



National Policy on Infant and Young Child Feeding



**National Nutrition Program
National Maternal and Child Health Center
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Preface

Breastfeeding is the best and safest way of feeding infants. Breast milk meets all the nutritional requirements a baby needs for the first six months of life. It provides the only perfect food for babies and infants protects them against infections and lays a foundation for healthy growth and development, emotionally, mentally and physically.

Breastfeeding immediately after birth helps to deliver the placenta and prevent post-partum haemorrhage. Exclusive breastfeeding for the first six months has many benefits for both the mother and baby. A breast fed child will develop intelligence, personality and self-confidence, and will grow up as a knowledgeable, intelligent and outstanding person in today's competitive society.

Exclusive breastfeeding for the first six months after birth can help with birth spacing; this allows a better quality of life for the mother, baby and the whole family.

Ninety-six per cent of mothers in Cambodia breastfeed. An increasing number of babies however are given supplements in addition to breast milk from very soon after birth. Advertising and promotion of infant feeding products discourages and undermines the custom of breastfeeding. There are many problems associated with formula feeding practice, in particular an increase in diarrheal, respiratory diseases and malnutrition.

There remains much work to be done to stop the spread of formula feeding that continues in both urban and rural areas, whilst at the same time there is an urgent need to improve the training of health workers in the practices and techniques that are necessary to help mothers breastfeed successfully.

The Ministry of Health of Cambodia affirms their commitment to the National Infant and Young Child Feeding Program by recognizing the benefits and superiority of this natural way of feeding infants. We are confident that this will be a major contribution to the health of our mothers and children now and in the future.

Phnom Penh, October 2008

Contents

- I. Background and rationale
- II. Abbreviations and definitions
- III. Context
- IV. Goals and objectives
- V. Coverage and scope
- VI. Policy guidelines/directives
 - a. Target beneficiaries
 - b. Maternal nutrition
 - c. Breastfeeding practices
 - d. Complementary feeding practices
 - e. Growth promotion, growth assessment, and growth monitoring
 - f. Food fortification (including universal salt iodization)
 - g. Exercising other feeding options
 - h. Infant and young child feeding in emergencies
 - i. Feeding for low-birth-weight infants
 - j. Feeding during and after illness
 - k. Feeding options for infants and young children of HIV positive mothers
 - l. Treatment and rehabilitation of malnourished children
 - m. Support systems
- VII. Implementing mechanism
 - a. Management and coordination
 - b. Supervision, monitoring and evaluation
 - c. Research and development
- VIII. Repealing clause
- IX. Effectivity

Appendix 1: Recommended complementary feeding guidelines for Cambodia

Bibliography

I. Background and rationale

Cambodia has seen remarkable improvements in child health and survival in recent years¹. Under-five mortality in Cambodia rapidly declined by 33%, from 124 to 83 deaths per 1,000 live births, over the period 2000 to 2005. Over the same period, infant mortality has declined by 31%, from 95 to 66 deaths per 1,000 live births.

Nutrition indicators have improved substantially over the same period, yet an unacceptably high proportion of Cambodian children remain malnourished. Analysis of the 2005 CDHS data using the WHO growth standard (2006) indicates that 44% of children less than five years of age have stunted growth (low height for age), 28% are underweight (low weight for age), and 8% are wasted (thin, or low weight for height)^{2,3}. About sixty-two percent of children under five are anemic. Globally, it is estimated that over 50% of disease deaths among children under five are the result of moderate and severe malnutrition⁴. Children who are malnourished are more likely to become ill, are more likely to have longer and more severe episodes of disease, and are more likely to die. Children who survive disease episodes are often left with a nutritional status worse than when they fell ill, and they are therefore more vulnerable to recurring disease.

Among underfives, the highest risk group is children between 6 months and 2 years of age, because malnutrition is highest among this age group, and the period from 6 to 23 months is a critical period for a child's physical and mental development. Losses in growth and development during this early period of life are irreversible in later life. According to the 2005 CDHS, levels of stunting increase dramatically during the 6-23 month old period, from about 5% of 6 month olds, to about 50% of 23 month olds. Anemia is also highest in this age group: almost 80% of children 6-23 months of age are anemic.

In Cambodia, the improving nutrition situation is partially credited to improved practices in breastfeeding. In 2005, 35.1% of infants were breastfed within 1 hour of birth (up from 11% in 2000), and 68.3% of infants were breastfed within 1 day of birth (up from 24.4% in 2000). Rates of exclusive breastfeeding also improved over this period. In 2005, 60% of infants less than 6 months of age were exclusively breastfed at the time of the survey. Because the 2000 and 2005 CDHS were carried out at different times of the year and used different questions, the two surveys are not comparable (CDHS 2000 reported 11% exclusive breastfeeding among children less than 6 months of age). Despite the fact that the data are not comparable, more detailed analyses still indicate that exclusive breastfeeding improved significantly over the period 2000-2005⁵.

However, the practice of giving pre-lacteal feeds remains common (57.2% and 55.7% in 2000 and 2005). Furthermore, after 6 months of age, few children receive appropriate quality and

¹ Cambodia Demographic and Health Survey, 2000 and 2005

² The CDHS 2005 publication cites 37% stunting, 36% underweight, and 7% wasting using the previous NCHS/WHO growth reference.

³ WHO Cambodia, and WHO 2006 Growth Standards.

⁴ Caulfield LE, de Onis M, Blossner M, and Black RE. Undernutrition as an underlying cause of child deaths associated with diarrhea, pneumonia, malaria, and measles et al. *Am J Clin Nut* 2004; 80(1):193-198.

⁵ Conkle, J. (2007). Exclusive Breastfeeding in Cambodia: An Analysis of Improvement from 2000 to 2005. Phnom Penh, Unicef.

quantity of complementary food, which is evidenced by the poor growth and high levels of anemia among children under-five years, particularly from 6-23 months of age.

Another statistic of concern is the growing use of infant formula. While usage is relatively low, the proportion of infants given infant formula doubled from 2000 to 2005 (1.7% to 3.6% of infants 0-6 months). The proportion of children who were never breastfed also increased from 3.6% to 5.2% over the same period. This is most likely attributed to the growing involvement of women in formal employment in Cambodia, and it also underscores the urgent need to enforce the Sub-decree and Joint Prakas on the Marketing of Products for Infant and Young Child Feeding (2005). Protection, promotion, and support of breastfeeding requires cooperation of multiple sectors, particularly the commercial sector, with regard to adopting, enabling, and enforcing policies that support mothers to give the best care possible to their infants and young children.

The need to update the previous IYCF Policy (2002) arises from the fact that the 2002 policy has a limited scope with regard to breastfeeding and does not mention complementary feeding. It does not mention the Baby-Friendly Hospital Initiative (BFHI) and Baby-Friendly Community Initiative (BFCI), which have been adopted in recent years as the main national strategies to promote, protect, and support good breastfeeding and to promote good complementary feeding practices. Other developments that warrant revision of the IYCF policy include the 2005 Sub-decree on Marketing of Products for Infant and Young Child Feeding, and the Joint-Prakas (Implementation Guidelines) for the Implementation of the Sub-decree.

This policy will serve as a guide for health workers and other concerned parties on infant and young child feeding, including ensuring the protection, promotion, and support of breastfeeding, timely and appropriate complementary feeding with continued breastfeeding, and appropriate feeding practices in difficult circumstances.

II. Abbreviations and Definitions

Abbreviations

| | |
|---------------|--|
| AFASS | Acceptable, Feasible, Affordable, Sustainable, and Safe (see definitions) |
| BFCI | Baby-Friendly Community Initiative |
| BFHI | Baby-Friendly Hospital Initiative |
| BMI | Body-mass-index (see definitions) |
| BMS | Breastmilk substitute (see definitions) |
| CDHS | Cambodia Demographic and Health Survey |
| HIV | Human Immunodeficiency Virus |
| IMCI | Integrated Management of Childhood Illness |
| IYCF | Infant and Young Child Feeding |
| KMC | Kangaroo Mother Care |
| LBW | Low Birth Weight |
| MCH | Maternal and Child Health |
| MOH | Ministry of Health |
| MPA-10 | Minimum Package of Activities, Module 10 (Integrated Nutrition) (see definitions) |
| NGO | Non-governmental Organization |
| NNP | National Nutrition Program |
| NNS | National Nutrition Strategy |
| NTWG | Nutrition Technical Working Group |
| OD | Operational District |
| ORS | Oral Re-hydration Solution |
| PHD | Provincial Health Department |
| PMTCT | Prevention of Mother to Child Transmission (of HIV) |
| RUTF | Ready to Use Therapeutic Food |
| SD | Standard Deviations |
| SGA | Small for Gestational Age |
| TBA | Traditional Birth Attendant |
| UNICEF | United Nations Children's Fund |
| VHSG | Village Health Support Group |
| WES | Water and environmental sanitation |
| WHO | World Health Organization |

Definitions

AFASS (Acceptable, Feasible, Affordable, Sustainable, and Safe) – the conditions that must be met when a HIV positive mother is counseled on her decision to use replacement feeding instead of breastfeeding to feed her infant or young child.

Acceptable: The mother perceives no social or cultural barrier to replacement feeding (including stigma or discrimination). She is supported by family members and community in opting for replacement feeding, or she will be able to cope with pressure from family and friends to breastfeed, and she can deal with the possible stigma attached to being seen with replacement food.

Feasible: The mother (or family) has adequate time, knowledge, skills and other resources to prepare the replacement food and feed the infant up to 12 times in 24 hours. The primary caregiver can understand and follow the instructions for preparing infant formula, and with support from the family can prepare enough replacement feeds correctly every day, and at night, despite her/his other responsibilities or work.

Affordable: The mother and family, with community or health-system support if necessary, can pay the cost of purchasing/producing, preparing, and using replacement feeding, including all ingredients, fuel, clean water, soap and equipment, without compromising the health and nutrition of the family. This concept also includes access to medical care if necessary for the child's diarrhoea and the cost of such care.

Sustainable: Availability of a continuous, uninterrupted supply of all ingredients and products needed for safe replacement feeding, for as long as the infant needs it, up to one year of age or longer. According to this concept there is little risk that formula will ever be unavailable or inaccessible, and another person is available and capable to feed the child in the mother's absence.

Safe: Replacement foods are correctly and hygienically prepared and stored, and fed in nutritionally appropriate quantities, with clean hands and using clean utensils, preferably by cup. This concept means that the mother or caregiver: - has access to a reliable supply of safe water, - prepares replacement feeds that are nutritionally sound and free of pathogens, - is able to wash hands and utensils thoroughly with soap, and to regularly boil the utensils to sterilize them, - can boil water for preparing each of the baby's feeds, - can store unprepared feeds in clean, covered containers and protect them from insects and animals.

Amenorrhoeic – Related to the suppression of menstrual flow for any reason other than pregnancy (i.e. lactation)

Body-mass-index (BMI) – An indicator of adult (in this case, maternal pre-pregnancy) nutritional status, defined as weight in kilograms divided by the square of height in meters, or kg/m^2 .

Breastmilk substitute (BMS) – Any food or drink marketed or otherwise represented as a partial or total replacement of breastmilk, whether or not suitable for that purpose.

Colostrum – The thick yellowish mother’s milk that is produced in the first days of birth, that is rich in nutrients and antibodies.

Complementary feeding – Feeding an infant or young child other food and drink as a nutritional complement to breastmilk.

Early initiation of breastfeeding – Breastfeeding that begins within one hour of birth.

Exclusive breastfeeding – The child receives no other food or drink other than breastmilk in the first six months of life.

Growth assessment – Measurement of child’s growth (normally weight-for-age) at a single point in time, in comparison to the standard growth expected of a well-nourished child at the same age.

Growth monitoring – Regular and repeated assessments of growth (normally weight-for-age) in comparison to the growth standards, and in comparison to a recent and previous weight assessment for the same child.

Growth promotion – The delivery of the essential package of proven interventions that address the immediate causes of poor growth, including: vitamin A & other micronutrient supplementation, deworming, prevention & treatment of illness (acute respiratory infection, diarrhoea, malaria) and health and nutrition education, including IYCF counseling.

Joint Pra-kas on the Marketing of Products for Infant and Young Child Feeding – Ministerial declaration of the Cambodian Ministries of Health; Commerce; Industry, Mines and Energy; and Information that governs the implementation of the Sub-decree on the Marketing of Products for Infant and Young Child Feeding.

Malnutrition (moderate) - Moderate malnutrition refers to weight-for-age or weight-for-height less than -2 standard deviations below the standard expected growth, as determined by the available growth charts.

Malnutrition (severe) - Severe malnutrition refers to weight-for-height less than -3 standard deviations below the standard expected growth, as determined by the available growth charts. Where weight-for-height measurement is not possible, or the standard growth chart is not available, a child with visible severe wasting or oedema of both feet due to malnutrition is considered severely malnourished.

Minimum Package of Activities, Module 10 (Integrated Nutrition) – In-service training module of the Ministry of Health, Kingdom of Cambodia, for training health center staff on integrated nutrition interventions.

Pre-lacteal feeding – Feeding any liquid or food to a child before the initiation of breastfeeding.

Replacement feeding – Feeding infants who are receiving no breast milk, with a diet that provides appropriate nutrients until the age at which they can be fully fed family foods. During the first 6 months of life, replacement feeding should be with a suitable commercial formula. After 6 months complementary foods should be introduced.

Skin-to-skin contact – Technique by which the newborn baby is placed on the mother's bare chest and the two are covered together. Skin-to-skin contact keeps the baby warm, promotes bonding of mother and child, and facilitates early initiation of breastfeeding.

Sub-decree on the Marketing of Products for Infant and Young Child Feeding (No. 133) - Cambodian regulation on the marketing of products for infant and young child feeding.

III. Context

This policy framework is guided by, and supports the realization of the following:

- Millennium Declaration, Millennium Development Goals (MDG)
- United Nations Convention on the Rights of the Child
- Cambodian Millennium Development Goals, 2003
- National Strategic Development Plan (NSDP), 2006-2010
- Health Strategic Plan II 2008-2015
- Cambodia Child Survival Strategy (CCSS), 2006
- National Nutrition Strategy 2008-2015
- Sub-decree on Marketing of Products for Infant and Young Child Feeding (No. 133) November 2005
- Joint Pra-Kas on the Implementation of the Sub-Decree on Marketing of Products for Infant and Young Child Feeding (No. 061) August 2007
- MOH Guidelines on Prohibiting of Marketing of Products for IYCF, 2001 (predated sub-decree, focuses on marketing within the health system).
- Sub-decree on the Management of Iodized Salt Exploitation (No. 69) October 2003
- Law on Management of Quality and Safety of the Products, Goods and Services (No. 0600/001) June 2000
- Ministry of Health Outreach Guidelines for Health Centers, March 2001.
- MOH Guidelines for Community Participation (drafted in June 2008, pending approval).
- Cambodia Labor Law Articles 184-186, regarding breastfeeding breaks, nursing rooms, and day care centers for working mothers.
- National Guidelines for the Prevention of Mother to Child Transmission of HIV. Ministry of Health, National Maternal and Child Health Center (2nd edition, September 2005)
- National Policy, Prevention of Mother-to-Child Transmission of HIV. PMTCT Technical Working Group, revised 27 August 2005.
- Law on the Prevention and Control of HIV/AIDS. National Assembly, Kingdom of Cambodia, July 2002.

- Implementing Guidelines of The Law on the Prevention and Control of HIV/AIDS. The National AIDS Authority, 2005.

IV. Goals and Objectives

The overall goal is to improve the survival and well being of infants and young children by improving their nutritional status, growth, and development through optimal feeding.

Specific objectives:

- All newborns are initiated to breastfeeding within one hour of birth
- All infants are exclusively breastfed for 6 months
- All infants are given timely, appropriate, and safe complementary foods
- Breastfeeding is continued up to two years and beyond
- Appropriate care, counseling, and other services for IYCF are provided to all infants and young children and their families, including children in special circumstances (such as times of emergency), and for HIV-positive mothers and their infants, and for children during times of illness.
- Linkages to related programs and appropriate support systems enhance caretaker's ability to provide appropriate and optimal infant and young child feeding.

V. Coverage and Scope

This policy shall cover the whole health sector, whether government or private, including public and private hospitals, professional groups, private sector companies, NGOs, and other stakeholders at all levels nationwide.

VI. Policy Guidelines/Directives

a. Target Beneficiaries.

The target beneficiaries of this policy are

- Pregnant women
- Infants, under 1 year of age
- Young children, 1 year up to 5 years of age
- Women of reproductive age

b. Maternal Nutrition

A woman's nutritional status before and during pregnancy (including short stature, low body-mass-index (BMI), and micronutrient status) is important for a healthy pregnancy outcome⁶. Nutrition interventions during pregnancy can improve body-mass-index and maternal micronutrient status for the health of the mother and the baby. Pre-pregnancy BMI of the mother is directly related to the weight and size

⁶ Black RE et al, for the Maternal and Child Undernutrition Study Group. Maternal and child undernutrition: global and regional exposures and health consequences. *Lancet* 2008; 371:243-60.

(length) of the infant at birth. Anemia in pregnancy is associated with pre-term delivery and maternal mortality. Iodine deficiency during pregnancy can limit fetal neurological development, and in severe cases can result in a child being born with irreversible mental retardation.

A mother's nutritional status has little effect on the volume or composition of breastmilk unless her malnutrition is severe. The concentration of some micronutrients in breastmilk depends on maternal health and nutritional status and intake, so the risk of infant depletion is increased by maternal deficiency⁷. In the case of vitamin A, the content in breastmilk is the main determinant of infant status because vitamin A stores are low at birth. Post-partum maternal supplementation with vitamin A increases the amount of vitamin A in breastmilk, which can improve the infant's status.

i. Additional calories during pregnancy and lactation.

All pregnant and lactating women shall be encouraged to eat an additional meal each day (for a total of 4 meals per day) to sustain the caloric requirements for healthy growth of the fetus, and to protect the mothers nutritional status during this physiologically demanding period of the life-cycle.

ii. Iron-folate supplementation in pregnancy and post-partum.

Pregnant women in Cambodia shall receive a total of 90 iron-folate tablets during pregnancy (60 tablets at the first antenatal care contact, and 30 tablets at the subsequent antenatal care contact). After delivery, all post-partum women shall receive 42 iron-folate tablets (given at the first post-partum contact).

iii. Post-partum supplementation with vitamin A.

All women giving birth in Cambodia shall receive oral vitamin A supplementation (200,000 IU) one time, within the first 6 weeks of delivery.

iv. Promotion of iodized salt.

Use of iodized salt shall be promoted for all households in Cambodia, especially for women of reproductive age, with specific reference to the benefits of iodized salt for the mother and infant during pregnancy and lactation.

c. Breastfeeding Practices

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants and young children. It is also an integral part of the reproductive process with important implications for the health of mothers. MOH initiatives such as the "Baby Friendly Hospital Initiative" and the "Baby Friendly Community Initiative" are designed to protect, promote and support mothers to

⁷ Allen LH. Maternal micronutrient malnutrition: effects on breastmilk and infant nutrition, and priorities for intervention. SCN News 1994; 11:21-24.

breastfeed optimally, and should be implemented to the widest extent possible throughout Cambodia.

i. Early Initiation of Breastfeeding

Infants shall be initiated to breastfeeding within one hour of delivery.

This will stimulate earlier onset of full milk production and promote bonding of mother and child. All medically trained personnel in the health care delivery system in all facilities (including doctors, nurses, and midwives) and other non-formal birth attendants (such as TBAs), shall ensure that newborns are put to the mother's chest and guided to the breast to initiate breastfeeding within one hour of delivery. Breastfeeding within one hour of delivery should include skin-to-skin contact of the mother and infant, which helps to keep the infant warm, helps start breastfeeding, promotes bonding, and helps the baby adjust to the new environment.

ii. No pre-lacteal feeding

Pre-lacteal feeding shall be discouraged. In Cambodia, it is a common practice to give water and other liquids to infants in the first days after delivery before the mother's breastmilk has come in. The practice of pre-lacteal feeding introduces health risks for the infant (introduction of pathogens and delayed onset of breastfeeding) and the mother (delayed onset of lactation due to reduced suckling by the infant). Mothers and caregivers should be encouraged to practice early and exclusive breastfeeding, and this includes discouragement of any kind of pre-lacteal feeding, such as water, honey, teas, or any other kind of food or drink in the first days of delivery.

iii. Exclusive Breastfeeding for the first six months

Infants shall be exclusively breastfed for the first six months of life (months 0-5.9) to achieve optimal growth and development. Exclusive breastfeeding means giving breastmilk alone and no other food or drinks, not even water, with the exception of vitamins and medicine drops as prescribed by a health care provider. Exclusive breastfeeding from birth is possible except for a few medical conditions, and unrestricted exclusive breastfeeding results in ample milk production. The nutrient needs of full-term, normal birth weight infants can be met by breast milk alone for the first six months. In addition, exclusive breastfeeding also reduces infant morbidity due to gastro-intestinal infections, and their mothers are more likely to remain amenorrheic for six months postpartum.

iv. Extended breastfeeding up to two years and beyond. **Breastfeeding shall**

be continued as frequently as possible and on demand for up to two years of age and beyond. Although volume of breastmilk consumed

declines as complementary foods are added, breastmilk contributes to the infant's health significantly. Breastfed children at 12-23 months of age whose intake is similar to the "average" amount of breastmilk consumed at that age (about 550 g/d in developing countries; WHO/UNICEF, 1998) receive 35-40% of total energy needs from breastmilk (Dewey and Brown, 2002).

The nutritional impact of breastfeeding is most evident during periods of illness, when the child's appetite for other foods decreases but breastmilk intake is maintained (Brown et al., 1990). It thus plays a key role in preventing dehydration and providing the nutrients required for recovery from infections.

d. Complementary Feeding Practices.

Ensuring appropriate and adequate complementary feeding, particularly in the 6-23 month age category, is one of the most important priorities for the survival, and optimal physical and mental development, of children. MOH strategies and initiatives, such as the National Nutrition Strategy 2008-2015, the Integrated Management of Childhood Illness (IMCI), the MPA-10 (Integrated Nutrition Module), the Baby-Friendly Community Initiative (BFCI) and the Community-IMCI, provide detailed programmatic guidance and tools for improving complementary feeding in Cambodia, and should be implemented to the widest extent possible.

i. Appropriate complementary feeding (definition).

Infants shall be given appropriate complementary foods from age six months in order to meet their evolving nutritional requirements.

Appropriate complementary feeding means:

Timely – meaning that complementary foods are introduced at six months of age when the child's need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding;

Adequate – meaning that complementary foods provide sufficient energy, protein, and micronutrients to meet a growing child's nutritional needs;

Safe – meaning that they are hygienically prepared and stored, and fed with clean hands using clean utensils and not bottles and teats or artificial nipples;

Properly fed – meaning that foods are given consistent with a child's signals of appetite and satiety, and that the meal frequency and feeding method are suitable for the child's age (actively encouraging the child, even during illness, to consume sufficient food using fingers, spoon, or self-feeding).

The recommended complementary feeding guidelines for Cambodia are **Appendix 1**.

ii. Ensure access to appropriate complementary foods.

Appropriate complementary feeding interventions shall encourage diversified approaches to **ensure access to foods that will adequately meet energy and nutrient needs of growing children, at the home- and community level**. Such approaches may include: multi-micronutrient "Sprinkles" (in-home fortification), homestead food production, positive

deviance (“Hearth”) programs, and other approaches or technologies that are plausible in their effectiveness.

Appropriate complementary feeding interventions shall also ensure education on the hygienic preparation of food (washing, cooking, storing), and the importance of personal hygiene and hand washing at the appropriate times (for children and caregivers), to minimize the risk of illnesses.

iii. Use of locally available and culturally acceptable foods.

Appropriate complementary food shall **include locally available and culturally acceptable foods that meet the energy and nutrient needs of young children**. Mothers shall be provided with sound and culture-specific nutrition counseling and recommendations of a widest array of indigenous food stuffs. The agriculture sector has a particularly important role to play in ensuring that suitable foods for use in complementary feeding are produced, readily available and affordable. Homestead food production programs can alleviate malnutrition in young children by improving access to nutritious foods, and by increasing the household socio-economic condition.

iv. Industrially processed foods.

Industrially processed complementary foods also provide an option for some mothers who have the means to buy them and the knowledge and facilities to prepare and feed them safely. **Processed-food products for infants and young children shall, when sold or otherwise distributed, meet applicable standards** recommended by the Codex Alimentarius Commission and also the Codex Code of Hygiene Practice for Foods for Infants and Children.

e. Growth promotion, growth assessment, and growth monitoring.

Growth promotion at the community level includes the delivery of the essential package of proven interventions that address the immediate causes of poor growth, including: vitamin A & other micronutrient supplementation, deworming, prevention & treatment of illness (acute respiratory infection, diarrhoea, malaria) and health and nutrition education, including IYCF counseling. Important supportive interventions should include maternal nutrition, water and environmental sanitation (WES), treatment of severe malnutrition, and fortification.

Growth assessment refers to a single measurement of a child’s growth (normally weight-for-age) in comparison to the standard growth expected of a well-nourished child at the same age.

Growth monitoring refers to the regular and repeated assessment of a child’s weight, in comparison to a growth standard, and in comparison to a recent and previous weight assessment for the same child.

In Cambodia, children’s weight should be assessed at birth, and at the health center

whenever possible, such as at immunization visits (6, 10, 14 weeks and 9 months), at vitamin A distribution, and at sick-child visits. Follow-up and counseling shall be provided to caregivers of any child whose weight is faltering and also to caregivers of children with a weight-for-age of less than -2SD z-score⁸ (as determined by plotting the weight for age on the Child Health Card).

Whenever it is feasible (i.e. where resources exist, from NGO or other targeted programs) to conduct regular growth monitoring as a tool for growth promotion at the community level, this can be considered. Growth monitoring must always be linked with appropriate growth promotion and counseling, and should only be considered as a tool for growth promotion when the time required does not distract from the delivery of appropriate counseling and provision of services.

All measurements of weight (in the context of growth assessment and growth promotion) should be recorded on the Child Health Card (yellow card).

f. Food fortification (including Universal Salt Iodization)

Food fortification of staple foods will help ensure that older infants and young children receive adequate amounts of micronutrients.

- i. The Ministry of Health and the Ministry of Planning (the MoP is the chair of the National Sub-committee for Food Fortification) shall continue to encourage manufacturers to fortify processed foods and food products with micronutrients. Potential vehicles for fortification include those commodities that are produced within Cambodia and are widely consumed by women and older children (such as sugar, fish sauce, soy sauce, or rice).
- ii. The Ministry of Industry, Mines, and Energy and the Ministry of Commerce shall monitor and enforce salt iodization according to the provisions of the national Sub-decree on the Management of Iodized Salt Exploitation (No. 69).
- iii. Families shall be encouraged and educated to use iodized salt in the preparation of complementary foods for older infants and young children, and in the preparation of family foods in general.

g. Exercising other feeding options

- i. Most mothers can and should breastfeed, just as most infants can and should be breastfed.
- ii. For those few health situations where infants cannot, or should not, breastfeed, the choice of best alternative depends on individual circumstances. Alternative options include – expressed breastmilk from an infant’s own mother, breastmilk from a healthy wet-nurse, or a breast-milk substitute fed with a cup.

⁸ Ashworth A, Shrimpton R, and Jamil K. Growth monitoring and promotion: a review of evidence of impact. *Maternal and Child Nutrition* (2008); 4:86-117.

- iii. In limited cases, for infants who do not receive breastmilk, feeding with a suitable breastmilk substitute – for example, an infant formula or other specially prepared formula that conforms with applicable Codex Alimentarius standards (global standards for food safety and labeling)– shall be demonstrated only by health workers, and only to the mothers and other family members who need to use it; and the information given shall include adequate instructions for appropriate preparation and the health hazards of inappropriate preparation and use. The national Sub-decree on Marketing of Products for Infant and Young Child Feeding (No. 133) shall be observed and enforced with regard to any distribution or use of infant formulas.

h. Infant and young child feeding in emergencies

Emergencies refer to natural or human induced calamities or crises, including but not limited to floods, droughts, typhoons, landslides, earthquakes, and political or other events, which result in refugee, internally displaced, or otherwise deprived populations.

- i. Families in emergency situations shall require special attention and practical support to be able to feed their children appropriately and adequately. Wherever possible, mothers and babies shall remain together and be provided the support they need to exercise the most appropriate feeding option under the circumstances. Health workers shall ensure the protection, promotion, and support of breastfeeding and timely, safe, and appropriate complementary feeding.
- ii. This policy should be widely disseminated to operational agencies providing assistance, and to non-operational agencies (including donors and the media). It should be integrated with other agency policies and procedures at all levels should be adapted accordingly. Any agency providing assistance to families in emergencies shall adhere to this policy and should ensure a basic orientation for all relevant national and international staff.

In emergencies immediate attention will be given to the protection, promotion and support for breastfeeding, especially exclusive breastfeeding.

- iii. As a general rule, the following is the range of feeding options for infants and young children in emergencies:
 - 1. Breastfeeding is the first and best feeding option for infants, and for young children in addition to complementary feeding.
 - 2. Expressed breastmilk, fed by cup, when breastfeeding is not possible.
 - 3. Infant formula, (preferably generically labeled), fed by cup, when no forms of breastmilk or breastfeeding are possible.
- iv. In order to protect and promote breastfeeding information and counseling support on the benefits of breastfeeding will be given as widely as possibly to pregnant women and postpartum/lactating mothers
- v. Infant formula should be used only under strict conditions, when:

1. Lactation status of mother has been assessed, in the case where relactation is not possible.
 2. An HIV-positive mother has chosen not to breastfeed.
 3. Children no longer have access to breastmilk, e.g. orphaned children, unaccompanied children, etc, and where there is assurance of supply of infant formula or as long as the infant needs it.
 4. Infant formula can be provided under close supervision, monitoring, and follow up by trained health staff, and mothers/caretakers are provided with adequate information and counseling on safe preparation of infant formula and appropriate infant feeding practices.
- vi. Artificial feeding is difficult in emergencies because the basic needs for safe preparation, such as clean water, fuel, and utensils, are scarce. Transporting and adequately storing breastmilk substitutes can cause additional problems. To minimize the risks of artificial feeding and avoid commercial exploitation of crises, the following procedures are strongly recommended:
1. Uncontrolled distribution of infant formula during emergencies can lead to early and unnecessary cessation of breastfeeding, and reliance on a limited supply of donations that do not extend for the complete duration and recovery of the crisis.
 2. In exceptional cases, when a small number of infants have to be fed on infant formula, health workers shall ensure that the formula is safe and suitable, and that caretakers are given adequate instruction for appropriate preparation, including the health hazards of inappropriate preparation and use.
 3. Donations of breastmilk substitutes, feeding bottles, and teats should be limited, if not refused.
 4. Breastmilk substitutes should never be part of a general food distribution. Distribution should be targeted only to infants with a clear need, and only for as long as needed (until maximum 1 year of age or until breastfeeding is re-established).
 5. If commercial infant formula is being provided free or at subsidized price for the purpose of replacement feeding the implementation of all the provisions of the Sub-decree on marketing of products for infant and young child feeding will be enforced.
 6. Where targeted distribution is warranted, any breastmilk substitutes must be fully labeled in Khmer language (preferably labeled or relabeled generically so as to avoid commercial exploitation), including information on the superiority of breastmilk, instructions for appropriate preparation of breastmilk substitutes, and risks of inappropriate preparation of breastmilk substitutes.
 7. Bottles and teats should never be distributed, and their use should be discouraged. Cup feeding should be encouraged instead.

Promotion of appropriate complementary feeding.

- vii. Nutrition counseling and distribution of information on appropriate complementary feeding practices will be ensured during emergencies.
- viii. As a general rule, interventions in times of emergency should ensure that the nutritional needs of the general population are met, with special attention to commodities suitable as complementary foods for young children. In situations where supplementary foods are available but sufficient food for the general population is not, pregnant and postpartum/lactating women and children 6-59 months of age should be targeted.
- ix. Complementary feeding for older infants (over six months) and young children (12-23 months) in emergencies may comprise:
 - 1. Basic food-aid commodities from general rations, with supplements of inexpensive locally available foods;
 - 2. Micronutrient fortified blended foods, e.g. corn soya blend or wheat soya blend.
 - 3. Additional nutrient-rich foods in targeted supplementary feeding programs.
- x. If the population is dependent on food aid, a micronutrient fortified food should be included in the general ration for older infants and young children. Ready to Use Therapeutic Food (RUTF) is formulated specifically for the rehabilitation of malnourished children (targeted intervention), and is not an appropriate complementary food for a general food distribution.
- xi. If nutrient-rich foods are lacking, and until they become available, multiple-micronutrient supplements should be provided to pregnant and postpartum/lactating women, and to children 6-59 months of age. However, if malaria is endemic in the area of the emergency, routine supplementation with iron and folic acid is not recommended for infants and young children. Malaria and iron-deficiency should be treated according to existing MOH guidelines.
- xii. Establish a registration of all children under five years of age with specific age categories: 0-<6 months, 6-<12 months, 12-<24 months, and 24-<60 months (2-5 years) to identify the size of potential beneficiary groups. Include registration of newborns within 2 weeks of delivery in order to target lactating mothers with food rations and extra breastfeeding support.

Handling of donations and supplies of breastmilk substitutes (BMS)

- xiii. In emergencies, donations of breastmilk substitutes (BMS) are dangerous and put infants' lives at risk. This information should be provided to potential donors (including foreign and local governments, Red Cross, NGOs, and the military) and the media, both in emergency preparedness and particularly during the early phase of an emergency response.
- xiv. Soliciting or accepting unsolicited donations of BMS should be avoided. Instead, interventions to support artificial feeding should budget for the purchase of BMS along with other essential needs to support artificial feeding, such as fuel, cooking equipment, safe water and sanitation, staff training, and skilled personnel.
- xv. Any donation of BMS, milk products, bottles and teats that have not been prevented should be collected by a designated agency, preferably from

points of entry to the emergency area, under the guidance of the coordinating organization (e.g. UNICEF together with the government). The products should be stored until the coordinating organization develops a plan for their safe use or their eventual destruction.

i. Feeding for low-birth-weight infants.

Low-birth weight (LBW) is defined as weight at birth less than 2500 grams. Low birth weight can be the result of pre-term birth (i.e. before 37 weeks gestation), or because the infant is small for gestational age (SGA, <10th percentile weight for gestation), or both. LBW infants are at higher risk of early growth retardation, infectious diseases, developmental delay and death during infancy and childhood. Appropriate care of LBW infants (including feeding, temperature maintenance, hygienic cord and skin care, and early detection and treatment of infections) can substantially reduce mortality in this vulnerable group.

- i. Breastmilk is the best source of nourishment for all LBW (pre-term and SGA) infants. Breastfeeding should be encouraged, and formula feeding should be discouraged, because of clear benefits related to lower rates of infection (including necrotizing enterocolitis) and improved neurodevelopment for the LBW child.
- ii. The majority of LBW infants are able to breastfeed. If not, cup feeding of expressed breastmilk should always be promoted over bottle-feeding, until breastfeeding can be established.
- iii. Because of the small gastric capacity of LBW babies, they should be fed often (every 2 hours) and with small amounts.
- iv. Mothers of LBW infants should be supported with breastfeeding counseling, including the importance of breastmilk and colostrum, and how to express breastmilk and feed with a cup if it is necessary. Expressing breastmilk is not only important to provide optimal nourishment for the new infant, but also ensure that the mother's breastmilk supply is maintained until the time that the infant is able to breastfeed.
- v. Kangaroo Mother Care (KMC) should be promoted and supported. KMC is a care given to a preterm or LBW infant in which the infant is kept between the mother's breast for skin-to-skin contact as long as possible, day and night, simulating the intrauterine environment. KMC helps the baby in two ways: (i) the infant gets the warmth of the mother's body, and (ii) can suck the milk from the mother's breasts as often as required.
- vi. In the clinical setting (i.e. neo-natal care units), mothers should be allowed to participate in the care and feeding of their LBW infant; this results in improved breastfeeding rates and earlier discharge from the hospital. If infants are determined to be too developmentally immature to breastfeed or to swallow from a cup and spoon, and intragastric tube feeding is used, all efforts should be made to support the mother to express and maintain breastmilk supply until as soon as the infant is able to breastfeed. If possible, expressed breastmilk should be used for intragastric tube feeding.

j. Feeding during and after illness

Sick children often suffer from lack of appetite. Breastfeeding is therefore an ideal source of nourishment, hydration, and comfort for a sick child. Breastfeeding can reduce the duration and severity of episodes of diarrhea.

Children less than six months of age

- i. Sick infants less than six months of age should receive more frequent breastfeeding, and longer duration feeds than usual during episodes of illness, and for 2 weeks after illness during the recovery period.
- ii. If the sick infant less than six months of age is no longer exclusively breastfeeding, the mother should be encouraged to return to exclusive and frequent breastfeeding until the child reaches 6 months.
- iii. The main fluid for sick children less than six months of age is breastmilk. If the child less than six months of age has diarrhea, give him/her oral rehydration solution (ORS) after each loose stool. Mothers and health care volunteers in the community should be educated on how to prepare and administer ORS to children with diarrhea.
- iv. If an infant with diarrhea shows signs of dehydration (sunken eyes, dry lips and tongue, and not passing urine), the infant should be taken immediately to the closest health center or hospital for medical care. Mothers and health care volunteers in the community should be educated to recognize signs of dehydration.

Children 6-59 months of age

- v. Sick children 6-59 months of age should increase their fluid intake, including more frequent breastfeeding than usual, during episodes of illness, and for 2 weeks after the illness during the recovery period.
- vi. Caregivers should encourage the sick child to eat soft, varied, appetizing favorite foods.
- vii. After illness, children should be given one extra meal per day for at least 2 weeks (recovery period).
- viii. If the child 6-59 months of age has diarrhea, give him/her oral rehydration solution (ORS) after each loose stool.
- ix. If a child with severe diarrhea shows signs of dehydration (sunken eyes, dry lips and tongue, and not passing urine), the child should be taken immediately to the closest health center or hospital for medical care.

k. Feeding options for infants and young children of HIV positive mothers

On-going infant feeding counseling and follow-up on feeding option for infants and young children of HIV positive mothers should be considered part of care and support services for HIV positive women provided during routine MCH (antenatal, delivery, postnatal) and specific HIV services (Continuum of Care). It should be provided by PMTCT counselors, Health Center midwives as part of antenatal and postnatal care services, referral hospital midwives, pediatric AIDS care teams, and trained NGO counselors. Feeding decisions that are made in counseling with trained health professionals are supported and followed up at the community level by home-based

care teams, BFCI mother support groups, and other community-based trained providers.

- i. The most appropriate infant feeding option for an HIV-infected mother depends on her individual circumstances, including her health status and the local situation. The most appropriate option also depends largely on the specific health services available and the counselling and support she is likely to receive from any public, private, or NGO service or program.
- ii. Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe (AFASS) for them and their infants before that time. The definitions of AFASS are as follows:

Acceptable - The mother perceives no social or cultural barrier to replacement feeding (including stigma or discrimination). She is supported by family members and community in opting for replacement feeding, or she will be able to cope with pressure from family and friends to breastfeed, and she can deal with the possible stigma attached to being seen with replacement food.

Feasible – The mother (or family) has adequate time, knowledge, skills and other resources to prepare the replacement food and feed the infant up to 12 times in 24 hours. The primary caregiver can understand and follow the instructions for preparing infant formula, and with support from the family can prepare enough replacement feeds correctly every day, and at night, despite her/his other responsibilities or work.

Affordable - The mother and family, with community or health-system support if necessary, can pay the cost of purchasing/producing, preparing, and using replacement feeding, including all ingredients, fuel, clean water, soap and equipment, without compromising the health and nutrition of the family. This concept also includes access to medical care if necessary for the child's diarrhoea and the cost of such care.

Sustainable – Availability of a continuous, uninterrupted supply of all ingredients and products needed for safe replacement feeding, for as long as the infant needs it, until at least one year of age or longer. According to this concept there is little risk that formula will ever be unavailable or inaccessible, and another person is available and capable to feed the child in the mother's absence.

Safe - Replacement foods are correctly and hygienically prepared and stored, and fed in nutritionally appropriate quantities, with clean hands and using clean utensils, preferably by cup. This concept means that the mother or caregiver: - has access to a reliable supply of safe water, - prepares replacement feeds that are nutritionally sound and free of pathogens, - is able to wash hands and utensils thoroughly with soap, and to regularly boil the utensils to sterilize them, - can boil water for preparing each of the baby's feeds, - can store unprepared feeds in clean, covered containers and protect them from insects and animals.

- iii. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended. Replacement feeding should be done by cup. Bottle feeding should be strongly discouraged.
- iv. If commercial infant formula is being provided free or at subsidized price for the purpose of replacement feeding the implementation of all the provisions of the Sub-decree no.133 on marketing of products for infant and young child feeding will be ensured.
- v. At six months, if replacement feeding is still not acceptable, feasible, affordable, sustainable and safe, continuation of breastfeeding with additional complementary foods is recommended, while the mother and baby continue to be regularly assessed. All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.
- vi. When a nutritionally adequate and safe diet without breastmilk can be provided, mothers should stop breastfeeding in a period of 2-3 days to 2-3 weeks with counseling and support to prevent potential risks and complications for the mother and the baby: mastitis and breast abscesses in the mother; distress, restlessness, loss of appetite, undernutrition and diarrhoea in the infant.
- vii. Mixed feeding should be always avoided because it carries the risks both of HIV transmission and mortality and diarrhea and other illnesses, and there is some evidence that it may carry a higher risk of HIV transmission than exclusive breastfeeding. Mixed feeding, though, may be difficult to avoid during transition from exclusive breastfeeding to replacement feeding. Expressed heat-treated breast-milk is recommended as a help in the transition from breastfeeding to replacement feeding, and for low-birth-weight infants at greater risk of artificial feeding. Hygienic practices are essential in handling expressed breastmilk to avoid diarrhoeal disease.
- viii. Whatever the feeding decision, health services should follow-up all HIV-exposed infants, and continue to offer infant feeding counseling and support, particularly at key points when feeding decisions may be reconsidered, such as during immunization (6 weeks, 10 weeks, 14 weeks) and at the time of early infant diagnosis (HIV-PCR) at 6 weeks and 6-7 months.
- ix. Breastfeeding mothers of infants and young children who are known to be HIV-infected should be strongly encouraged to continue breastfeeding.
- x. All public, private, and NGO stakeholders and service providers should emphasize breastfeeding protection, promotion and support in the general population. They should also actively support HIV-infected mothers who choose to exclusively breastfeed, and take measures to make replacement feeding safer for HIV-infected women who choose that option.
- xi. All managers and providers involved in support to HIV-positive mothers and their infants will preserve confidentiality, prevent and reduce stigma through not singling out HIV-positive women, will ensure that the HIV-positive mothers who choose not to breastfeed are not discriminated against and receive help to deal with possible stigma.
- xii. All public, private, and NGO stakeholders and service providers should aim to provide HIV-exposed infants (infants of HIV-positive mothers) and their mothers with a full package of child survival and reproductive health

interventions (including immunization, vitamin A supplementation, pre- and post-natal care, family planning, etc.) with effective linkages to HIV prevention, treatment, and care services.

- xiii. The full package mentioned above should be available before any free distribution of commercial infant formula is considered. Provision and use of infant formula will follow the Guidelines on Replacement Feeding in the Context of HIV.
- xiv. The Government will work on the development of the national accreditation system for facilities offering IYCF and HIV counseling.

1. Treatment and Rehabilitation of malnourished children

Moderate malnutrition

Infants and young children who are moderately malnourished (low weight-for-age, below -2SD z-score, as measured on the yellow Child Health Card) also need targeted support. Programs to rehabilitate moderately malnourished children are normally at the health center and community levels, and should include the following elements:

- i. Promotion of and counseling for breastfeeding and appropriate complementary feeding;
- ii. Whenever possible, targeted intensive nutrition counseling with regular cooking/feeding demonstrations as part of community-based programs (for example, Baby-Friendly Community Initiative, Positive-Deviance/“Hearth”);
- iii. In some cases, provision of nutritionally appropriate supplementary foods (for example, Ready to Use Therapeutic Food (RUTF) such as “Plumpy Nut”) is an appropriate community-based intervention alongside promotion and counseling;
- iv. Regular follow-up to ensure the recovery and maintenance of adequate weight;
- v. Referral of children who are very low weight-for-age (below -3SD z-score according to the Child Health Card), or who show clinical signs of severe malnutrition, for assessment at the nearest health center or referral hospital (trained and equipped in management of severe malnutrition).

Severe malnutrition

Infants and young children who are severely malnourished (weight-for-height below -3SD z-score, or showing clinical signs of wasting) are most often found in environments where improving the quality and quantity of food intake is particularly problematic, or children who are infected by HIV and experience chronic infections. Severely malnourished children and their families need targeted support for the child to recover normal weight and to prevent recurrence of malnutrition. Programs to rehabilitate severely malnourished children in the hospital (referral hospitals trained and equipped in management of severe malnutrition), clinic, health center or community setting, should include the following elements:

- vi. Provision of nutritionally appropriate and safe therapeutic foods (for example, RUTF such as “Plumpy Nut”), as outlined in the current MOH guidelines for the treatment of severely malnourished children (in line with WHO training on the Management of Severe Malnutrition);

- vii. Promotion of and counseling for breastfeeding and appropriate complementary feeding, especially for children under 2 years of age;
- viii. Referral to appropriate clinical treatment and counseling for infections such as tuberculosis, HIV, etc, as appropriate;
- ix. Education, including cooking and feeding demonstrations where possible, to mothers and caregivers;
- x. Referral to targeted assistance programs that provide food supplements to at-risk families;
- xi. Regular follow-up to ensure the recovery and maintenance of adequate weight, as per NNP/MOH guidelines.

m. Support Systems

- i. Mothers, fathers, and other caregivers shall have access to objective, consistent, and complete *information* and *skilled support* to help them initiate and sustain appropriate feeding practices. Health workers (in public and private facilities) should be knowledgeable and capable to provide this support as a routine part of prenatal, delivery, and post-natal care, and also of services provided for the well baby and sick child.
- ii. The Sub-decree on the Marketing of Products for Infant and Young Child Feeding (No. 133, November 2005), and the subsequent Joint Prakas on the Marketing of Products for Infant and Young Child Feeding (No. 061) August 2007) shall be strictly followed by all health care providers public and private, and enforced by the relevant Ministries. Civil servants, private citizens, and other concerned individuals and organizations are encouraged to report violations of the Sub-decree.
- iii. The Cambodian Labour Law Articles 184-185 grants working mothers the right to one hour per day paid breastfeeding breaks during work hours. This may be taken as 2 half-hour breaks, the exact time of which shall be agreed between the mother and her employer. Giving milk formula or payment instead of breastfeeding breaks is not allowed under the law.
- iv. The Cambodian Labour Law Article 186 requires an employer who employs 100 women or more to set up an operational nursing room, and an operational day care center.
- v. The Baby-Friendly Hospital Initiative (BFHI) of the National Nutrition Program, Ministry of Health, should be accelerated and sustained, with efforts focusing on (1) current BFHI hospitals maintaining compliance with the 10 Steps to Successful Breastfeeding, and (2) expansion of BFHI to new hospitals, particularly those in urban areas with the highest numbers of deliveries.
- vi. The Baby-Friendly Community Initiative (BFHI) of the National Nutrition Program, Ministry of Health, offers tools, resources, and guidelines for IYCF promotion at the community level. BFHI should be continued and expanded with support from MOH partners.
- vii. Other community level NGO programs to promote child survival, including optimal breastfeeding and complementary feeding, have an important role in implementation of this policy, and should coordinate activities closely with the local health centers, particularly with regard to training, implementation, and reporting of key indicators.

- viii. A strategy and plan for IYCF advocacy should be developed and implemented from the highest level. Such advocacy should be directed to decision makers and business leaders, focusing on (1) enforcement of the Sub-decree on Marketing of Products for Infant and Young Child Feeding, and (2) the rights of breastfeeding mothers in the workplace. The benefits of breastfeeding and optimal child feeding for the health of the nation are standard messages underlying all calls to action to decision makers and business leaders.
- ix. A Behavior Change and Communication strategy for IYCF shall be comprehensive in scope, consistent with the directives of this policy, and convey targeted messages to all relevant audiences (i.e. mothers, families, health workers, and the general public) via appropriate channels, including mass media.
- x. Training on IYCF, including in-service and pre-service training of health care providers, training of MOH staff, NGO staff, staff of private hospitals and clinics, shall be consistent with this policy.
- xi. Consistent with the accepted principles of conflict of interest, the Ministry of Health at all levels shall not forge partnerships with any manufacturers or distributors of infant formula, milk supplements, feeding bottles, teats, and other related products.

VII. Implementing Mechanism

All Departments and Programs of the Ministry of Health are responsible to follow this policy and adhere to the Sub-decree on the Marketing of Products for Infant and Young Child Feeding (No. 133, November 2005).

a. Management and Coordination

National level. At the national level, the over-all management and coordination of IYCF activities shall be the **National Nutrition Program (NNP)**, specifically the Manager and the appointed IYCF coordinator(s). The NNP has established, and is responsible for the leadership of the Nutrition Technical Working Group (NTWG). The NTWG shall include representation from appropriate government organizations, development partners and NGO agencies, and is responsible for providing technical assistance, building consensus among key parties, and developing strategies and implementation plans to meet the stated objectives of this national IYCF policy. The NNP and NTWG should prepare an action plan each year together with the relevant MOH departments, other line ministries, and external partners detailing strategies and assigning responsibilities.

The NNP is responsible to ensure that this policy is disseminated to hospitals and clinics (public and private), provincial health departments, operational district health offices, and health centers nationwide.

The NNP is also responsible for monitoring and reporting violations of the Sub-decree on Marketing of Products for Infant and Young Child Feeding (No. 133, November 2005). Violations should be reported to the relevant Department of the Ministry of Health (e.g. Department of Drugs and Food) or the relevant Departments

of the Ministry of Commerce (e.g. Department of Consumer Protection, or CamControl Department).

The **Hospital Department** and Referral Hospitals (at the National, Provincial, and Operational District levels) are responsible to follow the implementation of this IYCF policy, and to comply with Cambodian law as described in the Sub-decree on the Marketing of Products for Infant and Young Child Feeding (No. 133, November 2005), and report any violation of the Sub-decree to the relevant authorities.

Provincial Level. The Provincial Child Survival Management Committees (PCSMC) are responsible for planning, coordination, and monitoring of scale up of child survival interventions at the provincial and operational district levels. The Provincial Health Department (PHD) Director and the Nutrition Focal Point person (usually the person responsible for Maternal and Child Health) at the PHD are responsible for:

- Dissemination of this National IYCF Policy to other PHD staff, Operational District staff, related Ministries within the province (i.e. Ministry of Social Affairs and Labor, Ministry Women’s Affairs, etc), and all public and private hospitals in the province.
- Implementation of this National IYCF Policy and related IYCF programs of the Ministry of Health, including aspects of training, supervision, monitoring, and coordination within the province.
- Monitoring and reporting violations of the National Sub-decree on Marketing of Products for Infant and Young Child Feeding (No. 133, November 2005). Violations should be reported to the relevant Department of the Ministry of Health (e.g. Department of Drugs and Food) or the relevant Departments of the Ministry of Commerce (e.g. Department of Consumer Protection, or CamControl Department).

Operational District (OD) Level. The OD Chief and the Nutrition Focal Point person (usually the person responsible for Maternal and Child Health) at the OD level are responsible for:

- Dissemination of this National IYCF Policy to Health Centers, and public and private hospitals within the operational district.
- Implementation of this National IYCF Policy and related IYCF programs of the Ministry of Health, including aspects of training, supervision to the Health Center and community level, monitoring, and coordination within the operational district.
- Supporting and coordinating Health Center staff to plan and implement IYCF activities at the health center and village level.
- Monitoring and reporting violations of the National Sub-decree on Marketing of Products for Infant and Young Child Feeding (No. 133, November 2005). Violations should be reported to the relevant Department of the Ministry of Health (e.g. Department of Drugs and Food) or the relevant Departments of the Ministry of Commerce (e.g. Department of Consumer Protection, or CamControl Department).

Health Center Level. Health Center midwives are usually primarily responsible for IYCF activities. The Health Center Chief, together with the Health Center midwives, are responsible for:

- Implementation of this National IYCF Policy and related IYCF programs of the Ministry of Health, including aspects of training community level volunteers, supervision to the community level, monitoring, and coordination of IYCF activities within the Health Center area.
- Providing appropriate education and counseling to mothers coming to the health center on breastfeeding and complementary feeding.
- Monitoring and reporting violations of the Sub-decree on Marketing of Products for Infant and Young Child Feeding (No. 133, November 2005). Violations should be reported to the relevant Department of the Ministry of Health (e.g. Department of Drugs and Food, or National Nutrition Program) or the relevant Departments of the Ministry of Commerce (e.g. Department of Consumer Protection, or CamControl Department).

Community Level. At the community level, community volunteers such as VHSG, BFCI volunteers, or other NGO program staff or volunteers play a crucial role for supporting mothers on optimal IYCF practices as outlined in this policy. Community level health volunteers and health workers are responsible for:

- Providing basic counseling on breastfeeding and child feeding to mothers from pregnancy through the first five years of the child's life.
- Implementation of this National IYCF Policy and related IYCF programs of the Ministry of Health, including aspects of counseling to mothers and reporting to the health center.

Private Sector. All private hospitals and health care providers, and breastmilk substitute manufacturers and distributors are responsible to adhere to this Policy, and to comply with Cambodian regulations as described in the Sub-decree on the Marketing of Products for Infant and Young Child Feeding (No. 133, November 2005).

b. Supervision, Monitoring and Evaluation

Periodic monitoring and evaluation of the progress towards meeting the stated objectives of the national IYCF policy shall be institutionalized and integrated with ongoing program monitoring (e.g. community, health center, and hospital based health information systems, NGO and donor reporting systems, etc.) and periodic surveys (e.g. Cambodia Demographic and Health Survey). The NNP and the NTWG shall define the key indicators for monitoring and evaluating IYCF progress (as defined in the Health Strategic Plan, and National Nutrition Strategy). This minimum basic set of indicators should be phrased in a consistent manner to increase the comparability of various data sources, and any relevant information shall be submitted to the NNP as requested.

NGOs and other community-based programs should make every effort to work collaboratively with health authorities at all levels, to unify their reporting systems with the systems of the MOH.

c. Research and Development

Continuing clinical and population-based research and investigation of behavioral concerns are essential ingredients for improving IYCF strategies, programs, and practices. The NNP and the NTWG are responsible to identify and prioritize research needs that will contribute directly to the ongoing modification and improvement of IYCF program operations.

VIII. Repealing Clause- any previously existing policies, guidelines, or issuances, etc. that are found to be inconsistent with this policy shall be repealed (no longer apply).

IX. Effectivity – this Policy shall take effect immediately.

(Signature of Minister and Date)

Appendix 1: Recommended Complementary Feeding Guidelines for Cambodia

| RECOMMENDATIONS ON COMPLEMENTARY FEEDING | | | |
|---|---|---|---|
| Age | Texture | Frequency | Amount at each meal ⁹ |
| 6 month | Start with thick enriched Borbor, well mashed foods, e.g. mashed cooked banana, sweet potato, pumpkin, etc. | Start foods 2 times per day plus frequent breastfeeds at least 8 times per day | Start with 2-3 tablespoonfuls per feed |
| 7-8 months | Thick enriched Borbor , well mashed foods, | Increasing to 3 times per day plus frequent breastfeeds at least 8 times per day | Increasing gradually to 1/2 of Chan Chang Koeh at each meal |
| 9-11 months | Thick enriched Borbor , finely chopped or mashed foods, and foods that baby can pick up | 3 meals plus 1 snack between meals plus breastfeeds at least 6 times per day | Increasing gradually to 1 Chan Chang Koeh |
| 12-24 months | Family foods, chopped or mashed if necessary, thick enriched Borbor | 3 meals plus 2 snacks between meals plus breastfeeds as the child wants, at least 3 times per day | 1 Chan Chang Koeh |
| If baby is not breastfed, give in addition 1-2 extra meals per day. | | | |

Thick enriched Borbor that cannot fall/drip off spoon as base add:

- Fish, egg, blood, chopped meat, tofu, and beans
- *Vegetables: morning glory leaves, amaranth leaves, pumpkin, yellow sweet potato, and other vegetables*
- Cooking oil
- Iodized salt

Snacks: ripe fruits (banana, mango, papaya), fried banana/sweet potato, Angsom, bean/pumpkin sweet soup, etc.

⁹ Adapt the chart to use a suitable local cup/bowl to show the amount. One cup = 250mls; one tablespoon = 10mls. The amounts assume an energy density of 0.6 Kcal/g.

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