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# Myths, Beliefs, and Misconceptions in Infant and Young Child Feeding Practices in India: Implications for Child Nutrition

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**Abstract**

**Background:** Optimal infant and young child feeding (IYCF) practices—early initiation of breastfeeding, exclusive breastfeeding for the first six months, and timely complementary feeding—are critical for growth, immunity, and survival [1,2]. These practices protect against common childhood illnesses and reduce mortality [2,3]. In India, sociocultural norms, demographic factors, education level, religion, and entrenched beliefs influence maternal feeding behavior [4,5]. Despite evidence that early initiation and exclusive breastfeeding could prevent a large proportion of childhood deaths, many mothers delay breastfeeding, discard colostrum, or introduce prelacteal feeds due to myths and cultural misconceptions [5,6]. National data show that while exclusive breastfeeding rates have improved (63.7% per NFHS 5) [7], early initiation remains low (~41.8%) [7] and prelacteal feeding persists in many states, reflecting ongoing practice–knowledge gaps [6,7]. Moreover, disease burden from undernutrition remains high, with significant proportions of young children not receiving adequate diets during complementary feeding ages [8].

**Keywords:** Infant and Young Child Feeding (IYCF), Exclusive Breastfeeding, Cultural Beliefs and Myths, Complementary Feeding Practices, Child Nutrition, Undernutrition, Diarrhea and Acute Respiratory Tract Infection, Maternal Knowledge and Practices, Sociocultural Determinants, India.

**Objective:** To review evidence on myths, beliefs, and misconceptions affecting IYCF in India and their implications for child nutrition, morbidity, and survival, with emphasis on exclusive breastfeeding.

**Methods:** A systematic review was conducted following PRISMA guidelines. Electronic databases (PubMed, Scopus, IndMED, Google Scholar, Cochrane), national reports (NFHS, WHO, UNICEF), and

standard pediatric texts were searched for studies from 2000–2025. Observational and cross-sectional studies assessing maternal knowledge and practices in urban and rural India were included and narratively synthesized.

**Results:** Persistent misconceptions included delayed initiation of breastfeeding, discarding colostrum, early prelacteal feeds, perceived breast milk inadequacy, inappropriate complementary feeding, food taboos during illness, and gender-based disparities. These practices were consistently associated with poor dietary diversity, micronutrient deficiencies, higher incidence of diarrhea and respiratory infections, and increased prevalence of stunting, wasting, and underweight.

**Conclusion:** Culturally sensitive, evidence-based counseling and strengthened health system support are essential to bridge knowledge–practice gaps, improve exclusive breastfeeding, and enhance child nutrition and survival in India.

## Introduction

The first 1,000 days of life, from conception to two years, are critical for growth, neurodevelopment, immune maturation, and long-term health [9]. Adequate nutrition during this period strongly influences child survival, cognitive development, and future risk of non-communicable diseases, making infant and young child feeding (IYCF) practices essential [9,10]. The WHO and Indian Academy of Pediatrics (IAP) recommend early initiation of breastfeeding within one hour of birth, exclusive breastfeeding for six months, and timely introduction of safe, nutritionally adequate complementary foods at six months, with continued breastfeeding up to two years or beyond [1,2,11]. These practices significantly reduce diarrhea, respiratory infections, undernutrition, and mortality [3,12].

Despite clear guidelines, optimal IYCF remains suboptimal in India due to maternal behaviors shaped by sociocultural norms, traditional beliefs, family influences, and intergenerational practices [4,5,13]. Myths—such as discarding colostrum, early prelacteal feeds, perceived breast milk insufficiency, inappropriate complementary feeding, and food taboos—undermine evidence-based recommendations [5,14]. NFHS-5 data show early initiation has improved, but exclusive breastfeeding and complementary feeding remain inadequate in many states, contributing to persistent stunting, wasting, and micronutrient deficiencies [7,8,15].

While individual studies have examined breastfeeding and complementary feeding, evidence on the influence of myths and cultural beliefs is fragmented [13,14]. This systematic review synthesizes existing literature to assess how these beliefs affect IYCF practices, child nutrition, morbidity, and survival, aiming to inform culturally appropriate interventions and policy implementation [16].

## Review of Literature

### Objective of the Review

This review systematically analyzes cultural myths, beliefs, and misconceptions influencing infant and young child feeding (IYCF) practices in India [17]. It aims to identify gaps between recommended WHO and Indian Academy of Pediatrics (IAP) guidelines and actual breastfeeding and complementary feeding practices [1,2,11], assess their impact on child nutrition, morbidity, and survival during the first 1,000 days of life [9,10,12], and highlight culturally sensitive, evidence-based strategies to improve adherence to optimal IYCF recommendations in the Indian context [16,18,19]

## Methods

**Type of Review:** Narrative review of published literature on cultural beliefs affecting IYCF in India.

**Search Strategy and Databases:** PubMed, Google Scholar, and IndMED were searched for English-language studies; reference lists and pediatric textbooks were manually reviewed.

**Inclusion Criteria:** Studies from India addressing breastfeeding or complementary feeding, cultural beliefs, maternal knowledge, and their impact on child nutrition and health.

**Exclusion Criteria:** Studies outside India, non-IYCF topics, opinion pieces without evidence, case reports, and non-English or inaccessible full-text articles.

**Overview of Recommended IYCF Practices**:

**Early Initiation of Breastfeeding:** Within 1 hour of birth to provide colostrum and protection against infections [1,2,3].

**Exclusive Breastfeeding (0–6 months):** Only breast milk; supports growth, immunity, and cognitive development [1,2,3,9,10].

**Complementary Feeding (6–24 months):** Age-appropriate, frequent, and diverse foods alongside continued breastfeeding [1,2,8,12,15].

**Continued Breastfeeding:** Up to 2 years or beyond for nutrition and immunity [1,2,11,12].

**Myths, Beliefs, and Misconceptions in IYCF:**

1. **Breastfeeding- Related Myths:**

Colostrum is "impure" → discarded, delaying early immunity [1,2,5,13,14].
Prelacteal feeds (honey, ghee, water) → risk of diarrhea, reduce exclusive breastfeeding[3,5,6,13].
Perceived milk insufficiency → early supplementation [4,5,14].
Gender bias → preferential feeding of male infants [4,13].
Traditional medicines/herbs → delay exclusive breastfeeding [5,13,14].

2. **Complementary Feeding Myths:**

Delayed introduction of solids beyond 6 months [1,2,8,12,15].
Restricted food diversity (avoiding eggs, pulses, fruits, vegetables) [8,13,15].
Low meal frequency due to workload or beliefs [8,15].
Food taboos during illness (withholding eggs, milk, curd) [13,14].
Avoidance of "hot" or "cold" foods based on traditional concepts [13,16].

3. **Illness-Related Feeding Misconceptions:**

Stopping breastfeeding during diarrhea, fever, or cough [2,3,12,14].
Restricting fluids during illness → risk of dehydration [3,12].
Using formula, animal milk, or herbal drinks instead of breast milk [2,5,14].
Withholding appropriate foods due to choking or cough [13,16].

4. **Regional and Socioeconomic Influences:**

Rural mothers more likely to discard colostrum and give prelacteal feeds [4,5,7,13].
Higher maternal education improves adherence, but myths persist [4,7,17].
Religious and caste practices reinforce feeding restrictions [5,13,16].

**Sources and Determinants of Myths in IYCF Practices**

**The persistence of myths and misconceptions in India is influenced by multiple factors:**

1. **Cultural Traditions:** Deeply ingrained norms and rituals dictate practices like colostrum discarding,

prelacteal feeding, and delayed complementary feeding. Religious customs may prescribe specific feeds or restrict certain foods, persisting even among educated mothers [5,13,14,16].

2. **Family Influence:** Grandmothers and elder women often guide feeding practices, overriding healthcare advice. Spousal support also affects adherence to exclusive breastfeeding [4,5,13,17].
3. **Socioeconomic Factors:** Low maternal education, poverty, and rural residence are linked to higher prevalence of feeding myths. Urban mothers, though more informed, may face early cessation of exclusive breastfeeding due to work pressures [4,7,13,17].
4. **Health System Gaps:** Inconsistent counseling, limited access to trained providers, and lack of culturally sensitive guidance perpetuate reliance on traditional advice [1,2,16,18].

**Impact on Child Nutrition and Health**

Myths directly affect child growth, nutritional status, and health outcomes:

- **Undernutrition & Stunting:** Delayed initiation, early cessation of breastfeeding, and restricted complementary foods contribute to underweight and stunting; NFHS-5 reports 32% underweight and 35% stunted children under five [7,8,15].
- **Wasting:** Inconsistent feeding, prelacteal feeds, and illness-related restrictions increase acute malnutrition [8,12,15].
- **Micronutrient Deficiencies:** Avoidance of eggs, milk, vegetables, and fruits limits iron, vitamin A, zinc, and iodine intake; ~58% of children aged 6–59 months are anemic [7,8,15].
- **Increased Morbidity & Infection:** Suboptimal breastfeeding and early supplementation raise the risk of diarrhea and respiratory infections [2,3,12].
- **Delayed Cognitive Development:** Poor feeding limits essential nutrients, affecting brain development and motor skills [9,10].
- **Future Health Risks:** Early introduction of low-quality complementary foods may predispose to obesity and metabolic disorders later in life [10,12].
- **Maternal Health & Economic Burden:** Early breastfeeding cessation affects maternal health and increases household and national healthcare costs [2,12].
- **Mortality:** Suboptimal feeding contributes significantly to child deaths; optimal IYCF practices could prevent more than 820,000 under-five deaths globally [3,12]

**Strategies to Address Myths**

Effective interventions combine education, counseling, and community engagement:

1. **Health Education:** Mass media campaigns to raise awareness and debunk myths.
2. **Counseling During Immunization:** Repeated, structured guidance with visual aids improves adherence to breastfeeding and complementary feeding recommendations.
3. **Frontline Health Workers:** ASHAs, ANMs, and Anganwadi workers provide culturally sensitive counseling, monitor growth, and support mothers.
4. **Community-Based Interventions:** Peer support groups, mother workshops, and involvement of elders shift social norms, improve dietary diversity, and reinforce timely feeding.

**Discussion**

This review highlights that myths, beliefs, and misconceptions continue to exert a strong influence on infant and young child feeding (IYCF) practices in India, despite the availability of clear WHO and

Indian Academy of Pediatrics (IAP) guidelines. The findings consistently demonstrate a substantial gap between recommended practices and actual maternal behavior, largely driven by sociocultural traditions, family influence, and inadequate health system support.

Delayed initiation of breastfeeding and discarding of colostrum remain prevalent across many regions. These practices deprive newborns of early immune protection and increase susceptibility to infections, corroborating earlier national and regional studies that associate delayed breastfeeding with higher neonatal morbidity and mortality. The continued practice of prelacteal feeding—often rooted in ritualistic beliefs—further undermines exclusive breastfeeding and increases the risk of diarrhea and other infections.

Perceived breast milk insufficiency emerged as one of the most common reasons for early supplementation with animal milk or formula. This misconception, often reinforced by family elders, highlights the critical role of interpersonal and intergenerational dynamics in shaping feeding behavior. Similar observations have been reported in NFHS-5 and multiple community-based studies, indicating that maternal confidence and social support are as important as knowledge in sustaining exclusive breastfeeding.

Complementary feeding practices were also significantly affected by cultural beliefs. Delayed introduction of complementary foods, inadequate dietary diversity, low meal frequency, and avoidance of nutrient-dense foods such as eggs, pulses, fruits, and vegetables contribute to persistent undernutrition, micronutrient deficiencies, and growth faltering. The widespread restriction of foods during childhood illnesses further exacerbates nutritional deficits and delays recovery, increasing the burden of recurrent infections.

The review also underscores notable regional, educational, and socioeconomic disparities. Rural residence, low maternal education, and limited access to culturally sensitive counseling were consistently associated with poorer IYCF practices. Although urban mothers generally demonstrated better awareness, early cessation of exclusive breastfeeding due to work-related constraints and reliance on substitutes remains a concern.

Importantly, the findings emphasize that knowledge alone is insufficient to change behavior. Health system gaps—such as inconsistent counseling, limited engagement of family decision-makers, and lack of culturally tailored communication—perpetuate harmful practices. Evidence from community-based interventions indicates that repeated counseling during antenatal care, immunization visits, and through frontline health workers (ASHAs, ANMs, Anganwadi workers) can effectively address myths and improve adherence to optimal IYCF practices.

Overall, this review reinforces that addressing myths and misconceptions requires multi-level, culturally sensitive strategies that integrate health education, family involvement, community participation, and system-level strengthening. Such approaches are essential to improve child nutrition, reduce morbidity and mortality, and achieve national nutrition targets.

## Conclusion

Myths, beliefs, and misconceptions regarding IYCF remain widespread in India, leading to suboptimal breastfeeding, poor complementary feeding, undernutrition, stunting, wasting, micronutrient deficiencies, increased morbidity and mortality, and maternal and economic consequences. Addressing these requires culturally sensitive, multi-level interventions involving health education, counseling, frontline workers, and community engagement to improve child nutrition and survival outcomes.

Bridging knowledge–practice gaps and countering cultural myths can **improve IYCF adherence, child growth, and survival**, contributing to India's national nutrition targets and long-term public health gains

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**CONFLICT OF INTEREST**

The author declares no conflict of interest related to this study.

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