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Article

Factors Contributing to Breastfeeding Cessation Among Arab Women in Israel

Mahdi Tarabeih [1,*], Mohammad Sabbah [5], [3] Orsan Yahya [2], Sana Bisharat [4] and Khaled Awawdi [5]

[1] School of Nursing Sciences, The Academic College of Tel-Aviv-Yaffa, Rabenu Yeruham Street., P.O.B 8401, Yaffo, 6818211, Israel; mahdita@mta.ac.il

[2] Bar-Ilan University, Ramat Gan, 5290002 Israel; Clalit Health Services, 2 Haela Street, Migdal HaEmek, Israel; Orsanya@clalit.org.il

[3] Rambam Health Care Campus, 8 HaAliya HaShniya St, Haifa, 3109601, Israel; Ramat Gan Academic College 87 Pinhas Rotenberg St. Ramat-Gan 52275, Israel; Hamodi_sabbah@iac.ac.il

[4] The Holy Family Hospital Nazareth, Hagalil Street, Nazareth, Israel; sana@hfhosp.org

[5] Ramat Gan Academic College, 87 Pinhas Rotenberg Street. Ramat-Gan 52275 Israel; Awawdi.h@iac.ac.il

* Correspondence: mahdita@mta.ac.il

Abstract: Breastfeeding provides significant health benefits for both infants and mothers, but many women discontinue earlier than recommended. This study investigates the factors contributing to early breastfeeding cessation among Arab women in Israel, focusing on multiple factors, such as socio-demographic, work-related, cultural, and religious, impacting breastfeeding duration and shaping breastfeeding practices. A cross-sectional survey was conducted among 349 Arab women, 65% of whom were Muslim and 35% Christian. Logistic regression analyses were used to identify key predictors of breastfeeding cessation. Results showed that Christian Arab women were more likely to stop breastfeeding earlier than their Muslim counterparts. Mothers with four or more children and those balancing work demands were at higher risk of early cessation. Contrary to expectations, higher levels of religiosity were associated with a greater likelihood of stopping breastfeeding. Additionally, mothers who received personal breastfeeding guidance were more likely to discontinue, suggesting potential gaps in the quality of support provided. These findings underscore the importance of tailoring interventions to address the unique cultural and socio-economic challenges faced by Arab women in Israel. Recommendations include improving breastfeeding guidance quality, workplace support for breastfeeding mothers, and culturally sensitive interventions that consider the role of religiosity and family dynamics. This research provides valuable insights for healthcare providers and policymakers aiming to promote sustained breastfeeding practices in diverse populations. The study highlights the complexity of factors affecting breastfeeding cessation among Arab women in Israel, emphasizing the need for targeted interventions that address socio-demographic, cultural, and religious influences to promote sustained breastfeeding.

Keywords: breastfeeding cessation; Arab women; religiosity; socio-demographic factors; maternal health; cultural influences

Theoretical Background

The World Health Organization (WHO) identifies breastfeeding as the optimal means of providing nutrition to infants, recommending exclusive breastfeeding for the first six months of life [1]. Interestingly, exclusive breastfeeding rates tend to be higher in developing countries than in developed nations [2, 3]. Factors influencing breastfeeding rates differ greatly across regions and can include cultural norms, the presence of a partner, family support, and the number of gestations [5, 2, 4]. A recent study that examined early breastfeeding cessation rates across six countries identified multiple gestations as the only consistent factor associated with lower levels of early breastfeeding cessation across all regions [2]. Other factors were found to either promote or reduce breastfeeding rates in certain countries, underscoring the importance of studying these factors within specific local contexts [2].

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Breastfeeding, recognized for its numerous health benefits for both infants and mothers, remains a key public health priority globally [6]. Despite its known advantages, many women discontinue breastfeeding earlier than recommended, a phenomenon driven by a variety of socio-demographic, personal, and external factors. Understanding these factors is crucial in developing effective interventions to promote sustained breastfeeding, particularly in specific cultural contexts, such as among Israeli Arab women.

Breastfeeding in the Arab world, including among the Israeli Arab population, is influenced by cultural, religious, and socio-economic factors [7]. Religion, in particular, plays a significant role, with Islam and Christianity offering different perspectives on infant feeding [8]. Studies show that while both Muslim and Christian Arab women acknowledge the importance of breastfeeding, their rates of initiation and continuation vary, often due to differing levels of religiosity and cultural practices [9].

Research has consistently shown that Israeli Arab women are likely to initiate breastfeeding but are at risk of stopping earlier due to factors such as insufficient milk, work conditions, and lack of professional support [10]. According to a recent study on Israeli Arab women, the likelihood of breastfeeding cessation increases with certain socio-demographic characteristics, including ethnicity, number of children, and employment status. For instance, Christian Arab women are significantly more likely to stop breastfeeding than their Muslim counterparts [7]. Additionally, mothers with more than four children or those balancing full-time work were found to be more prone to early breastfeeding cessation.

Guidance and support provided to mothers during prenatal and postnatal care have also been identified as critical factors in breastfeeding persistence. However, the type of guidance matters; personal breastfeeding guidance was associated with an increased likelihood of cessation, perhaps reflecting the limitations in the quality of support provided [10].

The role of socio-economic factors cannot be overlooked. Studies reveal that financial pressures and the need for employment, especially in dual-income households, often force mothers to prioritize work over breastfeeding, especially when workplace support is limited [8]. Family and social support also significantly impact breastfeeding decisions, as mothers with strong family encouragement are more likely to continue breastfeeding, even under challenging circumstances [9].

Breastfeeding offers significant health benefits for both the infant and the mother. *For infants*, breastfeeding has been proven to reduce the risk of a wide range of diseases, including gastrointestinal infections, necrotizing enterocolitis, respiratory infections, sudden infant death syndrome (SIDS), allergies, asthma, type 2 diabetes, obesity, irritable bowel syndrome, and Crohn's disease [11-17]. In addition to its protective effects, breastfeeding enhances cognitive abilities and emotional intelligence in children [17]. Human breast milk is considered the normative source of nutrition for infants and plays a crucial role in nutritional security and health promotion [11-17]. *For mothers*, the benefits of breastfeeding are equally significant. Breastfeeding is associated with a lower risk of breast and ovarian cancers, osteoporosis, and cardiovascular diseases [17-19]. It is also linked to a reduced likelihood of postpartum hemorrhage and anemia [19]. Moreover, the physical act of breastfeeding fosters hormonal regulation and strengthens the bond between mother and infant [17].

Despite the clear health advantages, the prevalence of breastfeeding, particularly exclusive breastfeeding, remains low worldwide and in Israel. The World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) recommend exclusive breastfeeding for the first six months of life, with continued breastfeeding alongside complementary foods until at least two years of age [20]. The Israeli Ministry of Health supports similar guidelines, recommending exclusive breastfeeding for the first six months, followed by breastfeeding in combination with complementary foods [21].

Moreover, breastfeeding is influenced by various factors, including maternal education, employment, availability of lactation counseling, formula promotion, social support, and cultural or religious beliefs [22]. Religious scriptures, such as the Jewish Talmud, the Quran, and Bahá'í writings, regard breastfeeding as a positive and nurturing act [23-27]. Studies suggest that women with higher levels of religiosity are more likely to breastfeed than their less religious counterparts [28-30].

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Research conducted among Jewish and Muslim populations in Israel and abroad has shown that religion plays an important role in the initiation and duration of breastfeeding [29-35].

The guidelines from all leading professional organizations (gynecologists, pediatricians, and family physicians) recommend providing adequate support to breastfeeding mothers and structured breastfeeding education both before and after birth [35,36,37]. Nevertheless, many mothers feel that they receive inadequate information from their healthcare providers (HCPs) within the primary care setting [38].

One of the primary issues raised is that parents' expectations for personalized guidance from pediatricians regarding infant feeding were not always met. Many parents reported that the support and advice they received were insufficient, inconsistent, nonexistent, or contradictory [38]. Despite the well-documented medical benefits of breastfeeding, an Israeli study involving 2,114 mothers showed that at six months postpartum, only 22.5% of Jewish mothers and 12.3% of Arab mothers were exclusively breastfeeding their infants (true exclusive breastfeeding from birth). In the same study, women revealed that their doctor's opinion played a dominant role in their decision to breastfeed. However, two to six months after delivery, 90% of breastfeeding women reported receiving no breastfeeding support from their doctors, and only a minority regarded their physicians as reliable sources of information on this topic [39].

It is well established that various factors influence both the duration and exclusivity of breastfeeding. These include demographic, biological, religious, economic, social, and hospital-related factors. Demographic factors include age (older women are more likely to breastfeed than younger women), education level (the higher the education level, the greater the likelihood of exclusive breastfeeding), and income (as income increases, the likelihood of breastfeeding decreases, with women in lower economic statuses breastfeeding more frequently than those with higher economic statuses). Biological factors primarily relate to the ability to produce sufficient milk; studies show that mothers who are obese at the time of conception are less likely to breastfeed. Factors related to maternal beliefs include the sense of self-efficacy (the higher the self-efficacy, the greater the likelihood of breastfeeding). Social factors encompass the mother's employment status, the duration of maternity leave, and the level of support she receives from her partner. Hospital-related factors involve institutional practices such as rooming-in policies and early initiation of breastfeeding [6,40].

Raising awareness of the long-term benefits of breastfeeding during maternal health visits is crucial. The World Health Organization (WHO), the American Academy of Pediatrics (AAP), and the Israeli Ministry of Health all recommend exclusive breastfeeding for the first six months of a baby's life [41-45].

In Arab society, breastfeeding holds significant symbolic meaning due to religious reasons (both Islam and Christianity). In most cases, women are not part of the workforce and remain at home to raise their children, which makes breastfeeding a crucial and valued practice in this population. As in global trends, the awareness of the health benefits of breastfeeding for both infants and mothers is growing. However, cultural, social, and economic factors also influence the attitudes and implementation of breastfeeding in this population.

Regarding its traditional and religious significance, breastfeeding is considered a blessed commandment in Islam. It is recommended for a full two years. The Qur'an mentions the breastfeeding period in a verse that states: "Mothers shall breastfeed their children for two whole years..." (Surat Al-Baqarah [2:233] - The Noble Qur'an [46]. Breastfeeding is regarded as a religious duty of the mother toward her child, although it is understood that artificial feeding may be used, if necessary, with the child's best interests being taken into account. According to Islamic tradition, if a mother is unable to breastfeed, a wet nurse may be appointed to nurse the child. Breastfeeding by another woman (wet nurse) establishes "milk kinship" between the nursed child and the wet nurse and her family, a bond that is recognized in Islam as unique and well-defined by religious law [47]. This gives breastfeeding spiritual significance in addition to its health benefits.

In Christianity, breastfeeding is a valuable symbol of care, maternal love, and the spiritual grace bestowed by both the mother and the Church. It also serves as a symbol of the spiritual relationship between the believer and the Church. In Catholic tradition, Mary is often portrayed as the perfect

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mother. Depictions of Mary breastfeeding the infant Jesus are seen as a way in which she gives life to her son, both physically and spiritually [48,49, 50].

To reiterate, while breastfeeding provides well-documented health benefits for both infants and mothers, such as reduced risk of infections, obesity, and chronic diseases in infants, as well as lower risks of breast and ovarian cancer in mothers [51, 52], many mothers discontinue breastfeeding earlier than recommended [53]. Identifying the specific factors that lead to early cessation can inform targeted interventions to address barriers, such as lack of support, workplace challenges, and inadequate lactation counseling [54]. For example, maternal employment and insufficient workplace accommodations are significant barriers, with studies showing that return to work often coincides with breastfeeding cessation [55] Additionally, inadequate or inconsistent support from healthcare providers contributes to early discontinuation, as many mothers report not receiving adequate breastfeeding guidance [53]. Understanding these reasons is crucial for designing policies and healthcare practices that promote breastfeeding, thereby improving infant and maternal health outcomes and reducing healthcare costs [56].

To summarize, the decision to discontinue breastfeeding among Israeli Arab women is the result of a complex combination of socio-demographic, economic, belief-based, religious, personal, and external factors. Given the diverse religious background in Israel, which includes Muslim and Christian populations, this study aims to examine the impact of beliefs and religiosity on breastfeeding initiation among mothers in Israel, and how varying levels of religiosity influence breastfeeding practices in this diverse population. The research seeks to provide insights that can guide interventions to promote breastfeeding among groups with lower initiation rates.

Purpose of the Current Study

The primary goal of this study is to comprehensively explore the various factors influencing Arab Muslim and Christian women's decisions to stop or discontinue breastfeeding. These factors span across demographic characteristics, such as age, income, and education, as well as psychological, cultural, and social determinants. Additionally, the study examines maternal attitudes, access to breastfeeding support, and infant-related characteristics, such as health and feeding behaviors, which may also contribute to breastfeeding cessation. By analyzing this broad spectrum of factors, the research aims to offer a holistic understanding of the underlying causes that affect a mother's likelihood to discontinue breastfeeding prematurely. The findings are expected to provide valuable insights into how these predictors interact and influence breastfeeding practices, potentially revealing systemic or societal barriers that could be addressed through targeted interventions. As such we hypothesize the following:

The probability of mothers discontinuing breastfeeding is influenced by multiple factors, including age, ethnic group, religiosity level, number of children, education level, employment status, work scope, household income, previous experience with breastfeeding, duration of previous breastfeeding, guidance or instructions received regarding breastfeeding during prenatal follow-up or hospital stay, infant's age (in months), current breastfeeding status, source of nutrients for the baby, duration of exclusive breastfeeding, and other individual factors influencing the decision to breastfeed.

Method

Ethical Approval

The study was approved by the Institutional Review Board of Ramat Gan Academic College under approval number 2023-1010. All participants provided informed consent for their participation in the survey and for their data to be used by the research team.

Participants

There were 349 married Israeli Arab women, from 21 to 45 years old (M = 30.40, SD = 4.69), most were Muslim-Arabs (65%) and the rest were Christian-Arabs (35%); their religiosity level was gauged by a 5-point Likert-type scale consisting of 3 items (M = 4.63, SD = 0.68, α = .85), which indicates the

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sample is comprised of a rather religious group. Moreover, most hold an academic degree (64.8%) while the rest do not (e.g., post-secondary education, only high-school; 35.2%). Work-wise, most are working individuals (6.9% self-employed and 64.2% full- or part-time employees) while the rest are unemployed (28.9%); nearly half of the respondents have a household income below the local average salary (41.5%), roughly the same amount have an income around the average (38.4%) and the rest have an income above the average (20.1%); the scope of their work varies from 0% (i.e., unemployed) to 100% (i.e., full-time employee) with a mean of 56.59% (M = 0.56) and a standard deviation of 40% (SD = 0.40). Additionally, most women (67.3%) reported to have 4 or more individuals (themselves *excluded*) living under the same roof/in the same household, 24.6% of them reported of having 3 people in the same house, 6.3% reported 2 people and only 1.7% reported one more individual living with them. Specifically, the participants also reported to have either 0-1 children before the current pregnancy (34.4%), 2-3 children (40.7%) or 4 (or above) children (24.9%).

Measures

The research questionnaire was adapted from a baby nutrition survey developed by the Israel Center for Disease Control (ICDC). It was reviewed and validated by five experts in the field, and subsequently translated into Arabic—the participants' native language—to ensure maximum accessibility and to obtain more accurate and representative responses. Before distribution, a pilot study involving 30 individuals was conducted to evaluate the questionnaire, with minimal adjustments made based on the findings.

The survey was comprised of following questions: age, ethnic group, religiosity level, number of children, education level, employment status, work scope, household income, previous (experience with) breastfeeding, duration of previous breastfeeding, guidance/instructions received regarding breastfeeding, during prenatal follow-up or stay in the hospital, infant's age (in months), currently breastfeeding, nutrients source for the baby, duration of exclusive breastfeeding, and different factors influencing decision to breastfeed.

Procedure

The target population for this study consisted of Arab women (Muslim and Christian) who had given birth within the past year and breastfed their infants for at least four months postpartum. The initial sample included 349 participants. These participants were drawn from three different regions of Israel (north, central, and south) and represented a variety of age groups and socioeconomic backgrounds.

The sampling method utilized a snowball approach, wherein participants assisted the researchers in recruiting other potential participants through their personal net-works. Additionally, the questionnaire link was made available online, and physical copies were distributed by well-baby clinics (Tipat Chalav) nurses to breastfeeding women. The minimum age for participation was 18 years. The researchers had no prior relationship or familiarity with any of the participants, all of whom received detailed information about the study. Anonymity and confidentiality were assured, and participants were informed that their involvement would not provide any personal benefits or advantages but would contribute to the advancement of general knowledge in this area of research.

There were no known risks associated with participation in the study; however, as with any online activity, there was a potential risk of privacy breaches. Researchers made every effort to mitigate this risk by ensuring that the questionnaires were completed anonymously, with personal details used solely for research purposes.

Participants were informed that additional information could be obtained from the Ethics Committee [information omitted for double-blind study] via an inquiry form at the conclusion of the study. The research team could also be contacted through the email address provided in the questionnaire. Participants retained the right to discontinue the survey at any stage. Informed consent was explicitly obtained through a designated question at the beginning of the survey.

Data Analyses and Variables Details

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Statistical analyses were performed using the SPSS-PC (v28) statistical package. Prior to data analysis, data cleaning and distribution characteristics were performed. Descriptive statistics were used to describe the sample. The significance level was set at a default of $p < .05$.

To test the hypotheses, binary logistic regressions were analyzed in the following manner:

1. There were *6 dependent variables* with a dichotomous response scale (0 = no "was NOT a reason to stop"; 1 = yes "WAS a reason to stop") – all of which are different reasons for mothers to stop/halt breastfeeding their infant:

a. "Because you did not have enough milk or the milk was not good enough, and the baby constantly needed formula supplementation";

b. "Because of health issues of the baby: illness, hospitalization, or medication that prevented them from breastfeeding";

c. "Because of your own health issues: illness, hospitalization, or medication that prevented you from breastfeeding";

d. "Due to fatigue, discomfort, lack of time, or dissatisfaction with the breastfeeding experience";

e. "Due to lack of support and guidance from professionals for continuing breastfeeding"; and

f. "Because returning to work and work conditions were not supportive enough for continuing breastfeeding or expressing milk".

2. The predictor list consists of multiple variables ($n = 24$), that are continuous, dichotomous or categorical:

a. Age of the respondents (in years);

b. Ethnic group (0 = Muslim-Arabs; 1 = Christian-Arabs);

c. Religiosity level ($M = 4.63$, $SD = 0.68$, a = .85);

d. Number of children prior to the current pregnancy (0 = 0-1 children; 1 = 2-3 children; 2 = 4+ children);

e. Education level (0 = non-academic; 1 = academic);

f. Employment status (0 = unemployed; 1 = self-employed; 2 = part- or full-time employee);

g. Work scope (*i.e., the amount of time the employee works, such that a 100% job is working 42 hours a week de facto, in Israel*; R = 0%-100% or 0-1, $M = 0.56$, $SD = 0.40$);

h. Household income (0 = around the average; 1 = below the average; 2 = above the average);

i. Previous (experience with) breastfeeding (0 = no; 1 = yes);

j. Duration of previous breastfeeding (0 = did not breastfeed at all; 1 = 1-4 months; 2 = more than 4 months);

k. Guidance/instructions received regarding breastfeeding, during prenatal follow-up or stay in the hospital (0 = did not receive any guidance; 1 = group guidance; 2 = personal guidance);

l. Infant's age, in months (0 = 4-5 months; 1 = 5-6 months; 2 = more than 6 months);

m. Currently breastfeeding (0 = no; 1 = yes);

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n. Nutrients source for the baby (0 = *exclusive* breastfeeding; 1 = only *baby formulae*; 2 = *combined* breastfeeding);

o. If exclusive breastfeeding, what is the duration (0 = did not exclusively breastfeed at all; 1 = 1-4 months; 2 = more than 4 months);

p. Factors influencing decision to breastfeed (3-point Likert scale; 0 = did not impact my decision, 1= had some impacted on my decision, 2 = had significant impact on my decision): (1) Family members (e.g., mother, mother-in-law, sisters) and/or friends; (2) health clinic nurse; (3) hospital staff; (4) preparation course for delivering a baby; (5) previous successful experience with breastfeeding (of a previous baby); (6) financial considerations (e.g., breast milk is usually free); (7) desire to establish a good bond/attachment with the baby; (8) maintaining/sustaining the health of the baby; and (9) information derived from the media, and/or Internet and/or literature.

3. For categorical variables, contrasts were performed using the first category (the "0" group) as the reference category.

4. To compensate for the large variable list, the regressions' analysis method was set to forward-stepwise (criterion based on Wald's statistic), and as such, each analysis produced differentiated models with relevant predictors and model fit.

5. Confidence interval (95% CL) was calculated for the Exp(B) statistic (i.e., log-likelihood ratios).

Results

Reason #1 to Stop Breastfeeding

Prediction of the probability that "Because you did not have enough milk or the milk was not good enough, and the baby constantly needed formula supplementation" influenced the mother's decision to stop (= 1) / not stop (= 0) breastfeeding proved to be significant via omnibus Chi-square test with a relatively high coefficient of determination: χ^2 (9) = 158.98, $p < .01$, Nagelkerke's $R^2 = .49$. Further, the regression coefficients are displayed in Table 1.

Table 1. Logistic regression coefficients for reason #1 in relation to stopping breastfeeding.

Predictor	*b*	*SE*	*Sig.*	Exp(B)	$LL_{95\%}$	$UL_{95\%}$
Ethnicity (0 = Muslim; 1 = Christian)	0.95	0.34	.005	2.58	1.33	4.99
Number of Children (*ref* = none or 1 child)			.001			
2-3 Children	0.51	0.35	.149	1.66	0.83	3.32
4 or more Children	1.64	0.45	.000	5.18	2.13	12.60
Job Scope (0% = unemployed; 100% = full-time)	-1.16	0.38	.002	0.31	0.15	0.66
Breastfeeding Guidance (*ref* = did not receive any guidance)			.011			
Group Guidance	-0.01	0.43	.974	0.99	0.42	2.31
Personal Guidance	0.89	0.34	.008	2.42	1.26	4.68
Baby's Nutrients Source (*ref* = Exclusive Breastfeeding)			.000			
Baby food/formula only	3.43	0.50	.000	31.03	11.53	83.48
Combined Breastfeeding	1.54	0.38	.000	4.64	2.21	9.75
Family members and/or Friends	0.65	0.21	.002	1.91	1.27	2.87
Financial Considerations	0.59	0.20	.004	1.80	1.21	2.69

Notes. b = unstandardized regression coefficient (i.e., slope). SE = standard error. Sig = exact significance level. Exp(B) = log-likelihood ratios. LL and UL = lower and upper limits, respectively, of 95% confidence interval. ref = reference category (only for categorical variables).

Table 1 demonstrates the following, with regard to the mentioned reason #1:

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1. Christians are 2.58 times *more* likely to stop breastfeeding than Muslims.
2. Mothers with 4 or more children are 5.18 times *more* likely to stop breastfeeding than those with none or only 1 child.
3. The more workload the mothers have, they are 0.31 *less* likely to stop breastfeeding.
4. Mothers who received personal guidance are 2.42 *more* likely to stop breastfeeding than mothers who did not receive such guidance at all.
5. Mothers who rely only on baby formulae to feed their infant are 31.03 *more* likely to stop breastfeeding than mothers who opt for exclusive breastfeeding.
6. Mothers who rely on combined breastfeeding to feed their infant are 4.64 *more* likely to stop breastfeeding than mothers who opt for exclusive breastfeeding.
7. Family members and/or Friends *increase* the likelihood of stopping breastfeeding by 1.91.
8. Financial Considerations *increase* the likelihood of stopping breastfeeding by 1.80.

Reason #2 to Stop Breastfeeding

Prediction of the probability that "Because of health issues of the baby: illness, hospitalization, or medication that prevented them from breastfeeding" influenced the mother's decision to stop (= 1) / not stop (= 0) breastfeeding proved to be significant via omnibus Chi-square test with a high coefficient of determination: χ^2 (12) = 241.58, $p < .01$, Nagelkerke's $R^2 = .76$. Further, the regression coefficients are displayed in Table 2.

Table 2. Logistic regression coefficients for reason #2 in relation to stopping breastfeeding.

Predictor	*b*	*SE*	*Sig.*	Exp(B)	$LL_{95\%}$	$UL_{95\%}$
Ethnicity (0 = Muslim; 1 = Christian)	2.56	0.59	.000	12.89	4.03	41.22
Religiosity	1.21	0.51	.017	3.37	1.24	9.13
Number of Children (*ref* = none or 1 child)			.002			
2-3 Children	-0.17	0.68	.803	0.84	0.22	3.21
4 or more Children	1.84	0.74	.013	6.31	1.47	27.06
Education (0 = Non-academic; 1 = Academic)	1.47	0.59	.013	4.35	1.36	13.91
Breastfeeding Duration (*ref* = did not breastfeed at all)			.012			
1-4 Months	5.27	2.27	.020	194.81	2.26	16791.48
More than 4 Months	3.52	2.14	.101	33.63	0.50	2243.44
Baby's age (months) (*ref* = 4-5 months)			.000			
5-6 Months	2.16	0.96	.025	8.64	1.32	56.70
More than 6 Months	-1.78	0.69	.009	0.17	0.04	0.65
Family members and/or Friends	0.99	0.37	.007	2.70	1.32	5.54
Financial Considerations	1.49	0.31	.000	4.43	2.43	8.08
Information (from literature, media, internet)	-1.19	0.26	.000	0.30	0.18	0.50

Notes. b = unstandardized regression coefficient (i.e., slope). SE = standard error. Sig = exact significance level. Exp(B) = log-likelihood ratios. LL and UL = lower and upper limits, respectively, of 95% confidence interval. ref = reference category (only for categorical variables).

Table 2 demonstrates the following, with regard to the mentioned reason #2:

1. Christians are 12.89 times *more* likely to stop breastfeeding than Muslims.
2. Religiosity level *increases* the likelihood of stopping breastfeeding by 3.37.

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3. Mothers with 4 or more children are 6.31 times *more* likely to stop breastfeeding than those with none or only 1 child.

4. Mothers with academic education are 4.35 times *more* likely to stop breastfeeding than those who do not hold an academic degree.

5. Mothers who have been breastfeeding for more than 4 months are 194.81 *more* likely to stop breastfeeding than mothers who did not breastfeed at all.

6. Mothers with a baby of 5-6 months old are 8.64 *more* likely to stop breastfeeding than mothers with a baby of 4-5 months old;

7. However, Mothers with a baby of more than 6 months old are 0.17 *less* likely to stop breastfeeding than mothers with a baby of 4-5 months old.

8. Family members and/or Friends *increase* the likelihood of stopping breastfeeding by 2.70.

9. Financial Considerations *increase* the likelihood of stopping breastfeeding by 4.43.

10. Information derived from the Internet, literature or media *decreases* the likelihood of stopping breastfeeding by 0.30.

Reason #3 to Stop Breastfeeding

Prediction of the probability that "Because of your own health issues: illness, hospitalization, or medication that prevented you from breastfeeding" influenced the mother's decision to stop (= 1) / not stop (= 0) breastfeeding proved to be significant via omnibus Chi-square test with a good coefficient of determination: χ^2 (5) = 74.71, $p < .01$, Nagelkerke's $R^2 = .31$. Further, the regression coefficients are displayed in Table 3.

Table 3. Logistic regression coefficients for reason #3 in relation to stopping breastfeeding.

Predictor	*b*	*SE*	*Sig.*	Exp(B)	$LL_{95\%}$	$UL_{95\%}$
Religiosity	0.94	0.42	.026	2.55	1.12	5.81
Employment Status (*ref* = unemployed)			.012			
Self-employed	1.91	0.65	.003	6.77	1.91	24.02
Part- or Full-time Employee	0.39	0.38	.293	1.48	0.71	3.10
Financial Considerations	1.21	0.22	.000	3.34	2.19	5.09
Information (from literature, media, internet)	-0.52	0.15	.000	0.59	0.44	0.79

Notes. b = unstandardized regression coefficient (i.e., slope). SE = standard error. Sig = exact significance level. Exp(B) = log-likelihood ratios. LL and UL = lower and upper limits, respectively, of 95% confidence interval. ref = reference category (only for categorical variables).

Table 3 demonstrates the following, with regard to the mentioned reason #3:

1. Religiosity level *increases* the likelihood of stopping breastfeeding by 2.55.

2. Self-employed mothers are 6.77 times *more* likely to stop breastfeeding than those who are unemployed.

3. Financial Considerations *increase* the likelihood of stopping breastfeeding by 3.34.

4. Information derived from the Internet, literature or media *decreases* the likelihood of stopping breastfeeding by 0.59.

Reason #4 to Stop Breastfeeding

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Prediction of the probability that "Due to fatigue, discomfort, lack of time, or dissatisfaction with the breastfeeding experience" influenced the mother's decision to stop (= 1) / not stop (= 0) breastfeeding proved to be significant via omnibus Chi-square test with a moderate coefficient of determination: χ^2 (7) = 46.80, p < .01, Nagelkerke's R^2 = .21. Further, the regression coefficients are displayed in Table 4.

Table 4. Logistic regression coefficients for reason #4 in relation to stopping breastfeeding.

Predictor	*b*	*SE*	*Sig.*	Exp(B)	$LL_{95\%}$	$UL_{95\%}$
Religiosity	-0.42	0.21	.042	0.65	0.43	0.99
Number of Children (*ref* = none or 1 child)			.003			
2-3 Children	-0.06	0.40	.875	0.94	0.43	2.05
4 or more Children	1.28	0.45	.005	3.59	1.48	8.69
Breastfeeding Guidance (*ref* = did not receive any guidance)			.001			
Group Guidance	1.18	0.50	.018	3.25	1.22	8.65
Personal Guidance	1.49	0.41	.000	4.44	1.98	9.97
Baby's Nutrients Source (*ref* = Exclusive Breastfeeding)			.000			
Baby food/formula only	2.01	0.43	.000	7.43	3.19	17.30
Combined Breastfeeding	0.51	0.42	.223	1.66	0.73	3.75

Notes. b = unstandardized regression coefficient (i.e., slope). SE = standard error. Sig = exact significance level. Exp(B) = log-likelihood ratios. LL and UL = lower and upper limits, respectively, of 95% confidence interval. ref = reference category (only for categorical variables).

Table 4 demonstrates the following, with regard to the mentioned reason #4:

1. Religiosity level *decreases* the likelihood of stopping breastfeeding by 0.65.
2. Mothers with 4 or more children are 3.59 times *more* likely to stop breastfeeding than those with none or only 1 child.
3. Mothers who received group guidance are 3.25 *more* likely to stop breastfeeding than mothers who did not receive such guidance at all.
4. Mothers who received personal guidance are 4.44 *more* likely to stop breastfeeding than mothers who did not receive such guidance at all.
5. Mothers who rely only on baby formulae to feed their infant are 7.43 *more* likely to stop breastfeeding than mothers who opt for exclusive breastfeeding.

Reason #5 to Stop Breastfeeding

Prediction of the probability that "Due to lack of support and guidance from professionals for continuing breastfeeding" influenced the mother's decision to stop (= 1) / not stop (= 0) breastfeeding proved to be significant via omnibus Chi-square test with a small coefficient of determination: χ^2 (3) = 14.38, p < .01, Nagelkerke's R^2 = .07. Further, the regression coefficients are displayed in Table 5.

Table 5. Logistic regression coefficients for reason #5 in relation to stopping breastfeeding.

Predictor	*b*	*SE*	*Sig.*	Exp(B)	$LL_{95\%}$	$UL_{95\%}$
Exclusive Breastfeeding Duration (*ref* = did not breastfeed)			.021			
1-4 Months	-0.28	0.67	.682	0.76	0.20	2.84
More than 4 Months	-1.21	0.63	.049	0.30	1.02	1.63
Family members and/or Friends	0.73	0.23	.002	2.07	1.31	3.26

Notes. b = unstandardized regression coefficient (i.e., slope). SE = standard error. Sig = exact significance level. Exp(B) = log-likelihood ratios. LL and UL = lower and upper limits, respectively, of 95% confidence interval. ref = reference category (only for categorical variables).

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Table 5 demonstrates the following, with regard to the mentioned reason #5:

1. Mothers who have been exclusively breastfeeding for more than 4 months are 0.30 *less* likely to stop breastfeeding than mothers who did not breastfeed at all.

2. Family members and/or Friends *increase* the likelihood of stopping breastfeeding by 2.07.

Reason #6 to Stop Breastfeeding

Prediction of the probability that "Because returning to work and work conditions were not supportive enough for continuing breastfeeding or expressing milk" influenced the mother's decision to stop (= 1) / not stop (= 0) breastfeeding proved to be significant via omnibus Chi-square test with a moderate-low coefficient of determination: χ^2 (5) = 37.54, $p < .01$, Nagelkerke's $R^2 = .16$. Further, the regression coefficients are displayed in Table 6.

Table 6. Logistic regression coefficients for reason #6 in relation to stopping breastfeeding.

Predictor	*b*	*SE*	*Sig.*	Exp(B)	$LL_{95\%}$	$UL_{95\%}$
Number of Children (*ref* = none or 1 child)			.034			
2-3 Children	0.19	0.34	.582	1.21	0.62	2.35
4 or more Children	0.99	0.40	.013	2.70	1.23	5.91
Job Scope (0% = unemployed; 100% = full-time)	1.26	0.40	.002	3.51	1.61	7.65
Currently Breastfeeding (0 = no; 1 = yes)	-0.84	0.32	.008	0.43	0.23	0.80
Good Bond/Attachment with the Baby	1.38	0.38	.000	3.96	1.87	8.38

Notes. b = unstandardized regression coefficient (i.e., slope). SE = standard error. Sig = exact significance level. Exp(B) = log-likelihood ratios. LL and UL = lower and upper limits, respectively, of 95% confidence interval. ref = reference category (only for categorical variables).

Table 6 demonstrates the following, with regard to the mentioned reason #6:

1. Mothers with 4 or more children are 2.70 times *more* likely to stop breastfeeding than those with none or only 1 child.

2. The more workload the mothers have, they are 3.51 *more* likely to stop breastfeeding.

3. Mothers who currently breastfeed are 0.43 *less* likely to stop breastfeeding than those who are not currently breastfeeding.

4. The desire to establish a good bond/attachment with the baby increases the likelihood of stopping breastfeeding by 3.96.

Discussion

Breastfeeding is widely recognized for its immense benefits to both infants and mothers [57,58].International organizations, such as the World Health Organization [59] , recommend exclusive breastfeeding for the first six months of life, with continued breastfeeding alongside complementary foods for up to two years. Breastfeeding can reduce the risk of various infant diseases and improve cognitive development while also benefiting mothers by lowering the risk of breast and ovarian cancers [60]. Despite these known benefits, many women discontinue breastfeeding earlier than recommended due to various socio-demographic, personal, and external factors. Among Arab women in Israel, breastfeeding practices are influenced by cultural, religious, and socio-economic factors. Previous research highlights differences between Muslim and Christian Arab women regarding breastfeeding initiation and continuation, often influenced by their religiosity and social practices.

The current study aimed to explore the diverse factors contributing to breastfeeding cessation among Arab women in Israel, with a particular focus on how cultural and religious beliefs influence their decision-making. The study investigated socio-demographic characteristics such as age,

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education, employment, and income, as well as psychological and cultural determinants. Additional factors included the level of breastfeeding guidance received and infant-related health and feeding behaviors. The research sought to provide a comprehensive understanding of the systemic and personal factors that lead to early cessation of breastfeeding, with a particular focus on how religiosity, family support, and socio-economic factors impact breastfeeding decisions.

The study hypothesized that multiple factors influence the decision to discontinue breastfeeding among Arab women in Israel. These factors include age, ethnic group, level of religiosity, number of children, education, employment status, household income, and guidance received regarding breastfeeding. It was also hypothesized that women who are older, more religious, have higher education levels, or receive better breastfeeding support would be more likely to continue breastfeeding. The results of the study provided several significant insights.

Christian Arab women were found to be more likely to stop breastfeeding earlier compared to their Muslim counterparts. Higher levels of religiosity were associated with an increased likelihood of breastfeeding cessation, contrary to the hypothesis that religiosity would promote continued breastfeeding. This finding suggests that religiosity may play a complex role in breastfeeding decisions, potentially reflecting cultural expectations or religious practices [61].

Moreover, mothers with more children, particularly those with four or more, were more likely to stop breastfeeding earlier. This is likely due to the increased demands of caring for multiple children, which can make breastfeeding more challenging.

Additionally, employment status significantly impacted breastfeeding continuation, with full-time employees more likely to stop breastfeeding due to the challenges of balancing work and breastfeeding. Mothers with heavier workloads were also less likely to continue breastfeeding [62] .It important to note that, in Israel, a survey showed that the breastfeeding initiation rate is around 90%, with all women who began breastfeeding in the hospital reporting exclusive breastfeeding. However, exclusive breastfeeding rates drop significantly during maternity leave, largely due to challenges such as milk supply issues and technical difficulties with breastfeeding[63].

Also, surprisingly, personal guidance received during prenatal care or in the hospital was associated with an increased likelihood of breastfeeding cessation, possibly indicating that the quality of guidance or the circumstances in which it is given may not be fully supportive of sustained breastfeeding [58].

Furthermore, family members and friends played a significant role in influencing the decision to stop breastfeeding. Financial considerations also contributed to breastfeeding cessation, particularly for women in lower-income households [64].

Lastly, mothers who supplemented breastfeeding with formula or who relied entirely on formula feeding were significantly more likely to stop breastfeeding, highlighting the role of infant feeding behaviors in shaping breastfeeding practices.

These findings underscore the complexity of factors that contribute to breastfeeding cessation among Arab women in Israel. The interaction between socio-demographic, religious, and personal factors suggests that tailored interventions are needed to address the specific barriers faced by different subgroups within the population. Understanding these dynamics can inform the development of policies and healthcare practices to promote sustained breastfeeding and improve maternal and infant health outcomes in this population.

Limitations

If it important to note the limitations of the current research. The sample size, for instance, while sufficient for the analysis, consisted of 349 Arab women from Israel, primarily Muslims (65%) and Christians (35%). Although this sample provides valuable insights into the breastfeeding behaviors of these groups, the findings may not be fully generalizable to all Arab women in Israel or other regions. Cultural diversity within the Arab population and the influence of local socio-economic conditions may limit the applicability of these results to other contexts.

In addition, the reliance on self-reported data introduces potential biases such as recall bias, social desirability bias, and subjective interpretation of questions. Mothers may have underreported

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or overreported their breastfeeding practices or the factors influencing their decisions based on their perceptions or desire to present themselves in a positive light.

Also, the cross-sectional nature of the study only provides a snapshot of the breastfeeding practices and associated factors at a specific point in time. This design limits the ability to establish causality or understand how these factors evolve over time. Longitudinal studies would be needed to assess changes in breastfeeding practices and the long-term influence of various factors.

Moreover, while religiosity was included as a variable, the study measured it on a 5-point 3-item Likert scale, which may not capture the full complexity and diversity of religious beliefs and practices. The influence of specific religious teachings, cultural interpretations, and individual faith experiences could vary widely, making it difficult to fully understand how religiosity impacts breastfeeding behaviors.

Furthermore, while the study sheds light on the breastfeeding practices of Arab women in Israel, it does not allow for comparison with other ethnic groups within the country, such as Jewish or Druze women. Including these groups could have provided more comprehensive insights into the broader social and cultural factors influencing breastfeeding in Israel.

Lastly, the study primarily relied on quantitative methods and did not explore the qualitative aspects of breastfeeding cessation in depth. A mixed-methods approach, incorporating interviews or focus groups, could have provided richer, more nuanced insights into the personal and emotional experiences of mothers and their decision-making processes.

These limitations suggest that while the study provides valuable insights into the factors influencing breastfeeding cessation among Arab women in Israel, further research is needed to address these constraints and explore additional dimensions of the topic.

Recommendations

In light of the limitations and the findings emanating from the current stud, we posit several suggestions for future research. For example, longitudinal designs need to be considered in order to track breastfeeding practices over time. This approach would allow researchers to explore how factors influencing breastfeeding decisions change as infants grow and as mothers' circumstances, such as employment or family dynamics, evolve. It would also help establish causality and provide insights into long-term breastfeeding behaviors.

Additionally, to gain a deeper understanding of the personal and emotional experiences behind breastfeeding cessation, future studies should incorporate qualitative methods such as interviews, focus groups, or case studies. This would allow researchers to explore mothers' personal narratives, cultural values, religious beliefs, and social pressures that quantitative methods may not capture fully.

For generalizability, expanding the sample size to include more diverse groups, such as Jewish, Druze, and other ethnic or religious populations in Israel, could provide a more comprehensive view of breastfeeding practices across different communities. Additionally, including women from a wider range of socio-economic backgrounds would help clarify how financial factors intersect with cultural and religious beliefs to influence breastfeeding decisions.

Moreover, future research should further investigate the role of healthcare professionals in influencing breastfeeding continuation. This could include an examination of the quality and consistency of breastfeeding guidance provided, as well as an exploration of healthcare providers' attitudes and knowledge about breastfeeding support. Identifying gaps in the training or resources available to healthcare workers could inform better interventions.

Also, further studies should explore the complexities of religiosity and cultural beliefs in greater depth, possibly by using more nuanced measures of religiosity that take into account both personal faith practices and broader community norms. Understanding the specific religious teachings and interpretations that influence breastfeeding decisions could help create more targeted and culturally appropriate interventions.

At the workplace, given the significant role of employment in breastfeeding cessation, future research should focus on workplace policies and support systems for breastfeeding mothers. This

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could include examining the availability and effectiveness of maternity leave, breastfeeding-friendly work environments, and policies allowing for breast milk expression. Identifying best practices in workplace accommodations could inform policies aimed at supporting working mothers. Furthermore, future research should test the effectiveness of interventions designed to promote sustained breastfeeding. These could include educational programs, peer support initiatives, or workplace accommodations aimed at reducing the barriers to breastfeeding. Researchers could measure outcomes such as breastfeeding duration, maternal satisfaction, and infant health to assess the impact of such interventions.

Lastly, future research should consider exploring the relationship between maternal mental health, such as postpartum depression or anxiety, and breastfeeding practices. Understanding how mental health affects breastfeeding continuation could provide valuable insights for developing holistic support systems for mothers.

By addressing these areas, future research can contribute to a more complete understanding of the complex factors influencing breastfeeding decisions and help shape policies and interventions that promote sustained breastfeeding among diverse populations.

Conclusions

The study investigates the factors contributing to breastfeeding cessation among Arab women in Israel, focusing on the socio-demographic, cultural, religious, and personal determinants that influence their decisions to stop breastfeeding. Despite the known health benefits of breastfeeding, many women discontinue breastfeeding earlier than recommended. This study explores how cultural norms, religious beliefs, maternal education, employment status, and family support shape breastfeeding practices among Israeli Arab women, particularly in Muslim and Christian communities.

The findings highlight significant differences between Muslim and Christian Arab women, with Christian women being more likely to stop breastfeeding earlier. Factors such as the number of children, religiosity, employment status, and the nature of breastfeeding guidance received also play important roles. For example, mothers with more children or heavier workloads tend to cease breastfeeding sooner, while those with supportive family networks are more likely to continue breastfeeding. Surprisingly, personal guidance was linked to an increased likelihood of breastfeeding cessation, suggesting that the quality of professional support may not be fully adequate.

The study also underscores the significant role of infant-related factors, such as reliance on formula feeding, which contributes to early breastfeeding cessation. Family influence, financial pressures, and the baby's health also play crucial roles in shaping breastfeeding decisions.

The study acknowledges several limitations, including the reliance on self-reported data, the cross-sectional design, and a sample that may not fully represent all Arab women in Israel. It calls for future longitudinal and qualitative research to provide deeper insights and to explore how workplace policies and healthcare practices can better support breastfeeding mothers.

In conclusion, the study provides valuable insights into the complex factors that lead to breastfeeding cessation among Arab women in Israel, offering recommendations for more tailored interventions that could promote sustained breastfeeding and improve maternal and infant health outcomes in this population.

Supplementary Materials: The online questionnaire as supplementary material and supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/children10091438/s1.

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Institutional Review Board Statement: The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Institutional Review Board of the Ramat Gan Academic College, approval code

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#2023-1010, approval date: July 20, 2023. On the Appendix 1: Informed consent form for online studies, Part I: Informed Consent Form for Online Studies it is written to each participant who answered the questionnaire that "by clicking the "I agree" button, you express your consent to participate in the study. Thereby, each patient who filled out the questionnaire had given his/her informed consent.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study. The participants were given a detailed explanation of the study in their native language (Arabic or English) and were asked online to provide an informed consent form.

Data Availability Statement: Individual level data cannot be made publicly available due to legal and ethical restrictions. Aggregative data might be provided upon reasonable request to the corresponding author.

Conflicts of Interest: The authors declare no conflict of interest.

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Appendix 1: Informed consent form for online studies

Part I: Informed Consent Form for Online Studies

Greetings,

You are invited to participate in a study entitled "Characteristics and Factors Israeli Arab Mothers Related to Exclusive Breastfeeding. This study was conducted by researchers from the Ramat Gan Academic College and The Academic College of Tel Aviv-Jaffa. We thank you for dedicating your time and participating in the study.

The purpose of the study is to investigate the factors associated with exclusive breastfeeding amongst Arab mothers living in Israel.

The purpose of the study to investigate the factors predicting Exclusive breastfeeding among Arab mothers living in Israel

The time required to fill out the questionnaire is about 15 minutes. The questionnaire is anonymous and will be filled out anonymously, your answers are completely confidential, and will not be used in any way except for research purposes.

In this questionnaire, you will be presented with several different questions regarding the effect of treatments on the quality of life and emotional reactions of transplant recipients. You are asked to mark the correct answer next to each question.

You do not have to answer all the questions. If you feel uncomfortable, you may stop filling out the questionnaire at any stage.

By agreeing to fill out this questionnaire, you declare that you are over 18 years old.

It is assumed that participating in the research will not bring you any personal profit or advantage, but we hope that your participation will contribute to general knowledge in this research field.

It should be noted that we are not aware of any risks by participating in the study, but as with any online activity there is a certain risk of breach of privacy. We make every effort to reduce this risk by have the questionnaire filled out anonymously and not using the details except for the purpose of the study.

At the end of the study, you can get more information from the Ethics Committee of the Tel Aviv-Jaffa Academic College using the Debriefing form. In addition, you can contact the research team by email:

We thank you very much for filling out the questionnaires in full.

Regards,

Dr. Khaled Awawdi : Awawdi.h@iac.ac.il Dr. Tarabia Mahdi: mahdita@mta.ac.il

By clicking the "I agree" button, you express your consent to participate in the study. By clicking on the "I do not agree" button, you terminate your participation in the study.

Appendix A

Part A: Socio-Demographic and Employment Characteristics

1. Age? _____

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2. Marital Status:
1. Married or living with a partner
2. Single
3. Divorced or separated
4. Widowed
3. What is your nationality?
1. Arab Muslim
2. Arab Christian
3. Arab Druze
4. Region?
1. North
2. Central
3. South
5. Level of Religiosity. Please circle the extent to which you agree with the following statements. 1 = Strongly disagree, 5 = Strongly agree.
1. Do you believe in religious values?
2. Do you behave according to traditional religious values?
3. Do you observe the commandments of your faith?
6. How many children do you have from before your last birth? (Not including your most recent child)
1. 0
2. 1
3. 2
4. 3
5. 4 or more
7. How many people live in your household permanently?
1. 1
2. 2
3. 3
4. 4 or more
8. What is your level of education?
1. Primary
2. Secondary
3. Academic
9. Did you work before the birth or until shortly before it, and what are the characteristics of your job?
1. I did not work
2. Self-employed
3. Employed
10. Did you work before the birth or until shortly before it, and what was the extent of your work? (If you are employed at a different percentage than listed below, please mark the higher percentage.)
1. I did not work
2. I worked, full-time 100%
3. I worked, 75% part-time
4. I worked, 50% part-time
5. I worked, 25% part-time
11. Do you intend to return to work?
1. Yes
2. No
3. I don't know
4. I have already returned to work
12. At what age of the baby do you intend to return to work or have you returned to work?

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1. 1 month
2. 2 months
3. 3 months
4. Between 4 to 6 months
5. 6 months
6. I do not plan to return to work

13. The average income for a family recently measured is between 12,000 ₪ and 15,000₪ . How would you rate your family's income?

1. Below average
2. Average income
3. Above average

Part B: Details on Infant Feeding

Exclusive breastfeeding is defined as the natural feeding of breast milk or expressed breast milk without any supplementation of infant formula (IF), including any formula given in the hospital after birth.

1. During your prenatal follow-up or your stay in the hospital, did you receive guidance on breastfeeding, and in what form?

1. I did not receive any conversation or guidance on breastfeeding.
2. I received a group conversation or guidance on breastfeeding.
3. I received individual conversation or assistance regarding breastfeeding.

2. What was the nature of the feeding your infant received since the last birth in the past four months?

1. Infant formula (IF) only.
2. Partial/combined breastfeeding combined with IF.
3. Exclusive breastfeeding (breast milk and/or expressed breast milk) only.

3. If your infant's feeding method in the past four months was based on exclusive breastfeeding, how long did the breastfeeding last?

1. I did not breastfeed at all.
2. Up to one month.
3. Up to two months.
4. Up to three months.
5. Up to four months.
6. More than four months.

4. If the feeding method for your baby over the past four months, or part of that time, was based on exclusive breastfeeding, please indicate the degree of influence each of the following factors had on your decision to breastfeed:

Factors affecting decision to breastfeed	**Did not impact my decision**	**Had some impacted on my decision**	**Had significant impact on my decision**
Family Members (Mother, Mother-in-law, Sisters)	0	1	2
Health Clinic Nurse	0	1	2
Hospital Staff	0	1	2
Childbirth Preparation Course	0	1	2
Successful Previous Experience with Breastfeeding a Previous Child	0	1	2
Economic Consideration (Breast milk is free)	0	1	2
Desire for a Good Bond with the Child	0	1	2
Maintaining the Health of Your Baby	0	1	2

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Information from the Internet, Literature, and Media	0	1	2

5. If the feeding method for your baby over the past four months, or part of that time, was based on exclusive or partial breastfeeding, please indicate for each of the following reasons whether it was a reason for you to stop breastfeeding:

Reasons affecting decision to stop breastfeed	**Was NOT a reason to stop**	**WAS a reason to stop**
Because you did not have enough milk or the milk was not good enough, and the baby constantly needed formula supplementation.	0	1
Because of health issues of the baby: illness, hospitalization, or medication that prevented them from breastfeeding.	0	1
Because of your own health issues: illness, hospitalization, or medication that prevented you from breastfeeding.	0	1
Due to fatigue, discomfort, lack of time, or dissatisfaction with the breastfeeding experience.	0	1
Due to lack of support and guidance from professionals for continuing breastfeeding.	0	1
Because returning to work and work conditions were not supportive enough for continuing breastfeeding or expressing milk.	0	1

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