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Research Article

EFFECTIVENESS OF PEER-COUNSELING FOR PROMOTING OPTIMAL COMPLEMENTARY FEEDING PRACTICES AMONG INFANTS BELONGING TO URBAN SLUMS OF DELHI

Sabharwal Vandana, Passi Santosh Jain

Assistant Professor in Nutrition, Institute of Home Economics, Former Director, Institute of Home Economics Department of Foods and Nutrition, Institute of Home Economics, (University of Delhi), F-4 Hauz Khas Enclave, New Delhi

*Corresponding author email: vandanasabharwal25@gmail.com

ABSTRACT

Background: Promotion of appropriate complementary feeding practices is important in reducing malnutrition in infants and young children. Yet, India has dismal rates of optimal complementary feeding practices which are not rising. **Aim:** This study aimed to find the impact of the educational intervention directed through peer counselors to promote optimal complementary feeding practices. **Methods and materials:** This is an Interventional study, which has been conducted in an urban slum of Delhi using multi-stage random sampling. From the study area two sectors were randomly selected. From one sector, 54 pregnant women were selected who were not given any counselling forming the non-intervention group. From the other sector, 159 pregnant women were selected to form the intervention group (Igr) which were further divided into 3 sub-groups; one sub-group was imparted counselling by a nutrition professional (Igr A; n=53) and the other two (Igr B₁; n=53 and Igr B₂; n=53) by the peer counselors who were the local health workers trained for promoting optimal infant feeding practices. The infants were followed up till their first birthday and in order to study the impact of counseling, the complementary feeding practices of the intervention and the non-intervention groups have been compared. **Results:** In the intervention groups, the prevalence of exclusive breastfeeding at 6 months was significantly higher as compared to the non-intervention group (67.5 % vs. 4.2 %). In the intervention groups, 2.6 per cent infants received semi-solid/ solid foods before the age of 6 months, 75.1 percent between 6 - 7 months and the rest by the age of 9 months. However, in the Non-Igr, the respective figures were 48.9, 19.4 and 25.4 per cent; and at the age of one year, 6.4 per cent infants were still being given predominantly mother's milk. 99.3 per cent infants in the Igrs as compared to 82.3 per cent in the Non-Igr (P<0.05) continued to receive breast milk till the age of 12 months. **Conclusions:** The promotion of optimal complementary feeding through appropriately trained peer counselors is feasible, although it can only be achieved through consistent efforts and adequate training/monitoring of such interventions.

Keywords: Complementary feeding, Breastfeeding, Infant and young child feeding, Peer counselling.

INTRODUCTION

Malnutrition has rightly been called 'The Silent Emergency'. The proportion of malnutrition among children in India is one of the highest in the world. Despite unprecedented economic growth during the last decade, improvements in nutritional status of the

children in our country have been rather very slow. Data from the National Family Health Survey-3 (NFHS-3) ¹, indicate that about 46 percent of the children under 5 years of age are moderately to severely underweight (thin for age), 38 percent are

moderated to severely stunted (short for age), and approximately 19 percent are moderated to severely wasted (thin for height). The World Bank² estimates that, after Bangladesh, India ranks 2nd in the world with respect to the number of children suffering from malnutrition. In India, the prevalence of underweight in children is among the highest in the world and nearly double than that of Sub-Saharan Africa.

Malnutrition affects people of every age, although some segments of the population are at a greater risk of under nutrition. Identifying and understanding the most vulnerable groups is crucial in order to design an effective strategy to overcome malnutrition. Most of the growth faltering occurs between the ages of 6 to 24 months when the child is no longer protected by exclusive breastfeeding and is rather exposed to disease/ infection through contaminated food and water. Even a child adequately nourished after 24 months of age is unlikely to recover growth 'lost' in the first two years as a result of malnutrition³. Thus, this is the critical window of opportunity when the quality of a child's diet has a profound, sustained impact on his/ her health as well as physical growth and mental development.

Optimal infant and young child feeding (IYCF) practices help ensure young children get the best possible start in life. These include early initiation of breastfeeding; colostrum feeding; exclusive breastfeeding from birth till six months, followed by the addition of adequate amounts of mushy, semi-solid or solid complementary foods drawn from the local diet; coupled with continued breastfeeding sustained well into or beyond the second year along with gradually increasing the amount of complementary foods⁴.

In spite of numerous efforts, in India, the prevalence of optimal infant feeding practices remains low. As per the DLHS-3 data (2007-8)⁵, the exclusive breastfeeding rates among children under 6 months is merely 46.4%, initiation of breastfeeding within one hour of birth, 40.2% and introduction of complementary feeding at 6 months (in children aged 6-9 months) is only 23.9%. The NFHS-3 (2005-6) data also reflects that only 21 percent of the children aged 6-23 months confer to all the three quality parameters of IYCF recommended by WHO that is timely, adequate and safe feeding of the infants. Only 44 percent of breastfed children are fed at least there commended a minimum number of times and only

half of them consume food from three or more food groups. Feeding recommendations are even less likely to be followed for the non-breast-fed infants/ children aged 6-23 months.

The existing efforts for promotion of complementary feeding must be strengthened as well as mainstream and scaled up through adequate resource allocation, capacity development, and effective communication. There is evidence to suggest that individual and group counselling is an effective tool to improve duration of exclusive breastfeeding⁶ but there is minimal evidence available for improving complementary feeding practices using skilled counselling. In view of this, the present intervention study has been undertaken for promoting optimal complementary feeding through peer counselling and assessing the impact of counselling on aspects related to complementary feeding practices of the nursing mothers belonging to urban slums.

METHODOLOGY

This is an Interventional study, which has been conducted in an urban slum of Delhi. Before implementing the intervention, a cross-sectional survey was conducted in the study area in order to understand the prevailing infant feeding practices in the area. The results of this study highlighted that most women were following sub-optimal infant feeding practices and along with this there was a high prevalence of malnutrition among the infants⁷. This made this area appropriate setting for examining the potential benefits of counseling on optimal infant feeding practices.

Multi-stage random sampling was used for enrolling the subjects (pregnant women in the 6th month of pregnancy). The study area was divided into 4 sectors, from which two sectors were randomly selected for the study. These sectors were quite similar in their socio-demographic profile, but were not so near that the intervention imparted to the subjects from one sector could affect the infant feeding practices followed by the subjects belonging to the other sector. From these two sectors all the households with pregnant women in their second trimester were identified with the help of the records of a local NGO. From one sector, 54 pregnant women in their 6th month of gestation were randomly selected which formed the non-intervention group, who were not given any counselling. From the other sector, 159

pregnant women were selected forming the intervention group (Igr) which were further divided into 3 sub-groups based on physical demarcation of the area; one sub-group was imparted counselling on optimal infant and young child feeding practices by a nutrition professional (Igr A; n=53) and the other two (Igr B₁; n=53 and Igr B₂; n=53) by the peer counselors who were the local health workers trained for promoting optimal infant feeding practices by the nutrition professional. Thus, in view of the inclusion and exclusion criteria, 213 pregnant women (in the 6th month of pregnancy) were enrolled in the present study. Data was collected from 426 participants (213 pair of mother and infant in each household). Of the 213 pregnant mothers enrolled in the study, data from 6-12 months pp were available for 198 mother-infant dyads (Igr A: n=51; Igr B₁: n=50, Igr B₂: n=50 and Non-Igr: n=47)

Counselling was conducted in three sessions during pregnancy (7th, 8th and 9th month) to cover issues related to early initiation of breastfeeding, colostrum feeding, avoidance of prelacteal feeding and promoting exclusive breastfeeding to till six months pp (the results of this part of the study will be presented in a separate paper). Further, two counseling sessions were conducted during the 5th month postpartum. During these sessions the mothers were imparted knowledge about variety and consistency of complementary foods, responsive feeding, safe preparation and storage of complementary foods as well as continuation of breastfeeding for two years or beyond. Recipes of some easy to prepare home-made complementary foods were shared and the cooking method demonstrated. In addition to this, home visits were made within 48 hours of the childbirth as well as once during 5 - 7 days pp and thereafter bimonthly till the first birthday of the infant to reinforce the messages and counsel relatives of these women. The women in the non-intervention area, however, were not imparted any counselling. Thus, dual approach was employed for counselling the pregnant women, one by the nutrition professional herself and second by the peer counselors.

After enrolling the subjects, survey questionnaire with open and closed ended questions was used to elicit information on background details. The survey questionnaire was administered face to face by the nutrition professional and the peer counselors. Before

implementing the structured questionnaire, consent form in the local language was used to elicit written informed consent from all the participants. Afterbirth of the baby, child record cards were maintained that included bimonthly information regarding dietary practices/ nutrient intake of children as well as monthly anthropometric measurements. Data on the dietary intake of children were gathered using one day 24 hour recall method and further analysed using DIETFOFT. Data on feeding techniques and strategies and hygiene/ sanitation practices followed during complementary feeding were also gathered through observation both at the 9th and 12th months pp. In order to study the impact of counseling imparted by the nutrition professional/ peer counselors, complementary feeding practices of the intervention and the non-intervention groups have been compared. Further, within the intervention groups, infant feeding practices have been compared for the group counseled by the nutrition professional vs that by the peer counsellor-1 /peer counsellor-2.

The data were statistically analyzed using SPSS software. Descriptive analyses of all variables were conducted. In order to compare the difference between the variables in the intervention group's vs the non intervention group student's t test was conducted and to understand the difference among the three intervention groups and the non-intervention group inferential statistical test of ANOVA was applied.

RESULTS

Data on socio-demographic profile of the household: The results of the intervention study reveal that there were no significant differences with regard to socio-demographic profile of the subjects from all the groups. The age of subjects (pregnant women) ranged from 17 - 36 years; about 50 per cent being between 20 and 25 years. Majority of the respondents were illiterate or functionally literate; only 7.5 percent were reportedly employed, mostly as labourers, maids, or were engaged in small-scale work at home. Most of them were natives of Uttar-Pradesh, Bihar or Haryana. Majority of the subjects were Hindus belonging to lower caste/SC/ST category and had been residing in the area for three years or more. Among the study groups, there was no significant difference in the mean age at marriage

(17.63 ± 1.82 yrs) and the mean age at first childbirth (19.05 ± 2.05 yrs) of the subjects.

Data on breastfeeding practices till six months post partum (pp): With regard to breastfeeding practices, it was found that the mothers in the Igrs initiated breastfeeding earlier as compared to the Non-Igr; the mothers who initiated breastfeeding within one hour of childbirth was 63.4 per cent (Igr A), 55.8 per cent (Igr B₁) and 60.8 per cent (Igr B₂), as against only 3.8 per cent in the Non-Igr. Further, in the intervention groups, the majority (83.9 %) of the infants received mother's milk as their first feed, whereas in the non-intervention group; 80.6 per cent infants had received prelacteals like honey, buffalo's milk, cow's milk, gur, tea water among others. At one month, a significantly higher proportion of mothers (80.6 %) in the Igrs were practicing exclusive breastfeeding as compared to Non-Igr (13.5 %; P<0.05). Similar significant differences were reported at 60 ± 2 days, 90 ± 2 days, 120 ± 2 days, 150 ± 2 days and 180 ± 2 days pp (P <0.05). At the end of six

months, the number of exclusively breastfed infants was 67.5 per cent in the Igrs, against only 4.2 per cent in the Non-Igr.

Data on time of introduction of semi solid/ solid foods: Of the 213 pregnant mothers enrolled in the study, data from 6-12 months pp were available for 198 mother-infant dyads (Igr A: n=51; Igr B₁: n=50, Igr B₂: n=50 and Non-Igr: n=47). In the Igrs, 2.7 percent children were introduced to semi solid/solid foods before the age of six months; about two third infants started receiving semi solid/ solid foods between 6 - 7 months and the rest latest by the 9th month. In the Non-Igr, 48.9 per cent were receiving semi-solid/ solid foods before 6 months, 19.4 percent started receiving these feeds between 6 - 7 months and another 25.4 percent at a later age, while 6.4 per cent infants were still not being given any semi-solids by the age of one year (Table 1). Hence, with regard to timely introduction of complementary foods, a significant difference (P<0.05) existed in the Igrs vs. Non-Igr.

Table 1: Distribution of infants by age and introduction of semi-solid/solid foods

Infants' age (months)	Igr A (n=51)	Igr B ₁ (n=50)	Igr B ₂ (n=50)	Non-Igr (n=47)
< 6 m	1(1.9)	2(4.0)	1(2.0)	23(48.9)
6<7 m	39(76.4)	37(74.0)	39(78.0)	9(19.4)
7<8 m	9(17.6)	9(20.0)	8(16.0)	5(10.6)
8<9 m	2(3.9)	2(4.0)	2(4.0)	2(4.2)
9<10m	0(0.0)	0(0.0)	0(0.0)	3(6.4)
10<11 m	0(0.0)	0(0.0)	0(0.0)	2(4.2)
11<12 m	0(0.0)	0(0.0)	0(0.0)	0(0.0)
Till 12 months	51(100.0)	50(100.0)	50(100.0)	44(93.6)

Note: Figures in parentheses indicate percentages

Data on food group and nutrient intake of the infants: With respect to the type of foods, the intervention group was encouraged to prepare complementary foods (from the family pot) having thick/ soft consistency that provides satiety and nourishment to the child. Data on food group frequency was computed using a monthly three day 24 hours dietary recall method which indicated that between 6-12 months compared to the Non-Igr, the intake of cereal-legume gruel mixes was higher in Igrs (37.1 % in Igrs vs 6.4 % in Non- Igr). While almost all the mothers were feeding their infants with cereal and pulses in the Igrs, only 73.5 percent mothers were doing so in the Non-Igr. Dilution of milk was a common practice in the non-Igr (87.2 %

as compared to Igrs (5.9 %). In the Igrs, vegetables and fruits were fed to 57.6 per cent and 63.5 per cent infants respectively as compared to 23.3 per cent and 42.5 per cent in the Non-Igr. Commercial foods were fed to 14.9 per cent infants in the Non-Igr whereas in the Igrs no mother was using it. The data gathered from 24 hours dietary recall was further used to calculate the intake for macro and micronutrients from complementary foods. The data relating to energy intake from non-breastmilk sources indicate that the proportion of energy from these increased with the Childs' age in all the study groups. Compared to the Igrs the mothers in the Non-Igr had low breastfeeding frequency and were given more top feeds/ foods, but the quality and quantity of top foods

was poor (Table 2). At 9 and 12 months energy intake from complementary foods was higher in the Non-Igr as compared to the Igrs (P<0.05 at 9 months and NS at 12 months). However, during 9 and 12 month, the mean frequency of breastfeeding was higher in the

Igrs than in the Non-Igr; hence it can be assumed that the total energy intake (breast milk and non breast milk sources) was higher in Igrs than the Non-Igr.

Table 2: Data on frequency of breastfeeding and energy intake from the complementary foods only – birth till 12 months (24 hour dietary recall)

Month		Igr A		Igr B ₁		Igr B ₂		Non-Igr	
		N	(mean ± SD)	N	(mean ± SD)	N	(mean ± SD)	N	(mean ± SD)
180 ±2 days	Freq. of BF	51	11.47 ± 2.12 (4-15)	50	10.86 ± 2.22 (0-13)	50	11.26 ± 2.34 (3-14)	48	6.46 ± 3.56 (0-14)
	Energy intake from CF	4	369.94±230.5 (342-510)	7	314.63 ±186.73 (178-541)	6	286.22 ±170.92 (86-510)	39	259.28±113.56 (68-464)
210 ±2 days	Freq. of BF	51	11.47 ± 2.12 (4-15)	50	10.86 ± 2.32 (0-13)	50	1.26 ± 2.34 (3-14)	48	6.46 ± 3.56 (0-14)
	Energy intake from CF	39	162.85±101.7 (107-510)	38	182.12±95.26 (120-481)	41	183.63± 33.96 (106-481)	44	319.85±130.54 (46-502)
240 ±2 days	Freq. of BF	51	10.80 ± 1.88 (4-13)	50	10.40 ± 2.29 (0-14)	50	10.30 ± 2.02 (3-13)	48	5.42 ± 2.87 (0-11)
	Energy intake from CF	48	211.07±117.9 (80-559)	48	210.24 ±108.91 (89-481)	48	208.80 ±111.69 (89-481)	45	337 ± 133.19 (165-443)
270 ±2 days	Freq. of BF	51	8.78 ± 1.60 (5-13)	50	8.92 ± 1.97 (0-13)	50	8.24 ± 1.90 (2-13)	48	5.33 ± 2.83 (0-10)
	Energy intake from CF	48	258.14±187.2 (201-559)	47	251.64 ±124.03 (181-506)	48	272.51 ±163.16 (224-785)	45	388.71±161.54 (210-642)
300±2 days	Freq. of BF	51	8.55 ± 1.38 (4-11)	50	8.60 ± 1.94 (0-11)	50	7.88 ± 1.38 (5-11)	48	4.96 ± 2.94 (0-10)
	Energy intake from CF	51	325.56±159.7 (202-752)	50	311.71 ±129.72 (245-597)	50	302.13 ±152.98 (118-491)	44	426.93±175.70 (212-582)
330 ±2 days	Freq. of BF	51	8.14 ± 1.11 (6-10)	50	8.30 ± 1.75 (0-11)	50	7.45 ± 1.12 (4-9)	47	4.77 ± 3.03 (0-11)
	Energy intake from CF	51	414.58±171.7 (313-538)	50	404.34±130.65 (239-660)	50	382.95 ±132.26 (342-717)	44	446.03±178.27 (268-644)
360 ±2 days	Freq. of BF	51	7.40 ± 1.29 (5-10)	50	7.84 ± 1.87 (0-11)	50	6.88 ± 1.24 (3-9)	47	4.62 ± 2.63 (0-10)
	Energy intake from CF	51	502.28±164.9 (425-623)	50	495.33 ±165.24 (433-759)	50	448.22 ± 23.66 (398-606)	44	527.09 ± 99.73 (417-694)

* Figures in the parentheses indicate the range

Comparison of micronutrient intake from complementary foods indicates that at 9 and 12 months the intake of calcium, phosphorus, folate, vitamin A and B group vitamins was statistically higher in the Non-Igr (P<0.05) while the intake of iron and vitamin C was higher (although not significant) in the Igrs. This may be attributed to higher consumption of vegetables/fruits in the Igrs. Since during these months, the consumption of breast milk- a rich source of most micronutrients, was significantly higher as judged from the number of breastfeeding episodes and their duration in the

intervention groups, it is envisaged that the overall intake of energy and micronutrients could be higher in the Igrs than the Non-Igr.

Data on extended breastfeeding status of the infants: In this study, breastfeeding was almost universal in the intervention groups, although in the non-intervention group also 87.5 and 82.3 per cent mothers were breastfeeding their babies at 9 and 12 months respectively (Table 3). Thus, an increased number of women were able to successfully breastfeed from 6 - 12 months pp in the Igrs vis-à-vis

Non-Igr, significant differences were recorded at 9 - 12 months ($P < 0.05$).

Table 3 Distribution of the infants by extended breastfeeding status

Infants' age (months)								
	Igr A		Igr B ₁		Igr B ₂		Non-Igr	
	Number (%)		Number (%)		Number (%)		Number (%)	
	Index Child	Older Child	Index Child	Older Child	Index Child	Older Child	Index Child	Older Child
	n = 51		n = 50		n = 50		n = 48	
6-<9 months	51	45	49	43	50	44	43	42
Breastfed	(100.0)	(88.2)	(98.0)	(86.0)	(100.0)	(88.0)	(89.4)	(87.5)
Not breastfed	0	6	1	7	0	6	5	6
	(0.0)	(11.8)	(2.0)	(14.0)	(0.0)	(12.0)	(10.6)	(12.5)
	n = 51		n = 50		n = 50		n = 47	
9-<12 months	51	44	49	42	50	39	39	39
Breastfed	(100.0)	(86.3)	(98.0)	(84.0)	(100)	(78.0)	(82.3)	(82.3)
Not Breastfed	0	7	1	8	0	11	9	9
	(0.0)	(13.7)	(2.0)	(16.0)	(0.0)	(22.0)	(17.7)	(17.7)

Data on maternal attitude/ behaviour regarding complementary feeding of the infants:

Observations regarding self-feeding at 9 and 12 months indicate that in the Igrs significantly higher proportion of infants had learned to feed themselves than those in the Non-Igr ($P < 0.05$), but the difference was less pronounced at 12 months, possibly because these skills generally get develop by this age. It was also found that in the Igrs, the mothers were more conscious of the child's hunger cues throughout the period of 6 - 12 months ($P < 0.05$). A significantly higher percentage of mothers in the intervention groups also reportedly took appropriate steps if the child refused to eat and actively encouraged him/ her to eat. At 9 and 12 months, other behaviours/practices compared between the intervention and the non-intervention group included - feeding the child from his/her own bowl ($P < 0.05$), sitting with the child when he/she is eating ($P < 0.05$), feeding with love and affection ($P < 0.05$) and allowing the infant to eat food on his/ her own accord ($P < 0.05$). Though all the subjects in the study groups ($n=198$) reportedly washed their hands after defecating, only about three-fourth washed their hands before cooking meals. With regard to washing the infants' hands before feeding him/ her, significantly more mothers from the intervention groups followed the practice ($P < 0.05$). A positive impact of counselling was also seen on the practice of washing utensils before feeding the baby ($P < 0.05$) and rewarming of foods before feeding ($P < 0.05$).

DISCUSSION

Among the study population in urban slum of Delhi, counselling directed through nutrition professional and trained peer counselors, had a significant effect on promoting infant feeding practices especially complementary feeding practices. The groups counseled by the nutrition professional and the peer-counselors were almost similar in bringing about a positive change in these practices. This study, thus, highlights that educational intervention directed through the peer-counselors can improve complementary feeding practices as well as energy/ other nutrient intake from locally available foods. The intervention has proved useful for educating the mothers about appropriate complementary feeding practices, method of preparing complementary foods, improving their feeding skills and the overall hygienic practices.

With regard to breastfeeding practices, it was found that as compared to the Non-Igr, the mothers in the Igrs initiated breastfeeding earlier, the majority of the infants received mother's milk as their first feed and at the end of six months, the number of exclusively breastfed infants was higher. In the WHO Child Growth Standards study, trained lactation counselors supported the mothers to prevent and manage breastfeeding difficulties from soon after birth and at specified times during the first year after birth. By using this strategy, good compliance to exclusive breastfeeding was achieved in all the participating

countries including India⁹. A Cochrane review on support for breastfeeding mothers concluded that training on infant and young child feeding, which in turn led to more qualified professional and lay support to the mothers, resulted in prolonged breastfeeding duration¹⁰. The promotion of breastfeeding intervention trial (PROBIT) has also documented a significant improvement in the rates of exclusive breastfeeding in the intervention group, who received skilled, counselling support from the trained health workers¹¹. Bhandari et al (2003)¹² conducted a cluster randomized controlled trial in Haryana, India to assess the effect of a 3 day training programme. Improved rates of exclusive breastfeeding and reduction of diarrhoea was documented. A field experience in Lalitpur district has shown such training is feasible and doable at a scale and within 2 years practices have shown a positive change apart from gain in motivation of workers and their knowledge and skills¹³. In the present study, with regard to timely introduction of complementary foods, a significant difference existed in the Igrs vs. Non-Igr. The quality and quantity of the complementary foods being given to Igrs was also better than the non-Igrs and so was the frequency to continued breastfeeding. An earlier study to promote optimal infant feeding practices in rural Haryana also indicated that energy intake from complementary foods overall was significantly higher in the intervention group at 9 months ($p < 0.001$) and 18 months ($p < 0.001$)¹⁴.

There is increasing recognition that optimal complementary feeding depends not only on what is fed, but also on how, when, where, and by whom the child is fed¹⁵. The educational intervention in the present study also had a significant positive effect in improving maternal behaviour regarding complementary feeding particularly responsive feeding and hygienic practices. WHO also emphasizes that the complementary feeding program should take up a holistic approach to breastfeeding and transitional foods, including matters related to child feeding behaviors and food safety¹⁶. Breastfeeding should be continued after six months as it still remains to be an important source of energy and high quality nutrients through the first and second year of life as well as beyond. In this study, breastfeeding was almost universal in the intervention groups, but in the non-Igr few mothers had already

ceased breastfeeding. Previous longitudinal studies have demonstrated that in developing countries, a longer duration of breastfeeding is associated with greater linear growth when the data are analysed appropriately to eliminate the influence of confounding variables and reverse causation^{17, 18}.

CONCLUSION

The study indicates that it is possible to promote optimal complementary feeding practices through adequately trained and motivated peer counselors along with back-up mechanisms rendering the necessary support. Follow-up supervision of the peer-counselors is also essential to monitoring their progress as well as addressing the challenges these peer-counselors are not able to handle.

Improving optimal infant feeding practices among mothers requires behavioural change which is a continuum and changes at different stages in the infant's/ young child's life, hence the timing of interventions is also critical. It is thus important that the interventions are inducted at a time, which is as close as possible to the time of desired responses. Our findings support a counselling schedule of two sessions just prior to the introduction of complementary foods (5th month postpartum) coupled with monthly contacts thereafter as per the feasibility or the individual mother's needs. Mothers who, despite counselling failed to adopt optimal complementary feeding practices indicate that these mothers/ family due to their other problems require extra counselling sessions. Participation of influential family members such as mothers-in-law and husbands in these counselling sessions would perhaps enhance effectiveness of the counselling process as indicated in some other studies. Thus, there is an urgent need to educate the women as well as create an enabling environment for practicing optimal complementary practices with special emphasis on timely, adequate and appropriate complementary feeding and continued breastfeeding for two years or beyond. The study, therefore, advocates a dire need for positioning the system of peer counselling for the mothers during lactation for ensuring timely introduction of nutritious complementary foods from the family pot.

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