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Correlations between Sociodemographic Status, Attitude, Cultural Belief, and Family Support towards Complementary Feeding Practices

Anna Uswatun Qoyimah^{1*}, Zahroh Shaluhiyah², Sri Winarni³¹Health Promotion, Faculty of Public Health, Diponegoro University | annauswatun151@gmail.com²Health Promotion, Faculty of Public Health, Diponegoro University | shaluhiyah.zahroh@gmail.com³Biostatistics and Population, Faculty of Public Health, Diponegoro University | winarni@live.undip.ac.id* Corresponding Author: annauswatun151@gmail.com

ABSTRACT

Introduction: Proper nutrition is crucial during the first two years of life, as this period is a "critical window" for promoting optimal growth, health, and behavioral development. Complementary feeding refers to the introduction of additional foods and liquids when breast milk alone no longer meets an infant's nutritional needs. Providing adequate and appropriate complementary foods, along with proper feeding practices, can help prevent stunting and promote healthy eating habits.

Objective: This study aimed to identify the factors correlated with complementary feeding practices (i.e., MDD, MMF, MAD, and SSSFs) among children aged 6–23 months in Surakarta City.

Method: This cross-sectional study involved 110 mothers with children aged 6-23 months. Data were collected through questionnaires interviewed directly to the respondents. The variables in this study included the child's age, the mother's age, parity, maternal education level, maternal employment status, attitude, cultural beliefs, and family support. Complementary feeding practices were assessed using the composite indicators such as MDD, MMF, MAD, SSSFs as recommended by the WHO.

Result: This study identified that child's age (0.012 (OR: 3.71, CI: 1.28-10.75)), mother's age (0.001 (OR: 9.35, CI: 2.06-42.37)), parity (0.003 (OR: 4.16, CI: 1.54-11.21)), mother's education (0.018 (OR: 3.06, CI: 1.18-7.90)), attitude (0.028 (OR: 4.93, CI: 1.05-23.0)), cultural belief (0.000 (OR: 9.00, CI: 2.52-32.0)), and family support (0.000 (OR: 5.39, CI: 2.17-13.35)) were determinant factors of complementary feeding practice. Mothers with positive attitudes were 4.93 times more likely to engage in appropriate complementary feeding practices. Mothers with positive cultural beliefs were predominantly engaged in appropriate feeding practices with the odds by 9.00 times. Mothers with strong family support were 5.39 times more likely to practice appropriate complementary feeding. There was no statistically significant correlation between the mother's employment status (0.985 (OR: 0.99, CI: 0.35-2.78) and complementary feeding practices.

Conclusion: It is essential to educate mothers on the correct timing and process of transitioning to complementary feeding. Nutrition education should aim to enhance and correct knowledge and beliefs about these practices. Mothers should receive practical guidance on making informed decisions, considering factors such as affordability, availability, access, and the preparation of nutrient-dense foods.

Keywords: Attitude; Cultural Belief; Complementary Feeding; Family Support; Sociodemographic Status

INTRODUCTION

Inadequate dietary intake is a leading cause of long-term malnutrition in children. During the first two years of life, the primary factors contributing to malnutrition are suboptimal complementary feeding practices and breastfeeding, along with a high prevalence of infectious diseases. Proper nutrition is crucial during the first two years of life, as this period is a "critical window" for promoting optimal growth, health, and behavioral development. Complementary feeding refers to the introduction of additional foods and liquids when breast milk alone no longer meets an infant's nutritional needs [1]. It is essential to ensure that complementary feeding provides sufficient macro- and micronutrients to support healthy outcomes both in early life and later stages, while also fostering the optimal growth and development of infants [2]. Providing appropriate complementary feeding during the first two years is vital because malnutrition rates tend to peak during this period, and the resulting damage to physical growth and brain development can be irreversible [3]. Providing adequate and appropriate complementary foods, along with proper feeding practices, can help prevent stunting and promote healthy eating habits [4].

Based on the Indonesia's RPJMN 2020-2024, the stunting prevalence in 2020 (26.9%), 2021 (24.4%), and 2022 (21.6%) was still below the WHO target of under 20%. This rate has not met the national stunting reduction goal for 2022, which was set at 18.4% [5]. Based on UNICEF, the rate of stunting in Indonesia increases significantly during the complementary feeding period, rising from 22% at 6 months of age to 38% by the time children reach 2 years of age [6]. Based on Indonesia Basic Health Survey 2018, over 40% of infants in Indonesia are introduced to complementary foods too early (before 6 months), while 40% of children do not have a sufficiently diverse diet, and 28% are not fed frequently enough [7]. In addition, Surakarta was chosen by BKKBN since 2021 as a pilot city for stunting reduction and family data collection programs in Central Java. The prevalence of stunting in Surakarta has fluctuated, with rates recorded at 18.76% in 2019, 20.4% in 2021, and 16.2% in 2022 [8–11]. In 2024, family assistance data in Surakarta indicated that 68%, or 6,728 children aged under two years, were at risk of stunting out of 9,882 families with children aged under two years. To address this issue, the city of Surakarta has implemented a community empowerment program aimed at providing balanced nutrition for families at risk of stunting, particularly those with stunted toddlers called Dapur Sehat Atasi Stunting (DAHSAT). The DAHSAT program includes educational activities focused on improving nutrition and food consumption for pregnant women, breastfeeding mothers, and toddlers. DAHSAT is conducted in each sub-district and serves to strengthen food security for children at risk of stunting.

The World Health Organization (WHO) has established several indicators for infant and young child feeding (IYCF) practices, including the introduction of foods meeting the minimum acceptable diet (MAD), minimum meal frequency (MMF), minimum dietary diversity (MDD), and solid, semi-solid, or soft foods (SSSFs). These indicators are used to evaluate IYCF practices [12]. In Indonesia, the prevalence of MDD among children aged 6–23 months remained stagnant at 54% between 2014 to 2020, while MMF increased from 65% to 71%. Despite these improvements, IYCF practices in Indonesia are still below the recommended levels [13]. Various factors have been recognized as potential barriers to the early initiation of complementary feeding practices. These include socio-demographic aspects such as religious and ethnic background, the age of the mother and infant, family size, maternal education, employment status, marital status, and the child's age. Moreover, factors related to knowledge and practices, like delayed support for breastfeeding initiation and uncertainty about when to begin complementary feeding, also contribute to delays in starting these practices [14].

Inappropriate feeding practices are associated with low household socioeconomic status and unfavorable maternal attitudes. The formation of mothers' attitudes toward complementary feeding practices is influenced by cultural norms deeply embedded in the community, as well as by the sources of information available regarding feeding practices. Additionally, socio-cultural factors, such as food taboos, impact toddler feeding practices.[15] To translate these attitudes into effective practices, supporting factors and enabling conditions are essential, including support from husbands, parents, in-laws, and children. Family support plays a role in the prevalence of inappropriate complementary feeding practices for toddlers, as mothers often follow advice from parents and spouses regarding child feeding, which may not always align with recommended practices.[16] This study aimed to identify the factors correlated with complementary feeding practices (i.e., MDD, MMF, MAD and SSSFs) among children aged 6–23 months in Surakarta City. The study considered various related factors, including children's age, mother's age, parity, maternal education level, maternal employment status, attitude, cultural belief, and family support. The findings of this study can serve as key points for identifying crucial interventions or policies to improve complementary feeding practices.

METHOD

This study was conducted between June and July 2024, employing a quantitative analytic research design with a cross-sectional study approach. The research involved 110 mothers who have children aged 6-23 months. The population consisted of 6,728 mothers residing in Surakarta, with the study focusing on an accessible population of

1,774 mothers from five sub-districts (Semanggi, Mojosongo, Jebres, Sangkrah, and Banjarsari). The accessible population was purposively selected from five sub-districts in Surakarta with the highest stunting prevalence. The sample size was determined using the Slovin formula with margin of error by 10%. Then, to minimize incomplete and unfilled respondent data, we added 16% of the total sample used, which was 15 samples, resulting in 110 participants, and cluster sampling was employed as the sampling method.

$$n = \frac{N}{1 + Ne^2}$$

$$n = \frac{1.774}{1 + 1.774(0,1)^2} = 94,66 \approx 95$$

The inclusion criteria for respondents were mothers of children aged 6-23 months who had been identified as at risk of stunting based on assessments conducted by health workers. Mothers who were not the primary caregivers of their children were excluded from the study. Data were collected through questionnaires interviewed directly to the respondents, with the validity and reliability of the questionnaire previously tested among 30 mothers with children aged 6-23 months from different sub-districts within the research locations.

Independent variables in this study included the child's age, the mother's age, parity, maternal education level, maternal employment status, attitude, cultural beliefs, and family support. The dependent variable was complementary feeding practices. Complementary feeding practices measured using composite indicators such as Minimum Dietary Diversity (MDD), Minimum Meal Frequency (MMF), Minimum Acceptable Diet (MAD), and the Introduction of Solid, Semi-Solid, or Soft Foods (SSSFs) as recommended by the WHO.

MDD was defined as the consumption of at least five out of eight defined food groups by children in the 24 hours preceding the interview using 24-hour dietary recall. These eight food groups included breast milk; roots, grains, and tubers; nuts and legumes; dairy products; flesh foods; eggs; vitamin A-rich vegetables and fruits; and other vegetables and fruits. The total score of MDD is 8 and categorized as appropriate if score ≥ 5 . The introduction of SSSFs and MMF was measured using questionnaires. The introduction of SSSFs was measured by the proportion of children aged 6-8 months who had consumed solid, semi-solid, or soft foods. The total score of ISSSFs is 3 and categorized as appropriate if score is 3. MMF was determined by the frequency of food consumption according to the recommended MMF for the child's age group the day before the interview. The criteria for MMF were two meals per day for breastfed children aged 6-8 months, at least three meals per day for breastfed children aged 9-23 months, and at least four meals per day for non-breastfed children aged 6-23 months. For breastfeed children, total score of MMF is 2, categorized as appropriate if score is 2 and for non-breastfeed children, total score of MMF is 1, categorized as appropriate if score is 1. MAD was determined by the proportion of children who met both MDD and MMF criteria. The total score of MAD is 1 and categorized as appropriate if score is 1. Complementary feeding practices that did not satisfy one of the above criteria by WHO were classified as inappropriate complementary feeding practices.

The data were first analyzed using univariate, followed by bivariate analysis with Chi-square test to assess the correlation between the independent variables and the dependent variable. This study received ethical approval from the Health Research Ethics Committee at the Faculty of Public Health, Diponegoro University, with the reference number: 338/EA/KEPK-FKM/2024.

RESULTS

Table 1. Distribution of Sample Characteristics

Variables	n	%
Children's age		
6-11 months	27	24.5
12-23 months	83	75.5
Mother's age		
<20 and >35 years	23	20.9
20-35 years	87	79.1
Parity		
Primiparous	33	30
Multiparous	77	70
Mother's Education		
<12 years	32	29.1
≥ 12 years	78	70.9
Mother's Employment Status		

Unemployed	92	83.6
Employed	18	16.4
Attitude		
Negative Attitude	15	13.6
Positive Attitude	95	86.4
Cultural Belief		
Negative Cultural Belief	30	27.3
Positive Cultural Belief	80	72.7
Family Support		
Lack of Support	45	40.9
Good Support	65	59.1
Complementary Feeding Practices		
Inappropriate	67	60.9
Appropriate	43	39.1

The sociodemographic characteristics of the study participants provided several important insights into the factors correlated with complementary feeding practices. Table 1 presents the characteristics of the respondents from a sample of 110 participants, including variables such as the child's age, mother's age, parity, mother's education, and mother's employment status. The majority of the children were aged 12-23 months (75.5%), and most of the mothers were between 20-35 years old (79.1%). Regarding parity, a larger proportion of the mothers were multiparous (70%) compared to primiparous mothers (30%). The education level of most mothers was 12 years or higher (70.9%). A significant portion of the mothers were unemployed (83.6%), with only a small percentage being employed (16.4%). In terms of attitude, the majority of mothers exhibited a positive attitude (86.4%). Additionally, most mothers had positive cultural beliefs (72.7%) and received good support from their families (59.1%). However, the majority of mothers practiced inappropriate complementary feeding (60.9%).

Table 2. Bivariate Analysis

Variables	Complementary Feeding Practices						P-value	OR	95% CI	
	Inappropriate		Appropriate		Total				Lower	Upper
	n	%	n	%	n	%				
Children's Age										
6-11 months	22	81.5	5	18.5	27	24.5	0.012	3.71	1.28	10.75
12-23 months	45	54.2	38	45.8	83	75.5				
Mother's Age										
<20 and >35 years	21	91.3	2	8.7	23	20.9	0.001	9.35	2.06	42.37
20-35 years	46	52.9	41	47.1	87	79.1				
Parity										
Primiparous	27	81.8	6	18.2	33	30	0.003	4.16	1.54	11.21
Multiparous	40	51.9	37	48.1	77	70				
Mother's Education										
<12 years	25	78.1	7	21.9	32	29.1	0.018	3.06	1.18	7.90
≥12 years	42	53.8	36	46.2	78	70.9				
Mother's Employment										
Unemployed	56	60.9	36	39.1	92	83.6	0.985	0.99	0.35	2.78
Employed	11	61.1	7	38.9	18	16.4				
Attitude										
Negative Attitude	13	86.7	2	13.3	15	13.6	0.028	4.93	1.05	23.0
Positive Attitude	54	56.8	41	43.2	95	86.4				
Cultural Belief										
Negative Cultural Belief	27	90.0	3	10.0	30	27.3	0.000	9.00	2.52	32.0
Positive Cultural Belief	40	50.0	40	50.0	80	72.7				
Family Support										
Lack of Support	37	82.2	8	17.8	45	40.9	0.000	5.39	2.17	13.35
Good Support	30	46.2	35	53.8	65	59.1				

Table 2 presents the bivariate analysis using the Chi-square test for the correlation of sociodemographic status, attitude, cultural belief, and family support regarding complementary feeding practices.

For children's age and complementary feeding practices, a higher proportion of children aged 12-23 months had appropriate complementary feeding practices (45.8%) compared to those aged 6-11 months (24.5%). The p-value for children's age was 0.012 (OR: 3.71, CI: 1.28-10.75). This suggests that as children grow older, mothers may become more confident or knowledgeable about appropriate feeding practices. Similarly, a higher percentage of mothers aged 20-35 years practiced appropriate complementary feeding (47.1%) compared to mothers younger than 20 or older than 35 years (8.7%), with a p-value of 0.001 (OR: 9.35, CI: 2.06-42.37). This indicates that mothers within this age group may have more awareness or resources to provide proper complementary feeding. Regarding parity, a greater number of multiparous mothers practiced appropriate complementary feeding (48.1%) compared to primiparous mothers (18.2%), with a p-value of 0.003 (OR: 4.16, CI: 1.54-11.21). This suggests that experience from previous children may positively impact feeding practices. In terms of education level, mothers with 12 or more years of education were more likely to practice appropriate complementary feeding than those with less than 12 years of education, with a p-value of 0.018 (OR: 3.06, CI: 1.18-7.90). This highlights the potential role of education in promoting better feeding practices.

Furthermore, mothers with positive attitudes were more likely to engage in appropriate complementary feeding practices (43.2%) than those with negative attitudes (13.3%), with a p-value of 0.028 (OR: 4.93, CI: 1.05-23.0). This indicates that a mother's attitude may strongly influence feeding practices. Mothers with negative cultural beliefs were predominantly engaged in inappropriate feeding practices (90%), whereas those with positive cultural beliefs had an equal distribution between appropriate and inappropriate practices (50% each). The p-value for cultural beliefs was 0.000 (OR: 9.00, CI: 2.52-32.0). This suggests that culturally supportive beliefs play a key role in fostering appropriate feeding practices. Mothers with strong family support were more likely to practice appropriate complementary feeding (53.8%) compared to those lacking family support (17.8%). Mothers without sufficient family support had a significantly higher rate (82.2%) of inappropriate feeding practices, with a p-value of 0.000 (OR: 5.39, CI: 2.17-13.35). This underlines the importance of family involvement in supporting mothers' complementary feeding efforts. The result shows that no significant association is found between employment status and feeding practices with p-value of 0.985, suggesting that employment status alone does not impact complementary feeding practices.

DISCUSSION

Correlation between sociodemographic status towards complementary feeding practices

This study identified a significant correlation between several sociodemographic factors, including the child's age, mother's age, parity, and mother's education. The child's current age was significantly associated with appropriate complementary feeding practices, with children aged 6–11 months being less likely to receive appropriate complementary feeding. This observation aligns with studies conducted in Ethiopia [17–19], Nigeria [20], and Ghana [21], possibly due to misconceptions among mothers that younger infants cannot digest foods such as eggs, meat, and various fruits and vegetables as well as older children. Additionally, older children tend to have more frequent feeding times, increasing the likelihood of appropriate complementary feeding practices [1].

Children born to mothers younger than 20 years or older than 35 years exhibited a higher prevalence of inappropriate complementary feeding practices compared to those born to mothers aged 20–35 years. This could be because older mothers generally have more child-rearing experience than younger mothers, contributing to better nutritional outcomes for their children [22]. These findings are consistent with previous research by Nigatu (2018) and Fentahun Wubshet (2016) which also found that increasing maternal age is associated with higher breastfeeding prevalence and duration, while younger mothers are more likely to practice early complementary feeding [23–26]. Adolescent and young mothers are less likely to initiate breastfeeding and the success rate of exclusive breastfeeding is lowest among primiparous mothers aged ≥ 35 years [27,28]. Other studies have similarly found that mothers aged 18–35 years tend to practice more appropriate complementary feeding compared to those younger than 18 years or older than 35 years [29].

In this study, parity was also significantly associated with appropriate complementary feeding practices. Children with a birth order of second to fourth (multiparous) were more likely to receive appropriate complementary feeding, a finding supported by previous studies conducted in Ethiopia, Aligarh, and Nepal [30–32]. This may be due to the increased awareness and experience gained by mothers from previous feeding practices, which could enhance appropriate complementary feeding practices [1].

Furthermore, children of mothers with higher education levels were more likely to meet appropriate complementary feeding practices compared to those whose mothers had lower education levels. A similar study in Indonesia found that higher levels of knowledge among women were associated with better fulfillment of children's dietary needs [33], likely because educated mothers possess greater knowledge about child health and nutrition [34–

36]. Educated mothers are also more inclined to follow the advice of nutritionists and ensure their children are fed according to their age-specific nutritional requirements [37].

Working mothers were less likely to meet appropriate complementary feeding practices, a finding consistent with research conducted in the Philippines [38]. This may be because non-working mothers are more likely to stay home with their children, providing them with a healthier diet, which supports the attainment of appropriate complementary feeding practices [39].

Correlation between mother's attitude towards complementary feeding practices

Attitudes are shaped by a combination of knowledge, experience, and beliefs, such that positive knowledge and beliefs contribute to the formation of positive attitudes [40]. Attitude were significantly associated to complementary feeding practice. Mothers who had positive inclination toward complementary feeding practice have a chance to increase appropriate complementary feeding practice. This result is supported by the previous studies conducted in Uganda and Papua New Guinea [41,42]. This is consistent with Green's theory, which posits that positive attitudes lead to positive practices [40].

In this study, the majority of mothers agreed to exclusively breastfeed for at least 6 months, prepare nutritious complementary foods, pay careful attention to feeding practices to prevent stunting, offer a diverse range of foods, ensure appropriate meal frequency, meet the minimum milk feeding frequency, avoid providing foods high in sugar, and ensure sufficient daily fiber intake through fruits and vegetables.

Thus, maternal attitude toward complementary feeding was a significant factor in optimal complementary feeding. Mothers with a positive perception of the benefits of adequately feeding infants tend to adhere to complementary feeding guidelines [43]. This could be due to the counseling the mothers received from health care providers during their use of antenatal care services.

Another study indicated that most mothers exhibited poor attitudes regarding family nutrition, particularly in the selection and procurement of food. Many mothers believed that it was acceptable to disregard proper health guidelines when circumstances forced them to do so, a behavior often influenced by their socio-economic status and the availability of time to prepare food for the family [44]. It is essential to enhance maternal attitude on complementary feeding practice by promoting institutional delivery and increasing the use of antenatal care services.

Therefore, improving attitudes requires a well-planned approach by community health workers and cadres using effective methods, such as providing motivation and information in easily understood language. Mothers need to actively engage with health workers or cadres through sharing sessions, discussions, counseling, and consultations on stunting risks and appropriate feeding practices, enabling them to receive adequate guidance on stunting prevention strategies and proper feeding practices for their children.

Correlation between mother's cultural belief towards complementary feeding practices

Cultural belief systems are founded on a society's indigenous knowledge, religious practices, and traditions. These practices are typically passed down from one generation to the next [45]. Cultural norms, values, beliefs, and attitudes significantly shape individuals' behavior. As a result, sociocultural factors influence parental decisions regarding childcare and feeding practices. Misconceptions about dietary culture can contribute to unhealthy eating behaviors. By shifting people's perceptions and understanding of healthy food, it is possible to foster accurate concepts and promote the development of healthy eating habits [46].

In this study, a portion of mothers provided water and bananas to their infants before the age of 6 months, believing that breast milk alone was insufficient. Additionally, mothers gave herbal or traditional remedies when their children under 2 years old fell ill. A prevailing traditional belief was that if breast milk did not come in immediately after birth, it was acceptable to give newborns water or bananas. Mothers also held the belief that it was fine for a baby to eat without side dishes or meat, as long as they had eaten rice. Additionally, some mothers believed that consuming too much egg and meat could trigger allergies.

Child-feeding practices are often rooted in cultural beliefs that are transmitted within communities and passed down through generations in families [47]. The influence of grandmothers' perspectives, along with community beliefs and traditions, was acknowledged. However, while the advice of pediatricians and community health workers was trusted, it frequently conflicted with deeply rooted cultural and familial traditions [48]. Furthermore, cultural beliefs, including food taboos and perceptions held by mothers, households, and communities, also impact breastfeeding practices and complementary feeding, including the types of foods provided to young children [49].

Health professionals can support optimal infant feeding practices by respecting and integrating beneficial cultural beliefs while minimizing potential harm to babies. However, mothers should be advised against using traditional herbs [50]. Education should be a primary focus of complementary feeding research and initiatives. It is essential to educate mothers on the correct timing and process of transitioning to complementary feeding. Nutrition

education should aim to enhance and correct knowledge and beliefs about these practices. Mothers should receive practical guidance on making informed decisions, considering factors such as affordability, availability, access, and the preparation of nutrient-dense foods[51].

Correlation between mother's family support towards complementary feeding practices

Family support is a continuous process throughout life, with the type and nature of support varying at each stage or life cycle. Support can come from husbands, parents, and siblings [52]. Mothers who receive informational support tend to have higher levels of self-efficacy compared to those who do not. Emotional support, such as encouragement, advice, and appreciation, provides social persuasion. Furthermore, family support enhances a mother's confidence in providing complementary foods to infants at six months of age and enables them to do so appropriately [53].

This study indicates that mostly husbands assist in food preparation, provide adequate financial support, show interest in the food consumed by the child, and both husbands and parents appreciate the feeding practices implemented by the mother. Additionally, both husbands and parents provide healthy food for the child. Husbands offer support and assistance, mothers do not face difficulties in implementing proper feeding practices at home, and mothers feel supported by both their husbands and parents.

In this study, family support is significantly associated with appropriate complementary feeding practices. This indicates that respondents who received strong family support exhibited better behaviors in choosing complementary foods compared to those with weaker family support. Previous research has shown that proper family support in childcare plays a crucial role in children's nutritional status [54]. Specifically, in feeding infants, strong family support helps motivate mothers to provide appropriate complementary foods, offers psychological support, and ensures the preparation of balanced nutrition for the baby [55].

Emotional support can be expressed through trust, care, and attention. Positive emotional support from family, especially from the husband, provides strength to the mother to take action, as the support received influences one's decision to act [56]. Although husbands or other family members may not make daily decisions regarding parenting and feeding, they play a crucial role in supporting the mother. This support helps the mother feel more informed, calm, and reassured about continuing to care for her child, as it provides both material and psychological assistance from the husband.

A mother's decision to breastfeed and the duration of breastfeeding are influenced by various factors, with the support of the husbands being one of the most significant. Without engaging husbands to take an active, positive role in child feeding, interventions aimed at improving child feeding practices are less likely to succeed. Fathers play a crucial role in fostering their child's social and emotional development, and involving them in such interventions can be an effective strategy [57].

The limitations of this study are the reliance on self-reported data introduces the potential for response bias, as participants may have provided socially desirable answers rather than accurate representations of their behaviors or beliefs. This bias could affect the findings related to practices like dietary diversity, meal frequency, and cultural beliefs about feeding.

CONCLUSION

This study identified that child's age (0.012 (OR: 3.71, CI: 1.28-10.75)), mother's age (0.001 (OR: 9.35, CI: 2.06-42.37)), parity (0.003 (OR: 4.16, CI: 1.54-11.21)), mother's education (0.018 (OR: 3.06, CI: 1.18-7.90)), attitude (0.028 (OR: 4.93, CI: 1.05-23.0)), cultural belief (0.000 (OR: 9.00, CI: 2.52-32.0)), and family support (0.000 (OR: 5.39, CI: 2.17-13.35)) were determinant factors of complementary feeding practice. There was no statistically significant correlation between the mother's employment status and complementary feeding practices. Many mothers believed that it was acceptable to disregard proper health guidelines when circumstances forced them to do so, a behavior often influenced by their socio-economic status and the availability of time to prepare food for the family. Health professionals can support optimal infant feeding practices by respecting and integrating beneficial cultural beliefs while minimizing potential harm to babies. However, mothers should be advised against using traditional herbs. Education should be a primary focus of complementary feeding research and initiatives. It is essential to educate mothers on the correct timing and process of transitioning to complementary feeding. Nutrition education should aim to enhance and correct knowledge and beliefs about these practices. Mothers should receive practical guidance on making informed decisions, considering factors such as affordability, availability, access, and the preparation of nutrient-dense foods. Health professionals and policymakers could take several targeted actions, such as implementing culturally sensitive nutritional counseling that respects local beliefs and practices. Additionally, they could involve family members, especially key influencers like grandparents and spouses, in feeding education sessions to ensure that guidance on complementary feeding is reinforced at home.

SUGGESTION

To ensure appropriate complementary feeding practices among mothers with children aged 6–23 months, it is essential to enhance maternal attitude on complementary feeding practice by promoting institutional delivery and increasing the use of antenatal care services. Comprehensive complementary feeding practice counseling, incorporating a gender-sensitive approach, family support, and indigenous knowledge systems or resources, is essential for fostering positive behavior change in complementary feeding interventions. It is recommended that future research explore how particular elements of family support and cultural beliefs impact complementary feeding practices to inform the development of targeted interventions.

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