

Identify Maternal and Sociodemographic Factors Influencing Infant Feeding Practices: A Cross-Sectional Analytical Study: Impact Study

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Abstract:

Context: Inappropriate infant feeding practices remain a major contributor to childhood malnutrition, which increases vulnerability to infections, morbidity and mortality in developing countries. Optimal breastfeeding is one of the most effective interventions to reduce malnutrition, morbidity, and mortality. Identifying modifiable maternal and sociodemographic determinants of feeding practices is essential for designing targeted public health interventions. This study aimed to assess key factors influencing infant feeding practices.

Aims: To assess key maternal and sociodemographic factors influencing infant feeding

Methodology: A cross-sectional analytical study was conducted among 300 mothers of children aged <24 months. Data was collected through face-to-face interviews using a pre-validated, self-designed schedule. Information on sociodemographic characteristics, maternal education and employment, feeding practices, duration of exclusive breastfeeding, and timing of complementary feeding initiation was obtained.

Results: Exclusive breastfeeding for the first six months was reported by 78% mothers, while 10.7% practiced top feeding and 11.3% mixed feeding. Most mothers were aged 20–30 years (82%), 20.7% had low educational status, and 34.7% were employed. Over half belonged to nuclear families (56.3%) and rural areas (54.7%). Exclusive breastfeeding was significantly associated with homemakers, first-born children, and male infants ($p < 0.05$). Timely initiation of complementary feeding at six months occurred in 64.7% of cases, while 18% introduced it early and 17.3% delayed it. Common reasons for delay included perceived adequacy of breast milk (44.2%) and infant intolerance (40.4%).

Conclusions: Strengthening breastfeeding-friendly workplace policies, expanding maternity protection, and promoting community-based education to address misconceptions can improve feeding practices and child health outcomes.

Keywords: Exclusive Breastfeeding, Complementary Feeding, Maternal and Child Demographic Profile.

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Introduction

Globally, child mortality has declined due to improvements in antenatal and postnatal care, nutrition, hygiene, education, immunization coverage, access to healthcare services, and overall socioeconomic conditions.[1] However, the progress achieved in developing countries such as India has not been proportionate despite various government policies and public health initiatives compounded by recent COVID-19 pandemic that has posed additional challenges to achieve the Sustainable Development Goals.[2]

Despite global declines in child mortality, infant and under-five mortality remain high in India, with the latest NFHS-5 reporting an Infant Mortality Rate (IMR) of 28 per 1,000 live births and an under-five mortality rate (U5MR) of 33 per 1,000 live births, showing only modest improvement from NFHS-4.[3] Most infant deaths and morbidities can be reduced through a comprehensive life-cycle approach that addresses the needs of the mother-child dyad during adolescence, the pre-pregnancy period, antenatal, perinatal, and postnatal stages.[4] Although several government programs focus on

these phases, relatively few emphasize strengthening caregivers' knowledge regarding appropriate feeding practices during the neonatal period, infancy, and early childhood. Simple interventions—such as increasing awareness about optimal feeding practices as per WHO guidelines can have a substantial impact on long-term child health outcomes. [5,6]

Maternal demographic characteristics may significantly influence breastfeeding and complementary feeding practices. Several studies have explored this association and identified consistent patterns, although individual variations exist.[7] Evidence suggests that older mothers and those with higher levels of education are more likely to initiate and maintain exclusive breastfeeding and introduce appropriate complementary feeds compared to younger mothers or those with lower educational attainment.[8-13]

It is important to recognize that these associations are not universal, as breastfeeding and complementary feeding practices are shaped by multiple interrelated factors. Socioeconomic status, cultural beliefs, family and community support, and personal preferences all significantly influence maternal feeding decisions. Therefore, a comprehensive approach that provides appropriate support, education, and accessible resources is essential to promote optimal feeding practices among all mothers, irrespective of age or educational background.[14]

Given these multifactorial influences, targeted interventions addressing modifiable maternal, household, and community-level factors are essential. The present study aims to identify actionable maternal and sociodemographic determinants of infant feeding practices to make strategies that reduce malnutrition and improve child survival in India.

Subjects and Methods

The present cross-sectional study was conducted over a period of one year in the outpatient clinic of the Department of Paediatrics at a tertiary care centre. The sample size was calculated using Daniel's formula: $N = Z^2P(1 - P) / d^2$, where N represents the sample size, Z is the standard normal deviate at a 95% confidence level (1.96), P is the expected proportion (59.6%, representing the regional prevalence of exclusive breastfeeding as per NFHS-5), and d is the relative precision (10%).

After accounting for a 15% non-response rate, the final calculated sample size was 308, which was rounded to 310.

A total of 310 mothers of children aged 6–24 months attending the paediatric outpatient department for vaccination or minor illnesses were enrolled after obtaining written informed consent. Mothers of children with chronic illnesses, those requiring emergency care, or those unwilling to provide consent were excluded from the study. Ethical approval was obtained from the Institutional Ethics Committee prior to data collection (IEC ref no: AU/EC/FM/53/2017).

Data were collected through face-to-face interviews by one of the authors using a self-designed, pre-validated interview schedule after obtaining written informed consent from the participants. Maternal demographic details—including age, place of residence (urban or rural), educational status, occupation, type of family, mode of delivery (normal or caesarean), place of delivery (home or institutional), birth order, and the child's gender and age (in months)—were recorded. Information related to feeding practices as per IYCF indicators[12], such as initiation of breastfeeding, exclusive breastfeeding (EBF), top feeding, age at introduction of complementary feeding, as well as the frequency and consistency of complementary feeds, was also obtained using open ended questions.

The collected data were entered into Microsoft Excel and analyzed using SPSS version 28. Descriptive statistics were expressed as means, percentages, and proportions. Categorical variables were compared using the Chi-square test, while continuous variables were analyzed using the independent t-test. A p-value of less than 0.05 was considered statistically significant

Results

A total of 310 mother–child pairs were initially enrolled in the study. However, 10 children required emergency care and were excluded from the analysis. Consequently, the final sample comprised 300 mothers. The mean maternal age was 27.2 ± 4.3 years. Among the participants, 234 mothers (78%) practiced exclusive breastfeeding (EBF; Group 1), while 66 (22%) did not (non-EBF; Group 2), as shown in Figure 1. Among the non-EBF group, 32 (10.7%) practiced top feeding and 34 (11.3%) reported mixed feeding.

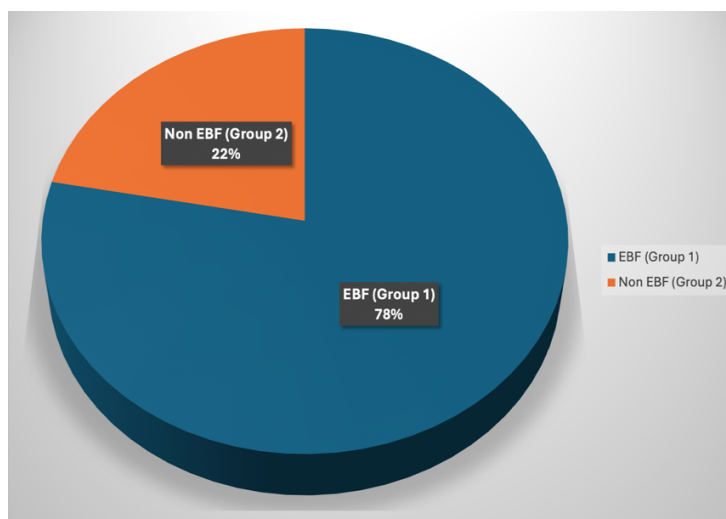


Figure 1: Distribution of cases in group 1 / 2.

a) Sociodemographic Characteristics

The sociodemographic profile of the study population is summarized in Table 1. The majority of mothers (246; 82%) were aged ≤ 30 years. Most participants were literate, with 238 (79.3%) having completed high school education or higher, while 62 (20.7%) had primary education or were illiterate.

Approximately 104 mothers (34.7%) were employed. More than half (169; 56.3%) belonged to nuclear families, and 164 (54.7%) resided in rural areas.

With respect to child characteristics, 176 (58.7%) were first-born, and 182 (60.7%) were male.

Table 1: Sociodemographic profile of Mothers. (N=300)

Characteristics	Number (% age)
Age (in years)	
≤ 30	246 (82)
> 30	54 (18)
Education of mother	
Illiterate/ primary	62(20.7)
High School and above	238(79.3)
Occupation	
Homemaker	196(65.3)
Working	104(34.7)
Type of Family	
Nuclear	169(56.3)
Joint	131(43.7)
Residence	
Rural	164(54.7)
Urban	136(45.3)
Birth-order	
1	176(58.7)
2 and above	124(41.3)
Gender of child	
Male	182(60.7)
Female	118(39.3)

Table 2 presents the association between exclusive breastfeeding and maternal sociodemographic characteristics. Among mothers practicing EBF, 194 (64.7%) were aged ≤ 30 years, while 40 (13.3%) were aged > 30 years. In terms of education, 52 (17.3%) mothers had no formal or only primary education, whereas 182 (60.7%) had completed high school or higher. Regarding occupation, 144 (48%)

were homemakers and 90 (30%) were employed. Chi-square analysis revealed no statistically significant association between maternal literacy and exclusive breastfeeding ($\chi^2(1, N=300) = 1.57, p = 0.21$). Similarly, maternal age and type of family were not significantly associated with exclusive breastfeeding ($\chi^2(1, N=300) = 0.59, p = 0.44$).

However, certain factors demonstrated a significant association with exclusive breastfeeding ($p < 0.05$). A higher proportion of mothers who were employed,

those with male children, and those with first-born children practiced exclusive breastfeeding compared to their counterparts.

Table 2: Association of Exclusive Breast Feeding with Sociodemographic profile of mothers.(N=300)

Characteristic	EBF (Group 1) N=234	Non EBF (Group 2) n=66	p-value
Age (in years)			
≤30	194	52	0.44
>30	40	14	
Education of mother			
Illiterate/Primary	52	10	0.21
High School & above	182	56	
Occupation			
Homemaker (n=196)	144	52	0.009
Working (n=104)	90	14	
Type of Family			
Nuclear (n=169)	133	36	0.740
Joint (n=131)	101	30	
Residence			
Rural (n=164)	124	40	0.272
Urban (n=136)	110	26	
Birth-order			
1 (n=176)	160	16	<0.01
2 and above (n=124))	74	50	
Gender of child			
Male (n=182)	165	17	<0.01
Female (n=118)	69	49	

b) Complementary Feeding Practices

Table 3 illustrates complementary feeding practices among the participants. Among the 300 mothers, 194 (64.7%) initiated complementary feeding at the recommended age of 6 months. Early initiation (<6 months) was reported by 54 (18%) mothers. Delayed initiation was observed in 48 (16%), including 40 (13.3%) who started between 7–12 months and 8 (2.7%) between 12–24 months. Additionally, 4

(1.3%) mothers had not initiated complementary feeding even at the time of the study.

Most children (172; 57.3%) received complementary feeding twice daily. Delayed initiation (≥ 7 months) was reported in 52 (17.3%) children. The primary reasons cited included the perception that breast milk alone was sufficient (23; 44.2%), infant vomiting (21; 40.4%), and refusal or non-acceptance of food (7; 13.5%).

Table 3: Pattern of complementary feeding practices among mothers (N=300)

Feeding Practice	Number (% age)
Initiation of complementary feeding (n=300)	
Before 6 months	54(18)
At 6 months	194(64.7)
7- 12 months	40(13.3)
12-24 months	8(2.7)
Not started	4(1.3)
Frequency of complementary feeding(n=300)	
Once Daily	41(13.66)
Twice Daily	172(57.34)
≥ Thrice Daily	87(29)
Consistency of food(n=300)	
Thick	219(73)
Thin	81(27)
Reason for delayed complementary feeding(n=52)	
Milk is enough	23(44.2)
Vomits everything	21(40.4))
Child don't accept	07(13.5)
Elders advised	1(1.9)

c) Factors Associated with Complementary Feeding

As shown in Table 4, among mothers aged ≤ 30 years, 164 (55.4%) initiated complementary feeding at 6–7 months. Similarly, 156 (52.7%) literate mothers followed the recommended timeline. However, no statistically significant association was observed between maternal age or literacy and complementary feeding practices. In contrast,

appropriate initiation of complementary feeding was significantly associated with other factors ($p < 0.05$). Homemakers (126; 42.5%), mothers from nuclear families (114; 38.5%), mothers of male children (126; 42.5%), and those with second or higher birth order children (110; 37%) were more likely to initiate complementary feeding at the recommended age.

Table 4: Association of complementary feeding with socio-demographic profile of mothers

Characteristic	Introduction of complementary feeding			P value
	<6month	6 -7month	7-24 month	
Age (in years)				
≤30	42(14.1)	164(55.4)	36(12.2)	0.21
≥30	12(4)	30(10.1)	12(4)	
Education of mother				
Illiterate/Primary	8(2.7)	38(12.8)	12(4)	0.43
High School & Above	46(15.5)	156(52.7)	36(12.2)	
Occupation				
Homemaker (n=196)	46(15.5)	126(42.5)	20(6.8)	0.00008
Working (n=104)	8(2.7)	68(23)	28(9.5)	
Type of Family				
Nuclear (n=169)	40(13.5)	114(38.5)	14(4.7)	0.00038
Joint (n=131)	14(4.7)	80(27)	34(11.5)	
Residence				
Rural (n=164)	46(15.5)	86(29)	30(10)	0.00001
Urban (n=136)	8(2.7)	108(36.5)	18(6)	
Birth-order				
1 (n=176)	52(17.5)	84(28.4)	37(12.5)	0.00001
2 and above (n=124))	2(0.7)	110(37.2)	11(3.7)	
Gender of child				
Male (n=182)	20(6.8)	126(42.5)	32(10.8)	0.00001
Female (n=118)	34(11.5)	68(23)	16(5.4)	

List of Abbreviations:

Abbreviation	Definition
IMR	Infant Mortality Rate
U5MR	Under-five mortality rate
IYCF	Infant and young child feeding
EBF	Exclusive breastfeeding
non-EBF	Non-exclusive breastfeeding
LMICs	Low- and middle-income countries

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Discussion

Globally, inappropriate and suboptimal feeding practices during the first year of life contribute to approximately two-thirds of child deaths. In low- and middle-income countries (LMICs), only about half of infants are breastfed within the first hour of

birth.[15] Exclusive breastfeeding rates remain below optimal levels, with just 37% of infants aged 0–5 months in LMICs receiving only breast milk.[16] The 2010 Global Burden of Disease study identified suboptimal breastfeeding as one of the three leading contributors to disease burden across much of Sub-Saharan Africa.[17]

The prevalence of EBF in the present study was 78%, which is comparatively higher than findings from several national surveys and regional studies. This may reflect improved awareness, effective antenatal counselling, and ongoing public health initiatives promoting optimal infant feeding

practices. Most participants had completed high school or held a degree, while the lowest proportion was among illiterate mothers. Maternal age and literacy were not significantly associated with exclusive breastfeeding in this study. This suggests that awareness regarding breastfeeding may be widespread across different educational and age groups, possibly due to the penetration of mass media campaigns and community-based health programs.

Previous studies have reported that literate mothers are generally more likely to practice exclusive breastfeeding compared to mothers with no formal education.[9] Similarly, Shafei et al. found that the most significant predictor of exclusive breastfeeding was receiving health education and possessing adequate knowledge about breastfeeding. They emphasized the importance of comprehensive breastfeeding education during pregnancy to promote exclusive breastfeeding.[18] Some studies, however, have not observed a consistent association between literacy and breastfeeding trends. One possible explanation for this shift could be the widespread availability of breastfeeding information through social media, smartphones, and other digital platforms, which may help mothers access guidance irrespective of formal education.

A significant association was observed between exclusive breastfeeding and being a working mother, living in a nuclear family, and having a male child ($p < 0.05$). Maternal employment has previously been linked to lower rates of exclusive breastfeeding, and several studies have emphasized the need for governmental and non-governmental organizations to establish supportive environments that enable mothers to continue exclusive breastfeeding in the workplace.[19-21] However, some reports have presented conflicting evidence, indicating that the relationship between maternal employment and breastfeeding practices may vary across different settings and populations.[22] This finding deviates from conventional evidence, where employment is often considered a barrier to EBF due to time constraints and workplace limitations. A possible explanation could be increased health awareness, better access to information, or supportive workplace environments among employed women in the study setting. The study also identified significant associations between EBF and child-related factors such as gender and birth order. Mothers of male children and first-born infants were more likely to practice exclusive breastfeeding. These findings may reflect underlying sociocultural preferences and greater attention given to first-time parenting, highlighting the continued influence of gender norms and family dynamics on feeding practices.

With regard to complementary feeding, nearly two-thirds of mothers initiated feeding at the

recommended age of 6 months. However, a notable proportion either introduced complementary feeding early or delayed it. Delayed initiation was primarily attributed to misconceptions such as the sufficiency of breast milk alone beyond six months, infant feeding difficulties, and perceived intolerance. These findings underscore the persistence of knowledge gaps and cultural beliefs that may hinder optimal feeding practices.

Similar findings were reported by Shrestha S et al., where among 250 mothers, 151 (60.4%) were aware of the need to initiate breastfeeding soon after birth, 179 (71.6%) knew about exclusive breastfeeding for six months, and 161 (64.4%) were aware of the appropriate age to start complementary feeding. However, only 139 (55.6%) of these mothers actually practiced timely complementary feeding. Early initiation of complementary feeding was observed in 34.8% of mothers, while 9.6% delayed it beyond six months.[23]

In another study by Sethi V, only 25.5% to 30% of mothers had knowledge of and practiced the correct consistency for complementary feeding—considerably lower than the 54.8% observed in the present study, suggesting better adherence to recommended feeding practices in our cohort.[24]

In summary, this study indicates that exclusive breastfeeding is not directly associated with maternal age or literacy level. This may reflect increased access to health information through social media and smartphones. Policymakers could leverage these platforms to deliver targeted, culturally appropriate information to women of childbearing age, particularly those who are illiterate or from lower socioeconomic backgrounds, to improve exclusive breastfeeding practices.

The study also found a significant association between exclusive breastfeeding and mothers who were working and living in nuclear families. This highlights the critical role of knowledge, autonomy and availability for a new mother in successfully practicing exclusive breastfeeding. Even when mothers are aware of its benefits, competing family and professional responsibilities may limit their ability to provide exclusive breastfeeding. These findings underscore the importance of sensitizing the entire family to support the mother, as well as implementing stricter workplace policies, such as adequate maternity leave, at the community level.

Similarly, the initiation of complementary feeding was significantly associated with homemaker mothers in nuclear families, reinforcing the importance of time and support in optimal infant feeding practices.

Overall, these findings suggest that policy interventions addressing family support, maternal time availability, and strategic use of digital

platforms could serve as cost-effective strategies to improve child nutrition, ultimately reducing morbidity and mortality in early childhood.

Conclusion and Policy Implications (IMPACT Study): The IMPACT study demonstrates a relatively high prevalence of exclusive breastfeeding; however, gaps persist in optimal infant feeding practices, particularly regarding timely initiation of complementary feeding. While maternal age and literacy were not significant determinants, factors such as maternal employment, child gender, and birth order influenced feeding behaviours, underscoring the role of sociocultural and contextual determinants. These findings highlight that improving infant feeding practices requires a shift beyond awareness-based approaches toward comprehensive, behaviour-focused strategies. At the policy level, this calls for strengthening behaviour change communication, promoting breastfeeding-friendly workplaces, adopting family-centred counselling approaches, leveraging digital health platforms for real-time support, addressing gender biases, and enhancing the capacity of frontline health workers through continuous training and robust monitoring systems.

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