



Original Research

Sick Child Feeding Practice and Associated Factors Among Mothers of Children < 2 Years in Dire Dawa Health Facilities, Eastern Ethiopia, 2025**Beakal Worku¹, Abdu Omer², Manaye Kassahun^{2*}**¹*Dire Dawa Regional Health Bureau, Dire Dawa City Administration, Ethiopia*²*Department of Public Health, College of Medicine and Health Sciences, Dire Dawa University, P.O. Box: 1362, Dire Dawa, Ethiopia***Abstract**

Background: Children's nutritional status can rapidly deteriorate during or after common childhood illnesses if increased nutritional needs are not adequately addressed. The first two years of life are critical for growth and development, as appropriate nutrition during this period reduces morbidity and mortality and improves long-term health outcomes. This study aimed to assess sick child feeding practices and associated factors among mothers of sick children under two years of age attending health facilities in Dire Dawa, Eastern Ethiopia, in 2025.

Methods: A facility-based cross-sectional study was conducted from April 1 to April 30, 2025. Data were collected using the Kobo tool and exported to SPSS version 25 for analysis. A total of 417 mothers of sick children under two years of age were selected using systematic random sampling. Bivariable and multivariable logistic regression analyses were performed to identify factors associated with sick child feeding practices. Adjusted odds ratios (AORs) with 95% confidence intervals (CIs) were used to measure the strength of associations, and statistical significance was declared at $p < 0.05$.

Results: A total of 417 mothers or caregivers participated in the study, with a mean maternal age of 35 years. Good sick child feeding practices were observed among 42.2% of mothers (95% CI: 37.4, 47.1). Higher family income (AOR = 3.33; 95% CI: 1.10, 9.90), frequent antenatal care visits (AOR = 2.50; 95% CI: 1.33, 4.72), and breastfeeding frequency of at least eight times per day (AOR = 2.54; 95% CI: 1.33, 4.72) were significantly associated with good sick child feeding practices.

Conclusion: More than half of the mothers demonstrated poor sick child feeding practices. Family income, frequency of antenatal care visits, and breastfeeding frequency were significant determinants. Strengthening nutrition counseling and promoting optimal infant and young child feeding practices, with greater involvement of fathers, are essential to improve feeding practices during childhood illness.

Keywords: Associated Factors, Childhood Illness, Dire Dawa, Ethiopia, Feeding Practice, Sick Child

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1. Introduction

Appropriate feeding practices during and after illness are essential to meet the increased nutritional needs of infants and young children ^[1]. Children under two years of age require energy-dense and nutritionally diverse diets to support optimal growth and development ^[2]. As part of the Global Strategy for the Integrated Management of Childhood Illness (IMCI), the World Health Organization (WHO) provides evidence-based guidelines on optimal feeding during and after common childhood illnesses to prevent rapid deterioration of nutritional status ^[1]. Optimal infant and young child feeding (IYCF) plays a critical role in enabling children to achieve their full developmental potential, with the period from pregnancy through the first two years of life recognized as a “critical window of opportunity” for preventing growth failure ^[3]. Recommended feeding practices for sick children include increased fluid intake, more frequent breastfeeding, and encouragement of age-appropriate and preferred foods ^[3,4].

The nutritional outcomes of sick children are strongly influenced by maternal knowledge, attitudes, and feeding practices. Despite established recommendations, many mothers encounter barriers such as cultural beliefs, limited awareness, and inadequate access to health services ^[5]. In developing countries, feeding practices during childhood illness remain suboptimal, with supplemental feeding rates ranging from 1% to 69.94% and continued breastfeeding among sick infants reported between 3% and 17% ^[6]. In sub-Saharan Africa, only 9.3% of children with diarrhea receive adequate food during illness ^[7]. Studies conducted in Ethiopia report wide variability, with appropriate feeding practices among sick children ranging from 15.4% to 47.6% ^[8], while some studies show relatively higher adherence, between 45% and 54% ^[9]. Factors influencing these practices include child characteristics, caregiver education and occupation, residence, antenatal and postnatal care attendance, child feeding counseling, and paternal involvement ^[9].

Despite national and international recommendations promoting continued and increased feeding during childhood illness, inappropriate practices persist. Mothers may reduce food or fluid intake due to concerns about worsening illness or loss of appetite ^[1]. In Ethiopia, inconsistent adherence to recommended feeding practices during illness remains evident, with limited context-specific evidence, particularly in urban settings such as Dire Dawa ^[8]. Optimal IYCF practices include exclusive breastfeeding for the first six months, timely introduction of energy-dense complementary foods, continued breastfeeding for at least two years, responsive feeding, and regular growth monitoring using WHO growth standards ^[10,11]. Malnutrition and infectious diseases continue to pose major public health challenges in resource-limited settings. Common illnesses such as diarrhea,

fever, and acute respiratory infections disrupt feeding behaviors through reduced appetite, impaired nutrient absorption, and caregiver misconceptions ^[12]. Dehydration resulting from vomiting or diarrhea is especially dangerous for infants and young children ^[13]. Additionally, household-level factors, including low socioeconomic status, limited parental decision-making, low paternal education, poor access to health services, short birth intervals, and inadequate dietary diversity, further compromise feeding practices ^[14,15].

Therefore, this study aims to assess sick child feeding practices and associated factors among mothers of children under two years of age attending health facilities in Dire Dawa. The findings will provide evidence to inform targeted interventions, strengthen counseling services at health facilities, and contribute to reducing childhood morbidity and mortality in Eastern Ethiopia.

2. Methods

2.1. Study Area and Period

This facility-based cross-sectional study was conducted from March to April 2025 in selected public health facilities within the Dire Dawa City Administration, Eastern Ethiopia. Dire Dawa is located approximately 515 kilometers east of Addis Ababa and is served by both public and private health facilities.

2.2. Study Design

A facility-based cross-sectional study design was employed to assess the study objectives.

2.3. Population

The source population included all mothers/caregivers of children aged less than 24 months who visited public health facilities in Dire Dawa for child illness management during the study period. The study population comprised randomly selected mothers/caregivers with sick children aged less than 2 years who attended under-five outpatient departments (OPDs) in selected public health facilities in Dire Dawa during the data collection period and who fulfilled the eligibility criteria.

2.4. Eligibility Criteria

2.4.1. Inclusion Criteria

Mothers of sick children aged 0–24 months who attended the selected public health facilities during the study period were included.

2.4.2. Exclusion Criteria

Mothers of children with chronic illnesses or emergency conditions requiring immediate referral were excluded from the study.

2.5. Sample Size Determination and Sampling Procedure

The sample size was determined using a single population proportion formula, assuming a proportion of mothers practicing appropriate sick child feeding of 45% [30], a 95% confidence level ($Z = 1.96$), and a 5% margin of error. After adding a 10% allowance for non-response, the final sample size was calculated to be 417 mother-child pairs.

A stratified sampling technique was employed. Public health facilities were first stratified into hospitals and health centers. One hospital and three health centers were selected using a simple random sampling (lottery) method. The sample size was proportionally allocated to each selected facility based on the average monthly under-five outpatient department (OPD) attendance. Finally, study participants were selected using a systematic random sampling technique with a sampling interval of $K = 2$.

2.6. Data Collection Tool and Procedures

Data were collected using a pretested, structured, interviewer-administered questionnaire implemented through the Kobo data collection tool. The questionnaire included sections on sociodemographic and economic characteristics, maternal and obstetric factors, health service-related factors, and infant and young child feeding practices during illness.

Minimum Dietary Diversity (MDD) was assessed by asking mothers whether the child had consumed foods from eight standard food groups during the previous 24 hours. Based on WHO guidelines [16], good MDD was defined as consumption of five or more food groups, while poor MDD was defined as consumption of fewer than five food groups. Minimum Meal Frequency was assessed among breastfed and non-breastfed children aged 6–23 months. The minimum required frequency was defined as at least two meals for breastfed infants aged 6–8 months, three meals for breastfed children aged 9–23 months, and four meals for non-breastfed children aged 6–23 months.

The questionnaire was initially developed in English and then translated into Amharic, Afan Oromo, and Somali. It was subsequently back-translated into English to ensure consistency. Data were collected by eight diploma-level nurses, with daily supervision provided by supervisors and the principal investigator.

2.7. Data Quality Assurance

Data quality was ensured through regular supervision and rigorous checking procedures. All collected data were reviewed daily for completeness and consistency. Data collectors and

supervisors received intensive training prior to data collection, including orientation on the study objectives, interview techniques, and ethical considerations. Practice interviews and group discussions were conducted to address potential challenges. Supervisors closely monitored data collection activities and promptly communicated any issues to the principal investigator for corrective action.

2.8. Study Variables

Dependent Variable: Sick child feeding practice.

Independent Variables: Sociodemographic factors (maternal age, maternal education level, maternal occupation), health service information (access to sick child feeding information), and obstetric history (antenatal visits, postnatal care services).

2.9. Operational Definitions

- ▶ **Sick child feeding practice:** A routine for feeding a baby during an illness, including increasing food intake through more frequent breastfeeding and longer feeds [3].
- ▶ **Good sick child feeding practice:** For non-breastfed babies aged 6–23 months, ≥ 4 meals a day; for breastfed babies aged 6–8 months, ≥ 2 meals a day (complementary food); for babies aged 9–23 months, ≥ 3 meals a day. For exclusively breastfed mothers, feeding at a higher frequency than normal (8 to 12 feeds per day) was considered good practice [3].
- ▶ **Poor sick child feeding practice:** Mothers who gave the usual amount of liquids, somewhat less amount and frequency of liquids than usual, or withheld feeding were considered as having poor sick baby-feeding practice [3].
- ▶ **Minimum Dietary Diversity:** Consumption of ≥ 5 food groups in the 24 hours preceding the survey (good) vs. < 5 food groups (poor), based on WHO guidelines [16].
- ▶ **Minimum Meal Frequency:** Proportion of breastfed and non-breastfed children aged 6–23 months receiving solid, semisolid, or soft foods at defined minimum frequencies (twice for breastfed 6–8 months, three times for breastfed 9–23 months, four times for non-breastfed 6–23 months).

2.10. Data Analysis

Data were analyzed using SPSS version 20. Descriptive statistics (frequency distribution, percentage, and means) were used to characterize respondents. Variables showing an association with the dependent variable at an alpha < 0.25 in bivariable analysis were entered into the multivariable logistic regression model. Adjusted Odds Ratios (AOR) with

corresponding 95% confidence intervals were estimated, and a p-value <0.05 was used to identify statistically significant associations. Multicollinearity was assessed by computing variance inflation factor (VIF > 10) and standard error (SE > 2).

3. Results

3.1. Socio-demographic Characteristics

A total of 417 mothers participated in the study. The majority were aged 25–34 years (63.6%), and 94.0% were married. Most mothers were housewives (52.0%) and had completed primary education (36.2%), with only 0.2% holding a university degree. A large proportion (99.5%) reported a monthly income greater than 2000 Ethiopian birr. Regarding family size, 47.0% had fewer than four members (Table 1).

Table 1: Sociodemographic characteristics of mothers who have sick young children in Dire Dawa town, Eastern Ethiopia, 2025 (n= 417)

Variables	Category	Frequency (n)	Percentage (%)
Mothers Age	15-19	2	0.5
	20-24	51	12.2
	25-29	135	32.4
	30-34	130	31.2
	>35	99	23.7
Marital Status	Married	392	94.0
	Single	11	2.6
	Divorced	13	3.1
	Widowed	1	0.2
Mothers Occupation	House wife	217	52.0
	Government employee	123	29.5
	Business women	39	9.4
	Private organization	21	5.0
	Daily labor	12	2.9
Mothers Education	Degree and above	1	0.2
	No formal Education	36	8.6
	Primary Education	151	36.2
	Secondary Education	85	20.4
	TVET	44	10.6
Monthly Income	<2000	2	0.5
	>=2000	415	99.5
Family Size	<4	196	47.0
	4-5	137	32.9
	>5	84	20.2

3.2. Maternal Obstetrics and Health Service-Related Characteristics

High utilization of antenatal care (ANC) services was observed, with 99.8% of mothers attending ANC follow-up. Among those who accessed ANC, the majority (96.2%, n=401) completed the recommended ≥ 4 visits. Most mothers delivered in health facilities (56.8% at health centers, 42.2% at hospitals). Skilled birth attendance was prevalent, with 83.9% assisted by health professionals. Nearly all mothers (98.3%, n=410) reported receiving counseling on Infant and Young Child Feeding (IYC) (Table 2).

Table 2. Maternal obstetrics and health service-related characteristics of mothers who have sick young children in Dire Dawa Health facility, Eastern Ethiopia, 2025 (n= 417)

Variables	Category	Frequency (n)	Percentage (%)
ANC follow up	No	5	1.2
	Yes	412	99.8
Frequency of ANC visit	<4 visit	12	2.9
	≥ 4 visit	401	96.2
Place of Delivery	Health Center	237	56.8
	Home	1	0.2
	Hospital	176	42.2
Birth attendant	Health Extensions	66	15.8
	Health Professional	350	83.9
Receiving Counseling on IYCF	No	6	1.4
	Yes	410	98.3

3.3. Child Related Characteristics

Among the children, 57.3% were aged 6–12 months, and 39.1% were under 6 months. Males constituted 55.2% of the sample. Nearly all mothers (96.2%) reported breastfeeding, though only 15.6% breastfed eight or more times per day. Bottle feeding was reported by 85.9% of respondents (Table 3).

Table 3. Child related characteristics

Variables	Category	Frequency (n)	Percentage (%)
Breastfeeding Status	No	10	2.4
	Yes	401	96.2
Number of Breastfeeding	≥ 8	65	15.6
	<8	344	82.5
Bottle feeding	No	54	12.9
	Yes	358	85.9
Age at introducing CF	≥ 6 months	258	61.9
	<6 months	151	36.2

3.4. Magnitude of Child Feeding Practices

Overall, 175 (42.2%; 95% CI: 37.1-47.1%) of mothers demonstrated good sick child feeding practices (Figure 3).

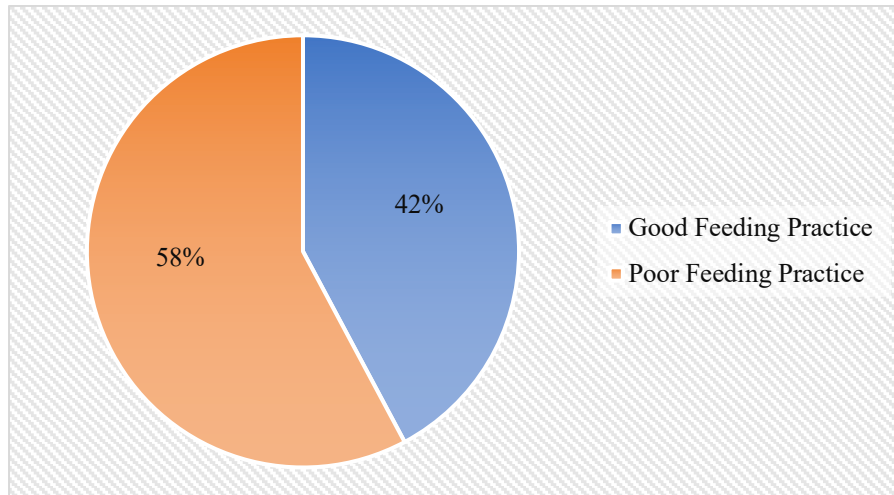


Figure 3: Magnitude of poor sick child feeding practice among mother/caregiver in Dire Dawa Health facility, Eastern Ethiopia, 2025

3.5. Factors Associated with Sick Child Feeding Practice

A stepwise bivariable and multivariable logistic regression analysis was performed. Variables with a p-value below 0.20 in the bivariable analysis, along with other important variables, were considered candidates for the multivariable model. Family income, child age, breastfeeding frequency, ANC visit, and child sex were initially identified as important factors.

In the multivariable logistic regression model, three variables showed statistically significant associations with good sick child feeding practices: monthly income above 2000 birr, four or more ANC visits, and breastfeeding frequency ≥ 8 times/day. Child age and sex were not statistically significant in the adjusted model.

The multivariable analysis indicated that mothers with a monthly income above 2000 ETB had 3.3 times higher odds of good sick child feeding practice than their counterparts (AOR = 3.33, 95% CI: 1.10–9.90). Increased breastfeeding frequency was also significantly associated with better good sick child feeding practice (AOR = 2.54; 95% CI: 1.33, 4.72). Mothers who increased breastfeeding frequency were 2.5 times more likely to feed their sick children appropriately. Furthermore, mothers with higher ANC visits had 2.5 times higher odds of having good sick child feeding practice (AOR = 2.50; 95% CI: 1.33, 4.72) (Table 4).

Table 4. Bivariable and Multivariable Logistic Regression of Factors Associated with Good Sick Child Feeding Practice (n = 417)

Variable	Category	Good Feeding (n)	Poor Feeding (n)	COR (95% CI)	AOR (95% CI)
Monthly Income	< 1000 birr (Ref)	11	19	1	1
	1001–2000 birr	22	14	2.72 (1.03, 7.14)	2.50 (0.89, 6.91)
	> 2000 birr	208	143	2.66 (1.34, 5.28)	3.33 (1.10, 9.90)
Breastfeeding Frequency	< 8 times/day	211	133	2.45 (1.33, 4.49)	2.54 (1.33, 4.72)
	≥ 8 times/day (Ref)	27	38	1	1
ANC Visits	< 4 visits (Ref)	2	10	1	1
	≥ 4 visits	239	162	7.39 (1.53, 35.6)	2.50 (1.33, 4.72)
Child Age	6–8 months (Ref)	33	18	1	1
	< 6 months	98	65	0.81 (0.45, 1.47)	1.26 (0.67, 2.50)
	9–23 months	110	93	0.65 (0.36, 1.19)	0.89 (0.50, 1.58)
Sex of Child	Female (Ref)	115	71	1.36 (0.81, 1.75)	1.07 (0.68, 1.68)
	Male	125	105	1.	1

4. Discussion

This study assessed the prevalence and determinants of sick child feeding practices among mothers of children under 24 months attending public health facilities in Dire Dawa. The findings showed that only 42.2% of mothers practiced appropriate feeding during child illness, indicating a substantial gap in adherence to recommended guidelines. This finding is comparable with studies conducted at Hiwot Fana Specialized Hospital and in Gamo Zone public health facilities, Eastern Ethiopia, where approximately 45.0% of mothers reported increased feeding during illness [3,9].

The prevalence observed in this study is lower than reports from Mirab Abaya District, Burayu Town, and Debre Berhan Town [17], which may be explained by differences in socioeconomic status, maternal education, health service utilization, and cultural practices. However, the prevalence is higher than findings from Debre Tabor Hospital [18], Kenya [19], Liberia [20], Malawi [21], and rural western Maharashtra, India [22–25], suggesting relatively better access to health services and feeding counseling in the study area.

Frequent antenatal care (ANC) visits were significantly associated with appropriate sick child feeding practices. This highlights the importance of strengthening ANC services to ensure consistent and comprehensive nutrition counseling, including specific guidance on feeding practices during childhood illness. Health facilities should prioritize integrating standardized infant and young child feeding counseling into every ANC visit.

Household income was another key determinant of appropriate feeding practices. Mothers from higher-income households were more likely to provide adequate feeding during illness, indicating that economic capacity plays a critical role in food availability and diversity. This finding emphasizes the need for targeted socioeconomic support programs aimed at improving household food security, particularly for low-income families.

Increased breastfeeding frequency during child illness was also significantly associated with appropriate feeding practices. This underscores the importance of promoting continued and frequent breastfeeding during illness through community education and health facility-based counseling. Healthcare providers should actively encourage mothers to increase breastfeeding frequency when children are sick, as breast milk remains a vital source of nutrition and immunity.

Overall, these findings suggest that improving sick child feeding practices requires a multifaceted approach. Strengthening maternal health services, particularly ANC-based nutrition counseling, addressing household economic constraints, and reinforcing breastfeeding promotion through both community and facility-based interventions are essential strategies to enhance appropriate feeding practices during childhood illness.

Despite its strengths, this study has some limitations. The cross-sectional design limits the ability to establish causal relationships between associated factors and sick child feeding practices. Additionally, the reliance on self-reported data may have introduced social desirability bias, potentially leading to an overestimation of appropriate feeding practices.

5. Conclusion

This study found that fewer than half (42.2%) of mothers adhered to recommended feeding practices for sick children under two years of age in Dire Dawa. Frequent ANC attendance, higher household income, and increased breastfeeding frequency were significantly associated with appropriate sick child feeding practices. These findings underscore the need to strengthen maternal health services, enhance nutrition counseling during ANC visits, and address socioeconomic disparities to improve child feeding practices during illness.

Abbreviations

ANC: Antenatal Care; AOR: Adjusted Odds Ratio; CI: Confidence Interval; COR: Crude Odds Ratio; ETB: Ethiopian Birr; IMCI: Integrated Management of Childhood Illness; IYCF: Infant and Young Child Feeding; MDD: Minimum Dietary Diversity; OPD: Outpatient Department;

SE: Standard Error; SPSS: Statistical Package for the Social Sciences; TVET: Technical and Vocational Education and Training; VIF: Variance Inflation Factor; WHO: World Health Organization.

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Author's Contribution

All authors contributed equally to the conceptualization and design of the study. They participated in the development of the methodology, data collection, data analysis, and interpretation of the findings. All authors were involved in drafting, reviewing, and revising the manuscript and approved the final version for submission.

Ethical Approval

Ethical clearance was obtained from the Ethical Review Committee of Dire Dawa University, College of Medicine and Health Science. Official cooperation letters were issued, and permission was secured from the Institutional Review Board (IRB). Respondents were informed about the study's purpose and assured of confidentiality.

Conflicting Interests

The author(s) declared no potential conflicts of interest concerning this research.

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Availability of Data and Materials

The data supporting the findings of this study are available from the corresponding author.

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