Pakistan Infant and Young Child Feeding Strategy, 2016- 2020

December 2015
Appropriate feeding practices are essential for the nutritional status, growth, development and survival of infants and young children. Infants should be exclusively breastfed for the first six months of life, and thereafter should receive nutritionally adequate and safe complementary foods while breastfeeding continues up to two years and beyond. Special attention and practical support is needed for feeding in exceptionally difficult circumstances, including low birth weight infants, malnourished children, infants and children in emergencies, infants born to HIV-positive mothers, and other vulnerable children living under challenging circumstances.

The Pakistan Infant Young Child Feeding Strategy builds on past and continuing achievements on progress/lessons learned and in addressing challenges on IYCF practices in Pakistan. It has been developed in the context of national policies, strategies and programmes in nutrition and child health. It is consistent with the Global Strategy for Infant and Young Child Feeding and is based on accumulated evidence on interventions with proven positive impact. It identifies comprehensive actions that will be taken to improve legislation, policies and standards to protect optimum infant and young child feeding practices, and to strengthen the capacity of health services and communities to promote and support the nutritional needs of infants and young children. The roles of the critical partners - government, academicians, international organizations, non-government organizations, community based organizations and other concerned parties - are also identified to ensure that collective action contributes to the full attainment of the Pakistan strategy’s goal and objectives.

The Pakistan IYCF Strategy will bring substantial benefits for individuals, families and the entire nation. Improvement in infant and young child feeding will have positive effect on reducing the stunting in Pakistan and will bring the achievement of Sustainable Development Goals (SDGs) closer. Investment in this crucial area is needed to ensure that every Pakistani child develops to her or his full potential, free from malnutrition and preventable illnesses. It is now time for everyone concerned to move swiftly to implement the Pakistan IYCF Strategy.
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Abbreviations/Definitions

**AIDS**: Acquired immune deficiency syndrome, which means that the HIV-positive person has progressed to active disease.

**Artificial feeding**: Feeding an infant on a breast-milk substitute.

**Baby-friendly Hospital Initiative (BFHI)**: An approach to transforming maternity practices as recommended in the joint WHO/UNICEF statement on *Protecting, promoting and supporting breastfeeding: the special role of maternity services* (1989). The BFHI was launched in 1991 by UNICEF and WHO. Baby-friendly hospitals practice the *ten steps to successful breastfeeding* (part of the joint statement) and observe the principles and aim of the *International Code of Marketing of Breast-milk Substitutes*, including not accepting free or low-cost supplies of breast-milk substitutes, feeding bottles, teats and pacifiers. To acquire the “baby-friendly” designation, a hospital must be externally assessed according to an agreed procedure using the Global criteria.

**Bottle-feeding**: Feeding an infant from a bottle, whatever is in the bottle, including expressed breast milk, water, formula, etc…

**Breast-milk substitute**: Any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not it is suitable for that purpose.

**Commercial infant formula**: A breast-milk substitute formulated industrially in accordance with applicable *Codex Alimentarius* standards to satisfy the nutritional requirements of infants during the first months of life up to the introduction of complementary foods.

**Complementary food**: Any food, whether manufactured or locally prepared, suitable as a complement to breast milk or to infant formula, when either becomes insufficient to satisfy the infant’s nutritional requirements.

**Complementary feeding**: The process of giving an infant food in addition to breast milk or infant formula, when either becomes insufficient to satisfy the infant's nutritional requirements.

**Cup-feeding**: Feeding from an open cup without a lid.

**Exclusive breastfeeding**: Breastfeeding while giving no other food or liquid, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

**Expressed breast milk**: Milk that has been removed from the breasts manually or by using a pump. **HIV**: Human immunodeficiency virus, which causes AIDS (Acquired Immune Deficiency Syndrome).

**HIV testing and counselling**: Testing which is voluntary, with fully informed consent, and confidential. This term means the same as the terms *voluntary testing and counselling (VCT)* and *voluntary and confidential testing and counselling (VCCT)*. Counselling should include life planning for the HIV-positive client, and if the client is pregnant or has recently given birth, counselling should include infant feeding considerations.
**HIV-positive**: Refers to persons who have taken an HIV test, whose results have been confirmed and who know and/or their parents know that they tested positive.

**HIV negative** refers to people who have taken a test with a negative result and who know their result.

**HIV-status unknown** refers to people who have not taken an HIV test or who do not know the result of their test.

**HIV-infected** refers to a person infected with HIV, but who may not know that he/she is infected. **Infant**: A child not more than 12 months of age.

**International Labour Organization (ILO): Maternity Protection Convention 183 and Recommendation 191**: The most up-to-date international labour standards on maternity protection. They were adopted by the International Labour Conference in June 2000. The Convention, which applies to all employed women, provides the right to maternity leave of not less than 14 weeks, cash and medical benefits, job security, workplace health protection and breastfeeding breaks. Mothers who continue breastfeeding after their return to work have the right to nursing breaks or a reduction in hours of work in order to breastfeed or to express breast milk. Additional provisions regarding the adaptation of nursing breaks to particular needs and the establishment of facilities for breastfeeding at or near the workplace are found in the Recommendation. ILO Conventions are international treaties, subject to ratification by ILO Member States. Recommendations are non-binding instruments, which set out guidelines for national policy and action. Both forms are intended to have a concrete impact on working conditions and practices in every country of the world.

**International Code of Marketing of Breast-milk Substitutes, and subsequent relevant World Health Assembly resolutions**: The instrument that was adopted in the form of recommendation by the World Health Assembly (WHA) in May 1981 to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. Since 1981, the WHA has also adopted a number of resolutions that clarify the Code, and have the same status. The Code and subsequent relevant resolutions are referred to collectively in the present context as the International Code.

**Maternity entitlements**: Provisions for maternity leave, cash and medical benefits, job security, workplace health protection, breastfeeding breaks, and other measures to protect the health and employment rights of employed women before and after childbirth. (See also ILO Maternity Protection Convention).

**Median duration of breastfeeding**: The age in months after which 50% of children are no longer breastfed.

**Micronutrient supplements**: Preparations of vitamins and minerals needed for infants. One important indication for giving micronutrient supplements is for infants who receive home prepared infant formulas (in some cases because their HIV-positive mothers have chosen replacement feed).
**Milk expression**: Removing milk from the breasts manually or by using a pump.

**Mother-support group**: A community-based group of women providing support for optimal breastfeeding and complementary feeding. A group may be informal or part of a larger network providing information, help and support from trained counselors and experienced mothers. Groups may meet regularly or simply provide individual mother-to-mother contacts. They may be organized by health workers or lactation consultants, but frequently they are managed autonomously by mothers within their own communities.

**Mother-to-child-transmission (MTCT)**: Transmission of HIV to a child from an HIV-infected woman during pregnancy, delivery or breastfeeding. The term is used in this document because the immediate source of the child’s HIV infection is the mother. An immediate source of the child’s HIV infection is the mother. A woman can acquire HIV through unprotected sex with an infected partner, through receiving contaminated blood or through non-sterile instruments (such as with intravenous drug users) or medical procedures.

**MDGs**: Millennium Development Goals (MDGs) were the eight international development goals for the year 2015 that had been established following the Millennium Summit of the United Nations in 2000, following the adoption of the United Nations Millennium Declaration.

**Optimal infant and young child feeding**: Exclusive breastfeeding for the first six months of life. Thereafter, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.

**Relactation**: Re-establishing breastfeeding after a mother has stopped, whether in the recent or distant past.

**Replacement feeding**: The process of feeding a child who is not receiving any breast milk with a diet that provides all the nutrients the child needs until the child is fully fed on family foods. During the first six months this should be with a suitable breastmilk substitute. After six months it should be with a suitable breastmilk substitute, as well as complementary foods made from appropriately prepared and nutrient-enriched family foods.

**SDGs**: Sustainable Development Goal. The sustainable development goals (SDGs) are a new, universal set of goals, targets and indicators that UN member states will be expected to use to frame their agendas and political policies over the next 15 years.

**Young Child**: A child from the age of more than 12 months up to the age of 03 years (36 months).
1. Introduction

1.1 Infant and young child feeding in Pakistan:

Appropriate feeding practices are essential for the nutritional status, growth, development and survival of infants and young children. These feeding practices, known collectively as infant and young child feeding (IYCF) practices\(^1\), include breastfeeding and complementary feeding. Infants should be breastfed within one hour of birth, exclusively breastfed for the first six months of life, and thereafter should receive nutritionally adequate and safe complementary foods while continuing breastfeeding up to two years and beyond.

Pakistan has a strong culture of breastfeeding. According to the National Nutrition Survey (NNS 2011), (based on past 24-hour dietary recall) 63.5% of mothers predominantly breastfed children from 0–6 months of age and 77.3% of mothers continued breastfeeding up to 12–15 months. According to the Pakistan Demographic and Health Survey (PDHS 2012-13), children less than six months of age are more likely to be breastfed than older children, with the proportion of children who are being breast fed declining with age, the data showing that 84 percent of children age 6-8 months followed by 83 percent of children age 9-11 months in Pakistan are still being breastfed. The recommended exclusive breastfeeding children for the first six months of life is met for only 38 percent of children, indicating hardly any improvement since 2006-07 (PDHS) when it was reported as 37 percent. Bottle feeding among children below two years is widespread. According to PDHS 2012-13, more than one in five babies less than two months of age is being fed using a bottle with a nipple, rising to 46 percent of children age 9-11 months; the highest proportion (51%) is found in the age group 20-23 months. Many aspects of infant and young child feeding are far from optimal.

The complementary foods are introduced early in some cases, with 10% percent of children under six months and 19 percent of children age 4-5 months consuming solid or semi-solid foods in addition to breast milk. Complementary foods given to infants and young children are often nutritionally inadequate and unsafe leading to malnutrition. Data on agricultural products such as vegetables, fruits and lentils shows that real prices have increased over the past two decades, making them less affordable. Diseases contribute to malnutrition, as children need more nutritious food when they are sick but often eat less and absorb less nutrients.

Diarrhea, ARI and fever are common childhood illnesses in Pakistan: in the two weeks prior to the interview, caregivers report that 23 % of children under 5 years had an episode of diarrhea, 16 % had ARI and 38 % had fever (PDHS 2012-13). Inappropriate infant and young child feeding practices are among the most serious obstacles to maintaining adequate nutritional status, and contribute to levels of malnutrition in Pakistan that are amongst the highest in the world.

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\(^1\) In the context of this Pakistan Strategy, infant and young children are defined as aged less than 3 years.
According to the NNS 2011, 31.5% of children under five years are underweight, 43.7% are stunted and 15.1% are wasted. Malnutrition is responsible, directly or indirectly, for about one-half of the deaths that occur annually among children under five years in Pakistan. About three-quarters of these deaths, occur during the first year of life. Malnourished children who survive are more frequently sick and suffer the life-long consequences of impaired physical and intellectual development. Rising incidences of overweight and obesity in children are also a matter of serious concern for later-life morbidity and mortality.

Micronutrient deficiencies are highly prevalent in children. The NNS 2011 cites vitamin A deficiency at 54.0% in children under five years. The same survey shows that anaemia affects 61.9% of children under five years, zinc deficiency 39.2% and iodine deficiency 40.0%, reflecting poor dietary intake of micronutrients in this age group.

According to NNS 2011, in pregnant women, anemia is 51.0%, iron deficiency anemia is 37.0%, vitamin A deficiency is 46.0%, zinc deficiency is 47.6%, vitamin D deficiency is 68.9% whereas in non-pregnant women anaemia status at 50.4%, iron deficiency anemia is 26.8%, vitamin A deficiency 42.1%, zinc deficiency is 41.3%, and vitamin D deficiency 66.8%. However, adequate iodine status was documented at the national level and in most of the provinces except Baluchistan, Azad Jammu Kashmir (AJK) and Gilgit-Baltistan (GB), which were documented as having inadequate iodine levels (<100 μg/l median iodine excretion) of iodine status. The NNS 2011 indicated that 58.1% of households were food insecure nationally.

NNS 2011 showed that in Pakistan, 51.9% mothers had normal weight, 14.1% were thin and 33.9% overweight, while thin mothers were found in the highest concentrations (16.4%) in rural areas compared to urban areas (9.0%). Numbers of overweight mothers were higher (48.4%) in urban areas as compared to rural (27.4%). Delaying the first birth and spacing of births three to five years apart also contributed to the best nutritional and survival outcomes for both mother and child. The importance of women's nutrition and reproductive health care to break the intergenerational cycle of malnutrition must be recognized and addressed through the same community-and -facility-based services working to improve infant and young child feeding.

The NNS 2011 indicates that wasting, stunting as well as micronutrient deficiencies are endemic in our country. The main contributing factors include the poor nutritional status of adolescent girls and women that ultimately affects pregnancy outcomes, low literacy and poor ability to provide essential and adequate child care. These are linked with a series of issues a child faces, including repeated illnesses, poor appetite and insufficient food intake. Many of these children die before their first birthday and those who survive suffer long-term consequences, such as stunting and challenged mental capacity.

Children facing exceptionally difficult health circumstances, including low birth weight, malnutrition, orphans, HIV, emergencies etc. are particularly vulnerable to inadequate infant and young child feeding practices. In Pakistan 25-29% of children are born with low birth weight. The HIV pandemic in other developing countries has shown that the risk of mother-to-child transmission of HIV through breastfeeding pose complex challenges to the promotion of breastfeeding, even among unaffected families.

Social and economic change can intensify the difficulties that families face in properly feeding and caring for their children. Urbanization in Pakistan means that more families depend on
informal employment with intermittent incomes and little or no maternity benefits outside government service. Most self-employed and nominally employed rural women face heavy workloads with no provisions for maternity leave or benefits. Poor quality and quantity of food, limited knowledge about nutritious food and the double burden of disease in the presence of political and security issues all contributing to malnutrition.

1.2 Contribution of infant and young child feeding to the Sustainable Developmental Goals.

The consequences of inappropriate feeding practices in early childhood are major obstacles to the government’s efforts towards sustainable socioeconomic development and poverty reduction. Research has shown that under-five mortality can be reduced by 13% by the way of optimal breastfeeding and a further 6% with optimal complementary feeding (Jones et al, 2003). The correction of inappropriate feeding practices can also prevent malnutrition and its consequences, including developmental delays, impaired educational ability, a lifetime of poor health, increased risk of chronic disease and early death.

Pakistan was not on track to achieve some of the MDGs, however the government has made significant achievements in the Millennium Development Goals (MDGs) for sanitation and also notable progresses in combating polio, increasing routine immunization and decreasing the number of out-of-school children. From 2015 onwards; the MDGs are being replaced by SDGs and again, the importance of improving maternal and child nutrition and its impact on health of the population, poverty eradication, economic growth and sustainable development are acknowledged and prioritized.

As per the recent development of the SDGs and according to the final Open Working Group proposal for SDGs, it is pertinent to share that Pakistan’s IYCF strategy in also line with the SDGs.

The most damaging effects of malnutrition occur during pregnancy and in the first two years of life, and the effects of this early damage on health, brain development, intelligence, educability, and productivity are largely irreversible. Nutrition is directly linked with some of the SDGs as follows:

**SDG1: End poverty in all its forms everywhere**

Malnutrition has long been known to undermine economic growth and perpetuate poverty. According to the Copenhagen Consensus, nutrition investments were declared as the most effective in reducing poverty and improving economic growth in developing countries. Appropriate feeding practices save lives and reduce the risk of childhood illnesses. It can delay next pregnancy that subsequently reduces the reproductive stress on the family. IYCF is one of the most effective strategies in reducing stunting and subsequently contributing to human capital formation and helping to break the inter-generational transmission of poverty and deprivation.
SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture.

High rates of malnutrition combined with food insecurity can be attributed to both intrauterine growth retardation and postnatal growth faltering. Acute malnutrition makes children more susceptible to infectious diseases, which may even lead to death. Chronic malnutrition (Stunting) undermines both physical and mental development as well as impaired immune systems with life-long consequences. Optimal infant and young child feeding (IYCF) practices form the cornerstone of child care and development. Breast milk is the best nutritious food for young children. Early initiation, exclusive breast feeding for six months and age-appropriate and safe complementary food, in addition to breast milk, are proven strategies to prevent malnutrition especially under two years of age.

SDG 3: Ensure healthy lives and promote well-being for all at all ages

Major investments in child health in Pakistan have yielded some declines in infant and under 5 mortality. Neonatal mortality declined slightly yet remains very high overall. However, the achievements are not possible unless the underlying causes of child mortality are addressed. Undernutrition is one of the main culprits for high child mortality. Early and exclusive breastfeeding helps children survive. It has a profound impact on a child’s survival, health, nutrition and development. Optimal breastfeeding of infants under two years of age has the potential to prevent over 800,000 deaths (13 per cent of all deaths) in children under five in the developing world (Lancet 2013). Breastfed children have at least a six times greater chance of survival in the early months than non-breastfed children. An exclusively breastfed child is 14 times less likely to die in the first six months than a non-breastfed child, and breastfeeding drastically reduces deaths from acute respiratory infection and diarrhea, two major child killers (Lancet 2008). The potential impact of optimal breastfeeding practices is especially important in developing country situations with a high burden of disease and low access to clean water and sanitation. Breastfeeding also lowers the risk of chronic conditions later in life, such as obesity, high cholesterol, high blood pressure, diabetes, and childhood asthma and childhood leukemia.

Pakistan still has a high maternal mortality rate and nutrition is one contributing factor to maternal death. Thus, it is critical to address adolescent and maternal mortality under nutrition in order to speed up the decline in maternal mortality. Early initiation protects mothers from postpartum hemorrhage, as well as reduce the risk of breast and ovarian cancer among women who breastfeed.

SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Breastfeeding is the foundation of good nutrition and allows all children to thrive and develop to their full potential. It also supports healthy brain development, improves cognitive performance and is associated with better educational achievement at age five.
SDG 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

Studies have shown that breastfed infants do better on intelligence and behavior tests into adulthood than formula-fed babies. The recent World Bank report warns that malnutrition is costing poor countries up to 3 percent of their yearly GDP, while malnourished children are at risk of losing more than 10 percent of their lifetime earnings potential.

PLEASE SEE CONTRIBUTION OF IYCF STRATEGY TO GOALS 9, 11, 12, 15 and 17 also below: reference: Sudan IYCF Strategy

<table>
<thead>
<tr>
<th>GOAL 9</th>
<th>Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation</th>
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<tr>
<td>GOAL 11</td>
<td>Make cities and human settlements preparation, inclusive, safe, resilient and sustainable</td>
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<td>GOAL 12</td>
<td>Ensure sustainable consumption and production patterns</td>
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<tr>
<td>GOAL 15</td>
<td>Protect, restore and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss</td>
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<tr>
<td>GOAL 17</td>
<td>Strengthen the means of implementation and revitalize the global partnership for sustainable development</td>
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Breastfeeding is associated with decreased milk industry waste, pharmaceutical waste, plastics and aluminum tin waste, and decreased use of firewood/fossil fuels for alternative feeding preparation.

The IYCF Strategy strength the use of traditional as well as other innovative entry points to expand to wider multi-sectorial collaboration for the promotion, protection and support of breastfeeding and complementary feeding interventions.

1.3 Programme achievements in IYCF:

1.3.1 Legislation:
Breast feeding promotion began in Pakistan in the early 1990’s, when a group of child health professionals recognized the erosion of breastfeeding practices and subsequent impact on the
nutrition and health of children. Since then, Pakistan has approved many of the global commitments to infant and young child feeding (Table 01).

Table 01: Ratification by Pakistan of global commitments to IYCF

<table>
<thead>
<tr>
<th>Global Commitment</th>
<th>Year of Release</th>
<th>Ratified by Pakistan</th>
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<tbody>
<tr>
<td>Convention on Elimination of all forms of Discrimination Against Women (CEDAW)</td>
<td>1979</td>
<td>✓</td>
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<tr>
<td>Convention on the Rights of the Child (CRC)</td>
<td>1989</td>
<td>✓</td>
</tr>
<tr>
<td>Millennium Development Goals</td>
<td>2000</td>
<td>✓</td>
</tr>
<tr>
<td>World Fit for Children Resolution</td>
<td>2002</td>
<td>✓</td>
</tr>
<tr>
<td>subsequent relevant World Health Assembly resolutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codex Alimentarius (Food Safety Standards)</td>
<td>1985</td>
<td>In part</td>
</tr>
<tr>
<td>Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding</td>
<td>1990</td>
<td>✓</td>
</tr>
<tr>
<td>ILO Maternity Protection Convention 183 and Recommendation 191</td>
<td>2000</td>
<td>In part</td>
</tr>
<tr>
<td>Sustainable Development Goals, SDGs</td>
<td>2016</td>
<td>✓</td>
</tr>
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</table>

After the World Health Assembly passed the resolution on the International Code of Marketing of Breast-milk Substitutes (1981), the Government of Pakistan passed an Ordinance, "Protection of Breastfeeding and Young Child Nutrition Ordinance” in 2002, to regulate the marketing of Breastmilk Substitutes. The breastfeeding movement was formalized into the Campaign for the Protection and Promotion of Breastfeeding in 1998. The breastfeeding support activities started within the primary healthcare system and in hospitals. Health professionals in hospitals were trained on the importance of breastfeeding and how to breastfeed appropriately. The media was used extensively in the promotion of breastfeeding. Ordinance 2002 was later strengthened by passing "Protection of Breastfeeding and Young Child Nutrition Rule 2009” and the federal infant feeding board was also notified.

In Pakistan, due to devolution of Ministry of Health in year 2009, each province has autonomy to work on provincial law/act on Breast feeding promotion and protection.


1.3.2 Policy and Standards:
In 2002, IYCF National policy was formulated and adopted which was applicable till 2008. Both the National Health Policy of 2002 and the Health Policy of 2009, have highlighted the nutritional link with the health policy, however, the focus on IYCF practices improvement was missing in the document and less emphasis was placed on this subject with its full entity.

Global IYCF strategy for Infant and Young Child Feeding is the only guidance document available to formulate the policy and strategy at the country level. Pakistan is currently formulating the National Health policy and IYCF Technical Advisory Group (TAG) is doing advocacy to incorporate the IYCF policy within the National Health Policy of the country.

The Scaling Up Nutrition (SUN) movement and other global initiatives has brought high level attention to the profound consequences of undernutrition for human, social and national development and catalyzed efforts in over fifty-six countries to address this problem. There is a recognition that the causes of undernutrition are multi-sectoral and, as such, the SUN movement, global partners and participating countries are emphasizing multi-sectoral approaches to addressing undernutrition.

Concurrently the global guidance and discourse on multi-sectoral approaches has grown in volume and sophistication, with attention to multi-stakeholder platforms, multi-sectoral coordination, nutrition-specific interventions and nutrition-sensitive interventions in sectors like agriculture, social protection, education and water, sanitation and hygiene. In 2013, Pakistan joined the Scaling-Up Nutrition (SUN) movement that advocates for shared space of action where nutrition action is not only prioritized but fully enabled. It gives importance to nutrition-related activities through nutrition-specific policies, strategies and plans (such as the International Code of Marketing of Breast-milk Substitutes, Maternity Leave Laws and Food Fortification Legislation) as well as to updated nutrition-sensitive policies in other sectors such as agriculture, education, water, sanitation, industry, social protection etc. which will reflect positive and equitable trends in the underlying, intermediate and proximate determinants of under nutrition. In January 2015, Federal Technical Advisory Group was notified with approved terms of reference (ToRs) for Federal Technical Advisory Group (IYCF TAG) were also approved.

These achievements have laid a strong foundation for breastfeeding activities in the country, but clearly a lot more is required to build awareness at all levels in the country. In addition, increased involvement of the health system, communities and families, and collaboration between all concerned sectors is crucial to achieve a successful IYCF plan. In the past, the focus has been on interventions at the facility level, such as the BFHI, therefore, there is a need to bring interventions to the communities, where mothers live and work, in a comprehensive manner.

1.3.3. Health System Support and Community Based Support:

In 2002, the Ministry of Health (MOH) established the Nutrition Wing (NW), with a comprehensive programme to reduce malnutrition among women and children. In 2004, the National Program for Family Planning and Primary Health care, known as Lady Health
Workers (LHW) program was launched. Under the LHW program, more than 95,000 LHWs were trained on the importance and promotion of breast feeding for giving education to mothers and households through interpersonal communication. Nutrition (with special focus on IYCF) is fully integrated into the curriculum of LHW, with the revised training package consisting of comprehensive nutrition related material. To a greater extent, IYCF practices are being integrated in Community Based Management of Malnutrition (CMAM) programme.

After the catastrophic flooding in Pakistan, in 2010, the preventive nutritional approach was integrated into an already on-going curative nutritional intervention, i.e. Community Management of Acute Malnutrition (CMAM) program. IYCF counselling was made more prominent in the daily tasks of health care providers, both at facility level and community level. IYCF counselling cards were adopted under the local context, however all efforts were made through project-based approach. Now is the time to integrate IYCF as core subject in pre-services, in-services curricula of health care providers at all level starting from medics to para medics.

Training on IYCF counselling to LHWs and health care providers is an on-going process and has been integrated in all newly developed PC1 for provincial nutrition interventions.

1.4 Formulation of the Strategy and Broad Plan of Action

The MoNHSR&C, UNICEF and other relevant stakeholders recognized the need of improving breastfeeding and complementary feeding practices in Pakistan, and initiated the development of the Pakistan IYCF Strategy for Infant and Young Child Feeding. This process began in November 2006, with a number of workshops convened by the Nutrition Wing, MOH with collaboration and support from UNICEF that started the process of formulating the National IYCF Strategy in April 2007 and finalized in 2008. The strategy was consistent with the Global Strategy for Infant and Young Child Feeding (UNICEF, WHO, 2002) and was based on accumulated evidence on interventions with proven positive impact. Unfortunately, the National IYCF Strategy was not endorsed.

However, given the considerable experiences gained especially in relation to large-scale emergencies, the need to review, revise and update the strategy was imperative. Therefore, Federal Technical Advisory Group (TAG) for IYCF felt the need for a broadly accepted Pakistan Strategy for IYCF, which is agreed upon by all stakeholders. The process of extensive consultation was initiated to revitalize and review the existing document and to formulate a broad framework of actions to protect, promote and support optimal IYCF practices in the country during 2015. In order to ensure maximum participation and to involve a wide range of stakeholders, different consultation rounds were done. The consultative workshops were attended by representatives of the Ministry of National Health Services Regulations and Coordination (MoNHSR&C, Provincial Health departments, Planning Commission, professional medical organizations, academia, Pakistan

2 Pakistan national Guidelines for the community based management of acute malnutrition, 2014
3 Planning commission document
4 ToR attached as annex
The IYCF Strategy builds on past and continuing achievements in infant and young child feeding in Pakistan. The strategy has been developed in the context of national policies, strategies and programmes in nutrition and child health. It identifies the comprehensive actions that will be taken to improve legislation, policies and standards to protect optimum infant and young child feeding practices, and to strengthen the capacity of health services and communities to promote and support the nutritional needs of infants and young children. The roles of the critical partners - government, international organizations, non-government organizations, community based organizations and other concerned parties – are also identified to ensure that collective action contributes to the full attainment of the Pakistan IYCF Strategy.

2. Pakistan IYCF Strategy:

2.1 Goal and objectives

The Pakistan IYCF Strategy builds on the existing achievements in Pakistan and provides a framework for actions to protect, promote and support the optimal infant and young child feeding. The overall goal of the Pakistan Strategy is to improve the nutritional status, growth and development, health, and survival of infants and young children in Pakistan through optimal infant and young child feeding practices.

Main Objectives of IYCF Strategy include:
1. To standardize infant and young child feeding (IYCF) practices for improved child health.
2. To specify roles and responsibilities of partners in promoting appropriate IYCF practices
3. To outline technical directives for IYCF interventions.
4. To improve stunting and under nutrition, targeting the critical window of 1000 days.

The specific objectives of the IYCF Strategy, to be achieved by 2020, are to:

1. Increase the percentage of newborns who are breastfed within one hour of birth from 40% to 50% (early initiation of breastfeeding)
2. Increase the percentage of infants aged less than 6 months of age who are exclusively breastfed from 38% to 58% (exclusive breastfeeding)
3. Increase the percentage of children aged 6-8 months who are breastfed and receive complementary foods from 57% to 67%
4. Increase the percentage of children aged 18-23 months who are still breastfed from 59% to 69% (continued breastfeeding)
5. Increase the percentage of children age 6-23 months are fed appropriately based on recommended infant and young child feeding (IYCF) practices (as per PDHS 2013) from 15% to 20%.

2.2 Statement on optimal infant and young child feeding Practices.

2.2.1 Breastfeeding
Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important health implications for mothers. Breastfeeding should be initiated within one hour of delivery, and no prelacteal foods should be given. Infants should be exclusively breastfed for the first six months (180 days) of life to achieve optimal growth, development and health. After that point in time, to meet their evolving nutritional requirements, infants should be fed nutritionally adequate and safe complementary foods and breastfed up to two years of age or beyond. Exclusive breastfeeding from birth is possible except for a few medical conditions, and unrestricted exclusive breastfeeding results in ample milk production. Optimal infant and young feeding practices by age of child are illustrated in Figure 1.

Even though it is a natural act, breastfeeding is also a complicated behavior that must be learned. Virtually all mothers can breastfeed provided they have accurate information, and support within their families and communities and from the health care system. They should also have access to skilled practical help from, for example, trained health workers, lay and peer counsellors who can help to build mothers’ confidence, improve feeding technique, and prevent or resolve breastfeeding problems.

Women in paid employment can be helped to continue breastfeeding by being provided with minimum enabling conditions, for example paid maternity leave, part-time work arrangements, on-site crèches, facilities for expressing and storing breastmilk, and breastfeeding breaks.

Maintenance of Breastfeeding:

Breastfeeding must be continued up to the age of two years or beyond. Continuing breastfeeding while giving adequate complementary foods to the baby provides all the benefits of breastfeeding to the baby. In other words, the child gets energy, high quality protein, vitamin A, anti-infective properties and other nutrients besides achieving emotional satisfaction from the breastfeeding much needed for optimum development of the child. Breastfeeding especially at night ensures sustained lactation.

In the beginning, when the complementary foods are introduced at six months of age, complementary food should be fed when the infant is hungry. As the child starts taking complementary foods well, the child should be given breastfeeding first and then the complementary food. This will ensure adequate lactation for sustained breastfeeding.

Recommendations:
1. Maintain breastfeeding up to two years of age:
   - Continue frequent, on-demand breastfeeding until 2 years of age or beyond.
   - Continued breastfeeding along with complementary foods during this period results in a decreased risk of morbidity and mortality especially in populations with high risk of contamination

2.2.2 Complementary Feeding

Complementary feeding is defined as the process starting when breast milk alone is no longer sufficient to meet the nutritional requirements of infants, and therefore other foods and liquids are needed, along with breast milk. The target age range for complementary feeding is generally taken to be 6 to 24 months of age, even though breastfeeding may continue beyond two years. Starting complementary feeding too early or starting it too late is both undesirable.

Giving complementary foods too soon is dangerous because:
- A child does not need these foods yet, and they may replace breast milk. If foods are given, the child takes less breast milk, and the mother produces less, so later, it may be more difficult to meet the child’s nutritional needs more difficult to meet the child’s nutritional needs
- A child receives less of the protective factors in breast milk, so the risk of illness increases
- The risk of diarrhea also increases because complementary foods may not be as clean as breast milk
- The foods given instead of breast milk are often thin, watery porridges or soups because these are easy for infants to eat. These foods fill the stomach but provide fewer nutrients than breast milk, and so the child’s needs are not met. Starting complementary feeding too late is also dangerous because:
  - A child does not get the extra food needed to fill energy and nutrient gaps
  - A child stops growing, or grows slowly.
  - The risk of malnutrition and micronutrient deficiencies increases

Appropriate complementary feeding depends on the accurate information and skilled support from the family, community and health care system. Inadequate knowledge about appropriate foods and feeding practices is often a greater determinant of malnutrition than the lack of food. Moreover, diversified approaches are required to ensure access to foods that will adequately meet energy and nutrient needs of growing children, for example use of home-and community-based technologies to enhance nutrient density, bio-availability and the micronutrient content of local foods.

Providing appropriate nutrition counselling to mothers of young children and recommending the widest possible use of locally available foodstuffs will help ensure that local foods are prepared and fed safely in the home. The agriculture and social welfare sectors have important roles to play to ensure the availability and affordability of suitable foods for complementary feeding.

Low-cost complementary foods made of local ingredients, using household or community production technologies can help to meet the nutritional needs of older infants and young children. Industrially processed complementary foods are an option for some mothers who can purchase,
prepare and feed them safely. Processed food products for infants and young children should always meet the quality standards issued by the Amended Pakistan Pure Food Act and other related policy documents.

Food fortification and universal or targeted nutrient supplementation will be necessary methods to ensure that older infants and young children receive adequate amounts of micronutrients for proper growth and development. These micronutrients include, vitamin A supplements, iron supplements, multiple micronutrient supplements or home fortificants, iodized salt, and vitamin A-fortified oil and other fortified products.

Current knowledge emphasizes on the importance of focusing on the family rather than on individual caregivers in designing interventions to improve complementary feeding. Assessing time allocation and time constraints in relation to food preparation and feeding are critical, as is estimating the real costs associated with implementing new feeding recommendations.

**Complementary feeding should be started at six months of age.**

Infants are particularly vulnerable during the transition period when complementary feeding begins. Based on scientific evidence for complementary feeding of the breastfed child, a set of guiding principles of complementary feeding (Table 2) were compiled by PAHO/WHO to help guide policy and programmatic action at global, national and community levels. These guiding principles for complementary feeding of the breastfed child encompass the concept of timeliness, adequacy, safety and responsiveness during complementary feeding. Specifically:

- **timeliness**– meaning that they are introduced when the need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding,
- **adequacy**– meaning that they provide sufficient energy, protein and micronutrients to meet a growing child’s nutritional needs,
- **safety**– meaning that they are hygienically stored and prepared, and fed with clean hands using clean utensils and not bottles and teats,
- **responsiveness**– meaning that they are given consistent with a child’s signals of appetite and satiety, and that meal frequency and feeding method (actively encouraging the child, even during illness, to consume sufficient food using fingers, spoon or self-feeding) are suitable for the age of the child.
Table 2. Guiding Principles of complementary feeding

<table>
<thead>
<tr>
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<th>Guiding Principles of complementary feeding</th>
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<tbody>
<tr>
<td>1</td>
<td>Practice exclusive breastfeeding from birth to 6 months; and Introduce complementary food at 6 months of age while continuing to breastfeed.</td>
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<tr>
<td>2</td>
<td>Breastfeed frequently and on-demand until child is two years of age or older.</td>
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<tr>
<td>3</td>
<td>Practice responsive feeding. Be sensitive to a child’s signals of appetite and satiety, feed slowly and patiently, experiment with different food combinations, tastes, textures and methods of encouragement, minimize distractions and ensure the meal frequency and feeding method is active and suitable for age.</td>
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<tr>
<td>4</td>
<td>Practice good hygiene and proper food handling and storage.</td>
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<td>5</td>
<td>Start with a small amount of food at six months of age and increase quantity gradually as child gets older.</td>
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<tr>
<td>6</td>
<td>Increase food consistency and variety gradually as child gets older.</td>
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<tr>
<td>7</td>
<td>Increase number of times that the child is fed complementary foods as child gets older.</td>
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<tr>
<td>8</td>
<td>Feed a variety of foods to be sure that nutrient needs are met.</td>
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<tr>
<td>9</td>
<td>Use fortified complementary foods or vitamin and mineral supplements for infants and mothers, as needed.</td>
</tr>
<tr>
<td>10</td>
<td>Increase fluid intake during illness, including more frequent breastfeeding. Encourage child to eat. Give food often more after illness.</td>
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Meeting energy and nutrient requirements

Amount of complementary foods needed
Start at six months of age with small amounts of food and increase the quantity as the child gets older, while maintaining frequent breastfeeding. The energy needs from complementary foods for infants with “average” breast milk intake in developing countries are approximately 200 kcal per day at 6-8 months of age, 300 kcal per day at 9-11 months of age, and 550 kcal per day at 12-23 months of age.

Estimated energy requirements from complementary foods, assuming an average breast-milk intake, are
- 200 kcal/day for infants aged 6–8 months,
- 300 kcal/day for infants aged 9–11 months, and
- 550 kcal/day for children aged 12–23 months.
Stages of complementary foods

First food for the young child
The staple cereal of the family should be used to make the first food for an infant. Porridge can be made with suji (semolina), broken wheat, atta (wheat flour), and ground rice, millet by using a little water or milk if available.

Adding sugar and ghee or oil is important as it increases the energy value of the food. In the beginning the porridge could be made a little thinner but as the child grows older the consistency has to be thicker. A thick porridge is more nutritious than a thin one. In case a family cannot prepare the porridge for the infant separately, pieces of half chapatti could be soaked in half a cup of milk or boiled water, mashed properly and fed to the baby after adding sugar and fat. Fruits like banana, papaya, chikoo, mango etc. could be given at this age in a mashed form. Infants could also be given reconstituted instant infant foods at this age, if affordable and can be safely and hygienically prepared.

Traditional foods for infants
Once the child is eating the cereal porridge well, mixed foods including cooked cereal, pulse and vegetable(s) could be given to the child. Most traditional foods given to infants in different parts of the country are examples of mixed foods like khichiri, dalia, suji kheer, etc. Sometimes traditional foods are given after a little modification so as to make the food more suitable for the

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5 UNICEF, IYCF Programming guide
child. For instance, *khichiri* can be made more nutritious by adding one or two vegetables in it while cooking.

**Modified family food**
In most families there is a cereal preparation in the form of *roti* or rice or pulses or a vegetable preparation. For preparing a complementary food for the infant from the foods cooked for the family, a small amount of *dal* or vegetable preparation should be separated before adding spices to it. To increase the consistency of this mixed food, pieces of chapatti and a little oil could be added and mashed well. If necessary, the mixture could be passed through a sieve to get a semi-solid paste. Modifying family’s food is one of the most effective ways of ensuring complementary feeding of infants.

Besides modified family food and reconstituted infant food mixes, foods like milk, curd, *lassi*, egg, fish and fruits and vegetables are also important to help in the healthy growth of the infants. Green leafy vegetables, carrots, pumpkin and seasonal fruits like papaya, mango, *chikoo*, banana etc., are important to ensure optimum vitamin A and iron status of the child.

A baby needs all foods from six months onwards, namely cereals, pulses, vegetables particularly green leafy vegetables, fruits, milk and milk products, egg, meat and fish, oil/ghee, sugar and iodized salt in addition to breastfeeding. A diversified diet of the infant along with breastfeeding will also improve the micronutrients status of the child.

In households which are foods insecure and/or where procurement of animal foods is not possible, nutrient supplementation and/or food fortification would help to ensure that older infants and young children receive adequate amounts of micronutrients.

**Home available cereals**
Infant food mixes can be made at home from food grains available in the household. Mixes could include taking any cereal (rice/wheat) or millet (bajra/jowar) and mix it with readily available pulses (Moong/Chana) as well as groundnuts or white til. These food items can be roasted, ground and mixed and stored separately in airtight containers. Porridge can be made from these homemade cereals with the addition of water or milk, sugar and oil/ghee. Cooked and mashed vitamin A rich fruits or vegetables can also be added, if available. The infant can be fed with this food whenever freshly cooked food is not available in the family. The infant food mix could also be made into preparations like halva, dalia etc., and given to the child.

**Commercially Available cereals**
Processed food products for young children when sold (if unavoidable), should meet the standards recommended by the Codex Alimentarius commission and also the Codex Code of Hygienic Practices for Foods for Infants and Children.

2.2.3 **IMPROVING FEEDING BEHAVIOURS:**
**Responsive Feeding**

Improving complementary feeding requires attention to foods as well as to feeding behaviour of caregivers. Responsive feeding includes adopting a caring attitude while feeding the young child such as talking and playing which in turn stimulates appetite and development. Infants and young children need assistance that is appropriate for their age and developmental needs to ensure that they consume adequate amounts of complementary food. Inappropriate feeding behaviours are an important determinant of malnutrition. Caregivers often are unaware of the importance of responsive feeding, or do not know how to practice it. They need support from health professionals and community-based workers to acquire the necessary knowledge and skills.

**Recommendations:**

Practice responsive feeding

- Caretakers or mothers should feed infants directly and assist older children when they feed themselves, being sensitive to their hunger and satiety cues.
- Feed slowly and patiently, and encourage children to eat, but do not force them.
- If children refuse some foods, experiment with other food combinations, tastes, textures and methods of encouragement.
- Minimize distractions during meals if the child loses interest easily.
- Feeding times should incorporate eye-to-eye contact and be loving moments for learning and bonding with children.
- Give complementary food in a katori or plate. Do not give complementary foods in a feeding bottle.

**Ensuring safe preparation and storage of complementary foods**

Careful hygienic preparation and storage of complementary foods is crucial to prevent contamination. Personal hygiene plays a very important role in feeding infants. If cleanliness is not observed, complementary feeding may do more harm than good to the child, by introducing infections to the infant. It is, therefore, important that all foods prepared for young infants are handled in a way that they are free from any germs.

Some of the hygiene considerations while preparing foods for infants are as under:

- Hands should be washed with soap and water before handling the food as germs that cannot be seen in dirty hands can be passed on to the food.
- Utensils used should be scrubbed, washed well, dried and kept covered.
- The foods prepared for infants should be cooked properly so as to destroy harmful bacteria present, if any.
- After cooking, handle the food as little as possible and keep it in a covered container protected from dust and flies.
- Cooked foods should not be kept for more than one to two hours in hot climate unless there is a facility to store them at refrigeration temperature.
- The hands of both mother and child should be washed before feeding the child.

**Recommendations:**
Complementary foods should be safely prepared and stored:

- Good hygiene and proper food handling practices minimize contamination by diseases or parasites.
- Wash caregivers and children’s hands before food preparation and eating.
- Store foods safely and serve food immediately after preparation.
- Use clean utensils for preparation, serving and feeding children.
- Avoid the use of bottles, which are difficult to keep clean.

**Food consistency**

Gradually increase food consistency and variety as the infant gets older, adapting to the infant’s requirements and abilities. Infants can eat pureed, infant’s requirements and abilities. Infants can eat pureed, mashed and semi-solid foods beginning at six months. By eight months, most infants can also eat “finger foods” (snacks that can be eaten by children alone). By 12 months, most children can eat the same types of foods as consumed by the rest of the family (keeping in mind the need for nutrient-dense foods). Avoid foods that may cause choking (i.e., items that have a shape and/or consistency that may cause them to become lodged in the trachea, such as nuts, grapes, raw carrots).

**Meal frequency and energy density**

Ensure meal frequency and energy density by

- Increasing the number of times the child is fed complementary foods as he/she gets older. The appropriate number of feedings depends on the energy density of the local foods and the usual amounts consumed at each feeding.
- On average, meal frequencies are recommended – assuming a diet with energy density of 0.8 kcal per gram or above and low breastmilk intake – are at least:
  - 2-3 meals per day for infants aged 6–8 months; 3 meals per day for infants aged 6–8 months;
  - 3-4 meals per day for infants aged 9-11 months and 12-23 months with additional nutritious snacks (such as a piece of fruit or bread / chapatti with butter) being offered 1-2 times a day, as desired. Snacks are defined as foods eaten between meals, usually self-fed, convenient and easy to prepare.
- If energy density is low, or if the child is no longer breastfed, more frequent meals may be required.

Some good complementary foods which are energy-rich, nutrient-rich, locally available and affordable, include thick cereals with added oil or milk; fruits, vegetables, legumes, meat, eggs, fish, and milk products. Energy density of foods given to young children can be increased in four different ways:

i) By adding a teaspoonful of oil or ghee in every feed. Fat is a concentrated source of energy and substantially increases energy content of food without increasing the bulk.

ii) By adding sugar to the child’s food. Children need more energy and hence adequate amounts of sugar should be added to child’s food.
iii) By giving malted foods. Malting reduces viscosity of the foods and hence child can eat more at a time. Malting is germinating whole grain cereal or pulse, drying it after germination and grinding. Infant Food Mixes prepared after malting the cereal or pulse will provide more energy to the child. Flours of malted food when mixed with other foods help in reducing the viscosity of that food. Amylase Rich Flour (ARF) is the scientific name given to flours of malted foods and must be utilized in infant foods.

iv) By feeding thick mixtures. Thin gruels do not provide enough energy. A young infant particularly during 6-9 months requires thick but smooth mixtures, as hard pieces in the semisolid food may cause difficulty if swallowed. The semi-solid foods for young infants can be passed through a sieve by pressing with a ladle to ensure that the mixed food is smooth and uniform without any big pieces or lumps.

**Nutrient content of complementary food and dietary diversity**

In order to meet the nutrient requirements, a young child should be fed a mixture of complementary foods. Staple cereals provide energy and nutrient but are poor sources of iron, zinc and calcium. This means that in order to meet the nutrient requirements, staple foods must be eaten with other foods for a child to get enough nutrients. Good complementary food is rich in energy, protein and micronutrients (particularly iron, zinc, calcium, vitamin A, vitamin C and folate).

**Recommendations:**
- Meat, poultry, fish or eggs should be eaten daily, or as often as possible. Where this is not possible, the use of fortified complementary foods and vitamin-mineral supplements are necessary to ensure the nutrient needs are met.
- Vitamin A-rich fruits and vegetables should be eaten daily. Serve vitamin A-rich foods with fats to increase absorption. Serve citrus fruits with iron- and protein-rich foods to increase absorption.
- Provide diets with adequate fat content.
- Avoid giving drinks with low nutrient value, such as tea, coffee and sugary drinks such as soda.
- The amount of iron absorbed from eggs, milk and plant foods e.g. cereals, legumes, vegetables and fruits in increased by eating at the same meal a) foods rich in vitamin C; b) flesh and organs/offal of animals; c) fish and other seafood. Iron absorption is decreased by drinking teas, coffee and soft drinks.
- Eating fermented cereals increases iron absorption.
- Limit the amount of juice offered in order to avoid displacing more nutrient-rich foods.
- Biscuits, rusks are not a good source of nutrient and should not be given as the main meal.

**Use of vitamin-mineral supplements or fortified products for infant and mother**

Vitamin-mineral supplements or fortified products be used by the infant and mother when needed.
• Use fortified complementary foods or Vitamin-mineral supplements for the infant, as needed.
• Provide breastfeeding (and pregnant) mothers with vitamin-mineral supplements or fortified products, both for their own health and to ensure normal concentrations of certain nutrients in their breast milk.
• Food fortification and universal or targeted nutrient supplementation may also help to ensure that older infants and young children receive adequate amounts of micronutrients.

Feeding during and after illness
During the complementary feeding period, i.e., from six months to two years of age, young children often suffer from infections like diarrhoea, measles, cold, cough etc. If their diet had been adequate, their symptoms are usually less severe than those in an undernourished child. A sick child needs more nourishment so that he could fight infections without using up nutrient reserves of her body. However, a child may lose appetite and may refuse to eat, but the child needs adequate nutrition to get better from illness.

Appropriate feeding during and after illness is important to avoid weight loss and other nutrient deficiencies. The cycle of infection and malnutrition can be broken if appropriate feeding of infant is ensured. Breastfed infants have lesser illness and are better nourished.

After the illness when the child is recovering, a nutritious diet with sufficient energy, protein and other nutrients is necessary to enable him to catch up growth and replacement of nutrient stores. The nutrient intake of child after illness can be easily increased by increasing one or two meals in the daily diet for a period of about a month or so.

Recommendations:
Continue feeding during illness and feed more after illness
• Increase fluid intake during illness, including more frequent breastfeeding and longer feeds both day and night.
• Encourage the sick child to eat soft, varied, appetizing, foods. The mother or caregiver should also offer the child’s favorite foods for his/her age group and help caregiver should also offer the child’s favorite foods for his/her age group and help and encourage the child to eat.
• Encourage the child to eat more food (at least one extra meal) after illness to catchup”. Food taboos (yogurt, rice, banana) are safe to give during or after diarrhea/ respiratory illness
• Make sure that children with measles, diarrhea and respiratory infections eat plenty of vitamin A-rich food.

Exercising other feeding options
The vast majority of mothers can and should breastfeed, just as the vast majority of infants can and should be breastfed. Only under exceptional circumstances can a mother’s milk be stances can
a mother’s milk be considered unsuitable for her infant. For those few health situations where infants cannot, or should not, be breastfed, the choice of the best alternative (expressed breastmilk from an infant’s own mother or a breastmilk substitute fed with a cup) must be decided on based on individual circumstances. Bottle feeding is strongly and actively discouraged at all times as it easily spreads infections that cause diarrhoea.

2.2.4 Growth Monitoring and Health Education & Promotion.
Weighing and measuring the child regularly and plotting the weight and height/length on the health card is an important tool to monitor the growth of the baby. Infants and young children should be weighed and measured every month in the presence of their mothers and the growth status of the child should be explained to the mother. If the child is malnourished, the mothers should be advised to provide additional food to the child every day. Malnourished children should be followed up at home and mothers are encouraged to come and ask questions regarding the feeding and care of the child.

The time of vaccination is an additional opportunity to weigh and measure a child and should not be missed. Anthropometric measurements should take place BEFORE the vaccination. LHW Health House should be the preferred location for conducting growth monitoring and nutrition promotion activities. In general, growth monitoring/promotion programs that require frequent, accurate weighing and measuring of all children, correct interpretation of measurements, and follow-up action have been difficult to maintain on a large scale in our health programs and subsequently counseling and follow-up activities have also been neglected.

IMCI guidelines recommend that health workers should use feeding guidelines as the criteria for assessing whether feeding is adequate and for proposing changes to mothers in how they feed their children. Growth faltering can be prevented before it occurs by dealing with feeding problems early. However, growth monitoring activities can be useful for targeting resources, increasing participation, mobilizing communities, and tracking progress in reducing malnutrition. Health managers should pay special attention to the counseling and follow-up components of growth monitoring activities in their area. Growth monitoring and promotion efforts should focus on young children from birth to 2 years and should ideally begin with monitoring nutrition practices in pregnant women. Growth monitoring activities should be accompanied by immunizations, early detection of infections, detection of risk signs in pregnant women, micronutrient supplementation, and, where needed, malaria prophylaxis, and deworming.

When a child with poor growth is detected, health workers should follow-up with home visits and look for underlying problems, such as inadequate maternal and child care and health practices. When a child continues to grow poorly, there should be a detailed assessment of the causes. Cases of severe malnutrition (children with edema in both feet, visible severe wasting, and very low weight-for-age) should be admitted/referred for clinical care immediately; and follow WHO guidelines (1999) for their management.

Utilizing the available nutrition and health services
There are a number of nutrition and health services available for young children in almost all places. The people in the community should be informed about various services which are available for children in the village, at the Lady Health Worker Health House, at the Basic Health Unit, Rural Health Centre, etc. Every effort should be made to encourage the community members to make use of these facilities so as to promote child health.

2.3. IYCF FEEDING IN DIFFICULT CIRCUMSTANCES AND EMERGENCIES

Families in difficult situations require special attention and practical support to be able to feed their children adequately. These situations include severe acute malnutrition, emergencies and HIV infection of the mother. In such cases, the likelihood of not breastfeeding increases, as do the dangers of artificial feeding and inappropriate complementary feeding. In all exceptionally difficult circumstances, mothers and infants should remain together and be given ample support to provide the most appropriate feeding options. Active measures are needed to identify infants, children and mothers in need of special attention so that their condition can be identified and treated, for example, through growth monitoring and promotion, nutritional surveillance in emergencies, and confidential voluntary counselling and testing (VCT) for HIV.

Recommendation
Caregivers, community health workers, home visitors, and other persons who circulate frequently among the shelters and homes of affected populations should be:

- Aware of the dangers of malnutrition and why it is essential to follow up on cases
- Able to recognize malnutrition’s early signs
- Know how to identify malnutrition’s underlying causes, for example infectious
- Equipped with appropriate information for reporting, referral and follow-up
- Able to recognize poor feeding practices and prepared to advise caregivers on their improvement, for example by demonstrating safe food preparation and feeding

2.3.1 Low Birth Weight (Preterm or IUGR Infants)

Feeding is the center piece of care for the low birth weight new-born. At the time of delivery, the health care provider should help the mother assess the feeding options appropriate for her circumstances. The mother’s options will depend on the level of prematurity of the circumstances.

Low birth weight infants need special attention. Most LBW infants are born at or near term and can and should be breastfed within the first hour after birth. The feeding guidelines for LBW infants as well as for infants weighing 2500 grams or more include initiation of breastfeeding within the first hour, exclusive breastfeeding (no pre lacteal feeds, liquids, or other foods), establishment of good breastfeeding skills, and frequent breastfeeds.
Most term LBW infants can initiate breastfeeding immediately. Exclusive breastfeeding is sufficient for term LBW infants for the first six months (with supplemental iron). However, they require greater care and attention to temperature maintenance and the establishment of good feeding practices than normal weight infants. They may want frequent feeding though they may tire easily.

Many pre-term infants are not able to breastfeed in the first days or weeks, but they will benefit greatly from expressed breastmilk. Pre-term infants initially may have difficulty suckling at the breast because they are unable to latch on and suckle effectively. Pre-term milk, which has a higher concentration of proteins than term milk, is especially suited for the preterm baby. The mother needs to know that every drop of breastmilk is valuable to her infant, especially colostrum. This sticky, yellow-white early milk is rich in antibodies, vitamin A, and other protective factors. With additional assistance and support, nearly every mother of a preterm infant will, in time, be able to breastfeed her infant.

All mothers after childbirth need emotional support, encouragement, good nutrition, and rest. Feeding a preterm infant can be especially demanding and exhausting. The initial feedings may represent a learning process requiring time and patience. The assistance and reassurance of health care providers and the support of family are particularly important during this time.

LBW infants should breastfeed frequently, 8–12 times per 24 hours, every 2–3 hours or more frequently, when needed. The smaller the infant, the more frequent the feeds need to be. LBW infants may take longer to feed than larger infants. They should be left at the breast and allowed to continue feeding when they are ready. Some may require expressed milk by cup after breastfeeding. Bottles are easily contaminated and should not be used. Artificial nipples/teats do not conform to an infant’s mouth the same way as a mother’s nipple.

In some pre-term infants, the ability to suck may be weak or absent. If the infant is unable to feed at the breast, the health care provider can help the mother of a pre-term infant express her breastmilk and feed it to the infant from a cup. The mother should start hand expressing as soon as possible after delivery. She can then give colostrum to the infant, sometimes drop by drop directly into the infant’s mouth or by spoon. She should express as much milk as possible every time the infant needs to feed, about every 2 to 3 hours, with no long interval between each breastmilk expression. Breastmilk expression often takes 20–30 minutes or longer for adequate expressing of milk. Many women cannot feel whether their breasts are producing milk; it is important to express even if the breasts do not feel full. If the milk supply is too low and needs to be built up, the mother should express more frequently for a few days (every hour during the day and every three hours at night).

An infant can rapidly become accustomed to a way of sucking from an artificial nipple which, when applied to the breast, can cause the mother pain and be less effective in removing the breastmilk. An infant can learn to feed from a small cup or glass, spoon, or other appropriate feeding device. These are all easier to clean than a bottle.

**Cup feeding**
When a LBW infant is fed by cup, he or she initially “laps” the milk with the tongue. This action does not interfere later with attachment when the infant is ready to feed at the breast.

**Spoon feeding**

Spoon feeding is safe, but many people find it more difficult than using a cup. For infants with breathing problems, spoon feeding may be the best approach until the breathing problem has lessened. Preterm infants can have breathing problems because of immature lungs. LBW infants born at term may have breathing problems from other causes, such as a severe infection (pneumonia) or meconium aspiration. Care should be taken not to pour the milk from the spoon into the infant’s mouth. The infant should be allowed to sip the milk from the spoon, or very small amounts can be put into the infant’s mouth.

**Identification and Management of severely acute malnourished children**

Severe acute malnutrition is defined by a very low weight for height (below -3 z scores of the median WHO growth standards), by visible severe wasting, or by the presence of nutritional edema. In children aged 6–59 months, an arm circumference less than 11.5 cm is also indicative of severe acute malnutrition.

Lady health workers or other health care providers can easily identify the children affected by severe acute malnutrition using simple colored plastic strips that are designed to measure mid-upper arm circumference (MUAC). In children aged 6–59 months, a MUAC less than 11.5 cm indicates severe acute malnutrition, which requires urgent treatment.

Lady health workers can also be trained to recognize nutritional edema of the feet, another sign of this condition. Once children are diagnosed with suffering from severe acute malnutrition, they need to be seen by a health worker who has the skills to fully assess them following the Integrated Management of Childhood Illness (IMCI) approach. The health worker should then determine whether they can be treated in the community with regular visits to the health center, or whether referral to in-patient care is required.

Early detection, coupled with decentralized treatment, makes it possible to start management of severe acute malnutrition before the onset of life threatening complications.

Severely malnourished children with complications require nutritional stabilization and treatment in facility settings followed by community-based rehabilitation as soon as they are stable. The children could be followed up every fortnight for growth monitoring, health checkup and supply of suitable ready-to-use therapeutic foods or dietary supplements for a period of three months. When malnourished children improve with appropriate feeding, they themselves would become educational tools for others.

Provision for welfare assistance of severely malnourished children during their period of rehabilitation should be incorporated through *zakat* and *bait-ul-maal* programs as well as through private sector donations.

**2.3.2 Feeding During Emergencies**
Emergency situations can be defined for this document as when natural or man-made calamities cause a community to be detached from its normal livelihood system. Infants and children are among the most vulnerable victims of natural or man-made emergencies, and this vulnerability often lasts long after the immediate crisis has ended. Interrupted breastfeeding and inappropriate complementary feeding heighten the risk of malnutrition, illness and mortality. The protection, promotion and support of infant and young child feeding practices should be in the first actions taken to address an emergency.

Floods, epidemics, interrupted breastfeeding and inadequate complementary feeding heighten the risk of acute malnutrition (low weight for height), illness and mortality. Children suffering from acute malnutrition are at high risk of death and need special emergency care. Four steps have to be taken to respond to acute malnutrition:

- Active screening of children, pregnant and lactating women for acute malnutrition (Weight/Height percentage of the median),
- Targeted supplementary feeding programs (TSFP) for the treatment of moderate malnutrition and the prevention of severe malnutrition, and
- Outpatient therapeutic feeding programs (OTP) for the treatment of severe malnutrition
- Stabilization care (SC) for the treatment of severe acute malnutrition with complication.

Uncontrolled distribution of breastmilk substitutes in refugee settings and resettlement areas, can lead to early and unnecessary cessation of breastfeeding and must be prevented. For the vast majority of infants, emphasis should be on protecting, promoting and supporting breastfeeding and ensuring judicious, safe and appropriate complementary feeding. A small number of infants may have to be fed on breastmilk substitutes. In that case, suitable substitutes, procured, distributed and fed safely as part of the regular inventory of foods and medicines, should be provided.

Clear action-orientated messages on appropriate practices should be given at points of contact with affected families in emergencies with due focus on the following essentials to ensure child survival, nutrition and health:

- Emphasis should be on protecting, promoting and supporting breastfeeding and ensuring timely, safe and appropriate complementary feeding, although there will always be a small number of infants who have to be fed on breast milk substitutes
- Pregnant and lactating women should receive priority in food distribution and should be provided extra food in addition to general ration.
- Complementary feeding of infants aged six months to 59 months should receive priority.
- Pregnant women, lactating women and children aged 6-59 months should be provided with extra rations of fortified supplementary foods and micronutrient supplements (vitamin A supplementation for children 9-59 months and postpartum women, iron-folate or multiple micronutrient supplements for pregnant and breastfeeding women, and children aged 6-59 months)
- Donated food should be appropriate for the age of the child.
- Immediate nutritional and care needs of orphans and unaccompanied children should be taken care of.
• Efforts should be made to reduce ill effects of artificial feeding, by ensuring adequate and sustainable supplies of breast milk substitutes, proper preparation of artificial feeds, supply of safe drinking water, appropriate sanitation, adequate cooking utensils and fuel.

### 2.3.3 Feeding in Maternal HIV, Maternal TB and Maternal Hepatitis B.

The prevalence of HIV in Pakistan is still low, and the opportunity exists to prevent the infection from expanding beyond the current low level. The Pakistan IYCF Strategy has a clear role to play in infant feeding issue. The overall objective of HIV and infant feeding actions is to improve child survival by promoting appropriate feeding practices.

WHO guidelines state “when replacement feeding is acceptable, feasible, affordable, sustainable, and safe, avoidance of all breast-feeding by HIV-infected mothers is recommended. Otherwise, exclusive breast-feeding is recommended during the first months of life and then should be discontinued as soon as it is feasible”. In Pakistan, the PMTCT care team should make a careful assessment of the mother’s ability to provide safe replacement feeding (ability to purchase powdered infant formula on a regular basis, ability to sterilize bottles, and access to clean water) in a sustainable manner and counsel the mother about the most appropriate choice for her situation.

According to the Guidelines for treatment and prevention of HIV and AIDS in Pakistan 2015, two options of infant feeding is recommended for HIV positive mothers: **Exclusive breast feeding (preferred and prioritized)** and exclusive replacement feeding through Breast milk substitute (BMS). **Exclusive breast feeding is recommended unless BMS is Acceptable, Feasible, Affordable, Sustainable and Safe (AFASS) before that time (for details, refer to guidelines).**

According to the National TB guidelines in Pakistan 2015 (revised), a breastfeeding woman who has TB should receive a full course of TB treatment. Timely and properly applied chemotherapy is the best to prevent transmission of tubercle bacilli to her baby. All anti-tuberculosis drugs are compatible with breastfeeding; a woman taking them can safely continue to breastfeed. Mother and baby should stay together and the baby should be given prophylactic Isoniazid for at least 6 months.

To substantially reduce perinatal transmission of hepatitis B, and virtually eliminate any risk of transmission through breastfeeding or breastmilk feeding, WHO recommends that all infants receive hepatitis B vaccine as part of routine childhood immunization. Where feasible, the first dose should be given within 48 hours of birth or as soon as possible thereafter. Immunization of infants will also prevent infection from all other modes of HBV transmission. There is no evidence that breastfeeding from an HBV infected mother poses an additional risk of HBV infection to her infant, even without immunization. Thus, even where HBV infection is highly endemic and immunization against HBV is not available, breastfeeding remains the recommended method of infant feeding in HBV. There is a considerable risk of morbidity and mortality among infants who are not breastfed.
Table 3: Time appropriate topics for discussion with mothers and families on IYCF

<table>
<thead>
<tr>
<th>Time in Life Cycle</th>
<th>Topics</th>
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</table>
| Pregnancy          | · Put the child to the breast with skin to skin contact within first hour after delivery  
|                    | · Feed colostrum                                                        |
|                    | · No pre-lacteal feeds                                                  |
|                    | · Multiple Micronutrients Supplements                                    |
| Delivery/          | · Put the child to the breast with skin to skin contact within first hour after delivery  
| postpartum         | · Good breastfeeding practices (i.e. positioning, attachment, emptying of the breast, frequency for day and night feeds) |
|                    | · Feeding of colostrum                                                  |
|                    | · Exclusive breastfeeding up to 6 months                                |
|                    | · Post-partum vitamin A supplement/iron-folate supplements               |
|                    | · Good nutrition for the breastfeeding mother                            |
| Child              | · Exclusive breastfeeding up to 6 months of age                          |
| 0-6 months         | · No breast milk substitutes (unless necessary for medical reasons) or bottles    |
|                    | · Good breastfeeding practices (i.e. positioning, attachment, emptying of the breast, frequency for day and night feeds) |
|                    | · Coping with lactation problems (engorgement, not enough milk, mastitis, cracked nipples etc.) |
|                    | · Nutrition for the breastfeeding mother                                 |
| Child              | · Introduction of complementary foods at 6 months                       |
| 6-11 months        | · Quantity, frequency, consistency, variety, safety of complementary foods for various age groups  
|                    | · No breastmilk substitutes or bottles                                   |
|                    | · How to complementary feed a child with individual bowl or plate.       |
|                    | · Nutrition for the breastfeeding mother                                 |
|                    | · Vitamin and minerals supplementation                                 |
| Child              | · Continued breastfeeding                                               |
| 12-23 months       | · No breast milk substitutes or bottles                                  |
|                    | · Introduction of family foods                                          |
|                    | · Continued use of individual plate or bowl for child                    |
|                    | · Good nutrition for children — frequency, quantity, quality, hygiene    |
|                    | · Nutrition for the breastfeeding mother                                 |
2.4 Strategies:

The priority strategies for infant and young child feeding in Pakistan fall into four categories: 1) legislation, policy and standards; 2) health system support; 3) community-based support; and 4) support in exceptionally difficult circumstances (Table 4).

Legislation, policies and standards are needed to protect infant and young child feeding practices. They include measures to prevent unethical marketing of breast-milk substitutes, to protect the breastfeeding rights of employed women, and to ensure adequate labelling and quality of products intended for consumption by infants and young children.

The practices and routines of all health facilities should actively promote the initiation and continuation of breastfeeding. Every opportunity should be taken during contacts between mothers and health service providers to give counseling on infant and young child feeding through integration of infant and young child feeding activities with health and nutrition programmes. Health service providers themselves need updated knowledge and skills to effectively support infant and young child feeding.

Mother need support for infant and young child feeding in the communities where they live. Community-based support of infant and young child feeding should therefore be an essential element of efforts to improve practices. The LHWs play vital role in this area.

Special emphasis on the protection, promotion and support of infant and young child feeding is needed when exceptionally difficult circumstances arise, for example, emergencies, floods, earthquake, HIV/AIDS and malnutrition. These circumstances often hinder the ability of a mother to feed her child at the very time when her child needs it most.

Table 4: Priority strategies for infant and young child feeding in Pakistan
Legislation, policy and standards

Strategy 1: Code of marketing of breast-milk substitutes
Strategy 2: Maternity protection in the workplace
Strategy 3: Codex standards
Strategy 4: National and provincial policies and plans.

Health system support

Strategy 5: Baby-friendly Hospital Initiative
Strategy 6: Mainstreaming and prioritization of IYCF activities
Strategy 7: Knowledge and skills of health service providers

Community-based support

Strategy 8: Community-based support for IYCF

IYCF in exceptionally difficult circumstances

Strategy 9: IYCF in exceptionally difficult circumstances

Others:

Strategy 10: Micronutrient Supplementation / fortification

Strategy 1: Code of marketing of breast-milk substitutes

Breastmilk is the best food for an infant’s first six months of life. It contains all the nutrients an infant needs and it stimulates the immune system and protects from infectious diseases.

Breastmilk substitutes is an expensive, inferior and often dangerous substitute for breastmilk, but formula manufacturers have nonetheless advertised and marketed them. Recognizing the need to regulate these practices, the World Health Assembly (WHA) adopted the International Code of Marketing of Breast-milk Substitutes in 1981, and subsequently the Government of Pakistan took action to promulgate the “Protection of breastfeeding and Young Child Nutrition Ordinance 2002” to implement the BMS code by regulating the marketing of breastmilk substitutes. Furthermore, Sindh Protection and Promotion of Breast Feeding and Child Nutrition Act 2013 in Sindh and Khyber Pakhtunkhwa Protection of Breast Feeding and Child Nutrition Act 2014 are endorsed by respective provincial governments.

The aim of the Ordinance and the Acts is to contribute to the provision of safe and adequate nutrition for infants, by ensuring appropriate marketing and distribution of breast-milk substitutes and to prohibit their promotion and to emphasize the need to protect breast feeding in all circumstances. The Code is monitored by the National Infant Feeding Board. The Federal as well as provincial governments shall ensure its compliance by establishing the enforcement mechanism.
The National IYCF Strategy calls to ensure that all provisions of the International Code and subsequent WHA resolutions are incorporated. The scope of the Ordinance should be broadened by formulation rules and regulation to ensure that all products intended for consumption by infants and young children are appropriately marketed and distributed and other provinces should follow the same legislation and Sindh and KP done. There is need to strengthen the monitoring and enforcement procedures for effective implementation of the National Ordinance so that violations are more effectively detected and swift legal action is taken. The awareness of policy-makers, infant-food manufacturers, health service providers and the general public about the Ordinance, needs to be raised.

**Strategy 2: Maternity protection in the workplace**

Increasing numbers of women are joining the workforce in both rural and urban areas of Pakistan, and their contribution to the economy is significant. At the same time, their ability to exclusively and continually breastfeed their infants and young children is essential to ensure a healthy, well nourished, and economically productive future workforce. The two roles of women as workers (economically productive) and mothers (reproductive) should be respected and accommodated by both the government and society.

The International Labour Organization (ILO) Maternity Protection Convention No. 183 was passed in 2001 to protect the maternity and breastfeeding rights of employed women. The Government of Pakistan took action for maternity protection in the workplace through the Maternity Leave Law, which granted women in government service in Pakistan with 90 days of flexible full pay leave. This should be increases up to 180 days maternity leave (50% with full pay and 50% with half average pay for first two children only). This maternity leave enables on-demand exclusive breastfeeding, bonding between mother and infant, mother’s recovery and care seeking for postnatal health services. Unfortunately, there is no maternity protection for the increasing numbers of mothers who work in the private sector. These working arrangements prevent working mothers from optimally feeding their infants and young children, and force them to choose between income today and protecting the child’s future health and development.

As maternity benefits are basic human rights for all women, the Pakistan IYCF Strategy calls for amendments to the current legislation to include all provisions of the ILO Maternity Protection Convention No. 183 for all employed women. The legislation needs to be widely publicized among all stakeholders, especially employers and the public, and a mechanism for its monitoring and enforcement should be established.
Employers should also be motivated to create better opportunities for women to breastfeed at the workplace including the creation of crèches, breastfeeding breaks, and comfortable private spaces to breastfeed.

**Strategy 3: Codex Alimentarius**

The Codex Alimentarius is the international body that aims to protect the health of consumers. Codex standards cover infant formula, tinned baby food, processed cereal-based foods for infants and children, and follow-up food. There are also Codex guidelines for formulated supplementary food for older infants and young children with advisory lists of mineral salts and vitamin compounds that may be used in these foods as well as a code of hygienic practices.

The Codex standards for infant formula and processed cereal-based foods for infants and children define the products and their scope and cover composition, quality factors, food additives, contaminants, hygiene, packaging, labelling and methods of analysis and sampling.

The Pakistan Pure Food Ordinance is to provide better control of the manufacture and sale of food for human consumption. It’s objective is to review/update and enforce the implementation of 1960 West Pakistan Pure Food Ordinance for fortification of Ghee and cooking oils with vitamin-A and D. A draft Pure Food Act 2007 has been prepared by NIH Islamabad. After devolution, Punjab government has approved Punjab Pure Food Rules, 2011; in lined with codex standard as well as has established Punjab Food Safety and Standards Authority. Other provinces are also expected to formulate the same in their own context and ensure that the rules are followed in true spirit.

<table>
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<tr>
<th><strong>Strategy 3: Codex Alimentarius</strong></th>
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<tbody>
<tr>
<td>Ensure that processed infant and complementary foods are safe and nutritionally adequate, in accordance with the relevant Codex Alimentarius standards.</td>
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</table>

The Pakistan IYCF Strategy calls for action to ensure that processed infant and complementary foods are safe, nutritionally adequate and appropriately labelled in accordance with the relevant Codex Alimentarius standards. There should be compulsory certification of all infant and complementary foods intended for consumption by infants and young children. In order to monitor and ensure compliance there is a need to establish Food Safety Authorities at federal and provincial levels.

**Strategy 4: Integrate IYCF strategy in to National and provincial policies and plans**

Optimum breastfeeding and complementary feeding practices not only improves short and long-term health outcomes but it contributes to a stronger economy by reducing health expenditure, improving educational achievement and productivity among adults. The focus of national development policies and plans on infant and young child feeding should commensurate with these impacts.
Examples of existing policies and plans that would benefit from a stronger focus on infant and young child feeding include, the Poverty Reduction Strategy Paper, National Nutrition Strategic Policy (2006), National Plan of Action for Nutrition (2003) and Pakistan Integrated Nutrition Strategy 2011. In January 2013, Pakistan joined Scaling up Nutrition (SUN) Movement to foster a multi-sectoral approach to address nutrition by overseeing policy, strategy and surveillance. Pakistan Vision 2025 has been developed after extensive inputs and deliberations of all stakeholders and approved by National Economic Council in May 2014. All national and provincial policies and programmes must be in line with vision 2025, and incorporate and recognize homes that have household food insecurity and families whose resources may be insufficient to meet the challenges of the IYCF recommendations. For such households, health workers should be given guidelines regarding how to access welfare programs, public social welfare funds, private and public sector partners who can assist in helping these families meet the requirements of the national IYCF recommendations.

<table>
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<tr>
<th>Strategy 4: National policies and plans</th>
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<tbody>
<tr>
<td>Incorporate infant and young child feeding interventions into national development policies and plans, major health initiatives and other projects to advocate for its importance and mobilize resources.</td>
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</table>

The Pakistan IYCF Strategy calls for IYCF to be strongly anchored within the broad development agendas of the government and in all relevant programmes. All opportunities should be taken to incorporate infant and young child feeding interventions into national policies and plans, major health initiatives, such as National Program for Family Planning and PHC, Maternal Neonatal and Child Health program, the Global Fund for Malaria, Tuberculosis and HIV/AIDS, and other projects to advocate for action and mobilize resources.

<table>
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<tr>
<th>Strategy 5: Baby Friendly Hospital Initiative:</th>
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<tr>
<td>Hospitals set a powerful example for mothers, and they all have an important role as centers of breastfeeding support. The Baby-Friendly Hospital Initiative (BFHI) was introduced in Pakistan in 1998 to improve hospital routines and procedures so that they are supportive of the successful initiation and continuation of optimal breastfeeding practices. A hospital is designated as “baby friendly” when it has agreed not to accept free or low-cost breastmilk substitutes, feeding bottles or teats, and to implement 10 specific steps to support breastfeeding (“Ten steps to successful breastfeeding”).</td>
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<tr>
<th>Strategy 5: Baby-Friendly Hospital Initiative</th>
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<tr>
<td>Ensure that every health facility successfully and sustainably practices all the “Ten steps to successful breastfeeding” and other requirements of the BFHI.</td>
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The Pakistan IYCF Strategy calls for a revitalization of efforts in BFHI to achieve full coverage of all health facilities in the country, including private and non-government facilities; to monitor the quality of implementation to ensure adequate standards of care; to strengthen the reassessment (recertification) of baby-friendly status; and to mainstream BFHI into the health system as an essential component of quality assurance and improvement of care. Ways should
also be found to strengthen the establishment of community-based support groups as an important avenue to increase coverage of skilled support (the tenth step of the “Ten steps to successful breastfeeding” of BFHI; see also Strategy 8). It should be included in pre-service and in-service training of all the health care providers.

**Strategy 6: Mainstreaming and prioritization of IYCF activities**

Optimal infant and young child feeding requires substantial behavior change on the part of a mother. This cannot be achieved through a single contact with a health service provider, Mothers need multiple contacts to acquire knowledge, reinforce positive behaviors and solve problems throughout the latter stages of pregnancy and during the first two years of life of a child. It is essential that IYCF along with hygiene and sanitation education must be incorporated, to the extent possible, as a priority action in all existing programmes and projects with which the mother has contact during this crucial period. However, IYCF has already been incorporated in existing MNCH programmes and services at PHC level, LHW programme as well as CMAM programmes.

The Pakistan Strategy calls for the integration of skilled counseling and support for infant and young child feeding at all points of contact between mothers and health service providers during pregnancy and the first two years of life of a child, including antenatal care, delivery care, postnatal care, immunization visits, growth monitoring and promotion, and child health services. Table 5 lists some of the major programmes and projects into which IYCF activities can be integrated. It is important that all these programmes and projects use consistent messages and materials to support infant and young child feeding, including the use of uniform guidelines, training materials, and job aids.

**Table 5: Existing health and nutrition programmes and projects in Pakistan into which IYCF activities can be integrated**

<table>
<thead>
<tr>
<th>Health contact point</th>
<th>Programme/project</th>
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<tbody>
<tr>
<td>Antenatal</td>
<td>Maternal, Neonatal and Child Health Program</td>
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<tr>
<td></td>
<td>National Program for Family Planning and Primary Health Care</td>
</tr>
<tr>
<td>Family planning</td>
<td>Family Planning Field Services Delivery</td>
</tr>
<tr>
<td>Growth Monitoring and Promotion</td>
<td>National Program for Family Planning and Primary Health Care</td>
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<tr>
<td></td>
<td>Expanded Programme on Immunization</td>
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<tr>
<td>Sick Child Consultations</td>
<td>Primary Health care service package at health facility.</td>
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<tr>
<td></td>
<td>National Program for Family Planning and Primary Health Care</td>
</tr>
<tr>
<td>Recognition and Management of Severe Acute malnutrition &amp; Severe Anemia</td>
<td>Integrated Management of Child Illness (facility and community)</td>
</tr>
<tr>
<td></td>
<td>Maternal, Neonatal and Child Health Program</td>
</tr>
<tr>
<td></td>
<td>National Program for Family Planning and Primary Health Care</td>
</tr>
<tr>
<td></td>
<td>National HIV &amp; AIDS/ TB/ Malaria program</td>
</tr>
</tbody>
</table>

**Strategy 7: Knowledge and Skills of Health Service Providers**

Health service providers, nutritionists and allied professionals who care for mothers need up-to-date knowledge on infant and young child feeding legislation, policies and guidelines, and skills training for interpersonal communication, counselling and community mobilization.

The most sustainable way to address the current knowledge and skill gaps is to include essential knowledge and competences in the pre-service curricula of all the health care providers both public and private sector. While such efforts progress, there is also need to increase the skills of those who are already in service through action-oriented, skills-focused training.

**Strategy 7: Knowledge and skills of health service providers**

Improve the knowledge and skills of health service providers at all levels to give adequate support to mothers on infant and young child feeding, including skills training on interpersonal communication, counselling and community mobilization.

The Pakistan Strategy calls for a revision and periodic update of pre-service and in-service curricula and training materials of all health care providers including community workers, volunteers and highly qualified medical doctors. Conditions to ensure sustainable implementation and training include guidelines on infant and young child feeding; teams of experienced trainers for both in-service and pre-service education; strict criteria for selection of trainers and trainees; and monitoring of the quality of training and follow-up.

**Recommendations:**

Provide skilled counseling and support for infant and young child feeding, during immunization sessions, at in- and outpatient services for sick children, at nutrition services, and at reproductive
health and maternity services. Given that in Pakistan, most mothers do not have access to health facilities, skilled nutrition counseling through the LHW program should be regularized.

1. Ensure effective therapeutic feeding of sick and malnourished children, including the provision of skilled breastfeeding support when required.
2. Promote good nutrition for pregnant women and lactating mothers.
3. Train health workers who care for mothers, children and families with regard to:
4. Counseling and assistance skills needed for breastfeeding and complementary feeding,
5. Feeding during illness and malnutrition,
6. Maternal nutrition, Health workers’ responsibilities under the International Code of Marketing of Breast Milk Substitute
7. Mothers/caretakers need access to skilled support to help them initiate and sustain appropriate feeding practices as well as to prevent and overcome difficulties. Trend health workers should provide this support, as a routine part of regular prenatal, delivery and postnatal care and in well baby and sick child services.
8. Monitor growth and development of infants and young children as a routine nutrition intervention, with particular attention to low birth weight and sick infants, and those born to HIV positive mothers; and to ensure that mothers and families receive appropriate education and counseling.
9. Actively screen all children for severely acute malnutrition at the health facility level, community level and food distribution sites and institute interventions. Give adequate care to acutely malnourished children, i.e., therapeutic feeding for severe malnutrition and supplementary feeding for moderate malnutrition.
10. Provide guidance on appropriate complementary feeding with emphasis on the use of suitable, locally available foods which are safely prepared and fed to young children.
11. Enable mothers to remain with their hospitalized children to ensure continued breastfeeding and adequate complementary feeding and, where feasible, allow breastfed children to stay with their hospitalized mothers.

**Strategy 8: Community-based nutrition support**

Every mother faces unique challenges in meeting her infant and young child’s needs for food during the first two years of life. Mothers need access, within their communities, to a reliable and accessible source of information, guidance and counselling to overcome the day-to-day challenges they face in practicing exclusive breastfeeding, continued breastfeeding and appropriate complementary feeding. This requires that support for breastfeeding and complementary feeding be extended from health facilities to the communities where mothers live and work. Keeping in view the power dynamics of the society, it is imperative engage family members especially mother in laws and husbands. The community workers from non-health sectors

<table>
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<th><strong>Strategy 8: Community-based support</strong></th>
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<tbody>
<tr>
<td>Develop community-based networks to help support appropriate infant and young child feeding at the community level, e.g. mother-to-mother support groups and peer or lady counsellors.</td>
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</table>
i.e. social mobilisers, local governance, teachers, local folks etc. and mass media should also be used to reinforce correct feeding messages

The Pakistan IYCF Strategy calls for much greater attention to community-based support of infant and young child feeding in Pakistan. Community-based support mechanisms have the potential to vastly improve infant and young child practices by increasing access to information, guidance and counselling. Counselling is a key intervention and can be delivered by a peer, family member. Lady Health Workers, community health worker or volunteer. Home visits, group meetings, and growth monitoring sessions, are all good opportunities for sharing information and counselling. The counsellor needs to have accurate knowledge and skills about infant and young child feeding, be equipped to negotiate feasible actions, and be able to inspire the mother with confidence in her abilities.

Community-based interventions should, build on existing structures, integrate with the health system, and involve partnerships with various sectors and groups, where it is possible. Interventions should extend the care that is provided within the health system to families in the home and mechanisms should be in place to refer mothers and infants with problems, preferably to a baby-friendly facility. The same community should also take steps to ensure that the National Ordinance and provincial laws on breastfeeding are respected, and that there is maternity protection in the workplace. Appropriate efforts should also be made to involve the private sector, including private practitioners, village doctors, midwives, traditional healers. There must also be sustained involvement of the health sector in support and supervising activities at the community level. Research shows that breastfeeding is also enhanced by the support and companionship of fathers and other family members (mother in laws, etc.). This should be promoted and encouraged at the community level.

The challenge is to identify which individuals or groups are most appropriate for promoting infant and young child feeding in the community. This depends on their frequency of contact with mothers during pregnancy and breastfeeding, geographical coverage and number, existing work load, ability to provide accurate information, advice and counselling skills, motivation and gender. More than one type of individual or group will be necessary to cover the all target groups and all areas of the country effectively. Box 6 lists existing community- based health workers and volunteers in Pakistan who could be agents for protecting, promoting and supporting infant and young child feeding. Many of these community based workers are already promoting child health and nutrition issues. In addition, mother-to -mother support groups peer could be utilized.

Table 6: Community-based health workers in Pakistan

<table>
<thead>
<tr>
<th>Community-based health workers and volunteers</th>
<th>Affiliated programme/project</th>
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<tbody>
<tr>
<td>Lady Health Workers</td>
<td>National Program for Family Planning and Primary Health Care</td>
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</table>
Community Midwife | National Maternal, Neonatal and child health program
---|---
Family Welfare Worker | Ministry of Population Welfare
Health Assistants/EPI assistants | Expanded Programme on Immunization, Ministry of Health
Community Mobilizers and Organizers | NGOs/INGOs/Community volunteers
Community Health Workers | UNICEF, WFP (Outreach workers, TSFP)
Traditional Birth Attendants | Non affiliated
Village doctors | Non affiliated
Rural practitioners | Non affiliated

**Strategy 9: IYCF in exceptionally difficult circumstances**

In all communities, there are some infants that require special attention, among whom the consequences of poor infant and young child feeding practices are most serious. In emergencies, the likelihood of not breast feeding and inappropriate complementary feeding increases. The use of BMS further deteriorates the situation and risk of malnutrition increases. Similarly, if the mother is infected with HIV, she and her baby need medical attention. TB, HBV and HBC are highly prevalent in Pakistan, mothers affected by these diseases also need counselling and support.

The Pakistan Strategy calls for special attention to supporting infant and young child feeding in exceptionally difficult circumstances including emergencies and HIV infection of the mother. For all these circumstances, there is need to develop emergency guidelines and protocols; build capacity among health service providers for counselling on infant and young child feeding, managing severe malnutrition and responding to nutritional emergencies; and to actively search for infants, young children and mothers in need of special attention.

**RECOMMENDATIONS**

- To ensure a section on feeding infant and young children in emergencies are placed in the National as well as Provincial Emergency Preparedness Plan document.
- Ensure that health workers have accurate and up-to-date information about infant feeding policies and practices, and that they have the specific knowledge and skills required to support caregivers and children in all aspects of infant and young child feeding in difficult circumstances. Nutrition component with special focus on IYCF, covering all aspects; needs to be integral part of their training.
- Create conditions that will facilitate exclusive breastfeeding by provision, for example, of appropriate maternity care and breast feeding corners, extra food rations and drinking water for pregnant and lactating women, and staff who have breastfeeding counseling skills.
- Ensure that health workers have accurate and up-to-date guidelines, policies and protocols about acute malnutrition, chronic malnutrition and micronutrient deficiencies and that they have the specific knowledge and skills required to support and treat acutely malnourished children.
- Include pregnant women and lactating mothers in supplementary feeding & nutrition support programs, and be educated on key IYCF key messages.
- Ensure that suitable complementary foods are selected and fed, consistent with the age and nutritional needs of infants and young children.
- Provide guidance for identifying infants who need to be fed with breastmilk substitutes, ensuring that a suitable substitute is provided and fed safely for as long as needed by the infants concerned.
- Ensure that health workers with knowledge and experience in all aspects of breastfeeding and replacement feeding are available to counsel HIV positive women.
- Ensure that whenever breastmilk substitutes are required for social medical reasons, for example, for orphans or in the case of HIV-positive mothers, they are provided for as long as the infants concerned need them. Ensure effective monitoring and for implementation of the code for Breastmilk Substitute.

**Strategy 10 Micronutrient supplementation / fortification**

Micronutrient (vitamin and mineral) malnutrition in Pakistan is a major problem especially among very young children, pregnant women as well as adolescent girls. The strategies proposed in the National Plan of Action for the Control of Micronutrient Malnutrition in Pakistan which recommends utilizing micronutrient supplementation, food fortification and behavioural change communications to initiate change, would be followed. It is recommended that micronutrients receiving primary attention should be iron, iodine and vitamin A, with increasing attention to zinc. For details refer to the National Plan of Action for the Control of Micronutrient Malnutrition in Pakistan document.

For children aged 6-24 months, home fortification with multi-micronutrient powder (MNP) to be added in the routine weaning food items is the intervention recommended by WHO and practised globally in areas with micronutrient deficiencies. Pilot conducted in Pakistan during 2007-8 through LHWs yielded excellent results in addressing the anaemia in infants and young children. For older group of children and pregnant & lactating women, the staple food fortification with necessary micronutrients is the solution of choice, practised in developing and developed countries alike. For Pakistan the recommended strategy is universal iodization of all edible salt produced in the country; Wheat Flour Fortification with iron, folic acid, Vitamin B and zinc etc.; and fortification of Edible Oil & Ghee with Vitamin A & D. These strategies are being implemented in the country with different level of intensity and success and need to be scaled up to cover the entire country.
2.4 Advocacy and behavior change communication

Infant and young child feeding requires both advocacy and behavior change. Advocacy is needed to keep infant and young child feeding high on the public health agenda and obtain proactive support for infant and young child feeding among leaders at all levels, including local elites, religious leaders, government officials and political leaders. Behavior change will focus on the actions that need to be taken by a mother, her husband and family, her employer, community and many others in support of breastfeeding and complementary feeding practices that will best serve the nutritional needs of her child.

Although changing the behavior of individuals in the short term is relatively easy, altering patterns of behavior over the long term is difficult. Effective long term behavior change rarely occurs in the absence of change at the policy, community, institutional and individual levels. Multiple audiences need to be reached including the mother, caregivers, family decision makers, religious leaders and other community members, employers, health service providers and policy makers. Each audience will view IYCF from a different perspective and have different knowledge, attitudes, beliefs, skills and information needs. A single message or approach is not likely to be effective in reaching all groups, and so multiple consistent messages must be communicated to these diverse audiences. The messages need to be given in a way that opens discourse between woman, their families and community, dispelling misconceptions and finding solutions to the problems. Communication channels need to be carefully chosen to enhance the likelihood of the message being heard and appropriately acted upon. Effective communication should include channels that are bidirectional, as well as unidirectional. It is also essential to ensure access for mothers, fathers and other caregivers to objective, consistent and complete information about appropriate feeding practices, free from commercial influences. In particular, they need to know about the recommended period of exclusive and continued breastfeeding; the appropriate time for introduction of complementary foods; what types of food to give, how much and how often; and how to feed these foods safely.

Because of the essential role of advocacy and behavior in achieving all strategies to improve infant and young child feeding, a comprehensive Advocacy and Behavior Change Communication strategy is needed. The process of developing this strategy involves:

- **Problem analysis**– identifying the target groups, problems and contributing factors, major individual and organizational stakeholders, and the main facilitating and constraining factors that will affect the choice of strategies
  - **Selecting the strategies**– defining what important changes need to take place at all levels for progress in infant and young child feeding to be made, and how communication can be used to bring about the change
  - **Identifying target audiences**, their knowledge, attitudes and practices
  - **Selecting behavior objectives and expected outcomes**
  - **Choosing collaborators**
• Developing appropriate messages, and identifying media and channels to deliver the messages

Due attention must be given to interpersonal communication, particularly counselling, to effectively change infant and young child feeding practices must be recognized. Every mother faces individual problems in feeding her infant and young child, and needs individually-tailored counselling and problem-solving to address these issues. Data from different sources research indicates that around two-thirds of women in the first few days after delivery have some problems with breastfeeding that can be resolved with counselling from a woman experienced in breastfeeding and trained in counselling. Health service providers, community based workers must be carefully selected for counselling services to ensure that they have the contact, experience, motivation and skills to counsel mothers. Communication strategies much address not only the individual behaviour change of the mother, but also the beliefs of those who influence her at all levels: family members, elders, and community members.

2.5 Monitoring, evaluation and research

Actions in support of infant and young child feeding must be monitored and evaluated to test and assess program effectiveness, justify the continuation or modification of program interventions and provide feedback at all levels. Monitoring of an ongoing program is continuous and aims to provide the management and other stakeholders with early indications of progress (or lack thereof) in the achievement of results and objectives. Evaluation is a periodic exercise that attempts to systematically and objectively assess progress towards and the achievement of a program’s objectives or goals. Because progress in IYCF depends so heavily on the achievement of behavioral aims and objectives, monitoring and evaluation of behavioral indicators should be given special attention.

A monitoring and evaluation national plan should be developed to provide a standardized framework on how needed information will be collected, processed, analyzed, interpreted, shared and used. All organizations working in the field of IYCF should follow the same monitoring and evaluation plan to ensure comparability. It is particularly important to ensure the consistent use of indicators for monitoring and evaluating trends in infant and young child feeding. Infant and young child feeding indicators should be incorporated into existing health information systems at every contact with a child less than 2 years of age. Responsibility for monitoring should be under the DDO at the district level.

Research, including operations research, is needed to determine the factors that contribute to poor infant and young child feeding practices at all levels (including the child, mother, family, community, health system and institutions and national policy levels); identify which groups most need and benefit from services; and identify cost-effective approaches to improving infant and young child feeding practices for evidence-based advocacy and programme implementation.
The results for monitoring, evaluation and research should be regularly reviewed and used to revise strategies and interventions for improving infant and young child feeding.

Based on WHO guiding principles for feeding breastfed (2003) and non-breastfed (2005) children, the IYCF practices indicator is comprised of all of the following three components:

1. Continued breastfeeding or feeding with appropriate calcium-rich foods if not breastfed
2. Feeding (solid/semi-solid food) minimum number of times per day according to age and breastfeeding status
3. Feeding minimum number of food groups per day according to breastfeeding status

<table>
<thead>
<tr>
<th>IYCF Practices indicator</th>
<th>Breastfeeding status BreastfedNon-breasted</th>
</tr>
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<tbody>
<tr>
<td>Fed (solid/semi-solid foods) minimum number of times per day</td>
<td>Continued Breastfeeding Fed milk or milk products</td>
</tr>
<tr>
<td>6-8 months</td>
<td>Two times</td>
</tr>
<tr>
<td>9-23 months</td>
<td>Three times</td>
</tr>
<tr>
<td>Fed minimum number of food groups* 6-23 months</td>
<td>Three groups</td>
</tr>
</tbody>
</table>

* The food groups include
1) grains, roots and tubers, including porridge, fortified baby food from grains
2) beans, legumes and nuts,
3) dairy products: infant formula, milk other than breast milk, cheese or yogurt or other milk products
4) flesh foods (meat, fish, poultry, and liver/organ meats),
5) eggs,
6) vitamin A rich fruits and vegetables (> 130 RE of vitamin A per 100 g),
7) other fruits and vegetables
8) foods made with fats and oils

Other Indicators to monitor for determining the impact of this strategy would include:

- Rate of early initiation of breastfeeding.
- Rate of exclusive breastfeeding
- Rate of continued breastfeeding to 24 months
- Frequency of complementary feeding between 6 and 24 months
- Diet diversity of children between 6 and 24 months of age
- Rate of stunting
- Rate of severe wasting
It is recommended to formulate a priority research agenda, detailed M& E plan and to undertake comprehensive reviews of IYCF on regular basis.

2.6 Stakeholders and their responsibilities

Governments and other concerned parties share responsibility for successful implementation of the Pakistan IYCF Strategy. Making the necessary changes from the community to national level demands many actions, including increased political will, public investment, awareness among health workers, involvement of families and communities, and collaboration between governments, international organizations and other concerned parties. Each partner should acknowledge and embrace its responsibilities, laid out in Box 7, for improving the feeding of infants and young children and for mobilizing required resources.

Table 7: Stakeholders and their responsibilities in implementing the IYCF strategy

<table>
<thead>
<tr>
<th>Government of Pakistan</th>
<th>Stakeholders:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ministry of National Health Services Regulation &amp; Coordination</td>
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<tr>
<td></td>
<td>National Program for Family Planning and Primary Health Care</td>
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<tr>
<td></td>
<td>National Maternal, Neonatal and Child health program</td>
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<tr>
<td></td>
<td>EPI Program</td>
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<td></td>
<td>Population welfare Departments</td>
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<tr>
<td></td>
<td>Non-health sectors (Education, WASH, Food)</td>
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<td></td>
<td>Provincial/ Regional Health and Education</td>
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<tr>
<td></td>
<td>Departments District Government Health and Education Departments</td>
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<tr>
<td></td>
<td>Ministry of Planning, Development &amp; Reforms</td>
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</table>

<table>
<thead>
<tr>
<th>Government of Pakistan</th>
<th>Responsibilities:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Formulate/ revise implement, monitor and evaluate policies and strategies related to infant and young child feeding</td>
</tr>
<tr>
<td></td>
<td>Identify and allocate human, financial and organizational resources for implementation of the Strategy, Education and training in IYCF for all health service providers (in service).</td>
</tr>
<tr>
<td></td>
<td>Provide accurate information through schools and other education channels to children and adolescents to promote greater awareness and positive perceptions</td>
</tr>
<tr>
<td></td>
<td>Observe in their entirety their responsibilities under the National Ordinance on breastfeeding and marketing of breast-milk substitutes</td>
</tr>
<tr>
<td></td>
<td>Promote achievement and maintenance of “baby-friendly” health facilities.</td>
</tr>
<tr>
<td></td>
<td>The government should advocate for and sensitize all stakeholders i.e. Health and non-health sectors ministries, institutions and partners to work in a coordinated and collaborative manner.</td>
</tr>
</tbody>
</table>

| Health professional bodies and research institutions |
### Stakeholders:
- Medical colleges, university and institutes
- Pakistan Medical Association
- Pakistan Pediatrics Association
- Society for obstetricians and gynecologist of Pakistan
- Pakistan Family Physician Forum
- Pakistan Nursing Council
- Pakistan Medical Research Council
- Pakistan Nutrition and Dieticians Society

### Responsibilities:
- Education and training in IYCF for all health service providers (Pre-service).
- Promotion of “baby-friendly” health facilities.
- Integration of IYCF into antenatal, postnatal, reproductive health, child health and nutrition services.
- Encourage the establishment and recognition of community support groups and refer mothers to them.
- Evidence generation and advocacy for policy changes if and when required.

### Non-governmental organizations, including community support groups

#### Stakeholders:
- All National and local NGOs, CBOs, development partners, Other Community support groups, including religious organizations and women’s, micro-credit financiers

#### Responsibilities:
- Provide members with accurate, up-to-date information about infant and young child feeding.
- Implementation of Integrated skill support for infant and young child feeding in community-based interventions and ensuring effective linkages with the health care system.
- Contribute to the creation of mother- and child-friendly communities and workplaces that routinely support appropriate infant and young child feeding. Work for full implementation of the principles and aim of the National ordinance of marketing of breast milk substitutes.

### Commercial enterprises and Industries

#### Stakeholders:
- Companies producing food products for infants and children.
- Companies producing and distributing products within the scope of the International Code of Breastmilk Substitutes

#### Responsibilities:
- Ensure that processes food products for infants and children, when sold, meet applicable Codex Alimentarius (International Food Safety) standards.
- All Manufactures and distributors of products within Scope of National Ordinance / Code for BMS are responsible for monitoring their marketing practices according to the principles and aims of the code.

### Social partners

#### Stakeholders
- Employers

#### Responsibility:
- Ensure that the maternity entitlements of all women in paid employment are met, including breastfeeding breaks and other workplace arrangements.

### Other Groups
### Stakeholders:

- SUN Business network
- Department of Education and private sectors dealing with education, media etc.,
- Child-care facilities
- Private Maternity Hospital and Home,
- Private children’s clinics

### Responsibilities:

- Provide accurate information through schools and other education channels to children and adolescents to promote greater awareness and positive perceptions
- Provide information on parenting, child care and products within the scope of the Ordinance on breast feeding for marketing of breast-milk substitutes Permit working mothers to care for their infants and young children
- Mass media influence popular attitudes towards parenting, child care and products within the scope of The code for BMS and National laws.
- Early child care and development centres / facilities permit and facilitate

### International organizations

#### Stakeholders:

UN agencies, international NGOs.

#### Responsibilities:

- Advocate for increased human, financial and institutional resources for implementation of the Pakistan Strategy.
- Support development of standards/ guidelines.
- Support policy development and promotion.
- Support national, regional capacity-building of decision makers as well as health care workers skills to support optimal IYCF practices.
- Support government technically in effective implementation and monitoring of IYCF strategy.

### Communities

#### Stakeholders:

- Parents, care givers, elders, Implementing partners (IPs)/CPs

#### Responsibilities:

- All community members especially parents and care givers have right to get accurate information on feeding children. They are directly responsible to use that information to feed their child.

#### Responsibilities:

- Provide members with accurate, up-to-date information about infant and young child feeding.
- Implementation of Integrated skill support for infant and young child feeding in community-based interventions and ensuring effective linkages with the health care system.
- Contribute to the creation of mother- and child-friendly communities and workplaces that routinely support appropriate infant and young child feeding. Work for full implementation of the principles and aim of the National ordinance of marketing of breast-milk substitutes.

### 2.7 Coordination
At the national level, a National IYCF Technical Advisory Group, chaired by the Director Nutrition, MONHSR&C, will be the highest technical body for strategic planning and coordination of infant and young child feeding interventions in Pakistan. This TAG includes senior representatives from all relevant government departments, professional groups, academic and research institutes, industry, development partners, UN agencies and NGOs. Box 8 provides the suggested composition of the TAG. It will meet every second months or as appropriate, or more frequently as required, and be responsible for the following broad tasks:

1. Review and approve changes to policies and strategies for infant and young child feeding
2. Coordinate actions in the infant and young child feeding between stakeholders
3. Review progress in the implementation of strategies for infant and young child feeding

The National IYCF Working Group will comprise of representatives from departments of the government, UN agencies, development partners and NGOs will provide technical support to strategize and plan, oversee implementation, and monitor and evaluate interventions IYCF at the national level. The following broad tasks will be performed by this working group:

1. Recommend new/changes to policies and strategies for IYCF and submit to the Steering Committee for approval
2. Develop technical guidelines on infant and young child feeding
3. Develop a multi-year plan of action for infant and young child feeding
4. Monitor the implementation of the plan of action and progress towards the objectives and targets of the Strategy.
5. Provide any other technical assistance required for effective implementation

To perform these functions, the National IYCF Working Group should be an integral part of the governmental system, with funding provided and mandate approved by the government.

Infant and young child feeding activities will be coordinated and monitored at provincial and district level through the Provincial Health department and District Health Management Team Meetings.

**Table 8: Composition of the National IYCF (Nutrition) Technical Advisory Group.**

<table>
<thead>
<tr>
<th>Sector</th>
<th>Members*</th>
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<tbody>
<tr>
<td><strong>Non-Governmental Social Sector</strong></td>
<td>Social organizations/Representatives of NGOs working on IYCF.</td>
</tr>
</tbody>
</table>
| **Professional and Research Organizations** | Pakistan Medical Association  
Pakistan Pediatrics Association  
Society for obstetricians and gynecologist of Pakistan.  
Pakistan Nutrition and Dieticians Society  
Family Physician forum  
Pakistan Nursing Council |
2.8 Integration with additional support strategies/ linkages with non-health sector strategies and interventions

IYCF education and behavior change communication can be integrated with small-scale agriculture and livestock production interventions. Improving bioavailability of nutrient by increasing production and consumption of nutrient dense and culturally acceptable food can improve the nutritional status.

There are many cash transfer interventions going on, to support vulnerable families. Community IYCF can be integrated in such initiatives to further enhance the impact of such schemes/programmes to attain positive nutritional outcomes especially targeting the critical window of 1000 days.

Similarly, introducing parental education package through education sector focusing maternal nutrition and IYCF will definitely be helpful in bringing positive results.
3. Broad Plan of Action:

This broad plan of action describes the actions required to implement the Pakistan IYCF Strategy. It is intended as the basis for the formulation of detailed action plans in respect of each activity.

3.1 Code of marketing of breast-milk substitutes

3.1.1 Periodically review and amend the National Ordinance on Breastfeeding and rules to ensure that:
- All provisions of the International Code and subsequent WHA resolutions are included.
- Scope of the National Code is broadened to ensure that all products intended for consumption by infants and young children, including complementary foods, are appropriately marketed and distributed, and that whole milk powder carries a warning message.
- Revise the penalties for violation of the National Ordinance.

3.1.2 Strengthen monitoring and enforcement procedures of the National Ordinance to more effectively detect Ordinance violations and to accelerate the legal process.
- Conduct a review of the strengths, weaknesses, opportunities and threats to the monitoring mechanism and enforcement procedures, and determine what improvements can be made
- Revise the monitoring system and enforcement procedures according to the recommendations of the review, and amend the National Ordinance if necessary.

3.1.3 Raise awareness of the National Ordinance and the need for effective implementation at the national level among key policy-makers, infant food manufacturers and the public.

3.1.4 Develop and disseminate user-friendly guidelines for government officials on the contents of the National Ordinance and guidance notes on staff interactions with infant formula manufacturers

3.1.5 Educate health service providers and others on their responsibilities under the National Ordinance

3.1.6 Accountability of Health care providers on breastmilk substitute through their statutory bodies such as PMA, PPA, SOGP

3.1.6 Regular coordination meetings of Infant feeding board for analyzing the situation on BMS code
3.2 Maternity protection in the workplace

3.2.1 Amend the Maternity Leave Law to include all provisions of the ILO Maternity Protection Convention No. 183 for all employed women, and periodically update as required.

3.2.2 Increase public awareness of the benefits of combining work and breastfeeding, and publicize legislation among all stakeholders, especially among employers and the public.

3.2.3 Advocate with employers to create better opportunities for women to breastfeed at the workplace including the creation of crèches, breastfeeding breaks, and comfortable private spaces to breastfeed at the workplace (“Mother-Friendly Workplaces”).

3.2.4 Encourage unions and worker groups to advocate for maternity entitlements which support women workers who breastfeed

3.2.5 Establish mechanism to monitor and enforce the legislation

3.3 Codex Alimentarius

3.3.1 Conduct a review of the use of the Codex Alimentarius in Pakistan and compliance with its standards on available products for infants and young children by involving Pakistan Food Authorities

3.3.2 Develop standards for nutrient content, safety, and appropriate labeling of processed complementary foods intended for infants and young children.

3.3.3 Enforce compulsory certification of all processed complementary foods by adding them to the list of items that must be obligatorily tested by the Lab before sales in Pakistan.

3.3.4 Ensure capacity development of executing and enforcement bodies, industries and commerce sector to implement codex Alimentarius.

3.4 Pakistan policies and plans

3.4.1 National IYCF policy needs to be incorporated into new revised health policy

3.4.2 Incorporate infant and young child feeding interventions into national as well as provincial developmental policies and plans, major health initiatives and other projects

3.4.3 Establish partnership with social safety programmes to enhance their technical capacity on IYCF sensitive program.

3.4.4 Provide provision for assistance to families unable to meet the challenges of incorporating infant and young child feeding intervention i.e. vocational trainings for mothers and microfinance schemes.

3.5 Baby-Friendly Hospital Initiative
3.5.1 Revitalization of BFHI to all health facilities providing mother and child services in the country, including private and non-government facilities.

3.5.2 Link baby-friendly health facilities with “baby-friendly” communities with the help of Lady Health Workers and community support groups.

3.5.3 Strengthen the monitoring of BFHI status in certified hospitals and periodically recertify health facilities as baby-friendly. Create a national monitoring system for BFHI certification and recertification, with guidelines for how often a health facility should be assessed for BFHI status.

3.5.4 Incorporate BHFI into the standard operating procedures of health facilities, including the facility’s quality control, monitoring and evaluation system.

3.5.5 Incorporate BFHI into the accreditation procedures of new health facilities.

3.6 Mainstreaming and prioritization of IYCF activities

3.6.1 Identify all contact opportunities between pregnant women, infants, young children and health, nutrition and development programmes/projects, and opportunities to mainstream (integrate) IYCF activities. Determine the limiting factors in integrating IYCF and explore solutions.

3.6.2 Advocate for mainstreaming and prioritization of IYCF activities.

3.6.3 Promote consistency of approaches across all programmes/projects, including the use of uniform guidelines, teaching and training materials, and job aids.

3.7 Knowledge and skills of health service providers

3.7.1 Assess levels of skills and knowledge, needs for improvement, and training needs of health service providers.

3.7.2 Develop guidelines and standard training materials and appropriate job aids on infant and young child feeding for health service providers at appropriate levels, including:

- Breastfeeding counseling
- Complementary feeding counseling
- HIV and infant feeding counseling
- Management of low birth weight
- Infant and young child feeding in emergencies
- Responsibilities for monitoring of the National Ordinance of marketing of breastmilk substitutes

3.7.3 Revise the curricula for pre-service and in-service training of health service providers at all levels to include appropriate content on infant and young child feeding.

3.7.4 Provide in-service training to health service providers.
3.7.5 Develop a pool of core trainers in infant and young child feeding
3.7.6 Monitor the quality of training and follow-up with supportive supervision.
3.7.7 Evaluation of training to assess the impact of trainings imparted.

3.8 Community-based support
3.8.1 Identify and train peer counsellors including Lady Health Workers, CMWs and community- support groups / mother support groups on standardized training packages to provide counselling and guidance to mothers in their communities.
3.8.2 Develop core team of trainers for peer counsellors, Lady Health Workers, Community outreach workers, Community Health workers (CHWs), Community midwives (CMWs) and community-based support groups.
3.8.3 Train peer counsellors including Lady Health Workers and community- support groups / mother support groups on standardized training packages
3.8.4 Develop and periodic review of training package to develop the knowledge and skills of peer counsellors and community-support groups
3.8.5 Establish community-based support groups and peer counsellors, within on-going connection to and NGO or community outreach activities of health system.
3.8.6 Monitor and supervise activities by community-based support groups and Lady Health workers

3.9 IYCF in exceptionally difficult circumstances
3.9.1 HIV and infant feeding:
- Periodically update the guidelines on HIV and infant feeding, as required, in light of new research findings and/or international recommendations
- Disseminate all guidelines, and any revisions, to public, private and NGO health facilities and service providers.
- Train health workers to effectively counsel HIV-positive parents and other household members so that they can make informed infant feeding choices and are supported in carrying out their choice
- Coordinate with stakeholders in the field of HIV/AIDS and sexually transmitted illnesses (STI) prevention to improve access to HIV voluntary counselling and testing, and counselling on infant feeding.
- Adapt the BFHI taking into account HIV/AIDS.
3.9.2 Infant and young feeding in emergencies:
• Establish or review the guidelines on infant and young child feeding in emergencies, in particular, the support for exclusive breastfeeding and complementary feeding, and regulation of breast-milk substitutes.

• Periodically update the guidelines, as required, in light of new research findings and/or international recommendations

• Disseminate all guidelines, and any revisions, to public, private and NGO health facilities and service providers.

• Collaborate with the government, NGOs and all other stakeholders working in disaster preparedness and response to ensure that IYCF is adequately reflected in emergency preparedness plans.

• Develop a communication package on IYCF in emergencies that can be rapidly produced, replicated and disseminated in the event of an emergency.

• Train a pool of health service providers, NGO workers and other stakeholders responsible for emergency preparedness and response in infant and young child feeding in emergencies.

3.9.3 Malnutrition and low birth weight

• Develop guidelines on the management of severe malnutrition (at facility and community level) and on the management of low birth weight infants.

• Review the existing SC guidelines in country health system context.

• Periodically update the guidelines, as required, in light of new research findings and/or international recommendations

• Disseminate all guidelines, and any revisions, to public, private and NGO health facilities and service providers.

• Develop and implement a training plan for health service providers in management of severe malnutrition and management of low birth weight infants.

• Support local development of an age appropriate fortified supplementary food for children and for pregnant and breastfeeding women.

3.10 Micronutrient supplementation / fortification

3.10.1 Establish guidelines on micronutrient supplementation/fortification especially Vit. A

3.10.2 Periodically update the guidelines, as required, in light of new research findings and/or international recommendations

3.10.3 Disseminate all guidelines, and any revisions, to public, private and NGO health facilities and service providers.

3.10.4 Develop a communication package on can be rapidly produced, replicated and disseminated

3.10.5 Develop and implement a training plan for health service providers for MMN supplementation & fortification.

3.11 Advocacy and behavior change communication

3.11.1 Conduct formative research on knowledge, attitudes and behaviors related to infant and young child feeding at all levels (including policy and programme managers, health service
providers, employers, infant food manufacturers, community members, parents and mothers) to help identify effective messages on IYCF.

3.11.2 Develop equity based advocacy and communication IYCF strategy with costed implementation plan on infant and young child feeding practices.

3.11.3 Develop advocacy and communication materials for all audiences/stakeholders to support the strategy.

3.11.4 Monitor the effectiveness of the advocacy and communication interventions, and adjust strategy if required.

3.12 Monitoring, evaluation and research

3.12.1 Develop a monitoring and evaluation framework/plan to monitor and evaluate the effectiveness of IYCF interventions:
   - Select a standard set of input, process, output and impact indicators, including behavioral indicators
   - For each indicator, identify criteria and targets; trigger points for remedial action; data collection methodology, and types and sources of data.

3.12.2 Incorporate IYCF indicators into existing information systems (DHIS, NIS) by modifying monitoring and reporting formats and trainings to collect data.

3.12.3 Review the monitoring data at the sub-district, district, Provincial and national level and provide constant feedback to stakeholders for appropriate action.

3.12.4 Conduct periodic evaluations of the impact of interventions on infant and young child practices every 2-3 years.

3.12.5 Identify priority research gaps to improve the design of interventions and programmes, and institutions which can help, technically and/or financially, to conduct and/or support the needed research.

3.12.6 Conduct operations research to measure the effectiveness of new approaches to infant and young child feeding and for evidence-based advocacy.

3.13 Coordination

3.13.1 Establishment of Federal IYCF TAG with defined Terms of References and membership.

3.13.2 Establishment of the federal and provincial IYCF Working Group, with defined Terms of References and membership.

3.13.3 Nutrition wing/unit of MoNHSR&C will be the focal point for overall responsibility for infant and young child feeding and will be the coordinating body between provincial IYCF TAG.
3.13.4 Provincial Nutrition focal person from department of health will be the coordinating body between Federal TAG and provincial IYCF matters.

3.14 Integration with additional support strategies/ linkages with non-health sector strategies and interventions

3.14.1 Integration of IYCF with small scale agriculture and livestock production interventions to improve food security with integrated communication for behavior change package on IYCF

3.14.2 Promote nutrient rich recipes using locally available foods.

3.14.3 Evaluate the impact of cash schemes on IYCF

3.14.4 Development of parental education package focusing maternal nutrition and IYCF and dissemination.

3.14.5 Integrate IYCF core messages into WASH related programming documents (WASH PC1) and implemented at WASH implementation areas.

3.14.6 IYCF Trainings for non-health sector community workers and CBOs.


PLEASE PROVIDE REFERENCES AND ANNEX’s