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

Public Health Department
Government of Maharashtra
April 2015
## Acronyms

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<tr>
<td>ANM</td>
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<td>ARSH</td>
<td>Adolescent Reproductive and Sexual Health</td>
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<td>ART</td>
<td>Anti Retroviral Therapy</td>
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<td>ARV</td>
<td>Anti Retroviral</td>
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<td>ASHA</td>
<td>Accredited Social Health Activist</td>
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<td>AWW</td>
<td>Anganwadi worker</td>
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<td>BDO</td>
<td>Block development Officer</td>
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<td>BF</td>
<td>Breastfeeding</td>
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<td>BFHI</td>
<td>Baby Friendly Hospital initiative</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>BPL</td>
<td>Below Poverty Line</td>
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<td>BPNI</td>
<td>Breastfeeding Promotion Network of India</td>
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<td>CBO</td>
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<td>CDPO</td>
<td>Child Development Project Officer</td>
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<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CMAM</td>
<td>Community based management of acute Malnutrition</td>
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<td>CNSM</td>
<td>Comprehensive Nutrition Survey Maharashtra</td>
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<td>CSR</td>
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<td>CTC</td>
<td>Child Treatment Centre</td>
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<td>DH</td>
<td>District Hospital</td>
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<td>FOGSI</td>
<td>The Federation of Obstetrics and Gynecological Societies of India</td>
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<td>GERD</td>
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<td>GMP</td>
<td>Growth Monitoring and Promotion</td>
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<td>General Nursing and Midwifery</td>
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<td>HMIS</td>
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<td>Integrated Management of Childhood Illness</td>
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<td>IMNCI</td>
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<td>IMS</td>
<td>Infant Milk Substitute</td>
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<td>IPD</td>
<td>Inpatient Department</td>
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<td>Indian Public Health Association</td>
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<td>IUGR</td>
<td>Intra Uterine Growth Restriction</td>
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<td>IYCN</td>
<td>Infant &amp; Young Child Nutrition</td>
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<td>JSSK</td>
<td>Janani Shishu Suraksha Karyakram</td>
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<td>Acronym</td>
<td>Full Form</td>
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<td>JSY</td>
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<td>KMC</td>
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<td>Maharashtra University of Health Sciences</td>
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<td>RSKS</td>
<td>Rashtriya Kishor Swasthya Karyakram</td>
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<td>SAM</td>
<td>Severe Acute Malnutrition</td>
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<td>SBA</td>
<td>Skilled Birth Attendant</td>
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<td>Sub Centre</td>
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<td>Taluka Health Officer</td>
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<td>ToT</td>
<td>Training of Trainers</td>
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<td>Abbreviation</td>
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<td>Women &amp; Child Development</td>
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Chapter 1: Overview of Maternal, Infant & Young Child Nutrition

1.1 Importance of Optimal Maternal Infant and Young Child Feeding

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

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

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

- Anemia during adolescence leads to pregnancy with poor body iron stores which in turn results in still births, IUGR babies, LBW babies and pre term deliveries with newborns having poor body iron stores. If Iron deficiency anemia among the adolescents is not addressed will lead to the vicious cycle of anemia, Low Birth Weight and intergenerational cycle of malnutrition.
- Iron and calcium deficiencies contribute substantially to maternal deaths
- Maternal iron deficiency and low body mass index is associated with babies with low weight (<2500 g) at birth
- Maternal and child under nutrition, and unstimulating household environments, contribute to deficits in children’s development and health and productivity in adulthood
- Maternal overweight and obesity are associated with maternal morbidity, preterm birth, and increased infant mortality
- Fetal growth restriction is associated with maternal short stature and underweight and causes 12% of neonatal deaths and 20% of stunting in childhood.

1 Lancet Series on Maternal & Child Health - 2008
• Under nutrition during pregnancy, affecting fetal growth, and the first 2 years of life is a major determinant of both stunting of linear growth and subsequent obesity and non-communicable diseases in adulthood.

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

Strategies to improve Maternal, Infant and Young Child Nutrition (MIYCN) are a key component of the child survival and development programs in many countries including India. The scientific rationale for this decision is clear, with steadily growing evidence underscoring the essential role of breastfeeding and complementary feeding as major factors in child survival, growth and development. The importance of breastfeeding as the preventive intervention with potentially the single largest impact on reducing child mortality has been highlighted. Improvement of complementary feeding has been shown to be the most effective in improving child growth, and thereby, together with maternal nutrition interventions, to contribute to reducing stunting.4

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

1.2 MIYCN in reducing Maternal morbidity & mortality

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

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3 Infant and young child feeding: programming guide. UNICEF, 2012
4 WHO/UNICEF Global strategy for infant and young child feeding, 2003
5 This recommendation is supported by evidence, is one of the Ten Steps to Successful Breastfeeding and is one of the core indicators for infant and young child feeding (2008 edition)
Women are more likely to suffer from nutritional deficiencies than men are, for reasons including women's reproductive biology, low social status, poverty, and lack of education. Sociocultural traditions and disparities in household work patterns can also increase women's chances of being malnourished. Many women who are underweight are also stunted, or below the median height for their age. Stunting is a known risk factor for obstetric complications such as obstructed labor and necessitates need for skilled intervention during delivery, to avoid injury or death for mothers and their newborns. Addressing women's malnutrition has a range of positive effects because healthy women can fulfill their multiple roles — generating income, ensuring their families' nutrition, and having healthy children — more effectively and thereby help advance countries' socioeconomic development. Women are often responsible for producing and preparing food for the household, so their knowledge — or lack thereof — about nutrition can affect the health and nutritional status of the entire family. Promoting greater gender equality, including increasing women's control over resources and their ability to make decisions, is crucial. Improving women's nutrition can also help nations achieve three of the Millennium Development Goals - Goal 1: Eradicate extreme poverty and hunger, Goal 4: Reduce child mortality & Goal 5: Improve maternal health.

1.3 MIYCN in reducing child morbidity and mortality

The 2003 landmark Lancet Child Survival Series\(^6\) ranked the top 15 preventive child survival interventions for their effectiveness in preventing under-five mortality. Exclusive breastfeeding up to six months of age and breastfeeding up to 12 months (for the purpose of that study only) was ranked number one, with complementary feeding starting at six months at number three. These two interventions alone were estimated to prevent almost one-fifth of under-five mortality in developing countries.

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

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

The impact is biggest in terms of reduction of morbidity and mortality from diarrhoea and pneumonia. Breastfeeding protects the effect on Haemophilus B one of the causative agents for respiratory infections. Non breast fed children have 250% higher risk of being

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hospitalised for pneumonia and asthma. Breast milk fed infants have reduced incidence of necrotizing enterocolitis, UTI, ear infections, asthma, meningitis and sepsis. Breastfeeding decreases chance of developing leukaemia and lymphoma by 30% in children.

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

1.4 MIYCN and Child Growth

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

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

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

Breastmilk alone is enough to meet all the nutritional needs of infants for the first six months of life. After six months of age, to meet all of a child’s nutritional requirements breastmilk needs to be complemented by other foods, although it continues to be an important source of nutrients as well as impacting disease morbidity and mortality. At this age children have high nutritional needs for rapid growth, and appropriate complementary feeding provides key nutrients (e.g. iron and other micronutrients, essential fatty acids, protein, energy, etc.).

9 Programming guide Infant & Young Child Feeding, UNICEF, June 2012
11 An Exploratory Study of Environmental and Medical Factors of Potentially Related to Childhood Cancer. Medical & pediatric Oncology, 1991; 19(2):115-21
Inadequate complementary feeding lacking in quality and quantity can restrict growth and jeopardize child survival and development.

### 1.5 MIYCN and Child Development

The period from pregnancy to about 36 months (specifically the first 1000 days – the critical window of opportunity) is a critical period in early childhood development for stimulating positive cognitive development, particularly in settings where ill health and under nutrition are common\(^\text{16}\). Mother’s optimal nutrition is the core for promoting optimal early childhood stimulation. Furthermore, a *Lancet* series on Child Development\(^\text{17}\) recognized tackling stunting and iron deficiency as two of the four most effective early childhood development interventions, along with addressing iodine deficiency and cognitive stimulation.

In addition, breastfeeding and responsive feeding provide constant positive interactions between mother and child which can contribute to emotional and psychological development of infants. There is also strong evidence of higher performance in intelligence tests among those subjects who had been breastfed as infants\(^\text{16}\).

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

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

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

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\(^\text{17}\) Engle P et al. Strategies to avoid the loss of developmental potential in more than 200 million Children in the developing world. The *Lancet* 2007; 369.


\(^\text{20}\) Annex 2, Comprehensive implementation plan on maternal, infant and young child nutrition endorsed by 65th World Health Assembly, Geneva, May 2012.

\(^\text{21}\) The UNICEF Community MIYCN Counselling Package can be used; it contains sessions tailored to the context of SAM.
mothers and care givers on MIYCN would contribute significantly in preventing the child from severe acute malnutrition.

Before discharge of children admitted with SAM, review of feeding practices of the malnourished children should be done. Counselling on exclusive breastfeeding or continued breastfeeding and timely, safe, appropriate and adequate complementary feeding (after 6 months of age) should be done. This should include demonstration of food preparation and sharing of recipes with mothers for optimal use of locally available foods for children 6-23 months.

1.7 HIV and Infant Feeding

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

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

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

1.8 MIYCN and breastfeeding mothers at work places

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

In Urban areas many families need and use Child Care Services (Day Care/Creche) while in rural areas infants are carried to work by mothers or are left at home with care takers many a times they being the older sibling at home. In the Scholars Research Library from the Annals of Biological research, 2011, it is mentioned that during the first six months of life, children who develop the best are those who have a tremendous amount of attention, and who enjoy a lot of fun play. When the children begin crawling at six or seven months of age, they need access to someone who is excited to teach them. This process helps to support their curiosity, increase their enthusiasm, and help their overall development. It is

22 Infant & Young Child Feeding Behaviours among working mothers in India: Implications for Global health Policy and Practice by Dr. Vinay Kumar et. al; International Journal of MCH & AIDS (2015), Vol 3, Issue 1, Pg 7-15
very rare for a caregiver to show the same amount of interest in a child that a parent would. This is because mothers are very quick to respond to a baby’s non-stop demands for love and attention.

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

1.9 MIYCN in emergencies –Natural and man-made disasters

Infants and young children are among the most vulnerable groups in emergencies. Interruption of breastfeeding and inappropriate complementary feeding increase the risks of malnutrition, illness and mortality. The MIYCN strategies need to specifically address MIYCN programming in emergencies for the following reasons:

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

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

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

1.10 Current Status of MIYCN in Maharashtra

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

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23 Infant and young child feeding: programming guide. UNICEF, 2012
a) Adolescent and maternal nutrition situation in Maharashtra

There is high level of under nutrition in rural areas among the adolescent girls and pregnant mothers. As high as 32.5% of mothers had low body mass index (BMI) < 18.5 kg/ m², which is much higher in rural areas (41.1%) compared to urban areas (22.2%)\textsuperscript{24}. Low BMI is the result of inadequate intake of calories due to multiple factors like food insecurity, poor dietary practices due to myths and misconceptions and gender bias. A total of 11% were overweight or obese (BMI ≥ 25 kg/ m²), much higher in urban areas (19.3% in urban compared to 4% in rural). 10.6% of mothers had height less than 145 cms.

Prevalence of anemia is high among adolescents and pregnant women in the state. As high as 58.3% and 8.2% of the adolescents (15-19 years) are having anaemia and severe anaemia respectively. Similarly 69.5% and 12% of pregnant mothers had anemia and severe anemia respectively in the state\textsuperscript{25}.

The levels of under nutrition is much higher in some tribal population. In Melghat region of Amravati district, 43% adults aged ≥ 20 years were severely or moderately underweight\textsuperscript{26}.

b) Infant and Young child nutrition situation in Maharashtra

The State of Maharashtra has made significant progress in improving the institutional delivery which is >90%. However, the early initiation of breastfeeding is only 71% (DLHS-4-2012-13). The data of the Comprehensive Nutrition Survey Maharashtra (CNSM, 2012) indicates that the nutritional status of children as assessed by both the prevalence of stunting and underweight deteriorated with increasing age (23.3% were stunted, 16.3% were wasted and 22.6% were underweight for children below 2 years of age\textsuperscript{27}); especially the sizeable deterioration occurred after completion of the first year of age indicating that opportunity for improving nutrition may diminish if timely and targeted essential interventions fail to reach these children. For example, the prevalence of stunting doubled from 15 per cent among children aged 9-11 months to 31 per cent among children aged 12-17 months and further to 41 per cent among children aged 18-23 months. This is indicative of a very small window of opportunity to improve the children’s nutrition. This is adequately presented in Figure 1.

\textsuperscript{24} District Level Household and Facility Survey -4, Maharashtra 2012-2013
\textsuperscript{25} District Level Household and Facility Survey -4, Maharashtra 2012-2013
\textsuperscript{26} Tannaz J. Birdi et. Al. Possible Causes of Malnutrition in Melghat, a Tribal Region of Maharashtra, India
\textsuperscript{27} IIPS, UNICEF. Comprehensive Nutrition Survey of Maharashtra 2013
Figure 2 presents the gaps in breastfeeding and complementary feeding of infants and young children under two in Maharashtra. Although nearly all children were ever breastfed, only 61 per cent children below six months were exclusively breastfed. It may be noted that though three-fourths of the children were fed minimum number of times (minimum meal frequency), less than 10 percent of children were fed minimum number of food groups (minimum dietary diversity), resulting in only 8 percent 6-23 month old children receiving a minimum acceptable diet.
1.11 Rationale for a comprehensive MIYCN policy in Maharashtra

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

Adequate provision of nutrients, beginning in early stages of life, is crucial to ensure good physical and mental development and long-term health. Poor availability or access to food of adequate nutritional quality or the exposure to conditions that impair absorption and use of nutrients has led to large sections of the population being undernourished, having poor vitamin and mineral status or being overweight and obese, with large differences among population groups\(^\text{28}\).

In women, both low body mass index and short stature are highly prevalent in low-income countries, leading to poor fetal development, increased risk of complications in pregnancy, and the need for assisted delivery.\(^\text{29}\) Maternal anaemia is associated with reduced birth weight and increased risk of maternal mortality. Anaemia rates have not improved appreciably over the past two decades\(^\text{30}\).

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

Optimal maternal, infant and young child feeding (MIYCN) contributes to improved nutrition and child survival in young children, and good nutrition is a foundation for sustainable development. The State of Maharashtra has been supporting the roll out of correct maternal, infant and young child feeding through its existing flagship programmes such as the National Health Mission (NHM) and the Integrated Child Development Services (ICDS). Currently, most of the frontline functionaries of health and nutrition are either trained or sensitised on MIYCN. As part of the NHM initiative, the State has been promoting institutional deliveries to provide quality care to pregnant women, lactating mothers, and the

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\(^\text{28}\) Annex 2, Comprehensive implementation plan on maternal, infant and young child nutrition endorsed by 65th World Health Assembly, Geneva, May 2012.


newborn along with implementing maternity benefits schemes such as Janani Suraksha Yojana (JSY) and Janani Shishu Suraksha Karyakram (JSSK).

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

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

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

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

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

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

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

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

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

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

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

1.14 Goal

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

This policy aims at

• Contributing to reduction of MMR from 68 to 30 per 100 000 live births by 2020, NMR from 18 to 9 per 1000 live births by 2020, IMR from 24 to 12 per 1000 live births by 2020; U5MR from 28 to 14 per 1000 live births by 2020.

• Contributing to reduction of stunting among children under two from 22.3% to 12% by 2020.

• Contributing to reduction in incidence of Severe Wasting in children under two from 4.5% to 2.5% by 2020. 31

1.15 The Implementation Objectives

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

• Ensure that all women give birth to a healthy baby, by providing adequate nutrition during pregnancy & Folic Acid supplementation in the periconception period, counselling them on adequate nutrition and providing support for institutional delivery.

31 Based on CNSM, 2012 data that provides a baseline for MIYCN indicators for children under 2 from Maharashtra.
During any emergency situation all pregnant women and lactating mothers should get extra food ration including essential micronutrient supplementation and medical examination during pregnancy and lactation period.

Advocate for appropriate interventions that promote and support the practice of optimal MIYCN for all women, including employed mothers.

Ensure that all workplaces support the mother to breastfeed as per the recommendations and provide adequate maternity leave and benefits to achieve the same

Ensure that mothers feel comfortable about nursing in public (NIP) and that the public places are supportive to NIP

Ensure that workplaces and public places create facilities for breastfeeding (Hirkani’s Rooms).

Ensure that mothers and their families are counselled in the antenatal period about the benefits of maternal nutrition, breastfeeding, early initiation, breastfeeding positions and problems in first few days, how to prevent these and about exclusive breastfeeding.

Ensure that all mothers are given to hold their babies in skin-to-skin contact in about 5 mins of birth in order to initiate breastfeeding within one hour of delivery and maintain this contact till the first breastfeed is completed (Breast Crawl)

Ensure that mothers are counselled to breastfeed their children exclusively for 6 months through individual and group counselling.

Ensure that all postnatal mothers receive timely help for adequate nutrition & breastfeeding problems in the postnatal period

*Raise the rates of timely initiation of breastfeeding within one hour of birth, from 71% to at least 90% by 2017.*

Ensure that all women exclusively breastfeed their infants in the first six months of their life through counselling at points of contact with the public health and ICDS systems.

*Raise the rates of exclusive breastfeeding for children 0-6 months old from 61% to 80% by 2017*

Ensure that all women start introduction of appropriate complementary foods at the beginning of seventh month along with continued breastfeeding.

*Raise the rates of timely introduction of complementary foods (with continued breast feeding) in infants 6–8 months old increased from 58% to at least 80% by 2017*

Ensure that all women provide age-appropriate quality complementary foods to their children, with adequate (recommended) meal frequency.

*Raise the rates of minimum acceptable diet (quality of diet based on feeding of four or more food groups every day and age-appropriate frequency of feeding apart from breast milk) for children 6-24 months old from 10% to 50% by 2017.*

Ensure that all VHNDs become Four Dimensional (4D) by assessing Diet (Feeding practices), Development, Drugs (ancillary treatment: micronutrient supplementation, contraceptive advice etc) and finally Dose (Immunization)

*Ensure that nutrition and feeding is assessed in conjunction with WHO Growth standards*

Ensure that all women provide appropriate foods and feeding to sick children along with therapeutic feeding (e.g. ORS and zinc during diarrhoea) during illness and ensure hygienic practices during feeding.

Ensure that infant / Young Child is given additional feeds after recovery from illness, especially diarrhoea.
- Ensure that all mothers provide appropriate feeding to the child during their own illness. If the mother is infected with HIV, she should be encouraged to exclusively breastfeed her infant for the first 6 months.
- Ensure that all infants and young children who are exposed to or infected with HIV are provided with appropriate foods and feeding as per their age, nutrition and health status.
- Ensure that all low birth weight infants including those born with very low birth weight should be put to breast immediately after birth and fed breast milk.
- Ensure that all children diagnosed with malnutrition are provided with recommended IYCN counselling along with therapeutic feeding and care through facilities (e.g. Nutrition Rehabilitation Centres (NRC), Child Treatment Centres (CTC), and Village Child Development Centres (VCDC)) or managed at the community level.
- Ensure that all children below 6 months in emergency situations are provided only with breast milk by keeping mothers and their children together and no formula foods should be given to them.
- Enhance optimal MIYCN in other exceptionally difficult circumstances.
- Ensure all the delivery points and health facilities both in rural and urban, Govt. and private are accredited as Baby Friendly Hospitals under BFHI.
- Ensure that all Health Care Providers (Governmental and Non-Governmental) and ICDS staff are adequately trained in MIYCN
- To crystallize roles and responsibilities of each Government Department, Private Sectors and Development Partners for optimally implementing MIYCN Policy.
Chapter 2: MIYCN Policy guidelines

2.1 Overview

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

The policy guidelines have been divided into Five categories:

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

2.2 Addressing Adolescent, Prepregnancy & Maternal Nutrition

<table>
<thead>
<tr>
<th>Issue</th>
<th>Policy Guideline</th>
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<tbody>
<tr>
<td>1</td>
<td>There are high levels of undernutrition in adolescent girls &amp; pregnant women. As high as 32.5% of mothers had low body mass index (BMI) &lt; 18.5 kg/m², which is much higher in rural areas (41.1%) compared to urban areas (22.2%) (CNSM 2012)</td>
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<tr>
<td>2</td>
<td>Short stature, low BMI, Vitamin &amp; Mineral deficiencies in pregnancy contribute to maternal morbidity &amp;</td>
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mortality, fetal growth restriction, infant mortality and stunted growth & development. In Maharashtra, 58.3% of adolescents (15-19 yrs) are anaemic and 69.5% pregnant women are anemic of which 12.0% suffer from severe anemia. (DLHS IV, 2012-13) and health care throughout the life cycle.

All Adolescent girls, women in age group of 15-49 years, Pregnant & Lactating mothers should be routinely tested for Hemoglobin and given IFA supplementation deworming medicine as per National Iron Plus Initiative guidelines and should be counselled for compliance.

Along with this all pregnant women and lactating mothers should also receive other necessary micronutrients (including Vitamin D3 and Calcium) in adequate quantities.

3 Micronutrients deficiencies like iodine deficiency and folate deficiency constitute for single greatest cause of preventable brain damage in fetus and infants and increases risk of fetal malformation in form of neural tube defects. Birth defects account for 7% of all neonatal mortality & 3.3 million under 5 deaths. In India prevalence of birth defects varies from 61 to 69.9/1000 live births.

All families and communities should be counselled for use of iodized salt for cooking and iodized salt should be made available under PDS.

The newly married couples should be counselled for planned pregnancy and women in the reproductive age group who are planning pregnancy should be provided with Tab. folic acid in periconception period.

4 In developing countries babies conceived less than six months after a prior birth were found to be 42% more likely to be born with a low birth weight than those born after more than two years; babies conceived within 6–11 months after a prior birth were 16% more likely to have a low birth weight.

All pregnant women & their spouses should be counselled for Family Planning during the ANC visits.

A choice of family planning methods including PPIUCD should be given to the couple during the Post natal period (HBNC, Immunization or any other contact point)

2.3 Feeding the infant/young child under "normal" circumstances

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<tr>
<td>5 Although 92% of births in Maharashtra are institutional, only 71% of mothers initiate breastfeeding within one hour of birth, and 69% infants (0-5 months) are exclusively breastfed (DLHS 4).</td>
<td>All mothers undergoing normal as well as LSCS deliveries should be counselled to give skin-to-skin contact (Breast Crawl) in order that baby initiates breastfeeding within an hour of delivery, to continue this skin-to-skin contact till the first breastfeed is completed. Skin to skin contact between mother and newborn should be continued for at least 6 months.</td>
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32 Lancet series on Maternal & child Health 2008
33 WHO – Neurological disorders: A Public Health Approach
encouraged by ‘bedding in’ the mother and the baby together.  

Skin to skin contact (Kangaroo Mother care) can be given to all newborns as it helps in better bonding between the mother and child, optimal temperature maintenance & better feeding.

| 6 | Fetal growth restriction and sub-optimal breast feeding together are responsible for more than 19% of all under 5 child deaths \(^{36}\) | All mothers should be counselled for proper breast care from ANC period and to exclusively breastfeed their infants and the feeding should be on cues (which include sucking movements and sucking sounds, hand to mouth movements, rapid eye movements, soft cooing or sighing sounds, lip smacking, restlessness etc. Crying is a late cue and may interfere with successful feeding) for the first completed 6 months (180 days) of the infant's life unless medically contradiated.

In case of lactational failure, mothers should be supported for relactation through supplementary suckling technique as per Government of India guidelines. \(^{37}\) |

| 7 | 42% of infants 6 to 9 months do not get timely complementary feeding, and 90% of children (6-24 months of age) do not receive minimum acceptable diet. (CNSM, 2012). | Parents shall be counselled to introduce adequate, safe (homemade, fresh & hygenically prepared), proper consistency and appropriately fed complementary foods after completion of 6 months of the infant's life while they continue breastfeeding for up to 2 years or beyond.

Every Kitchen should have hand washing facility and the caregivers should be encouraged for practicing handwashing with soap before food preparation and child feeding. |

| 8 | Micronutrients deficiency adversely affect child health & survival and deficiency of Iodine & Iron together with stunting contribute to children not reaching their developmental potential. \(^{38}\) | Every child should receive appropriate micronutrient supplements as per age. Vitamin A supplementation every 6 months between 9 months to 5 yrs of age in appropriate dosage.

All children suffering from Diarrhoea and acute malnutrition should be given Zinc supplementation as per guidelines.

Nutrition education should be given to all mothers |

\(^{36}\) Lancet series of Maternal & child Health 2008 
\(^{37}\) Facility based management of Severe Acute Malnutrition 
\(^{38}\) Lancet series of Maternal & child Health 2008
| and care givers for dietary diversity to include macronutrient dense & micronutrient rich foods and use of iodized salt in diet. All infants and young children should get IFA supplementation from 6 months of age as per the NIPI guidelines of GoI 2013.  

| 9 | Regular growth monitoring is done by ICDS. In Maharashtra, 22.6% children under the age of 2 years are underweight.  
Growth Monitoring & Promotion is an important arm of MIYCN policy. All infants & children upto 3 yrs of age should be weighed monthly and thereafter minimum quarterly weight monitoring should be done using new WHO growth standards. Similarly, growth monitoring for all sick infants & children seen in OPD and IPD is necessary.  
Review of feeding practices & counselling on exclusive breastfeeding for first six months (180 days), introduction of appropriate complementary foods from beginning of 7th month onwards with continued breastfeeding for 2 years and beyond. Demonstration of food preparation and sharing of receipes for optimal use of locally available foods for children 6-23 months old is necessary.  
Supplementary nutrition should be provided free of cost to all pregnant women and upto 6 months post childbirth, and to children in age group of 6 months to 6 yrs, through the local anganwadi. In the case of children, up to class VIII or within the age group of six to fourteen years, whichever is applicable, one mid-day meal, free of charge, everyday, except on school holidays, in all schools run by local bodies, Government and Government aided schools should be provided under Mid Day Meal Scheme as per THE NATIONAL FOOD SECURITY ACT 2013.  |

39 Comprehensive Nutrition Survey Maharashtra 2012
2.4 Feeding the Infant/Young Child of a working mother at work places

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<tr>
<td>More than 40% of women in Maharashtra are working women, with 30.79% in rural areas &amp; 11.88% in urban areas. Of these almost 80% work on daily wages with 41.14% working as agricultural labourer, 35.84 as cultivators and 3.65% in household industry.</td>
<td>All working mothers in organized sectors should get all benefits as per the Maternity Benefit Act 1961 &amp; Maternity Benefit (Amendment) Act 2008. All Working mothers from the tribal areas, drought &amp; flood prone areas, marginalized population, working in unorganized sectors should be given loss of wages for the last trimester and first 6 months of post natal period to support the optimum nutrition &amp; rest for the pregnant women and exclusive breastfeeding for first six months of infants life. All working mothers in organized &amp; unorganized sectors should get equal opportunity to nurse and breast feed their infants even at work places. Workplaces should create safe facilities with adequate privacy/Hirkani kaksha for helping working mothers to nurse and breastfeed their infants. Adequate facilities in organized sector workplaces should be available at the nursing/lactation room to support mother to express and store (Refrigerate) the breast milk to be fed to the child. All working mothers should get adequate break time (atleast 25-40 min) every 3-4 hours or as per the workflow to support breastfeeding for the child. There should be provision of creche services for the children of working mothers as per The Factories Act 1948, ammended by the Factories (Amendment) Act 1987 (Act 20 of 1987). In unorganized sector the creche should be established with the anganwadi as per the MWCD directives for Strengthening &amp; Restructuring of ICDS – dated 22nd October 2012.</td>
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</table>

40 Report on statistical profile on women labour by Ministry of Labour & Employment, GoI – 2007-08
Paternity Benefits:
At present there are no Paternity benefits available to fathers in Maharashtra for child’s birth. Fathers have very important role to play by ensuring the well being of the postnatal mother and the new born by supporting adequate nutrition and care for both. Central Government has allowed 15 days of Paternity leave to a male member of the service with less than 2 surviving children.  

All males with less than two surviving children working in organized sectors and unorganized sectors should be entitled for 15 days of Paternity leave during the confinement of his wife for childbirth or upto six months from the date of delivery of the child. This leave should be utilized by the person to support the health and nutrition well being of the mother and newborn.

The leave should be a paid leave and should not be debited against the leave account. In exceptional circumstances of maternal death or serious maternal illness Paternity or maternal psychiatric illness the father of the newborn should be granted additional Paternity leave for 30 days (Total 45 days) to ensure the well being and nutrition rehabilitation of the infant.

In organized as well as unorganized sector the employer shall not normally refuse Paternity Leave under any circumstances.

2.5 Feeding the Infant/ Young Child who is exposed to HIV

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<th>Issue</th>
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<td>12</td>
<td>Mother-to-Child transmission of HIV is a major route of HIV infection in children. However, out of an estimated 27 million pregnancies in a year, only about 52.7% attend health services for skilled care during child birth in India. Many pregnant women do not undergo routine HIV counselling and testing. In Maharashtra, 23% pregnant women do not undergo HIV counselling and testing during pregnancy (MSACS 2013-2014).</td>
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<tr>
<td>13</td>
<td>Without intervention, one in Ten children born to HIV-infected All infants less than 6 months of age who are exposed to or infected with HIV should receive</td>
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Mothers get infected with HIV through breastfeeding\(^43\).

Exclusive breastfeeding for at least first 6 months completed after which complementary feeding should be introduced gradually, irrespective of whether the infant is diagnosed HIV negative or positive by EID.

Only in situations where breastfeeding cannot be done (maternal death, severe maternal illness) or individual mother's choice (at her own risk), then exclusive replacement feeding may be considered. However for exclusive replacement feeding all criteria for replacement feeding must be met:

- 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 provide health care that offers comprehensive child health services.

Mixed feeding (Breast milk and replacement feeds) should not be done within first 6 months of infants life.

Breastfeeding should NOT be stopped abruptly and mother who decide to stop breastfeeding should stop gradually over one month.

The guidelines for feeding of an infant including breastfeeding and complementary feeding should be adhered to strictly as per the National guidelines for Prevention of Parent–to-Child Transmission of HIV by NACO.

### 2.6 Feeding Infant and Young Child in Other Specific Situations

\(^{43}\) DeCock et al. JAMA.2000; 283:1175-1182
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<tr>
<th>Issue</th>
<th>Policy Guideline</th>
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<tr>
<td>14. Feeding in preterm / low birth weight infants</td>
<td>Breast milk intake is not adequately promoted for low birth weight (LBW) babies. In Maharashtra, 20% children born are LBW (CNSM 2012). Mothers and care takers of low birth weight (LBW) babies should be promoted and facilitated to give KMC (Kangaroo Mother Care). KMC helps faster stabilization, optimal temperature maintainance, better feeding, higher weight gain, lesser complications, early discharge from NICU/SNCU/NBSU, better neurodevelopment and hence lesser health costs. KMC should be continued at home after discharge. Mothers of infants who are born with low birth weight but can suckle should be encouraged to breastfeed, unless there is a medical contra-indication. Mothers of low birth weight infants who cannot suckle well shall be encouraged and assisted to express breast milk and to give it by cup, spoon or Intragastric tube. If the baby is transferred to NBSU/SNCU/NICU, mothers should be supported to start breastmilk expression within hours of delivery, continue it atleast 3 hourly during the day time and atleast once at night. Arrangements should be made to transfer this milk to the baby. Ensure early transfer of mothers with the baby in NBSU/SNCU/NICU and that NBSU/SNCU/NICU has arrangement to accommodate the mothers in the immediate vicinity and that mothers are permitted to visit and hold and touch the baby at will if the baby’s condition permits. Ensure that majority of babies are on exclusive breastfeeding or on breastfeeding plus expressed breastmilk at discharge from the NBSU/SNCU/NICU. In settings where safe and affordable milk banking facilities are available or can be set up such as SNCU, LBW infants including those with VLBW, who cannot be fed on mother’s own milk should be fed donor milk (non HIV infected) human milk.</td>
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Periodic feeding should be practiced on medical advise in case of very small infant who is likely to become hypoglycemic unless fed regularly, or an infant who doesnot demand milk in initial few days.

Age appropriate micronutrients should be given to all preterm & LBW babies.

| 15 | **Feeding of malnourished infants and children**  
Malnourished infants and children do not receive adequate care, support and management. In Maharashtra, 4.5% children under two are severely wasted (CNSM 2012), |
| --- | --- |
| 16 | **Feeding in special circumstances**  
(a) **Feeding during illness**  
Feeding during illness is important for recovery and for prevention of undernutrition. Even sick babies mostly continue to breastfeed and the infant can be encouraged to eat small quantities of nutrient rich foods, but more frequently and by offering foods that a child likes to eat. After the illness (eg; diarrhoea) the nutrient intake of child can be easily increased by 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 or in case of maternal death.**  
Most maternal illnesses do not need cessation of breastfeeding. In case where mother is suffering from painful and/or infective breast conditions like breast abscess & mastitis may need temporary cessation of breastfeeding and need treatment for the primary condition. Breastfeeding should be started as soon as possible after completion of treatment.  
Chronic infections like tuberculosis, leprosy, or medical conditions like hypothyroidism need |
treatment of the primary condition and do not warrant discontinuation of breastfeeding.

Breastfeeding is contraindicated when the mother is receiving certain drugs like anti-neoplastic agents, Lithium, anti-thyroid drugs like thioracil, recreationally abused drugs like 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. Expert medical advise should be taken for the timing of breastfeeding when the mother is on any medication.

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.

**In case of maternal death or when mother’s milk is not available or is contraindicated:**
Replacement Feeding Options should be considered as per the choices.
- Expressed Donor milk from the lactating mothers
- Locally available modified animal milk
- Formula milk

Given the importance of breast milk to the infant, breastfeed for the infant should be encouraged by wet nursing by a lactating mother in family or community if culturally accepted or breastmilk available from milk banks. Where breastfeed is not available, modified animal milk should be used to feed the infant after following all safety & hygiene measures.

Formula milk is the last choice when all other options have been exhausted despite best

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efforts. The formula milk should be given under the guidance of a pediatrician and it should be in compliance with the IMS act.

| (c) Infant feeding in various conditions related to the infant | Breastfeeding on cues should be promoted in normal active babies. However, in difficult situations like very low birth weight, sick, or depressed babies, alternative methods of feeding can be used based on neuro-developmental status. These include feeding expressed breast milk through intra-gastric tube or with the use of cup and spoon. For very sick babies, expert guidance should be sought.

An expert should be consulted in individualized cases with special situations like Gastro-Oesophageal Reflux Disease (GERD), Infants with Inborn errors of metabolism (Galactosemia, phenylketonuria etc) & Infants with surgical problems like babies with cleft lip / palate, hypotonic conditions, chin recession need special techniques to feed..

| 17 Feeding in Emergencies and other difficult conditions | 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.

Mothers, caretakers, and families should be counselled and supported to practice optimal MIYCN in emergencies and other exceptionally difficult / special circumstances. Mothers and their infants should be kept together to facilitate continued feeding and care.

Infants born into populations affected by emergencies should be breastfed from birth to completion of 6 months (180 days) of age. In case where biological mother’s milk is not available, alternative feeding options like replacement feeding options should be considered (as discussed under para in case of maternal death).
| 18 | **Nutrition support to Migrant Population anywhere in the state.**
It is a well known fact that migration happens mostly in population who are from BPL category, from tribal and marginalized areas for purpose of employment reason. These migrant workers stay at the place of work which may be far away from the local settlement. Agriculture provides maximum (32.4 per cent) employment for the migrants in rural area while non-agriculture industry provides highest employment to migrants (27 per cent) in urban area.\(^{46}\) | Complementary foods should be prepared and fed frequently consistent with the principles of good hygiene and proper food handling. Safe drinking water supply should be ensured.\(^{45}\)

All pregnant women and lactating mothers & children between 6 months to 6 years should get supplementary nutrition from the local Anganwadi along with all essential micronutrient supplements anywhere in the state.

Creche services should be made available by the employer or at the local anganwadi and services should be provided by the local anganwadi worker or creche worker along with additional supplementary nutrition. |

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\(^{45}\) Guidelines for Enhancing Optimal Infant & Young Child Feeding Practices; Government of India; 2013

\(^{46}\) A report by Govt. of Maharashtra on Migration Particulars based on data collected in state sample of 64\(^{th}\) round of NSS (July 2007-June 2008)
Chapter 3 : Implementation Strategy

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

3.1 Implementation Framework

Actions to promote infant and young child feeding have been grouped at the following three levels:
- At health facilities
- During community outreach activities
- During community and home based care

3.1.1 At Health Facility Level

Contact opportunities for Promotion of MIYCN in a health facility
- During and after institutional delivery:
  - Inpatient services for children:
  - Outpatient services and consultations for pregnant women, mothers and children:

<table>
<thead>
<tr>
<th>KEY PRACTICES AND SERVICE PROVIDERS IN HEALTH FACILITY</th>
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<tr>
<td>Interventions</td>
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<td>------------------------------------------------------</td>
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</table>
| ANTENATAL CLINIC: at all MCH facilities and PPTCT/ delivery points | • Counsel all pregnant women for optimum nutrition, rest and compliance for IFA consumption.  
• Counselling on avoiding mental stress, smoking, use of tobacco in any form or alcohol consumption during pregnancy  
• Counselling for early initiation, colostrum and exclusive breast feeding during third trimester.  
• Counselling for nipple problems & Breast care  
• Specific counselling and management if mother is HIV positive  
• Importance of colostrum feeding  
• Counselling for birth spacing | • Staff Nurses;  
• Nutrition Counsellor (when available at the facility);  
• ICTC counsellor | • Medical officer  
• ASHA |
| POSTNATAL WARD: At all delivery point                  | • Ensure initiation of breastfeeding within one Hour  
• Support for early initiation of breastfeeding, avoiding pre-lacteal feeds, promoting colostrum feeding, and establishment of exclusive breastfeeding; | • SBA/NSSK trained service provider/s conducting delivery (ANM, SN, MO); | • Doctors  
• Staff nurses |
| OUTPATIENT SERVICES/CONSULTATIONS (IMMUNIZATION CLINIC, PEDIATRIC OPD, HIGH RISK CHILD CLINIC, ICTC) | • Prevention and treatment of breastfeeding problems like engorgement, mastitis, breast abscess, cracked nipples etc  
• 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  
• Teach every mother technique of hand expression of breastmilk  
• Birth weight, identification of LBW babies and appropriate management. Practise KMC.  
• 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  
• 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 MIYCN and nutrition during pregnancy and lactation;  
• Review of breastfeeding practices of individual child and nursing mother and counselling on age appropriate infant feeding practices;  
• Review of feeding practices, counselling and support on feeding options in context of HIV (for mothers identified as HIV positive)  
• Setting up of Hirkani Kaksha and | • Nutrition Counsellor at high load facilities  
• ANM if only she is available, Staff Nurses;  
• Nutrition counsellor at NRC  
• ICTC counsellor  
• Medical officer |
### INPATIENT SERVICES (SICK CHILDREN ADMITTED IN PAEDIATRIC WARDS):
At all MCH facilities/ delivery points

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<th>Services</th>
<th>Staff Responsibilities</th>
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<tr>
<td>- Monitoring of lactation and breast conditions, support to resolve any problems</td>
<td>- Staff Nurses; Nutrition Counsellor at NRC</td>
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<tr>
<td>- Anthropometric measurements of all inpatient children; identification of children with undernutrition and appropriate nutrition counselling and management</td>
<td>- Matron</td>
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<td>- Counselling on early childhood development (play and communication activities) using MCP card</td>
<td>- Medical officer</td>
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<td>- Implementation of IMS Act</td>
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<td>- Age appropriate messages regarding feeding of sick child and child care practices</td>
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### SPECIAL NEWBORN CARE UNITS (SPECIAL NEWBORN CARE UNITS, NEWBORN STABILIZATION UNITS)

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<th>Services</th>
<th>Staff Responsibilities</th>
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<tr>
<td>- 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.</td>
<td>- Staff Nurses; Nutrition Counsellor at high case load facilities</td>
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<td>- Age appropriate feeding advice on discharge.</td>
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### NUTRITION REHABILITATION CENTRES (NRCs)

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<th>Services</th>
<th>Staff Responsibilities</th>
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<td>- To start with appropriate therapeutic foods like F75, F100 along with health and nutritional protocols.</td>
<td>- Staff Nurse, Nutrition Counsellor</td>
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<td>- Review of feeding practices of severely malnourished child and counselling on appropriate therapeutic feeding practices including what to feed and how to feed.</td>
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<td>- Reinstate the breastfeeding in lactational failure by supplementary suckling technique.</td>
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<td>- Appropriate feeding advice before discharge.</td>
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<td>- 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)</td>
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<tr>
<td>- Counselling on early childhood development (play and communication activities) using MCP card</td>
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<td>- Implementation of IMS Act</td>
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<td>- Age appropriate messages regarding feeding of sick child and child care practices</td>
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3.1.2 Key Interventions At Community Outreach Level

MCH contact opportunities during Community outreach

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

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

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<tr>
<th>Interventions</th>
<th>Actions and key practices</th>
<th>Primary responsibility</th>
<th>Supporting Role</th>
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</table>
| Village Health & Nutrition days (VHND): AWC or Sub Centre , as relevant | • Estimation of BMI for Adolescent girls, newly married women to know identify undernutrition (BMI < 18.5)  
• Counselling and practical guidance on breastfeeding as an integral component of birth preparedness package – prepare mothers for early initiation of BF;  
• Group counselling on maternal breastfeeding                                                                 | • ANM  
Where feasible, demonstration of food preparation and sharing of recipes for optimal use of locally available foods for mothers & children 6-23 months; In special situation, | • AWW,  
• ASHA,  
• LHV  
• ICDS supervisor |
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<tr>
<th>Nutrition and Infant Feeding</th>
<th>Demonstrate Preparation of Safe Replacement Feed</th>
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| Village Child Development Centres (VCDC) at AWCs | - 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 |
| Routine Immunisation sessions (RI sessions) : AWC or Sub Centre as relevant | - Group counselling on age appropriate MIYCN practices and maternal nutrition |
| Biannual Rounds for Vitamin A supplementation ; or during months dedicated to child health. AWC or Sub Centre as relevant | - Group counselling on MIYCN and maternal nutrition; linkage with Growth Monitoring and Promotion sessions through ICDS. |
| IMNCI / sick child check up | - Assessment of age appropriate feeding and |

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| Home visits to newborn (up to 42 days) in postnatal period in HBNC | • 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 HBNC | ASHA | • ANMs  
• AWWs |
| During routine activities of Anganwadi centres: (Growth monitoring and promotion sessions;) | • Growth Monitoring using Mother and Child Protection Card  
• Group counselling/communication on MIYCN and maternal nutrition;  
• Where feasible, demonstration of food preparation and sharing of | Anganwadi worker | • ASHAs/ helpers, Self help groups, Mothers support groups |

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

**Community contacts include:**
- Postnatal Home visits
- Home visits for mobilising families for VHND
- Growth monitoring and health promotion sessions at Anganwadi centers.
- Mothers’ Group Meetings /Self Help Groups’ Meetings
supplementary feeding; counselling sessions), Anganwadi Centre

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

3.1.4 Key Interventions during Emergencies and Other Difficult/Special Circumstances

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

| KEY PRACTICES AND SERVICE PROVIDERS IN EMERGENCY AND OTHER DIFFICULT/SPECIAL CIRCUMSTANCES. |
|---------------------------------------------------------------|---------------------------------------------------------------|
| Interventions | Actions and key practices | Primary responsibility | Supporting Role |
| Establishing the Rapid Response Team for maintaining the optimum health & nutrition for the pregnant women, lactating mothers, infants and young children. | • Support the nutrition rehabilitation of pregnant women & lactating mothers along with Infant & young children.  
• Emphasize protecting, promoting, and supporting breastfeeding and ensuring timely, nutritionally adequate, safe, and appropriately fed complementary foods, consistent with the age and nutritional needs of older infants and young children.  
• Guide health workers to identify infants who need to be fed with Replacement feeds either for social or medical reasons, ensuring that a suitable substitute is provided and fed safely for as long as needed by the infants concerned.  
• Use donations of replacement feeds and feeding utensils for children in difficult circumstances | State Public Health Department, District Administration, | Department of Women & Child, Department of Medical Education, Development Partners, NGOs and other stakeholders, Local Community |
only if approved and cleared by the Public Health Department before distribution. Feeding bottles and cups with spouts should not be accepted.

- Strengthen education and communication to ensure that children continue to be fed when they or their mothers fall sick. The feeding should be even more frequent during illness and while the child is recovering.
- Avoid separating mothers and their infants to facilitate continued feeding and care.
- Ensure that health workers & Community workers have accurate and up-to-date information about the Maternal & Infant/Young child feeding policies, guidelines and practices, and that they have the specific knowledge and skills required to support children and their caregivers in all aspects of MIYCN in difficult circumstances.
- Adopt the BFHI, as well as other forms of protection and promotion of breastfeeding, and provide the necessary support to mothers for continuing breastfeeding and not accept artificial feeds.

### 3.2 Integration, Coordination and Collaboration

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

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

Harmonization of messages and integration of MIYCN in initiatives targeting Women and children such as BFHI, IMCI, PMTCT, ART, and Home Based Care (HBC) programs as well as other reproductive health interventions, will be actively pursued.
Comprehensive approach shall be used as a means of ensuring MIYCN promotion at the various key contact points (ANC, delivery, post-natal/family planning, immunizations, growth monitoring/well child, and sick child consultations), in addition to promotion at schools and within the community. It will be important to strengthen the use of community based health workers, peer counsellors, and mother support groups as well as links with agricultural and other extension workers in the promotion of optimal MIYCN.

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

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

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

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

**Resource Mobilization**

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

### 3.4 Roles and responsibilities:

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

- The department will act as the principal implementer, mentor and coordinator of all the critical MIYCN interventions aimed at achieving the goal and objectives of these Policy guidelines and ensure that other related guidelines are in accordance with this policy.

- It will technically lead the implementation and liaise and co-ordinate with other line departments that will be directly or indirectly responsible for implementation of the Policy through their service delivery platform.

- Strengthen the implementation of the MIYCN interventions by creating a state level task force with representation from professional bodies, academia, NGOs, technical institutes and health functionaries and setting up of an independent unit within the Directorate of health services –Nutrition Unit for spear heading the implementation and co-ordination of this policy.

- Facilitate the training of all the health professionals and health workers and all others who work with women and care givers on MIYCN in recognising malnutrition and Low birth weight, following the Baby Friendly Hospital Initiative and preparedness for MIYCN during emergencies and in difficult circumstances.

- The department will prepare the technical guidelines and communication strategy while rolling out of the Policy.

- The department will undertake training and sensitization of the health workers on monitoring and evaluation of various replacement feeds for infants exposed to HIV.

- The department will be responsible for updating and developing the state guidelines and materials on MIYCN, management of children with severe acute malnutrition, prevention and management of low birth weight and dissemination of those in the local languages for the implementers, mothers, caregivers and the communities. It will ensure the technical correctness of the information. The other departments will use these materials for dissemination.

- The department will ensure that professionally trained personnel in Public health/nutrition will be appointed as the Nutritionist/dieticians at the delivery points & Health care centers with large load for implementation of MIYCN and management of children with severe acute malnutrition.

- The department will ensure that all the manpower both medical and nursing are trained and skilled in MIYCN integrated counselling training in the district, SDH and women’s hospital and maternity homes.

- The department will also develop, review /update the critical indicators for MIYCN and malnutrition in the HMIS reporting and analysis for action at various levels.

- The department will establish MIYCN counselling and other support services in the health facilities at the relevant MCH contacts in Primary Health centres, Rural hospitals, Sub District hospitals, General Hospitals, District hospitals and Women’s Hospitals.

- Ensuring the institutionalisation of the ten steps to successful Breast Feeding in all the maternities - Baby Friendly Hospital Initiative.
• Ensure strong IEC and sensitization of IAP, NNP, NNF, FOGSI, IPHA & IAPSM.
• Plan provision of part time/full time services of lactation consultant and Counsellors at all maternity services in the government sector and issue such guidelines to the private sector.

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

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

**Role of the Department of Medical and Nursing Education:**
• The department of Medical education is responsible for implementation of the FDA and monitoring of the medical colleges.
• The medical institutes are the technical hubs that provides the health professionals to man the health facilities at all the levels. It has a very crucial role to play in roll out of MIYCN.
• It will ensure that the MIYCN is mainstreamed in the medical curriculum and nursing curriculum of the state through its apex university –Maharashtra University of health
sciences and Maharashtra Nursing Council. Besides integrated in the curriculum it should be part of the evaluation of their course work.

- It will ensure that MIYCN training is integrated for health and nursing cadre in pre-service curriculum and in service training. For medical officers MIYCN training will be linked to credits for maintaining the registration with MMC.

- Developing integrated course on MIYCN counselling and skill based training for the Dieticians, Medical officers, ICDS functionaries and lactation Counsellors.

- The department will ensure that the Nursing council will be involved in rolling out MIYCN in the state and districts through their nursing schools and will include MIYCN in nursing curriculum (ANM/GNM/BSc Nursing).

- Support the capacity building on MIYCN and maternal Nutrition during pregnancy and Lactation for the lactation counsellors for private nursing homes, hospitals and government supported health institutions.

**Role of MUHS**

- MUHS, Pune regional centre will be a nodal institute for MIYCN trainings.

- PSM department will coordinate MIYCN trainings.

- Monitor the training of all concern medical college.

- Plans and establish a training programme to train and certify mother support group leaders in large numbers through medical colleges. The obstetric department should be assigned the responsibility for this training programme. The protocols and training strategies of the existing Mother Support Groups in the state (eg. By BPNI Maharashtra) may be utilized for such a course.

**Role of Department of Tribal Development:**

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

- The department will make provision in the form of social protection scheme / maternity benefit scheme / conditional cash transfer scheme to improve maternal, infant and young child nutrition.

- The department will have special focus on monitoring the MIYCN indicators for PVTGs.

- Support provision of double fortified salt, fortified aata and Multimicronutrient powders for home fortification of complementary feeds in the tribal areas through PDS.

- Support family food security by ensuring livelihood support through National Rural Livelihood Mission (NRLM)

**Role of Department of Rural Development:**

- The department will ensure that all the districts in the state have trained and skilled health and ICDS staff to support implementation of MIYCN.
• The CEO Zilla Parishad will monitor the MIYCN training and MIYCN indicators in the districts jointly with DHO, Dy CEO (WCD) and Dy CEO (VP).

• The department will ensure that all field functionaries (Gramsevaks, VDO and BDO) are sensitized on MIYCN.

• The department will ensure that MIYCN indicators are mainstreamed into the special initiative of child friendly Gram Panchayats.

• Based on these critical indicators of child survival and growth GPs can be accredited and provided additional support for the Gram Panchayats.

• District plans to be developed for reducing the MMR, IMR and prevention of undernutrition (stunting, wasting) and this should be regularly monitored by CEOs. This should be a part of CEOs critical agenda.

• The department will ensure that through National Rural Livelihood Mission (NRLM), the women self-help groups and village organizations will be sensitized on MIYCN.

Role of Revenue Department:

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

Role of Grampanchayat:

• Ensure rest and no labour for pregnant woman in the last trimester of pregnancy.

• Ensure Maternity benefit schemes implemented in the state.

• Implementation and promotion of child friendly gram panchayat which can support flexible working hours for the mothers with young infants and also provision of work place or Creche.

• Promotion of IYCN practices through implementation of IEC strategy

• Supporting working mothers for continuing breastfeeding minimum 2 years. This can be encouraged by community contribution for supporting mothers to practice the four MIYCN practices. The creation of Mother Care centres based on the successful initiatives in Aurangabad, Ahmed nagar and Jalgaon through community contribution to prevent low birth weight and child under nutrition.

• GPs in the tribal blocks getting the 5% devulution PESA funds should also earmark some funds for MIYCN activity and monitoring.

Role of Department of Urban Development:

• The department will ensure that all urban local bodies (especially corporations) are sensitized on MIYCN.

• The department will ensure that all the health and ICDS facilities and the community workers are trained and skilled in MIYCN.
• All corporation run hospitals and maternity homes and private hospitals are baby friendly.

• Plan and implement Maternity Benefit schemes for Urban working mothers specially those from slums & BPL category.

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

Role of Department of Water Sanitation:
• The department will ensure that all health and ICDS facilities will have access to safe drinking water and toilet facility.
• The department will ensure integration of water sanitation and hygiene interventions (WASH) in the MIYCN capacity building.
• The department will ensure that all the field functionaries (Swachhata Doot) are sensitized on MIYCN.

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

Role of Food & Drug Administration Bureau:
• Monitor the regulations on marketing of Infant and Young Child Foods

Role of Food and Civil Supplies Department:
• Ensure supply of double fortified salt, fortified flour and fortified complementary foods for infants under PDS.
Role of District Collector:
- Strengthen the structures, services, and interventions needed for the implementation of these policy guidelines.
- Develop comprehensive policy implementation strategies.
- Monitor & support implementation of this policy & IMS act.
- Carry out intensive social mobilization of all stakeholders in the district to promote and protect optimal MIYCN.

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

Role Of Academia like IAP, NNF & FOGSI
- Continuous hand holding of public Health Department for rolling of MIYCN Policy.
- Rolling out of MIYCN Policy in the Private sector.
- Ensuring implementation of IMS Act stringently.
- Active Participation in Accreditation process of public and medical colleges Hospital.
- Ensure BFHI training & assessment.

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

Role of Non-Governmental, Community Based and Religious Organizations (NGOs & CBOs)
In collaboration with the relevant Local Government officials:
- Mainstream MIYCN into their agendas.
- Advocate for the child’s rights to food and nutrition.
• Provide support to districts and communities to promote MIYCN, growth monitoring and promotion and to implement other roles and responsibilities.

• Where possible provide direct support to mothers, families and communities.

• Involve religious leaders for influencing behavior of communities.

Role of Corporate Sector:

• Ensure establishment of crèche / Hirkani’s Room in the office premises.

• Abide to the government policy of maternity & paternity leave.

• Support MIYCN through CSR.

Role of Political Leaders:

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

Role of Mothers / Mother Support Groups:

• Breastfeed exclusively for the first six months of a child’s life.

• Take responsibility to learn what is required in preparing foods and feeding infants and young children; and pay particular attention to hygiene, correct mixing and feeding methods.

• Prepare safe foods by adhering to basic principles of hygiene.

• If using replacement feeding, ensure that you have some means for accurate measurement of both water and the powdered or liquid milk so that these ingredients can be mixed accurately and correctly.

• Form and/or participate in Mother Support Groups and alert the nearest health facility or stakeholders in the community for more support.

• Mother Support Groups will provide adequate support to new mothers and take up issues within the family and community that would hinder effective implementation of MIYCN.

• Mother Support Groups will play important role in mobilizing other community members to support MIYCN.

• Mother Support Groups can facilitate large scale implementation of MIYCN actions in the communities and progressively through a phased manner can be part of block-district health and nutrition plans.

• Mother Support Groups can be empowered for community based monitoring of critical MIYCN indicators and also become an excellent channel for social mobilization and behavior change communication.

• To utilize existing mother support groups for providing counselling at Institutional Hospitals
Senior Mother Support Counsellor or MIYCN trainers should be promoted and facilitated for advanced accreditations like IBCLC (International Board Certified Lactation Consultant)

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

Role of community:
- Community leaders should participate in the sensitization and mobilization of their members in activities relevant for optimal MIYCN.
- Organize a social support network for affected families and take steps to minimize stigmatization and discrimination.
- Provide love and attention to children in difficult circumstances.
- Protect and promote appropriate MIYCN in difficult circumstances.

Budget Provision:
All the departments are required to make adequate budgetary provisions for implementation of activities envisaged in the policy in the Annual Program Implementation Plan.

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

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

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

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

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

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

**BASIC DISTRICT PLAN**

- District Planning For MIYCN Trainings
- Advocacy Meeting
- District Sensitization Of MOs & selection of 24 delegates for TOT
- District Sensitization ICDs CDPOs, ACDPOs & Supervisors & selection of 24 delegates for TOT

**FIRST TOT:** 3 Days 48 Delegates

- EXAM: 1 Day 2 Papers (10am - 5pm)
- Capacity Building and Demo Sensitization
- IYCN District Trainers Certified

**FINAL TOT** (By selected trainers)

Highly experienced team of specialised trainers from state level/district level trainers.

Special module in simple language with stress on technique, counselling skills & community education.
Orientation of PRI members

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

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

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

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

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

In Maharashtra, mid media initiatives under traditional approaches that can be tapped for implementing communication strategy on MIYCN like Traditional Massage Women (TMW), Creche Owners, kirtankars, kalapathak, bhajani mandal, dindi, yatra, jatra, bhagwat saptah, ardhvarshik vadhdivas, etc. Platform of Mothers meetings, mahila mandals can be used for orienting women on MIYCN.
Chapter 4: Monitoring and Evaluation

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

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

Adding unscheduled visits (that is, the worker is unaware of the visit in advance) in addition to any planned visits by State/District/Block and PHC level Officials.
- Observing (using a checklist) performance of a task.
- Gathering direct feedback from caregivers (e.g. home visits made by supervisor).
- Conducting service provider interviews to test their knowledge
- Conducting periodic group reviews at different levels.

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

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

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

4.1 Monitoring Indicators

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

<table>
<thead>
<tr>
<th>Process Indicators</th>
<th>Monitoring by</th>
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<tr>
<td>Health Department:</td>
<td></td>
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<tr>
<td>▶ Percentage of districts with multi-sectoral Microplans for MIYCN activities</td>
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<tr>
<td>▶ Number &amp; percentage of hospitals that are certified baby-friendly</td>
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within one year

- Number & percentage of health workers trained on integrated MIYCN counselling
- Number & percentage of health facilities with at least one health worker trained in MIYCN counselling
- Number and % of health facilities with a dedicated Nutrition Counsellor /MIYCN Counsellor (Denominator will be District hospitals, FRUs with high delivery load)
- Number & percentage of joint review of MIYCN activities (including training for MIYCN counselling & support) with health & ICDS departments taken by PHC MO/Supervisor; THO/CDPO
- Number & percentage of adolescents, pregnant women, lactating mothers, infants & young children checked for Hemoglobin status and prevalence of anemia (Mild Moderate & Severe)
- Number and % of Institutes with Functional Hirkani Kakshs.

**ICDS Department:**

- Number & percentage of Anganwadi workers trained on integrated MIYCN counselling and support
- Number & percentage of villages/AWCs with mother support groups formed
- Number & percentage of Mother support groups meetings/conducted activities in a month (at least one meeting/activity per month is expected)
- Number & percentage of AWCs having functional adult and infant/baby weighing scales

### Outcome Indicators:

#### Health Department:

- Number & Percentage of adolescents consuming at least 4 tabs of IFA (100 mg elemental iron & 500 mcg of FA) per month under WIFS scheme
- Number & percentage of adolescents whose BMI is less than 18.5
- Number & Percentage of pregnant women consuming at least 200 tabs of IFA (100 mg elemental iron & 500 mcg of FA) during pregnancy
- Number & Percentage of Lactating mothers consuming at least 200 tabs of IFA (100 mg elemental iron & 500 mcg of FA) in postnatal period.
- Percentage of infants initiated to breast feeding within 1 hour of birth
- Percentage of infants under 6 months of age exclusively breastfed
- Percentage of infants between 6-8 months of age with complementary foods introduced
- Number & Percentage of children between 6 months to 60 months receiving biweekly IFA supplementation (20 mg elemental iron & 100 mcg of FA)
- Number & Percentage of children between 6 to 10 yrs receiving weekly IFA supplementation (45 mg elemental iron & 400 mcg of FA)
- Number and percentage of children with diarrhoea given zinc with ORS
- Number and percentage of children between 9 months to 5 yrs who have received vitamin A supplementation and deworming in last 6 months

**ICDS Indicators:**
- Number & percentage of Pregnant & Lactating women receiving SN
- Number & percentage of infants & children receiving supplementary nutrition (SN), additional SN or therapeutic feeding against the number & percentage of underweight.
- Number & percentage of infants & children upto 5 yrs who are underweight
- Number & percentage of adolescents whose BMI is less than 18.5

**Other Outcome Indicators:**
- Number & percentage of children still breastfeeding at 12-15 months
- Number & percentage of children still breastfeeding between 20-23 months
- Percentage of infants who had minimum dietary diversity
- Percentage of infants who had minimum meal frequency
- Percentage of infants and young children 6-23 months of age who received a minimum acceptable diet

**Impact Indicators**
- Percentage of stunted children under 2 years of age
- Percentage of stunted children under 5 years of age
- Percentage of wasted children under 2 years of age
- Percentage of wasted children under 5 years of age
- Percentage of underweight children under 2 years of age
- Percentage of underweight children under 5 years of age
- Percentage of children with any anemia under 5 years of age
- Percentage of children with Severe anemia under 5 years of age
- Percentage of adolescents (Boys & Girls) with any anemia
- Percentage of adolescents (Boys & Girls) with Severe anemia
- Percentage of pregnant women with any anemia
- Percentage of pregnant women with Severe anemia
- Percentage of lactating mothers with any anemia
- Percentage of lactating mothers with severe anemia
- Percentage of Low birth weight babies born
- Percentage of babies born with congenital malformation

**ICDS MPR**

**Periodic Nutrition Surveys**

**Periodic Nutrition Surveys.**
4.2 Components of Monitoring and evaluation:

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

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

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

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