Education and Poverty: A Paradigm of Inequity and Disempowerment to Breastfeeding Women

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Abstract

Background: There is a considerable lack of studies on the role of education on early infant feeding practices. Although governments encourage women education, they do not provide them with the equitable tools for achieving their double role in development, child care and seeking a career.

Aim: To examine how education of mothers influences their breastfeeding and complementary feeding practices in the first two years of life in 25 countries by level of income.

Methods: Data from the UNICEF global data base for infant feeding indicators was analyzed by income groups and level of education in 25 developing countries in the Eastern Mediterranean region, West Africa and East Asia. The variables studied included a number of breastfeeding and complementary feeding indicators.

Results: By income group and level of education, exclusive breastfeeding and continued breastfeeding were considerably lower in the higher income group countries and more highly educated mothers and increased by decreasing income level and decreasing level of education of the mothers. However the indices for complementary feeding practices were higher in the higher income countries and highly educated mothers and decreased with decreased income level of the country and decreasing level of education of mothers.

Conclusions: The paradoxical findings between poor patterns of feeding and the shift towards educating more women for expanding the economical workforce signposts a prototype of inequity. This paradigm shift requires the empowerment of breastfeeding women by education whilst supporting them to breastfeed in their study and workplaces by enacting more effective and supportive maternity laws to ensure their dual role in the economy is achieved.

Key words: Breastfeeding; complementary feeding; maternal education; income level, women empowerment, equity, maternity support

Background

Women have always been positioned to work and serve inside homes, doing housework and caring for children. However with industrialization and need for economic growth and development, this changed and women became positioned working inside and outside homes. This paradigm shift did not consider their gender needs for equity, it made them equal to their gender counterparts but not equitable in their double roles to serve both their family and their society.

Maternal education has been shown to be strongly associated with nutrition outcomes during infancy and early childhood. The threshold of maternal education was also found to be associated with extent of malnutrition as higher levels of maternal education has been shown to reduce the odds of child stunting, underweight and wasting [(1)]. In addition, improving maternal education can also increase child survival [(2)] and child health [(3)].

However the extent to which maternal education influences early infant feeding practices is controversial. It is argued that higher education may be associated with higher levels of income, urban dwellings and paid support in childcare and this may encourage mothers to breastfeed. Also that higher level of educated mothers tend to get married to highly educated men and thereby have better access to health and medical care [(4)]. Whilst on the other hand, higher levels of education may be associated with poor feeding practices as mothers tend to be working mothers or have access to delivery in private hospitals that do not provide support to mothers in breastfeeding and give early formula feeds to babies that lead to breastfeeding difficulties and early discontinuation of breastfeeding. Also, these same mothers can afford to leave their children to child care takers who are not educated and feed them bottles [(5)]. However any education among mothers enables her to access information about how to care for her child and decreases the possibility of death [(6)]. However, based on such contradictory arguments, it is not clear how much maternal education influences infant feeding practices.

Hence the aim of this study is to examine the relationship between the level of education and the various patterns of breastfeeding and complementary feeding practices in the countries of the Eastern Mediterranean region (EMR) and the neighboring countries in East and central Asia and Central and West Africa.

Methods:

Data from the UNICEF Global database was compiled for infant feeding with a focus on exclusive breastfeeding (EBF), predominant breastfeeding (PBF), and continued breastfeeding (CBF) for 12-15 months and 20-23 months, complementary feeding (CF) and early initiation of breastfeeding (EIBF). This database compiled data from all the previous and current national surveys for countries which include mainly Demographic Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS). These surveys underwent reanalysis by UNICEF and presented by variables that include national point estimates, sex, residence, level of education and wealth quintiles (UNICEF, 2018) for EBF, PBF, EIBF, CBF and CF [(7, 8, 9, 10)].

Early initiation of breastfeeding (EIBF) is defined as the percentage of newborns put to the breast within one hour of birth to total live births in the same period.

Minimal meal frequency (MMF) is an indicator used to assess the adequacy of the practice of complementary feeding. It is defined as the percentage of children 6-23 months of age who were fed solid, semi-solid or soft foods the minimum number of times or more during the previous day AND the number of non-breastfed children 6–23 months of age who received solid, semi-solid or soft foods or milk feeds the minimum number of times or more during the previous day to all children (breastfed and non-breastfed) aged 6-23 months at the time of the survey. Minimum frequency is defined as: 2 times solid, semi-solid or soft foods for breastfed infants 6–8 months of age; 3 times solid, semi-solid or soft foods for breastfed children 9–23 months of age; and 4 times solid, semi-solid or soft foods and/or milk feeds for non-breastfed children 6–23 months of age.

Minimum dietary diversity (MDD) is an important indicator used to assess the adequacy of the quality of complementary feeding practices. It is defined as the percentage of children 6-23 months of age

who received a minimum diet diversity of at least >5 food groups (out of 8) in the previous day of the survey to all children (breastfed and non-breastfed) aged 6-23 months at the time of the survey. The eight food groups are: (i) breastmilk; (ii) grains, roots and tubers; (iii) legumes and nuts; (iv) dairy products (infant formula, milk, yogurt, cheese); (v) flesh foods (meat, fish, poultry and liver/organ meats); (vi) eggs; (vii) vitamin-A rich fruits and vegetables; (viii) other fruits and vegetables.

Minimum acceptable diet (MAD) is defined as the percentage of children 6-23 months of age who received a minimum acceptable diet i.e. who had at least the minimum dietary diversity and the minimum meal frequency during the previous day AND Non-breastfed children 6-23 months of age who received at least two milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day to all breastfed and non-breastfed children aged 6-23 months at the time of the survey.

A comparative analysis between different countries was made using the World Bank classification of countries. The low income countries (LIC) include Afghanistan, Niger, Somalia, Syria and Yemen. The low middle income countries (LMIC) include Bangladesh, Egypt, Indonesia, Mauritania, Pakistan, Sudan, Tunisia and State of Palestine. Upper middle income countries (UMIC) include Algeria, Iran, Iraq, and Jordan. However the latter (Jordan) has recently been upgraded to become upper income country, but the national surveys were done when it was in the UMIC category.

Also comparative analysis was made by regional analysis using the World Health Organization (WHO) regions that include the Eastern Mediterranean region (EMR) countries as Afghanistan, Egypt, Jordan, Iraq, Pakistan, Palestine, Somalia, Syria, Sudan, Morocco, Tunisia and Yemen. The remaining countries in Africa belong to the Afro region and in Asia belong to the South East Asia region (SEAR) of the WHO.

The data is estimated as percent frequency distribution and compiled in excel sheets. Countries with data about the level of education were included in our study. The mean and standard deviation score (SD) was estimated for the country groups. The data is presented in tables and figures.

Results

Table (1) presents the breastfeeding patterns for EBF, PBF, EIBF, CBF 12 to 15 months and CBF for 20-23 months by level of education in the different country groups of LIC, LMIC and UMIC. EBF was highest in mothers with high education of the LMIC (39.1±15.4) and lowest in the UMIC countries particularly in those with primary (20.7± 4.7) or no education (21.0±2.2). However in LIC there was tendency for EBF with increasing level education from 26.8±12.7 in the illiterate to 31.7±4.8 in those with secondary education, but a decrease again in the higher levels to 23.2±0.7. Figure 1 presents EBF patterns in countries by income country group and educational level. PBF was almost double EBF and ran parallel to the findings in EBF as shown in figure 2 which demonstrates the patterns of EBF and PBF by level of education in the different income groups.

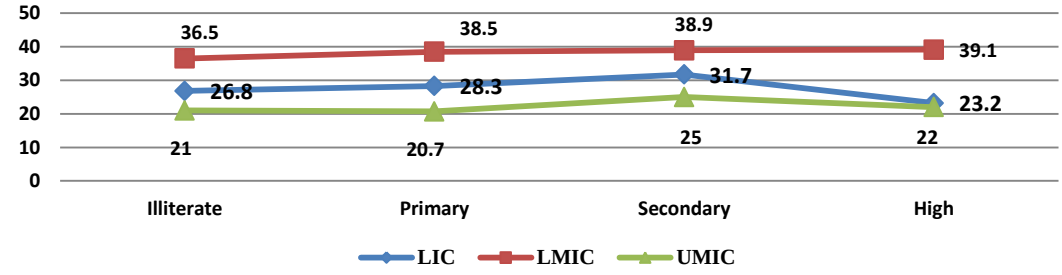
EIBF was highest in the illiterate group in both the LMIC and UMIC decreasing with increasing level of education. However in the LIC it showed an increasing trend with increasing level of education but was lowest in the highly educated in all income groups as shown in table (1).

CBF for 12-15 months was highest in the illiterate mothers of the LMIC (88.4± 5.9)

decreasing progressively by level of education in all income groups. The lowest rates were in the highly educated mothers of the UMIC (41.2±9.4). CBF for 20-23 months was highest in the illiterate mothers of the LMIC (51.6±19.9) and lowest in the UMIC particularly in the highly educated mothers of these countries (17.9±1.3) (Table 1). The difference and trends of CBF are shown in figure 3 which presents the CBF for 12-15 months vs. 20-23 months by level of education in the countries under study.

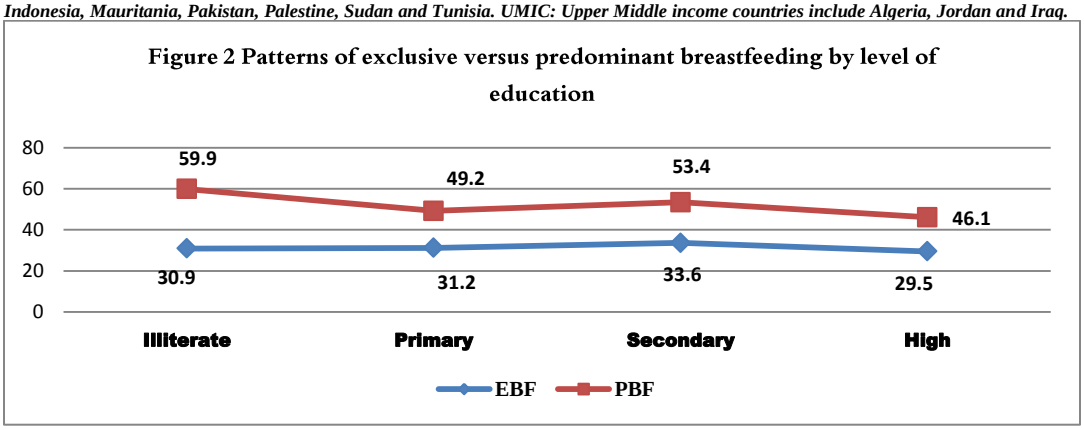
Table (2) presents the complementary feeding practices for MMF, MDD and MAD by level of education in the different country groups of LIC, LMIC and UMIC. MMF was highest in the highly educated mothers of the UMIC (74.2±12.7) followed by the highly educated of the LMIC (69.4±9.7) and decreased progressively with decreasing level of education being lowest in the illiterate mothers of LMIC 43.2±14.9. Again MDD was highest in the highly educated of all income groups: UMIC (59.3±15.4), LMIC (50.9±10.9) and LIC (49.0± 2.9) and decreased progressively with decreasing level of education being lowest in the illiterate mothers of LIC (18.0± 8.4) and LMIC (22.2±15.5). Consequently MAD was highest in the highly educated of the LMIC (34.6±8.7) and decreased progressively by decreasing level of education being lowest in the illiterate mothers of the LIC (9.4±4.9) LMIC (14.9±6.1) and UMIC (16.9) and below the threshold of MAD (20) in those with primary education in the LIC and LMIC. Figure 4 presents MAD by level of education in low, lower middle and upper middle income countries. Figure 5 presents the patterns and trends of CF by level of education in the Eastern Mediterranean countries.

Figure 1 Patterns of Exclusive Breastfeeding by level of income using the World Bank Classification



LIC: Lower income countries include Afghanistan, Somalia, Syria and Niger. LMIC: Lower middle income countries include Bangladesh, Egypt, Indonesia, Mauritania, Pakistan, Palestine, Sudan and Tunisia. UMIC: Upper Middle income countries include Algeria, Jordan and Iraq.

Figure 2 Patterns of exclusive versus predominant breastfeeding by level of education



EBF: exclusive breastfeeding, PBF: predominant breastfeeding.

Table (1) Breastfeeding patterns by country income group and level of education in the countries under study

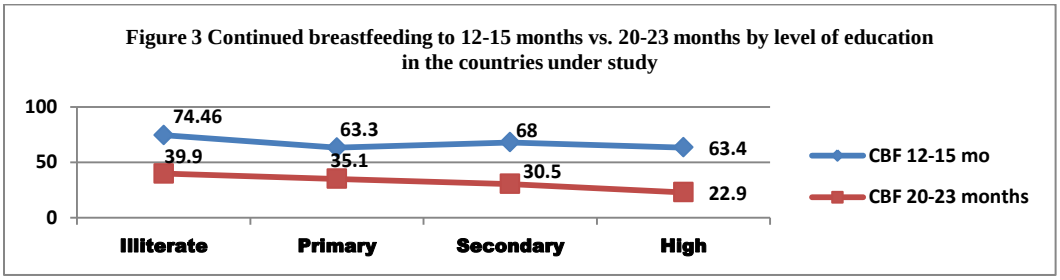
	LIC	LMIC	UMIC
Exclusive breastfeeding (number of countries; mean±SD)			
Illiterate	**(4) 26.8±12.7**	**(8) 36.5± 15.4**	**(2) 21.0±2.2**
Primary	**(4) 28.3±11.2**	**(9) 38.5±12.0**	**(3) 20.7± 4.7**
Secondary	**(3) 31.7±4.8**	**(7) 38.9±17.0**	**(3) 25.0± 1.0**
High	**(2) 23.2±0.7**	**(7) 39.1±15.4**	**(2) 22.0± 4.6**
Predominant breastfeeding (number of countries; mean±SD)			
Illiterate	**(3) 47.6±15.6**	**(7) 63.2±12.8**	**(2) 52.3±1.0**
Primary	**(3) 44.3±18.5**	**(8) 57.9±11.8**	**(3) 40.7±9.9**
Secondary	**(2) 53.1±2.5**	**(7) 57.2± 17.6**	**(2) 42.9±2.5**
High	**(2) 42.4±8.2**	**(7) 52.9±14.2**	**(2) 38.0±7.3**
Early initiation of breastfeeding (number of countries; mean±SD)			
Illiterate	**(4) 38.1±9.5**	**(7) 50.2± 17.7**	**(5) 33.5±11.5**
Primary	**(4) 41.6±11.3**	**(8) 44.5±16.4**	**(5) 29.8±8.9**
Secondary	**(3) 47.0± 14.7**	**(6) 40.6±17.3**	**(3) 23.3±8.3**
High	**(2) 36.0±6.9**	**(6) 39.4±15.7**	**(2) 22.7±7.2**
Continued breastfeeding 12-15 months (number of countries; mean±SD)			
Illiterate	**(4) 74.8±14.0**	**(6) 88.4± 5.9**	**(2) 58.5±4.3**
Primary	**(4) 71.1±19.6**	**(7) 80.9± 12.9**	**(3) 47.4±2.8**
Secondary	**(3) 76.8±15.3**	**(6) 75.6±16.8**	**(2) 45.3±4.3**
High	**(2) 73.5±10.2**	**(6) 69.1±19.8**	**(2) 41.2±9.4**
Continued breastfeeding 20-23 months (number of countries; mean±SD)			
Illiterate	**(3) 49.2± 8.2**	**(6) 51.6±19.9**	**(3) 21.9±4.4**
Primary	**(3) 49.5± 14.0**	**(8) 45.5±25.1**	**(3) 25.4±1.67**
Secondary	**(2) 49.5± 10.5**	**(8) 42.5± 22.9**	**(2) 21.2±12.1**
High	**-**	**(7) 33.8± 23.9**	**(2) 17.9±1.3**

LIC: Low Income Countries LMIC: Lower Middle Income Countries UMIC: Upper Middle Income Countries

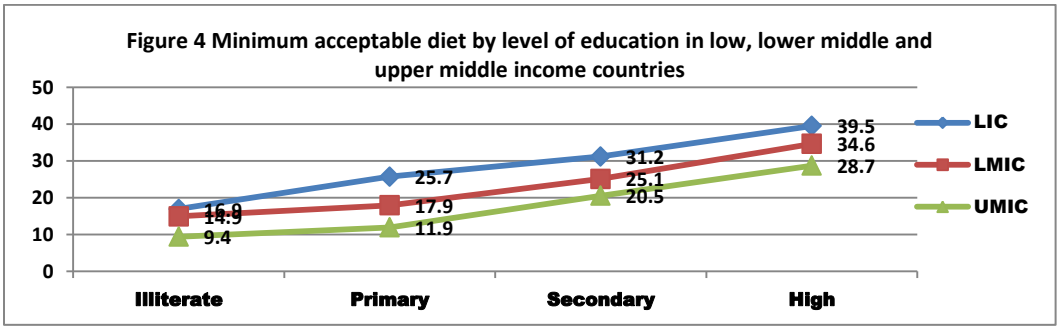
Table (2) Indices of complementary feeding by country income group and level of education in the countries under study

Level of income	LIC	LMIC	UMIC
Minimum meal frequency (MMF) (number of countries; mean±SD)			
Illiterate	**(3) 50.9±0.64**	**(10) 43.2±14.9**	**(3) 56.6±13.3**
Primary education	**(3) 53.3± 3.9**	**(11) 49.0±14.8**	**(3) 56.6±5.1**
Secondary education	**(2) 54.7±3.7**	**(8) 58.4±15.1**	**(2) 65.9±13.6**
High education	**(1) 48.9±0**	**(8) 69.4±9.7**	**(2) 74.2±12.7**
Minimum dietary diversity (MDD) (number of countries; mean±SD)			
Illiterate	**(3) 18.0± 8.4**	**(9) 22.2±15.5**	**(2) 38.6±17.6**
Primary education	**(3) 22.4± 8.5**	**(10) 30.8±12. 2**	**(2) 50.0±12.5**
Secondary education	**(3) 32.9± 6.1**	**(9) 40.7±12.4**	**(2) 50.5±13.8**
High education	**(2) 49.0± 2.9**	**(9) 50.9±10.9**	**(2) 59.3±15.4**
Minimum Acceptable diet (MAD) (number of countries; mean±SD)			
Illiterate	**(2) 9.4±4.9**	**(4) 14.9±6.1**	**(1) 16.9**
Primary education	**(2) 11.9±3.6**	**(4) 17.9±6.8**	**(1) 25.7**
Secondary education	**(2) 20.5± 2.4**	**(4) 25.1± 5.9**	**(1) 31.2**
High education	**(2) 28.7± 0**	**(4) 34.6±8.7**	**(1) 39.5**

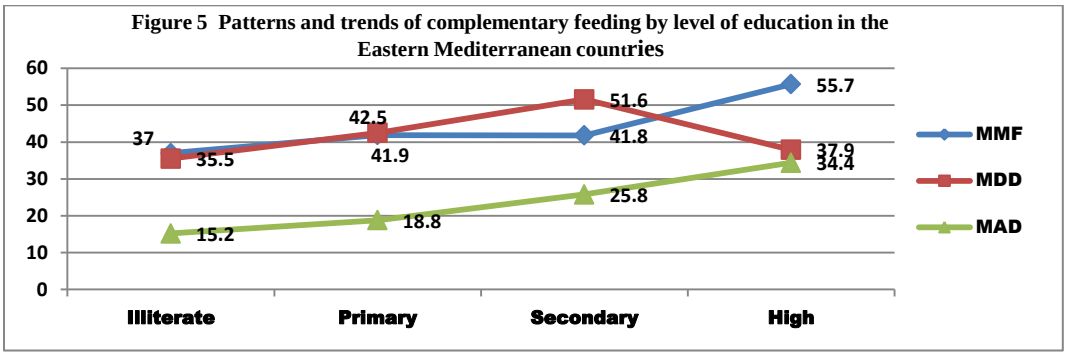
LIC: Low Income Countries LMIC: Lower Middle Income Countries UMIC: Upper Middle Income Countries



LIC: Lower income countries include Afghanistan, Niger, Syria and Yemen.LMIC: Lower middle income countries include Djibouti, Egypt, Indonesia, Mauritania, Pakistan, Palestine, Sudan and Tunisia. UMIC: Upper Middle income countries include Algeria, Iraq and Jordan.



LIC: Lower income countries include Afghanistan and Niger.LMIC: Lower middle income countries include Egypt, Indonesia, Pakistan, Palestine and, Sudan.UMIC: Upper Middle income countries include Jordan.



MMF: Minimum meal frequency, MDD: Minimal dietary diversity, MAD: Minimum acceptable diet

Discussion

Maternal education plays a significant role in improving nutritional status of infants and young children [(11)]. Although knowledge about education and early infant feeding is controversial, still the relationship between childhood malnutrition is strongly associated with parental knowledge about early infant feeding practices [(12, 13)]. In this study we have found contradictory findings between maternal educational status and early breastfeeding practices. Unfortunately, in the countries under study, EBF was low and predominant breastfeeding (PBF) was the prevailing breastfeeding pattern. Less than one third of the populations of the countries under study were exclusively breastfeeding with a slight tendency to be higher in those with secondary and higher education than in those with primary or no education. However this tendency disappeared when analyzed in relation to income level, as the LIC and UMIC (extremes of wealth) which showed a significant decrease in EBF in mothers with higher education compared to those with illiterate, primary or secondary education. However the LMIC countries showed no differences among the different groups of mothers with different education level. EBF was highest in the LMIC and lowest in UMIC. The explanation for these findings is probably related to awareness and national campaigns for breastfeeding promotion in these countries and the effect of the Baby-Friendly Hospital Initiative (BFHI) in promoting EBF in the first six months of life. The decline in EBF in the UMIC probably reflects the increasing engagement of nursing women in employment in struggling economies. These mothers are more inclined to introduce supplements when they go back to work. Also most of these mothers with higher education can afford to give birth in private hospitals that rarely abide by the BFHI practices, which place them at risk of early discontinuation of breastfeeding.

The EMR countries are facing many challenges related to the chronic conflict [(14, 15)]. Furthermore, the health systems in these countries are in a state of political instability which makes them vulnerable to the marketing practices of infant milk formula companies, since there is no strong regulatory system to control them. Moreover the weakened economy by the conflicts and chronic emergencies makes them vulnerable to seek support from these companies, despite the WHO resolutions in this regards [(16, 17)]. These small businesses, as private clinics of doctors, private medical practices and pharmacies, respond and believe the claims and false pretenses these companies make about their products being an actual substitute

to mother's milk, when mothers have difficulties with breastfeeding. They convince decision makers and media people to make the public believe these claims and gain political support to disseminate these products as part of the emergency subsidy food supplies needed for the vulnerable populations, increasing the toll of morbidity, rather than saving lives.

Marketing practices of infant milk formula companies and non-Baby-friendly health facility practices do not only reduce EBF but also CBF rates and increase short term deaths from communicable diseases and long term morbidity from non-communicable diseases. They reduce the potential breastfeeding can have on increasing cognitive, intellectual and psychological wellbeing and thereby influence the country's economy on the long-term. Difficulties in breastfeeding can be remedied like any ailment and when breastfeeding is not possible it should be replaced by milk from another mother. Breastfeeding is not food that can be replaced by another type of food or milk from another animal, it is a living tissue that is needed by the growing child to achieve their potential for optimum growth and development in order to become a complete human being [(18)].

EBF was lowest in the UMIC with no difference between educational levels being highest in women with secondary education. EBF was highest in LIC with no marked differences between educational levels but the highest values were among the more educated mothers compared to the illiterate mothers. The LMIC showed a marked decrease in EBF among the highly educated mothers. These countries are struggling with their economy and women in such an economy are mostly working mothers whose short maternity leave, whether in the public sector (12 to 16 weeks) and private sector (6 weeks), force them to introduce other foods or drinks before six months. This explains the lower EBF rates in these countries. Moreover, the overall trends in the countries under study and globally showed that the lowest scores of EBF was among the highly educated mothers.

PBF usually runs in parallel with EBF, but is more commonly practiced than EBF as mothers are inclined to give supplements to their babies driven by fears or worries that their milk is scanty or not meeting the demands of the baby, or under pressure from their surrounding social network especially when the baby cries or gives mothers and parents sleepless nights, or when the weather is hot so they think that the baby needs drinks or remedies to relieve their colic. Working mothers, who are unaware of how to express breastmilk and leave it with a caretaker to feed the baby during their absence, make them use supplements other than their own milk.

Unfortunately, many doctors prescribe formula to mothers who present with breast or nipple conditions or when the baby is sick or has a congenital anomaly or is admitted to the special baby care unit or if mothers are sick. Most of these conditions are remediable by professionals trained in lactation or breastfeeding management and can be supported to continue breastfeeding. Such conditions make PBF a common practice and increase the possibility of early discontinuation of breastfeeding [(19)].

PBF was highest among illiterate mothers and decreased with increasing level of education. This was more commonly seen in countries with low income as Afghanistan and Somalia where PBF may be attributed to traditional practices or misbeliefs rather than medical conditions or working mothers. While in

countries with higher economies differences in PBF by level of education were much smaller indicating that other factors may be involved.

Initiating breastfeeding by placing newborns to the breast skin to skin within one hour of birth is still a practice facing many challenges. This is because EIBF is closely associated with the type and place of delivery and practices of birth attendants and whether they were trained in the BFHI or in child birth mother friendly practices that encourage natural child birth, no mother infant separation and early initiation through skin-to-skin contact for one hour or up to the first suckle at the breast. These influence the early cessation of breastfeeding and thereby shortened duration of breastfeeding [(20)]. EIBF was highest in Sudan, Mauritania and Sudan where natural and home deliveries are more common. It was lowest in Iraq and Pakistan. There were marked differences by level of education in countries like Egypt, Jordan, Syria and Tunisia.

Analysis by income group showed that EIBF was lowest in the UMIC and particularly among mothers with higher levels of education (22.7% in the highly educated vs. 33.5% in the illiterate mothers). It was highest in the illiterate mothers of the LIC but decreased progressively with increasing level of education from 50.2% in the illiterate to 39.4% in the highly educated. The latter was still higher than the illiterate mothers of the UMIC and mothers with higher education of LMIC. EIBF decreased with increasing country income level and increasing level of maternal education. Since EIBF is a practice that depends on the mode and place of delivery, it appears that with higher income level and higher education there is probably a higher tendency for these mothers to be exposed to medicalized births in birthing centers that do not adhere to the global criteria of the UNICEF/WHO updated guidelines of the BFHI. These births are usually influenced by the marketing practices of infant milk formula companies or health staff that are not trained in the state of art early infant feeding and birth practices that encourage breastfeeding.

WHO and UNICEF recommend that breastfeeding should be continued for at least two years or more. This is supported by evidence based benefits for both the mother and the child. Despite the evidence supporting reduced breast and ovarian cancer for the mother, and increased intellectual, cognitive and psychological benefits for the child, this practice is increasingly decreasing around the world. CBF at two years decreases by one third or less the CBF rates at one year [(21)].

CBF for one year (12 to 15 months) was highest in the illiterate mothers (74.46±11.21) and decreased progressively by increasing level of education to 63.4±20.4 in the highly educated. However the standard deviation increased with increased level of education indicating that there was considerable variation in the continuity pattern in mothers with increasing level of education and that some mothers prefer to continue while others are driven by other factors to discontinue breastfeeding. The latter mothers are those who are either working or can afford to either buy readymade marketed foods or take their child to private clinics that are influenced by the marketing of infant milk formula. This is more evident in CBF at 20-23 months that decreased by one half with increasing level of education from almost 40% in the illiterate to 22% in the highly educated mothers.

The level of economic status of the country also influenced continuity rates of

breastfeeding. Countries of the UMIC group tended to have considerably shorter CBF rates at one and two years compared to mothers of LIC and LMIC countries. In the LIC there was no difference in the continuity rates in mothers with different levels of education in the second year. However in the LMIC there was increasing tendency for CBF to decrease with increasing level of education. The latter may reflect the tendency for mothers in LIC to have access to more social network support than mothers of LMIC who tend to live in nuclear families and do not have access to encouragement to continue breastfeeding to two years.

Complementary feeding (CF) is assessed by three main indicators, timely introduction of foods at 6-8 months, meal frequency and meal diversity, among many other indicators for assessing iron consumption and other micronutrient intakes. In this study we found that women with higher levels of education (secondary and high) had better CF practices than illiterate mothers or mothers with primary education. This is probably related to their higher income that permits them to buy more expensive foods especially meats and other costly food items. The chronic emergencies and conflicts particularly in the EMR countries accentuate the decreased diversity (MDD) and thereby the lowers the MAD [(22)].

Conclusions

EBF and CBF for two years continue to represent challenges and threats for achieving global targets for adequate early infant feeding practices in countries of the upper middle and high income particularly in the highly educated mothers. On the other hand many of the developing countries have not reached targets for empowering women to continue their education to higher levels. Our study showed that most of the sampled mothers in the surveys came from those with primary education and the original sample size of mothers with higher education (from the demographic surveys) was much lower reflecting the high drop-out rates. This educational gap between the income groups is one of the reasons impeding development. However we have to bear in mind that empowering women to achieve higher levels of education should be accompanied by increasing maternity support provided to the working highly educated mothers [(23, 24)]. This is done by enacting laws for protecting maternity rights to exclusively breastfeed for six months and having *Breastfeeding friendly workplaces* that encourage women to continue breastfeeding for two years, among many other communication strategies for promoting breastfeeding [(25)].

Interestingly, in this study we found that women with higher levels of education (secondary and high) had better CF practices compared to illiterate mothers or mothers with primary education. This paradoxical finding between lower and higher educational levels of mothers in the rates of breastfeeding indices versus complementary feeding practices mothers indicates an imbalance between women equity and empowerment. So that on the one hand less education increases breastfeeding and reduces quality of CF, while on the other hand more education undermines breastfeeding but improves CF. This paradox indicates an unbalanced state of equity between education and optimal infant feeding practices which is probably caused by lack of empowerment rather than in information and education. Since more education is accompanied by working in workplaces that do not support these women

in optimally breastfeeding her child these women become disempowered to breastfeed.

Thereby closing the gap between gender equity and empowerment requires support in maternity leave and making workplaces breastfeeding friendly in order to assist working highly educated mothers to breastfeed their child and thereby contribute in their dual role in the economic growth of their country.

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دور التعليم والفقر في إنصاف وتمكين المرأة في الرضاعة الطبيعية

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نبذة مختصرة

خلفية: هناك نقص كبير في الدراسات حول دور التعليم في ممارسات التغذية المبكرة و اللاحقة للرضع. السؤال التى يدور في الأذهان هى هل تم انصاف المرأة بالتعليم في ظل انخفاض اقتصاد الأسرة و الحاجة إلى خروجها للعمل . مازالت الجمعيات الأهلية تطالب بدعم الأم العاملة المرضع و لكن بدون جدوي ، فما عاقبة ذلك على صحة و نمو الطفل و الذى هو جيل و اقتصاد ومستقبل البلاد؟

الهدف : دراسة العلاقة بين مستوى تعليم الأمهات المرضعات ومختلف أنماط الرضاعة الطبيعية وممارسات التغذية التكميلية في أول عامين من الحياة.

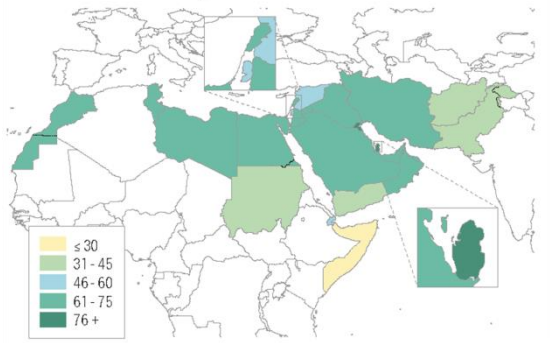
أساليب الدراسة: تم تحليل البيانات المستمدة من قاعدة بيانات اليونيسف العالمية لمؤشرات تغذية الرضع من قبل مجموعات الدخل ومستوى التعليم في 25 دولة نامية في منطقة شرق المتوسط وغرب إفريقيا وشرق آسيا. وشملت المتغيرات التي تمت دراستها عددًا من مؤشرات الرضاعة الطبيعية والتغذية التكميلية.

نتائج الدراسة : كانت الرضاعة الطبيعية الخالصة والإرضاع المستمر من الثدي أقل بكثير في بلدان المجموعة ذات الدخل المرتفع والأمهات الأكثر تعليماً و بالأخص التعليما العالي ، و بالعكس فقد كانت معدلات الرضاعة أعلى مع انخفاض مستوى الدخل وانخفاض مستوى تعليم الأمهات. ومع ذلك ، كانت مؤشرات ممارسات التغذية التكميلية أعلى في البلدان ذات الدخل المرتفع والأمهات المتعلمات تعليماً عالياً وانخفضت مع انخفاض مستوى دخل البلد وانخفاض مستوى تعليم الأمهات.

الاستنتاجات: تشير النتائج المتناقضة بين التعليم وأنماط التغذية إلى وجود فجوة بين التعليم والإنصاف ، وهذا لا يمكن علاجه إلا من خلال تمكين النساء المرضعات من الوصول إلى مستويات أعلى من التعليم مع دعمهن للرضاعة الطبيعية عن طريق سن قوانين أكثر فعالية وداعمة للأمومة في أماكن العمل و ادماج الرضاعة الطبيعية في المناهج الدراسية و توعية الأمهات و الذكور بأهمية الرضاعة الطبيعية لتشجيع الأناث ودعمهن بسن السياسات التى تدعم حقوق الأم و الطفل في الأمومة الآمنة بالرضاعة الطبيعية لعامين.

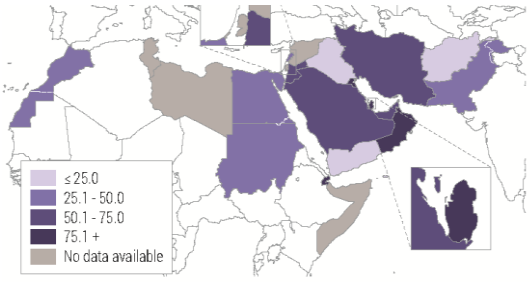
RANKING COUNTRIES IN THE EASTERN MEDITERRANEAN REGION BY HEALTH SERVICE DELIVERY

Coverage of essential health services



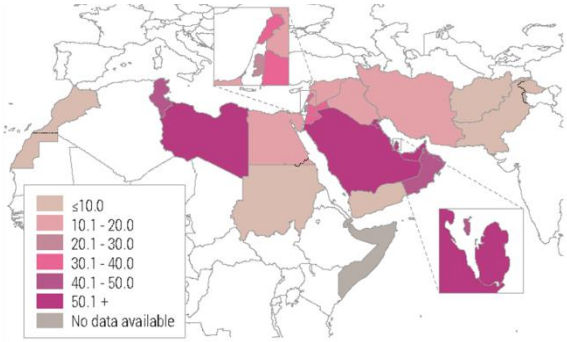
Egypt ranks high in coverage of essential health services (61-75).

Compulsory financing arrangements as percentage of current health expenditure



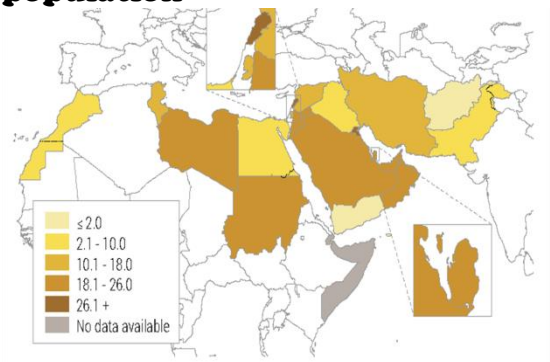
Egypt ranks intermediary in relation to compulsory financing (25.1-50.0)

Density of nursing and midwifery per 10,000 population



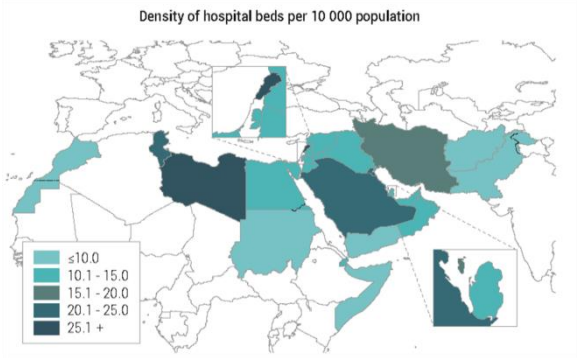
Egypt ranks low (8.1 per 10,000 population) in density of nurses and midwives.

Density of physicians per 10,000 population



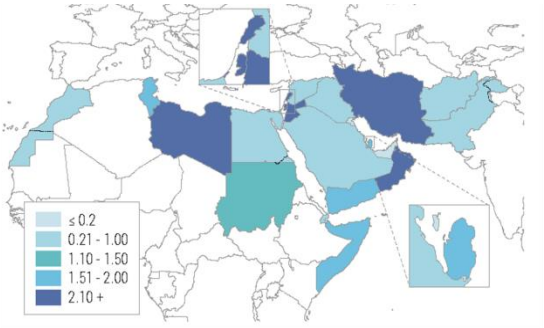
Egypt ranks very low (15 per 10,000 population) in density of physicians.

Density of hospital beds per 10,000 population



Egypt ranks intermediary among EMR countries for health facilities (14.3/10,000 population).

Density of primary health facilities per 10,000 population



Egypt ranks high among EMR countries for health facilities (0.6/10,000 population)

World Health Organization. Regional Office for the Eastern Mediterranean. Eastern Mediterranean Region: framework for health information systems and core indicators for monitoring health situation and health system performance 2018 / WHO Regional Office for the Eastern Mediterranean, 2019.