THE COMMITTEE ON THE RIGHTS OF THE CHILD

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REPORT ON THE SITUATION OF INFANT AND YOUNG CHILD FEEDING IN NEPAL

May 2015 (revised May 2016)

Data sourced from:

National Neonatal Health Strategy (2004), National Neonatal Long Term Plan (2005), Newborn Health and Program Nepal (2007), Nepal Demographic and Health Survey (2006), Nepal Demographic Health Survey (2011), World Breastfeeding Trends Initiative (WBT*i*) Assessment of Nepal (2012), Nutrition Technical Committee (2011)

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SUMMARY

*The following **obstacles/problems** have been identified:*

- National health and nutrition monitoring system does not incorporate all indicators related to infant and young child feeding (IYCF).
- National Breastfeeding Promotion & Protection Committee (BPPC) is currently inactive.
- National information, education and communication (IEC) materials on IYCF is inadequate, geographical coverage of IYCF is insufficient, and sustainability related to funding is not secured.
- Lack of nodal person in charge of the monitoring and enforcement of the Breastmilk Substitutes Act 1992 (BMS Act), and Nepal Breast Milk Substitute Regulation, 1994 resulting in persistent violations of the International Code of Marketing of Breastmilk Substitutes.
- Lack of skilled staff in the health facilities, lack of concrete action taken to revive the Baby-friendly Hospital Initiative (BFHI) and absence of monitoring of the certified hospitals to ensure compliance with the BFHI criteria.
- Maternity protection is not standardized and does not cover women working in the informal & private sector. As provided by the Labour Rules 1993, maternity leave does not constitute a right but only a benefit for which permission has to be taken from the employer or the authority who may or may not allow it (section 36, Labour Rules 1993).
- Inadequate counseling to HIV positive mothers due to a lack of training of health professionals about the prevention of mother-to-child transmission at all levels.
- Lack of training of national emergency relief staff and programme managers on IYCF in emergencies. Following the earthquake that occurred on 25th April 2015, Nepal has been facing an emergency situation, with more than 16,000 people injured and thousands of people without shelter. Donations of breastmilk substitutes (BMS) have been requested by the Nepalese government.
- Lack of promotion of locally available food for mothers during pregnancy and children after six months of age.
- Lack of access to health care and nutritious food for pregnant and lactating mothers.
- Lack of a comprehensive strategy towards tackling the root causes of hunger and malnutrition with severe impact on growth, development and health of children.

Our recommendations *include:*

- Integrate all indicators related to IYCF into the national health and nutrition monitoring system.
- Reactivate the national BPPC and place it under supervision of the Nutrition Technical Committee.
- Ensure adequate and sustainable funding for development and dissemination of IEC materials in different languages which provide full and correct information on IYCF and cover all geographic locations.
- Enforce the BMS Act at all levels and implement an effective monitoring mechanism at central & local level.
- Revitalize the BFHI throughout the country and monitor compliance of the certified hospitals with the BFHI criteria on a regular and systematic basis.
- Standardize maternity protection for all working women and extend it to women working in the informal & private sector. Maternity leave should be provided as a right.
- Provide adequate counseling on IYCF for HIV positive women and ensure adequate training of health professionals on mother-to-child transmission at all levels and ensure the availability and accessibility of care and support services to women and children living with HIV/AIDS at the VDC level. The support services should include not only the provision of ARV drugs, but also economic and income-generation skill development and educational programs. Besides such support services, social security schemes should be extended to the infected single women and their children.
- Address the HIV/Aids infected and affected women's issue of livelihood opportunities and social security schemes and ensuring their and their children's nutrition requirements.
- Avoid soliciting donations of BMS unless based on an assessment of a real need and do not accept unsolicited donations.
- Provide national emergency relief staff and programme managers with training on IYCF in emergencies, especially breastfeeding protection and support.
- Promote with universal coverage locally available and culturally acceptable food for pregnant and lactating women as well as for infants.
- Ensure that women access the healthcare as provisioned by laws and programs and extend it to their food and nutrition security – even more so for women during the pregnancy period and after delivery.
- Adopt a comprehensive national strategy to ensure food and nutrition security for all, particularly targeting to the marginalized and disadvantaged groups of society, which are vulnerable to food insecurity.[1]

[1] Such strategy should be based on the existing international standards on the right to adequate food, including the General Comment No. 12 of this Committee, the Voluntary Guidelines on the Right to Food in the Context of National Food Security, the Voluntary Guidelines on Responsible Tenure of Land, Forest and Fisheries and the Directive Principles on Extreme Poverty and Human Rights, among all other relevant standards on the field.

1) General points concerning reporting to the CRC

In 2014, the CRC Committee will review Nepal's combined 3rd and 5th periodic report.

At the last review in 2005 (session 39), in its Concluding Observations[2], the CRC Committee did not specifically refer to breastfeeding but it referred to health care in general. The Committee recommended Nepal to: "*(a) Continue taking all appropriate measures to improve the health infrastructure, (...), in order to ensure access to basic health care and services adequately provided with appropriate resources, including basic medicines for all children, and targeting rural areas in particular; (c) Facilitate greater access to primary health-care services; (d) Continue strengthening measures to* ***combat childhood illnesses, paying particular attention to the needs of children belonging to high-risk groups****; (e) Engage in awareness-raising efforts to provide the general public, in particular, families, children and health-care providers, including traditional health practitioners, with appropriate knowledge of basic first aid and health care; (f) Strengthen the data collection system (...).*" (para 62)

2) General situation concerning breastfeeding in Nepal

General data

	2001[3]	**2006**[4]	**2011**[5]
Birth rate, crude (per 1,000 people)	33.5	28.4	700
Neonatal mortality rate (per 1,000 live births)	39	33	33
Infant mortality rate (per 1,000 live births)	64.4	48	46
Infant under 5 mortality rate (per 1,000 live births)	91.2	61	54
Maternal mortality ratio (per 100,000 live births)	-	281	-
Delivery care coverage: • Skilled attendant at birth • Institutional delivery • C-section	 13% 9% 0.8%	 18.7% 18% 2.7%	 36% 35.3% 4.6%
Stunting (under 5 years)	57%	49%	41%

[2] CRC Committee, Concluding Observations to Nepal, 2005. Available at: http://tb.ohchr.org/default.aspx?Symbol=CRC/C/15/Add.261
[3] 2001 Nepal Demographic and Health Survey (NDHS 2001). Available at: http://dhsprogram.com/pubs/pdf/FR132/FR132.pdf
[4] 2006 Nepal Demographic and Health Survey (NDHS 2006). Available at: http://dhsprogram.com/pubs/pdf/fr191/fr191.pdf
[5] 2011 Nepal Demographic and Health Survey (NDHS 2011).Available at: http://dhsprogram.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf

Breastfeeding data

	2001[6]	**2006**[7]	**2011**[8]
Early initiation of breastfeeding	31.1%	35.4%	44.5%
Exclusive breastfeeding <6 months	78.8 % (< 4 months)	53%	69.6%
Continued breastfeeding (20-23 months)	87.3%	95%	93%
Timely complementary feeding (6-9 months)	66.2%	75%	70.4%
Median duration of breastfeeding (in months)	32.8	34.3	33.6
Infants <6 months receiving bottle feeding	3.9%	4%	6%

Early initiation of breastfeeding

About 700,000 babies are delivered annually in Nepal. According to Nepal Demographic and Health Survey 2011 (NHDS 2011), only 45% of them are given breastmilk within one hour after delivery. This rate is higher in urban areas (50.8%) than in rural areas (43.9%). Although figures show a 10% increase between 2006 and 2011, it means that **more than one child out of two is not optimally breastfed right after birth**.

Exclusive breastfeeding and bottle feeding under 6 months

Exclusive breastfeeding significantly **increased from 53% in 2006 to 70% in 2011**. However, in the same period, the percentage of bottle-fed infants under 6 months almost doubled (3.9% in 2001, 4% in 2006 and 6% in 2011).

Mean duration of breastfeeding, continued breastfeeding and complementary feeding

The mean duration of breastfeeding (about 34 months) shows that majority of children are breastfed until 2 years or beyond. In 2011, **more than 9 children out of 10 were still breastfed at 20-23 months of age**.

Despite these good figures, statistics also show that the **percentage of infants aged 6-9 months receiving timely complementary food decreased** from 75% in 2006 to 70% in 2011.

[6] 2001 Nepal Demographic and Health Survey (NDHS 2001). Available at: http://dhsprogram.com/pubs/pdf/FR132/FR132.pdf
[7] 2006 Nepal Demographic and Health Survey (NDHS 2006). Available at: http://dhsprogram.com/pubs/pdf/fr191/fr191.pdf
[8] 2011 Nepal Demographic and Health Survey (NDHS 2011).Available at: http://dhsprogram.com/pubs/pdf/FR257/FR257%5B13April2012%5D.pdf

The high rates of exclusive and continued breastfeeding might be a result of the promotion of nutrition of exclusive and continued breastfeeding as well as complementary feeding under the 2004 National Nutrition Policy and Strategy. Besides, it is to be noted that some provisions of the International Code of Marketing of Breastmilk Substitutes has been included in a national law enacted in 1992 in Nepal (see section 3 hereafter).

Infant mortality

The rate of infant mortality has gradually decreased in the past decade but the rate of neonatal mortality did not. Major causes of infant mortality in Nepal are neonatal infection, diarrhoea & pneumonia. Indeed, infectious diseases are major cause of infant mortality in developing countries, and optimal breastfeeding practices provide protection against them.

3) Government efforts to encourage breastfeeding

Nepal's recently adopted constitution recognizes the right of the child under article 39, which spells out inter alia the right to health.[9] The Children's Act, 1992under article 4 "Right to maintenance and upbringing, education and health care" puts an obligation on the government to "render assistance in making arrangements for the proper health care to the pregnant mothers and the mothers who have recently given birth to a child". [10]

National policies

The Government of Nepal has developed several strategies and programmes related to the health and nutrition of infants and young children:

- The National Neonatal Health Strategy (2004): This strategy aims at improving the health and survival of newborns. One of its strategic objectives is to promote healthy newborn practices at all levels of the health system. It is to be noted that Nepal was the first low-income country to adopt a national newborn strategy, influencing similar strategies in other countries.[11]
- The National Nutrition Policy & Strategy (2004): Even though this document does not directly mention breastfeeding in its objectives, reference to it is made in the section about HIV positive women. In addition, breastfeeding and complementary feeding are included as part of the

[9] Constitution of Nepal 2072 (2015) Article 39, Right of the Child
[10] The Children's Act 1992
[11] Pradhan Y.V. et al. Newborn survival in Nepal: a decade of change and future implications. 2012. Health Policy and Planning. Available at: http://heapol.oxfordjournals.org/content/27/suppl_3/iii57.full.pdf+html

strategy for reducing Protein Energy Malnutrition (PEM) and as part of the strategies on anemia control and life style disease control.[12]

- The National Neonatal Long Term Plan 2005-2017 (NNLTP) (2005): In line with the Second Long Term Plan Health Plan (1997-2017), the Nepal Health Sector Programme Implementation Plan and Millennium Development Goals, the NNLTP aims to improve maternal and neonatal health and survival, especially among poor and socially excluded communities, with indicators drawn from the MDGs. This plan puts an increased specific emphasis on neonatal health and the recognition of the importance of skilled birth attendance in reducing maternal and neonatal mortalities.[13] In 2006, the Safe Motherhood and Neonatal Long Term Health Plan 2006-20017 was formulated and incorporated the NNLTP.

- The National Policy on Skilled Birth Attendants (2005): Developed by the Ministry of Health & Population, it aims at ensuring availability, access and utilization of skilled care at every birth. IN 2004-2005, the rate of skilled attendants at birth was of 20.2% only, and the WHO suggested that it should increase to at least to 60%.

- The Community Based Newborn Care Programme (2005): Developed by the Ministry of Health & Population, it has been implemented in many districts in phase-wise manner.[14]

- The Community Based Integrated Management of Childhood Illnesses (2007): Developed by the Child Health Division, it aims to improve breastfeeding and management of sick newborns.

In addition, a Nutrition Technical Committee (NUTEC) was formed in 2011 under Nutrition Section of Child Health Division to link other sectors like Health, Nutrition effectively / to bring all stakeholders in one platform.[15] In 1992, the national Breastfeeding Promotion & Protection

[12] The National Nutrition Policy & Strategy (2004). Available at: http://dohs.gov.np/wp-content/uploads/chd/Nutrition/Nutrition_Policy_and_Strategy_2004.pdf

[13] For more information, see http://umeshg.com.np/national-safe-motherhood-newborn-health-long-term-plan-2006-2017/

[14] Implementation of CB-NCP began in 10 pilot districts in 2009 with seven components: (1) behaviour change and communication to increase home health behaviours; (2) promotion of institutional delivery and clean delivery practices for home deliveries; (3) early postnatal care home visits; (4) identification and management of newborn infection; (5) extra home visits for care of low birth-weight newborns; (6) prevention and management of hypothermia; and (7) recognition of the non-breathing baby, initial stimulation and resuscitation. The programme is being gradually expanded to more districts.

Reference: Pradhan Y.V., Upreti S.R., Pratap K.C.N., Khadka N., Syed U., Kinney M.V., Adhikari R.K., Shrestha P.R., Thapa K., Bhandari A., Grear K., Guenther T., Wall S.N. 2012. *Nepal Newborn Change and Future Analysis Group.* Newborn survival in Nepal: a decade of change and future implications. Health Policy Plan. 2012 Jul;27 Suppl 3:iii57-71.

[15] The roles and functions of NUTEC are, among other things : provide technical and public health managerial advice and support to key sectors on the design of national and sectoral policies, strategies, plans and activities to ensure that nutrition concerns are adequately addressed; supervise the implementation of national and sectoral policies, strategies, plans and activities; advocate on behalf of nutrition with appropriate governmental line ministries and partners to

Committee (BPPC) has been formed.[16] The BPPC is a high-level committee with Health Secretary as Chairperson & other higher-level officials as staff. However, it hardly holds any meeting and it is ineffective. In spite of extensively drafted Mother's Milk Substitute Act –Nepal, implementation of this act has never been done satisfactorily due to various reasons, the most important being a paucity of skilled manpower to monitor the violation of this regulation.[17] Therefore, **we suggest transferring the power from the BPPC to the NUTEC to make it more effective**.

Last but not least, a Multi-sector Nutrition Plan for accelerating the reduction of maternal and Child Under-nutrition in Nepal 2013-2017 (MSNP).[18] This plan, prepared by the Planning Commission of Nepal, Government of Nepal to address chronic malnutrition, includes infant and young child feeding as a major intervention. It aims at improving maternal and child nutrition, which will result in the reduction of Maternal Infant and Young Child (MIYC) under-nutrition, in terms of maternal BMI and child stunting, by one third. MSNP will contribute to attaining its long-term vision and mid-term goal by achieving three major outcomes:

- Outcome 1: Policies, plans and multi-sector coordination improved at national and local levels.
- Outcome 2: Practices that promote optimal use of nutrition 'specific' and nutrition 'sensitive' services improved, ultimately leading to an enhanced maternal and child nutritional status.
- Outcome 3: Strengthened capacity of central and local governments on nutrition to provide basic services in an inclusive and equitable manner.

However, **the MSNP, is not implemented in all districts**. As it is not covering all the geographical areas, and due to shortcomings with regard to organization, coordination among government line agencies in districts, information and awareness, the majority of children, in particular those belonging to marginalised and vulnerable communities in remote areas (e.g. indigenous people, Dalits, disabled etc.) are not able to access this program.

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increase awareness, understanding and prioritization of nutrition issues, to substantiate investment for specific nutrition interventions and ensure that nutrition concerns are kept high on the political agenda; mobilize increased funding support for nutrition in Nepal by leveraging resources from sector MoF allocations, district budgets, development partners, international funding agencies, NGOs and other stakeholders; facilitate sharing of information on nutrition, both within and between sectors, including data on nutrition, best practices, lessons learned, and research findings; identify knowledge gaps and research priorities to inform the design of more effective nutrition interventions; facilitate the strengthening of monitoring on nutrition to ensure that nutrition indicators are integrated into national and sectoral monitoring, evaluation, and reporting frameworks and systems; strengthen multi-sectoral coordination and promote partnerships for nutrition; form sub-groups under the NUTEC to address specific issues on and as need arises basis.

[16] The BPPC was formed as per provisions of the 'Mother's Milk Substitutes (Control of Sale and Distribution) Act' of Nepal which was enacted in 1992 and rules were gazetted in 1994.

[17] See BPNI, Workshop on Implementation of Mothers' Milk Substitute Act of Nepal. Available at: http://bpni.org/project/BMS-code-workshop-Nepal.pdf

[18] See http://scalingupnutrition.org/wp-content/uploads/2013/03/Nepal_MSNP_2013-2017.pdf

In addition, the MSNP is part of the programme Scaling Up Nutrition (SUN). It is of concern that SUN focuses on Ready-to-use Therapeutic Foods, for which there is no significant added value for its use in the treatment of Moderate and Severe Acute Malnutrition and instead could interfere with positive aspects of food culture such as breastfeeding and infant and young child feeding practices.[19]

A general criticism of such policies and strategies is that they lack human rights-based approach; they are not fully anchored in a system of rights and corresponding obligations established by national and international law, nor do they strengthen accountability of non-implementation of these policies and programmes.

Campaigning

As pointed out by experts, **efforts to promote breastfeeding are not sufficient and limited to the World Breastfeeding Week** (August 1—7) only.[20]

The International Code of Marketing of Breastmilk Substitutes

Although a national law, the 'Mother's Milk Substitutes (Control of Sale and Distribution) Act'[21] (hereafter: the BMS Act) having many provisions of the Code has been enacted in 1992, there is still no mechanism in place to monitor and report violations. Even though the BMS Act clearly bans sponsorship of medical personnel, baby food companies continue to find ways and means to reach out to health professionals in order to promote their products. In a 2011 assessment, experts assert that hospitals staff were not aware of the national legislation implementing the Code and that breastmilk substitutes were widely available in pharmacies and markets.[22] In addition, monitoring has not been effective due to lack of identification of focal point at the central level as well as district levels and the overall lack of trained staff to monitor the BMS Act. Some NGO has taken the companies' violating the Code to the court and court has penalized those companies but it has no effect on companies due to lack of proper monitoring system.

Therefore, there is a **need for effective monitoring and enforcement of the BMS Act**.

[19] See IBFAN Statement: Cochrane Review on Commercial Ready-to-use Therapeutic Foods (2013), accessible at: http://ibfan.org/ips/IBFAN-calls-for-a-review-of-UN-September-2013.pdf
[20] Subedi N. *Baby-Friendly Hospital Initiative: Situation in Nepal.* 2012. Health Prospect 2012; 11: 53-54. Available at: http://www.nepjol.info/index.php/HPROSPECT/article/view/7436/6031
[21] The Mother's Milk Substitutes (Control of Sale and Distribution) Act, 2049 (1992). Available at: http://www.moadwto.gov.np/downloadfile/InfantMilkSubstitutesAct_1322220410.pdf
[22] Subedi N. 2012. *op. cit.*

Courses / ***Training of Health Professionals***

The government of Nepal has been conducting training on infant and Young Child Feeding based on the WHO/UNICEF training course on breastfeeding counseling[23] for different categories of health workers in many districts. However, **the training course on IYCF currently integrated in pre-service and in-service curricula of health professionals is inadequate and not skill-based.**

In addition, the Nepal Breastfeeding Promotion Forum also has been conducting master training, mid-level training and frontline workers training based on the Infant and Young Child Feeding Counseling '4-in-1' training course developed by BPNI/IBFAN Asia.

4) Baby-Friendly Hospital Initiative (BFHI)

The Baby-Friendly Hospital Initiative was launched in Nepal in 1994 and health workers from 22 hospitals all over the country were trained until 1996.[24] Following this training, in the period 1997-1998, 7 of these hospitals were certified as 'baby–friendly' (out of a total of 103 hospitals). In 2011, an assessment was carried out, which revealed that none of the certified hospitals was anymore complying the Ten Steps to Successful Breastfeeding.[25]

Since then, no concrete action has been taken to revive the BFHI in the country. There is still a **lack of adequate skilled staff in the health facilities**, while compliance of the certified hospitals is **not systematically and regularly monitored**. Therefore, although there has been an increase of the number of institutional deliveries, the rate of early initiation of breastfeeding within one hour after delivery has not significantly increased.

5) Maternity protection for working women

Maternity protection is critical to enable working mothers to breastfeed optimally. Therefore, all working women, including women working in the informal sector, should enjoy maternity protection.

[23] See World Health Organization/UNICEF. Breastfeeding counselling: a training course. Available at: http://www.moadwto.gov.np/downloadfile/InfantMilkSubstitutesAct_1322220410.pdf

[24] Subedi N. 2012. *op. cit.*; Adhikari M., Khanal V., Karkee R. and Gavidia T. 2014. *Factors associated with early initiation of breastfeeding among Nepalese mothers: further analysis of Nepal Demographic and Health Survey, 2011.* International Breastfeeding Journal 2014, 9:21. Available at: http://www.internationalbreastfeedingjournal.com/content/pdf/s13006-014-0021-6.pdf

[25] Subedi N. 2012. *op. cit.*; Labbok M.H. *Global Baby-Friendly Hospital Initiative Monitoring Data: Update and Discussion.* 2012. Breastfeeding Medecine, Vol . 7, N .4, p. 215. Available at: http://www.researchgate.net/publication/230617756_Global_baby-friendly_hospital_initiative_monitoring_data_update_and_discussion/file/79e415037abf6c5f21.pdf

In Nepal, maternity protection is included in several acts and regulations.[26] This is of concern that the 2006 Labour Ordinance covering employees working in the private sector is not in line with the rules covering the civil employees, and that women working in the informal sector are not at all covered by any of these rules. This is particularly relevant for women belonging to marginalized and disadvantaged groups, as their participation in the work force is largely in the informal sector. The situation is more pertinent in rural and remote areas of Nepal, with consequent negative impact on nutrition of both women and children due to shortage of income.

Maternity leave

Scope: The Labour Act and Rules cover persons engaged in the administrative functions of any enterprise with 10 or more employees, while the Civil Service Act and Rules apply to any person who is holding a post in the civil service.

Conditions and duration: Maternity leave depends on the law covering the employee.

- ***Labour Act and Rules:*** Maternity leave is granted for a period of 52 days (7 weeks) for pre- and post-delivery for up to two births. Employees are entitled to further periods of maternity leave if their first two children have died. No qualifying conditions are placed on the entitlement to maternity leave for the first two pregnancies in any period of service.

  It is important to note that as provided by the Labour Rules 1993, maternity leave does not constitute a right, but only a benefit for which permission has to be taken from the employer or the authority who may or may not allow it (section 36, Labour Rules 1993).

- ***Civil Service Act and Rules:*** Maternity leave is granted for a period of 60 days (8 weeks) for pre- and post-delivery. No qualifying conditions placed on the entitlement to maternity leave for the first two pregnancies in any period of service. Civil employees are allowed to extend the period of maternity leave up to 6 months.

Compulsory leave: There are no compulsory leave provisions.

Cash benefits: The scope of the entitlement to cash benefits mirrors the entitlement to maternity leave, with same duration. Maternity leave benefits are paid by the employer at the employee's ordinary rate of pay (100%).

[26] Labour Rules No. 2050, 1993; Labour Act, 1992, amended by Labour (First Amendment) Act, 1998 and by Labour (Second Amendment) Ordinance, 2006; Civil Service Act No. 2049, 1993, amended by Civil Service (Second Amendment) Act, No. 2064, 2007; Civil Service Rules No. 2050, 1993, amended by Civil Service (Eighth Amendment) Rules, No. 2067, 2010.

Paternity leave

There are no provisions for paternity leave except for civil service employees whose wife is pregnant. In this case, they are entitled to '*maternity care leave'* of 15 days before and/or after the delivery. Such entitlement is restricted to two leaves during a service period.

Breastfeeding:

Breastfeeding breaks: Breastfeeding workers and employees in enterprises with 50 or more workers or employees are entitled to time as needed and to a place to breastfeed.

Breastfeeding facilities: Where 50 or more female workers and employees are engaged in the work, the owner of the enterprise shall have to make provisions of a healthy room for the use of children of such female workers and employees.

6) HIV and infant feeding

In Nepal, 0.2% of the adult population is infected by HIV. The antenatal care coverage (at least one visit) is of 58%, which means that more than 4 women out of 10 receive no prenatal care at all. In 2013, less than 500 pregnant women were living with the HIV. Among them, some 120 (27%) received ARV therapy for prevention of the mother-to-child transmission. The estimated mother-to-child transmission rate is of 30.8%.[27]

Regarding the feeding of infants born to HIV infected women, the National Guidelines on the Prevention of Mother-to-Child Transmission of HIV in Nepal (2008)[28] clearly states that "[i]n families where the custom is to breast feed and replacement (formula) feeding is not affordable, feasible, acceptable, safe and sustainable […], the overall risk to the baby from malnutrition, HIV and other infections can be minimized by exclusively breast feeding to 6 months of age. Mixed feeding must be strictly avoided." However, even though there is some improvement on HIV and infant feeding, there is still **inadequate counseling to HIV positive mothers due to a lack of adequate training of health professionals about the prevention of mother-to-child transmission at all levels.**

There is a close relation between the well-being of children and the health status of their mothers: An adequate health condition is essential to be able to work and feed themselves and their families; moreover, just a healthy body is able to assimilate nutrients. Sickness, on the contrary can affect the nutritional intake and negatively affect the access to food of the entire family, especially of children.

> *"In Bahrabis VDC, Bajura district, 24 children (age 5-16 years) of HIV Aids infected women are facing extreme food shortage. Out of these 24 children, 5 are HIV positive and have to take ART regularly. However, in spite of being able to access*

[27] UNICEF online HIV/AIDS database 2014. Available at: http://data.unicef.org/hiv-aids/global-trends
[28] National Guidelines on the Prevention of Mother-to-Child Transmission of HIV in Nepal. 2008. Available at: http://www.nepalccm.org/resources/hiv/pdf/annexc1.pdf

the ART service, due to poverty, the medicine is often consumed without the necessary accompanying nutritious food."[29]

Addressing the infected and affected women's issue of livelihood opportunities and social security schemes and ensuring their nutrition requirement for effective treatment remains challenging. Voluntary counselling and testing (VCT) services, ARV drugs and substitution drugs which are only available in district headquarters are not easily accessible for the affected communities in particular those who live in rural remote areas. Lack of funds for transportation and stay during the treatment are major hindrances as there is lack of adequate provision for monetary support and assistance to cover for the expense of long distance travel and stay during the treatment.[30]

7) Infant feeding in emergencies (IFE)

In emergencies and relief situations, infants and young children are among the most vulnerable due to the risk of interruption of breastfeeding and inappropriate complementary feeding leading to increased risks of malnutrition, illness and mortality.

Nepal has made a notable progress in development of emergency preparedness plan and response which clearly address the infant feeding during emergencies. A national coordinator has been identified and is in charge of liaising with UN and agencies, NGOs and the military forces as well as with other partners working in emergency situations.

On the 25th April 2015, a magnitude 7.8 earthquake hit Nepal and caused more than 8,000 deaths. Currently, the country is facing an emergency situation, with more than 21,000 people injured and thousands of people without shelter. The Nepalese government listed breastmilk substitutes (BMS) as needed item and subsequently, donations of BMS have been made by several countries as a result of this listing. In 1988, a magnitude 6.8 earthquake hit Armenia. Consequently, the Armenian diaspora and the international cooperation and relief agencies sent donations of infant formula. It resulted in a dramatic fall of breastfeeding rates in the following years. Therefore, in compliance with the Operational Guidance on Infant and Young Child Feeding in Emergencies[31] adopted by the World Health Assembly, **it is crucial for the Nepalese government to avoid soliciting donations of BMS unless based on an assessment of a real need as well as to avoid accepting unsolicited donations.**

[29] FIAN Nepal case documentation, District AIDS coordination committee and Bajura Plus http://www.fiannepal.org

[30] Cited from: FIAN Parallel Information: The Right to Adequate Food in Nepal, 2014, submitted to the CESCR in 2014, available at: http://www.fian.org/fileadmin/media/publications/FIAN_Nepal_parellel_information_to_CESCR-final_version10Sep2014_2_.pdf
For further information please also refer to: Parallel report: The Right to Adequate Food of Women in Nepal, 2011, submitted to the CEDAW in 2011, available at:
http://www.fian.org/fileadmin/media/publications/2011_7_Nepal_Women_RtF.pdf

[31] See http://www.ennonline.net/operationalguidanceiycfv2.1

8) Complementary feeding and the right to adequate food and nutrition

With reference to the definition of the right to adequate food as laid out by the former Special Rapporteur on the right to food, Olivier De Schutter,[32] the human right to adequate food and nutrition is a comprehensive concept intrinsically linked to the full realization of women's and children's rights, and within the conceptual framework of food sovereignty. As a result, States should be held accountable to respect, protect, and fulfil the right to adequate food and nutrition in an integrated manner by ensuring that all structural causes of hunger and malnutrition are addressed in all relevant governance and policy processes.

To implement the right to adequate food and nutrition a comprehensive national strategy needs to be adopted, to ensure food and nutrition security for all, particularly targeting the marginalized and disadvantaged sections of society including their children. Such a strategy should be based on human rights principles that define the objectives, and formulation of appropriate policies and corresponding human rights benchmarks.[33] Such comprehensive strategy which provides a guiding framework to advance the realization of the right to adequate food and eradication of hunger and malnutrition does not yet exist in Nepal.

Under the Convention on the Rights of the Child (CRC), States Parties' obligations to respect, protect and fulfil the right to adequate food and nutrition are described under articles 24 and 27. More specifically, under article 24, States Parties "recognize the right of the child to the enjoyment of the highest attainable standard of health", which is elaborated in the article and perceived to encompass the right to adequate food and nutrition.[34]

[32] Final report of the former Special Rapporteur on the right to food Olivier De Schutter to the Human Rights Council, 24 January 2014, page 3 : *« The right to food is the right of every individual, alone or in community with others, to have **physical and economic access at all times to sufficient, adequate and culturally acceptable food that is produced and consumed sustainably, preserving access to food for future generations.** (…) each person should have access to a diet that "as a whole contains a mix of nutrients for physical and mental growth, development and maintenance, and physical activity that are **in compliance with human physiological needs at all stages throughout the life cycle** and according to gender and occupation".2 Thus, the normative content of the right to food can be summarized by reference to the requirements of availability, accessibility, adequacy and sustainability, all of which must be built into legal entitlements and secured through accountability mechanisms. »*

[33] The Right to Adequate Food: Fact Sheet No 34 by OHCHR and FAO, 2010, page no. 26

[34] Under this article, the CRC recognizes that the right to adequate food and nutrition in relation with the right to health goes beyond the provision of nutritious food and calls for the nutrition information and education of, as well as support to, those responsible for the children's care and well-being, in particular mothers and parents. In this context, the CRC states that in addition "**to combat[ing] disease and malnutrition…through the provision of adequate nutritious foods**" States Parties shall also take steps "**to ensure appropriate pre-natal and post-natal health care for mothers**"and "**ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding…**".

Malnutrition is badly impacting on growth and development of under-five children in Nepal. The number of under-five stunting and underweight children are critically high. Anaemia among children aged 6-59 months is considerably high and critical in number (46%). Child mortality, which is directly associated with the food and nutritional status, is also very high in Nepal. One in every 22 Nepalese children dies before reaching age one year, and one in every 19 does not survive to his/her fifth birthday.[35] Only one-quarter of breastfed children age 6-23 are fed food from four or more other food groups and a minmum number of times per day as per the recommendation of the Infant and Young Child Feeding (IYCF) practices.[36]

In its article 27.3, the CRC further links the right to adequate food and nutrition to social protection measures by stating that States shall take steps "to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition…".

The provision of social security is essential to satisfy the minimum core content of ESCR, including the essential food stuff required for survival in the context of the right to food. Under Article 43, the Constitution spells out "the right to social security for economically poor, physically incapacitated and helpless person, helpless single women, persons with physical impairment, children, persons who cannot look after themselves (…) as provided for by law". However, existing legal provisions surrounding social security lack a human rights-based focus and fail to enable the citizens to claim their right in case of denial and violation of the right in question and to hold the authorities concerned accountable.

> *"In Mahadevsthan VDC, in Dhading district, settled predominantly by the indigenous Chepang community, all families are marginal farmers. However, yields are only sufficient for three months per year. Due to the inadequacy of agricultural land coupled with a lack of alternative income opportunities, the Chepang families face frequent famines. Particularly breast-feeding women and their children are suffering from hunger and malnutrition. Figures point to 84 children in Mahadevsthan VDC suffering from malnutrition and 152 children showing symptoms of the same. In 2014 two people died of hunger in this VDC."* [37]
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> *"Another case in point is the lack of proper wages, social security and health care has been leading to severe food insecurity and malnutrition of women in Surkhet*

[35] Nepal, 2011 Demographic and Health Survey, Key Findings, accessed at: https://dhsprogram.com/pubs/pdf/SR189/SR189.pdf
[36] Ibid.
[37] Famine in Chepang settlement, takes toll on kids, Wednesday, February 11th, 2015 , National News Agency Nepal (RSS), accessed at http://www.nepalmountainnews.com/cms/2015/02/11/famine-in-chepang-settlement-takes-toll-on-kids/

district, Jhupra hamlet, Baluwatar 1, of Jarbutta VDC, belonging to the Gandharva community. Their daily work entails collecting sand from the Jhupra stream banks, crushing stone and loading the heavy stones into trucks with a meagre payment.

From working in the cold river and due to carrying heavy loads 12 of 18 women are found physically worn out with backache and joint problems, as well as serious uterine ailments. Their access to healthcare is limited as the nearest health post is located two hours walk from the hamlet and they cannot afford the health services.

Nutritionally these women hardly get to eat two meals a day and most of the time they have to satisfy themselves with simple rice taken with "fado", a mixture of water and wheat flour. This gets even more severe during the pre-natal and postnatal conditions with lack of diet and detrimental effects on the health and nutrition of both mother and child. There is a lack of protein intake (i.e. milk, egg, fish) during pregnancy. Women have to work during their entire pregnancies and also immediately after giving birth. Immediately, these women do not have any alternative or other income source to change their situation. Hunger and malnutrition exacerbate their health problems day by day. Their earning, which is below par the minimum wage per day determined by the local government, is just insufficient to manage even daily food stuff of 4-8 family members. This has made them compromise with the enjoyment of their other basic rights, including education to their children." [38]

[38] Cited from: Cited from: FIAN Parallel Information: The Right to Adequate Food in Nepal, 2014, submitted to the CESCR in 2014, available at: http://www.fian.org/fileadmin/media/publications/FIAN_Nepal_parellel_information_to_CESCR-final_version10Sep2014_2_.pdf

ANNEX 1: World Breastfeeding Trends Initiative (WBTi) - Assessment of Nepal 2012

Indicators	Gaps
National Policy Programme and Coordination	• National Committee on Breastfeeding does not meet regularly & it is inactive • Inadequate plan of action on IYCF • Lack of Budget line
Baby Friendly Hospital Initiative (BFHI)	• None existence of BFHI hospital • No concrete action to revive BFHI • Inadequate or absence of skill trained staff on health facility • No regular monitoring system in place • No sustainable system in place
Implementation of the International Code of Marketing of Breast milk Substitute	• Lack of stringent system for reporting violation at centre and district level • Continued violation of BMS Act (1992) • Lack of knowledge of official in monitoring the implementation of BMS Act • Lack of awareness and poor knowledge about the provision of the BMS Act in health professionals
Maternity Protection	• Existing policy and legislation covers only government employees • Paid maternity leave in government is only 60 days • The national legislation does not cover women working in private & informal sectors • No legislation providing health protection for pregnant and breastfeeding workers
Health and Nutrition Care System	• Inadequate IYCF in curricula • Inadequate standards and guidelines for mother friendly child birth procedures and support in health facilities • Health workers not adequately trained in practical skills to support mothers
Mother Support and Community Outreach	• Services unavailable on counseling pregnant and lactating women • Lack of counseling and listening skills among community level workers • Lack of adequate crèche facilities in government & private sectors

	• Poor national coverage of IYCF support services
Information Support	• Inadequate national IEC strategy for improving IYCF • Lack of sufficient budget to scale up IEC strategies • Inadequate coverage, restricted only during World Breastfeeding Week • Lack of National Level campaign on IYCF to targeted audience
HIV & Infant Feeding	• Weak advocacy and implementation of policy and guidelines on HIV and Infant Feeding at all level • Lack of adequate training to health worker on HIV & Infant feeding • Lack of monitoring system to determine effect of intervention to prevent HIV transmission • Lack of adequate counseling to the HIV positive mothers
Infant Feeding during Emergencies	• Lack of human resources experienced in infant feeding during emergencies • Lack of adequate resources including IEC materials identified for training & implementation • Lack of integration of IYCF during emergencies in pre-service & in-service training • No mechanism to monitor violation of BMS Act during relief operation
Monitoring and Evaluation	• Inadequate monitoring & evaluation program activities related to IYCF • Nutritional surveillance or health monitoring system does not include all key components of IYCF practice