Feeding lessons

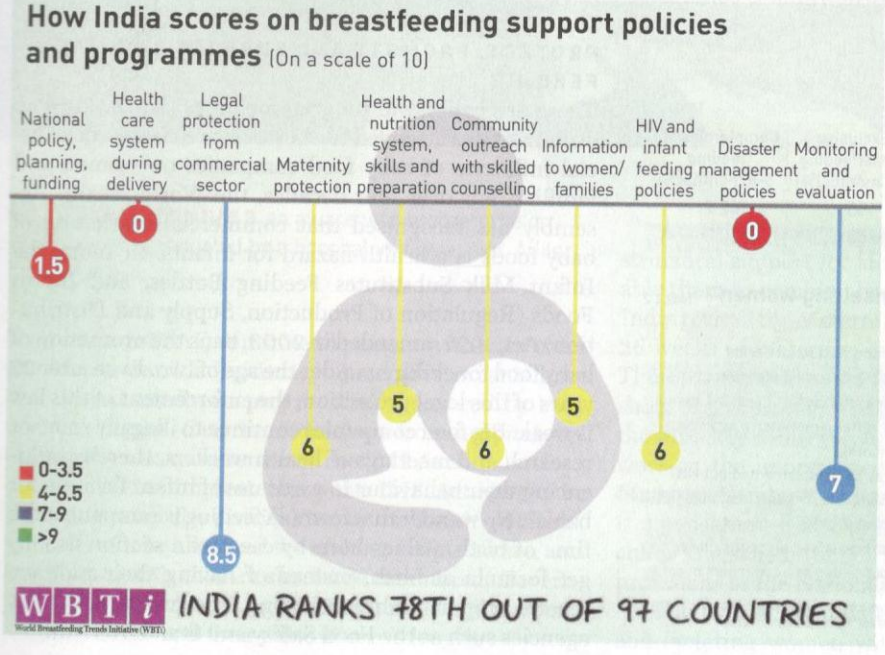
Optimal feeding of infants is fundamental to tackling the burden of malnutrition. BY **ARUN GUPTA**

THE RELEASE OF THE COMPREHENSIVE National Nutrition Survey (CNNS 2016-2018) has renewed interest in tackling malnutrition in India. The conceptual framework for child undernutrition, developed by UNICEF, recognises breastfeeding, good complementary feeding, caring and health care to minimise disease burden as immediate underlying factors that determine malnutrition in all its forms.

According to the CNNS, 35 per cent of the children under five were stunted (HAZ <-2 SD), 17 per cent were wasted (WHZ <-2 SD), and 33 per cent were underweight (WAZ <-2 SD). India has set ambitious targets to annually reduce stunting to 25 per cent by 2022. In the past decade the focus of dealing with malnutrition has been tilting in favour of treating severe malnutrition with ready-to-use therapeutic foods (RUTF), projected as a magic solution for saving babies. However, a recent study from eastern India concluded: "Given that the risk of mortality is lower than expected among children older than 6 months and that many deaths occur because of prematurity or low birth weight during the neonatal period, outpatient treatment for SAM [severe acute malnutrition] using RUTF for children over 6 months may be too late to avert a substantial number of deaths from undernutrition in Indian children. This further strengthens the case for prioritising prevention through known health, nutrition, and multisectoral interventions in the first 1,000 days of life."

Nutrition action in India needs a rethink and reassessment. Some fundamental corrections are needed to change the focus from treatment to prevention.

One key approach is to ensure optimal feeding practices during the first 24 months of life. These are critical to a child's survival, health, nutrition and development, not because children are vulnerable at this age but because their brains develop almost entirely in the first two years. The practices include initiating breastfeeding within an hour of birth and skin-to-skin contact with the



Inadequate breastfeeding results in 1,00,000 preventable child deaths in India, an international study has found.

mother immediately after birth, exclusive breastfeeding for the first six months, and continued breastfeeding along with adequate complementary feeding thereafter until two years or beyond.

Fundamental corrections are suggested in policy and programme to ensure optimal practices more on how to do rather than what to do, given that the Government of India is seized of the matter in principle. The proposed corrections are also based on our findings and analysis of the hospital practices in relation to breastfeeding. If we made these corrections, they are likely to bring a shift towards preventive health care much needed by every child of new India, and rapidly reduce malnutrition.

WHY FOCUS ON OPTIMAL FEEDING PRACTICES?

According to the World Health Organisation (WHO), non-exclusive breastfeeding and inadequate complementary feeding contribute to stunting and are among the important causes of wasting. An international study on the cost of not breastfeeding estimates that in India, inadequate breastfeeding results in 1,00,000 preventable child deaths (mainly due to diarrhoea and pneumonia), 34.7 million cases of diarrhoea, 2.4 million cases of pneumonia, and 40,382 cases of obesity. The health impact on mothers translates into more than 7,000 cases of breast cancer, 1,700 of ovarian cancer and 87,000 of type 2 diabetes. India spends Rs.727.18 crore on health care to battle illness.

Optimal feeding has the potential to simultaneously reduce the risk or burden of both undernutrition and excess weight, obesity or diet-related non-communicable diseases (NCDs), including type 2 diabetes, cardiovascular diseases and some cancers. Improving breastfeeding rates has been explicitly stated to contribute to attainment of Sustainable Development Goals (SDGs) 2030 of health, nutrition, education, poverty, reducing inequalities, and inclusive economic growth. India is committed to SDGs.

Infant Feeding Indicators TABLE 1

Survey	Initiation of breastfeeding within 1 hour(%)	Exclusive breastfeeding 0-6 months(%)	Complementary feeding 6-8 months(%)
NFHS-4 (2015-16)	41.5	55	42.2
CNNS (2016-18)	5	58	53

WHO recommendation for counselling women TABLE 2

Specifics	Recommendations
When	Counselling during pregnancy and post natal period
Frequency	At least 6 times: 1st-Antenatal, 2nd-immediately after birth within 2-3 days, 3rd- at 1-2 week after birth, 4th- at 3-4 month, 5th-at 6 months for CF and 6th-after 6 months. In addition, every 2-3 months from 6-24 months.
Mode	Face-to-face counselling. It may be complemented but NOT
By whom	replaced by telephone counselling and /or other technologies. Appropriately trained health-care professionals and community-based lay and peer breastfeeding counsellors should provide breastfeeding counselling as a continuum of care.

Source: WHO guidelines: HYPERLINK "https://www.who.int/nutrition/publications/guidelines/counselling-women-improve-bf-practices/en/"Counselling of Women to Improve Breastfeeding Practices)

The Union Ministry of Health and Family Welfare launched the "Breastfeeding and IYCF Report Card" in August 2019, which counts on these three feeding practices. The report card is based on the National Family Health Survey (NFHS-4). Table 1 shows how India performs on the coverage of three indicators stipulated under NFHS and CNNS. Infant feeding practices are "inadequate" despite an overwhelming evidence of its impact on human health. It leaves more than one crore infants out of the safety net every year right during their first few months of life. These are the ones who slip into various degrees of malnutrition.

Several factors contribute to inadequate infant feeding practices. Inadequate attention to policy and programmes for removing barriers to optimal feeding practices; inadequate planning and budget allocation; poor support to women in public and private health facilities; continued aggressive promotion of commercial baby foods; and inadequate structural support to women in both formal and informal workplaces are some of them. India made some headway in addressing the problem in the past decade, but the implementation of existing policies should be strengthened and programmatic interventions should be scaled up.

In 2018, the World Breastfeeding Trends Initiative (WBTi), which assesses the state of policies and programmes in over 100 countries, launched its fifth report for India. It showed persistently weak attention to crucial policy and programme areas. Figure 1 shows how India fares on all the 10 indicators of policy and programmes out of a score of 10. The colour coding is based on scores, green, blue, yellow and red in descending order of performance. India is way behind, at number 78 out of 97 countries.

A major correction is needed. Reaching all children and pregnant and lactating women with services they need to succeed is imperative.

PROTECT, PROMOTE AND SUPPORT OPTIMAL FEEDING

There are policy and programme areas that need to be examined and attended to. A critical area is the commercial influence of baby food companies on women and families. For over four decades, the World Health Assembly has recognised that commercial marketing of baby foods is a health hazard for infants. In India, the Infant Milk Substitutes Feeding Bottles, and Infant Foods (Regulation of Production, Supply and Distribution) Act, 1992, amended in 2003, bans the promotion of baby food for children under the age of two. Even after 27 years of this legal protection, the enforcement of this law is weak. Big food companies continue to illegally sponsor research and meetings of health workers, thereby influencing their behaviour towards use of infant formula for babies. No wonder that formula feeding is rampant at the time of birth. Babies born by caesarean section usually get formula at birth, instead of having their mothers receive support for breastfeeding. The government's key agencies such as the Food Safety and Standards Author-

V. RAJU

MOTHERS ATTENDING an awareness programme on breastfeeding conducted by a hospital in Vijayawada. A file photograph.

ity of India (FSSAI) continue to partner with such companies and provide legitimacy. State governments have been found to rely on programmes sponsored by baby food companies. Our recent findings from hospitals revealed very weak awareness of the IMS Act.

The task of implementing the IMS Act should be decentralised at the district level by authorising officers, funds should be allocated for making people aware, and compliance with the Act should be monitored. Government departments and agencies should keep baby food manufacturers and their allies at arm's length.

A critical policy intervention would be to ensure structural support for lactating mothers in order to enable them to combine breastfeeding and work. In 2017, India revised the Maternity Benefit Act of 1961 to provide 26 weeks of maternity leave and breastfeeding breaks. This Act extends to workers of mines, tea plantations, shops and establishments, as per a clarification issued by the Ministry. However, more than 90 per cent of women work in the unorganised sector. The Pradhan Mantri Matritva Vandana Yojana (PMMVY) provides a cash compensation of Rs.5,000 to women for the firstborn child. The scheme should be made universal under the provisions of the National Food Security Act, 2013.

The IMS Act mandates reaching out to all pregnant and lactating women with accurate and unbiased in-

TABLE 3

Indicators	INDIA – Assessment Year 2018	SRI LANKA – Assessment Year 2019
National Policy, Programme and Coordination	1.5	10.0
Baby Friendly Hospital Initiative	0.0	10.0
Implementation of the International Code	8.5	7.0
Maternity Protection	6.0	6.0
Health and Nutrition Care Systems	5.0	10.0
Mother Support and Community Outreach	6.0	10.0
Information Support	5.0	8.0
Infant Feeding and HIV	6.0	10.0
Infant Feeding during Emergencies	0.0	10.0
Monitoring and Evaluation	7.0	10.0
Total Score (Policy and Programmes)	45.0/100	91.0/100
Exclusive Breastfeeding	55%	82%

Source: World Breastfeeding Trends Initiative(WBTi), 2019.

formation. While information campaigns are there, especially during specified months, face-to-face skilled counselling for each pregnant and lactating woman is the missing piece, as confirmed by recent findings from hospitals. Counselling means helping a mother decide on the best way of feeding her infant instead of just telling her to breastfeed. Counselling helps women build their confidence in their own milk supply. The WHO in 2018 provided guidelines for counselling women on when to breastfeed, how and with what frequency (Table 2) and recommended face-to-face counselling.

Antenatal counselling on breastfeeding seems to be rare. The health care system should initiate breastfeeding within an hour of birth and support women to provide skin-to-skin contact with their babies. Exclusive breastfeeding requires multi-sectoral support spread over health, women and child development, labour, disaster management, HIV monitoring and information and broadcasting. While babies are still in hospitals after birth, mothers need skilled support to maintain exclusive breastfeeding. While the government has recognised the need of lactation support in the hospitals, new recruitments are not encouraged. A dedicated skilled lactation counsellor in a hospital can certainly make a huge difference to early breastfeeding rates and also control the use of unnecessary infant formula.

Outreach counselling for the quality of complementary feeding is critical after an infant is six months old. According to the CNNS report, timely complementary feeding was initiated for 53 per cent of infants aged six to eight months; only 21 per cent were fed an adequately diverse diet; and 6 per cent received a minimum acceptable diet (which includes both frequency and diversity). This raises a serious question on how we deal with this situation. It is important to monitor how children are fed and how they grow.

Dietary assessment for an individual child should be institutionalised. If the child is not getting four or more food groups in the diet, counselling is required and the diet must be compensated in poor households. Monitoring a child's growth trajectory is another step. At least four nutrition and lactation counsellors should be recruited at the block level to play a mentoring role for community-level health workers such as ASHA, ANM and AWW and to conduct and supervise individual dietary assessments and growth monitoring of each child born in the block.

> While information campaigns are there, face-to-face skilled counselling for each pregnant and lactating woman is the missing piece.

THE WAY FORWARD

India needs to ensure that these services reach every pregnant and lactating mother. The existing health system must be strengthened at the block level and in each health facility. Specially trained workers can turn the tide on malnutrition. Children should be fed diverse foods instead of being given dietary fortifications.

Strengthening counselling services may cost about Rs.1 crore for every district annually. It is an expenditure that the Central and State governments should bear in the interest of building a new India and future brain power. A plan of action should be documented, with yearly actions and budgets, a coordinating mechanism, and a national scheme for protection and promotion of breastfeeding and complementary feeding.

The WHO, UNICEF and World Bank recommend that an estimate of at least $4.7 (Rs.335) per newborn baby is required to achieve high rates of feeding indicators. India could do local estimates and fix a budget line in its health accounts.

The answer may lie in a Prime Minister's Stanpan Suraksha and Samvardhan Yojana (PMSSSY).

Will it be helpful if India invests in promoting breastfeeding? The answer is yes. A comparison with Sri Lanka in the WBTi report card tells us why. Table 3 reflects on the 10 policies and programmes in which Sri Lanka scores high in almost all areas and maintains a high rate of exclusive breastfeeding. India scored a low 45 out of 100, whereas Sri Lanka scored 91. Sri Lanka scored green code in eight indicators and became the first country in the world to achieve a "green" colour code by the WBTi. This could well be one of the critical components of getting the health and nutrition indicators right in Sri Lanka. □

Dr Arun Gupta, a paediatrician with more than four decades of experience, and creator of the World Breastfeeding Trends Initiative (WBTi), coordinates the work of South Asia for International Baby Food Action Network (IBFAN). The 1998 Right Livelihood laureate, he is the central coordinator of Breastfeeding Promotion Network of India (BPNI) and convener of the Nutrition Advocacy in Public Interest (NAPi), a national think tank.