

Prevalence and Determinants of Exclusive Breastfeeding Among Mothers in Giza, Egypt: A Cross-Sectional Study.

Nafousa A Afify; Yomna M Bayoumi; Marwa R Salem; Eman H El-Sebaie, and Sara A Heikal

Public Health and Community Medicine Department, Faculty of Medicine, Cairo University.

ABSTRACT

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Corresponding author

Sara Ahmed Heikal
Mobile: 01005222145
Email:
dr_s.heikal@kasralainy.edu.eg

Received: 15 October
2025

Accepted: 12 November
2025

Published: 24 November
2025

Citation:

Afify NA; Bayoumi Y
M; Salem MR; El-Sebaie
EH, and Heikal SA
(2025): Prevalence and
Determinants of
Exclusive Breastfeeding
Among Mothers in Giza,
Egypt: A Cross-Sectional
Study., *BNNI*, (2) 1-22
Doi:
10.21608/bnni.2025.467
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Breastfeeding (BF) is vital for child health, yet in Egypt, exclusive breastfeeding (EBF) rates drop sharply after birth. Our study assessed the prevalence of EBF among six-month-old infants at Talbia Family Health Center and examined socioeconomic and behavioral determinants, maternal perceptions, and practices. An analytical cross-sectional study was conducted at the Talbia Family Health Center over a period of 9 months. A convenience sample of 339 mothers attending the six-month vaccination clinic was interviewed using a structured questionnaire to estimate the prevalence of EBF and to assess the socio-demographic data, economic status, biomedical factors, breastfeeding practices, and perceptions regarding EBF. The prevalence of EBF at six months was 34%, with a mean duration of 4.35 ± 1.6 months. The mean maternal age was 28.7 ± 4.4 years; mothers aged 30–34 years were significantly less likely to practice EBF ($p = 0.03$). Only 34% initiated breastfeeding within the first hour, while prelacteal feeding was common. Most mothers practiced on-demand feeding (80%), 95% attended ANC, and pregnancy complications significantly affected EBF ($p=0.04$). Reported barriers included maternal medical conditions (32%), perceived insufficient milk (31%), and return to work (19%). Although 78% knew the definition of EBF, this did not ensure sustained practice. Most mothers expressed willingness to practice EBF in future pregnancies and emphasized the need for greater community support. **Conclusion:** Suboptimal EBF is influenced by multiple interrelated factors. Enhancing physician support, addressing maternal health concerns, and fostering a supportive community environment are essential to improving exclusive breastfeeding practices.

Keywords: Exclusive breastfeeding, Maternal perceptions, Breastfeeding barriers, Infant feeding practices, Community awareness, Egypt

INTRODUCTION

The American Academy of Pediatrics recommends exclusive breastfeeding (EBF) for the first six months of life, followed by continued breastfeeding with complementary foods for at least one year (**American Academy of Pediatrics, 2012**). In 1991, the Baby-Friendly Hospital Initiative (BFHI) was launched by WHO and UNICEF to promote, protect, and support breastfeeding practices globally (**WHO and UNICEF, 2018**).

Breastfeeding provides protective benefits for both mother and child against a range of short- and long-term illnesses (**CDC, 2019**). Breast milk supplies essential nutrients, antibodies, enzymes, and minerals, and it adapts to the infant's changing needs (**WHO, 2020**). It also supports maternal psychological health by reducing the risk of postpartum depression (**Miksic et al., 2020**). Exclusive breastfeeding further lowers the risk of chronic conditions such as obesity, allergies, diabetes, and asthma. For mothers, it aids postpartum weight loss, promotes uterine contraction, and reduces the risk of breast

cancer, ovarian cancer, and type 2 diabetes (**Nasir et al., 2024**).

Despite these proven benefits, global EBF rates remain below recommended levels. Between 2013 and 2018, only 43% of newborns began breastfeeding within the first hour of birth, and just 41% of infants under six months were exclusively breastfed (**Jameel et al., 2024; WHO and UNICEF, 2022**). To improve maternal and child health outcomes, the Global Breastfeeding Collective has set targets for 2030 of 70% for early initiation and exclusive breastfeeding, 80% for continuation at one year, and 60% for continuation at two years. Achieving these goals requires stronger national policies and sustained commitment (**WHO and UNICEF, 2022**).

The prevalence of early initiation of breastfeeding in Eastern and Southern Africa is 70%, nearly twice as high as in South Asia (37%) (**UNICEF, 2025**). In Egypt, only about 40% of infants under six months are exclusively breastfed, and by four to five months, this figure drops sharply to just over one in ten children. Although bottle feeding is discouraged, approximately one-

fifth of children under two years of age are bottle-fed (**MOHP, 2015**).

Many barriers to EBF were reported, including the marketing of breast milk substitutes (**Piwoz and Huffman, 2015**), cultural and social taboos (**Wanjohi, 2016**), work-life conflicts, insufficient breastfeeding support (**WHO and UNICEF, 2022**), sleep deprivation, and frequent infant crying (**Ny et al., 2025**).

Globally, nearly half of newborns receive pre-lacteal feeds such as sugar water, honey, tea, animal milk, infant formula, or plain water within the first three days of life, undermining the early establishment of breastfeeding (**UNICEF, 2017**). The widespread promotion of breast milk substitutes remains a pressing public health concern (**Piwoz and Huffman, 2015**).

Breastfeeding is a shared societal responsibility, as without sufficient support systems from healthcare providers, civil society, and policymakers, and without coordinated national investments, global breastfeeding rates are unlikely to increase. Persistently low rates lead to socioeconomic burdens and long-term effects on

maternal and child health (**Ny et al., 2025**).

Giza Governorate represents one of Egypt's most densely populated and socioeconomically diverse regions, encompassing both urban and peri-urban communities. This diversity provides a suitable population for assessing variations in breastfeeding practices across different sociodemographic groups. According to the Egypt Demographic and Health Survey (**EDHS 2014**), early initiation and exclusive breastfeeding practices varied widely between governorates, with Giza showing lower-than-national-average EBF rates and notable disparities between urban and rural sectors (**Ali et al, 2020; El-Gamel and El-Nemer, 2023**).

The present study aims to assess the prevalence of exclusive breastfeeding among six-month-old infants attending Talbia Family Health Center. Talbia Family Health Center serves the catchment area covering Eltalbia, Elharam, and Faysal, and it is considered one of the Ministry of Health and Population (**MOHP**) centers of excellence. The study aims to identify key socioeconomic, clinical, and behavioral determi-

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nants and explore maternal perceptions and practices related to exclusive breastfeeding.

METHODS

Study Design and Setting

A cross-sectional study was conducted from March to September 2020 to assess the prevalence of exclusive breastfeeding (EBF) and its associated factors among mothers of six-month-old infants attending the vaccination clinic at Talbia Family Health Center (TFHC) in Omraneia District, Giza Governorate. TFHC serves a catchment area comprising El-Talbia, El-Haram, and Faysal, with a total population of 229,276 across 45,855 families and an average of 208 infants registered monthly.

Sample Size

The sample size was determined using the standard formula for estimating a single population proportion in a cross-sectional study design. The calculation was based on an assumed prevalence of exclusive breastfeeding at six months of 30%, as precise local data were limited. Using a 95% confidence

level ($Z = 1.96$) and a 5% margin of error ($d = 0.05$). The initial sample size was calculated as follows: $n = (Z^2 * P * (1-P)) / d^2 = (1.96^2 * 0.30 * 0.70) / 0.05^2$, which gives approximately 323 participants (Lwanga and Lemeshow, 1991). The final study, conducted using systematic random sampling, enrolled 339 Egyptian mothers of 6-month-old infants who had ever been breastfed.

Only mothers who provided informed consent were enrolled. Exclusion criteria included infants with specific health problems requiring special feeding programs, congenital anomalies, genetic diseases, or any metabolic or physical disorders. Infants who had never been breastfed were also excluded.

Study Duration and Data Collection Tool

The study was conducted over nine months from March 2020 to December 2020. Eligible mothers were invited to participate in face-to-face interviews. Data collection was based on closed-ended questions adapted from validated questionnaires to identify determinants of EBF, and open-

ended questions to explore maternal perceptions (MOHP, 2015; Beyene et al., 2019). Interviews were conducted once a week (on Tuesdays), coinciding with the vaccination clinic for six-month-old infants. A total of 20–25 mothers were selected each week using systematic random sampling from the attendance list and the serial numbers assigned by the clinic's nurse. A single trained investigator collected data to ensure consistency and minimize interviewer bias. Each interview lasted approximately 10–15 minutes and was conducted privately in the waiting area after explaining the study's purpose and content. Participation was voluntary, and only mothers who provided consent were included.

The questionnaire comprised the following sections:

1. **Personal data:** maternal age and place of residence.
 2. **Socio-demographic and economic characteristics:** assessed using the validated Fahmy socioeconomic scale (Fahmy et al. 2015), which covers six domains with a total score of 54 points.
 3. **Biomedical factors:** completeness of antenatal care (ANC) visits, pregnancy complications, gestational age, mode of delivery (vaginal or cesarean section), type of anesthesia (general, spinal/epidural, or none), postnatal care (PNC) attendance and place of care, delivery complications, breastfeeding counseling before and after delivery.
 4. **Breastfeeding practices:** timing of initiation, use of prelacteal feeds, feeding pattern (on-demand versus scheduled), use of bottles or pacifiers, and age at introduction of supplementary feeding.
 5. **Maternal perceptions of EBF:** assessed using open-ended questions covering knowledge of EBF and colostrum benefits, opinions on adequacy of EBF for six months, timing of food introduction, perceived barriers, suggestions to promote EBF, and intentions for future breastfeeding.
- A pilot test was conducted with 10% of the calculated sample size (not included in the study) to

assess the clarity of the questions. Two questions were deleted due to non-specific responses. The wording of one question was changed.

Statistical Analysis

Pre-coded data were initially entered into Microsoft Excel (Office 2010) and subsequently imported into IBM SPSS Statistics version 25 for analysis. Descriptive statistics (means and standard deviations) were calculated. Categorical data were expressed as frequencies and percentages. Univariate analysis (Chi Square or Fisher Exact tests) was applied to assess associations between EBF and socio-demographic or clinical factors. A p-value of < 0.05 was considered statistically significant (**Daniel and Cross, 2013**). Results were presented in tables and graphs for clarity. Socioeconomic variables were scored using the Fahmy scale (**Fahmy et al., 2015**). Scores were divided into quartiles: low status (<27 points), middle status ($27-<40.5$ points), and high status ($40.5-<54$ points). Qualitative responses from open-ended questions were analyzed using open coding to identify major

themes, subthemes, and interrelations.

Ethical considerations:

Ethical clearance for the study protocol was granted by the Faculty of Medicine Research Ethics Committee at Cairo University (Approval code: MS-73-2020) before the initiation of data collection, which took place between March 2020 and December 2020. All participating mothers were treated in accordance with the Helsinki Declaration on biomedical ethics. Oral consent from the mother was obtained after a detailed explanation of the study's objectives and the significance of completing the form. Only those who agreed were included, and those who refused were excluded from the study

RESULTS

The sociodemographic characteristics of the studied group revealed that about two-thirds of the study population (71%) were aged 25 to <35 years, with a mean age of 28.7 ± 4.4 years. Most mothers (81.7%) had a university education or higher, and none were illiterate. The majority of the

population (77.8%) came from high socioeconomic levels. Maternal age significantly influenced EBF, with lower rates among mothers aged 30–34 ($p = 0.03^*$) but higher rates in those over 35 (47.5%). **Education** level showed no significant association with EBF. Similarly, **occupation** had little effect, as working mothers had a lower practice of EBF (**35.2%**) with no statistical significance ($p = 0.06$), as shown in Table 1. The prevalence of EBF at the age of 6 months was 34%, 28% of infants entered complementary food at the age of 4 months, and the mean duration for exclusive breastfeeding was 4.35 ± 1.6 Months, as displayed in Figures 1,2.

Biomedical factors were also assessed. Table 2 shows the link between biomedical factors and exclusive breastfeeding. Most of the mothers (95.5%) attended antenatal visits with no significant difference in EBF. Pregnancy complications were significantly associated with high rates of exclusive breastfeeding ($P=0.04$). In contrast, mode of delivery (vaginal or cesarean), type of anesthesia used, and gestational age (preterm or full term) showed

no statistically significant association with exclusive breastfeeding. Reported complications included pre-eclampsia, threatened abortion, hemorrhage, and other conditions such as abdominal hernias and thrombosis, as in **Table 2**.

The study analyzed feeding practices and their influence on exclusive breastfeeding (EBF) rates. While 34% of mothers initiated breastfeeding within the first hour after birth and 45.7% within 24 hours, the timing of initiation did not significantly affect EBF outcomes. The majority 80% were breastfed on demand. However, prelacteal feeds such as formula or herbal supplements were common, given to 59.6% of mothers, potentially disrupting early exclusive breastfeeding with no significant difference between the exclusive and non-exclusive groups. In contrast, bottle use was prevalent (44.8%) and strongly associated with lower EBF rates ($p < 0.01$), as shown in **Table 3**.

The study assessed maternal knowledge and perceptions regarding exclusive breastfeeding (EBF). While most of the mothers (78.1%) knew that breastmilk alone could sufficiently

nourish an infant for six months, this conviction was significantly stronger among non-EBF mothers ($p < 0.001$). Although most participants (94%) recognized the critical role of colostrum, citing its immunological and nutritional benefits, the data revealed suboptimal EBF rates of 33%, as shown in **Table 4**.

Several key barriers to exclusive breastfeeding (EBF) were found; the most common were mothers' medical conditions (32.2%), such as breast engorgement, abscesses, sore nipples, medication use, postpartum depression, and lack of sleep. Followed by (31.9%) of the mothers perceived insufficient milk supply. Notably, returning to work and doctors' recommendations following American guidelines were significantly more prevalent barriers in the non-EBF group compared to the EBF group, as presented in **Table 5**.

The study highlights several key recommendations to improve exclusive breastfeeding (EBF) rates, based on mothers' feedback. The most frequently suggested intervention was community support and awareness campaigns (36.8%). Another major

recommendation was improving maternal nutrition (23%). Additionally, pre-delivery breastfeeding education (13.3%) was proposed to better prepare expectant mothers with proper techniques, positioning, and realistic expectations before childbirth. Other suggestions included extending maternity leave policies and creating more breastfeeding-friendly spaces in workplaces and public areas to reduce barriers for working mothers.

DISCUSSION

Exclusive breastfeeding (EBF) rates vary considerably across countries and over time. In Egypt, UNICEF reported a clear improvement over the years, with exclusive breastfeeding becoming much more common among infants in their first five months of life (**WHO, 2020**). Nevertheless, EMRO indicated that the overall national prevalence was still lower than expected (**Murtagh and Moulton, 2011; WHO, 2017**). In Europe, the regional average was very modest, with some countries such as Kyrgyzstan and Georgia showing relatively high uptake, while others like Poland and Bulgaria recorded extremely low

levels (**Bagci Bosi et al., 2016**). By the age of six months, very few infants in the region were still exclusively breastfed, except in certain countries, such as Slovakia and Hungary, where the practice was more common (**Bagci Bosi et al., 2016**). These differences likely reflect both methodological variations and temporal changes.

The present study found that only about one-third of mothers exclusively breastfed their infants during the first six months, which agrees with results observed in a rural Egyptian study, where less than one-third, 29% of mothers practiced exclusive breastfeeding for 6 months in Giza and El Fayoum governorates (**El Shafei and Labib, 2014**).

In this study, mothers aged 20–35 years were less likely to practice EBF compared with older mothers. This trend agrees with other studies showing younger mothers to be more adherent (**El Shafei and Labib, 2014**), while some evidence from other countries suggested that very young mothers were more prone to artificial feeding due to limited knowledge or body image concerns (**Kandeel et al., 2018; Mathew et al., 2019**).

Regarding educational attainment, most of the mothers in this study were university-educated. However, education level did not appear to influence the practice of exclusive breastfeeding. Some international studies reported the opposite (**Maharlouei et al., 2018; Hegazi et al., 2019**), with higher education linked to lower exclusive breastfeeding rates, while in Egypt, educated mothers were more likely to breastfeed exclusively (**El Shafei and Labib, 2014**), possibly reflecting greater awareness. Interestingly, other surveys have shown that women without formal education breastfeed for longer durations, often due to unemployment and staying at home (**MOHP, 2015**).

The employment status of the mothers shows that exclusive breastfeeding (EBF) was slightly higher among working mothers (35.2%) compared to non-working mothers (31.8%); the difference was not statistically significant ($P = 0.06$). This might reflect increasing awareness, better education, or stronger motivation to maintain breastfeeding despite work challenges. However, employment can still indirectly

affect breastfeeding practices through factors such as limited maternity leave, lack of workplace facilities for breastfeeding, and time constraints. Therefore, interventions focusing on workplace breastfeeding support, such as longer maternity leave, lactation rooms, and flexible working hours, could further promote EBF among working mothers. Evidence from other studies often shows unemployed mothers maintaining exclusive breastfeeding longer, while employment tends to be a barrier (Mathew et al., 2019; Hegazi et al., 2019; Maharlouei et al., 2018).

The socioeconomic level of the mothers in this study did not show any significant association with exclusive breastfeeding. This homogeneity may have masked differences. In other contexts, however, longer breastfeeding durations have been linked to lower socioeconomic groups (Mathew et al., 2019), with reports from Nigeria showing an inverse association (Onah et al., 2014).

Neither delivery mode nor anesthesia type Mode of delivery and type of anesthesia seem to influence breastfeeding practices

in this study, with more practice of EBF seen among mothers with cesarean deliveries (35%) and with those with spinal or epidural anesthesia (35.3%), which may reflect improvements in hospital practices, such as early skin-to-skin contact, rooming-in policies, and enhanced breastfeeding counseling after cesarean birth. This finding is in line with similar findings from Egypt and India (Mathew et al., 2019; El Shafei and Labib, 2014). However, evidence from Iran suggests that vaginal delivery and anesthesia type may play a significant role (Maharlouei et al., 2018).

Interestingly, mothers with pregnancy complications in the study were significantly more likely to practice EBF than those without complications ($P = 0.04$). This may reflect increased medical follow-up and exposure to breastfeeding counseling during antenatal and postnatal care. Notably, most mothers (95.5%) attended antenatal visits. Although antenatal attendance was not significantly associated with exclusive breastfeeding, regular ANC visits provided opportunities for counseling and education. Additionally, hospital-based

management and adherence to the Baby-Friendly Hospital Initiative likely reinforced early breastfeeding practices as recommended by WHO (WHO and EMRO, 2017). Similar observations have been reported in other studies emphasizing the role of healthcare support in sustaining exclusive breastfeeding (Mathew et al., 2019; Hegazi et al., 2019). Nevertheless, the relatively small number of mothers with complications in this study warrants cautious interpretation, and further research is recommended to explore this relationship in larger populations. In other contexts, other studies revealed that pregnancy complications are significantly related to artificial feeding (Kandeel et al., 2018; Amin et al., 2010).

Despite generally high awareness of EBF and colostrum benefits, participants did not practice EBF, highlighting a gap between knowledge and behavior, which are likely influenced by social pressures, work demands, or perceived milk insufficiency. Similar gaps between knowledge and practice were reported in Nigeria, and a study in Ethiopia

demonstrated that perceived insufficient breast milk was a key factor associated with early discontinuation of EBF (Beyene et al., 2019; Onah et al., 2014).

The main barriers reported by mothers in our study were health-related conditions and concerns about insufficient milk supply. Employment obligations and physician advice were also significant factors leading to the discontinuation of exclusive breastfeeding, highlighting the need for improved workplace policies and maternal support to promote exclusive breastfeeding. This aligns with previous literature that identifies lactation difficulties and returning to work as the most common barriers, though other studies emphasize formula prescriptions and workplace constraints (Kamal et al., 2021; Ali and Abdelmola, 2020).

When asked for recommendations, many mothers in our study highlighted the importance of raising community awareness to overcome breastfeeding challenges. Others emphasized the role of good maternal nutrition. In contrast, other research identified prior breastfeeding experience, extended

maternity leave, and adequate training on breastfeeding techniques as critical enablers for longer exclusive breastfeeding duration (Maharlouei et al., 2018).

STUDY LIMITATIONS

Small subgroup sizes, especially among mothers with pregnancy complications, may reduce statistical power. Although the study found a significant association between pregnancy complications and exclusive breastfeeding, this finding should be interpreted with caution. Moreover, the cross-sectional design precludes establishing causality. The observed relationship may reflect differences in maternal health status, access to healthcare facilities, or breastfeeding counselling and support during the perinatal period rather than a direct causal effect. Further studies with larger sample sizes, diverse populations, and longitudinal designs are recommended to validate and confirm this association.

CONCLUSION

At Talbia Family Health Center, exclusive breastfeeding

(EBF) was generally uncommon and lasted for only a few months. Multiple interrelated factors were addressed, as mothers who practiced co-sleeping and feeding on demand, and avoided bottles, were more likely to maintain EBF; The gap between Maternal knowledge about EBF sufficiency and the benefits of colostrum and the practice. At the same time, employment and medical advice often act as barriers. Positive maternal attitudes and community awareness supported breast-feeding, and it was somewhat more frequent among working mothers, public ANC users, and mothers of preterm infants.

RECOMMENDATIONS

The present study recommendations are presented at three levels. At the health facility level, exclusive breastfeeding (EBF) counseling should be integrated into antenatal and postnatal care. Nurses, in particular, should receive training in EBF promotion. Additionally, mother support sessions should be provided, and the quality and accountability of postnatal care should be improved. At the community level, efforts should

focus on launching EBF awareness campaigns, enforcing the Breast Milk Substitutes (BMS) marketing code, and extending paid maternity leave to six months. At the Ministry of Health level, priorities should include monitoring EBF during well-baby visits and reviving the Baby-Friendly Hospital Initiative. For future research, broader studies are needed to examine the determinants of EBF, explore health system and stakeholder barriers, and investigate the rising rates of cesarean section and their impact on EBF.

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Table (1): Sociodemographic characteristics and their relation to the pattern of breastfeeding.

sociodemographic characteristics		Non-exclusive Breastfeeding n=225	Exclusive Breastfeeding n= 114	Total n=339	P-value
Maternal Age	<20	1(0.3%)	0	1(0.3%)	0.339^
	20-24	34(63%)	20(37%)	54(16%)	0.59
	25-29	102(65.8%)	53(34.2%)	155(45.7%)	0.92
	30-34	67(75.3%)	22(24.7%)	89(26.3%)	0.03*
	>35	21(52.5%)	19(47.5%)	40(11.8%)	0.053
Maternal working state	Not working	109 (68.1%)	51 (31.9%)	160(47.2%)	0.06
	Working	116 (64.8%)	63(35.2%)	179(52.8%)	
Education	University and above	183(66.1%)	94(33.9%)	277(81.7%)	0.7
	Less than a university	42(67.7%)	20(32.2%)	62(18.2%)	
Socioeconomic level	low	5 (100%)	0	5(1.2%)	0.35
	Moderate	47 (66.2%)	24 (33.8%)	71(21%)	
	High	173 (65.8%)	90(34.2%)	263(77.8%)	

^Calculated by Fisher's Exact test, Chi-square test.

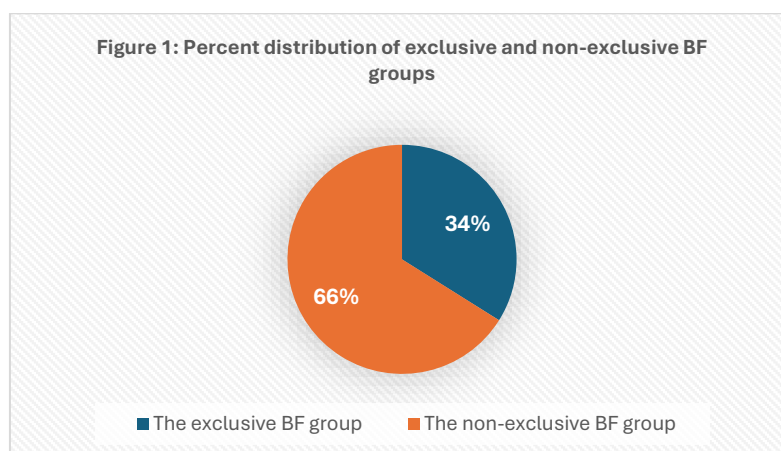


Figure 1: Percent distribution of the enrolled mothers according to the pattern of breastfeeding

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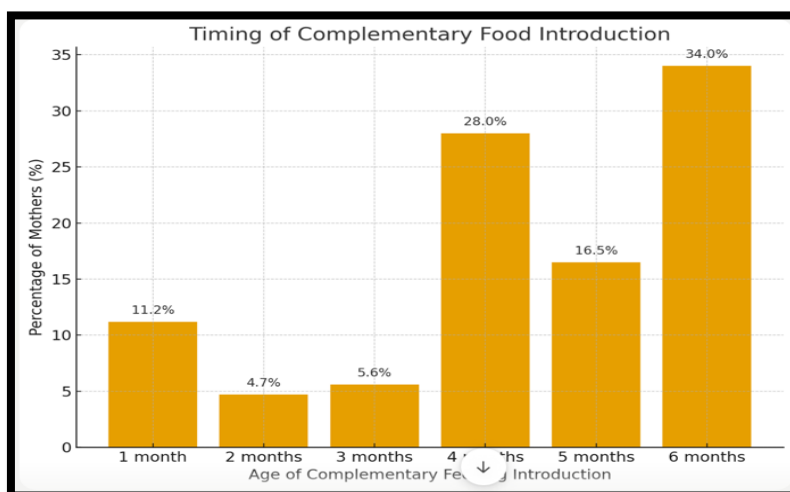


Figure 2. Timing of Complementary Food Introduction Among Mothers (n=339)

Table 2: Association Between Maternal and Infant Biomedical Factors and Exclusive Breastfeeding (N=339)

Biomedical factors		Non-exclusive Breastfeeding n=225	Exclusive Breastfeeding n= 114	Total n=339	P value
Attending ANC visits	Didn't attend	12 (80%)	3 (20%)	15 (4.4%)	0.49
	Attend at least 4 visits	213(65.7%)	111(34.3%)	324(95.5%)	
Pregnancy complications	No	194(68.1%)	91(31.9%)	285 (84.4%)	0.04*
	Yes	31 (57.4%)	23 (42.6%)	54 (15.6%)	
Mode of delivery	Vaginal delivery	60 (71.4%)	24 (28.6%)	84 (25%)	0.31
	Cesarean section	165 (64.7%)	90 (35.3%)	255 (75%)	
Anesthesia used	No anesthesia used	42(73.7%)	15 (26.3%)	57(16.8%)	0.4
	General	42(65.6%)	22(34.4%)	64 (18.8%)	
	spinal /epidural	141 (64.7%)	77(35.3%)	218(64.3%)	
Gestational age	Preterm baby	14(60.9%)	9(39.1%)	23(6.5%)	0.47
	Full-term baby	211(66.6%)	105(33.2%)	316(93.5%)	

Calculated by the Chi-square test.

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Table 3: Association Between Infant Feeding Practices and Exclusive Breastfeeding (N=339)

Feeding practice		Non-exclusive Breastfeeding n=225	Exclusive Breastfeeding n= 114	Total n=339	P value
Initiation of breastfeeding	Within an hour	75(65.2%)	40(34.8%)	115 (34%)	0.55
	During the first 24 hours	107(69%)	48(31%)	155 (45.7%)	
	After the first 24 hours	43(62.3%)	26(37.7%)	69 (20.4%)	
Patterns of BF	On demand	178(65.7%)	93(34.3%)	271 (80%)	0.61
	Every 2-3 hours	47(69.1%)	21(30.9%)	68 (20%)	
Prelacteal feeds	No	95(69.3%)	42(30.7%)	137 (40.4%)	0.41
	Yes	130(64.4%)	72(35.6%)	202 (59.6%)	
Uses bottles	No	100(53.5%)	87(46.5%)	187 (55.2%)	<0.01*
	Yes	125(82.2%)	27(17.8%)	152 (44.8%)	

*Calculated by Chi-square test.

Table 4: Maternal Knowledge Regarding Colostrum and Six-Month Exclusive Breastfeeding (EBF) Sufficiency, by Actual Breastfeeding Practice (N=339)

Maternal knowledge		Non-exclusive Breastfeeding n=225	Exclusive Breastfeeding n= 114	Total n=339	P value
EBF is enough for 6 months	No	66 (89.2%)	8 (10.8%)	74 (21.9%)	<0.001
	Yes	159 (60%)	106(40%)	265 (78.1%)	
Role of colostrum	No	11 (55%)	9 (45%)	20 (6%)	0.28
	Yes	214 (67.1%)	105 (32.9%)	319 (94%)	

*Calculated by Chi-square test.

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Table 5: Percent distribution of the barriers challenging EBF among mothers of both groups (N=339)

Responses	Non-exclusive Breastfeeding n=225	Exclusive Breastfeeding n= 114	Total n=339	P- value
Mothers' medical problem	77 (34.4%)	32 (27.8%)	109(32.2%)	0.13
Perceived insufficient milk	75 (33.5%) 33	33 (28.7%)	108(31.9%)	0.24
Work conditions	51 (22.8%)	13 (11.3%)	64(18.9%)	0.01
Don't know the technique, lack of preparation	37 (16.5%)	25 (21.7%)	62(18.3%)	0.3
Too many responsibilities and familial pressure	26 (11.6%)	21 (18.3%)	47(13.9%)	0.12
Doctor's advice, guidelines	33 (14.7%)	8 (7%)	41(12.1%)	0.03
Embarrassed outdoor	12 (5.4%)	5 (4.3%)	17(5%)	0.57*
The medical problem of the baby (tongue-tie, jaundice, or poor weight gain)	5 (2.2%)	3 (2.6%)	8 (2.4%)	0.12*

**Calculated by Fisher's Exact test*

انتشار ومحددات الرضاعة الطبيعية الحصرية بين الأمهات في الجيزة، مصر: دراسة مقطعية

**نفوسة على عفيفي، يمنى محمد على بيومى ، مروة رشاد سالم، ايمان هاني السباعي وساره أحمد
هيكل**

قسم الصحة العامة وطب المجتمع كلية الطب جامعة القاهرة

الملخص العربي

تُعد الرضاعة الطبيعية (BF) خطوة أساسية لضمان مستقبل صحي للطفل. وتشير الرضاعة الطبيعية الحصرية (EBF) إلى تغذية الرضيع بحليب الأم فقط خلال الأشهر الستة الأولى من العمر. في مصر، تنخفض معدلات الرضاعة الطبيعية الحصرية بشكل حاد بعد الولادة. هدفت هذه الدراسة إلى تحديد معوقات الرضاعة الطبيعية الحصرية من أجل تعزيز فوائدها. أجريت دراسة مقطعية تحليلية في مركز صحة الأسرة بالطابية خلال ٩ أشهر. تم مقابلة الأمهات المترددات على عيادة تطعيمات الستة أشهر لتقدير معدل انتشار الرضاعة الطبيعية الحصرية حيث جرى مقابلة ٣٣٩ أم باستخدام استبيان مُهيكل تضمن بيانات سوسيوديموغرافية، الحالة الاقتصادية، العوامل الطبية، ممارسات الرضاعة، وتصورات الأمهات حول الرضاعة الطبيعية الحصرية. كان معدل انتشار الرضاعة الطبيعية الحصرية عند عمر ستة أشهر منخفضاً، حيث تم إرضاع أقل من خمس الرضع رضاعة حصرية. بلغ متوسط مدة الرضاعة الحصرية أكثر من أربعة أشهر بقليل. كانت الأمهات اللواتي تتراوح أعمارهن بين ٣٠-٣٤ سنة أقل ممارسة للرضاعة الحصرية بشكل ملحوظ $p = 0.03$ في حين أن نحو ثلث الأمهات بدأن الرضاعة خلال الساعة الأولى، قدّمت كثير منهن تغذية ما قبل الرضاعة (prelacteal feed). معظم الأمهات ٨٠٪ مارسن الرضاعة عند الطلب ، وحضرت ٩٥٪ من الأمهات زيارات متابعة الحمل واثرت مضاعفات الحمل بشكل ملحوظ علي الرضاعة الطبيعية الحصرية. $P = 0.04$ من أبرز المعوقات التي أبلغت عنها الأمهات: المشكلات الصحية، الشعور بعدم كفاية الحليب، والعودة إلى العمل. على الرغم من معرفة ثلثي الأمهات بتعريف الرضاعة الحصرية، إلا أن المعرفة وحدها لم تترجم إلى ممارسة مستمرة. وبشكل مشجّع، عبّرت معظم الأمهات عن رغبتهن في ممارسة الرضاعة الحصرية في الأحمال القادمة، وأكدن الحاجة إلى زيادة الوعي المجتمعي والدعم. **الاستنتاج:** تتأثر الرضاعة الطبيعية الحصرية بعوامل متعددة ومتداخلة. يُعد تعزيز دعم الأطباء، معالجة مشكلات صحة الأم، وتهيئة بيئة مجتمعية داعمة خطوات أساسية لتحسين الممارسات المتعلقة بالرضاعة الطبيعية الحصرية.

الكلمات المفتاحية: الرضاعة الطبيعية الحصرية، تصورات الأمهات، معوقات الرضاعة، ممارسات تغذية الرضع، الوعي المجتمعي، مصر