



OPINION LEADER PERSPECTIVES ON INFANT AND YOUNG CHILD NUTRITION IN BIHAR, INDIA:

Findings and Recommendations for Action

November 3, 2014

Alive & Thrive is an initiative to save lives, prevent illness, and ensure healthy growth and development through improved breastfeeding and complementary feeding practices. Good nutrition in the first 1,000 days, from conception to two years of age, is critical to enable all children to lead healthier and more productive lives. In its first five years (2009 to 2014), Alive & Thrive demonstrated that innovative approaches to improving feeding practices could be delivered with impact and at scale in three contexts: Bangladesh, Ethiopia, and Viet Nam. Alive & Thrive is now supporting others to scale up nutrition by applying and adapting tested, proven approaches and tools in contexts such as Burkina Faso, India, and Southeast Asia. With its emphasis on learning and innovation, Alive & Thrive is expanding its focus in Bangladesh to maternal nutrition and taking a more multisectoral approach in Ethiopia. Alive & Thrive is funded by the Bill & Melinda Gates Foundation and the governments of Canada and Ireland and managed by FHI 360

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Acronyms

ANM – Auxiliary Nurse & Midwife

ASHA – Accredited Social Health Activists

AWW – Aaganwadi Worker

BDO – Block Development Officer

BMS – Breastmilk Substitutes

CSR – Corporate Social Responsibility

DfID B-TAST – Department of International Development Bihar—Technical Assistance Support Team

DLHS – District Level Household Survey

GNM – General Nursing & Midwifery

HMIS – Health Management Information System

ICDS – Integrated Child Development Services

IPMS – Integrated Performance Management System

ISSNIP – ICDS Systems Strengthening and Nutrition Improvement Project

IYCF – Infant and Young Child Feeding

MIS – Management Information System

NFHS – National Family Health Survey

NGOs – Non-governmental Organizations

NRC – Nutrition Resource Centre

NRHM – National Rural Health Survey

OPD – Out Patient Department

PHED – Public Health Engineering Department

WASH – Water, Sanitation and Hygiene

OVERVIEW

This research sought to identify opportunities to increase support for stronger Infant and Young Child Feeding (IYCF) policies and improved policy and program implementation in the state of Bihar, India. To accomplish this goal, it was important to understand how to work with and motivate the government, decision-makers and opinion leaders to provide strong leadership and support for this critical issue.

The objectives of this research were to better understand:

- the barriers to greater political and public support for child nutrition;
- possible solutions to these barriers;
- motivations in favor of supporting (IYCF); and
- channels of communication and points of engagement with opinion leaders.

Methodology

From June through August, 2014, individual interviews were held with more than 20 opinion leaders in health and nutrition and related sectors in Bihar, India. For this study, “opinion leader” refers to any individual whose work is directly or indirectly related to child nutrition—and who has either a clear insight into the political and programmatic barriers to improving it, or who has an opportunity to increase commitment to child nutrition in their own right.

Respondents included individuals from government ministries and programs; health practitioners; Non-governmental Organization (NGO) leaders; and religious leaders. Selection criteria for respondents included having a clear role in child nutrition activities and practices in the state, either directly or indirectly; gathering a variety of viewpoints across different types of organizations and sectors related to child nutrition; and their availability to participate within the timeline allocated for the project.

Topics covered in the discussions included:

- priority health and development challenges facing the state and local communities;
- knowledge of nutrition, undernutrition and IYCF;
- key state policy issues, like the Indian Milk Substitutes Act and maternity entitlements;
- perceived government support for child nutrition;
- obstacles, barriers and opportunities for improving political and public support of IYCF; and
- suggestions for information sharing, communications and advocacy with opinion leaders

Nearly all interviews were audio recorded and transcribed. Those conducted in Hindi were also translated into English during the transcription process. The study team analyzed each transcript according to a series of codes—or common discussion themes—that were developed based on the interview guide and discussion responses. Each response code was then analyzed across all responses to identify common themes, salient points and notable insights or discrepancies in the answers of different respondents.

Interview respondents were assured that their anonymity would be protected and their responses would not appear in any way associated with their name. With the exception of occasional brief quotes or extracts to highlight a key point, all responses in this report are represented in aggregate form only.

KEY FINDINGS

The following key findings represent common themes that emerged across multiple interviews with leaders. Where sentiment was particularly strong or consistent, it is noted. It is also noted where an opinion is anecdotal and only appeared once.

Overall, opinion leaders indicated that political commitment to child health and nutrition has improved over the past decade—and in particular, very recently. However, this has yet to translate into action. Increased priority at the national level, and increased priority from NGOs and donors, have both contributed to the increased commitment. In addition to a generalized sense that nutrition is increasingly prioritized, the momentum was demonstrated through:

- Pivotal political moments, including the former Prime Minister’s assertion that the undernutrition of the nation’s children is a “national shame”
- The recent launch (9 August 2014) of Kuposhan Mukta Bihar (Malnutrition Free Bihar) on the anniversary of the Quit India movement, wherein all state departments were present for important dialogue on shared roles and convergence
- Greater opinion leader recognition of the need for multi-sectoral approaches to nutrition and a recognition that nutrition cannot be addressed through health efforts alone
- Recent efforts to establish nutrition strategies and/or missions at both the national and state level

However, this good news was also moderated by important caveats. In general, respondents indicated there may be a disconnect between the government’s stated intentions and what actually results in terms of follow through and implementation.

Key Health and Nutrition Issues in Bihar

Appropriate Child Feeding Practices for Infants and Young Children

- **According to interviewees, undernutrition in Bihar is largely not due to scarcity of food, but rather incorrect feeding practices.** Breastfeeding and complementary feeding practices are suboptimal, including the late initiation of complementary feeding. This is further aggravated by inadequate frequency and lack of food diversity. Additionally, despite a high rate of institutional deliveries, early initiation of breastfeeding is still low. Stakeholders noted that this trend may be due to lack of counseling to ensure early initiation of breastfeeding after delivery (an area of potential opportunity, given it is a health system intervention and a one-time event). Additionally, stakeholders noted that:
 - » Some stakeholders in the state recognize the term IYCF, but don’t have deep knowledge about what it constitutes. It is now primarily associated with complementary feeding, while earlier it was mostly breastfeeding, according to interviewees. Unfortunately, many partners who are supporting the government do not have complete understanding of the optimal IYCF practices, they added. It was also cited that the right messaging is important (for example, exclusive breastfeeding should mean ‘not even’ water).
 - » Counseling on IYCF practices is either very low or non-existent all together. Stakeholders noted a need to focus on behavioral change and interpersonal communication. Areas for improvement include training programs for frontline health workers.

- » Many stakeholders expressed doubt that exclusive breastfeeding is really being followed—even no water—despite what is reported.
- » While it is now more common to give colostrum than in the past, a big issue is giving honey and water. Feeding habits are cultural and still very much influenced by older women living in the home.
- **Significant and varied sub-optimal feeding practices continue to be the norm—even among some opinion leaders.** Respondents highlighted a variety of anecdotal norms around child feeding that dominate people’s perceptions of optimal practices. Challenges begin with early initiation, when colostrum is often thrown out instead of fed to the newborn. This norm is particularly hard to change, as gynecologists often instruct mothers to wait to give milk until 3 hours after birth. Mother-in-laws are insistent on giving young children other liquids—especially after the four month mark—and honey and water beginning soon after birth. There is a belief—even among some respondents of this research project—that breastmilk production lessens at 4 months and needs to be supplemented in small amounts with soup and other liquids. As one respondent said, “These are practices that elders have been using for 100 years” and are very hard to change. Additionally, another challenge is that for some mothers, complementary feeding is introduced later than the recommended 6 month mark.

“Healthy children we give mixed vegetable mesh, fruit juice, juice of dal from the 5th month...”

Stunting

- **Stunting not highlighted as a top priority.** It was noted that with the introduction of Kuposhan Mukht Bihar (Malnutrition Free Bihar Campaign), stunting is becoming more of a popular term among government officials—but there is still not clarity on how to address it. There is a belief among some stakeholders that while it is a positive step that the recent state nutrition policy has stunting as an indicator, the state cannot proceed with prioritizing stunting unless there is a guideline and directive from the national level (which is currently lacking). Among about half of the respondents, stunting was either not mentioned at all or acknowledged only briefly as a problem.
- **Knowledge of stunting low overall; general awareness of malnutrition improving.** When asked about knowledge of stunting, many stakeholders were of the view that the policymakers and other state actors in Bihar cannot differentiate between stunting, wasting and underweight. “There is not much understanding of stunting. People know it, generally, along with other issues like child feeding, but we are not working much on malnourishment. We instead work toward early breastfeeding and complementary feeding—everybody is more working toward that.” Among the technical community, stunting and wasting are familiar terms, but at district level, the awareness is not there. However, stakeholders noted that in regards to district policymaker knowledge on malnutrition generally, there has been improvement: “Like in last 3 years, in beginning, there was really low level of understanding at the leadership level, state or district. But now it’s relatively better, now they understand what to be done better, not completely, I cannot say that they are now completely mastered that but at least now they appreciate what we suggest.”
- **Underweight is understood as the primary indicator for undernutrition, not stunting.** Stakeholders noted that with the exception of a new nutrition policy, stunting is never cited as an indicator, and for convenience, underweight is the primary indicator for children 6 and under. While stunting has now become a major focus at the global level, it is only slowly being recognized as an important indicator at the national level. Stakeholders noted that the government is looking into more monitoring of stunting and wasting to align with the new strategy, but the question is how to implement these changes and whether the political power exists to support them.

Handwashing and sanitation

- The underlying issue of water, sanitation and hygiene was raised by a majority of respondents—and about half of those acknowledged the linkages between nutrition and Water, Sanitation and Hygiene (WASH). One stakeholder noted that due to work over the last 3 years through the Department of International Development Bihar—Technical Assistance Support Team (DfID B-TAST) community awareness program, there has been an enhanced understanding at the policy maker level of the linkages. Three departments (Public Health Engineering Department (PHED), Social Welfare and Health) now have a good understanding of linkages and are starting to work together more closely. “Only health or nutrition official can’t do it, you have to give better quality water, there has to be sanitation then only we can improve.” However, insufficient safe drinking water and inadequate access to toilets continue to be a key barrier to improved outcomes. One respondent indicated that 75 percent of households don’t have access to a toilet facility. Contaminated water is a challenge for both malnutrition and health status.
- There is low awareness of key hygiene behaviors among the general public, but this is improving. Stakeholders widely noted the problem of contamination issues with lack of handwashing after latrine use and before food preparation, noting that among the public, there is low awareness of hygiene and contamination issues. “The counselling is important, you need to stay neat and clean, before eating you need to wash your hands so your child might not suffer from diarrhea.” However, several stakeholders noted that awareness among the public on this issue is improving, and that due to electronic media, there is now a better understanding of cleanliness and hygiene.

Additional highlights

- **There is both insufficient supply of needed services and infrastructure—and insufficient demand.**

Respondents indicated consistently that a major barrier to health and nutrition is the lack of trained workforce. Across multiple interviews, numerous types of insufficient resources were highlighted, including:

- » Lack of trained staff, including insufficient doctors and nurses, and insufficient Accredited Social Health Activists (ASHAs) and Auxiliary Nurse & Midwife (ANMs)
- » Insufficient infrastructure, including not enough public health centers, and insufficient resources like hospital supplies and beds
- » Insufficient capacity among existing staff to adopt new interventions, due to lack of time, resources and knowledge
- » Lack of available services, including treatment services, preventive services, Integrated Child Development Services (ICDS) services
- » Not enough schools and colleges (including ANM schools, General Nursing & Midwifery (GNM) schools)

“This is not the correct time to talk about quality where in the access itself is not there for all the people....”

On the demand side, even when a health facility is available and operational, some people are not aware of it or their right to use it. Many don’t know the value of health prevention, and have little to no awareness of nutrition. Participants highlighted that there is limited “health seeking behavior”—which is even more difficult to develop when the services aren’t there to support them.

- **Stakeholders expressed an interest in greater engagement with the private sector.** Respondents indicated an interest in the state coordinating private investments in health infrastructure—even in areas like electricity. Corporate Social Responsibility (CSR) activities “need to be mainstreamed.” One example given was airports—which are owned by the state but involved the private interests of companies. The respondent indicated that something similar needs to be done with healthcare and healthcare centers. One respondent indicated that there needs to be more incentive for health workers to promote “products and profits within the system”—for example, working with companies to help link soap (as a product) with handwashing (as a behavior).
- **More work is needed to emphasize nutrition across the entire life-cycle, to women and girls specifically.** Numerous respondents highlighted the lack of a continuous, integrated look at health and nutrition across the life-cycle. This begins with the entire perinatal period and includes family planning, child health, maternal health, education and beyond. One respondent highlighted that there is no pre-conception nutrition program for women. Programs instead start after conception and confirmation of pregnancy.

Likewise, there should be increased focus on women and girls—who were highlighted as suffering from worse nutrition issues than men and boys, while having greater potential to impact nutrition outcomes both through their roles as caretakers and because of the intergenerational cycle of malnutrition.

Government Support for Child Nutrition and Infant and Young Child Feeding

- **Despite improvements, nutrition is still not a top priority. Leadership at the highest levels is a critical factor.** Multiple interviewees noted that while top level leadership is there—including the former Chief Minister (Mr. Nitish Kumar)—departmental leadership is currently not very influential. As one stakeholder said, “There is will, there is proactiveness and receptivity, but when it comes to implementation, there are big impediments.” Another noted: “The challenge is not political will, but implementation and delayed decision making.”

Stakeholders also noted that changes in government due to elections have an impact, often resulting in a loss of momentum. “The government might have support for child nutrition- but different ministers come in and run the system how they want; the next minister comes and does different things. This reduces focus.” Additionally, when the chief minister conducted political rallies, this helped keep the health agenda visible, and had the result of pushing the system to improve, and inspiring partners to take up actions and technical ideas.

- **There are many urgent issues competing for political priority.** Respondents highlighted a broad array of urgent health and development issues, including but not limited to: poverty, education, fertility rate, natural disasters, landlessness, migration and lack of health services. Education was highlighted as a priority in the state—one respondent indicated that health activities once had greater importance within the education sector than it does now. Several respondents specified that there is not universal access to health services.

“Despite being acknowledged as a national shame, nutrition is not a national priority, since there is no single department looking exclusively for nutrition.”

- A primary barrier for greater progress on nutrition is the fact that no single department is responsible for nutrition.** Multiple respondents emphasized a disconnect between the two national bodies—Ministry of Health and Family Welfare and Integrated Child Development Services (ICDS)—which are both tasked with some component of child nutrition. Despite both ministries operating workforces of frontline workers, they do not coordinate or create joint planning on nutrition. The result is limited convergence of activities at the state and district level—with some going so far as to say that “nutrition has no home.” They added, “The two ministries at the national level do not come and sit together to talk on nutrition. Convergence is not possible even at the national level, and we are expecting the same at the state and district level?” Stakeholders suggest that greater convergence between the health department and ICDS, both of which report to the Development Commissioner, is needed. One interviewee specifically noted that the district magistrate is key to making sure everything happens, taking up the interventions, etc. “Everything depends on him.”
- There is a disconnect between nutrition mandates at the national and state levels.** There is broad consensus that issues are best served when there is a clear mandate at the national level that pushes priority at the state level. As one respondent remarked, “There is a very low priority for nutrition even now, the reason being that unless it is the priority for the national level, and everything is done in a very strategic manner at the national level, it won’t be a priority in the state.”
- There is limited awareness of guidelines and policies—and they are not often linked with practices on the ground.** Guidelines are updated and shared, but there is a common belief that they are dissociated from practice. People refer to planning documents at the development level—but not at the implementation level. At the implementation level they see only the work that they have to do. There is still work to do to bring it from “society mode to mission mode.”

“These [guidelines] are just ‘book languages.’ These practices don’t happen really...There is no proper practice.”
- There is increasing focus on including IYCF in national policies and strategies—including in the new nutrition policy.** There is an increasing realization among stakeholders that IYCF practices cannot be changed by working with just health or ICDS functionaries—it has to be holistic. This is a major limitation in the training of Aanganwadi Worker (AWW) and ASHA workers. For example, the Ministry has given separate guidelines for Nutrition Resource Centres (NRCs) and for IYCF—but has not established the link between the two.
- Greater national guidance is needed on IYCF guidelines and interventions, and complementary feeding is the most neglected aspect.** With no perceived guidelines on complementary feeding at the national level, it is thus not a priority at state or district levels. Respondents felt that guidelines across the child feeding spectrum need to be endorsed and pushed down from the national level, so that every state can follow them accordingly—which is the best way to ensure uniform action in India.
- Multiple respondents pointed to the Manav Vikas (Human Development) mission as a positive step in the right direction.** Stakeholders noted that in the last year, the Government has been more receptive and proactive on nutrition, with the establishment of the Manav Vikas mission by the chief minister. The mission focuses on key development indicators. As one stakeholder said, “There is definite receptivity and proactiveness, but of course, amid a lot of political chaos and lack of departmental leadership.” Development partners are eagerly anticipating release of a mission document of the state, by which every department will be accountable to deliver as per the mission agenda. “So that’s likely to move things faster, more focused because goals are very clearly defined, you need to achieve this and there are even milestones set within two years, 5 years, 10 years down the line. This is how that document... we hope that will add in implementation part.”

- **Donor partners and NGOs have an influential role in setting policies.** According to stakeholders, the government has been taking nutrition more seriously and the development partners have been getting a good response from the government. There is a task force to develop the nutrition policy, Kuposan Mukht Bihar. Stakeholders outside of government have a seat at the table and are invited to quarterly stakeholder meetings by the departments. “They invite all donor partners to those meetings and this is the one forum where new idea has been put to the government through which it has been influencing.” Donor partners were successful in establishing a high level advisory committee at the development commissioner level, which is a forum where new ideas can be put to the policymakers.

Monitoring Data on Child Nutrition in Bihar

- **Broad consensus: not enough data, not consistent data, not timely data.** Stakeholders overwhelmingly shared the opinion that there is a dearth of data for their state and it is not available in a timely manner. Different programs use different data sources—and sometimes, programs use multiple competing data sets to try and get a clear picture of the nutrition situation. Several noted that what is available could be better utilized: “We have to make use of whatever the data we have; data should not just be collected, it needs to be reviewed periodically, too.”
- **Indicators need updating to match global standards, optimal IYCF feeding practices.** The biggest monitoring issue was the topic of indicators and that the data collected is not useful—a challenge with the data collected at both national and state level. One of the interviewees cited that indicators for complementary feeding are an issue at the national level because none of the data—be it NFHS, District Level Household Survey (DLHS), annual survey—captures complementary feeding in the way it should be, including diversity, frequency and quantity. Additionally, the annual survey also does not capture breastfeeding indicators as indicated in global guidelines. “I think whatever data we are using currently, the indicators are quite old now, like nearly 10 year old... 2004-05... and there is really lack of numbers or quantitative data to actually see what the status is.”
- **Underweight is emphasized as the primary indicator; height is not being tracked consistently. Growth monitoring is not happening properly or consistently.** Multiple stakeholders noted that it is the mandate of ICDS to only monitor underweight, citing that “the Ministry is not ready for height right now.” Growth monitoring is not happening properly—due to lack of training and equipment. One of the leaders said, “The simplest mechanism that your system is telling you to do is to find out the weight. If you are not weighing a child, then how would you get to know the nutrition status?” Several stakeholders noted the challenge of advocating for greater emphasis on growth monitoring, noting that if the Ministry at the central government level is not ready to measure height, it would be difficult for the state to adopt it. Suggestions included asking organizations to take up any opportunity to measure children—such as during the immunization session or Out Patient Departments (OPDs) in health facilities, among others.
- **Data collected is not reliable.** It was cited that all National Rural Health Survey (NRHM) data are available on the website with data being collected through web, mail and telephone. However, numerous stakeholders noted that there is a challenge of data being “fudged” in the field. With mobile networks being widely available, the government is looking at how effectively the data collected through mobile phones could be used. Some stated that while the sewikas (frontline health workers) have been provided with a mobile to track data, they frequently send the data of the same children again and again. They are supposed to send photos of children daily.

- **Lack of data is an impediment to issue prioritization, as well as policy development and implementation.**

It was widely recognized among stakeholders that the lack of timely data on key indicators is a major impediment to executing an effective nutrition strategy. Multiple stakeholders suggested that better monitoring could lead to more government action. “I can’t say what’s the status because we are not measuring...We are waiting for NFHS to see what has been moved in last decade.” Nutrition is also getting “layered into other components, like the major four incentive rated indicators that the government is currently driving” and given that there is no monitoring data, it is not getting prioritized.

- **Some stakeholders are optimistic that new technology will improve data availability.** While overall, interviewees agreed that there is a lack of useful data, about a fourth of them noted that there is positive movement to integrate data generated from other institutions and departments.

“So there is a need to integrate all these but as of now these data is not accounted because they cater to different parameters. So a time will come very soon when all these data will be integrated.”

“It has improved tremendously. And now you have HMIS and IPMS (planned). You can add data on that. ICDS is also trying to have the revised MIS. The data availability has improved.”

Some stakeholders were optimistic that some data challenges would be addressed with an updated Health Management Information System (HMIS) system, or a mobile-based system. The integrated management information system will track data from the Anganwadi centers, with self-reporting done through mobile phones.

“Bihar is a front runner utilizing that technology in AWCs. If it will be done here, then I think it may be replicated by Govt. of India in other states also.”

While the technological advances are promising, unless the indicators are updated to align with global recommendations, growth monitoring is widely accepted and conducted, and the issue of fraudulent data is addressed, the data monitoring issue will continue to be a major challenge in Bihar.

The Role of Medical Professionals

- **Doctors play an important role in shaping feeding practices in their communities—but often don’t know correct practices, or knowingly advise the wrong behaviors.** There was broad consensus that it is common for doctors to promote breastmilk substitutes (BMS) in their practices. Some respondents indicated that even the most senior professionals don’t know enough about nutrition. Training is needed to reach professionals at all levels—nursing staff, medical superintendents, gynecologists, pediatricians, and community based workers. In some cases, when doctors have the correct knowledge, it is not relayed due to lack of time and resources, according to stakeholders. Regardless, it is clear that respondents feel that they should (or the government should) set an important cultural standard for practices. As one noted, “If doctors haven’t stopped giving breastmilk substitutes in Delhi, why would they do so in this place [Bihar]?”
- **Many doctors do not proactively promote breastfeeding. Several leaders speculate that is because it is not perceived as their professional priority.** One respondent indicated that doctors only do what feels is important to do—what drives their conscience. If child feeding were to become a professional priority then it was speculated that things would change—doctors are very esteemed, and what they recommend, the community will do.

“If the doctor has said this (breastmilk substitutes are needed) then only that is true. If he says mothers’ milk is not necessary, then that is it.”

Breastmilk Substitutes and the Indian Milk Substitutes Act

- Breastmilk substitutes and related products are common—and promoted by healthcare providers at all levels, from doctors to ANMs.** Participants noted that breastmilk substitutes continue to be common. This was attributed in part to the fact that private companies have so many resources to promote them—they have more communications channels with which to reach mothers. One respondent indicated that products are often sold at private counters and factories.
- Breastmilk substitutes have special status and are associated with the habits of the wealthy.** Formula is popular in urban areas, where people want to live in modernized ways. Urban women are working more, and think that if they have money it is good to give formula to their baby to be healthier. In rural areas, BMS packets are given a status in mothers' meetings. "We give it to our child because rich people also buy it, so it's very good." Families need better awareness of the benefits of breastmilk and the risks of formula feeding—to change these norms. However, there are exceptions to this; one respondent indicated that "where there is poverty and lack of education, mothers breastfeed their babies."
- The Indian Milk Substitutes Act (India's version of the International Code of Marketing of Breastmilk Substitutes) is not widely known or understood.** Among the respondents who knew what the IMS Act was, there were shared opinions that there was low awareness among opinion leaders more broadly. Respondents indicated that there is no implementation or support in Bihar to ensure that it is followed. As one respondent said, "The IMS act exists, but not many are aware of it. There needs to be a push for implementation of the IMS Act, but before that medical professionals need to understand the [basics of] of IYCF."
- Formula companies target doctors and health workers.** As one respondent said, "Even some companies who produce such kind of milk, they are approaching civil surgeons, medical professionals, doctors....and as a medical professional you should recommend this."
- The state is perceived as having a "conservative idea" about formulas.** A committee was formed by the state to study what is available in the market so they can take necessary steps—ostensibly to strengthen compliance with the IMS Act. However, one respondent felt that the state's actions were "a bit conservative"—seemingly implying that they are not aggressive enough to establish strong policies.

"Breastmilk substitutes are a status symbol—the more economically advantaged, the more people think it is best."

"The biggest factor is that doctors are promoting this. Doctors are writing powdered milk, because of their personal interest. Even in Patna we have seen, many of my family members... when delivery is conducted in good hospital, good doctor, practicing doctor, they are...[promoting]...because of some personal interest. If they will write some milk powder then they will get some commission and all. In rural areas also. For any reason if she visited the doctor they will be advised milk powder."

Maternity Entitlements/Baby Friendly Workplaces

- **Multiple respondents believed there are too few provisions to support working moms, and contradictions and inconsistencies in who receives maternity leave.** Some government workers nationally get 6 months, but not those appointed by state government. Women in the formal sector are provided three months (1.5 before birth, 1.5 after birth).¹ Yet as one respondent highlighted, the very women who are promoting practices (ANM, GNM) are not given the support they need to adopt optimal feeding practices themselves. “These are very serious issues that have moral aspects....How will she teach others when she is not getting any...for her own child? Immediately after the delivery she has to join her job...so she does not get dismissed from it. How wrong is it?” It was noted that some people aren’t even aware that their rights include maternity benefits.
- **Women’s empowerment is a major barrier to improving maternity entitlements.** The lack of maternity entitlements were directly tied by respondents to an underlying problem with women’s empowerment in the state. There is no support for female babies in many areas—let alone workplace support for working mothers.

Multi-sectoral Involvement in Child Nutrition

While interviewees cited the following other sectors for addressing nutrition issues in the state (other than ICDS and Health and PHED), multi-sectoral involvement in nutrition was not a major theme of the interview discussions.

- Convergence between the Corporate Social Responsibility and the Block Development Officer (BDO) at the village level is much needed
- Housing
- Rural development
- Energy
- PHED
- Agriculture, irrigation
- Education department
- Panchayati Raj Institutions (play a major role at the community level)
- State rural health livelihood mission
- Rural Development department
- Media
- Village leaders
- Chair of municipal corporation

Stakeholders noted generally that more collaboration across sectors would be beneficial at all levels.

“We need to form a team including ASHAs, AWWs, teachers, health workers, Workers of Mahila Samakhya” at ground level.

1. As per the Ministry of Women and Child Development, Government of India rules, Anganwadi workers of ICDS are allowed paid absence of 180 days of maternity leave. (<http://wcd.nic.in/icds/icdsteam.aspx>). However the Maternity Benefit Act, 1961 states leave of 12 weeks, six weeks before and six after the delivery date. (<http://www.ilo.org/dyn/travail/docs/678/maternitybenefitsact1961.pdf>)

Key Information Sources for Opinion Leaders

- **Type, format.** A variety of preferred information types and formats were raised throughout the interviews:
 - » Documentation of evidence; field based implementation learnings
 - » Research reports, journals
 - » Conferences
 - » Facebook chats with nutritionists
 - » Electronic/internet media
 - » Websites (common sites mentioned: state health site, nursing council site, NRHM site, government health department, Bihar nurse council, Bihar health website.
 - » Community center for Bihar-specific information
 - » Data from Civil Surgeon's office in Patna
 - » Demographer in health department
 - » Science Congress
 - » Health management information system
 - » Government sources

In terms of format, interviewees were split on whether they preferred printed or electronic data. Some respondents cited a need for a knowledge network at the state level, while others said they don't have time to check knowledge networks or belong to email groups or Facebook chat groups. UNICEF has a solution exchange at the national level but there is no bottom up approach in initiating and disseminating discussions on nutrition issues. UNICEF is planning a knowledge platform forum where all those people who have been trained on IYCF get an opportunity to share their knowledge and experience.

- **Trusted and reliable sources of information.** When asked about policymakers' preferred sources of evidence, interviewees cited the following:
 - » "Policymakers listen to academicians, global reports and examples from other states; national level and anything that has an Indian context; international journals like Lancet; case studies; information from peers."
 - » Multiple stakeholders noted the importance of official information from appropriate channels: "Any other information source might not be correct, might be exaggerated or might be motivated so it's better to stick to official channels and make them perfect and error free."
 - » Data from India is more credible than outside sources. "So [global/national studies from other regions] are available, the problem is they are not fully compatible or indicative of similar results for taking such initiatives because the situation in India is entirely different —especially Bihar is all the more very different—you have a different social structure here."

- **The role of the news media**

While widely acknowledging the important role of media in disseminating relevant information, several interviewees also cautioned that the media can have both positive and negative impacts. Stakeholders believe that media is a good platform to reach policymakers, as long as it is delivered in a thoughtful way. "... It brings a lot of awareness. It forces policy...to take action. So if we can do that, why not with nutrition?"

They were of the opinion that media tends to sensationalize issues and not reflect positive stories, noting that the media would be happier to report a child death because of malnutrition than reporting a positive story from a new program. Respondents did note that media is also used for delivery of messages on health. "Media does play a role but not in influencing policy making but raising awareness on certain issues," they added. Polio was cited as an example of a successful program that was highlighted by the media, as was routine immunization. They also noted, "Any adverse effect after any vaccination/ immunization was duly reported (e.g. death due to administration of Vitamin A in Gaya district led to significant adverse reporting). Many times programs suffer a set back because of adverse reporting but then the entire process of sensitization of the media in this mechanism leads to improvement in the process." Despite potential challenges, stakeholders acknowledged that the media is an important avenue to reach policymakers and other opinion leaders.

RECOMMENDATIONS FOR ACTION

Synthesizing results and common themes from more than twenty in-depth interviews, the following recommendations should be considered for future advocacy efforts at both the government ministry and program (government and NGO) levels. It should be noted that a key recurring theme in the interviews was the importance of the central level issuing guidance on key issues to drive action and implementation at the state level. Because the purview of advocacy efforts in Bihar do not include national-level advocacy, the following recommendations focus on what can be accomplished at the state level and below.

Priority Advocacy Asks and Areas of Focus

1. **Raise understanding and commitment to stunting reduction as the priority focus for nutrition and health programs—and of IYCF as a key driver of stunting reduction.** Key considerations include:
 - » Package and present the evidence in a more compelling way for policymakers, including establishing direct links between stunting and lifelong health impacts, and broader social and economic development outcomes.
 - » Make direct comparisons between stunting and underweight as growth measures to facilitate understanding about why both measures are important.
 - » Illustrate the ways in which poor nutrition undermines progress in other sectors and interventions; position it as foundational to the success of broader health and development efforts.
 - » Leverage global recommendations alongside national and state nutrition policies and plans of action to make the case for stunting and IYCF—including ensuring alignment of priorities and indicators across strategies. Place a greater effort on dissemination, ensuring that guidelines are understood and applied at the community level.
2. **Improve monitoring and data systems.** Timely and high-quality data that illustrates the causes and consequences of stunting is needed to help policymakers make informed decisions, including:
 - » More regular and consistent growth monitoring, with a focus on height—not just weight
 - » Additional personnel to do the data monitoring and greater rigor to ensure that numbers are not “fudged”
 - » More and better maintained equipment to conduct growth monitoring
 - » Greater monitoring of programs and their results, to help establish evidence base for interventions (and not just outcomes)
 - » Updating indicators to match global recommendations, with a particular focus on stunting as a key indicator
3. **Prioritize the role of health workers and medical practitioners in advocacy efforts.** A committed and well-equipped health workforce—at all levels—is absolutely essential to building political and cultural support for better nutrition. Potential opportunities to strengthen commitment to IYCF among health workers include:
 - » Ensure that thorough IYCF training is included in pre-service and in-service curriculum for health workers.

- » Stronger implementation and enforcement of the IMS Act in health facilities, to ensure that formula companies are not marketing to health workers and that health workers/facilities are not promoting formula to mothers and families. An initial step would be research to identify the type and frequency of violations in health centers.
- » Consider a companion advocacy plan targeted to doctors and medical practitioners that emphasizes their responsibility and their ethical conscience in promoting breastfeeding.
- » Consider a targeted and time-limited advocacy plan to support early initiation of breastfeeding—a potential “quick win.” There is broad recognition that this key practice is not happening, even while women are directly under the supervision of the health system.

The Process for Policy Change



4. Develop strong and specific multi-stakeholder partnerships and interdepartmental coordination. Multi-sectoral collaboration is critical—not just because it can improve nutrition, but because nutrition cannot be addressed through health-only interventions. But aligning activities within health programs is also an immediate need. Priority areas for improved coordination include the Ministry of Health and ICDS; the Ministry of Health and PHED, WASH programs; and the Ministry of Health and other sectors (e.g. education, agriculture) that can develop nutrition-sensitive interventions. Additional criteria for these partnerships include:
 - a. Increased focus on women and girls
 - b. Specific, action-based linkages between nutrition and WASH—including linking handwashing with complementary feeding
 - c. Increased synergies between education programs and Anganwadi Centers
 - d. Collaborations on issues of joint interest—including health system strengthening, capacity development, and maternal, newborn and girl’s health

Additional considerations for advocacy efforts moving forward include:

- Advocacy efforts and “policy asks” should be developed with a clear view to solutions to the lack of capacity and infrastructure within the health system—a key underlying barrier to greater nutrition. A critical underlying issue is the need for health system strengthening, including:
 - » Greater infrastructure—including from more space, more hospital beds, and more tools like monitoring equipment.
 - » A larger and better trained health workforce. IYCF training for frontline workers needs to be expanded to include greater detail on full range of IYCF practices and how to counsel on them.
 - » Universalized health services and health equity, to ensure the poorest and most marginalized are included in programs and successes.
- Direct outreach to high-level government partners should be maintained and continually reevaluated. Current needs include working toward greater alignment between the strategies and mandates of different ministries and departments; sharpening policy asks to be clearer and more attainable; and seeking opportunities to present the evidence base in compelling formats.
- An initial maternity entitlement “policy ask” could be to increase support for ASHAs and AWWs—the women who are working to promote best practices in their own occupation, but often do not have the support they need to adopt those practices.

Advocacy targets (audiences)

An advocacy plan with the potential areas of focus listed above could begin with renewed outreach to the following advocacy targets:

- **State-level leadership**, including the chief minister, cabinet, cabinet subcommittees overseeing the Manav Vikas Mission. It is clear that priority for nutrition begins at the very top of the political system. Continued engagement at this level should be prioritized.
- **Multi-sectoral ministries and programs**, including education, social welfare, health and PRI, rural development. These additional sectors were often highlighted as important places to begin and/or escalate multi-sectoral approaches.
- **Medical leadership**. This may include work targeted to medical societies and universities. The clear role that doctors play in influencing practices in their communities makes them a critical advocacy target.

Awareness raising tools and products

Synthesizing feedback across all interviews, there was no one-size-fits-all approach to developing advocacy communications tools. Rather, it is important to consider various needs and preferences when developing different products, including an emphasis on the local context (both Bihar and India nationally), drawing on highly regarded international research (e.g. Lancet), and making the information itself easy to access and digest. Specific content products for consideration include:

- Multi-sectoral briefs and/or presentations—Develop educational materials that explain why nutrition matters, and how it is a foundational issue to broader health and development, for multiple opinion leader audiences.
- Basic suite of educational tools on key topics of importance including stunting, breastfeeding, and complementary feeding. Tools should be adapted for different audiences—for example, doctors will need more scientific background, where policymakers need more impact data on national outcomes.

- Policy brief and/or presentation on the importance of monitoring data—Clearly articulate for decision makers why better monitoring data is needed (for better decision-making and impact) and how to achieve it.

Additional opportunities

Various anecdotal points emerged across the interviews that should also be taken into account as advocacy plans develop. These include:

- The proposed **UNICEF knowledge network** should be leveraged for key IYCF advocacy priorities, and included as a communications channel in planning efforts.
- There is potential for **local champion cultivation and engagement**, including greater use of political leader allies, prominent doctors, and journalists.
- **Greater use of mass media** is a consensus intervention to sensitize and create awareness of IYCF practices among all audiences.
- There is some interest in **greater private sector engagement**, which could begin with the creation of a “private sector working group” to investigate opportunities for engagement.
- The IICDS Systems Strengthening and Nutrition Improvement Project (ISSNIP) has included **direct policymaker engagement** in their annual plan, including targeted education for about 40 parliamentarians. This effort should be investigated for possible collaboration and linkages with IYCF advocacy priorities.
- Utilize and expand the capacity of the **nutrition technical advisory group** as an influencing body, including participation in relevant government committee/working group meetings.

Looking ahead

Experience developing IYCF advocacy and policy change strategies in other countries has demonstrated a common process that can be applied in specific contexts. That process is best summarized in the following graphic:

Applying the recommendations in this document to the above process for policy change would result in the following high-level approach:

- Establish and Sustain Partnerships
 - » Develop a stronger nutrition working group that meets more regularly and makes joint recommendations to the government
 - » Facilitate greater interaction between Health and ICDS to facilitate a long-term discussion about how to integrate nutrition efforts
 - » Conduct outreach to priority targets in other sectors and ministries around key moments (e.g. dissemination of data, launch of new activities, etc.)
- Develop the Evidence Base
 - » Provide clear, compelling data about stunting and IYCF and their impact on health, social and economic development; include clear information about the stunting vs. underweight as an indicator
 - » Provide research that informs global IYCF recommendations (e.g. why begin complementary feeding after 6 months?)
 - » Provide research-based information on how poor nutrition undermines progress in other sectors and interventions

- Develop messages and materials
 - » Package in various communications formats, including policy briefs, PowerPoint presentations, videos and others
 - » Engage the media as a key information source to disseminate key messages and report on progress and milestones
 - » Seek new and unique opportunities to build commitment, like issuing a “doctor’s pledge” to support IYCF and having pledge banners available to sign at consensus building events
- Build consensus
 - » Identify existing meetings and events that have importance to political and program decisions, and identify opportunities to elevate nutrition on the agenda
 - » Host meetings, events, and roundtables with policy- and decision-makers to present the evidence base and invite inquiry—and deliver explicit “asks” for policy-level action
 - » Conduct direct outreach to policymakers and parliamentarians through desk-side briefings and smaller meetings
 - » Develop a plan for dissemination of materials and tools at the local level, including civil surgeons offices

This process is dynamic and adaptable—as the needs, barriers and opportunities for policy change will change over time. With a dedicated effort and the close involvement of partners that bring resources, relationships and expertise to the table, there is great potential for advocacy to make meaningful contributions to the effort to improve child nutrition in Bihar.