

IYCF FULL ASSESSMENT FORM: 0-23 MONTHS

SCENARIO A

1. COLLECT BASIC INFORMATION					
Counsellor's ID	111	Location		Date of assessment	05/06/25
Caregiver's name	Abeer	Relationship to child	Mother/Father/Grandmother/Sibling/Other: _____		
Child's name	Lama	Sex	Male/Female	Child's ID No.	101
Child's D.O.B.	01/02/25	Child's age	4 months	Caregiver's age	25 years
				Is caregiver an adolescent?	☐ Yes ☒ No
Caregiver's name		Relationship to child			
Facility ID	12	Facility name		District	Akkar
Source of referral	☒ Self-referral ☐ SRA – from _____ service ☐ No SRA – direct from _____ service				
Is the child living with disability that impacts feeding or access to care?	If yes, please describe: <i>Suspected disability, tight muscles. Stiff a lot of the time. Feeding has been a struggle.</i>		Is the mother or primary caregiver living with disability that impacts feeding or access to care?	If yes, please describe: <i>No</i>	
No. of previous children:	0	No. of previous breastfed children:	0		
MUAC (if measured)	109.1 mm	WFA/WFL Z-score	WFA<-3 Z-score		

Anthropometric Assessment Table for Infants Aged 6 Weeks to 5 completed months and 6 months to 23 completed months

MUAC 6 weeks to 5 completed months			
Indicator	Severe	Moderate / At Risk	Normal
Mid-Upper Arm Circumference (MUAC)	< 110 mm	Not well defined*	≥ 110 mm (not at risk)**
MUAC 6 to 59 months			
Mid-Upper Arm Circumference (MUAC)	<115mm	≥ 115 to >125	≥ 125
All children birth to 59 months			
Weight-for-Length Z-score (WLZ)	< -3 Z-score	≥ -3 to < -2 Z-score	≥ -2 Z-score
Weight-for-Age Z-score (WAZ)	< -3 Z-score	≥ -3 to < -2 Z-score	≥ -2 Z-score
Bilateral pitting oedema	Present (regardless of other indicators)	—	Absent

* MUAC thresholds for moderate risk in 0–6 months are not standardized globally; use MUAC <110 mm as an indicator of severe risk only per 2023 WHO guideline.

** MUAC alone should not be used for monitoring or discharge in infants <6 months. Combine with clinical signs, weight gain, and feeding assessment

2. CHECK FOR DANGER SIGNS ²		
Lethargic/unconscious?	☐ Yes	☒ No
Vomits everything?	☐ Yes	☒ No
Unable to drink/breastfeed?	☐ Yes	☒ No
Difficulty breathing? (respiration rate, chest indrawing)	☐ Yes	☒ No
Low or high temperature? (< 35.5 or ≥ 38°C)	☐ Yes	☒ No
Bilateral pitting oedemata? (+/++/+++)	☐ Yes	☒ No
Caregiver appears out of touch with reality or infant appears to be at risk from caregiver's behaviour?	☐ Yes	☒ No
ACTION: IF ANY MARKED AS YES → URGENT REFERRAL TO HEALTH SERVICES BEFORE CONTINUING IYCF ASSESSMENT		

3. ASK ABOUT FEEDING PRACTICES	
Please tell me about your experiences of feeding your baby. What concerns or questions would you like to discuss today?	<i>Stiff a lot of the time. Feeding has been a bit of a struggle for mother. Trouble breastfeeding, hard to get her to take in enough. Mother worried about her weight gain and is experiencing a lot of stress.</i>

What and how is the baby fed? <i>(Select all that apply)</i>	☒ Breastfeeding – at mother's breast ☐ Expressed breastmilk – mother's own ☐ Expressed breastmilk – informally shared ☐ Donor human milk ☐ Breastfed by a woman who is not the child's mother ☐ Some artificial feeding (BMS) ☐ Fully artificially fed (BMS) ☐ Fully artificially fed (BMS)		
	☐ Bottle ☐ Spoon ☐ Cup		
Does the baby eat or drink anything other than breastmilk?³	☐ Yes	☒ No	
(If yes) What else do you give the baby?	☐ Infant formula ☐ Other milks ☐ Water ☐ Tea/coffee ☐ Sugary drinks/soda ☐ Juice: _____ ml/cups Medicine ☐ Food ☐ Other ⁴ : _____		
ACTION: IF NON-BREASTFED OR PARTLY BREASTFED → COMPLETE FULL ASSESSMENT – NON-BREASTFED CHILD CARE PLAN			
Do you use a pacifier for the baby?	☐ Yes	☒ No	
Is the baby currently sick?	☐ Yes	☒ No	
(If sick) Since your baby has been sick, have there been any changes in the way you have been feeding?			
Breastfeeding	☐ More/no change	☐ Less often	☐ Stopped
(If 6-23 months) Complementary feeding	☐ More/no change	☐ Less often	☐ Stopped
Extras	☐ Extra nutritious food	☐ Infant formula	
4. CHECK DIAPER OUTPUT			
How many wet diapers does baby have in 24 hours?	<u>5</u> times		
Does the baby's urine have a strong smell or colour?	☐ Yes	☒ No	
How many soiled diapers does baby have in 24 hours?	<u>2</u> times ⁵		
Have there been any recent changes from usual?	☐ Less frequent stooling	☐ Diarrhoea	☒ No changes
ACTION: IF DIAPER OUTPUT IS LOW/CONCERNING → EXPLORE POSSIBLE LOW MILK SUPPLY ACTION: IF CHILD HAS DIARRHOEA → REFER TO HEALTH SERVICES			
5. ASK ABOUT BREASTFEEDING/BREASTMILK FEEDING			
How often do you breastfeed/feed your baby breastmilk?	<u>5</u> times total	<u>1</u> times in the night	
How do you decide when to feed your baby?	☒ Responsive	☐ Scheduled	
(If breastfeeding) Do you experience any pain or discomfort while breastfeeding?	☒ Yes ☐ Extreme ☐ Moderate ☒ Mild	☐ No	

6. REQUEST PERMISSION TO OBSERVE THE MOTHER BREASTFEEDING (IF APPLICABLE)

Assess breast health:

Did not assess

Colour: ☐ Normal ☐ Redness **Condition:** ☐ Normal ☐ Shiny ☐ Hard ☐ Warm

☐ Engorged ☐ Damaged nipple ☐ Suspected blocked duct

☐ Suspected mastitis ☐ Suspected thrush ☐ Suspected breast abscess

ACTION: IF THRUSH, BREAST ABSCESS OR MASTITIS → REFER TO HEALTH SERVICES FOR TREATMENT

Signs breastfeeding is going well

BODY POSITION

- ☐ Mother relaxed and comfortable
- ☐ Mother's back and arms are well supported
- ☒ Baby's body close, facing breast
- ☒ Starts feed with baby's nose opposite nipple
- ☐ Baby's head free
- ☐ Baby's head and body straight (in line)
- ☐ Baby's chin touching breast

Signs of possible difficulty

BODY POSITION

- ☒ Shoulders tense/leaning over baby
- ☐ Baby's body far away from mother's body
- ☐ Starts feed with baby's mouth opposite nipple
- ☐ Baby's head cannot move back freely
- ☐ Baby's neck twisted/not in line with shoulder and hip
- ☐ Baby's chin not touching breast

Signs breastfeeding is going well

RESPONSES

- ☐ Baby reaches for breast if hungry
- ☒ [Baby roots for breast]
- ☐ Baby explores breast with tongue
- ☐ Baby calm and alert
- ☐ Baby stays attached to breast
- ☐ [Signs of milk ejection] – leaking, afterpains

EMOTIONAL STATE AND BONDING

- ☐ Secure, confident hold
- ☒ Eye contact
- ☐ Mirroring of facial expressions between parent and child
- ☒ Much touching by mother
- ☐ Responsive to baby's needs

SUCKLING/ATTACHMENT

- ☐ Mouth wide open
- ☐ Lower lip turned outwards
- ☐ Tongue cupped around breast
- ☐ Cheeks round
- ☐ More areola above baby's mouth
- ☐ Slow deep sucks, bursts with pauses
- ☐ Can see or hear swallowing

END OF FEED

- ☐ Baby releases breast
- ☐ Nipple looks normal/round/erect
- ☐ Baby suckled for 5+ minutes
- ☒ Mother keeps breast available/offers other breast
- ☐ Baby's hands are relaxed/open
- ☐ Baby looks relaxed/satisfied/sleepy
- ☐ Breasts feel softer

Signs of possible difficulty

RESPONSES

- ☐ No response to breast
- ☐ [No rooting observed]
- ☐ Baby not interested in breast
- ☐ Baby restless or crying
- ☒ Baby slips off breast
- ☐ [No signs of milk ejection]
- ☒ Mother shows signs of pain/discomfort
- ☐ Baby coughs/gags/chokes

EMOTIONAL STATE AND BONDING

- ☐ Nervous/limp hold
- ☐ No eye contact
- ☐ Shaking or poking baby/breast
- ☐ Little touching
- ☐ Struggles to soothe baby when crying

SUCKLING/ATTACHMENT

- ☐ Mouth not wide open/points forward
- ☐ Lower lip turned in
- ☐ Baby's tongue not seen
- ☒ Cheeks tense or pulled in
- ☐ More areola below baby's mouth
- ☐ Rapid sucks only
- ☒ Can hear smacking or clicking

END OF FEED

- ☐ Mother takes baby off breast
- ☐ Nipple looks creased/squashed/flattened
- ☐ Baby suckled for <5 minutes
- ☐ Mother does not keep breast available offer other
- ☐ Baby's hands are clenched/near face
- ☒ Baby fusses/cries/appears unsatisfied

Time spent breastfeeding 15 minutes

7. ASSESS MATERNAL/CAREGIVER WELLBEING⁶

Over the last two weeks, have you experienced any of the following feelings?			(If yes) Frequency in the last 2 weeks?					
Feeling anxious or worrying uncontrollably	☒ Yes	☐ No	☐ Sometimes	☒ Often	☐ Almost every day			
Difficulties coping with daily chores	☒ Yes	☐ No	☒ Sometimes	☐ Often	☐ Almost every day			
Little interest or pleasure in doing things that you used to enjoy	☐ Yes	☒ No	☐ Sometimes	☐ Often	☐ Almost every day			
Feeling down, depressed or hopeless	☐ Yes	☒ No	☐ Sometimes	☐ Often	☐ Almost every day			
On a scale of 1 (very unsupported) to 5 (very supported), how supported to you feel by family and friends in caring for your baby?				1	2	3	4	5
Who do you mostly rely on for support, if anyone?		Mother						
How does your family feel about you breastfeeding?		Family thinks breastfeeding is not working, telling mom to start complementary feeding.						
ACTION: IF ANSWERED YES – OFTEN / ALMOST EVERYDAY OR SCORE 1 – 3 → COMPLETE FULL ASSESSMENT <u>AND</u> REFER FOR MHPSS ASSESSMENT								
Do you have any concerns about the baby's growth and development or level of alertness, compared to other babies of a similar age?				☒ Yes		☐ No		
ACTION: IF ANSWERED YES → CONTINUE WITH FULL ASSESSMENT <u>AND</u> REFER TO HEALTH AND ECD SERVICES								
How is your current health?		Tired but okay.						

8. ASSESS COMPLEMENTARY FEEDING PRACTICES (6-23 MONTHS. IF UNDER 6 MONTHS, SKIP)

Who helps/assists the child with eating?				
How many times did (name) eat solid, semi-solid or soft foods yesterday during the day or at night? <i>Times</i> _____				
To meet minimum meal frequency: Breastfed children: should receive complementary foods at least twice a day between 6-8 months and at least three times a day between 9-23 months Non-breastfed children: should receive solid, semi-solid, or soft foods (including milk feeds) at least four times a day.		Is the child meeting the Minimum Meal Frequency?	☐ Yes	☐ No
Yesterday, during the day and night what did you give your child to eat? (minimum diet diversity)	WHAT?	HOW MUCH? (cups/handfuls)	TEXTURE? (thick/thin/chopped/whole)	
Breast milk				
Grains, roots, tubers, and plantains				
Pulses, beans, legumes, lentils, and nuts				
Dairy products (e.g., milk, infant formula, yoghurt, cheese)				
Flesh foods (e.g.; meat, fish, poultry, liver/organ meats)				
Eggs				
Vitamin A rich fruits and vegetables (e.g., spinach, carrots, sweet potatoes, mangoes)				
Other fruits and vegetables				
Check: ≥ 5 food groups?		☐ Yes	☐ No	
Did you give your child micronutrient powder (MNP)?		☐ Yes	☐ No	
What do you use to feed your child liquids?		☐ Open cup ☐ Cup with spout ☐ Bottle		

At what important times in the day do you wash your hands with water and soap?		☐ Before preparing food ☐ Before eating ☐ Before feeding child ☐ NONE (if none, understand why and counsel on hand washing)	
Do you wash the child's hands with clean water and soap before they eat?		☐ Yes	☐ No
Have you noticed the child experiencing any difficulties when eating? (If yes, please check below)		☐ Yes	☐ No
☐ Coughing/choking ☐ "Wet"/"gurgly" voice breathing ☐ Discomfort ☐ Watery eyes ☐ Changes in colour/breathing			
ACTION: IF SIGNS OF POSSIBLE ASPIRATION ARE PRESENT → CONTINUE FULL ASSESSMENT <u>AND</u> REFER FOR PAEDIATRIC ASSESSMENT			
9. NOTE DOWN ANY KNOWN RISK FACTORS (e.g., noted when referred)			
Child	☐ Premature ☐ Low birth weight ☐ Under 6m with growth failure ☐ Sick ☐ Multiple ☐ Malnourished ☐ Disability impacting feeding ☐ Signs of extreme distress ☐ Maternal orphan ☐ Separated/unaccompanied		
Mother/caregiver	☐ Malnourished ☐ Severely ill ☐ Recovering from Caesarean birth/difficult birth ☐ Disability impacting feeding Voluntary disclosure only: ☐ MHPSS difficulties ☐ SGBV survivor ☐ HIV positive ☐ First time mother ☐ Adolescent mother		
ACTION: IF RISK FACTOR(S) ARE PRESENT → ENROL FOR COUNSELLING + REFER TO REQUIRED SERVICES			
10. NOTE DOWN ANY OBSERVATIONS MADE DURING THE ASSESSMENT			
Quality of mother's/caregiver's-child interaction (holding, touching, visual contact, verbal exchange, mirroring, playing)	☐ Poor	☐ Moderate	☒ Good
Child's reaction to the mother's/caregiver's stimulation	☐ Poor	☒ Moderate	☐ Good
Mother's/caregiver's reaction to the child's calls for attention and need for comfort	☐ Poor	☐ Moderate	☒ Good
Mother's/caregiver's awareness of child's movements	☐ Poor	☒ Moderate	☐ Good
Mother's/caregiver's response to child needing correction	☐ Poor	☐ Moderate	☐ Good
Child moves both arms and legs equally	☐ Yes		☒ No
Normal tone and posture	☐ Yes		☒ No
Mother/caregiver requested infant formula	☐ Yes		☒ No
11. COUNSELLING ACTIONS/DECIDE ON CARE PLAN			
Possible problems:			
Counselling actions taken:	☐ Positioning and attachment: _____ ☐ Stress management: _____ ☐ Information given on: _____ ☐ Supplies provided: _____ ☐ Referrals made: health/nutrition/MHPSS/ECD/FSL/WASH/other: _____ ☐ Other: _____		
Further counselling needed?	☐ Yes		☒ No
ACTION: IF NO → REFER FOR OTHER IYCF SERVICES		☐ Education ☐ Peer group support ☐ Other _____	
Reason for further counselling (refer to triage tool)			
Support to be provided			

BASIC SUPPORT AND COUNSELLING		ADVANCED SUPPORT AND COUNSELLING	
☐ Positioning and attachment ☐ Maternal confidence ☐ Milk expression ☐ Cup/spoon feeding ☐ Flat or inverted nipples ☐ Sore or damaged nipples ☐ Engorgement ☐ Increase/decrease milk production ☐ Restorative care/emotional support ☐ Wet nursing ☐ Breastfeeding in public/crowded spaces ☐ Breastfeeding at night ☐ Infection Prevention Control ☐ Rejecting donations of BMS/feeding bottles/teats ☐ Preparing for crisis/evacuation ☐ Encourage age-appropriate feeding ☐ Complementary feeding ☐ Maternal diet ☐ Other: _____		☐ Manage mastitis/thrush ☐ Manage tongue tie ☐ Breastfeed LBW or preterm infant/KMC ☐ Breastfeeding during maternal/child severe illness ☐ Feeding with a disability impacting feeding ☐ Feeding while experiencing mental health difficulties ☐ Relactation ☐ Suppress lactation (stillbirth/infant loss) ☐ Maintaining lactation during separation ☐ Breast refusal ☐ Other: _____	
Follow up date:			
Time spent today:			