IOSR Journal of Nursing and Health Science (IOSR-JNHS)
e-ISSN: 2320–1959.p- ISSN: 2320–1940 Volume 10, Issue 6 Ser. III (Nov. – Dec. 2021), PP 01-19
www.iosrjournals.org

Knowledge regarding infant, young child feeding practices among mothers in Mirpur slum area, Dhaka.

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Abstract
Introduction:
Exclusive breastfeeding for the first six months followed by complementary feeding along with breastfeeding is crucial for proper growth and development of a child. Lack of knowledge and proper feeding practices contribute to higher childhood morbidity and mortality. Assessment of mother's knowledge about breast feeding and complementary feeding and their practices and study of factors affecting them is of outmost important for health planners and policy makers.
Objectives:
To study the knowledge and practices of mothers about complementary feeding in infant and young child and factors influencing it.
Methodology:
A slum based cross-sectional study was conducted between January, 2020 to August, 2020 at Mirpur slum area Dhaka, involving mothers of children from 6 to 24 months of age who applying systematic sampling technique excluding mothers of child less than 6 months and more than 24 months and using semi-structured questionnaire. During the study period, 105 mothers were interviewed.
Results:
Eighty-seven percent of mothers had knowledge about the duration of exclusive breast feeding but only 33.0% practiced it and only 21.0% breast fed their children up to 3 months. Eighty-seven percent of mothers knew when to start complementary feeding and 53.27% of mothers used the marketed weaning food. lito alone was offered by 28.27% as complementary food. Though 36.6% had proper knowledge of frequency of complementary feeding, only 33.27% were actually practicing it and 9.9% were offering more frequent than recommendation. About half of the mothers fed their child with the food of appropriate consistency and 66.0% fed with the appropriate amount.
Conclusions:
There was a knowledge and practice gap of duration of exclusive breast feeding and initiation and continuation of ideal complementary feeding.
Recommendation:
Finally it can be recommended that further large scale study should be done with appropriate sample size and study design.

Date of Submission: 20-11-2021 Date of Acceptance: 05-12-2021

List of acronym

AA	**:**	Arachidonic acid
AAP	:	American Academy of Pediatrics
AGE	:	Acute gastroenteritis
BF	**:**	Breastfeeding
CI	**:**	Confidence interval
CF	:	Complementary feeding
DoHS	:	Department of health services
EBF	:	Exclusive breastfeeding
EGF	:	Epidermal growth factor
GH	:	Growth hormone
GI	:	Gastrointestinal
HIV	:	Human immunodeficiency virus
IBFAN	;	International breastfeeding action network

IEC	:	Information, education and communication
IF	:	Infant formula
IgA	:	Immunoglobulin A
IGFs	:	Insulin like growth factors
INGO	:	International nongovernmental organization
IRB	:	Institutional review board
IYCF	:	Infant and young child feeding
MoHFW	:	Ministry of health and family welfare
NAMS	:	National academy of medical science
NGF	:	Nerve growth factor
NGO	:	Nongovernmental organization
PHC	:	Primary health centre
PL	:	Placental lactogen
TGF	:	Transforming growth factor
UNICEF	:	United nations international children's emergency fund
WBTI	:	World breastfeeding trend initiative
WHO	:	World health organization
SPSS	:	Statistical package for the social science

I. Introduction

An appropriate diet is critical in growth and development of children especially in the first two years of life. Breastfeeding gives children the healthiest start in life. Breast milk provides all the energy and nutrients needed for the first six months of life and continues to partially fulfill children's nutritional needs until age 2 and beyond, alongside nutritious complementary foods. The benefits of breastfeeding for mothers and babies are universal and apply as much to industrialized societies as to low- and middle-income countries.[1,2] An effective exclusive breast feeding coverage has been estimated to avert 13%–15% of deaths among children under five years of age especially in middle and low earning settings.[3] Childhood mortality is a very tragic phenomenon of the world. It is still high in most of the developing countries. Bangladesh is working towards achieving the Sustainable Development Goals (SDGs) by 2030 to reduce maternal and child mortality. Bangladesh has been trying its best to achieve these goals though it has a long way to go.[4] Bangladesh is Substantial global progress has been made in reducing child deaths since 1990. Substantial global progress has been made in reducing child death since 1990. The total number of under -5 deaths worldwide has decline from 12.6 million in 1990 to 5.3 million in 2018. On average, 15,000 children under -5 die each day compared with 34,000 in 1990. Since 1990, the global under -5 mortality rate has dropped by 59%, from 93 deaths per 1,000 live births in 1990 to 39 in 2018. This is equivalent to 1 in 11 children dying before reaching age 5 in 1990, compared to 1 in 26 in 2018.

Poor nutrition increases the risk of illness, and is responsible, directly or indirectly.[5] Inappropriate nutrition can also lead to childhood obesity which is an increasing public health problem in many countries there are several factors that contribute to malnutrition. The main contributing factors for under five stunting are sex of child, child age, diarrhoea episode, deprivation of colostrum, duration of breastfeeding, prelacteal feeds, type of food, age of introduction of complementary feeding and method of feeding.[6] Infant and young child feeding (IYCF) practices recommend exclusive breastfeeding up to age of six months timely initiation of feeding solid, semisolid foods from six months onwards. It also recommends feeding small amounts, increasing the amount of foods and frequency of feeding as the child gets older while maintaining breast feeding as demanded by the child.[7]

There is strong evidence that human milk feeding decreases the incidence and/or severity of a wide range of infectious diseases.[8] United Nations International Children's Emergency Fund (UNICEF) has launched the baby friendly hospital initiative (BFHI) to strengthen maternity practices to support breastfeeding. One of the important components of this initiation is to start breast feeding immediately after birth. The frequency, timing and duration of breastfeeding are also important. Variation in these parameters can have an important impact on child health. Complementary feeding (CF) is another very important component of infant feeding. After 6 months, mother's milk alone is not sufficient for the growing child and CF should be started timely and in adequate amounts with good quality. Frequency, quality and amount of top feeds given during the weaning period to children are important factors in the pathogenesis of malnutrition. Inappropriate feeding practice during this period is found to be the major cause of malnutrition.[9]

Complementary feeding is required in appropriate quantity, quality, and frequency to fulfill the daily energy needs for growth and development of child. Cultural practices beliefs and knowledge of parents regarding appropriate feeding practices influence CF. It has been shown in India that only 17.5% of mothers started complementary feeding at recommended time (at 6 month of age), 77.0% had delayed complementary feeding and 5.5% started complementary feeding early.[10]

In Bangladesh, the slum population of Bangladesh, women in the intervention group initiated breastfeeding earlier, were less likely to provide pre-lacteal and post-lacteal foods to their infants and more likely to practice EBF at 5 months compared to the control group.[11] Thus, there are strategies available that are effective in changing mothers' feeding practices in the developing countries that might be beneficial for child health, growth and development. Despite these efforts to promote EBF, however, the vast majority of Bangladeshi mothers introduced non-breast milk foods before the infant is 6 months of age. It is these feeding decisions and the practices that follow from them, that deserve further attention, both in terms of understanding the practices and their causes and to fully develop theoretical models that explain those practices.

Knowledge on feeding practices of infants and young children (IYC) is crucial for undertaking or improving health and nutrition programme in a country. The knowledge and practices for infant and young children feeding, one of the determinants of health and nutrition has not been well studied in Nepal. Promotion of optimal breast feeding and complementary feeding has been recognized as a key priority of Ministry of Health and Family Welfare (MOHFW) and national strategy on IYCF has already been drafted. So, it is presumed that it is worthy to conduct the study to assess the practice of complementary feeding in children between 6 months to 24 months of age and to assess the knowledge regarding complementary feeding and reasons for inappropriate feeding practices for evidence based programme planning and intervention. It is also envisaged that it will provide information about existing knowledge and practices of the mothers so that the appropriate steps could be taken to fulfill the goals of the appropriate complementary feeding practices.

1.2 Rationale of the study

"The greater our knowledge increases the more our ignorance unfolds"
-John. F. Kennedy

Exclusive breastfeeding for the first six months followed by complementary feeding along with breastfeeding is crucial for proper growth and development of a child. Lack of knowledge and proper feeding practices contribute to higher childhood morbidity and mortality. Complementary foods need to be nutritionally adequate, safe, and appropriately fed in order to meet the young child's energy and nutrient needs. However, complementary feeding is often fraught with problems with foods being too dilute, not fed often enough or in too small amounts, or replacing breast milk while being of an inferior quality. Both food and feeding practices influence the quality of complementary feeding and mothers and families need support to practice good complementary feeding. Many health scientists, policy makers, planners and administrators have studied Slums in urban areas from different perspectives. But the present study is somewhat different from other studies as my focus is on the complementary breast feeding practice of slum's mothers how one influences the other and what its spread is with the mainstream practice found in the city. The present study not only analyses the physical and demographic condition but also the complementary feeding style practice of the slum dwellers as stated above. The study is relevant as it may help us to get an idea the way of life in Slum in Dhaka city as well as in others city of the Country. This study will provide information about Complementary Feeding knowledge and practices in slum area. This will enable the researcher, health planners and policy makers to assess the impact of Bangladesh's Complementary Feeding awareness campaign and Complementary feeding education drives in the slum. The findings of the study may be useful in designing health education programmes that are targeted at mother education considering their knowledge, attitudes, beliefs and practices pertaining to Complementary feeding and breast feeding behaviors. It will also help those who are very much interested about Complementary feeding practices and those who want to know eagerly about the subject that can Complementary feeding related problem prevention properly. As these studies inquire on different aspects of the Complementary feeding, it will help in the long run to study of Complementary feeding practices.

1.3 OPERATIONAL DEFINITION

Infant and young child feeding practice: It included the following practices: early initiation of breast feeding, colostrums feeding, use of bottle for feeding, prelacteal feeding, duration of exclusive breast feeding, introduction of complementary feeding, meal frequency, use of oil/ghee in preparing child's food and feeding practice of diverse foods.

Infant and young children: Children less than two years of age (between 0-23 months)

Early initiation of breastfeeding: Proportion of children born in the last 24 months who were put to the breast within one hour of birth.

Exclusive breastfeeding: The infant has received only breast milk from the mother or a wet nurse, or expressed breast milk, and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

Bottle-feeding: Requires that the infant received any liquid (including breast milk) or semi-solid food from a bottle with nipple/teat.

Complementary feeding: It included feeding breast milk (including milk expressed or from a wet nurse) and solid and semi-solid foods. It allowed any food or liquid including non human milk and formula feeding for the children 6-23 months of age. It did not include the non breast feed children.

Meal frequency: It was defined as the number of times the child was fed as per the age requirement in addition to the breast-feeding per day. According to WHO, two meals per day for 6 months old children, 3 times for 7-8 months children, 3 meals and 1 snack for 9-11 and 3 meals and 2 snacks for 12-24 months old children.

1.4 Research Question:

What is the level "Knowledge regarding infant young child feeding practices among mothers' in Mirpur slum area, Dhaka, Bangladesh ?

1.5 Limitations of Study

1. This was a slum based study, so it might not have represented the community as whole.
2. Recall period might have introduced recall biases in relation to questionnaires relating to breast feeding and initiation of complementary feeding as the age of the children ranged up to 24 months.
3. There could be confusion regarding the unit of measurements like glass to the mothers. This might again be a source of bias in the study.

II. Literature Review

Exclusive breast feeding till age of 6 months followed by complementary feeding along with breast feeding as per demand of the child is the recommendation for optimal growth and development of children. However, the knowledge and practices of breastfeeding and complementary feeding vary from country to country, region to region within a country as well as within the same community. The different literatures on these issues are reviewed as follows.

Breast feeding

The WHO/UNICEF defined breastfeeding as child receiving breast milk direct from the breast or expressed. Likewise exclusive breastfeeding means the infant has received only breast milk from the mother or a wet nurse, or expressed breast milk and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements, or medicines. Similarly, predominant breastfeeding means the infant's predominant source of nourishment has been breast milk. However, the infant may also have received water and water-based drinks (sweetened and flavored water, teas, infusions, etc.), fruit juice; oral rehydration salts solution (ORS), drop and syrup forms of vitamins, minerals and medicines, and ritual fluids (in limited quantities). With the exception of fruit juice and sugar water, no food-based fluid is allowed under this definition. Exclusive breastfeeding and predominant breastfeeding together constitute full breastfeeding. Bottle-feeding means the child has received liquid or semi-solid food from a bottle with a nipple/teat.[13]

Complementary Feeding

Complementary feeding is defined as the process started when breast milk is no longer sufficient to meet the nutritional requirements of infants, and therefore, other foods and liquids are needed along with breast milk. The target range for complementary feeding is generally taken to be 6 to 24 months of age (When describing age ranges of 6–24 months, it means that the child has completed 6 months but has an age less than 2 years) even though breastfeeding may be continued beyond two years.[15] When breast milk is no longer enough to meet the nutritional needs of the infant, complementary foods should be added to the diet of the child. The transition from exclusive breastfeeding to family foods referred to as complementary feeding typically covers the period from 6 to 18-24 months of age, which is a very vulnerable period.[16] It is the time when malnutrition starts in many infants, contributing significantly to the high prevalence of malnutrition in children under five years of age world-wide. WHO estimates that 2 out of 5 children are stunted in low income country. From the

age of 6 months, an infant's need for energy and nutrients starts to exceed what is provided by breast milk and complementary feeding becomes necessary to fill the energy and nutrient gap.[17]

If complementary foods are not introduced at this age or if they are given inappropriately an infant's growth may falter. In many countries, the period of complementary feeding from 6–23 months is the time of peak incidence of growth faltering, micronutrient deficiencies and infectious illnesses.[18]

Even after complementary foods have been introduced, breastfeeding remains a critical source of nutrients for the young infant and child. It provides about one half of an infant's energy needs up to the age of one year and up to one third during the second year of life. Breast milk continues to supply higher quality nutrients than complementary foods and also protective factors. It is therefore, recommended that breastfeeding on demand is continued with adequate complementary feeding up to 2 years or beyond.[15]

Complementary foods need to be nutritionally adequate, safe, and appropriately fed in order to meet the young child's energy and nutrient needs. However, complementary feeding is often fraught with problems, with foods being too dilute, not fed often enough or in too small amounts, or replacing breast milk while being of an inferior quality. Both food and feeding practices influence the quality of complementary feeding and mothers and families need support to practice good complementary feeding.[18]

Complementary feeding is started on age of 6 months because enzyme system and gastrointestinal wall have adequately matured to digest a variety of foods by 6 months. Head and neck muscles are strong enough for head control and the coordination of tongue, lip and swallow. Oral reflexes have developed to swallow semi-solid and solid foods, immune system is ready to handle other foods and to protect against pathogens and allergies and kidney system will not be overloaded. After 6 months of age, it becomes increasingly difficult for breastfed infants to meet their nutrient needs from human milk alone. Furthermore, most infants are developmentally ready for other foods at about 6 months of age. In settings where environmental sanitation is very poor, waiting until even later than 6 months to introduce complementary foods might reduce exposure to food-borne diseases.

However, as infants begin to actively explore their environment at this age, they will be exposed to microbial contaminants through soil and objects even if they are not given complementary foods. Thus, 6 months is the recommended appropriate age at which complementary foods to be introduced.[1]

The recommended age for introduction of complementary foods has become a controversial issue: 4–6 months or >6 months. The arguments for both of these options are comprehensively reviewed in the recent literature, including a discussion about the time of introduction of complementary foods those in terms of benefit-risk ratio, morbidity, growth and nutritional status of children.[15]

A Study in Bangladesh, the slum population of Bangladesh, women in the intervention group initiated breastfeeding earlier were less likely to provide pre-lacteal and post-lacteal foods to their infants and more likely to practice EBF at 5 months compared to the control group.[11]. Thus, there are strategies available that are effective in changing mothers' feeding practices in the developing countries that might be beneficial for child health, growth and development. Despite these efforts to promote EBF, however, the vast majority of Bangladeshi mothers introduced non-breast milk foods before the infant is 6 months of age. It is these feeding decisions and the practices that follow from them that deserve further attention both in terms of understanding the practices and their causes and to fully develop theoretical models that explain those practices.[9]

Guiding principles for complementary feeding

After 6 months of age, it becomes increasingly difficult for breastfeed infants to meet their nutrient needs from human milk alone. Furthermore, most infants are developmentally ready for other foods at about 6 months. In settings where environmental sanitation is very poor, delayed introduction of complementary foods might reduce exposure to food-borne diseases. However, because infants are beginning to actively explore their environment at this age, they will be exposed to microbial contaminants through soil and objects even if they are not given complementary foods. Thus, 6 months is the recommended appropriate age to introduce complementary foods[19] During the period of complementary feeding, children are at high risk of under nutrition.[20]

Amount of complementary foods should be started at six months of age with small amounts of food and increase the quantity as the child gets older, while maintaining frequent breastfeeding. The energy needs from complementary foods for infants with "average" breast milk intake in developing countries are approximately 200 kcal per day at 6−8 months of age, 300 kcal per day at 9−11 months of age, and 550 kcal per day at 12−23 months of age. In industrialized countries these estimates differ somewhat (130, 310 and 580 kcal/d at 6−8, 9−11 and 12−23 months, respectively) because of differences in average breast milk intake and increase in the number of times that the child is fed complementary foods as he/she gets older. The appropriate number of feedings depends on the energy density of the local foods and the usual amounts consumed at each feeding. For the average healthy breastfed infant, meals of complementary foods should be provided 2−3 times per day at 6−8 months of age and 3−4 times per day at 9−11 and 12−24 months of age. Additional nutritious

snacks (such as a piece of fruit or bread or chapatti with nut paste) may be offered 1-2 times per day, as desired. Snacks are defined as foods eaten between meals, usually self-fed, convenient and easy to prepare. If energy density or amount of food per meal is low or the child is no longer breastfed more frequent meals may be required.[15]

Complementary foods are often of inadequate nutritional quality or they are given too early or too late in too small amounts or not frequently enough. Premature cessation or low frequency of breastfeeding also contributes to insufficient nutrient and energy intake in infants beyond 6 months of age.

The *Guiding principles for complementary feeding of the breastfed child* set standards for developing locally appropriate feeding recommendations.[15] They provide guidance on desired feeding behaviors as well as on the amount, consistency, frequency, energy density and nutrient content of foods.

Current status of infants and young children feeding

Poor breastfeeding and complementary feeding practices are widespread. Worldwide, it is estimated that only 34.8% of infants are exclusively breastfed for the first 6 months of life, the majority receiving some other food or fluid in the early months.[21]

A comparative study of infant and young child feeding practices in South Asian Countries found that lowest rates of timely initiation of breast feeding were found in India (23.5%) and Bangladesh (27.5%) as compared to Nepal (35.4%) and Sri Lanka (56.3%). Similarly, exclusive breastfeeding rates were almost equal in Bangladesh (42.5%) and India (46.4%) but higher in Nepal (53.1%). Complementary foods are often introduced too early or too late and are often nutritionally inadequate and unsafe. Data from 64 countries covering 69.0% of births in the developing world suggest that there have been improvements in this situation

A Slum based study conducted in Pokhara Municipility of Nepal on infant feeding practices revealed that almost 60.0% of mothers were practicing exclusive breast-feeding at 5 months, almost 40.0% started complementary feeding before the recommended age of 6 months and about 22.0% delayed introduction of complementary feeding.[24]

III. Methodology

3.1 Conceptual frame work of variables

Independent variables **Dependent variables**

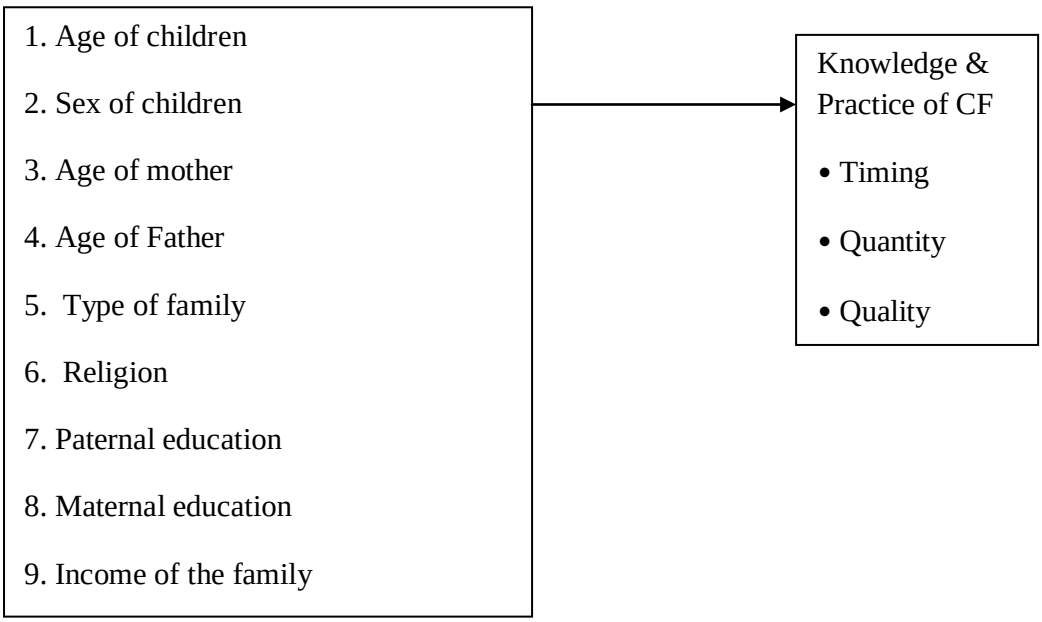


Fig: Conceptual frame work of variable

3.2 Study objective

General Objective

• To assess knowledge regarding infant, young child feeding practices among mother's and factors influencing it.

Specific Objectives

• To assess the socio-demographic charities of Study Population
• To assess the knowledge of mothers regarding complementary feeding.
• To evaluate the practices of complementary feeding in terms of quantity, quality and timing.
• To determine the factors influencing the inappropriateness of complementary feeding.

3.3 Study design:

This study was a Cross sectional descriptive study.

3.4 Place of the study:

This study was conducted in the Slum dwellers of a slum in Mirpur, section -1 of Dhaka city.

3.5 Study Population:

Mothers of children of 6 to 24 months of age of a slum in Mirpur, section-1 of Dhaka city.

3.6 Study period:

The study duration was conducted for eight months started from January to August, 2020

3.7 Sample size:

Sample size estimated (Study design) $n= Z^2pq/d^2$

(Here, n= Desired sample Size, Z=standard normal distribution, usually considered 1.96 at 95% Confidence Interval (CI), P= population of the target population, it is regarded 50% (0.5), q= 1-p therefore, 1-0.5=0.5, d= Allowable error in the study 5% (0.05)

As per equation, sample size

n = (1.96)2 x 0.5/ (0.05)2
= 384.16 (384)

Calculated Sample Size = 384

Feasible SS= 5 x 21 days=105 (due to the time limitation & resource constrain).

3.8 Sampling Technique:

Convenience sampling technique was followed.

3.9 Data collection Instruments:

The instruments for data collection were structured and semi structured questionnaire according to the objectives of the study.

3.10 Criteria of Data collection:

Inclusion criteria:

- All mothers of 6 months to 24 months children in the study area
- Mother who has given consent.

Exclusion criteria:

- Mothers of child less than 6 months and more than 24 months.
- Mothers of children with known anomalies.
- Mothers whose child was very sick needing emergency care.
- Mothers who failed to provide consent for any reason

3.11 Pre-testing and Finalization:

I have designed the draft interview schedule and also completed pre testing. Based on findings of pre-testing finding the translation, consistency and integrity of the interview schedule was checked then finalized the schedule.

3.12 Data management and analysis plan:

The data was analyzed using Statistical Package for Social Science (SPSS) version system.

3.13 Data processing and Analysis:

Data processing involved the following step:

- Questionnaires making.
- Data collection & Cross-checking.
- Data editing.
- Data entry & Entry verification.
- Entering data as per-questionnaires structure is SPSS.
- Verifying the logic and accuracy of the data as per filled up questionnaire
- Inputting data into SPSS work sheet.
- Tabulating as per objective and requirement in Quantum (an upgraded-16 version of SPSS)
- Program development as per analysis plan.
- Report generation.

3.14 Ethical Consideration:

- Permission from Ethical review committee of Bangladesh Open University
- The study was conducted with the formal permission of the Community leaders of the study area.
- Informed oral consent was obtained from each of the respondent.
- Confidentiality of the respondents was maintained.
- Respondents preserve the rights to refuse and withdraw from the study accepted.

3.15. Activity Schedules:

Months	Sample Collection	Question Making	Data Collection	Data Analysis	Report Writing
January-July	√	√			
August	-	-	√	√	
September-October	-	-	-	√	√

Figure: Time Frame of Research

3.16 Area Description:

An overview of Mirpur Slum

- Established: 1980
- Location: Ward no. 12 of DNCC under Mirpur sectoin-1, Dhaka-1216
- Previously known: Karim Mia's slum.
- Area of the slum: One acre.
- Actual Owner of Land: Ministry of Housing and Public Works and Dhaka WASA.
- Total population: 1250.
- Total Families: 277

IV. Results

This chapter deals with the description of the data obtained from 105 respondents of the study. The part includes the descriptive information about the characteristics of study population and knowledge and practices related to infant and young child feeding in relation to ideal timing, frequency and duration.

Child age in months

Almost half (50.8%) of the under 2 children were in the age group of more than 12 months and 25.8% were under 6-8 months. The range was 6 months to 24 months with the mean of 12.84 months with the SD of 5.529.

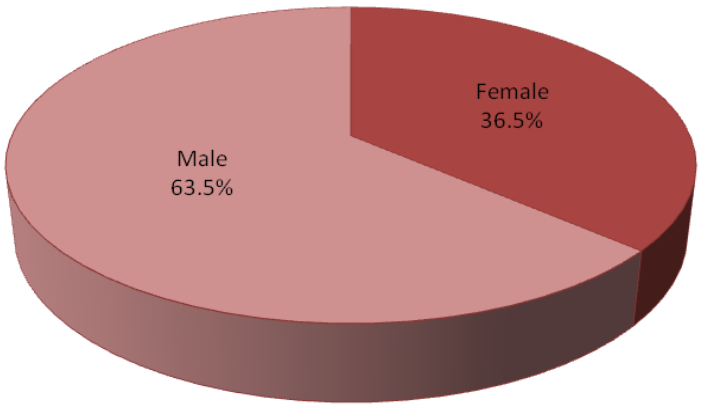
Table No 4. 1: Distribution of the Child age in months

Age	Frequency (N)	Percentage (%)	Mean age + SD
6-8 Months	27	25.8	12.84+5.529
9-11 Months	25	23.4	
12 or above	53	50.8	
Total	**105**	**100**	

Gender of children

Among the studied children 63.5% were males and rest was females.

Figure No 4.1: Gender distribution of the Child.



Age of Respondents

From the table below, it is clear that 7.99% of the respondents above 30 years old beside 80.36% of the respondents belonged to 21-30 years, 11.65% of the respondents 20 years old among all respondents

Table No 4. 2: Distribution of the respondents by age

Age	Frequency (N)	Percentage (%)
<20	128	11.65
21-30	884	80.36
31-40	88	7.99
Total	**105**	**100**

Educational status of respondents

From the table below, it is obvious that 66.7% of the respondents were class I-V group, 26.7% of the respondents Illiterate and 6.7% the respondents were class VI-X.

Table no 4.3: Distribution of the respondents by educational status

Educational status	Frequency (N)	Percentage (%)
Illiterate	28	26.7
Class I-V	70	66.7
Class VI-X	07	6.7
Total	**105**	**100**

Religion

The study shows that 100% of the respondents were Muslim.

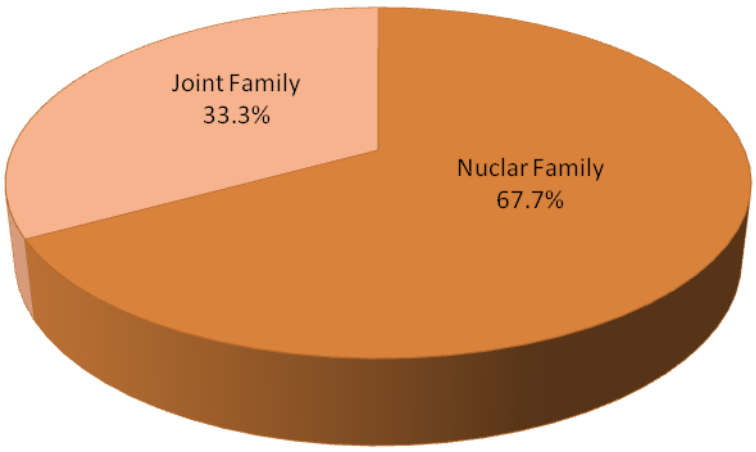
Table no 4.4: Distribution of the respondents by Religion

Religion	Frequency (N)	Percentage (%)
Islam	105	100
Hindu	0	0
Total	**105**	**100**

Family Structure

From the below figure above, it is clearly evident that 66.7% of the respondents were nuclear family and 33.3% of the respondents were extended family.

Figure no 4.2: Distribution of the respondents by Family structure



Family member

It is clearly evident that 46.7% households living with 1-3 Members, 4-5 Members 20% Households and 6 and above members living 33.3% households.

Table no 4.5: Distribution of the respondent's family member.

Family member	Frequency (N)	Percentage (%)
1-3	49	46.7
4-5	21	20.0
6 and above	35	33.3
Total	**105**	**100**

Monthly Income of the family

It is clear that 70% of the respondents earn 5001-10000Tk. a month, 30% of the respondents earn taka 1001 to taka 5000Tk.

Table no 4.6: Distribution of the respondent according to monthly Income of the family.

Income	Frequency (N)	Percentage (%)
>5000	74	70
5,001-10,000	31	30
Total	**105**	**100**

Knowledge of mother about infant and young child feeding

Table 4.7 shows that Most of the mothers (87.3%) had knowledge about the duration of exclusive breastfeeding and the time to start complementary feeding. Only 12.7% mothers had no ideas about when to start complementary feeding as well as the duration of exclusive breast-feeding. In contrast to the knowledge to start complementary feeding and exclusive breast feeding it was observed that 6 out of 10 mothers did not know about the frequency of feeding to their child as per age of their child. Only 36.6% mother knew about the frequency of feeding required to their child.

Table 4.7: Mother's knowledge related characteristics of infant and young child feeding. (n = 105)

Characteristics		Frequency (N)	Percentage (%)
Knowledge to start complementary feeding			
Yes	92	87.3	
No	14	12.7	
Total	105	100	
Knowledge about duration of exclusive breast feeding			
Yes		92	87.3
No		14	12.7
Total		105	100
Knowledge of frequency of complementary feeding			
Yes		38	36.36
No		67	63.4
Total		105	100

.

Practices of Infant and young child feeding

Below table shows the practices about the complementary feeding**.** One fifth (91.1%) had practice of exclusive breast feeding less than 6 months. However, it was observed that 8.9% mothers had practice of exclusive breast feeding more than 6 months.

The commonest reason for prolonged exclusive breast feeding was their perception of breast milk being enough for their children and few (1.81%) did not know why they were practicing so.

Almost 90.0% mothers offered their clostrum to their child as first feed and 11.0% mothers used infant formulas as first feed to their child. Whereas vey negligible number had offered the cow/buffalo milk and water as first feed to their child. Around one third (28.27%) mothers used *Lito* as the complementary food and one fourth (25.46%) mothers used both *lito* and *dal bhat* as the complementary food, whereas, around one fifth respondents used *lito* and c*erelacs* as the complementary food for their child.

Around 80.0% mothers made the lito with mixing cereals and pulses, however, 7.90% mothers used only cereals for making lito and 13.27% used ghee during preparation of lito.

Almost half of the respondents used commercial complementary food for their child and almost 2/3rd of mothers used separate container for the complementary food preparation.

Table: 4.8: Practice related characteristics of Infant and young child feeding

Characteristics	Frequency (N)	Percentage (%)
Exclusive breast feeding (n=105)		
Before 6 month	96	91.1
After 6 months	09	8.90
Complementary food offered		
Lito	30	28.7
Cerelacs	07	6.72
Dal bhat	08	7.54
Lito, cerelac	20	19.09
lito ,dal ,bhat	27	25.46
Cerelac, dal bhat	05	4.63
All (lito,cerelac, dal bhat)	08	8.27
Reason for delayed complementary feeding (n=09)		
Vomits everything	1	0.18
Milk is enough	5	6.45
Elder told to do so	1	0.27
Child did not accept other foods	1	0.09
Don't know	1	1.81
Preparation of complementary feeding (n=105)		
Cereals	08	7.91
Cereals and pulses	82	78.73
Cereals pulses and ghee	14	13.27
Cereals pulses ghee and green vegetables	1	0.09
Use of marketed complementary feeding		
Yes	56	53.27
No	49	46.72
Use of separate container for the complementary feeding		
Yes	70	66.90
No	35	33.09

Frequency, consistency and amount of practiced complementary feeding

The table shows that feeding practices in relation to quality, quantity and timing of complementary feeding. More than half (56.81%) of mothers fed their child less than prescribed frequencies per day. Where as one among 10 mothers fed more frequent than required and only one third mothers fed their children as per recommendation.

Likewise half of the mothers fed their child either thin or thick food and 4 among 5 mothers feed their child appropriate amount.

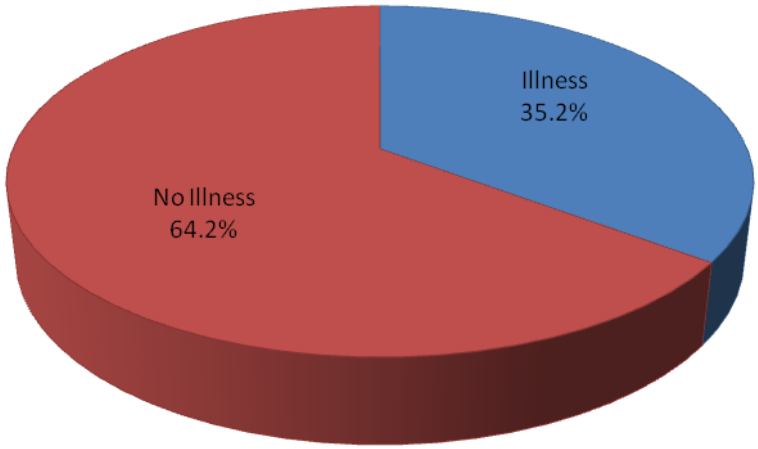
Table 4.9: Frequency, consistency and amount of practiced complementary feeding (n=105)

Characteristics	Frequency (N)	Percentage (%)
Frequency of complementary feeding		
Less than required	60	56.81
As required	35	33.27
More than required	10	9.90
Consistency of complementary feeding		
Thick	32	31.00
Thin	19	18.09
Appropriate	53	50.91
Amount of complementary feeding		
Inappropriate	25	24.18
Appropriate	80	75.82

Illness due to Complementary Feeding

Among the total participant, a majority (64.8%) of the respondents said that no illness due to complementary feeding beside 35.2% said illness occurred due to complementary feeding.

Figure no 4.3: Distribution of the respondent's Children according to illness due to Complementary Feeding (n=105)



V. Discussion

In Bangladesh, the slum population of Bangladesh, women in the intervention group initiated breastfeeding earlier, were less likely to provide pre-lacteal and post-lacteal foods to their infants and more likely to practice EBF at 5 months compared to the control group[11]. Thus, there are strategies available that are effective in changing mothers' feeding practices in the developing countries that might be beneficial for child health, growth and development.

Infant and young child feeding practices include early initiation of breast feeding within one hour of life, timely introduction of solid/semi solid foods from the age of six months increasing in amount and frequency over time along with breast feeding as demanded by child. The Bangladesh demographic health survey has showed that IYFC practices are still low in Bangladesh. Only 57.0% of the children are fed according to the recommended practices; that is feeding milk and milk products and food items from the recommended food groups and minimum recommended frequency. The Bangladesh demographic health survey concluded that complementary foods are not introduced in a timely fashion for all children in Bangladesh.

Seventy percent of infants have been given complementary foods by age 6-9 months. Most of the participants in this study were of age group of 21 to 30 years (80.36%).This age group is the most common reproductive age in our country. All of the participants of this study were Muslims. This reflects the religion system in our country where Muslim are a big majority lived in the Slum followed by Hindu and others. Literacy rate of Slum is low; most of the participants in our study 66.7% of the respondents were class one to five.

It was observed in the study that 87.3% mothers had knowledge of duration about the exclusive breast feeding and 12.7% mothers did not have the knowledge about it. It is encouraging to note that the percentage of mothers who knew the duration of exclusive breast feeding was found to be high (87.3%). However, it seems that having knowledge alone is not enough to realize the knowledge into practices in the community. For instances, the percentage of mothers practicing exclusive breastfeeding as per recommendation observed in this study was much lower (33.0%) than expected. It shows the gap between knowledge and practice is high despite the fact that Bangladesh's Breast Milk Substitute Act promotes and protects breastfeeding and regulates the unauthorized or unsolicited sale and distribution of breast milk substitutes.(Ministry of health and family welfare).

Most mothers (87.3%) knew when to start complementary feeding but only 36.6% mothers knew about the frequency of complementary feeding in the present study. A few mothers (6.2%) give exclusive breast feeding only for less than a month and 1/5th of the mothers (21.0%) less than three months which is very early than recommended by WHO. This early initiation of giving other foods might be due to the fact that mothers are engaged in other jobs or the belief of equally effectiveness of other formula feeds to the child. Similar findings were also observed by other studies conducted in Nepal and India.

This study found that 87.3% of mothers used colostrums as first feed and the remaining percentage of mothers used infant formulas, cow/buffalos milk and water as first feed. Similar findings were reported by BDHS survey and the other studies done in urban as well as rural communities in Bangladesh. Our finding of colostrum use as a first feed is much higher than reported by another study done in Nigeria, a underdeveloped country like ours. This Nigerian study showed that only 18.0% of infants received colostrums as a first feed. Another study conducted in the same country (Nigeria) in semi urban setting found exclusive breast-feeding rate to be low (33.0%). The first feeding other than colostrums is not recommended to the newborn baby but some of the infants were given other feeds (12.7%) in our study.

Though, most of the mothers begin to feed their infants with colostrums, the percentage of mothers giving exclusive breast feeding goes decreasing with the age of child. This study found almost all (94.82%) mothers fed their infants with only breast milk till the age of one month which came down to 33.19% at the age of 6 months.

This evidence shows that the trend of mix feeding is increasing. This phenomenon is true for the developed world well. A study done in Switzerland showed that 94% of the infants were breastfed in the first months, but with the increasing age of infant, infant formula became the primary source of nutrition or the supplement to breast milk. By the age of 5 months, as much as half of the infants received formula milk.

It was found in this study that around 9.0% mothers practiced exclusive breast feeding more than 6 months and the most common reasons given by them were enough milk production, acceptability of the mother's milk by babies, suggestion of the elders in the family and vomiting of other feeds by the baby. Another study conducted in the city of Nepal (Pokhara) reported that even higher percentage of mothers continued exclusive breast-feeding beyond six months. The differences between the findings of those two studies could be due to the difference in study population. The study done in Pokhara was community based however the reasons given for the continuing exclusive breast feeding beyond six months of age were the same as observed in our study. This practice is not desirable and needs to improve the situation though the possible solution to overcome this problem has not been dealt in that study.

The reasons for early stoppage of exclusive breast feeding and initial breast feeding with other feeds rather than breast milk was not dealt in this study. It would have been interesting to identify the reasons for such practices. This will be topic for further research.

It seems that the trend of using marketed weaning food is increasing. It was found in this study that 53.27% of mothers used the marketed weaning foods. However, most respondents had given both marketed as well as homemade complementary feeding. This

could be due to easily availability of these foods, time constraints, diseases of the baby and wide advertisement of commercial foods in the market. Similar phenomenon was observed by Aggarwal et.al in India. They reported that 19% of mothers used marketed weaning food. Study showed that 28.27% of the mothers offered only *lito* for complementary food and around one of every five mothers used *lito* and *cerelacs* as the complementary feeding and one in every four mothers used *lito* and *dal bhat* as the complementary food and one in every ten mother used whatever food they found at home as complementary food. Other community based studies done in other parts of Bangladesh also found similar results. Though, *lito* is considered as a good complementary food and lot of efforts have been given in educating mothers about the importance of *lito* and the proper method of preparing it. It was found in this study that only 3 out of ten mothers practiced the recommendation and *cerelacs* has been used an additional to *dal bhat, lito* or cerelac alone by half of the mothers. Three among 4 mothers prepared lito in the proper way in terms of main ingredients as per recommendation but they did not use fat which is the major source of energy in the lito. Only around 14.0% of mothers used the ghee as the integral part of weaning food and only a little percentage of mothers used green vegetables. About 8.0% used only cereals in the preparation of lito, which is considered as wrong practice. This evidence shows that there is a need of intervention in the preparation of the complementary food in the community.

Separate container for each child is recommended to feed the child for complementary feeding. The use of separate container for complementary feeding helps to reduce infectious diseases especially diarrheal diseases. It was found in the study that 66.9% of mothers used the separate container for complementary feeding. In the contrary, much less percentage (49.0%) used the separate container for complementary feeding in the study done in other area. It is a common practice of giving food in the same container to different children in some communities in our country.

Though 87.3% of mothers had knowledge about the time of initiation of complementary food, 31.0% of mothers started complementary feed within 3 months of age and 8.9% of mothers did not start complementary feeding even at 6 months of age. Both practices are not only desirable but also harmful to our children but unfortunately, are being still practised in the developing world. It was found in our study that the reasons for late starting of complementary feeding were: milk is enough, elders told to do so, vomits everything and don't know why they did it but they did it. Similar type of finding was observed in another study done in India. Our study found that 33.27% of mothers were giving the feeds as per WHO guidelines and 9.90% were giving more often than prescribed frequency. Combining together 43.17% of mothers were giving feed at adequate frequency. When assessing the knowledge about the frequency of complementary feeding, it was found that more than 1/3rd (36.6%) had proper knowledge of frequency of complementary feeding. This shows that almost all the mothers having knowledge are practicing the complementary feeding. However, this finding is much less as compared to the reports by BDHS. This might be because of the different location of the study.

Similar finding was observed in India by Aggarwal et.al. We have to be cautious about the observation on more frequent feeding than recommendation as it may be the cause of obesity in the future even in

developing countries. Consistency of complementary feeding is one of the important components of appropriate complementary feeding. The feed may be thick, thin or appropriate according to consistency. This study found that half of the mothers fed their child either thick or thin feeds and only 50.91% mother fed their children appropriate complementary feeding by consistency. Consistency of CF is not mentioned in our BDHS, however, the study done in India found the 25.5% to 30.0% mothers knew and practiced the recommended complementary feeding by consistency which is lower than our finding. This variation might be due to the difference in study population and their demographic characteristics. It would have been more useful and informative if such characteristics were studied in our country and made the comparisons with it.

It is interesting to note that 3 among 4 mothers in our study had fed their baby the appropriate amount of feeding. This reveals that mothers in our part of world are more concerned about the amount of feed offered to their child. Though the amount of feed is sufficient, they may be still deficient in calories and nutritional values. These feeds are either thick or thin and don't have all the ingredients required to be the ideal complementary feeding. This might be one of the possible factors for high prevalence of under-nutrition, wasting and stunting despite the use of correct amount of feeding. This supports the importance of women education. This finding also indicates that mothers are involved more in the care and rare of the infant and young child than the fathers.

VI. Conclusion

The ideal feeding was practiced only in a minority of children. There was a big gap between the knowledge of mothers about duration of exclusive breast-feeding and their practices. However, the practices of giving colostrums were interestingly very high. Some of the mothers used lito as a weaning food but a few mothers knew the proper method of its preparation. Amount of complementary feeding given to children was enough in the majority of the children but its consistency and frequency were found to be not appropriate as per recommendation in more than half of the children. Finally, large gap was observed in knowledge and appropriate feeding practices and raised the serious issues of concern for different stakeholders in child health on improving the feeding practices. Finding of this study will be useful to health planners and health policy makers working in government and nongovernmental organizations working in the field of health and nutrition to improve the practices of mothers about infant and young child feeding.

The analysis part of this study was concentrated only on major IYCF issues; that is duration of exclusive breast feeding and initiation of complementary feeding, appropriate feeding practices and associated demographic and socioeconomic factors for inappropriate feeding practices. There are other feeding issues that need to be explored and analyzed for developing better feeding practices and reducing the childhood morbidity and mortality in the country.

VII. Recommendations

- There is a knowledge practice gap in breast feeding. Effort should be made to encourage the practice of exclusive breast feeding.
- Appropriate feeding practice is very low and effort should be made to increase the appropriate feeding practices by putting more effort in consistency of food and timing of feeding.
- Immunization clinic is the best place and vaccination time is the ideal time for educating mothers about appropriate feeding practices.
- Information Campaigns and Advertising to raise awareness of complementary feeding practices in slum area.
- Government should increase publicity of breast feeding among slum area.
- It has been advised to conduct the similar study in community.

Acknowledgement

Firstly, all praises to the almighty Allah for giving me patience, strength and ability to perform this work. With the blessing of Allah, this dissertation has come into being in due time.

Individual efforts can never contribute to a successful completion of any venture. I would be failing in my duty if I did not state my gratitude and appreciation to the following individuals who have made valuable contribution towards the thesis work.

I would like to express my heartfelt gratitude and profound regards to my reverend guide **Dr. Sheikh Mohammad Mahbubus Sobhan**, Register (Clinical Research), National Heart Foundation Hospital & Research Institute for his constant encouragement, support and proper guidance for the completion of this thesis work. I would also like to extend my sincere gratefulness to my honorable teacher Assistant professor **Dr. Mohammad Abdullah Al Mamun,** Department of Public Health, for his generous help for given us thesis guideline and statistical related lecture. It is my great pleasure and honor to express my gratitude to the

honorable teacher **Dr. Shamim Jubayer Bithin** whose comments and suggestions have added very significantly to the accuracy and clarity of the thesis. It is my privilege and great honor to **Prof. Dr. Sharker Md. Numan,** Dean**,** School of Science & Technology, Bangladesh Open University for expert guidance, appreciation, sincere advice and continuous support for establish the research based University. I offer added thanks specially all my senior and junior colleagues and also the respectable members of Mirpur slum area who directly or indirectly helped me during the study period.

Finally, it is with particular pleasure that I must again acknowledge my debt to all the mothers' who were involved with this study during my data collection period.

References

[1]. brief Global breastfeeding Collective advocacy brief obesity 2020 pdf. https://www.unicef.org/breastfeeding/files/Global-Breastfeeding-Collective-advocacy-brief-obesity-2020.pdf
[2]. Bfhi-implementation-2018.pdf https://www.who.int/nutrition/publications/infantfeeding/bfhi-implementation-2018.pdf
[3]. Exclusive breastfeeding practice during first six months of an infant's life in Bangladesh https://bmcpediatr.biomedcentral.com/track/pdf/10.1186/s12887-018-1076-0
[4]. A broad spectrum of health challenges-selected issues. EN_WHS2018_Part3 https://www.who.int/gho/publications/world_health_statistics/2018/EN_WHS2018_Part3.pdf?ua=1
[5]. Children food and nutrition, Sowc-2019.pdf https://www.unicef.org/media/60806/file/SOWC-2019.pdf
[6]. Teshome B, Koigi-makau W,Getahun Z,Taye G. Magnitude and determinates of stunting in children under five of age in food surplus region of Ethiopia: The case of West Gojam Zone. Ethiop J. health Dev. 2009; 23(2): 98-106.Black RE. Maternal and child under nutrition: global and regional exposures and health consequences
[7]. GUIDING PRINCIPLES FOR COMPLEMENTARY FEEDING OF THE BREASTFEED CHILD https://www.who.int/nutrition/publications/guiding_principles_compfeeding_breastfed.pdf
[8]. Human Milk and Allergic Diseases : An unsolved Puzzle https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5579687/pdf/nutrients-09-00894.pdf
[9]. Introduction of complementary foods in a cohort of infants https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5295078/pdf/nutrients-09-00034.pdf
[10]. Factors Affecting Breastfeeding and Complementary Feeding Choices for Children Aged 24 to 48 Months https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7199838/pdf/MBSEH-53-165.pdf
[11]. Reasons for early or late initiation of complementary feeding: A study of pokhara ajphr-3-4A-15.pdf
[12]. Aggrawal A, Verma S, Feridi MA and Chand D. Complementary Feeding–Reasons for Inappropritateness in Timing,Quality and consistency, Indian J Pediatr
[13]. World Health Organization. WHO Global Data Bank on Breastfeeding. Geneva: World Health Organization
[14]. WHO Collaborative Study Team: Role of Breastfeeding on the Prevention of Infant Mortality Effect of breastfeeding on infant and child mortality due to infectious diseases in less developed countries: a pooled analysis. Lancet
[15]. PAHO/WHO. Guiding principles for complementary feeding of the breastfed. Washington DC: Pan American Health Organization/World Health Organization. htpp:// ww.who.int child adolescent _health document/9241593431 len /index/html
[16]. Dewey K and Brown K. Update on technical issues concerning complementary feeding of young children in developing countries and implications for intervention programs. Food and Nutrition Bulletin.
[17]. Dewey KG and Adu-Afarwuah S. Systematic review of the efficacy and effectiveness of complementary feeding interventions in developing countries. Maternal and Child Nutrition.
[18]. WHO. The optimal duration of exclusive breastfeeding: report of an expert consultation. Geneva: World Health Organization (WHO/NHD/ WHO/FCH/CAH 01.24).
[19]. Shrimpton R . Worldwide timing of growth faltering: implications for nutritional interventions. Pediatrics;107(5):e.
[20]. WHO. Global Data Bank on Infant and Young Child Feeding.Geneva:WHO..
[21]. UNICEF. Progress for children: a world fit for children. Statistical Review Number 6. New York: UNICEF.
[22]. N Srivastav and A. Sandhu. Index of measuring child feeding practices. Indian Journal of pediatric.
[23]. Subba SH,Chandrashekhar TS, Binu VS, Joshi HS, Rana MS and Dixit SB. Infant feeding practices of mothers in an Urban areas in Nepal, Kathmandu University Medical Journal.

ANNEX

Informed Consent Sheet in English

I am Md. Moshfek Shah, Post graduate student of MPH (Master of Public Health). I am going to conduct study on ***Knowledge regarding infant, young child feeding practices among mothers in Mirpur slum area, Dhaka.***

I am willingly participating in the study and I have been explained fully about the details, its purposes and its possible implications in the future. I have had opportunity to ask questions about it and any questions that I asked have been answered to my satisfaction. I consent voluntarily to participate as participant in this research and understand that I have the right to withdraw from the research at any time without in any way affecting my medical care from the hospital.

Md.Moshfek Shah
The Researcher Participant

Appendices
APPENDIX-A: CONSENT FORM
BANGLADESH OPEN UNIVERSITY
Department of Public Health
Questionnaire
On
KNOWLEDGE REGARDING INFANT, YOUNG CHILD FEEDING PRACTICES AMONG MOTHERS IN MIRPUR SLUM AREA, DHAKA

I am a student of Masters of Public Health (MPH) at Bangladesh Open University. I have come to you to collect some information for conducting the research entitled "Knowledge regarding infant, young child feeding practices among mothers in Mirpur slum area, Dhaka" The information you will provide to me will be used only for my research purpose. All of your information will be kept strictly confidential. You have every right to withdraw from the study at any time. I expect your full cooperation for this purpose.

Informed written consent

I (write your name) ……. have learnt about the objective of this particular research. Information given by me would be kept confidential and would be only used for research purposes. I have all the right to withdraw myself at any time, I want and it would take approximately 15 to 20 minutes to complete. I am giving my consent with full sense and without any provocation.

……..
Signature/thumb print of the respondent
Dated……..

QUESTIONNAIRES:

Serial no…….. Date :……..

Study on "Knowledge regarding infant, young child feeding practices among mothers' in Mirpur slam area, Dhaka"

Part A: Basic information :

1. What is your name ? ----------
2. Age ? ----------
3. Sex ?

❑ Male ❑ Female

4. What is your religion ?

❑ Islam ❑ Hindu ❑ Christian ❑ Others

5. What is your marital status ?

❑ Married ❑ Unmarried ❑ Divorce ❑ Separate

6. What is your level of education ?

❑ No formal education ❑ Up to class –V ❑ From class VII to class X
❑ Graduation and above ❑ SSC ❑ HSC

Part B : Identifying the Socio-demographic status of Mirpur slam area.

7. What is your occupation ?

❑ Govt. service ❑ Non-Govt. Service ❑ Business

❑ Student ❑ Agriculture work ❑ Unemployed
❑ House wife ❑ Laborer ❑ Others

8. What is your residence ?
❑ Rural ❑ Urban

9. Who takes decision in your family ?
❑ Husband ❑ Father ❑ Mother ❑ You
❑ All together

10. How many months old is your baby ?
❑ 0-6 months ❑ 06-12 months ❑ 12-24 months

Part C : Identifying the knowledge regarding infant & young child feeding practice in the Slum area

11. Did you ever breastfeed ?
❑ Yes ❑ No

12. Did you practice bottle feeding ?
❑ Yes ❑ No

13. Have you any idea about exclusive breast feeding ?
❑ Yes ❑ No ❑ Don't know

14. How much does your baby weight ?
❑ Yes ❑ No ❑ Don't know

15. Do you know the minimum dietary diversity ?
❑ Yes ❑ No ❑ Don't know

16. Do you have any idea minimum acceptable diet from 06 to 24 months ?
❑ Yes ❑ No ❑ Don't know

17. I would like to ask you continued breast feeding up to-------- months
❑ Yes ❑ No ❑ Don't know

18. Do you feed any process food made from shop ?
❑ Yes ❑ No

19. Do you feed milk based products ?
❑ Yes ❑ No ❑ Don't know

20. Have you any conception about fat, iron, protein, carbohydrate, Zinc ?
❑ Yes ❑ No ❑ Don't know

21. Have you any general idea that breast milk is the best source of nutrition for babies during the first 06 months ?
❑ Yes ❑ No ❑ Don't know

22. Did you know infant should be breastfed within one hour of birth ?
❑ Yes ❑ No ❑ Don't know

23. Have you idea infant & young child feeding practices directly affect the nutritional status of children under two years of age & ultimately impact child survival ?

☐ Yes ☐ No ☐ Don't know

24. Do you know feeding practices in the developing countries that might be beneficial for child health, growth and development ?

☐ Yes ☐ No ☐ Don't know

25. Do you know complementary feeding is required in appropriate quantity, quality, and frequency to fulfill the daily energy needs for growth and development of child ?

☐ Yes ☐ No ☐ Don't know

26. Do you know that complementary foods need to be nutritionally adequate, safe and appropriately fed in order to meet the young child's energy and nutrient needs ?

☐ Yes ☐ No ☐ Don't know

27. Do you have any idea that human milk feeding decreases of a wide range of infectious diseases ?

☐ Yes ☐ No ☐ Don't know

28. Do you know poor nutrition increases the risk of illness ? Have you knowledge that childhood mortality is a very tragic prenomenon of the world ?

☐ Yes ☐ No ☐ Don't know

29. Do you know about complementary feeds at six months with continued breast feeding till two years ?

☐ Yes ☐ No ☐ Don't know

30. Have you any vaccinated your child ?

☐ Yes ☐ No ☐ Don't know

31. Have you ever seen/heard of the personal hygiene ?

☐ Yes ☐ No ☐ Don't know

32. Do you think you should to well inform about infant & young child feeding practice ?

☐ Yes ☐ No ☐ Don't know

33. Have you heard that every citizen has the basic right to adequate health care ?

☐ Yes ☐ No ☐ Don't know

34. Where do you go when your baby feel illness ?

☐ Village doctor ☐ Nutritionist ☐ Medicine store ☐ Govt. Hospital

35. What is your opinion regarding the waiting time ?

☐ Yes ☐ No

WORK SCHEDULE:

Activities	January	Feb	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Topic Selection												
Planning & designing												
Literature Review												
Selection of Study area												

Instrument development												
Pretesting & Finalizing												
Data Collection												
Data Analysis												
Data Tabulation												
Report Writing												
Finalizing the Report												
Final Submission												

Md.Moshfek Shah. "Knowledge regarding infant, young child feeding practices among mothers in Mirpur slum area, Dhaka." *IOSR Journal of Nursing and Health Science (IOSR-JNHS)*, 10(06), 2021, pp. 01-19.