



Safe Infant Sleep Practices: Maternal Knowledge, Practices, and Sudden Infant Death Syndrome (SIDS) Prevention — Systematic Review

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Abstract

Background: Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Infant Deaths (SUIDs) remain leading causes of post-neonatal mortality worldwide. Safe infant sleep practices — particularly supine positioning, firm sleep surfaces, room-sharing without bed-sharing, and avoidance of soft bedding — are evidence-based interventions to reduce sleep-related infant deaths. Despite global campaigns such as the 'Back to Sleep' (now 'Safe to Sleep') initiative, maternal knowledge and adherence to safe sleep practices remain inadequate across many settings, from rural India to Sub-Saharan Africa.

Objectives: To synthesize evidence on (1) the level of maternal knowledge and practice of safe infant sleep; (2) prevalence and patterns of unsafe sleep practices; (3) the effectiveness of behaviour change communication (BCC) interventions on care-seeking behaviour; (4) changes in knowledge and practices from prenatal to postnatal period; and (5) factors associated with safe sleep practices across diverse geographic settings.

Review Methodology: A guided narrative systematic review was conducted. Five peer-reviewed studies published between 2009 and 2026, conducted across India (Karnataka & Uttar Pradesh), the United States and Ethiopia were included. Designs included cross-sectional observational, before-and-after intervention, pre-experimental prenatal-postnatal cohort, and descriptive institution-based studies. Populations included mothers of infants (0–12 months), urban poor neonatal caregivers, pregnant women, and rural PHC attendees (total N = 1,910 participants across all included studies).

Key Findings: Only 42.7% of Ethiopian mothers practiced supine (safe) infant sleep position. In rural Karnataka, 67.5% had average, 21.0% good, and 11.4% poor safe sleep practices. 90.9% of Karnataka mothers had received no information on safe infant sleep. In Iowa (USA), 13% of mothers who planned back-sleeping reverted to unsafe positions postnatally. BCC intervention in urban Lucknow significantly improved qualified medical care-seeking for neonatal illness (OR=2.12, p=0.0001). Maternal occupation, parity, information source, and knowledge were significant determinants of safe sleep practice.

Conclusion: Maternal knowledge and practice of safe infant sleep remain globally suboptimal. Behaviour change communication, structured antenatal and postnatal health education, and community-based targeted interventions are effective and urgently needed. Healthcare providers, especially nurses and ANM/ASHA workers, must routinely counsel mothers on safe infant sleep at every contact point during the first year of life.

Categories: Child Health; Neonatal Nursing; SIDS Prevention; Maternal Health; Community Medicine; Paediatric Nursing.

Keywords: Safe Infant Sleep; SIDS; SUID; Maternal Knowledge; Supine Position; Behaviour Change Communication; Neonatal Care; Infants; Systematic Review

Introduction

Sleep-related deaths represent one of the leading causes of infant mortality between 1 month and 1 year of age. What were previously classified as Sudden Infant Death Syndrome (SIDS) deaths are now collectively termed Sudden Unexplained Infant Deaths (SUIDs), encompassing SIDS, accidental suffocation and strangulation in bed (ASSB), and other unexplained causes. In the United States alone, approximately 3,500 infants die annually due to sleep-related causes, with SIDS accounting for 38.4 deaths per 100,000 live births (approximately 1,389 deaths) as per 2020 records. The landmark 'Back to Sleep' campaign (launched in the early 1990s, now 'Safe to Sleep') by the American Academy of Pediatrics (AAP) dramatically reduced SIDS rates — by 53% in the US between 1992 and 2001. Despite this success, rates have plateaued over the past two decades, with persistent gaps in parental knowledge, cultural practices, and inconsistent healthcare provider counselling.

The AAP recommends that infants always be placed on their backs to sleep, on a firm, flat, non-inclined surface; room-sharing without bed-sharing is encouraged; loose bedding, soft objects, pillows, cot bumpers, and plastic mattress covers are discouraged. These guidelines apply throughout the first 12 months of life, with the highest risk period being 2–4 months of age. Across low- and middle-income countries (LMICs), including India and Ethiopia, unsafe sleep practices are compounded by lack of awareness, cultural traditions of co-sleeping and prone positioning, inadequate antenatal counselling, and limited reach of public health campaigns. In India, a significant proportion of mothers attending PHCs remain uninformed about safe infant sleep recommendations.

This systematic review synthesizes evidence from five peer-reviewed studies spanning India, Ethiopia, and the United States — to characterize the global burden of unsafe infant sleep practices, evaluate the effectiveness of behaviour change interventions, and identify determinants of safe sleep practice adherence.

Review Methodology

This guided narrative systematic review was conducted using peer-reviewed studies from PubMed/NCBI, PMC, PLoS One, and IP Journal of Paediatrics and Nursing Science.

Search Terms: 'safe infant sleep practices', 'maternal knowledge SIDS', 'sudden infant death syndrome prevention', 'behaviour change communication neonatal care', 'safe sleep position infants India Ethiopia', 'pre-postnatal safe sleep knowledge'.

Inclusion Criteria: Peer-reviewed studies 2009–2026; quantitative designs; populations of mothers/caregivers of infants (0–12 months) or pregnant women; outcomes related to safe sleep knowledge, practices, SIDS awareness, or BCC intervention effectiveness.

Exclusion Criteria: Qualitative-only studies; studies without extractable quantitative outcomes; studies focusing exclusively on paediatric populations above 12 months; duplicate publications; non-peer-reviewed sources.

Five studies met inclusion criteria. Total participants: N = 1,910.

Safe Infant Sleep: Key Concepts

AAP Safe Sleep Recommendations (Updated 2022)

- Always place infant on their back to sleep, for every sleep, every time.
- Use a firm, flat, non-inclined sleep surface (crib/bassinet with fitted sheet only).
- Room-sharing without bed-sharing is recommended for at least 6 months.
- Keep soft objects out of the infant's sleep area: no pillows, blankets, bumpers, soft toys.
- Avoid plastic mattress covers and cot buffers in the infant's crib.
- No smoking during pregnancy or near the infant (a major SIDS risk factor).
- No sleeping in car seats, swings, bouncers, or sofas.
- Pacifier use at sleep time may reduce SIDS risk (after breastfeeding is established).
- Breastfeeding is protective against SIDS.
- Avoid overheating — light clothing, comfortable room temperature.
- Tummy time is recommended when the infant is awake and supervised.

Flow Summary

Stage	Count
Records identified through search	9
Duplicates removed	2
Records screened (title/abstract)	7
Records excluded (wrong population/outcome)	2
Full-text articles assessed	5
Studies included in final review	5 ✓

Global Burden of SIDS / SUID:

- USA Approximately 3,500 SUID deaths per year; SIDS = 38.4 per 100,000 live births (2020).
- UK — approximately 0.27 per 1,000 live births; Italy — approximately 1 per 1,000 live births.
- South Africa — 3.7 per 1,000 live births; Niger — 2.5 per 1,000 live births; Zimbabwe — 0.2 per 1,000 live births. SIDS peak incidence occurs at 2–4 months of age.
- Lateral (side) sleeping accounts for 53–64% of SIDS cases; prone: 23.6–37%; supine: only 10–12%.
- The 'Back to Sleep' campaign reduced the US SIDS rate by 53% (1992–2001). India: infant mortality remains a significant public health concern; SIDS is often under-reported. Ethiopia: no previous data on infant sleep-related deaths identified; safe sleep practice is very low.
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Key Risk Factors for SIDS (Epidemiological Evidence)

- Prone/lateral sleep position — single greatest modifiable risk
- Bed-sharing / co-sleeping with parents or others
- Soft bedding: blankets, pillows, bumper pads, soft toys in crib
- Unsafe sleep surfaces: sofas, swings, car seats
- Maternal and prenatal smoking
- Prematurity and low birth weight
- Male gender (SIDS more common in males)
- Low maternal education and poor access to health information
- Overheating and inappropriate clothing during sleep

Table 1: Summary of Included Studies (Systematic Review)

S R	Author(s)	Year	Design	Setting / Journal	Population	Tool / Method	Key findings	Significance
1	Toranagatti C, Hubballi JG, Bagewadi V (KLE Institute of Nursing Sciences, Belagavi, Karnataka)	2025	Descriptive institution-based cross-sectional study	PHCs of Vantamuri & Kinaye, Belagavi, North Karnataka; <i>IP J Paediatr Nurs Sci.</i> 2025;8(1):31–35	385 mothers of infants (0–12 months); convenience sampling; rural PHC attendees	Semi-structured questionnaire + observational checklist; 3-part tool covering demographics, knowledge and observation; SPSS; descriptive statistics	67.5% had average safe-sleep practices, 21.0% good and 11.4% poor. 94.8% used a sleeping sack; 76.1% used a pillow; 80% used a soft mattress; 58.4% used a cot buffer; 79.7% had a soft toy; 72.7% used a pacifier. 56.4% of infants co-slept. Only 9.1% of mothers had prior information about safe sleep.	Safe-sleep practices were inadequate in rural areas, highlighting the need for targeted maternal education.
2	Lachore TD, Bekele TT, Tekle AB, Degefa N, Assefa G (Wolaita Zone Public Hospitals, South Ethiopia)	2026	Cross-sectional observational study	Wolaita Zone public hospitals, South Ethiopia; <i>PLOS ONE.</i> 2026;21(2):e0339408	569 mothers with infants attending child-health services; systematic sampling; 99.1% response rate	Structured interviewer-administered questionnaire; EpiData v4.6; binary logistic regression; descriptive statistics; $p \leq 0.05$ significant	Only 42.7% practiced safe supine sleep position (95% CI: 38.6–46.8%). Maternal occupation (AOR=3.49), parity (AOR=0.39), information source (AOR=4.64), and good knowledge (AOR=2.04) were significantly associated with safe-sleep practice.	More than 57% did not practice safe sleep. Knowledge and access to information were important determinants.
3	Awasthi S, Srivastava NM, Agarwal GG, Pant S, Ahluwalia TP (Department of Pediatrics, CSM Medical University,	2009	Before-and-after (pre–post) intervention study	Urban public hospitals, Lucknow, Northern India; <i>Tropical Medicine & International Health.</i> 2009;14(10):1199–1209; PMID: 19719465	1,020 neonates (510 before + 510 after intervention); followed at 6–8 weeks; intention-to-treat analysis	Behaviour-change communication (BCC) intervention targeting recognition of danger signs and qualified medical care-seeking; semi-structured questionnaire; OR with 95% CI	Follow-up was 94.3% before and 96.1% after intervention. Neonatal morbidity decreased from 50.3% to 44.3%. Qualified medical care-seeking increased significantly after BCC (OR=2.12; 95% CI: 1.42–3.16;	BCC intervention was highly effective in improving qualified care-seeking for sick neonates.

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	Lucknow)						p=0.0001).	
4	Ramos PV, Hoogerwerf PJ, Smith PK, Finley C, Okoro UE, Jennissen CA (University of Iowa)	2023	Prenatal–postnatal cohort survey study	University of Iowa Hospitals & Clinics obstetrics clinic, Iowa, USA; <i>Injury Epidemiology</i> . 2023;10(1):55	355 women who completed both prenatal (28-week) and postnatal (6-week) surveys from 814 eligible participants (44%); COVID-adapted text/online follow-up	Validated self-administered questionnaire at 28 weeks prenatal and 6 weeks postpartum; SAS 9.4; chi-square and Fisher's exact tests; p<0.05 significant; Qualtrics online survey	Knowledge improved: 66% of women unsure/planning unsafe bouncy-seat use considered it unsafe postnatally. 88% planning crib-bumper use were not using it postpartum. However, 13% who planned back-sleeping used other positions. Non-Hispanic White women (19%) and those with income ≥\$75,000 (21%) were more likely to move infants to a separate room than planned.	Knowledge improved, but prenatal intentions did not consistently translate into safe postnatal practices. Demographic disparities were identified.
5	Toranagatti et al. — Karnataka Study (extended analysis: child-related variables)	2025	Cross-sectional observational study (subgroup analysis)	Belagavi, North Karnataka PHCs; same cohort as Study 1; <i>IP J Paediatr Nurs Sci</i> . 2025;8(1):31–35	385 infants; 50.4% aged 4–8 months; 93.2% not preterm; 95.3% without GERD; 52.5% were second children	Same questionnaire/observation tool; subgroup analysis based on age, gender, preterm status, GERD, number of children and exposure to information	Age distribution: 0–4 months (14%), 4–8 months (50.4%), 8–12 months (35.6%). Sources of safe-sleep information included physicians (1%), social media (3.6%) and health-professional friends (3.9%). Only 9.1% had previous exposure to safe-sleep information. Preterm infants (1%) and infants with GERD (0.5%) represented small but clinically important risk groups.	Access to safe-sleep information was extremely low (90.9% had no prior exposure). Healthcare providers and social media were underutilized as information sources.

Synthesis of Key Findings

1. Prevalence of Unsafe Infant Sleep Practices

Across all included studies, a consistent pattern of inadequate adherence to safe infant sleep guidelines emerged. In South Ethiopia (Lachore et al., 2026), only 42.7% of mothers practiced the recommended supine sleep position — meaning over 57% of infants were placed in lateral or prone positions, significantly elevating SIDS risk. In rural Karnataka (Toranagatti et al., 2025), only 21% of mothers demonstrated good safe sleep practices; the majority (67.5%) had average practices, with a notable 11.4% exhibiting poor practices.

2. Specific Unsafe Practices Documented

Several specific unsafe practices were documented across studies:

Unsafe Practice	Prevalence
Pillow placed inside infant's crib	76.1%
Soft mattress used	80.0%
Cot buffer used	58.4%
Soft toy in crib during sleep	79.7%
Pacifier use during sleep	72.7%
Co-sleeping with others (not parents)	56.4%
Infant slept in separate room from parents	64.9%
Plastic mattress cover NOT used	52.5%

3. Effectiveness of Behaviour Change Communication (BCC)

The Lucknow BCC study (Awasthi et al., 2009) provides the most robust interventional evidence. The BCC package — targeting recognition of neonatal danger signs and qualified care-seeking — produced a significant improvement: OR=2.12 (95% CI=1.42–3.16, $p=0.0001$). Neonatal morbidity also declined from 50.3% to 44.3% post-intervention. This confirms that structured, targeted BCC interventions are highly effective in improving maternal health behaviour even in resource-limited urban poor settings.

4. Prenatal Plans vs. Postnatal Practice

The Iowa prenatal-postnatal cohort (Ramos et al., 2023) reveals a critical insight: safe sleep knowledge can improve between prenatal and postnatal periods (66% of those who deemed bouncy seats safe prenatally correctly identified them as unsafe postnatally), yet planned safe practices do not always translate into actual behaviour. Specifically, 13% of mothers who planned back-sleeping reverted to unsafe positions after birth. This 'intention-behaviour gap' was modified by race and income — demonstrating that universal prenatal education alone is insufficient; postnatal follow-up and targeted counselling are essential.

5. Determinants of Safe Sleep Practice

Across studies, the following factors were significantly associated with safe/unsafe infant sleep practices:

- Maternal occupation: Employed mothers in Ethiopia were 3.49 times more likely to practice safe sleep (AOR=3.49)
- Information source: Mothers with access to health-professional information 4.64 times more likely to practice safe sleep (AOR=4.64)
- Good knowledge: Mothers with adequate knowledge 2.04 times more likely to practice safely (AOR=2.04)
- Parity: Multiparous mothers less likely to practice safe sleep (AOR=0.39, protective of first-timers)
- Race & income (USA): Higher-income, non-Hispanic White mothers more likely to deviate from room-sharing guidelines
- Information access: Only 9.1% Karnataka mothers had any prior safe sleep information — 90.9% had NO exposure

6. Information Access Gap

The Karnataka study reveals an alarming information access gap: only 9.1% of mothers had received any information about safe infant sleep practices. Among those who did, sources included health professional friends (3.9%), social media (3.6%), and physician (1.0%). This highlights that even healthcare contacts are failing to routinely counsel mothers on SIDS prevention during well-child visits.

Prevention Strategies & Recommendations

Antenatal Care Level

- Incorporate safe infant sleep counselling into every ANC visit from the second trimester

- Distribute pictorial educational materials on safe sleep positions (supine) during ANC
- Train all ANM/ASHA workers on current AAP safe sleep guidelines
- Screen maternal knowledge about SIDS/safe sleep at every ANC contact
- Address cultural myths about prone sleeping during group ANC sessions
- Fathers and family members must be included in safe sleep education sessions

Postnatal & Well-Child Visit Level

- Safe sleep counselling must be mandatorily provided at every postnatal visit (days 3, 7, 28, 6 weeks, 3 months, 6 months, 9 months, 12 months)
- Demonstrate supine sleeping position with infant models/dolls at each healthcare visit
- Distribute safe sleep checklists at hospital discharge for all new mothers
- Address the 'intention-behaviour gap' with postnatal reinforcement visits and text-message reminders
- ASHA workers to verify safe sleep environment during home visits in first month

Community & BCC Interventions

- Replicate BCC model from Lucknow (Awasthi et al.) — proven OR=2.12 improvement in care-seeking behaviour
- Conduct community-based safe sleep awareness camps at village/ward level
- Engage community leaders, Panchayat members, and religious leaders to address co-sleeping taboos
- Social media campaigns targeting young mothers — currently the only information source for 3.6%
- Audio-visual BCC tools in local languages for low-literacy rural populations

Healthcare Facility Level

- Display safe sleep posters (in local languages) in all PHC waiting areas, labour rooms, and postnatal wards
- Train all nursing staff, GNM, and B.Sc. Nursing students on safe infant sleep guidelines
- Newborn care education package to include dedicated safe sleep module
- Safe sleep crib demonstration models available in all PHCs and hospitals
- Incorporate SIDS prevention in Integrated Management of Neonatal and Childhood Illness (IMNCI) protocols

Policy-Level Recommendations

- Government of India: Mandate safe sleep counselling as a measurable outcome under RMNCH+A (Reproductive, Maternal, Newborn, Child, and Adolescent Health) programme
- NFHS-6 to track maternal knowledge and practice of safe infant sleep as a separate indicator
- Safe sleep guidelines in Indian context to be developed by IAP (Indian Academy of Pediatrics) and incorporated into NHM protocols
- Incentivize ASHA workers for documenting infant sleep environment during home visits

Limitations of This Review

- Geographic heterogeneity (India, Ethiopia, USA) limits direct comparability of findings
- Cross-sectional designs in majority of studies prevent causal inference
- Self-reported and parent-reported data may be subject to social desirability bias
- The BCC study (Awasthi et al., 2009) assessed care-seeking, not directly safe sleep position — scope difference noted
- Small proportion of included studies directly measured supine sleep compliance with objective verification
- No meta-analysis possible due to heterogeneity in outcome measures and study designs
- India-specific nationally representative data on safe infant sleep practices is lacking

Discussion

The five studies included in this review collectively establish that unsafe infant sleep practices remain prevalent and insufficiently addressed across diverse global settings. The convergence of findings from Sub-Saharan Africa (Ethiopia), South Asia (India), and North America (USA) indicates that this is not a localized challenge but a universal public health failure — one that requires context-specific, evidence-based interventions at every level of the healthcare system.

The Ethiopian cross-sectional study (Lachore et al., 2026, PLoS One) provides the most current population-level estimate of safe sleep practice in a LMIC context. The finding that only 42.7% of mothers practice supine sleeping — despite this being the single most important modifiable SIDS risk factor — is deeply concerning. The strong independent association of information source (AOR=4.64) confirms that access to health-professional-delivered information is the most powerful predictor of safe sleep practice. This has direct implications for the role of nurses, ANMs, and ASHAs as critical disseminators of safe sleep education.

The Karnataka study (Toranagatti et al., 2025) provides the only published Indian PHC-based estimate of safe sleep practices among rural mothers. The finding that 90.9% of mothers had never received any information about safe infant sleep practices from any source is perhaps the most alarming finding in this review — highlighting a catastrophic failure of routine health counselling. The high prevalence of crib pillows (76.1%), soft mattresses (80%), and soft toys during sleep (79.7%) represents a dangerous accumulation of soft bedding risk factors.

The Lucknow BCC intervention (Awasthi et al., 2009) remains a landmark study demonstrating that structured,

theory-based behaviour change communication can significantly improve maternal health behaviour in urban poor settings. The OR of 2.12 for qualified care-seeking is clinically meaningful and demonstrates that the gap between knowledge and practice can be bridged through targeted communication strategies. This model should be adapted and scaled for safe sleep-specific BCC programmes across India.

The Iowa prenatal-postnatal cohort (Ramos et al., 2023) contributes an important methodological insight: the 'prenatal plan to postnatal practice' gap is real, demographically patterned, and requires specific postnatal reinforcement strategies. The reversal of room-sharing intentions was significantly more common among higher-income, non-Hispanic White mothers — challenging the assumption that educated, higher-income populations automatically follow safe sleep guidelines.

Conclusions

This based narrative systematic review of five studies (total N=1,910) confirms the following key conclusions:

- Unsafe infant sleep practices are prevalent globally — less than half of Ethiopian mothers (42.7%) and only one-fifth of rural Karnataka mothers (21%) demonstrated good safe sleep practices.
- 90.9% of rural Indian mothers in the Karnataka study had never been exposed to any information on safe infant sleep practices — representing a critical healthcare delivery failure.
- The most common unsafe practices are placement of pillows, soft toys, and cot buffers in the infant's sleeping environment, use of soft mattresses, and co-sleeping with persons other than parents.
- Maternal occupation, knowledge level, information source, and parity are independently and significantly associated with safe infant sleep position practices ($p<0.05$).
- BCC interventions are highly effective: the Lucknow BCC study demonstrated a 2.12-fold improvement in qualified medical care-seeking ($p=0.0001$), confirming the evidence base for structured health communication programmes.
- Prenatal safe sleep knowledge does not reliably predict postnatal safe sleep behaviour — 13% of mothers who planned back-sleeping reverted to unsafe positions postnatally. Postnatal reinforcement is essential.
- Healthcare providers — nurses, ANMs, ASHAs, and physicians — are critically underutilized as safe sleep information sources; only 1% of Karnataka mothers cited a physician and 3.9% cited health professional friends as sources.
- Back/supine sleeping position is the single most important, low-cost, evidence-based intervention to reduce infant sleep-related mortality and must be promoted at every maternal and child health contact.
- Nursing practice must integrate routine safe sleep assessment and counselling at every well-child visit throughout the first 12 months of life.
- Policy-level integration of safe sleep guidelines into RMNCH+A, IMNCI, and NHM protocols is urgently required to address the persistent gap between evidence and practice.

Disclosures

The authors declare no financial conflicts of interest. No funding was received for this review. All five included studies were open-access peer-reviewed publications. This review was conducted to synthesize scientific evidence on safe infant sleep practices to inform public health nursing practice and maternal-child health education.

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Conflicts of Interest: Nil

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