INTERNSHIP TRAINING

AT

CARE INDIA, BIHAR

KNOWLEDGE AND FEEDING PRACTICES OF MOTHER REGARDING INFANT IN AGE GROUP 6 -12 MONTH IN SANDA VILLAGE, DHANARUWA BLOCK, DISTRICT PATNA

BY

PRANAV KUMAR KAMAL

PG/14/047

UNDER THE GUIDANCE OF

Dr. PREETHA GS

POST GRADUATE DIPLOMA IN HOSPITAL AND HEALTH MANAGEMENT

2014-16

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

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Completion of Dissertation from Care India, Bihar

The certificate is awarded to

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In recognition of having successfully completed his Internship in the department of

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and having successfully completed his Project on

Knowledge & feeding practices of mother regarding Infant age group 06-12 months Sanda Village of Dhanarua Block of Patna District, Bihar

Date: 12th May, 2016

Care India, Bihar

He comes across as a committed, sincere & diligent person, who has a strong drive & zeal for learning.

We wish him all the best for future endeavours.

CARE INDIA PATNA BIHAR

Training & Development

for **Head-Human Resources**

13/5/16

TO WHOMSOEVER IT MAY CONCERN

This is to certify that **Pranav Kumar Kamal**, a student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at **Care India, Bihar** from **11th April, 2016** to **12th May, 2016**.

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

Dr. A.K. Agarwal
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Certificate of Approval

The following dissertation titled **"Knowledge & feeding practices of mother regarding Infant age group 06-12 months Sanda Village of Dhanarua Block of Patna District, Bihar"** is hereby approved as a certified study in management, carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

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Certificate from Dissertation Advisory Committee

This is to certify that **Mr Pranav Kumar Kamal,** a graduate student of the **Post-Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He is submitting this dissertation titled **"Knowledge & feeding practices of mother regarding Infant age group 06-12 months Sanda Village of Dhanarua Block of Patna District, Bihar** in partial fulfilment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.** This dissertation has the requisite standard and to the best of our knowledge. No part of it has been reproduced from any other dissertation, monograph, report or book.

Dr. Preetha GS
Associate Dean(Reseach)
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CARE INDIA PATNA BIHAR

Mr. Sharad Chaturvedi
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FEEDBACK FORM

Name of the Student : **Pranav Kumar kamal**

Dissertation Organisation : **Care India, Bihar**

Area of Dissertation : **Knowledge & feeding practices of mother regarding infant age group 06-12 months Sanda Village of Dhanarua Block of Patna district.**

Attendance : 100%

Objectives achieved : Completed the given Project on time.

Deliverables : Learned the basic organisational Profile knowledge on the functioning of Care. IRDS organogram.

Strengths : Hard working, dedicated to achieve the desired goals.

Suggestions for Improvement:

CARE INDIA PATNA BIHAR

Date:

Place:

Signature of the Officer-in-Charge
Organisation Mentor (Dissertation)

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "**Knowledge &feeding practices of mother regarding Infant age group 06-12 month Sanda village of Dhanarua Block of Patna District, Bihar"** and submitted by**PRANAV KUMAR KAMAL,** Enrolment No. **PG/14/047** under the supervision of **Dr. PREETHA GS** for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from **11th April, 2016** to**12th May, 2016** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Pranav Kr. Kamal

PRANAV KUMAR KAMAL
PG/14/047
PGDHM (2014-16) - Health

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LIST OF ABBREVIATIONS

LQAS	Lots Quality Assurance Sample
FLW	Front Link Worker
IFA	Iron Folic Acid
ASHA	Accredited Social Health Activist
VHSND	Village Health Sanitation and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
BCC	Behaviour Change Communication
MLE	Monitoring Learning Evaluation
AWW	Anganwadi Worker
AWH	Anganwadi Helper
ICDS	Integrated Child Development Services Scheme
INHP	Integrated Nutrition and Health Programme
SHGs	Self Help Groups
N-TSU	Nutrition-Technical Support Unit
ANM	Auxiliary Nurse Midwife
WHO	World Health Organization
MoHFW	Ministry of Health and Family Welfare
MoWCD	Ministry of Women and Child Development
DPO	District Programme Officer
CDPO	Child Development Programme Officer
LS	Lady Supervisor
IEC	Information Education Communication
THR	Take Home Ration
HSC	Health Sub Centre
AWC	Anganwadi Centre

ACKNOWLEDGEMENT

Every successful story is a result of an effective team work, a team which comprises of a good coach and good team players. Likewise this project report is no exception. This has been a meticulous effort of a group of people along with me. I want to take this opportunity to thank each and every one who has been a part of this report.

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ORGANIZATION PROFILE

CARE INTERNATIONAL

CARE International is a leading humanitarian organization fighting global poverty. It places special focus on working alongside poor women because, equipped with the proper resources, women have the power to help whole families and entire communities escape poverty. Women are at the heart of their community-based efforts to improve basic education, prevent the spread of disease, and increase access to clean water and sanitation, expand economic opportunity and protect natural resources. The organization also delivers emergency aid to survivors of war and natural disasters, and help people rebuild their lives.

In the fiscal year 2015, CARE worked in 95 countries around the world, supporting 890 poverty-fighting development and humanitarian aid projects to reach more than 65 million people.

CARE International is a global confederation of 14 National Members and one Affiliate Member with the common goal of fighting global poverty. Each CARE Member is an autonomous non–governmental organization and implements program, advocacy, fundraising and communications activities in its own country and in developing countries where CARE has programs.

At the beginning, there was a package: a CARE package, aimed to reduce hunger and show solidarity with the people of war-torn Europe.

At the end of World War II in 1945, twenty-two American charities, a mixture of civic, religious, cooperative and labor organizations got together to found CARE. Originally known as the *Cooperative for American Remittances to Europe*, it began to deliver millions of CARE packages across Europe. This was basically a small shipment of food and relief supplies to hungry recipients - with a huge impact on people's lives.

During the next three decades, CARE shifted its focus from helping Europe to delivering assistance in the developing world. It started programs in the areas of education, natural resources management, nutrition, water and sanitation, and healthcare in Southern Africa, South Asia and South America. Broadening the geographic focus and expanding beyond the original food distribution programs, CARE started to assist people affected by major emergencies – from famine in Ethiopia to hurricane recovery in Honduras.

Over the previous decades, Care has continuously developed its approach to reducing poverty. In 1945, CARE was established on the premise that poverty was mainly due to a lack of basic goods, services, and healthcare. As the organization grew, so did their understanding of poverty. CARE's scope widened to include the view that poverty is often caused by the absence of rights, opportunities and assets, largely due to social exclusion, marginalization, and discrimination. In the early 1990's, its work grew into what they call a 'rights based approach' to development.

In 1993, in an effort to reflect the wider scope of its programs, vision and impact, CARE changed the meaning of its acronym to "Cooperative for Assistance and Relief Everywhere". By 2007, it started focusing on women's empowerment realizing that women are the key: by empowering women entire families can be lifted out of poverty.

Some key networks in which CARE is involved or is a signatory to are:

Code of Conduct for the International Red Cross & Red Crescent Movement at NGOs in Disaster Relief

The Sphere Project

Humanitarian Accountability Partnership International (HAP)

Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP)

People in Aid

INGO Accountability Charter

CARE is a signatory to and holds itself accountable to internationally accepted humanitarian standards and codes of conduct, and works with other aid organizations and United Nations agencies to improve humanitarian action and to influence policy.

CORE VALUES

Respect: Affirm the dignity, potential and contribution of participants, donors, partners and staff.

Integrity: Actions consistent with the mission. Being honest and transparent in what they do and say, and accept responsibility for their collective and individual actions.

Commitment: Work together effectively to serve the larger community.

Excellence: Constantly challenge themselves to the highest levels of learning and performance to achieve greater impact.

VISION AND MISSION

Their vision is to seek a world of hope, tolerance and social justice, where poverty has been overcome and people live in dignity and security. CARE will be a global force and partner of choice within a worldwide movement dedicated to ending poverty, and will be known everywhere for its unshakeable commitment to the dignity of people.

CARE strives to serve individuals and families in the poorest communities in the world. Drawing strength from their global diversity, resources and experience, they promote innovative solutions and are advocates for global responsibility.

CARE INDIA

CARE has been working in India for over 65 years, helping alleviating poverty and social exclusion by facilitating empowerment of women and girls from poor and marginalized communities. In India, CARE focuses on the empowerment of women and girls because they are disproportionately affected by poverty and discriminations; and suffer abuse and violations in the realization of their rights, entitlements and access and control over resources. They do this through well

planned and comprehensive programmes in health, education, livelihoods and disaster preparedness and response.

To be able to bring about lasting change, CARE India addresses underlying causes of poverty and social injustice. For example, they implement a gender transformative framework within their programmes to address unequal power relations at the grassroots level.

CARE in India works across 14 States and 38 projects, touching the lives of 37 million people.

Some of the notable initiatives of CARE India are:

CARE India response on Cyclone Phailin hit on the Eastern Coast of India.

CARE India Tsunami relief programme.

CARE India response to floods in Uttarakhand.

CARE India has been working extensively in different parts of India. They work with grassroots initiatives, state and district governments, communities and individual from all over the country.

As of now, CARE India is present in 14 states of India, with the head office being in Delhi.

Please see below for the list of the 14 states:

HISTORY OF CARE INDIA

CARE came to India in June, 1946 when one of its co-founder, Lincoln Clark, signed the CARE Basic Agreement in New Delhi at the Office of Foreign Affairs. The agreement was limited to contributions of technical books and scientific equipment for universities and research institutes. In November 1949, the first Chief of Mission, Melvin Johnson, arrived in India to establish operations. Subsequently on the invitation of the then President of India, he developed a CARE India Food Package that caused a renegotiation of the CARE Agreement to include importation of food through Indo-CARE Agreement on 6 March 1950. The CARE Office during 1950's in Delhi was a hutment (a long, thin building) located in Janpath, Connaught Place. CARE had three additional offices and warehouses in India located in Bombay, Madras, and Calcutta.

The initial programmes those days included assistance to educational institutions, relief camps and assistance to hospitals in form of books, laboratory equipment, tools supplies etc. When the Mid-Day Meal (MDM - school lunch) program started in 1960, state offices were established and the staff in Delhi and state offices increased. Since 1960's CARE has been supporting government's school feeding programs. CARE has been providing nutritious food for the beneficiaries of Integrated Child Development Services (ICDS) on the request of GOI since 1982. CARE supported the Government's ICDS in the states of Andhra

Pradesh, Bihar, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and West Bengal. As a part of support from USAID, CARE implemented a long term project named Integrated Nutrition and Health Project (INHP) from 1996 till 2010 and reached to about 1297 blocks in nine major states of India. Recognized worldwide for its contribution in disaster response and rehabilitation operations, CARE in India has supported the efforts of Government of India and individual state governments as and when major disasters occurred in the country. CARE has provided relief to several natural disasters since 1966 with Jammu and Kashmir floods 2014 and Hud Hud in Andhra Pradesh being the most recent. Some of the efforts include response to flood relief in West Bengal in 1979, cyclone in Andhra Pradesh in 1977 and in 1996, and earthquake relief in Latur, Maharashtra in 1993, and Odisha super cyclone in 1999.

CARE India's current 'Programme' approach stems from a redrawn vision, under which, working with partners on projects has been overlapped with holistic, long term, deep impact "programmes" that work directly with key populations to ensure that the root causes of poverty and marginalisation of people, particularly poor women and girls, are tackled strategically and collaboratively.

OUR APPROACH

As CARE India moves ahead, their key programming approaches will include social analysis and action, gender transformative value chain approaches, leadership and life skills strengthening, building capacities and leadership roles at multiple levels, advocacy on national and international platforms and facilitating links and dialogues between public, private and civil society.

Where We Work.

FOUR MAIN FUNCTIONAL AREAS

Overview

Disaster Preparedness

Education

Health

Livelihood

HISTORY

CARE INDIA INITIATIVES IN HEALTHCARE

HEALTH PROGRAMMES

Delivering healthcare to over a billion people is a very complex challenge. CARE India works in close collaboration with State and Central Government and other partner organizations to secure accessible and quality maternal and child healthcare among marginalized communities. It works towards identifying the root causes of healthcare challenges, provides innovative solutions, and helps implement secure and quality healthcare services in India. CARE India believes that a healthy mother and a healthy baby is the route to a productive and a developed nation. Hence, CARE has specially focused upon providing comprehensive solutions to address public health problems. CARE India promotes essential new born care and immunization, reducing malnutrition,

preventing infant and maternal deaths and protecting those affected by or susceptible to HIV/ AIDS and TB. CARE works closely with its partners to achieve good health care for everyone.

Various programmes of CARE India are:

ENSIGN: Enhancing the Sustainable Farming Initiative through Gender and Nutrition. (Bankura District, West Bengal)

RACHNA: Reproductive and Child Health Nutrition & Awareness. (Rajasthan)

HEVS extending CHCMI: Health Education among SHG & VHSNC Members. (Puruliya, West Bengal)

SEHAT: Sustainable Education and Health among Tribal. (Sidhi and Shahdol districts of Madhya Pradesh)

BRIDDHI: Ensuring improvement in the nutritional status among severely malnourished children through growth monitoring, Behaviour Change Communication, strengthening Health (including treatment) and Nutrition service delivery system. (West Bengal)

SWASTH: Sector Wide Approach to Strengthen Health. (Bihar)

EMPHASIS: Enhancing Mobile Populations' Access to HIV & AIDS Services, Information & Support. (Delhi NCR, West Bengal, Uttarakhand and Maharashtra)

OHSP: Technical and management inputs to TMST, Government of Odisha Health Sector and Nutrition Plan. (15 districts of Odisha)

MDR-TB: Treatment, adherence and follow up of Multidrug-resistant tuberculosis.

(West Bengal)

SKEAP: Strengthening Kala Azar Elimination Program. (Eight districts in Bihar)

AXSHYA: Bridging one of the most challenging gaps in Tuberculosis control - diagnosis and treatment of DR-TB - through programmatic activities. (Madhya Pradesh, Chhattisgarh and Jharkhand)

BTAST: Bihar Technical Assistance Support Team. (Bihar)

MPNP: Madhya Pradesh Nutrition Project. (Tikamgarh, Panna and Chhatarpur districts of Madhya Pradesh)
Mother and Child Health Project. (Odisha and Madhya Pradesh)
UHI: Urban Health Initiative. (11 cities of Uttar Pradesh)
FHI: Family Health Initiative. (Bihar)
N-TSU: Nutrition Technical Support Unit. (Bihar)

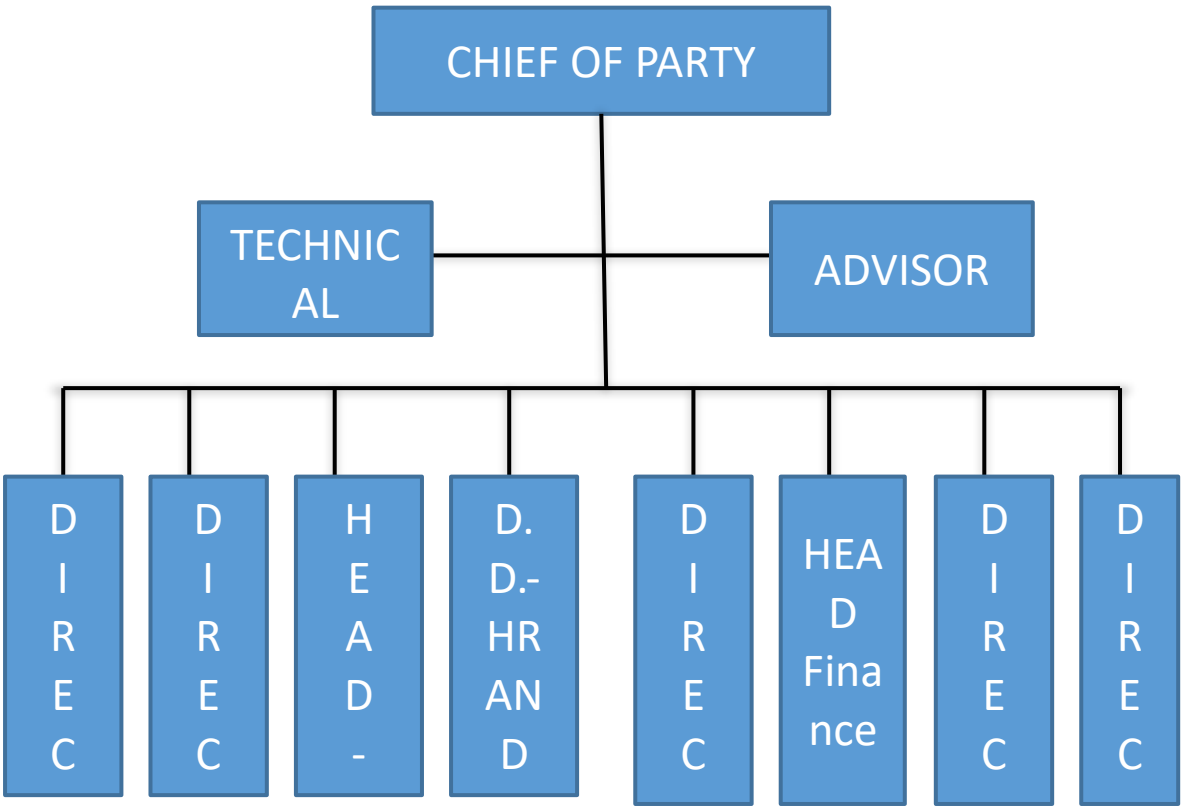
NUTRITIONAL TECHNICAL SUPPORT UNIT

For CARE India, the N-TSU project offers the opportunity to provide long term support to the Bihar state government's Integrated Child Development Services (ICDS) scheme. The ICDS scheme attempts to harness human, institutional and financial resources to do more, with high quality and with increased precision and efficiency. The goal of N-TSU is to achieve greater impact on the overall development of children in the state by addressing under-nutrition, especially focusing on Young Child Feeding practices, mainly through giving vigorous Home visits by the various stakeholders to the households of beneficiaries.
Recognizing that the Ministry of Women and Child Development alone cannot meet the needs of all children, CARE India is assisting the government to undertake convergence with other ministries and departments. CARE India is drawing from its field-tested, proven approaches to systematically create an enabling policy environment for ICDS, build trust across sectors, document models and promote convergence. Besides this, CARE India is facilitating training and capacity building of government functionaries, promoting safe drinking water, hygiene and sanitation at the household and community levels, promoting wheat fortification carrying BCC intervention, undertaking community mobilization and participatory governance. Finally, CARE India is responsible for working with block and district level ICDS personnel to improve their capabilities in data-driven management – using information to make

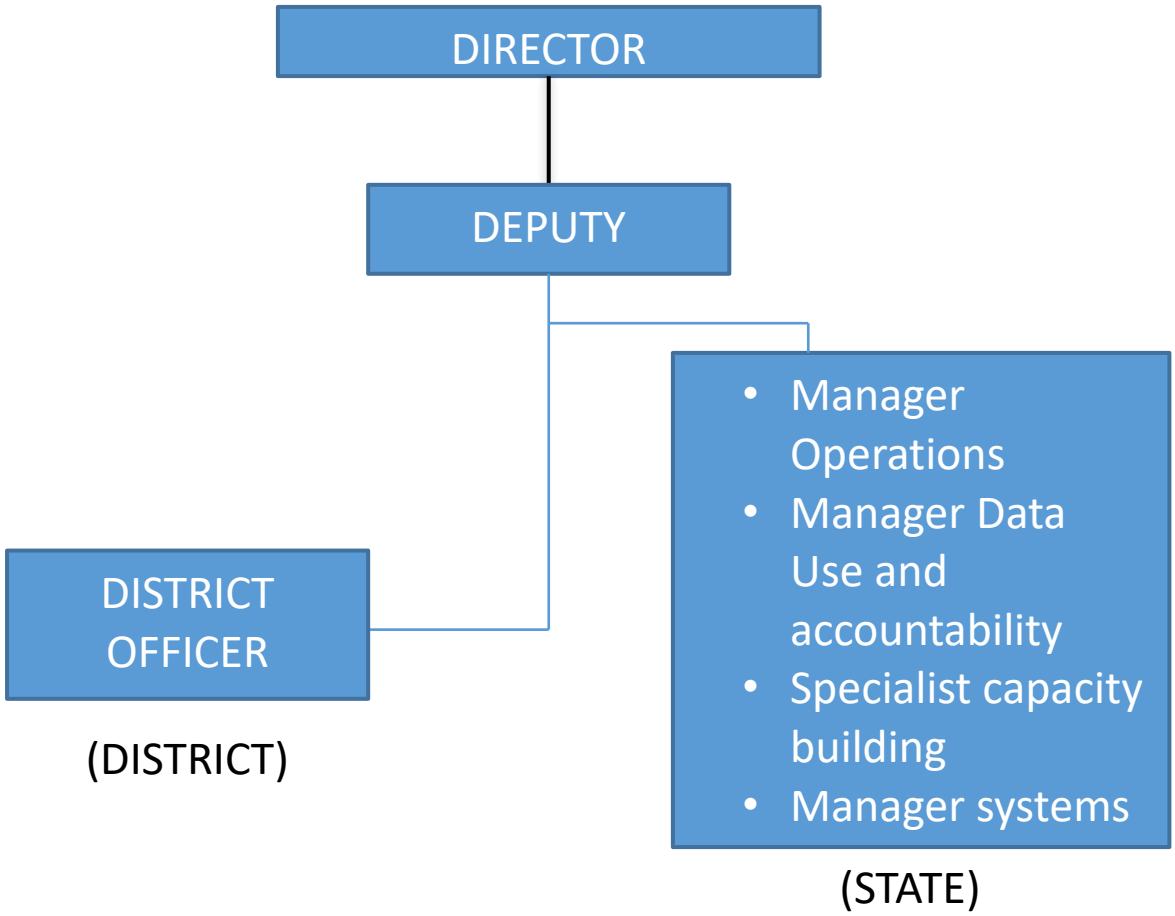
evidence-based decisions to iteratively strengthen programs and improve outcomes.

Through monthly convergence meetings, N-TSU plans to re- establish the importance of convergence and coordination amongst the different government departments and other stake holders that contribute in reduction of malnutrition.

BIHAR MANAGEMENT TEAM



N-TSU PROJECT TEAM



KEY LEARNINGS

- Work profiles of government officials, i.e. DPOs, CDPOs and LSs and uddipika in the Department of Social Work, Government of Bihar, is heavily loaded with add-on responsibilities like election duties, land issue resolutions, etc; which often results in a compromise with their actual job-specific work.
- How cast system affect the functioning the AWC and also provide restriction during home visit upper cast doesn't allow lower cast AWW to inter the own house
- The physical state of AWCs is miserable, with unmaintained dust-filled registers, unreadable IEC on walls, no electricity and an acute shortage of space for the conduction of AWC functions, especially on VHSNDs.
- AWCs are equipped with Nutritional and Health education kits and materials, to be used by the FLWs on VHSNDs for educating women; but they are mostly unaware of the proper message to be communicated or the way to deliver it.
- Degree of ignorance is very high of nutrition related activity on VHSND site .
- People tend to look at an AWC as a spot to merely provide them ration and vaccinations, and thus are widely uninterested in the other services provided, and consider it to be a waste of time.
- There is a severe shortage of home visits by the FLWs, and this result in an improper knowledge of women on topics like exclusive breast feeding, complimentary feeding, family planning and birth preparedness.
- Since long, the entire focus in the field of healthcare in Bihar has been on immunization and institutional deliveries only, and thus the nutrition component was missed heavily, which has resulted in very high malnutrition rates in Bihar.

- There are huge gaps in the logistics or supplies of the essential materials like registers, growth charts, IFA tablets, THR, etc at the AWCs, which majorly affect their day to day functioning.
- A lot of meetings like ANM Tuesday meetings, HSC meetings, Sector meetings.

VILLAGE PROFILE

- Sanda is a Village in Dhanarua Block in Patna District of Bihar State, India in Patna Division, located 35 KM towards South from District headquarters Patna and 6 KM from Dhanarua & 36 KM from State capital Patna.
- Area of the Village is 524 hectares.
- Barni (3 KM) , Moriawan (3 KM) , Baribigha (4 KM) , Rewan (4 KM) , Kosut (4 KM) are the nearby Villages to Sanda. Sanda is surrounded by Dhanarua Block towards East, Kako Block towards South, Modanganj Block towards South, and Jehanabad Block towards South.
- Masaurhi, Jehanabad, Hilsa, Islampur are the nearby Cities to Sanda.
- This Place is in the border of the Patna District and Nalanda District. Nalanda District Hilsa is east towards this place.
- Population- 5630 (female-2671 & Male-2959)

Availability	Non-Availability
School 8th	Middle school
Concrete road	Connecting road
Drainage System	Maintenance
Piped water supply	Maintenance
Transportation	Limited period
AWC	
HSC	
Electricity	Consistent Fluctuations
Jeevika	YES (1)
DISSERTATION PROJECT	DISSERTATION PROJECT
DISSERTATION PROJECT	DISSERTATION PROJECT
DISSERTATION PROJECT	DISSERTATION PROJECT

INFRASTRUCTURE STATUS

- Total Irrigated area 365.07Hectare, non-irrigated area 116.34Hectare.
- Agriculture practice in this village is very diverse. People do cultivate various crop, vegetables, the production of onion is done at huge level which gets exported to Patna, West Bengal and Jharkhand.
- Apart From Onion various kind of vegetables are cultivated by all kind of farmers either for self-consumption or for the market.

- Agricultural practices has changed a lot in last 15years by the introduction of new seeds and different kind of pesticides which is used to increase the production output.
- Deliberate shifts in the dietary patterns of the households due to availability of various readymade foods and availability of markets close or within the village
- The percentage of migration has raised phenomenally due to unavailability of work under MGNREGA from last 1 and ½ years.
- Existing platform are not used to tackle the problem of migration.
- The issue of governance is at helms of the problem because of the attitude of the Sarpanch towards the development of the village.

LIVELIHHOD AND AGRICULTURE STATUS

Land Holding	Livelihood	Agriculture	Allied Activities	Migration
Nil	Daily wage labour	Contract farming	Goat rearing	Frequent
Marginal	Farming, business in nearby markets	Limited	goat, cow	High
Small	Farming, business	Dependent on rain and credit availability	Goat, cow, small business	Seasonal
High	Farming	Multiple cropping	Dairy activities	less

DISSERTATION PROJECT

INTRODUCTION

World health organization (WHO) recommends exclusive breast-feeding (BF) for the first six month of age, addition of complementary feeds (CF) at six months with continued bf till two years which if followed appropriately can decrease infant mortality by 19 percent and prevent malnutrition especially in developing countries like ours. Infant and young child feeding (iycf) practices recommend exclusive breastfeeding up to age of six months; timely initiation of feeding solid, semisolid foods from six months onwards. Complementary feed Bridge the energy, vitamin A and iron gaps which arise in breastfed infants at 6 month of age.

Exclusive breast-feeding provides adequate nutrition up to 6 months of age for the majority of infants, while some infants may need complementary foods before 6 months in addition to breast-feeding in order to support optimal growth and development.

WHO has recommended further research in priority areas to broaden the range of effective interventions and programmatic approaches to improve complementary feeding? There is scarcity of studies on practices about CF and factor affecting for such practises. Knowledge of these factors will be helpful in planning interventions to improve feeding practices.

In this document, we will analyse the relation between the introduction of complementary feeding and the impact it might have on the child's health

RATIONALE

Infancy holds a very important place in the life of every individual because the entire structure of man's life is formed during this time. Proper nutrition of children leading to adequate growth and good health is the essential foundation of human development. It has been documented that too early introduction of feeds under conditions of poor environmental sanitation to likely increase ineffective morbidity and mortality delaying the introduction of supplements too later is likely cause under nutrition. Breast milk is sufficient to support adequate growth majority of infants up to 6 months.

Introduction of complementary feeding is critical for meeting the protein, energy & micronutrient needs of the children from the age of 6 months. Optimal infant feeding contributes to improved dept outcomes & better active learning capacity in young children. Complementary feeding period is a difficult phase in the infant's life because is the food supplements are not adequate the child becomes undernourished.

PROBLEM STATEMENT

Inadequate infant and young child feeding practices contribute to the sharp increase in malnutrition –almost fourfold between the first few months of life and the completion of 2 yrs of age. It is estimated that worldwide 10.9 million children under five years of age die every year of which 2.42 million deaths occur in India alone. The global strategy of infant and young child feeding recognizes that $^{2}/_{3}$ of these deaths occur during the 1^{st} year & is related to inappropriate infant feeding practice. Educational interventions teaching families to feed hygienic

simple, cheap, energy-rich complementary foods to breastfed infants after 5-6 months can improve child growth, even under impoverished conditions.

Lack of awareness & knowledge about complementary feeding – amount, frequency, type of food etc contributes significantly to poor nutritional status among children even in families where adults meet their daily requirements. Need for educating mothers for promotion of proper infant feeding practices. Studies have shown that it is possible to improve infant feeding practices through action oriented messages.

REVIEW OF LITERATURE

A study was conducted at AIMS residential colony to assess the weaning practices among mothers of infants in the age group of 6-12 months and compared these practices among different demographic variables. 50 mothers of infants were assessed by using self-administered questionnaires and were grouped in two categories according to their age of commencement of weaning, 42 (84%) infants were received weaning foods in addition to milk, were 8 (16%) were practicing delayed weaning. Even several problems were observed in early weaning which revealed infrequent feeding, usage of expensive commercial cereals in diluted form, improper food preparation practices etc. The study concluded that mothers of this community lacked knowledge inappropriate weaning practices and balanced diet. (1)

A study was conducted on infant feeding and weaning practices in some rural areas of Rajasthan. Which included 238 rural mothers, the final result revealed that the mean age of weaning was 27.1 months, 81% of mothers were illiterate, 23% initiated breast feeding within 24 hours of delivery, 77% discarded colostrums, 9.1% of them introduced supplementary food before 3 month of age, 15.6% introduced between 3-6 months, 36% began weaning at 6-12 months, and

24% waited until after 12 months of age. The study suggested to introduce teaching strategies among mothers on weaning practices.18

Complementary feeding and child nutritional status

Adequate nutrition during the first few years of life is fundamental for child survival and prevention of malnutrition (Amosu, et al., 2011). The immediate consequences of inadequate nutrition include morbidity, mortality and delayed mental and physical development, while the long term consequences include impaired intellectual performance, reproductive performance, work capacity and increased risk of chronic diseases (WHO, 2001). The introduction of appropriate complementary foods after 6 months is a critical issue on child survival and can save 6% of all under five deaths (Jones *et al.,* 2003). Higher rates of malnutrition for the under five are observed in this critical period of complementary feeding. In Kenya, both moderate and severe stunting are highest (46%) in the age of 18-23 months and wasting is highest (11%) in the age of 6-8 months (KNBS and ICF Macro, 2010).

Timely introduction to complementary foods

WHO recommends exclusive breastfeeding for 6 months and introduction of complementary foods at 6 months of age with continued breastfeeding (PAHO/WHO, 2003).The time of introduction and type of complementary food given to an infant are very important for the child‟s nutritional status. According to current recommendations (WHO, 2007), complementary feeding should be introduced into the child's diet at the age of 6 months. Early introduction of complementary foods increases infant morbidity and mortality while late introduction of complementary foods is harmful to the health of the baby, because

infant growth stops or slows down and the risk of malnutrition and micronutrient deficiency increases (PAHO/WHO, 2003).

A cross sectional exploratory study was conducted to assess the knowledge and attitude of mothers, on infant feeding in a rural area of Karnataka. The findings of the study showed that majority of women (83.4%) felt that semi-solids have to be introduced into the diet before the child completes 5 months. Most of them felt three months was ideal. This belief of early complementary feeding to be clarified by health education sessions with mothers. The findings of the study reinforced the need to develop appropriate health education programs.[5]

GENERAL OBJECTIVE

To access complementary feeding practices in mother having child age group 6 -12 month district Patna.

SPECIFIC OBJECTIVE

1. Timing of complimentary feeding.
2. Type of complimentary feeding.
3. To access FLW to give advice on dietary diversity during home visit.

METHODOLOGY

Study design - descriptive cross-sectional study

Study area - Sanda village Dhanarua block district Patna.

STUDY POPULATION

Mothers of age group 6-12 month child

SAMPLE SIZE

As per SRS 2011 population composition report, In Bihar, less than 4 year old children account for 10.2% of the population. Considering uniform distribution,

children of 6 to 12 months of age will be approximately 1.49% of the total population.

The total population of Sanda village is 3,125, and considering the trends of population composition in Bihar, the approximate number of children in Sanda in the age group of 6 to 12 months (and 29 days) would be nearly 47.

$$Sample\ Size = \frac{\frac{z^2 \times p(1-p)}{e^2}}{1+(\frac{z^2 \times p(1-p)}{e^2 N})}$$

Where, N – Population size; e – Margin of error; z – Z score (based on the desired Confidence Level)

Using the above formula of Sample size calculation,

In our case, sample size = 32 (at 95% Confidence level and 10% Margin of Error)

Considering the required sample size, the number of samples to be collected for the study is proposed to be nearly 35.

SAMPLING TECHNIQUE- Convenience sampling.

DATA COLLECTION TOOLS AND TECHNIQUES

The data collection technique would be survey-based, using the 'breast feeding and complimentary feeding practices' section of a standard pre-tested questionnaire, called "LQAS+", used by the Bihar TSU, Care India; specifically designed to target the mothers of children aged 6 to 12 months.

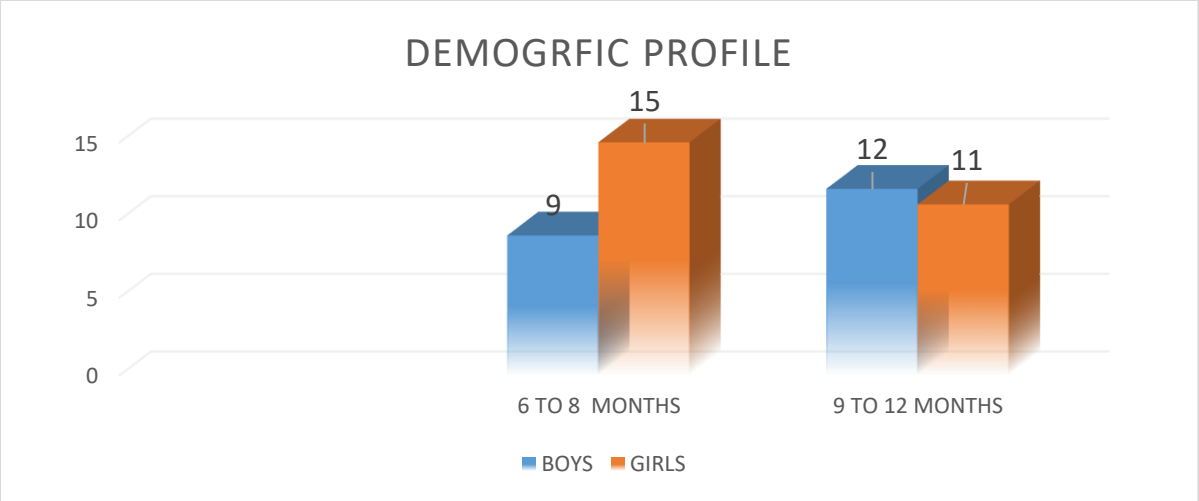
PLAN OF DATA COLLECTION

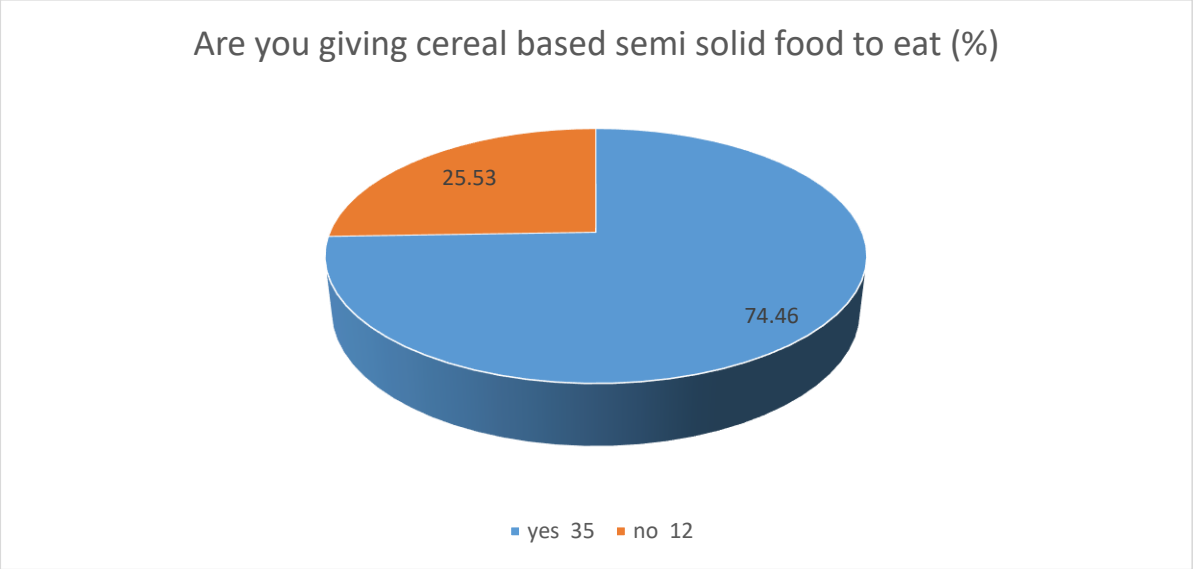
Available eligible respondents will be visited personally and after taking consent will be interviewed using questionnaire. Data collection for the study will be spread over a period of 1 week duration.

Beforehand, all aspects of confidentiality will be reassured. In case a respondent feels tired or uncomfortable, she will be allowed to take a break, following which survey process can resume. The participants will be free to terminate the survey at any time.

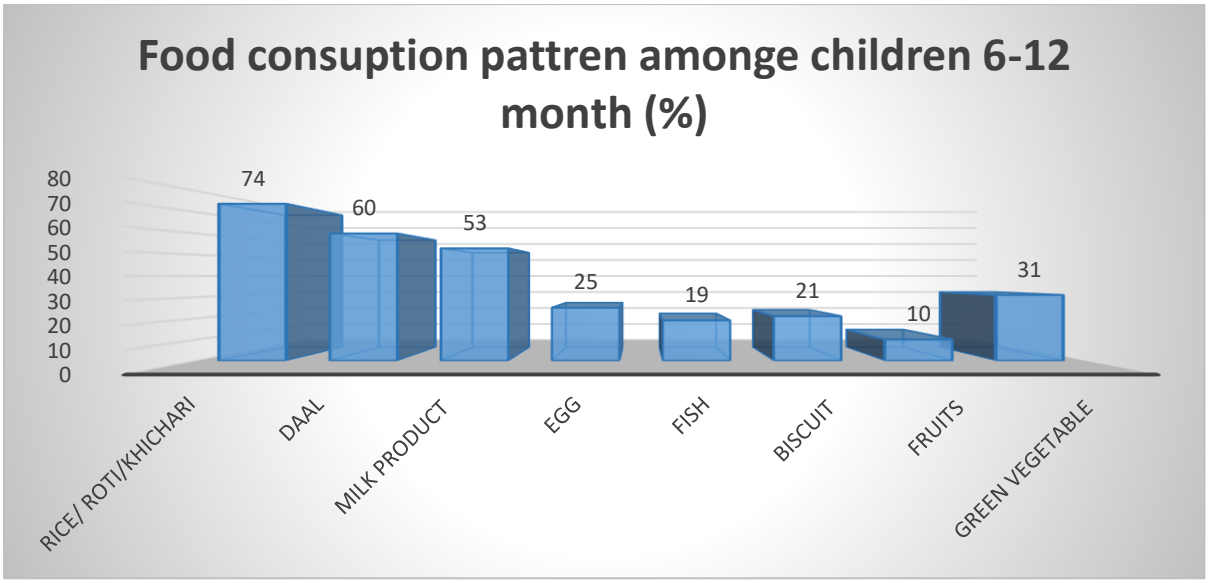
PLAN OF DATA ANALYSIS

The collected data will be compiled and analysed using various functions in Microsoft Office Excel software. Frequency tables, Bar Charts and Pie Graphs will be used to represent the findings of this study, as and when required.

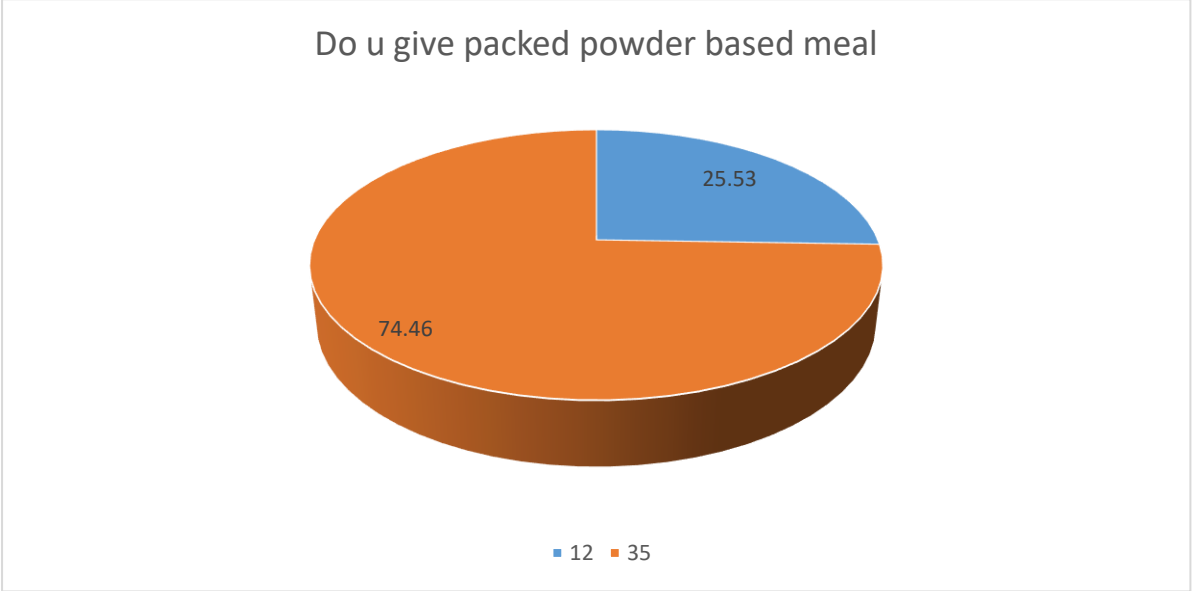




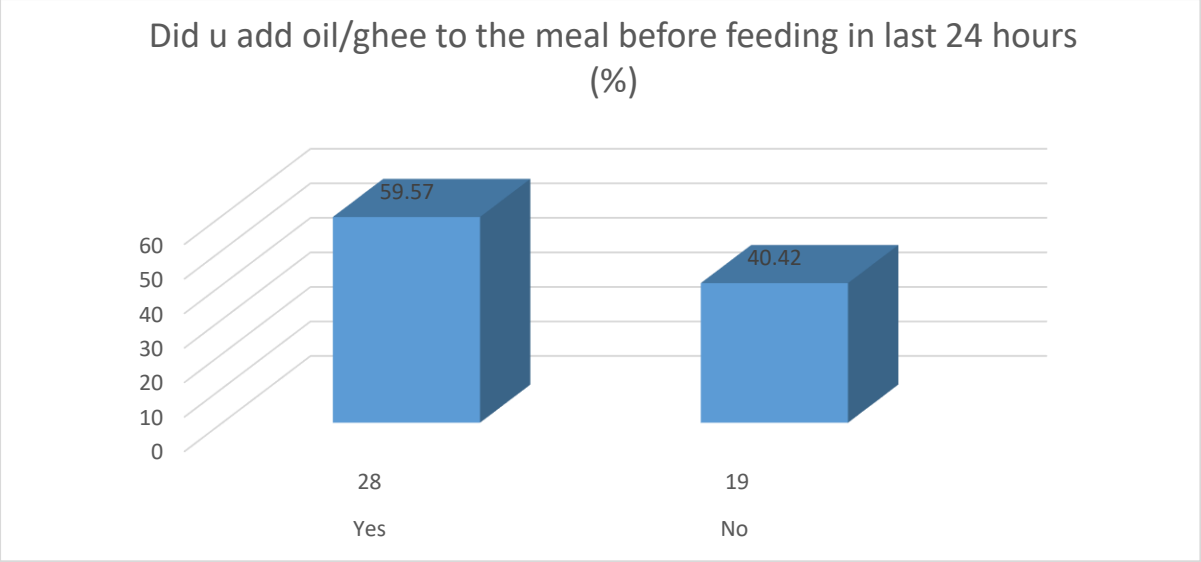
The above pie chart displays that 74.46% gave cereals based semi solid food to eat while 25.53% did not give it.



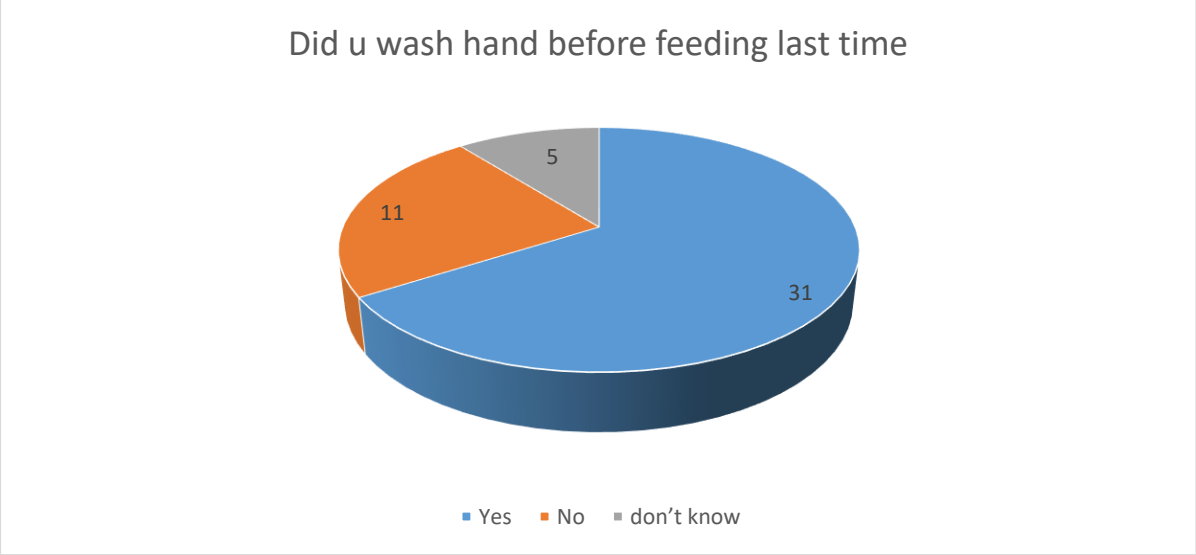
The above bar diagram shows that children were given Daal for consumption (60%) while 70% for rice/roti/khichari, then milk product (60%), green vegetable (40%), egg and biscuit (30%), fish (20%) and fruits (10%)



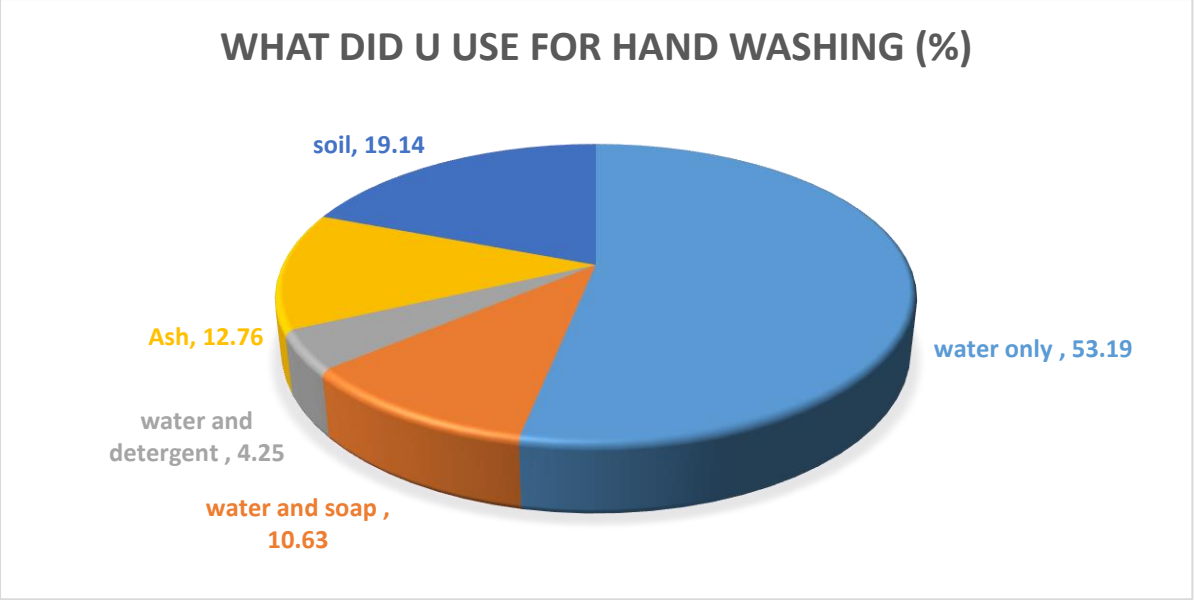
The above diagram illustrates that 74.46% had given packed powder based meal while 25.53% did not give.



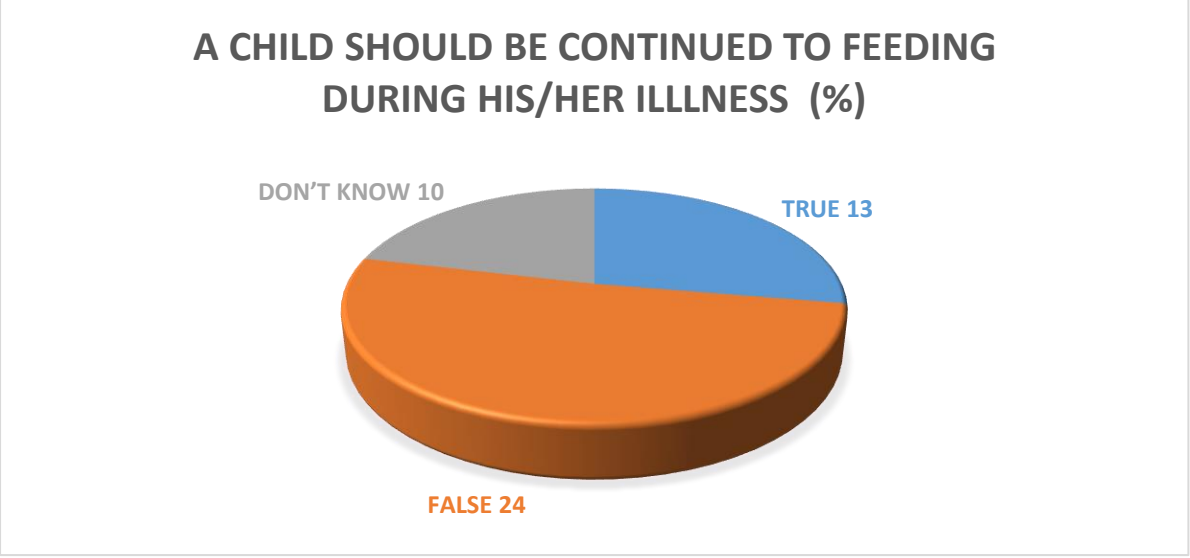
The above figures depicts that 59.57% i.e. (28 sample) had added oil/ghee to the meal before feed in last 24 hours than 40.42% i.e. (19 sample) did not added oil/ghee.



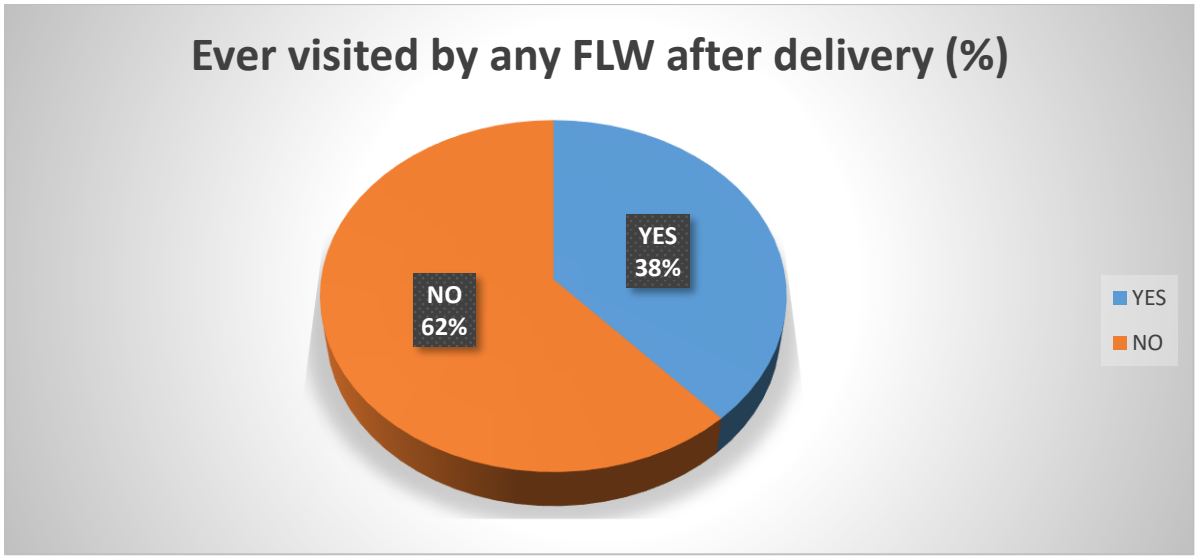
The above pie diagram displays that 31% wash hand before feeding while 11% did not wash hands and 5% do not remember.



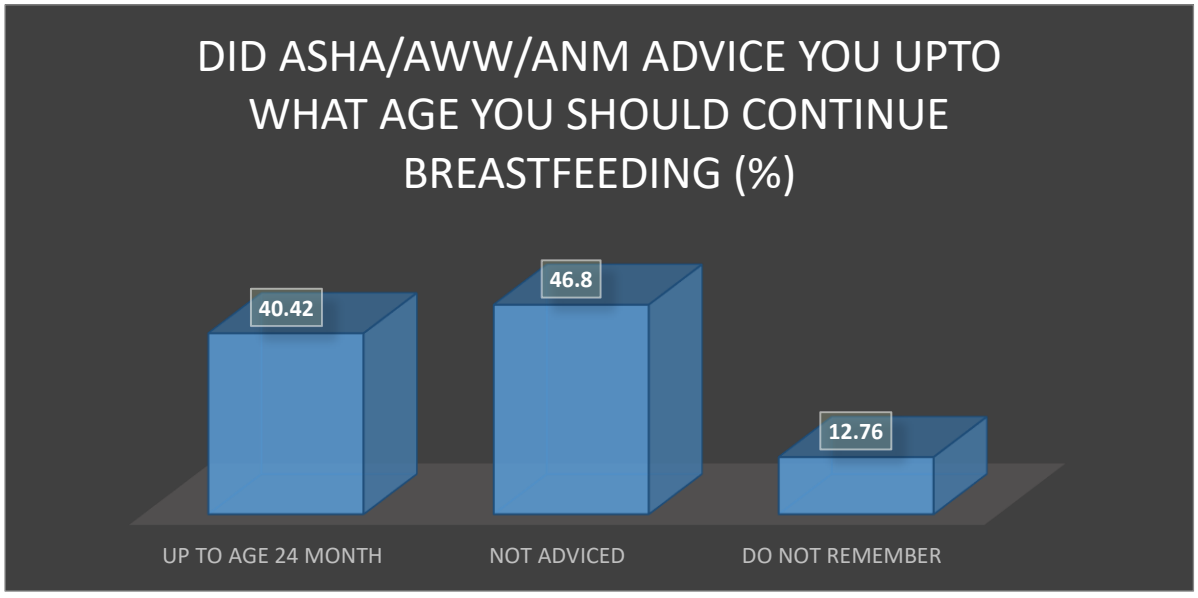
The above pie diagram shows that 53.19% had used water, 19.14% used soil, 12.76% used ash, 10.63% used water and soap and 4.25% used water and detergent for hand washing.



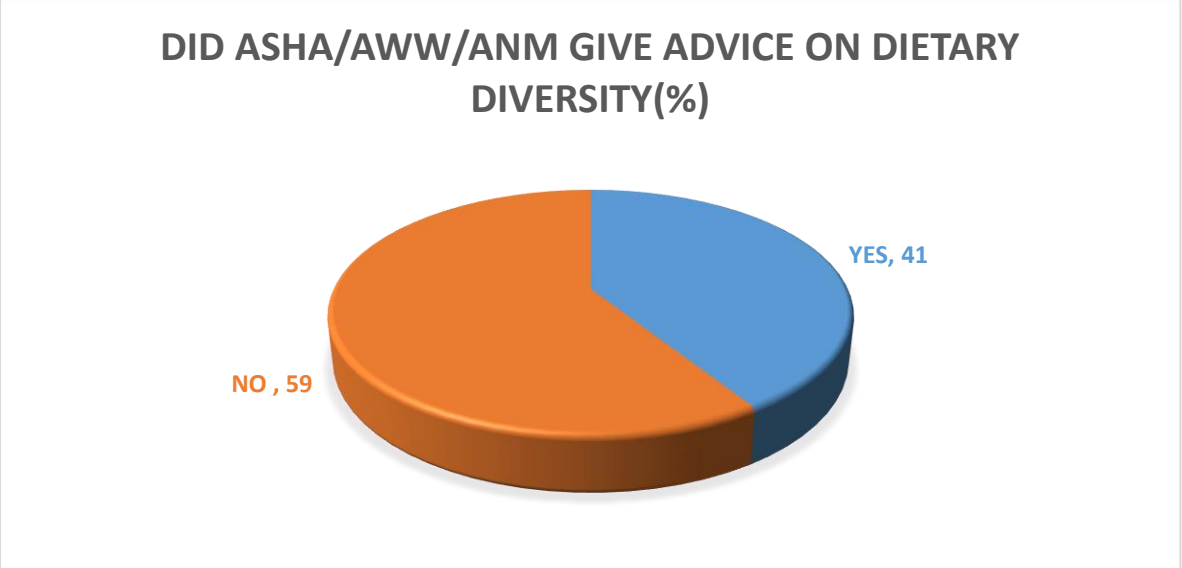
The above pie diagram illustrates that 13 sample said its true to feed during illness , 24 sample said its false and 10 sample said they do not know whether a child should be continued to feeding during his/ her illness.



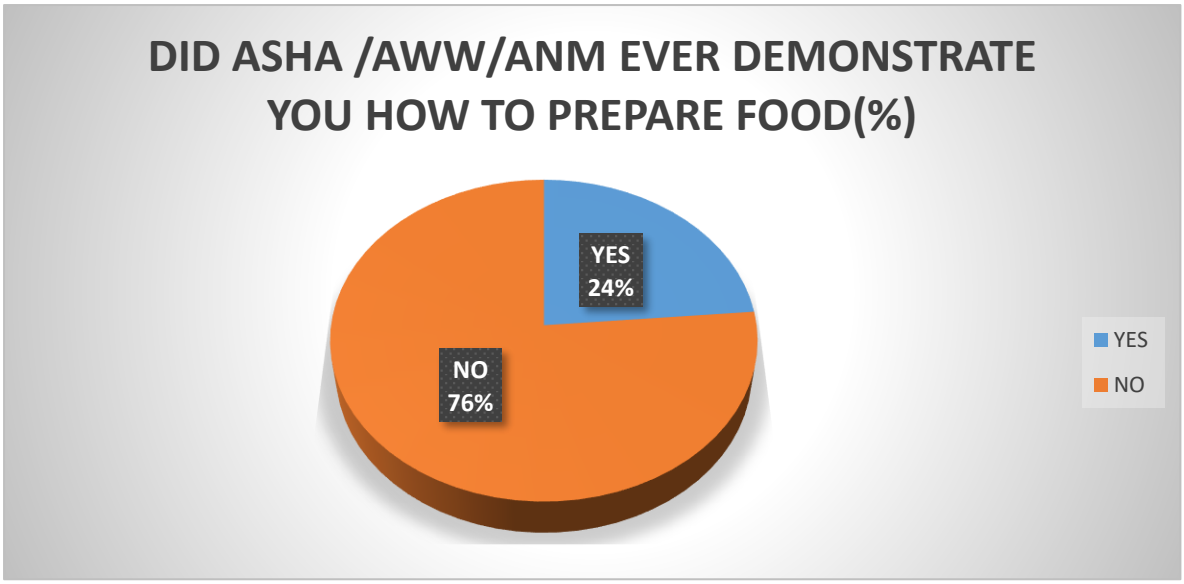
The above pie diagram shows that 62% of sample were not visited by any FLW after delivery while 38% of sample had a visit by a FLW after their delivery.



The above figure shows that 40.42 sample said up to 24 months , 46.8% said they never got advice while 12.76% of sample do not remember.



The above diagram displays that 59% said that ASHA/AWW/ANM never gave advice on dietary diversity while 41% said they had given advice.



The above figure shows that 76% said that the ASHA/AWW/ANM never ever demonstrated how to prepare food while 24% said yes they had demonstrated.

DISCUSSION

Our study shows 74.46% gave cereals based semi solid food to eat while 25.53% did not give it. Lack of knowledge regarding importance of complimentary feeding or no regular home visit by FLW.

Food consumption pattern among children 6-12 month. Daal for consumption (60%) while 70% for rice/roti/khichari, then milk product (60%), green vegetable (40%), egg and biscuit (30%), fish (20%) and fruits (10%), Dietary diversity of food was found to be in limited and regular diet is rice /roti/khichari/daal also be inadequate.

59.57%. Had added oil/ghee to the meal before feed than 40.42% did not added oil/ghee so that child did not get enough calories which is require to daily basis.

Proper hand sanitation is most important to keep baby diseases free our study result shows that 31% wash hand before feeding while 11% did not wash hands and 5% do not remember. And 53.19% had used water, 19.14% used soil, 12.76% used ash, 10.63% used water and soap and 4.25% used water and detergent for hand washing.

In our study we try to check knowledge regarding whether feeding continued during his/her illness our result shows 13 sample said its true to feed during illness , 24 sample said its false and 10 sample said they do not know whether a child should be continued to feeding during his/ her illness.

Home visit by FLW is also less only 38% it may hamper to deliver of health information, regarding breastfeeding practices.

Food preparation demonstration 76% said that the ASHA/AWW/ANM never ever demonstrated how to prepare food while 24% said yes they had demonstrated. The major proportion of household are left behind knowledge to how to preparation food.

CONCLUSION

Possible reasons for suboptimal breastfeeding are primarily, lack of proper information to mothers, total lack of counselling on feeding of infants, inadequate health care support, aggressive promotion of baby foods by the commercial industries and lack of proper support structures at the community and work place like maternity entitlements. To achieve high rates of exclusive breastfeeding for the first six months and appropriate complementary feeding, thereafter, one needs to act comprehensively and use all sets of strategies which include interventions by health and related sectors, While it is well established now that 'one to one counselling' and 'group counselling', works for exclusive breastfeeding and have potential to increase exclusive breastfeeding at 1 and 6 month significantly, complementary feeding can be enhanced through education programmes, and counselling; however, food supplements are required for food insecure populations.

The hygiene practices are major area of concern in the community and it definitely needs comprehensive affords by FLW to promote healthy lifestyle and practices which can be targeted on the occasion of VHSND and home visit, necessarily supplemented by regular monitoring and follow-up .

As infants grow, the consistency of complementary foods should change from semisolid to solid foods and the variety of foods offered should increase. By eight months, infants can eat 'finger foods' and by 12 months, most children can eat the same types of food as the rest of the family.

Feeding behaviours are anchored in a wider belief system that influences what, when, where and how people feed their children. The most effective interventions are based on an in-depth assessment of this system; they address major barriers, using various channels and resources to support behaviour change.

Policies and programmes to improve complementary feeding require involvement and coordination across sectors, including health, nutrition,

agricultural and social welfare. The private sector can also play an important role in improving access to and utilization of safe and adequate complementary foods.

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