and interventions on IFE.

11. Include infant and young child feeding in emergency assessments/surveys.

Agreed on 12th March 2008 in Bali, Indonesia.

Front cover: A mother exclusively breastfeeding her baby in a cyclone affected village in Myanmar. N Berry/SC UK, Myanmar, 2008.
Back cover (left to right): Breastfeeding counselling training in Indonesia post-earthquake, UNICEF, 2006; Ali Maclaine, Bangladesh, cyclone Sidr, 2007; Post tsunami. Aceh, Indonesia, UNICEF, 2005; 张淑一，中国，2007.




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