Reaching the Under 2s

Universalising Delivery of Nutrition Interventions in District Lalitpur, Uttar Pradesh

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Editor

Prof. K.P. Kushwaha

Department of Paediatrics
B. R. D. Medical College
Gorakhpur-273013
Uttar Pradesh, India

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PUBLISHED BY

Dr. K.P. Kushwaha
Project Director, BFCHI-Lalitpur
Professor and Head, Dept. of Paediatrics
B. R. D. Medical College,
Gorakhpur-273013, Uttar Pradesh, India
Email- komal.kushwaha@gmail.com

बाबू सिंह कुशवाहा
मंत्री
अवस्थापना विकास,
भूतत्व एवं खनिकर्म
सहकारिता, परिवार कल्याण तथा
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दिनांक : .....

संदेश

मुझे यह जानकर अत्यन्त प्रसन्नता हो रही है कि जनपद–ललितपुर में नवम्बर–2006 से शिशु आहार और पोषण जैसे महत्वपूर्ण विषय पर माताओं और बच्चों को सहायता देने के लिए बाबा राघवदास मेडिकल कालेज, गोरखपुर के बाल रोग विभाग द्वारा योजना चलाई गई, जिसकी उपलब्धियों की रिपोर्ट यहॉ प्रस्तुत की जा रही है। यह परियोजना यूनिसेफ और प्रदेश सरकार के सम्मिलित प्रयास से संचालित की गई है। रिपोर्ट से स्पष्ट है कि स्तनपान एवं शिशु आहार सहायता से ललितपुर के लगभग 70 हजार माताओं एवं बच्चों को लाभ पहुॅचा है। उक्त जनपद में जन्म के प्रथम घंटे में स्तनपान शुरू करने वाली माताओं की संख्या में वृद्धि एवं नवजातकों को 06 माह तक सिर्फ अपना दूध पिलाने वाली माताओं की संख्या बढ़ी है। अब दो तिहाई से अधिक 06 माह से बड़े बच्चे मॉ के दूध के साथ–साथ ऊपरी आहार लेने लगे हैं। ललितपुर में सहरिया और कबूतरा जैसे कुछ ऐसे वर्ग के लोग, जो बहुत पिछड़े और गरीब हैं, उन्हें भी इस योजना से आशातीत् लाभ मिला है।

ऐसा प्रतीत होता है कि सिर्फ शिशु आहार को बढ़ावा देने मात्र से ही ललितपुर जैसे सीमांत और पिछड़े जिले के शिशुओं के स्वास्थ्य में अत्यंत सुधार हुआ है। मैं उम्मीद करता हूॅ कि यह योजना प्रदेश के अन्य जिलों में भी चलाई जायेगी।

योजना की सफलता हेतु कामना करता हूॅ।

(बाबू सिंह कुशवाहा)

श्री के0पी0 कुशवाहा,
आचार्य एवं विभागाध्यक्ष,
परियोजना निदेशक,
बाल रोग विभाग,
बी0आर0डी0मेडिकल कालेज,
गोरखपुर।

—शुभकामना संदेश—

मुझे यह जानकर अत्यधिक प्रसन्नता की अनुभूति हो रही है कि उ0प्र0 के ललितपुर जनपद में यूनीसेफ लखनऊ और बी0आर0डी0मेडिकल कालेज, गोरखपुर के बाल रोग विभाग द्वारा जिला प्रशासन के सहयोग से **''बेबी फ्रेन्डली हेल्थ इनिसिएटिव परियोजना''** को सफलतापूर्वक चलाकर अच्छे परिणाम प्राप्त हुए हैं । इस कार्यक्रम के माध्यम से शिशु स्वास्थ्य में आशातीत सुधार एवं शिशु मृत्यु दर में अत्यधिक कमी आयी है । निश्चित रूप से यह परिणाम हमारे स्वस्थ समाज का मार्गदर्शक साबित होगा ।

ललितपुर से प्राप्त आशातीत उपलब्धियों को जन–जन तक पहुचानें के उद्देश्य से **बी0एफ0एच0आई0** परियोजना के एक **'प्रगति विवरणिका'** का प्रकाशन किया जाना प्रशंसनीय एवं सराहनीय है । आशा है कि इसका लाभ समाज के विभिन्न वर्ग के लोग उठा सकेगें बल्कि चिकित्सकों, स्वास्थ्य कर्मियों एवं समाज सेवियों में इस प्रकार के रचनात्मक कार्य में जुड़नें की लालसा होगी ।

ललितपुर जिले से प्राप्त अच्छे सुसज्जित **'प्रगति विवरणिका'** के सफल प्रकाशन हेतु अपनी हार्दिक शुभकामना देता हूँ ।

शुभकामनाओं सहित ।

(रणवीर प्रसाद)
I.A.S.
जिलाधिकारी,
ललितपुर ।

जिला कार्यक्रम प्रबन्धन इकाई,राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

ललितपुर,उ0प्र0।

संदेश

छः माह तक केवल स्तनपान की अवधारणा को मूर्त रूप प्रदान करने में बी0आर0डी0 मेडिकल कालेज गोरखपुर द्वारा संचालित बी0एफ0एच0आई0 प्रोजेक्ट के माध्यम से जनपद–ललितपुर के अन्तर्गत जिस तरीके से चरण बद्ध ढग से कार्य को अन्जाम दिया गया एवं आशातीत सफलता को प्राप्त किया गया उसके लिए सभी बी0एफ0एच0आई0 परिवार बधाई के पात्र है।

जनपद–ललितपुर जो अत्यन्त पिछडा व सुविधा वंचित क्षेत्र है में समुदाय के मध्य अभी और कार्य करने की आवश्यकता है। इन्ही शुभकामनाओं के साथ–

भवदीय

आर.के.करवरिया
जिला कार्यक्रम प्रबन्धन इकाई
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
ललितपुर,उ0प्र0।

संदेश

बाल रोग विभाग बी0आर0डी0 मेडिकल कालेज गोरखपुर द्वारा संचालित तथा यूनिसेफ लखनऊ एवं जिला प्रशासन ललितपुर के सहयोग से चलायी जा रही परियोजना ने विगत वर्षों से अच्छे परिणाम प्राप्त किये है। फलस्वरूप जनपद में शिशु मृत्युदर तथा कुपोषण में कमी आयी, परियोजना द्वारा सम्पादित अनेक गतिविधियों में मैंने प्रतिभाग किया है। परियोजना द्वारा किये जा रहे कार्य सराहनीय है।

परियोजना द्वारा प्राप्त उपलब्धियों को जन जन तक पहुचानें के उद्देश्य से **प्रगति विवरणिका** का प्रकाशन प्रशंसनीय है। **प्रगति विवरणिका** के सफल प्रकाशन हेतु में BFCHI परिवार को हार्दिक शुभकामना देता हूँ।

शुभकामनाओं सहित

17/7/10

बुद्धिराम
मुख्य विकास अधिकारी
ललितपुर उ0प्र0

मुख्य चिकित्साधिकारी कर्यालय ललितपुर

संदेश

बाल रोग विभाग बी0आर0डी0 मेडिकल कालेज गोरखपुर द्वारा संचालित एवं यूनीसेफ लखनऊ तथा जिला प्रशासन ललितपुर के सहयोग से चलायी जा रही परियोजना ने सफलता पूर्वक अच्छे परिणाम प्राप्त किये है। इस कार्यकम के माध्यम से शिशु स्वास्थ्य तथा कुपोषण मे आशातीत कमी आयी है। निश्चित रूप से परियोजना द्वारा प्राप्त सफलता स्वास्थ्य समाज के लिये अनुकरणीय है।

परियोजना द्वारा प्राप्त उपलब्धियों को जन–जन तक पहुचाने के उदेश्य से, प्रगति विवरिण का प्रकाशन किया जाना प्रशंसनीय एवं सराहनीय है।

मै पत्रिका के सफल प्रकाशन एवं सफलता हेतु अपनी हार्दिक शुभकामनाये देता हूँ।

शुभकामनाओं सहित

डा0आर0के0 निरंजन
मुख्य चिकित्साधिकारी
ललितपुर उ0प्र0

(संदेश)

बी0आर0डी0 मेडिकल कालेज गोरखपुर द्वारा यूनीसेफ की सहायता से संचालित परियोजना बी0एफ0सी0एच0आई0 द्वारा आई0सी0डी0एस0 के समस्त आंगनबाड़ी केन्द्रों पर माता समूहों का गठन कर स्तनपान एवम् अनुपूरक आहार विषयक सलाह प्रदान की जा रही है।

जिससे जनपद ललितपुर में छः माह तक केवल स्तनपान/जन्म के एक घंटे के भीतर स्तनपान कराने वाली महिलाओं का प्रतिशत बड़ा है एवम् कुपोषण रोके जाने में सहायक सि : हुई है।

मेरे द्वारा स्वयं परियोजना के जिला समन्वयक श्री प्रवीण दुबे एवम् मानीटरों तथा सुपरवाइजो के साथ भ्रमण किया एवम् उनके कार्यों की समय–समय पर समीक्षा की गयी है।

निः संदेह संस्था का कार्य उत्तम है, मैं संस्था के उज्जवल भविष्य की कामना करता हूँ।

परियोजना द्वारा प्राप्त उपलब्धियों को जन–जन तक पहुंचाने के उददेश्य से प्रगति विवरणी का प्रकाशन किया जाना प्रसन्नता का विषय है।

मैं पत्रिका के समान प्रकाशन एवम् संस्था की निरन्तर प्रगति हेतु शुभकामनाएं देता हूँ।

शुभकामनाओं सहित

16/7/2010

(प्रदीप कुमार)
जिला कार्यक्रम अधिकारी,
आई0सी0डी0एस0
ललितपुर।

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On top of the people to thank is Mrs. Margaret Narayan, the then programme officer (ECD), Unicef Field Office, Lucknow who gave shape to my experience during 2006 when she agreed to put a project on community level implementation of breastfeeding and infant and young child feeding (IYCF) counselling. Firstly, she managed to organise two hours sensitisation lecture at Lalitpur district headquarter for doctors and administrative officers. Dr. M.M.A. Faridi and Dr. B.B. Gupta, both the national trainers of the Breastfeeding Promotion Network of India(BPNI) for IYCF, delivered these lectures. This event opened the door of this district for the project entitled 'Baby Friendly Community Health Initiative' (BFCHI), which was later supported by Unicef Field Office, Lucknow. Mrs. Narayan took the responsibility of getting no-objection from health and ICDS departments in Lalitpur.

I am especially indebted to Mr. S.N. Tripathi (PCS), District Magistrate of Lalitpur in 2007, who influenced me most at the initial days and made our work easier in coordinating the activities. And bundle of appreciation for the present District Magistrate , Shri Ranvir Parsad (IAS), who has envisioned this as a useful project to be sustained in the district.

My sincere thanks are due to Sri Budhiram, CDO, Dr. Balkishan, CMO, Sri SN Tiwari, DDO and Sri Pradeep Kumar, DPO; they have been also very helpful. The CDPOs and supervisors of all blocks were very supportive. All the Dy. CMOs, doctors, nurses, ANMs and LHVs working at District Hospital and at PHCs have helped us tremendously.

With a deep sense of gratitude I wish to thank Dr. R.K. Niranjan, CMO, who is taking very keen interest in breastfeeding counselling work which is reducing the burden of sick children needing hospitalization.

The other national and state level trainers of BPNI who are involved in this project; Dr. Ajay Gaur (Gwalior), Dr. Azra Ahmed (Aligarh), Miss Dimple Save (Bhopal), Mrs. Nisha Jain (Bhopal), Dr. S. Srivastava (Lucknow), Dr. AP Shahi (Gorakhpur), Dr. VM Bhatia (Gorakhpur), and Dr. (Mrs) Kiran Kushwaha (Gorakhpur). I am very thankful to them all for rendering wholehearted support.

Dr. (Smt.) Gayatri Singh, programme officer, nutrition, Unicef Field Office, Lucknow, has been very meticulous in continuation of this community level counselling project. She deserves my very special gratitude for realising the continuity of this work.

I was helped by Mr. BK Nayak, Head Master and leader, Primary Teachers Unions, Lalitpur, Mr. S. D. Tiwari, President, Adharshila Seva Samiti (NGO), Lalitpur and Mr. Sunil Jain Vice-President, Adharshila Seva Samiti (NGO), Lalitpur in identifying the two groups of block level mentors / counsellors cum trainers.

I would be failing in my duty if I don't acknowledge the role played by all the middle level trainers and village level mother support group members who made every effort that yielded success . They were, and are the pillar of success and my hat is off to them.

I would like to appreciate the role played by Dr. Arun Gupta, Regional Coordinator, International Baby Food Action Network (IBFAN), Asia, who has been a source of inspiration to my team to boost their moral and interest.

Dr. JP Dadhich, national coordinator of BPNI played a crucial role during the project in analyzing its findings and writing this report, I applaud his role. Many thanks to Dr. Y.P. Gupta, also, who is the director, Y.G. Consultants &

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Mr. Praveen Dubey, the project coordinator worked from district to household level in networking, supervising and monitoring this project. He was the central pillar of our work, and still is, I am indebted for his contribution. I may have missed some people, I express my sincere gratitude to all the noble persons who have been involved in making this success visible.

K.P. Kushwaha
Project Director, BFCHI
Professor and Head, Dept. of Paediatrics,
B. R. D. Medical College,
Gorakhpur-273013, Uttar Pradesh, India
Email- komal.kushwaha@gmail.com

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ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BCC	Behavior Change Communication
BFCHI	Baby Friendly Community Health Initiative
BPNI	Breastfeeding Promotion Network of India
CDO	Chief Development Officer
CDPO	Child Development Project Officer
CHAI	Catholic Health Association of India
CHC	Community Health Centre
DLHS	District Level Household Survey
DM	District Magistrate
DPO	District Programme Officer
FGD	Focus Group Discussions
HIV	Human Immunodeficiency Virus
IBFAN	International Baby Food Action Network
ICDS	Integrated Child Development Services
IYCF	Infant and Young Child Feeding
KMC	Kangaroo Mother Care
LHV	Lady Health Visitor
MSG	Mother Support Group
NFHS	National Family Health Survey
NGO	Non Governmental Organization
NRHM	National Rural Health Mission
PHC	Primary Health Centre
PRI	Panchayati Raj Institute
SC	Sub-Centre
SD	Standard Deviation Unit
SRS	Sample Registration System
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
UP	Uttar Pradesh
WHO	World Health Organization

PREFACE

India implements the *National Guidelines on Infant and Young Child Feeding* and the *Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act 1992,* and the *Amendment Act 2003*, (IMS Act) with the sole objective of protection and promotion of breastfeeding in order to improve the state of the child' health and nutrition, combat malnutrition and save children from deaths.

It is with this very intent that India has taken so many actions in its existing programmes like ICDS, RCH and NRHM run by two ministries. The State governments have been striving hard to implement these programmes and achievements are un- even, looking at the review of outcomes. Most notably, it's the infant and neonatal mortality that India is still struggling to reduce rapidly and meet the desired Millennium Development Goal 4 on child mortality. For this purpose, the global scientific community and the 'Countdown to 2015', have recognized that there is a need to universalise the reach of 8 postnatal interventions on a priority; three among them concern infant feeding.

Given the evidence we have, that early and exclusive breastfeeding for the first six months can contribute substantially to enhance child survival, and good complementary feeding can contribute to reduction in stunting, it becomes imperative that action on early nutrition must be taken.

Unfortunately, except initiation of breastfeeding, that too very slowly, no other feeding indicators have shown a rise in India over the past two decades. This is because Government of India and the States governments have implemented the National Guidelines on Infant and Young Child Feeding or the IMS Act in part, and that too on a an ad-hoc basis.

This project BFCHI, led by a medical college team in U.P., provides useful model with additional human resources that shows how to implement the national guidelines in its entirety. Not only the project has demonstrated to set up a delivery mechanism for early nutrition interventions, it has shown a reach of 80-90 %, to pregnant and lactating women for education of breastfeeding and complementary feeding.

And it has given a hope to bring a rise to breastfeeding and complementary feeding indicators. Substantial improvements are possible in four indicators related to infant feeding, namely, pre-lacteal feeding, early initiation of breastfeeding within one hour of birth, exclusive breastfeeding for the first six months, and complementary feeding plus breastfeeding at 6-9 month, is possible in just over two years.

The model provides a platform for research and advocacy for other states to scale up nutrition interventions.

There are several lessons that can be learnt from here, while the nation wants to tag a priority to Under 2s. Early nutrition interventions make a perfect entry point to universalise the reach. Having said that, there is additional need to truly integrate Infant and Young Child Feeding (IYCF) into existing programmes both at technical and managerial level. Lalitpur shows the way to go, from lip service to serious action.

Dr. Arun Gupta, MD, FIAP,
Regional Coordinator, International Baby Food Action Network (IBFAN) Asia.
Member, Prime Minister's Council on India's Nutrition Challenges
Member, Steering Committee, World Alliance for Breastfeeding Action (WABA)

Executive Summary

Introduction

This is the report of an ongoing project in District Lalitpur reaching out to under- 2s in a population of one million having more than 30,000 annual births, establishing a system of universal reach with infant feeding counselling, improved supervision, convergence, and resultant change in feeding behaviours.

Why the Project?

Child nutrition is closely linked to child mortality, morbidity and malnutrition. In the backdrop of a state having very high infant mortality and high levels of under-nutrition in children, very low rates of optimal breastfeeding practices, and poor health care indicators for children, it becomes critical to plan for improvement of feeding behaviours in order to enhance child nutrition, survival, development and growth. There has so far, been no feasible and operational model of the size that could be taken to scale and be sustainable. To bridge this gap, a project titled 'Baby Friendly Community Health Initiative' (BFCHI) was conceptualised at end of 2006, and implemented in the whole district of Lalitpur, U.P. The project is led by the Department of Paediatrics, B.R.D. Medical College, Gorakhpur, in collaboration with the district administration, Lalitpur, Government of Uttar Pradesh and UNICEF (U.P), and is still continuing.

What and When?

The project, which was initiated in the year 2006 is firmly in place now. The intervention utilized community-based as well as facility-based strategy for promotion of optimal IYCF practices through skilled counselling, better supervision and monitoring with the aim of reaching out to all pregnant and lactating women, to contribute to the nutrition and health status of their children Under 2.

How was it done?

A baseline pre-intervention evaluation was done to document feeding practices. The implementation mechanisms included building the capacity of whole district in providing infant feeding counselling at family level with a support system at block and district level. This was achieved through having in place additional human resources, 48 local graduate women “mentors” - eight in each of the six blocks, who were trained as trainers using a 7-day training course, the '3 in 1' Infant and Young Child Feeding Counselling: A training programme, (Integrated breastfeeding, complementary feeding and infant feeding & HIV counselling) developed by the Breastfeeding Promotion Network of India (BPNI). The 7-day training provided them with the knowledge and skills of counselling on feeding practices as well as training skills to train village level counsellors. They provided support at block and district level counselling centres. Some of them also acted as block supervisors. The mentors trained a team of 3-4 ‘village level counsellors’ from among Anganwadi workers, ASHA, Dai (Traditional Birth Attendant) or a link mother from the same village - who formed a 'mother support group' (MSG); they did home visiting, and facility based counselling to provide education to mothers and families on breastfeeding and complementary feeding. They used the 'counselling guides' received along with their training, for the purpose of counselling mothers. They also used IEC materials like pamphlets, posters etc. The village level counsellors helped and supported mothers with feeding difficulties, and referred them to block level counselling centres if they were not able to solve any problems.

These mentors trained over 3330 village level counsellors using a 3-day BPNI training package on IYCF. The team from the medical college Gorakhpur led the project, trained the mentors and helped establish supervision processes at district and block levels. During the project a small honorarium of INR 3000 per month was paid to block level mentors. Post-intervention evaluation was done in 2007, 2008 and 2009.

What did it lead to?

Quantitative

The pre intervention (2006) and post intervention (2007) evaluation showed significant improvement in four feeding practices, namely, reduction in prelacteal feeding from 44.4% to 28.3%, increase in initiation of breastfeeding within one hour of birth from 39.2% to 57.9%, exclusive breastfeeding for the first six months from 6.85% to 24.9%, and introduction of complementary foods along with continued breastfeeding between 6-9 months from 4.6% to 35.8%. The independent evaluation in 2008 recorded further improvement in the feeding practices in which

initiation of breastfeeding within one hour went up to 72%, exclusive breastfeeding for first 6 months to 50% and complementary feeding along with continued breastfeeding between 6 to 9 months went up to 85%. Use of prelacteal feeds decreased to 15%.

Qualitative

Qualitative evaluations in 2008 and 2009 through interviews and Focus Group Discussions (FGDs) revealed that the village level counsellors were visiting homes of pregnant/lactating mothers and providing education for exclusive breastfeeding, supporting mothers with feeding difficulties and advising them for complementary feeding by holding meetings/personal contacts etc. Mentors and village level counsellors were found to be supportive and enjoyed good rapport with in the community. The project reach was nearly universal, as 84-90 percent mothers reported having received advice on various infant feeding practices by AWWs (63-67 percent), ASHAs (16-21 percent), and Dais (5-16 percent). Thus, the project has created a favourable atmosphere for continuation of such activities, with the provision of counselling firmly in place. This means the project reached more than 25000 women each year on breastfeeding and complementary feeding education, which is crucial to save babies and improve nutrition status. These evaluations confirmed the findings of improvement in breastfeeding and complementary feeding practices. In contrast to earlier practices, people now used different complementary foods like home cooked *dal* (lentils*), roti* (bread*)*, rice, *sattu* (bengal grams floor with sugar and water), khichdi (rice and lentil mix), boiled patato, banana, *kheer* (rice and milk porridge), *dalia* (wheat porridge), and vegetables etc.

This project has demonstrated real convergence at village level and heightened motivation of workers to prevent malnutrition and morbidity associated with it in infants and young children. Currently, the number of mentors has reduced down by one third because of financial constraints. Lessons learnt clearly reveal that there is a need for better coordination amongst the village counsellors as well between them and the block mentors.

What are the conclusions?

Establishing a system of nearly universal reach with infant and young child feeding counselling is feasible in a short time of 2-3 years, at the scale of a district having population of 1 million and more than 30,000 annual births. This is possible through additional human resources and good quality training and supervision. The project reveals that women can be identified and trained locally. They can do home visits with some incentives. It is evident that real convergence between the two key functionaries of the ICDS and NRHM is possible. This model provides a way for reaching the Under 2s, through a focus on infant and young child feeding counselling. It seems entirely possible to make use of medical colleges for capacity building of the mentors. There is a need to improve coordination among the workers, at village level and between village and block level, which could be done through appointing a dedicated village nutrition counsellor. Additional nutrition counsellor at the village level will also help increase the intensity of worker to family ratio, which is the key to improve child health and nutrition.

What are the recommendations?

Following are the recommendations to policy makers:

1. Create additional human resource for nutrition education at district/block level and at a cluster of 5-10 villages, who are especially trained to look after infant and young child feeding and nutrition. They can serve as trainers and mentors for the village level counsellors and provide supervision, referral support as well as manage counselling centres at this level.
2. Appoint an additional nutrition worker/counsellor at village level who could coordinate creation of mother support groups and focus on nutrition counselling and education for the under 2.
3. Develop institutional capacity in the medical colleges at state level to provide leadership, impart training to the mentors, follow up and establish supervision. They should also include the curriculum of infant and young child feeding into basic education of nurses and doctors.
4. Adopt the 3-day training curriculum of IYCF used in this model for training of all frontline workers, both in ICDS and NRHM. This should also be put in pre-service modules. Adopt the 7-day training curriculum used in this project for training of mentors at the supervisory level.
5. 'Infant and Young Child Feeding Counselling' should be recognised as a specific "service" under the ICDS and NRHM. This should be linked to the roll out of new WHO growth standards.
6. Create a 'budgetary support' line item for the above activities as mid course correction, leading to 12th five year plan.
7. Conduct orientation on IYCF and nutrition of other key personnel like district health and WCD officials, district administrators, PRIs, NGOs, private medical personnel to create a facilitating environment.

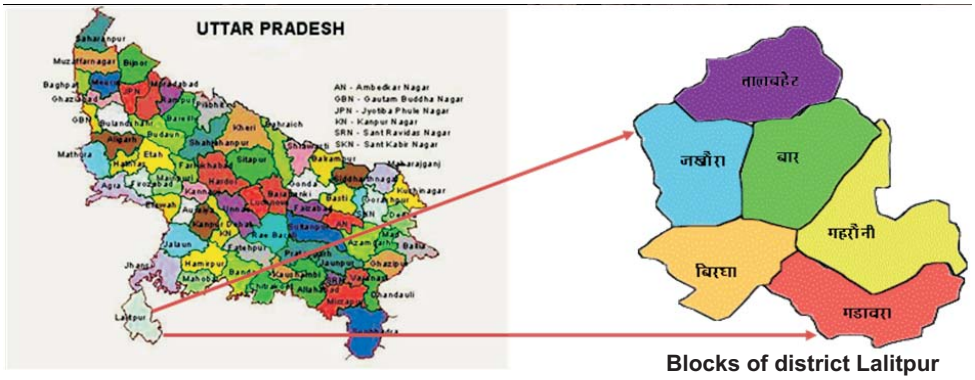
INTRODUCTION

It is a scientifically established fact that optimal infant and young child feeding practices, which include early initiation of breastfeeding within one hour after birth, exclusive breastfeeding for the first six months and continued breastfeeding for two years or beyond along with adequate and appropriate complementary feeding starting after six months, provide ideal nutrition to infants and young children. Therefore, optimal infant and young child feeding practices are central to children's survival, growth and development. Field experience demonstrates that rapid improvements can be made in breastfeeding through skilled counselling supports to the families at the community-level. There is a unique global and national consensus to reach out to under 2s because this being a critical window of opportunity to address the nutrition and child survival issues. India's resolve to improve infant and young child feeding (IYCF) practices is reflected in the national guidelines on IYCF (2006).

In spite of adequate scientific evidence in favour of optimal infant and young child feeding practices, a large population of infants and young children in our country is deprived of the optimal benefits of correct infant and young child feeding practices. This fact is also true for the state of Uttar Pradesh and the district of Lalitpur in the state of Uttar Pradesh. The NFHS-3 (2005-06) data revealed that in Uttar Pradesh 7% infants were breastfed within one hour of birth, 51.3% were exclusively breastfed below 6 months and the median duration of exclusive breastfeeding was only 2.4 months. Among children 6-23 months 35% were fed appropriate number of food groups. Uttar Pradesh had an infant mortality rate of 72.7 per 1000 live births (NFHS-3).

Keeping these facts in view, an intervention project titled "the Baby Friendly Community Health Initiative (BFCHI)" was conceptualised, planned and implemented by the Department of Paediatrics, B.R.D. Medical College, Gorakhpur, U.P. in collaboration with the district administration of Lalitpur and UNICEF (U.P). The work began in the year 2006, and is still on.

The BFCHI project uniquely utilised local human resources and existing health and nutrition infrastructure who were adequately equipped to



Blocks of district Lalitpur

bring counselling services and related skill support to families with pregnant women with children between 0 -24 months. The project relied on supervision and monitoring, mentoring, creation of family level network of infant and young child feeding counselling persons and reaching out to all pregnant & lactating women with counselling on breastfeeding & complementary feeding.

This preliminary report is an attempt to highlight the results of this community-based intervention, which may provide direction to the national nutrition and health programmes in India for scaling up in other parts of the country.

This report is also to invite researchers to study the feeding patterns, health and nutritional outcomes of infants and young children and impact on other health seeking behaviours.

Objectives of the Project

The overall objective of the project was to test a district-based model for promoting optimal infant and young child feeding practices with the view of its scaling up through the ICDS and NRHM programmes. This in turn would contribute to improve the nutritional status of children 0-2 years.

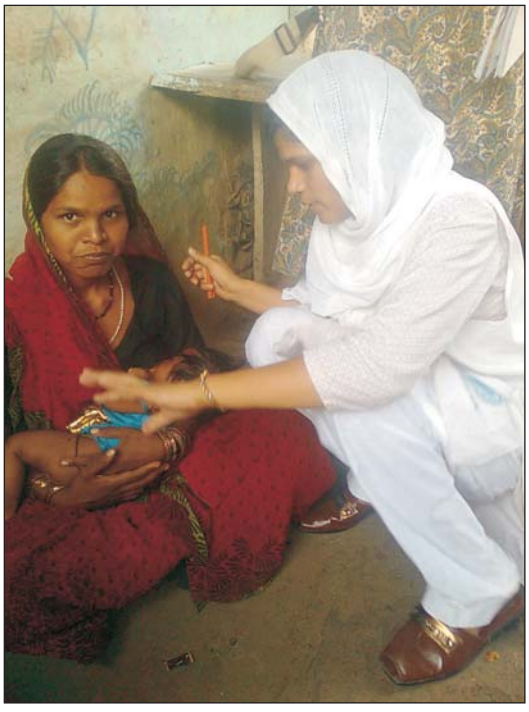
PROJECT STRATEGY

Two major strategies were adopted for the project including a community based and a facility-based strategy for ensuring optimal IYCF practices with the participation of families. The implementation mechanisms included providing infant feeding counselling at village, block and district level; administrative meetings of stakeholders at sector and district level; project review meetings; linkages with ICDS, health and village volunteers and strengthening of immunization programme.

Community-based strategy

The community-based strategy focused on providing counselling support at the village level starting from antenatal period through birth and upto 2 years. This required building an army of skilled nutrition counsellors at every village backed by a mentoring/support on nutrition counselling at a cluster of 6-8 villages.

Under this strategy, three women, one AWW, one ASHA and one helper of AWW or TBA or an active mother from village formed a mother support group (MSG). They served the major role of registering mothers during pregnancy, providing antenatal education, support to breastfeeding at birth in case of home delivery and thereafter guide and give skilled support to mothers and babies for optimal feeding practices at house hold level. Each member from the mother support group was responsible for 10-15 households and promotion of IYCF practices and utilization of ICDS and health services. They also sensitized the other community groups like Balbandhus, Self Help Groups, CHAI and



other Community Based Organizations.

Facility -based strategy

Focus of the facility-based strategy was on the availability of counselling services at PHCs, CHCs and District Hospital.

At the facility level specially trained mentors who acted is lactation counsellors complemented the existing nursing staff to provide counselling support to mothers delivering at the health facility and to all sick babies requiring feeding support. The counsellors helped mothers with breastfeeding difficulties through one to one and sometimes group counselling and skill support. They also gave advise on complementary feeding to mothers after 6 months of breastfeeding period. These mentors conducted training of MSGs, NGOs and health personal at block and district level. They also had regular field visits in the villages allotted to them on fixed days.

Institution providing leadership

The BRD Medical College was to play a role in arranging and organizing trainings, supervision, monitoring and also a facilitating role with the objective of building the capacity of the government departments i.e. ICDS and Health to effectively manage the BFCHI project.

ACTIVITIES

Conceptualisation and planning

After conducting a rapid assessment of infant and young child feeding practices initially in 3 of the 6 blocks of the district, a project on baby friendly community health initiative was submitted to UNICEF for support. Once the project was approved for financial support, implementation process started as described below.

Pre-intervention evaluation of IYCF practices (November-2006)

A baseline evaluation of infant and young child feeding practices in the selected sample population was done. Details of the survey process are given in the results section.

One day orientation of health officers, doctors and district administrators at district head quarter

An interdepartmental meeting at the district headquarter was convened to develop consensus on the goal, purpose, objectives, expected results of the plan of action. During the meeting two national trainers on infant and young child feeding from Breastfeeding Promotion Network of India (BPNI) delivered lectures on breastfeeding and complementary feeding.

Identification and capacity building of mentors

Forty eight graduate women from 6 blocks of Lalitpur were identified to serve as middle level trainers (MLTs) and mentors for the community level counsellors. Twenty four of them were trained during 22nd to 28th Jan, 2007 and another 24 from 5th to 11th July, 2007 at Department of Pediatrics, BRD Medical College, Gorakhpur by 4 national and state trainers using the 6 days IBFAN Asia/BPNI's 3 in 1 training modules*. One day on the essential newborn care.

Training of village level counsellors (MSGs)

These Middle Level trainers in turn trained Anganwadi workers, helpers, ASHAs (ICDS & Health frontline functionaries) and dais (traditional birth attendants) in the district on a three day training plan (IBFAN/BPNI's '3 in 1' training modules). These trainings were monitored by the team of experts from BRD medical college and UNICEF. A total of 3339 women were thus trained. They have been able to set up more than 1000 Mothers Support Groups in 951 ICDS villages. In addition in 2009-10, 96 mother support groups in 'Shariya' communities, and 66 mother support groups in 'Poorvas' (Majras) have been established where ICDS services have not reached and ASHAs is also not posted.

* Infant and Young Child feeding Counselling: A training course- The 3 in 1 course (Integrated breastfeeding, complementary feeding and infant feeding & HIV counselling)'

Training of 1800 MSGs from 600 villages was conduted between March, 2007 to September, 2007. The mothers support groups after training started counseling activities in community. Thus during October, 2007 600 villages has trained workers for infant and young child feeding counselling & support. During 2009 June, 1053 family counsellors (MSGs) from 351 left over villages. ICDS and urban ICDS centres were also similarly trained and deputed in their areas for counselling.

Village level counsellors were trained at block level.

Formation of mother support groups

The trained team of AWWs, dais and link mothers formed a team of three female workers in each village to promote and support optimal infant and young child feeding. At least one member from the mother support group was available 24 hours for counselling and providing practical help to mothers in need. They arranged meetings with pregnant and lactating mothers once in a week (Saturday) at the center. During these meetings they provided education on infant and young child feeding and help and support mothers with feeding difficulties. In the case they failed, they would refer the mothers to the block level counselling centers or the district level centers. Each member of MSG received a token amount of Rs. 50 per month (Rs. 150 for 3 workers in each village per month) for their services.

Box-1

Counselling visits by the MSG members

Each pregnancy was recorded as early as possible and initial information about breastfeeding was provided

Home delivery attended by one of the MSG member (or visited within 1 hour), and breastfeeding support provided

MSG member visits the lactating mother on 3rd, 6th, 15th, 30th, 90th and 180th day and in between anytime when needed to provide support for breastfeeding, growth monitoring etc.

Providing counselling services

In Box-1 you can see how the counsellors followed up with pregnant and lactating women to provide counselling services.

Orientation of other stakeholders

To sensitize and to upgrade the knowledge and skills of the functionaries engaged in the mother and child care in the district, orientation programmes for following categories of personnel were organised:

- Health and development officials, doctors (1 day)
- Orientation of ANMs, LHVs, and NGOs (1 day)
- Training of ANMs, LHVs and nurses (3 days)

Annual orientation of village level counsellors

The village level counsellors were oriented once in a year to update their knowledge and skills.

Creating counselling services

- In addition to the setting up of village level counselling, 6 block IYCF centres were established in the block hospital premises, where 2 mentors were available for counselling support for a period of 6 hours each day.

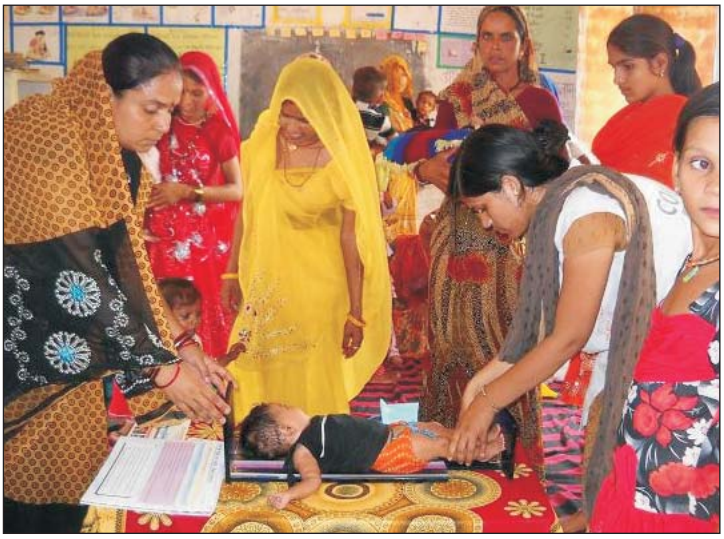
- One referral centre was established in the District Female Hospital to deal with the cases referred from the field. One counsellor was made available in an eight hourly shift.

Community participation

- Two large 'melas' (public fair) were organized with stalls depicting the actual field based actions. Deserving mother support group members were given public recognition. This helped boosting their morale.
- World breastfeeding Week was observed in each village by organizing rallies each year since 2007.
- Mentors delivered lectures during 'Chaupals' in Ambedkar Villages.
- Mentors go and participate in the behavior change in community (BCC) meetings organized by others like 'Balbandhus' and 'CHAI'.
- Mentors also go out to participate in the Government programmes/meetings/Melas at block and district level and give their input.

Paying honorarium to workers

Project Director (1) is paid Rs. 4,500 per month and is based at Gorakhpur. Project coordinator (1) has been paid Rs. 12,000 per month and is based at Gorakhpur. Mentors/block supervisors (18) are paid Rs. 3000 per month (in the earlier years this number was 48 and they were paid Rs. 1000 per month). In addition to this they are paid actual travel expenses.



Data Collection Methods

Pre-intervention evaluation (November 2006)

A survey tool was developed and field tested. Nine surveyors were trained for 1 day in the method of asking questions and completing the survey form. Local male and female field investigators and volunteers of the project were recruited and trained by an expert.

Post-intervention evaluation (December 2007)

This repeat survey was done in 3 blocks in the villages surveyed during baseline survey using similar tools with a sample size of 480 and babies in the similar age groups as in the baseline survey.

Sampling Design

To assess the impact of breastfeeding and complementary feeding practices, cluster sampling and multi-stage sampling design was adopted. At the first stage, *panchayats* were selected from each block using a PPS sampling technique in all the three blocks. At the second stage, mothers who had a child within 0-3 months 3-6, 6-12 & 12-24 months were selected from the sample villages. Standard statistical methods were used to calculate the same size.

Data Collection

Data collection for the baseline evaluation was started in the 2nd week of November, 2006 and was completed by the last week of November, 2006 and second evaluation started in the second week of December, 2007 and was completed by the first week of January of the next year 2008. Data collected by the investigators was scrutinised by the consultant in the field to check consistency and completeness by statistician.

During the survey, information was collected from mothers of infants with zero to three months and three to six months, six to twelve and twelve to twenty four months old. The mothers with zero to three months and three to six months old babies were asked a series of questions relating to initiation of breastfeeding, child behaviour during feeding, problems in initiation and continuation of breastfeeding.

The mothers of infants with six to twelve and twelve to twenty four months old were interviewed for breastfeeding and complementary feeding practices.

Project evaluation by an independent agency (2008)*

Project evaluation by an independent agency (YG Consultants, New Delhi) was done during March-April 2008 in all 6 blocks of District Lalitpur.

The methodology adopted for this evaluation was desk review of the data available in the baseline survey and interaction with the project coordinator, *Anganwadi* workers, *dais* and *ASHAs*, mentors/counsellors, and focus group discussions (FGDs) with mothers and mothers-in-law in select villages of the project area. For interaction/interviews of various personnel, semi-structured questionnaire/check list was used.

A total of 190 mothers with infants of 0-3 months and 190 mothers with infants of 7-9 months were interviewed in 20 villages. The actual sample size achieved and instruments used for data collection are given below:

Sample Achieved

Number of villages	20
Number of mothers with infants of 0-3 months old	193
Number of mothers with infants of 7-9 months old	202
Family level counsellors (AWWs/Dais/Asha)	41
Block level counsellors	6
District level counsellors	2
FGD with mothers/mothers-in-law	9
Project coordinator/assistant project coordinator	1

* http://www.bpni.org/BFHI/Lalitpur-Evaluation-Report-2008.pdf

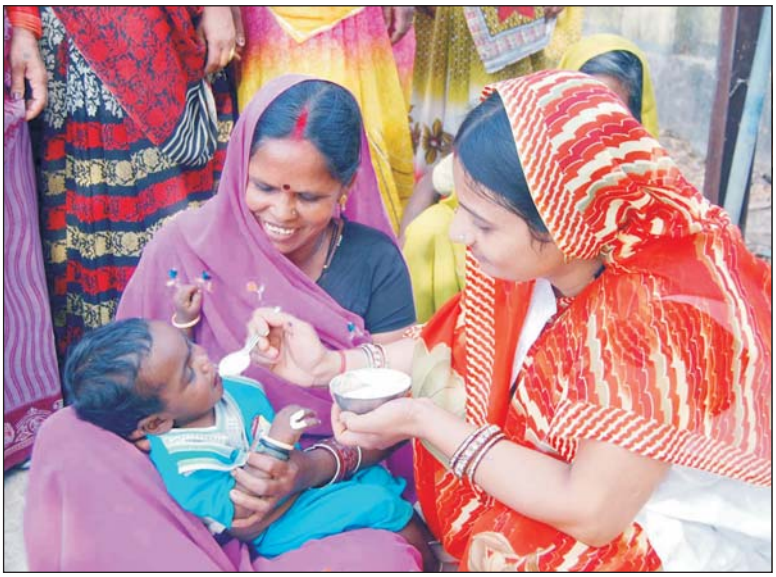
Instruments for Data Collection

The following instruments were used for quantitative and qualitative data collection:

i. Checklist for project coordinator/assistant project coordinator
ii. Checklist for officer in-charge
iii. Interview schedule for mothers with infants of 0-3 months
iv. Interview schedule for mothers with infants of 7-9 months
v. Interview schedule for village level counsellors (AWWs/Dais/Asha)
vi. Interview schedule for mentors/counsellors.
Vii. FGD guidelines

Review of the project by a social researcher (2009)*

A social researcher from Tata Institute of Social Science (TISS), Mumbai, who was doing her internship with the Breastfeeding Promotion network of India (BPNI), undertook a review of the BFHI Project in Lalitpur to seek the role of lactating counsellor in women's life. She visited anganwadi centers and interacted with the families and counsellors in Birdha, Mehroni and Jakhora block of the district. She also visited the primary health centre, the district hospital and met the Chief Medical Officer (CMO, Lalitpur) and the DDO (District dev. Officer, Lalitpur). She conducted a meeting with all the monitors, supervisors and the project co-coordinator for B.F.H.I Project. She also, interviewed women in the above mentioned villages regarding the role of monitors and supervisors in their lives.



* http://www.bpni.org/BFHI/lalitpur-report.pdf

MONITORING AND SUPERVISION

Monitoring and supervision of the project implementation was accomplished by the coordinating team. The whole process comprised of following steps:

- The project coordinator based at Gorakhpur and the block level mentors/counsellors visited the field area as per the planned schedule to supervise and monitor the project area (6 blocks).
- Monthly reports were presented to the project Coordinator, who further submitted the report to the project director.
- Regular review meetings were chaired by the District Magistrate/Chief Development Officer with participation of all departments' heads.
- Joint monitoring was done by DPO and project coordinator in villages and at blocks for 3-6 days in a month.
- CDPOs and block mentors monitored the block level activities (6 days in a month).
- ICDS supervisors and block mentors were also involved in monitoring at village level.

For continued documentation following information was collected and records maintained.

- MSG register: Information about mothers who have been helped and supported.
- Daily progress register was maintained for information from the project coordinator and four block mentors who provided the services of block supervisors also.
- A quarterly report was presented to the UNICEF, Lucknow by the project director.

RESULTS AND OBSERVATIONS

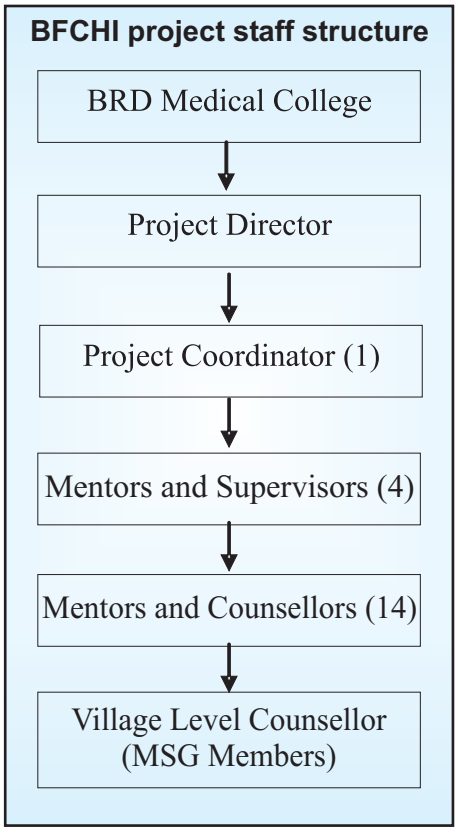
The results and observations of the projects are given below. These include results from pre- and post intervention evaluations; independent evaluation and a field review of the project by a social scientist.

Results of this project have been very encouraging as for as delivery of early nutrition interventions is concerned. It appears that this project has been able to establish a system of providing infant feeding counselling at universal scale. This work has also led to improved feeding behavior from the data available so far. While much of this can be attributed to additional human resources appointed in this project and their quality training, the effect of other ongoing complimentary interventions in the district cannot be undermined.

Functionaries in place

Project director

He is based at Gorakhpur and provides technical guidance, training and direction to the project.



Project coordinator

He is based at Gorakhpur and responsible for overall and coordination and supervision.

Village level counsellors

In the whole district there are 3339 village level counsellors who have been skill trained. These are among AWWs, ASHAs, TBAs. Helpers and active mothers from villages, who have been trained in infant and young child feeding counselling, hand washing, keeping and maintaining babies warm, immunization, identifying sick babies and referral.

Mentors/ block counsellors and trainers

They are 18 mentors, 4 of whom also work as block supervisors. They are two for each block and two for the district centre. During 2007, they were 48 of them but their number has been now brought down due to financial constraints. They have been trained using the 6-day module of 'Middle Level Trainers on IYCF counselling, and one day additional module on essential newborn care.

Home visiting and centre based counselling

All counsellors maintained a dairy of day to day activities, their success and failures and reported it to the block monitors.

A total of six lac fifty five thousand seven hundred twenty one, one to one counselling sessions has been done between 1.1.2008 to 31.6.2010, many mothers required frequent counseling sessions. Counselling was either provided at house, or at the meeting of the MSG networks. Similarly, at the facilities, more than one lac counselling sessions were conducted which included both antenatal and post natal counselling.

Impact on feeding behaviors

Quantitative

The intervention has led to an improvement in the infant feeding indicators. When data obtained from the base line evaluation (Pre-intervention) conducted during the November 2006 was compared with the data obtained from the Second evaluation (Post-

intervention) conducted during the December 2007 it revealed that initiation of breastfeeding within 1 hour of birth has improved from 39.2% to 57.9%, exclusive breastfeeding for 6 months has gone up from 6.8% to 24.9% and complementary feeding along with continued breastfeeding between 6-9 months from 4.6% to 35.8%. Use of prelacteal feeds like water, honey animal milk, tea etc has come down from 44.4% to 28.3%. All these changes are statistically significant. (Table 1 & Fig. 1)

The independent evaluation in 2008 recorded further improvement in the feeding practices in which initiation of breastfeeding within 1 hour of birth has improved to 72.0%, exclusive breastfeeding for 6 months has gone up to 50.0% and complementary feeding along with continued breastfeeding between 6-9 months has gone up to 85.0%. Use of prelacteal feeds like water, honey animal milk, tea etc has come down to 15.0%. (Table 2)

Table 1: Status of infant feeding practices (Pre- and Post- intervention)

Feeding parameter	Base line evaluation (Pre intervention) November 2006	Second evaluation (Post Intervention) December 2007	p value
Prelacteal feeds given	44.4%	28.3%	<0.001
Initiation of breastfeeding within one hour of birth	39.2%	57.9%	<0.001
Exclusive breastfeeding for 6 months	6.85%	24.9%	<0.001
Complementary foods along with continued breastfeeding	4.6%	35.8%	<0.001

Fig. 1: Status of infant feeding practices (Pre- and Post- intervention)

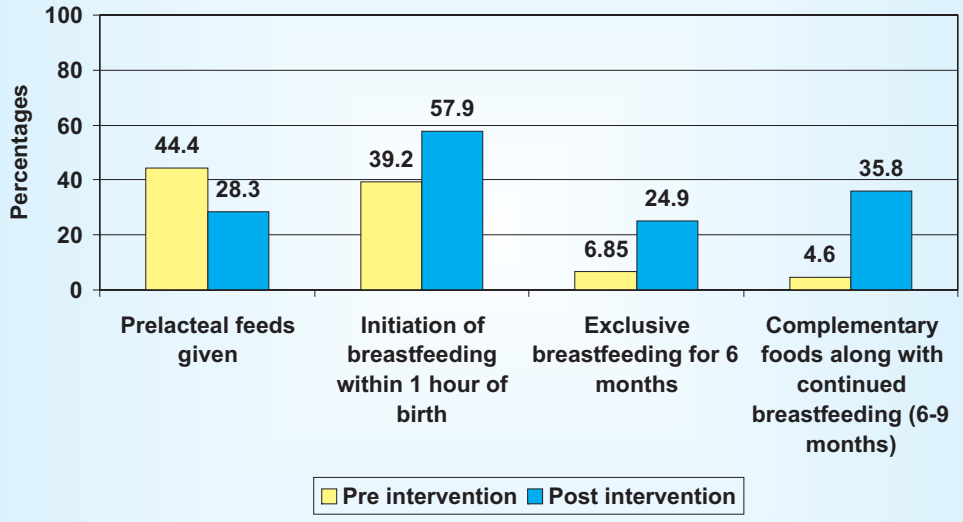


Table 2: Status of infant feeding practices as per the independent evaluation April 2008

Feeding parameter	Status
Prelacteal feeds given	15.0%
Initiation of breastfeeding within one hour of birth	72.0%
Exclusive breastfeeding for 6 months	50.0%
Complementary foods along with continued breastfeeding	85.0%

Qualitative

The April, 2008 evaluation highlights following improvements in relation to universalising the reach:

1. All the counsellors interviewed at district and block level were found providing counselling to pregnant and lactating mothers at their respective places. Besides, they visited field area where they solved problems of frontline workers relating to initiation of breastfeeding, complementary feeding and exclusive breastfeeding.
2. The family level counsellors interviewed at the community level were found visiting homes of pregnant/lactating mothers and providing education for exclusive breastfeeding, supporting mothers with feeding difficulties and advising them for complementary feeding by holding meetings/personal contacts etc.
3. Majority of mothers (85 percent) reported that they were given advice about as to when to start breastfeeding by AWWs (63 percent), Ashas (21 percent), block level counsellors (15 percent) and Dais (11 percent).
4. Nearly 90 percent of the mothers were advised for exclusive breastfeeding for six months. Out of them, 65 percent were advised by AWWs, 16 percent by *Ashas* and six percent by *dais*. Block level counsellors gave advice to 10 percent mothers.
5. Around 84 percent of mothers were told about complementary feeding, of which 67 percent were advised by AWWs, 18 percent by ASHAs and only 5 percent by Dais, while in the case of 18 percent mothers, the advice was imparted by the block level mentors/counsellors.

Improved knowledge of workers and women

In the year 2009, a social researcher with the Breastfeeding promotion Network of India (BPNI) did a field visit to evaluate the project with a specific objective to look into the role of mentors and village counsellors in women's life. She also recorded the voice feed back, transcript of some of them can be read in the section on experience. Some of the highlights from her report are given below.

1. The counsellor follow the strategy of influencing the family members first than the woman regarding exclusive breastfeeding, which has been successful in influencing the values and beliefs of people in villages regarding breastfeeding.
2. Most women breastfed their children in the first hour of birth.
3. Women mostly know about the characteristics of exclusive breastfeeding. Like no water has to be given to the child for 6 months along with any other top feed.
4. Most women know about the illnesses children can get if not exclusively breastfed. eg . pneumonia, diarrhea etc
5. The basic food given to the children in complementary feed after 6 months is home cooked dal, roti (with ghee), rice, sattu (chana flour with water and sugar) , khichdi, boiled patato, banana, kheer, dalia, vegetables and corn grinded with curd and salt. Initially not much emphasis was given on complementary feeding.
6. The mentors/supervisors used their skills well when they teach about correct and incorrect attachment of the baby's mouth at the breast
7. Functionaries have been successful in reaching out to the target group to a significant extent.

Experience Sharing by Project staff and Community Members

प्रदेश में शिशुओं एवम् गर्भवती, महिलाओ को मृत्यु एवं कुपोषण से मुक्ति दिलाने एवं राष्ट्रीय स्वास्थ्य के मानकों को प्राप्त करने में यह महत्वाकाँक्षी योजना जो कि जनपद ललितपुर के सभी आंगनबाड़ी केन्द्रों पर लागू की गई इसमें स्तनपान एवं अनपूरक आहार परामर्श कार्य किया गया। जिससे सुनने को ही नही स्वंय करके देखने को मिला यह जन समुदाय के लिये एक वरदान है। मेरा मानना है कि प्रदेश के हर जनपद में यदि BFCHI परियोजना चलाई जाये तो बाल मृत्यु दर कम करने में यह मील का पत्थर साबित होगी।

आई० एम० ओझा, विकास खण्ड विरधा

To get rid of mortality and malnutrition among the infants, and pregnant women in the states and to achieve national standards; this ambitious plan which was implemented in the anganwadi centres in the district of Lalitpur for breastfeeding and complementary feeding counselling is a blessing for the country. I believe that BFCHI, if implemented in all the districts of the states, will prove to be a milestone in reducing IMR.

(I.M. Ojha, Development Block, Birdha)

हम शुरू से बच्चों के साथ काम करना चाहते थे और समाज के लिये कुछ करना चाहते थे। मुझे सबसे अच्छा लगा कि इस परियोजना में काम करने का मौका मिला पहले मैं समझती थी की स्तनपान में कोई काम ही नही होगा लेकिन बी०आर०डी० मेडिकल कालेज में 7 दिवसीय प्रशिक्षण के दौरान जो जानकारी मिली उसका पालन करके हमने स्तनपान एवं पूरक आहार पर जन–समुदाय में परामर्श दिया जिससे देखने को मिला की बाल मृत्यु एवं कुपोषण कम करने मे यह संजीवनी की तरह काम कर रहा है।

प्रर्मिला झाँ,
विकास खण्ड बिरधा, सुपरवाईजर

We wanted to contribute to the society I am happy that I got an opportunity to work in this project. Earlier I use to think that breastfeeding does not required any intervention but my training in BRD Medical College for 7 days has given me knowledge which I utilize in counselling the community for breastfeeding and complementary feeding. This is resulting in decreasing infant deaths and malnutrition.

(Pramila Jha, Supervisor, Development Block, Birdha)

जब यह परियोजना ललितपुर मे शुरू हुई तब जनवरी 2007 को मेडिकल कालेज मे और मेरी पत्नी ने 7 दिवसीय प्रशिक्षण प्राप्त किया इस प्रशिक्षण को प्राप्त करने के बाद हमारे मन मे इच्छा जागृत हुई कि क्यों नही समाज मे कमजोर असहाय परिवारों के बच्चों की मदद की जाए। इस परियोजना मे जुड कर सबसे पहले इसका प्रयोग अपने बच्चे पर ही देखा। 2007 दिसम्वर मे अपने बच्चे को एक घण्टे के अन्दर ही कोलेट्रम फीड कराई और 6 माह तक केवल मां का ही दूध पिलाया इसके अतिरिक्त इसको कुछ नही दिया और 6 माह बाद अनपूरक पोषाहार शुरू किया । उसी के बाद हमारे चचरे भाई का बच्चा हुआ जो कि मां के दूध के साथ–साथ पानी और ऊपर गाय का दूध पिलाया करते थे। बाद में हमने अपने बच्चे में और भाई के बच्चे में बहुत ज्यादा अन्तर पाया, हमारे भाई का बच्चा हमेश बीमार बना रहता है और हमारा बच्चा स्वस्थ।

राजेन्द्र मालवीय
ब्लाक मानीटर जखौरा

I got training alongwith my wife for 7 days at medical college. After this training we desired to help children of weaker section of the society. After getting connected with this project, we used the skill for our own child. The child received breastfeeding within one hour of birth, was exclusively breastfed for 6 months after which complementary food was started. We also gave the same advise to our cousin brother who use to give his child cow's milk as a supplement. We noticed that our child was healthy while our cousins child was frequently ill.

(Rajinder Malviya, Block Monitor, Jakhora)

बी०एफ०सीएच०आई० परियोजना से मानसिक व व्यावहारिक परिवर्तन हुआ जिसके फलस्वरूप स्वयं अपने परिवार के बच्चों के लिये स्तनपान आहार ही उचित माना। स्वच्छता – टीकाकरण से लाभ हुआ एवं अन्य परिवारों को परामर्श देने से आत्म शान्ति महसूस हुई। परियोजना मां शिशु के सम्बन्धों में मजबूती के लिये कडी के रूप में उभर कर आया जिससे परिवार व समाज में लाभों का परिणाम स्पष्ट नजर आ रहा है। कुरिति, अज्ञानता व रूढिवादिता से हट कर सही मार्ग दिखाई दिया।

एच० डी० पाराशर
स्तनपान एवं अनपुरक आहर

BFCHI project has led to psychological and behavioral changes resulting in practice of breastfeeding in my own family. Counselling to other family have given me peace of mind. The project has resulted in strong bonds between mothers and children leading to benefits to the family and society. This has led to a correct path away from harmful traditional practices and lack of knowledge.

(HD Parashar)

बी०एफ०सी०एच०आई० परियोजना में 3 दिवसीय प्रशिक्षण प्राप्त करने के उपरान्त लगा कि ब्रेस्ट फीडिंग से सम्बंधित काफी सूक्ष्म जानकारियाँ प्राप्त हुई। पूर्व में हमें यह भान था कि हमें ओर कुछ सीखने की आवश्यकता नहीं पर शायद ऐसा नहीं था। वर्तमान में मैं प्राथमिक स्वास्थ्य केन्द्र पर आशा के कार्य के साथ–साथ बी०एफ०एच०आई० काउन्सलर के रुप में भी स्तनपान एवं शिशु आहार परामर्श का कार्य कर रही हूँ। इसके अलावा ग्राम स्तर पर गठित माता समूह के साथ भ्रमण और बैठक का कार्य भी करती हूँ। इस कार्यक्रम से जुड़कर मुझे बेहद खुशी महसूस हो रही है। बिना दवा के किसी महिला को स्तनपान की सही जानकारी देकर उसके बच्चे को पूरा दूध मिल जाना आश्चर्य की बात है।

अन्जना, आशा,
बिरधा, ललितपुर

After getting 3 days training in the BFCHI project I realized that I have received a lot of finer information. Earlier I thought that there is no need to learn anything but this was not correct. Presently I am working as ASHA in the primary health centre and also I am contributing as a BFCHI counsellor. A part from this I travel and have meetings in the mother support group at village level. I am very happy to get connected to this programme. This is really a surprising thing that a woman can provide adequate milk to her baby with correct knowledge without any drug.

(Anjana, ASHA, Birdha)

हम लोग भी ब्रेस्टफीडिंग पर पहले से कार्य कर रहे थे, हम अपने ज्ञान को सम्पूर्ण समझ रहे थे, किन्तु इस प्रशिक्षण के बाद हमें पता चला कि ब्रेस्टफीडिंग के बारे में हमारा ज्ञान कुछ भी नहीं था। प्रशिक्षण में प्राप्त सूक्ष्म तकनीकि जानकारियां निश्चित ही हमारे कार्य क्षेत्र में सहायक सिद्ध हो रही हैं। महिलाये हमें सम्मान से देखती है और शायद एक सही मित्र भी मानती हैं। कुछ महिलायें जिनको पूरा दूध नहीं होता था और परामर्श देने के बाद दूध होने लगा वे हमें भगवान का दर्जा देती हैं। इससे बड़ी उपल्बधि शायद मेरे लिये कुछ भी न हो।

लक्ष्मी आंगनबाड़ी,
मनगुवां, जखौरा, ललितपुर

We were already working for breastfeeding promotion thinking that our knowledge was complete. After this training we understood that our knowledge was incomplete. There are many finer technical information which is helping us know. Women now respect us and consider us is their friend. Some women with perception of inadequate milk are now having adequate milk and consider us as the God. This is the biggest achievement for me.

(Lakshmi, Anganwadi Worker, Manguan, Jakhora, Lalitpur)

Mothers and Mother-in-law

About the practice of giving prelacteal feeds

पहले बुजुर्ग कहते थे कि बच्चे को पानी पिलाओ नही तो सुखा रोग हो जायेगा। पर पानी देने से वो बीमार हो जाते थे। अब जब से हमें counselling में बताया गया है कि पानी देने से नुकसान होता है हम नहीं देते और बच्चे बीमार नहीं होते।

(Earlier, we used to give water to the infant as advised by the elders. Elders used to say that child will get illness if water is not given. Although, the children used to become ill after getting water. Now, we have been counselled not to give water and our children are now healthy.)

About the help given by the counselor of the mother support group

हमारी तो पहली डिलीवरी थी, दीदी नहीं होती तो तो हमें कौन बताता की बच्चे को अपना दूध पिलाना है, छः महीने तक उपर से पानी, खाना, दूध कुछ नहीं देना, अपनी खुराक का ध्यान रखना है, आयरन की गोली खानी है।

(This was my first delivery. Sister helped me to understand the breastfeeding, avoiding other foods/milk/water upto six months of age, taking care of my own diet and consuming the iron tablets.)

About need for the complementary foods

छः महीने के बाद बच्चे की जरूरत बढ़ जाती है, आंगनवाड़ी दीदी ने बताया की बच्चे को थोड़ा खाना देना चाहिए, उससे सेहत ठीक रहती है।

(After six months, child's need increases. Anganwadi worker has told us to give some food which will keep her healthy…….)

ASHA

About the early initiation of breastfeeding

जब हमने डिलीवरी से पहले औरतों को शुरू में ही बताया की जन्म के तुरन्त बाद पहला दूध बच्चे को पिलाना कितना जरूरी है बीमारी से बचाने के लिए, तो वो बोले यहां तो ऐसा रिवाज नहीं है। लेकिन हमारे समझाने से वो मान गये और अपना दूध पैदायश के तुरन्त बाद अपने बच्चे को पिलाने लगे हैं।

(When initially we told the expectant women to initiate the breastfeeding soon after birth, they resisted that this is not the custom here. But later on, after counselling by me, they agreed and now they initiate the breastfeeding soon after the birth.)

About the perceived problem by the lactating mothers

उनको जानकारी नहीं है, वो कहती है दूध पूरा नहीं निकल रहा, कभी कहती है कि बच्चा रो बहुत रहा है, शायद भूखा है और दूध पूरा नहीं पी पा रही है।

(They are lacking in the knowledge. They say that milk is not enough. Sometimes they say that child is crying probably because she/he is hungry and milk is not enough.)

About the change in practices after BFCHI implementation

बहुत बदलाव आया है, बच्चे को मां का ही दूध पिलाते है। एक नवजात लड़की जो कि सवा किलो कि थी, वो अपने आप दूध नहीं पी पा रही थी। उसको मां ने अपना दूध निकाल कर चम्मच से पिलाया और वो बच्चा अब स्वस्थ है।

(There is a tremendous change. They are giving only mother's milk. One newborn girl, whose birth weight was only 1.250 kg, could not suckle herself. So, mother expressed her milk and fed the child with spoon and cup. That girl is now doing well.)

SUCCESSFUL CASE STUDIES

Case Study 1: *Changing attitudes!*

Mehrunnessa was blessed with a daughter. The child was born at home, and now 3½ months old. It was midnight when delivery pain started. Aftab could not take Mehrunnessa to nearby PHC although both husband and wife and other family members were aware that in case delivery takes place at PHC/Hospital mother will get Rs. 1400/- and all care from trained nurse and doctor free of cost. Lalita and Suman who were working in the village as ASHA and AWW told the family, particularly Mehrunnessa, about these facilities. However Mehrunnessa could not reach to PHC at midnight and delivered the baby at home. Mother and Sister-in-laws assisted her. Luckily there were no complications and normal delivery took place. Trained Dai of the village Munnibai came in the morning to attend both mother and newborn on call. It was first delivery of young Mehrunnessa who felt exhausted after the baby was born.

In the morning Mehrunnessa was given light tea and 2 biscuits. She was given bath with lukewarm water. Solid food (i.e. roti and dal) was given to her in the morning on 2nd day. After birth, the new born was also given bath with lukewarm water by mother-in-law. This practice is common in accordance with the local culture. Next day onwards Mehrunnessa started her normal diet (light diet). She started breastfeeding after 2 days. The new born was kept on diluted goat's milk for 2 days. “We do not give first breastmilk which is not a milk but some thick yellowish substance. If newborn is given that, the baby may fall sick”, said her mother-in-law. She told further that Mehrunnessa was unable to feed the baby through she tried with the help of her sister-in-law. On the third day Mehrunnessa tried to feed the baby. Her sister-in-law helped her in holding the baby in a right position so that right attachment in established and the child is able to suck the breast and get milk. Breastmilk was oozing out although in less quantity. Surprisingly, child was refusing to suckle and crying. Mehrunnessa tried separately to console the baby and feed her but all in vein. Hence her mother-in-law decided to feed the new born the diluted goat's milk. She told Mehrunnessa is very young in age and weak in constitution. Therefore, there is insufficient breastmilk. And thus I decided to give "animal milk to the baby". Initially child was fed milk with cotton wick and gradually after some days with "katori and chammach" (bowl and spoon).

On the same day Lalita (ASHA) visited Mehrunnessa to enquire about her health and the newborn girl as well as to know whether baby was given breastfeeding or not. On reaching there, Lalita found mother-in-law of Mehrunnessa was feeding the baby with cotton wicks. She was surprised and asked Mehrunnessa and her mother-in-law "Why the baby was not on breastfeeding?" Mehrunnessa then told that the child was refusing suckling of breast and crying. She was supported by mother-in-law and said that "as there is insufficient breastmilk and Mehrunnessa was unable to feed the baby. Child was hungry. I then decided giving diluted goat's milk to the baby”. Lalita was not convinced with the reasons given by Mehrunnessa. She had a doubt in her mind. She then asked Mehrunnessa to feed the baby in her presence. With lots of unwillingness Mehrunnessa picked up the baby, held her and put on breast. Baby became restless although Mehrunnessa tried to put baby on breast repeatedly. Baby after suckling once or twice refused and started crying.

Lalita observed that the positioning of child was not proper and the only nipple was inside the mouth of child. She then helped Mehrunnessa in holding the child correctly in such a way that it develops a good attachment and the baby takes the mouth full of breast inside mouth. Gradually the baby started suckling and after 5/7 minutes again started crying. Lalita then explained to Mehrunnessa that "You were not holding the baby properly. Now I have shown you how to do it. You follow this pattern. Until you hold her in a right position how the baby would feel comfortable and suckle. And until sucking of breast is not done in right way and there is a proper attachment between mother and baby, baby may not get enough feed. All of you felt that due to young age and weak constitution Mehrunnessa is unable to produce milk. It is not the fact. Now I have shown you how to hold the baby. You do it accordingly and

do it several times. You all will see the result." Even then Mehrunnessa and her mother-in-law were not confident but agreed to do so as was instructed by Lalita (ASHA).

Next morning Lalita again came to Mehrunnessa's house. But this time she came with Salma (name changed), the counsellor of the project. "I was not very sure about mother-in-law particularly, that she would allow Mehrunnessa to breastfeed the baby because of her strong belief and perception that Mehrunnessa is unable to produce milk".

On arriving, Salma asked Mehrunnessa to feed the baby. She observed positioning and attachment of child. Child continued suckling breast for longer time. Salma then asked Mehrunnessa to put the child on other breast. Child was suckling for a while and then started crying again. They found breasts were swollen and reddish in colour. At that time Salma and Lalita decided to give a massage at the back of Mehrunnessa. With the permission of mother-in-law they gave massage. They also kept a cloth pad soaked in warm water in between breasts.. But they were sure that they if the baby suckled the breasts, milk will start flowing out and breasts will look differently. Mehrunnessa would feel light and requirement of milk for the child would be met properly. They taught the technique of massage to sister-in-law of Mehrunnessa and asked her to do so 3-4 times in a day for 2-3 days.

Success came after 3 days. Mehrunnessa herself was feeling less heaviness of breast and child stopped crying as she was getting sufficient milk. Mother-in-law then stopped giving "top feed" (goat's milk) to the baby.

Mehrunnessa felt satisfied so was her mother-in-law. Mehrunnessa said "I have lots of milk now and the child does not cry at all. Lalita didi and Salma madam taught me how to hold the baby when feeding. I didn't know it since it is my first child. I feed the child on demand. She herself stops suckling when she is satisfied. I do not force baby to discontinue suckling. Baby takes 10-15 minutes per feeding…… . At night also now I give feeding when child cries". Mehrunnessa continued the exclusive breastfeeding the baby as per instruction given to her by Salma madam and Lalita didi. The child is growing properly and she was given immunization also at AWC by ANM. Only now the third dose of DPT and Polio are to be given. "We are extremely thankful to both Lalita didi and Salma Aapa. For their help only I feel satisfied that I could give breastfeeding to my daughter" said Mehrunnessa.

On the whole, the family was found very receptive and positively oriented. This attitudinal change of Mehrunnessa and her mother-in-law especially, could be possible because of successful attempt of ASHA and counsellor in removing their negative perception and ensuring proper positioning and attachment of child with mother while breastfeeding.

Case Study 2: *Supporting mother to successfully breastfeed!*

Manju is working as ASHA in the village. She helps AWW as well as ANM Sunita in getting pregnant women to AWC/SC for checkups, immunization as well as immunization of infants/children. Manju (ASHA) used to make home visits regularly both for pregnant as well as lactating mothers. She also used to motivate all pregnant women in the village to have their delivery at PHC/CHC. But according to Manju (ASHA), “carrying out all these jobs in this village is not easy. Elderly women in the village are not ready for antenatal checkups, or to send their pregnant daughter-in-law/daughter to hospital for the delivery, if woman possesses normal health. When I started working as ASHA, I was told in the training by ANM (Sunita) that all pregnant women in the village must get 2 TT injections, take iron tablets for 3 months and get check ups by ANM at SC/AWC, take more food and avoid heavy work in field particularly in advanced stage of pregnancy. Delivery should be at hospital and definitely not at home. The child must be breastfed within one hour after birth and not 3 days after birth. But in the village the check ups during pregnancy, if at all done, is preferred to be carried out by village Dai (Munni Devi) on whom elderly women have more faith and traditionally villagers depend on Dai solely for all pregnancy, delivery and after delivery related matters, not on us. In case any problem arises the villagers prefer to go to private hospital. Even now this trend is common until 'Sarkar' started giving Rs.1400/- to mothers, when they deliver child in Hospital….. This money at least helped us to interact and motivate elderly women to talk about these aspects……..”.

Maya delivered the baby at PHC. Maya's husband took her to PHC. He told “I never wanted to face any problem. Already I lost one child a year before”. At this point Maya's mother-in-law came and joined the discussion. She was then asked “Is Maya breastfeeding her child? After delivery when the breastfeeding started? Why breastfeeding is given to the new born as soon as possible?. Is there any advantage? What is the practice in the village?"

Mother-in-law told “…. baby was born in PHC. The nurse gave baby to Maya within an hour and asked her to feed the baby. Maya had a stitch and she was in pain. Even then when nurse insisted she tried and somehow managed to feed the baby. Baby was crying and again nurse told to feed the baby when crying. Next day in the afternoon Maya came back home. As told by the sister, Maya was trying to feed the baby. But she was having pain while sitting for feeding the baby. Because baby was not in a position to get breastmilk he was crying. I then decided to give goat's milk to baby so that he should not starve and allow Maya to recoup in 2-3 days time. Although, in between I gave the child to Maya for feeding. But I noticed Maya's breasts were swollen and she was complaining pain also. When the child was brought near the breasts he showed no interest to suckle the breast. I noticed no milk is flowing out and hence the child was disinterested. Thus child was continued to be fed with diluted goat's milk.”

After a day Manju (ASHA) came to see the health condition of Maya and the baby. She found the child being fed with goat's milk with cotton wick. Manju was surprised. She asked mother-in-law "why Maya is not giving feed to the baby? What's wrong?" Mother-in-law replied “She is not having breastmilk and therefore child is on goat's milk”. Maya also told “Manju didi, the child is not suckling. I am trying since I have reached home. My Breastmilk is not sufficient, it is not flowing out. I am feeling lots of heaviness in breast. What should I do? The child was crying. And so my mother-in-law started goat's milk……..”.

At that time counsellor Salma, on routine house to house visit, reached there. On hearing the whole story, Salma told Maya to feed the baby in her presence. Manju also insisted. Maya then picked up the child and put him on breast for feeding. Both Salma and Manju found Maya was finding some difficulty in sitting. However, with some back support she sat and held the baby on breast for giving feed. Salma noticed that child was not suckling properly because nipple of breast was not inside the month of baby fully. She immediately told ASHA (Manju) to help Maya in holding the baby properly and told “until child keeps nipple fully in his mouth, suckling will not be done. If there is no suckling, there will be no formation of breastmilk and flow of milk. Proper holding of baby on breast is most important. And mother should be in happy mood when feeding the baby”. If mother is in stress or in pain, formation of breastmilk also gets disturbed. “Therefore you should be in happy mood while feeding the baby…..”

At this point Manju asked counsellor whether she should apply massage to Maya to which Salma agreed.. They shared the importance of massage at mother's back, with the consent of mother-in-law. Maya told “Manju didi massaged my back". “Light massage was also given on breasts while Salma didi helped her by placing a warm pad (soaked in warm water) in between breasts. This activity was continued for 7-10 minutes. After that Salma asked Manju to squeeze out breastmilk in a small container (katori). When some milk could be collected Salma asked my mother-in-law to feed that to the baby with a spoon.

Thus Maya learnt how to hold baby while feeding the baby. She also was relieved of heaviness of breasts which was bothering her a lot and inhibiting in ensuring feeding baby.

Case Study 3: *Helping mother with breastfeeding problems!*

About 3 months back, Namita gave birth to a baby girl to home. During her pregnancy local AWW and ASHA used to visit her regularly and accompanied her to ANM at SC for registration and all antenatal services. Namita took all services suggested by ASHA. But regarding consumption of iron tablet she was sceptical. After its consumption for a few days she experienced some nauseating feeling and loss of appetite and discontinued it. Besides, she had no other problem during antenatal period.

As per advice of ASHA and ANM, Namita's husband

decided that delivery would take place at PHC. Both husband and wife were interested in getting Rs. 1400/- after hospital delivery. But at midnight she had a labour pain and early morning the child was born with the help of an elderly woman in neighbourhood and her sister-in-law. Dai came on call, later.

ASHA came to know about birth of child a day after and she rushed to Namita's house. She also informed AWW and members of MSG. ASHA as well as AWW were concerned whether Namita gave colostrum feeding to baby or not as in village the trend is not to give colostrum to the newborn. Social custom was that for 1-2 days child is kept on water with honey as according to them breastmilk is formed only after 2-3 days. The yellowish substance that comes out from breast after delivery is dirt of mother's body.

On reaching, ASHA found Namita trying to feed the baby with the help of her sister-in-law. But apparently it seemed she was not very comfortable in holding the child and confident to feed the baby. It was her first child and hence she was totally inexperienced in this act.

Namita was trying to feed the baby from right breast while she was avoiding left breast totally. She complained that it is paining. ASHA could see the left breast was reddish in colour and swollen, and nipple of the breast was cracked and inverted. However, she did not say anything to Namita and went to AWW to inform her of the problem. In the afternoon both ASHA and AWW came to Namita's place. AWW in the meantime informed project counsellor also.

On reaching, AWW asked Namita about her problem and found Namita's left breast had some stiffness, swollen and red in colour. Because of this Namita was feeding baby from right breast only and expressed her doubt that such feeding was insufficient for the baby because in-spite of feeding child was restless and crying.

Both AWW and ASHA counselled Namita that the problem of left breast will be rectified once milk is squeezed out it. Breastmilk got accumulated there and therefore it is swollen and stiff. However, their analogy did not satisfy Namita and her sister-in-law.

Next morning project counsellor reached there and discussed with ASHA and AWW about Namita's problem. Project counsellor then asked ASHA to help Namita in feeding the baby from the right breast. Namita started feeding the baby and in 4-5 minutes time child stopped suckling and got restless. Counsellor observed though Namita was feeding the baby she herself was in pain and tension, which was visible apparently on her face and her attention to child was deviated. Counsellor then asked both ASHA and AWW to give massage at the back of Namita, hot fomentation in between breasts and squeeze out milk from left breast which was full with milk. She also found problem in attachment between mother and child. The counsellor also discussed the problem her superior in project on phone. She then got the instruction on phone that child should be attached with mother longer time and after giving massage and hot fomentation on chest, breastmilk should be squeezed out in a container and be fed to baby. This should be done at short intervals. If milk is not released such attempt should be continued.

Counsellor then got confidence and followed the instructions received. This procedure continued with the help of ASHA for 2 days. Counsellor was also visiting Namita in those days. On second day, Namita has much less pain on left breast as milk was squeezed out in a container while breastfeeding was continued from other breast. Gradually inverted nipple got protruded and as the pain got reduced Namita, started giving feeding the baby from both breasts.

At this point Namita's husband commented _ “I had no faith in counsellor's word and the action taken by ASHA and AWW. I on the other hand was ready to call local doctor. But when I heard counsellor was talking on phone to senior doctor, I became little hopeful and developed faith that they are trying sincerely and not bluffing us. Now I have developed lots of faith on them and very much thankful to them”. Same way Namita also showed her gratitude to ASHA, Counsellor and AWW.

LESSONS LEARNT

During 2006 base line survey villagers did not cooperate easily and it look time to persuade them to open as the investigators were from outside of the district. ICDS and health functionaries and NGOs were very resistant in the beginning of 2007 and they were having the opinion that they are already providing breastfeeding and complementary counselling and asked questions like what's new. But during sensitisation meetings they realised that there was so much to know more and to do. Villagers in one block did not allow the training of members of MSGs, thinking that the project might be like any other programmes but later with support of administration and by persuasion of 'Pradhans' (elders), they allowed the training.

Many AWCs were not operating but with the active involvement of DPO they started opening and operating.

NGOs like Balbandhus and CHAI believed that they are also counselling mothers on feeding but after only one day training they said that they were just giving little information to mothers and were knowing nothing about skills and counselling.

Many villages people did not even know what is AWW and AWC but after wall writings, Panchayat level meetings and training of mothers from villages they started taking interest in these services.

There is an identified need to improve coordination among village workers and between them and block level mentors. Having additional worker at village level, who is dedicated nutrition counsellor or activist can solve this problem.

Identification of women from the neighboring villages is possible and so is their training. Medical college based training and leadership proved to be quite a useful for the team that led this change.

It is likely that special training imparted to two levels of workers, the mentors and village counselors, helped in increasing their confidence and motivation as one can see from their voices in the experience section. After active implementation of the project many myths of feeding practices have been busted, people's participation has improved.

Initial funding was made available for 48 mentors, which has now been scaled down to 18 including supervisors. Work is on and that may be a lesson to see if we can work with lesser number of mentors per block i.e. 2 to 3.

Overall lesson is that its possible to reach Under 2 universally, provided we have additional human resources and with good quality training input.

Conclusions

Establishing a system of nearly universal reach with infant and young child feeding counselling is feasible at the scale of a district having population of 1 million and more than 30,000 annual births. This is possible through additional human resources and good quality training. In Lalitpur district the project has demonstrated it using eight women 'mentors' at block level, who are identified locally, and given a week long training on infant and young child feeding.

This training also enables them to train village level counsellors. Besides training village-level counselors, the mentors also acted as block level counsellors, and provided referral support. Some of them can work as supervisors at block level.

Universal counselling at family level is possible through developing a network of 3-4 women workers. They can be trained using the 3-day skill training in infant and young child feeding as well as given one-day re-orientation every year. In Lalitpur, more than 3000 village level counsellors worked through home visits and centre meetings to counsel women. Real convergence is also possible through involvement of the many departments and having joint and uniform training of Anganwadi Worker, ASHA, TBAs and other women at village level.

Further, it is possible to enhance optimal breastfeeding and complementary feeding rates as shown in Lalitpur, through improved knowledge of people and improved skill and motivation of workers, who can make the system to work and reach almost all women.

This project has addressed key gap in the current programmes of reaching the Under 2s, through a focus on infant and young child feeding counselling, an area that needs utmost attention.

It seems entirely possible to make use of medical colleges for capacity building, creating a nucleus of block level mentors for leading this effort in other districts of the country. However, there are some lessons learnt, including the need to improve coordination among the workers, at village level and between village and block level. This could be done through appointing a dedicated village nutrition counsellor. Based on these conclusions specific recommendations have been made, which may be considered for the future policy and programme reform.

RECOMMENDATIONS

In order to universalise the reach to Under 2s, and to contribute to their health and nutrition status through improved breastfeeding and complementary feeding practices, following recommendations are made for the policy makers.

Opportunities are there and round the corner, what needs to be done is to make political choices and invest in Under 2s and that too in a big way. Governments need to commit resources both in human and financial terms.

These recommendations include:

1. Create additional human resource for nutrition education at district/block level and at a cluster of 5-10 villages, who are especially trained to look after infant and young child feeding and nutrition. They can serve as trainers and mentors for the village level counsellors and provide supervision, referral support as well as manage counselling centres at this level.
2. Appoint an additional nutrition worker/counsellor at village level who could coordinate creation of mother support groups and focus on nutrition counselling and education for the under 2.
3. Develop institutional capacity in the medical colleges at state level to provide leadership, impart training to the mentors, follow up and establish supervision. They should also include the curriculum of infant and young child feeding into basic education of nurses and doctors.
4. Adopt the 3-day training curriculum of IYCF used in this model for training of all frontline workers, both in ICDS and NRHM. This should also be put in pre-service modules. Adopt the 7-day training curriculum used in this project for training of mentors at the supervisory level.
5. 'Infant and Young Child Feeding Counselling' should be recognised as a specific "service" under the ICDS and NRHM. This should be linked to the roll out of new WHO growth standards.
6. Create a 'budgetary support' line item for the above activities as mid course correction, leading to 12th five year plan.
7. Conduct orientation on IYCF and nutrition of other key personnel like district health and WCD officials, district administrators, PRIs, NGOs, private medical personnel to create a facilitating environment.

Department of Pediatrics
B. R. D. Medical College
Gorakhpur-273013
Uttar Pradesh