



GUIDELINES FOR Enhancing Optimal Infant And Young **CHILD FEEDING** Practices



MINISTRY OF HEALTH AND FAMILY WELFARE
Government of India, 2013



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ENHANCING OPTIMAL INFANT AND
YOUNG CHILD FEEDING PRACTICES

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MESSAGE



Since its inception in 2005, the National Rural Health Mission endeavours for reduction of Under Five Mortality and has been developing and implementing unique strategies towards this. Malnutrition is attributed to more than one third of these under five deaths in the country. Childhood malnutrition rates are high with 43 percent children in India under five years are reported to be underweight and 48 percent stunted. Trend of faltering growth in children begins in critical period of first two years of life and major cause is due to faulty Infant and Young Child feeding practices. One of the key reasons for under nutrition setting-in early in life is the faulty and sub-optimal infant and young child feeding practices, which is further compounded by factors such as repeated episodes of childhood illnesses and low birth weight.

As depicted in National data sets like the National Family Health Survey and District level surveys, poor Infant and Young Child Feeding practices are observed by care givers. Dismal rates of early breastfeeding, stagnant rates of exclusive breastfeeding rates and poor rates of appropriate complementary feeding are a cause of concern and would require focussed attention of the health care system. The present guidelines are designed for interventions at facility and community levels and have been developed by the Child Health division with inputs from experts and in consultation with UNICEF, BPNI, WHO.

National Rural Health Mission provides a valuable opportunity to bring greater attention and commitment to promote IYCF interventions, both at the health facility and community outreach level. I am confident that these guidelines would enhance capacity of Healthcare Providers in achieving higher rates of Appropriate Infant and Young Child Feeding Practices towards reduction of childhood morbidity and mortality.

(P.K. Pradhan)



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PREFACE



Addressing infant and young child under nutrition is a national priority. The Ministry of Health and Family Welfare through its flagship programme, the National Rural Health Mission, is committed to taking appropriate and adequate steps and contribute towards reduction of undernutrition in children under five years of age.

Events leading to undernutrition often predate the birth of the child; maternal undernutrition, less spacing between births and high birth order result in birth of low birth weight babies. Under the National Rural Health Mission, a Life Cycle Approach has been adopted for interrupting the intergenerational cycle of undernutrition. Delayed initiation of breastfeeding and inappropriate feeding practices in the new-born period and first year of life exacerbate undernutrition in infants and children.

Promotion of optimal Infant and Young Child Feeding practices has been recognised as an important intervention not only for preserving nutritional status of children but also for child survival. While interventions to prevent deaths due to common childhood illnesses in children with severe acute undernutrition have been included in the national health programme, it is equally important that focus be brought back to preventive measures. This will ensure that new cases are not added to the already existing burden of child undernutrition in the country.

The reproductive, maternal, child and new born health services delivered through the public health system provides a many contact opportunities with pregnant and lactating women and mothers with children younger than five years of age. These opportunities must be capitalised for growth monitoring, counselling on infant and young child feeding practices and reinforcing the key messages in child care and nutrition.

The **Guide on Enhancing Optimal Infant and Young Child Feeding Practices through the Health System** reiterates our commitment to improving child nutrition. It provides the States with guidance on the steps that are to be taken towards the promotion of optimal infant and young child feeding through the health system and making the necessary provisions to deliver these services.

(Anuradha Gupta)



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FOREWORD



Infant and Young Child Feeding is a set of well-known, common and scientific recommendations for appropriate feeding of new-born and children under two years. The first two years of life provide a critical window of opportunity for ensuring children's appropriate growth and development through optimal feeding.

Early and exclusive breastfeeding along with appropriate complementary feeding is now recognised as one of the most effective interventions for child survival particularly to address morbidity and mortality related to three major problems i.e. neonatal infections, diarrhoea and pneumonia. While breastfeeding provides optimal nutrition to the child, improvements in complementary feeding can substantially reduce stunting and related burden of disease. Exclusive breastfeeding prevents 13 percent of the estimated under-five deaths and appropriate complementary feeding prevents another 6 percent of the same.

Improvement in IYCF indicators in the country would require major strengthening of counselling strategies to encourage appropriate IYCF practices. For this purpose, infant and young child feeding interventions require to be scaled up in the country through adequate resource allocation, capacity development and effective communication at all levels of the health system.

This *Operational Guide* has been written specifically for the State and District RCH Officers, Child Health & Nutrition Nodal Officers and Programme Managers in order to provide guidance on the IYCF interventions that can be integrated into on-going maternal and child health activities under NRHM.

Dr. Rakesh Kumar

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ABBREVIATIONS

ANC	Ante-natal care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
A-V	Audio-visual
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BPNI	Breastfeeding Promotion Network of India
CHC	Community Health Centre
DH	District Hospital
DLHS	District Level Household Survey
DPMU	District Programme Management Unit
FRU	First Referral Unit
IAP	Indian Academy of Paediatrics
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centres
IFA	Iron Folic Acid
IMS Act	Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, and Amendment Act 2003
IPC	Interpersonal Communication
IYCF	Infant and Young Child Feeding Practices
IEC-BCC	Information Education Communication- Behaviour Change Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
LBW	Low birth weight
LHV	Lady Health Visitor
MUAC	Mid Upper Arm Circumference
MCH	Maternal and Child Health
MO	Medical Officer
MCP card	Maternal and Child Health Protection card
NACO	National AIDS Control Organisation
NSSK	Navjaat Shishu Suraksha Karyakram
NBSU	Newborn Stabilisation Unit
NFHS	National Family Health Survey
NRC	Nutrition Rehabilitation Centres
OPD	Outpatients Department
PHC	Primary Health Centre
PIP	Programme Implementation Plan
RCH	Reproductive and Child Health
RMNCH	Reproductive Maternal Newborn and Child Health
SBA	Skilled Birth Attendant
SN	Staff Nurse
SNCU	Sick Newborn Care unit
SPMU	State Programme Management Unit
TOT	Training of Trainers
VLBW	Very Low Birth Weight
WHO	World Health Organisation
WFP	World Food Programme



THE IYCF PROGRAMME GUIDE

Interventions promoting infant and young child feeding are known to improve child survival, growth and intellectual development. **Infant and Young Child Feeding (IYCF)** practices are simply a set of recommendations to achieve appropriate feeding of *new-born and children under two years of age* so that they achieve optimal nutrition outcomes in populations. As recommended by the National Guidelines on Infant And Young Child Feeding (2006), the IYCF practices include the well-known practices of (1) initiating breastfeeding within one hour of birth, (2) exclusive breastfeeding for the first six months (180 days of age) of life, (3) initiation of appropriate complementary feeding from the age of 6 months and (4) continued breastfeeding for two years or beyond.

This Programme Guide has been written specifically for the State and District RCH Officers, Child Health & Nutrition Nodal Officers and Programme Managers to provide guidance on the IYCF interventions so that these are integrated effectively in the on-going maternal, newborn and child health activities under the NRHM.

The **first section** of the Programme Guide deals with Planning and implementation of IYCF practices at the (1) Health Facility (2) Community (home based care) and (3) Community Outreach.

This Guide presents a number of options to the Programme Managers from which best locally suited set of activities can be selected and integrated into the on-going state programmes.

The **second section** includes technical guidelines developed by the Infant and Young Child Feeding Chapter of the Indian Academy of Paediatrics in 2010, and the National Guidelines for IYCF developed by the Ministry of Women and Child Development in 2006. The Section on HIV and Infant Feeding has been revised based on the recommendations made in the ***Nutrition Guidelines for HIV affected children***, published recently by National AIDS Control Organisation. In addition, general recommendations have been included regarding feeding of low birth weight infants based on the ***WHO Guidelines for optimal feeding of low birth weight infants in low and middle income countries, 2011***.

It is expected that by using this Programme Guide, States will bring renewed focus and vitality into programmes/interventions for supporting and promoting, infant and young child feeding practices, which is evidence based cost-effective strategy for tackling high rates of undernutrition and consequent child mortality in the country.



SECTION - I

OPERATIONAL GUIDELINES

INTRODUCTION

1.1 Defining Infant and Young Child Feeding

Infant and Young Child Feeding (IYCF) is a set of well-known and common recommendations for appropriate feeding of new-born and children under two years of age. IYCF includes the following care practices:

OPTIMAL IYCF PRACTICES

- a. Early initiation of breastfeeding; immediately after birth, preferably within one hour.
- b. Exclusive breastfeeding for the first six months of life i. e 180 days (no other foods or fluids, not even water; but allows infant to receive ORS, drops, syrups of vitamins, minerals and medicines when required)
- c. Timely introduction of complementary foods (solid, semisolid or soft foods) after the age of six months i. e 180 days.
- d. Continued breastfeeding for 2 years or beyond
- e. Age appropriate complementary feeding for children 6-23 months, while continuing breastfeeding. Children should receive food from 4 or more food groups [(1) Grains, roots and tubers, legumes and nuts; (2) dairy products ; (3) flesh foods (meat fish, poultry); (4) eggs, (5) vitamin A rich fruits and vegetables; (6) other fruits and vegetables] and fed for a minimum number of times (2 times for breastfed infants 6-8 months; 3 times for breastfed children 9-23 months; 4 times for non-breastfed children 6-23 months)
- f. Active feeding for Children during and after illness.

Early Initiation of Breastfeeding means breastfeeding all normal newborns (including those born by caesarean section) as early as possible after birth, ideally within first hour. Colostrum ,the milk secreted in the first 2-3 days, must not be discarded but should be fed to newborn as it contains high concentration of protective immunoglobulins and cells. No pre-lacteal fluid should be given to the newborn.

Exclusive breastfeeding for the first 6 months means that an infant receives only breast milk from his or her mother or a wet nurse, or expressed breast milk, and no other liquids or solids, not even water. The only exceptions include administration of oral rehydration solution, oral vaccines, vitamins, minerals supplements or medicines. .

Complementary feeding means complementing solid/semi-solid food with breast milk after child attains age of six months. After the age of 6 months, breast milk is no longer sufficient to meet the nutritional requirements of infants. However infants are vulnerable during the transition, from exclusive breast milk to the introduction of complementary feeding, over and above the breastmilk. For ensuring that the nutritional needs of a young child are met breastfeeding must continue along with appropriate complementary feeding. The term “complementary feeding” and not “weaning” should be used. The complementary feeding must be:

- Timely – meaning that they are introduced when the need for energy and nutrients exceeds what can be provided through

exclusive breastfeeding;

- Adequate – meaning that they provide sufficient energy, protein and micronutrients to meet a growing child’s nutritional needs;
- Safe – meaning that they are hygienically prepared and stored, and fed with clean hands using clean utensils, and not bottles and teats.

1.2 Benefits of optimal Infant and Young Child Feeding

Early and exclusive breastfeeding is now recognised as one of the most effective interventions for child survival particularly to address morbidity and mortality related to three major conditions i.e. neonatal infections, diarrhoea and pneumonia. Scientific evidence shows that early initiation of breastfeeding can reduce neonatal mortality significantly. Exclusive breast feeding upto 6 months can prevent upto 13% of the estimated under-five deaths¹. Breastfeeding also provides constant positive interactions between mother and child which can contribute to emotional and psychological development of infants. It has been found to have direct positive impact on brain development.

Breastfeeding has a protective effect against childhood obesity and lowers the risk of several chronic conditions including asthma, diabetes and heart disease, in adult life and thus contributes to long-term benefits.

While breastfeeding provides optimal nutrition to the child and prevents infections, the timely initiation and age appropriate complementary feeding can substantially reduce stunting and related burden of disease. The first 1000 days are critical for any child and regarded as a window of opportunity for survival and development. Investment in nutrition during this period is essential

as undernutrition leads to stunting during this time which is largely irreversible. Solution to prevent stunting is to attain growth potential for children by optimal Infant and young child feeding during the first 1000 days. Appropriate complementary feeding can prevent 6% of the estimated under-five deaths and have larger impact to lessen morbidity and malnourishment rates.


Optimal breastfeeding and **complementary feeding** practices together can prevent deaths in children under five years by significantly reducing mortality from infections like diarrhoea and pneumonia. In addition, these practices allow children to reach their full growth potential and prevent irreversible stunting, as well as acute under-nutrition.

To summarize, the adoption of appropriate IYCF practices by the families:

Benefits of breastfeeding

FOR THE BABY

- Improved growth and nutrition status
- Less likely to die
- Increased bonding
- Lower risk of chronic diseases (diabetes, heart disease, asthma, Some cancers)
- Less diarrhoea and respiratory infections
- Lower risk of over weight/ obesity
- Improved cognitive and motor development
- Less Car infections GI disorders, Skin Conditions and side




FOR THE MOTHER

- Mother less likely to become pregnant in early months
- Faster maternal recovery and weight loss post partum
- Lower risk of maternal cancers (ovarian and breast cancer)
- Less post partum depression

Benefits of optimal complementary feeding (timely adequate, appropriate and safe)

- Less likely to die
- Optimal growth
- Prevention of stunting and acute malnutrition
- Less diarrhoea and respiratory Infections
- Prevention of over weight/obesity
- Less risk of anemia
- Improved cognitive development
- Better psychosocial development
- Improved productivity and economic status
- Less risk of zinc and other micronutrient deficiencies



¹Jones G et al. THE LANCET . Vol 362.July5, 2003. www.thelancet.com

²Jones G et al. Lancet. 2003;362:65–71.

- Reduces the risk of child mortality
- Reduces the risk of preventable infant and childhood illnesses
- Enhances cognitive functions and increases productivity
- Helps in spacing pregnancies as breastfeeding is the an effective contraceptive (98.2%) during the first six months of lactation
- Reduces burden on health system and costs for societies by protecting against malnutrition (both under-nutrition and obesity) and infectious and chronic diseases

1.3 IYCF: Situation in India & Need for reinforced action

Undernutrition is a contributory factor in one third to half of all deaths taking place in children under five years of age. 43 percent children in India under five years are reported to be underweight and 48 percent are stunted (NFHS-3; 2005-06). Onset of malnutrition occurs in the very early years of growth. Even during first six months of life, when most children are breastfed, 20-30 percent are underweight. Underweight prevalence increases rapidly from birth to age 20-23 months.

One of the key reasons for undernutrition in early life is the faulty and sub-optimal infant and young child feeding practices, which is further compounded by factors such as low birth weight and repeated episodes of illnesses like diarrhoea and acute respiratory infections . The first two years of life provide a critical window of opportunity for ensuring appropriate growth and development of children through optimal feeding.

Country level trends in 3 major IYCF indicators over past 15 years are depicted in figure 1.

Over the period, there has been a slow but steady increase in early initiation of breastfeeding, especially after launch and operationalization of NRHM. However there has been no improvement in the status of exclusive breast feeding for six months and complementary feeding (6- 9 months).

The survey data analysis suggests that introduction of liquids and solid or semi-solid foods often takes place before the recommended age of six months. Almost 30 percent of children start receiving complementary food (CF) at the age of 4-5 months. Similarly, delayed CF is also common.

Figure 1 : Trends in IYCF indicators- India

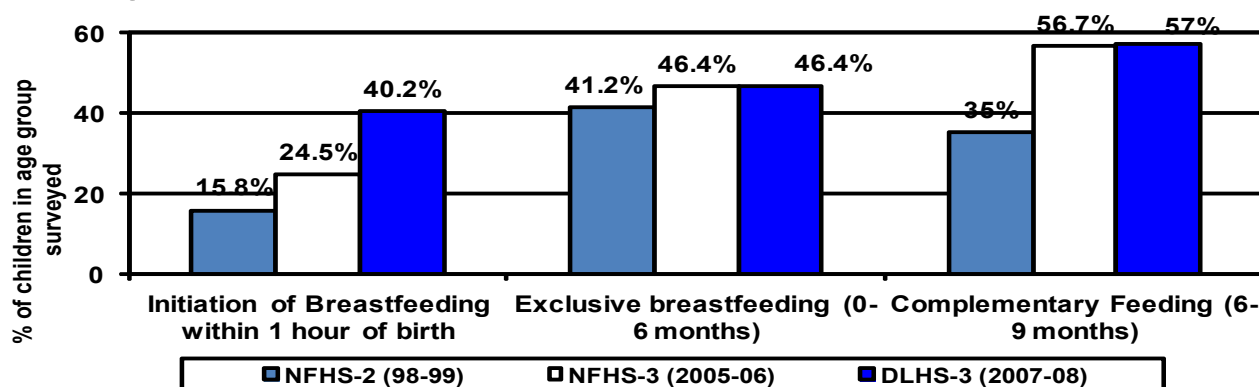
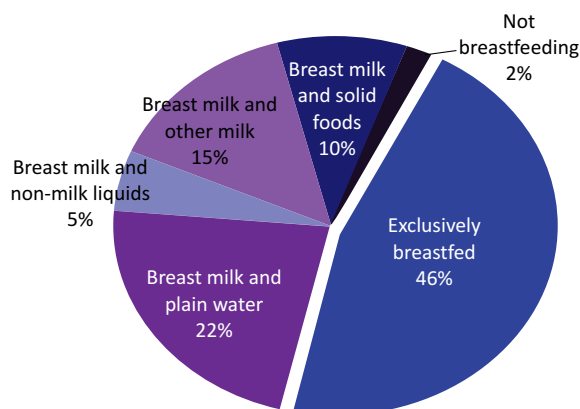


Figure 2 : Feeding practices of children under 6 months of age



Source: Report-Nutrition in India, NFHS III (2005-06)

Overall, only 21 percent of children aged 6-23 months are fed according to all three quality parameters of IYCF practices recommended by WHO (timely, adequate and safe). Only 44 percent of breastfed children are fed at least the recommended minimum number of times (NFHS3), but only half of them consume food from three or more food groups. Feeding recommendations are even less likely to be followed for non-breastfeeding children age 6-23 months.

Poor IYCF practices and prolonged malnutrition leads to stunting during this critical period of life. Stunted Children not only falter in physical but in

cognitive growth as well. Stunting is irreversible and can have long-term effects on cognitive development, school achievement, economic productivity in adulthood and maternal reproductive outcomes (Dewey et al 2011). Tackling childhood stunting is a high priority for reducing child morbidity and mortality, and for fostering economic development. For this, the existing efforts for promotion of infant and young child feeding must be strengthened as well as mainstreamed and scaled up in the country through adequate resource allocation, capacity development, and effective communication at all levels of the health system and the community.

India's National Nutrition Policy and the National Plan of Action on Nutrition clearly articulates the role of health sector in promoting breastfeeding through training of health workers. Similarly, the National Guidelines on Infant and Young Child Feeding 2006 and the Infant Milk Substitutes: Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992, and Amendment Act 2003 also state the role of health care system in ensuring Optimal Infant and Young Child Feeding Practices. While the adoption of good IYCF practices on the ground remained suboptimal, NRHM provides an immense opportunity to strengthen and scale up the optimal IYCF practices.

INTERVENTIONS FOR PROMOTING IYCF PRACTICES IN HEALTH SYSTEMS

The National Rural Health Mission provides a valuable opportunity to bring greater attention and commitment to promote IYCF interventions at the health facility, the community outreach and household levels.

The strengthening of IYCF interventions requires the following three areas of action:

1. **Protection:** By ensuring implementation of the IMS Act i.e. the Infant Milk Substitutes feeding bottles, and infant foods (Regulation of Production, Supply and Distribution) Act 1992, and Amendment Act 2003 (see Annexure - II for details),
2. **Promotion:** By providing accurate information and skilled counselling to all women, family and community members.
3. **Support:** By providing support measures for sustained appropriate feeding through maternity protection.

1. PROMOTING APPROPRIATE IYCF PRACTICES THROUGH THE HEALTH NETWORK

The following section presents strategies and actions for integrating and promoting appropriate IYCF practices through the health network since coverage and utilisation for maternal and child health services are consistently increasing. Mothers and children have regular contacts with the health service providers during pregnancy and the first two years of life of the child, be it for pre and postnatal care or immunization. The increased

coverage and regular contacts provide great opportunity to influence mothers and caregivers towards optimal feeding practices. Health service providers are in a position for undertaking timely actions to influence Infant and Young Child Feeding practices through messages, counselling and advice during healthcare service delivery and informal communication with the beneficiaries. Similarly network of ANMs and ASHAs are in a position to reinforce appropriate IYCF practices during home visits and outreach activities.

Actions to promote infant and young child feeding have been grouped at the following three levels: **(1) at health facilities (2) during community outreach activities and (3) during community and home based care.**

The key contact points that are available at various levels are presented in the following sections. Each State therefore must try and find unique contact opportunities which must be capitalised to promote optimal IYCF practices including one-to-one infant feeding counselling support for the mothers, and demonstration of appropriate feeding practices.

II-(A) KEY INTERVENTIONS AT HEALTH FACILITY LEVEL

1. Contact opportunities For Promotion of IYCF in a health facility

(a) During and after institutional delivery

With the launch of Janani Suraksha Yojana and Janani Shishu Suraksha Karyakram, increased numbers of institutional deliveries

and skilled attendance at birth provides tremendous opportunity for ensuring early initiation of breastfeeding and promoting exclusive breastfeeding during stay at the health facility. Initiation of breast feeding should be done in labour room itself. Health facilities must aim for complete coverage of early initiation of breastfeeding for all normal deliveries and at the earliest possible for complicated deliveries.

Medical Officers, Staff Nurses, LHV's and ANMs posted at the delivery points are responsible for communication and counselling of women delivering at the health facility. The staff must undertake the following actions: measure birth weight, identify low birth weight babies, counsel and support mothers to initiate breastfeeding soon after birth. Staff nurses are recommended to be mobilised (from labour room, postnatal ward; new born care facility or NRC, as is feasible in facility specific context) by rotation specifically for the purpose of counselling mothers in the postnatal wards and for solving common problems related to initiation of breastfeeding.

In high case load facilities (e.g.; a District Hospital), **Nutrition Counsellor/s trained in IYCF counselling and lactation management** may be employed for providing support to mothers delivering in the health facility or referred from peripheral health facilities for any reason.

(b) Inpatient services for children

Inpatient services for the children comprise the following:

- Sick child admission in Paediatric Wards
- Nutrition Rehabilitation Centre (NRC)

- New-born care facilities (Stabilisation units, Special New-born Care Units)

The key responsibility for communication and counselling of mothers /caregivers on IYCF is that of Staff Nurses and Medical Officers. In addition, the Staff Nurses should be instructed to take anthropometric measurements of all children admitted to health facilities and appropriate nutrition counselling should be provided to caregivers of children identified as underweight or stunted. In high case load facilities (eg; a District Hospital), Nutrition Counsellor/s may be employed.

Where a Nutrition Counsellor is already associated or part of the NRC, his/her services should be used to educate and counsel mothers with young children admitted to the hospital. The role of Nutrition counsellor is to provide IYCF counselling to inpatient, outpatient and labour rooms in rounds.

Nutrition Counsellors trained in lactation management may also be employed at health facilities with Special New-born Care Units (SCNU). As many babies admitted to the SCNU are likely to be low birth weight and/or preterm and sick babies, optimal support for breastfeeding has to be provided in the follow up period after discharge. Nutrition counsellors must provide counselling and support not only to mothers/ caregivers of children discharged from SCNU but also to caregivers of other babies including LBW and preterm babies born at these facilities or referred from peripheral health facilities. They must regularly visit children admitted as inpatients and counsel caregivers of children identified as underweight or stunted.

'Rooming in' facilities for mothers of babies admitted to newborn care facilities should be provided as this will go a long way in

instilling confidence in mothers and improving breastfeeding rates in preterm and sick babies once they are on the way to recovery.

Doctors, Nurses and other staff posted at health facilities, especially those responsible for delivery of MCH services, should be well versed with the IMS Act as they have the responsibility to ensure compliance especially Section 8 and 9 of the Act within the health facility and the health system. A brief note outlining the key provisions under this law is presented in Annexure - II.

c. Outpatient services and consultations for pregnant women, mothers and children:

Outpatient services comprise the following:

- Antenatal clinic
- IYCF Counselling Centre
- Sick Child consultation in outpatient department

The **key responsibility** for growth monitoring, communication and counselling of mothers / caregivers is that of Staff Nurses and Medical Officers. ANMs posted at a health facility can also take on this role.

(i) Antenatal Clinics:

In high ANC case load facilities (e.g.; District Hospital, CHC), Nutrition Counsellor/s are recommended to be employed. The services of the Nutrition Counsellor, trained in IYCF and lactation management, should be used to provide group counselling and inter personal counselling to pregnant women and mothers of children presenting in Outpatients Department on daily basis and on designated days (e.g. immunization day, antenatal clinic).

(ii) IYCF Counselling Centres

Establishment of IYCF Counselling Centres in the outpatients' area in high case load facilities (DH, CHCs) , dedicated Maternal and Child Hospitals, is recommended. A Nutrition counsellor/ IYCF counsellor should be appointed to manage these centres and should be available for fixed hours (coinciding with timing of outpatient services) at this centre to counsel and solve referral problems.

This centre should also review growth and the immunisation status of the child for the first two years of life and provide appropriate advice and information.

The **package of services** should include the following:

1. Growth monitoring (growth curve / pattern may be reviewed and age appropriate advice given; when MCP card is available with the parents/ caregivers, it should be used as the reference point)
2. Communication and counselling on IYCF
3. Information about services available through community outreach (e.g.; immunisation)
4. Provision for Vitamin A and IFA supplements (if not received in the outreach) for children older than 6 months.
5. In case child is born prematurely or with low birth weight, one to one counselling session should be conducted with the mother/care givers and follow up visits to the centre requested.

IMPLEMENTATION OF THE IMS ACT

One key strategy is to protect breastfeeding from commercial influence. Health care providers must not allow the health systems to be used for promotion of any baby foods or companies manufacturing such foods. The Act also prohibits any kind of direct or indirect benefit from the manufacturers of baby food companies including sponsorships, research grants, funding of seminars or association of health workers. Activities for implementation of this Act can include 1-day sensitization programme on IMS Act for Civil Surgeon, Chief Medical Officer, doctors and nurses. Under the IEC, hoardings on IMS Act provisions could be installed outside health facilities and prominent public places. For details see Annexure - II.

iii). Activities for reaching out to mothers/care givers at the health facility

Mothers and caregivers can be reached through:

- **One to one counselling** by the service provider is the best way to reach out to mothers and caregivers in the post natal period when they are more receptive to messages on child care and feeding. Similarly, one to one counselling is required with mother of a sick child for review of child feeding practices and reinforcement of key messages related to feeding during and after illness. Mothers of undernourished children and low birth weight babies should also receive one to one counselling regarding specific feeding needs. Communication guides (Flip charts) are recommended to be used along with skilled counselling to make it more effective.
- **Group counselling sessions** on fixed days and time, should be organised at MCH facilities at pre-decided contact points that

include outpatient ANC services, child health services, immunization points and inpatient areas like postnatal wards and paediatric wards, new-born care units and Nutrition Rehabilitation Units.

- **Use of audio-visual aids** in waiting areas and postnatal ward and at ANC clinics is a good way of reaching out to mothers and family members who also have a critical role in supporting optimal child feeding practices.
- **Appropriate IEC material** (eg; posters) in local language should be displayed at strategic locations (eg; waiting areas, outside labour room, outdoor consultation rooms, obstetric and paediatric wards) in the health facility.

KEY PRACTICES AND SERVICE PROVIDERS IN HEALTH FACILITIES:

ANTENATAL CLINIC: at all MCH facilities and PCTC/ delivery points

Actions & key practices:

- Counselling for early initiation, colostrum and exclusive breast feeding during third trimester
- Specific counselling and management if mother is HIV positive
- Importance of colostrum feeding

Primary Responsibility: Staff Nurses; Nutrition Counsellor (when available at the facility) ; ICTC counsellor

Supporting Role: Medical officer, ASHA

POSTNATAL WARD: at all delivery points

Actions & key practices:

- Ensure initiation of breastfeeding within one hour
- Support for early initiation of breastfeeding , avoiding pre lacteal feeds , promoting colos-

trum feeding, and establishment of exclusive breastfeeding;

- Management of breast conditions
- 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
- Birth weight, identification of LBW babies and appropriate management
- Counselling on infant feeding options in context of HIV (for mothers identified as HIV positive) during antenatal period and after birth
- Inclusion of early breastfeeding column in all delivery registers
- PNC ward and delivery room must have IEC materials on walls for early initiation of breastfeeding & exclusive breastfeeding in local language

Primary Responsibility: SBA/NSSK trained service provider/s conducting delivery (ANM, SN, MO) ; Nutrition Counsellor at high load facilities

Supporting role: Doctors, Staff nurses

OUTPATIENT SERVICES/CONSULTATIONS (IMMUNISATION, HEALTHY CHILD CLINIC, SICK CHILD CLINIC, ICTC)

At all MCH facilities/ delivery points

Actions & key practices:

- Ensure exclusive breastfeeding message and complementary feeding messages are reinforced
- Growth monitoring of all inpatient children and use of WHO Growth charts for identification of wasting and stunting and appropriate management
- Group counselling on IYCF and nutrition during pregnancy and lactation;
- Review of breastfeeding practices of individu-

al child and nursing mother and counselling on age appropriate infant feeding practices;

- Review of feeding practices, counselling & support on feeding options in context of HIV (for mothers identified as HIV positive)

Primary Responsibility: ANM if only she is available, Staff Nurses; Nutrition Counsellor at high case load facilities ; ICTC counsellor

Supporting Role: Medical officer

INPATIENT SERVICES (SICK CHILDREN ADMITTED IN PAEDIATRIC WARDS)

At all MCH facilities / delivery points

Actions & key practices:

- Monitoring of lactation and breast conditions, support to resolve any problems
- Anthropometric measurements of all inpatient children; identification of children with under nutrition and appropriate nutrition counselling and management
- Counselling on early childhood development (play and communication activities) using MCP card
- Implementation of IMS Act
- Age appropriate messages regarding feeding of sick child and child care practices

Primary Responsibility: Staff Nurses; Nutrition Counsellor at high case load facilities

Supporting Role: Matron , Medical officer

SPECIAL NEW BORN CARE UNITS(SPECIAL NEWBORN CARE UNITS, NEWBORN STABILIZATION UNITS)

Actions & key practices:

- 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

- age appropriate feeding advice on discharge

Primary Responsibility:

Staff Nurses; Nutrition Counsellor at high case load facilities

Supporting Role:

Medical officer

NUTRITION REHABILITATION CENTRES (NRCS)

Actions & key practices:

- Review of feeding practices of severely malnourished child and counselling on appropriate therapeutic feeding practices including what to feed and how to feed
- Appropriate feeding advice before discharge
- 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)
- Counselling on early childhood development (play and communication activities) using Mother Child Protection Card

Primary Responsibility:

Staff Nurse, Nutrition Counsellor

Supporting Role: Medical Officer

II-B. KEY INTERVENTIONS AT COMMUNITY OUTREACH LEVEL

1. MCH contact opportunities during Community outreach

The following contacts are critical opportunities for IYCF 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 rounds
- IMNCI/sick child consultation at community level
- Special campaigns (eg; during Breastfeeding Week)
- Any State specific initiative

ASHAs, need to be provided intensive training so as to equip and position them as effective promoters of optimal IYCF practices

2. Activities for reaching out to mothers/care givers at community outreach

Mothers and care givers should be reached through:

- » Growth Monitoring Sessions: Growth monitoring (weight recording in MCP card) is undertaken at AWC and /or during VHNDs, This activity is a good entry point for nutrition counselling and promoting IYCF practices.
- » Group counselling sessions: at fixed day and time, should be organised at VHND. Mothers accompanying children for immunisation, micronutrient supplementation provide a captive audience for discussing infant and young child feeding practices.

- » One to one counselling and group counselling should be conducted during outreach by the ANM/ ASHA for children with moderate/ severe under-nutrition. Children with severe under-nutrition are to be referred to an appropriate facility for further evaluation after screening (using MUAC cut off of < 115 mm as the criteria). One to one counselling provides an opportunity to assess the socio economic and cultural barriers in the practice of optimal IYCF and then to customise key messages accordingly.
- » Display of Appropriate IEC material (eg; posters): IEC material in local language should be displayed at strategic locations (eg; community walls, AWC, Panchayat Bhawans etc). Context specific messages promoting local cultural practices that are beneficial and dispelling locally prevalent myths can be developed and displayed at VHND sessions.
- » Planning for IEC, BCC material and tools should be undertaken as part of the PIP planning process. This will ensure that appropriate audio-visual aids and IPC-BCC tools (like flip charts) are available with ANM and ASHA to facilitate discussions.

IPC tools developed at State level can be made available to community workers as job aids. Adequate budget provisions should be available in the PIP to develop, print and disseminate IEC material.

However, the various actions for behaviour change communication on child feeding practices should not be restricted to special events (like the Breastfeeding Week or Nutrition Week) but be a part of all the health related events and activities taking place throughout the year. This will not only reinforce key messages but also reach to more audiences in the community and promote adoption of correct IYCF practices.

IYCF PRACTICE DISSEMINATION THROUGH WORKERS IN COMMUNITY

Village Health & Nutrition days (VHND):
AWC or Sub Centre , as relevant

Actions & key practices to be promoted
: Counselling and practical guidance on breastfeeding as an integral component of birth preparedness package – prepare mothers for early initiation of BF;

Activities: Group counselling on maternal nutrition and infant feeding

Health service provider: ANM

Where feasible, demonstration of food preparation and sharing of recipes for optimal use of locally available foods for children 6-23 months; In special situation, demonstrate preparation of safe replacement feed

Supporting Role: AWW, ASHA, LHV and ICDS supervisor

Routine Immunisation sessions (RI sessions)
: AWC or Sub Centre as relevant

Activities: Group counselling on age appropriate IYCF practices and maternal nutrition

Health service provider: ANM

Supporting Role: ASHA, AWW

Biannual Rounds for Vitamin A supplementation; or during months dedicated to child health (e.g. ; Shishu Sanrakshan Maah)-
AWC or Sub Centre as relevant

Activities: Group counselling on IYCF and maternal nutrition;

Health service provider: ANM

Supporting Role: ASHA, AWW

IMNCI / sick child consultation : community level, Sub centre, AWC

Activities: Assessment of age appropriate feeding and feeding problems; counselling on age appropriate feeding and feeding during illness

Health service provider: ANM

Supporting Role: ASHA and AWW

Community level Actions by ASHA/ANM:

Dada-Dadi/Nana-Nani Sammelan: In addition to using the platform of VHND, Monthly group counselling sessions can be held at each village by ASHA where she communicates and does IPC regarding Infant Young Child Feeding to secondary care givers who are major influencers in child feeding at home such as grandparents (dada, dadi- paternal grandparents; nana, nani-maternal grandparents), father or relatives. Such an advocacy strategy would contribute in improving IYCF practices. ASHA may be appropriately incentivized for conducting this activity. A register should be maintained by ASHA for conducting the sessions, signatures/thumb impression taken of attendees and payment made to ASHA by the ANM after conduct of such meetings.

II-C. KEY INTERVENTIONS DURING COMMUNITY AND HOME BASED CARE

1. MCH contact opportunities during home visits

Community contacts include:

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

Frontline health workers (ANMs and ASHAs), conduct home visits for providing postnatal and newborn care as part of ongoing MCH programme. It has also been proposed that ASHAs make home visits for following up the newborns with Low Birth Weight for a longer period (up to 2 years).

At places, Mothers' Groups and /or Self Help Groups are active and offer a good platform for discussing IYCF practices. These groups are facilitated by AWWs and themes for discussion include IYCF and child care.

2. Activities for reaching out to mothers/ caregivers during home visits and community level activities:

Mothers and caregivers must be reached through:

(i) **One to one counselling** during home visits by the ANM and ASHA is the best way to reach out to mothers and caregivers in the community. One to one counselling provides an opportunity to assess the socio economic and cultural barriers in the practice of optimal IYCF and then to customise key BCC messages accordingly. It is also an opportunity to teach mothers about proper child positioning and attachment for initiating and maintaining breastfeeding. It is critical to solve the problem of 'not enough milk', which is almost a universal perception among mothers/ caregivers and family members.

Mothers whose babies are born with low birth weight or identified as underweight on the MCP card can be given specific feeding advice. Any feeding problems must be identified and addressed.

As the Home Based Newborn Care Scheme now requires that every child be visited at home (6-7 times during first 42 days of life), the messages on IYCF can potentially reach every mother and household. Specific points for discussion

on feeding, examination/observation and key messages to be delivered at each of the 6 visits (or 7 in case of home delivery) should be clearly specified to ASHAs and ANMs during the training on IYCF

It is important to detect growth faltering during first few months; it is usually due to faulty feeding practices and / or infections. Appropriate diagnosis must be made at this time and faulty feeding practices must be corrected. If required, these children should be referred to higher health facility for suitable management and advice.

(ii) Group counselling sessions, at fixed day and time, should be organised at VHND. Where possible, audio-visual aids and tools (like flip charts developed in local languages) should be used by ANMs to provide information and counseling. AWWs and ASHAs should provide active and adequate facilitation of these sessions.

AWWs conducting group counselling sessions for expectant and lactating mothers should ensure key IYCF messages are discussed in all the sessions. Similar approach should be used during Growth Promotion and Monitoring Sessions and Group counselling sessions at AWCs. Mothers of children identified as moderately or severely underweight or with weight plotting in yellow & orange zone of the growth chart (Mother and Child Protection Card) should be counselled more intensively. Mothers of children with normal growth pattern should also be included in these discussions (Positive Deviance Model) so that such women are encouraged to share information and experiences regarding preparation of age appropriate feeding for young children and practical solutions to common feeding problems. During the sessions, these mothers (and /or AWW) should also be encouraged to demonstrate the best use of locally available and acceptable foods.

(iii)_Display of Appropriate IEC material (eg;

posters): IEC material in local language should be displayed at strategic locations (eg; community walls, AWC, Panchayat Bhawans etc). Context specific messages promoting local cultural practices that are beneficial and dispel locally prevalent myths should be developed and displayed. IPC Tools for home visits (like flipcharts) developed by various organisations /agencies in the state can be made available to community workers as a job aides.

DISSEMINATION OF OPTIMAL IYCF PRACTICES THROUGH WORKERS IN COMMUNITY - HOME CONTACTS

Home visits to newborn (up to 42 days) in postnatal period. The activities would include :

- Birth weight recording within 24 hours, for home deliveries
- Support early initiation of breastfeeding, colostrum feeding and establishment of exclusive breastfeeding; resolve any problems
- Identification of low birth weight babies and appropriate feeding advice
- Advice on feeding frequency and duration
- One to one counselling of mothers, care givers and family members on maternal nutrition during lactation and infant feeding practices
- 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 IYCF

Primary Responsibility: ASHAs

Supporting Role: ANMs, AWWs

During routine activities of Anganwadi centres: (Growth monitoring and promotion

sessions; supplementary feeding; counselling sessions), Anganwadi Centre

Activities:

- Growth Monitoring using Mother and Child Protection Card
- Group counselling/communication on IYCF and maternal nutrition;
- Where feasible, demonstration of food preparation and sharing of recipes for optimal use of locally available foods for children 6-23 months;
- Assessment of age appropriate feeding practices and feeding problems, counselling on age appropriate feeding and feeding during illness
- Counselling on early childhood development (play and communication activities) using MCP card

Primary Responsibility: AWWs

Supporting Role: AWWs/ helpers

On any other occasion of home visit by the community health worker:

The worker should have a vigil to notice if any child under two years of age is not feeding well or appears malnourished. Subsequent to necessary advice, this has to be brought to the notice of the ANM for appropriate advice and management. The child should also be linked up with the AWW.

SPECIAL ROLE OF ASHAs IN PROMOTION OF IYCF:

- ASHAs to follow up each child under age of six months through home visits every month (end of 2nd, 3rd, 4th, 5th and 6th) for weight monitoring and promoting exclusive breastfeeding. The visit at the end of 6th

month will include counselling on initiation of complementary feeding with specific details on how and what to feed the child. ASHAs may be provided an incentive if the child is in "Green zone" of growth chart in MCP card at end of six months. List of infants not being exclusively breastfed should be submitted to ANM, along with reasons for discontinuation of exclusive breastfeeding. ANM has the supervisory responsibility and could give appropriate timely inputs. - Such an action would be helpful in increasing exclusive breastfeeding to a great extent.

- ASHAs are expected to undertake two home visits in late infancy - at the end of 9th and 12th month. During these visits, ASHAs must promote continuation of breastfeeding and complementary feeding using locally available semi-solid foods. ASHA should assess appropriateness of complementary food in terms of quantity, frequency and type of foods being fed. During each of these contacts, ASHAs should record child's weight in the MCP card, if it has not been recorded in during the VHND sessions. An additional incentive may be considered for ASHA for completion of the whole set of these visits over one year, provided the child is in Green Zone of MCP card at one year of age.
- ASHA will organize mother-to-mother support groups on IYCF using a participatory methodology for primary as well secondary care giver
- She will track every Low Birth Weight baby for growth monitoring and promotion of continued breastfeeding till 2 years of age along with adequate and appropriate complementary feeding.

TRAINING OF KEY SERVICE PROVIDERS IN HEALTH SYSTEM

Health service providers have important role in not only promoting optimal IYCF practices but also in ensuring these practices are followed. This could be done by providing essential information on breastfeeding and complementary feeding, counselling and supporting mothers/caregivers in solving common feeding problems. It is therefore important that their capacity is augmented through pre-service as well as in-service training on IYCF.

All health care providers who interact with mothers and young children should acquire the basic knowledge and skills to integrate breastfeeding, lactation management and infant and young child feeding principles into the care that they routinely provide. Some aspects of IYCF are integrated in many existing pre-service and in-service training programmes for the health cadres these include:

- IMNCI – Pre-Service and In-Service Training
- F-IMNCI – Pre-Service and In-Service Training for Doctors and Nurses
- Skilled Birth Attendance Training
- ASHA module 6 & 7
- Infant and Young Child Feeding Counselling for Medical Undergraduates and Nursing Students – A Training Package (Pre Service)
- Regular Curriculum of Medical and Nursing Students (IYCF counselling component should be included)
- Facility Based Management of Severe Acute Malnutrition

- IYCF trainings for recruited Nutrition Counsellors

However at facility level, advanced set of skills are essential for the service providers who are directly involved in the provision of counselling support to mothers and families. The services providers must be equipped to deal with concerns and problems related to lactation failure. They should be able to provide solutions to problems like breast engorgement, mastitis etc, and provide special counselling on IYCF to mothers who feel they don't have enough breast milk, low birth weight babies, sick new-born, undernourished children, adopted baby, twins and babies born to HIV positive mothers and in emergency like floods and earth quake etc. For this, a detailed, hands-on training for improving counselling skills of health workers should be provided.

The existing training packages that can be used for this purpose is the Infant and Young Child Feeding Counselling: A Training Course. The 4 in 1 course (An Integrated course on Breastfeeding, Complementary Feeding & Infant feeding, HIV counselling and Growth Monitoring). This package provides core training material for all levels including Master trainers, Mid-Level Trainers, facility based service providers and frontline workers. However, the trainings vary in duration for master trainers and service providers; a 4 days package for frontline workers has also been developed in 2012.

The pre service training package, a three day

training programme, on Infant and Young Child Feeding Counselling for medical undergraduates and nursing students consists of a Student's Handbook and a Teacher's guide. The training package for teaching faculty builds on and complements the skills imparted in IMNCI and aims at building skills of medical and nursing students on IYCF counselling and management of feeding problems. The training period includes 3 classroom sessions (of 3 hours each) and 5 clinical sessions. The training of faculty may be combined with Pre-service IMNCI training and conducted for a total of 8 days (5.5 days for IMNCI and 2.5 days for IYCF). State/s should develop the IYCF training plan, depending on the number and cadre of health personnel and the level of skills to be developed.

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

STATE LEVEL PLANNING: IDENTIFYING TRAINING NEEDS AND PREPARING TRAINING PLANS

It is important that all states develop comprehensive state and 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.

District Training plans should be developed keeping in view the following aspects:

- » Planning for training needs to be done from sub-centre upwards
- » Total training load to be calculated keeping in view the facilities which are functional and availability of District Training Institutions
- » Skills training to be categorised as core skills (for workers at all levels of health facilities) and specialised skills (for 'counsellors');
- » Identify core skills already provided through existing training programmes, these are to be reinforced by supervisor/mentors. For specialised skills, specialised (advanced) IYCF training to be given only to identified service providers
- » Specific time frame set for completion of training of each cadre (may be spread over 1-3 years). The training plans should approach training timelines with priority and thrust.
- » Financial allocation for trainings in District Action Plans.

A plan for training of trainers should be prepared at state level so as to undertake all the trainings planned by the districts. Database of trained manpower must be available at the state. The state should prepare a budget for these trainings and include it in their PIP. 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.

The State may also take initiative and facilitate trainings of Staff Nurses and ANMs in the private sector.

FINANCIAL GUIDELINES

An assessment of resources required for IYCF programme at facility and community outreach level should be undertaken based on the action plans and budgeted as part of Child Health component included under the 'Child Health Training' component under the RCH flexipool. A consolidated IEC budget is available under the Mission flexipool under which 'child health specific IEC' could be included. An indicative budget for implementing various activities in a district with population of 20 lakhs is presented in the table below :

Estimation of number of health facilities and human resources in a district with an average population of 20 lakhs:

- 1 District Hospital (DH) with 2-3 MCH Specialists (Gynaecologists, Paediatricians), 10-15 staff nurses posted in labour room, postnatal ward and paediatric ward, antenatal and paediatric OPD. If the DH also has a SNCU and NRC, then the number of doctors and staff nurses who are directly in contact with new born and children under 2yrs of age will be higher. (4 doctors and 10 SNs in SNCU; 1 doctor and 7-8 SNs and 1 Nutrition Counsellor in NRC)
- 15 CHCs (FRUs) with 2 Specialists (Gynaecology, Paediatrics), 10-12 staff nurses posted in labour room and postnatal ward in each facility. Some FRUs have NBSUs, so

additional staff is likely to be posted here (1 MO and 4 SNs).

- 60 PHCs with 60-80 Medical officers
- 400 SCs with 400 ANMs, 60 LHV's, 2,000 ASHAs

(District & state specific variations are to be taken into account)

Assessment of Requirements based on Assumptions:

There are likely to be about 30 delivery points (excluding sub centres), each will require basic equipment for growth monitoring. Additionally, the DH and some CHCs will require separate equipment for inpatient and outpatient areas.

Assuming that the DH and 2 CHCs are high case load facilities (& designated delivery points), then 3 IYCF counselling centres and 3 Nutrition/IYCF Counsellors will be required at these facilities.

Training load:

For advanced counselling skills: 5 facilities x 2 persons=10 participants

Training of Medical Officers and Staff Nurses: About 100 participants

Training of frontline workers (ANMs + LHV's): 460 participants

Training of ASHAs (during monthly meetings): 2000 participants

Activity	Indicative Unit cost	No. of units	Total cost	Remarks
District Level				
Health facility				
Equipment (for both inpatient & OPD)	Rs. 2500 per site (Sites in 1 DH (2-one each in paediatric ward & outdoor patients' clinic), 5 FRU (10- same as in case of DH), 60 PHCs (1 each)	90 x2500	2,25,000	Weighing scale, Stadiometer, Infantometer, WHO growth standards (Charts) at each health facility , separately for inpatient and outpatient areas; a facility may have more than one site where equipment is required
Infrastructure IYCF Counselling Centres	Rs. 10,000 per centre (preferably located at DH, FRU)	3 x 10,000	30,000	Infrastructure cost includes minor renovations, paint, curtains, furniture, equipment (infantometer, weighing scales, WHO growth standards (Charts), doll & breast model, syringe pump, 250 ml capacity steel bowl, spoon, specific stationary, counselling flip chart
Salary of Lactation/ Nutrition Counsellor at High case load (of pregnant women, mothers, children) facilities	Rs. 12,500-month per counsellor (at high case load facilities: tertiary care centres, DH, FRUs)	3 or 4 in DH/high case load CHC/FRUs may already have counsellors in place)	12,500X3X12 = 4,50,000	Indicative cost since these, will vary according to salary scale in the state.
Subtotal			7.7 lakhs	
Community outreach				
Equipment: weighing machine, MUAC tape, WHO child growth charts, mother child protection card	Rs. 750 per sub-centre	400	3,00,000	
Job aides (flip chart etc.)	Rs. 200 per ANM and ASHA trained/ oriented on IYCF	400 ANMs (may vary in case there is second ANM also), 60 LHV's, 2000 ASHAs	4,92,000	
Subtotal			7.92 lakhs	

Activity	Indicative Unit cost	No. of units	Total cost	Remarks
Trainings				
Training of trainers (ToTs) on IYCF counselling skills		1 batch		ToTs are Paediatrician or F-IMNCI trained MO
Training of identified health care providers (MO, SN nutrition counsellor/s) as IYCF Counselling Specialists		2 batches/district		As recommended earlier, each facility with high delivery load or MCH case load should train at least two providers as IYCF Counselling Specialists
Training of Frontline workers (ANM, LHVs)		12 batches		The training should be organised at block/district level, can be held in continuation with IMNCI, or NSSK trainings for ANMs
Orientation of ASHAs in monthly meetings		80 meetings per district /year (2 training sessions can be held for ASHAs during block level monthly meetings; 50-60 ASHAs expected in each meeting		Training material for facilitators, hand-outs, refreshments
Total cost (No. of districts x cost per district)				
State Level				
State Coordination and Resource Centre for IYCF (preferably a Government Teaching Hospital)	Proposal to be submitted by State	One		
Translation of training materials into local language/s	As per proposals State Costs	Need based		To be arranged locally; co-ordinated by State resource centre

Activity	Indicative Unit cost	No. of units	Total cost	Remarks
Printing of modules, training material		Need based		To be included in budget for CH trainings, based on the number of persons to be trained & training package/s
IEC, BCC				
Printing of IEC for state, districts; production of AV material	As per plan under NRHM for IYCF activities as proposed in DHAP			To be included in consolidated IEC budget
Development of audio-visuals and print material				
IEC campaign in districts				
Meetings of the Coordination Committee on Nutrition				
Organisation of meeting (for planning and review, 6 monthly)				To be budgeted in programme management cost under PIP
Subtotal				
Appropriate incentive would be provided for home visits of ASHA for weight monitoring at 2nd, 3rd, 4th, 5th, 6th, 9th and 12th month.				

SYSTEM STRENGTHENING

Health System strengthening and support, from National level to Village level, is essential for effective implementation of IYCF and other nutrition activities.

1. National Apex body for IYCF – Child Health Division, MoHFW

The Child Health Division at the Ministry of Health & Family Welfare will be the nodal agency coordinating various stakeholders in context of IYCF and other nutrition related actions at the national level.

2. National Training Centres for IYCF

The National Training Centre for IYCF should be planned to be established in an apex Medical College for creating resource pool of Master Trainers, developing IEC and other technical material. The identified National Training Centre will also be responsible for support in setting up of State Coordination and Resource Centres for Nutrition (SCRCN) in various states. The SCRCNs will ensure that the training of service providers is undertaken at state level for effective roll out of IYCF promoting activities as well as other nutrition initiatives such as micronutrient supplementation and prevention and management of severe acute malnutrition (SAM).

3. National Technical Nutrition Support Unit

A national level Nutrition Technical Support Unit will be formed by the Ministry of Health and Family Welfare. This Group will serve as the

chief advisory body for the technical matters and will guide the nutrition policy and strategy at the national level. The members of this Group will include nutrition /public health/IYCF experts and the group composition may be amended from time to time. Prominent Civil Society Organisations, NGOs and Research bodies working in the field would be included in this Group as and when required.

4. State Coordination and Resource Centres for Nutrition (SCRCN)

SCRCN should be established in government medical colleges with specific TORs and funding.

These centres will provide technical support for planning, training and implementation of nutrition interventions including IYCF, micronutrient supplementation, prevention and care of severe acute malnutrition (SAM) as well as management of SAM at the Nutrition Rehabilitation Centres. Besides they will be providing orientation to the health workers in the IMS Act.

The State Annual Plans for NRHM could therefore include a roadmap towards development of SCRCN.

5. State Coordination Group on Nutrition

A State Coordination Group is recommended to be formed with members from Departments of Health and WCD, development partners, domain experts, representatives of professional bodies and senior faculty members of medical colleges and home

science colleges. The mandate of this Coordination group would be to provide technical support for all nutrition interventions in the state, and facilitate convergence between various departments. Decisions regarding adaptation of various existing guidelines, training materials and other technical issues would be taken by this group. Another important function of the State Coordination Group would be to periodically review the progress made in the implementation of activities and use of funds earmarked for nutrition related activities. The Group is recommended to meet at least twice a year, first during the PIP planning process and later in the year to review the progress based on the selected monitoring indicators.

A State level officer from the Health Department is recommended to be deputed for the group activities, including monitoring the implementation of the IMS Act.

6. Developing a detailed Nutrition Action Plan for State and Districts

States are advised to formulate a detailed nutrition action plan along with time-line. These plans should incorporate various activities for IYCF practices. Earlier section of this guideline provides a menu of options for promotion of optimal IYCF-

practices activities that can be included in the plan, and which should be reflected in the child health component of the PIP. As with the state plan, the district plan and budget should be presented in the PIP. The existing (approved) plans should be reviewed in the light of the recommendations made in this guide and any gaps in planning and monitoring should be plugged.

A District level officer from the Health Department is recommended to be deputed for monitoring the implementation of IMS Act in his/her district. Similarly at facility level, Medical Officer is recommended to be deputed to monitor the strict implementation of the IMS Act.

7. State and District Level Awareness generation for the IMS Act:

A large percentage of deliveries take place through the private health care system network. The states therefore could consider undertaking initiatives to involve private sectors in staff training, effective promotion of correct IYCF practices, and monitoring adherence to the IMS act. States are also advised to converge with private sectors for ensuring coverage of mothers delivering at private hospitals.

ADVOCAY & IEC/BCC PLAN

Knowledge alone does not lead to behavioural change, particularly for translating knowledge regarding exclusive breastfeeding (EBF) into adoption of appropriate EBF practice. Besides undertaking effective communication for influencing community norms and improving household IYCF practices, an enabling environment needs to be created. The latter involves; reduction in workload, support from family members, as well as counselling support from peers.

6.1 Behaviour Change Communication (BCC)

The period from pregnancy to the second year of child's life present a critical window of opportunity to ensure optimal growth and development of both; mother and child. There are several critical entry points when mothers and children have contact with health services - such as immunization or growth assessment/monitoring – these contacts are excellent opportunities for providing EBF and appropriate complementary feeding support (as in Chapter 2).

1. Critical points for State & District Programmes are:

- Breastfeeding and complementary feeding practices can change over a relatively short period of time and therefore need continued reinforcement for sustaining the inputs and ensuring adoption of the appropriate IYCF practices.
- Key elements of a behaviour change communication strategy include the following

tasks which must be undertaken a) Behavioural assessment b) targeted, concise messages promoting doable actions with use of consistent messages and appropriate materials c) counselling and communication skill development of health and community workers and d) multiple exposure of specific audiences to messages through appropriate media, and social support

- Interpersonal communication, folk and traditional media, and mass media are chief forms of BCC. During the training high priority and attention must be given to imparting interpersonal counselling skills.
- For ensuring universal coverage the key challenge is to integrate high quality breastfeeding counselling and the support required for sustained EBF into the primary health care package. In this context, home visits, are essential during the critical first week and months of life when mothers are most likely to abandon exclusive breastfeeding.
- Along with the health system, NGOs could be involved in training and supervising the community cadres.

2. Key elements for Health Facility level counselling delivered through Medical Officers, Staff Nurse, ANM during inpatient and out patient interfaces:

- Focussing on Right message (accuracy) delivered to right person at the right time.

- Impart consistent messages repeatedly and frequently. Repeated contacts and messages help to reinforce both knowledge and practice.
- Provide Counselling to –
 - » primary care givers (mothers)
 - » secondary care givers (mothers-in-law, fathers etc.)
- Actively address the issue of ‘not enough milk’ which is a frequent problem expressed by mothers /caregivers and family members for not sustaining the practice of exclusive breastfeeding.
- Ensure timely referral for mothers with breastfeeding and complementary feeding problems when needed.
- Ensure mothers are provided the required encouragement, skills and practical help as well as empathetic listening for appropriate IYCF practices.
- Remember one to one counselling provides an opportunity to assess the socio economic and cultural barriers regarding optimal IYCF and thus facilitates customising the key messages. One-on-one counselling is particularly effective in promoting exclusive breastfeeding.
- Note maternal counselling during pregnancy, immediately after child birth and at key contacts in the post-natal period has significant effect on continuation of exclusive breastfeeding for the recommended 6 months.
- Organize mother-to-mother support groups on IYCF using a participatory methodology.

3. Additional points to remember in community Level BBC

- Frontline Community level workers (ASHA, AWW, ANM) to set specific targets for activities, either as individuals or as a group: e.g. enumerate expected pregnant and lactating women that need to be followed up, number of group sessions to be conducted, number of support groups to be created, number of IYCF contacts to be made each month at growth monitoring sessions, number of community meetings organised etc. These targets can be discussed and set during the training period and reinforced and followed up during mentoring and supervision. Setting targets gives a concrete structure and facilitates to focus on implementation of selected set of activities as well as helps in monitoring performance.
- Higher focus to be given to vulnerable groups such as mothers working in unorganised and private sector or mothers belonging to migrant population.
- Besides breastfeeding counselling in health services, provide support to mothers through women’s support groups as well as by peers or lay counsellors .Such actions benefit mothers greatly .

6.2 Information Education and Communication

The State IEC Division is advised to draw out a comprehensive plan for IEC on MCH/RCH issues, clearly delineating the key child health issues to be covered through various media segments and plan a campaign to improve IYCF using audience-appropriate mix of interpersonal, group and mass-media channels.

Appropriate IEC materials must be made available to health facilities for display at strategic locations.

Audio-visual resources on breastfeeding and other IYCF practices, in local languages, must be distributed to all health facilities (that have provision of A-V equipment). These actions should also be linked to training and counselling services.

State Health departments must ensure that that messages on early and exclusive breastfeeding, in regional languages, are displayed at all key places such as delivery rooms and post - natal wards for imparting the information to mothers admitted or visiting the health centres. Where community radio is available, the use of radio is a useful medium for dissemination of IYCF messages.

6.3 Advocacy

Besides IEC, effective advocacy is essential for impacting on mass levels. Following actions may be taken to ensure an effective advocacy campaign.

- Review Policy and Program Changes required
- Identify potential influencers.
- Identify evidence based approaches to convince the influencers.
- Involve influencers in developing communication plans.
- Identify the focus group or the audience
- Decide on specific advocacy messages
- Decide how to best deliver these selected messages
- Develop a plan to monitor effectiveness of advocacy.

Public meeting/workshops may be organised for advocacy at each level of governance as suggested below:

Level	Activity	Involvement
State	Workshops, Public Lecture, Melas, Group Meetings. Or identify potential activities suited to the population	Leadership, actors, social activists, religious leaders
District		
Block		Panchayat leaders, religious heads, teachers, or other potential influencers
Village		

Care should be taken towards adhering to the IMS Act during advocacy workshops, meetings and other actions.

Organising campaigns linked to important events.: 'World Breastfeeding Week' is observed globally, including in India, during 1-7 August every year while the National Nutrition Week is observed in India in the first week of September. A theme or a slogan can be chosen each year for Campaigns during these weeks so that the key message is retained in the community for a long time. Communication campaigns can be planned for increasing awareness about the benefits of breastfeeding; partnership can be forged with agencies /professional bodies that are involved

in promotion of child health, breastfeeding and IYCF.

Print and electronic coverage on breastfeeding could be built around these events targeting mothers, caregivers/families and community leaders /influencers on specific 'theme for the year'. TV and radio spots on key messages relating to appropriate IYCF practices are already available through various agencies and these materials could be used as such or adapted suitably for state specific /local context. New spots may be

developed by the state IEC cell. Special guests (eg; community leaders, local influential persons) could be invited to speak during the event. Competitions for parents, mothers, fathers and family members could also be organised around the theme of breast feeding and IYCF.

Information must be disseminated in an entertaining

and interactive way. The activities could include Nukkad Nataks, puppet shows and similar events that attract and hold attention of local community members. Inviting journalists to cover these events is another way of generating awareness among the general population

SUPERVISION, MONITORING & EVALUATION

At the Sixty-fifth World Health Assembly (May 2012), WHO's Member States reinforced the Global Strategy by endorsing a comprehensive implementation plan for maternal, infant and young child nutrition. The plan sets six targets, one of which is for at least 50% of babies under six months-of-age to be exclusively breastfed by 2025. This global target is not far beyond India's reach, if not already achieved. The last NFHS and DLHS data suggested 46.4% EBF. However huge inter and intra-state disparities exist.

District level surveys like DLHS and AHS provide vital information that could be used for prioritising the districts for planning and implementing state/district level IYCF actions. Supervision and monitoring the implementation of plans of action, as described below, is essential part of such plans of actions.

Supervision and monitoring : Supervision and monitoring is crucial for success of IYCF initiatives . Monitoring of the IYCF Promotion programme 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 could 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.

For monitoring implementation of the IMS Act, state, district, block and facility level officials must be designated. A detailed list of Supervisory cadre at each level is given in Chapter 2.

For routine monitoring of IYCF activities, a reporting system which focusses on a few selected key indicators (presented in Table 4) 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.

Indicators For Monitoring

A set of indicators that are recommended to be used to monitor and evaluate various IYCF interventions are presented below:

Table 4: Monitoring Indicators for IYCF interventions

PROCESS AND OUTPUT INDICATORS

1. **# and % of health workers (MOs, SNs, ANMs, Programme Managers, Nodal persons) trained on IYCF**

(Denominator will be the training load identified by the state for each cadre)

2. **# and % of health facilities with at least two HW/s trained on integrated IYCF counselling**

(Denominator will be the delivery points in the state/district)

3. **# and % of health facilities with a dedicated Nutrition Counsellor/IYCF Counsellor**

(Denominator will be District hospitals; states can consider including FRUs with high delivery load)

4. **# and % of health facilities with functional IYCF Counselling Centres**

(Denominator will be delivery points at DH, FRUs identified for establishing Lactation Support Centres during the year)

5. **# and % newborn received at least 6 IYCF related visits in the postnatal period by a community worker**

(Denominator will be total number of live births in the catchment area during the reporting period)

6. **% and # of districts conducting breastfeeding or IYCF campaign**

(Denominator will be the number of districts identified by the State in the Annual PIP)

OUTCOME INDICATORS

1. **Early initiation of breastfeeding:** % of infants who were breastfed within one hour of birth (to be reported in HMIS every month)

Other outcome indicators that are recommended to be collected regularly at the state/district level but assessed through periodic surveys at national/state level (like the Annual Health Survey and the DLHS) are:

2. **Exclusive breastfeeding under 6 months:** Proportion of infants 0–5 months of age who are fed exclusively with breast milk

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

3. **Introduction of solid, semi-solid or soft foods:** Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods

*Infants 6–8 months of age who received solid, semi-solid or soft foods during the previous day
Infants 6–8 months of age*

4. **Minimum dietary diversity:** Proportion of children 6–23 months of age who receive foods from 4 or more food groups

*Children 6–23 months of age who received foods from ≥ 4 food groups during the previous day
Children 6–23 months of age*

While the indicators in above table provide a broad framework for monitoring and evaluation of IYCF intervention, state may consider using indicators and monitoring tools adapted to local context and needs.e.g: Exit interviews of pregnant and lactating women



SECTION - II

TECHNICAL GUIDELINES

INFANT AND YOUNG CHILD FEEDING TECHNICAL GUIDELINES

1. BREASTFEEDING

- (a) Breastfeeding should be promoted to mothers and other caregivers as the gold standard feeding option for babies.
- (b) Antenatal Counselling individually or in groups organized by maternity facility should contain messages regarding advantages of breastfeeding and dangers of artificial feeding. The objective should be to prepare expectant mothers for successful breastfeeding.
- (c) Breastfeeding must be initiated as early as possible after birth for all normal newborns (including those born by caesarean section) avoiding delay beyond an hour. In case of operative birth, the mother may need motivation and support to initiate breastfeeding within the first hour. Skin to skin contact between the mother and newborn should be encouraged by 'bedding in the mother and baby pair'. The method of "Breast Crawl" can be adopted for early initiation in case of normal deliveries. Mother should communicate, look into the eyes, touch and caress the baby while feeding. The new born should be kept warm by promoting Kangaroo Mother Care and promoting local practices to keep the room warm.
- (d) Colostrum, milk secreted in the first 2-3 days, must not be discarded but should be fed to newborn as it contains high concentration of protective immunoglobulins and cells. No pre-lacteal fluid should be given to the newborn.
- (e) Baby should be fed "on cues"- The early feeding cues includes; 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. Periodic feeding is practiced in certain situations like in the case of a very small infant who is likely to become hypoglycemic unless fed regularly, or an infant who 'does not demand' milk in initial few days. Periodic feeding should be practiced only on medical advice.
- (f) Every mother, especially the first time mother should receive breastfeeding support from the doctors and the nursing staff, or community health workers (in case of non-institutional birth) with regards to correct positioning, latching and treatment of problems, such as breast engorgement, nipple fissures and delayed 'coming-in' of milk.
- (g) Exclusive breastfeeding should be practiced from birth till six months requirements. Human milk provides sufficient energy and protein to meet nutritional requirements of the infant during the first 6 months of life. Therefore, no other food or fluids should be given to the infant below six months of age unless medically indicated. After completion of six months of age, with introduction of optimal complementary feeding, breastfeeding should be continued for a minimum for 2 years and beyond depending on the choice of mother and the baby. Even during the second year of life, the frequency of breastfeeding should be 4-6 times in 24 hours, including night feeds.

- (h) Mothers need skilled help and confidence building during all health contacts and also at home through home visits by trained community worker, especially after the baby is 3 to 4 months old when a mother may begin to doubt her ability to fulfill the growing needs and demands of the baby.
- (i) Mothers who work outside should be assisted with obtaining adequate maternity/ breastfeeding leave from their employers; they should be encouraged to continue exclusive breastfeeding for 6 months by expressing milk for feeding the baby while they are out at work, and initiating the infant on timely complementary foods. They may be encouraged to carry the baby to a work place crèche wherever such facility exists. The concept of "Hirkani's room" may be considered at work places (Hirkani's room is a specially allocated room at the workplace where working mothers can express milk and store in a refrigerator during their work schedule). Every such mother leaving the maternity facility should be taught manual expression of her breast milk.
- (j) Mothers who are unwell or on medication should be encouraged to continue breastfeeding unless it is medically indicated to discontinue breastfeeding.
- (k) At every health visit, the harms of artificial feeding and bottle feeding should be explained to the mothers. Inadvertent advertising of infant milk substitute in health facility should be avoided. Artificial feeding is to be practiced only when medically indicated.
- (l) Frontline health workers should be trained in various skills of counselling and especially in handling sensitive subjects like breastfeeding and complementary feeding.
- (m) If the breastfeeding is noted to be temporarily discontinued due to an inadvertent situation, "re-lactation" should be tried as soon as possible. Such cases should be referred to a trained lactation consultant/health worker. The possibility of "induced lactation" should be explored according to the needs of the specific case.
- (n) All efforts should be taken to provide appropriate facilities so that mothers can breastfeed babies with ease even in public places.
- (o) Adoption of latest WHO Growth Charts is recommended for growth monitoring.

2. COMPLEMENTARY FEEDING

- (a) Appropriately thick complementary foods of homogenous consistency made from locally available foods should be introduced at six completed months to all babies while continuing breastfeeding along with it. This should be the standard and universal practice. During this period breastfeeding should be actively supported and therefore the term "weaning" should be avoided.
- (b) To address the issue of a small stomach size which can accommodate limited quantity at a time, each meal must be made energy dense by adding sugar/jaggery and ghee/butter/oil. To provide more calories from smaller volumes, food must be thick in consistency - thick enough to stay on the spoon without running off, when the spoon is tilted.
- (c) Foods can be enriched by making a fermented porridge, use of germinated or sprouted flour and toasting of grains before grinding.
- (d) Adequate total energy intake can also be ensured by addition of one to two nutritious

- snacks between the three main meals. Snacks are in addition to the meals and should not replace meals. They should not be confused with foods such as sweets, chips or other processed foods.
- (e) Parents must identify the staple homemade food comprising of cereal-pulse mixture (as these are fresh, clean and cheap) and make them calorie and nutrient rich with locally available products.
 - (f) The research has time and again proved the disadvantages of bottle feeding. Hence bottle feeding should be discouraged at all levels.
 - (g) Population-specific dietary guidelines should be developed for complementary feeding based on the food composition of locally available foods. A list of appropriate, acceptable and avoidable foods can be prepared.
 - (h) Iron-fortified foods, iodized salt, vitamin A enriched food etc. are to be encouraged.
 - (i) The food should be a “balanced food” consisting of various (as diverse as possible) food groups/components in different combinations. As the babies start showing interest in complementary feeds, the variety should be increased by adding new foods in the staple food one by one. Easily available, cost-effective seasonal uncooked fruits, green and other dark coloured vegetables, milk and milk products, pulses/legumes, animal foods, oil/butter, sugar/jaggery may be added in the staples gradually.
 - (j) Junk food and commercial food, ready-made, processed food from the market, e.g. tinned foods/juices, cold-drinks, chocolates, crisps, health drinks, bakery products etc. should be avoided
 - (k) Giving drinks with low nutritive value, such as tea, coffee and sugary drinks should also be avoided.
 - (l) Hygienic practices are essential for food safety during all the involved steps viz. preparation, storage and feeding. Freshly cooked food should be consumed within one to two hours in hot climate unless refrigerated. Hand washing with soap and water at critical times- including before and after preparing and feeding and after using the toilet. Hand washing should be ensured for the child as well before and after feeding and after using toilet.
 - (m) Practice of responsive feeding is to be promoted. Young children should be encouraged to take feed by praising them and their foods. Self-feeding should be encouraged despite spillage. Each child should be fed under supervision in a separate plate to develop an individual identity. Forced feeding, threatening and punishment interfere with development of good / proper feeding habits. Along with feeding, mother and care givers should provide psycho-social stimulation to the child through ordinary age-appropriate play and communication activities to ensure early childhood development.
 - (n) A skilled help and confidence building is also required for complementary feeding during all health contacts and also at home through home visits by community health workers.
 - (o) Consistency of foods should be appropriate to the developmental readiness of the child in munching, chewing and swallowing. Foods which can pose choking hazard are to be avoided. Introduction of lumpy or granular foods and most tastes should be done by about 9 to 10 months. Missing this age may lead to feeding fussiness later. So use of mixers/grinders to make food semisolid/pasty should be strongly discouraged. The details of food including; texture, frequency and average amount are enumerated in Table below.

Age (months)	Energy needed per day in addition to breast milk (from WHO document) (Calories)	Texture	Frequency	Average amount of each meal	Iron requirement (mg/day) ¹ (ICMR RDA)	Iron content (Assuming number of meals/day as advised in column 3)	Food Iron content gap (mg/day)	Amount of raw green leafy vegetables (to be cooked and added to food) (g/day) ²
6-8	200	Start with thick porridge, well mashed foods	2-3 meals per day plus frequent Breast-feeding. Depending on appetite offer 1-2 snacks	Start with 2-3 tablespoons increasing to ½ of a 250 ml cup	5	1.0 - 2.0 mg	3-4	25
9-11	300	Finely chopped or mashed foods, and foods that baby can pick up	3-4 meals plus breast-feed. Depending on appetite offer 1-2 snacks	½ of a 250 ml cup/bowl	5	2.0 - 2.5 mg	2.5-3.0	25
12-23	550	Family foods, chopped or mashed if necessary	3-4 meals plus breast-feed. Depending on appetite offer 1-2 snacks	¾ to one 250 ml cup/bowl	9	2.5 - 3.5 mg	5.5-6.5	40

If baby is not breastfed, give in addition: 1-2 cups of milk per day, and 1-2 extra meals per day. The amounts of food included in the table are recommended when the energy density of the meals is about 0.8 to 1.0 Kcal/g. If the energy density of the meals is about 0.6 kcal/g, the mother should increase the energy density of the meal (adding special foods) or increase the amount of food per meal. For example:

- for 6 to 8 months, increase gradually to two thirds cup
- for 9 to 11 months, give three quarters cup
- for 12 to 23 months, give a full cup.

The table should be adapted based on the energy content. Find out what the energy content of complementary foods is in your setting and adapt the table accordingly.

¹Iron requirement is based on 5% bio-availability from cereal-pulse based diets.

²Green leafy vegetables like amaranth (chaulai sag/dantu), spinach (palak), turnip leaves (shalgam ka sag), mint leaves (pudhina) and small amounts of lemona (nimbu) and tamarind (imli) added to the diet daily will sum up to provide the amount of iron recommended.

These are broad guidelines. Recipes should be adapted based on local customs.

Additional pointers to improving quality of feeds:

- Complementary feeds containing a cereal-pulse combination of rice/rice flakes (poha)/wheat and roasted bengal gram dhal/soyabean/green gram dhal would increase intakes of iron, compared to other cereal: pulse combinations due to either higher absorption and/or higher iron content.
- Soaking, germination/sprouting of cereals and pulses will reduce their phytate content by

about half. To do this, soak grains overnight, and then lay on a clean wet cloth for 1-2 days. After germination, the grains can be lightly dry roasted and powdered for cooking.

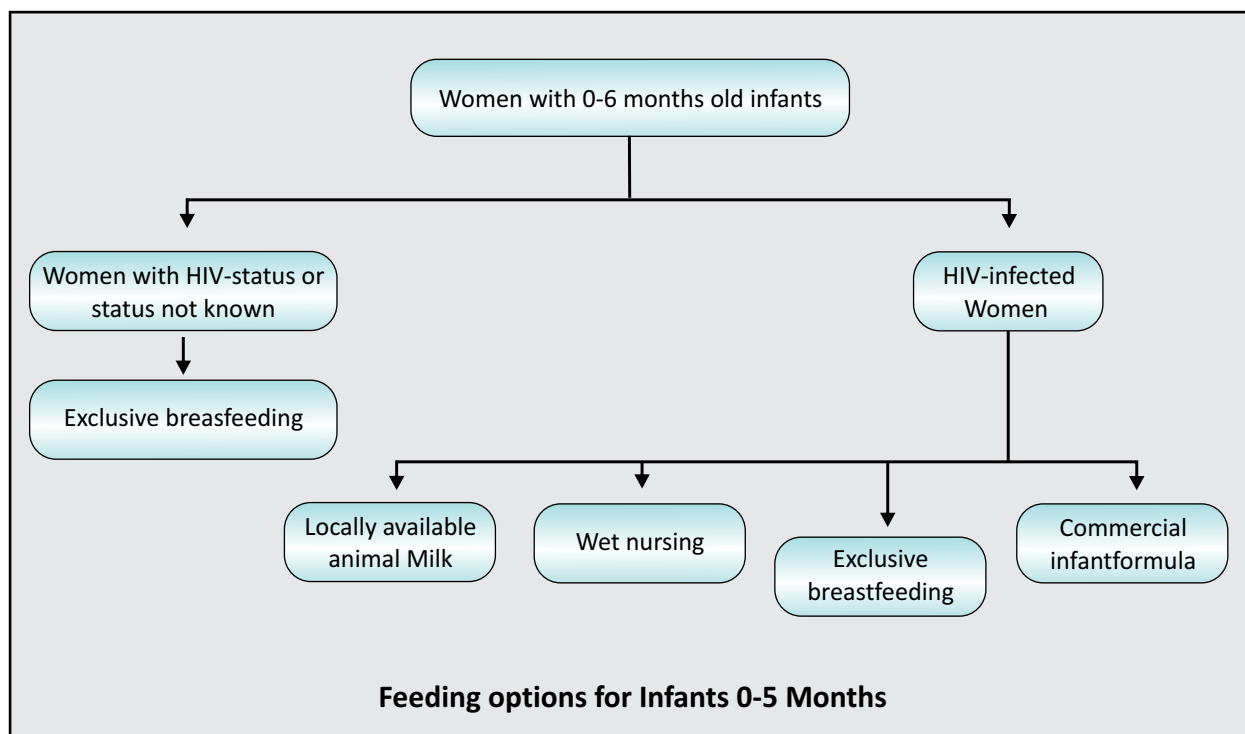
- If locally available fruits like guava (in children over 1 year of age), papaya, musambi (sweet lime), orange, and lime rich in ascorbic acid are provided as a freshly made mash along with the food, it will increase absorption of iron.
- If an iron supplement is to be given, it is best provided after meals. This will reduce the risk of adverse events. To improve bioavailability of iron taken after the meal, use grains that are less inhibitory for iron absorption. For this purpose, rice is most neutral, followed by wheat and lastly millets. Examples of rice based complementary foods with lower inhibitory effect are a cereal: pulse combination of rice: roasted Bengal gram or rice: sprouted and roasted green gram. These combinations can be made into local recipes like rice khichdi or rice pongal or idlis for younger children. For older children, poha with crushed groundnuts can also be given. It is important to remember that the foods listed here are specifically for the day on which iron is given.

3. HIV AND INFANT FEEDING

Principles of feeding HIV exposed and infected infants are as follows:

1. Exclusive breastfeeding is the recommended infant feeding choice in the first 6 months, irrespective of whether mother or infant is provided with ARV drugs for the duration of breastfeeding.
2. Mixed feeding should not be practiced.

3. Only in situations where breastfeeding cannot be done or on individual parents' informed decision, replacement feeding may be considered only if all the criteria for replacement feeding are met (see box in Situation 3).
 4. Exclusive breastfeeding should be done for at least 6 months, after which complementary feeding may be introduced gradually, irrespective of whether the infant is diagnosed HIV negative or positive by early infant diagnosis.
 5. Either mother or infant should be receiving ARV prophylaxis or ART during the whole duration of breastfeeding. ARV prophylaxis should continue for one week after the breastfeeding has fully stopped.
 6. For breastfeeding infants diagnosed HIV negative, breastfeeding should be continued until 12 months of age
 7. For breastfeeding infants diagnosed HIV positive, ART should be started and breastfeeding should be continued till 2 years of age.
 8. Breastfeeding should stop once a nutritionally adequate and safe diet without breast-milk can be provided.
 9. Abrupt stopping of breastfeeding should NOT be done. Mothers who decide to stop breastfeeding should stop gradually over one month.
- Determining the HIV status of mothers is important to make the best feeding choice for the infant. Women whose status is unknown should be offered HIV testing. Mothers who do not know their HIV status should know that exclusive breastfeeding will markedly reduce the risk of the infant being infected as compared to mixed feeding.



INFANTS (0-6 MONTHS) BORN TO HIV-INFECTED WOMEN

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.

Infants (0-6 months) born to HIV-infected women

Breast feeding is the feeding option of choice

- ✓ Initiate breast feeding within one hour of birth
- ✓ Exclusively breast feed for the first six months
- ✓ Ensure correct attachment at the breast
- ✓ Prevent and treat breast conditions
- ✓ Look for and treat oral ulcers or candidiasis of infant
- ✓ Do not mix feed

Situation 1: Mother is on ART for her own health, started before/during pregnancy

Maternal antiretroviral therapy significantly reduces the HIV transmission through breast feeding. Infants born to these mothers are advised 6 weeks of nevirapine (NVP) (for breastfeeding infants) or 6 weeks of zidovudine (ZDV)/ NVP (for non breast feeding infants) to reduce the risk of early post natal transmission as per the new WHO (2009) guidelines. Subsequently, no further prophylaxis needs to be given to the baby even if he/she is breastfed. In this group of infants, breastfeeding would provide all its benefits, while eliminating replacement feeding associated morbidity and mortality, with a highly reduced risk of infection transmission. No additional drugs/interventions are needed for these infants.

Making Breastfeeding Safe

- ✓ Exclusive breastfeeding for six months Mixed feeding to be avoided at all costs
- ✓ Practice good breastfeeding techniques
- ✓ Recognize and promptly manage breast like mastitis, sore nipple and abscess. Do not breastfeed the infant from affected breast
- ✓ Check for and promptly treat oral ulcers or candidiasis in infant
- ✓ Mothers should follow safe sex practices and avoid other high risk behaviour to prevent reinfection throughout the period of breastfeeding
- ✓ Seek medical help, if need arises
- ✓ Mothers should be evaluated for eligibility for HAART in the post - partum period

Situation 2: Mother is not on ART but has been started on ARV prophylaxis during pregnancy that is continued during lactation:

For this group of infants, again, breastfeeding is associated with a reduced risk of HIV transmission by the ongoing ARV prophylaxis and is the feeding option of choice. WHO (2009) recommendations provide two alternative options for women who are not on ART and breastfeed in resource-limited settings:

- 1) If a woman received AZT during pregnancy, daily nevirapine is recommended for her child from birth until one week after the end of the breastfeeding period.
or
- 2) If a woman received a three-drug regimen during pregnancy, starting from as early as 14 weeks of gestation, a continued regimen of triple therapy is recommended till one week after the end of the breastfeeding period.

For all HIV-infected pregnant women who are not eligible for ART, ARV prophylaxis for preventing

HIV transmission through breast milk should continue until one week after all exposure to breast milk has ended.

Situation 3: If the ARV prophylaxis to cover period of lactation is not available to the HIV-infected woman:

Exclusive breastfeeding (EBF) is still recommended unless conditions suitable for replacement feeding are met with (see box). This recommendation is based on the evidence that EBF is associated with reduced mortality over the first year of life in HIV-exposed as well as unexposed infants as compared to mixed and replacement feeding.

Give Replacement Feeding only when ALL of the following conditions are met

- ☑ safe water and sanitation are assured at the household level and in the community, and
- ☑ the mother or other caregiver can reliably afford to provide sufficient RF (milk), to support normal growth and development of the infant, and
- ☑ the mother or caregiver can prepare it frequently enough in a clean manner so that it is safe and carries a low risk of diarrhoea and malnutrition, and
- ☑ the mother or caregiver can in the first six months exclusively give RF, and the family is supportive of this practice and
- ☑ the mother or caregiver can health care that offers comprehensive child health services.

Situation 4: When the infant is HIV-infected:

If infants and young children are known to be HIV-infected, mothers are strongly encouraged to exclusively breastfeed for the first 6 months of life and continue breastfeeding as per the recommendations for the general population, that is, up to two years or beyond.

HIV-infected women who opt for replacement feeding or in situations where breast milk is not available for the infants e.g. maternal death,

sickness, twins etc.

These babies should be given locally available animal milk. Animal milk (pre-packed processed milk or fresh animal milk) is easily available, economical and culturally acceptable in comparison to commercial feeding formulas. As per the Indian adaptation of IMNCL guidelines, it is also recommended for infants of mothers who are HIV-negative/ have unknown status and are not able to breastfeed for any reason. Animal milk is invariably boiled before consumption in India, a practice that improves its safety.

Commercial infant feeding formula, while offering the advantage of a standard composition, is expensive and often carries a higher risk of bacterial contamination. However, depending upon the individual circumstances, commercial infant formula may also be used for replacement feeding where it is preferred by the family and is feasible and affordable.

Replacement Feeding Options

- ☑ Locally available animal milk
- ☑ commercial infant feeding formula
- ☑ Wet nursing where culturally accepted and practiced

In certain areas of India where wet nursing is culturally accepted and practiced, counsellor should discuss this with the family during the antenatal period. It is important to be sure that the lactating woman is HIV-negative, follows safe sexual practices throughout the period of lactation to avoid acquiring HIV infection, and is aware of the small but existing risk of reverse transmission of HIV infection to her in case the infant is infected.

Advice to Mothers who opt for Replacement Feeding

- ☑ Completely avoid breastfeeding at all times
- ☑ Practice safe replacement feeding including hygienic preparation and storage of replacement feeds and correct technique of feeding using cup/paladai/katori-spoon
- ☑ Left over milk at the end of a feeding session should not be used for refeeding the infant
- ☑ Regularly monitor for early detection of nutritional deficiencies, growth deviation and infections among the infants
- ☑ Infants to be given multivitamin and iron supplementation
- ☑ Manage breast engorgement in the post-natal period
- ☑ Encourage physical contact with the baby for comforting the baby and development of mother-infant bonding
- ☑ Use suitable family planning measures

Infants (6-23 months) born to HIV-infected women

For infants more than 6 months of age, complementary feeding should be started irrespective of HIV status and initial feeding options.

For situations 1 & 2, where ART or ongoing ARV prophylaxis is being administered to the mother or infant, breastfeeding should be continued for the first 12 months of life along with complementary foods. Breastfeeding should then be stopped only once a nutritionally adequate and safe diet without breast milk can be provided. Continuing breast feeding for 12 months is feasible in these situations since HIV transmission risk would be further reduced in presence of ARV interventions. This is a big advantage since stopping breast feeding soon after 6 months without ensuring adequate complimentary feeding may lead to growth faltering.

Mothers or infants who have been receiving ARV

prophylaxis should continue prophylaxis for one week after breastfeeding is fully stopped. Stopping breastfeeding abruptly is not advisable. Mothers known to be HIV-infected who decide to stop breastfeeding at any time should stop gradually within one month.

For situation 3, where ongoing ARV prophylaxis is not available and the mother had opted for exclusive breastfeeding, a re-evaluation is to be done at 6 months. If at this time, conditions suitable for replacement feeding are met, cessation of breastfeeding is recommended as quickly as possible taking into account the comfort level of both the mother and her infant. If replacement feeding is still not feasible at this stage, continuation of breastfeeding with additional complementary foods is recommended. All breastfeeding should stop only when a nutritionally adequate and safe diet without breast milk can be provided by complementary feeds including animal milk. For infants who were on replacement feeding, animal milk should be continued as before, in addition to complementary feeds. These infants should receive two additional complementary feeds as compared to babies who continue to receive breastfeeds.

4. FEEDING IN OTHER SPECIFIC SITUATIONS

(A) FEEDING DURING SICKNESS

Feeding during sickness 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 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.

(B) INFANT FEEDING IN MATERNAL ILLNESSES

1. Painful and/or infective breast conditions like breast abscess and mastitis and 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 possible after completion of treatment
2. Chronic infections like tuberculosis, leprosy, or medical conditions like hypothyroidism need treatment of the primary condition and do not warrant discontinuation of breastfeeding.
3. Breastfeeding is contraindicated when the mother is receiving certain drugs like anti-neoplastic agents, immuno-suppressants, anti-thyroid drugs like thiouracil, amphetamines, gold salts, etc. 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.

(C) INFANT FEEDING IN VARIOUS CONDITIONS RELATED TO THE INFANT

- (i) Breastfeeding on demand 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.

- (ii) Gastro-Oesophageal Reflux Disease (GERD): Mild GERD is a condition when a child regurgitates the feed soon after the feeding. It is often treated conservatively through thickening the complementary foods, frequent small feeds and upright positioning for 30 minutes after feeds.
- (iii) Diarrhoea (Primary Lactose Intolerance): is congenital and may require long term lactose restriction. Secondary Lactose Intolerance is usually transient and resolves after the underlying GIT condition has remitted.
- (iv) 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.

Infants born into populations affected by emergencies should normally be exclusively breastfed from birth to 6 months i.e 180 days of age. Every effort should be made to identify alternative ways to breastfeed infants whose biological mothers are unavailable.

Complementary foods should be prepared and fed frequently, consistent with principles of good hygiene and proper food handling. Safe drinking water Supply should be ensured.

5. FEEDING IN PRETERM/ LOW BIRTH WEIGHT INFANTS

Low birth weight (LBW) has been defined by the World Health Organization (WHO) as weight at birth less than 2500 g. LBW can be a consequence of preterm birth (defined as birth before 37 completed weeks of gestation), or due to small size for gestational age (SGA, defined as weight for gestation <10th percentile), or both. LBW thus defines a heterogeneous group of infants: some are born early, some are born at term but are SGA, and some are both born early and SGA.

Being born with LBW is generally recognized as a disadvantage for the infant. LBW infants are at higher risk of early growth retardation, infectious disease, developmental delay and death during infancy and childhood.

Infant mortality rates can be substantially reduced by improving the care of LBW infants which includes feeding, temperature maintenance, hygienic cord and skin care, and early detection and treatment of complications and complete timely immunization. Interventions to improve feeding of LBW infants can improve the immediate and longer term health and well-being of the individual infant and have a significant impact on neonatal and infant mortality levels.

Feeding recommendations for low birth weight infants :

1. All Low-birth-weight (LBW) infants, including those with very low birth weight (VLBW), should be fed breast milk.
2. LBW infants who are able to breastfeed should be put to the breast as soon as possible after birth (and when they are clinically stable). If unable to suckle, these babies should be fed with expressed breast milk using a katori and spoon.
3. LBW infants should be exclusively breastfed until 6 months i.e 180 days of age.
4. LBW infants who cannot breastfeed and need to be fed by an alternative oral feeding method should be fed by cup or spoon or as prescribed by the paediatrician.
5. Very low birth weight infants should be given 10 ml/kg of enteral feeds preferably expressed breast milk, starting from 1st day of life with the remaining fluid requirement met by IV fluids.
6. LBW infants, including those with VLBW, who cannot be fed mother's own milk should be fed donor (non HIV infected) human milk. (This recommendation is relevant only to settings where safe and affordable milk banking facilities are available or can be set up such as SNCU).



ANNEXURES

Annexure I

Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborn infants 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 one-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 breast milk, 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.

Annexure II

The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 and As Amended Act in 2003

This Act provides for the regulation of production, supply and distribution of infant milk substitutes, feeding bottles and infant foods with a view to the protection and promotion of breastfeeding and ensuring the proper use of infant foods and for matters connected to it. It extends to the whole of India. It also lays the responsibility of health workers and of the government to provide accurate information to people. Following are the basic provisions of the IMS Act.

THE IMS ACT PROVISIONS

IMS Act is violated if any baby Food Company, its distributor or supplier, or any person

1. Promotes any food by whatever name, for children up to two years.
2. Promotes use of infant foods before the age of six months.
3. Advertises by any means—television, newspapers, magazines, journals, through SMS, emails, radio, pamphlets etc.
4. Distributes the product or samples to any person.
5. Contacts pregnant or lactating mothers using any person.
6. Gives any kind of inducements like free gifts, tied sales, to anyone.
7. Distributes information and educational material to mothers, families etc. (They can give educational material to health professionals like doctors, nurses etc provided it has information prescribed in clause 7 of the IMS Amendment Act, 2003. The education material should have only factual information and should not promote the products of the company).
8. Gives tins, cartons, accompanied leaflets of these products having pictures of mothers or babies, cartoons or any other such images to increase saleability.
9. Displays placards, posters in a hospital, nursing home, chemist shop etc. for promoting these products.
10. Provides direct or indirect inducements to health workers
11. Demonstrates to mothers or their family members how to feed these products. However, a doctor can demonstrate this to the mother.
12. Gives benefits to doctors, nurses or associations like IAP, IMA, NNF etc, for example, funds for organizing seminars, meeting, conferences, contest, fee of educational course, sponsoring for projects, research work or tours.
13. Fixes commission of employees on the basis of volume of sales of these products.

HIGHLIGHTS OF THE ACT

- Prohibits all persons from any kind of promotion of infant milk substitutes, infant foods or feeding bottles
- Prohibits the advertisement of infant milk substitutes and feeding bottles to “ensure that no impression is given that feeding of these products is equivalent to, or better than, breastfeeding.
- Prohibits providing free samples and gifts to pregnant women, mothers of infants and members of the families.
- Prohibits donation of free or subsidised supplies of products for health care institutions and prohibits incentives and gifts to health workers.
- Prohibits display of posters at health care facilities / hospitals /health centres.
- The Act also prescribes that all labels of IMS /Infant food, must say in English and local, languages that breastfeeding is the best. Also, the labels must not have pictures of infants or women or phrases designed to increase the sale of the product.
- Prohibits any contact of employers manufacturing and distributing company with pregnant women, even for providing educational material to them.

PENALTIES FOR CONTRAVENTION

Violations of the Act attract imprisonment for up to three years and/or fine up to Rs.5000.

Penalty with regard to the Label on container or quality of infant milk substitute, feeding bottle and infant food is punishable with imprisonment up to 6 month extended to 3 years and fine at least Rs.2000.

WHAT HEALTH SERVICE PROVIDERS CAN DO

- Seek correct and scientific information about breastfeeding. feeding bottles and infant foods.
- Understand the hazards of using infant milk substitutes,
- Create awareness on promotion and protection of breastfeeding.
- Report violations to the right authorities. Inform/publicise addresses and names of organisations where you can report violations.

Annexure III


COMPREHENSIVE MESSAGE OF COUNSELLING TO THE MOTHER: RECOMMENDATION DURING HEALTH

Up to 6 months of age	6 months up to 12 months	12 months up to 2 years	2 years & older
<ul style="list-style-type: none"> Breastfeed as Often as the child wants. day & night. at least 8 times in 24 hrs. Do not give any other food or fluids not even water. <p>Remember:</p> <ul style="list-style-type: none"> Continue breastfeeding if the child is sick 	<ul style="list-style-type: none"> Breastfeed as often as the child wants Give at least 1 katori serving at time of: Mashed roti/bread mixed in thick dal with added ghee/oil or khichdi with added oil/ ghee. Add cooked vegetables also in the servings or Sevian/dalia/ halwa/ Kheer prepared in milk/ or Mashed boiled potatoes Offer banana/biscuit/ cheeko/ mango/papaya 3 times per day if breastfed. 5 times per day if not breastfed and 1-2 snacks <p>Remember:</p> <ul style="list-style-type: none"> Keep the child in your lap & feed with your own & child's hand with soap & water every time before feeding 	<ul style="list-style-type: none"> Breastfeed as often as the child wants Offer food from the family pot Give at least 1 and half katori serving at a time of : Mashed roti/bread mixed in thick dal with added ghee/oil or khichdi with added oil/ ghee. Add cooked vegetables also in the servings or Mashed roti/rice/ bread mixed in sweetened milk or Sevian/dalia/halwa/ kheer prepared in milk or Offer banana/biscuit/ cheeko/ mango/papaya as snacks Give 5 times per day if "not breastfeed and 3-4 times if breastfed and 1-2 snacks <p>Remember:</p> <ul style="list-style-type: none"> Sit by the side of child & help him to finish the serving Wash your own & child's hand with soap & water every time before feeding 	<ul style="list-style-type: none"> Give family foods at 3 meals each day Also, twice daily. give nutritious food between meals, Such as Banana/ biscuit/cheeko/ mango/papaya as snacks. <p>Remember:</p> <ul style="list-style-type: none"> Ensure that the child finishes the serving Teach your child wash his hands with soap and water every time before feeding

Annexure IV

Sample IEC materials on Breastfeeding

Maa Sab Jaanti Hai Ads_Hindi			
File Name	Primary (P), Secondary (S) audience	Location for display	Alternative IEC Format
POSTER Early Initiation of breast-feeding.pdf KeeingNewbornWarm.pdf Seeking care.pdf 	P: Caregivers and family; S: Frontline worker	Primarily newspaper ads to be released accordingly during special events. If converted to Posters/translides, can be displayed in waiting area at CHCs/PHCs/Dist hosp/ Labour room/ SNCU Doctors chambers AWW centres During VHNDs Use during world health promotion days such as World Breast Feeding Day (Aug 01-07); National Nutrition Week (Sept 01-07); World Food Day (Oct 16); Children's Day (Nov 14)	Back-light Translides Horizontal posters
BUS PANEL Sakhi dadi Bus-Pannel.jpg	P: Community	On backs and sides of buses.	Hoardings Wall painting
Breastfeeding FAQs and Breastfeeding posters			
File Name	Primary (P), Secondary (S) audience	Location for display	Alternative IEC Format
Breastfeeding FAQ	P: Caregivers and family; S: Frontline worker/ AWW	Primarily to be printed and widely distributed during: ASHA visits to homes with pregnant women, or mother of newborn child. Community meetings (for women) Should be available at Anganwadi centres/CHCs/PHCs. Should be used during training and orientation of frontline workers on breast feeding practices.	Must be distributed during VHNDs and during World Breast Feeding Day (Aug 01-07); National Nutrition Week (Sept 01-07); World Food Day (Oct 16); Children's Day (Nov 14)

Breastfeeding poster	P: Caregivers and family; S: Front-line worker/ AWW	Anganwadi centres, CHCs/PHCs/ Dist hosp/ Labour room/ SNCU/ Doctors chambers During VHNDs Must be used during World Breast Feeding Day (Aug 01-07); National Nutrition Week (Sept 01-07); World Food Day (Oct 16); Children's Day (Nov 14)	<ul style="list-style-type: none"> • Leaflet (Can be kept at the health centres, given during events, VHNDs for carry back by caregivers) • Newspaper ad • Hoarding • Kiosks
BF_WallPainting.jpg	P: Community;	Walls of Anganwadi centres, CHCs, PHCs, local markets	<ul style="list-style-type: none"> • Hoarding • Bus panels • Stickers
POSTER Breastfeeding and complementary feeding 	P: Caregivers and family; S: Frontline worker/ AWW	Anganwadi centres, CHCs/PHCs/ Dist hosp/ Labour room/ SNCU/ Doctors chambers Display during VHNDs Must be used during World Breast Feeding Day (Aug 01-07); National Nutrition Week (Sept 01-07); World Food Day (Oct 16); Children's Day (Nov 14)	<ul style="list-style-type: none"> • Leaflet (Can be kept at the health centres, given during events, VHNDs for carry back by caregivers) • Newspaper ad • Hoarding • Kiosks
BF_WallPainting.jpg	P: Community;	Walls of Anganwadi centres, CHCs, PHCs, local markets	<ul style="list-style-type: none"> • Hoarding • Bus panels • Stickers



After six months give your baby other nutritious food along with mother's milk to ensure the baby's growth and development.

- Give your baby a small bowl (serving) of other nutritious food at least four times a day. You can give food like mashed Khanda, Upma, Dalia, vegetables and fruits.
- Since your baby has no teeth, make sure the additional nutritious food you give is properly mashed so that the baby can eat it easily.

Ministry of Women and Child Development
Government of India, New Delhi

Correct nutrition for a fruitful life.



Till your baby completes six months, give only mother's milk to ensure the baby's good health. Don't give even water.

- Mother's milk is a complete food for your baby for the first six months.
- Mother's milk has all the nutrients that protect your baby from diseases.
- Mother's milk has enough water for your baby's needs even during the hot summer months.
- Mother's milk is very essential for your baby's proper growth and mental development.



Ministry of Women and Child Development
Government of India, New Delhi

Correct nutrition for a fruitful life.

No one knows better than a mother ...

... that her milk gives the child strength to fight against disease.

It is important that the child gets the mother's first milk, yellow milk right after birth. This strengthens the child's immune system so that he is able to fight against disease.

छोटे बच्चों को परिवार का नियमित भोजन अपने हाथ धो कर स्वयं खिलाएं।

Bus Shelter 30x4"



Bus Back Panel 16x12"



Bus Side 7x4"





National Rural Health Mission

Ministry Of Health & Family Welfare

Government of India

Nirman Bhawan, New Delhi