

Original Research Article

Prelacteal feeding practices among mothers of infants: prevalence, patterns, and determinants

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ABSTRACT

Background: Prelacteal feeding is the practice of providing a newborn any food or fluid other than mother's milk, before breastfeeding is established. It delays the early initiation of breastfeeding, and increases the risk of neonatal infections. Prelacteal feeding is still strongly ingrained in Indian culture and traditions, despite national guidelines discouraging this practice. The objective of the study was to determine the prevalence of prelacteal feeding among mothers of children aged up to one year, to describe the types of prelacteal feeds used and identify the associated determinants.

Methods: A community-based cross-sectional study was conducted among 400 mothers of children aged up to one year. Multistage stratified sampling was employed, and data were collected using a validated semi-structured questionnaire. Associations between socio-demographic/obstetric factors and prelacteal feeding practice were evaluated and a p value of <0.05 was considered statistically significant.

Results: Among the 400 participants, 211 (52.8%), had given prelacteal feeds to their newborn, while 162 (40.5%) had not and 27 (6.8%) were unaware. Ghutti was the most commonly used feed (114; 54.0%). Elder's suggestion was the predominant reason cited (107; 50.7%). No socio-demographic/obstetric factors showed a statistically significant association with prelacteal feeding practice.

Conclusions: Prelacteal feeding was practiced by more than half of the mothers in this community. The absence of a significant association with any individual-level socio-demographic or obstetric factor may suggest that the practice is sustained by deep-rooted, family-mediated cultural norms that cut across education and socio-economic strata.

Keywords: Prelacteal feeding, Infant and young child feeding, Ghutti, Colostrum, Community-based study

INTRODUCTION

It is universally acknowledged that breast milk is the primary and ideal source of nutrition for a newborn. Colostrum, the antibody-rich first milk secreted in the first few days following delivery, provides both holistic nourishment and immunological protection.¹ Through the baby-friendly hospital initiative (BFHI) and its "ten steps to successful breastfeeding," the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) specifically advise that, unless medically indicated, newborns should only be given breast milk. Breastfeeding should ideally begin within an hour of

birth.^{2,3} Prelacteal feeding is defined as the practice of giving any food or fluid other than mother's milk to a newborn before breastfeeding is established - directly contradicts this recommendation and represents one of the earliest and most significant deviations from ideal infant feeding practice.⁴

Prelacteal feeding increases the newborn's susceptibility to neonatal sepsis, diarrheal illness, and other infections during the most immunologically vulnerable stage of life because it is linked to delayed breastfeeding initiation, decreased suckling stimulus for lactogenesis, and denial of colostrum.⁵ The practice is deeply ingrained in cultural

belief systems in many South Asian communities, including large parts of India; substances like honey, sugar water, animal milk, ghutti (a herbal/religious preparation), or plain water are given in the belief that they cleanse the infant's gut, facilitate digestion, grant religious blessings, or are just what elderly members of the family have always recommended.⁶ Rather than being solely the result of individual maternal choice, these beliefs are frequently passed down through the generations and strengthened by family decision-making systems.^{7,8}

Although there has been an improvement over previous survey rounds, secondary analysis of the national family health survey-5 (NFHS-5, 2019–21) has revealed that a significant proportion of newborns still receive a prelacteal feed at the national level.⁹ National-level averages may obscure significant regional and sociocultural heterogeneity, as evidenced by the significantly disparate prevalence estimates reported by facility- and community-based research from various regions of India, which range from less than one-quarter to more than half of neonates. Age, caste, socioeconomic level, and place of delivery were also associated with the practice of prelacteal feeding in a community-based study from rural Uttar Pradesh, highlighting the fact that its determinants are context-specific and cannot be generalized across settings.¹⁰

Designing culturally relevant, family-inclusive behaviour change communication strategies requires an understanding of the local prevalence, the particular prelacteal feed type used, the reasons given by mothers, and the sociodemographic and obstetric correlates of the practice. There are not many field practice area-based studies from Haryana that specifically address prelacteal feeding, so this study was planned to fill this evidence gap. The current study intends to ascertain the prevalence of prelacteal feeding among mothers of children up to one year of age in the rural and urban field practice area of a medical college in Ambala, Haryana; characterize the types of prelacteal feeds used and the reasons for the practice; and identify the sociodemographic and obstetric determinants of prelacteal feeding.

METHODS

From March 2025 to February 2026, a community-based cross-sectional study was carried out in the field practice area of the department of community medicine, of a medical college in Ambala district, Haryana, India. The study population comprised of mothers with children under the age of one year who were permanent residents of the chosen field practice area. Mothers who were unable to participate, were unavailable during data collection, had children with significant congenital abnormalities that affected feeding, or were migrants or non-permanent residents were excluded.

A minimum sample size of 355 participants was obtained by applying the standard formula for prevalence studies, based on the prevalence of exclusive breastfeeding of

63.7%, as reported by the NFHS-5 for India (2019-21) and considering absolute precision of 5% and at a 95% confidence interval.⁹

$$n = 4pq/L^2$$

This was rounded up to 400 mother-child dyads to account for potential non-response and to improve the precision of estimates.

Multistage stratified sampling was used for recruitment: villages and sub-center areas within the field practice area were first stratified by residential category (rural/urban), a proportionate number were chosen by systematic random sampling, and then eligible mother-child dyads were chosen from village- and sub-center-level listings (assembled with the help of ASHAs, anganwadi workers, and immunization records) using systematic random sampling. The next eligible home on the list was contacted as a replacement in cases when a chosen participant was unavailable after 3 attempts or declined to participate.

A pre-tested, semi-structured questionnaire (available in Hindi and English) was used to gather data through in-person interviews with mothers or primary caregivers. The questionnaire recorded the sociodemographic profile, obstetric and child characteristics, and comprehensive information on infant feeding practices, including whether or not a prelacteal feed had been given, the type of feed given, and the mother's primary reason for giving it. The study protocol received approval from the institutional ethics committee (IEC) (ref no: IEC-3265 dated: 18/02/2025), prior to commencement. All participants provided written informed consent in their native vernacular language; participation was completely voluntary, and all data confidentiality and anonymity were scrupulously upheld. Data were entered into microsoft excel and analysed using statistical package for the social sciences (SPSS) version 28. Categorical variables were summarized as frequencies and percentages; associations between categorical variables and prelacteal feeding practice were assessed using the chi-square test, with fisher's exact test used when cell counts were small. Statistical significance was defined as a p value of less than 0.05.

Operational definition

Based on NFHS-IV (2015–16), any food or liquid other than mother's milk given to a baby before to the start of breastfeeding was considered a prelacteal feed.¹¹

RESULTS

Socio-demographic profile

A total of 400 mother-child pairs who fulfilled the inclusion criteria were enrolled. With a mean age of 28.05 ± 3.33 years, the majority of mothers (248; 62.0%) belonged to the 26-30 age group. Most of the mothers were

educated up to high school level (141; 35.1%), followed by graduates or above (90; 22.5%). The majority of mothers (306; 76.5%) were homemakers. 58.3% of participants were from rural background. The majority (313; 78.3%) were residing in nuclear families. According to the modified B. G. Prasad scale 2025, 87.7% of participants belonged to the upper middle socioeconomic class (Table 1).¹²

Obstetric and child characteristics

Majority 58.3% of the children were male, and the mean age of the children was 6.91 ± 2.91 months. Most mothers were multiparous (338; 84.5%). Private institutional delivery predominated (271; 67.8%), followed by government facility delivery (95; 23.8%) and home delivery (34; 8.5%). Most mothers (280; 70.0%) had more than four antenatal checkups, and 304 (76.0%) had completed recommended schedule of tetanus vaccination. For 269 (67.3%) women, healthcare professionals were their main source of information about infant feeding practices, followed by relatives (91; 22.7%) and the media (40; 10.0%). 218 (54.5%) mothers reported their pregnancy as planned (Figure 1).

Prevalence of prelacteal feeding

Among the 400 participants, 211 mothers (52.8%) reported having practiced prelacteal feeding, whereas 162 mothers (40.4%) did not practice it, and 27 mothers (6.8%) were unaware of whether any prelacteal feed had been given to their child (Table 2).

Types of prelacteal feeds used

Of the 211 mothers who practiced prelacteal feeding, 114 (54.0%) reported giving ghutti, an herbal/religious preparation; this was followed by honey (47, 22.3%) and sugar water (35, 16.6%). Fifteen mothers (7.1%) reported feeding gripe water (Figure 2).

Reasons for giving prelacteal feed

The most common cited reason for giving prelacteal feeding was elder's suggestion which was reported by 107 (50.7%) mothers who practiced prelacteal feeding. This was followed by culture and customs which was the reason reported in 83 (39.3%) cases.

A smaller proportion of mothers, 21 (10.0%), believed that prelacteal feeding benefits the child and therefore had given it (Figure 3).

Association between socio-demographic/obstetric factors and prelacteal feeding practice

The association between sociodemographic and obstetric characteristics and prelacteal feeding practice was evaluated among 373 participants for whom information about whether prelacteal feeding was practiced or not was clearly available (mothers who reported "don't know" were excluded). Table 3 illustrates that while mothers who gave birth at home had a numerically higher percentage of prelacteal feeding (70.0%) than those who gave birth in private institutional (56.3%) or government (52.8%) settings, none of the factors examined - age of mother, occupation, education, residence, socioeconomic status, type of family, parity, place of delivery, number of antenatal visits, or whether the pregnancy was planned - showed a statistically significant association with prelacteal feeding practice.

Table 1: Socio-demographic profile of study participants (n=400).

Variables	Category	Frequency (%)
Age of mother (years)	≤20	13 (3.3)
	21-25	61 (15.2)
	26-30	248 (62.0)
	>30	78 (19.5)
Education	Illiterate	35 (8.8)
	Primary	59 (14.8)
	Middle	54 (13.5)
	High school	141 (35.1)
	Intermediate	21 (5.3)
	Graduate or above	90 (22.5)
Occupation	Homemaker	306 (76.5)
	Working	94 (23.5)
Residence	Rural	233 (58.3)
	Urban	167 (41.7)
Type of family	Nuclear	313 (78.3)
	Joint	87 (21.7)
Socioeconomic status	Upper	32 (8.0)
	Upper middle	351 (87.7)
	Middle	17 (4.3)

Table 2: Prevalence of prelacteal feeding (n=400).

Prelacteal feeding	Frequency (N)	Percentage (%)
Yes	211	52.8
No	162	40.4
Don't know	27	6.8
Total	400	100.0

Table 3: Association between socio-demographic and obstetric factors and prelacteal feeding practice (n=373).

Variables	Category	Prelacteal feed given, yes N (%)	Prelacteal feed given no, N (%)	χ^2 , P*
Age of mother (years)	≤20	06 (50.0)	06 (50.0)	2.23, 0.53
	21-25	31 (54.4)	26 (45.6)	

Continued.

Variables	Category	Prelacteal feed given, yes N (%)	Prelacteal feed given no, N (%)	χ^2 , P*
	26–30	126 (55.0)	103 (45.0)	
	>30	48 (64.0)	27 (36.0)	
Education	Illiterate	18 (60.0)	12 (40.0)	2.14, 0.83
	Primary	29 (51.8)	27 (48.2)	
	Middle	31 (60.8)	20 (39.2)	
	High school	78 (59.1)	54 (40.9)	
	Intermediate	12 (57.1)	09 (42.9)	
	Graduate or above	43 (51.8)	40 (48.2)	
Occupation	Homemaker	165 (57.3)	123 (42.7)	0.16, 0.69
	Working	46 (54.1)	39 (45.9)	
Residence	Rural	119 (53.8)	102 (46.2)	1.38, 0.24
	Urban	92 (60.5)	60 (39.5)	
Type of family	Nuclear	161 (55.3)	130 (44.7)	0.62, 0.43
	Joint	50 (61.0)	32 (39.0)	
Socio-economic status	Upper	16 (51.6)	15 (48.4)	0.77, 0.68
	Upper middle	184 (56.6)	141 (43.4)	
	Middle	11 (64.7)	06 (35.3)	
Parity	Primiparous	32 (52.5)	29 (47.5)	0.32, 0.57
	Multiparous	179 (57.4)	133 (42.6)	
Place of delivery	Private institutional	143 (56.3)	111 (43.7)	2.72, 0.26
	Government facility	47 (52.8)	42 (47.2)	
	Home delivery	21 (70.0)	09 (30.0)	
No. of ANC visits	≤4	63 (55.8)	50 (44.2)	0.01, 0.92
	>4	148 (56.9)	112 (43.1)	
Planned pregnancy	Yes	111 (54.7)	92 (45.3)	0.49, 0.48
	No	100 (58.8)	70 (41.2)	
Total		211 (56.6)	162 (43.4)	

*P<0.05 statistically significant; Chi-square test applied. Frequencies and percentages are calculated within each category (row-wise)

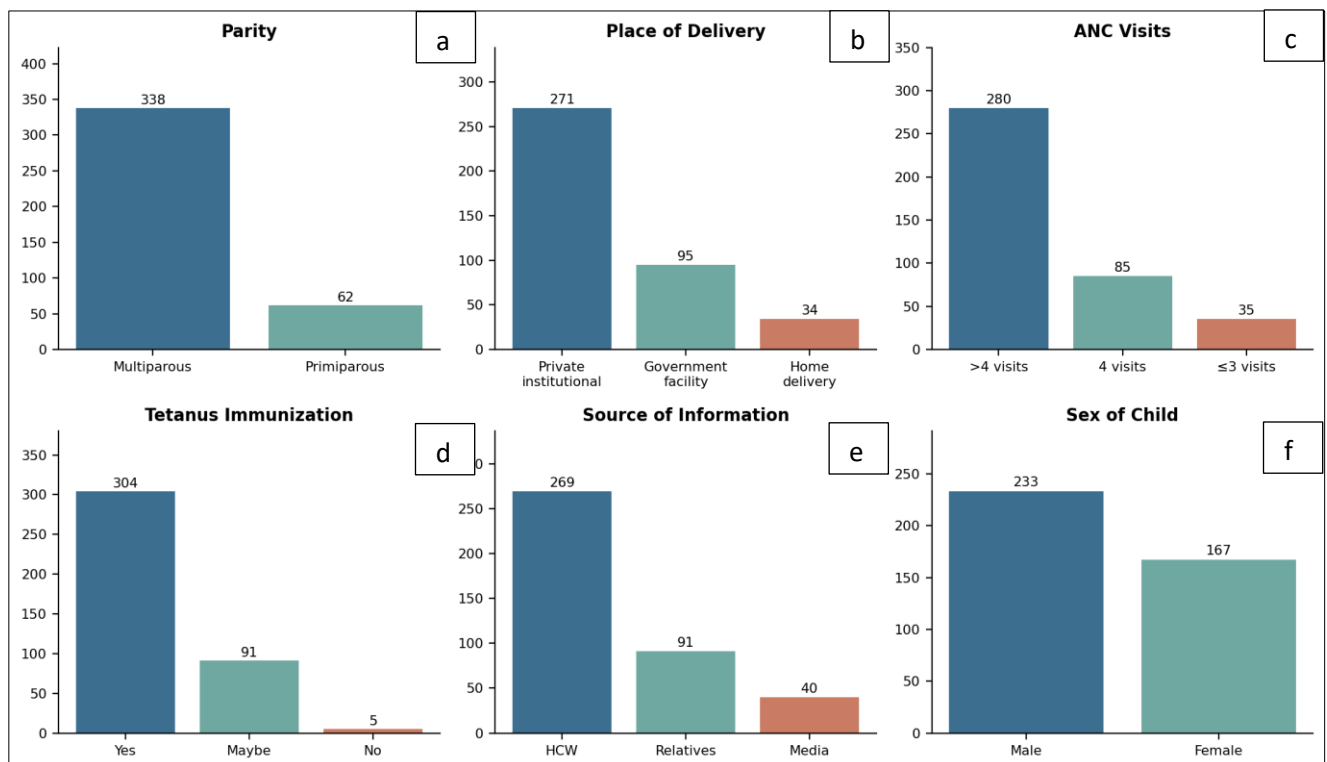


Figure 1 (a-f): Obstetric and child characteristics.

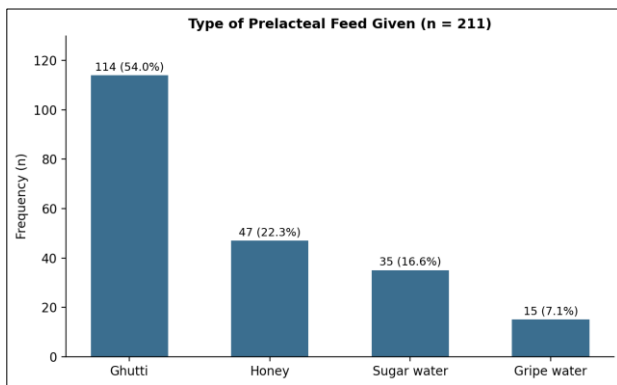


Figure 2: Type of prelacteal feed given.

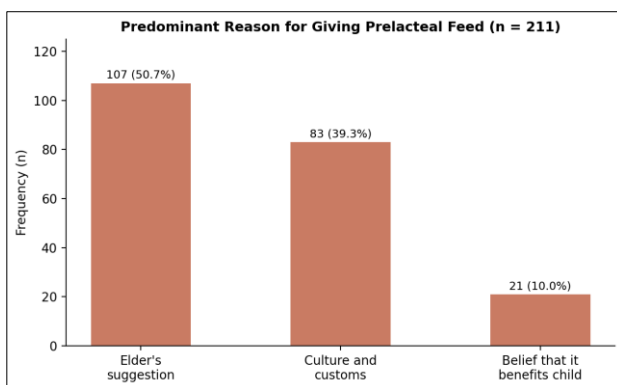


Figure 3: Predominant reason for giving prelacteal feed.

DISCUSSION

The present study reports a high prevalence of prelacteal feeding (52.8%) in the study area. This implies that more than half of the newborns in this community were given something other than breast milk prior to the establishment of breastfeeding, which is directly contrary to WHO/UNICEF recommendations that discourage any prelacteal feeding.^{1,2}

When compared with existing literature, the prevalence of prelacteal feeding in this study (52.8%) is considerably higher. Panigrahi et al in a tertiary hospital-based study in north Karnataka reported this prevalence as 39% while Achalkar et al in urban Raichur reported 28.5% prevalence of prelacteal feeding.^{13,14} Even lesser prevalence was reported like 24.7% reported by Rani et al in urban slums of Visakhapatnam, and the 23.1% reported by Singh et al in a rural area of Delhi.^{15,16} It is, however, broadly comparable to the 40.1% reported by Roy et al in a community-based study of rural Uttar Pradesh.¹⁰ In a study by Meharda et al 62.6% children received prelacteal feeding which is even higher than the present study.¹⁷ An even higher prevalence of 72.05% was reported by Parashar et al from Uttar Pradesh.¹⁸ In Berhampur, Odisha, 374 children had an overall prelacteal feeding prevalence of 37.97%, according to Karmee et al.¹⁹ The significantly higher prevalence found in the present study is probably

due to the sample's predominately rural, community-based nature as well as the enduring strong traditional beliefs supporting practice of prelacteal feeding in this catchment area.

In this study, the most often administered prelacteal feed was ghutti (54.0%), which was followed by honey (22.3%) and sugar water (16.6%). This finding is similar to findings in another study by Panigrahi et al, who similarly reported honey, sugar water, and ghutti as the commonly fed prelacteal substances.¹³ In a study by Mahmood et al in rural Uttar Pradesh, ghutti (42.9%) was again the most popular prelacteal feed, followed by plain boiled water (21.4%), tea (21.4%), and milk other than breastmilk (14.3%).²⁰ While Srinivasa et al found that sugar water (39.5%) was the most popular prelacteal feed in their rural tertiary-care context, followed by boiled water (22.9%) and animal milk (18.7%), Singh et al reported a somewhat different pattern, with honey (52.1%) more common than ghutti (31.3%).^{16,21} These inter-study variation in the particular substance used highlight the fact that, although prelacteal feeding is a common practice in Indian settings, the specific practice is shaped by locally available household substances and prevailing cultural beliefs. This emphasizes the need for locally tailored counselling messages rather than a uniform national message alone.

The most common justification for prelacteal feeding in this study was elder's recommendation (50.7%), followed by culture and customs (39.3%) and the conviction that it is beneficial to the child (10.0%). This result closely resembles that of Singh et al, who found that 64.6% of mothers offered prelacteal feeds because their elders had advised it, or because of religious reasons (47.9%) and a belief in the child's benefit (18.7%).¹⁶ In a similar study, Panigrahi et al reported that mothers' explanations for the practice included assumptions about speech development and a laxative effect, beliefs about aiding digestion, and familial pressure.¹³ In the context of Indian families, infant feeding decisions during the early newborn period are often made or heavily influenced by grandmothers and other senior family members rather than by the mother alone, as seen by the continuous significance of elder-mediated counsel across the cited related research.

There was no statistically significant association found between prelacteal feeding practice and any of the sociodemographic variables including age, education, occupation, residence, family type, or socioeconomic status. In contrast, Roy et al found that prelacteal feeding in rural Uttar Pradesh was significantly predicted by age, caste, and site of delivery (age: adjusted OR 1.76, 95% CI 1.13-2.74).¹⁰ Mothers with graduate-level education demonstrated a prelacteal feeding rate (51.8%) that was not significantly different from illiterate mothers (60.0%), indicating that formal education alone may not be sufficient to override deeply held family and cultural beliefs regarding newborn feeding. This finding highlights the lack of a significant education or socioeconomic gradient in the current study. This pattern is similar with

the larger body of research on newborn and young child feeding in India, where it has been demonstrated that structured health-system engagement and exposure to the media are more consistently linked to good feeding practices than education status alone.⁶

Prelacteal feeding was not significantly associated with place of delivery, number of prenatal visits, parity, or planned or unplanned pregnancy status in this study; however, mothers who gave birth at home had a higher rate of the practice (70.0%) than mothers who gave birth in an institution (52.8-56.3%). Although this numerical trend - home deliveries are less likely to be attended by trained birth attendants who can actively discourage prelacteal feeding immediately after birth - is clinically plausible, it was not statistically significant. This could be due to the relatively small number of home deliveries (n=34) and the overwhelming influence of family decision-making, which seems to function independently of the delivery setting. Prelacteal feeding may not be sufficiently addressed as a distinct counselling point in routine prenatal contacts as currently constituted, as evidenced by the lack of a significant correlation with the number of antenatal visits (70.0% of mothers had more than four visits).

When taken as a whole, the lack of a significant correlation between prelacteal feeding and any specific maternal or obstetric characteristic, along with elders' recommendations and culture/customs collectively accounting for 90.0% of the reasons mentioned, strongly suggests that cultural norms at the family and community levels, rather than individual maternal knowledge, education, or contact with the health system, are what sustain prelacteal feeding in this community. This has immediate programming ramifications: counselling techniques that just focus on the mother without involving grandmothers and other senior family decision-makers are unlikely to significantly lower the practice. Prenatal visits, immediate postnatal contact, and village health and nutrition days (VHNDs) should all include structured counselling on colostrum feeding and early breastfeeding initiation, specifically naming and discouraging prelacteal feeds. Family members should also be actively involved. Since private hospitals account for the majority of deliveries in this catchment region (67.8%), BFHI, which requires that newborns only receive breast milk unless medically necessary, should be methodically strengthened and extended.

Limitations

Causal inference about the factors influencing prelacteal feeding is not possible due to the cross-sectional study design. Generalizability to other areas with distinct sociocultural backgrounds is limited by the single-site study area. Recall and social desirability bias can affect self-reported and recalled data on prelacteal feeding practices, especially for mothers of older infants. The "culture and customs" category's underlying psychological and theological factors were not further broken down.

Caste and religion are examples of potential confounders that were not evaluated and might not have been completely taken into consideration.

CONCLUSION

In this community-based study from Ambala, Haryana, the prevalence of prelacteal feeding was 52.8%, meaning that over half of neonates were given anything other than breast milk prior to the establishment of breastfeeding. The most popular prelacteal feed was ghutti. The most common explanation given was elder's recommendation, which was followed by culture and customs. Age, education, occupation, housing, family type, socioeconomic level, parity, place of delivery, number of prenatal visits, and planned pregnancy status were all studied, however none of these demonstrated a statistically significant correlation with the practice. These results demonstrate that prelacteal feeding in this context is primarily motivated by family-mediated cultural beliefs that transcend socio-demographic strata. This emphasizes the necessity of family-inclusive behaviour change communication, active involvement of elders and grandmothers, enhanced immediate postnatal counselling on colostrum feeding, and extension of BFHI practices to private institutional deliveries in order to decrease practice of prelacteal feeding and promote optimal infant feeding throughout India.

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