



International Journal of Research Publication and Reviews

Journal homepage: www.ijrpr.com ISSN 2582-7421

Weaning Needs of infants

Seema Devi¹, Kanchan kulshrestha²

¹Research scholar, Department of homescience G.D.M(P.G) College, Modinagar(U.P)

²Associate professor, Department of homescience G.D.M(P.G) College, Modinagar(U.P)

ABSTRACT-

The term "weaning" comes from the word "wemian" which means to accustom. Weaning begins from the moment supplementary food is started and continues till the child is taken off the breast completely. Solid food added to an infant's diet is called beikost there is an increase in activities of enzymes at the time of weaning. Liquid supplements vitamins and mineral and mineral supplements are essential to meet the nutritional requirements of the baby. And solid Juices of fresh fruits such as oranges, tomatoes, grapes, or soup of drumstick leaves can be introduced to meet the vitamin C requirement. One teaspoon of fruit juice can be given to the baby from the third week onwards, at this stage the fruit juice must be diluted with equal quantities of boiled water. This can be increased to about three tea spoons (without dilution) by 2 to 3 months. Boiled leafy vegetables, carrots and tomatoes can be introduced from the third month. After boiling.

Key words- Infants, Weaning, Supplements

Introduction

Mash and strain the vegetables. Add salt and lime juice. Mashed banana, pumpkin. Egg yolk, meat soup without seasoning. Porridge, double-cooked cereals and pulses, roasted pulse-cereal powders sweetened with jaggery are the other items that can be introduced by the sixth month. Ripe fruits are also good for them. Only one food must be introduced at a time though a variety of items can be given to familiarize with new tastes. Only a small quantity of food nuts is given to the baby in the beginning.

Does not force the baby to take more otherwise it will reject it in course of time? If the baby vomits or shows dislike for a food do not force him to eat it. After an interval start again and if the dislike persists substitute it with another food. Provide variety in supplementary foods because infants like older people if proper supplementation is not provided to the infants its growth is retarded. Foods rich in proteins, calories and other nutrients must be supplemented to prevent malnutrition because the baby is growing vigorously at this stage.

Some Recipes

Some recipes and their nutritive value are given in this chapter. These can be included in the diet of an infant to improve the nutrient intake. Green gram dale, kheer, rice wheat or ragi porridge, ragi milk, halwa, chandankheer, idli, groundnut halwa, pongal, sweet kichiri, vegetable soup and fruit juices are some of the foods that can be given to a pre-school child.

Ragi, Wheat or Ric

Ragi flour	- 30 gm(2 tbsp) or any other flour.
Groundnuts	- 30 gms
Jaggery	- 50 gms
Water	- 2 glasses

Method: Mix ragi flour small amount of water and make it into a paste. Roast and grind groundnuts into a paste. Add ragi flour paste to boiling water and stir continuously. Crush the jaggery and dissolve in paste and allow the mixture to cook for five minutes and remove from the fire.

Nutritive value: This porridge supplies about 11.5 gms proteins and 225 kals.

Ragi Milk Halwa

Ragi (grains)	- 100 gms
Milk	- Half Cup
Jaggery	- 50 gms
Water	- 2 glasses

Method: Clean and soak ragi for 10-12 hours and grind into a paste. Dilute with water and strain the mixture through a thin cloth. Add milk and cook it

on low heat. Stir to avoid lump formation. Add jaggery to the cooked milk.

Groundnut Halwa

Shelled groundnuts	- 100 gms
Jiggery	- 50 gms

Method: Soak groundnut for 6 to 8 hours and grind into a paste. Add 20 to 25 ml of water to the paste and keep on fire. Add jiggery. Allow to cook for 5 minutes and remove from the fire.

Pongal

Rice	- gms(one fistful)
Dal	- 20 gms(2 tbsp)

Method: Cook dal, and a little salt, and mash it well with a ladle. Cook rice, add mashed dal. Add a little ghee to it. Serve this with a soup prepared from greens.

Nutritive value: 6.2 gm protein 120 kals (without ghee).

KheerPongal

Rice	-50 gms (4 tbsp, heaped)
Amaranth	-50 gms(one medium size bunch)
Or any other greens	
Green gram dal	-50 gms (4 tbsp)
Groundnut oil	-10gms
Salt	- to tast
Cumin	-a pinch

Method: Roast rice and green gram dal and powder them. Boil amaranth, mash and strain. Mix amaranth puree with rice and dal powders and make into a paste. Add this mixture to the boiling water Fry cumin in oil and season the pongal.

Nutritive value: 4.0 gm protein, 100 kals.

Low Cost Recipes

Chandankheer

Roasted Bengal	
Gram flour	- 25 gms (2 tbsp)
Milk	- 200 ml (1 glass)
Sugar	- 15 gms

Method: Add a little milk to the Bengal gram flour to form a paste. Boil the remaining milk and add bengal gram flour paste to it. Stir continuously to avoid lumps. Allow it to cook for five minutes. Add sugar and remove from the fire.

Nutritive value:4.0 gms protein, 110 kals.

Sweet Khichiri

Wheat	-	45 gms (4 tbsp)
Roasted Bengal	-	45 gms (3 tbsp)
Gram dal		
Jaggery	-	50 gms (4 tbsp)

Method: Lightly roast wheat and Bengagengal gram dal and powder them. Make into a thin batter. Add water to jiggery and make it into a syrup. Add jiggery syrup to the batter and allow cooking till there is no raw flavor.

Nutritive value: 5.0 gms protein, 150 kals.

Drumstick Leaf or Spinach Chapathi		
Drumstick leaves	-	25gms
Onion (big)	-	15 gms
Salt and water	-	enough
Wheat floor	-	enough
Chillies(Green)	-	1

Method:

Chop onion and chilli. Clean and cut leaves into pieces and cook. Mix all three to wheat flour and make it into a soft dough. Divide into balls and make chapatti and cook it. Nutritive value: 8.0 gm proteins, 196 kals, The growth rate declines after the child is one year old, but the foundation of good health is laid during the pre-school age. In India about 20 per cent of the total deaths occur among toddlers in the age group of 1 to 4 years.

A child who has failed to grow during this crucial period may not make up the loss in growth even with an excellent diet in later life. Deficiency of vitamin A which leads even to blindness and anemia are common disorders found in children in the age group of 1 to 5 years. About 1 to 2 per cent of per-school children suffer from severe deficiency diseases like kwashiorkor and marasmus. Studies in India have shown that the performance of

children, who had earlier suffered from malnutrition, was clearly inferior to that of children who had not gone through malnutrition. Their diets in general consist of cereals, roots, tubers and vegetables. Important items like pulses, leafy vegetables, yellow vegetables, milk and milk products and other protein sources and fruits, are consumed much below their requirement. Deficiency of protein calories, vitamin A and iron are very common among this group due to their inadequate dietary habits. Non-availability of infectious diseases are the main causes of malnutrition, Physical and mental retardation set in and high mortality takes place among infants. It has also been shown by studies that the measurement of head circumference usually indicates that the brain volume is less among malnourished children. Malnutrition reduces memory and hearing ability and impairs intellectual functioning.

Studies infant feeding practices

In India there is delayed initiation of complementary feeding, with only 31% of the children being given semi solids along with the breast between six and nine months of age according to NFHS 1 data for '92- '93. However between four and six months the average is 44% (55% in urban and 41% in rural areas). The average hides the regional differences among states by way of location (viz) urban and rural. It is in Bihar, Rajasthan and Uttar Pradesh that the least percentage of infants (15% and 17% respectively) is introduced semi-solids. The maximum number of infants introduced to complementary foods during this period is from the North Eastern States of Manipur, Meghalaya and Nagaland as well as Kerala in the South. For TamilNadu it is 55%, which increases to 79% at about 10–12 months.

Anthropometric references and standards

A growth standard defines a recommended pattern of growth that has been associated empirically with specified health outcomes and the Mineralization of long term risk of diseases. The growth standard is developed using the reference data from populations that have stabilized in terms of secular increment in anthropometry and that have not been subjected to discernible external constraints on growth (dietary deficiencies, infections etc.) (Butte et al 2000).

particular concern with regard to the amount of bioavailable iron and zinc provided. This is because these foods are usually high in phytate, which binds these minerals and limits their absorption by the child. Phytate concentration can be reduced via germination, fermentation, soaking, or pounding, but these techniques are probably not sufficient to compensate for the low iron and zinc content of typical plant-based complementary foods.

Infant and young child nutrition has been engaging the attention of scientists and planners since long for the very simple reason that growth rate in the life of human beings is maximum during the first year of life and infant feeding practices comprising of both the breastfeeding as well as complementary feeding have major role in determining the nutritional status of the child

(Government of India 2006).

Socio- economic factors like income occupation, family and cast has been considered as important factors in influencing perceptions which determine characteristic rapid growth rate, high nutritional requirements, immature immunological esteem which increase susceptibility to infection and sole dependence on their caretakers it is also said that the eventual nutritional status of a child depends not only on householder resources and food availability but also on the actions of the family members, primarily of the parents and especially of the mothers which substantially determine the health and nutritional status of the children in developing countries. In agrarian societies the traditional practices of child rearing and feeding are more.

The BFHI Global Criteria (2006) stated "Place babies in skin-to-skin contact with their mothers immediately following birth for at least an hour and encourage mothers to recognize when their babies are ready to breastfeed, offering help if needed" (UNICEF/WHO 2006).

Conclusion

particular concern with regard to the amount of bioavailable iron and zinc provided. This is because these foods are usually high in phytate, which binds these minerals and limits their absorption by the child. Phytate concentration can be reduced via germination, fermentation, soaking, or pounding, but these techniques are probably not sufficient to compensate for the low iron and zinc content of typical plant-based complementary foods.

Infant and young child nutrition has been engaging the attention of scientists and planners since long for the very simple reason that growth rate in the life of human beings is maximum during the first year of life and infant feeding practices comprising of both the breastfeeding as well as complementary feeding have major role in determining the nutritional status of the child.

introduction of weaning food to late can lead to under nutrition and increased diarrhea morbidity. The child may be unwilling to accept new food.

References

-
- Agostini, C., Decsi, T., Fewtrell, M., Goulet, O., Kolacek, S., Koletzko, B., Michaelson, K.F., Moreno, L., Puntis, J., Rigo, J., Shamir, R., Szajewska, H., Turk, D., van Goudoever, J. (2008) 'Complementary feeding: A commentary by the ESPGHAN Committee on Nutrition'. *Journal of Paediatric Gastroenterology and Nutrition*, 46 (1) pp.99-110. <http://www.ncbi.nlm.nih.gov/pubmed/18162844>
- Batal M., Boulghourjian C. and Akik C. (2010) Complementary feeding patterns in a developing country: a cross-sectional study across Lebanon Eastern Mediterranean; *Health Journal*; Vol. 16 No. 2 www.emro.who.int/emhj-volume-16-2010/volume-16...2/article10.html

- Ray, I., and Chandra, A. K. (2011). An anthropometric study on the children of Tripura: Nutritional and health coverage and redefining WHO percentile cut-off points. *International Journal of Scientific and Research Publications*, 3(5).
- Plessis Du Kruger LM, Sweet HS, (2013). Complementary feeding: a critical window of opportunity from six months onwards. *S Afr J Clin Nutr*;26(3)(Supplement):S129S14www.ajol.info/index.php/sajcn/article/download/9780/87147.
- Olatona F. A., Odozi M. A., Amu E. O (2014). Complementary Feeding Practices among Mothers of Children under Five Years of Age in Satellite Town, Lagos, Nigeria ; *Food and Public Health* , 4(3): 93-98 <http://article.sapub.org/10.5923.j.fph.20140403.04.html>.
- Onyangore Faith, Were Gertrude, Mwamburi Lizzy (2015). Assessing Handling of Complementary Foods towards Prevention of Iron Losses among Infants in Keiyo South Subcounty, Kenya *Food Science and Quality Management* Vol.36. <http://www.iiste.org/Journals/index.php/FSQM/article/view/19772>
- Population Council. (2010). Increasing complementary feeding in rural Uttar Pradesh: Implications for behavior change communication, Policy Brief No. 6. New Delhi: Population Council. <http://www.popline.org/node/214513>