A significant proportion of infant and young child mortality can be prevented by the provision of a diverse diet. Globally, an estimated 45% of deaths of children under the age of 5 are because of malnutrition. More than two-thirds of these deaths are associated with inappropriate child-feeding practices. This situation is the worst in Ethiopia. Thus, the objective of this study was to determine the status of dietary diversity and identify relevant variables. A community-based cross-sectional study was conducted with 335 randomly selected mothers/caregivers who had infants and young children aged between 6 and 23 months. Data were collected by interview with a structured questionnaire. The data were analyzed using SPSS Version 23. A multivariable logistic regression model was fitted to identify factors associated with dietary diversity practices and statistical significance was declared at $p < 0.05$. Only 12.6% (95% CI; 9.2, 16.6) of children aged 6 to 23 months had adequate dietary diversity. Having a backyard garden and primary education were associated with adequate dietary diversity practices. In this study, the status of adequate dietary diversity feeding practice is low. Therefore, interventions targeting dietary diversity should encourage households to have backyard gardens, and strengthening counseling of mothers/caregivers attending antenatal care and postnatal care is proposed for achieving adequate dietary diversity practices.

1. Introduction

Nutrition is a crucial, universally recognized component of children’s rights. Children have the right to adequate nutrition and access to safe and nutritious food [1]. However, globally it is estimated that undernutrition is responsible, directly or indirectly, for at least 35% of deaths in children less than 5 years of age. It is also a major cause of disability, preventing children who survive from reaching their full development potential [2].

Based on the evidence that malnutrition is a serious global problem with devastating consequences, governments around the world, with the support of the international community and other concerned parties, are taking seriously their commitments to protect and promote the health and nutritional well-being of infants and young children and set a target to end all forms of malnutrition by 2030 [1, 3]. Also, the importance of better nutrition is recognized under Sustainable Development Goal (SDG2) as “ending hunger, achieve food security and improved nutrition and promote sustainable agriculture goal” and nutrition is an essential component for achieving many of the other SDGs [4].

Infant and young child feeding (IYCF) is one of the actions being implemented as part of the priority child survival and development programs of the United Nations International Children’s Emergency Fund (UNICEF) and World Health Organization (WHO). The WHO and UNICEF’s recommended different optimal infant and young child-feeding practices, nutritionally adequate (diverse food), and safe complementary feeding are among them...
Dietary diversity is a proxy for adequate micronutrient density of foods and it is one of the core indicators for assessing the quality of children’s diets [6]. Evidence suggests that a diversified diet has the single greatest potential impact on child survival. A diverse, frequent, and acceptable diet from 6 to 23 months is essential to improved growth, micronutrient status, and cognitive performance, and to prevent wasting. If appropriate complementary feeding practices were scaled up to nearly universal levels, approximately 100,000 deaths in children under 5 years of age could be averted each year [5, 7].

Access to a diverse diet is not a reality for many children in the world. Globally, less than one-third of the world’s infants and young children are fed at least four food groups, leaving nearly 70% at risk of undernutrition including micronutrient deficiencies such as vitamin A deficiency, as well as anemia [7]. Research from the Republic of Benin has shown that the minimum of national dietary diversity ranges from 49% among 6–1-month-old to 75% for 18–23-month-old children [8]. Similarly, the Demographic and Health Surveys’ result showed 23% of children in Rwanda and 16% in Burundi did minimum dietary diversity [9]. In Ethiopia, only 14% of children 2–5 years of age receive an adequately diverse diet, demonstrating low dietary diversity [10].

Studies have elicited a wide range of predictors of dietary diversity, including the level of maternal education and socioeconomic status of the household [11], households that grow fruit and vegetables and own livestock, age of the child, mothers/caregivers who received IYCF messages during postnatal care (PNC), maternal knowledge on IYCF [12, 13], maternal age, husband’s education, marital status, seasonal availability of food, access to all food groups, and source of health information [13].

The government of Ethiopia has demonstrated its commitment to nutrition by developing a standalone National Nutrition Strategy (NNS) [14] and a National Nutrition Program (NNP) [15, 16]. Despite the achievements in establishing strategies and policies, the figures of inadequate dietary diversity show the problem of an unfinished agenda [5] and are among the unachieved targets on the National Nutrition Programme I (NNPI) in Ethiopia [16].

The NNP of Ethiopia supports operational research to answer key operational questions such as why inadequate dietary diversity remains a problem in the country [15]. Thus, it is crucial to have up-to-date information about the existing dietary diversity feeding practice and related variables to create effective complementary feeding interventions. To the investigators’ knowledge, the status of dietary diversity feeding practice and its associated factors have not been effectively assessed in the study area. The purpose of this study was, therefore, to determine the magnitude of adequate dietary diversity practices and identify associated variables.

2. Materials and Methods

2.1. Study Design and Setting. The study was conducted in Birbir town, located in the Gamo and Gofa zones, Ethiopia. Birbir town, the capital of Mirab Abaya district, is located about 465 kilometers from Addis Ababa to the south, at an elevation of 1285 meters above sea level. A community-based cross-sectional study design was conducted from April 26 to May 6, 2018.

2.2. Population and Inclusion and Exclusion Criteria. All mothers/caregivers having an infant and young child aged 6 months to 23 months years old in Birbir town were the source population. Mothers/caregivers-child pairs in the selected kebeles (the smallest administrative unit of Ethiopia) during the study period were the study population. All mothers/caregivers-child pair who are permanent residents were included.

2.3. Sample Size Determination and Sampling Procedure. A single population proportion formula was used to determine the required sample size based on the following assumptions. The proportion of adequate dietary diversity practice was assumed to be 27.3% [17], with a 95% level of confidence and 5% margins of error, and

\[ n = \frac{z_{\alpha/2}^2 \times p \times (1 - p)}{d^2} \]

\[ = \frac{(1.96)^2 \times (0.273) \times (0.733)}{(0.05)^2} \]

\[ = 304.8 \]

\[ = 305. \]

Allowing for a 10% nonresponse rate, the final target sample size was 335.

From the total of eight kebeles in Birbir town, four kebeles (Alpha, Tena Tabya, Menaheria, and Enkutatash Kebeles) were selected randomly by using the lottery method. The total sample size was allocated proportionally based on the number of households who have children between 6 and 23 months of age in their respective kebeles. A list of households was obtained from health extension workers. Systematic random sampling was employed to select 335 study participants. The sampling interval was calculated by dividing the total number of households by the number of households to be selected from each kebele. A random starting point was fixed for each kebele to select the first household by using each kebele center as a starting point and a pen was pinned to identify the beginning direction. Then, all kth [4] households were selected until the required sample size was obtained from each of the selected kebeles. When there was more than one eligible study subject in the household, one study subject was selected randomly by the lottery method. When there was no eligible subject in the selected household, the next immediate neighbor household with eligible study subjects was included in the study.

2.4. Data Collection Tool and Procedure. Data were collected using interviewer-administered structured-questionnaires.
The questionnaire was developed by reviewing related literature [17–23]. It was initially prepared in English and then translated into Amharic and backtranslated to English to ensure its consistency. Then, it was pretested in Arba Minch town on 5% of the sample size (N = 17). The questionnaire included sociodemographic and economic variables, infant and young child characteristics, household characteristics, maternal and child health-service utilization characteristics, maternal awareness about dietary diversification, external influences to the mothers/caregivers on child-feeding, and dietary diversification practices. Dietary diversity practiced was assessed with nine questions. The seven food groups used for tabulation of this indicator were cereals, roots, and tubers; legumes and nuts; dairy products (milk, yogurt, and cheese); flesh foods (meat, fish, poultry, and liver/organ meats); eggs; vitamin A rich fruits and vegetables; and other fruits and vegetables [2, 16].

2.5. Data Quality Management. The questionnaire was pretested and modifications were made with regard to skipping and flow of the questions. Daily supervision was carried out to check the completeness of the questionnaire. Errors identified during data collection were corrected at the field and errors that occurred during/after data entry were addressed by revising the original questionnaire.

2.6. Data Processing and Analysis. Data were coded and entered into EpiData version 3.1 and exported to SPSS version 23 for analysis. First, descriptive analyses were conducted to describe the variables involved in the study. Then, the magnitude of dietary diversity was computed. Bivariate logistic regression was conducted to assess the association between each categorical variable with the outcome variable and to identify candidate variables (with a p value ≤0.25) to be included in the multivariable logistic regression model. Then, the multivariable logistic regression model was fitted using the default (enter) variable selection method to identify variables independently associated with the outcome variable of interest at a 5% significance level. The adjusted odds ratio (AOR) and the corresponding 95% CI for the variables in the final model were reported. The goodness of fit of the final model was assessed using Hosmer and Lemeshow goodness of fit test. The model was a good fit with a p value of 0.3. The over percentage of classification was 87.4%.

2.7. Operational Definitions. Dietary diversity was defined as adequate if children (aged 6–23 months) received foods from at least four of seven food groups ((1) Grains, roots, and tubers, (2) legumes and nuts, (3) dairy products, (4) flesh foods, (5) eggs, (6) vitamin A rich fruits and vegetables, (7) other fruits and vegetables) within the 24 h preceding the interview.

2.8. Ethical Consideration. The official letter from the School of Public Health, Arba Minch University, was secured and a permission letter was obtained from Gamo Zonal Health Department. Participants were informed about the objectives, risks, and benefits of the study. Verbal consent was obtained. Participant’s involvement in the study was voluntary and those who wish to quit their participation at any stage were informed to do so without any restriction.

3. Results

3.1. Sociodemographic, Economic, and Household Characteristics. A total of 334 mothers/caregiver-child pairs participated in this study to create a response rate of 99.7%. One hundred sixty-three (48.8%) of mothers/caregivers were less than or equal to 24 years of age. Of the total participants, 160 (47.9%) were orthodox in religion. Most of the participants, 134 (40.1%), had completed primary education (grades 1–8) and 160 (47.9%) of the women were housewives (Table 1).

3.2. Infant and Young Child Health-Related Characteristics. Most of the children (n = 202, 60.5%) were between 12 and 23 months of age, and more than half (n = 184, 55.1%) were male. From the total number of children who participated in the study, 317 (94.9%) were being breastfed at the time of the survey. Most of the children (n = 244, 73.1%) were not, or had not been, ill in 2 weeks before the survey (Table 2).

3.3. Maternal Health-Service Utilization. A total of 324 participants (97%) had antenatal care follow-up when they were pregnant for the index child, and 302 (90.4%) of the 334 mothers/caregivers delivered their children at health facilities. Regarding postnatal care visits, from 230 mothers/caregivers who had visits, 140 (60.9%) had three or more visits (Table 3).

3.4. Child-Feeding Practices. A total of 308 (92.2%) participants did not provide varieties of food for their children. Among the participants who had been influenced by the diversification of food, 16 were influenced by neighbors and family members.

The proportion of children who were receiving the recommended dietary diversity was 12.6% (95% CI; 9.2, 16.6). Most of the children (n = 254, 76.0%) feed on grain, roots, and tubers, followed by dairy products 172 (51.5%); only a few (n = 18, 5.4%) consumed legumes and nuts (Figure 1).

In the multivariable analysis, higher maternal educational status and having a backyard garden were significantly associated with appropriate dietary diversity practice. Children from households that had backyard gardens had higher odds of maintaining adequate dietary diversity when compared with children from households that did not have backyard gardens (AOR = 2.34; 95% CI: 1.11, 5.10). Furthermore, the odds of feeding adequate dietary diversity to a child’s age of 6–23 months were lower among mothers/caregivers who had attained only primary education (AOR = 0.30; 95% CI: 0.12, 0.81) compared with those who had no formal education (Tables 4 and 5).
The key contribution of this paper is to show the status of dietary diversity practices and associated variables among 6–23-month children in Birbir town. The findings have important implications, particularly in Ethiopia, where the burden of malnutrition especially micronutrient deficiency is high and dietary diversity is a proxy indicator for adequate micronutrient density of foods [24].

The results in the current study are comparable with the EDHS 2016 report in which only 14% of children had an adequately diverse diet [10]. This result is consistent with previous studies conducted in the country in which dietary diversity feeding practice is found to be (12.6%) in Dangil town [25] and (10.6%) Gorche districts of Sidama zone [12].

The Ethiopian government on the national nutritional program had set a target to increase the proportion of children aged 6–23 months with adequate dietary

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### Table 1: Sociodemography and economy of mothers/caregivers and household characteristics on the study conducted to assess dietary diversity feeding practice and associated factors among 6–23-month children in Birbir Town, Ethiopia, 2018 (n = 334).

| Variable (Continued) | Number | Percent |
|----------------------|--------|---------|
| **Monthly income (in birr*)** |        |         |
| ≤3000                | 284    | 85.0    |
| >3000                | 50     | 15.0    |
| **Family size**      |        |         |
| ≤3                   | 104    | 31.1    |
| 4–6                  | 187    | 56.0    |
| ≥7                   | 43     | 12.9    |
| **Head of the house**|        |         |
| Male                 | 314    | 94.1    |
| Female               | 20     | 5.9     |
| **Number of under-five-year-old children** |        |         |
| 1–2                  | 306    | 91.6    |
| ≥3                   | 28     | 8.4     |
| **Mothers/caregivers involved in decisions about feeding child (ren)** |        |         |
| Yes                  | 328    | 98.2    |
| No                   | 6      | 1.8     |
| **A household with backyard gardening** |        |         |
| Yes                  | 92     | 27.5    |
| No                   | 242    | 72.5    |
| **A place to obtain food** |        |         |
| Own production       | 242    | 72.5    |
| Purchase             | 92     | 27.5    |

*Birr: Ethiopia’s official currency.*
However, in this study, the status of dietary diversity practice was found to be 12.6% (95% CI: 9.2, 16.6) which is very low compared with these targets. Similarly, the dietary diversity feeding practice observed in the present study was low compared with previous studies conducted in Ethiopia (Addis Ababa (59.9%) [26], Haramaya town (25.2%) [27], Wolita sodo town (27.3%) [17], and Bale Zone (28.5%) [20]. It is also lower than the study from Moramanga district (42.1%) and Morondava district (47.6%) at Madagascar [11]. The discrepancy with the study done in Moramanga and Morondava might be due to the difference in the age of the participants. The previous study measures dietary diversity of children from 6 to 59 months but in this study dietary diversity was assessed among 6 to 23-month-old children. As the age of children increases, it may encourage mothers/caregivers to initiate complementary feeding which increases the probability of providing diversified foods [28]. Furthermore, the difference with the studies done at Oromia region (Bale Zone and Haramaya Town) [20, 27] might be due to different interventions to improve proper child-feeding practices in the local contexts. A possible reason for dissimilarity with the study done at Wolita sodo might be the sample size. The sample size of this study was lower than the sample size of the study done at Wolita sodo.

| Variable                                      | Number | Percent |
|-----------------------------------------------|--------|---------|
| Age of the child (in months)                  |        |         |
| 6–11                                          | 132    | 39.5    |
| 12–23 months                                  | 202    | 60.5    |
| Sex                                           |        |         |
| Male                                          | 184    | 55.1    |
| Female                                        | 150    | 44.9    |
| Breastfeeding child at the time of the survey |        |         |
| Yes                                           | 317    | 94.9    |
| No                                            | 17     | 5.1     |
| Birth order                                   |        |         |
| First                                         | 148    | 44.3    |
| Second                                        | 106    | 31.7    |
| Third and above                               | 80     | 24.0    |
| Birth interval                                |        |         |
| <24 months                                    | 16     | 8.6     |
| ≥24 months                                    | 170    | 91.4    |
| Morbidity for the last 2 weeks                |        |         |
| Yes                                           | 90     | 26.9    |
| No                                            | 244    | 73.1    |
| Type of morbidity                             |        |         |
| Diarrhea                                      | 28     | 31.1    |
| Vomiting                                      | 24     | 26.6    |
| Fever with chills                             | 20     | 22.2    |
| Other                                         | 18     | 20.1    |
| Child growth monitoring follow-up             |        |         |
| Yes                                           | 262    | 78.4    |
| No                                            | 72     | 21.6    |
| Vaccination history                           |        |         |
| Vaccinated                                    | 328    | 98.2    |
| Not vaccinated                                 | 6      | 1.8     |

### Table 2: Health-related characteristics of children (N=334).

| Variable                                      | Number | Percent |
|-----------------------------------------------|--------|---------|
| Number of ANC visits                          |        |         |
| 1 to 3 visits                                 | 56     | 16.8    |
| Four or more visits                           | 268    | 80.2    |
| Place of delivery                             |        |         |
| Health facility                               | 302    | 90.4    |
| Other                                         | 32     | 9.6     |
| PNC visits                                    |        |         |
| Yes                                           | 230    | 68.9    |
| No                                            | 104    | 31.1    |
| Number of PNC visits                          |        |         |
| One visit                                     | 30     | 13.0    |
| Two visits                                    | 60     | 26.0    |
| Three or above visits                         | 140    | 60.9    |
| Heard when to start complementary food         |        |         |
| Yes                                           | 306    | 91.6    |
| No                                            | 28     | 8.4     |
| Source of information about complementary food |        |         |
| Health professionals                          | 233    | 76.1    |
| Mass media                                    | 36     | 11.7    |
| Family members                                | 23     | 7.5     |
| Other                                         | 14     | 4.6     |

### Table 3: Maternal health-service utilization and child-feeding practices.
Figure 1: Types of food groups consumed among 6–23 months children. Factors associated with appropriate dietary diversity feeding practice.

Table 4: The result of bivariate and multivariable logistic regression to assess the association of adequate dietary diversity feeding practice and sociodemographic, economic, and household factors among 6–23-month children in Birbir Town, Ethiopia, 2018, (n = 334).

| Variable                                      | Dietary diversity |          | COR (95% CI) | AOR (95% CI) |
|-----------------------------------------------|-------------------|----------|--------------|--------------|
|                                               | Adequate (%)      | Inadequate (%) |              |              |
| Age of the mothers/caregivers (years)         |                   |           |              |              |
| ≤24                                           | 20 (12.3)         | 143 (87.7) | 1            |              |
| 25–30                                         | 14 (11.8)         | 105 (88.2) | 0.95 (0.46, 1.97) |              |
| ≥31                                           | 8 (15.4)          | 44 (84.6)  | 1.30 (0.54, 3.16) |              |
| Educational status of mothers/caregivers      |                   |           |              |              |
| No formal education                           | 14 (18.9)         | 60 (81.1)  | 1            |              |
| Primary                                       | 10 (7.5)          | 124 (92.5) | 0.35 (0.15, 0.82)* | 0.30 (0.12, 0.81)** |
| Secondary                                     | 16 (18.6)         | 70 (81.4)  | 0.98 (0.44, 2.17) | 0.85 (0.35, 2.06) |
| College and above                             | 2 (5.0)           | 38 (95.0)  | 0.23 (0.05, 1.05)* | 0.23 (0.05, 1.16) |
| Marital status at the time of the survey      |                   |           |              |              |
| Married                                       | 38 (12.0)         | 278 (88.0) | 0.48 (0.12, 1.88)* | 0.46 (0.12, 1.83) |
| Other                                         | 4 (22.2)          | 14 (77.8)  | 1            |              |
| Monthly income (in birr)*                     |                   |           |              |              |
| ≤3000                                         | 36 (12.7)         | 248 (87.3) | 1            |              |
| >3000                                         | 6 (12.0)          | 44 (88.0)  | 0.94 (0.37, 2.36) |              |
| Family size                                   |                   |           |              |              |
| ≤3                                           | 8 (7.7)           | 96 (92.3)  | 0.51 (0.16, 1.58)* | 0.85 (0.24, 2.99) |
| 4–6                                          | 28 (15.3)         | 159 (84.7) | 1.08 (0.42, 2.81) | 1.14 (0.39, 3.24) |
| ≥7                                           | 6 (14.0)          | 37 (86.0)  | 1            |              |
| Read newspaper                                |                   |           |              |              |
| Yes                                           | 34 (12.0)         | 250 (88.0) | 0.71 (0.31, 1.64) |              |
| No                                            | 8 (16.0)          | 42 (84.0)  | 1            |              |
| Listen to radio                               |                   |           |              |              |
| Yes                                           | 24 (12.0)         | 176 (88.0) | 0.88 (0.45, 1.69) |              |
| No                                            | 18 (13.4)         | 116 (86.6) | 1            |              |
| Watch TV                                      |                   |           |              |              |
| Yes                                           | 28 (11.5)         | 216 (88.5) | 0.70 (0.35, 1.41) |              |
| No                                            | 14 (15.6)         | 76 (84.4)  | 1            |              |
| A household with backyard gardening           |                   |           |              |              |
| Yes                                           | 18 (19.6)         | 74 (80.4)  | 2.21 (1.14, 4.23)* | 2.34 (1.11, 5.10)** |
| No                                            | 24 (9.9)          | 218 (90.1) | 1            |              |
| A place to obtain food                        |                   |           |              |              |
| Own production                                | 34 (14.0)         | 208 (86.0) | 1.72 (0.76, 3.86)* | 0.87 (0.23, 3.24) |
| Purchased                                     | 8 (8.7)           | 84 (91.3)  | 1            |              |
| Head of household                             |                   |           |              |              |
| Male                                          | 40 (12.7)         | 274 (87.3) | 1.31 (0.29, 5.87) |              |
| Female                                        | 2 (10.0)          | 18 (90.0)  | 1            |              |

*Significant at p value ≤0.25; **significant at p value <0.05; COR: crude odds ratio; AOR: adjusted odds ratio, *Birr: Ethiopia’s official currency.
In this study, being a child in a household that had a backyard garden was an important determinant of adequate dietary diversity feeding practice, suggesting the importance of interventions at the household level. This is consistent with another study conducted before [12]. This may be explained by the fact that having a backyard garden can provide an entry point to reach mothers/caregivers in households and influence their feeding practices by improving access to local foods [5, 29].

We found a negative association between maternal educational status and dietary diversity feeding practices. Mothers/caregivers who had primary education were found to be less likely to practice adequate dietary diversity feeding compared with those who have no formal education. This result is contradictory to that of previous studies done [20, 25–27]. This discrepancy might be explained by the maternal experience of ANC and PNC visits. In this study, 90% and 70% of mothers/caregivers who had no formal education attend at least four and above ANC visits and PNC visits, respectively, whereas 67.5% and 62.5% of mothers/caregivers who had primary education attend at least 4 and above ANC visits and PNC visits, respectively. As a result, mothers/caregivers who had no formal education might have high opportunities for getting health and nutrition knowledge by trained health workers on IYCF practices which helped them to feed diverse diets to their children [20].

To sum up, the study has incorporated many variables and successfully showed important recommendations that can be used in the formulation of interventions to improve IYCF practice in the study area. However, this study may have its limitations in that it used only a 24h recall method which tells us only a one-time phenomenon but did not demonstrate the dietary habits of the participants and affected by the variation of days. Also, there might be social desirability and recall bias in reporting the type of food given to children. However, an effort was taken to minimize such biases by probing the study participants and explaining the purpose for asking particular questions.

### 5. Conclusions and Recommendation

In this study, the status of adequate dietary diversity feeding practice is low. Having a backyard garden and primary education were independent factors associated with adequate dietary diversity. Therefore, interventions targeting

| Variable                                | Adequate N (%) | Inadequate N (%) | COR (95% CI) AOR (95% CI) |
|-----------------------------------------|----------------|------------------|---------------------------|
| Age of child                            |                |                  |                           |
| 6–11 months                             | 12 (9.1)       | 120 (90.9)       | 1                         | 1                          |
| ≥12 months                              | 30 (14.9)      | 172 (85.1)       | 1.74 (0.85, 3.54)∗       | 0.74 (0.34, 1.63)           |
| Sex of child                            |                |                  |                           |
| Male                                    | 22 (12.0)      | 162 (88.0)       | 0.88 (0.46, 1.68)         |                            |
| Female                                  | 20 (13.3)      | 130 (86.7)       | 1                         |                            |
| Breastfeeding                           |                |                  |                           |
| Yes                                     | 36 (11.4)      | 281 (88.6)       | 1                         | 1                          |
| No                                      | 6 (35.3)       | 11 (64.7)        | 4.26 (1.48, 12.21)∗       | 2.98 (0.85, 10.45)          |
| Morbidity for the last two weeks        |                |                  |                           |
| Yes                                     | 10 (11.1)      | 80 (88.9)        | 0.83 (0.38, 1.76)         |                            |
| No                                      | 32 (13.1)      | 212 (86.9)       | 1                         |                            |
| Child growth monitoring follow-up       |                |                  |                           |
| Yes                                     | 36 (13.7)      | 226 (86.3)       | 1.75 (0.71, 4.34)∗        | 1.95 (0.59, 6.45)           |
| No                                      | 6 (8.3)        | 66 (91.7)        | 1                         |                            |
| ANC visits                              |                |                  |                           |
| ≤3 visits                               | 4 (6.1)        | 62 (93.9)        | 1                         | 1                          |
| 4 and above visits                      | 38 (14.2)      | 230 (85.8)       | 2.56 (0.88, 7.45)∗        | 1.95 (0.59, 6.45)           |
| PNC visits                              |                |                  |                           |
| Yes                                     | 34 (14.8)      | 196 (85.2)       | 2.08 (0.93, 4.67)∗        | 2.18 (0.69, 6.87)           |
| No                                      | 8 (7.7)        | 96 (92.3)        | 1                         | 1                          |
| Place of delivery index child           |                |                  |                           |
| Health facility                         | 38 (12.6)      | 264 (87.4)       | 1.01 (0.34, 3.03)         |                            |
| Other                                   | 4 (12.5)       | 28 (87.5)        | 1                         |                            |
| Heard when to start complementary food  |                |                  |                           |
| Yes                                     | 38 (12.4)      | 268 (87.6)       | 0.85 (0.28, 2.58)         |                            |
| No                                      | 4 (14.3)       | 24 (85.7)        | 1                         |                            |
| Influence on child feeding              |                |                  |                           |
| Yes                                     | 4 (15.4)       | 22 (84.6)        | 1.29 (0.42, 3.95)         |                            |
| No                                      | 38 (12.3)      | 270 (87.7)       | 1                         |                            |

Note: *significant at p value ≤0.25; **significant at p value <0.05; COR: crude odds ratio; AOR: adjusted odds ratio.
dietary diversity should encourage households to have backyard gardening, and strengthening counseling of mothers/caregivers attending ANC and PNC is proposed for achieving adequate dietary diversity feeding practices.

Abbreviations

ANC: Antenatal care  
IYCF: Infant and young child feeding  
NNP: National Nutrition Program  
NNS: National Nutrition Strategy  
PNC: Postnatal care  
UNICEF: United Nations International Children’s Emergency Fund  
WHO: World Health Organization.

Data Availability

The data used to support the findings of this study are not publicly available due to restrictions on the publication of human subjects’ data but these data can be available from the corresponding author upon reasonable request.

Conflicts of Interest

The authors declare that there are no conflicts of interest regarding the publication of this paper.

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