Insight

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Feed babies when they are born

As Indian policy makers fumble, Bangladesh and Sri Lanka zoom ahead

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The attention of the world is on India. The global community is trying to motivate our country into achieving the UN's Millennium Development Goals (MDGs). Recently, Bill Gates met Anbumani Ramadoss, Union minister for health, and donated $24.3 million, not for a new IT Park, but to prevent infant mortality.

Among the MDG's eight goals, the fourth one is to reduce child morality by two-thirds by 2015. India contributes to nearly 25 percent of global child deaths. If we miss this target, the world will miss it too.

According to the Government of India's (GoI) current estimates, the Infant Mortality Rate (IMR) is about 63 per thousand live births. India aims to reduce this figure to 30 per thousand live births by 2010.

A second important Objective of the United Nation's MDGs is to reduce by half the number of underweight children below the age of five. According to a Planning Commission official, who was speaking at a UN meeting on MDGs about a year ago, India is doing well in six out of eight MDGs. But we are struggling to meet the two MDGs of child mortality and under-nutrition. Something must be seriously wrong. India is trying hard to find solutions through its health and nutrition sectors.

In this article we examine India's report card on survival and development, and analyse the current programme with a critique of the forward-looking mid-term appraisal of the 10th Five Year Plan. Finally, we suggest key recommendations to achieve a better deal for India's little children.

Preventing children's deaths: the evidence: In the year 2003, , *The Lancet* published a child survival series, which showed that at least one proven and practical intervention is available for preventing or treating each main cause of death among children younger than five. If all these interventions were universally available, something like 63 per cent of child deaths would be prevented.

In other words, the interventions needed to reduce child mortality by two-thirds by 2015 are available. But these are not being delivered to the mothers and children who need them. *The Lancet* group did an exercise to determine how many children could be saved from death if the current coverage level of interventions were increased to universal coverage. According to this analysis, breastfeeding was identified as the single most effective preventive intervention, which could prevent 13 per cent to 16 per cent of all childhood deaths. Adequate complementary feeding between six months to 24 months could prevent an additional six per cent of deaths. Other interventions, if scaled up can also reduce child deaths; For example, measles vaccine, one percent newborn temperature management, two percent Vitamin A , one percent clean delivery , safe water and sanitation and 15 percent oral rehydration therapy.

India's abysmal report card: With a population of over 1 billion people, India has the highest number of under-five deaths in the world. Globally, a whopping 10.9 million children under the age of five die annually. Four million die in their first month. About 2.42 million (roughly one quarter) of these deaths are in India alone. And

two thirds of these deaths occur in the first year and are related to inappropriate feeding practices.

The IMR indicates the quality of health care we provide to our babies. It is the most important indicator of a country's social and economic progress. According to the UNICEF's Progress for Children- September 2004, a report card on child survival, India is lagging behind and must accelerate its annual rate of reduction of child deaths from two percent to over six percent to meet the fourth MDG.Worse, the children who survive do not develop their full potential. According to the NFHS-2 (National Family Health Survey) of India, undernutrition among children is at its highest. Forty seven percent of children under the age of three are underweight. Of the estimated 75 million survivors below the age of three, about 36 million are underweight. This has profound negative consequences on the physical and mental health of children and hence of Indian society.

The National Guidelines on Infant and Young Child Feeding clearly point out that malnutrition among children occurs almost entirely during the first two years of life and is virtually irreversible after that. According to the NFHS-2, malnutrition in children sets in below six months and peaks around 18 months, after which it plateaus.

Nutrition during the first years of life is critical for early child development because almost all brain growth takes place during this period. In the long run, healthier adults contribute to greater economic productivity. Child malnutrition impairs the cognitive development, intelligence, strength, energy and productivity of a nation. When malnutrition strikes during the first two years, it disturbs the foundation of life and development.

"Malnutrition has been responsible, directly or indirectly, for 60 percent of the 10.9 million deaths annually among children under five. Well over two-thirds of these deaths, which are often associated with inappropriate feeding practices, occur during the first year of life," according to the WHO/UNICEF's Global Strategy for Infant and Young Child Feeding.

But in India only 20 percent of infants, six months old, are exclusively breastfed. Just 33 percent get adequate complementary feeding at 6-9 months.

Our obligations to children: The Convention on the Rights of the Child and other human rights instruments place an obligation on all parties to enable mothers, families and other caregivers make informed decisions about optimal infant and young child feeding – exclusive breastfeeding for six months, and introduction of appropriate complementary feeding while continuing breastfeeding for two years or longer.

Skilled, practical and emotional support should be provided to mothers so that they can achieve the highest attainable standard of health and development for their infants and young children. The National Plan of Action on Nutrition 1995 in its objectives clearly includes this activity. It's stated objective is to ensure that 'healthcare providers receive high quality training in breastfeeding and appropriate complementary feeding practices, lactation management etc. using updated training materials and right techniques….".

The Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 (IMS Act) was enacted with the same objectives-- to save infants from malnutrition and death. The Act considers artificial feeding to have dangerous consequences.

India is not prepared: Are we worried enough? The Prime Minister in his list of 46 thrust areas included formulating a Children's Charter, and a National Plan of Action for Children.

The National Rural Health Mission (NRHM) was also started. The health minister stated that the nation would see the result of these efforts in three years time. We may get better centres and more health workers. But the point is: how many infant deaths will get reduced? Who will be accountable for these deaths since more than half are preventable, according to current evidence?

Boosting ASHA at the MCH: The Tenth Plan Mid Term Appraisal (MTA) says: "…if we cannot meet the social and health targets that include infant mortality and under-nutrition among children, MDGs are not likely to be achieved. With the current pace of progress, it appears unlikely that many of the targets will be met. The solution to these issues lies in institutional structures through which public intervention in these areas operates…."

The 10th Plan has state specific goals for exclusive breastfeeding and complementary feeding. But these are yet to be realised. So hopes are being placed on the 11th Plan. If we cannot tackle the problem of infant nutrition on a war footing, it will be very difficult to reduce child mortality.

The NRHM and RCH II have just taken off. The proposal to restructure the health delivery system and involve Panchayati Raj Institutions (PRIs) is a good one. The 30 percent increase in finance each year is also welcome. Strengthening institutions as well as maternity and child health (MCH) clinics and having a new health worker, ASHA, who will be responsible for home visits is also good strategy.

A functioning MCH clinic at block level is definitely critical. Apart from dealing with risks related to labour, the clinic should examine risks associated with artificial feeding of infants.

The MCH clinics can serve as referral breastfeeding support centres manned by a trained woman worker. Training inputs are important to enhance the skills of all health workers so that they can provide breastfeeding counselling and lactation management. An additional benefit is that a trained health worker will be able to counsel and handle prevention of transmission of HIV from the mother via breastfeeding.

When a mother tells a health workers " I don't have enough milk', she needs confidence building steps to boost her supply of milk and not advice to opt forartificial milk. .According to our experience at BPNI (Breastfeeding Promotion Network of India) such a mother needs a week's training.

These efforts should be complemented by ASHA, a female worker who will be expected to lead community action. ASHA needs skill training too as her duties include breastfeeding counselling. She will also visit households where babies are born during the first few days. NACO has included about 17 hours of breastfeeding education in its new training course for counsellors. The course material was developed in partnership with BPNI and UNICEF. Perhaps the ministry of health can also provide similar training material for

health workers.

In fact the RCH II or NRHM should offer a universal "neonatal integrated package" as has been recommended by the Millennium Task Force. The course should include clean delivery, neonatal resuscitation, prevention of hypothermia, and breastfeeding education.

But health workers and people engaged in making policy must understand what breastfeeding education is. It is different from 'providing information'. For example, currently the NRHM is promoting exclusive breastfeeding through the electronic media. But this is only 'imparting information'. 'Breastfeeding education' should be imparted by a trained worker to a lactating mother in her home. It requires one to one interaction.

In the 1980s, Brazil launched a media campaign, which led to a large number of women getting interested in breastfeeding. When these women faced problems in breastfeeding they approached health workers. But the health workers could not help them to solve these problems. Cynthia Green, a researcher who analysed 10 years of Latin America's campaign on breastfeeding, concluded that an information campaign should not be launched before health workers are trained.

The NRHM must immediately ensure that skilled help is available to breastfeeding mothers. The WHO, UNICEF and BPNI in India have done enough work on breastfeeding management. NRHM should ensure universal training of its health workers in breastfeeding and lactation management.

The NRHM should also find out the impact of this recently launched media campaign.

The benefits of enhancing exclusive breastfeeding are many. There is sufficient evidence to show that it reduces diarrhoea, pneumonia and newborn infections— three major killers of babies. If we can wipe out the deficits of exclusive breastfeeding in India, infant deaths can be cut by 19-20 percent.

Additionally, better child health will reduce the need for health interventions that come later, like IMNCI, (Integrated Management of Neonatal and Childhood Illnesses) which the Government of India plans to launch in one fourth of districts. Universal preventive interventions will provide a perfect continuum of care from the maternal to the infancy period with a focus on the newborn. ANMs (auxiliary nurse midwife) nurses, doctors should be trained on infant and young child feeding practices before they begin active service. This is fundamental to the health outcome of infants.

Smart kids from the ICDS: A restructuring of the ICDS (Integrated Child Development Scheme) is on the cards. The intention is to universalise the ICDS and have more *anganwadi* centres along with day care facilities. More money will be given for food. Supplementary food distribution remains a focus area for the ICDS.

Why have we forgotten why the ICDS was started? Its aim was holistic: the development of women and children with a special focus on children up to two years old. Having more *anganwadi* centres may not ensure this aim. The ICDS must reposition itself to provide nourished and healthy children.

Child malnutrition should be prevented. According to Shanti Ghosh, "The ICDS programme was expected to prevent the incidence of severe malnutrition of the kind that has been reported in some parts of the country. However, after 30 years of operation, the ICDS is yet to have an impact on the poor nutritional status of children. The ICDS has to be converted into a true health, nutrition and development programme, and not limited to a food dole programme."

We need to drastically change our mindset about the outcome of the ICDS. Is it 'food' that is required or 'feeding'? Can we think of a paradigm shift in thinking? Can the objective of the ICDS be "smart kids"?

This can only be ensured through optimal infant nutrition provided by optimal infant feeding practices particularly exclusive breastfeeding for the first six months. Only about 20 percent of India's infants are exclusively breastfed till they reach six months. While we talk of universalising the ICDS, can we link another sentence with it? Universalise exclusive breastfeeding for the first six months. In addition to a better deal for children, this step can motivate women to use services better as it builds trust.

The ICDS should launch an Infant and Young Child Feeding Counselling service to educate mothers on health and nutrition. This area has been found to be the most neglected in several studies and evaluations. So, having breastfeeding support centres in the ICDS centres run by properly trained and skilled women can achieve the objective of reducing child deaths.

Such a service will support women who are facing problems while breastfeeding, like not having enough milk, and build their confidence. The service will position breastfeeding as a visible strategy and complement what NRHM is trying to do through the electronic media.

Trained health workers can also mobilise community opinion towards exclusive breastfeeding. They can refer more serious problems to MCH clinics proposed in the RCH. Currently training of workers is inadequate to make them skilled counsellors. Unfortunately this does not figure in the 26 days of training given to AWWs (*anganwadi* workers). Why can't we look at the curriculum and put in what is required for infant health and development?

Unfortunately the children who get supplementary nutrition are already suffering from irreversible damage as malnutrition sets in between three and 18 months. Studies have shown that it is not lack of food but lack of proper feeding which is the main culprit. Reaching 1.4 million habitations is important. Ensuring universal optimal infant and young child feeding helps even when you can't reach people with 'food'.

Having day care centres is a good idea. But the proposal completely misses 0-6 month babies, as if they do not exist in India. Or it assumes that they are all just fine. It may be a better idea to convert day care centres into breastfeeding support centres. These can provide the support envisaged in day care centres.

A ROAD MAP FOR THE FUTURE

Ensure food security for the tiny infant: There is a misconception among policy makers that breastfeeding is not a problem in India. We are a breastfeeding nation, it is believed. There are other bigger barriers we need to cross. In the last budget, the finance minister, P Chidambaran's speech focused on supplementary nutrition. If the finance minister and the Prime Minister understood where the solutions lie, outlays will be provided for 'smart kids'.

The emphasis on food security by economists, political leaders, advisors, consultants, judges, civil servants, health and development managers, UN agencies, reproductive health and nutrition departments, is alright.

But it misses the tiny infants right to food. This right is ensured if mothers are helped to succeed in exclusive breastfeeding for the first six months and they continue breastfeeding for two years or beyond along with adequate complementary feeding.

Breastfeeding should be recognised as an'input' in discussions on food security. It requires many steps to ensure optimal practice. Another mission for women and children is being proposed, but why is the Prime Minister, Manmohan Singh, silent on the National Nutrition Mission? Its objective was to review our nutrition strategies and it was launched through a gazette notification on 31 July 2003. Could it be that he does not know about it?

Route money for breastfeeding: In order to increase exclusive breastfeeding and complementary feeding rates, it is important to identify and budget sufficient resources so that activities listed in the National Guidelines on Infant and Young Child Feeding are fully implemented.

Also the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 (IMS Act) should be enforced. Unfortunately the Tenth Plan notes that this intervention does not require addition resources. One can agree it is a cost-effective intervention, but it surely requires some money.

Certainly women need help and support. Accurate information about infant feeding, counselling during pregnancy, assistance at birth, support immediately after birth for six months to breastfeed exclusively, skilled help to solve problems if they do arise are some of the measures needed. Studies have revealed that 13 percent of women face problems during breastfeeding. These are preventable. If unresolved these problems encourage women to opt for artificial feeding.

Monitor child health at village level: To be effective at village and district level, monitoring of a baby's health should include indicators such as the health of the baby when he/she is born and for the next six months.

Exclusive breastfeeding for the first six months should serve as a key proxy indicator. The government can introduce colour-coded village child health and development cards. Green could signify good progress, yellow, mediocre progress and red, poor progress. These could even spark a community movement.

Every village can prominently display these cards. It would depict what progress the village has made. Block and district magistrate can review the progress made and hold health workers accountable. Political parties should include this performance in their area representative reports. The government should judge the health of states on what percentage of villages get green, yellow or red cards. Villagers could be proud of green cards. There could be competition among villagers.

Demand clear outputs on child health: The health system should deliver more infants surviving and the department of Women and Child Development (WCD) should allow them to develop to their fullest potential

Can we also think of one leadership for child health and development?

This step will solve the ongoing demand year after year for better coordination both at policy and the grassroots between these two departments.

Meet national and international goals: For achieving the MDGs on 'poverty and hunger' and 'child mortality', we must meet our national goals on optimal infant and young child feeding. This is important not only because we are committed to the MDGs or the goals set by the 10th Plan, but because it is the way forward to optimal human development of our society.

We are in 2006. There is severe danger that these goals will not be met as we have made little progress. It is important that we take this more seriously and remain focused. We need to try and do things differently and get away from the current mindset of 'treating child undernutrition' by doling out 'food' to older children.

Instead we should try to prevent child under nutrition by ensuring optimal infant feeding.

Not only will this strategy contribute to both the MDGs, it will also help fulfil children's rights to health, survival, development, protection and participation.

What will it take to reduce child malnutrition by half and child mortality by two-thirds by 2015? We must carry out the existing nutrition and health package for infants to ensure their survival and for those who do survive, their optimal development. Even if we are not able to significantly reduce the proportion of underweight babies as stipulated, there is a possibility that we can enhance their development.

This national target is achievable even in a short time span of three to five years. But it requires political will, money and an efficient health care service. Since improving infant feeding provides an opportunity to provide a continuum of care from pregnancy to birth and beyond, it can help build trust with families and provide a head start to improving health care systems. Repositioning of the ICDS can result in behaviour change at household level. Health systems must mainstream breastfeeding, similar to immunisation, so that services become baby friendly and guarantee infant survival.

India should compete: A study in Bangladesh demonstrated that by increasing exclusive breastfeeding from 39 to 70 percent, infant mortality dropped by 32 percent. Can we think of such steps? Bangladesh and Sri Lanka are moving ahead on MDG-4, will India like to compete or lag behind? India is touching new economic heights and it would be a shame if we did not forge ahead in reducing infant mortality. If we don't then the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992 (IMS Act) as amended in 2003, and the National Guidelines on Infant and Young Child Feeding will lose their intent.

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