COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN

Session 58 / June-July 2014

REPORT ON THE SITUATION OF INFANT AND MATERNAL HEALTH AND WORK-RELATED ISSUES IN INDIA

June 2014

Data sourced from:

DLHS-3, NFHS-3, 12th Five year plan-Planning Commission-Government of India, Operational Guidelines on enhancing IYCF by MOH-Government of India, NACO guidelines- MOH-Government of India, WBT*i* India Assessment Report 2012

Prepared by:

IBFAN Asia Regional Coordination Office – Breastfeeding Promotion Network of India (BPNI)

The right to health of women through the protection, promotion and support of breastfeeding

Working women who become mothers hold a double role that is not always easy to bear. Recognizing "the great contribution of women to the welfare of the family and to the development of society […] [and] the social significance of maternity" (CEDAW Preamble) means acknowledging that it is a collective responsibility to create an **enabling environment for women to fulfil both roles of mother and worker**. Indeed, both maternity and work are means for women's empowerment and emancipation.

Women should be given the correct information as well as the legislative and institutional support to act in their children's best interest while they continue working and being active in public life. To this end, **maternity protection** at work, and **adequate paid maternity leave** in particular, are critical interventions that States have the obligation to implement in order to simultaneously realize the right of women to work and the right of women and their children to health, allowing new mothers to rest, bond with their child and establish a sound breastfeeding practice. Therefore, working mothers are also entitled to healthy surroundings at their workplace, and more specifically, to breastfeeding breaks and breastfeeding facilities.

Breastfeeding is an essential part of women's reproductive cycle: it is the third link after pregnancy and childbirth. It protects mothers' health both in the short and long term by, among others, reducing postpartum bleeding, aiding the mother's recovery after birth (synchronization of sleep patterns, enhanced self-esteem, lower rates of post-partum depression, easier return to pre-pregnancy weight), offering the mother protection from iron deficiency anaemia, delaying the return of fertility thus providing a natural method of child spacing (the Lactational Amenorrhea Method - LAM) for millions of women who do not have access to modern form of contraception, and decreasing the incidence of osteoporosis and the risk of ovarian-, breast- and other reproductive cancers later in life. For these reasons, **promoting, protecting and supporting breastfeeding is part of the State obligation** to ensure women receive appropriate services in connection with the post-natal period. In addition, if a woman cannot choose to breastfeed because of external conditions beyond her control, she is stripped of bodily integrity and denied the opportunity to enjoy the full potential of her body for health, procreation and sexuality. The right to breastfeed does not disappear with the fact that some women may choose alternative methods of feeding their children.

Optimal breastfeeding practices as recommended by WHO Global Strategy for Infant and Young Child Feeding[1] (early initiation of breastfeeding within one hour after birth, exclusive breastfeeding for 6 months followed by timely, adequate, safe and appropriate complementary feeding practices, with continued breastfeeding for up to 2 years or beyond) also provide the key building block for child survival, growth and healthy development[2]. Enabling women to follow such recommendations means empowering them by giving them the opportunity and support to best care for their child.

Breastfeeding and human rights

Several international instruments make a strong case for protecting, promoting and supporting breastfeeding, and stipulate the right of every human being, man, woman and child, to optimal health, to the elimination of hunger and malnutrition, and to proper nutrition. These include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), in particular art. 1 and 5 on gender discrimination on the basis of the reproduction status (pregnancy and lactation), art. 12 on women's right to health and art. 16 on marriage and family life, the International Covenant on Economic, Social and Cultural Rights (CESCR), especially art. 12 on the right to health, including sexual and reproductive health, art. 11 on the right to food and art. 6, 7 and 10 on the right to work, the Convention on the Rights of the Child (CRC), especially art. 24 on the child's right to health. Interpreted jointly, these treaties support the claim that '**breastfeeding is the right of both the mother and her child, and is essential to fulfil every child's right to adequate food and the highest attainable standard of health**'. As duty-bearers, States have the obligation to create a protective and enabling environment for women to breastfeed, through adoption of measures that protect, promote and support breastfeeding.

[1] WHO 2002, Global Strategy on Infant and Young Child Feeding, http://www.who.int/nutrition/publications/infantfeeding/9241562218/en/index.html

[2] IBFAN, What Scientific Research Says?, http://www.ibfan.org/issue-scientific-breastfeeding.html

SUMMARY

*The following **obstacles/problems** have been indentified:*

- Lack of written national policy on IYCF/Breastfeeding.
- No concrete action to revive BFHI (to improve health care support to breastfeeding mothers).
- Lack of stringent system for reporting violations of the Code & continued violations to enforce IMS Act.
- The National legislation does not cover women working in private and informal sector.
- Lack of national information, education, and communication strategy for improving IYCF practices.
- National guidelines on Infant Feeding & HIV not yet made into policy.

***Our recommendations** include:*

- The National Guidelines should be reviewed, and given the shape of a national policy with plans and budgets, implementation and operational guidelines, for capacity building on indicators to implement the remaining indicators.
- Immediate action should be taken to revive the BFHI programme in its spirit to implement the 10 Steps.
- Appoint more proactive organizations/have more new organizations for monitoring IMS Act. IMS Act should be enforced more effectively.
- Uniform policy for protecting and supporting breastfeeding for mothers including informal & private sectors.
- Advocacy for comprehensive National IYCF policy that includes an IEC Strategy.
- There should be a comprehensive national policy including IYCF in HIV/AIDS.

1) General situation concerning breastfeeding in India

WHO recommends: 1) **early initiation of breastfeeding** (within an hour from birth); 2) **exclusive breastfeeding** for the first 6 months; 3) **continued breastfeeding** for 2 years or beyond, together with adequate and safe complementary foods.[3]

Despites these recommendations, globally more than half of the newborns are not breastfed within one hour from birth, less than 40% of infants under 6 months are exclusively breastfed and only a minority of women continue breastfeeding their children until the age of two.

Rates on infant and young child feeding:

- ***Early initiation:*** Proportion of children born in the last 24 months who were put to the breast within one hour of birth
- ***Exclusive breastfeeding:*** Proportion of infants 0–5 months of age who are fed exclusively with breast milk
- ***Continued breastfeeding at 2 years:*** Proportion of children 20–23 months of age who are fed breast milk

Complementary feeding: Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods

General data[4]

Population (0-6 years)	15,87,89,287
Male	8,29,52,135
Female	7,58,37,152

Infant mortality rates (per 1,000 live births): Total : 44 Rural : 48 Urban : 29

Maternal mortality rate (per 100,000 live births) : 212 (2007-09)

Breastfeeding data

Indicator	NFHS 3 (2005-2006)[5]	DLHS 3 (2007-2008)[6]
Early initiation of breastfeeding	23.4%	40.5%
Exclusive breastfeeding	46.3%	46.8%
Complementary feeding 6-9 months with continued breastfeeding	55.8%	57.1%
Median duration of breastfeeding	24.4 months	-

[3] http://www.who.int/topics/breastfeeding/en/
[4] **SRS BULLETIN 2012**
[5] National Family Health Survey -3 (NFHS-3) 2005-2006
[6] District Level Household and Facility Survey (DLHS-3) 2007-08

The annual Health Survey of 2010-11 has been conducted in 9 Indian states (Rajasthan, Uttar Pradesh, Uttarakhand, Bihar, Jharkhand, Orissa, Madhya Pradesh, Chhattisgarh and Assam) and shows increase of early initiation of breastfeeding rate, but no increase of exclusive breastfeeding rate.

About **26 million babies are annually delivered in India**. According to National Family Health Survey -3 (NFHS-3) data, **20 million are not able to receive exclusive breastfeeding** for the first six months of their life and **about 13 million do not get good timely and appropriate complementary feeding** after six months along with continued breastfeeding. Unfortunately, exclusive breastfeeding for the first six months has not shown any rise over the past two decades since India began measuring this indicator.

According to the NFHS-3, the rate of early initiation of breastfeeding (within one hour following delivery) is only 23.4%. More recent data from the District Level Household and Facility Survey (DLHS-3) shows little improvement, which is encouraging; according to the data issued from 534 districts, early initiation of breastfeeding is now about 40%. It varies from 4.2% to 93.3%.

Similarly, according to NFHS-3, **exclusive breastfeeding up to the age of six months is only of 46.3%**. Looking at the DLHS-3 data, it varies from 0.30% to 77% depending on states and districts. Exclusive breastfeeding is between 0-11% in 112 districts, 12-49% in 373 districts, 50-89% in 49 districts and there is not even one district with 90-100% exclusive breastfeeding showing discrepancy between districts.

According to the NFHS-3, introduction of complementary feeding along with continued breastfeeding in 6-9 months age is only 55.8 %. The DLHS-3 revealed that introduction of complementary feeding along with continued breastfeeding in 6-9 months age is only 23.9%.

Breastfeeding data in rural and urban areas

	Initiation of Breastfeeding		Exclusive breastfeeding		Complementary feeding	
	Rural	Urban	Rural	Urban	Rural	Urban
DLHS 3 (2007-08)	39.8	42.5	48.1	43.2	26.2	23.7
NFHS 3 (2005-06)	21.5	28.9	48.3	40.3	53.8	62.1

There is not much difference in the rates of breastfeeding between urban and rural population, however the slight **difference in the rates of initiation of breastfeeding in urban population could be increase in institutional births**. However the slight higher rates of exclusive breastfeeding in the rural population might be the economic reasons.

Major causes of infant mortality in India are known to be neonatal infections, diarrhea and pneumonia, and one WHO study attributes 53% of pneumonia and 55% of diarrhea deaths to poor feeding during first six months.

2) Maternity protection for working women

The main reason given by majority of working mothers for ceasing breastfeeding is their **return to work following maternity leave**.

It is therefore necessary to make adjustments in the workload of mothers of young children so that they may find the time and energy to breastfeed; this should not be considered the mother's responsibility, but rather a **collective responsibility**. Therefore, States should adopt and monitor an adequate policy of maternity protection in line with ***ILO Convention 183 (2000)***[7] that facilitate six months of exclusive breastfeeding for women employed in all sectors, and facilitate workplace accommodations to feed and/or to express breastmilk.

Maternity Protection is very critical for successful breastfeeding unless the mother and the baby are together, it would not be possible to enhance exclusive breastfeeding. However it is also important that all other actions for promotion and protection must also be in place to realize the benefits of maternity entitlements otherwise women may still fall out of exclusive breastfeeding and adopt harmful practices of formula feeding, if they don't have access to accurate and unbiased information and counselling on breastfeeding and complementary feeding. There is need to **extend support and maternity benefits to women in the unorganized sector as well as they form the major chunk (almost 90%) of working women**.

Maternity Leave & Breastfeeding Breaks:

In India, the rights of working mothers to maternity benefits were recognized with the introduction of the Maternity Benefit Act in 1961. The Act extends to the whole of India and applies to every establishment which may be industrial, commercial, agricultural or otherwise. It provides maternity leave for **twelve weeks**; and **two breastfeeding breaks per day** of the prescribed duration for nursing the child until the child attains the age of fifteen months.

The Act however does not holistically address the issues regarding the woman's compulsions to work right up to the last stage of pregnancy and resumption of work soon after child birth. Even after 50 years since Maternity Benefit Act came into existence it has not been effectively implemented for several reasons.

Extension of Maternity Leave:

In 2008, in a major recognition of the fact that the mother and child need to be together for first six months in order to ensure exclusive breastfeeding to the infant, the Central Government adopted the recommendations of the Sixth Pay Commission and gave a generous allowance of **180 days of maternity leave** on full pay and in addition **paid Child Care Leave for a period of 2 years as part of maternal entitlements to its women employees**; a few state governments have followed this precedent. These entitlements, however, can be accessed by a **miniscule fragment of women**.

[7] ILO, C183 - Maternity Protection Convention, 2000 (No. 183)

Maternity Entitlements for Informal Sector:

- The National Maternity Benefit Scheme (NMBS) was launched by the Central government in 2001 to provide nutrition support to below poverty line pregnant women through **one time payment of Rs.500/-** prior to delivery to women above 19 years of age for two live births.
- In 2005 the government of India launched Janani Suraksha Yojana(JSY) under the National Rural Health Mission to provide **cash incentive for women to have an institutional delivery**.
- The Dr. Muthulakshmi Maternity Assistance Scheme (DMMAS) in **Tamil Nadu** was enhanced from a **single payment to provide Rs.6000/- spread over two instalments of 3000/- each before delivery** for nutritional support during pregnancy and after delivery to compensate for their loss of income. In 2009 the scheme has started paying the complete amount in one instalment i.e. after delivery.
- In order to provide uniform maternity entitlements to women in both organized and unorganised sectors, the government of India launched a **new scheme for pregnant and lactating women** called the "Indira Gandhi Matritva Sahyog Yojana (IGMSY)" - Conditional Maternity Benefit (CMB) with an aim to **improve the health and nutrition status of pregnant and lactating women as well as to create opportunities for engagement of pregnant women** with Anganwadi centres (AWC) to ensure nutrition and health education counselling, growth monitoring and promotion of optimal infant and young child feeding practices. Women are entitled for **cash benefits of Rs.4000** in three instalments per women between the second trimesters till the child attains the age of 6 months to partly compensate for wage loss to women during pregnancy and lactation. All Government (Central and State) employees will be excluded from the scheme as they are entitled for paid maternity leave.
- According to the latest National Food Security Ordinance 2013, **every pregnant and lactating mother is entitled to a free meal at the local anganwadi** (during pregnancy and six months after child birth) as well as **maternity benefits of Rs 6,000**, in instalments.

1) The International Code of Marketing of Breastmilk Substitutes

Evidence clearly shows that a great majority of women can breastfeed and will do so if they have the accurate and full information and support, as called for by the Convention on the Rights of the Child. However**, direct industry influence** through advertisements, information packs and contact with sales representatives, as well as indirect influence through the public health system, submerge women with **incorrect, partial and biased information**.

The International Code of Marketing of Breastmilk Substitutes (the Code) was adopted by the World Health Assembly in 1981. It is a **minimum global standard** aiming to protect appropriate infant and young child feeding by requiring States to regulate the marketing activities of enterprises producing and distributing breastmilk substitutes in order to avoid misinformation and undue pressure on parents to use such products when not strictly necessary. Even if many countries have adopted at least some provisions of the Code in national legislation, the implementation and enforcement are suboptimal, and violations persist.

India has been successful in implementing the *Infant Milk Substitute, Feeding bottles and infant foods (regulation of production, supply and distribution) Act, 1992 Amendment Act 2003 (IMS Act)* as a follow-up to the International Code. It has been able to effectively curtail the promotion by the baby food industry through electronic and print media. It has also been able to ban sponsorships by the industry to medical professionals, but there are still loopholes and doctors are being lured by the baby food industry to support their activities. Thus, **effective enforcement of the IMS Act is required** through **effective monitoring mechanisms** at state and district level.

The government of India has taken note of this action and has issued communications to governments in States and Union Territories to appraise them about violations of IMS Act. Haryana state health department and Haryana Food and Drug Administration raised the premises of a wholesale distributor of Nestle infant milk substitute food products against labelling of their product violating the IMS Act.

Despite being well versed with the IMS Act and its regulations, the **infant food companies are openly challenging and breaking the law.** The campaign "*Nestle Does a Greenwash!!"* comes while the company is facing a criminal trial in a court in Delhi for violating the IMS Act. The matter was taken note by the MWCD and refused participation in a promotional event of Nestle.[8]

All these violations have been documented BPNI Bulletin No 36 October 2012 "Dark Clouds and a Silver Lining!!"[9]

Monitoring of these laws:

The IMS Act is unique. **BPNI and ACASH are notified in the Gazette of India** and have been **assigned a role to monitor the compliance of the Act** along with two more semi government organizations. The major role of BPNI was being defined as a special advocate for sound infant feeding policies. [10]

2) Baby Friendly Hospital Initiative (BFHI) and training of health workers

Lack of support to breastfeeding by the health care system and its health care professionals further increase difficulties in adopting optimal breastfeeding practices.

The Baby-Friendly Hospital Initiative (BFHI), which consists in the implementation by hospitals of the 'Ten steps for successful breastfeeding', is a key initiative to ensure breastfeeding support within the health care system. However, as UNICEF support to this initiative has diminished in many countries, the **implementation of BFHI has significantly slowed down**. Revitalization of BFHI and expanding the Initiative's application to include maternity, neonatal and child health services and community-based support for lactating women and caregivers of young children represents an appropriate action to address the challenge of adequate support.

[8] www.**bpni**.org/**Nestle-Does-a-GREENWASH**.html*).*

[9] http://www.bpni.org/bulletin/Bulletin_36.pdf)

[10] http://www.wcd.nic.in/cw/GOI3.pdf

BFHI was **launched in 1993**. There have been weak attempts to revive it, but without any concrete action or understanding of how it will really be implemented. Assessments of 2005 or 2008 have used the same data that existed then. **No concrete action has been taken to revive it**. There is **inadequate or absence of skill training of the staff** of the health facility. There is **no regular monitoring** system and sustainability in place.

As there is some interest on having breastfeeding interventions implemented, this requires a serious thinking and planning in order to provide support to women while they deliver in the health facilities. There is **concern over the increasing institutional deliveries without adequate space, or staff or infrastructure** and exclusive breastfeeding for the first six months, even the initiation of breastfeeding within one hour of birth has not shown same kind of rise since then.

The Ministry of Health & Family Welfare, Government of India and State Governments should take **effective steps to revive the much fading off initiative** as improved IYCF interventions are becoming more relevant as institutional deliveries are on the rise.

3) HIV and infant feeding

The HIV virus can be passed from mother to the infant though pregnancy, delivery and breastfeeding.

The ***2010 WHO Guidelines on HIV and infant feeding***[11] call on national authorities to recommend, based on the AFASS12 assessment of their national situation, **either breastfeeding while providing antiretroviral medicines** (ARVs) **or avoidance of all breastfeeding**. The Guidelines explain that these new recommendations do not remove a mother's right to decide regarding infant feeding and are fully consistent with respecting individual human rights.

There are national guidelines on HIV and infant feeding, but they have not yet been made into policy. There is increasing need for intensive counselling on infant feeding practices as there is increased evidence on dangers of mixed feeding in transmission of HIV to the baby. The woman needs not just information but skilled and most important continuous support in following the option chosen for infant feeding. There is an **urgent need to upgrade skills of counsellors and health workers in infant feeding options**, and to strengthen implementation of the IMS Act and its monitoring. Some of the guidelines available are as follows:

- National Aids Control Organization 2013. National Guidelines for Prevention of Parent-to-Child Transmission (PPTCT) of HIV. Ministry of Health and Family Welfare. Government of India.
- National Aids Control Organization 2012. Nutrition Guidelines for HIV-Exposed and infected children (0-14 years of age). Ministry of Health and Family Welfare. Government of India 2012.
- IBFAN Asia Position Statement on HIV and Infant Feeding 2012[13]

[11] *2010 WHO Guidelines on HIV and infant feeding*: http://whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf
[12] Affordable, feasible, acceptable, sustainable and safe (AFASS)
[13] www.**ibfanasia**.org/**HIV/Position-Statement-HIV**-IYCF.pdf

4) Government measures to promote and support breastfeeding

Adopted in 2002, the ***Global Strategy for Infant and Young Child Feeding*** defines 9 operational targets:

1. Appoint a **national breastfeeding coordinator** with appropriate authority, and establish a multisectoral **national breastfeeding committee** composed of representatives from relevant government departments, non-governmental organisations, and health professional associations.

2. Ensure that every facility providing maternity services fully practises all the **"Ten steps to successful breastfeeding"** set out in the WHO/UNICEF statement on breastfeeding and maternity services.

3. Give effect to the principles and aim of the **International Code of Marketing of Breastmilk Substitutes** and **subsequent relevant Health Assembly** resolutions in their entirety.

4. Enact imaginative **legislation protecting the breastfeeding rights of working women** and establish means for its enforcement.

5. Develop, implement, monitor and evaluate a com**prehensive policy on infant and young child feeding**, in the context of national policies and programmes for nutrition, child and reproductive health, and poverty reduction.

6. Ensure that the health and other relevant sectors **protect, promote and support** exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to the support they require – in the family, community and workplace – to achieve this goal.

7. Promote timely, adequate, safe and appropriate **complementary feeding with continued breastfeeding**.

8. Provide guidance on feeding infants and young **children in exceptionally difficult circumstances**, and on the related support required by mothers, families and other caregivers.

- Consider what **new legislation or other suitable measures may be required**, as part of a comprehensive policy on infant and young child feeding, to give effect to the principles and aim of the International Code of Marketing of Breastmilk Substitutes and to subsequent relevant Health Assembly resolutions.

The Parliament of India, while enacting the Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992 (IMS Act), clearly expressed its concerns about the fact that **promotion of breastmilk substitutes is more pervasive than promotion of breastfeeding**, and thus contributes to **decline in breastfeeding**. The Parliament referred to it as a **dangerous trend that leads to disease and malnutrition** among children. Baby food industry created a huge market for the 'infant formula' as an alternative to breastfeeding, using all kinds of pervasive promotion techniques to woo parents including undermining women's confidence in breastfeeding. Moreover, work places are not very friendly to breastfeeding. This led to **proliferation of formula feeding** when corporations misused health systems and even contributed to separation of mothers and babies.

Actions taken so far have been ad–hoc, piecemeal and limited to imparting some information to women or families and matters related to support to women at work places, access to skilled counseling, coordinated

approaches, and education on breastfeeding have long been neglected. Protection of this endangered practice from the commercial baby food manufacturers has to be fully ensured in order to improve breastfeeding rates.

The Integrated Child Development Services, Kishori Shakti Yojana and Nutrition Programme of the MWCD for Adolescent Girls have provisions for improving nutrition, health and development of children, including adolescent girls. These programmes also aim to promote awareness on health, hygiene, nutrition and family care.

Recently, **MWCD has strengthened and restructured the Integrated Child Development Services** (ICDS) and the implementation of the ICDS scheme in the mission mode. Wherein under the mission mode the programme would ensure holistic - physical, psychosocial, cognitive and emotional - development of young children less than 6 years of age in a nurturing, protective, child friendly and gender sensitive family, community, programme and policy environments. **The infant and young child feeding promotion and counseling has been included as a service.**

The findings of the India assessment on Policy and Programmes 2012, conducted by Breastfeeding Promotion Network of India (BPNI) utilizing **World Breastfeeding Trends Initiative** (WBT*i*) tool, are detailed in Annex 1.

Courses on breastfeeding:

Based on the courses given by WHO/UNICEF[14], **BPNI/IBFAN Asia developed in 2004-2005 the programme "Infant and Young Child Feeding Counselling – a training course"**, a "3-in-1" integrated course on breastfeeding, complementary feeding and Infant Feeding & HIV. In 2012, with the availability of the WHO growth monitoring material issued in 2011, BPNI/IBFAN Asia updated its training programme to an integrated "4-in-1" course on breastfeeding, complementary feeding, Infant Feeding & HIV and growth monitoring, calling it the **"4-in-1" training programme - Capacity building initiative for health/nutrition workers**.

BPNI training course has been field tested by National Institute of Public Cooperation and Child Development and has conducted trainings at all level and developed Master Trainers, Middle Level Trainers and build capacity of Front Line Workers.

Numbers of people trained by BPNI so far:

TRAINED PROFESSIONALS	NUMBER
National Trainers	149
IYCF Counselling Specialist	536
Middle Level Trainers	1256
Frontline Workers	13780

[14] Breastfeeding Counselling: a training course (1993), HIV and Infant Feeding Counselling: a training course (2000), Complementary Feeding Counselling: a training course (2001)

5) Recommendations on breastfeeding by the Committee on the Rights of the Child

The **Convention on the Rights of the Child** has placed breastfeeding high on the human rights agenda. Article 24[15] mentions specifically the importance of breastfeeding as part of the child's right to the highest attainable standard of health. Better breastfeeding and complementary feeding practices, the right to information for mothers and parents, the protection of parents by aggressive marketing of breastmilk substitute products – through the implementation of and compliance with the International Code of Marketing of Breastmilk Substitutes (WHO/UNICEF, 1981) - as well as the need for strong and universal maternity protection are now systematically discussed during State parties reviews by the CRC Committee.

India was last reviewed by the CRC Committee in May-June 2014. However, the Concluding Observations have not yet been issued.

In its concluding observations following the previous review done in 2004, the CRC Committee recommended the government of India to *"ensure access for all children to primary, free and quality health services…; combat malnutrition;* ***promote health nutrition habits, including breastfeeding****; improve immunisation uptake and increase access to safe drinking water and adequate sanitation; strengthen measures to prevent mother-to-child transmission inter alia by combining it with activities to reduce maternal mortality…."*

Progress in this area includes:

- The Government of India undertook several measures to provide assistance to parents and legal guardians in their child rearing responsibilities.
- Until 2005, the Ministry of Women & Child Development (MWCD) was implementing two schemes, namely 'Assistance to Voluntary Organisations for Crèches for the Children of Working and Ailing Women' with provisions of sleeping and day-care facilities, supplementary nutrition, medicines and contingencies, as well as monitoring of crèches and the 'National Crèche Fund' to provide assistance for opening of new crèches and converting existing AWCs into Anganwadi-cum-Crèche Centres.
- In 2006, both of the above mentioned Schemes were merged into *Rajiv Gandhi National Crèche Scheme (RGNCS) for Children of Working Mothers*, launched on January 1, 2006. The RGNCS provides for improved services and enhanced financial norms, besides increasing the number of crèches in the country.

[15] *"States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: […] (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents."* Art 24.2 (e), CRC

ANNEX 1

INDICATORS	GAPS
National Policy, Programme and Coordination	• Lack of written national policy on IYCF/breastfeeding • National Guideline on IYCF do not have clear plan with objectives • Lack of budget line • National Breastfeeding Committee does not meet regularly
Baby-Friendly Hospital Initiative (BFHI) (Health Care Support to Breastfeeding mothers)	• No concrete action to revive BFHI (to improve health care support to breastfeeding mothers) • Inadequate or absence of skill training of the staff of the health facility • No regular monitoring system in place • No sustainable system in place
Implementation of the International Code of Marketing of Breastmilk Substitutes [16]	• Continued violations and inadequate mechanism to enforce IMS Act • Lack of a stringent system for reporting violations at state and district level • Lack of knowledge of officials in monitoring the implementation of IMS Act • Lack of awareness and poor knowledge about the provisions of the IMS Act
Maternity Protection	• Six month maternity leave does not cover all states, only the central government employees • The national legislation does not cover women working in private and informal sector • Inadequate protection for women in informal /unorganised and agriculture sectors • Lack of paternity leaves in public /private sectors which need to be expanded • No legislation, providing health protection for pregnant and breastfeeding workers
Health and Nutrition Care System	• Inadequate IYCF curricula • Inadequate guidelines for mother-friendly childbirth procedures and support • Listening and counselling skills for IYCF are not a part of the pre service or in service training of health workers like AWW, ANM and ASHA • Inadequate information to health and nutrition workers about IMS

[16] Implemented in India through the *Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992* (IMS Act)

INDICATORS	GAPS
	Act • Inadequate information about HIV/ AIDS
Mother support and Community Outreach	• Inadequate community based support system and services on infant and young child feeding (IYCF) practice • Counselling for IYCF is not provided as a service to lactating women in National Rural Health Mission or ICDS • Poor national coverage for IYCF support services • Inadequate training of community workers in IYCF counselling
Information Support	• Lack of national information, education and communication (IEC) Strategy for improving IYCF practices • Inadequate coverage, restricted only during the World Breastfeeding Week (WBW) • Inadequate counselling and group education services • Lack of local consistent and intensified IEC
HIV and Infant Feeding	• National guidelines not yet made into policy • Need to upgrade skills of counsellors and health workers in infant feeding options, and to strengthen implementation of the IMS Act and its monitoring. • Lack of training on counselling practices (PPCT) in HIV and impact upon breastfeeding. • Inadequate VCCT (Voluntary and Confidential Counselling and Testing) • Inadequate counselling to HIV women regarding infant nutrition • Follow-up of mothers not adequate. • No special efforts for creating awareness to counter misinformation on HIV • Lack of monitoring system to prevent HIV transmission through breastfeeding on infant feeding practices
Infant feeding during emergencies	• There is no policy on infant feeding in emergency contingency action plan • No persons have appointed to coordinate national and international donor agencies on IYCF. • No monitoring / document use of infant milk substitute and support to breastfeeding during disasters/ emergencies • There is no mechanism to monitor violations of IMS Act during relief operations • There is no pre-service and in-service training for disaster management on IYCF or provision of breastfeeding support counsellors as a response during disaster management supply

INDICATORS	GAPS
	chain.
Monitoring and evaluation	• Inadequate monitoring and evaluation programme activities related to IYCF • Need to improve MIS system and reporting to decision makers and programme managers • Huge gap between the National surveys • NNMB does not include IYCF indicators under its Nutritional surveillance

About the International Baby Food Action Network (IBFAN)

IBFAN is a 35-year old coalition of more than 250 not-for-profit non-governmental organizations in more than 160 developing and industrialized nations. The network works for better child health and nutrition through the protection, promotion and support of breastfeeding and the elimination of irresponsible marketing of breastmilk substitutes. IBFAN is committed to the Global Strategy on Infant and Young Child Feeding (2002) – and thus to assisting governments in implementation of the International Code of Marketing of Breastmilk Substitutes (International Code) and relevant resolutions of the World Health Assembly (WHA) to the fullest extent, and to ensuring that corporations are held accountable for Code violations. In 1998, IBFAN received the Right Livelihood Award "for its committed and effective campaigning for the rights of mothers to choose to breastfeed their babies, in the full knowledge of the health benefits of breastmilk, and free from commercial pressure and misinformation with which companies promote breastmilk substitutes".