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**Original Research Article**

# Knowledge, attitude and practices of various feeding practices among the mothers and caregivers of infants aged 0-12 months in the Northeastern State of Nagaland, India

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## ABSTRACT

**Background:** This study was undertaken to determine the knowledge, attitudes and practices of various feeding practices of mothers and caregivers of infants aged 0-12 months in the Northeastern state of Nagaland, India.
**Methods:** A cross-sectional study was conducted from January 2022 to March 2022. A total of 210 mothers and caregivers of infants aged 0-12 months from the Mon district of Nagaland were enrolled in the study. A standardised pre-tested questionnaire consisting of relevant questions on the knowledge, attitudes and practices of the mothers and caregivers regarding various feeding practices, and the most preferred homemade complementary foods provided to the infants was used. All the data collected via different parameters were statistically analysed, and the results obtained were tabulated.
**Results:** The results showed that out of the 210 respondents, 97.14% were mothers, and 2.86% were fathers who were either divorced or widowers and were the sole caretakers of the infants. The KAP questionnaire showed that the respondents' overall knowledge about breastfeeding and various complementary feeding practices was poor (54.0%), their overall attitude was good (38.10%), and their overall practice regarding breastfeeding and various complementary feeding practices was average (60.95%). The study also showed that rice kanji was the most preferred complementary food being used in Nagaland, and semolina porridge was the least favored item (1.90%).
**Conclusion:** This study showed that proper knowledge and socio-demographic profile of mothers and caregivers play an important role in choosing the right complementary foods, determining the time of initiation and following the rightful practices of complementary feeding in infants with the right attitude.

**Keywords:** Breastfeeding, Weaning, Complementary foods, Child nutrition, Northeast India

## INTRODUCTION

The term “breastfeeding” has been historically described as a simultaneous dyadic behaviour: the mother feeding her infant at her breast. It is defined as a child’s right to be breastfed in the Innocenti declaration.[1] Exclusive breastfeeding (EBF) is giving breast milk only to the infant, without any additional food or drink, not even water, in the first six months of life, except for mineral supplements, vitamins, or medicines.[2] The World Health

Organization (WHO) recommends exclusive breastfeeding for the first six months of life and continuation until 2 years, along with complementary foods.[3] EBF for 6 months is important for the health of both the mother and the growing infant by reducing mortality and morbidity. It minimizes the risk of infants experiencing diarrhoea diseases, upper respiratory tract infections, pneumonia, sudden infant death syndrome, malocclusion, and obesity in later life and could improve the child's neurocognitive functions.[2] Breastfeeding, occasionally referred to as the final stage of labour, imparts complete nutrition and early protection against illness and is the ideal way of feeding infants. Initiating early breastfeeding after delivery is also beneficial for the mother as it lowers the risk of the mother's postpartum haemorrhage and anaemia, boosts the immune system and reduces the incidence of diabetes and cancer. Breastfeeding also provides a sense of bonding among the mother and the child, and a sense of well-being and increased self-esteem for many women.[4,5] The mother's diet modulates the fat globules in the breastmilk to secrete micro-RNAs, helpful in targeting several genes in the infant. Studies have also found that multipotential stem cells are also secreted into breastmilk, which persists within the breastfed infants. As a result, breastmilk is considered not only as a potent nutritional supplement for the infant but also as the most specific personalised medicine that the infant receives in their life, when health imprinting and gene expressions are fine-tuned for their future life.[6]

Weaning originates from the Anglo-Saxon word "wenian", meaning "to become adapted to something different". WHO and UNICEF recommend providing infants with adequate weaning for the first two years to protect them from infections and provide adequate nutrition for growth.[7] The transition from an all-milk diet to a diet also consisting of non-milk foods in an infant's first year of life can be referred to as weaning, and this transition is found to have long-term and short-term implications on the infant's growth, development, and health.[8] All solid and liquid foods provided to the infant other than breast milk or infant formula are referred to as complementary feeding or weaning.

WHO states that complementary foods should be introduced to the infant after 6 months when "breast milk alone is no longer sufficient to meet the nutritional requirements in terms of energy and nutrients of infants".[9] It is estimated that yearly 1,00,000 deaths of children younger than 5 years can be avoided just by implementing appropriate complementary feeding. Proper complementary feeding provides an array of opportunities for preventing malnutrition, including stunting, wasting, overweight and obesity. Whereas inappropriate feeding can affect the growth, organ development, and metabolism in children, which can, in turn, have long-term programming effects on a person's health and development.[10] Various factors, such as maternal, socio-environmental and informational factors, play essential roles in shaping complementary feeding practices. Moreover, maternal knowledge regarding infant nutrition and feeding is also necessary to establish proper complementary feeding practices. On the other hand, a negative attitude towards complementary feeding and low maternal self-efficacy are found to be related to inappropriate feeding practices.[11] Poor complementary practices are associated with increased risk of respiratory and gastrointestinal infections, underweight and mortality.[12] Globally, the rate of continued breastfeeding drops from 74% at 1 year of age to 46.3% at 2 years of age. 1/3rd of infants of 4-5 months are fed solid foods, whereas about 20% of infants aged 10-11 months are not introduced to any solid foods. Moreover, globally, only 28.2% of children aged 6-23 months receive a minimally diverse diet.[13]

UNICEF has stated that globally, only 72% of infants aged 6-8 months are introduced to solid foods, i.e., over 1 in 4 children were not fed any solid, semi-solid or soft food. Only 62% children globally, aged 6-23months, consume vegetables or fruits, i.e., nearly 2 in 5 children did not consume fruits or vegetables. Also, despite recommending that children aged 6-23 months can be fed eggs, fish, or meat daily, only 47% children were given eggs, fish or meat, which is even less than half of the child population globally. One in two children globally (49%) were not given the minimum number of meals or snacks recommended daily. Only 34% of children aged 6-23 months were fed foods from at least five of the eight recommended food groups, i.e., nearly 2 in 3 children were not meeting the minimum dietary diversity. Moreover, only 21% of children aged 6-23 months globally consume a minimum acceptable diet, i.e., nearly 2 in 5 children lack a nutrient-rich diet.[14]

In India, the delayed introduction of complementary feeding is widespread, more amongst rural mothers than in urban mothers, mostly due to little knowledge regarding the right time to start weaning, the child not accepting the feed and vomiting, misconceptions, customs, and false beliefs prevalent in the community. It was also seen in various studies that the mean age of introducing complementary foods in different states of India ranged from 7.7 months to 13.50 months on average.[15] Complementary foods in India generally consist of rice, milk, cheese, yogurt, eggs, meat, fish, poultry, pumpkin, ragi, guava, citrus fruits, Cerelac, Nestum, grains, roots and tubers, etc.[12]

Complementary foods vary from one household to another depending on the mother's preference, availability of the foods, the choice of the baby and many other factors. Apart from the commercially available complementary feeds, mothers opt for locally available and homemade foods for the baby due to various reasons, such as choosing budget-friendly options and knowing exactly what they are feeding to their baby, as they can select their fruits, vegetables and other foods instead of relying on the flavors chosen by the manufacturer. Thus,

this paper aims to learn about various breastfeeding practices, including exclusive breastfeeding for the first 6 months of life and various complementary foods provided to infants by mothers and caregivers, mainly locally available or homemade complementary foods.

## METHODS

### *Study design*

A descriptive cross-sectional study was conducted.

### *Study duration*

The study was conducted from January 2022 to March 2022.

### *Sample size*

The sample size of this study was 210 mothers and caregivers.

### *Study population and study area*

The study participants included mothers and caregivers of infants aged 0-12 months who resided in various sub-districts under Mon district, Nagaland. To fulfil the objectives, the study was confined to fourteen towns and villages in the Mon district: Mon, Wakching, Naginimora, Tizit, Hunta, Shangnyu, Longshen, Phomching, Aboi, Chen, Angjangyang, Mopong, Monyakshu, and Tobu. A group of 210 mothers of infants (N=210), aged 0 -12 months, residing in Mon, Nagaland, were randomly selected to obtain information about their various feeding practices. There are 14 subdivisions under Mon district, and from each sub-district, an equal number of samples were collected (n=15).

Figure 1 shows the various study areas included in this study and the sample size collected from them.

### *Inclusion criteria*

The sample was selected considering the following factors, mothers and caregivers who had babies aged between 0 and 12 months, willingness to participate, informed consent.

### *Exclusion criteria*

Children who are not within the age of 0 to 12 months. Unwillingness of the individual to participate in the study. Mothers with medical conditions that prevent them from breastfeeding. Individuals who are not the primary caregivers.

Ethical approval was not taken for this study. However, informed signed consent was taken from all participants before their inclusion in the study.

### *Data collection*

*Socio-demographic economic characteristics*

The socio-demographic profile of the participants was obtained using a standardised pre-tested questionnaire consisting of relevant questions and an observational study on the following topics: age, occupation, income, religion, educational qualification, etc.

*Dietary assessment*

Data on dietary patterns were obtained using a structured questionnaire and observational study, including a Food Frequency Questionnaire (FFQ). During the study, the participants were personally interviewed to report their dietary information for the commonly used food items mentioned in the FFQ during the past year.

*Knowledge, attitude and practices of mothers and caregivers*

A three-point Knowledge, Attitude and Practice scale was adopted. The scale was organized into three sections: nutritional knowledge, nutritional attitude and nutritional practices among the mothers and caregivers of infants aged 0-12 months. The nutritional knowledge section was designed to evaluate the nutritional knowledge of the respondents; the nutritional attitude section was designed to determine the understanding of the attitude towards feeding practices of the respondents; and the last section, the practice section, was designed to evaluate the nutritional practices done by the respondents. The knowledge, attitude and practice section contained 10 sets of statements. Each section contained two possible answers: “yes” and “no”. For evaluation, a score between 0 and 10 was used, with a correct answer considered as one point while an incorrect answer was regarded as zero points. A score less than 50 was considered poor nutritional KAP, 50 to 75 was considered average, and more than 75 was considered to have a good level of knowledge, attitude, and practice.

*Most preferred homemade complementary food provided to the infants*

The participants were asked about their most preferred complementary food, which they provide to the infants regularly at various stages of weaning. The participants were asked about the type of food provided to the body and the time of initiation of these complementary foods; their responses were recorded, and the data collected were analysed.

### *Statistical analysis*

All the data collected via different parameters were statistically analysed, and the results obtained were tabulated. The percentage was calculated using the formulae.

Percentage=Number of responses obtained/total number of respondents×100

## RESULTS

### *Socio-demographic profile*

The socio-demographic profile depicts the combined profile of the background information of the selected mothers and caregivers of the Mon district of Nagaland. A total of two hundred ten mothers and caregivers were surveyed from fourteen sub-districts of Mon district, Nagaland. Table 1 shows the socio-demographic profile of the mothers and caregivers with percentages. Of the respondents, 97.14% were mothers, and 2.86% were fathers who were the sole caretakers. The majority of respondents, 52.38%, fell into the 21-30 age group, followed by 41.43% in the 31-40 age group. In terms of occupation, 37.62% were engaged in farming, 30.95% were self-employed, 17.62% were government employees, and 13.81% were in business. The most common monthly income bracket was ₹11,000-₹20,000 (40.95%). Regarding education, 46.19% had received secondary level education, 30.48% had a higher level of education, and 23.33% had primary level education.

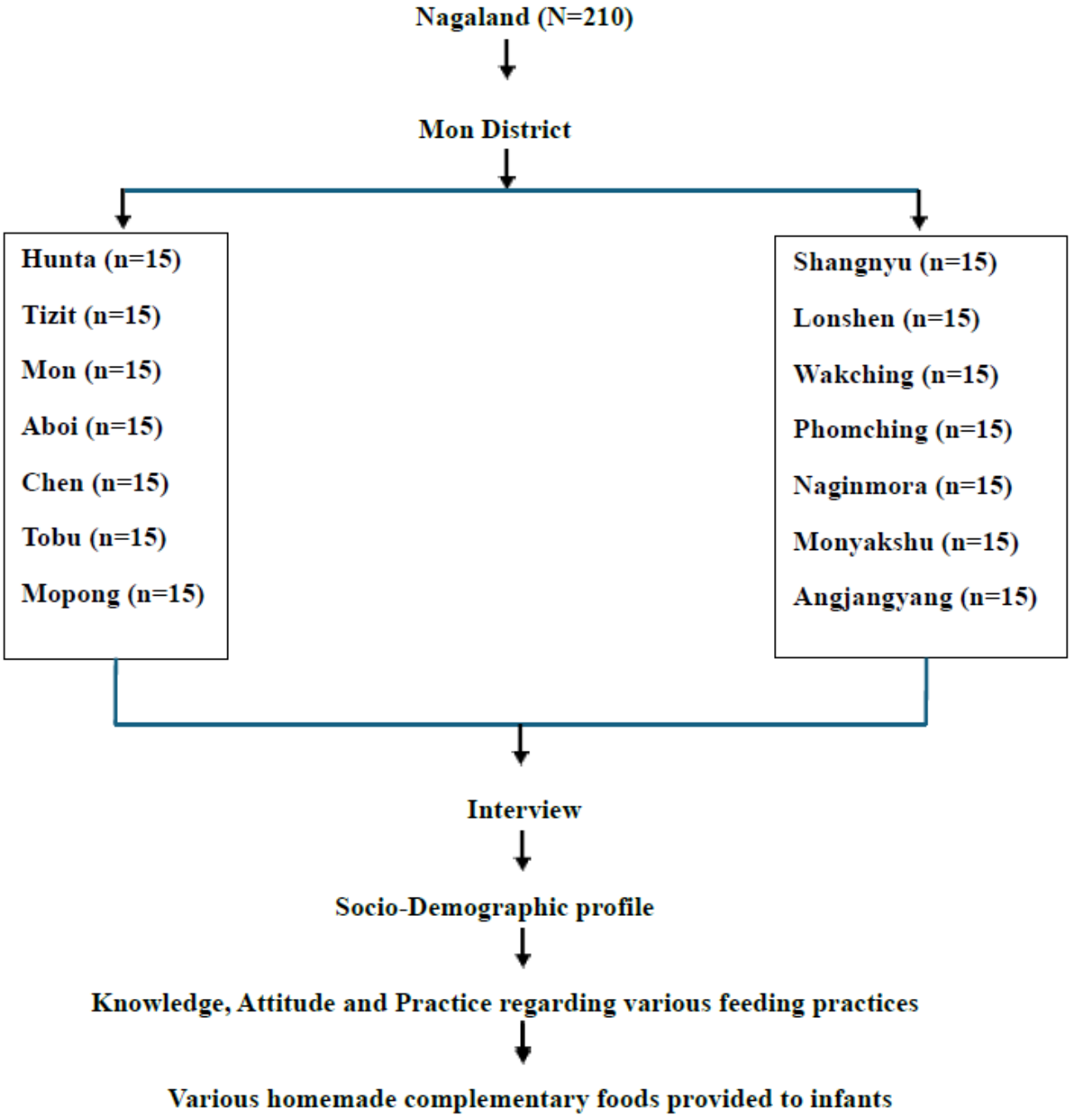


**Figure 1: Sample size and area selected for the study.**

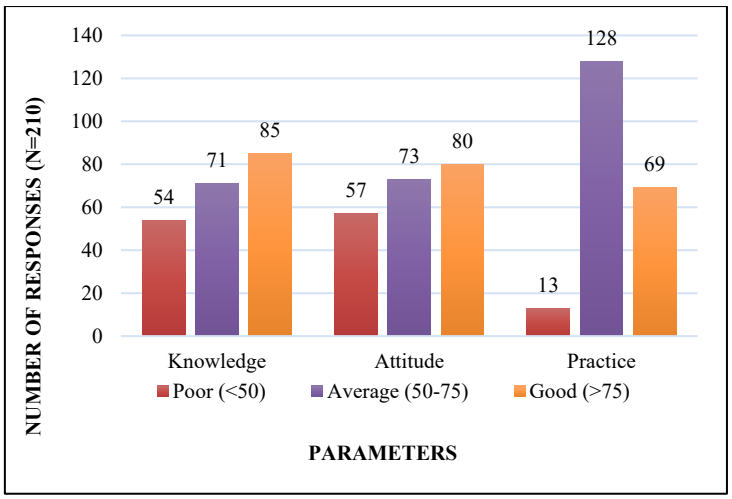


**Figure 2: Knowledge, attitude and practice score of the mothers and caregivers related to various feeding practices.**

**Table 1: Socio-demographic profile of the mothers and caregivers.**

| Characteristics | Number (n=210) | % |
|---|---|---|
| **Sex of the caregiver** | | |
| Male | 6 | 2.86 |
| Female | 204 | 97.14 |
| **Relationship of the caregiver with the baby** | | |
| Mother | 204 | 97.14 |
| Father | 6 | 2.86 |
| Grandmother/Grandfather | 0 | 0 |
| Other | 0 | 0 |
| **Age of the caregiver (in years)** | | |
| 21–30 | 110 | 52.38 |
| 31–40 | 87 | 41.43 |
| 41–50 | 9 | 4.29 |
| 51–60 | 4 | 1.90 |
| **Occupation** | | |
| Government employee | 37 | 17.62 |
| Businessman | 29 | 13.81 |
| Self employed | 65 | 30.95 |
| Farmer | 79 | 37.62 |
| **Income (in ₹)** | | |
| 0-10,000 | 14 | 6.67 |
| 11,000-20,000 | 86 | 40.95 |
| 21,000-30,000 | 74 | 35.24 |
| >30,000 | 36 | 17.14 |
| **Caregivers' educational status** | | |
| None | 0 | 0 |
| Primary school | 49 | 23.33 |
| Secondary school | 97 | 46.19 |
| Higher | 64 | 30.48 |
| **Age of the baby (in months)** | | |
| 0-5 | 124 | 59.05 |
| 6-12 | 86 | 40.95 |
| **Sex of the baby** | | |
| Male | 72 | 34.29 |
| Female | 138 | 65.71 |

**Table 2: Various types of homemade complementary foods provided to the infants by their mothers and caregivers.**

| Characteristics | Number of responses (n=210) | % |
|---|---|---|
| **Rice kanji** | 154 | 73.33 |
| **Sweet potato (mashed)** | 32 | 15.24 |
| **Yam (mashed)** | 16 | 7.62 |
| **Corn porridge** | 27 | 12.86 |
| **Beans porridge** | 5 | 2.38 |
| **Dal khichdi** | 7 | 3.33 |
| **Tapioca (mashed)** | 30 | 14.29 |
| **Stewed apple** | 6 | 2.86 |
| **Semolina porridge** | 4 | 1.90 |
| **Millet porridge** | 12 | 5.71 |
| **Rice-Pumpkin porridge** | 10 | 4.76 |

**Table 3: Time of initiation of complementary food for the infants.**

| Characteristics | Number of responses (n=210) | % |
|---|---|---|
| **Before 6 months** | 40 | 19.05 |
| **At 6 months or later** | 114 | 54.29 |

***Knowledge, attitude, and practice (KAP) Scores of the mothers and caregivers related to various feeding practices***

Figure 2 shows the response of the mothers and caregivers about their knowledge, attitude and practices related to various feeding practices. The KAP scores related to various infant feeding practices were assessed.

*Knowledge*

The results showed that 54.0% of respondents had poor knowledge, 33.81% had average knowledge, and only 12.19% had good knowledge about various feeding practices.

*Attitude*

38.10% of respondents had a good attitude, 34.76% had an average attitude, and 27.14% had a poor attitude towards various feeding practices.

*Practice*

The majority of respondents, 60.95%, demonstrated average practice, while 32.86% had good practice and 6.19% had poor practice of various feeding practices.

***Dietary and food consumption patterns***

Table 2 denotes the various types of homemade complementary food provided to the infants. When asked about the most preferred homemade complementary food, 73.33% of respondents preferred Rice Kanji. This was followed by sweet potato (mashed) at 15.24%, Tapioca (mashed) at 14.29%, and corn porridge at 12.86%. The least preferred homemade foods were dal khichdi (3.33%), stewed apple (2.86%), beans porridge (2.38%), and semolina porridge (1.90%).

***Time of initiation of complementary foods***

Table 3 presents the timing of complementary feeding among the respondents. Of the 210 mothers and caregivers, 154 had introduced complementary foods to their infants. Among them, 54.29% (n=114) initiated feeding at six months or later, while 19.05% (n=40) began before six months. The knowledge and attitude scores of the respondents were generally good; however, in terms of practice, 60.95% demonstrated only an average level.

With regard to complementary food preferences, rice kanji was reported as the most commonly given food (73.33%), followed by sweet potato porridge (15.24%), whereas semolina (suji) porridge was the least preferred (1.90%). The preference for these foods appeared to reflect their availability and accessibility, as most respondents were engaged in farming and 40.95% reported a monthly household income between ₹11,000 and ₹20,000.

## DISCUSSION

Research consistently shows that caregiving has always primarily been a female responsibility, with women making up about 67% of family caregivers and up to 80–90% in childcare centres.[16] This aligns with the findings of the current study, where most caregivers were also women, reaffirming the well-established understanding of gendered roles in childcare.

Feeding practices reported in earlier studies indicate that exclusive breastfeeding, mixed breastfeeding, and formula feeding were practiced by 32.8%, 14.5%, and 52.7% of respondents, respectively.[17] In comparison, the present study observed that while knowledge and attitudes of mothers and caregivers towards breastfeeding and complementary feeding were relatively good, practices were less optimal, with 60.95% of respondents reporting only average practice levels. The disparity between knowledge and practice has similarly been documented in other studies.[18]

Employment and perceptions of inadequate milk supply were identified as key barriers to breastfeeding in earlier research, with 29% of mothers citing employment and 48% citing insufficient breast milk as reasons for resorting to formula feeding.[17] These barriers resonate with the findings of the current study, where cultural and socioeconomic factors, particularly farming-based livelihoods and household income, appeared to influence infant feeding choices.

Knowledge and support from caregivers have been shown to positively impact breastfeeding practices.[19] On the other hand, low awareness regarding the recommended duration of exclusive breastfeeding and the timing of complementary feeding remains a challenge.[20] Similar findings have been reported in the United States, where lack of family and social support or early return to work negatively impacted breastfeeding rates.[21] Other studies suggest that when mothers are given knowledge about the benefits of breastfeeding, they are more inclined to practice it.[22] Likewise, creating a positive breastfeeding attitude and having a supportive group of family, peers, and partners contributes to positive breastfeeding intent.[23] In the present study, mothers largely relied on advice from relatives and healthcare workers, reflecting the need to strengthen community-level messaging.

In terms of complementary feeding, previous studies show that grains, roots, and tubers are the most widely used foods (96%), followed by dairy products (44.9%), eggs (12.4%), and flesh foods (5.7%).[24] Biscuits have also been reported as a common complementary food in India (32%).[25] The present study corroborates these findings, with rice-based preparations, particularly rice kanji, being the most preferred complementary food (73.33%), followed by sweet potato porridge (15.24%), while suji/semolina porridge was least preferred (1.90%). The reliance on such foods appears to be strongly influenced by socioeconomic status and agricultural occupations, as many of the commonly preferred foods were grown in the respondents' fields and were cost-effective, especially during harvest seasons.

Previous evidence also indicates that early initiation of complementary feeding before six months can displace breast milk, reduce nutrient absorption, and increase risks of infections and allergies.[26] In the present study, although most respondents had good knowledge, the practice of timely complementary feeding initiation was inconsistent. This gap may be attributed to maternal perceptions, cultural taboos, and economic constraints.

Mothers in the current study demonstrated good knowledge and attitude towards breastfeeding and complementary feeding, but their practices were only moderately satisfactory. This reinforces prior findings that adequate knowledge does not always translate into improved practice without strong family, cultural and institutional support systems.[27]

### *Limitations*

The geographical barriers of the remote study area made it difficult to access a diverse and representative population. A related challenge was the lack of a sample frame, as no comprehensive list of the target population existed, further hindering the ability to draw a truly representative sample. Furthermore, recruitment challenges were significant, as building the necessary trust to gain participation from the community was difficult.

## CONCLUSION

This study showed that proper knowledge of mothers and caregivers is very important for the timely initiation and rightful practice of complementary feeding in infants with the right attitude. Moreover, the socio-demographic profile of the mothers and caregivers is also very important in deciding which complementary food is introduced chiefly to the infants. It is also seen that the percentage of females taking responsibility for the caregiving role for infants is higher than males.

Lack of knowledge may result in delayed or untimely initiation of complementary foods, which may lead to various health complications in the infant. Thus, it can be concluded that proper knowledge and a healthy attitude towards complementary feeding can work wonders for the timely initiation of complementary foods in infants.

### *Recommendations*

Further research can be conducted on a large scale in all the districts of Nagaland to study the understanding of rural as well as urban people on exclusive breastfeeding and the importance of timely initiation of complementary feeding in infants. Also, very few studies have been conducted on the complementary feeding practices in the Northeastern states of India, so further research can be done in all eight Northeastern states to better understand their food habits and how they impact complementary feeding practices in infants

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