Islamic Republic of Afghanistan
Ministry of Public Health

National Infant and Young Child Feeding Policy and Strategy 2009 - 2013

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List of Acronyms

AHS	**Afghanistan Health Survey**
BCC	**Behaviour Change Communication**
BFHI	**Baby-Friendly Hospital Initiative**
BHC	**Basic Health Centre**
BMS	**Breast Milk Substitutes**
BPHS	**Basic Package of Health Services**
BPNI	**Breastfeeding Promotion Network of India**
CBHC	**Community-Based Health Care**
CDC	**U.S. Centre for Disease Control and Prevention**
CGHN	**Consultative Group on Health and Nutrition**
CHC	**Comprehensive Health Centre**
CHW	**Community Health Worker**
CMAM	**Community-based Management of Acute Malnutrition**
ENA	**Essential Nutrition Actions**
EPHS	**Essential Package of Hospital Services**
FAO	**Food and Agriculture Organization of the United Nations**
GMP	**Growth Monitoring and Promotion**
HHS	**REACH end-of-project household survey**
HMIS	**Health Management Information System**
IBFAN	**International Baby Food Action Network**
IEC	**Information, Education, Communication**
IFE	**Infant Feeding in Emergencies**
IMCI	**Integrated Management of Childhood Illnesses**
IYCF	**Infant and Young Child Feeding**
KAP	**Knowledge Attitude Practice**
MAIL	**Ministry of Agriculture, Irrigation and Livestock**
MCH	**Maternal and Child Health**
MICS	**Multiple Indicator Cluster Survey**
MoC	**Ministry of Commerce**
MoE	**Ministry of Education**
MoJ	**Ministry of Justice**
MoMI	**Ministry of Mines and Industry**
MoPH	**Ministry of Public Health**
MoRA	**Ministry of Religious Affairs**
MoWA	**Ministry of Women's Affairs**
MRRD	**Ministry of Rural Rehabilitation and Development**
PHCC	**Provincial Health Coordination Committee**
PRT	**Provincial Reconstruction Team**
REACH	**Rural Expansion of Afghanistan's Community Health services project**
SC/US	**Save the Children/ United States**
TFU	**Therapeutic Feeding Unit**
UNICEF	**United Nations Children's Fund**
USI	**Universal Salt Iodization**
VAD	**Vitamin A Deficiency**
WABA	**World Alliance for Breastfeeding Action**
WFP	**World Food Programme**
WHO	**World Health Organization**

1. Background

1.1. Introduction: Why does Afghanistan need an Infant and Young Child Feeding Policy and Strategy?

Improving Infant and Young Child Feeding practices is essential to achieve the Health and Nutrition Sector Strategy objective of reducing child mortality. Afghanistan has the 3rd highest child mortality rate in the world (191 per thousand live births), with 327,000 children under 5 dying each year[1]. Malnutrition is a major underlying cause of child mortality and morbidity in Afghanistan, because poor nutritional status compromises a child's ability to resist and recover from infections. Of the 327,000 children under age five who die each year in Afghanistan, at minimum 114,450 (35%) would have survived if they had been adequately nourished to support a strong immune system to fight infections. Malnutrition also affects children's ability to learn in school and to become productive adults. Prevention of malnutrition and associated diseases would significantly reduce households' health care costs. The economic costs of malnutrition to households and to the country undermine development efforts.

Undernutrition in its various forms is highly prevalent in Afghanistan. According to the National Nutrition Survey (MoPH, 2004[2]) and other surveys[3], between 6 to 15% of children under 5 suffer from acute malnutrition (wasting), and over 50% from chronic malnutrition (stunting). Over 70% of children under 5 are iron and/or iodine deficient (MoPH, 2004).

Improper IYCF practices are a major cause of undernutrition in Afghanistan. Around 40% of admissions in therapeutic feeding units (for the treatment of severe acute malnutrition) are under 6 months of age, pointing to breastfeeding problems as a primary cause. Furthermore, nutritional survey results show that acute malnutrition is highest in children 6-29 months of age. These data suggest that nutrition interventions should focus in this age group, and that improving feeding of children under 2 years of age would lead to significant reductions in malnutrition rates. Improvements in early childhood nutrition also contribute to improved health outcomes in later life.

Potential impact of improving IYCF. A review of child survival interventions in 42 countries revealed that promotion, support and protection of exclusive breastfeeding for the first six months of a child's life prevents 13% of all deaths under 5 years in countries with a high child mortality rate[4]. The review also showed that continued breastfeeding up to two years with appropriate introduction of solid/semi-solid foods at six months (complementary feeding) contributes to a 6% reduction in child mortality.

International requirements on IYCF. In 2002, the Fifty-fifth World Health Assembly and the UNICEF Executive Board endorsed The Global Strategy for Infant and Young Child Feeding. According to clauses 36 and 37 of the Global Strategy, "The primary obligation of governments is to formulate, implement, monitor and evaluate a comprehensive national policy on infant and young child feeding" and "a detailed action plan should accompany the

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[1] UNICEF. (2006). Afghanistan Statistics. Accessed at: http://www.unicef.org/infobycountry/afghanistan_statistics.html
[2] MOPH, UNICEF, CDC and Tufts University. (2004). National Nutrition Survey. Atlanta, GA: CDC.
[3] MOPH Public Nutrition Policy and Strategy (2003)
[4] WHO. (2003). Global Strategy for Infant and Young Child Feeding. Geneva: WHO.

comprehensive policy". For this reason, the Public Nutrition Department of MoPH has elaborated the present IYCF Policy and Strategy for 2009-2013. The present document is the result of an extensive consultation process facilitated by the Public Nutrition Department and USAID/BASICS, UNICEF, WHO, WFP, FAO), NGOs, MoPH Departments (HPD, CBHC & IMCI), MAIL, MRRD, MoWA and MoC. The recommendations from a National Consensus-building Workshop on IYCF, conducted in March, are incorporated here.

Complementarity with other MoPH Policies and Strategies. The present document is designed to complement the MoPH Policies and Strategies on Child and Adolescent Health, Public Nutrition, Reproductive Health, as well as the Health and Nutrition Communication Strategy, by describing specific policy issues and strategic approaches related to Infant and Young Child Feeding, in accordance with the Global Strategy on IYCF.

1.2. Definitions of Infant and Young Child Feeding Practices

Early initiation of breastfeeding
Early initiation of breastfeeding within the first hour of birth is recommended so that infants receive the 'first milk' (colostrum), which is rich in immunological factors and nutrients required by the neonate. Colostrum is available to the child only during the earliest days postpartum.

Exclusive breastfeeding (0-6 months)
Exclusive breastfeeding refers to a breast milk-only diet for the infant during the first six months of life. Other liquids (i.e. water, tea, juices, and ritual liquids) and solid/semi-solid foods are to be avoided. Exclusive breastfeeding has been shown to be associated with a reduced incidence of diarrhoea, respiratory infections and allergies. Promotion of exclusive breastfeeding is a key child survival strategy in resource-constrained countries[5].

Continued breastfeeding (until 2 years)
Continued breastfeeding at a sustained high level at least for the first year and continued breastfeeding until two years and beyond is beneficial for both infants' nutrition and mothers' lactational amenorrhea (cessation of menses during lactation), a natural method of birth spacing.

Appropriate complementary feeding (introduction of solid/semi-solid foods)
Children 6-24 months old are to continue breastfeeding adding "nutritionally adequate, safe and appropriate" *complementary foods* until age two years during their transition to the family diet[6]. These first foods are termed 'complementary' because they are to be given as a complement (addition) to breast milk. After the age of six months breast milk provides some but not all of the nutrients a child needs for healthy growth and development and additional foods from the family food supply are required for the child. Complementary feeding is essential to provide needed nutrients, specifically iron, zinc, vitamin A, energy and protein for the growing infants that are in insufficient quantities in breast milk to meet the nutrient requirements for health and growth.

[5] WHO collaborative study team on the role of breastfeeding on the prevention of infant mortality. (2000). Effect of breast feeding on infant and child mortality due to infectious diseases in less developed countries: a pooled analysis. Lancet, 355 (9202).
[6] WHO. (2001). Guiding Principles for Complementary Feeding of the Breastfed Child. Geneva: WHO.

Complementary foods should not replace breastfeeding as a source of nourishment for the child. They are therefore *not* 'weaning' foods, because children are encouraged to fully continue breastfeeding during this period and should not be referred to as such. These foods are also different from 'supplementary' foods (given from outside sources to the household as a therapeutic treatment to a sick child for a short period of time).

Breast Milk Substitutes (BMS): any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose. These include infant formula, other milk products, therapeutic milk, and bottle-fed complementary foods marketed for children up to 2 years of age and complementary foods, juices, teas marketed for infants under 6 months.

1.3. Situation Analysis

1.3.1. Infant and Young Child Feeding Practices in Afghanistan

Formative research and field experience show that most caregivers do not follow appropriate IYCF, as demonstrated by the data presented in Table 1, below. Furthermore, the data presented in Table 1 must be interpreted with caution for the following reasons: the indicators used in different surveys are not systematically the same and thus not always comparable; data can be affected by "responder bias", whereby interviewees say they do the recommended practice even if they do not; finally, there are considerable variations across regions, making it difficult to extrapolate provincial data to the rest of the country and to interpret national averages. The lack of appropriate data on IYCF is in itself a problem that needs to be addressed.

Table 1: Overview of survey results on IYCF practices in Afghanistan.

Source (Year)	Coverage	Breastfeeding				Complementary Feeding	
		Breastfeeding initiation	EBF among 0-6 mo.	% BF at 1 year	% BF at 2 years	Age of intro of CF	% fed at that age
AHS (2006)	National	37% in 1st hour	70%	---	---	6-9 mos.	28%
HHS (2006)	National	N/A	40%	71%	--	6 mos.	27%
MICS (2003)	National	92.7% in 1st day	N/A	91%	54%	6-9 mo.	28%
UNICEF (2003)	Herat	59.2% in 1st hour; 82.2% use colostrum	19.4%	93%	34%	6-9 mo.	71%
UNICEF/CDC (2002)	Badghis	N/A	95%	96%	52%	6 mo	21%
UNICEF/MoPH (2003)	Parwan	N/A	12.5%	64%	63%	6-9 mo.	40%
SC/US (2002)	Jowzjan	~ 50% fed colostrum	0%			"most mothers had introduced foods or liquids at 4 mo."	

There are indications that the data presented in Table 1 actually over-estimate adequate IYCF practices. Field experience and formative research show that common inadequate feeding practices include the following:

***Initiation of breastfeeding*:**

- Breastfeeding is rarely initiated in the first hour of birth
- The use of ritual pre-lacteal foods (such as ghee, butter, tea, or even dirt) is common
- Colostrum is often discarded, as it is considered to be dirty (because people believe it has stayed in the breast for 9 to 10 months.)
- Many mothers do not know correct positioning and attachment of the infant to the breast, which limits optimal suckling and breast milk production.

Exclusive breastfeeding until 6 months:

- True exclusive breastfeeding is believed to be extremely rare, as caregivers often give tea, sugared water or soaked bread before the age of six months (data in Table 1 most likely report "predominant breastfeeding" rather than "exclusive breastfeeding)
- Many mothers believe they have "insufficient milk", which is often due to poor positioning and attachment. The perception of milk insufficiency often leads them to use formula milk, but most caregivers do not know how to prepare the milk to ensure it has the right consistency; bottle feeding is frequent and poor hygiene of the bottles and teats leads to infections
- Many caregivers give pacifiers and teats to suckle; these are a source of infection and can affect the child's attachment to the breast and suckling.

***Continued breastfeeding*:**

- Most mothers continue to breastfeed for at least one year, and even beyond; however, they are very likely to wean the child early if they become pregnant while lactating.
- It is common for mothers to stop or reduce breastfeeding when they or the child is ill; the cessation of suckling reduces their breast milk production and often leads them to wean the child early as they feel their milk is insufficient.

Complementary foods:

- Complementary foods are often introduced either too early or too late
- The consistency and composition of complementary foods is inadequate: they often consist of watery soups that do not meet infants' energy requirements; the foods lack protein and micronutrient-rich foods.
- Complementary feeds are often given infrequently and in insufficient quantities.
- Young children are often fed from the family dish, which is seldom adapted to their own requirements (too diluted, or too thick, etc.)
- Caregivers do not know to increase the frequency and density of complementary foods as the child grows older.

Maternal nutrition, health and well-being

Infant and young child feeding is affected by mother's health, nutritional status and mental well-being. Maternal mortality rates are amongst the highest in the world (national estimate: 1600 per 100,000 live births) and the prevalence of underweight among non-pregnant Afghan women 15-49 years of age was 21%, which is a high prevalence of adult underweight based on the WHO classification[7]. Furthermore, nearly 50% of women are estimated to be iron deficient and nearly 80% are likely to suffer from iodine deficiency[8]. Food taboos limiting women's intake of nutrient-rich foods during pregnancy and lactation are common. Mother's

[7] (WHO, 1995).

[8] MOPH, UNICEF, CDC and Tufts University. (2004). National Nutrition Survey. Atlanta, GA: CDC.

health is affected by early marriages and pregnancies, low birth spacing and a high workload. Their capacity to care for their child is affected by their limited education, lack of peer support, pressure from family members to comply with traditional practices, high workload, and limited resources (in particular diverse foods). Furthermore, many women suffer from poor mental health, with a high incidence of stress and depression linked to the insecure political situation and other social factors. This can affect mothers' relationship with their child, and has been found to be a common cause of breastfeeding problems, mothers' "milk insufficiency", and consequently undernutrition, especially amongst infants under 6 months.

Infant and Young Child Feeding in Emergencies:
In addition to challenges associated with chronic poverty and limited development, the Afghan population is exposed to recurrent emergencies, related to conflict and natural disasters (earthquakes, floods, droughts). Emergency responses and food distributions are therefore common. Several emergency providers become involved in donations and distributions of Breast Milk Substitutes (BMS), such as commercial milk formula, which undermine efforts by the MoPH to promote exclusive breastfeeding and adequate IYCF.

1.3.2. Infant and Young Child Feeding interventions implemented since 2002

The Ministry of Public Health (in particular the Public Nutrition Department) and its partners have been very active since 2002 to promote improved IYCF in Afghanistan. Current initiatives are described in Table 2, below.

Table 2: Initiatives addressing IYCF in Afghanistan since 2002

Topic	Activity	Main partners
IYCF (general)	IEC materials on IYCF	MoPH/NGOs, UNICEF, FAO, WHO, WFP
	IMCI Mother Card on IYCF	MoPH/NGOs/WHO/BASICS
	Afghan Family Nutrition Guide	MAIL/MoPH/NGOs/FAO
	Improved IYCF and Recipe Manual developed through formative research	MAIL/MoPH/FAO
	Introduction of nutrition education, including IYCF, in agriculture projects, literacy classes and schools	MAIL/FAO/NGOs
	Positive Deviance / Hearth	SC-US/MoPH
Breastfeeding promotion	Baby-Friendly Hospital Initiative	MoPH/UNICEF/
	Breastfeeding counselling: 3000 counsellors and 80 master trainers trained at national and provincial levels	MoPH/UNICEF/WHO/NGOs
	Re-lactation support for mothers in TFUs	ACF/MoPH
	Growth monitoring and promotion (pilot)	BASICS/MoPH/NGOs
	40 Provincial Nutrition and Reproductive Health Officers trained on Maternal Nutrition	MoPH/Tech Serv
	Breastfeeding promotion campaign: • Mass media campaign • Celebration of World Breastfeeding Week	MoPH/NGOs/MoReligious Affairs/MOWA/UNICEF/WHO/WFP
	Afghanistan has adopted the *International Code of Marketing of Breast Milk Substitutes*	MoPH / MoJ/UNICEF/IBFAN/International Code Documentation Centre
	South Asia Breastfeeding Forum 3, 2006 in Kabul	MoPH/MoFA/WABA/IBFAN/WHO/UNICEF
Complementary Feeding	Development of IMCI Complementary Feeding Card	MoPH/WHO/UNICEF
	Integration of cooking demonstrations in health, agriculture & education projects (using manual)	MAIL/FAO/NGOs/MoPH
Micronutrients	Supplementation as part of BPHS/EPHS	MoPH/MI/UNICEF/NGOs
	Iodised Salt; Fortified flour (iron, B-vitamins)	MoPH/MoC/MoMines/Private Sector
	Diet diversification: horticulture, poultry, livestock…	MAIL

However, the effectiveness and impact of these interventions has been limited by:

- Limited outreach at community and household levels
- Limited scale and coverage
- Lack of staff and resources for outreach (in particular female staff)
- Limited knowledge and skills of relevant staff
- Low community mobilization
- Illiteracy
- Limited resources and capacity for technical support and supervision at national and provincial levels

The present National IYCF Policy and Strategy are designed to address priority issues for improving IYCF and overcome the constraints that are limiting current interventions' impact.

2. Infant and Young Child Feeding Policy

2.1. Infant and Young Child Feeding Policy Statement

All Afghan infants and young children have the right to benefit from optimal breastfeeding and complementary feeding and caring practices to protect them from all forms of undernutrition and its adverse consequences.

2.2. Vision for the IYCF Policy and Strategy

All Afghan children benefit from optimal infant and young child feeding and caring practices and all caregivers have the knowledge, skills and resources required for optimal infant and young child feeding and care.

2.3. Goal and objective of the National IYCF Policy and Strategy

The IYCF Policy and Strategy is designed to contribute to the objectives of the Afghanistan National Health and Nutrition Sector Strategy 2008-2013[9] of reducing child and maternal mortality and malnutrition.

Its overall goal is the same as the overall goal of the Public Nutrition Policy and Strategy, namely: **To reduce all forms of undernutrition**, **thereby improving the growth, development and health of Afghan infants and young children, through improved infant and young child feeding practices.**

The objective of the Infant and Young Child Feeding Policy, and its associated Strategy is:
To increase the percentage of child caregivers adopting appropriate infant and young child feeding and caring practices (by 20%, by 2013).

Strategic components and approaches to achieve this objective are described in section 3 of the present document.

2.4. Purpose of the Infant and Young Child Feeding Policy and Strategy

The purpose of the present Policy and Strategy is to describe the Government of Afghanistan's position on IYCF, in accordance with the Global Strategy on IYCF. All key stakeholders directly or indirectly involved in IYCF, notably health sector professionals, NGOs, UN agencies, military, and private sector, are responsible, and will be held accountable, for respecting the present Policy.

This document also clarifies the strategies that need to be adopted and interventions to be implemented to achieve the policy objectives. It will serve to support advocacy and resource mobilization, as well as coordination between the main implementing partners (MoPH Departments, BPHS partners, NGOs, UN, private sector, communities). Finally, it provides guidance on how to monitor the protection and promotion of optimal IYCF in Afghanistan.

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[9] Health and Nutrition Sector Strategy, 1387-1391(2007/8-2012/13), MoPH-Afghanistan.

2.5. Policy components

Nine policy components have been identified. The implementation of these policy components will be supported by the "guiding policy principles" described in section 2.6, the strategies and activities described in Section 3, and in relevant guidelines.

2.5.1. Early initiation of breastfeeding

- Women of child-bearing age, in particular pregnant women, are to be educated on, and supported in, initiating breastfeeding within one hour of childbirth, and feeding colostrum to their newborn child. (This includes promotion of skin-to-skin contact within a half-hour of childbirth).

- Newborn infants should not be given any food or drink other than breast milk unless *medically* indicated. Pre-lacteal feeds of any kind should not be provided to the newborn.

- Mothers should be assisted in correct positioning of the child and how to maintain optimal lactation.

2.5.2. Exclusive breastfeeding to six months

- Women of child-bearing age, in particular pregnant women and lactating women, are to be educated on the importance and benefits of exclusive breastfeeding (for the first 6 months after birth), and supported in providing only breast milk to their baby for the first six months of life.

- Mothers should be encouraged to breastfeed on demand.

- Caregivers should be strongly discouraged from giving artificial teats or pacifiers to breastfeeding infants.

2.5.3. Use of commercial formula and respect of the Code of Marketing of Breast Milk Substitutes

- Suitable cows' milk based commercial formula should be recommended only if a mother is not able to breastfeed for medical reasons, or if the infant is orphaned and wet-nursing is not possible.

- Caregivers using Breast Milk Substitutes should be educated on appropriate preparation of formula milk and measures required to reduce the risk of contamination. The feeding by cup should be promoted.

- All Breast Milk Substitute Providers (whether private, non-profit, or public) should comply with all measures stipulated in the Code of Marketing of Breast Milk Substitutes that has been endorsed by the Government of Afghanistan.

2.5.4. Continued breastfeeding to two years and beyond

- Women of child-bearing age, in particular pregnant and lactating women, are to be educated on the benefits of, and supported in, maintaining high levels of breastfeeding

in the first year of the child's life and continuing breastfeeding until two years of age, even if they become pregnant or ill during lactation.

2.5.5. Introduction of solid/semi-solid foods at six months

- All parents should be educated before the child reaches the age of six months about when and how to introduce appropriate complementary foods.

- Complementary feeding should be:
    - *timely*—introduced at the appropriate age (generally six months), when the need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding;
    - *adequate*—providing sufficient energy, protein and micronutrients (vitamins & minerals) to meet the growing child's nutritional needs;
    - *safe*—hygienically stored and prepared, and fed to the child with clean hands using clean utensils and not bottles or teats;
    - *properly fed*—given according to the child's signals of hunger or fullness, and that meal frequency and feeding method are suitable for the child's age. These methods include actively encouraging the child to consume sufficient food using fingers, spoon or self-feeding, even during illness.

- Complementary foods should be increasing in consistency, diversity and frequency of feeding as children grow up.

- Caregivers should be educated and supported in ensuring optimal hygiene during complementary food preparation and consumption (including hand-washing of the caregiver and child)

- Promoted complementary foods should be locally available, affordable to low-income households, nutritionally balanced, and culturally acceptable.

2.5.6. Promotion of micronutrient-rich foods and appropriate supplementation

- Caregivers should be encouraged and supported to feed the child micronutrient-rich foods, in particular those rich in:
    - Iron & zinc: Animal flesh (i.e. sheep, beef, goat), legumes (beans, chick pea, lentil), certain green vegetables (i.e. spinach, ladyfinger/okra), and dried fruits and nuts.
    - Vitamin A: meat, eggs, and various coloured fruits and vegetables (to be given with some oil or fat, as vitamin A is fat-soluble).

- Children above 6 months should receive appropriate micronutrient supplements as per the national protocols.

- All family members should be encouraged to use iodized salt.

- All family members should be encouraged to use fortified flour where available.

2.5.7. Maternal health and nutrition

- Women of child-bearing age, in particular pregnant and lactating mothers, should be educated on their nutritional requirements (including increased requirements during pregnancy and lactation) and supported in meeting these nutritional requirements.

- All pregnant and lactating women should be provided with micronutrient supplements as per national protocols.

- Family and community members should be encouraged to support pregnant and lactating mothers in ensuring they meet their nutritional requirements, rest sufficiently, and have the time required to feed their infant and young children optimally.

2.5.8. Children in exceptionally difficult circumstances

- **Low Birth Weight (LBW) babies:** caregivers of LBW babies should be encouraged to apply the same IYCF practices as for other children; Kangaroo Mother Care (Aghosh-e Garm-e Madar) should be promoted.

- **Feeding sick children:** sick children should continue breastfeeding and be fed appropriate complementary foods if above six months; the frequency of feeds, and amounts and density of feeds should be adjusted to the sick child's increased nutritional requirements and limited appetite (e.g. smaller feeds more frequently).

- **Hospitalized infants, children and mothers:** should a lactating mother and/or her child be ill, health facilities should be able to accommodate both mother and child, and health staff should support the mother to continue breastfeeding and provide adequate complementary feeding.

- **Severely malnourished children**: children suffering from severe acute malnutrition should be referred to the appropriate treatment facility and receive treatment as per national protocols. Mothers who have breastfeeding difficulties should receive breastfeeding counselling and, when necessary, mothers (or if mother deceased an appropriate other e.g. grandmother) should be supported to re-lactate. This is particularly important for infants under 6 months of age.

- **Infants of HIV-positive mothers**: HIV-positive mothers should be counseled on the risks and benefits associated with breastfeeding and formula-feeding in the case of HIV-AIDS, so as to make an informed choice on the feeding method they choose.

2.5.9. Infant and Young Child Feeding in Emergencies

- In all emergency situations, relief interventions and emergency service providers must comply with the policy components and principles described in the IYCF Policy.

- Further the above parties should adhere to the Code of Marketing of Breast Milk Substitutes as a minimum requirement and the internationally endorsed Operational Guidance for Infant and Young Child Feeding in Emergencies.

- Mothers should be provided with the additional support, counselling, and resources, required to protect and promote optimal IYCF in emergency situations.
- Donated (free) or subsidised supplies of Breast Milk Substitutes, bottles and teats, are prohibited in order to ensure that breastfeeding is not undermined.

2.6. Guiding Policy principles

The design of the IYCF policy and strategy has been inspired by the 7 Working Principles of the MoPH for 2005-2009, and guiding principles described in the ANDS Health and Nutrition Sector Strategy. The following principles are of particular importance for Infant and Young Child Feeding. Their application to IYCF is described below.

Promoting healthy lifestyles and discouraging practices proven to be harmful
IYCF counselling and promotion of optimal IYCF are at the heart of the IYCF Policy and Strategy. Promotion of IYCF cannot be limited to awareness raising. It requires transfer of practical skills (e.g. through breastfeeding counselling and participatory cooking sessions adapted to mothers' circumstances), peer support, and assistance to caregivers in mobilizing the resources required to apply IYCF (time, food, etc.).

Community participation and community-based interventions
Optimal ICYF should also be promoted and appropriate counselling provided at the community level. Community ownership, support of community leaders and active participation of caregivers and their families are essential for effectiveness and sustainability.

Ensuring equitable access to, and provision of, quality, basic, essential health services
Equitable access to IYCF counselling requires that optimal IYCF practices should be promoted at all levels of the health system. All health workers have a responsibility for promoting optimal IYCF and should be trained to fulfil these responsibilities.

***Sustainability*:**
IYCF education and counselling should promote the use of local resources to ensure efficiency, affordability, sustainability and replicability. Should supplementary rations be distributed as part of emergency food aid or supplementary feeding programmes, ration providers should also inform beneficiaries of the nutritional value of local foods and establish linkages to agriculture and food security projects (see below).

Inter-sectoral collaboration:
Optimal IYCF should be promoted by a broad range of stakeholders beyond the health sector. The Ministry of Public Health will work in partnership with other ministries, in particular the ministries of: Agriculture Irrigation and Livestock (MAIL), Women's Affairs (MoWA), Rehabilitation and Rural Development (MRRD), Education (MoE), Religious Affairs (MoRA), Labour and Social Affairs (MoLSA), Justice (MOJ), Trade and Commerce (MoTC), and Ministry of Interior (MoI) to promote IYCF and the application of the Code of Marketing of BMS. At the community level, optimal IYCF can be promoted through a broad range of development interventions, including literacy courses, agriculture projects, community development interventions, etc. Linkages to food security interventions are of particular importance.

Scaling-up of evidence-based interventions

Interventions that have proven to be effective for promoting optimal IYCF should be implemented nationwide.

3. Strategy for Promoting Optimal Infant and Young Child Feeding

The IYCF Policy and Strategy is designed to contribute to the objectives of the Afghan National Health and Nutrition Sector Strategy and the overall goal of the Public Nutrition Policy and Strategy by focusing on the following objective:

To increase the percentage of child caregivers adopting appropriate infant and young child feeding and caring practices (by 20% by 2013)**.**

This objective will be achieved through the following three strategy components:

1. *Application of IYCF Policy and Strategy supported by advocacy, technical guidance and law enforcement.*

2. *Caregivers know optimal IYCF practices and are supported in providing optimal care and mobilizing the resources required for IYCF, through IEC/BCC and community support interventions.*

3. *IYCF promotion and counselling is effectively implemented as part of the BPHS and EPHS in all health facilities.*

Capacity-building of various categories of personnel involved in implementation will be an integrated component of each strategic priority/output. Advocacy and resource mobilization will be essential to enable the implementation of the activities required to achieve these outputs. An advocacy and resource mobilization plan will therefore be developed. The activities to be implemented to achieve these outputs/strategic priorities are described below.

3.1. Advocacy, regulations and guidelines

The implementation of the IYCF Policy and Strategy entails that sufficient resources and political support are mobilized, that supportive legislation and regulations are enforced, and that adequate guidelines are developed and applied.

3.1.1. Dissemination, advocacy and resource mobilization for the National Infant and Young Child Feeding Policy and Strategy:

The implementation of the National IYCF Disseminate the National IYCF Policy and Strategy will require several supportive steps to be implemented. They include:

- Dissemination of the strategy amongst all key stakeholders (MoPH, MAIL, MoJ, MoMI, MoEd, MoRA, MoWA, NGO's, private sector). This can be done by preparing a policy brief (e.g. leaflet) to be distributed to key decision-makers, relevant Government officials and civil servants, NGOs, UN agencies, Provincial Reconstruction Teams (PRT), and private sector stakeholders. Participation in relevant meetings and forums to disseminate information on the IYCF policies will also be important.

- Regular updating of the IYCF action plan and preparation of a resource mobilization plan, in collaboration with technical partners, donors and relevant MoPH departments to mobilize funds (including proposal preparation).

- Reviewing MoPH nutrition-related policies, strategies and guidelines and make sure IYCF policy priorities and strategies are adequately reflected in these documents

3.1.2. Enforcement of the Code of Marketing of Breast Milk Substitutes

The Government of Afghanistan has adopted the Code of Marketing of Breast Milk Substitutes, which is now officially approved by the Ministry of Justice, endorsed by the Cabinet, signed by the President and published in the Official Gazette. It is now essential to put in place enforcement mechanisms to ensure the Code is respected. This requires the establishment of a National Committee responsible for defining enforcement mechanisms and monitoring the application of the Code and disseminating information on the Code and related regulations to all key stakeholders (Provincial Departments of Health, Provincial Reconstruction Teams, private sector, all health facilities, MoWA, NGOs, etc.). Code monitors shall be trained (with technical assistance from IBFAN).

3.1.3. Application of the Maternity Protection Act

The Maternity Protection Act has been passed by the Ministry of Labour and Social Affairs. It stipulates that working mothers are entitled to a paid 13 week maternity leave and are allowed 2 hours / day for (paid) breastfeeding breaks while they are lactating.
Enforcement and monitoring mechanisms must now be defined to ensure that employers respect mothers' rights. This also entails disseminating information to women on their rights so they can encourage their employers to apply them. Guidelines could be developed for relevant Government departments and employers, as well as guidance for mothers, to support the application of the Maternity Protection Act.

3.1.4. Harmonizing, strengthening and completing Infant and Young Child Feeding Guidelines

The MoPH and its partners have already produced a number of training materials, namely on breastfeeding counselling, BFHI, and complementary feeding (including improved recipes and participatory cooking sessions). However, a comprehensive and harmonized set of guidelines, providing guidance on how IYCF can be promoted in different circumstances (e.g. in health facilities, at community-level, in emergencies, etc.) is lacking. These guidelines should therefore be developed and used to inform the development of training packages adapted to the needs of various audiences (e.g. different categories of health staff; personnel working in other sectors such as education and agriculture). Training activities and related material development are specified under outputs 2 and 3.

3.1.5. Application of Infant and Young Child Feeding in Emergencies Guidelines

The present IYCF policy clearly stipulates the obligation of emergency service providers to respect the IYCF policy statements in all situations, and in particular to avoid free distributions of infant formula or other Breast Milk Substitutes and respect the Code. Afghan guidelines on IFE should be developed, based on the internationally endorsed Operational Guidance on IFE. These guidelines should preferably be part of the general IYCF guidelines mentioned under 3.1.4. Until finalisation of the national guidelines emergency service providers should adhere to the Operational Guidance on IFE.

The IYCF policy and IFE guidelines should be disseminated to all relevant stakeholders, in particular the Disaster Management Committee, the PRTs, NGOs and Provincial Development Councils, and the MoPH should monitor that the policy and guidelines are applied in emergency situations.

3.2. Behaviour change through awareness raising, counselling and community support

Improving IYCF practices essentially involves promoting behaviour change, whereby families adopt improved breastfeeding and complementary feeding practices. Behaviour change requires caregivers to have the necessary:

- knowledge
- motivation
- skills
- resources
- supportive environment

The following strategic approaches will be implemented to promote and support behaviour change. (Note: activities conducted under output 3 will also contribute to behaviour change). These strategic approaches are complementary and all necessary: none alone can lead to sustainable behaviour change. For example, awareness raising must be accompanied by personalised counselling and peer support at community level and in health facilities.

3.2.1. Harmonized Public Awareness Raising

Currently the Ministry of Public Health Public Nutrition Department and Healthy Behaviour Department are organizing a large National Breastfeeding Communication Campaign. It will be launched during the National Breastfeeding Week in August (1st - 7th) 2009. This campaign will use various media (posters, leaflets, TV & radio spots, integration of message in TV series, etc.) and is being implemented in partnership with NGOs and other ministries, such as MAIL, MoWA, MoRA, MRRD, and MoE. Furthermore, the Ministry of Public Health has been implementing World Breastfeeding Week since 2003 with a broad range of partners. It will continue to do so annually.

The present IYCF Policy and Strategy plans to expand the National Breastfeeding Communication Campaign to cover complementary feeding and IYCF as a whole. Messages on complementary feeding should notably focus on the amount of foods to be given, the composition and frequency of feeds. Appropriate caring practices, and health and hygiene practices related to feeding, should also be promoted.

In addition to the campaign, regular awareness raising activities will be conducted on IYCF in partnership with media, other ministries, religious leaders and community leaders. (see Logical Framework in Annex 2 for detailed activities).

Ideally, KAP surveys (Knowledge Attitude Practice surveys) should be conducted in areas selected to cover regional and cultural diversity. This would also provide useful baseline information and help refine the messages. Reference should also be done to existing formative research carried out by MoPH, UNICEF, Save the Children and FAO. Monitoring KAP surveys should also be conducted in selected areas to assess the impact of awareness-raising activities.

Public awareness activities will increase caregivers' knowledge and also help mobilize community leaders to build their support for community-level interventions described below.

3.2.2. Counselling through community support groups and interventions

It is essential that education and counselling activities be conducted at the community-level to support behaviour change. In addition to knowledge and skills regarding adequate breastfeeding, complementary feeding and care, mothers require peer support, time, and access to the resources required for optimal child feeding (in particular diverse foods). It is therefore essential to also involve other family members in IYCF promotion, in particular men.

Counselling and generating this support can be best done through the establishment of community support groups associated with a wide range of community development interventions. Various models and approaches can be used, such as the establishment of "Baby-Friendly Communities", or "Mother Support Groups. The groups can be established through existing circles such as literacy classes, family health action groups, women's shuras, etc. As far as possible, IYCF counselling should be conducted through existing groups and platforms. Flexibility is required to build on local opportunities, to adapt to different cultural settings and better respond to local caregivers' needs.

Community support groups can be facilitated by a woman volunteer from the community, with experience of working with women and women's groups, such as literacy teachers, *dahias*, CHW's, heads of women's *shuras*, etc[10]. They would be trained on breastfeeding counselling, preparation of improved local recipes and participatory cooking sessions. Resources for participatory cooking sessions would be mobilized by community members themselves, for example with each woman bringing some food and utensils to the session. (See detailed activities in the logical framework in Annex 2).

Note: this work does not need to be implemented through the health sector and by health workers only. Agriculture 'Home Economics Officers', teachers and women's shuras can work in partnership with MoPH to implement these activities. Nutrition counselling is likely to be more effective when associated with other development activities that increase women's general knowledge, resources and confidence. (see also 3.2.3)

The support groups can be linked to and/or initiated from hospitals and health facilities participating in the Baby-Friendly Hospital Initiative.

An essential component of the community support activities should be support to households in diversifying their household food production and / or income, so as to enable them to access the ingredients required for optimal feeding. This can be done by implementing activities such as vegetable gardens and orchards, poultry rearing, goat keeping, bee-keeping (honey for income), and food processing. Such projects should be implemented side-by-side with IYCF counselling. For example, demonstration gardens should be established in hospitals (in particular where TFUs exist) and other health centres. If direct implementation is difficult, linkages and partnerships should be sought with other partners implementing food security projects.

[10] It is important to avoid introducing salaries or incentives of facilitators as this could undermine the sustainability and replicability of the intervention. Rather, mechanisms can be explored whereby volunteers receive in kind contributions from the women they are assisting.

3.2.3. Integration of Infant and Young Child Feeding in non-health community-level interventions

As far as possible, IYCF promotion should be integrated in “non-health” community-level interventions, in particular agriculture and education programmes. For example, participatory cooking sessions can be held as part of agricultural extension activities and food processing work with women producer organizations. IYCF message can be integrated in school and literacy trainings, and where possible, participatory cooking sessions can be held as practical work during literacy classes. (See activities in Annex 2).

3.3. Integration of Infant and Young Child Feeding promotion & counselling in the Basic Package of Health Services & Essential Package of Hospital Services

Promotion of appropriate IYCF is already an integral part of the public nutrition component of the Basic Package of Health Services and Essential Package of Hospital Services. However, BPHS partners, health facility managers and health staff require further support to enhance the quality, appropriateness, and coverage. The following activities are suggested to strengthen IYCF activities, in particular coverage, as part of the BPHS and EPHS.

3.3.1. Expansion of Baby-Friendly Hospital Initiative to more health facilities

The Baby-Friendly Hospital Initiative is currently being implemented in five hospitals (in Kabul and Eastern region), which have yet to be fully certified as Baby-Friendly. Priorities for applying the BFHI in Afghanistan include:

- Supporting health facilities in completing the entire BFHI process, in particular applying the 10th step to successful breastfeeding, i.e. establishment of breastfeeding support groups. This will notably be achieved through activities described under output 2 (see section 3.2.2).
- Expanding the coverage of BFHI certified facilities to more hospitals, and to health facilities providing MCH services.

Detailed activities for expanding the coverage of BFHI are described in the logical framework in Annex 2.

3.3.2. Integration of Infant and Young Child Feeding counselling in all health facilities

Messages about adequate IYCF are currently disseminated as part of health and nutrition education sessions in most health facilities and through CHWs. However, these messages will not likely generate behaviour change if not accompanied by counselling.

It is therefore important to integrate IYCF counselling (including breastfeeding demonstration and participatory cooking sessions) as part of health education activities in health facilities, in particular Comprehensive Health Centres and Basic Health Centres. This can be done by establishing IYCF corners in health facilities, or conducting IYCF counselling as part of “child health corners”.

It is also absolutely essential that breastfeeding counselling and re-lactation assistance are part of the management of acute malnutrition, whether it is provided in Therapeutic Feeding Units or Community-based Management of Acute Malnutrition. Mothers of severely malnourished

children should also participate in cooking sessions on improved complementary feeding practices. Furthermore, there should be at least one referral centre at each province for referral of complicated and difficult lactation and IYCF cases.

It may not be realistic, at this stage, to expect mobile teams and community-health workers to conduct actual counselling (except if part of community support activities described in section 3.3.2), but they should at least provide information to caregivers on adequate IYCF practices.

All BPHS partners and hospitals are encouraged to implement these activities, and BPHS donors encouraged to provide the funds required for their implementation. Technical support can be provided by the Public Nutrition Department and its technical partners. These activities will be supported by those described in section 3.3.3.

3.3.3. Training of health staff on Infant and Young Child Feeding

Training of all health staff on appropriate IYCF practices and good IYCF counselling skills is absolutely essential for the integration of IYCF in health services. This should be done by integrating IYCF into the curricula of all medical and paramedic education institutions including community midwifery school and postgraduate programs (esp. residency training programs in paediatrics, obstetrics and gynaecology).

Furthermore, IYCF should be part of in-service trainings for different staff categories, including doctors, nurses, midwives, community midwives, and CHWs. This can notably be done as part of the IMCI trainings. At least two MCH staff in each facility should be trained on IYCF counselling, and all CHWs and outreach staff should be trained to conduct education on IYCF. (See detailed activities in Annex 2)

4. Institutional Approach

4.1. Institutional framework and main partners

The implementation of the IYCF Policy and Strategy will be supervised and monitored by the Ministry of Public Health Public Nutrition Department, at central level, and at provincial level, through Public Nutrition Officers.

The Public Nutrition Department receives technical and financial support from technical agencies, in particular WHO, UNICEF, FAO, WFP, USAID/BASICS, IBFAN, BPNI, WABA, Micronutrient Initiative, and other punctual sponsors (e.g. IAEA). These partners can notably assist the PND in mobilizing human and financial resources required to implement the IYCF Policy and Strategy.

Implementation of the IYCF Policy and Strategy, in particular at community-level and health-facility level will be done through partnerships with the BPHS partners, and other NGO's working with communities.

Collaboration with the private sector, and emergency service providers (including the military) will be essential, notably to ensure the Code of Marketing of BMS is respected.

4.2. Coordination mechanisms

Effective coordination mechanisms are essential to support the effective implementation of the IYCF Policy and Strategy. Coordination should be managed through existing coordination bodies and mechanisms, strengthening them if and as required.

An IYCF Working Group is already established at the central level, under the leadership of the MoPH Public Nutrition Department. It includes representatives of the main stakeholders listed above. It should be strengthened and its Terms of Reference revised so as to include overseeing the implementation of IYCF Policy & Strategy, monitoring the application of the policy priorities and activities, and taking strategic decisions concerning its implementation. Furthermore, a Committee for monitoring the application of the Code of Marketing of Breast Milk Substitutes is in the process of being established, under the leadership of the Public Nutrition Department.

Effective coordination mechanisms should be established at the provincial level to oversee district and community level activities, namely for the public awareness activities, the establishment of IYCF community support activities, and trainings. This can include the preparation, implementation and supervision of IYCF provincial work plans, where possible. Provincial committees can also be responsible for monitoring the application of IYCF policies, in particular the Code of Marketing of BMS.

4.3. Estimated budget

The total estimated budget for the implementation of this four-year strategy is over **$8,400,000**. The table below provides a summary budget by the main components and a detailed budget is provided in annex 4.

Note: this budget does not include regular Public Nutrition Department staff and support costs. Currently, only one medical doctor is responsible full-time for supervising IYCF issues, at the central level. Another two technical staff are required to adequately support the IYCF strategy implementation, together with associated support costs (computer, transport, etc.).

Component	Budget required
1. Policies, regulations, guidelines	**$544 500**
1.1 National IYCF Policy & Strategy	$46 000
1.2 The Code of Marketing of BMS	$425 500
1.3 Maternity protection	$35 000
1.4 IYCF Guidelines	$38 000
1.5 Infant and Young Child Feeding in Emergencies	
2. Behaviour change on IYCF	$6 147 000
2.1 Public Awareness Raising	$1 634 000
2.2 Establishment of community support groups and interventions	$2 382 000
2.3 Integration of IYCF in non-health community-level interventions	*$2 131 000*
3. IYCF in BPHS & EPHS	**$1 717 700**
3.1 Expansion of BFHI	$562 000
3.2 Integration of IYCF counselling in all health facilities	$652 500
3.3 Training of health staff in IYCF	$503 200
COMPLETE TOTAL	**$8 409 200**

5. Monitoring and evaluation

Effective monitoring and evaluation must also be established to assess progress towards the strategy objectives. Monitoring and evaluation should be supported by regular monitoring, progress reviews, and eventually, operational research.

Indicators for monitoring the objectives, components and strategic approaches are proposed in Annex 2. (Note: these indicators may be slightly modified when survey and M&E tools are designed).

5.1. Regular monitoring and evaluation

Adequate M&E tools (including self-assessment tools) should be developed to support effective monitoring of the IYCF Policy and Strategy. Indicators should, as far as possible, be integrated in the HMIS, national monitoring checklists, and third party evaluations. Furthermore, relevant staff (in particular PNO's) should be trained on the use of the M&E tools and measures to take corrective action. Regular monitoring of field activities by MoPH staff (in particular Provincial Nutrition Officers) will be essential.

Monitoring can also be done by integrating IYCF indicators in surveys, such as the MICS survey, and other studies. It will be necessary to assess whether there are any specific operational research needs and develop an operational research plan accordingly.

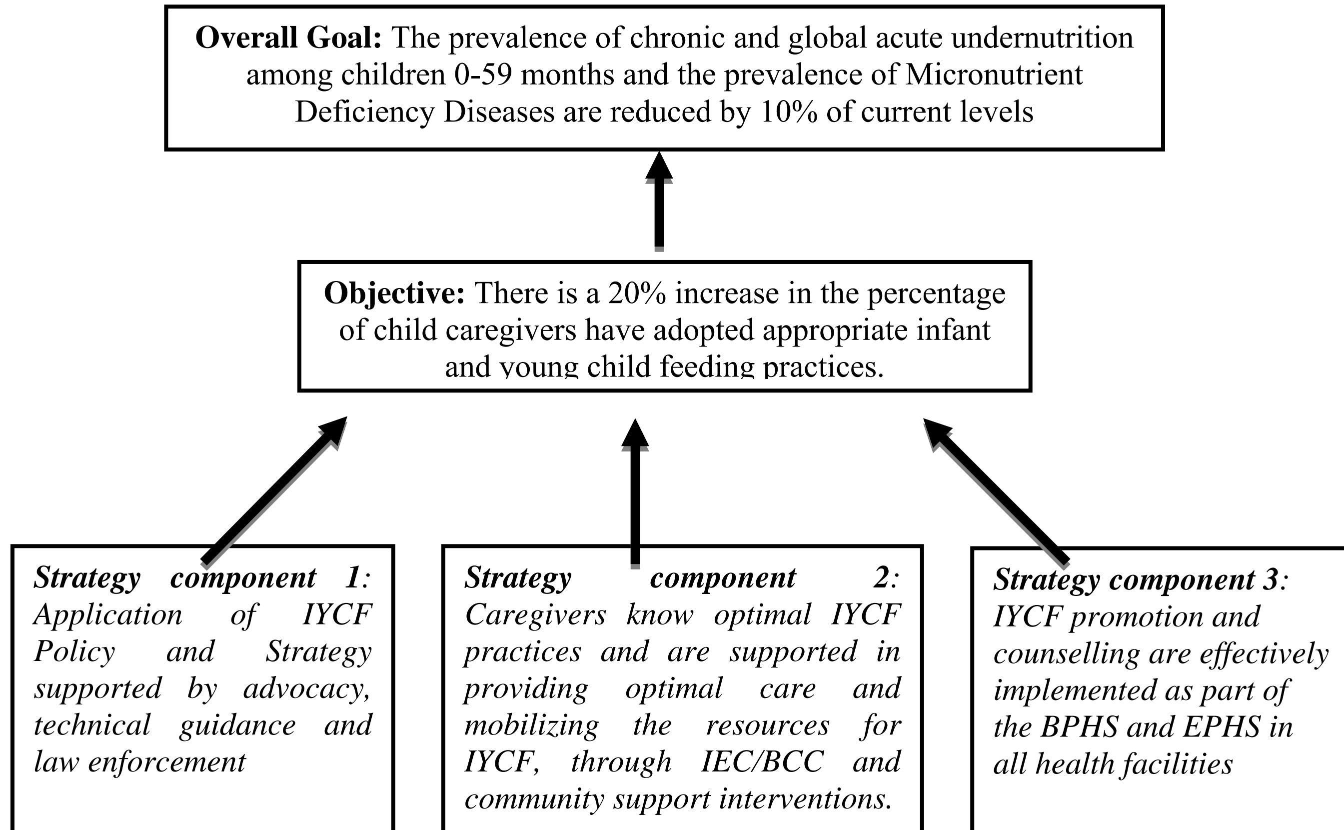
5.2. Operational research

Formative research has already been carried out on breastfeeding practices in 2002 and 2003 (notably with UNICEF and Save the Children support), and on complementary feeding practices and recipes (by FAO and MAIL in 2006). However, new operational research needs may arise during the IYCF Policy and Strategy implementation. If there are research needs, an operational research plan should be developed and resources mobilized to implement it.

5.3. Progress Reviews

The information generated by the M&E system should be used to regularly assess progress on the implementation of the IYCF Policy and Strategy and make necessary adjustments in the implementation plan. Furthermore, progress should be reported to the relevant authorities and stakeholders, for issues of accountability, but also to maintain / generate motivation to pursue implementation. A national review workshop should be conducted annually (including the preparation of the following annual work plan). Progress on the implementation of the IYCF Policy and Strategy should also be reviewed at the regional level through regional workshops. Progress can be reviewed at least once a year at the provincial level using the Provincial Health Coordination Committee (PHCC) or other forums. Finally, information on this progress should be shared through the Consultative Group on Health and Nutrition (CGHN), as well as other through media, such as "Sehat" and "Salamaty" journals.

Annex 1 Results Chain



Annex 2: Logical Framework Analysis

Goal and objective		Indicators[11]	Baseline	Target	Means of verification	Risks & Assumption
Overall Goal	The prevalence of chronic and global acute undernutrition among children 0-59 months and the prevalence of MDDs are reduced by 10% of current levels	• Prevalence of Chronic undernutrition (stunting) among children under 5. • Prevalence of acute undernutrition (wasting) among children under 5. • Prevalence of Iron Deficiency in children under 5	• 54% • 6.7-10% • 72%	• 49% • 5-9% • 65%	National Nutrition survey & MICS	Security Legal & Political support Funding

[11] The indicators presented here may be slightly modified when M&E tools and surveying tools are designed. However, the targets will be equivalent to the targets presented here.

Objective	To increase the percentage of child caregivers that have adopted appropriate infant and young child feeding and caring practices.	• % increase in the percentage of mother that have initiated breast feeding within first hour after birth • % increase in the percentage of mothers that are exclusively breastfeeding until the child is 6 months • % increase in the percentage of mothers that continue breastfeeding until the child is two years or older. • % increase in the percent of children that are receiving complementary foods at the age of 6 months • % of children's under 2 with diet diversity scores ≥4 food groups consumed in previous 24 hours *(see new WHO indicators for IYCF in annex 5)*	37%* (AHS) 19-70%* 54% (MICS 2003) 28% (MICS 2003) N/A - TBD *Note: the MICS 2009 will provide updated national baseline data. Regional surveys can provide more specific estimates	20% increase 20% increase 20% increase 20% increase 20% increase	National Nutrition Survey Regional surveys MICS	Security Legal & Political support Funding
Component and strategic approaches		**Indicators**	**Baseline**	**Target**	**Means of verification**	**Risks & Assumption**
Component 1	*Application of IYCF Policy and Strategy supported by advocacy, technical guidance and law enforcement.*	• Relevant government officials, civil servants, NGO and health sector personnel, and private sector aware the IYCF Policy & Strategy • Resources for IYCF mobilised • National Committee for the Code of Marketing of BMS active • Violations of the Code and Maternity Protection Act denounced and condemned • National IYCF Guidelines used by stakeholders	• 0 $2m for 2009 No committee 0 No guidelines	• 100% At least 2m/year through MoPH 1 committee According to events 1 guidelines set	Code Commit. Reports Regular monitoring	Political support Resources mobilised

<table>
<tr><td>Strategic Approaches</td><td colspan="6">

National IYCF Policy and Strategy:

1. Disseminate the National IYCF Policy and Strategy amongst all key stakeholders (MoPH, MAIL, MoJ, MoMI, MoEd, MoRA, MoWA, NGO's, private sector).
    - Preparation of a policy brief/leaflet for key decision makers, civil servants, NGOs and private sector stakeholders on the Government of Afghanistan's IYCF policy
    - Participation in relevant meetings and forums to disseminate information on the IYCF policies.
2. Regular updating of IYCF action plan and preparation of a resource mobilization plan to support the implementation of the IYCF Policy & Strategy
3. Review MoPH related sub-policies, strategies and guidelines and make sure IYCF has been reflected in these documents

The Code of Marketing of Breast Milk Substitutes

4. Establish a National Committee for the Enforcement of the Code
5. Establish enforcement mechanisms for the Code of Marketing of BMS
6. Disseminate information on the Code (including translations) and related legislation to all key stakeholders (Provincial Departments of Health, PRTs, private sector, all health facilities, MOWA, NGOs, etc.) through posters, leaflets, and workshops
7. Training of Code monitors (IBFAN)

Maternity protection

8. Establish enforcement mechanisms and develop guidelines for the implementation of the Maternity Protection Act
9. Inform working women of their rights under the Maternity Protection Act (e.g. through leaflets and radio; can be part of IYCF Public Awareness Campaign)

IYCF Guidelines

10. Review existing international guidelines and national training packages and develop a comprehensive and coherent set of harmonized guidelines covering IYCF policy and priorities and strategic interventions, namely: IYCF promotion in different health facilities (including BFHI guidelines); IYCF promotion at community level; Infant and Young Child Feeding in Emergencies; Implementation of the Code, etc.
11. Disseminate guidelines to the relevant stakeholders, and conduct trainings on their implementation (c.f. also training activities under outputs 2 and 3)

Infant and Young Child Feeding in Emergencies

12. As part of the Afghan IYCF guidelines, develop a section on IYCF in Emergencies based on the internationally endorsed Operational Guidance for IFE
13. Disseminate the IFE Guidelines to all relevant stakeholders (including the Disaster Management Committee, the PRT, NGOs and Provincial Development Councils) and ensure they are implemented in emergency situations.

</td></tr>
<tr><th colspan="2">Component and strategic approaches</th><th>Indicators</th><th>Baseline</th><th>Target</th><th>Means of verification</th><th>Risks & assumption</th></tr>
</table>

Component 2	*Caregivers know optimal IYCF practices and are supported in providing optimal care and mobilizing the resources required to apply adequate IYCF through IEC/BCC and community support interventions*	• 70% of Afghan adult and adolescent population is aware of key IYCF practices • 90% shura members aware of good IYCF • Number of IYCF community support groups established and operational • Number of women receiving satisfactory breastfeeding counselling *at community level* • Number of mothers having participated in at least 5 participatory cooking sessions	• TBD • TBD • 0 • 0 • TBD	• 70% • 90% • 1500 • 20000 • 20000	National Nutrition Survey (&/ or KAP surveys) HMIS Monitoring visits Impact assessment and surveys	Security Political and community support Resources mobilised

Strategic Approaches

Public Awareness Raising

1. Implement the National Breastfeeding Communication Campaign (to be launched during World Breastfeeding Week 1-7August 2009)
2. Celebrate World Breastfeeding Week annually
3. Expand the National Breastfeeding Communication Campaign to cover complementary feeding and IYCF as a whole, and conduct regular IYCF awareness activities:

- Identification and mobilization of key partners for public awareness activities, namely MoPH, MAIL, MoWA, MoRA, MoE, MRRD and public media.
- Conduct sample baseline KAP surveys, where possible (referring to formative research conducted in 2002 and 2003)
- Identification and definition of harmonized messages to be used by all stakeholders, under MoPH PND lead.
- Development of adequate materials, including posters, leaflets, radio and TV spots
- Training of relevant stakeholders on the IEC messages (including key health staff -cf link to output 4-, religious leaders, community leaders, journalists, etc.)
- Implementation of Public Awareness Activities through the various media identified
- Post-awareness raising monitoring survey (KAP)

Establishment of community support groups and interventions

1. Identification of opportunities for establishing IYCF community support groups, on the basis of existing networks and projects (e.g. health shuras, women's shuras, Growth Monitoring and Promotion, etc.) and/or integrating IYCF counselling in existing community development activities.
2. Mobilization of elders and community leaders to establish support for the community support groups and/or community-based IYCF counselling
3. Identify facilitators who can provide counselling at community level, through community support groups and/or other development interventions (e.g. CHW, dahia, literacy teacher, head of women's shura, etc.) and determine their training needs
4. Development of training materials and job aids for community-level IYCF counsellors and support group facilitators
5. Training of IYCF counsellors and /or support group facilitators on adequate IYCF counselling and psycho-social support skills
6. Provide IYCF counsellors and /or support group facilitators with the resources required to conduct adequate counselling (e.g. BF counselling kit; cooking set;)
7. Provide regular assistance and supervision to IYCF support groups and IYCF counsellors operating at community level.
8. Monitor the implementation of counselling sessions and participatory cooking sessions
9. Establish linkages and partnerships with food security projects aiming to diversify household food production and income generation (if locally in place) or mobilize resources and expertise to implementation food security interventions if they are not in place.

Integration of IYCF in non-health community-level interventions

1. Establish pool of IYCF trainers in MAIL and train extension workers (in particular women) on IYCF counselling
2. Integration of IYCF messages and participatory cooking sessions in agricultural projects
3. Include IYCF in the curricula of literacy training and train literacy teachers on IYCF.

Component and strategic approaches	Indicators	Baseline	Target	Means of	Risks &

					verification	assumption
Component 3	*IYCF promotion and counselling is effectively implemented as part of the BPHS and EPHS in all health facilities*	• Number of facilities certified as Baby-friendly • 50% of the EPHS facilities and health centres (CHC&BHC) provide IYCF counselling as part of the MCH services. (=700) • 50% of doctors, nurses, community midwives and CHWs demonstrate correct counselling skills on IYCF • Average number of women receiving breastfeeding counselling per month per counsellor in health services • Number of health facilities conducting participatory cooking demonstrations	5 in process • TBD • 4,000 (% TBD) • Check with counsellor • Check with FAO	• >30 • >50% • 50% • >3/month/ counsellor • >100	MoPH reports Training reports HMIS	Security Political support Resources mobilised

Strategic Approaches

Expansion of Baby-Friendly Hospital Initiative to more hospitals and selected health facilities providing MCH services

1. Review lesson learned from the current BFHI
2. Train pool of BF assessors/advocates at the central and regional level.
3. Develop tools, conduct assessment/re-assessment to certifying health facilities as Baby-friendly
4. Train health facility staff on measures required to comply with BFHI criteria and implement these measures
5. Supervise and monitor facilities and provide certificates for facilities complying with BFHI criteria

Integration of IYCF counselling in all health facilities

6. Develop guidelines and establish IYCF corners in health facilities, including breastfeeding counselling and participatory cooking sessions (N.B. can be part of child health corner)
7. Ensure IYCF counselling is part of health education activities, including breastfeeding demonstration and participatory cooking sessions
8. Ensure breastfeeding counselling and re-lactation assistance are part of the management of acute malnutrition (in TFU and CMAM)
9. Identify at least one referral centre in each province for referral of complicated and difficult lactation and IYCF cases.

Training of health staff on IYCF

10. Integrate IYCF into the curricula of all medical and paramedic education institutions including community midwifery school and postgraduate programs (esp. residency training programs in paediatrics, obstetrics and gynaecology).
11. Develop training packages and job aids on IYCF for different health staff categories, including: doctors, nurses, midwives, community midwives, and CHWs
12. Integrate IYCF training modules as part of in-service trainings, in particular for MCH staff, CHWs & midwives (e.g. as part of C-IMCI training)
13. Distribute printed material and job aids to all facilities, including for CHWs and community midwives as part of C-IMCI
14. Train and establish pool of trainers at the national level and in “each region” on MBFI and IYCF, in particular by training Provincial Nutrition Officers on IYCF
15. Train at least 2 MCH staff of each health facility.
16. Train out-reach staff to enable them to integrate IYCF in out-reach services.

Annex 3: Work plan

Components / strategic approaches	**2009**		**2010**				**2011**				**2012**				**2013**			
	III	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**
1. Policies, regulations, guidelines																		
1.1 National IYCF Policy & Strategy																		
Disseminate the National IYCF Policy and Strategy amongst all key stakeholders	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Regular updating of IYCF action plan and preparation of a resource mobilization plan	X		X				X				X				X			
Review MoPH related sub-policies, strategies and guidelines	X	X	X	X	X													
1.2 The Code of Marketing of BMS																		
Establish and regular meetings of National Committee for the Enforcement of the Code		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Establish enforcement mechanisms		X																
Disseminate information on the Code and related legislation	X	X																
Training of Code monitors	X	X																
Monitor Code implementation			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1.3 Maternity protection																		
Establish enforcement mechanisms and develop guidelines			X	X														
Inform working women of their rights under the Maternity Protection Act					X	X	X	X	X	X	X	X	X	X	X	X	X	X
1.4 IYCF Guidelines																		
Develop IYCF guidelines	X	X	X	X														
Disseminate guidelines and conduct trainings on their implementation			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
1.5 Infant and Young Child Feeding in Emergencies																		
Develop IFE Guidelines & integrate in IYCF guidelines	X	X	X	X														
Disseminate the IFE Guidelines & monitor application			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Components / strategic approaches	**2009**		**2010**				**2011**				**2012**				**2013**			
	III	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**
2. Behaviour change on IYCF																		
2.1 Public Awareness Raising																		
Implement the National Breastfeeding Communication Campaign	X	X																
Celebrate World Breastfeeding Week	X				X				X				X				X	
Expand to IYCF as a whole, and conduct regular IYCF awareness raising:																		
• Mobilization of key partners	X	X	X	X	X													
• Baseline KAP surveys		X	X	X	X	X												
• Identification of messages		X	X	X	X	X												
• Development of materials			X	X	X	X												
• Trainings on the IEC messages				X	X	X	X											
• Implement Public Awareness						X	X	X	X	X	X	X	X	X	X	X	X	X
• Impact monitoring survey (KAP)																X	X	X
2.2 Establishment of community support groups and interventions																		
Identification of opportunities	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mobilization of community leaders Identify facilitators	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop training materials & job aids		X	X	X	X													
Training of IYCF counsellors and facilitators & provide resources			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Regular assistance and monitoring					X	X	X	X	X	X	X	X	X	X	X	X	X	X
Establish linkages with food security			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Target number of support groups:		20				100				300				800				1500
2.3 Integration of IYCF in non-health community-level interventions																		
Establish pool of IYCF trainers in MAIL and train extension workers	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X
Integration of IYCF messages and participatory cooking sessions in agricultural projects	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Include IYCF in literacy curricula	X	X	X	X	X													
Train literacy teachers on IYCF		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Components / strategic approaches	**2009**		**2010**				**2011**				**2012**				**2013**			
	III	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**
3 IYCF in BPHS & EPHS																		
3.1 Expansion of BFHI																		
Review lesson learned from current BFHI	X	X																
Develop tools to assess BFHI status		X	X	X	X	X												
Train pool of BF assessors/advocates at the central and regional level			X	X	X	X	X	X	X	X								
Conduct assessments/re-assessments on BFHI status of health facilities					X	X	X	X	X	X	X	X	X	X	X	X	X	X
Train health facility staff on BFHI					X	X	X	X	X	X	X	X	X	X	X	X	X	X
Monitor facilities and provide certificates					X	X	X	X	X	X	X	X	X	X	X	X	X	X
Targets per year		5				10				15				20				30
3.2 Integration of IYCF counselling in all health facilities																		
Develop guidelines on IYCF corners		X	X	X														
Establish IYCF corners in health facilities				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Ensure IYCF counselling is part of health education activities				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Ensure breastfeeding counselling and relactation assistance are part of the management of acute malnutrition	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Identify at least one IYCF referral centre / province	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Targets / year (health facilities with IYCF counselling)		40				100				200				400				700
Training of health staff on IYCF																		
Integrate IYCF into the curricula of medical and paramedic education institutions				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Develop training packages and job aids on IYCF for different health staff categories	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Integrate IYCF training modules as part of in-service trainings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Train and establish pool of trainers at the national level and in "each region	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Distribute printed material and job aids to all facilities	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Coordination, M&E and research	**2009**		**2010**				**2011**				**2012**				**2013**			
	III	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**	**I**	**II**	**III**	**IV**
Coordination mechanisms																		
IYCF Working Group meetings	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Establish effective coordination mechanisms at provincial level	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Monitoring and evaluation																		
Develop and adopt IYCF monitoring tools for use at different levels	X	X	X	X	X													
Build capacity of the staff to use monitoring tools and take corrective action				X	X	X	X	X										
Incorporate IYCF selected indicators in national monitoring systems				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Incorporate IYCF main indicators in national surveys (in particular MICS	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Include IYCF in IMCI and CBHC supervisory checklists/tools	X	X	X															
Conduct regular monitoring visits on IYCF				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Operational research																		
Identify research needs; if needs, develop operational research plan	X	X	X	X														
Mobilize resources				X	X	X												
Implement the plan						X	X	X	X	X	X	X	X	X	X	X	X	X
Progress Reviews																		
National review workshops	X		X			X				X				X				X
regional workshops			X			X				X				X				X
Review progress of implementation of IYCF strategic plan at the provincial level		X		X		X		X		X		X		X		X		X
Use “Sehat” and “Salamaty” Journals & CGHN to report and provide feedback on progress				X			X				X				X			X

Annex 4: Estimated costs of the Infant and Young Child Feeding strategy

The cost for each component of the IYCF strategy is provided below, broken down by activity and type of resources.

*N.B. The "Potential Sources of support" (column 6) are not donors but technical assistance providers (through which donor funding can be channelled in addition to direct support to MoPH)

Components / strategic approaches	Resources needed (year 1)	Number of units	Unit costs	Amount needed (total)	Potential Source of support*
1. POLICIES, REGULATIONS, GUIDELINES					
1.1 National IYCF Policy & Strategy					
Disseminate the National IYCF Policy and Strategy amongst all key stakeholders	Translation (Dari & Pashtoo)	2	$1 500	$3 000	BASICS
	Printing (English, Pashtoo and Dari)	3	$1 000	$3 000	BASICS
	PND staff &support costs				MoPH
Regular updating of IYCF action plan and preparation of a resource mobilization plan	PND staff &support costs				MoPH
	Technical assistance (4 months over 4 years)	4	$10 000	$40 000	
Total 1.1				**$46 000**	
1.2 The Code of Marketing of BMS					
Establishment and regular meetings of National Committee for the Enforcement of the Code	PND staff &support costs				MoPH
	Technical assistance (4 months over 4 years)	4	$10 000	$40 000	IBFAN, UNICEF?
	Support to Committee est & regular meetings (2/year, 4 years)	8	$1 000	$8 000	UNICEF + IBFAN
	National meeting (2009)	1	$7 000	$7 000	UNICEF+IBFAN
Establish enforcement mechanisms	PND staff &support costs				MoPH
	TA above can contribute				IBFAN?
Disseminate information on the Code and related legislation	Translation (in English & Pashto)			*Already done*	UNICEF
	Printing costs (in dari & pashto)			*Already done*	
	PND staff &support costs				MOPH
Training of Code monitors	Annual trainings in 5 regions, each year	15	$4 000	$60 000	UNICEF

Monitor Code implementation	Bi-annual field visits by provincial staff to each district (incremental coverage)	1 380	$200	$276 000	UNICEF + IBFAN
	Annual visit by central level staff to each province (incremental coverage)	69	$500	$34 500	
	PND staff &support costs				MoPH
	BPHS/EPHS staff time				BPHS donors
Total 1.2				**$425 500**	
1.3 Maternity protection					
Establish enforcement mechanisms & develop guidelines	PND staff & support costs				MoPH
	Technical assistance	1	$10 000	$5 000	
Inform working women of their rights under the Maternity Protection Act	PND staff & support costs				
	Dissemination of info through media	1	$10 000	$10 000	
	Sensitization workshops for employers (1/region/year, 4 years; 1 day)	20	$1 000	$20 000	
Total 1.3				**$35 000**	
1.4 IYCF Guidelines					
Develop IYCF guidelines	International consultant 2 months	2	$10 000	$20 000	
Disseminate guidelines and conduct trainings on their implementation	Translation (Dari and Pashto)	2	$1 500	$3 000	
	Publication costs (in Eng, Dari and Pashto) *(training costs in components 2 & 3, below)*	3	$5 000	$15 000	BASICS, WHO, UNICEF?
Total 1.4				**$38 000**	
1.5 Infant and Young Child Feeding in Emergencies					
Develop IFE Guidelines & integrate in IYCF guidelines	*International consultant (same as above)*			*Part of above*	
Disseminate the IFE Guidelines & monitor application	*Publication costs*			*Part of above*	
TOTAL 1				$544 500	

Components / strategic approaches	Resources needed (year 1)	Number of units	Unit costs	Amount needed (total)	Potential Source of support*
2. BEHAVIOUR CHANGE ON IYCF					
2.1 Public Awareness Raising					
Implement the National Breastfeeding Communication Campaign (1 year: 2009-2010)	PND staff time & support costs				MOPH
	Material development			$150 000	UNICEF & WHO
	Dissemination through media				
	Transport costs				
	campaign staff costs?				
Celebrate World Breastfeeding Week	PND staff time & support costs				MOPH
	Materials and campaign implementation (lumpsum, 4 years)	4	$100 000	$400 000	UNICEF & WHO
Expand to IYCF as a whole, and conduct regular IYCF awareness raising (2010-2013):	PND staff time & support costs				MoPH
	Technical assistance (1 international or national consultant, as per need, e.g. 6 months total)	6	$10 000	$60 000	UNICEF, WHO, FAO, WFP
	Baseline KAP survey	1	$100 000	$100 000	
	Development of materials	1	$100 000	$100 000	
	Trainings on messages (1 training / region, 4 years)	20	$4 000	$80 000	
	Field work (staff & transport) in each province, 4 years	136	$4 000	$544 000	
	Dissemination through media	1	$100 000	$100 000	
	Impact monitoring survey	1	$100 000	$100 000	
Total 2.1				**$1 634 000**	
2.2 Establishment of community support groups and interventions	PND staff & support costs				MoPH
	Technical assistance (6 months total)	6	$10 000	$60 000	BASICS, FAO, UNICEF, FAO, WHO, WFP (MDG-Fund)
Develop training materials & job aids	Design / review of training materials & job aids (Technical assistance) -team for 2 months	2	$3 000	$6 000	
	Translation (Dari & Pashto)	2	$1 000	$2 000	
	Printing (Dari & Pashto)	2	$6 000	$12 000	

Training of IYCF counsellors and facilitators & provide resources	Regional trainings (2/year in each region, 4 years)	40	$4 000	$160 000	
Regular assistance and monitoring	Field visits (1/district/2months)	7 140	$300	$2 142 000	
Establish linkages with food security					
TOTAL 2.2.				**$2 382 000**	
2.3 Integration of IYCF in non-health community-level interventions					
Establish pool of IYCF trainers in MAIL and train extension workers	PND / MAIL / MoE staff and support costs				MoPH/MAIL/MoE
	Technical assistance (6 months over 4 years)	6	$10 000	$60 000	FAO, with support from UNICEF, WHO, and BASICS
	Master trainings (3) and regional trainings (1/region/year for 3 years)	18	$4 000	$72 000	
Integration of IYCF messages and participatory cooking sessions in agricultural projects	Provincial trainings for field staff (1/province + refresher)	68	$4 000	$272 000	FAO, with UNICEF, WHO, and BASICS
	Monitoring visits (at least 1/district/year; incremental)	690	$300	$207 000	
Include IYCF in literacy curricula	Preparation of literacy materials / job aids / training materials	1	$200 000	$200 000	FAO, Habitat, UNICEF
Train literacy teachers on IYCF	Provincial trainings for literacy teachers (1/District + refresher course)	660	$2 000	$1 320 000	
Total 2.3				***$2 131 000***	
TOTAL 2				**$6 147 000**	

Components / strategic approaches	Resources needed (year 1)	Number of units	Unit costs	Amount needed (total)	Potential Source of support*
3. IYCF in BPHS & EPHS					
3.1 Expansion of BFHI					
Review lesson learned from current BFHI	Technical assistance (4 mo)	4	$10 000	$40 000	UNICEF, WHO?
	PND staff and support costs				MOPH
	External assessment of BFHI (incremental)	80	$1 000	$80 000	UNICEF, WHO
Develop tools to assess	PND staff time				MOPH

BFHI status	Technical assistance (2 months)	2	$10 000	$20 000	UNICEF, WHO
	Print materials	1	$30 000	$30 000	
Train pool of BF assessors/advocates at the central and regional level	PND staff time & support costs				MOPH
	Trainings for assessors at regional level (1 training/region/year, 4 yrs)	20	$4 000	$80 000	UNICEF, WHO
Train health facility staff on BFHI	PND staff time				MOPH
	Provincial trainings (2/province)	68	$4 000	$272 000	UNICEF, WHO
	EPHS/BPHS staff time				BPHS
Monitor facilities, conduct assessments / reassessments, and provide certificates	PND staff time & support costs				MOPH
	EPHS/BPHS staff time				BPHS
	Monitoring visits (1/province/year; incremental)	80	$500	$40 000	UNICEF, WHO
Total 3.1				**$562 000**	
3.2 Integration of IYCF counselling in all health facilities					
Develop guidelines on IYCF corners (part of IYCF guidelines, above)	*See above*				
Establish IYCF corners in health facilities & identify at least one IYCF referral center / province (training covered in 3.3)	Technical support to BPHS/EPHS partners by PND staff				MoPH
	EPHS/BPHS staff time				BPHS
	2 visits in each facility for establishment (assessment and support)	3 420	$100	$342 000	
Ensure IYCF counselling is part of health education activities and management of acute malnutrition (training covered in 3.3)	PND staff time and support costs				MoPH
	EPHS/BPHS staff time				BPHS
	Bi-annual field visits by provincial staff to each district (incremental coverage)	1 380	$200	$276 000	
	Annual visit by central level staff to each province (incremental coverage)	69	$500	$34 500	
Total 3.2				**$652 500**	

3.3 Training of health staff on IYCF					
Integrate IYCF into the curricula of medical and paramedic education institutions	PND staff and support costs				MoPH; UN MDG-Fund, Univ of Massachus setts
	Technical assistance	6	$10 000	$60 000	
	Material development	4	$20 000	$80 000	
	Training of trainers (for faculty professors; 4/year)	16	$4 000	$64 000	
Develop training packages and job aids on IYCF for different health staff categories	PND staff and support costs				MoPH
	Technical assistance	4	$10 000	$40 000	UNICEF, WHO, FAO, WFP
	Material development	4	$20 000	$80 000	
Integrate IYCF training modules as part of in-service trainings	PND staff and support costs				MOPH
	Regular MoPH training				MoPH?
	Additional training to complement regular in-service training (1/province)	34	$4 000	$136 000	UNICEF, WHO, BASICS
Train and establish pool of trainers at the national level and in "each region	PND staff and support costs				MOPH
	Training costs (1 training year 1 + 3 refresher courses)	4	$4 000	$16 000	UNICEF, WHO, FAO
Distribute printed material and job aids to all facilities	PND staff and support costs				MOPH
	transport costs	34	$800	$27 200	UNICEF, WHO
Total 3.3				**$503 200**	
TOTAL 3				**$1 717 700**	

COMPLETE TOTAL	**$8 409 200**

Annex 5: Infant and Young Child Feeding References for Afghanistan

Afghan materials (available in Dari and/or Pashto):

Breastfeeding Counselling Training Package translated in Dari

Baby-Friendly Hospital Initiative training package translated in Dari/Pashto

Code of Marketing of Breast Milk Substitutes (2009) Translated in Dari/Pashto/English

The Afghan Family Nutrition Guide (MAIL, MoPH, FAO, 2007)

Healthy Food, Happy Baby, Lively Family: Improved Recipes and Feeding Practices for Afghan Mothers and Children (MAIL, MoPH, FAO, UNICEF, 2008), and relevant training materials (FAO)

WHO/UNICEF Global Strategy on Infant and Young Child Feeding, translated in Dari and Pashto.

International references:
WHO/UNICEF Global strategy on Infant and Young Child Feeding (2002):
http://www.who.int/nutrition/topics/global_strategy/en/

Code of Marketing of Breast Milk Substitutes (1981)
http://www.who.int/nutrition/publications/code_english.pdf

Operational Guidance on Infant and Young Child Feeding in Emergencies (IFE Core Group):
http://www.ennonline.net/pool/files/ife/ops-guidance-2-1-english-010307.pdf

Annex 6: WHO recommended Infant and Young Child Feeding indicators

- **Early initiation of breastfeeding:** Proportion of children born in the last 24 months who were put to the breast within one hour of birth

Children born in the last 24 months who were put to the breast within one hour of birth
Children born in the last 24 months

Additional indicators may include:

Children born in the last 24 months who were put to the breast within 24 hours of birth
Children born in the last 24 months

Children born in the last 24 months who received colostrum (not discarded)
Children born in the last 24 months

- **Exclusive breastfeeding under six months:** Proportion of infants 0-5 months of age who are fed exclusively on breast milk

Infants 0-5 months who received only breast milk during the previous day
Infants 0-5 months of age

Note: Using the previous day recall period will overestimate the proportion of infants who are exclusively breastfed. Some infants who are given other liquids irregularly may not have received them the day before the survey.

An additional indicator may include:

Predominant breastfeeding under six months: Proportion of infants 0-5 months of age who have breast milk as their main source of nourishment. This indicator recognizes that the infant receives certain liquids (water, tea, watery liquids, ritual fluids).

Infants 0-5 months of age who received breast milk as a main source of nourishment
Infants 0-5 months of age

- **Introduction of solid, semi-solid or soft foods (Complementary feeding):** Proportion of infants 6-8 months of age who receive solid, semi-solid or soft foods

Infants 6-8 months of age who ate solid, semi-solid or soft foods in the previous day
Infants 6-8 months of age

- **Continued breastfeeding at one year:** Proportion of children 12-15 months of age who are fed breast milk

Children 12-15 months of age who were fed breast milk in the previous day
Children 12-15 months of age

- **Continued breastfeeding at two years:** Proportion of children 20-23 months of age who are fed breast milk

Children 20-23 months of age who were fed breast milk in the previous day
Children 20-23 months of age