



## **Maternal, Infant and Young Child Nutrition (MIYCN) Policy Maharashtra**

**Public Health Department  
Government of Maharashtra  
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## **Acronyms**

ANC	Antenatal care
ANM	Auxiliary Nurse Midwife
ARSH	Adolescent Reproductive and Sexual Health
ART	Anti Retroviral Therapy
ARV	Anti Retroviral
ASHA	Accredited Social Health Activist
AWW	Anganwadi worker
BDO	Block development Officer
BF	Breastfeeding
BFHI	Baby Friendly Hospital initiative
BMI	Body Mass Index
BPL	Below Poverty Line
BPNI	Breastfeeding Promotion Network of India
CBO	Community Based Organizations
CDPO	Child Development Project Officer
CEO	Chief Executive Officer
CMAM	Community based management of acute Malnutrition
CNSM	Comprehensive Nutrition Survey Maharashtra
CSR	Corporate Social Responsibility
CTC	Child Treatment Centre
DH	District Hospital
DLHS	District Level Household Survey
DPMU	District Programme Management Unit
EID	Early Infant Diagnosis
FA	Folic Acid
FDA	Food and Drug Administration
FOGSI	The Federation of Obstetrics and Gynecological Societies of India
FRU	First Referral Unit
GERD	Gastro Esophageal Reflux Disease
GMP	Growth Monitoring and Promotion
GNM	General Nursing and Midwifery
HBNC	Home Based Newborn care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IAP	Indian Association of Pediatrics
IAPSM	Indian Association of Preventive and Social Medicine
IBCLC	International Board Certified Lactation Consultant
ICDS	Integrated Child Development Services
ICTC	Integrated Counselling and Testing Centre
IFA	Iron & Folic Acid
IMCI	Integrated Management of Childhood Illness
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IMS	Infant Milk Substitute
IPD	Inpatient Department
IPHA	Indian Public Health Association
IUGR	Intra Uterine Growth Restriction
IYCN	Infant & Young Child Nutrition

JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
KMC	Kangaroo Mother Care
LBW	Low Birth Weight
LHV	Lady Health Volunteer
LSCS	Lower Segment Cesarean Section
MCH	Maternal and Child Health
MCP	Mother Child Protection
MIYCN	Mother Infant & Young Child Nutrition
MMC	Maharashtra Medical Council
MMR	Maternal Mortality Ratio
MO	Medical Officer
MPR	Monthly Progress Report
MUAC	Mid Upper Arm Circumference
MUHS	Maharashtra University of Health Sciences
NACO	National AIDS control Organization
NBSU	New Born Stabilization Unit
NFHS	National Family Health Survey
NGOs	Non Governmental Organizations
NHM	National Health Mission
NICU	Neonatal Intensive Care Unit
NIP	Nursing in Public
NNF	National Neonatal Forum
NNP	Neonatal Nurse Practitioner
NRC	Nutrition Rehabilitation Centre
NRLM	National Rural Livelihood Mission
NSSK	Navjaat Shishu Suraksha Karyakram
OPD	Outpatient Department
ORS	Oral Rehydration Solution
PDS	Public Distribution System
PHC	Primary Health Centre
PIP	Program Implementation Plan
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal care
PPIUCD	Post Partum Intra Uterine Device
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchyat Raj Institutions
PSM	Preventive & Social Medicine
PVTG	Particularly Vulnerable Tribal Groups
RF	Replacement Feed
RI	Routine Immunization
RJMCHN	Raj Mata Jijau Mother and Child Health & Nutrition Mission
RKSK	Rashtriya Kishor Swasthya Karyakram
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SC	Sub Centre
SDH	Sub District Hospital
SHG	Self Help Group
SN	Staff Nurse
SN	Supplementary Nutrition
SNCU	Sick Newborn Care Unit
SPMU	State Program Management Unit
THO	Taluka Health Officer

ToT	Training of Trainers
U5MR	Under 5 Mortality Rate
UTI	Urinary Track Infection
VCDC	Village Child Development Centre
VDO	Village Development Officer
VHND	Village Health and Nutrition Day
VLBW	Very Low Birth weight
VP	Village Panchayat
WABA	World Alliance for Breastfeeding Action
WCD	Women & Child Development
WH	Women's Hospital
WHO	World Health Organiztion
WHO	World Health Organiztion
WIFS	Weekly Iron & Folic Acid Supplementation

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## **RATIONALE FOR A COMPREHENSIVE MATERNAL INFANT & YOUNG CHILD NUTRITION POLICY**

The 68<sup>th</sup> World Health Assembly has declared it as a decade of action on nutrition (2016-2025). India is a signatory to this declaration as it has been signed by Hon'ble Union Health Minister on behalf of the Government of India.

Thus, mandating the country to bring sharper focus on the need to eradicate hunger and prevent all forms of malnutrition, particularly, under nourishment, stunting, wasting, under-weight and obesity in children under 5 years of age and anaemia in women and children, among other micro nutrient deficiencies as well as reverse the rising trends in over weight and obesity and reduce the burden of diet related non communicable diseases in all age groups.

Having a policy mandates all the stake holders such as Government, Academia, NGOs, community organisations, professional bodies such as Indian Academy of Paediatrics, Federation of Obstetrics and Gynaecology, Indian Medical Council, development agencies and the families and communities to ensure optimal growth and development for the young children, adolescents and their mothers to create a society that will contribute to the progress of the State.

# Chapter-1

## Overview of Maternal, Infant & Young Child Nutrition

### 1.1 Importance of Optimal Maternal Infant and Young Child Feeding

With competing priorities, disease-specific interventions, and an interest in technologies, campaigns and products, the health and nutrition impact provided by Optimal maternal, infant and young child nutrition (MIYCN) is often underestimated. Interventions to improve maternal, infant and young child nutrition need increased attention and commitment if sustainable achievements in child survival, growth and development are to be attained. Successful MIYCN interventions rely on behaviour and social change implemented at scale, which can only be reached through political commitment, adequate resource allocation, capacity development and effective communication. Current investments in nutrition in general and MIYCN in particular, are very small given the magnitude of the problem and the potential impact.

Maternal nutrition during pregnancy has a pivotal role in the regulation of placental-fetal development and thereby affects the lifelong health and productivity of offspring. An optimal maternal nutrient supply has a critical role in fetal growth and development. Maternal suboptimal nutrition during pregnancy results in intrauterine growth restriction (IUGR) and newborns with low birth weight. Intrauterine growth restriction is associated with increased perinatal morbidity and mortality, and newborns with low birth weight have increased risk for development of adult metabolic syndrome.

There is a growing body of evidence to show that improving the nutrition in girls, pre-pregnant and pregnant women prevents maternal, newborn and child deaths. Further low birth weight due to poor maternal nutrition increases the risk of common chronic diseases like diabetes mellitus and high blood pressure in the adult life and increases risk of premature death. Recent evidence show that:

- Anemia during adolescence leads to pregnancy with poor body iron stores which in turn results in still births, IUGR babies, LBW babies and pre term deliveries with newborns having poor body iron stores. If Iron deficiency anemia among the adolescents is not addressed will lead to the vicious cycle of anemia, Low Birth Weight and intergenerational cycle of malnutrition.
- Iron and calcium deficiencies contribute substantially to maternal deaths<sup>1</sup>
- Maternal iron deficiency and low body mass index is associated with babies with low weight (<2500 g) at birth
- Maternal and child under nutrition, and unstimulating household environments, contribute to deficits in children's development and health and productivity in adulthood

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<sup>1</sup> Lancet Series on Maternal & Child Health - 2008



- Maternal overweight and obesity are associated with maternal morbidity, preterm birth, and increased infant mortality
- Fetal growth restriction is associated with maternal short stature and underweight and causes 12% of neonatal deaths and 20% of stunting in childhood<sup>2</sup>.
- Under nutrition during pregnancy, affecting fetal growth, and the first 2 years of life is a major determinant of both stunting of linear growth and subsequent obesity and non-communicable diseases in adulthood

Further, Pregnancy and breastfeeding can deplete the stores of vitamins and minerals in a mother's body, particularly iron folate, which is vital to a baby's healthy development in the womb. Healthy birth spacing reduces the chance that a baby will be premature or underweight. Waiting longer to conceive after a birth means a mother can give her new baby the best start in life; she will have more time to care for her baby and for breastfeeding. It also gives parents time to prepare for the next pregnancy, including ensuring there are enough household resources to cover the costs of food, clothing, housing and education.

Strategies to improve Maternal, Infant and Young Child Nutrition (MIYCN) are a key component of the child survival and development programs in many countries including India. The scientific rationale for this decision is clear, with steadily growing evidence underscoring the essential role of breastfeeding and complementary feeding as major factors in child survival, growth and development. **The importance of breastfeeding as the preventive intervention with potentially the single largest impact on reducing child mortality has been highlighted. Improvement of complementary feeding has been shown to be the most effective in improving child growth, and thereby, together with maternal nutrition interventions, to contribute to reducing stunting<sup>3</sup>.**

As a global public health recommendation, infants should be exclusively breastfed for the first six months of life (180 days) to achieve optimal growth, development and health. Thereafter, to meet their evolving nutritional needs, infants should receive safe and nutritionally adequate complementary foods while breastfeeding continues for up to two years of age (2<sup>nd</sup> birthday) and beyond.<sup>4</sup> In addition, a growing body of evidence underscores the important global recommendation that skin-to-skin contact be initiated in about 5 mins of birth in order that breastfeeding be initiated within the first hour of birth<sup>5</sup>. This skin-to-skin contact should be continued uninterrupted till the time baby completes the first breastfeed.

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<sup>2</sup> Source: Robert E Black et al and the Maternal and Child Nutrition Study Group. Maternal and child under nutrition and overweight in low-income and middle-income countries [www.thelancet.com](http://www.thelancet.com) Published online June 6, 2013 [http://dx.doi.org/10.1016/S0140-6736\(13\)60937-X](http://dx.doi.org/10.1016/S0140-6736(13)60937-X)

<sup>3</sup> Infant and young child feeding: programming guide. UNICEF, 2012

<sup>4</sup> WHO/UNICEF Global strategy for infant and young child feeding, 2003

<sup>5</sup> This recommendation is supported by evidence, is one of the Ten Steps to Successful Breastfeeding and is one of the core indicators for infant and young child feeding (2008 edition)

## **1.2 MIYCN in reducing Maternal morbidity & mortality**

Adolescent girls are particularly vulnerable to malnutrition because they are growing faster than at any time after their first year of life. They need protein, iron, and other micronutrients to support the adolescent growth spurt and meet the body's increased demand for iron during menstruation. Adolescents who become pregnant are at greater risk of various complications since they may not yet have finished growing. Pregnant adolescents who are underweight or stunted are especially likely to experience obstructed labor and other obstetric complications. There is evidence that the bodies of the still-growing adolescent mother and her baby may compete for nutrients, raising the infant's risk of low birth weight and early death.

Women are more likely to suffer from nutritional deficiencies than men are, for reasons including women's reproductive biology, low social status, poverty, and lack of education. Sociocultural traditions and disparities in household work patterns can also increase women's chances of being malnourished. Many women who are underweight are also stunted, or below the median height for their age. Stunting is a known risk factor for obstetric complications such as obstructed labor and necessitates need for skilled intervention during delivery, to avoid injury or death for mothers and their newborns.

Addressing women's malnutrition has a range of positive effects because healthy women can fulfill their multiple roles — generating income, ensuring their families' nutrition, and having healthy children — more effectively and thereby help advance countries' socioeconomic development. Women are often responsible for producing and preparing food for the household, so their knowledge — or lack thereof — about nutrition can affect the health and nutritional status of the entire family. Promoting greater gender equality, including increasing women's control over resources and their ability to make decisions, is crucial. Improving women's nutrition can also help nations achieve three of the Millennium Development Goals - Goal 1: Eradicate extreme poverty and hunger, Goal 4: Reduce child mortality & Goal 5: Improve maternal health.

## **1.3 MIYCN in reducing child morbidity and mortality**

The 2003 landmark Lancet Child Survival Series<sup>6</sup> ranked the top 15 preventive child survival interventions for their effectiveness in preventing under-five mortality. Exclusive breastfeeding up to six months of age and breastfeeding up to 12 months (for the purpose of that study only) was ranked number one, with complementary feeding starting at six months at number three. These two

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<sup>6</sup>Jones G. *et al.* How many child deaths can we prevent this year? (Child Survival Series) *The Lancet* 2003 Vol. 362.

interventions alone were estimated to prevent almost one-fifth of under-five mortality in developing countries.

Across the globe, every year an estimated 13 million children are born with intrauterine growth restriction and about 20 million with low birth weight<sup>7</sup>. A child born with low birth weight has a greater risk of morbidity and mortality and is also more likely to develop noncommunicable diseases, such as diabetes and hypertension, later in life.

The 2008 Lancet Nutrition Series<sup>8</sup> also reinforced the significance of optimal IYCN on child survival. Optimal IYCN, especially exclusive breastfeeding, was estimated to prevent potentially 1.4 million deaths every year among children under five (out of the approximately 10 million annual deaths). It has been proved that early initiation of breastfeeding within one hour contributes to 22% reduction in neo-natal mortality in Ghana. Neonatal and post neonatal deaths were found 5-6 times lower in infants fed with colostrum.

The impact is biggest in terms of reduction of morbidity and mortality from diarrhoea and pneumonia. Breastfeeding protects the effect on Haemophilus B one of the causative agents for respiratory infections. Non breast fed children have 250% higher risk of being hospitalised for pneumonia and asthma<sup>9</sup>. Breast milk fed infants have reduced incidence of necrotizing enterocolitis, UTI, ear infections, asthma, meningitis and sepsis. Breastfeeding decreases chance of developing leukaemia<sup>10</sup> and lymphoma<sup>11</sup> by 30% in children.

The evidence also points at several benefits of breast feeding for mothers such as less likely to develop Ovarian and Breast cancer, and lowers the risk of developing maternal type II diabetes.

## 1.4 MIYCN and Child Growth

Optimal MIYCN is essential for child growth. The period (First 1000 days) during pregnancy and a child's first two years of life is considered a **"critical window of opportunity"** for prevention of growth faltering. Recent anthropometric data from low-income countries confirms that the levels of under-nutrition increase markedly from 3 to 18-24 months of age<sup>12</sup>.

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<sup>7</sup> United Nations Children's Fund and World Health Organization, Low birthweight: country, regional and global estimates. New York, United Nations Children's Fund, 2004.

<sup>8</sup> Black R. *et al.* Maternal and child undernutrition: global and regional exposures and health Consequences. (Maternal and Child Undernutrition Series 1). *The Lancet* 2008.

<sup>9</sup> [Programing guide Infant & Young Child Feeding. UNICEF, June 2012](#)

<sup>10</sup> Shu X-O, *et al.* Breastfeeding and the risk of childhood acute leukemia. *J Natl Cancer Inst* 1999; 91: 1765-72

<sup>11</sup> An Exploratory Study of Environmental and Medical Factors of Potentially Related to Childhood Cancer. *Medical & pediatric Oncology*, 1991; 19(2):115-21

<sup>12</sup> Victora, C., *et al.* Worldwide Timing of Growth Faltering: Revisiting Implications for Interventions. *Pediatrics* 2010; 125; e 473-e480.

After birth, a child's ability to achieve the standards in growth is determined by the maternal nutritional status as well as adequacy of dietary intake (which depends on infant and young child feeding and care practices and food security), as well as exposure to disease<sup>13</sup>. Under-nutrition and infection are intertwined in a synergistic vicious cycle. Therefore, support to quality child feeding practices (breastfeeding, complementary feeding, feeding during illness and hygiene) and improvement of household food security, together with disease prevention and control programmes, are the most effective interventions that can significantly reduce stunting and acute malnutrition during the first two years of life.

Breastfeeding impacts growth in several ways, such as through reduction of morbidity due to infections, stronger immunological response to disease due to transfer of maternal antibodies and provision of the optimum balance of nutrients, growth factors, enzymes, hormones and other bioactive factors. For example, reviews of evidence on the effects on child health and growth of exclusive breastfeeding for six months have presented lower morbidity from gastrointestinal and allergic diseases, which in turn can prevent growth faltering due to such illnesses<sup>14</sup>. Breast milk contains substances essential for optimal development of the infant's brain, with effects on both cognitive and visual functions.

Breastmilk alone is enough to meet all the nutritional needs of infants for the first six months of life. After six months of age, to meet all of a child's nutritional requirements breastmilk needs to be complemented by other foods, although it continues to be an important source of nutrients as well as impacting disease morbidity and mortality<sup>15</sup>. At this age children have high nutritional needs for rapid growth, and **appropriate complementary feeding** provides key nutrients (e.g. iron and other micronutrients, essential fatty acids, protein, energy, etc.). Inadequate complementary feeding lacking in quality and quantity can restrict growth and jeopardize child survival and development.

## 1.5 MIYCN and Child Development

The period from pregnancy to about 36 months (specifically the first 1000 days – the critical window of opportunity) is a critical period in early childhood development for stimulating positive cognitive development, particularly in settings where ill health and under nutrition are common<sup>16</sup>. Mother's optimal nutrition is the core for promoting optimal early childhood stimulation. Furthermore, a *Lancet* series on Child Development<sup>17</sup> recognized tackling stunting

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<sup>13</sup> Scrimshaw NS et al. Interactions of nutrition and infection. Geneva: World Health Organization. 1968.

<sup>14</sup> Kramer MS, Kakuma R. The optimal duration of exclusive breastfeeding: a systematic review. *Advances in Experimental Medicine and Biology* 2004; 554:63-77.

<sup>15</sup> Jones G. et al. How many child deaths can we prevent this year? (Child Survival Series) *The Lancet* 2003 Vol. 362.

<sup>16</sup> Sternberg R.J. Intelligence and lifelong learning: what's new and how can we use it? *Am Psychology* 1997 Oct; 52(10):1134-9.

<sup>17</sup> Engle P et al. Strategies to avoid the loss of developmental potential in more than 200 million Children in the developing world. *The Lancet* 2007: 369.

and iron deficiency as two of the four most effective early childhood development interventions, along with addressing iodine deficiency and cognitive stimulation.

In addition, breastfeeding and responsive feeding provide constant positive interactions between mother and child which can contribute to emotional and psychological development of infants. There is also strong evidence of higher performance in intelligence tests among those subjects who had been breastfed as infants<sup>18</sup>.

## **1.6 MIYCN and Children with Severe Acute Malnutrition (SAM)**

Malnutrition has a negative impact on cognitive development, school performance and productivity. Stunting and iodine and iron deficiencies, combined with inadequate cognitive stimulation, are leading risk factors contributing to the failure of an estimated 200 million children to attain their full development potential. Each 1% increase in adult height is associated with a 4% increase in agricultural wages<sup>19</sup> and eliminating anaemia would lead to an increase of 5% to 17% in adult productivity. Malnutrition is an impediment to the progress towards achieving Millennium Development Goals 1 (Eradicate extreme poverty and hunger), 2 (Achieve universal primary education), 3 (Promote gender equality and empower women), 4 (Reduce child mortality), 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases)<sup>20</sup>.

Children with SAM are nine times at risk of death. It is recommended that any training on management of SAM (facility-based or Community based management of acute malnutrition (CMAM)-(Village Child Development Centres in Maharashtra) including during an emergency should include a module on MIYCN counselling<sup>21</sup>. MIYCN and CMAM should be conceptualized and planned as two integral parts of a single programme to prevent and treat under nutrition, not as two completely separate programmes. The design, planning, training, community mobilization, health and ICDS worker activities and supervision structures should address both CMAM and MIYCN in one single package. Empowering mothers and care givers on MIYCN would contribute significantly in preventing the child from severe acute malnutrition.

Before discharge of children admitted with SAM, review of feeding practices of the malnourished children should be done. Counselling on exclusive breastfeeding or

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<sup>18</sup> Horta, B *et al.* Evidence on the long-term effects of breastfeeding: systematic review and Meta-analyses. WHO 2007.

<sup>19</sup> Haddad L, Bouis HE. The impact of nutritional status on agricultural productivity: wage evidence from the Philippines. Warwick (United Kingdom of Great Britain and Northern Ireland), Development Economics Research Centre. Papers, No. 97, 1989.

<sup>20</sup> Annex 2, Comprehensive implementation plan on maternal, infant and young child nutrition endorsed by 65th World Health Assembly, Geneva, May 2012.

<sup>21</sup> The UNICEF Community MIYCN Counselling Package can be used; it contains sessions tailored to the context of SAM.

continued breastfeeding and timely, safe, appropriate and adequate complementary feeding (after 6 months of age) should be done. This should include demonstration of food preparation and sharing of recipes with mothers for optimal use of locally available foods for children 6-23 months.

## 1.7 HIV and Infant Feeding

HIV infection has both a direct impact on the nutritional status of women and children who are infected and an indirect effect through alterations in household food security and inappropriate choices of infant-feeding practices in order to prevent mother-to-child transmission of HIV. Poor food security also increases risk-taking behaviour by women that places them at increased risk of becoming infected with HIV.

For all infants born to HIV-infected women, breastfeeding is strongly recommended as the feeding option of choice. This holds true irrespective of whether the mother is receiving ART, ARV prophylaxis during pregnancy and lactation, or neither. In view of emerging evidence, extended anti-retroviral (ARV) prophylaxis to infant and/ or mother should be considered for preventing postnatal transmission of HIV.

With provision of anti-retroviral interventions, **breastfeeding is made dramatically safer** and the “balance of risks” between breastfeeding and replacement feeding is fundamentally changed. The mother’s own health is also protected.

## 1.8 MIYCN and breast feeding mothers at work places

Employment modifies breastfeeding behaviour of a woman in significant manner with full time employment having the most detrimental impact. In a study by Mandal and his co-workers it has been established that, in comparison with non-working mothers, the probability of breastfeeding cessation among full time workers was four times as higher for women availing maternity leave of less than 6 weeks while it was half for women with less than 12 weeks of leave.<sup>22</sup>

In Urban areas many families need and use Child Care Services (Day Care/Creche) while in rural areas infants are carried to work by mothers or are left at home with care takers many a times they being the older sibling at home. In the Scholars Research Library from the Annals of Biological research, 2011, it is mentioned that during the first six months of life, children who develop the best

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<sup>22</sup> Infant & Young Child Feeding Behaviours among working mothers in India: Implications for Global health Policy and Practice by Dr. Vinay Kumar et. al; International Journal of MCH & AIDS (2015), Vol 3, Issue 1, Pg 7-15

are those who have a tremendous amount of attention, and who enjoy a lot of fun play. When the children begin crawling at six or seven months of age, they need access to someone who is excited to teach them. This process helps to support their curiosity, increase their enthusiasm, and help their overall development. It is very rare for a caregiver to show the same amount of interest in a child that a parent would. This is because mothers are very quick to respond to a baby's non-stop demands for love and attention.

In Maharashtra there are higher number of women working in unorganized sector like in fields, construction sites, brick kilns etc as daily wage labourer than the women working in organized corporate sector. The maternity benefits are available to mothers working in the organized sector but is missing completely in the unorganized sector. This policy guidelines will help support breast feeding and nursing of children to the working mothers in the organized as well as unorganized sectors .

## **1.9 MIYCN in emergencies –Natural and man-made disasters**

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. The MIYCN strategies need to specifically address MIYCN programming in emergencies<sup>23</sup> for the following reasons:

Maternal nutrition during emergencies is compromised which in turn affects the fetal nutrition. During emergencies/disasters and epidemics pregnant and lactating mothers are prone to malnutrition & infections. Hence pregnant women and lactating mothers should be given food supplements/food grains with priority along with recommended micronutrient supplements and should receive medical check ups at frequent intervals.

The best food for all infants in exceptionally difficult circumstances and emergencies is their own mother's milk unless medically contraindicated. Breastfeeding is safe, free and a crucial life-saving intervention for vulnerable children whose risks of death increase markedly in emergencies. Emergency situations exacerbate risks for non-breastfed children and those who are on mixed feeding. Both exclusive breastfeeding up to 6 months and continued breastfeeding after 6 months are crucial in reducing the risk of diarrhoea and other illnesses in older children, which is heightened in emergencies.

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<sup>23</sup> Infant and young child feeding: programming guide. UNICEF, 2012

Donations of breast milk substitutes undermine breastfeeding and cause illness and death. Safe, adequate, and appropriate complementary feeding, which significantly contributes to prevention of under nutrition and mortality in children after 6 months, is often jeopardized during emergencies and needs particular attention. MIYCN is central to reducing the high risk of undernutrition during emergencies.

## **1.10 Current Status of MIYCN in Maharashtra**

Maharashtra has made progress in addressing neo-natal mortality, IMR and under-5 mortality. However, the reduction in IMR as per the SRS 2013 has been only by one point and neonatal mortality continues to be a challenge in the high burden districts and blocks.

### **a) Adolescent and maternal nutrition situation in Maharashtra**

There is a high level of undernutrition in rural areas among adolescent girls and women in the reproductive age group. As per the latest NFHS 4 data, 23.5% women in the age group of 15-49 years have body mass index (BMI) below 18.5 kg/ m<sup>2</sup>. The prevalence of low BMI is 30% among women residing in the rural areas and 16.8% women from the urban areas had BMI < 18.5 kg/m<sup>2</sup>. Nearly a quarter of the women (23.4%) from this age group are either overweight or obese with BMI > 25 kg/m<sup>2</sup><sup>24</sup>.

The prevalence of anemia is high among 15-49 year old women in the state. Whereas 47.9% non-pregnant women are anemic, the proportion of anemia is slightly higher among pregnant women at 49.3%.

### **b) Infant and Young child nutrition situation in Maharashtra**

The nutritional status of the children as assessed through the measurement of height and weight indicates that among children under 5 years of age as per NFHS-4 are as follows: 34.4% are stunted, 25.6% are wasted, 9.4% severely wasted and 36% are underweight.

The Comprehensive Nutrition Survey Maharashtra (2012)<sup>25</sup> was the first survey carried out in the country that provided estimates of nutritional status and feeding practices of children in their first two years of life. This survey provided key insights regarding the onset of undernutrition among young children as well gaps in their feeding practices.

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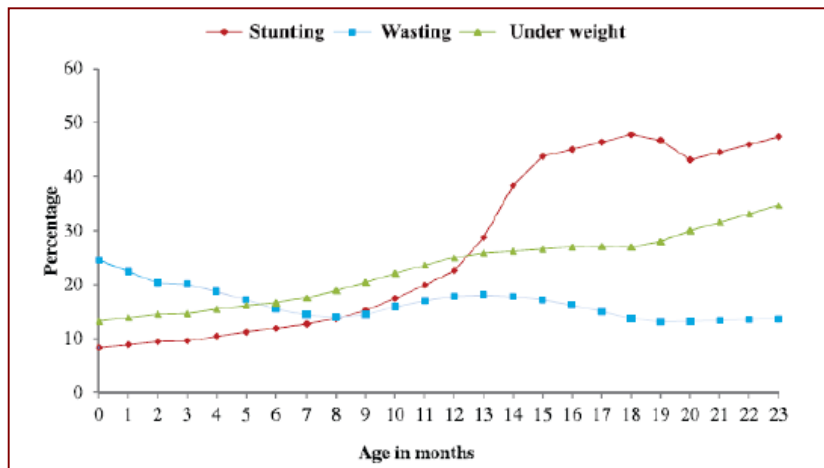
<sup>24</sup> National Family Health Survey 4 Fact Sheet for Maharashtra 2016

<sup>25</sup> IIPS and UNICEF 2012



For example, the CNSM data indicated that the nutritional status of children as assessed by both the prevalence of stunting and underweight deteriorated with increasing age (23.3% were stunted, 16.3% were wasted and 22.6% were underweight for children below 2 years of age<sup>26</sup>.); especially the sizeable deterioration occurred after completion of the first year of age indicating that opportunity for improving nutrition may diminish if timely and targeted essential interventions failed to reach these children. For example, the prevalence of stunting doubled from 15 per cent among children aged 9-11 months to 31 per cent among children aged 12-17 months and further to 41 per cent among children aged 18-23 months. This is indicative of a very small window of opportunity to improve the children's nutrition. This is adequately presented in Figure 1.

Figure 1



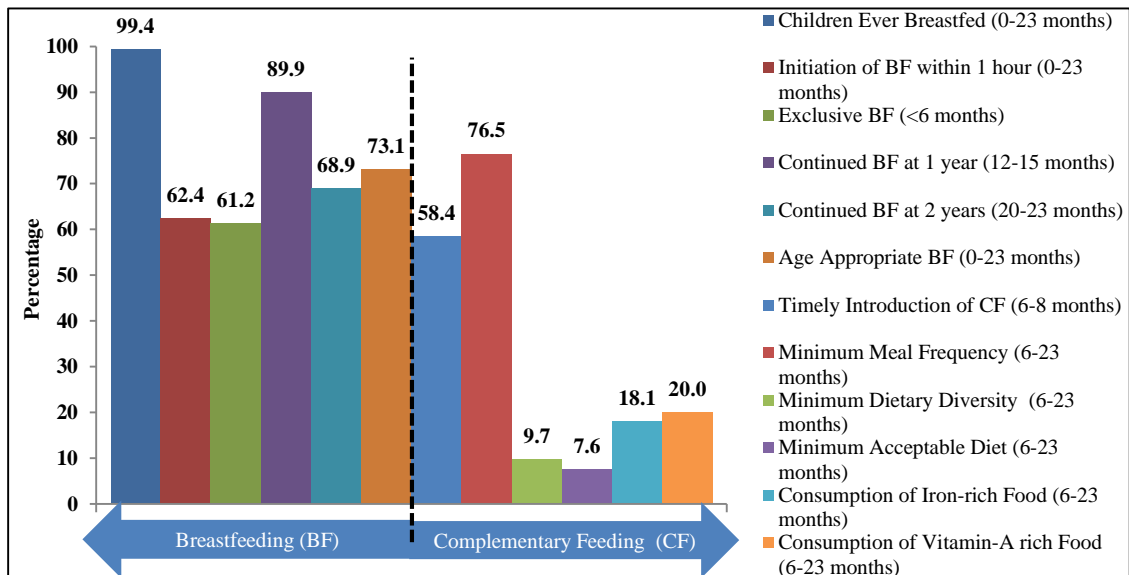
As per NFHS 4, 90.3% deliveries that take place in Maharashtra are institutional. However, initiation of breastfeeding within one hour birth takes place for only 57.5% of the newborn. Only 56.6% children under 6 months of age are exclusively breastfed, and only 43.3% 6-8 month old children are fed semi-solid or solid complementary food along with breast milk. Overall, only 6.5% children age 6-23% months receive an adequate diet.

CNSM 2012 data provided an excellent gap analysis of breastfeeding and complementary feeding practices of young children in the state (Figure 2). Similar data from NFHS 4 are yet to be released and only the fact sheet is currently available.

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In CNSM, although nearly all children were ever breastfed, only 61 per cent children below six months were exclusively breastfed. It may be noted that though three-fourths of the children were fed minimum number of times (minimum meal frequency), less than 10 percent of children were fed minimum number of food groups (minimum dietary diversity), resulting in only 8 percent 6-23 month old children receiving a minimum acceptable diet.

Figure 2



## **1.11 Rationale for a comprehensive MIYCN policy in Maharashtra**

A state policy on MIYCN is an important pre-requisite to successful strategic planning and implementation. A comprehensive policy will ensure optimal attention to an action on maternal, infant and young child nutrition at various levels within the health system, at the community level and in other key sectors such as Women and Child Development, Water and Sanitation, Rural Development, Tribal Development and Urban Development, Education, Social Welfare, Medical Education, Planning, Higher technical education, existing flagship programmes, professional bodies and academia.

Adequate provision of nutrients, beginning in early stages of life, is crucial to ensure good physical and mental development and long-term health. Poor availability or access to food of adequate nutritional quality or the exposure to conditions that impair absorption and use of nutrients has led to large sections of the population being undernourished, having poor vitamin and mineral status or being overweight and obese, with large differences among population groups<sup>27</sup>.

In women, both low body mass index and short stature are highly prevalent in low-income countries, leading to poor fetal development, increased risk of complications in pregnancy, and the need for assisted delivery.<sup>28</sup> Maternal anaemia is associated with reduced birth weight and increased risk of maternal mortality. Anaemia rates have not improved appreciably over the past two decades<sup>29</sup>.

This policy envisages addressing two basic fundamental rights, i.e. Right to Motherhood, and Right to Survival, Growth & Development of young children. This policy would provide the opportunity for the policy makers and programme implementers, front-line functionaries, mother and care givers, community members to ensure the implementation of recommended MIYCN practices and the principles of actions and critical areas of implementation with accountability. The policy will also provide the opportunity for high level advocacy with key sectors to ensure that MIYCN is recognised as an important contributor to achieving the determined State goals for reducing the maternal mortality & morbidity, neo-natal mortality, infant mortality, U-5 mortality, and child under-nutrition. All relevant sectors must have MIYCN on their agenda.

Optimal maternal, infant and young child feeding (MIYCN) contributes to improved nutrition and child survival in young children, and good nutrition is a

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<sup>27</sup> Annex 2, Comprehensive implementation plan on maternal, infant and young child nutrition endorsed by 65th World Health Assembly, Geneva, May 2012.

<sup>28</sup> Black RE et al. Maternal and Child Undernutrition Study Group. Maternal and child undernutrition: global and regional exposures and health consequences. *Lancet*, 2008; 371:243-260.

<sup>29</sup> United Nations System Standing Committee on Nutrition. Progress in nutrition: Sixth report on the world nutrition situation. Geneva, United Nations System Standing Committee on Nutrition Secretariat, 2010.

foundation for sustainable development. The State of Maharashtra has been supporting the roll out of correct maternal, infant and young child feeding through its existing flagship programmes such as the National Health Mission (NHM) and the Integrated Child Development Services (ICDS). Currently, most of the frontline functionaries of health and nutrition are either trained or sensitised on MIYCN. As part of the NHM initiative, the State has been promoting institutional deliveries to provide quality care to pregnant women, lactating mothers, and the newborn along with implementing maternity benefits schemes such as Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK).

The national and global evidence clearly points out the importance of institutionalization of MIYCN practices both at the facility and community that can significantly impact on improving young child survival, growth and development. The State is committed to ensuring that young children are provided with the best start in life for optimal growth and development.

In addition to all the available guidance and guidelines on MIYCN at the national and State level, a comprehensive MIYCN policy is the need of the hour to build accountability and responsibility of the service providers at all levels from the health and nutrition care systems, other core sectors, academia, professional bodies, NGOs, and the community members.

## **1.12 Existing Policies and Guidelines pertaining to MIYCN**

India has recently updated guidelines published in 2013 for enhancing infant and young child feeding practices developed by the Ministry of Health and Family Welfare. However, there is no national policy on MIYCN.

The 1993 National Nutrition Policy of the Ministry of Women and Child Development, Government of India states that the major nutrition issues related to young children are under nutrition, deficiencies of iron, iodine, and vitamin A, and prevalence of low birth weight, seasonal infections, urbanization, and nutrition problems related to natural calamities and disasters. These issues are still relevant and would directly or indirectly affect infant and young child feeding practices.

The 2013 updated National Guidelines for Prevention of Parent to Child Transmission (PPTCT) of HIV include a chapter on recommended infant feeding practices for HIV exposed and infected infants and children up to 2 years. The Nutrition Guidelines for HIV exposed and infected children 0-14 years (2013) provide a comprehensive guidance on safe breastfeeding up to 12 months, criteria for replacement feeding, complementary feeding of 6-23 month old children with quantity, quality and frequency of meals, and guidance based on nutrition requirements of HIV infected children up to 14 years with special focus on children with special needs and severe acute malnutrition.

The State departments (Public Health and Women and Child Development) follow the national guidelines and state-specific policy or guidelines on MIYCN have not been formulated.

To be incorporated into the primary health care system, MIYCN has to be included as one of the major preventive interventions in the state health policies and strategies, as well as monitored and evaluated on a regular basis, preferably with indicators included in the health management information systems (HMIS).

## 1.13 Rationale for MIYCN through health system

Health service providers both from Government and private sectors are often influential figures in the society and the messages, counselling and advice they provide play a crucial role in ensuring optimal MIYCN practices. The experiences of mothers in the existing health care services and centres exert a strong influence on breastfeeding initiation and later infant feeding behaviour.

In Maharashtra, the current public health delivery system is strong and has the ability to integrate MIYCN practices using its various contact points such as ARSH clinics, ANC clinics, PNC clinics, the VHND, Immunisation Session, High-Risk Clinics, District, Sub district & Rural Hospitals, Maternity Homes, Women's Hospitals, Facility based newborn care and home visits provided by ASHAs as part of the home-based new-born care and implementation of the IMNCI protocol.

With implementation of the policy, MIYCN will be one of the major preventive interventions in the State Health plans (the Maternal and Child Health Programme Implementation Plan with approved budgets) and will be monitored and evaluated on regular basis with indicators included in the health management information system.

## 1.14 Goal

To provide an implementation framework for ensuring the optimal nutrition status of women, and enhancing the nutrition, health, growth and development of infants and young children, as well as strengthening the care and support services to their parents and caretakers to help them achieve optimal IYCN through the existing health and nutrition system.

This policy aims at

- Reduction of MMR from 68 to 30 per 100 000 live births by 2020, NMR from 18 to 9 per 1000 live births by 2020, IMR from 24 to 12 per 1000 live births by 2020; U5MR from 28 to 14 per 1000 live births by 2020.
- Reduction of stunting among children under five from 34.4% (NFHS-4) to 20% by 2020.
- Contributing to reduction in incidence of Wasting in children under five from 25.6% (NFHS-4) to 10% by 2020.<sup>30</sup>
- Reduction in severe wasting in children under five from 9.4% (NFHS-4) to <5% by 2020.
- Reduction in underweight in children five from 36% (NFHS-4) to 15% by 2020.
- Reduction in anaemia among children 6-59 months from 53.8% (NFHS-4) to 25% by 2020.
- Reduction in anaemia in non-pregnant women age 15-49 from 47.9% (NFHS-4) to <20% by 2020.

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30 Based on CNSM, 2012 data that provides a baseline for MIYCN indicators for children under 2 from Maharashtra.

- Reduction in anaemia among pregnant women age 15-49 from 49.3% (NFHS-4) to <20% by 2020.
- Improving the maternity care of mothers who had full ante natal care from 32,4% (NFHS-4) to 90% by 2020.
- Improving the rates of providing health check-up of infants after birth from doctor/nurse/ANM within two days of birth from 30.5% (NFHS-4) to 80% by 2020.
- Reduction in low birth weight babies from 20% (RSOC-2015) TO <5% by 2020.

## **1.15 The specific Objectives for policy implementation**

- Ensure that all postnatal mothers receive timely help for adequate nutrition & breastfeeding problems in the postnatal period  
***Improve the rates of timely initiation of breastfeeding within one hour of birth in children under age 3, from 57.5% (NFHS-4) to at least 70% by 2018.***
- Ensure that all women exclusively breastfeed their infants in the first six months of their life through counselling at points of contact with the public health and ICDS systems.  
***Improve the rates of exclusive breastfeeding for children under 6 months of age from 56.6% (NFHS-4) to 70% by 2018***
- Ensure that all women start introduction of appropriate complementary foods at the beginning of seventh month along with continued breastfeeding.  
***Improve the rates of timely introduction of solid or semi solid complementary foods (with continued breast feeding) in children age 6–8 months from 43.3% (NFHS-4) to at least 65% by 2018***
- Ensure that all women provide age-appropriate quality complementary foods to their children, with adequate (recommended) meal frequency.
  - ***Improve the rates of breastfeeding children age 6-23 months receiving adequate diet from 5.3 % (NFHS-4) to 35% by 2018.***
  - ***Improving the total number of children age 6-3 months receiving adequate diet from 6.5% (NFHS-4) to 35% by 2018.***
  - ***Ensuring children under five with diarrhoea receiving ORS with zinc from 13% (NFHS-4) to 50% BY 2018.***

## **1.16 The Programme Implementation**

### **Objectives**

- Ensure that all adolescents have a healthy BMI by giving them knowledge on appropriate nutrition, Health & sanitation, providing them with Iron Folic Acid supplementation to minimize the prevalence of Iron Deficiency Anemia.

- Ensure that all women give birth to a healthy baby, by providing adequate nutrition during pregnancy & Folic Acid supplementation in the preconception period, counselling them on adequate nutrition and providing support for institutional delivery.
  - During any emergency situation all pregnant women and lactating mothers should get extra food ration including essential micronutrient supplementation and medical examination during pregnancy and lactation period.
  - Advocate for appropriate interventions that promote and support the practice of optimal MIYCN for all women, including employed mothers.
  - Ensure that all workplaces support the mother to breastfeed as per the recommendations and provide adequate maternity leave and benefits to achieve the same
  - Ensure that mothers feel comfortable about nursing in public (NIP) and that the public places are supportive to NIP
  - Ensure that workplaces and public places create facilities for breastfeeding (Hirkani's Rooms).
  - Ensure that mothers and their families are counselled in the antenatal period about the benefits of maternal nutrition, breastfeeding, early initiation, breastfeeding positions and problems in first few days, how to prevent these and about exclusive breastfeeding.
  - Ensure that all mothers are given to hold their babies in skin-to-skin contact in about 5 mins of birth in order to initiate breastfeeding within one hour of delivery and maintain this contact till the first breastfeed is completed (Breast Crawl)
  - Ensure that mothers are counselled to breastfeed their children exclusively for 6 months through individual and group counselling.
- ***Ensure that all VHNDs become Four Dimensional (4D) by assessing Diet (Feeding practices), Development, Drugs (ancillary treatment: micronutrient supplementation, contraceptive advice etc) and finally Dose (Immunization)***
  - ***Ensure that nutrition and feeding is assessed in conjunction with WHO Growth standards***
    - Ensure that all women provide appropriate foods and feeding to sick children along with therapeutic feeding (e.g. ORS and zinc during diarrhoea) during illness and ensure hygienic practices during feeding.
    - Ensure that infant / Young Child is given additional feeds after recovery from illness, especially diarrhoea.
    - Ensure that all mothers provide appropriate feeding to the child during their own illness. If the mother is infected with HIV, she should be encouraged to exclusively breastfeed her infant for the first 6 months.
    - Ensure that all infants and young children who are exposed to or infected with HIV are provided with appropriate foods and feeding as per their age, nutrition and health status.



- Ensure that all low birth weight infants including those born with very low birth weight should be put to breast immediately after birth and fed breast milk.
- Ensure that all children diagnosed with malnutrition are provided with recommended IYCN counselling along with therapeutic feeding and care through facilities (e.g. Nutrition Rehabilitation Centres (NRC), Child Treatment Centres (CTC), and Village Child Development Centres(VCDC)) or managed at the community level.
- Ensure that all children below 6 months in emergency situations are provided only with breast milk by keeping mothers and their children together and no formula foods should be given to them.
- Enhance optimal MIYCN in other exceptionally difficult circumstances.
- Ensure all the delivery points and health facilities both in rural and urban, Govt. and private are accredited as Baby Friendly Hospitals under BFHI.
- Ensure the implementation of Infant Milk Substitute, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 2003.
- Ensure that all Health Care Providers (Governmental and Non-Governmental) and ICDS staff are adequately trained in MIYCN
- To crystallize roles and responsibilities of each Government Department, Private Sectors and Development Partners for optimally implementing MIYCN Policy.

## Chapter 2 : MIYCN Policy guidelines

### 2.1 Overview

This chapter details the various issues for MIYCN policy and their accompanying policy guidelines.

The policy guidelines have been divided into Five categories:

- Addressing adolescent, pre pregnancy & maternal nutrition
- Feeding the Infant/Young Child in "Normal" Circumstances
- Feeding the infant/Young child of working mother at workplaces
- Feeding the Infant/Young Child Exposed to HIV/AIDS
- Feeding Infant and Young Child in Other Specific Situations

### 2.2 Addressing Adolescent, Prepregnancy & Maternal Nutrition

	<i>Issue</i>	<i>Policy Guideline</i>
1	There are high levels of undernutrition in adolescent girls & pregnant women (NFHS-4). As high as 23.5% of mothers had low body mass index (BMI) < 18.5 kg/m <sup>2</sup> , which is much higher in rural areas (30%) compared to urban areas (16.8%)	<p>All adolescent girls should be empowered with knowledge on optimum nutrition, health, hygiene &amp; sanitation through platform of Rashtriya Kishor Swastha Karyakram and SABLA.</p> <p>The BMI of Adolescent girls, young women, married &amp; pregnant women (In first trimester only) should be measured on VHNDs, at ANC clinics &amp; Adolescent Health clinics and those with low BMI should receive counselling on increasing dietary intake, diversity, use of toilet and hand washing.</p> <p>All pregnant women &amp; lactating mothers should be provided with one Hot cooked meal, free of cost, in local anganwadi throughout her pregnancy and upto 6 months after childbirth as per THE NATIONAL FOOD SECURITY ACT 2013, <b>or</b> should get additional 5kgs of ration which should include 4kg of cereals and 1 kg of pulses/lentils free of cost through PDS</p>

		anywhere in state after she submits the pregnancy confirmation certificate from appropriate authority to the period upto 6 months after childbirth.
2	Short stature, low BMI, Vitamin & Mineral deficiencies in pregnancy contribute to maternal morbidity & mortality, fetal growth restriction, infant mortality and stunted growth & development <sup>31</sup> . In Maharashtra, 47.9% of adolescents (15-19 yrs) are anaemic and 49.3% pregnant women are anaemic of which 12.0% suffer from severe anaemia. (NFHS-4)	<p>Adolescents, young women, pregnant women and lactating mothers should be appropriately cared for and encouraged for optimum nutrition and health care throughout the life cycle.</p> <p>All Adolescent girls, women in age group of 15-49 years, Pregnant &amp; Lactating mothers should be routinely tested for Hemoglobin and given IFA supplementation deworming medicine as per National Iron Plus Initiative guidelines and should be counselled for compliance.</p> <p>Along with this all pregnant women and lactating mothers should also receive other necessary micronutrients (including Vitamin D3 and Calcium) in adequate quantities.</p>
3	Micronutrients deficiencies like Iodine deficiency and folate deficiency constitute for single greatest cause of preventable brain damage in fetus and infants and increases risk of fetal malformation in form of neural tube defects <sup>32</sup> . Birth defects account for 7% of all neonatal mortality & 3.3 million under 5 deaths. In India prevalence of birth defects varies from 61 to 69.9/1000 live births. <sup>33</sup>	<p>All families and communities should be counselled for use of iodized salt for cooking and iodized salt should be made available under PDS.</p> <p>The newly married couples should be counselled for planned pregnancy and women in the reproductive age group who are planning pregnancy should be provided with Tab. folic acid in preconception period.</p>
4	In developing countries babies conceived less than six months after a prior birth were found to be 42% more likely to be born with a low birth weight than those born after more than two years; babies conceived within 6–11 months after a prior birth were 16% more	<p>All pregnant women &amp; their spouses should be counselled for Family Planning during the ANC visits.</p> <p>A choice of family planning methods including PPIUCD should be given to the couple during the Post-natal period (HBNC, Immunization or any other contact point)</p>

<sup>31</sup> Lancet series on Maternal & child Health 2008

<sup>32</sup> WHO – Neurological disorders: A Public Health Approach

<sup>33</sup> Birth Defects in India: Hidden Truth, need for urgent attention by Rinku Sharma, Indian Journal of Human Genetics, 2013 Apr-Jun 19(2), 125-129

	likely to have a low birth weight. <sup>34</sup> Currently, in Maharashtra, the low birth weight babies are 20%.	
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## 2.3 Feeding the infant/young child under "normal" circumstances

	<b>Issue</b>	<b>Policy Guideline</b>
5	Although 92% of births in Maharashtra are institutional, only 57.5% of mothers initiate breastfeeding within one hour of birth, and 56.6% infants (0-5 months) are exclusively breastfed (NFHS-4).	<p>All mothers undergoing normal as well as LSCS deliveries should be counselled to give skin-to-skin contact (Breast Crawl) in order that baby initiates breastfeeding within an hour of delivery, to continue this skin-to-skin contact till the first breastfeed is completed. Skin to skin contact between mother and newborn should be encouraged by 'bedding in' the mother and the baby together.</p> <p>Skin to skin contact (Kangaroo Mother care) can be given to all newborns as it helps in better bonding between the mother and child, optimal temperature maintenance &amp; better feeding.</p>
6	Fetal growth restriction and sub-optimal breast feeding together are responsible for more than 19% of all under 5 child deaths <sup>35</sup>	<p>All mothers should be counselled for proper breast care from ANC period and to exclusively breastfeed their infants and the feeding should be on cues (which include sucking movements and sucking sounds, hand to mouth movements, rapid eye movements, soft cooing or sighing sounds, lip smacking, restlessness etc. Crying is a late cue and may interfere with successful feeding) for the first completed 6 months (180 days) of the infant's life unless medically contradicted.</p> <p>In case of locational failure, mothers should be supported for relaxation through supplementary suckling technique as per Government of India guidelines.<sup>36</sup></p>

<sup>34</sup> Every Woman's Right Report-June 2012, How Family Planning Saves Children's Lives, Save the Children.

<sup>35</sup> Lancet series of Maternal & child Health 2008

<sup>36</sup> Facility based management of Severe Acute Malnutrition

7	43% of infants got timely complementary feeding, and 5.3% got adequate diet. (NFHS-4).	<p>Parents shall be counselled to introduce adequate, safe (homemade, fresh &amp; hygienically prepared), proper consistency and appropriately fed complementary foods after completion of 6 months of the infant's life while they continue breastfeeding for up to 2 years or beyond.</p> <p>Every Kitchen should have hand washing facility and the caregivers should be encouraged for practicing handwashing with soap before food preparation and child feeding.</p>
8	Micronutrients deficiency adversely affect child health & survival and deficiency of Iodine & Iron together with stunting contribute to children not reaching their developmental potential. <sup>37</sup> Children aged 9-59 months who received Vit.A dose in last six months is 70.5% (NFHS-4)	<p>Every child should receive appropriate micronutrient supplements as per age. Vitamin A supplementation every 6 months between 9 months to 5 yrs of age in appropriate dosage.</p> <p>All children suffering from Diarrhoea and acute malnutrition should be given Zinc supplementation as per guidelines.</p> <p>Nutrition education should be given to all mothers and care givers for dietary diversity to include macronutrient dense &amp; micronutrient rich foods and use of iodized salt in diet.</p> <p>All infants and young children should get IFA supplementation from 6 months of age as per the NIPI guidelines of GoI 2013.</p>
9	Regular growth monitoring is done by ICDS. In Maharashtra, 36.6% children under the age of 5 years are underweight. <sup>38</sup> (NFHS-4)	Growth Monitoring & Promotion is an important arm of MIYCN policy. All infants & children upto 3 yrs of age should be weighed monthly and thereafter minimum quarterly weight monitoring should be done using new WHO growth standards. Similarly, growth monitoring for all sick infants & children seen in OPD and IPD is necessary.

<sup>37</sup> Lancet series of Maternal & child Health 2008

<sup>38</sup> Comprehensive Nutrition Survey Maharashtra 2012

		<p>Review of feeding practices &amp; counselling on exclusive breastfeeding for first six months (180 days), introduction of appropriate complementary foods from beginning of 7<sup>th</sup> month onwards with continued breastfeeding for 2 years and beyond. Demonstration of food preparation and sharing of recipes for optimal use of locally available foods for children 6-23 months old is necessary.</p> <p>Supplementary nutrition should be provided free of cost to all pregnant women and upto 6 months post childbirth, and to children in age group of 6 months to 6 yrs., through the local Anganwadi. In the case of children, up to class VIII or within the age group of six to fourteen years, whichever is applicable, one mid-day meal, free of charge, everyday, except on school holidays, in all schools run by local bodies, Government and Government aided schools should be provided under Mid-Day Meal Scheme as per THE NATIONAL FOOD SECURITY ACT 2013.</p>
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## 2.4 Feeding the Infant/Young Child of a working mother at work places

	<i>Issue</i>	<i>Policy Guideline</i>
10	More than 40% of women in Maharashtra are working women, with 30.79% in rural areas & 11.88% in urban areas. Of these almost 80% work on daily wages with 41.14% working as agricultural labourer, 35.84 as cultivators and 3.65% in household industry <sup>39</sup> .	<p>All working mothers in organized sectors should get all benefits as per the Maternity Benefit Act 1961 &amp; Maternity Benefit (Amendment) Act 2008</p> <p>All Working mothers from the tribal areas, drought &amp; flood prone areas, marginalized population, working in unorganized sectors should be given loss of wages for the last trimester and first 6 months of post-natal period to support the optimum nutrition &amp; rest for the pregnant women and exclusive breastfeeding for first six months of infants</p>

<sup>39</sup> [Report on statistical profile on women labour by Ministry of Labour & Employment, GoI – 2007-08](#)

		<p>life.</p> <p>All working mothers in organized &amp; unorganized sectors should get equal opportunity to nurse and breast feed their infants even at work places.</p> <p>Workplaces should create safe facilities with adequate privacy/Hirkani kaksha for helping working mothers to nurse and breastfeed their infants.</p> <p>Adequate facilities in organized sector workplaces should be available at the nursing/lactation room to support mother to express and store (Refrigerate) the breast milk to be fed to the child.</p> <p>All working mothers should get adequate break time (atleast 25-40 min) every 3-4 hours or as per the workflow to support breastfeeding for the child.</p> <p>There should be provision of crèche services for the children of working mothers as per The Factories Act 1948, amended by the Factories (Amendment) Act 1987 (Act 20 of 1987). In unorganized sector the crèche should be established with the Anganwadi as per the MWCD directives for Strengthening &amp; Restructuring of ICDS – dated 22<sup>nd</sup> October 2012.</p>
11	<p><b>Paternity Benefits:</b></p> <p>At present there are no Paternity benefits available to fathers in Maharashtra for child’s birth. Fathers have very important role to play by ensuring the well-being of the postnatal mother and the new born by supporting adequate nutrition and care for both.</p> <p>Central Government has allowed 15 days of Paternity leave to a male member of the service with</p>	<p>All males with less than two surviving children working in organized sectors and unorganized sectors should be entitled for 15 days of Paternity leave during the confinement of his wife for childbirth or upto six months from the date of delivery of the child. This leave should be utilized by the person to support the health and nutrition well-being of the mother and newborn.</p> <p>The leave should be a paid leave and should not be debited against the leave account. In exceptional circumstances of maternal death or serious maternal illness Paternity</p>

	less than 2 surviving children. <sup>40</sup>	<p>or maternal psychiatric illness the father of the newborn should be granted additional Paternity leave for 30 days (Total 45 days) to ensure the well-being and nutrition rehabilitation of the infant.</p> <p>In organized as well as unorganized sector the employer shall not normally refuse Paternity Leave under any circumstances.</p>
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## 2.5 Feeding the Infant/ Young Child who is exposed to HIV

	<i>Issue</i>	<i>Policy Guideline</i>
12	<p>Mother-to-Child transmission of HIV is a major route of HIV infection in children. However, out of an estimated 27 million pregnancies in a year, only about 52.7% attend health services for skilled care during child birth in India<sup>41</sup>. Many pregnant women do not undergo routine HIV counselling and testing. In Maharashtra, 23% pregnant women do not undergo HIV counselling and testing during pregnancy (MSACS 2013-2014).</p>	<p>Counselling and voluntary confidential testing of HIV should be done for all pregnant mothers as part of the routine ANC.</p> <p>All pregnant women diagnosed with HIV should be linked to HIV services for their own health as well as to ensure prevention of HIV transmission to newborn babies under the PPTCT programme.</p> <p>As per WHO new guidelines (June 2013), life-long ART (Triple drug regimen) should be provided to all pregnant women &amp; breastfeeding mothers living with HIV regardless of the CD4 count or clinical stage, both for their own health &amp; prevent vertical HIV transmission from mother-to-child.</p>
13	<p>Without intervention, one in Ten children born to HIV-infected mothers gets infected with HIV through breastfeeding<sup>42</sup>.</p>	<p>All infants less than 6 months of age who are exposed to or infected with HIV should receive exclusive breastfeeding for atleast first 6 months completed after which complementary feeding should be introduced gradually, irrespective of whether the infant is diagnosed HIV negative or positive by EID.</p>

<sup>40</sup> The All India Services (Leave) Rules, 1955

<sup>41</sup> Updated Guidelines for Prevention of Parent To Child Transmission (PPTCT) of HIV using Multi Drug Anti Retroviral Regimen in India by NACO; Dec 2013

<sup>42</sup> DeCock et al. JAMA.2000; 283:1175-1182



		<p>Only in situations where breastfeeding cannot be done (maternal death, severe maternal illness) or individual mother's choice (at her own risk), then exclusive replacement feeding may be considered. However for exclusive replacement feeding all criteria for replacement feeding must be met:</p> <ul style="list-style-type: none"><li>• Safe water and sanitation are assured at the household level and in the community, and</li><li>• The mother or other caregiver can reliably afford to provide sufficient RF (milk), to support normal growth and development of the infant, and</li><li>• The mother or caregiver can prepare it frequently enough in a clean manner so that it is safe and carries a low risk of diarrhea and malnutrition, and</li><li>• The mother or caregiver can in the first six months exclusively give RF, and the family is supportive of this practice and</li><li>• The mother or caregiver can provide health care that offers comprehensive child health services.</li></ul> <p>Mixed feeding (Breast milk and replacement feeds) should not be done within first 6 months of infants life.</p> <p>Breastfeeding should NOT be stopped abruptly and mother who decide to stop breastfeeding should stop gradually over one month.</p> <p>The guidelines for feeding of an infant including breastfeeding and complementary feeding should be adhered to strictly as per the National guidelines for Prevention of Parent-to-Child Transmission of HIV by NACO.</p>
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## 2.6 Feeding Infant and Young Child in Other Specific Situations

	<i>Issue</i>	<i>Policy Guideline</i>
14	<p><b>Feeding in preterm / low birth weight infants</b></p> <p>Breast milk intake is not adequately promoted for low birth weight (LBW) babies. In Maharashtra, 20% children born are LBW (RSOC-2015).</p>	<p>Mothers and care takers of low birth weight (LBW) babies should be promoted and facilitated to give KMC (Kangaroo Mother Care). KMC helps faster stabilization, optimal temperature maintenance, better feeding, higher weight gain, lesser complications, early discharge from NICU/SNCU/NBSU, better neurodevelopment and hence lesser health costs. KMC should be continued at home after discharge.</p> <p>Mothers of infants who are born with low birth weight but can suckle should be encouraged to breastfeed, unless there is a medical contra- indication.</p> <p>Mothers of low birth weight infants who cannot suckle well shall be encouraged and assisted to express breast milk and to give it by cup, spoon or Intra-gastric tube.</p> <p>If the baby is transferred to NBSU/SNCU/NICU, mothers should be supported to start breastmilk expression within hours of delivery, continue it at least 3 hourly during the day time and at least once at night. Arrangements should be made to transfer this milk to the baby.</p> <p>Ensure early transfer of mothers with the baby in NBSU/SNCU/NICU and that NBSU/SNCU/NICU has arrangement to accommodate the mothers in the immediate vicinity and that mothers are permitted to visit and hold and touch the baby at will if the baby's condition permits.</p> <p>Ensure that majority of babies are on exclusive breastfeeding or on breastfeeding</p>

		<p>plus expressed breastmilk at discharge from the NBSU/SNCU/NICU</p> <p>In settings where safe and affordable milk banking facilities are available or can be set up such as SNCU, LBW infants including those with VLBW, who cannot be fed on mother's own milk should be fed donor milk (non HIV infected) human milk.</p> <p>Periodic feeding should be practiced on medical advise in case of very small infant who is likely to become hypoglycaemic unless fed regularly, or an infant who does not demand milk in initial few days.</p> <p>Age appropriate micronutrients should be given to all preterm &amp; LBW babies.</p>
15	<p><b>Feeding of malnourished infants and children</b></p> <p>Malnourished infants and children do not receive adequate care, support and management. In Maharashtra, 9.3% children under two are severely wasted (NFHS-4),</p>	<p>Malnourished children should be provided with timely, adequate and quality medical care, nutritional rehabilitation and follow up.</p> <p>Breastfeeding should be continued as feeding on cues.</p> <p>Malnourished children should be given additional meals along with all essential micronutrients in adequate age appropriate dosage free of charge through local Anganwadis to bridge the nutrition gap as per THE NATIONAL FOOD SECURITY ACT 2013.</p> <p>WASH facilities should be supported in the households of malnourished children. Influential individuals, especially men should be engaged to help installation and maintainance of handwashing facility in the kitchen.</p>
16	<p><b>Feeding in special circumstances</b></p> <p><b>(a) Feeding during illness</b></p>	<p>Feeding during illness is important for recovery and for prevention of undernutrition. Even sick babies mostly continue to breastfeed and the infant can be encouraged to eat small quantities of nutrient rich foods, but more frequently and by offering foods that a child likes to eat. After the illness (eg; diarrhoea) the nutrient intake of child can be easily increased by</p>

		<p>increasing one or two meals in the daily diet for a period of about a month; by offering nutritious snacks between meals; by giving extra amount at each meal; and by continuing breastfeeding.</p>
	<p><b>(b) Infant feeding in maternal illnesses or in case of maternal death.</b></p>	<p>Most maternal illnesses do not need cessation of breastfeeding. In case where mother is suffering from painful and/or infective breast conditions like breast abscess &amp; mastitis may need temporary cessation of breastfeeding and need treatment for the primary condition. Breastfeeding should be started as soon as possible after completion of treatment.</p> <p>Chronic infections like tuberculosis, leprosy, or medical conditions like hypothyroidism need treatment of the primary condition and do not warrant discontinuation of breastfeeding.</p> <p>Breastfeeding is contraindicated when the mother is receiving certain drugs like anti-neoplastic agents, Lithium, anti-thyroid drugs like thiouracil, recreationally abused drugs like amphetamines, gold salts, etc<sup>43</sup>. Breastfeeding may be avoided when the mother is receiving following drugs- atropine, reserpine, psychotropic drugs. Other drugs like antibiotics, anaesthetics, anti-epileptics, antihistamines, digoxin, diuretics, prednisone, propranolol etc. are considered safe for breastfeeding. Expert medical advise should be taken for the timing of breastfeeding when the mother is on any medication.</p> <p>Psychiatric illnesses which pose a danger to the child's life e.g. postpartum psychosis, schizophrenia may need a temporary cessation of breastfeeding. Treatment of primary condition should be done and breastfeeding should be started as soon as</p>

<sup>43</sup> Nelson Textbook of Pediatrics, 17<sup>th</sup> edition, pg.no 160

		<p>possible after completion of treatment.</p> <p><b><u>In case of maternal death or when mother's milk is not available or is contraindicated:</u></b></p> <p>Replacement Feeding Options should be considered as per the choices.</p> <ul style="list-style-type: none"> <li>• Expressed Donor milk from the lactating mothers</li> <li>• Locally available modified animal milk</li> <li>• Formula milk</li> </ul> <p>Given the importance of breast milk to the infant, breastfeed for the infant should be encouraged by wet nursing by a lactating mother in family or community if culturally accepted or breastmilk available from milk banks. Where breastfeed is not available, modified animal milk should be used to feed the infant after following all safety &amp; hygiene measures.</p> <p>Formula milk is the last choice when all other options have been exhausted despite best efforts. The formula milk should be given under the guidance of a pediatrician and it should be in compliance with the IMS act.</p>
	<p><b>(c) Infant feeding in various conditions related to the infant</b></p>	<p>Breastfeeding on cues should be promoted in normal active babies. However, in difficult situations like very low birth weight, sick, or depressed babies, alternative methods of feeding can be used based on neuro-developmental status. These include feeding expressed breast milk through intra-gastric tube or with the use of cup and spoon. For very sick babies, expert guidance should be sought.</p> <p>An expert should be consulted in individualized cases with special situations like Gastro-Oesophageal Reflux Disease (GERD), Infants with Inborn errors of metabolism (Galactosemia, phenylketonuria etc) &amp; Infants with surgical</p>

		problems like babies with cleft lip / palate, hypotonic conditions, chin recession need special techniques to feed..
17	<p><b>Feeding in Emergencies and other difficult conditions</b> Optimal MIYCN for children in emergencies and other difficult / special circumstances is not adequately promoted.</p> <p>The children in this category include those in emergency situations; orphans; children in foster care and children born to unwed adolescent mothers; mothers suffering from physical or mental disabilities, drug or alcohol dependence; or mothers who are imprisoned or part of any disadvantaged and/or otherwise marginalized populations.</p>	<p>During emergencies, priority health and nutrition support should be arranged for pregnant and lactating mothers. Donated or subsidized supplies of breast milk substitutes (e.g. infant formula) should be avoided, must never be included in a general ration distribution, and must be distributed, if at all, only according to well defined strict criteria. Donations of bottles and teats should be refused, and their use actively avoided.</p> <p>Mothers, caretakers, and families should be counselled and supported to practice optimal MIYCN in emergencies and other exceptionally difficult / special circumstances. Mothers and their infants should be kept together to facilitate continued feeding and care.</p> <p>Infants born into populations affected by emergencies should be breastfed from birth to completion of 6 months (180 days) of age. In case where biological mother's milk is not available, alternative feeding options like replacement feeding options should be considered (as discussed under para in case of maternal death).</p> <p>Complementary foods should be prepared and fed frequently consistent with the principles of good hygiene and proper food handling.</p> <p>Safe drinking water supply should be ensured.<sup>44</sup></p>
18	<p><b>Nutrition support to Migrant Population anywhere in the state.</b> It is a well known fact that migration happens mostly in population who are from BPL</p>	<p>All pregnant women and lactating mothers &amp; children between 6 months to 6 years should get supplementary nutrition from the local Anganwadi along with all essential micronutrient supplements anywhere in the state.</p>

<sup>44</sup> Guidelines for Enhancing Optimal Infant & Young Child Feeding Practices; Government of India; 2013

	<p>category, from tribal and marginalized areas for purpose of employment reason. These migrant workers stay at the place of work which may be far away from the local settlement. Agriculture provides maximum (32.4 per cent) employment for the migrants in rural area while non-agriculture industry provides highest employment to migrants (27 per cent) in urban area.<sup>45</sup></p>	<p>Creche services should be made available by the employer or at the local anganwadi and services should be provided by the local anganwadi worker or creche worker along with additional supplementary nutrition.</p>
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<sup>45</sup> A report by Govt. of Maharashtra on Migration Particulars based on data collected in state sample of 64<sup>th</sup> round of NSS (July 2007-June 2008)

## Chapter 3 : Implementation Strategy

If MIYCN has to be incorporated into the primary health care system, it has to be included as one of the major preventive interventions in the state health policies and strategies, as well as monitored and evaluated on a regular basis, preferably with indicators included in the health management information systems (HMIS).

### 3.1 Implementation Framework

Actions to promote infant and young child feeding have been grouped at the following three levels:

- At health facilities
- During community outreach activities
- During community and home based care

#### 3.1.1 At Health Facility Level

Contact opportunities for Promotion of MIYCN in a health facility

- During and after institutional delivery :
- Inpatient services for children:
- Outpatient services and consultations for pregnant women, mothers and children:

<b>KEY PRACTICES AND SERVICE PROVIDERS IN HEALTH FACILITY</b>			
<b>Interventions</b>	<b>Actions and key practices</b>	<b>Primary responsibility</b>	<b>Supporting Role</b>
ANTENATAL CLINIC: at all MCH facilities and PPTCT/ delivery points	<ul style="list-style-type: none"> <li>• Counsel all pregnant women for optimum nutrition, rest and compliance for IFA consumption.</li> <li>• Counselling on avoiding mental stress, smoking, use of tobacco in any form or alcohol consumption during pregnancy</li> <li>• Counselling for early initiation, colostrum and exclusive breast feeding during third trimester.</li> <li>• Counselling for nipple problems &amp; Breast care</li> <li>• Specific counselling and management if mother is HIV positive</li> <li>• Importance of colostrum feeding</li> </ul>	<ul style="list-style-type: none"> <li>• Staff Nurses;</li> <li>• Nutrition Counsellor (when available at the facility) ;</li> <li>• ICTC counsellor</li> </ul>	<ul style="list-style-type: none"> <li>• Medical officer</li> <li>• ASHA</li> </ul>



	<ul style="list-style-type: none"> <li>• Counselling for birth spacing</li> </ul>		
<p>POSTNATAL WARD: At all delivery point</p>	<ul style="list-style-type: none"> <li>• Ensure initiation of breastfeeding within one Hour</li> <li>• Support for early initiation of breastfeeding, avoiding pre-lacteal feeds, promoting colostrum feeding, and establishment of exclusive breastfeeding;</li> <li>• Prevention and treatment of breastfeeding problems like engorgement, mastitis, breast abscess, cracked nipples etc</li> <li>• Direct observation by the health service provider for technique and attachment while breast feeding the infant for the first time and on a subsequent occasion</li> <li>• Teach every mother technique of hand expression of breastmilk</li> <li>• Birth weight, identification of LBW babies and appropriate management. Practise KMC.</li> <li>• Counselling on infant feeding options in context of HIV (for mothers identified as HIV positive) during antenatal period and after birth</li> <li>• Inclusion of early breastfeeding column in all delivery registers</li> <li>• PNC ward and delivery room must have IEC materials on walls for early initiation of breastfeeding &amp; exclusive breastfeeding in local language</li> </ul>	<ul style="list-style-type: none"> <li>• SBA/NSSK trained service provider/s conducting delivery (ANM, SN, MO);</li> <li>• Nutrition Counsellor at high load facilities</li> </ul>	<ul style="list-style-type: none"> <li>• Doctors</li> <li>• Staff nurses</li> </ul>
<p>OUTPATIENT SERVICES/ CONSULTATIONS</p>	<ul style="list-style-type: none"> <li>• Ensure exclusive breastfeeding message and complementary feeding</li> </ul>	<ul style="list-style-type: none"> <li>• ANM if only she is available,</li> </ul>	<ul style="list-style-type: none"> <li>• Medical officer</li> </ul>

<p>(IMMUNIZATION CLINIC, PEDIATRIC OPD, HIGH RISK CHILD CLINIC , ICTC:</p>	<p>messages are rein- forced.</p> <ul style="list-style-type: none"> <li>• Growth monitoring of all inpatient children and use of WHO Growth charts for identification of wasting and stunting and appropriate management</li> <li>• Group counselling on MIYCN and nutrition during pregnancy and lactation;</li> <li>• Review of breastfeeding practices of individual child and nursing mother and counselling on age appropriate infant feeding practices;</li> <li>• Review of feeding practices, counselling and support on feeding options in context of HIV (for mothers identified as HIV positive)</li> <li>• Setting up of Hirkani Kaksha and MIYCN Counselling centers.</li> </ul>	<p>Staff Nurses; • Nutrition counsellor at NRC • ICTC counsellor</p>	
<p>INPATIENT SERVICES (SICK CHILDREN ADMITTED IN PAEDIATRIC WARDS) : At all MCH facilities/ delivery points</p>	<ul style="list-style-type: none"> <li>• Monitoring of lactation and breast conditions, support to resolve any problems</li> <li>• Anthropometric measurements of all inpatient children; identification of children with undernutrition and appropriate nutrition counselling and management</li> <li>• Counselling on early childhood development (play and communication activities) using MCP card</li> <li>• Implementation of IMS Act</li> <li>• Age appropriate messages regarding feeding of sick child and child care practices</li> </ul>	<p>• Staff Nurses; Nutrition Counsellor at NRC</p>	<ul style="list-style-type: none"> <li>• Matron</li> <li>• Medical officer</li> </ul>

<p>SPECIAL NEW BORN CARE UNITS (SPECIAL NEWBORN CARE UNITS, NEWBORN STABILIZATION UNITS)</p>	<ul style="list-style-type: none"> <li>• Counselling on breastfeeding / breast milk feeding of low birth weight and preterm babies, helping mother for cup feeding the baby and, age appropriate feeding advice before discharge.</li> <li>• Age appropriate feeding advice on discharge.</li> </ul>	<ul style="list-style-type: none"> <li>• Staff Nurses;</li> <li>• Nutrition Counsellor at high case load facilities</li> </ul>	<ul style="list-style-type: none"> <li>• Medical officer</li> </ul>
<p>NUTRITION REHABILITATION CENTRES (NRCs)</p>	<ul style="list-style-type: none"> <li>• To start with appropriate therapeutic foods like F75, F100 along with health and nutritional protocols.</li> <li>• Review of feeding practices of severely malnourished child and counselling on appropriate therapeutic feeding practices including what to feed and how to feed.</li> <li>• Reinstate the breastfeeding in lactational failure by supplementary suckling technique.</li> <li>• Appropriate feeding advice before discharge</li> <li>• Demonstration of recipes (quantity and consistency) and replacement feed if indicated, and sharing of recipes for optimal use of locally available foods (before discharge from NRCs)</li> <li>• Counselling on early childhood development (play and communication activities) using Mother Child Protection Card</li> </ul>	<ul style="list-style-type: none"> <li>• Staff Nurse,</li> <li>• Nutrition Counsellor</li> </ul>	<ul style="list-style-type: none"> <li>• Medical Officer</li> </ul>
<p>Human Milk Bank at Women's Hospital, Civil Hospital, Medical College Hospital</p>	<ul style="list-style-type: none"> <li>• Collection of breastmilk</li> <li>• Appropriate processing, storage and microbiological testing</li> <li>• Disbursement to SNCU/NICUs</li> </ul>	<ul style="list-style-type: none"> <li>• Dept of Microbiology. If not Dept of Pathology</li> </ul>	<ul style="list-style-type: none"> <li>• Dept of Neonatology and Obstetrics</li> </ul>

and Private Institutional Hospitals where 24 hours of uninterrupted electricity supply is guaranteed with the specialities like Microbiologist and Pathologist are available.	and the babies discharged from their in, supplementation of IUGR babies and normal babies in need of supplementation		
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### 3.1.2 Key Interventions At Community Outreach Level

#### MCH contact opportunities during Community outreach

The following contacts are critical opportunities for MIYCN promotion. The key responsibility for communication and counselling of mothers /care givers during these contacts is of ANMs along with support from ASHAs & AWWs.:

- Village Health and Nutrition Days
- Routine immunisation sessions
- Biannual Vitamin A Supplementation & Deworming rounds
- IMNCI/sick child check up at community level
- Special campaigns (eg; during Breastfeeding Week)
- Home based New born care by ASHA

<b>KEY PRACTICES AND SERVICE PROVIDERS IN COMMUNITY OUTREACH LEVEL</b>			
<b>Interventions</b>	<b>Actions and key practices</b>	<b>Primary responsibility</b>	<b>Supporting Role</b>
Village Health & Nutrition days (VHND):  AWC or Sub Centre , as relevant	<ul style="list-style-type: none"> <li>• Estimation of BMI for Adolescent girls, newly married women to know identify undernutrition (BMI &lt; 18.5)</li> <li>• Counselling and practical guidance on breastfeeding as an integral component of birth preparedness package – prepare mothers for early initiation of BF;</li> <li>• Group counselling on maternal nutrition and infant feeding</li> </ul>	<ul style="list-style-type: none"> <li>• ANM Where feasible, demonstration of food preparation and sharing of recipes for optimal use of locally available foods for mothers &amp; children 6-23 months; In special situation, demonstrate preparation of safe replacement feed</li> </ul>	<ul style="list-style-type: none"> <li>•AWW,</li> <li>•ASHA,</li> <li>•LHV</li> <li>•ICDS supervisor</li> </ul>
Village Child	<ul style="list-style-type: none"> <li>• Review of feeding</li> </ul>	AWW	ANM

<p>Development Centres (V CDC) at AWCs</p>	<p>practices of severely malnourished child and counselling on appropriate therapeutic feeding practices including what to feed and how to feed</p> <ul style="list-style-type: none"> <li>• Appropriate feeding advice before discharge.</li> <li>• Demonstration of recipes (quantity and consistency) and replacement feed if indicated, and sharing of recipes for optimal use of locally available foods (before discharge from NRCs).</li> <li>• Counselling on early childhood development (play and communication activities) using Mother Child Protection Card</li> </ul>		
<p>Routine Immunisation sessions (RI sessions) : AWC or Sub Centre as relevant</p>	<ul style="list-style-type: none"> <li>• Group counselling on age appropriate MIYCN practices and maternal nutrition</li> </ul>	<p>ANM</p>	<ul style="list-style-type: none"> <li>• ASHA</li> <li>• AWW</li> </ul>
<p>Biannual Rounds for Vitamin A supplementation; or during months dedicated to child health. AWC or Sub Centre as relevant</p>	<ul style="list-style-type: none"> <li>• Group counselling on MIYCN and maternal nutrition; linkage with Growth Monitoring and Promotion sessions through ICDS.</li> </ul>	<p>ANM</p>	<ul style="list-style-type: none"> <li>•ASHA</li> <li>•AWW</li> </ul>
<p>IMNCI / sick child check up : community level, Sub centre, AWC</p>	<ul style="list-style-type: none"> <li>• Assessment of age appropriate feeding and feeding problems; counselling on age appropriate feeding and feeding during illness</li> </ul>	<p>ANM</p>	<ul style="list-style-type: none"> <li>• ASHA</li> <li>• AWW</li> </ul>

### 3.1.3 Key Interventions During Community And Home Based Care

#### Community contacts include:

- Postnatal Home visits
- Home visits for mobilising families for VHND
- Growth monitoring and health promotion sessions at Anganwadi centers.
- Mothers' Group Meetings /Self Help Groups' Meetings

<b>KEY PRACTICES AND SERVICE PROVIDERS IN COMMUNITY AND HOME BASED CARE</b>			
<b>Interventions</b>	<b>Actions and key practices</b>	<b>Primary responsibility</b>	<b>Supporting Role</b>
Home visits to newborn (up to 42 days) in postnatal period in HBNC Weighing on digital weighing scale with a 5 gm difference. Weight on Day 0, 3, 7, 14 and 30 days.	<ul style="list-style-type: none"> <li>• Birth weight recording within 24 hours, for home deliveries</li> <li>• Support early initiation of breastfeeding, colostrum feeding and establishment of exclusive breastfeeding; resolve any problems</li> <li>• Identification of low birth weight babies and appropriate feeding advice</li> <li>• Advice on feeding frequency and duration</li> <li>• One to one counselling of mothers, care givers and family members on maternal nutrition during lactation and infant feeding practices</li> <li>• Key messages to be delivered at each of the 6 visits (or 7 in case of home delivery) can be provided to ASHAs during the training on HBNC</li> </ul>	ASHA	<ul style="list-style-type: none"> <li>• ANMs</li> <li>• AWWs</li> </ul>
During routine activities of Anganwadi centres: (Growth monitoring and promotion	<ul style="list-style-type: none"> <li>• Growth Monitoring using Mother and Child Protection Card</li> <li>• Group counselling/communication on MIYCN and maternal nutrition;</li> <li>• Where feasible, demonstration of food preparation and sharing of</li> </ul>	Anganwadi worker	<ul style="list-style-type: none"> <li>• ASHAs/ helpers, Self help groups, Mothers support groups</li> </ul>

<p>sessions;  supplementary  feeding;  counselling  sessions),  Anganwadi  Centre</p>	<p>recipes for optimal use of locally available foods for children 6-23 months;</p> <ul style="list-style-type: none"> <li>• Assessment of age appropriate feeding practices and feeding problems, counselling on age appropriate feeding and feeding during illness</li> <li>• Counselling on early childhood development (play and communication activities) using MCP card</li> </ul>		
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### 3.1.4 Key Interventions during Emergencies and Other Difficult/ Special Circumstances

Emergencies and other difficult/special circumstances call for a special and supportive environment for health, community, and emergency workers, as well as families, in order to support appropriate MIYCN as required.

<b>KEY PRACTICES AND SERVICE PROVIDERS IN EMERGENCY AND OTHER DIFFICULT/SPECIAL CIRCUMSTANCES.</b>			
<b>Interventions</b>	<b>Actions and key practices</b>	<b>Primary responsibility</b>	<b>Supporting Role</b>
Establishing the Rapid Response Team for maintaining the optimum health & nutrition for the pregnant women, lactating mothers, infants and young children.	<ul style="list-style-type: none"> <li>• Support the nutrition rehabilitation of pregnant women &amp; lactating mothers along with Infant &amp; young children.</li> <li>• Emphasize protecting, promoting, and supporting breastfeeding and ensuring timely, nutritionally adequate, safe, and appropriately fed complementary foods, consistent with the age and nutritional needs of older infants and young children.</li> <li>• Guide health workers to identify infants who need to be fed with Replacement feeds either for social or medical reasons, ensuring that a suitable substitute is provided and fed safely for as long as needed by the infants concerned.</li> <li>• Use donations of replacement feeds and feeding utensils for children in difficult circumstances only if approved and cleared by the Public Health Department before distribution. Feeding bottles and cups with spouts should not be accepted.</li> <li>• Strengthen education and communication to ensure that</li> </ul>	State Public Health Department, District Administration,	Department of Women & Child, Department of Medical Education, Development Partners, NGOs and other stakeholders, Local Community



	<p>children continue to be fed when they or their mothers fall sick. The feeding should be even more frequent during illness and while the child is recovering.</p> <ul style="list-style-type: none"> <li>• Avoid separating mothers and their infants to facilitate continued feeding and care.</li> <li>• Ensure that health workers &amp; Community workers have accurate and up-to-date information about the Maternal &amp; Infant/Young child feeding policies, guidelines and practices, and that they have the specific knowledge and skills required to support children and their caregivers in all aspects of MIYCN in difficult circumstances.</li> <li>• Adopt the BFHI, as well as other forms of protection and promotion of breastfeeding, and provide the necessary support to mothers for continuing breastfeeding and not accept artificial feeds.</li> </ul>		
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### **3.2 Integration, Coordination and Collaboration**

Strategic linkages will need to be forged with the different Departments of Government of Maharashtra, programs and policies in order to achieve the maximum impacts while implementing these MIYCN Policy Guidelines.

Coordination and collaboration enhances the effective participation of key stakeholders, maximizes the use of resources, provides guidance, and sets standards of achievement. Given the multi-sectoral nature of the interventions required, other important stakeholders will be involved as recommended in the section on roles and responsibilities.

Harmonization of messages and integration of MIYCN in initiatives targeting Women and children such as BFHI, IMCI, PMTCT, ART, and Home Based Care (HBC) programs as well as other reproductive health interventions, will be actively pursued.

Comprehensive approach shall be used as a means of ensuring MIYCN promotion at the various key contact points (ANC, delivery, post- natal/family planning, immunizations, growth monitoring/well child, and sick child consultations), in addition to promotion at schools and within the community. It will be important to strengthen the use of community based health workers, peer counsellors, and mother support groups as well as links with agricultural and other extension workers in the promotion of optimal MIYCN.

Any agency/partner involved in the procurement, management, distribution, targeting, and use of breast milk substitutes and related products for children in difficult circumstances shall do so in accordance with the Infant Milk Substitute Act Regulations of 2003 and should get clearance from the Department of Food and Drugs Administration.

### **3.3 Strengthening Growth Monitoring and Promotion (GMP) including Screening and Referral**

In order to conduct GMP at the health facility and AWC (community levels), it will be necessary to build the capacity of facility and community based health workers, including growth promoters and leaders of mother support groups, on growth monitoring and counselling.

The traditional form of growth monitoring (using weight for age) can work alongside the use of MUAC for easier identification of the malnourished. They can then be referred for further care and support. Importantly, GMP that is carried out at the community level shall be used as a contact point for promoting best MIYCN practices. Integration of GMP into Village Health Nutrition Day strategy will be required.

#### **Resource Mobilization**

Implementation of this policy will require human, material, organizational and financial resources. The Dept. of Public Health in collaboration with other key stakeholders shall mobilize the necessary resources, which are necessary for the effective implementation of these policy guidelines.

### **3.4 Roles and responsibilities:**

At the State level MIYCN policy is proposed to be endorsed by the Cabinet as one of the critical agenda for providing the best start for the children of Maharashtra. It will ensure that adequate budgets are also earmarked for the implementation and there by building accountability at all the levels. Ensuring the implementation of the MIYCN policy will also contribute to reduction in Infant Mortality Rate, Child Mortality Rate and Stunting in young children.

#### **Role of the Department of Public Health:**

- The department will act as the principal implementer, mentor and coordinator of all the critical MIYCN interventions aimed at achieving the goal and objectives of these Policy guidelines and ensure that other related guidelines are in accordance with this policy
- It will technically lead the implementation and liaise and co-ordinate with other line departments that will be directly or indirectly responsible for implementation of the Policy through their service delivery platform.

- Strengthen the implementation of the MIYCN interventions by creating a state level task force with representation from professional bodies, academia, NGOs, technical institutes and health functionaries and setting up of an independent unit within the Directorate of health services –Nutrition Unit for spear heading the implementation and co-ordination of this policy.
- Facilitate the training of all the health professionals and health workers and all others who work with women and care givers on MIYCN in recognising malnutrition and Low birth weight, following the Baby Friendly Hospital Initiative and preparedness for MIYCN during emergencies and in difficult circumstances.
- The department will prepare the technical guidelines and communication strategy while rolling out of the Policy.
- The department will undertake training and sensitization of the health workers on monitoring and evaluation of various replacement feeds for infants exposed to HIV.
- The department will be responsible for updating and developing the state guidelines and materials on MIYCN, management of children with severe acute malnutrition, prevention and management of low birth weight and dissemination of those in the local languages for the implementers, mothers, caregivers and the communities. It will ensure the technical correctness of the information. The other departments will use these materials for dissemination.
- The department will ensure that professionally trained personnel in Public health/nutrition will be appointed as the Nutritionist/dieticians at the delivery points & Health care centers with large load for implementation of MIYCN and management of children with severe acute malnutrition.
- The department will ensure that all the manpower both medical and nursing are trained and skilled in MIYCN integrated counselling training in the district, SDH and women's hospital and maternity homes.
- The department will also develop, review /update the critical indicators for MIYCN and malnutrition in the HMIS reporting and analysis for action at various levels.
- The department will establish MIYCN counselling and other support services in the health facilities at the relevant MCH contacts in Primary Health centres, Rural hospitals, Sub District hospitals, General Hospitals, District hospitals and Women's Hospitals.
- Ensuring the institutionalisation of the ten steps to successful Breast Feeding in all the maternities -.Baby Friendly Hospital Initiative.
- Ensure strong IEC and sensitization of IAP, NNP, NNF, FOGSI, IPHA & IAPSM.

- Plan provision of part time/full time services of lactation consultant and Counsellors at all maternity services in the government sector and issue such guidelines to the private sector.

## **Role of the Department of Women and Child**

### **Development:**

- The department will be co facilitating the implementation of the MIYCN policy guidelines through Integrated Child Development Schemes-ICDS.
- It will ensure that the standard Policy guidelines are disseminated to all the level of the ICDS functionaries' right from district to the anaganwadi workers at the village level.
- It will also ensure that the MIYCN will be linked with Growth monitoring and promotion sessions to prevent child malnutrition.
- It will also focus on the child development and MIYCN component for counselling mothers and care givers during the home visits and monthly weighing sessions
- It will ensure the integration of the MIYCN guidelines as part of the existing training modules.
- It will develop a cadre of certified trainers in MIYCN to support the roll out. Within the ICDS.
- It will integrate MIYCN for accreditation of the anganwadi centres as baby friendly.
- It will ensure that MIYCN indicators are captured through their revised MIS and it is reviewed on regular basis.

### **Role of the RJMCHN Mission:**

- Facilitate training and monitoring support for health and ICDS in the blocks and districts on MIYCN.
- Facilitate creation of trainers for roll out of MIYCN trainings in the districts.
- Facilitate capacity building of NGOs/ CBOs / SHGs on MIYCN.
- Support in design and implementation of comprehensive IEC strategy for MIYCN.
- Support in integration of MIYCN in other department's agenda.

## **Role of the Department of Medical and Nursing**

### **Education:**

- The department of Medical education is responsible for implementation of the FDA and monitoring of the medical colleges.
- The medical institutes are the technical hubs that provides the health professionals to man the health facilities at all the levels. It has a very crucial role to play in roll out of MIYCN.
- It will ensure that the MIYCN is mainstreamed in the medical curriculum and nursing curriculum of the state through its apex university –Maharashtra University of health sciences and Maharashtra Nursing Council. Besides integrated in the curriculum it should be part of the evaluation of their course work.
- It will ensure that MIYCN training is integrated for health and nursing cadre in pre-service curriculum and in service training. For medical officers MIYCN training will be linked to credits for maintaining the registration with MMC.
- Developing integrated course on MIYCN counselling and skill based training for the Dieticians, Medical officers, ICDS functionaries and lactation Counsellors.
- The department will ensure that the Nursing council will be involved in rolling out MIYCN in the state and districts through their nursing schools and will include MIYCN in nursing curriculum (ANM/GNM/BSc Nursing).
- Support the capacity building on MIYCN and maternal Nutrition during pregnancy and Lactation for the lactation counsellors for private nursing homes, hospitals and government supported health institutions.

### **Role of MUHS**

- MUHS, Pune regional centre will be a nodal institute for MIYCN trainings.
- PSM department will coordinate MIYCN trainings.
- Monitor the training of all concern medical college.
- Plans and establish a training programme to train and certify mother support group leaders in large numbers through medical colleges. The obstetric department should be assigned the responsibility for this training programme. The protocols and training strategies of the existing Mother Support Groups in the state (eg. By BPNI Maharashtra) may be utilized for such a course.

### **Role of Department of Tribal Development:**

- The department will monitor the key MIYCN indicators as part of comprehensive health and nutrition plan for tribal areas.

- The department will make provision in the form of social protection scheme / maternity benefit scheme / conditional cash transfer scheme to improve maternal, infant and young child nutrition.
- The department will have special focus on monitoring the MIYCN indicators for PVTGs.
- Support provision of double fortified salt, fortified aata and Multimicronutrient powders for home fortification of complementary feeds in the tribal areas through PDS.
- Support family food security by ensuring livelihood support through National Rural Livelihood Mission (NRLM)

### **Role of Department of Rural Development:**

- The department will ensure that all the districts in the state have trained and skilled health and ICDS staff to support implementation of MIYCN.
- The CEO Zilla Parishad will monitor the MIYCN training and MIYCN indicators in the districts jointly with DHO, Dy CEO (WCD) and Dy CEO (VP).
- The department will ensure that all field functionaries (Gramsevaks, VDO and BDO) are sensitized on MIYCN.
- The department will ensure that MIYCN indicators are mainstreamed into the special initiative of child friendly Gram Panchayats.
- Based on these critical indicators of child survival and growth GPs can be accredited and provided additional support for the Gram Panchayats.
- District plans to be developed for reducing the MMR, IMR and prevention of undernutrition ( stunting, wasting) and this should be regularly monitored by CEOs. This should be a part of CEOs critical agenda.
- The department will ensure that through National Rural Livelihood Mission (NRLM), the women self-help groups and village organizations will be sensitized on MIYCN.

### **Role of Revenue Department:**

- Divisional Commissioner to ensure the review of district action plans reievow of integrated plan of the district for MIYCN and its progress to be reviewed.

### **Role of Grampanchayat :**

- Ensure rest and no labour for pregnant woman in the last trimester of pregnancy.
- Ensure Maternity benefit schemes implemented in the state.

- Implementation and promotion of child friendly gram panchayat which can support flexible working hours for the mothers with young infants and also provision of work place or Creche.
- Promotion of IYCN practices through implementation of IEC strategy
- Supporting working mothers for continuing breastfeeding minimum 2 years. This can be encouraged by community contribution for supporting mothers to practice the four MIYCN practices. The creation of Mother Care centres based on the successful initiatives in Aurangabad, Ahmed nagar and Jalgaon through community contribution to prevent low birth weight and child under nutrition.
- GPs in the tribal blocks getting the 5% devolution PESA funds should also earmark some funds for MIYCN activity and monitoring.

### **Role of Department of Urban Development:**

- The department will ensure that all urban local bodies (especially corporations) are sensitized on MIYCN.
- The department will ensure that all the health and ICDS facilities and the community workers are trained and skilled in MIYCN.
- All corporation run hospitals and maternity homes and private hospitals are baby friendly.
- Plan and implement Maternity Benefit schemes for Urban working mothers specially those from slums & BPL category.

### **Role of Municipal Corporations:**

- Promote MIYCN in the Corporation hospitals, Urban Health centres / Health posts
- Promote MIYCN in private sector with help of IAP, NNP & FOGSI
- Accrediate all delivery point hospitals and Health Centres as BFHI
- Implement & Monitor IMS act
- Monitor MIYCN indicators monthly
- Hand holding with ICDS department for implementation of MIYCN in community
- Train the MOs and nursing staff at all delivery points for MIYCN
- Atleast 1% of Health budget in corporations and councils should be earmarked for MIYCN activities and IEC of MIYCN.

### **Role of Department of Water Sanitation:**

- The department will ensure that all health and ICDS facilities will have access to safe drinking water and toilet facility.



- The department will ensure integration of water sanitation and hygiene interventions (WASH) in the MIYCN capacity building.
- The department will ensure that all the field functionaries (Swachhata Doot) are sensitized on MIYCN.

### **Role of Department of Agriculture:**

- Empower its extension workers to support families and communities to produce and consume locally available crops and to rear animals of improved nutritional quality.
- Ensure household food security.
- Encourage kitchen gardening in schools, AWCs and community.

### **Role of Food & Drug Administration Bureau:**

- Monitor the regulations on marketing of Infant and Young Child Foods

### **Role of Food and Civil Supplies Department:**

- Ensure supply of double fortified salt, fortified flour and fortified complementary foods for infants under PDS.

### **Role of District Collector:**

- Strengthen the structures, services, and interventions needed for the implementation of these policy guidelines.
- Develop comprehensive policy implementation strategies.
- Monitor & support implementation of this policy & IMS act.
- Carry out intensive social mobilization of all stakeholders in the district to promote and protect optimal MIYCN.

### **Role of BPNI Maharashtra**

- Support policy formulation and implementation
- Technical support for Training modalities and modules
- Provide faculty for planning and execution of MIYCN trainings
- BFHI training and assessments
- Capacity building of core group of MIYCN experts

### **Role Of Academia like IAP, NNF & FOGSI**

- Continuous hand holding of public Health Department for rolling of MIYCN Policy.

- Rolling out of MIYCN Policy in the Private sector.
- Ensuring implementation of IMS Act stringently.
- Active Participation in Accreditation process of public and medical colleges Hospital.
- Ensure BFHI training & assessment.

### **Role of Development partners:**

- Enhance advocacy for MIYCN through all stakeholders.
- Provide technical support, especially on staff training, development of appropriate MIYCN tools, communication strategy, manuals for management of malnutrition and LBW, tools and job aides in an integrated manner.
- Contribute to the mobilization of resources and provide funds for the implementation of this policy.
- Support the Public Health Department and DWCD at State and District levels to implement their roles and responsibilities.

### **Role of Non-Governmental, Community Based and Religious Organizations (NGOs & CBOs)**

In collaboration with the relevant Local Government officials:

- Mainstream MIYCN into their agendas.
- Advocate for the child's rights to food and nutrition.
- Provide support to districts and communities to promote MIYCN, growth monitoring and promotion and to implement other roles and responsibilities.
- Where possible provide direct support to mothers, families and communities.
- Involve religious leaders for influencing behavior of communities.

### **Role of Corporate Sector:**

- Ensure establishment of crèche / Hirvani's Room in the office premises.
- Abide to the government policy of maternity & paternity leave.
- Support MIYCN through CSR.

### **Role of Political Leaders:**

- Advocate for and provide budgetary allocations for the implementation of these Policy Guidelines and any other related MIYCN Laws and Policies.

### **Role of Mothers / Mother Support Groups:**

- Breastfeed exclusively for the first six months of a child's life.

- Take responsibility to learn what is required in preparing foods and feeding infants and young children; and pay particular attention to hygiene, correct mixing and feeding methods.
- Prepare safe foods by adhering to basic principles of hygiene.
- If using replacement feeding, ensure that you have some means for accurate measurement of both water and the powdered or liquid milk so that these ingredients can be mixed accurately and correctly.
- Form and/or participate in Mother Support Groups and alert the nearest health facility or stakeholders in the community for more support.
- Mother Support Groups will provide adequate support to new mothers and take up issues within the family and community that would hinder effective implementation of MIYCN.
- Mother Support Groups will play important role in mobilizing other community members to support MIYCN.
- Mother Support Groups can facilitate large scale implementation of MIYCN actions in the communities and progressively through a phased manner can be part of block-district health and nutrition plans.
- Mother Support Groups can be empowered for community based monitoring of critical MIYCN indicators and also become an excellent channel for social mobilization and behavior change communication.
- To utilize existing mother support groups for providing counselling at Institutional Hospitals
- Senior Mother Support Counsellor or MIYCN trainers should be promoted and facilitated for advanced accreditations like IBCLC (International Board Certified Lactation Consultant)

### **Role of Fathers and other caregivers:**

- Develop an interest in promoting, supporting and protecting MIYCN.
- Participate in decision making on MIYCN in the family.
- Provide physical, psychological and financial support during pregnancy delivery and lactation for optimal MIYCN.
- Participate in the care of infants and young children.
- Ensure support for adequate nutrition during pregnancy during pregnancy and lactation period

### **Role of community:**

- Community leaders should participate in the sensitization and mobilization of their members in activities relevant for optimal MIYCN.

- Organize a social support network for affected families and take steps to minimize stigmatization and discrimination.
- Provide love and attention to children in difficult circumstances.
- Protect and promote appropriate MIYCN in difficult circumstances.

## **Budget Provision:**

All the departments are required to make adequate budgetary provisions for implementation of activities envisaged in the policy.

### **3.5 Capacity Building for MIYCN :**

Capacity Development is core to successful implementation of MIYCN Policy/programming in the State. Currently MIYCN has been mainstreamed in NHM PIP and thrust area being the delivery points. However it needs further strengthening at all levels by ensuring that those trained are skilled for implementation, supervision, training of other functionaries, and ensuring that protocols are implemented in the facility and community so that mothers and caregivers are empowered to practice optimal MIYCN practices.

Therefore the key component of the roll out of the MIYCN policy will be planning and implementation of a strong capacity development of health and nutrition functionaries as well as NGOs, communities, academia, professional bodies to build up teams of experienced trainers who can take it further to communities, mothers and care givers. A team of lactation counsellors should be created at all districts and should be deputed at the post natal wards and pediatric wards for counselling. Minimum 2 hours advocacy meetings should be organized for all departmental heads at the state as well as district levels.

The trainings for Medical college teaching staff and nursing staff will be conducted through MUHS while for the Private Practitioners, practicing Pediatricians and Obstetricians the trainings will be coordinated through IMA, IAP and FOGSI.

State level yearly MIYCN updates need to be organized for the lead trainers and the core group. National level MIYCN conferences to be organized once in 3 years. After successful organization of state and national level conferences, the state with its progress in MIYCN can also think of organizing an International MIYCN Conference.

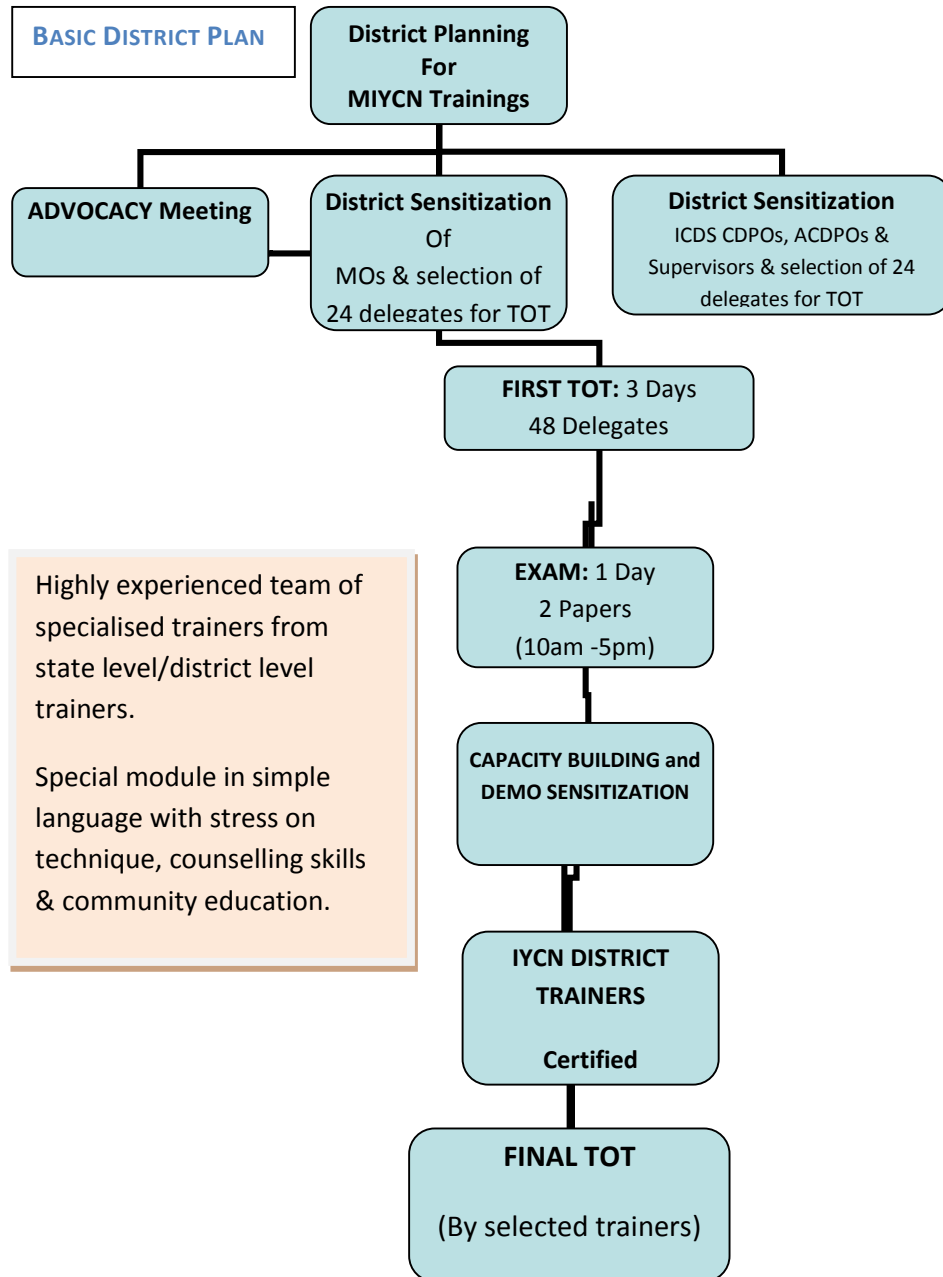
The lead trainers and core faculty will be promoted and facilitated to attend state, national and international level MIYCN Conferences organized by other organizations. BPNI Maharashtra and some medical colleges organize quality MIYCN conferences at state level. IAP IYCF Chapter and BPNI hold similar conferences at National Level. International organizations like WHO, UNICEF, WABA, Academy of Breastfeeding Medicine, International Lactation Consultant Association and La Leche League International are well known for organizing excellent MIYCN Conferences.

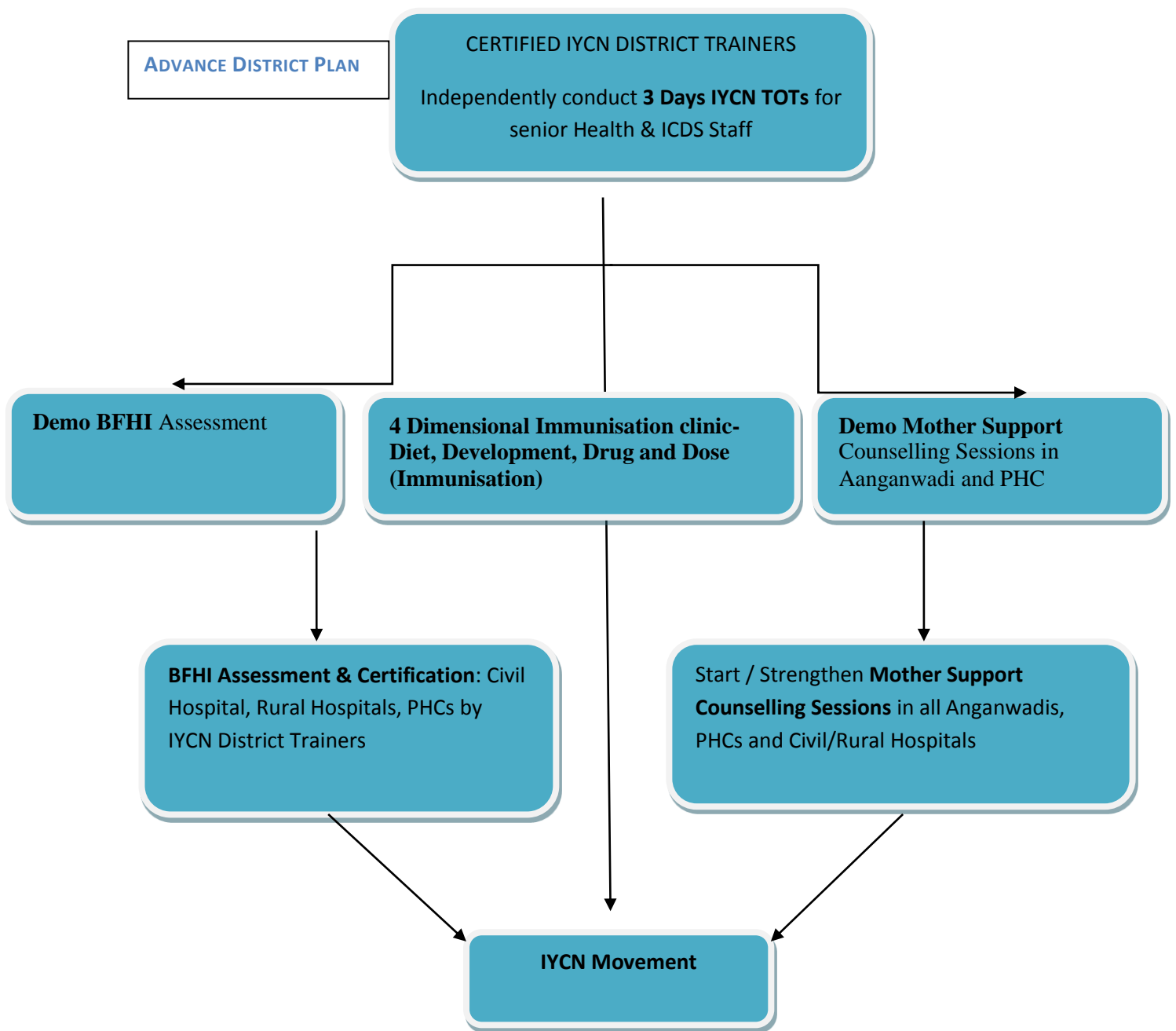
Web seminars will also be an important strategy for capacity building of the core group.

The lead trainers and core group members would be promoted and facilitated to take international accreditation (IBCLC: International Board Certified Lactation Consultant)) after 5 years of work in MIYCN. Their necessary certification for credit hours and experience certificates in lactation counselling will be provide by the concerned authority.



## Strategies for scaling up of MIYCN capacity building





### Orientation of PRI members

- 2 hours IYCN sensitisation by trained IYCN trainer during monthly meetings at Panchayat Samitis for sarpanch, gram sevak, gram panchayat members etc.
- Taluka health officer will plan the sensitisation workshop.
- The PRIs trained /sensitized will provide necessary support/provisions for mothers to practice MIYCN.



### 3.6 Communication strategy for MIYCN

Communication for MIYCN, an essential contributor to large-scale behavioral and social change, should be an intrinsic element of any national Child Survival/Health and Nutrition programme. An effective MIYCN communication strategy is evidence and results-based. Communication should be viewed broadly: not as only a community-based action, or only a mass-media campaign, but as a comprehensive national strategy and set of actions with a broad stakeholder base and participation, and the use of multiple communication channels.

An effective communication strategy can be developed by using participatory processes with stakeholders and beneficiaries and by analyzing formative research data and other evidence on MIYCN to tailor the optimal set of objectives, approaches, activities, communication tools, channels, and messages. Communication broadly encompasses **advocacy, social mobilization, social marketing, and behaviour and social communication.**

It is critical to learn from experiences with different approaches to communication on MIYCN. Successful programmes have demonstrated that investment in the process required to design and implement an evidence-based, participatory communication strategy using multiple appropriate channels would produce results. Inter Personal communication is the best strategy for bringing the behaviour change in the community.

Six key steps for the design and development of a communication strategy and implementation plan:

- Establishment of a State coordination mechanism for implementation of the MIYCN policy, which will also review the current communication strategy.
- Undertaking and analyzing a communication situation assessment and formative research.
- Development of a communication strategy and operational plan.
- Design of messages and materials and selection of channels.
- Implementation of the communication plan.
- Monitoring interim communication outcomes and evaluating impact on behaviors.
- Based on evaluation report re-develop communication strategy.

In Maharashtra, mid media initiatives under traditional approaches that can be tapped for implementing communication strategy on MIYCN like Traditional Massage Women (TMW), Creche Owners, *kirtankars*, *kalapathak*, *bhajani mandal*, *dindi*, *yatra*, *jatra*, *bhagwat saptah*, *ardhvarshik vadhdivas*, etc. Platform of Mothers meetings, mahila mandals can be used for orienting women on MIYCN.

## Chapter 4 : Monitoring and Evaluation

District level surveys like DLHS provides vital information, it should be used for prioritizing the districts for planning and implementing state/district level MIYCN actions.

Supervision and monitoring the implementation of plans of action, as described below, is essential part of such plans of actions. Supervision and monitoring is crucial for success of MIYCN initiatives. Monitoring of the MIYCN Promotion should be undertaken as part of a comprehensive Nutrition and /or Child Health interventions in a block/district. Monitoring should be "institutionalized" as a part of the expected tasks of the health staff, with agreed targets for regularly scheduled supervisory visits. For effective supervision, the following supervision strategy should be considered:

Adding unscheduled visits (that is, the worker is unaware of the visit in advance) in addition to any planned visits by State/District /Block and PHC level Officials.

- Observing (using a checklist) performance of a task.
- Gathering direct feedback from caregivers (e.g. home visits made by supervisor).
- Conducting service provider interviews to test their knowledge
- Conducting periodic group reviews at different levels.

The State Task force under the chairmanship of Chief Secretary as well as the District Task Force under the District Collector/Municipal Commissioner should meet atleast twice in a year to monitor the progress in implementation of MIYCN.

For monitoring implementation of the IMS Act, state, district, block and facility level officials must be designated.

For routine monitoring of MIYCN activities, a reporting system, which focuses on a few selected key indicators, is recommended. These short listed indicators are feasible to collect and are useful for programme planning implementation at block and district level and informed policy making at state and national level. Periodic review of progress against the micro-plan at the block/district level and against the State Programme Implementation Plan is important to ensure that implementation is on track. Moreover, it would facilitate identification of bottlenecks in programme implementation and provide support in strengthening the specific identified problem.

### 4.1 Monitoring Indicators

A set of indicators that are recommended to be used to monitor and evaluate various MIYCN interventions are as follows:

<b>Process Indicators</b>	<b>Monitoring by</b>
<p><b><u>Health Department:</u></b></p> <ul style="list-style-type: none"> <li>❖ Percentage of districts with multi-sectoral Microplans for MIYCN activities</li> <li>❖ Number &amp; percentage of hospitals that are certified baby-friendly within one year</li> <li>❖ Number &amp; percentage of health workers trained on integrated MIYCN counselling</li> <li>❖ Number &amp; percentage of health facilities with at least one health worker trained in MIYCN counselling</li> <li>❖ Number and % of health facilities with a dedicated Nutrition Counsellor /MIYCN Counsellor (Denominator will be District hospitals, FRUs with high delivery load)</li> <li>❖ Number &amp; percentage of joint review of MIYCN activities (including training for MIYCN counselling &amp; support) with health &amp; ICDS departments taken by PHC MO/Supervisor; THO/CDPO</li> <li>❖ Number &amp; percentage of adolescents, pregnant women, lactating mothers, infants &amp; young children checked for Hemoglobin status and prevalence of anemia (Mild Moderate &amp; Severe)</li> <li>❖ Number and % of Institutes with Functional Hirkani Kakshs.</li> </ul> <p><b><u>ICDS Department :</u></b></p> <ul style="list-style-type: none"> <li>❖ Number &amp; percentage of Anganwadi workers trained on integrated MIYCN counselling and support</li> <li>❖ Number &amp; percentage of villages/AWCs with mother support groups formed</li> <li>❖ Number &amp; percentage of Mother support groups meetings/conducted activities in a month (at least one meeting/activity per month is expected)</li> <li>❖ Number &amp; percentage of AWCs having functional adult and infant/baby weighing scales</li> </ul>	<p>Monthly HMIS data</p> <p>ICDS MPR</p>
<b>Outcome Indicators:</b>	
<p><b><u>Health Department :</u></b></p> <ul style="list-style-type: none"> <li>❖ Number &amp; Percentage of adolescents consuming at least 4 tabs of IFA (100 mg elemental iron &amp; 500 mcg of FA) per month under WIFS scheme</li> <li>❖ Number &amp; percentage of adolescents whose BMI is less than 18.5</li> <li>❖ Number &amp; Percentage of pregnant women consuming at least 200 tabs of IFA (100 mg elemental iron &amp; 500 mcg</li> </ul>	

<p>of FA) during pregnancy</p> <ul style="list-style-type: none"> <li>❖ Number &amp; Percentage of Lactating mothers consuming at least 200 tabs of IFA (100 mg elemental iron &amp; 500 mcg of FA) in postnatal period.</li> <li>❖ Percentage of infants initiated to breast feeding within 1 hour of birth</li> <li>❖ Percentage of infants under 6 months of age exclusively breastfed</li> <li>❖ Percentage of infants between 6-8 months of age with complementary foods introduced</li> <li>❖ Number &amp; Percentage of children between 6 months to 60 months receiving biweekly IFA supplementation (20 mg elemental iron &amp; 100 mcg of FA)</li> <li>❖ Number &amp; Percentage of children between 6 to 10 yrs receiving weekly IFA supplementation (45 mg elemental iron &amp; 400 mcg of FA)</li> <li>❖ Number and percentage of children with diarrhoea given zinc with ORS</li> <li>❖ Number and percentage of children between 9 months to 5 yrs who have received vitamin A supplementation and deworming in last 6 months</li> </ul>	<p>Monthly HMIS data</p>
<p><b><u>ICDS Indicators :</u></b></p> <ul style="list-style-type: none"> <li>❖ Number &amp; percentage of Pregnant &amp; Lactating women receiving SN</li> <li>❖ Number &amp; percentage of infants &amp; children receiving supplementary nutrition (SN), additional SN or therapeutic feeding against the number &amp; percentage of underweight.</li> <li>❖ Number &amp; percentage of infants &amp; children upto 5 yrs who are underweight</li> <li>❖ Number &amp; percentage of adolescents whose BMI is less than 18.5</li> </ul>	<p>ICDS MPR</p>
<p><b><u>Other Outcome Indicators:</u></b></p> <ul style="list-style-type: none"> <li>• Number &amp; percentage of children still breastfeeding at 12-15 months</li> <li>• Number &amp; percentage of children still breastfeeding between 20-23 months</li> <li>• Percentage of infants who had minimum dietary diversity</li> <li>• Percentage of infants who had minimum meal frequency</li> <li>• Percentage of infants and young children 6-23 months of age who received a minimum acceptable diet</li> </ul>	<p>Periodic Nutrition surveys</p>
<p><b><u>Impact Indicators</u></b></p>	
<ul style="list-style-type: none"> <li>• Percentage of stunted children under 2 years of age</li> <li>• Percentage of stunted children under 5 years of age</li> </ul>	

<ul style="list-style-type: none"><li>• Percentage of wasted children under 2 years of age</li><li>• Percentage of wasted children under 5 years of age</li><li>• Percentage of underweight children under 2 years of age</li><li>• Percentage of underweight children under 5 years of age</li><li>• Percentage of children with any anemia under 5 years of age</li><li>• Percentage of children with Severe anemia under 5 years of age</li><li>• Percentage of adolescents (Boys &amp; Girls) with any anemia</li><li>• Percentage of adolescents (Boys &amp; Girls) with Severe anemia</li><li>• Percentage of pregnant women with any anemia</li><li>• Percentage of Pregnant women with Severe anemia</li><li>• Percentage of lactating mothers with any anemia</li><li>• Percentage of lactating mothers with severe anemia</li><li>• Percentage of Low birth weight babies born</li><li>• Percentage of babies born with congenital malformation</li></ul>	Periodic Nutrition Surveys.
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## **4.2 Components of Monitoring and evaluation :**

### **1) Monthly /Quarterly reports:**

The progress should be reviewed by District Reproductive & Child Health officers (DRCHO) and the Resident Medical Officer – Out Reach (RMO-OR) every month. MIYCN program should be one of the agenda items of RCH or Child Health & Nutrition review meetings at all the levels. Each month the data relating to progress of MIYCN activities should be collected on a standard reporting format by the districts and transmitted electronically to the State Programme Management Unit. The Nodal person at the DPMU and SPMU should analyze the reports and provide relevant feedback to the officers responsible for implementation.

### **2) Assessment from Surveys:**

The focus of this component should be information on MIYCN indicators such as early breastfeeding, exclusive breastfeeding and complementary feeding rates that is collected by Statistics through the census and other surveys (NFHS-4), as well as on statistics collected by other government institutions. These include sample surveys, registers and administrative data sets emanating from the three spheres of government and other organs of state. The private sector, research institutions and NGOs also generate statistics which are in the public domain and which could exert an influence on monitoring.

### **3) Concurrent Evaluation:**

District/National level surveys such as NFHS, DLHS does provide information on MIYCN indicators such as anemia in adolescents and pregnant women, early breastfeeding, exclusive breastfeeding and complementary feeding rates. However such surveys are infrequent and do provide information for the district levels only, blocks level or facility level coverage cannot be assessed from such surveys. Hence states should plan concurrent monitoring and evaluation mechanisms for informed planning and implementation of MIYCN interventions. Monitoring and evaluation framework should be used for tracking the progress towards the goals, outcomes and outputs of the program.

Concurrent evaluation for MIYCN practices should be carried out at Divisional and State level in each district at least quarterly (Once in three months). 10 Randomly selected beneficiaries from each district (4 beneficiaries from DH/WH delivery registers, 4 beneficiaries from SDH/FRU/RH registers and 2 from PHC/SC delivery points) should be visited in the community to validate MIYCN practices. Preferably cases delivered during last month to be validated to avoid recall bias. Total Mothers of 5 children (6-12 month old) from the same villages should be interviewed for validation of Complementary feeding practices. A Cluster Sample Survey can be planned annually for getting information to the block level and below.







#### **4. Programme performance evaluation:**

Based on information that is collected by government institutions in the course of fulfilling their mandates and implementing the policies of government. These should include output and outcome information collected at district level for strategic and annual performance plans and budgets, and at local level for Integrated Development Plans and Service Delivery and Budget Implementation plan.

#### **5. Monitoring and evaluation of Trainings and capacity building:**

PHI Nagpur and all Health Family Welfare Training Centers (HFWTs) should develop comprehensive district training plans. The training plans must be prepared, taking into account the number of delivery points (especially high delivery case load facilities) and service providers to be provided additional skills on IYCF communication and / or counselling. Since a large number of frontline workers will have to be trained, stress should be laid on capacity building of supervisors, who could then reinforce these skills during supervision and mentoring. The state must also identify all personnel who have already been trained/ received orientation on IYCF and related areas through specific 'in service' training programmes.

A plan for training of trainers should be prepared at state level so as to undertake all the training planned by the districts. Database of trained manpower must be available at the state. The achievement of the training targets should be periodically reviewed along with feedback on the delivery of IYCF information and counselling services at community and facility levels.

It is recommended that FRUs with high delivery load, District Hospitals and facilities with Newborn Care Units and Nutrition Rehabilitation Centres should have 2 or more facility based service providers trained in advanced lactation management and IYCF counselling skills.



Quarterly Reporting Format (from the district/state)							
Trainings on IYCF							
Name of the training	Duration	No. of doctors trained		No. of Staff nurses/ GNM's trained		No. of frontline functionaries trained (specify the cadre/s)	
		Planned	Achieved	Planned	Achieved	Planned	Achieved

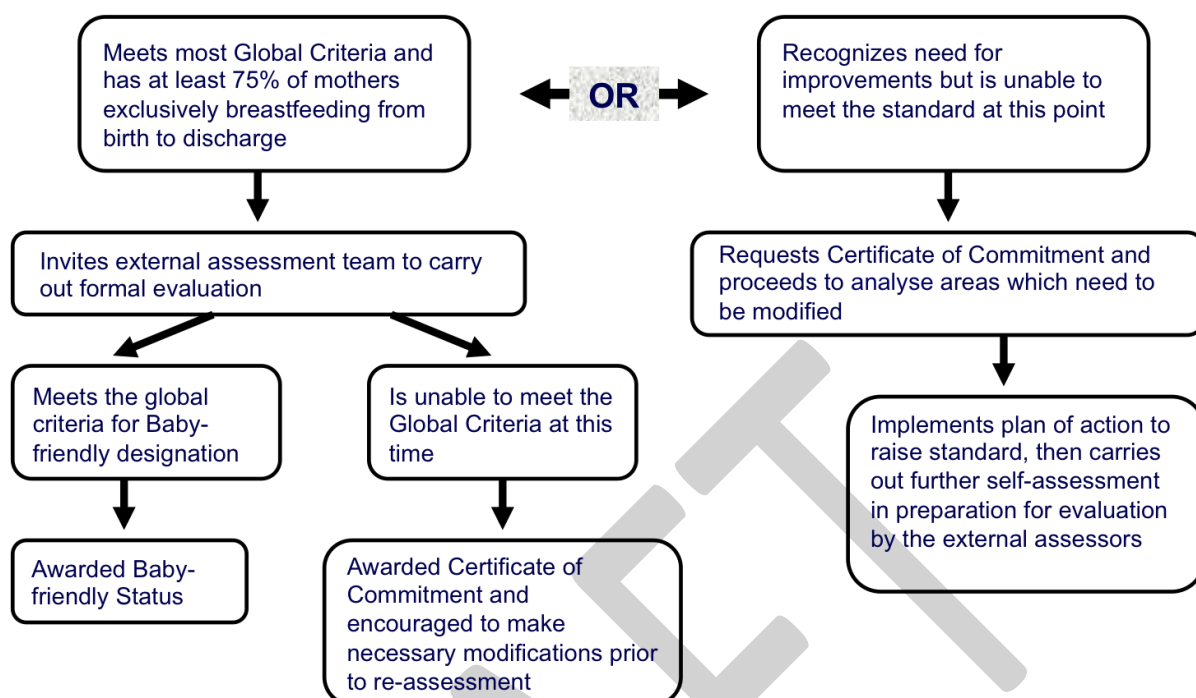
Quarterly Reporting Format (from the district/state)							
Trainings on IYCF Counselling Skills							
No. of State Master Trainers for IYCF Counselling training package		No. of Medical Officers/Doctors trained in IYCF counselling		No. of Staff Nurses trained in IYCF counselling		No. of ANMs trained in IYCF counselling	
Planned	Achieved	Planned	Achieved	Planned	Achieved	Planned	Achieved

Monthly/Quarterly Reporting Format (from the State/UT)										
State:						Month:				
Districts	No. of districts conducting Outreach campaign/s		No. of delivery points (at FRUs) with at least two staff trained in IYCF counselling		No. of health facilities with dedicated Nutrition or IYCF Counsellor		No. of facilities with functional IYCF Counselling Centres		No. of institutional live births in the month	No. of newborns initiated breastfeeding in first hour of birth
	Planned	Achieved	Planned	Achieved	Planned	Achieved	Planned	Achieved		

## 6. Monitoring and Evaluation for BFHI:

To contribute to the provision of safe and adequate nutrition for infants by the protection and promotion of breastfeeding, and ensuring the proper use of breast-milk substitutes, when these are necessary one of the objectives of IYCF policy is to transform government/private maternity facilities baby friendly through implementation of the "Ten steps to successful breastfeeding" under BFHI.

## The route to Baby-friendly designation



Government delivery point facilities should be certified BFHI compliant in phased manner through continuous monitoring from state level using following monitoring and reporting format.

### Quarterly Monitoring format for BFHI Compliance (from district/state)

Sr.No.	Name of the District	L3 Delivery point facilities (DH/WH/SDH/FRU)			L2 Delivery point facilities (Non FRU RH/PHC)		
		Total L3 Delivery points	Number of BFHI Compliant Facilities	Percentage of BFHI Compliant facilities	Total L2 Delivery points	Number of BFHI Compliant Facilities	Percentage of BFHI Compliant facilities
1							
2							
3							
.							
.							
31							
32							
33							
<b>State Total</b>							

## 7. Monitoring and Evaluation for IEC:

Sr.No.	Activity	Planned	Achieved
1	Printing of IEC for state, districts; production of AV material		
2	IEC campaign in districts		
3	Meetings of the Coordination Committee on Nutrition		
4	Organization of meeting (for planning and review, 6 monthly)		
5	Development of IEC visuals and print material for IYCF		

DRAFT

## Key Policy recommendations :

- Ensure every adolescent, pregnant women & the new born have access to optimal health & nutrition services
- Every adolescent girl is part of the weekly iron foilc acid supplementation and has access to life skill training and appropriate information for their own growth & development / Optimal implementation of WIFS & RKSK
- Every Pregnant mother is registered by 12 weeks and monitored for all key ANC interventions with special focus on compliance for consumption of IFA, monitoring of maternal weight gain, Blood pressure & ensuring institutional delivery with the focus on reducing the Low Birth Weight babies being born.
- Special timely and quality care for High risk pregnant women.
- Provision of quality intrapartum care and counselling for birth spacing
- Ensuring Skin to skin contact, early initiation of breastfeeding and birth weight monitoring
- Ensuring exclusive breastfeeding upto six months along with age appropriate quality complementary foods and feeding with continued linked with age appropriate immunization & growth monitoring and promotion.
- Ensure implementation of age specific micronutrient supplementation
- Ensuring optimal health & nutrition support for mothers, infants & young children during emergency and illness
- A robust monitoring system in place at all levels to monitor the key MIYCN indicators as envisaged in the policy

## Chapter 5 : Supportive Information

### 5.1 Baby Friendly Hospital Initiative (BFHI)

'Baby Friendly Hospital Initiative' (BFHI) was launched by WHO and UNICEF in 1991-92. 'Baby Friendly Hospital' certificate would be awarded to the maternity service implementing 'Ten Steps to Successful Breastfeeding' which are listed in the 1989 WHO-UNICEF joint statement 'Protection, Promotion and Support of Breastfeeding, the Special role of Maternity Services' (WHO 1989).

BFHI is now an integral part of WHO/UNICEF 'Global Strategy for IYCF (Infant and Young Child Feeding)' of 2002.

BFHI Certification is the gold standard of help and support for initiation, establishment and continuation of successful breastfeeding expected to be provided by the maternity services due to its unique role as follows:

- Frequent and Prolonged contact with mother in Antenatal and Postnatal Period.
- Contact during a critical period when mother's attitudes can be greatly influenced.
- Negative effect of obstetric problems and interventions on initiation and establishment of breastfeeding.
- Positive birthing environment and experience facilitates both delivery and breastfeeding by enhancing Oxytocin levels.
- Initiation of breastfeeding is the 4th stage of labour. In a broader sense, initiation of BF means establishment of lactation (1-2 wks)
- Breastfeeding is initiated in maternity home.
- Many breastfeeding problems like less milk, cracked nipples and engorgement occur more commonly in first few days of life when mother is likely to be with maternity services or in contact with it.
- Acts of omission and commission in supporting breastfeeding have great impact on not just early neonatal mortality but even late neonatal mortality, IMR, U5MR and future health.

#### **The benefit of following Baby friendly Practices to the maternity services:**

- Antenatal Counselling Sessions would help to develop a rapport between the staff and the mother (and her family too)
- Early initiation: lower incidence of postpartum hemorrhage.
- Bedding in and exclusive breastfeeding: time saving for the staff
- Space saving because there would not be a need for a baby room.
- Lesser incidence of neonatal infections, hypoglycemia and hyperbilirubinemia

- Mothers more empowered at discharge
- Higher exclusive breastfeeding rates at discharge and in first 6 months with higher continued breastfeeding beyond 6 months
- Improved neonatal (Edmond et al, 2006), infant and child mortality and morbidity

**The BFHI documents were revised in 2009 (WHO/UNICEF 2009) and the following major components were added**

- Baby-friendly communities
- BFHI and Prevention of Mother-to-Child Transmission of HIV/AIDS
- Mother-baby friendly facilities
- Baby-friendly neonatal intensive care and paediatric units
- Baby-friendly physician's office
- Baby-friendly complementary feeding
- Mother-baby friendly health care – everywhere

**Compliance with the IMS code is also required for health facilities to achieve Baby-friendly status.**

**The main points in the Code include:**

- no advertising of breast-milk substitutes and other products to the public;
- no free samples to mothers;
- no promotion in the health services;
- no donations of free or subsidized supplies of breast-milk substitutes or other products in any part of the health care system;
- no company personnel to contact or advise mothers;
- no gifts or personal samples to health workers;
- no pictures of infants, or other pictures or text idealizing artificial feeding, on the labels of the products;
- information to health workers should only be scientific and factual;
- Indian Parliament passed IMS Act in 1993 (Based on IMS Code) and amended it in 2003

### **5.1.1 Ten Steps to Successful Breastfeeding**



Every facility providing maternity services and care for newborn infant should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk unless medically indicated.
7. Practice rooming-in – allow mothers and infants to remain together – 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

### **5.1.2 BFHI Facility Assessment Form**

**(Based on WHO-UNICEF Guidelines)**

Maternity Home: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Type of Maternity Home: Government / Municipal/ Trust / Private

CEO: \_\_\_\_\_ Phone: \_\_\_\_\_

Obstetrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Matron: \_\_\_\_\_ Phone: \_\_\_\_\_

MSG Leader: \_\_\_\_\_ Phone: \_\_\_\_\_

Total Bed Strength: \_\_\_\_\_ Total Deliveries the last calendar year: \_\_\_\_\_

Date: \_\_\_\_\_

This is to state that I / we the undersigned have assessed above maternity facility for Baby Friendly Practices. Observations on Ten Steps are attached. Based on these observations I \ we recommend to

- Certify the maternity facility
- Reassess after suggested changes (marked as crosses)

Sign: \_\_\_\_\_ Sign: \_\_\_\_\_

Assessor 1: \_\_\_\_\_ Assessor 1: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

Cc: Secretary, BPNI Maharashtra  
Maternity Home CEO



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STEP 3: Inform all pregnant women about the benefits and management of breastfeeding.

3.1	Antenatal Counselling on IYCN & Baby Care conducted	
3.2	At least 60 % mothers attend the session	
3.3	Session addresses following Benefits of BF & Hazards of animal milk (formula) & Bottle Feeding Recommendations Colostrum, Demand Feeding, Bedding In Positioning, Engorgement, Cracked Nipple, Adequacy Working Mothers	
3.4	All information given to mothers (printed or otherwise) is scientifically correct.	

Notes:

Step 4: Help mother initiate first skin to skin contact and breastfeeding within one hour of birth.

4.1	Mothers delivered normally are given their babies to hold, with skin contact within 5 minutes and offered help to initiate breastfeeding within one hour.	
4.2	Mothers delivered by Caesarean sections are given their babies to hold within a half hour of being able to respond or not more than 4 hours following general anesthesia and offered help to initiate breastfeeding.	
4.3	Breastfeeding is initiated in labour room for all deliveries except those delivered by caesarean section	
4.4	Baby is given bath at least 12 hrs after delivery.	

Notes:

Step 5: Show mothers how to breastfeed (Proper Position and Attachment) & how to maintain lactation (Expression Technique), even if they should be separated from their infants.

5.1	All nurses know & demonstrate correct attachment & positioning.	
5.2	All nurses know & demonstrate expression correctly.	
5.3	Majority of mothers know & demonstrate correct attachment & positioning.	
5.4	Majority of mothers know & demonstrate expression correctly.	
5.5	Mothers of babies transferred to NICU are given help to start expression soon after delivery.	
5.6	Such mothers are transferred with the babies within 48 hrs in case of non-caesarean deliveries.	

Notes:

Step 6 Give newborn infants no foods or drink other than breast milk.

6.1	Facility prohibits giving honey, glucose water, jaggery before first breastfeed.	
6.2	More than 90 % babies (including those delivered by Caesarean section) are given exclusive breastfeeding during stay.	
6.3	Cross feeding is not permitted.	

Notes:

Step 7 Practice rooming-in-allow mothers and infants to remain together 24 hrs a day

7.1	Bedding in is practiced 24 hrs and there are no cradles	
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Notes:

Step 8: Encourage breastfeeding on demand

8.1	Mothers are advised to breastfeed their babies whenever their babies are hungry and as often as their babies want	
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Notes:

Step 9: Give no artificial teats or pacifiers (also called dummies / soothers) to breastfeeding infants.

9.1	Use of feeding bottles, pacifiers and dummies is prohibited	
9.2	Mothers are made aware about hazards of using these items and counselled not to use them anytime later	
9.3	Facility prohibits distribution & display of promotional material for above items, infant formulas & foods.	
9.4	Facility - staff refuse free or low cost supplies of infant milk and foods	

Note:

Step 10: Foster the establishment of breastfeeding support groups & refer mother to them on discharge from hospital & clinic.

10.1	Establishment of Mother Support Group is encouraged and mothers are provided help for breastfeeding problems to succeed breastfeeding. If Mother Support group does not exist, access to help by an expert is provided to overcome breastfeeding problems.	
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Note:

## **5.1.3 Questionnaire for Assessing facility staff for BFHI Certification**

### 1.1 What is BFHI

- Do you have a Breastfeeding Policy? Kindly tell few points from the policy?

### 1.2 Antenatal Counselling

- How do you counsel mothers about breastfeeding in the Antenatal period?
- Is Breast examination necessary during pregnancy?
- If nipples are found to be short or flat or retractile during antenatal period, how would you manage?
- What clothes do you advice for the mothers after delivery to facilitate breastfeeding?

### 1.3 Postnatal Counselling

#### 1.3.1 Inadequate milk

- If a mother complains in the first few days that the milk has not come in, how do you counsel her? What % of normal & Caesarean babies need to be given top milk or glucose water?
- Which formula do you use? At what discounted price is it available?
- What do you use to feed supplement: Bottle, wati-spoon?
- Which pacifiers do you use to pacify the crying babies?
- How frequently should the babies be fed after delivery?
- How to wake up a sleepy baby?
- How to know that baby is hungry?
- How to know if baby is getting enough in first few days (Urine, Stool and weight)

#### 1.3.2 Cracked Nipples:

- What is the cause of cracked nipples and how do you manage?
- What is good attachment and positioning? Show different holds for breastfeeding including that for Caesarean deliveries and twins



### 1.3.3 Engorgement

- How do you manage engorgement? (Expression Technique)

2. State recommendations for initiation and period of total and exclusive breastfeeding.

### 3. Myths about Breastfeeding

- Can mother feed in lying down position?
- What dietary restrictions should a breastfeeding mother observe?
- After how long should a mother feed from the other breast during a feed?
- How to judge about adequacy of breastfeeding in a 1 month old exclusively breastfed baby?

### 4. Myths about complementary feeding

- With what type of complementary foods should the complementary feeding be initiated?
- What is the role of top milk in complementary foods?
- Which biscuits and chocolates should be part of complementary foods?
- Which tinned food should be used as complementary food?

### 5. Special Issues

#### 5.1 Initiation of Breastfeeding by Breastcrawl

- How is feeding initiated after birth?

#### 5.2 LSCS

- How do you manage feeding in LSCS babies? What percent need supplementation?

#### 5.3 NICU

- What percent of babies are on total or partial top feeding at discharge?
- Where do you admit mothers of NICU babies?
- How early are mothers transferred there? How is breastmilk transport arranged in that period?
- How early is expression started?

#### 5.4 HIV

- What is the feeding policy for babies of HIV positive mothers?

#### 5.5 Post-Discharge Support

- How do you manage breastfeeding support for mothers after discharge?
- How do you monitor for adequacy of feeding after discharge?

## 6. Counselling

- Write all the points of counselling.
- What is close question? Give example
- What is reflect back? Give example
- What is empathy? Give example
- What is the meaning of accept mother's wrong thinking and feelings? Give 3 methods of acceptance.
- What is to be given, whether suggestion or advise or both?

## 5.2 Hand Expression of Breast Milk :

### **Why Hand expression is recommended:**

- Hand expression is the most useful way to express milk. It needs no appliance, so a woman can do it anywhere, at any time.
- It is easy to hand express when the breasts are soft. It is more difficult when the breasts are engorged and tender. So teach a mother how to express her milk in the first or second day after delivery. Do not wait until the third day, when her breasts are full.
- Key point: A woman should express her own breast milk. The breasts are easily hurt if another person tries. If you are showing a woman how to express, show her on your own body as much as possible, while she learns from you. If you need to touch her to show her exactly where to press her breast, be very gentle.

### **How to prepare a container for the expressed breast milk:**

- Choose a cup, glass, jug or jar with a wide mouth.
- Wash the cup in soap and water. (She can do this the day before.)
- Pour boiling water into the cup, and leave it for a few minutes. Boiling water will kill most of the germs.
- When ready to express milk, pour the water out of the cup first.

How to express breast milk by hand:

- Teach a mother to do this herself. Do not express her milk for her. Touch her only to show her what to do, and be gentle. Teach her to:
- Wash her hands thoroughly.

- Sit or stand comfortably, and hold the container near her breast.
- Put her thumb on her breast ABOVE the nipple and areola, and her first finger on the breast BELOW the nipple and areola, opposite the thumb. She supports the breast with her other fingers
- Press her thumb and first finger slightly inwards towards the chest wall. She should avoid pressing too far or she may block the milk ducts.
- Press her breast behind the nipple and areola between her finger and thumb. She must press on the lactiferous sinuses beneath the areola.
- Sometimes in a lactating breast it is possible to feel the sinuses. They are like pads, or peanuts. If she can feel them, she can press on them.
- Press and release. Then repeat as often as necessary. This should not hurt - if it hurts, the technique is wrong. At first no milk may come, but after pressing a few times, milk starts to drip out. It may flow in streams if the oxytocin reflex is active. Press the areola in the same way from the sides, to make sure that milk is expressed from all segments of the breast.
- Avoid rubbing or sliding her fingers along the skin. The movement of the fingers should be more like rolling.
- Avoid squeezing the nipple itself. Pressing or pulling the nipple cannot express the milk. It is the same as the baby sucking only the nipple.
- Express one breast for at least 3 - 5 minutes until the flow slows; then express the other side; and then repeat both sides. She can use either hand for either breast, or change when they tire.
- Explain that to express breast milk adequately takes 20 - 30 minutes, especially in the first few days when only a little milk may be produced. It is important not to try to express in a shorter time.

## **About the volume of breast milk**

If a mother is expressing more than her baby needs, let her express the second half of the milk from each breast into a different container. Let her offer the second half of the EBM first. Her baby gets more hind milk that way, which helps him to get the extra energy that he needs.

If a mother can only express very small volumes at first, give whatever she can produce to her baby. Even very small amounts help to prevent infection. Help the mother to feel that this small amount is valuable. This helps her confidence, and will help her to produce more milk.

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## Further Reading References :

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