

IYCF Strategy and Action Plan for South Central Somalia

2013-2017



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Executive Summary

Infant and young child feeding (IYCF) programming is an intervention which can have a significant impact on reducing mortality and morbidity in young children. In fact, broad coverage of breastfeeding and complementary feeding interventions can reduce up to 20% of deaths in young children. IYCF indicators for Somalia are significant sub-optimal which means that Somali children do not get the best start in life.

After focusing predominately on the management of acute malnutrition for 20 years, stakeholders in Somalia have begun to see the necessity and value of shifting the focus to more preventative programming and especially to IYCF. IYCF is one of the six key outcomes defined in the Somali Nutrition Strategy and IYCF and maternal nutrition are essential components of the Basic Nutrition Services Package. Since 2010 scale-up of IYCF programmes has been slowly ongoing. Efforts were delayed in southern Somalia in 2011 due to reoccupation with the famine response, however the process became reinvigorated mid-2012.

The IYCF Strategy and Action Plan for South Central Somalia was developed through a consultative process involving Nutrition Cluster partners. Four consultative meetings were held (2 in Mogadishu and 2 in Nairobi) to review various drafts and to discuss pending issues. The overall objective of the strategy is to improve the nutritional status, growth, development, and survival of infants and young children through promotion and support for optimal feeding practices. Specially, the IYCF Strategy seeks to achieve the following key objectives: (1) A supportive environment for IYCF is created; (2) Adequate access to quality services for IYCF is ensured; and (3) Progress and success for IYCF is documented and disseminated. The Strategy is based around 4 of the 6 WHO pillars for health systems strengthening – Leadership and Governance, Capacity Development, Service Delivery, and Health Information. This approach will ensure that the overall system is working towards the IYCF goals.

The overall implementation and monitoring of the Strategy will be achieved by an IYCF Technical Committee. A five year timeline will allow for implementation, monitoring and evaluation of activities as well as some impact assessment. The Action Plan is meant to be a living document to be revamped each year during the microplanning process.

1. Background

1.1 Introduction

Optimum infant and young feeding (IYCF) practices are essential for survival, growth and development of infants and young children. These feeding practices are comprised of breastfeeding, complementary feeding and feeding of the sick child. The WHO/UNICEF Global Strategy¹ for infant and young child feeding states that:

- 1) Infants should be initiated to breastfeeding within the first half to 1 hour following their birth.
- 2) They should be exclusively breastfed up to 6 months of age and from then on,
- 3) They should receive safe, nutritionally adequate and age appropriate complementary foods while continuing to breastfeed up to 2 years and beyond to meet their evolving nutritional needs.

The Convention on the Rights of the Child states that access to adequate nutrition with appropriate family support for optimum infant feeding practices is a right for every child. The optimal feeding of infants and young children requires adequate health and nutrition for the mother, the right support from the family and the community, and the health care system. It also requires special attention and special measures in exceptionally difficult circumstances such as feeding low birth weight babies, malnourished children, infants and young children in emergencies, infants born to HIV-positive mothers, or feeding other vulnerable children living under challenging circumstances.

In Somalia, however, it has not been easy to ensure optimal IYCF practices largely due to:

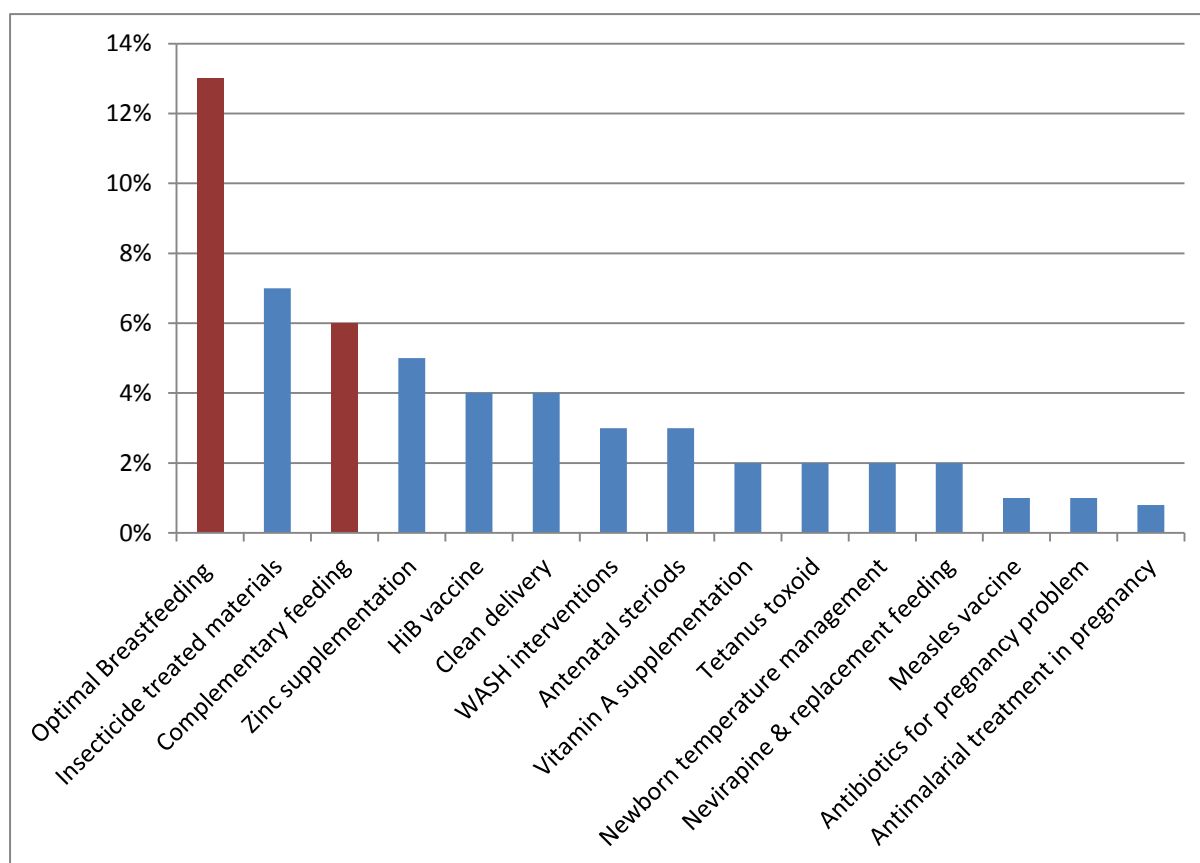
- strong beliefs and cultural practices, for example, the requirement to give babies water when it is hot or the idea that it is biological impossible for a mother to produce enough milk to breastfeed exclusively
- limited accessibility to health care services and hygiene and sanitation infrastructure as well as poor health-seeking behaviours
- General lack of a supported community cadre of health worker to ensure communication of key messages within communities
- Poor access and availability of foods to ensure a diversified diet especially for young children

With this in mind, the Nutrition Cluster partners decided from 2010 to strengthen programming for IYCF in Somalia. IYCF needs to be given a more prominent position in programming considering its important contribution to infant and young child survival, growth and development. A process for drafting an IYCF Strategy and Action Plan for Somalia was planned for 2011 but had to be delayed in south-central Somalia due to preoccupation with the famine response.

¹ Global Strategy for Infant and Young Child Feeding Practices. WHO/UNICEF. 2002

1.2 Justification

Of all proven preventative health and nutrition interventions, IYCF has the single greatest potential impact on child survival. This is depicted in evidence presented in the Lancet 2008 Series on Maternal and Child Undernutrition Series, see graph 1 below.



Graph 1. Preventative health and nutrition interventions with their potential impact on increasing young child survival.

Therefore ensuring a high coverage of IYCF interventions in a country can increase young child survival by close to 20%. The 2008 Lancet series further confirmed the importance of IYCF on child survival. This research found that exclusive breastfeeding could potentially prevent 1.4 million deaths every year among children under five years of age out of the 10 million child deaths estimated globally. An estimated 1/3 of under five mortality is caused by undernutrition of which poor breastfeeding practices and inadequate complementary feeding is the primary causes².

Many programs and agencies are now focusing on what has been termed the “critical window of opportunity” which encompasses the gestation period and up to 24 months of age. This time period represents a key time for prevention of growth faltering and to promote optimal brain development. Recent data show that children aged 3 to 23 months are most critically susceptible to under nutrition and stunting as this is when the child is most affected by inadequate food intake. This is also when the child is most vulnerable to infections given his/her weak immunity. More studies³ further emphasize the role of stunting as one of the major factors leading to poor development.

² Quantifying the benefits of breastfeeding: A summary of evidence. PAHO, 2002.

³ The Lancet Series. Early Childhood Development. September 2011.

Nutrition programs for the last 20 years have largely sidelined preventative nutrition interventions in favour of curative ones. The evidence now exists for the impact and importance of focusing on preventative interventions such as IYCF. In addition, a significant body of research and program evaluations has shown which IYCF programs are effective in increasing coverage and impact.

The Somali Nutrition Strategy (2011-2013) stresses the integration of evidenced-based and holistic nutrition interventions. IYCF and maternal nutrition are one of the six outcomes prioritized for inclusion in the strategy. In addition, IYCF and maternal nutrition and care are essential components of the Basic Nutrition Services Package (BNSP) which provides a framework of activities that should be implemented at community and facility level throughout the lifecycle. The situation analysis presented in the following sections demonstrates the need to drastically and comprehensively scale-up IYCF programming in order to support a reduction in neonatal and young child mortality as well as promote optimal infant and young child development.

1.3 Situation Analysis

1.3.1 High mortality and malnutrition

Somalia has one of the highest under five mortality rates in the world at 180/1,000 live births, with the burden of mortality being typically higher in the south and central zones of the country. Mortality among young children rates skyrocketed in 2011 during the famine in the southern regions of Somalia. Crude and under 5 death rates surpassed emergency thresholds and it is estimated that tens of thousands of children in southern Somalia died from malnutrition in 2011.

Acute malnutrition in Somalia is also among the highest globally. In a standard year the median for Global Acute Malnutrition (GAM) is between 14-16% and SAM between 2-4%. However, famine was declared in the south of Somalia in 2011 primarily attributed to exceedingly high rate of GAM (up to 58% in one region). Since then the GAM prevalence has continued to decline to 22% at the beginning of 2012 and 16% by mid-2012. Southern Somalia bears the burden of most of the malnutrition, housing 71% of the all acutely malnourished children nationwide. Stunting is also a problem in Somalia and in a standard year around 20% of young children are stunted and will not reach their full development potential⁴.

1.3.2 Immediate causes of malnutrition

(a) Inadequate dietary intake

Acute or chronic malnutrition can be caused by an inadequate intake of a quality diet. Diets can be inadequate in terms of micronutrient content as well as poor in quality proteins and fats. Both vitamin A and iron deficiency are significant public health concerns. In the south and central zones of Somalia 40.7% of children suffer from vitamin A deficiency while 58.3% are iron deficient. Deficiencies in these key micronutrients are also significant in women which affect the outcomes of infants. These deficiencies have significant consequences in terms of immune system functioning, concentration and intelligence, productivity, etc. Diets in south and central Somalia are

⁴ All data on acute and chronic malnutrition obtained for the Food Security and Nutrition Analysis Unit for Somalia.

predominately centralized on cereals, oils/fats, and milk products. Meats or other animal products (except for milk), and nutrient rich vegetables and fruits are rarely consumed.

(b) Disease

Poor nutritional status compromises a child's ability to resist and recover from an illness. In addition, disease decreases a child's appetite and can disrupt absorption of nutrients from consumed foods, thereby increasing their risk of developing malnutrition resulting in a vicious circle. Prevalence of diseases in south central Somalia is high, with frequent outbreaks of acute watery diarrhea/cholera being the most common. In a national survey conducted by FSNAU in 2009, the prevalence of diarrhea in young children in the preceding two weeks to the survey was 18.8%, 16.3% for acute respiratory illness, and 26.2% for suspected fever.

1.3.3 Underlying causes of malnutrition

a) Inadequate care

Sub-optimal infant and young child care and feeding practices have a significant impact on malnutrition in Somalia. IYCF indicators in the south and central zones of the country are amongst some of the worst in the world. Breastfeeding is initiated late with only 17.4% of women initiating within the first hour after birth. The prevalence of exclusive breastfeeding is extremely low at 2.8%, with most infants receiving additional milk and other liquids from the beginning. Despite being dictated in the Koran, the continuation of breastfeeding is poor with only 34.9% of mothers continuing to offer breastmilk until the child reaches 24 months. The introduction of complementary foods is also not optimal in terms of timing, density, and diversity of foods offered. Feeding of the sick child poor, although most mothers continue feeding sick children very few (5.6%) offer increased feeds and 32.6% even decrease feeds. One positive practice that Somali mothers and families engage in is active feeding. Young children are encouraged and given time to consume foods.

In addition to inadequate care of infants and young children, women are subjected to some sub-optimal care practices. Women do not consume a variety diet in pregnancy, with their foods being low in iron, vitamin A, vitamin C among others. There are reports of women fasting in their third trimester in order to avoid having to deliver a large baby. This can lead to poor outcomes for both mother and child. Few women deliver at health facilities or access ante- or post-natal care from a qualified health worker. In addition, women are not encouraged by their family or by their communities to practice optimal infant feeding. Women are not given the space, time or support to practice exclusive breastfeeding.

b) Household food insecurity

In a standard year household food insecurity is not an issue in most areas, with potentially the exception of IDP households. In Somalia, poor consumption of quality foods is more due to culture norms and preferences than necessarily to access. The key exception is in years of extreme drought or famine.

c) Unhealthy household environment and lack of health services

Poor water, hygiene and sanitation practices are common in Somalia and are a key contributor to malnutrition. There is low access to safe water or to sanitation facilities. Hygiene practices such as hand washing at key times with soap or ash are uncommon. Access to health services is poor in many areas, especially rural areas of south and central Somalia. Where health facilities exist, few provide consistent services in terms of drug availability and presence of a qualified health worker. Health seeking behaviours are also poor, with usage of contemporary services often being a last resort.

1.4 Challenges in IYCF programming

As noted above, IYCF practices in south central Somalia are significantly sub-optimal. However, almost every mother has the ability to breastfeed exclusively if she is given the time and support to do so. Analysis on beliefs, attitudes and the social and policy environment have highlighted the following gaps:

At household level

- Lack of knowledge by mothers and other key decision makers on the importance of optimal IYCF and its various practices
- Maternal undernutrition means weakened mothers for delivery and for breastfeeding
- Widespread social and cultural beliefs that hinder optimal practices such as a belief that women do not have the ability to exclusively breastfeed for the first six months; or that colostrum is harmful so initiation of breastfeeding should be delayed; or that a woman cannot breastfeed while pregnant
- Women not given the space, support, time or other resources to practice optimal IYCF
- Food insecurity in poor households affects resources and can hamper a woman's ability to practice optimal behaviours
- Early or late introduction of appropriate complementary foods, as well as a lack of diversity in foods used to feed young children
- Poor water and sanitation facilities and practices, poor storage of complementary foods

At community level

- Poor support in communities for some desirable practices, especially exclusive breastfeeding (in terms of time, resources and confidence in the behaviors)
- Poor access to qualified health services and skilled support for IYCF
- Low availability and usage of micronutrient dense food for the mother and for complementary feeding
- Availability, even in rural communities, of commodities which hinder optimal practices such as bottles and breastmilk substitutes

At national level

- Formal and informal employment situations are not conducive to practice optimal behaviours, often forcing mothers to be separated from infants and young children
- Health facilities and many NGOs do not have IYCF specific or IYCF sensitive policies
- No implementation of the Code for the Marketing of Breastmilk Substitutes means that formula and other products are readily available and are distributed in emergencies

- Limited reach and scope of a centralized government means a significant lack of social services and a lack of other supportive policies and legislation
- Lack of supportive partnerships and networks, especially community-based ones to support optimal practices
- Limited supportive supervision of available service providers
- Food insecurity as a cause of livelihood insecurity and asset stripping contribute to high poverty which complicates the ability to practice optimal behaviours

1.5 Progress in IYCF

While the gaps and obstacles to optimal practices seem significant it is also important to highlight current positive behaviours and opportunities that exist as well as the work that has occurred to promote and support optimal IYCF behaviours.

Positive behaviours

- Somali families exhibit significant love and care of young children and genuinely wish to do what they feel is best for them
- Unlike in many other cultures, young Somali children are often fed actively. Caregivers engage with them during their meals, encouraging them to eat
- Most young children (below 2 years) often get their own plate which supports consumption of adequate quantities of food as young children often eat slower than others
- Animal milks are a primary source of nutrition for young children which support consumption of adequate fats, proteins, and calcium (the downfall here being the availability of milk fluctuating depending on the season and climatic variations)

Opportunities

- Several opportunities exist in south and central Somalia to scale up community-based programming which is essential for affecting population level change. Lessons can be learnt from experience in Mogadishu as well as Somaliland and Puntland
- There are a significant number of NGOs with varying capacities but who are willing and able to support IYCF programming (resources permitting). There is a need to continue to build their capacity and provide sustained support, and mobilize resources to do so
- Work being done on ensuring skilled delivery provides a significant opportunity for ensuring early initiation of breastfeeding. Research shows that when breastfeeding is established early it is more likely that a mother will continue breastfeeding optimally
- Various planned community-based cadres of health workers will help to support increased coverage at that level of programming

Work to date

Despite the good intentions of many NGOs and UN agencies, there is still insufficient work and support to date in the south central Somalia for IYCF. Complications of the famine delayed response for most partners, especially in the 8 southern regions. Planned trainings could not occur and implementation by agencies focused on life-saving activities such as the treatment of severe acute

malnutrition.

Work completed includes two training-of-trainers and several roll-out trainings by individual agencies. Counseling implementation to date is largely confined to facilities or nutrition sites with very few services being offered at a community level. A monitoring system has been piloted but requires more refinement before going to scale. Implementation of the monitoring system should start by the end of 2012.

The IYCF Action Plan that accompanies this document provides a framework and guidance as to what should be done next for IYCF in south and central Somalia. There is a significant amount of work that remains to ensure IYCF indicators demonstrate that each Somali child is getting the best possible start in life. Implementation of the strategy and action plan will go a long way in ensuring the development of smart and strong future generations of Somalis.

1.6 Formulation of the Strategy and Action Plan

The results of several pieces of research, such as the KAP study from 2007 and the Micronutrient and IYCF Assessment from 2009 have demonstrated to concerned parties the need for a concerted and comprehensive approach to IYCF in Somalia. Development of the strategy was planned for 2011 but was delayed for the famine response. The process was initiated in the second quarter of 2012. Several rounds of consultative meetings were held in Nairobi and Mogadishu with a wide variety of partners. Detail partners. The strategy takes into account the Global IYCF Strategy and also borrows from the IYCF strategies and action plans which have been adopted in Somaliland and Puntland. The documents take into account the needs of communities, the capacities of service providers as well as the considerable challenges that programming in Somalia entails. Partners have made stringent efforts to be realistic, needs-based, and to take into account best practices and known cost-effective interventions. It is expected that the IYCF strategy and action plan will ensure a more strategic and collaborative approach to IYCF programming and will work towards achieving sustained behavioural changes this improving under five nutrition status and improving morbidity and mortality.

2. Objectives of the IYCF Strategy 2013-2017

The national strategy builds on achievements and opportunities and aims to provide a framework for promoting, protecting and supporting adequate infant and young child feeding practices in order to achieve optimum child growth, survival and development.

2.1 Overall Goal

The strategy's overall goal is to improve the nutritional status, growth, development and survival of infants and young children through promotion and support for optimal infant and young child feeding and care practices.

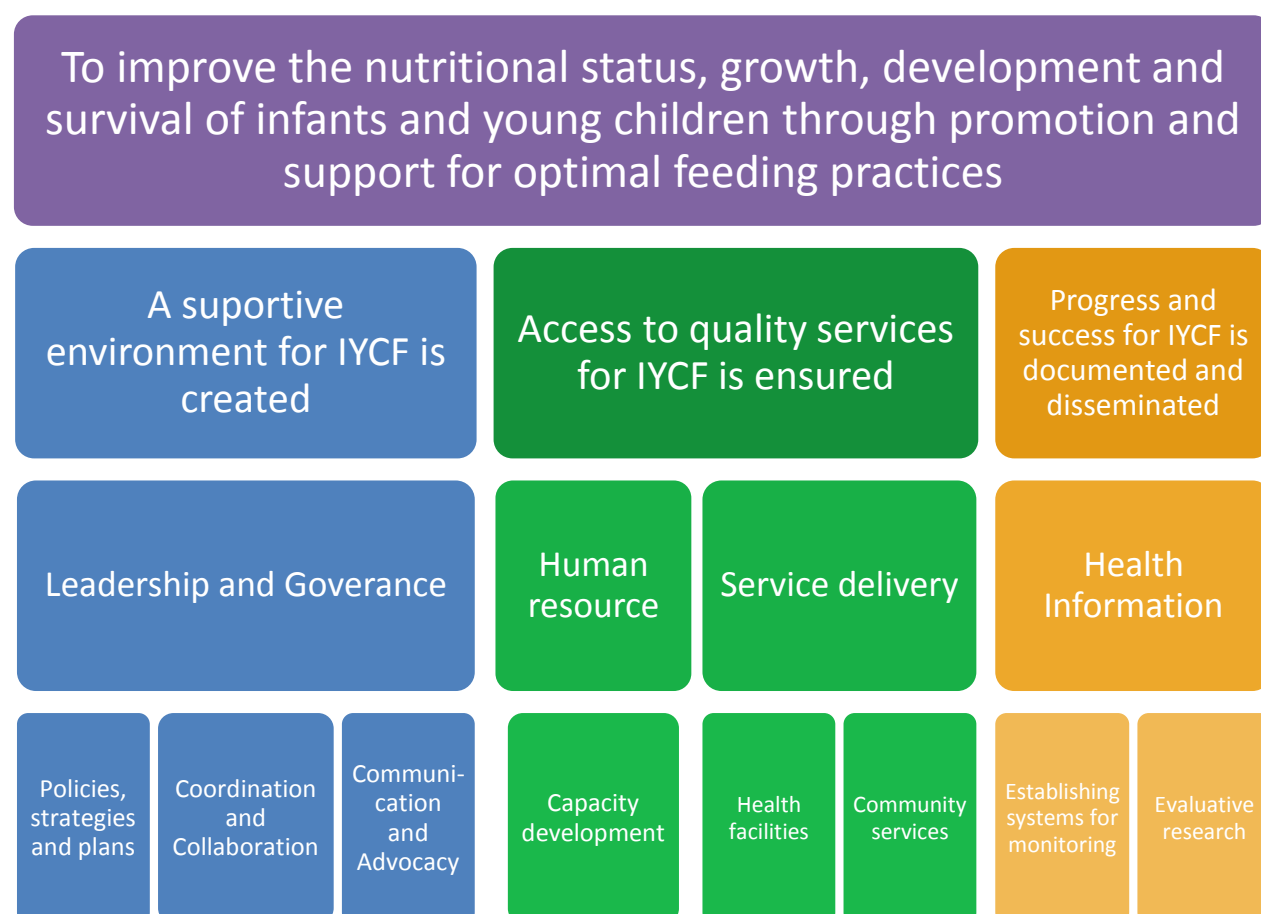
2.2 Objectives

The strategy has 3 objectives:

1. A supportive environment for IYCF is created
2. Access to quality services for IYCF is ensured

3. Progress and success for IYCF is documented and disseminated

Each objective has a series of outputs and outcomes that come under it. Outputs and outcomes are structured along WHO's building blocks for health systems strengthening, as can be seen in the diagram below. This is to ensure that activities work towards building an entire system that is supportive of IYCF. The building block component of Essential supplies is not included at this time.



3. Statement on Optimal Breastfeeding practices

There are 11 optimal breastfeeding practices, although in most situations only a few of these are discussed or acknowledged. When all of these practices come together, an infant will receive the best start in life possible

- a. Place infant skin-to-skin immediately after birth

Placing a child skin-to-skin at birth keeps the newborn warm, assists in bonding, and can help stimulate or condition the hormones required for the initiation of breastfeeding. It can also make early initiation of breastfeeding easy and convenient.

b. Early Initiation of breastfeeding

Breastfeeding should be initiated within 30 minutes or up to an hour after birth. This allows the infant to start taking colostrum, the “first milk”. Taking colostrum helps to clean the infants system and also ensures that the infant starts to receive the immunological components of breastmilk so that he can start fighting diseases. The initiation of breastfeeding also helps stop the mother from bleeding.

c. Exclusive breastfeeding for the first 6 months of life

In the first 6 months of life infants only need breastmilk to survive and to thrive. Breastmilk has the perfect components that are adapted to the human infant. Since 80-85% of breastmilk is water, infants do not even need additional water, even in from hot climates. The only things that should be given in addition to breastmilk are medicines prescribed by a doctor.

d. Breastfed on frequently – night and day

The production of breastmilk is stimulated by the removal of milk from the breast. Therefore the more milk is removed, the more milk that will be produced. Frequent breastfeeding will ensure that the milk is produced and that the infant gets enough nutrition. In the first 6 months it is very important to breastfed around the clock, including during the night.

e. Breastfed on demand

Infants should be given breastmilk on demand. Some infants will want to be breastfed every 2 hours while others will want it every 3 hours. Crying is a later sign of hunger in an infant, therefore a mother needs to recognize other cues the infant is giving that he is hungry (ex. Fidgeting, reaching for the breast, etc.).

f. Use proper positioning and attachment for breastfeeding

Breastfeeding will be difficult and painful if an infant is not positioned and attached properly. Improper practice can lead to breastfeeding difficulties should as crackled nipples as well as low supply of breastmilk. Mothers should be supported to identify and correct the four signs of positioning and attachment.

g. Let infant finish feeding from one breast before switching him to the other

Different components of breastmilk come at different times during a breastfed on one breast. This is especially important for water and fats. That is why it is important to let the infant finish feeding from one breast before switching to the other.

h. Continue breastfeeding for 2 years or longer

Breastmilk should form a major part of a young child’s diet until they are at least 2 years of age. Breastmilk provides the essential energy and micronutrients, as well as immune protection components for these young children.

i. Continue to breastfed if mother or child is ill

Breastfeeding can and should continue through illness of mother or of the child. Breastfeeding provides comfort for a sick child – as well as the essential immunological components to help him fight off illness. Breastmilk is unaffected by maternal illnesses, however be careful with medications that the mother may be taking for the illness. This should be discussed with a doctor as some medications are transmitted through breastmilk.

- j. Mother should eat and drink to satisfy hunger and thirst

Even a moderately malnourished woman can still breastfeed her infant adequately. However, a breastfeeding woman should eat and drink until she is satisfied. Where possible a variety of foods (especially meats, vegetables, fruits and energy dense foods) should be consumed. Drinking sufficient clean water is vital for breastmilk production.

- k. Avoid bottle feeding

Bacteria, viruses, and parasites can be easily introduced during bottle feeding. Bottles are difficult to clean/sterilize. Water used to clean them or to prepare formula feeds can also be contaminated. In addition, children who bottle feed develop nipple confusion and may refuse the breast afterwards. In an alternative feeding (from breastfeeding) is required than it should be with a cup and not with a bottle.

4. Statement on Optimal Complementary feeding practices

Optimal complementary feeding of young children can help to ensure that they continue to develop mentally and physically.

- a. Continued breastfeeding

As mentioned in section 4.8, breastfeeding should continue until the child is two years or older. Breastmilk should continue to provide the infant with energy, micronutrients and immunological components

- b. Frequency

Because young children have small stomachs, they need small frequent meals or snacks in addition to breastfeeds. The number of meals/snacks per day should increase as they age.

- c. Amount

When starting complementary feeding, carers should use very small quantities (tastes) of food. As they child gets older the portion sizes should be increased.

- d. Texture

Foods for young children should be semi-solid to solid. Liquid foods are not appropriate for the most part because they fill the child's stomach but are not nutrient dense. For example, porridge should be thick enough that it does not run off of a spoon.

e. Variety

Young children need a wide variety of foods to ensure they get a good balance of proteins, fats and micronutrients. Since children can only consume small quantities of nutrient dense foods. In Somalia many young children are not fed vegetables or fruits on a regular basis, although this is very important to ensuring they get enough micronutrients. In addition, ideal foods are eggs, meats, liver, kidney, milk, green leafy vegetables, pulses, orange or yellow-flesh vegetables (pumpkin, sweet potato), fruits, etc.

f. Active Feeding

It is important to engage and interact with young children while they are eating. They need to be encouraged to finish their meals or snacks. In Somalia most caretakers engage in active feeding of young children.

g. Hygiene

Appropriate hygiene is required when preparing foods or feeding young children. . Hand washing, proper preparation and storage of foods are key.

5. Feeding in difficult circumstances

a. Feeding low birthweight infants (LBW)

Low birth weight defined as weight at birth less than 2500 gms is one of the most contributing factors to neonatal and infant mortality, illness and malnutrition. LBW babies may be so because they are born before completing 37 weeks of gestation or they are born at term but weigh less than 2500gms. Studies show that a LBW is associated with the development of diabetes and heart disease in adulthood. Appropriate feeding practices during pregnancy can reduce the risks of giving birth to a LBW baby, mortality and morbidity associated with LBW. LBW babies who are medically stable can and should be breastfed within half to 1 hour following their birth. Breast milk is especially beneficial for a preterm baby as it contains higher concentrations of anti-infective substances which protect the preterm baby against infections and help him/her to grow. LBW infants that are too weak to suckle effectively can be given expressed breastmilk. In addition, patterns of breastfeeding can be altered to ensure adequate weight gain. For example, increasing breastfeeds will ensure that milk the child is getting is richer in fats which will support optimal weight gain.

Mothers of preterm babies need extra emotional support, encouragement, good nutrition and rest. Feeding a preterm baby can be especially demanding and exhausting. The assistance and reassurance of a health worker and support from family members are particularly important to promote proper care and feeding of the preterm baby.

b. IYCF in emergencies

Typically the optimal feeding of infants and young children becomes threatened during emergencies due to a variety of reasons such as family separation, stress, increase in communicable diseases, poor hygiene and sanitation situations etc. Infants and young children

are particularly vulnerable during emergencies because of their increased developmental needs as well as increased susceptibility to illnesses as a result of their weak immunity. It is vital at this time to promote, protect and support adequate feeding practices among young children less than 2 years of age in order to reduce the risks associated with inappropriate feeding practices, particularly, the use of infant formula and the communication of disease. Thus, infants should be exclusively breastfed from birth up to 6 months of age and those infants who cannot be breastfed by their biological mother, every effort should be made to find a wet-nurse or to provide adequate and hygienic replacement feeding options. Children from 6 months up to 2 years should continue to be breastfed and also to consume a variety of small diverse, hygienically prepared meals.

Whenever breast-milk substitutes are required for medical reasons, the use of these substitutes should be strictly controlled and carried out under stringent conditions to prevent any artificial feeding coming into the general population and undermining breastfeeding. A nutritionally adequate breast-milk substitute should be fed by cup only to those infants who must be fed on breast-milk substitutes. A mother or caregiver who must feed her baby a breast milk substitute must be well counseled and provided with all the necessary equipment to ensure safe and hygienic preparation and use of the milk substitute. The use of feeding bottles and teats must be actively discouraged at all times.

In exceptionally difficult circumstances, it is important to create conditions that will support the mother to breastfeed her infant as well as to provide appropriate complementary feeds for children up to 2 years, for example, by providing extra food rations and drinking-water and counseling support by staff members who have appropriate breastfeeding and maternity care counseling skills. Further, active measures should be put in place to identify infants, children and mothers who need special attention so that their conditions can be rapidly assessed in order to refer them for treatment for example through selective feeding programs or through confidential volunteer counseling and testing in case HIV/AIDS may be suspected.

c. IYCF during acute malnutrition

Acute malnutrition is highly prevalent in Somalia with a median global acute malnutrition of around 15% each year. Infants and young children who have diagnosed acute malnutrition should be encouraged to continue breastfeeding in addition to conforming to prescribed nutritional supplements. Individual or group counseling for IYCF should be available at nutrition centers in order to diagnose and hopefully correct inappropriate practices.

d. Feeding during illnesses, including acute diarrhea and HIV/AIDS

In most cases during illness the appetite is reduced and therefore food intake decreases at the same time that energy needs are increased as the body fights infection and repairs itself. To meet the increased fluid and energy requirements, children's fluid (and especially breastmilk) and food intake should be increased during illness. Continued breastfeeding prevents dehydration and provides important micronutrients that assist in recovery from infection. Following illness, children need increased nutrient intake to make up for the nutrient losses and to support catch-up growth.

Infants who are exclusively breastfeeding are unlikely to become ill, but if they do, breastfeeding frequency can be increased to prevent weight loss.

The feeding of infants in the context of HIV/AIDS is dealt with in the Somali HIV/AIDS guidelines which are based on the WHO 2010 recommendations. Exclusive breastfeeding for infants up to 6 months is strongly recommended as well as continued breastfeeding for children up to 2 years of age. If a woman is exclusively breastfeeding there is a minimal risk of virus transition and the protective nutrition and immunological components gained are essential for continued growth and development, and fighting of infection for the infant. If an HIV/AIDS positive mother practices predominant, partial, or mixed feeding not only is the chance of passing the HIV virus to the infant greater but also the risk of mortality is significantly increased due to the transmission of other contaminants in feeding bottles, unclean water, or formula/non-human milks. If complete replacement feeding is practiced there will be no HIV virus transmission from breastmilk, however the risk of mortality is still significantly higher when compared to exclusive breastfeeding due to the likely contamination with other viruses/bacteria associated with artificial feeding. After 6 months of age the introduction of complementary foods or fluids is unlikely to increase viral transmission as the infant's intestines are less permeable to the HIV virus.

6. Family and community support for improving practices

A woman in Somalia does not make the decision on how to feed her infant or young child in isolation. Her decision is strongly influenced by those that surround her, especially mothers, grandmothers, and the father. Socio-cultural traditions and norms have a significant impact on attitudes and practice. Religious leaders, TBAs or strong local female leaders can also have a significant influence, in most cases stronger than that of a professionally qualified health worker. Therefore, understanding the influences being exerted by the family, peers and other community members (especially community leaders) is key to improving practices. Barriers and motivations from these groups must be identified and addressed or promoted depending on their nature. The networks which women and families create can be capitalized on in order to increase and promote positive practices and beliefs. Those trained in IYCF counseling can also help a mother identify the influencers in her life and come up with strategies to address them. For example, if a grandmother is especially overbearing, a father can be leveraged to support the wife in her desire to practice optimal behaviours.

7. Strategies for IYCF programming

As previously mentioned, the IYCF Strategy and Action Plan is modeled on a health systems strengthening approach and considers the pillars of:

- **Leadership and Governance.** Upstream work which consists of coordination, communication, and advocacy as well as ensuring that strategies, policies and legislation (when possible) is in place to support and promote optimal IYCF
- **Capacity development.** Increasing the skills and knowledge of service providers, decisions

makers, and the community for the practice of optimal IYCF behaviours.

- **Service Delivery.** Ensuring that there is access to skilled support at community and facility level and that utilization of the services is enhanced.
- **Health Information.** Establishing and maintaining systems to collect and disseminate information on IYCF for monitoring and evaluation purposes.

Activities aligned to the pillars must occur at community and facility level.

The pillars themselves are linked under the three objectives as previously mentioned.

7.1 Objective One: A supportive environment for IYCF is created

Output 1.1: Structures for coordination and collaboration are established and functional

Establishing a strong and active IYCF coordination structure is essential for implementation and monitoring of the strategy and action plan. The coordinating body should report to the Cluster system and representation should include a diverse range of local and international NGOs as well as UN agencies. As stability returns to southern Somalia the active inclusion of other actors should be promoted.

Output 1.2: Strategies and policies are in place that facilitate the creation of an enabling environment for IYCF

The IYCF Strategy will ensure a concerted and comprehensive approach to addressing IYCF in the country. An IYCF policy will act as a guide in agencies or government for how various activities should be enacted. The strategy and policy will also help support and justify the integration of IYCF with other sectors, especially health, WASH, livelihoods, and protection. The strategy promotes the contextualization and adoption (in as far as is possible) of the International Code for the Marketing of Breastmilk Substitutes (referred to as “the Code”) as well as the ILO Maternity protection act. The Code regulates how breastmilk substitutes and other foods/liquids for young children can be marketed and distributed. The maternity protection act ensures that pregnant and breastfeeding women are supported to adopt optimal practices without threatening their livelihood.

Output 1.3: A communication and advocacy strategy for IYCF ensures the protection and promotion of optimal practices

Communication is a vital part of an IYCF response considering that IYCF behaviours are strongly influenced by social and cultural factors. A communication and advocacy strategy will support social and structural changes necessary for all mothers and carers to adopt optimal behaviours. Novel approaches will be tested in order to develop new ways to reach the most vulnerable populations.

7.2 Objective Two: Access to quality services for IYCF is ensured

Output 2.1: A skilled workforce has the means and tools to deliver quality IYCF services

Skills and abilities for IYCF need to be improved in south central Somalia before adequate geographical and quality coverage of services is achieved. A skilled workforce includes not only health workers within the formal system but also community level workers and volunteers. Capacity

building is not to be treated as a one-off event. Skill building will not be limited to training but will also include other learning opportunities such as supportive supervision, mentoring, on-the-job training etc.

Output 2.2: Services for IYCF are available at all levels of the health system including the communities

Skilled support for IYCF as well as general IYCF promotion should be available at all levels of the health system and especially within communities. This will ensure women will get current advice and support on feeding their infants and young children and will also support problem solving to deal with issues as they emerge.

Output 2.3: IYCF is protected and promoted in emergencies

IYCF programming is a vital part of any emergency response, but it is difficult to implement if skills do not already exist in-country or if proper planning is not in place. IYCF will be incorporated into Disaster Risk Reduction as well as Early Warning Early Action Programming.

7.3 Objective Three: Progress and success for IYCF is documented and disseminated

Output 3.1: Monitoring systems ensure routine data is captured and used to assess implementation progress

Establishment of monitoring systems for IYCF programming is a key weakness of many country programs. A monitoring system will be established that captures routine IYCF activities. In addition supportive supervision will ensure quality programming. Routine data collection will feed back into programming planning and evaluation processes.

Output 3.2: Evaluative research assesses impact and success of IYCF programming

Impact will be assessed based on overall indicators looking at knowledge, behavior and practices. Shifts in relevant socio-cultural norms will be documented over the long term. Evaluations will ensure that the necessary information is collected on breastfeeding, complementary feeding as well as micronutrients. Evaluations of the strategy and action plan implementation itself will also be conducted at mid-term (mid-2015) and end-term (end-2017).

8. Communication for Development (C4D) and IYCF

Communication, although included in leadership and governance is actually a cross cutting pillar. Communication for Development (C4D) is defined (by UNICEF) as a systematic, planned and evidence-based strategic process to promote positive and measurable individual behaviour and social change that is an integral part of development programmes, policy advocacy and humanitarian work.. C4D is an essential part of IYCF programming, especially considering the strong social and cultural beliefs and practices associated with feeding this age group. C4D programming, capacity development and support in the context of IYCF will seek to ensure that the necessary social change occurs, over time, to support optimal IYCF practices.

9. Strategy and Action Plan Implementation

The strategy document is accompanied by an Action Plan to support implementation of the recommended activities. An IYCF Technical Committee will guide and monitor implementation of the Action Plan to ensure the process is adhered too. Yearly microplanning will ensure that activities are not missed and that responsibilities are assigned where possible. Progress against commitments and indicators will be assessed by the Technical Committee on a twice yearly basis. At the midterm of the strategy (mid-2015) a full review of the Strategy and Action Plan will ensure that progress is documented and that adjustments are made as appropriate.

10. Monitoring and Evaluation

One of the key weaknesses of IYCF programming or initiatives in most countries, is monitoring and evaluation. Effective monitoring systems need to be put in place to ensure that information is fed back into programming planning and implementation. In addition, information is needed to support the measurement of output in terms of geographical coverage and programme quality. Long term evaluation processes and frameworks should help capture positive shifts in community and societal-level change, and to document outcomes.

The Strategy and Action Plan itself should be evaluated at midterm (mid-2015) and endterm. In addition other evaluations such as KAP studies should be conducted to evaluate impact of IYCF programming.

11. Action Plan

Goal: To improve the nutritional status, growth, development and survival of infants and young children through promotion and support for optimal feeding practices

Mid-term indicators

By mid-2015 the prevalence of exclusive breastfeeding of children under 6 months increases by 5% from the 2009 FSNAU assessment

By mid-2015 the prevalence of the early initiation of breastfeeding increases by 10% from the 2009 FSNAU assessment

By mid-2015 the prevalence of adequately fed infants is assessed

A program for home-based fortification of complementary foods for children 6 up to 24 months is initiated by the end of 2013

End-term indicators

By the end of 2017 the prevalence of exclusive breastfeeding of children under 6 months increases by 15% from the 2009 FSNAU assessment

By the end of 2017 the prevalence of the early initiation of breastfeeding increases by 20% from the 2009 FSNAU assessment

By the end of 2017 the prevalence of adequately fed infants is increased by 5% from the initial assessment

By the end of 2017 the prevalence of anemia in children 6 up to 24 months is decreased by 10% for the 2009 FSNAU assessment

Objective 1 - A supportive environment for IYCF is created

Output⁵ 1.1 Structures for coordination and collaboration are established and functional

Outcome⁶ 1.1.1 – IYCF is effectively coordinated

Mid-term indicator:

A mid-term evaluation of the strategy conducted in 2015 shows a functional and effective coordination system for IYCF

A twice yearly report issue by the coordination body indicates progress against activities and indicators

By mid-2015, yearly plans from at least two other Cluster/sectors (other than Nutrition) include IYCF-sensitive activities

End-term indicator:

A final evaluation conducted in 2017 indicates that the overall objectives of the IYCF Strategy have been achieved

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
Terms of Reference for an IYCF Coordinating body are established and the Coordination body is established and functioning at national level	X					
The IYCF Coordinating body elects a Chair	X					
IYCF Coordinating body submits a twice yearly update on strategy progress to the Nutrition Cluster and other stakeholders	X	X	X	X	X	
The IYCF Coordination body ensures that multi-sectorial partnerships are created to enhance programming (ex. Health, WASH, livelihoods, child protection etc)	X	X	X	X	X	
IYCF focal points are identified in the Cluster coordination	X					

⁵ Outputs are conditions for impact. Such as availability, access, knowledge, coverage, and appropriate utilization

⁶ Outcomes look at impact itself – change in status, intake, function etc.

mechanisms at regional level						
Regional IYCF Coordinating bodies are established and functioning			X	X	X	

Output 1.2 Strategies and policies are in place that facilitate the creation of an enabling environment for IYCF

Outcome 1.2.1 – A strategic framework for IYCF guides stakeholders in south central Somalia

Mid-term indicators

A program audit in 2015 indicates that 60% of Nutrition Cluster partners are aware of and implement programs based on the strategic framework

End-term indicators

A final evaluation conducted in 2017 indicates that the overall objectives of the IYCF Strategy have been achieved

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
IYCF Strategy and AP developed through a consultative process and validated by Cluster partners	X					
Strategy and AP are translated into Somali	X					
Strategy and AP are disseminated to all relevant partners	X					

Outcome 1.2.2 – IYCF activities are integrated into nutrition and health programming

Mid-term indicators

A program audit in 2015 indicates that nutrition and health programs have integrated IYCF components

End-term indicators

A final evaluation conducted in 2017 indicates that the overall objectives of the IYCF Strategy have been achieved

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
IYCF Policy is developed through a consultative process and validated by Nutrition Cluster and Health Sector partners	X					
IYCF Policy is translated into Somali	X					
IYCF Policy is disseminated to all relevant partners	X					
Nutrition and health stakeholders uphold the IYCF policy	X	X	X	X	X	

Outcome 1.2.3 –Cluster partners uphold the concepts represented in the Code

Mid-term indicators

By the end of 2014 Cluster partners have adopted and uphold a contextualized Code for Somalia

End-term indicator

By the end of 2017 Cluster partners uphold the Code for Somalia and 10% of partners are engaged in advocacy activities outside of Nutrition Cluster partners

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
A working group (offshoot from the IYCF Coordinating body) is convened to contextualize the Code	X					
The Nutrition Cluster for Somalia in collaboration with the IYCF Coordinating body establishes a monitoring system and a system to deal with violators		X				
The Code is translated, adopted and upheld by Cluster partners		X	X	X	X	
Advocacy outside of Cluster partners for the Code concepts is conducted			X	X	X	

Outcome 1.2.4 – Cluster partners uphold the concepts of maternity protection

Mid-term indicators

By the end of 2014, 15% Cluster partners have adopted and uphold a maternity protection policy

By the end of 2015, five other Clusters or sector have been sensitized on maternity protection issues and the policy

End-term indicator

By the end of 2017, 30% Cluster partners uphold a maternity protection policy

By the end of 2015, two other Clusters have adopted the maternity protection policy

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
Formative research is conducted to ensure concrete understanding of barriers and motivators for working women to sustain optimal breastfeeding practices in the formal and informal sectors	X				X	
Communication and advocacy activities for maternity and breastfeeding protection are developed based on the formative research		X	X	X	X	
The ILO Maternity Protection Convention C183 is reviewed by the IYCF coordinating body/Cluster and where possible the conventions recommendations are contextualized for Somalia and disseminated through the Nutrition Cluster and other Clusters through the inter-Cluster working group			X			
A maternity protection policy is developed and proposed to the Cluster for validation				X		
Sensitization sessions and advocacy to other Cluster regarding the maternity protection policy is undertaken			X	X	X	

A maternity protection guidance document is developed and proposed to the private and public sectors in Somalia					X	
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Output 1.3 – A Communication and Advocacy Strategy for IYCF ensures the protection and promotion of optimal practices

Outcome 1.3.1 – A strategic framework for communication and advocacy for IYCF guides stakeholders in south central Somalia

Mid-term indicators

A program audit in 2015 indicates that 80% of relevant stakeholders are aware of and implement programs based on the strategic framework

End-term indicators

A final evaluation conducted in 2017 indicates that the overall objectives of the Communications and Advocacy Strategy for IYCF have been achieved

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
The IYCF Coordinating body contracts services for the development of an IYCF Communication and Advocacy Strategy	X					
The strategy is validated, adopted and disseminated by the coordination body and the nutrition Cluster	X					
Activities in the strategy are implemented and monitored	X	X	X	X	X	

Objective 2 – Adequate access to quality services for IYCF is ensured

Output 2.1 – A skilled workforce has the means and tools to deliver quality IYCF services

Outcome 2.1.1 - Gaps in the capacity or ability of the nutrition and health sectors to deliver quality IYCF services are identified and filled

Mid-term indicators

By the end of 2014 a skills audit and a learning, training and development plan to fill the gaps is implemented

End-term indicators

By the end of 2017 a skills audit demonstrates that 80% of gaps identified in the first skills audit have be filled appropriately

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
A skills audit for IYCF is undertaken	X				X	
A learning, training and development plan for IYCF is developed and implemented based on the skills audit	X	X				
Existing training and work tools are reviewed, adapted and translated as needed	X	X			X	
Additional tools are developed and disseminated as needed		X				
Standardized supportive supervision tools are established to ensure ongoing development of capacity		X	X	X	X	

Output 2.2 – Services for IYCF are available at all levels of the health system including communities**Outcome 2.2.1 – Health facilities promote and support optimal IYCF practices****Mid-term indicator**

The mid-term program audit in 2015 shows that 50% of health facilities supported by health and nutrition Cluster partners offer individual IYCF counseling

End-term indicator

The end-term evaluation in 2017 shows that 80% of health facilities supported by health and nutrition Cluster partners offer IYCF Counseling (individual or group)

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
Health facilities are aware of and implement the IYCF policy	X	X	X	X	X	
Health facilities are equipped in terms of trained personnel and materials/tools to offer individual counseling for optimal IYCF practices	X	X	X	X	X	
Where possible, health facilities support group counseling of optimal IYCF practices	X	X	X	X	X	

Outcome 2.2.2 – Communities promote and support optimal IYCF practices

Mid-term evaluation

One new program per region for community-based IYCF activities are established by the end of 2014

End-term evaluation

At least 80% of districts have programs for community-based IYCF activities are functional by the end of 2017

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
Community structures offer individual and group counseling and support for IYCF	X	X	X	X	X	
Specific communication activities are implemented to ensure an enabling environment among behaviour influencers (ex. Older women, fathers, etc.)		X	X	X	X	
An identification and referral system for complicated cases is established between communities and health facilities		x	x	x	x	

Outcome 2.2.3 – Anemia among children below two years is reduced in south central Somalia

Mid-term indicator

A home-based fortification strategy for south central Somalia is established and implementation has started by the end of 2014

End-term indicator

Anemia status among children below two years has decreased by 10% by the end of 2017

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
Sensitization of donors and other key stakeholders on home-based fortification is undertaken	X					
A home-based fortification strategy is established by a key technical group in conjunction with IYCF coordinating body	X					
Partnerships and activities as outlined in the strategy are implemented and monitored	X	X	X	X	X	

Output 2.3 – IYCF is protected and promoted in emergencies**Outcome 2.3.1 – Contingency planning and emergency response includes IYCF specific activities****Mid-term indicator**

By the end of 2014, DRR frameworks and contingency planning from the Nutrition and Health Cluster includes IYCF specific activities or indicators

Operational guidance for IYCF in emergencies is contextualized and disseminated to Nutrition and Health Cluster partners by the end of 2014

End-term indicator

By the end of 2017, DRR frameworks and contingency planning from the Nutrition, Health, WASH, and Protection Cluster includes IYCF specific activities or indicators

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
Sensitization of decision makers for DRR and EWEA	X					
IYCF programming is included in Disaster Risk Reduction frameworks as well as Contingency planning		x	x	x	X	
Operation guidance for IYCF in emergencies is contextualized and disseminated		X				

Objective 3: Progress and success for IYCF is documented and disseminated

Output 3.1 – Monitoring systems ensure routine data is captured and used to assess implementation progress

Outcome 3.1.1 – Monthly reporting for IYCF captures routine information and feedback from analysis is shared

Mid-term indicators

Monthly reporting rate for partners implementing IYCF programs is 75% by the end of 2014

The IYCF Coordinating body reports progress on a quarterly basis to the Nutrition Cluster and Health Cluster/sector by the end of 2013

End-term indicator

Monthly reporting rate for partners implementing IYCF programs is 85% by the end of 2017

The IYCF Coordinating body continues to report on progress on a quarterly basis to the Nutrition and Health Cluster by the end of 2017

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
A monthly report system for IYCF interventions is implemented	X					
An IYCF database is maintained	X	X	X	X	X	

The IYCF coordinating body produces a quarterly report for the Nutrition Cluster and other relevant Clusters or coordinating bodies	X	X	X	X	X	
Mechanisms to ensure feedback of the routine monitoring data back to communities and implementing agencies is established and functional	X	X	X	X	X	

Output 3.2 – Evaluative research assesses impact and success of IYCF programming

Outcome 3.2.1 – Impact of programming for IYCF is measured and used to increase program quality

Mid-term indicator

A national qualitative and quantitative KAP study is conducted in 2014 and used to inform the mid-term evaluation in 2015

End-term indicator

A national qualitative and quantitative KAP study is conducted in 2017 and used to inform the end-term evaluation

A national micronutrient deficiency study is conducted in 2017

Activity	Y1	Y2	Y3	Y4	Y5	Responsible
Lessons learnt, success stories and baseline case studies are documented in mid-term and end-term evaluations	X	X	X	X	X	
A qualitative and quantitative study on knowledge, attitudes, and practices for IYCF is conducted in 2014 (includes community understanding of IYCF programs)		X				
A qualitative and quantitative study on knowledge, attitudes, and practices for IYCF is conducted in 2017(includes community understanding of IYCF programs)					X	

A micronutrient deficiency (measuring iron status, anemia, and vitamin A status) study is conducted in 2017					X	
Mechanisms to ensure feedback of national surveys back to communities and implementing agencies is established and functional		X			X	

Outcome 3.2.2 – The IYCF Strategy and Action Plan is evaluated and adjusted as needed

Mid-term evaluation

By the end of 2015 a comprehensive mid-term evaluation of the entire IYCF Strategy and Action Plan is conducted and adjustments made as needed

End-term evaluation

By the end of 2017 a comprehensive end-term evaluation of the entire IYCF Strategy and Action Plan is conducted

Activity	Y1	Y2	Y3	Y4	Y5	Mid-term indicator	End indicator
A program audit coupled with KAP study results and consultative meetings is used to conduct a mid-term evaluation of the entire IYCF Strategy and Action Plan in 2015			X				
Results of the mid-term evaluation are used to readjust the strategy and action plan as needed			X				
A program audit coupled with KAP study results and consultative meetings is used to conduct an end-term evaluation of the IYCF Strategy and Action Plan in 2017					X		