



Caregivers' Perception of Infant and Young Child Feeding (IYCF) at Unguwa Uku Primary Health Centre Nutrition Clinic, Kano

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Abstract

Background: Evidence suggests that the prevalence of undernutrition and its associated consequences among children remains high in Kano. Caregivers' perceptions play a key role in shaping breastfeeding and complementary feeding behaviours. This study explored caregivers' perceptions of Infant and Young Child Feeding (IYCF), dietary diversity and sources of information on IYCF at the nutrition clinic of Unguwa Uku Primary Health Centre, Tarauni LGA, Kano State. **Methods:** Using a qualitative narrative enquiry, in-depth interviews were conducted with caregivers who were purposively recruited. The recorded interviews were transcribed, translated into English and analysed using Braun and Clarke's criteria for thematic analysis. **Results:** A total of 15 interviews were conducted. The themes that emerged were: perception of breastfeeding and complementary feeding, dietary diversity and feeding routines, sources of information and cultural beliefs. Most caregivers perceived early initiation of breastfeeding and exclusive breastfeeding as important for infant health and well-being, although variations in perceptions were observed. The results further revealed reliance on cereals, limited inclusion of proteins and fruits and narrow dietary variety. Furthermore, Community Health Extension Workers (CHEWs) working in health facilities were the major sources of information on IYCF. Similarly, some cultural beliefs affected IYCF as reported by some of the caregivers. **Conclusion:** The study highlights the importance of targeted nutrition education and counselling within the primary healthcare system.

Keywords: Caregivers, Infant and Young Child Feeding (IYCF), undernutrition, perception

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Introduction

Undernutrition in children under five years of age remains one of the most persistent global public-health challenges, undermining child survival, growth, and long-term development. Despite substantial progress in some regions, an estimated 150 million children globally under five years old were stunted in 2024,

while 50 million were wasted, and 38 million were underweight. These burdens are concentrated in low- and middle-income countries and are driven by a complex interplay of food insecurity, poverty, poor sanitation, infectious disease, and inadequate

maternal and infant care practices (UNICEF, WHO & World Bank, 2025).

In sub-Saharan Africa, undernutrition continues to be a significant contributor to child morbidity and mortality, with West African countries bearing the greatest burden (Akombi et al., 2017; Siddiqui et al., 2020). In Nigeria, child undernutrition remains alarmingly high, with recent data indicating 40% stunting, 8% wasting, and 27% underweight among children under five years (Federal Ministry of Health and Social Welfare, 2025). Nearly half of all stunted children in the country are found in the North East and North West regions, where socioeconomic and cultural barriers, poor maternal education, and inadequate feeding practices persist (Amare, Benson & Fadare, 2018; Ataguba & Nwosu, 2020). A study conducted in Kano State, particularly at Murtala Muhammad Specialist Hospital, reported the prevalence of stunting, underweight and wasting to be 48.6%, 41.9% and 22.8%, respectively. (Maje, Koki and Muhammad, 2019).

Infant and Young Child Feeding (IYCF) practices play a crucial role in preventing undernutrition because the World Health Organisation (WHO) emphasises exclusive breastfeeding for the first six months and appropriate complementary feeding thereafter as key strategies for improving child nutrition outcomes (WHO, 2020). However, inappropriate feeding practices, limited caregiver knowledge, and poor maternal education remain prevalent in many communities, especially in Northern Nigeria (Dhami, Ogbo & Osuagwu, 2019; John et al., 2024). These challenges are further compounded by poverty, food insecurity, and limited access to health and nutrition education (Ahmad et al., 2020).

Mitchodigni et al. (2018) identified social and cultural myths about childhood feeding as determinants of infant and young child

feeding practices in most traditional African settings. There is, however, a dearth of information regarding the caregivers' perception of infants and young children's feeding. Therefore, this study aimed to explore caregivers' perception of IYCF, dietary diversity and sources of information on IYCF among infants' caregivers attending the nutrition clinic of Unguwa Uku PHC, to identify existing knowledge gaps and improve nutrition outcomes among children under five years in the community.

Methods and Materials

Methodological Orientation: The study adopted a narrative enquiry methodological orientation to explore caregivers' perceptions and experiences regarding Infant and Young Child Feeding (IYCF) at Unguwa Uku Primary Health Centre nutrition clinic, Kano. Narrative enquiry was considered appropriate because it emphasises participants' stories and personal accounts, enabling an in-depth understanding of how caregivers construct meaning around IYCF practices within their cultural, social, and health-service contexts. This approach allowed caregivers to describe their feeding experiences, challenges, and interactions with health workers in their own words, thereby generating rich, contextualised data that go beyond surface-level responses. By focusing on narratives, the study aimed to capture the complexity of caregivers' decision-making processes and the factors shaping their perceptions and behaviours related to recommended IYCF practices.

The philosophical perspective underpinning this study is social constructionism because it views reality as socially created through interactions, language, and shared meanings rather than as an objective truth (Berger & Luckmann, 1966). It emphasises that knowledge and understanding are context-dependent, shaped by cultural, historical, and social influences. Through language, people construct meanings that define what is considered "normal" or "true," while power

relations determine which perspectives dominate. Since social norms and values evolve, socially constructed realities are fluid and subject to change. This study was reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007).

Research Team and Reflexivity: The study was conducted by a team of eight (8) researchers (6 males and 2 females) with credentials ranging from MSc to PhD. The investigator holds professional training in nursing and public health and has received formal instruction in qualitative research methods. At the time of the study, the investigator was engaged as a student with an academic and public health focus. The in-depth interviews were conducted by the principal investigator, who also served as the primary facilitator of the narrative enquiry alongside the two female researchers. This was necessary, looking at the socio-cultural context of the study participants, in order to promote rapport with the caregivers to enable them to express their views adequately. The investigator had prior experience and training in qualitative interviewing, narrative enquiry, and ethical conduct of research.

No prior personal relationship existed between the researcher and the participants before data collection. Participants were informed that the interviewer was a student conducting an academic study on caregivers' perceptions of Infant and Young Child Feeding, and the purpose and voluntary nature of participation were clearly explained. The researcher acknowledged a professional interest in maternal, infant, and young child nutrition, which could influence data interpretation. To enhance reflexivity and reduce potential bias, the researcher used open-ended questions, encouraged participants to share their experiences in their own words, maintained field notes to reflect on assumptions and reactions, and engaged in

discussions with a supervisor to validate emerging interpretations.

Theoretical Framework: The Ecological Systems Model, developed by Urie Bronfenbrenner in 1979, was used in this study because it provides a framework for understanding how different physical, social, political, cultural and environmental factors influence human development. The model emphasises the interaction between an individual and their surrounding systems, highlighting the role of multiple levels of influence on growth and behaviour (Bronfenbrenner, 1979).

Participant Selection and Setting: Participants were selected using purposive sampling to recruit caregivers who were directly involved in the feeding of infants and young children (Patton, 2015) and who were attending the nutrition clinic at Unguwa Uku Primary Health Centre, Kano. This sampling strategy was chosen to ensure that participants had relevant experiences and could provide rich, information-focused narratives related to Infant and Young Child Feeding practices. Eligible caregivers were approached face-to-face at the clinic by the researcher and provided with information about the study. Those who expressed willingness to participate and provided informed consent were enrolled.

The final sample size of 15 participants was guided by the principle of data saturation (Creswell & Poth, 2018), with three additional interviews continuing to further confirm the saturation. The study setting - Unguwa Uku Primary Health Care Facility – has a dedicated nutrition clinic receiving cases of undernutrition and giving appropriate treatment to affected children.

Data Collection & Management

An in-depth interview guide, which comprised open-ended questions structured to elicit responses on their perceptions of IYCF, was used. Key questions in the guide include: tell us your opinion about IYCF, what are your perceptions regarding breastfeeding, complementary feeding, types of food used for complementary feeding, feeding frequency, timing of feeding, age of introduction of feeds, sources of information on IYCF and cultural beliefs affecting IYCF. Informed consent was obtained from each of the invited participants before the interviews, and the interviews were conducted with the selected participants between May 16th and 30th 2025. Out of the 20 participants invited, 15 were interviewed with each interview lasting approximately 30minutes.

Methodological Integrity

Methodological integrity was ensured by aligning the narrative enquiry design with the study's aim of exploring caregivers' perceptions of IYCF. Credibility was supported through in-depth interviews, audio recording, and field notes, while dependability was enhanced by using a semi-structured interview guide and documenting procedures. Reflexive practices and discussions with supervisors strengthened confirmability, and providing clear descriptions of the setting and participants supported transferability. These strategies ensured that the findings were trustworthy, transparent, and grounded in participants' experiences.

Data Analysis: Data analysis was conducted systematically to ensure that caregivers' narratives were accurately interpreted and meaningfully organised. All interview transcripts were coded by the principal

investigator, with guidance from the supervisor to enhance analytic rigour and ensure consistency. A coding framework was developed, and themes were derived inductively from the data to reflect patterns, experiences, and perceptions expressed by participants regarding Infant and Young Child Feeding practices. The coding process and emerging themes were documented to maintain an audit trail. Qualitative data were managed manually and organised in a structured format to facilitate analysis.

Ethical Consideration: Ethical approval was obtained from the Health Research and Ethics Committee (HREC) of Kano State Ministry of Health with reference number (NHREC/17/03/2018).

Results

A total of 15 in-depth interviews were conducted based on the point of data saturation (Speziale et al, 2011) and also in line with the required number of participants for a narrative enquiry (Creswell, 2014).

Findings from Table 1 revealed that all participants were mothers aged between 20 and 51 years, mostly in their 20s to 40s. The majority had non-formal education (n=8), while a few had formal education at the primary (n=2), secondary (n=3), tertiary (n=1), or adult education (n=1) levels. Most participants (n=12) were involved in petty trading, with only one in formal employment and two unemployed, reflecting a largely informal economy.

Participants had between 1 and 6 children, with an average of 3 children per mother. Most lived in rural areas (n=12), with only 3 residing in urban settings, indicating a predominantly rural study population.

Table 1: Distribution of Participants according to Socio-Demographic Characteristics (n=15)

Participant ID	Age in years	Highest educational status	Occupation	No. of U5 children in the household	Residential location
P1	28	No formal education	Petty trading	5	Rural
P2	32	No formal education	Petty trading	1	Rural
P3	25	No formal education	Petty trading	6	Rural
P4	26	Adult education	Nil	4	Rural
P5	51	No formal education	Petty trading	3	Rural
P6	22	No formal education	Petty trading	4	Rural
P7	40	No formal education	Petty trading	6	Rural
P8	26	Secondary	Petty trading	2	Rural
P9	20	No formal education	Petty trading	3	Rural
P10	46	No formal education	Petty trading	3	Rural
P11	33	Primary	Petty trading	3	Urban
P12	22	Secondary	Nil	3	Urban
P13	26	Secondary	Petty trading	2	Rural
P14	25	Primary	Petty trading	2	Urban
P15	32	Tertiary	Civil service	4	Urban

Analysis of the interview transcripts on caregivers' perceptions of IYCF revealed three (3) themes: breastfeeding and complementary feeding, dietary diversity and feeding routines, sources of knowledge and cultural beliefs.

Theme 1: Perception of breastfeeding and complementary feeding

This theme emerged from three (3) sub-themes: early initiation of breastfeeding; understanding of exclusive breastfeeding; and readiness and timing of complementary feeding.

Early initiation of breastfeeding

Most caregivers perceived early initiation of breastfeeding as essential for the infant's health, emphasising the first few hours after birth as critical. Excerpts from the interview with some of the participants are as follows:

"I believe breastfeeding immediately after birth is very important for my baby's health" (P1)

"Breastfeeding within the first hours after delivery gave the child a strong start" (P7)

Understanding of exclusive breastfeeding

Perception of exclusive breastfeeding varied, ranging between four and seven months; while some mentioned six months, others reported it can be discontinued earlier.

Excerpts from the interview with some of the participants are as follows:

"I feel that feeding my baby only breastmilk for the first six months is very important for their health and growth" (P1)

"In my experience, continuing breastfeeding for four months before giving other foods seems best for my child's comfort and digestion" (P7)

Readiness and timing of complementary feeding

Regarding complementary feeding, most of the participants believed that complementary feeding should commence after 6months of exclusive breastfeeding, whereas early initiation at 4-5months was reported by some. Some of the participants reported as follows:

"I believe that starting complementary feeding at 6months of age meets the needs of the child" (P1)

"For me, I think complementary feeds can be introduced once the child is 4months old" (P8)

“In my experience, complementary feeds can be introduced from 6months of age after completion of exclusive breastfeeding” (P14)

Theme 2

Dietary diversity and feeding routines

This theme emerged from three (3) sub-themes: reliance on cereals, limited inclusion of proteins and fruits and narrow dietary variety; structured feeding schedules; and responsive feeding.

Reliance on cereals, limited inclusion of proteins and fruits and narrow dietary variety

Participants mentioned that the types of food to be used for complementary feeding include staples (pap, pasta, rice, millet gruel), proteins (egg, fish, beans, soya bean cake), and liquids (water, tea, milk). Some of the participants reported as follows:

“Complementary feeds should include pap and pasta” (P1)

“For me, I think complementary feeds such as water, gruel, pap and tea can be introduced” (P8)

“Complementary feeds commonly used include water, pasta, millet gruel and tea” (P14)

Structured feeding schedules

Furthermore, most of the participants reported that children should be fed multiple times daily, ranging from three to six times. While some mentioned a structured feeding around morning, afternoon, evening and night, others fed on demand. Excerpts include:

“Children should be fed 3times per day in the morning, afternoon and evening” (P3)

“In normal circumstances, a child should be fed 5 times every day, mostly in the morning, afternoon, evening and night” (P7)

“Most at times, a child should feed 4times every day – in the morning, afternoon and evening” (P11)

Responsive feeding

While most of the participants reported structured feeding schedules, others fed on demand, as reported by P1.

“Normally, children should be fed based on demand” (P1)

Theme 3: Sources of information and cultural beliefs

The theme emerged from four (4) sub-themes: formal health sources of IYCF; informal/community sources; cultural food taboos, traditional beliefs and myths; and rejection of cultural influence.

Formal health sources of IYCF:

Community Health Extension Workers (CHEWs) are overwhelmingly the most common and consistent sources of IYCF information cited by nearly all participants. Some of the participants have reported as follows:

“Information on IYCF is mostly obtained from CHEWs working at health facilities” (P1)

“Women can get information on visits to health facilities from CHEWs and occasionally from vaccinators (P7)

“The main source of information on IYCF is CHEWs” (P10)

Informal/community sources

While most of the participants reported having received information on IYCF from CHEWs working in health facilities, informal sources such as neighbours and family members.

“Sometimes, information on IYCF is gotten from neighbours and family members” (P2)

Cultural food taboos, traditional beliefs and myths

Similarly, cultural beliefs shaped caregivers' perceptions of IYCF. Some reported food taboos, such as avoiding eggs or pap, a few mentioned supernatural influences like witchcraft and local charms, while others

stated that cultural beliefs had no impact on IYCF. Excerpts reported include the following:

“Mothers are often warned that giving eggs prevents a child from talking early in life” (P1)

“Some people believe that giving pap to a child causes the child to be underweight” (P2)

“We are often told that the use of local charms prevents a child from afflictions, including undernutrition” (P7)

“There are a lot of food taboos in our locality and caution about witchcraft” (P11)

Rejection of cultural influence

While many acknowledged the existence of food taboos, some rejected them, as reported by P8.

“I do not know of any cultural beliefs regarding IYCF in my community” (P8)

Discussion

In the present study, most caregivers believed that breastfeeding should be initiated immediately after birth, with a few believing that it can be initiated about two hours later. Similarly, the majority supported exclusive breastfeeding for the six months, while some reported shorter durations of four or five months. This variation in perception reflects differences in personal experiences, cultural practices, and possibly exposure to health education messages. The emphasis on early initiation aligns with global recommendations, highlighting that caregivers recognise the perceived benefits of early breastfeeding, such as promoting infant immunity, mother–child bonding, and proper nutrition.

These findings compare favourably with several other studies. For instance, Gizaw et al. (2023) in a qualitative study from rural Ethiopia, reported that caregivers recognised the need to initiate breastfeeding within the first few hours of birth. Likewise, Krivtsova and Keith (2021), in a qualitative study from the London Borough of Ealing, indicated that

caregivers reported that breastfeeding should be initiated immediately after birth, and complementary feeding should commence at six months, consistent with the dominant view in the present study. Leurur et al. (2019), in a qualitative study among Maasai women in Tanzania, also found that most women adhered to the WHO’s recommendation, showing striking similarity with the findings of the current study, probably due to their being in traditional African settings.

Regarding the duration of exclusive breastfeeding, the findings align closely with Dusingizimana et al. (2020), who reported from rural Rwanda that nearly all mothers supported exclusive breastfeeding for six months, with only a few recommending earlier introduction of other foods. Similarly, Iyer et al. (2024), in the findings of a qualitative component of a mixed-methods study from Western Sydney, Australia, found that mothers generally endorsed six months of exclusive breastfeeding.

However, the findings of the present study contrast with those of Olkaba et al. (2024), who, in a community-based qualitative study in Toke Kutaye district of Ethiopia, reported poor maternal perception regarding the timing of breastfeeding initiation, duration of breastfeeding, and introduction of complementary feeding reflecting variations in maternal education, access to health information and health facility delivery rates between the two populations.

Overall, the present findings demonstrate better maternal knowledge and practice compared to some settings where poor perception persists (Olkaba et al., 2024), but also show room for improvement given that some caregivers still report delayed initiation or shortened breastfeeding duration.

Regarding complementary feeding, most participants reported that complementary feeding should begin at six months, in line

with WHO recommendations, although a minority indicated that it could start earlier at four to five months. Reported complementary foods included staples such as pap, pasta, rice, and millet gruel; proteins such as eggs, fish, beans, and soya bean cake; and liquids like water, tea and milk.

These findings are largely consistent with Gizaw et al. (2023), who reported that mothers supported the introduction of additional foods after six months, with common complementary foods including barley gruel, maize porridge, false banana bread, sweet potatoes, and cow milk. The similarity in both settings suggests that staple cereals and cow milk remain key weaning foods in many African contexts, though the variety of food choices in the present study may reflect greater dietary diversity, possibly due to urban exposure.

The present study also aligns with Afolabi and Afolabi (2021) from South-western Nigeria, who reported that participants acknowledged six months as the recommended age but often considered introducing complementary foods earlier if breast milk was perceived as insufficient. Findings from Shittu et al. (2024) in Jigawa State, Nigeria, further support this observation. Although mothers emphasised early initiation of breastfeeding, they also encouraged supplementing with liquids such as water, holy water and water mixed with date palm juice. This cultural practice mirrors the use of water reported in the present study, suggesting that beliefs around hydration for infants remain widespread across the two regions.

Conversely, Leurer et al. (2019) reported a very different pattern among Maasai women in Tanzania, where mothers frequently delayed the introduction of solids until eight or nine months, underscoring the influence of cultural norms on feeding decisions. Their report that ugali (maize porridge) is the most common first food aligns with the use of pap

and other cereals reported here, reaffirming the central role of cereal-based gruels as the first complementary food across African contexts.

In the present study, CHEWS working in health facilities emerged as the main source of information on IYCF for most participants. Other reported sources included neighbours and knowledge passed on within the home. These findings share some similarities with Joseph and Earland (2019), who, in a qualitative exploration of sociocultural determinants of exclusive breastfeeding in rural North-west Nigeria, also identified health workers as a key potential source of information on appropriate infant feeding practices. This consistency suggests that health professionals are trusted messengers for IYCF information in Nigerian settings, both rural and urban.

However, the present findings differ from those of Leurer et al. (2019) in Tanzania, who reported that the most common source of breastfeeding information was intergenerational knowledge passed down from elder women, with only some mothers mentioning health workers as information providers. This contrast highlights the shift towards formal health education in the present setting, reflecting increased healthcare access or improved maternal education.

Similarly, Krivtsova and Keith (2021), in a qualitative study of working mothers in the London Borough of Ealing, reported that mothers relied mainly on the NHS website for infant feeding information, citing trust in its evidence-based content. This is notably different from the present findings, where digital or online sources were not reported, reflecting disparities in internet access, health literacy, and availability of trusted digital platforms between the two populations.

Generally, the present study demonstrates a positive trend of caregivers seeking IYCF

information from trained health personnel, which may enhance adherence to WHO-recommended feeding practices. Nonetheless, the reliance on neighbours and home-based knowledge underscores the need for continuous community sensitisation to ensure that informal advice does not conflict with evidence-based recommendations.

In the present study, cultural beliefs and food taboos were reported by most caregivers as major influences on IYCF practices, while a smaller proportion stated that they did not adhere to such beliefs. Reported taboos included the restriction of certain foods, such as eggs and specific proteins, based on the belief that they could negatively affect a child's behaviour or health. This finding aligns with Gizaw et al. (2023), who highlighted the strong influence of cultural beliefs on child feeding. In their study, a common belief was that if a child does not begin eating before six months, they will not adapt to food later and could develop health problems. This belief drives early introduction of complementary foods, contradicting WHO recommendations for exclusive breastfeeding during the first six months of life.

Both findings suggest that cultural norms significantly shape feeding decisions, sometimes leading to practices that may compromise child nutrition. The difference lies in the specific form of belief: while the present study emphasises food taboos restricting certain items, Gizaw et al. (2023) focused on beliefs that promote early initiation of complementary feeding. Taken together, these findings demonstrate that cultural influences can either restrict or encourage certain feeding behaviours, and both may contribute to undernutrition when they diverge from recommended practices.

Conclusion

This study explored caregivers' perceptions of Infant and Young Child Feeding (IYCF), dietary diversity and sources of information

on IYCF at the nutrition clinic of Unguwa Uku Primary Health Centre using a narrative enquiry approach. The findings indicate that most caregivers perceive early initiation of breastfeeding and exclusive breastfeeding as important for infant health, demonstrating general alignment with recommended IYCF practices. However, variations in perceptions were observed regarding the timing of breastfeeding initiation and the duration of exclusive breastfeeding, with some caregivers believing that delayed initiation or shorter periods of exclusive breastfeeding were acceptable. The study therefore underscores the importance of strengthening context-sensitive nutrition education and counselling at the primary healthcare level, with greater emphasis on addressing caregivers' beliefs, concerns, and practical challenges.

Recommendations

Since caregivers demonstrated varied perceptions of IYCF, regular nutrition education campaigns, led by trained health workers or community volunteers, should be implemented to promote exclusive breastfeeding, appropriate complementary feeding and proper meal frequency and diversity. Similarly, addressing undernutrition requires coordinated efforts across sectors, namely health, agriculture, education, and social services. Since some negative food taboos were reported by some caregivers, further qualitative research is needed to explore cultural beliefs and traditional practices influencing caregivers' perceptions and responses to undernutrition in this community.

Strengths of the Study

A major strength of this study is that it was conducted in an actual PHC nutrition clinic, ensuring that findings are based on real patient experiences. This strengthens the external validity of the study and increases its practical relevance for health practitioners, caregivers and policymakers. Collecting primary data directly from caregivers further

enhances the study's accuracy and credibility. This approach allows the researcher to tailor data collection tools to the study objectives and directly engage with respondents for clarification.

Furthermore, there is also a relative scarcity of empirical studies focused on community-level data in Tarauni LGA or Kano State. This study fills an important gap and contributes valuable local data that can inform region-specific strategies for combating undernutrition. Similarly, with ongoing concerns about malnutrition and child mortality in Nigeria, this study addresses a critical public health issue by aligning with national and international efforts such as the Sustainable Development Goals (SDG 2 & 3), which target zero hunger and improved health.

Limitations

The study was conducted in Unguwa Uku PHC within one Local Government Area of Kano State, which may limit the generalizability of the findings to other areas with different socio-cultural, economic or health service contexts. Similarly, much of the

data on caregiver perceptions relied on self-reporting, which may be prone to recall bias, exaggeration or social desirability bias. Moreso, considering that the interviews were conducted during clinic hours when mothers were being consulted and given therapeutic feeds, some of the participants might have been in haste to conclude the interview prematurely, thereby preventing them from elaborately expressing their perceptions on IYCF.

Conflict of Interest

The authors declare no known conflict of interest that could have influenced the work reported in this paper.

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