Public Health Resource Network (PHRN)
5 A, Shahpur Jat
Jungi House
New Delhi-110049
Tel: +91-11-26499563

International Baby Food Action Network (IBFAN), Asia /
Breastfeeding Promotion Network of India (BPNI)
BP-33, Pitampura, Delhi 110 034, India
Tel: +91-11-27343608, Fax: 27343606
Email: bpni@bpni.org, info@ibfanasia.org
Website: www.bpni.org, www.ibfanasia.org

BPNI-IBFAN Asia/December 2008

WBTi
World Breastfeeding Trends Initiative (WBTi)

World Breastfeeding Trends Initiative (WBT*i*)

India Report 2008

Public Health Resource Network (PHRN)
Breastfeeding Promotion Network of India
International Baby Food Action Network (IBFAN), Asia

ABOUT PHRN

The Public Health Resource Network (PHRN) aims to provide support to public health practitioners working in the districts in all aspects of district health planning and public health management in the context of The National rural Health Mission.

The central element of this initiative is a capacity building effort structured as a distance learning programme. This distance learning programme is substitute to formal professional public health raining and it does not carry with it any guarantee of increased employment of career options. It is meant to support individuals and organizations both within and outside the health department who are committed to working for a more equitable and effective public health system.

This programme compliments official training and education programs through an open-ended, more informal and immediate reaching out with information tools and a diversity of programme options and perspectives. Our major work areas include: Distance Learning Programme, Fast Track Capacity Building Programme, Community Health Fellowship, Collaboration with IGNOU as well as Networking, Research and Advocacy.

ABOUT BPNI

The Breastfeeding Promotion Network of India (BPNI) is a registered, independent, non-profit, national organization that works towards protecting, promoting and supporting breastfeeding and appropriate complementary feeding of infants & young children. BPNI believes that breastfeeding is the right of all mothers and children. BPNI works through advocacy, social mobilization, information sharing, education, research, training and monitoring the company compliance with the IMS Act. BPNI does not accept funds or sponsorship of any kind from the companies producing infant milk substitutes, feeding bottles, related equipments, or infant foods (cereal foods).

The World Breastfeeding Trends Initiative (WBT*i*) is IBFAN Asia's flagship programme. WBT*i* is being implemented as an integral part of two projects "Global Breastfeeding Initiative for Child Survival" (GB*i*CS) in partnership with the Norwegian Agency for Development Cooperation (Norad) and Global Proposal for Coordinated Action of IBFAN & WABA: Protecting, Promoting and Supporting Breastfeeding through Human Rights and Gender Equality" in partnership with the Swedish International Development Cooperation Agency (Sida).

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Dr. Arun Gupta
Dr. Vandana Prasad
Dr. J.P. Dadhich
Mrs. Radha Holla Bhar
Dr. Ajay Gaur
Dr. Anurag Singh

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Website: www.bpni.org, www.ibfanasia.org

The World Breastfeeding Trends Initiative (WBT*i*)- India Report 2008

REPORT WRITING AND EDITING

- **Writers and Editors:** Dr. Arun Gupta, Dr. Vandana Prasad, Dr. J.P. Dadhich, Mrs. Radha Holla Bhar, Dr. Ajay Gaur and Dr. Anurag Singh
- **Design & Layout:** Amit Dahiya

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Website: www.ibfanasia.org

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IBFAN Asia acknowledges the support of Norad and Sida for launching and implementing the World Breastfeeding Trends Initiative (WBT*i*) across 51 countries of the world.

Vandana Prasad and Arun Gupta

मणि शंकर अय्यर
MANI SHANKAR AIYAR

मंत्री
पंचायती राज और उत्तर-पूर्वी क्षेत्र विकास
भारत सरकार
नई दिल्ली-110 001
Minister
Panchayati Raj and
Development of the North Eastern Region
Government of India
New Delhi-110 001

FOREWORD

Optimal breastfeeding is increasingly becoming recognized as one of the most effective interventions for reducing infant mortality and keeping India on track for meeting the Millennium Development Goal 4 – reduction in child mortality. The National Family Health Survey – 3 (2005-06) has clearly shown the dismal rates of timely initiation of breastfeeding and exclusive breastfeeding at six months of age. If optimal breastfeeding rates have to improve, policies and programmes need to be put in place to protect, promote and support this essential intervention.

India has endorsed the Global Strategy for Infant and Young Child Feeding, which lists 10 areas of action to universalize optimal breastfeeding. It also emphasizes the importance of timely introduction of adequate and safe complementary feeding, and imparting accurate information for enabling the family to provide the energy and nutrient needs of growing children. The India assessment of 2008, initiated by the International Baby Food Action Network Asia, tracks, assesses and monitors these areas and highlights the gaps that need to be filled, so that the country can effectively support its women to practice optimal breastfeeding. The report highlights deficiencies in all areas that require action, justifying a highly coordinated and budgeted activity for achieving high rates of optimal breastfeeding.

While the India Report 2008 reinforces the need to protect, promote and support breastfeeding and ensure the introduction of timely complementary feeding to meet the growth and nutritional requirements of infants, at all levels – from the level of policy and planning, to the place where women breastfeed – at home, in the community, at the health centres and in the workplace, the Report does not adequately focus on the indispensable role of Panchayati Raj Institutions in propagating, supporting and sustaining initiatives aimed at Optimal Breastfeeding. This is a glaring lacuna that needs to be immediately filled. I trust India Report 2009 will address this issue.

New Delhi
29 November 2008

(Mani Shankar Aiyar)

258, विज्ञान भवन एनेक्सी, मौलाना आजाद रोड, नई दिल्ली–110 011, दूरभाष : 011-23022400, 23022401
258, Vigyan Bhavan Annexe, Maulana Azad Road, New Delhi-110 011. Tel.: 011-23022400, 23022401

Executive Summary

This is the India's 2008 Report of the assessment of the state of implementation of the *Global Strategy for Infant and Young Child Feeding*, and accomplished under the World Breastfeeding Trends Initiative (WBT*i*) of IBFAN Asia.

The WBT*i* , which serves as a lens to find out gaps in policy and programmes, help nations initiate action to bridge these gaps. This programme is already running in over 50 countries. The brainchild of IBFAN Asia, WBT*i* is an integral part of two global project jointly funded by Norad and Sida.

Public Health Resource Network and Breastfeeding Promotion Network of India jointly coordinated the India 2008 assessment. This report has been developed after a detailed study and analysis of existing policy and programme documentation. The core group that led this analysis also used pertinent information that we received from Government of India through Right to information Act, and several key documents, websites, and published information. The web-based tool kit, according to WBT*i* guidelines, has rated the findings. India scores 69 out of total of 150 and stands in YELLOW band in grid of Red, Yellow, Blue, and Green in ascending order of performance or achievement.

The report has found glaring gaps in both policy and programmes and has not shown any improvement since 2005 when a similar assessment was conducted.

Assessment findings were also discussed with a larger group and consensus was achieved in identification of gaps and recommendations for bridging them. Following are the salient features of the report. For indicators 1-5, we provide data to compare the situation in 2005 and 2008; for indicators 6-15, which are related to policy and programmes, gaps and recommendations are highlighted. Details can be viewed in the following pages.

Key Findings (Indicator 1-5)

Indicator	2005	2008
1. Percentage of babies breastfed within one hour of birth	15.8%	24.5%
2. Percentage of babies of 0<6 months of age exclusively breastfed in the last 24 hours	46.9%	46.4%
3. Babies are breastfed for a median duration of how many months	25.4months	24.4 months
4. Percentage of breastfed babies less than 6 months old receiving other foods or drink from bottles	13.7%	16.4%
5. Percentage of breastfed babies receiving complementary foods at 6-9 months of age	35%	56.7%

Indicator 6: National Policy, Programme and Coordination

Gaps

1. Lack of effective coordination mechanisms though structures do exist.
2. Lack of policy status for National Guidelines on Infant and Young Child Feeding.
3. Guidelines do not have a clear plan with objectives and allocated budget.

Recommendations

- Draft National Plan of Action to be adopted as a policy
- Separate funding to protect, promote and support breastfeeding infant for 0-6 months should be made available to ensure women are supported and are able to stay close to babies.

Indicator 7: Baby Friendly Hospital Initiative (Ten steps to successful breastfeeding in the maternity services)

Gaps

1. No sustained action to revive BFHI
2. No mention of BFHI in NRHM document, especially with reference to hospitals and nursing homes that will be contracted for conducting deliveries under Janani Suraksha Yojna
3. BFHI has not shown any progress from 2005 in any manner, whether quantity of quality.

Recommendations

- Immediate steps should be taken to revive the BFHI programme
- Under the NRHM, at least 20% of all hospitals should move to attain BFHI status in 2 years' time
- BFHI should be prominently placed in all child health policies and programmes
- Health MIS should include BFHI

Indicator 8: Implementation of the International Code

Gaps

1. Inadequate mechanisms to enforce *"The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992", as Amended in 2003* (IMS Act).
2. Inadequate mechanisms for reporting violations at state and district levels
3. District officials are not trained in monitoring the implementation of IMS Act as well as their information about the provisions of the IMS Act is very poor.

Recommendations

- IMS Act should be enforced effectively, explicit monitoring mechanisms at state and district level should be in place.
- Enforcement of the IMS Act to be made more effective
- Reporting of the violations of the Act to be made more easy
- State-wise nominations of the nodal officers for monitoring and implementation of the Act

Indicator 9: Maternity Protection

Gaps

1. There is no policy framework for protecting and supporting breastfeeding in private sector and informal sector
2. There is no legislation that covers the above sectors
3. Maternity leave does not cover all states, only the central government employees
4. Paternity leave does not cover all state governments and private sector
5. No monitoring mechanism for implementation of maternity protection as part of policy framework

Recommendations

- There should be policy framework for protecting and supporting breastfeeding for mothers including working mothers in the informal sector
- This should translate to actual mechanism for implementation and adequate budgetary allocations
- Contractual workers with public and private sector should also be covered for the maternity leave
- An umbrella legislation for both formal and informal sector is required
- Six months maternity leave and paternity leave should be expanded to state government and private sector
- There should be a monitoring mechanism for implementation for maternity protection (at par with the PNDT Act), as a part of the policy framework

Indicator 10: Health and Nutrition Care Systems

Gaps

1. There is no practical training given to doctors and nurses on IYCF in pre-service education
2. Listening and counselling skills for IYCF not part of pre-service or in-service training of AWW, ANM and ASHA

Recommendations

- IYCF training of doctors and nurses during their internship
- District health authorities should be responsible for monitoring of AWW, ASHA training
- ASHA refresher course to contain IYCF training

Indicator 11: Mother Support and Community Outreach - Community-based Support for the pregnant and breastfeeding mother

Gaps

1. Counselling for IYCF is not provided as a service to lactating women in NRHM or ICDS
2. Crèche facilities not mentioned in either NREGA or Unorganised Workers Bill

Recommendations

- NREGA should have provision for Crèches
- AWW should be trained as IYCF counsellor and IYCF counselling should be provided as a service to lactating women.
- Unorganized workers' bill should contain provision for crèches
- Expansion of the Rajiv Gandhi Scheme, ICDS; 11th Plan recommendations must be implemented
- Crèches at the worksite must be implemented and monitored.
- Crèches should be monitored specifically by the WBTi tool as an important agency of support to lactating mothers and IYCF.

Indicator 12: Information Support

Gaps

1. Lack of stated strategy on IEC
2. Lack of budget head
3. Inadequate coverage

Recommendations

- Advocacy for comprehensive National IYCF policy that includes an IEC strategy
- Work out and demand a budget for IEC for IYCF (district/block level) with reference to work already done with Planning Commission
- As with other issues related to IYCF this should be located in a national overseeing body

Indicator 13: Infant Feeding and HIV

Gaps

1. National guidelines not yet made into policy
2. BFHI does not include HIV-related indicators
3. Inadequate counselling to HIV women regarding infant nutrition
4. Inadequate training for PPTCT

Recommendations

- Monitoring/ field studies to find out counselling practices in HIV and impact upon breastfeeding
- Inclusion of HIV related indicators for BFHI
- Further studies are required on transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants.
- Comprehensive national policy including IYCF in HIV
- Training for PPTCT (currently at 2.5 hrs) needs to have separate module and separate training (5½ to 6 days) for infant feeding counselling options

Indicator 14: Infant Feeding during Emergencies

Gaps

1. There is no policy on IYCF in Contingency action plans
2. There is no mechanism to monitor violations of IMS Act during relief operations
3. There is no training for disaster management teams on IYCF

Recommendations

- Inclusion of IYCF guidelines in case of disaster (from national guidelines) needs to be included in contingency action plan
- Monitor / document use of infant milk substitutes and support to breastfeeding during disasters / emergencies.
- Monitor / document for violations of IMS Act during disaster / emergencies
- Training for 'disaster managers'

Indicator 15: Mechanisms of Monitoring and Evaluation System

Gaps

1. NRHM does not have indicators on exclusive breastfeeding and complementary feeding
2. Too large a time gap between two consecutive NFHS surveys
3. Inadequate indicators on quality and quantity of complementary feeding
4. No age-wise disaggregation for children between 1-2 years when malnutrition peaks

Recommendations

- Recommend to government to do annual report on IYCF indicators
- Improve indicators on complimentary feeding quality / quantity
- Age wise further disaggregation for under twos (between 1- 2 years)

Introduction

This document is the report of the assessment of the state of implementation of the *Global Strategy for Infant and Young Child Feeding*, reflecting current policy and programmes that support optimal infant and young child feeding (IYCF) practices in India. The assessment was conducted during the period of July October 2008 using the process of the World Breastfeeding Trends Initiative (WBT*i*), an innovative initiative developed by **International Baby Food Action Network Asia (IBFAN Asia)** as a system for Tracking, Assessing and Monitoring (TAM) the *Global Strategy for Infant and Young Child Feeding* using a web-based toolkit. Public Health Resource Network (PHRN) and Breastfeeding Promotion Network of India (BPNI) jointly coordinated the India assessment.

The World Breastfeeding Trends Initiative (WBT*i*) is a global initiative to assess policy and programmes that support women for breastfeeding. It measures the rates of practice of optimal infant and young child feeding, as well as the progress of nations on the ten indicators of policy and programmes based on the framework of action in the *Global Strategy for Infant and Young Child Feeding*, an essential component of any strategy for meeting the rights of the child, particularly the child's right to survival, health and adequate nutrition. The Global Strategy was ratified at the World Health Assembly in 2001, and subsequently adopted by UNICEF.

The WBT*i* serves as a lens to find out gaps in policy and programmes at national level and help nations initiate action to bridge these gaps. WBT*i* assessments are being implemented in more than 50 countries now, and will be conducted in over a hundred countries by 2009. This will help create one of the largest databases for information on policy and programmes that support breastfeeding women in the world.

The brainchild of IBFAN Asia, WBT*i* is an integral part of the project "Global Breastfeeding Initiative for Child Survival" (GB*i*CS), in partnership with NORAD, in line with Norway's flagship programme, the 'Global Campaign for the Health Millennium Development Goals' launched in September 2007. The initiative is also receiving support from Sida through a "Global Proposal for Coordinated Action of IBFAN And WABA: Protecting, Promoting and Supporting Breastfeeding through Human Rights and Gender Equality".

Thus far, the initiative has succeeded in not just involving, but creating a level of enthusiasm seldom seen before, amongst several IBFAN and other civil society groups as well as governments across Asia, Latin America, and Africa.

In the region of South Asia all eight SAARC countries (Afghanistan, Bhutan, Bangladesh, India, Nepal, Maldives Pakistan, and Sri Lanka) participated in the WBT*i* and presented the findings at the South Asia Breastfeeding Partner's Forum 5 held at Bhutan. All these countries also took part in a similar exercise in 2005 and compared what more needs to be done. The India Report 2008 provides in detail the findings of the assessment, compares it with the status in 2005, analyses gaps and offers some recommendations to bridge them. This process has helped to build understanding and trust between civil society groups belonging on many issues for advocacy on policy and programme support to breastfeeding.

The WBT*i* is just the beginning of the journey to pursue the genuine implementation of the

national plans of action on infant and young child feeding. In South Asia, the process began which with training in August, is already showing positive impact as countries are working with multiple stakeholders to look for ways to effectively implement the Global Strategy.

The WBT*i* involves reassessments every few years to fine tune action to universalise optimal infant and young child feeding. Reassessments are being planned for 2011.

Background

In this section detailed description is given on the status of child malnutrition and survival in South Asia, and India along with what are our global and national commitments. South Asia, home to about 1.4 billion people, has the highest number of under-five deaths and under-five children who are underweight. More than 70 million out of total of 146 million under-five under weight children are in South Asia (UNICEF SOWC 2006).

These countries are struggling to attain the required pace of reduction of child mortality according to the Child Survival Report Card (UNICEF 2004). South Asia has shown persistently high rates of infant mortality that has largely remained resilient to change. Current rates of annual reduction are dismal in spite of significant improvement in the survival and development of children over decades. Lot more needs to be done as according to estimates (IBFAN Asia Pacific 2006), the region has annual estimated births put as about 37 million, and more than 77 million children under the age of five are underdeveloped and undernourished, thus unlikely to achieve their full growth and potential development.

According to the WHO's 2002 *Global Strategy for Infant and Young Child Feeding*, 'Malnutrition has been responsible, directly or indirectly, for 60% of the 10.9 million deaths annually among children under five. Well over two-thirds of these deaths, which are often associated with inappropriate feeding practices, occur during the first year of life. No more than 35% of infants worldwide are exclusively breastfed during the first four months of life; complementary feeding frequently begins too early or too late, and foods are often nutritionally inadequate or unsafe. Malnourished children who survive are more frequently sick and suffer life-long consequences of impaired development. Raising incidences of overweight and obesity in children are also a matter of serious concern. Because poor feeding practices are a major threat to social and economic development, they are among the most serious obstacles to attaining and maintaining health that face this age group….' (Global Strategy 2002). Optimal infant feeding contributes significantly to the overall development of those who survive, as its promotion leads to prevention of child malnutrition.

India's Situation

Of the currently estimated 9.7 million under-five deaths globally, 2.1 million are in India alone. 27 million births occur every year in India out of which 1.7 million children die before one year of age and 1.08 million newborns die within one month of age. The under -five mortality rate (U5MR) for India was estimated as 76 for the year of 2006. India has made progress in the reduction of child mortality with the average annual rate of reduction in U5 mortality between 1990 and 2006 being around 2.6 per cent. However, If India is to reach the MDG Goal of 38 by 2015, the average annual rate of reduction over the next nine years must be far higher, or around 7.6 per cent. In India 43 per cent of children under age five are underweight (SOWC UNICEF 2008). Infant Mortality Rate (IMR) in 2007 was 55/1000 live births(Office of the Registrar General and Census Commissioner. Sample Registration System Bulletin. October 2008) The annual rate of decline of IMR has been 1.8 points per year in the current decade. At the same rate, projected IMR in 2012 will be 46/1000 live births. This will be 18 points higher than the

MDG goal 4 of IMR < 28/1000 live births. 52 percent of under-five deaths continue to occur in the first month of life. 75% of neonatal deaths occur in first week of life, which means that the proportion of U 5 deaths by neonatal causes is disproportionately high.

The primary causes of infant mortality are newborn infections, diarrhea, and pneumonia. Breastfeeding is the number one intervention for all these three causes. More recent data from Lancet 2008 revealed that suboptimal breastfeeding during first six months is the leading factor for high infant mortality.

Infant and young child feeding practices: 38 per cent of newborns in the developing countries start breastfeeding within one hour of birth while in India this figure is 24 per cent. In India 46% of infants under six months are exclusively breastfed, however exclusive breastfeeding rapidly declines to about 20% by the time children are six month old. Exclusive breastfeeding rates remain low in virtually all the states. The percentage of children age 6-9 months who are given complementary food is 56.7 per cent. While 56% of children receive 6-23 months initiated timely complementary foods, only 21% received appropriate complementary foods (minimum no of times, minimum no of food groups) (NFHS -3)

Global and National Commitments

The World Health Assembly (WHA) adopted the *Global Strategy for Infant and Young Child Feeding* in May 2002 and the UNICEF Executive Board in September 2002 endorsed it. In addition to four targets suggested by the *Innocenti Declaration* (1990), the *Global Strategy* provided five additional targets to achieve optimal infant and young child feeding practices as a means to prevent child malnutrition and reduce infant and young child mortality. *WHA Resolution 58.32* urges Member States to protect, promote and support exclusive breastfeeding for six months, as a global public health recommendation, taking into account the findings of the WHO Expert Consultation on optimal duration of exclusive breastfeeding, and to provide for continued breastfeeding up to two years of age or beyond. It reiterates full implementation of the *Global Strategy*, which encourages Member States, among many actions, to formulate a comprehensive national policy, a legal framework to promote maternity leave and a supportive environment for six months exclusive breastfeeding, a detailed plan of action to implement, monitor and evaluate the policy, and allocation of adequate resources for this process.

UN member countries, along with national and international partners, reaffirmed their commitment to further reduce infant and child mortality by adopting the Millennium Development Goals (MDGs) (UN 2001), which represent the widest possible commitment in history to address global poverty and ill health. The fourth goal (MDG-4), relates to reducing U5MR by two-thirds between 1990 and 2015. Public health experts predict that the MDG to reduce under-5 mortality by two-thirds cannot be met unless neonatal mortality is at least halved, which will require greater emphasis on measures to improve newborn health as well as to increase the reach to all. Recent commitments also include *Innocenti Declaration 2005* on IYCF calling for protection, promotion and support of breastfeeding urgently for achievement of the Millennium Development Goals by 2015 (UN 2005). World Health Assembly resolution 61.20 adopted in May of 2008 calls for heightened action on Infant and Young Child Feeding and reiterating implementation of the *Global Strategy for Infant and Young Child Feeding*, and Innocenti declarations, as well as avoiding conflicts of interests in programmes on child health.

About WBT*i*

The WBT*i*: How it works?

It involves a three-phase process.

The **first phase** involves initiating a national assessment of the implementation of the *Global Strategy*. It guides countries and regions to document gaps in existing practices, policies and programmes. This is done based on national documentation by involving multiple partners. Their analysis and the process itself bring governments and other civil society partners together to analyse the situation in the country and find out gaps. The gaps identified are used for developing recommendations for priority action for advocacy and action. The WBT*i* thus helps in establishment of a practical baseline demonstrating to programme planners, policy makers where improvements are needed to meet the aims and objectives of the Global Strategy. It assists in formulating plans of action that are effective to improve infant and young child feeding practices and guide allocation of resources. It works as a consensus building process and helps to prioritise actions. The initiative thus can impact on policy at the country level, leading to action that would result in better practices.

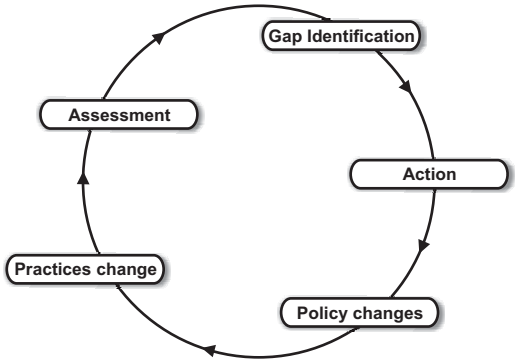
During the **second phase**, WBT*i* uses the findings of phase 1 to score, rate, grade and rank each country or region based on **IBFAN Asia's Guidelines for WBT*i*** thus building some healthy competition among the countries in the region or among regions.

In the **third phase**, WBT*i* calls for repetition of the assessment after 3-5 years to analyse trends in programmes and practices as well as overall breastfeeding rates in a country, to report on programmes and identify areas still needing improvement. This repetition can be also used to study the impact of a particular intervention over a period of time.

IBFAN groups and specialists can assist in planning processes, capacity building, analysis and reporting.

WBT*i* is:

A: Action oriented
B: Brings people together
C: Consensus and commitment building
D: Demonstrates achievements and gaps
E: Efficacy improving programme



The 15 indicators of WBT*i*

The WBT*i* focus is based on a wide range of indicators, which provide an impartial global view of key factors.

The WBT*i* has identified 15 indicators. Each indicator has its specific significance. Part-I has 5 indicators, based on the WHO tool, dealing with infant feeding practices and Part II has 10 indicators dealing with policies and programmes. Once assessment of gaps is carried out and data verified, the data on 15 indicators is fed into the web-based toolkit. Scoring, colour-rating and grading is done for each individual indicator. The toolkit objectively quantifies the data to provide a colour- rating and grading i.e. **'Red'** or **'Grade D', Yellow** or **'Grade C', Blue** or **'Grade B'**

Indicators

Part I

1. Percentage of babies breastfed with in one hour of birth
2. Percentage of babies 0<6 months of age exclusively breastfed in the last 24 hours
3. Babies are breastfed for a median duration of how many months
4. Percentage of breastfed babies less than 6 months old receiving other foods or drink from bottles
5. Percentage of breastfed babies receiving complementary foods at 6-9 months of age

Part II

6: National Policy, Programme and Coordination
7. Baby Friendly Hospital Initiative (Ten steps to successful breastfeeding)
8. Implementation of the International Code
9. Maternity Protection
10. Health and Nutrition Care Systems
11. Mother Support and Community Outreach - Community-based Support for the pregnant and breastfeeding mother
12. Information Support
13. Infant Feeding and HIV
14. Infant Feeding during Emergencies
15. Mechanisms of Monitoring and Evaluation System

Background information: Background information on MDG goals **1, 4, and 5** is collected but is not scored, colour-rated or graded. It can be used to provide a better understanding of the health, nutritional and socioeconomic context which influences infant and young child feeding practices and programmes.

and **Green** or **'Grade A'**. The toolkit has the capacity to generate visual maps or graphic charts to assist in advocacy at all levels e.g. national, regional and international.

Each indicator has the following components:

- The key question that needs to be investigated.
- A list of key criteria as a subset of questions to consider in identifying achievements and areas needing improvement, with guidelines for scoring, rating and grading how well the country is doing.
- Background on why the practice, policy or programme component is important.

Part I: Infant and Young Child Feeding Practices in Part I ask for specific numerical data on each practice based on data from random household survey that is national in scope.

Part II: A set of criteria has been developed for each target based on the *Innocenti Declaration of 2005*, which set 5 additional targets. It takes into consideration most of the targets of the *Global Strategy*. For each indicator, there is a subset of questions. Answers to these can lead to identifying achievements and gaps. This shows how one country is doing in a particular area of action on Infant and Young Child Feeding.

Once information about the indicators is gathered and analysed, it is then entered into the web-based toolkit through the 'WBT*i* Questionnaire'. Further, the toolkit scores, colour- rates and grades each individual indicator as per IBFAN Asia's Guidelines for WBT*i*.

Methodology

Coordination

The coordination of the assessment was undertaken by the BPNI / IBFAN Asia and the Public Health Resources Network (PHRN).

The Core Group

A core group comprising of Ms. Radha Holla Bhar from Breastfeeding Promotion Network of India (BPNI), Dr. Vandana Prasad from Public Health Resources Network (PHRN), Dr. JP Dadhich from IBFAN Asia, Dr. Ajay Gaur from the Department of Paediatrics, Medical College, Gwalior and Dr. Anurag Singh from the Department of Paediatrics, Medical College, Jodhpur initially met on 6th September 2008 at New Delhi. The process of the assessment was discussed and indicators for data collection were assigned to each core group member as under:

Indicator 1-5		**Dr. Ajay Gaur**
Indicator 6	***National Policy, Programme and Coordination***	**BPNI**
Indicator 7	***Baby Friendly Hospital Initiative*** *(Ten steps to successful breastfeeding)*	**Dr. Ajay Gaur**
Indicator 8	***Implementation of the International Code***	**BPNI**
Indicator 9	***Maternity Protection***	**PHRN**
Indicator 10	***Health and Nutrition Care Systems***	**Dr. Anurag Singh**
Indicator 11	***Mother Support and Community Outreach*** - *Community-based Support for the pregnant and breastfeeding mother*	**PHRN**
Indicator 12	***Information Support***	**Dr. Anurag Singh**
Indicator 13	***Infant Feeding and HIV***	**Dr. Ajay Gaur**
Indicator 14	***Infant Feeding during Emergencies***	**BPNI**
Indicator 15	***Mechanisms of Monitoring and Evaluation System***	**PHRN**

The core group had several meetings and electronic interactions to prepare a draft assessment document. For the individual indicator, available supporting documents were searched to answer each subset of the questionnaire. The supporting documents were procured from published documents, websites of relevant organisations, and answers to the Right to Information queries sent to various government agencies. Core groups members worked hard to study and analyse several pieces of information that we collected from sources including the ones we got using the Right to Information Act.

The National Workshop

On 4th October 2008, a national workshop for policy makers, professionals, and civil society organisations was held at New Delhi.

The workshop started with a brief introductory session. Dr. Vandana Prasad welcomed the participants. She briefly enumerated the assessment process. Dr. Arun Gupta from BPNI elaborated upon the concept of the WBT*i* and its larger role in advocacy and programme implementation. Dr. JP Dadhich summarized the outline of the workshop programme.

Programme can be viewed in the Annexure-1.

This was followed by a PowerPoint presentation on the World Breastfeeding Trends Initiative (WBT*i*) by Radha Holla Bhar (Annexure-3). She highlighted the concept, relevance and basis of the WBT*i,* and inputs required to accomplish the assessment.

Dr. Vandana Prasad then made a PowerPoint presentation on the India assessment findings using WBT*i* (Annexure-4). She started with a brief account of the earlier assessment held in the year 2005. Then she dealt with the process followed to draft the present assessment document. This was followed by a description of the assessment for each indicator and the trends since the last assessment.

During the post-lunch session, participants undertook a group discussion to discuss and finalize the draft assessment document after being briefed on the process by. Dr. JP Dadhich. Dr. Vandana Prasad, Ms. Haripriya Soibam, Dr. JP Dadhich, Dr. Ajay Gaur, Ms. Radha Holla Bhar and Dr. Anurag Singh coordinated the discussions. The groups were arranged as follows:

Group 1 Indicators 1-5, 6,7,8
Group 2 Indicators 9,10,11
Group 3 Indicators 12,13,14,15

Each group made presentations in a plenary session, highlighting the necessary changes in the draft assessment findings as proposed by the group. A consensus was thus achieved to agree on the gaps.

Gaps and Development of Recommendations

Partcipants were once gain divided in thee groups for a discussion on how to bridge these gaps, and each group after having deliberated it made a presentation in the plenary sessions of others to contribute as well. Finally a set of identified gaps for the each indicator saw the recommendations to bridge the gaps.

During the brainstorming session that followed, participants discussed ways and means of doing this over the next three years.

Sharing at South Asia Breastfeeding Partner's Forum and developing Action plan 2009-2011

These findings of the assessment and the set of recommendations were shared at the South Asia Breastfeeding Partner's Forum in Bhutan, during the month of October along with seven countries. An action plan for three years was then developed using the experience and lesions from each country on how to deal with the gaps identified. Annexure-5 shows India plan 2009-2011.

The draft report was then prepared and circulated among the partcipants and inputs received have also been taken into account in completion of this report.

Partner Organisations

1. Breastfeeding Promotion Network of India (BPNI)
2. Federation of Obstetric & Gynaecological Societies of India (FOGSI)
3. Indian Academy of Pediatrics (IAP)
4. Indian Association of Preventive and Social Medicine (IAPSM)
5. Indian Council of Medical Research (ICMR)
6. International Baby Food Action Network (IBFAN), Asia
7. Jan Swasthya Abhiyan (JSA)
8. Mobile Crèches
9. National AIDS Control Organisation (NACO)
10. National Health Systems Resource Centre (NHSRC)
11. Office of Commissioners to the Supreme Court on Right to Food (CWP 196/2001).
12. Public Health Resource Network (PHRN)
13. Trained Nurses' Association of India (TNAI)
14. United Nations Children's Fund (UNICEF)

Assessment findings

The WBT*i* has identified 15 indicators in two parts, each indicator having specific significance.

1. Part-I deals with infant feeding practices (indicator 1-5)
2. Part II deals with policy and programmes (indicator 6-15)

Part 1: Infant and Young Child Feeding Practices

The Part I include specific numerical data on each infant and young child feeding practice from a random household survey that is national in scope. Part I assessment finding is about infant and young child feeding practices, which is the actual result of how policy and programmes support these practices to happen in the communities.

Five indicators 1-5 are dealt with separately. In the description of each indicator, there is a key question addressing the indicator itself followed by its background. Then the result of the indicator is expressed in numeric value, with percentage along with a graph.

Then comes the rating and grading system as per WBT*i* guidelines. The indicator result is given in first column, WHO's key to rating and WBT*i* guidelines in the next column. WBT*i* tool kit helps to provide this scoring as well as colour rating and grading.

Source of this result, year and its scope is mentioned next.

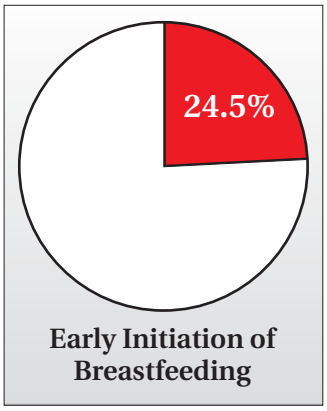
Summary comment is given in the end of each 1-5 indicator, which provides its progress, as well as any other important related information.

The toolkit uses the data that is fed into it, and rates and grades it into colours i.e. Red or grade 'D', Yellow or grade 'C', Blue or grade 'B' and Green or grade 'A'. The cut off points for each of these levels of achievement were selected systematically, based on the WHO's "Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". WBT*i* used the key to rating as of WHO's tool.

Indicator 1: Early Initiation of Breastfeeding

Key question: *Percentage of babies breastfed within one hour of birth*

Background: Many mothers, in the world, deliver their babies at home, particularly in the developing countries and more so in the rural areas. Breastfeeding is started late in many of these settings due to cultural or other beliefs. According to the new guidelines in Baby Friendly Hospital Initiative (BFHI) "Step" 3 of the *Ten Steps to Successful Breastfeeding*, the baby should be placed "skin-to-skin" with the mother in the first half an hour following delivery and offered the breast within the first hour in all normal deliveries. If the mother has had a cesarean section the baby should be offered breast when mother is able to respond and it happens within few hours of the general anesthesia also. Mothers who have undergone cesarean sections need extra help with breastfeeding otherwise they initiate breastfeeding much later. Optimally, the baby should start to breastfeed before any routine procedure (such as bathing, weighing, umbilical cord care, administration of eye medications) is performed. Early breastfeeding helps better temperature control of the newborn baby, enhances bonding between the mother and the baby, and also increases chances of establishing exclusive breastfeeding early and its success. Evidence from a large community study has established early initiation as a major intervention to prevent neonatal mortality.



Early Initiation of Breastfeeding

Indicator/ Result: Early Initiation of Breastfeeding **24.5%**

Score, colour-rate and grade

Indicator 1	WHO's *Key to rating %*	Existing Status %	IBFAN Asia Guideline for WBT*i*		
			Scores	*Colour-rating*	*Grading*
Initiation of Breastfeeding (within 1 hour)	0-29	**24.5%**	3	RED	D
	30-49		6	YELLOW	C
	50-89		9	BLUE	B
	90-100		10	GREEN	A

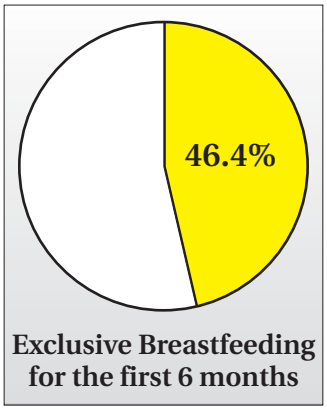
Source: National Family Health Survey (NFHS)-3, International Institute for Population Science, 2005-2006

Summary Comments: India's early initiation rate is among the worst, not even a quarter of women - from about 20 million are able to begin breastfeeding within one hour of birth, in spite of the fact that it has huge implication on the success of exclusive breastfeeding later and also on newborn infections and mortality according to the available evidence. There are encouraging reports now available that shows significant progress being made in some states after 2007. This is a positive development. However is some states there has been a further decline, particularly in those states where institutional deliveries have gone up, which is disturbing. Much more needs to be done to reach out to all women locally with correct information and to provide practical support for breastfeeding at the time of birth. More and intense support is required for the low birth weight babies. Analysis has also shown that this indicator has significant impact on reducing child malnutrition.

Indicator 2: Exclusive breastfeeding for the first six months

Key question: *Percentage of babies 0<6 months of age exclusively breastfed in the last 24 hours*[2]*?*

Background: Exclusive breastfeeding for the first six months is very crucial for survival, growth and development of infants and young children. It lowers the risk of illness, particularly from diarrhoeal diseases. WHO commissioned a systematic review of the published scientific literature about the optimum duration of exclusive breastfeeding and in March 2001, the findings were submitted for technical review and scrutiny during an Expert Consultation. This Expert Consultation recommended a change to exclusive breastfeeding for 6 months from earlier recommendation of 4 months. The World Health Assembly (WHA) in May 2001 formally adopted this recommendation through a Resolution 54.2 /2001. The World Health Assembly in 2002 approved another resolution 55.25 that adopted the *Global Strategy for Infant and Young Child Feeding*. Later the UNICEF Executive Board also adopted this resolution and the Global Strategy for Infant and Young Child Feeding in September 2002, bringing a unique consensus to this health recommendation. Further, in areas with high HIV prevalence there is evidence that exclusive breastfeeding is more protective than "mixed feeding" against risks of HIV transmission through breastmilk. New analysis published in the Lancet clearly points to the role of exclusive breastfeeding during first six months for Infant survival and development.



Exclusive Breastfeeding for the first 6 months

Indicator/ Result: Exclusive breastfeeding for the first six months 46.4%

Score, colour-rate and grade

Indicator 2	WHO's *Key to rating %*	Existing Status %	IBFAN Asia Guideline for WBT*i*		
			Scores	*Colour-rating*	*Grading*
Exclusive breastfeeding for the first six months	0-11		3	RED	D
	12-49	46.4%	6	YELLOW	C
	50-89		9	BLUE	B
	90-100		10	GREEN	A

Source: *National Family Health Survey (NFHS)-3, International Institute for Population Science, 2005-2006*

Summary Comments

Exclusive breastfeeding is much more a complex behaviour, it needs behaviour change at many specific times. For example, giving nothing other than mother's milk right from birth to six months is met with several challenges including cultural practices, lack of proper information and above all strong interference by the commercial sector that aggressively promotes formula in the health systems. This is why not much has changed since 15 years, when the benefits of exclusive breastfeeding started to become known. It is clear that giving simple information is not enough. This area needs a lot more attention: women need counselling on optimal

[2] Exclusive breastfeeding means the infant has received only breastmilk (from his/her mother or a wet nurse, or expressed breastmilk) and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

practices on a continued basis, beginning from pregnancy. Women also need support at the work place in the form of crèches; informal sector needs to take measure that would allow mothers and babies to be together for six months of life. Improving exclusive breastfeeding would be a critical input to check the rise of malnutrition, which goes on increasing from 15% to 30% during this period as per NFHS 3.

Indicator 3: Median duration of breastfeeding

Key question: *Babies are breastfed for a median duration of how many months?*

Background: The *Innocenti Declaration* and the *Global Strategy for Infant and Young Child Feeding* recommend that babies continue to be breastfed for two years of age or beyond along with adequate and appropriate complementary foods starting after six months of age. Breastmilk continues to be an important source of nutrition and fluids and immunological protection for the infant and the young child. The continued closeness between mother and child provided by breastfeeding helps in optimal development of the infant and young child.

Indicator/ Result: Median duration of breastfeeding **24.4months**

Score, colour-rate and grade

Indicator 3	WHO's *Key to rating*	Existing Status %	IBFAN Asia Guideline for WBT*i*		
			Scores	*Colour-rating*	*Grading*
Median Duration of Breastfeeding	0-17 Months		3	RED	D
	18-20 Months		6	YELLOW	C
	21-22 Months		9	BLUE	B
	23-24 Months	24.4 months	10	GREEN	A

Source: *National Family Health Survey (NFHS)-3, International Institute for Population Science, 2005-2006*

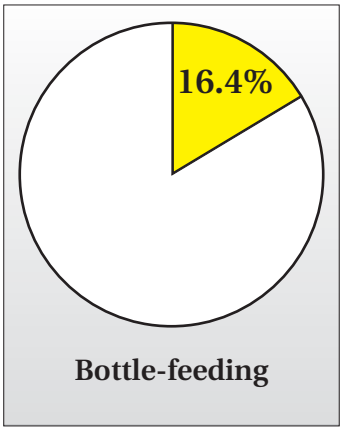
Summary Comments

Median duration of breastfeeding is excellent in India, which has been traditionally a breastfeeding nation. In fact what India is losing is value of breastfeeding during second year of life along with complementary feeding. However, even this period has shown a decrease since NFHS-2. It is important that focus is maintained on this indicator so that no further drop occurs.

Indicator 4: Bottle feeding

Key question: *What percentage of breastfed babies less than 6 months old receives other foods or drinks from bottles?*

Background: Babies should be breastfed exclusively for first 6 months of age and they need not be given any other fluids, fresh or tinned milk formulas as this would cause more harm to babies and replace precious breastmilk. Similarly after six months babies should ideally receive mother's milk plus solid complementary foods. If a baby cannot be fed the breastmilk from its mother's breast, it should be fed with a cup. (If unable to swallow, breastmilk can be provided by means of an infant feeding tube.) After 6 months of age, any liquids given should be fed by cup, rather than by bottle. Feeding bottles with artificial nipples and pacifiers (teats or dummies) may cause 'nipple confusion' and infants' refusal of the breast after their use. Feeding bottles are more difficult to keep clean than cups and the ingestion of pathogens can lead to illness and even death. Pacifiers also can easily become contaminated and cause illness.



Indicator/ Result: Bottle feeding 16.4%

Score, colour-rate and grade

Indicator 4	WHO's *Key to rating %*	Existing Status %	IBFAN Asia Guideline for WBT*i*		
			Scores	*Colour-rating*	*Grading*
Bottle feeding (<6 months)	30-100%		3	RED	D
	5-29%	**16.4%**	**6**	YELLOW	**C**
	3-4%		9	BLUE	B
	0-2%		10	GREEN	A

Source: *National Family Health Survey (NFHS)-3, International Institute for Population Science, 2005-2006*

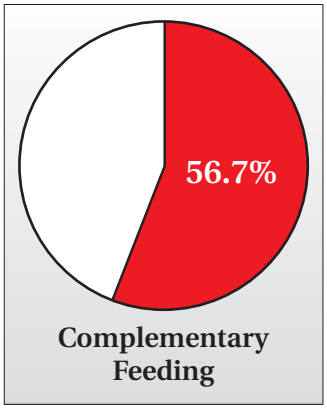
Summary Comments

Bottle-feeding is on the rise; urbanisation and so-called development is leading it. One of the major reasons is that it is seen as a modern method of feeding and is not perceived to be harmful. Communication is required to create public awareness about the harmful effects of formula feeding and bottle- feeding. This would be a most beneficial again at the local level.

Indicator 5: Complementary feeding

Key question: *Percentage of breastfed babies receiving complementary foods at 6-9 months of age?*

Background: As babies grow continuously and need additional nutrition along with continued breastfeeding after they are 6 months of age, complementary feeding should begin with locally available, affordable and sustainable indigenous foods. Babies should be offered soft or mashed foods in small quantities, 3-5 times a day. Complementary feeding should gradually increase in amount and frequency as the baby grows. Breastfeeding on demand should continue for 2 years or beyond. Complementary feeding is also important from the care point of view: the caregiver should continuously interact with the baby and take care of hygiene to keep it safe.



The indicator proposed here measures only whether complementary foods are provided in a timely manner, after 6 months of age along with breastfeeding. Complementary feeds should also be adequate, safe and appropriately fed, but indicators for these criteria are not included because data on these aspects of complementary feeding are not yet available in many countries. It is useful to know the median age for introduction of complementary foods, what percentage of babies are not breastfeeding at 6-9 months and also how many non-breastfeeding babies are receiving replacement foods in a timely manner. These figures can help in determining whether it is important to promote longer breastfeeding and/or later or earlier introduction of complementary foods. This information should be noted, if available, although it is not scored. It is also possible to generate more information as additional and help guide local program.

Indicator/ Result: Complementary breastfeeding **56.7%**

Score, colour-rate and grade

Indicator 5	WHO's *Key to rating*	Existing Status %	IBFAN Asia Guideline for WBT*i*		
			Scores	*Colour-rating*	*Grading*
Complementary Feeding (6-9 months)	0-59%	**56.7%**	3	RED	D
	60-79%		6	YELLOW	C
	80-94%		9	BLUE	B
	95-100%		10	GREEN	A

Source: *National Family Health Survey (NFHS)-3, International Institute for Population Science, 2005-2006*

Summary Comments

This indicator is very important to India, and the positive point is that during the last five to seven years the complementary feeding rates have improved from 33% to 56%. What is needed is to enhance the quality of complementary feeding and sustain it. Again a complex practice, optimal complementary feeding needs accurate information and intense counselling. For food insecure populations support to family is also required in procuring food. Skilled counselling is required along with the learning to make adequate and appropriate foods at home.

COMPARISON WITH 2005 ASSESSMENT

While initiation of breastfeeding seems to have improved from NFHS-2 (1998-99) from 15.8% to 24.5%, and complementary feeding initiation between 6-9 months has gone up from 35% to 56.7%, three indicators seem to have worsened. Exclusive breastfeeding for the first six months has dropped from 46.9% to 46.4%, median duration of breastfeeding from 25.4 months to 24.4 months, while bottle feeding has increased from 13.7% to 16.4%. Existing status in all above-mentioned indicators was determined on the basis of NFHS-3 data.

Indicator	Status in the assessment in 2005	Current status 2008
1. Percentage of babies breastfed within one hour of birth	15.8%	24.5%
2. Percentage of babies of 0<6 months of age exclusively breastfed in the last 24 hours	46.9%	46.4%
3. Babies are breastfed for a median duration of how many months	25.4months	24.4 months
4. Percentage of breastfed babies less than 6 months old receiving other foods or drink from bottles	13.7%	16.4%
5. Percentage of breastfed babies receiving complementary foods at 6-9 months of age	35%	56.7%

Given the fact that each indicator 1-5 needs effective action plan, and unlikely to improve with current level of activity, India needed to think seriously to have a concrete plan of action with a budgetary provision and a mechanism of accountability established. Once this is in place communication for people to know about these activities along with accountability should be put in place. Following indicators 6-15 would have to implemented effectively if at we wanted to change the existing practices towards the GREEN rating.

Part II: IYCF Policies and Programmes

Part II deals with policy and programmes. In fact it is a comprehensive study of the back end support to achieve indicators 1-5.

The description of indicators 6-15 again begins with a key question and its background. It is followed by a result that is given in the table format and depicts subset of questions that have been answered using the available information, documentation and sometimes observations. Another column shows the relevant result checked in the column opposite the subset of questions.

This result is then scored and rated according to the WBT*i* guidelines. Each indicator has a maximum score of ten. There are some subset of questions that are of subjective nature and have been answered using available information and consensus among the core group.

Achievement is given a tick in the Results column. Rest is a deficit except in indicator 8 in which it is progressive in nature. Total score of each indicator is given at the and of the table.

Next is the areas where gaps have been found and recommendations to bridge these gaps developed in discussion with the national groups.

Sources of these findings provided altogether at the end of Part-II finding.

Summary comments in the end provide other relevant information and progress on these indicators.

In Part II a set of criteria has been developed for each target based on the *Innocenti Declaration* and beyond, i.e. considering most of the targets of the *Global Strategy*. For each indicator there is a subset of questions leading to key achievement, indicating how a country is doing in a particular area. Each question has possible score of 0-3 and the indicator has a maximum score of 10. Once information about the indicators is entered, the achievement on the particular target indicator is then rated and graded i.e. Red or grade 'D', Yellow or grade 'C', Blue or grade 'B' and Green or grade 'A'. After the tool kit provides the scores, it uses following guidelines for rating.

IBFAN Asia Guideline for WBT*i*

Scores	*Colour-rating*	*Grading*
0 - 3	RED	D
4 - 6	YELLOW	C
7 - 9	BLUE	B
More than 9	GREEN	A

Indicator 6: National Policy, Programme and Coordination

Key question: *Is there a national infant and young child feeding/breastfeeding policy that protects, promotes and supports optimal infant and young child feeding and the policy is supported by a government programme? Is there a mechanism to coordinate like National Infant and Young Child Feeding Committee and Coordinator?*

Background: The *Innocenti Declaration* was adopted in 1990. It recommended that all governments have national breastfeeding committees and coordinators as established mechanisms to protect, promote and support breastfeeding in the country. The World Summit for Children (2000) recommended all governments to develop national breastfeeding policies. The *Global Strategy for Infant and Young Child Feeding* calls for urgent action from all member states to develop, implement, monitor and evaluate a comprehensive policy on IYCF.

The table given below depicts the existing situation in India on National Policy, Programme and Coordination.

	Criteria of Indicator 6	Scoring	Results
6.1	A national Infant and Young Child Feeding/ Breastfeeding policy has been officially adopted/ approved by the government	2	
6.2	The policy promotes exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	2	
6.3	A National Plan of Action has been developed with the policy	2	
6.4	The plan is adequately funded	1	
6.5	There is a National Breastfeeding Committee	1	✓
6.6	The National Breastfeeding (Infant and Young Child Feeding) Committee meets and reviews on a regular basis	1	
6.7	The National Breastfeeding (Infant and Young Child Feeding) Committee links with all other sectors like health, nutrition, information etc., effectively	0.5	✓
6.8	Breastfeeding Committee is headed by a coordinator with clear terms of reference	0.5	✓
	Total Score	**2/10**	

Indicator 6 deals with national policy, programs and coordination. It deals with issues related to national policy on IYCF, national plan of action based on the national policy, national breastfeeding committee and financial allocations for IYCF. Discussion on the issue was based on National Guidelines on IYCF, 11th Plan goals, National Nutrition Policy, draft National Plan of Action, RTI replies received from the Ministry of Women and Child Development and minutes of the National Breastfeeding Committee meetings.

Gaps

The group found that our country does have a very good document in the form of National Guidelines for IYCF, which is consistent with *Global Strategy for Infant and Young Child Feeding*. During the previous assessment, the document was considered a policy on the condition that action to strengthen it would be taken. As this has not happened, the group agreed that the National Guidelines should not be considered as a policy for this assessment. The group also observed that a plan of action was developed with a lot of effort but has not been put into practice except doing adhoc actions. Key gaps identified include

1. Lack of effective coordination mechanisms though structures do exist.
2. Lack of policy status for National Guidelines on Infant and Young Child Feeding.
3. Guidelines do not have a clear plan with objectives and allocated budget.

Recommendations

NBC/National IYCF Committee should be replaced by National IYCF/Breastfeeding Authority to ensure budgeted plan of action and coordination at all levels from nation to states. This will ensure moving away from ad hoc to more coordinated actions.

- Draft National Plan of Action to be adopted as a policy
- Separate funding to protect, promote and support breastfeeding infant for 0-6 months should be made available to ensure women are supported and are able to stay close to babies.

Summary Comments

Policy issues on breastfeeding or infant and young child feeding have so far been neglected except having legislation in place, which will be dealt in another indicator. Over the past three years there has been some discussions on the policy issues; however no action is taken so far to make this issue a priority among child health or nutrition interventions. The National Guidelines on Infant and Young Child Feeding is a wonderful document; if given the shape of policy and implemented, with an allocated budget, it could move things in the right direction.

Indicator 7: Baby Friendly Hospital Initiative (Ten steps to successful breastfeeding)

Key question:

7A) What percentage of hospitals and maternity facilities that provide maternity services have been designated "Baby Friendly" based on the global or national criteria?

7B) What is the skilled training inputs and sustainability of BFHI?

7C) What is the quality of BFHI program implementation?

Background: The *Innocenti Declaration* calls for all maternity services to fully practise all the Ten Steps to Successful Breastfeeding set out in *Protecting, promoting and supporting breastfeeding: the special role of maternity services, a Joint WHO/UNICEF Statement*. UNICEF's 1999 Progress Report on BFHI lists the total number of hospitals/maternity facilities in each country and the total number designated "Baby Friendly". According to the Step 2 of ten steps, all staff in maternity services should be trained in lactation management. UNICEF and WHO recommend that all staff should receive at least 18 hours of training and that higher level of training is more desirable. Several countries initiated action on BFHI; however, progress made so far has been in numbers mostly and reports suggest that fall back happens if the skills of health workers are not sufficiently enhanced. The *Global Strategy for Infant and Young Child Feeding* indicates that revitalization of BFHI is necessary and its assessment is also carried out periodically to sustain this programme and contribute to increase in exclusive breastfeeding.

The indicator focuses on both quantitative and qualitative aspects. It looks at the percentage of hospitals and maternity facilities designated BFHI and also at the programme quality, e.g., skilled training inputs in BFHI, which is key to sustaining it, and how it is monitored and evaluated.

The tables given below depict the existing situation in India on BFHI

7A) Quantitative

7.1) What percentage of hospitals and maternity facilities that provide maternity services have been designated "Baby Friendly" based on the global or national criteria?

Criteria	Scoring	Results
0 - 7%	1	
8 - 49%	2	✓
50 - 89%	3	
90 - 100%	4	
Rating on BFHI quantitative achievements:	**2/4**	

7B) Qualitative

7.2) What is the skilled training inputs and sustainability of BFHI?

BFHI designated hospitals that have been certified after a minimum recommended training of 18 hours for all its staff working in maternity services

Criteria	Scoring	Results
0 - 25%	1	
26 - 50%	1.5	✓
57 - 75%	2.5	
75% and more	3.5	
Total Score	**1.5/3.5**	

Qualitative

7C) What is the quality of BFHI program implementation?

	Criteria	Scoring	Results
7.3	BFHI programme relies on training of health workers	0.5	
7.4	A standard monitoring system is in place	0.5	
7.5	An assessment system relies on interviews of mothers	0.5	✓
7.6	Reassessment systems have been incorporated in national plans	0.5	
7.7	There is a time-bound program to increase the number of BFHI institutions in the country	0.5	
	Total Score	**0.5/2.5**	
	Total Score 7A, 7B and 7C	**4.0/10**	

Indicator 7 deals with quantitative as well as qualitative issues related to the Baby Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding). The discussion was based on NIPCCD report on multi-country study on infant and young child feeding, BFHI concept document from Ministry of Health and Family Welfare, Govt. of India, a published chapter on BFHI in the book titled "Science of Infant Feeding" and the invitation to BPNI from Ministry of Health and Family Welfare to discuss revitalizing BFHI.

Gaps

The group agreed that the following gaps exist. In fact the status seems to the same.

1. No sustained action to revive BFHI
2. No mention of BFHI in NRHM document, especially with reference to hospitals and nursing homes that will be contracted for conducting deliveries under Janani Suraksha Yojna
3. BFHI has not shown any progress from 2005 in any manner, whether quantity of quality.

Recommendations

- Immediate steps should be taken to revive the BFHI programme
- Under the NRHM, at least 20% of all hospitals should move to attain BFHI status in 2 years' time
- BFHI should be prominently placed in all child health policies and programmes
- Health MIS should include BFHI

Summary Comments

Baby Friendly Hospital initiate (BFHI) was aimed at improving the standard of care in the health facilities through improved early and exclusive breastfeeding. The design also included continued support in the community through fostering support groups. This element never got any attention. Whatever was implemented earlier also did not look at quality inputs required to provide skills to health workers who actually assist in delivery in the health facility. Several reasons account for lack of attention to this indicator, including lot of opposition to the title of the initiative and calling a facility baby friendly only on the basis of breastfeeding. Attention also shifted within agencies that have been supporting it. The Government of India continued to discuss the issue, but policy decisions could not be taken. Improving breastfeeding intervention is becoming more relevant now because more and more women deliver in health institutions and HIV is also making its inroads. This should be looked as a standard of care in health facility.

Indicator 8: Implementation of the International Code

Key question: *Are the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolution given effect and implemented? Has any new action been taken to give effect to the provisions of the Code?*

Background: The *Innocenti Declaration* calls for all governments to take action to implement all the articles of the *International Code of Marketing of Breastmilk Substitutes* and the subsequent World Health Assembly resolutions. The aim of the Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. The "State of the Code by Country" by the International Code Documentation Centre (ICDC) on countries' progress in implementing the Code provides sufficient information on the action taken.

Nations are supposed to enact legislation as a follow-up to this. Several relevant subsequent World Health Assembly resolutions, which strengthen the *International Code of Marketing of Breastmilk Substitutes* have been adopted since then and have the same status as the Code and should also be considered. The *Global Strategy for Infant and Young Child Feeding* calls for heightened action on this target. According to WHO, 162 out of 191 Member States have taken action to give effect to the Code, but the ICDC report brings out the fact that only 32 countries have so far brought national legislation that fully covers the Code. The ICDC uses criteria to evaluate the type of action.

The Code has been reaffirmed by the World Health Assembly several times while undertaking resolutions regarding various issues related with infant and young child feeding.

The table given below depicts the existing situation in India on Implementation of the International Code.

	Criteria	Scoring	Results
8.1	No action taken	0	
8.2	The best approach is being studied	1	
8.3	National breastfeeding policy incorporating the Code in full or in part but not legally binding and therefore unenforceable	2	
8.4	National measures (to take into account measures other than law), awaiting final approval	3	
8.5	Administrative directive/circular implementing the Code in full or in part in health facilities with administrative sanctions	4	
8.6	Some articles of the Code as a voluntary measure	5	
8.7	Code as a voluntary measure	6	
8.8	Some articles of the Code as law	7	
8.9	All articles of the Code as law	8	✓
8.10	All articles of the Code as law, monitored and enforced	10	
	Total Score	**8/10**	

Indicator 8 deals with implementation of the International Code. It addresses issues related to adoption of the Code as national legislation. The discussion was based on the published gazette notifications and published text of the IMS Act. The group looked at continued activities of baby food industry in the health system and realised that this particular area needs more attention.

Gaps

While the group acknowledged that the country has done exceedingly well in enacting and subsequently suitably amending the legislation based on the International Code, the following gaps exist:

1. Inadequate mechanisms to enforce *"The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992", as Amended in 2003* (IMS Act).
2. Inadequate mechanisms for reporting violations at state and district levels
3. District officials are not trained in monitoring the implementation of IMS Act as well as their information about the provisions of the IMS Act is very poor.

Recommendations

- IMS Act should be enforced effectively, explicit monitoring mechanisms at state and district level should be in place.
- Enforcement of the IMS Act to be made more effective
- Reporting of the violations of the Act to be made more easy
- State-wise nominations of the nodal officers for monitoring and implementation of the Act

Summary Comments

India has been in the forefront of implementing the Code, and was one of the few in the world to legislate as a follow up to the International Code. It has certainly been able to bring about the down promotion to people directly through electronic or print media. It has also clearly included all baby foods for children up two years and banned any promotion. Even though there is clear clause to ban sponsorship of the medical personnel, companies continue to find ways and means to reach out to doctors to support their activities. This area needs effective enforcement of the Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 as amended in 2003.

Indicator 9: Maternity Protection

Key question: *Is there legislation and are there other measures (policies, regulations, practices) that meet or go beyond the International Labor Organization (ILO) standards for protecting and supporting breastfeeding for mothers, including those working mothers in the informal sector?*

Background: The *Innocenti Declarations* (1999, 2005) and WHO *Global Strategy for IYCF* (2002) call for provision of imaginative legislation to protect the breastfeeding rights of working women and further monitoring of its application consistent with *ILO Maternity Protection Convention No 183, 2000* (MPC No. 183) and Recommendation 191. MPC No. 183 specifies that women workers should receive:

- Health protection, job protection and non-discrimination for pregnant and breastfeeding workers
- At least 14 weeks of paid maternity leave
- One or more paid breastfeeding breaks daily or daily reduction of hours of work to breastfeed

Furthermore, Recommendation 191 encourages facilities for breastfeeding to be set up at or near the workplace.

The concept of maternity protection involves 7 aspects: 1) the scope (in terms of who is covered); 2) leave (length; when it is taken, before or after giving birth; compulsory leave); the amount of paid leave and by whom it is paid employer or government; 3) cash and medical benefits; 4) breastfeeding breaks; 5) breastfeeding facilities; 6) health protection for the pregnant and lactating woman and her baby; 7) employment protection and non-discrimination.

Only a limited number of countries have ratified C183, but quite a few countries have ratified C103 and/or have national legislation and practices which are stronger than the provisions of any of the ILO Conventions.

Maternity protection for all women implies that women working in the informal economy should also be protected. *Innocenti Declaration* 2005 calls for urgent attention to the special needs of women in the non-formal sector.

Adequate maternity protection also recognizes the father's role in nurturing and thus the need for paternity leave.

The table below depicts the existing situation in India on Maternity Protection.

	Criteria	Scoring	Results
9.1	Women covered by the national legislation are allowed the following weeks of paid maternity leave		
	a. Any leave less than 14 weeks	0.5	✓
	b. 14 to 17weeks	1	
	c. 18 to 25 weeks	1.5	
	d. 26 weeks or more	2	
9.2	Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily.	1	
	a. Unpaid break	0.5	
	b. Paid break	1	✓
9.3	Legislation obliges private sector employers of women in the country to give at least 14 weeks paid maternity leave and paid nursing breaks.	1	
9.4	There is provision in national legislation that provides for work site accommodation for breastfeeding and/ or childcare in work places in the formal sector.	1	✓
9.5	Women in informal/unorganized and agriculture sector are:	1	
	a. accorded some protective measures	0.5	✓
	b. accorded the same protection as women working in the formal sector	1	
9.6	a. Information about maternity protection laws, regulations, or policies is made available to workers	0.5	✓
	b. There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.'	0.5	
9.7	Paternity leave is granted in public sector for at least 3 days.	0.5	✓
9.8	Paternity leave is granted in the private sector for at least 3 days.	0.5	
9.9	There is legislation providing health protection for pregnant and breastfeeding workers and the legislation provides that they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.	0.5	✓
9.10	There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	0.5	✓
9.11	ILO MPC No 183 has been ratified, or the country has a national law equal to or stronger than C183.	0.5	
9.12	The ILO MPC No 183 has been enacted, or the country has enacted provisions equal to or stronger than C183.	0.5	
	Total Score	**5.0/10**	

Indicator 9 pertains to Maternity Protection. It includes duration of maternity leave for the formal and informal sector, inclusion of mother friendly work place in national legislation and country's status on ratifying and enacting ILO MPC 183.

The discussions acknowledged that there has been some advances in this sector. However, much remains to be done for women working in the informal sector. In 2008, maternity leave for women working in the central government has been extended to six months; they can now avail of paid leave up to two years for child care, before the child is 18 years of age. Three more states have maternity leave for six months. The state of Tamil Nadu has taken the initiative to launch the Muthulakshmi Reddy Scheme that provides Rs 6000 to women below the poverty line over a period of six months to support late pregnancy and lactation. The 11th Plan has recommended that other states also follow suit. However, it is not yet certain in what manner this scheme is due to be universalised. The group also noted that while no legislation exists, the Integrated Child Development Scheme (ICDS) programme intervenes with nutritional assistance and health care for pregnant and lactating women. The Supreme Court Order of 13th December 2006 directs the government to universalise this. The 11th Plan Document highlights the need for giving women nutritional and financial assistance during lactation.

Gaps

In spite of the advances, the group identified the following gaps:

1. There is no policy framework for protecting and supporting breastfeeding in private sector and informal sector
2. There is no legislation that covers the above sectors
3. Maternity leave does not cover all states, only the central government employees
4. Paternity leave does not cover all state governments and private sector
5. No monitoring mechanism for implementation of maternity protection as part of policy framework

Recommendations

- There should be policy framework for protecting and supporting breastfeeding for mothers including working mothers in the informal sector
- This should translate to actual mechanism for implementation and adequate budgetary allocations
- Contractual workers with public and private sector should also be covered for the maternity leave
- An umbrella legislation for both formal and informal sector is required
- Six months maternity leave and paternity leave should be expanded to state government and private sector
- There should be a monitoring mechanism for implementation for maternity protection (at par with the PNDT Act), as a part of the policy framework

Summary Comments

This indicator is critical for successful breastfeeding; unless the mother and the baby are together, it would not be possible to enhance exclusive breastfeeding in the target populations. However it is also important to note that all other actions for promotion and protection must also be in place to realize the benefits of maternity entitlements otherwise women may still fall out of exclusive breastfeeding and adopt harmful artificial feeding practices if they don't have access to accurate and unbiased information and counselling on breastfeeding and complementary feeding.

Indicator 10: Health and Nutrition Care Systems

Key question: *Do care providers in these systems undergo skills training, and do their pre-service education curriculum support optimal infant and young child feeding; do these services support mother and breastfeeding friendly birth practices, do the policies of health care services support mothers and children, and whether health workers responsibilities to Code are in place?*

Background: The *Global Strategy for Infant and Young Child Feeding* indicates clearly how to achieve its targets and improving these services is critical for this. It has been documented that curriculum of providers is weak on this issue. And it is also seen that many of these health and nutrition workers lack adequate skills in counselling for infant and young child feeding which is essential for the success of breastfeeding.

Ideally, new graduates of health provider programmes should be able to promote optimal infant and young child feeding practices from the outset of their careers. All providers who interact with mothers and their young children should attain the basic attitudes, knowledge and skills necessary to integrate breastfeeding counselling, lactation management, and infant and young child feeding into their care. The topics can be integrated at various levels during education and job. Therefore the total programme should be reviewed to assess this.

The table given below depicts the existing situation in India on Health and Nutrition Care System.

	Criteria	Results		
		Adequate	Inadequate	No reference
10.1	A review of health provider schools and pre-service education programmes in the country indicates that infant and young child feeding curricula or session plans are adequate/inadequate	2	1 ✓	0
10.2	Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care.	2	1 ✓	0
10.3	There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers.	2	1 ✓	0
10.4	Health workers are trained with responsibility towards Code implementation as a key input.	1	0.5	0 ✓
10.5	Infant feeding-related content and skills are integrated, as appropriate, into training programmes focusing on relevant topics (diarrhoeal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, etc.)	1	0.5 ✓	0

	Criteria	Results		
		Adequate	Inadequate	No reference
10.6	These in-service training programmes are being provided throughout the country.	1	0.5 ✓	0
10.7	Child health policies provide for mothers and babies to stay together when one of them is sick	1	0.5	0 ✓
	Total Score	**4/10**		

The indicator 10 reviews schools and pre-service education programmes for the health providers, standards and guidelines for mother-friendly childbirth procedures and support, in-service training programmes providing knowledge and skills related to infant & young child feeding. etc.

Gaps

The group identified the following gaps:

1. There is no practical training given to doctors and nurses on IYCF in pre-service education
2. Listening and counselling skills for IYCF not part of pre-service or in-service training of AWW, ANM and ASHA

Recommendations

- IYCF training of doctors and nurses during their internship
- District health authorities should be responsible for monitoring of AWW, ASHA training
- ASHA refresher course to contain IYCF training

Summary Comments

Universalising early initiation and exclusive breastfeeding requires that all health workers, from health professionals in facilities to frontline workers in the community are trained adequately in IYCF and in listening and counselling skills. While there are some efforts to include such skills in the curriculum of medical colleges, this needs to be extended to cover all medical, nursing, and ANM training colleges. The time allotted to training on IYCF for frontline workers should be extended and the curricula should include not just information but also skills in listening and counselling.

Indicator 11: Mother Support and Community Outreach - Community-based Support for the pregnant and breastfeeding mother

Key question: *Do care providers in these systems undergo skills training, and do their pre-service education curriculum support optimal infant and young child feeding; do these services support mother and breastfeeding friendly birth practices, do the policies of health care services support mothers and children, and whether health workers responsibilities to Code are in place?*

Background: Community-based support for women is essential for succeeding in optimal breastfeeding practices. Step 10 of BFHI and the Global Strategy for IYCF, which includes mother support and peer support, recognizes this need. Mother Support, as defined by the Global Initiative for Mother Support (GIMS) is

> "any support provided to mothers for the purpose of improving breastfeeding practices for both mother and infant and young child." Women need the support of evidence-based public health policies, health providers, employers, friends, family, the community, and particularly of other women and mothers."

Mother support is often seen as woman-to-woman (or more commonly known as mother-to-mother) but generally covers accurate and timely information to help a woman build confidence; sound recommendations based on up-to-date research; compassionate care before, during and after childbirth; empathy and active listening, hands-on assistance and practical guidance. It also includes support and counselling by health professionals and health care workers. Various community outreach services can also support women in optimal IYCF.

The activities in these contexts include woman-to-woman support, individual or group counselling, home visits or other locally relevant support measures and activities that ensure that women have access to adequate, supportive and respectful information, assistance and counselling services on infant and young child feeding. Mother support enhanced by community outreach or community-based support has been found to be useful in all settings to ensure exclusive breastfeeding for the first six months and continued breastfeeding with appropriate and local complementary foods for 2 years or more. There needs to be a review and evaluation of existing community support systems, especially for the provision of counselling in infant and young child feeding. Women who deliver in a hospital need continued support in the home and in the community, with support for all members of the family, including the father and grandmother of the baby.

Crèches are an important community based system of offering support to mothers for IYCF. In this regard, India has not progressed significantly. However, as with maternity entitlements, the 11th Plan makes a recommendation for expansion of crèche services and anganwadi cum crèches to be set up. It remains to be seen whether this will be actualised. The National Rural Employment Guarantee Act (NREGA) provides for one woman to be paid through the National Rural Employment Guarantee Scheme funds to look after children if five or more children accompany the women to the worksite.

The table below depicts the existing situation in India on Mother Support and Community Outreach.

	Criteria	Results		
		Yes	To some degree	No
11.1	All pregnant women have access to community-based support systems and services on infant and young child feeding.	2	1 ✓	0
11.2	All women have access to support for infant and young child feeding after birth.	2	1 ✓	0
11.3	Infant and young child feeding support services have national coverage.	2	1 ✓	0
11.4	Community-based support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development strategy (inter-sectoral and intra-sectoral.	2	1	0 ✓
11.5	Community-based volunteers and health workers possess correct information and are trained in counselling and listening skills for infant and young child feeding.	2	1 ✓	0
	Total Score	**4/10**		

The indicator 11 includes issues like access to counselling services on infant and young child feeding in the community during pregnancy and after birth and access to crèche and childcare facilities that will enable women to carry out exclusive breastfeeding. It also deals with status of skilled training to the counsellors. The group noted that according to NFHS 3, only 10.7% women are informed about supplementary food by the community health worker.

Gaps

Gaps identified include:

1. Counselling for IYCF is not provided as a service to lactating women in NRHM or ICDS
2. Crèche facilities not mentioned in either NREGA or Unorganised Workers Bill

Recommendations

- NREGA should have provision for Crèches
- AWW should be trained as IYCF counsellor and IYCF counselling should be provided as a service to lactating women.
- Unorganized workers' bill should contain provision for crèches
- Expansion of the Rajiv Gandhi Scheme, ICDS; 11th Plan recommendations must be implemented
- Crèches at the worksite must be implemented and monitored.
- Crèches should be monitored specifically by the WBTi tool as an important agency of support to lactating mothers and IYCF.

Summary Comments

Access to skilled counselling and support for each woman within the community is the key to successful universalisation of optimal IYCF. Though health and child care programmes pay lip service to this, it is not practised at the ground level. Support to breastfeeding women includes

availability of community recognition of the need for exclusive breastfeeding for six months, availability of crèches at worksites with trained functionaries to enable women, especially those working in the unorganized sector, to maintain proximity with their babies. PRI training needs to include orientation on IYCF so that they can monitor provision of services to enable successful exclusive breastfeeding in the community.

Indicator 12: Information Support

Key question: *Are comprehensive Information, Education and Communication (IEC) strategies for improving infant and young child feeding (breastfeeding and complementary feeding) being implemented?*

Background: Information, education and communication (IEC) strategies are critical aspects of a comprehensive programme to improve infant and young child feeding practices. IEC approaches may include the use of electronic (TV, radio, video), print (posters, counselling cards, flip charts, manuals, newspapers, magazines) media, interpersonal (counselling, group education, support groups) and community activities to communicate important information and motivational material to mothers, families and the community.

Behaviour change is an important strategy, often used in counselling sessions, home visits, action-oriented group discussions and dramas focused on problem solving. IEC strategies are comprehensive when they use a wide variety of media and channels to convey concise, consistent, appropriate, action-oriented messages to targeted audiences at national, facility, community and family levels.

The table below depicts the existing situation in India on Information Support.

	Criteria	Results		
		Yes	To some degree	No
12.1	There is a comprehensive national IEC strategy for improving infant and young child feeding.	2	1	0 ✓
12.2	IEC programmes (e.g. World Breastfeeding Week) that include infant and young child feeding are being actively implemented at local levels	2	1 ✓	0
12.3	Individual counselling and group education services related to infant and young child feeding are available within the health/ nutrition care system or through community outreach.	2	1 ✓	0
12.4	The content of IEC messages is technically correct, sound, based on national or . international guidelines.	2 ✓	1	0
12.5	A national IEC campaign or programme using electronic and print media and activities has channelled messages on infant and young child feeding to targeted audiences in the last 12 months.	2	1 ✓	0
	Total Score	**5/10**		

The indicator deals with Information Support. It asks for a comprehensive national IEC strategy and IEC programmes for improving infant and young child feeding. It also looks in to the quality of IEC material developed.

Gaps

The group undertook a general discussion on the subject. Some advertisements were available and many had heard and seen some advertisements on FM radio and TV. But these are sporadic, even though they are by and large technically correct. The group noted that there is no IEC policy on infant and young child feeding available in our country at present. Gaps identified include:

1. Lack of stated strategy on IEC
2. Lack of budget head
3. Inadequate coverage

Recommendations

- Advocacy for comprehensive National IYCF policy that includes an IEC strategy
- Work out and demand a budget for IEC for IYCF (district/block level) with reference to work already done with Planning Commission
- As with other issues related to IYCF this should be located in a national overseeing body

Summary Comments

The ban on promotion of formula feeding in the media has not been accompanied by adequate promotion of early and exclusive breastfeeding for six months and adequate complementary feeding with continued breastfeeding thereafter. Such promotion should not be limited to the World Breastfeeding Week as is the case currently. Policy needs to be developed to communicate and educate on optimal IYCF at all levels, using national media as well as local village level media and appropriate budget allocations needs to be made for this. Districts should get their own budgets for IEC on IYCF.

Indicator 13: Infant Feeding and HIV

Key question: *Are policies and programmes in place to ensure that HIV - positive mothers are informed about the risks and benefits of different infant feeding options and supported in carrying out their infant feeding decisions?*

Background: The Global Strategy for IYCF highlights the importance of correct policy and programme work in this area for achieving the targets. The UN Framework for priority action on infant feeding and HIV activities lists:

1. Develop or revise (as appropriate) a comprehensive national infant and young child feeding policy, which includes HIV and infant feeding.
2. Implement and enforce the International Code of Marketing of Breastmilk substitutes and subsequent relevant WHA resolutions
3. Intensify efforts to protect, promote and support appropriate infant and young child feeding practices in general, while recognizing HIV as one of a number of exceptionally difficult circumstances.
4. Provide adequate support to HIV-positive women to enable them to select the best feeding option for themselves and their babies, and to successfully carry out their infant feeding decisions.
5. Support research on HIV and infant feeding, including operations research, learning, monitoring and evaluation at all levels, and disseminate findings.

The risk of HIV transmission through breastfeeding presents policy makers, infant feeding counsellors and mothers with a difficult dilemma. They must balance the risk of death due to artificial feeding with the risk of HIV transmission through breastfeeding. These risks are dependent on the age of the infant and household conditions and are not precisely known. Other factors must be considered at the same time, such as the risk of stigmatization (e.g. if not breastfeeding may signal the mother's HIV status), the financial costs of replacement feeding and the risk of becoming pregnant again. Policies and programmes to meet this challenge should provide access to HIV voluntary and confidential counselling and testing (VCCT) and, for HIV-positive mothers, counselling and support for the chosen method of feeding, such as safe exclusive breastfeeding or exclusive artificial feeding. Safeguards should be in place to protect, promote and support breastfeeding in the rest of the population.

The table given below depicts the existing situation in India on HIV and Infant Feeding.

	Criteria	Results		
		Yes	To some degree	No
13.1	The country has a comprehensive policy on infant and young child feeding that includes infant feeding and HIV	2	1	0 ✓
13.2	The infant feeding and HIV policy gives effect to the International Code/ National Legislation	1	0.5	0 ✓
13.3	Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.	1	0.5 ✓	0

	Criteria	Results		
		Yes	To some degree	No
13.4	Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.	1	0.5 ✓	0
13.5	Infant feeding counselling in line with current international recommendations and locally appropriate is provided to HIV positive mothers.	1	0.5	0 ✓
13.6	Mothers are supported in making their infant feeding decisions with further counselling and follow-up to make implementation of these decisions as safe as possible.	1	0.5 ✓	0
13.7	Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.	1	0.5	0 ✓
13.8	On-going monitoring is in place to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status.	1	0.5 ✓	0
13.9	The Baby-friendly Hospital Initiative incorporates provision of guidance to hospital administrators and staff in settings with high HIV prevalence on how to assess the needs and provide support for HIV positive mothers.	1	0.5	0 ✓
	Total Score	**2/10**		

Indicator 13 addresses HIV and infant feeding, looking specifically at policy, training and monitoring. The findings were based on following sources:

Website of the national AIDS control organization (NACO); Revised PPTCT training curriculum participants manual. Module 4. Infant feeding in the context of HIV Infection. Dec 2004. published by NACO, UNICEF, WHO, CDC; National Guidelines on Infant and young child feeding, II Edition-2006. Ministry of Women and child development. Food and Nutrition board. Government of India 2006; UNICEF, WHO, NACO, IAP Manual for management of HIV/AIDS in children: Infant feeding policy & practice. 2005;South Asia breastfeeding Partners Forum-4 Report published by BPNI/IBFAN Asia; Dr. R.K.Aggarwal President IAP in President's page in Indian Paediatrics. Importance of IYCF in achieving MDG. 45:70; 721, 2008 and Gender , Child Survival &HIV/AIDS: From evidence policy. Joint statement based on conference held in Toronto, Canada, May 2006, Sponsored by York University and WABA.

Gaps

The group agreed that while there is theoretically a policy of sorts, and some kind of training, the practice differs in institutions and hospitals, including some baby friendly hospitals. Gaps identified include:

1. National guidelines not yet made into policy
2. BFHI does not include HIV-related indicators
3. Inadequate counselling to HIV women regarding infant nutrition
4. Inadequate training for PPTCT

Recommendations

- Monitoring/ field studies to find out counselling practices in HIV and impact upon breastfeeding
- Inclusion of HIV related indicators for BFHI
- Further studies are required on transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants
- Comprehensive national policy including IYCF in HIV
- Training for PPTCT (currently at 2.5 hrs) needs to have separate module and separate training (5 1/2 to 6 days) for infant feeding counselling options

Summary Comments

As evidence is increasing about the dangers of mixed feeding in transmission of HIV to the baby, there is a concomitantly increasing need for intensive counselling on infant feeding options. Such counselling needs to take into account the cultural aspects of HIV, any stigma attached, the difficulties associated with replacement feeding, the risks of not being able to sustain exclusive replacement feeding. The woman needs not just information but skilled and continuous support in practising the chosen form of feeding. There is urgent need to upgrade skills of counsellors and health workers in infant feeding options, make it a part of the baby friendly hospital initiative and strengthen implementation of the IMS Act and its monitoring.

Indicator 14: Infant Feeding during Emergencies

Key question: *Are appropriate policies and programmes in place to ensure that mothers, infants and children will be provided adequate protection and support for appropriate feeding during emergencies?*

Background: Infants and young children are among the most vulnerable groups in emergencies. Interruption of breastfeeding and inappropriate complementary feeding increase the risks of malnutrition, illness and mortality. In emergency and relief situations the responsibility for protecting, promoting and supporting optimal infant and young child feeding practices and minimizing harmful practices should be shared by the emergency-affected host country and responding agencies. Concise Operational guidance on how to ensure appropriate feeding in emergency situations and comply with international emergency standards has been developed by interagency Infant Feeding in Emergencies Core Group. Practical details on how to implement the guidance are included in companion training materials, also developed through interagency collaboration.

The table given below depicts the existing situation in India on Infant Feeding during Emergencies.

	Criteria	Results		
		Yes	To some degree	No
14.1	The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies	2	1	0 ✓
14.2	Person(s) tasked with responsibility for national coordination with the UN, donors, military and NGOs regarding infant and young child feeding in emergency situations have been appointed	2	1	0 ✓
14.3	An emergency preparedness plan to undertake activities to ensure exclusive breastfeeding and appropriate complementary feeding and to minimize the risk of artificial feeding has been developed	2	1	0 ✓
14.4	Resources identified for implementation of the plan during emergencies	2	1	0 ✓
14.5	Appropriate teaching material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel.	2	1	0 ✓
	Total Score	**0/10**		

The indicator examines policies, training, nature of interventions and monitoring of infant and young child feeding during emergencies.

Gaps

The group agreed that while the National Guidelines and the NIPCCD report stressed the need for including Infant and Young Child Feeding in Contingency Action Plans, this was not being done. Gaps identified included:

1. There is no policy on IYCF in Contingency action plans
2. There is no mechanism to monitor violations of IMS Act during relief operations
3. There is no training for disaster management teams on IYCF

Recommendations

- Inclusion of IYCF guidelines in case of disaster (from national guidelines) needs to be included in contingency action plan
- Monitor / document use of infant milk substitutes and support to breastfeeding during disasters / emergencies.
- Monitor / document for violations of IMS Act during disaster / emergencies
- Training for 'disaster managers'

Summary Comments

Correct IYCF during emergenices and disasters is crucial to keep down mortality and prevent disease. Though the National Guidelines for Infant and Young Child Feeding and the NIPCCD report on IYCF stress the need for ensuring optimal breastfeeding in disasters and emergencies, it is not included in any contingency plan. Women are neither counselled nor supported for correct IYCF. During disasters, there is the added danger of promotion of artificial feeding, especially formula feeding, which can threaten exclusive and continued breastfeeding. Thus violations of the IMS Act also need to be monitored closely in such situations. Disaster Management policy and contingency plans for all kinds of emergencies and disasters need to make IYCF support and counselling a central part of the strategy, and training of disaster managers should include this component.

Indicator 15: Mechanisms of Monitoring and Evaluation System

Key question: *Are monitoring and evaluation data routinely collected and used to improve infant and young child feeding practices?*

Background: Monitoring and evaluation (M & E) components should be built into all major infant and young child feeding programme activities and collection of data concerning feeding practices integrated into national nutritional surveillance and health monitoring systems or surveys. Monitoring or management information system data should be collected systematically and considered by programme managers as part of the management and planning process. When appropriate, both baseline and follow-up data should be collected to measure outcomes. Use of internationally agreed-upon indicators and data collection strategies should be considered, in an effort to increase availability of comparable data. It is important that strategies be devised to help insure that key decision-makers receive important evaluation results and are encouraged to use them.

The table given below depicts the existing situation in India on Monitoring and Evaluation.

	Criteria	Results		
		Yes	To some degree	No
15.1	Monitoring and evaluation components are built into major infant and young child feeding programme activities.	2	1 ✓	0
15.2	Monitoring or Management Information System (MIS) data are considered by programme managers in the integrated management process.	2	1 ✓	0
15.3	Baseline and follow-up data are collected to measure outcomes for major infant and young child feeding programme activities.	2 ✓	1	0
15.4	Evaluation results related to major infant and young child feeding programme activities are reported to key decision-makers	2 ✓	1	0
15.5	Monitoring of key infant and young child feeding practices is built into a broader nutritional surveillance and/or health monitoring system or periodic national health surveys.	2	1 ✓	0
	Total Score	**7/10**		

The indicator examines whether or not monitoring and evaluation components are built into major infant and young child feeding programme activities, and their utilisation.

Gaps

The group came to the conclusion that while NFHS3 data informs plans developed by the Planning Commission and the ICDS, monitoring and evaluation data from ICDS and NRHM are not sufficiently integrated into action plans. The National Nutrition Monitoring Bureau that conducts nutritional surveillance does not include IYCF indicators. Gaps identified include:

1. NRHM does not have indicators on exclusive breastfeeding and complementary feeding
2. Too large a time gap between two consecutive NFHS surveys
3. Inadequate indicators on quality and quantity of complementary feeding
4. No age-wise disaggregation for children between 1-2 years when malnutrition peaks

Recommendations

- Recommend to government to do annual report on IYCF indicators
- Improve indicators on complimentary feeding quality / quantity
- Age wise further disaggregation for under twos (between 1 - 2 years)

Summary Comments

National nutritional surveillance should include IYCF indicators, and should be conducted more frequently. The MIS of NRHM and ICDS should not just include IYCF indicators, they should become part of routine development of action plans at all levels, central, state and district. The findings should be used to identify specially vulnerable groups so that immediate supportive action can be devised and taken at the local levels. As malnutrition peaks within the first two years of life, the government needs to report annually on IYCF indicators to fine tune interventions needed.

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Summary part 1: Infant and young child feeding (IYCF) practices

IYCF Practices	Result	Score
Indicator 1: Early Initiation of Breastfeeding	24.5%	3/10
Indicator 2: Exclusive breastfeeding for the first six months	46.4%	6/10
Indicator 3: Median duration of breastfeeding	24.4months	10/10
Indicator 4: Bottle feeding	16.4%	6/10
Indicator 5: Complementary feeding	56.7%	3/10
Score (Part-I)		**28/50**

Guideline s

Scores (Total) Part-I	*Colour-rating*	*Grading*	*Existing Situation*
0 - 15	RED	D	
16 - 30	YELLOW	C	✓
31 - 45	BLUE	B	
46 - 50	GREEN	A	

Summary Part II: IYCF Polices and Programmes

Targets	Score (Out of 10)
Indicator 6: National Policy, Programme and Coordination	2/10
Indicator 7: Baby Friendly Hospital Initiative (Ten steps to successful breastfeeding)	4/10
Indicator 8: Implementation of the International Code	8/10
Indicator 9: Maternity Protection	5/10
Indicator 10: Health and Nutrition Care Systems	4/10
Indicator 11: Mother Support and Community Outreach - Community-based Support for the pregnant and breastfeeding mother	4/10
Indicator 12: Information Support	5/10
Indicator 13: Infant Feeding and HIV	2/10
Indicator 14: Infant Feeding during Emergencies	0/10
Indicator 15: Mechanisms of Monitoring and Evaluation System	7.0/10
Score Part II (Total)	**41/100**

Guideline s

Scores (Total) Part-II	*Colour-rating*	*Grading*	*Existing Situation*
0 - 30	RED	D	
31 - 60	YELLOW	C	✓
61 - 90	BLUE	B	
91 - 100	GREEN	A	

Total of Part I and Part II (indicator 1-15): IYCF Practices and Policies and Programmes

Total score of infant and young child feeding practices; policies and programmes (indicators 1-15) are calculated out of 150.

Guideline s

Scores	*Colour-rating*	*Grading*	*Existing Situation*
0 - 45	**RED**	**D**	
46 - 90	**YELLOW**	**C**	✓ **69/100**
91 - 135	**BLUE**	**B**	
136 - 150	**GREEN**	**A**	

Concluding Remarks and the Way Forward

The 2008 India Report reveals glaring gaps in both policy and programmes that support breastfeeding and infant and young child feeding. It is quite evident that not much has significantly changed over the past three years in the policy environment except that maternity benefits have been provided to a miniscule number of women working for the Central government; such benefits are not available to women working in the private and the informal sectors. There has also been little progress in the acknowledgement of crèches as a support to breastfeeding and the number of crèches to support women working in the informal sector continues to be woefully inadequate. Programme focus on breastfeeding and complementary feeding is just a lip service; serious inputs are needed to increase early and exclusive breastfeeding. New data from the districts suggest that early breastfeeding is increasing; however, this increase is not commensurate with the increase in institutional deliveries; rather, there has been a decline in the first hour breastfeeding where institutional deliveries have gone up. This is a worrying point. These gaps can only be bridged through active implementation of the comprehensive recommendations being made in the report. These include **skilled support to women at the time of birth and later to support breastfeeding. Policy on maternity entitlements must be announced for the private sector, informal sector, including self-employed women and agricultural labourers. The requisite number if crèches need to be set up with quality. These require trained humanpower and adequate resources. Laws regulating the presence of crèches on worksites need to be strictly implemented.** Along with programmes that actively promote and support breastfeeding, it could make tremendous difference to the lives of both women and children.

Over the past 15 years, of NFHS 1, 2 and 3, we have seen that initiation of breastfeeding has increased just about 1% each year, exclusive breastfeeding has in fact declined, and complementary feeding has improved from 33% to 56%. There are some lessons to be learnt from the few studies and implementation models to enhance early and exclusive breastfeeding. These should be considered in next programme cycle. **The upcoming Child Health Policy should be an excellent opportunity to address these gaps. However, the Ministry of Health has to assume some responsibility in this regard too.**

To find ways and means to achieve what is needed to bridge the gaps found, an action plan was developed for civil society groups at the South Asia Breastfeeding Partner's Forum 5 at Bhutan; this includes advocacy and work with the government departments. Further, breastfeeding happens at home when in a couple of days after women deliver in institutions, and 60% deliveries continue to deliver at home; **therefore some kind of responsibility for implementing the required interventions and improving the outreach needs to be placed with Panchayati Raj Institutions.**

Areas that have not seen breastfeeding or infant feeding at all include the HIV and Emergencies and Disaster Management. **Preparedness to meet the needs of women and children during disasters must recognize breastfeeding support as an "emergency response" and include " establishing breastfeeding support" in the supply chains.** Needless to say, NACO has to take more serious steps to ensure that **infant feeding options are available and supported through skilled training of workers in the ICTCs** and that its policies are translated into action at ground level.

Protection of breastfeeding from commercial sector continues to be a serious issue. Though the Indian government has passed the Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 as amended in 2003 (IMS Act), which is the strongest piece of legislation across the world to protect breastfeeding, it is least enforced. The IMS Act is our obligation to protect women and children, stated in its objects and reasons; however implementing the Act does not figure in the business of the government programmes either at centre or at state level where the action lies. The health system, including health professionals and providers at all levels are often ignorant about this Act; there is no system for monitoring violations. Commercial sector continues to flout the law through offering support to health workers thus undermining breastfeeding. **Mechanisms to implement the Act need to be put in place. The National Commission for Protection of Child Rights (NCPCR) could take charge of its implementation,** and Ministry of Health, and the Foods Standards Authority should include it in their plans of action. New challenges are emerging in the form of public private partnerships wherein international organisations are pushing towards "food products" for the poor people. **To control public private partnerships a legislation needs to be developed to clearly regulate and protect consumers from conflicts of interests.**

Finally, India has a National Guidelines on Infant and Young Child Feeding, a wonderful document, but one that is neither respected nor implemented. A "Plan of Action on Infant and Young Child Feeding", based on the Guidelines, was developed by several professional and civil society organisations and government organizations working together for two years or more. It was adopted at a National Consultation of the new WHO growth standards; **this Plan of Action needs to budgeted and adopted as a policy along with the Guidelines.**

The REAL issue that will transform nutrition in India is breastfeeding - really exclusive for the first six months and prolonged breastfeeding for two years and beyond. But the problem is - we have no product, no gimmick, and no magic bullet. Decision makers need to understand that changing the paradigm of infant feeding is worth a huge investment. We know that the economic benefits of breastfeeding to a family and a nation are of exceptional value even in terms of hard currency. We also know what works for enhancing breastfeeding practices; this is one to one or group skilled counseling along with the requisite systemic support.

In spite of decades of studies and data showing that breastfeeding is the single most important intervention for survival and nutrition, it is deplorable that NOTHING has been done except for a few posters, a little training, and lip service. **Breastfeeding, to succeed, needs investment and a clear policy backed by money and clear actions.**

At the policy level, breastfeeding interventions must be seen as an integral and central part of preventive care approach in the new Child Health Policy, having its own budget line, just as other interventions that are curative in nature have. The fact that exclusive breastfeeding for the first six months can reduce diarrhoea and pneumonia by more than twice justifies this action. **Moreover, besides having its own budget line, breastfeeding interventions must be coordinated at a highest level, both at the level of Ministries and at the Prime Minister's National Council on India's Nutrition Challenges.**

We hope that next three years would result in bridging these gaps and the next assessment in 2011 would reveal many more positive changes, and also move India to a better colour. India was in the YELLOW band in 2005, India continues to be in the YELLOW band in 2008. The country should move to Blue and then aspire to reach the GREEN as defined in the WBT*i* in order to ensure that every child born meets its right to survival with health.

Annexures

Annexure-1

The World Breastfeeding Trends Initiative (WBT*i*): India Country Assessment Workshop

Indian Medical Association building, New Delhi

4th October 2008

Agenda for the workshop

Time	Topic	Resource Person
0930 1000 hrs	Registration	
1000 1030 hrs	Welcome	Dr. Vandana Prasad, PHRN
	Introduction	Dr. Arun Gupta, BPNI
1030 1130 hrs	World Breastfeeding Trends Initiative (WBT*i*)	Radha Holla Bhar
1130 1200 hrs	Tea	
1200 1300 hrs	WBT*i* India assessment findings	Dr. Vandana Prasad
1300 1400 hrs	Lunch	
1400 1500 hrs	**Group Discussion to finalize the draft**	**Coordinators:**
	Group 1 Indicator 1-5, 6,7,8	JP Dadhich/ Ajay Gaur
	Group 2 Indicator 9,10,11	Vandana Prasad/ Haripriya Soibam
	Group 3 Indicator 12,13,14,15	Radha Holla Bhar/ Anurag Singh
1500 1600 hrs	**Group presentations**	
	Group 1	
	Group 2	
	Group 3	
1600 1630 hrs	Concluding remarks	
1630 1700 hrs	Tea	

Annexure-2

The World Breastfeeding Trends Initiative (WBT*i*): India Country Assessment Workshop

Indian Medical Association building, New Delhi

4th October 2008

List of Participants

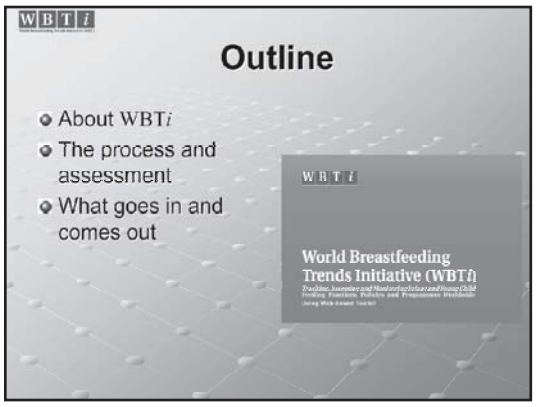
Sr. No.	Name	Organisation
1	Dr. Ajay Gaur	Associate Professor (Paediatrics), Medical College, Gwalior
2	Dr. Anurag Singh	Asst. Professor (Paediatrics), Medical College, Jodhpur
3	Dr. Arun Gupta	BPNI
4	Dr. Bari Dalyne	IAPSM
5	Dr. Chander Kant	Head of Dept. of Paediatrics, Sanjay Gandhi Hospital, Member BPNI Central Coordination Committee
6	Dr. J P Dadhich	IBFAN Asia
7	Dr. M. Saraswathi	NACO
8	Dr. Madhuri A. Patel	FOGSI
9	Dr. R K Agarwal	IAP
10	Dr. Reeta Raisily	ICMR
11	Dr. Sudeshna Sengupta	Mobile Creches
12	Dr. V. Rajasekhar	NHSRC
13	Dr. Vandana Prasad	PHRN/ JSA
14	Mr. Ajay Kumar	BPNI
15	Ms. Beena Bhatt	IBFAN Asia
16	Ms. Deepika Srivastava	UNICEF
17	Ms. Dipa Sinha	Office of Commissioners to the Supreme Court on Right to Food
18	Ms. Haripriya Soibam	PHRN
19	Ms. Maria E. Martin	BPNI
20	Ms. Minakshi Jha	BPNI
21	Ms. Nanthini Subbiah	TNAI
22	Ms. Radha Holla	BPNI

Annexure-3

The World Breastfeeding Trends Initiative (WBT*i*)

(Mrs. Radha Holla Bhar)

1



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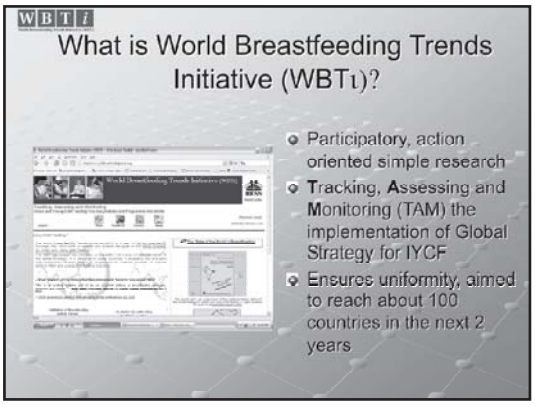

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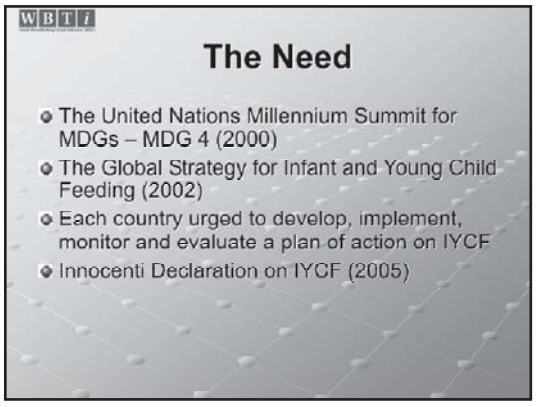

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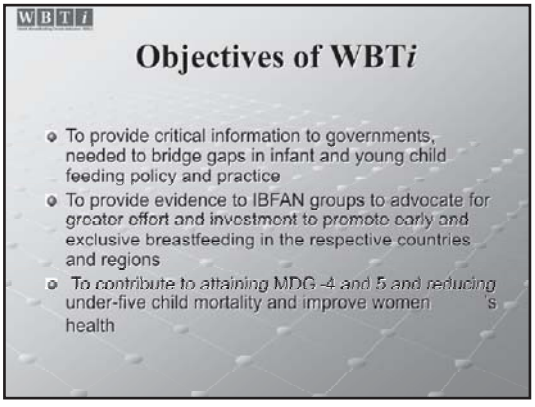

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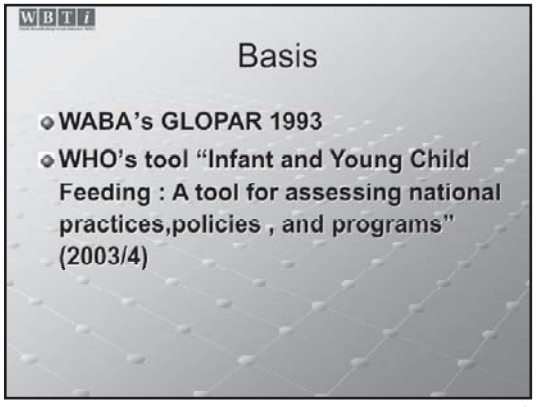

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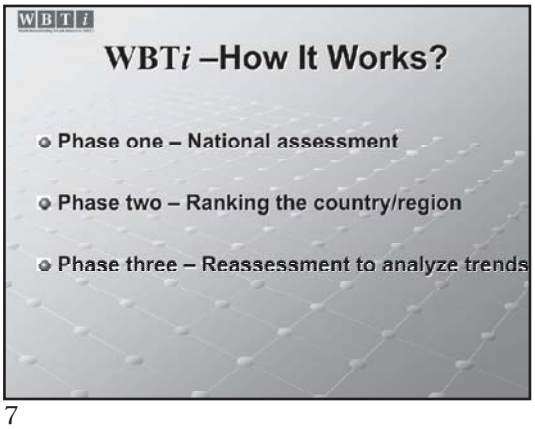

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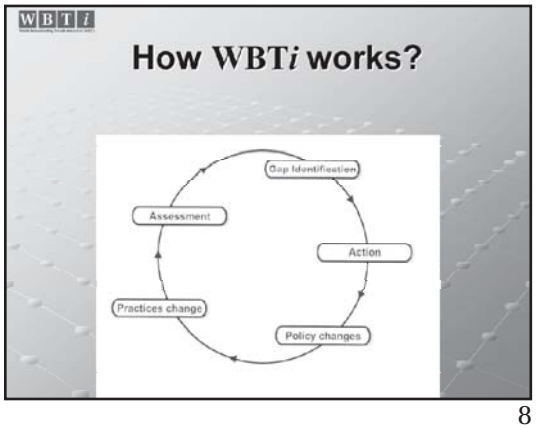

8

WBT*i*

- **A:** Action oriented
- **B:** Brings people together
- **C:** Consensus and commitment building
- **D:** Demonstrates achievements and gaps
- **E:** Efficacy improving programme

9

Indicators Part-I

1. Early Initiation Rates
2. Exclusive breastfeeding Rates <6months
3 Median duration of Breastfeeding
4 Bottle Feeding Rates
5 Timely Complementary feeding Rates

11

Indicators Part-II

11-Mother Support and Community Outreach
12-Information Support
13-Infant feeding and HIV
14-Infant feeding during Emergencies
15-Monitoring and Evaluation

13

Contd..

- Follow up and offer IBFAN services for capacity building in code implementation, planning and facilitation, training of workers, and other programmes related to IYCF
- Advocacy with the use of report cards at national, regional and global levels to gather support in bridging gaps in programme and policy

15

The Assessment Process

- Using 15 indicators – Quantitative, Qualitative
- To document achievements and gaps in the existing policy, program and practices in reference to IYCF

12

Indicators Part-II

6- National Policy Program and Coordination
7- BFHI
8-Implementation of the Code
9-Maternity Protection
10-Health and Nutrition Care

14

What Goes in?

- Coordination
- *Training/orientation*
- Organizing national consultations and discussions leading to national assessment
- Analyzing and publishing the country report cards
- Compiling and publishing state of world's breastfeeding, nationally and regionally
- Publishing results through WBTi web tool

16

WBT*i*

World Breastfeeding Trends Initiative (WBT*i*)

www.worldbreastfeedingtrends.org

Thank you

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Annexure-4

The World Breastfeeding Trends Initiative (WBT*i*)- India Assessment 2008 (Dr. Vandana Prasad)

WBT*i*

India Assessment 2008

1

Why an assessment

WBT*i* is a tool that assists countries to map their progress in implementing the Global Strategy.

The first WBT*i* India Assessment was held in 2006, as part of a South Asia assessment of 8 countries.

India was ranked sixth, with all countries except Afghanistan and Bhutan, ahead of it. The ranks of the last two countries reflected a total lack of data on IYCF.

India's individual score was 68 out of a possible total of 150.

The second assessment is being conducted in 2008 to gauge whether the country has made any progress in implementing the Global Strategy, identify existing gaps that need to be filled, and make recommendations to policy makers.

2

Country Status in South Asia 2006

1 Sri Lanka 116/150
2 Bangladesh 91.5/150
3 Maldives 88.5/150
4 Pakistan 75.5/150
5 Nepal 71.5/150
6 India 68/150
7 Afghanistan 30/150
8 Bhutan 30/150

3

The Process

The First Step

- Coordination
  - IBFAN Asia
  - People's Health Resources Network
- Selection of Core Partners and data collection
  - People's Health Resources Network
  - IBFAN Asia
  - Dr. Ajay Gaur
  - Dr. Anurag Singh
- Analysis and recommendations
  - by policy makers, professionals, and civil society organisations at Workshop on 4th October 2008

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Indicators 1-5: Part 1

Infant and Young Child Feeding Practices

	2008	2006
Percentage of babies breastfed within one hour of birth	24.5%	15.8%
Percentage of babies of 0-6 months of age exclusively breastfed in the last 24 hours	46.3%	46.9%
Babies are breastfed for a median duration of how many months	24.4 months	25.4 months
Percentage of breastfed babies less than 6 months old receiving other foods or drink from bottles	16.4%	13.7%
Percentage of breastfed babies receiving complementary foods at 69 months of age	55.8%	35%

While initiation of breastfeeding initiation of complementary fe eding between 6 -9 **months seem to have improved from NFHS2 (1998** -99),

- **exclusive breastfeeding for the first 6 months has fallen from** 46.9% to 46.3%
- **median duration of breastfeeding from 25.4 months to 24.4 month** s
- **bottle feeding has increased from 13.7% to 16.4%.**

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Indicators 6-15: Part 2

Indicator 6: National Policy, Programme and Coordination

•There appears to be no change from the 2006 assessment.

•During the previous assessment, the National Guidelines for Infant and Young Child Feeding was considered a policy on the condition that action to strengthen it would be taken. As this has not happened, the Guidelines have not been considered policy for this assessment.

• However, as a result of advocacy, the 11th Plan document highlights the role of optimal IYCF - early and exclusive breastfeeding for six months, followed by continued breastfeeding with the introduction of complementary foods thereafter to prevent mortality and malnutrition.

6

Indicators 6-15: Part 2

Indicator 7: Baby Friendly Hospital Initiative

There has no been change in the findings since the assessment in 2006 in any of the parameters for the indicator– number of institutions declared as BFHI, training criteria, assessment criteria, and so on.

However, the MOHFW has started showing interest in reviving the initiative.

A workshop on this was organised by the Ministry on 18th June 2008, at the National Institute of Health and Family Welfare. The Breastfeeding Promotion Network of India was one of the participants at the workshop

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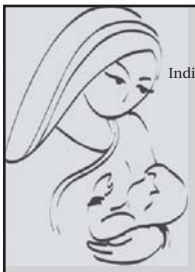

Indicators 6-15: Part 2

Indicator 8: Implementation of the International Code

The *Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992* was strengthened through an amendment in 2003.

While the law exists, it is under constant threat. In 2005, the threat to rescind the law and bring its provision under a new food law was successfully countered.

Violations of the Act continue. The case against Nestle, filed by ACASH on behalf of the government 13 years ago, has still not decided.

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Indicators 6-15: Part 2

Indicator 9: Maternity Benefits for Protecting and Supporting Breastfeeding among Working Mothers

Several important actions have taken place on this indicator since the last assessment:

1. Maternity Leave for central government employees has been extended to 6 years.
2. Women working in the central government can now avail of paid leave up to two years for child care, provided the child has not crossed 18 years of age.

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Indicators 6-15: Part 2

Indicator 9: Maternity Benefits for Protecting and Supporting Breastfeeding among Working Mothers

3. The National Rural Employment Guarantee Act, 2006, has made availability of childcare facilities at the worksite a legal provision; the wages for the woman chosen to mind the children will be paid out of NREGA funds.
4. The "Dr. Muthulakshmi Reddy Maternity Benefit Scheme" in Tamil Nadu involves cash support of Rs 1,000 per month for six months starting from the 7th month of pregnancy, for care during pregnancy and after delivery, to enable poor women to practise exclusive breastfeeding.
5. The 11th Plan document has attempted to universalise this scheme for women below the poverty line. A budget of Rs. 9000 crore has been set aside for this.
6. The Supreme Court of India, in its Order of 13th December 2006, has directed the government of India to universalise ICDS, including provision of supplementary nutrition for pregnant and lactating women.

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Indicators 6-15: Part 2

Indicator 10: Health and Nutrition care

There has been little change since the last assessment in the building of capacity of health and nutrition care providers at all levels.

However, a few actions are being done at sectoral and state levels:

- The ASHA training module has IYCF information included in it, but not skill training
- While the AWW training module does not provide adequate time for skill training, the Medical College of Jodhpur is conducting TOT on IYCF for ICDS functionaries with special emphasis on skill building
- The IMNCI training package for physicians has two sessions of 3 hours each, one of which is exclusively on breastfeeding counselling.

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Indicators 6-15: Part 2

Indicator 11: Mother Support and Community Outreach

There has been no change in providing support to women in the community since the last assessment, especially as frontline workers such as ASHA, Anganwadi Workers and ANMs are not being imparted with listening and counselling skills.

The outreach of NRHM and ICDS to pregnant and lactating women is inadequate. According to NFHS 3, only 10.7% of women receive information about supplementary nutrition from the Community Health Worker.

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Indicators 6-15: Part 2

Indicator 12: Information Support

As in 2006, there is at present no comprehensive national IEC strategy for improving infant and young child feeding.

As earlier, actions are undertaken during the World Breastfeeding Week from August 1 -7 each year. These activities have an IEC component

The Ministry of Women and Child Development brings out occasional advertisements in print media on nutrition, of which IYCF, especially exclusive breastfeeding is a component.

NRHM broadcasts public health messages on television and FM channels regularly; these include IYCF components.

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Indicators 6-15: Part 2

Indicator 13: Infant Feeding and HIV

Since the 2006 assessment, the country has taken the following actions:

- **A comprehensive set of Guidelines on IYCF has been brought out that includes Infant Feeding and HIV.**
- **The Guidelines give effect to the International Code/National legislation.**
- **Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.**
- **Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.**

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Indicators 6-15: Part 2

Indicator 13: Infant Feeding and HIV

- **Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.**
- **However, the following gaps continue to exist**
- **Mothers are not adequately supported in making their infant feeding decisions with further counselling and follow-up to make implementation of these decisions as safe as possible.**
- **There is no on -going monitoring to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status.**

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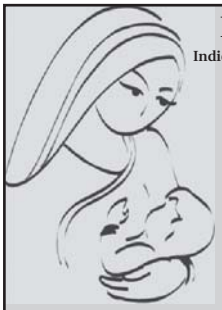

Indicators 6-15: Part 2

Indicator 14: Infant Feeding During Emergencies

The ratings for this indicator are the same as for the previous assessment. No further action has been taken on IYCF during emergencies.

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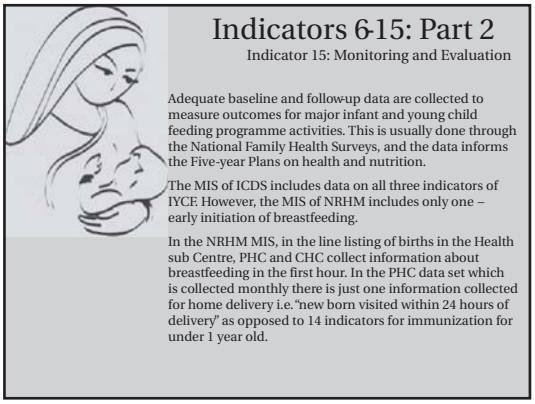
Indicators 6-15: Part 2
Indicator 15: Monitoring and Evaluation
Adequate baseline and follow-up data are collected to measure outcomes for major infant and young child feeding programme activities. This is usually done through the National Family Health Surveys, and the data informs the Five-year Plans on health and nutrition.
The MIS of ICDS includes data on all three indicators of IYCF. However, the MIS of NRHM includes only one – early initiation of breastfeeding.
In the NRHM MIS, in the line listing of births in the Health sub Centre, PHC and CHC collect information about breastfeeding in the first hour. In the PHC data set which is collected monthly there is just one information collected for home delivery i.e. "new born visited within 24 hours of delivery" as opposed to 14 indicators for immunization for under 1 year old.

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Annexure-5

Action Plan Developed at South Asia Breastfeeding Partners Forum-5, Thimpu, Bhutan

Activity	2009	2010	2011
Policy & Programmes	• Pursue actively with Govt. to form a National policy on IYCF • Organize National level advocacy meeting – Project report card, gaps & policy status • Demand for separate budget for IYCF • Demand to Constitute National IYCF authority • Conceptualization & Implementation of WBT*i* – Prepare project proposal, sub national tool – Training of states to launch this in states. • State assessment for IYCF indicators. • Provide Technical inputs on IYCF	• Organize National level advocacy meeting • State assessment for IYCF indicators. • Provide Technical inputs on IYCF	• Organize National level advocacy meeting • State assessment for IYCF indicators. • Provide Technical inputs on IYCF
BFHI	• Advocacy to revive BFHI in country • Prepare concept note on BFHI • Reach NRHM to incorporate BFHI in NRHM draft document		
Monitoring & Evaluation	• Request & demand Government to have annual report on IYCF Indicators.	• Conduct National Level research to collect Data on IYCF	

The Legislation	• Observe BPNI Day as "IMS ACT DAY" • 2008 BPNI Day as "WBT*i* Day" • Dissemination of IMS Act information • Reach NCPCR & collaborate for protection of IMS Act.	• Pursue with Govt. for amendments	
Maternity Protection	• Prepare Maternity Protection Kit & disseminate it to sub national level • Amendment in existing legislation for maternity protection to harmonize the recent change of extending 6th pay commission to organize and unorganized sector	• Dissemination of Maternity Protection Kit to sub national Level	• Dissemination of Maternity Protection Kit to sub national Level
Health & Nutrition System	• Revive National core group on Pre service IYCF • Prepare & submit the project on Pre-Service IYCF	• Extending Pre-Service IYCF to different states Medical colleges & Nursing Schools.	• Extending Pre-Service IYCF to different states Medical colleges & Nursing Schools.
Mother Support & Community Outreach	• Continue demand for counseling training of Health & Nutrition Team	• Training of Health & Nutrition Team	• Training of Health & Nutrition Team
HIV & Infant feeding	• Reach out to research institutes / NACP / State AIDS control society to institutionalize IYCF / HIV Counseling training in their Calendar. • Preparing Technical document based on available research & dissemination	• Preparing Technical document based on available research & dissemination	• Preparing Technical document based on available research & dissemination
Infant feeding during emergencies	• Reach National Disaster Management Authority to include Breastfeeding as a major emergency response. • Preparing Technical document based on available research & dissemination	• Preparing Technical document based on available research & dissemination	• Preparing Technical document based on available research & dissemination