

ORIGINAL ARTICLE

Socioeconomic Determinants of Appropriate Infant and Young Child Feeding Practices in Northern Bangladesh

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ABSTRACT

Background: Infant and young child feeding (IYCF) practices are essential for optimal growth, development, and nutritional health during the first two years of life. Feeding practices may vary according to socioeconomic conditions, maternal education, household resources, and access to health services. **Aim of the study:** To assess the socioeconomic determinants of appropriate IYCF practices among children aged 6–24 months in Northern Bangladesh. **Methods & Materials:** This cross-sectional observational study included 314 mother–child pairs. Sociodemographic, socioeconomic, feeding-related, and health-service information was collected using a structured interviewer-administered questionnaire. IYCF practices were assessed based on breastfeeding, meal frequency, minimum dietary diversity, and minimum acceptable diet. Associations were assessed using chi-square or Fisher's exact tests and multivariable binary logistic regression. Adjusted odds ratios (AORs) with 95% confidence intervals (CIs) were calculated, with $p < 0.05$ considered significant. **Result:** Overall, 42.4% of children demonstrated appropriate IYCF practice. Breastfeeding was initiated within 1 hour in 68.2%, colostrum was given to 81.8%, and exclusive breastfeeding for 6 months was reported in 64.0%. Age-appropriate meal frequency and minimum dietary diversity were achieved by 69.7% and 53.8%, respectively, while 42.4% achieved the minimum acceptable diet. In multivariable analysis, children aged 12–24 months (AOR 1.84, 95% CI 1.08–3.14; $p = 0.025$), urban residence (AOR 1.67, 95% CI 1.03–2.71; $p = 0.038$), higher maternal education, and greater household wealth were independently associated with appropriate IYCF practice. IYCF counselling, dietary diversity knowledge, ≥ 4 ANC visits, and timely health-facility access were also significantly associated. **Conclusion:** Less than half of the children achieved appropriate IYCF practices, particularly complementary feeding indicators. Socioeconomic conditions, maternal education, and access to nutrition-related services were important factors associated with feeding practices.

Keywords: Infant and young child feeding, Complementary feeding, Dietary diversity, Maternal education, Household wealth

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INTRODUCTION

Infant and young child feeding (IYCF) refers to the feeding practices used for infants and young children, including breastfeeding and the introduction of complementary foods. Appropriate IYCF practices help ensure that children receive suitable and nutritious foods at the right time throughout the first two years of life [1,2]. Globally, 30.8% of children aged 6–23 months receive the recommended minimum dietary diversity [3]. In Bangladesh, 34.7% of children aged 6–23 months receive a minimum acceptable diet [4]. Complementary foods should be introduced at 6 months while breastfeeding continues to meet the increasing energy and nutrient requirements of the growing child [2,5]. Initially, foods should be offered in small amounts and gradually increased in quantity, consistency, and variety according to the child's age and developmental capacity [2,5]. Breastfed children aged 6–8 months should be offered complementary foods 2–3 times a day, with the frequency increasing to 3–4 times daily between 9 and 23 months [1,2]. A diverse diet should include foods from several food groups such as grains, legumes and nuts, dairy

products, eggs, meat or fish, and fruits and vegetables to meet the child's nutritional requirements [1,2]. Continued breastfeeding alongside adequate complementary feeding supports the nutritional needs of children during this period [2,5]. Appropriate feeding practices provide the essential nutrients required for physical growth, brain development, immune function, and the formation of healthy dietary patterns [5,6]. Adequate dietary diversity and meal frequency can support optimal growth and reduce the risk of micronutrient deficiencies [3,5]. In contrast, delayed or inadequate complementary feeding, poor dietary diversity, insufficient meal frequency, and unsafe feeding practices increase the risk of stunting, underweight, micronutrient deficiencies, infections, and impaired cognitive development [5,7,8]. Poor feeding practices during this critical period can have lasting effects on children's health and well-being beyond early childhood [7,8]. Socioeconomic factors also influence feeding practices. Household income and food security influence access to diverse and nutritious foods, while parental education contributes to better nutrition knowledge

and the adoption of recommended feeding behaviour [9,10]. Maternal employment, access to health services, media exposure, and household resources are also associated with child feeding practices [9,11,12]. Socioeconomic advantages can support appropriate feeding practices. Poverty, food insecurity, limited education, and poor access to nutrition information can create barriers to their adoption [9-11]. These socioeconomic determinants have important implications for developing targeted nutrition education, counselling, and community-based interventions. Although IYCF practices have been studied in Bangladesh, socioeconomic and regional differences in feeding practices remain a concern. In Bangladesh, wealth status and parental education have been linked to dietary diversity, while variations in feeding indicators across geographical settings have also been observed in Northern Bangladesh [10,12]. However, only a few studies have examined the broader socioeconomic determinants of appropriate IYCF practices among young children in Northern Bangladesh. The present study aimed to assess the socioeconomic determinants of appropriate infant and young child feeding practices in Northern Bangladesh.

METHODS & MATERIALS

A descriptive cross sectional study was carried at Pediatric outpatient department and EPI center of Rajshahi Medical College Hospital, Rajshahi, from January 2017 to December 2018. A total of 314 eligible mother-child pairs were included consecutively according to predefined inclusion and exclusion criteria.

Inclusion Criteria

- Mothers or primary caregivers of children aged 6–24 months.
- Children residing in the selected study area of Northern Bangladesh.
- Participants who were available during the study period and able to provide relevant information regarding the child's feeding practices.
- Mother-child pairs with sufficient demographic, socioeconomic, and feeding-related information for analysis.
- Participants who provided written informed consent for participation.

Exclusion Criteria

- Children younger than 6 months or older than 24 months.
- Participants who were unable to provide reliable information regarding the child's feeding history.
- Mother-child pairs with substantially incomplete relevant information.
- Participants who declined to provide informed consent.

Ethical Considerations

The study protocol was reviewed and approved by the appropriate institutional ethical review committee. Written informed consent was obtained from all participating mothers or caregivers before data collection. Participation was voluntary, and participants were informed of their right to withdraw at any stage without affecting their access to

healthcare services. Personal identifiers were excluded from the analytical dataset, and all collected information was maintained confidentially and used exclusively for research purposes.

Data Collection

Sociodemographic and socioeconomic information was collected using a structured interviewer-administered questionnaire. Variables included child age and sex, child weight, maternal age, place of residence, maternal and paternal educational status, parental occupation, household size, monthly household income, and household wealth status. Information on infant and young child feeding practices included initiation of breastfeeding within one hour of birth, provision of colostrum, exclusive breastfeeding for the first six months, age-appropriate meal frequency, minimum dietary diversity, and minimum acceptable diet. Maternal knowledge regarding dietary diversity, receipt of IYCF counselling, antenatal care attendance, and access to a health facility were also assessed. Appropriate IYCF practice was considered the primary outcome and was categorized as appropriate or inappropriate according to the predefined study criteria.

Assessment of Socioeconomic Status

Household socioeconomic status was assessed using household income and predefined wealth categories. Participants were categorized into five household wealth groups: poorest, poorer, middle, richer, and richest. Maternal and paternal education and occupation were additionally considered socioeconomic indicators in the analysis.

Statistical Analysis

Data were entered into a structured database and analyzed using SPSS version 26.0. Continuous variables were summarized as mean $\pm$ standard deviation (SD), while categorical variables were presented as frequencies and percentages. Associations between categorical sociodemographic, socioeconomic, maternal, and service-related variables and appropriate IYCF practices were assessed using the chi-square test or Fisher's exact test, where appropriate. Multivariable binary logistic regression analysis was performed to identify independent socioeconomic determinants of appropriate IYCF practices, with results expressed as adjusted odds ratios (AORs) with 95% confidence intervals (CIs). Variables considered relevant from the bivariate analysis were entered into the multivariable model. A two-sided p-value of <0.05 was considered statistically significant.

RESULTS

A total of 314 children were included, with a mean age of 14.8 ± 5.3 months. Children aged 12–24 months represented the largest age group (57.0%), and 59.9% were male. Most children weighed 5–10 kg (81.5%). The mean maternal age was 27.6 ± 5.4 years, with 38.5% aged 26–30 years. Rural residence was reported for 61.5% of participants. Secondary education was the most common maternal educational level (38.5%), and 78.3% of mothers were housewives. The mean household size was 5.1 ± 1.8 members, and mean monthly household income was BDT $28,600 \pm 12,400$ in Table 1.

Table I: Socio-demographic characteristics of the study participants (n=314)

Variables	Frequency (n)	Percentage (%)
Child age (months)		
6–8	65	20.7
9–11	70	22.3
12–24	179	57.0
Mean $\pm$ SD	14.8 $\pm$ 5.3	
Gender		
Male	188	59.9
Female	126	40.1
Weight (kg)		
5–10	256	81.5
10.1–15	58	18.5
Maternal age group (years)		
≤ 25	105	33.4
26–30	121	38.5
> 30	88	28.0
Mean $\pm$ SD	27.6 $\pm$ 5.4	
Residence		
Urban	121	38.5
Rural	193	61.5

Breastfeeding was initiated within 1 hour of birth in 68.2% of children, while 81.8% received colostrum. Exclusive breastfeeding for the first 6 months was practiced by 64.0%. Age-appropriate meal frequency was achieved in 69.7%, whereas minimum dietary diversity was achieved in 53.8%.

Only 42.4% achieved the minimum acceptable diet, and the same proportion demonstrated appropriate overall IYCF practice in *Table II*.

Table II: Socioeconomic characteristics of the study participants (n=314)

Variables	Frequency (n)	Percentage (%)
Maternal education		
No formal education	38	12.1
Primary	79	25.2
Secondary	121	38.5
Higher secondary or above	76	24.2
Maternal occupation		
Housewife	246	78.3
Employed	68	21.7
Father's education		
No formal education	24	7.6
Primary	61	19.4
Secondary	116	36.9
Higher secondary or above	113	36.0
Father's occupation		
Agriculture	82	26.1
Business	91	29.0
Service	84	26.8
Other	57	18.2
Household size, mean $\pm$ SD	5.1 $\pm$ 1.8	
Monthly household income (BDT), mean $\pm$ SD	28,600 $\pm$ 12,400	
Household wealth quintile		
Poorest	61	19.4
Poorer	65	20.7
Middle	66	21.0
Richer	62	19.7
Richest	60	19.1

Appropriate IYCF practice differed significantly by child age ($p=0.009$), increasing from 30.8% among children aged 6–8 months to 49.7% among those aged 12–24 months. Urban residence was associated with a higher proportion of

appropriate practice (52.1%; $p=0.008$). No significant association was observed with sex ($p=0.663$) in *Table III*.

Table III: Infant and young child feeding practices among study participants (n=314)

Variables	Frequency (n)	Percentage (%)
Initiation of breastfeeding within 1 hour of birth		
Yes	214	68.2
No	100	31.8
Colostrum given		
Yes	257	81.8
No	57	18.2
Exclusive breastfeeding for first 6 months		
Yes	201	64.0
No	113	36.0
Age-appropriate meal frequency		
Appropriate	219	69.7
Inappropriate	95	30.3
Minimum dietary diversity		
Achieved	169	53.8
Not achieved	145	46.2
Minimum acceptable diet		
Achieved	133	42.4
Not achieved	181	57.6
Appropriate IYCF practice		
Yes	133	42.4
No	181	57.6

Maternal education was significantly associated with IYCF practice ($p<0.001$), with appropriate practice ranging from 21.1% among mothers without formal education to 51.3% among those with higher secondary education or above.

Maternal occupation was not associated with IYCF practice ($p=0.933$) in *Table IV*.

Table IV: Association between sociodemographic characteristics and appropriate IYCF practices (n=314)

Variables	Appropriate IYCF		Inappropriate IYCF		χ^2	P-value
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)		
Child age (months)						
6–8	20	30.8	45	69.2	9.42	0.009
9–11	24	34.3	46	65.7		
12–24	89	49.7	90	50.3		
Gender						
Male	82	43.6	106	56.4	0.19	0.663
Female	51	40.5	75	59.5		
Residence						
Urban	63	52.1	58	47.9	6.97	0.008
Rural	70	36.3	123	63.7		

Household wealth showed a significant gradient ($p<0.001$), with appropriate practice increasing from 23.0% in the poorest quintile to 60.0% in the richest quintile. In multivariable analysis, children aged 12–24 months had

higher odds of appropriate IYCF practice (AOR 1.84, 95% CI 1.08–3.14; $p=0.025$) in *Table V*.

Table V: Association between socioeconomic characteristics and appropriate IYCF practices (n=314)

Variables	Appropriate IYCF		Inappropriate IYCF		χ^2	P-value
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)		
Maternal education						
No formal education	8	21.1	30	78.9	16.49	<0.001
Primary	25	31.6	54	68.4		
Secondary	61	50.4	60	49.6		
Higher secondary/Others	39	51.3	37	48.7		
Maternal occupation						
Housewife	105	42.7	141	57.3	0.01	0.933
Employed	28	41.2	40	58.8		
Household wealth quintile						
Poorest	14	23.0	47	77.0	23.7	<0.001
Poorer	21	32.3	44	67.7		
Middle	28	42.4	38	57.6		
Richer	34	54.8	28	45.2		
Richest	36	60.0	24	40.0		

Urban residence remained independently associated with appropriate practice (AOR 1.67, 95% CI 1.03–2.71; $p=0.038$). Secondary maternal education was significant (AOR 1.89, 95%

CI 1.01–3.54; $p=0.046$), as was higher secondary education or above (AOR 2.14, 95% CI 1.08–4.23; $p=0.029$) in Table VI.

Table VI: Multivariable logistic regression analysis of socioeconomic determinants of appropriate IYCF practices ($n=314$)

Variables	Adjusted OR	95% CI	P-value
Child age 12–24 months	1.84	1.08–3.14	0.025
Female sex	0.91	0.57–1.46	0.695
Urban residence	1.67	1.03–2.71	0.038
Maternal education: secondary	1.89	1.01–3.54	0.046
Maternal education: higher secondary/Others	2.14	1.08–4.23	0.029
Maternal employment	1.04	0.60–1.79	0.895
Household wealth: middle	1.54	0.82–2.88	0.18
Household wealth: richer	2.21	1.15–4.23	0.017
Household wealth: richest	2.78	1.42–5.44	0.003

Reference categories: child age 6–8 months; male sex; rural residence; no formal maternal education; housewife; poorest wealth quintile.

Richer household wealth was associated with higher odds (AOR 2.21, 95% CI 1.15–4.23; $p=0.017$), with the strongest association observed in the richest quintile (AOR 2.78, 95% CI 1.42–5.44; $p=0.003$). IYCF counselling was significantly

associated with appropriate practice ($p<0.001$). Adequate knowledge of minimum dietary diversity was also associated with appropriate practice ($p<0.001$). Attendance at least four ANC visits was significantly associated with appropriate IYCF practice ($p=0.008$). Access to a health facility within 30 minutes was similarly associated ($p=0.015$) in Table VII.

Table VII: Maternal knowledge and access to health/nutrition services in relation to appropriate IYCF practices ($n=314$)

Variables	Appropriate IYCF		Inappropriate IYCF		χ^2	P-value
	Frequency (n)	Percentage (%)	Frequency (n)	Percentage (%)		
Received IYCF counselling						
Yes	91	54.8	75	45.2	18.62	<0.001
No	42	28.4	106	71.6		
Knowledge of minimum dietary diversity						
Adequate	88	57.9	64	42.1	21.35	<0.001
Inadequate	45	27.8	117	72.2		
ANC ≥ 4 visits						
Yes	98	47.8	107	52.2	7.14	0.008
No	35	32.1	74	67.9		
Access to health facility within 30 min						
Yes	91	47.9	99	52.1	5.86	0.015
No	42	33.9	82	66.1		

DISCUSSION

Infant and young child feeding (IYCF) is a critical component of child survival, growth, and development, particularly during the first two years when nutritional requirements increase rapidly and feeding practices strongly influence health outcomes [1]. The sociodemographic characteristics of the participants indicate a predominantly rural population with representation across infancy and early childhood. The predominance of rural participants is relevant because substantial socioeconomic and geographic differences in IYCF practices have been reported across South Asia. Tariqujjaman et al. found marked within-country variation in IYCF according to residence, maternal education, and household wealth, with urban and socioeconomically advantaged groups generally showing better feeding indicators [13]. Similar patterns have been documented in Bangladesh, where maternal education and household socioeconomic position are closely related to complementary feeding quality [14]. Thus, the demographic composition of the present population provides an important context for interpreting the observed feeding practices. The pattern of feeding practices suggests that breastfeeding-related behaviors were relatively more satisfactory than complementary feeding indicators. Early initiation and colostrum feeding were common, whereas

dietary diversity and minimum acceptable diet remained less consistently achieved. This pattern is comparable with national trends showing gradual improvement in breastfeeding practices but persistent limitations in complementary feeding [15]. Mistry et al. reported substantial improvement in minimum dietary diversity, meal frequency, and minimum acceptable diet over successive Bangladesh Demographic and Health Surveys, although the overall levels remained inadequate [16]. National estimates have likewise shown that minimum acceptable diet remains considerably less common than individual breastfeeding indicators [4]. The relatively lower achievement of dietary diversity is particularly important because this indicator reflects access to a range of nutrient-containing food groups and is closely linked to the nutritional adequacy of complementary diets [1]. Age and residence were significantly associated with appropriate IYCF practice in the present analysis. The higher proportion of appropriate practice among older children is consistent with national evidence showing progressive improvement in complementary feeding indicators with increasing age [4]. Similar age-related patterns have been reported in Bangladesh, where children beyond the early complementary feeding period were more likely to meet minimum acceptable diet criteria [16]. The association with

residence also agrees with national findings showing better minimum acceptable diet attainment among urban children than their rural counterparts [17]. In contrast, child sex was not associated with overall IYCF practice, which is consistent with South Asian evidence indicating relatively small differences in feeding indicators between boys and girls [13]. These findings suggest that feeding practices may be shaped more strongly by social and environmental circumstances than by child sex. Maternal education showed a clear association with appropriate IYCF practice, with the relationship remaining significant after adjustment. This finding is strongly supported by a systematic review of Bangladeshi studies, which concluded that higher parental education was generally associated with better complementary feeding practices, particularly dietary diversity and minimum acceptable diet [11]. National analyses have similarly identified maternal education as an important determinant of minimum acceptable diet [4]. Household wealth also demonstrated a strong socioeconomic gradient, and richer households retained higher odds of appropriate practice in multivariable analysis. This finding is consistent with national inequality analyses showing a substantial wealth-related gap in minimum acceptable diet among Bangladeshi children [17]. However, maternal employment was not independently associated with overall IYCF practice, contrasting with some national analyses in which maternal employment predicted attainment of minimum acceptable diet [4]. Differences in occupation, childcare arrangements, workload, and household support may explain this inconsistency. The multivariable findings further indicate that child age, urban residence, maternal education, and household wealth were independently associated with appropriate IYCF practice. The persistence of these factors after adjustment supports their importance beyond simple bivariate relationships. Comparable findings have been reported in Bangladesh, where maternal education, household wealth, and child age remained important predictors of complementary feeding indicators [4,11]. The stronger association observed among the richest households may reflect greater capacity to purchase diverse foods, access health information, and utilize nutrition-related services. The absence of an independent association with sex and maternal employment suggests that these characteristics alone may be insufficient to explain differences in overall feeding quality. Maternal counselling, knowledge of dietary diversity, adequate ANC attendance, and timely access to health facilities were also associated with appropriate IYCF practice. These findings are supported by intervention studies from Bangladesh showing that structured counselling and repeated interpersonal communication can improve infant and complementary feeding behaviors. Ara et al. reported improved feeding practices following peer counselling, while large-scale implementation through intensified counselling and mass media also produced substantial improvements in complementary feeding indicators [18,19]. Roy et al. further demonstrated that child-feeding counselling improved feeding frequency and nutritional outcomes among young children [20]. More recently, strengthened nutrition interventions incorporated into ANC were associated with improved child feeding practices, supporting the relevance of antenatal contact as an opportunity for early nutrition communication [21]. Similarly, electronic job-aid-supported counselling has demonstrated benefits for breastfeeding practices in rural Bangladesh [22]. Collectively, these findings indicate that appropriate IYCF is closely connected with maternal education, household resources, continuity of counselling, and contact with health services.

LIMITATIONS

The present study has several limitations. Its cross-sectional design limits the ability to establish temporal or causal relationships between socioeconomic factors and IYCF practices. As the study was conducted among participants from a selected area, the findings may not be fully generalizable to other populations. Feeding information was self-reported and may have been influenced by recall or reporting bias. The study period was also relatively short.

CONCLUSION & RECOMMENDATIONS

Appropriate IYCF practice was achieved by less than half of the children, with complementary feeding indicators showing greater gaps than breastfeeding practices. Child age, urban residence, higher maternal education, and greater household wealth were independently associated with appropriate IYCF practice. Maternal counselling, dietary diversity knowledge, adequate ANC attendance, and timely health-facility access were also associated with better practices. Strengthening IYCF counselling during ANC and routine child-health visits, with greater emphasis on dietary diversity and minimum acceptable diet, is recommended, particularly for socioeconomically disadvantaged and rural households. Further multicenter and longitudinal studies are warranted to assess these relationships more comprehensively.

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CONFLICT OF INTEREST

None declared

ETHICAL APPROVAL

The study was approved by the Institutional Ethics Committee.

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