

Knowledge, Attitude, and Practices Regarding Breastfeeding Among Mothers in Benghazi, Libya

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Abstract

Breastfeeding is fundamental to infant nutrition, protection against childhood illness, and maternal health. Despite established recommendations for early initiation and exclusive breastfeeding, inappropriate feeding practices continue to occur in many settings. Maternal knowledge and attitudes, cultural beliefs, family influences, and access to professional support may affect the extent to which recommended breastfeeding practices are followed. This study aimed to explore breastfeeding-related knowledge, attitudes, and practices among mothers in Benghazi, Libya, and to identify areas of knowledge gaps and practices that may need further support. The objective of this study was to evaluate the knowledge, beliefs, and practices of mothers in Benghazi, Libya, on breastfeeding, with particular emphasis on areas of inadequate knowledge and practice that might be amenable to support. This is a cross-sectional study conducted in the neonatal department of Benghazi Medical Center, Benghazi, Libya, from June to December 2024. The sample consisted of 305 mothers aged 20-45 years. We used a standardized questionnaire to collect information on maternal and neonatal characteristics, as well as mothers' knowledge, attitudes, and practices regarding breastfeeding. Before rolling out the questionnaire to the full sample, we piloted it with 30 mothers to check that the questions were clear and measured what they were meant to. All data were analyzed in SPSS (version 26); findings are presented as frequencies, percentages, means, and standard deviations. Participants had a mean age of 34.23 ± 3.13 years. Most mothers were well aware of breastfeeding's general benefits: 92.5% knew breast milk supplies the nutrients infants need, and 93.1% recognized its role in protecting against infection and disease. That said, several specific gaps emerged: only 30.8% correctly identified colostrum's protective function, and nearly two-thirds (65.2%) admitted they didn't know what it does. Awareness of breastfeeding's contribution to birth spacing was similarly low, at just 28.9%. Taken together, 58.76% of mothers demonstrated fair knowledge, 26.28% poor knowledge, and only 14.96% good knowledge. Regarding attitudes, 44.6% demonstrated a fair attitude, 43.3% a poor attitude, and only 12.1% a good attitude. Although 72.8% of mothers reported initiating breastfeeding within the first 24 hours after delivery, 52.5% reported giving pre-lacteal feeds, while 79.3% had not received advice from a lactation counsellor before initiating breastfeeding. Overall, 60.0% of mothers demonstrated poor breastfeeding practices, compared with 34.1% with fair practices and only 5.9% with good practices. The results showed that there is a significant gap between the general awareness of the benefits of breastfeeding and the effective implementation of the recommended breastfeeding practices among mothers in Benghazi. Knowledge of the nutritional and protective benefits of breast milk was generally good, but there were major gaps in knowledge about colostrum, birth spacing, breastfeeding technique, and timely initiation. High rates of pre-lacteal feeding and low utilization of professional lactation counseling are also areas needing attention. Improving access to trained lactation counselors, strengthening antenatal and early postnatal breastfeeding education, and engaging family members in breastfeeding support may help to tackle persistent misconceptions and promote healthier breastfeeding practices among mothers in Benghazi.

Keywords. Breastfeeding, Knowledge, Attitudes, Practices, Pre-lacteal feeding.

Introduction

Breastfeeding is one of the most important practices for promoting the health, growth, and development of infants. Breast milk provides infants with essential nutrients and contains protective components that help reduce the risk of common childhood illnesses, including diarrhea and respiratory infections. Breastfeeding also provides important health benefits for mothers. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) recommend initiating breastfeeding within the first hour after birth, exclusive breastfeeding for the first six months of life, and the introduction of adequate and safe complementary foods at six months while continuing breastfeeding up to two years of age or beyond [1,2]. Despite the well-established benefits of breastfeeding and the existence of international recommendations, many mothers do not fully follow recommended breastfeeding practices. Breastfeeding may be initiated late, pre-lacteal feeds may be given to newborns, and some mothers may discontinue breastfeeding earlier than recommended. These practices can be influenced by several factors, including maternal knowledge, attitudes, education, employment, cultural beliefs, family influence, and access to professional healthcare support. Knowledge, attitude, and practice (KAP) are important factors that may influence breastfeeding behavior. A mother may understand some of the general benefits of breastfeeding while still having misconceptions about specific practices, such as the importance of colostrum, the appropriate timing of breastfeeding initiation, breastfeeding frequency, or the use of pre-lacteal feeds. Previous research has shown that breastfeeding practices are influenced not only by maternal knowledge but also by attitudes, family and social support,

cultural beliefs, and contact with healthcare services[3]. Family members and traditional beliefs may play an important role in decisions related to infant feeding. Although family support can positively influence breastfeeding, incorrect or outdated information may also contribute to inappropriate practices. Therefore, healthcare professionals have an important responsibility to provide mothers with accurate, evidence-based information and practical breastfeeding support during pregnancy and after delivery. Previous studies conducted in different countries have identified important gaps between maternal knowledge and actual breastfeeding practices.[4], For example, inadequate breastfeeding practices were reported among postnatal mothers, despite awareness of some of the benefits of breastfeeding. Similarly, Abulreesh et al. (2021) identified several attitudes and barriers that may negatively influence breastfeeding initiation and continuation. These findings suggest that improving breastfeeding outcomes requires more than simply providing general information; mothers may also need continuous counselling, family support, and practical assistance.[5]

In Libya, breastfeeding remains an important maternal and child health issue. Previous research conducted in Benghazi examined factors affecting exclusive breastfeeding and identified maternal characteristics as important factors associated with breastfeeding practices.[6] However, there remains a need to further understand mothers' current knowledge, attitudes, and practices regarding breastfeeding within the local context of Benghazi. Understanding these factors is important for identifying gaps in breastfeeding education and support. Such information can assist healthcare professionals, policymakers, and health educators in developing interventions that address specific misconceptions and barriers rather than focusing only on general awareness of breastfeeding benefits. This is particularly important because appropriate breastfeeding practices require not only knowledge but also positive attitudes, professional support, and an environment that enables mothers to apply recommended practices. Therefore, the present study aimed to assess the knowledge, attitudes, and practices regarding breastfeeding among mothers in Benghazi, Libya. The study also aimed to identify areas in which mothers demonstrated adequate knowledge and areas where important gaps and misconceptions remained. The findings may contribute to the development of targeted educational and counselling interventions to improve breastfeeding knowledge, attitudes, and practices among mothers.

Breastfeeding and Recommended Infant Feeding Practices

Breastfeeding is widely recognised as an essential component of infant and young child nutrition. Breast milk provides appropriate nutrition during early life and contributes to infant growth, development, and protection against common childhood illnesses. Breastfeeding also provides important benefits for maternal health. The World Health Organization (WHO) and UNICEF recommend initiating breastfeeding within the first hour after birth, providing exclusive breastfeeding during the first six months of life, and introducing safe and nutritionally adequate complementary foods at six months while continuing breastfeeding up to two years of age or beyond. Despite these recommendations, appropriate breastfeeding practices are not determined by knowledge alone. Maternal beliefs, attitudes, family traditions, cultural practices, employment, access to healthcare services, and the availability of professional breastfeeding support may all influence whether recommended practices are followed.[1,2]

Maternal Knowledge of Breastfeeding

Maternal knowledge plays an important role in successful breastfeeding. Mothers need more than a general awareness that breast milk is beneficial; they also require practical knowledge regarding early initiation, exclusive breastfeeding, feeding on demand, the importance of colostrum, correct attachment, and the continuation of breastfeeding alongside complementary feeding. A systematic review conducted by Dukuzumuremyi et al. (2020) examined maternal knowledge, attitudes, and practices regarding exclusive breastfeeding in East Africa. The review found that awareness of breastfeeding was generally high, but knowledge of specific recommendations was less consistent. In particular, understanding of the recommended duration of exclusive breastfeeding and the importance of early initiation was often inadequate. The authors concluded that antenatal education, early postpartum education, and continued breastfeeding counselling are important for improving maternal knowledge and attitudes. This distinction between general and specific knowledge is particularly relevant to the present study. A mother may understand that breast milk is healthy while still lacking knowledge about when breastfeeding should begin, whether pre-lacteal feeds should be given, or how breastfeeding contributes to appropriate infant feeding during the first months of life.[3]

Maternal Attitudes Toward Breastfeeding

Attitudes represent another important component of breastfeeding behaviour. A mother may possess adequate knowledge but still experience uncertainty, negative beliefs, social pressure, or practical barriers that affect her decisions. Previous research has demonstrated that positive maternal attitudes are associated with better breastfeeding practices, although attitudes alone do not guarantee successful implementation. The systematic review by Dukuzumuremyi et al. highlighted the relationship between maternal knowledge, attitudes, and exclusive breastfeeding practices, suggesting that improvement in one domain may contribute to improvement in the others. Negative attitudes may arise from misconceptions about breastfeeding, concerns regarding maternal health or body weight, the belief that formula feeding is superior, or cultural acceptance of practices such as pre-lacteal feeding. Therefore, breastfeeding education should address beliefs and misconceptions in addition to providing factual information.[3]

Breastfeeding Practices and the Knowledge–Practice Gap

The existence of knowledge does not necessarily mean that recommended practices will be followed. This difference between what mothers know and what they actually do is often described as a knowledge–practice gap. Dukuzumuremyi et al. found that although awareness of exclusive breastfeeding was common in many East African populations, actual breastfeeding practices remained below recommended standards. The review emphasised the importance of combining health education with continued counselling and support rather than relying solely on the provision of information. [3] Several practical issues may contribute to this gap. Mothers may receive conflicting advice from relatives, follow traditional practices, lack professional support after delivery, or encounter difficulties with breastfeeding technique. For this reason, practical counselling and direct support during the antenatal and postnatal periods may be particularly important.

Family, Community, and Cultural Influences

Family members can strongly influence infant-feeding decisions. Mothers may receive advice from their mothers, mothers-in-law, husbands, relatives, and friends. Such support can be beneficial when accurate information is provided, but it can also reinforce traditional practices that are inconsistent with current recommendations. A scoping review of breastfeeding interventions in Arabic-speaking countries found that breastfeeding promotion requires more than individual education. Community-based interventions, family support, health-system improvements, and education of healthcare professionals can all contribute to improved breastfeeding knowledge and practices. The review also identified challenges within Arab countries related to health-professional capacity and broader social support for breastfeeding. These findings are particularly relevant to the Libyan context, where family relationships and cultural traditions may play an important role in maternal decision-making. Understanding the primary sources from which mothers obtain breastfeeding information is therefore important when designing effective interventions. [7]

The Role of Healthcare Professionals and Breastfeeding Counselling

Healthcare professionals have an important responsibility in providing evidence-based breastfeeding information and practical support. Antenatal education can prepare mothers before delivery, while immediate postpartum support can help mothers initiate breastfeeding and overcome early difficulties. WHO and UNICEF recommendations emphasise early initiation of breastfeeding and continued support for appropriate infant feeding. Professional counselling may help mothers understand the importance of the first hour after birth, exclusive breastfeeding during the first six months, and the introduction of complementary foods at the appropriate age. The review of breastfeeding interventions in Arabic-speaking countries further showed that interventions targeting mothers, communities, healthcare professionals, and health systems can improve breastfeeding-related outcomes. Multi-component approaches that combine education with antenatal and postnatal support appear particularly valuable. [7]

Breastfeeding in Libya and the Research Gap

Although breastfeeding is widely practised in Libya, there remains a need for further research examining maternal knowledge, attitudes, and practices within specific local populations. Previous research conducted in Benghazi, including the study by Abdulmalek LJ (2018), identified maternal and sociodemographic factors as relevant to breastfeeding practices. However, local evidence examining knowledge, attitudes, and self-reported practices together remains important for identifying specific gaps that may be addressed through health education and professional support. The present study therefore contributes local evidence by examining the three interconnected domains of knowledge, attitudes, and practices among mothers in Benghazi. Identifying weaknesses within each domain may help healthcare professionals and policymakers develop more targeted interventions that address not only what mothers know, but also what they believe and what they actually do. [6]

Methods

Study Design and Setting

A cross-sectional study was conducted at the neonatal department at the Benghazi Medical Centre (BMC), in Benghazi, Libya. The study period spanned from June 2024 to December 2024. To assess the knowledge, attitude, and practice of mothers' breastfeeding in Benghazi. The target population of the study was mothers in the age range of 20 to 45 years. A comprehensive sampling approach was used to ensure a representative and accurate study sample; all eligible patients meeting the inclusion criteria were included in the study.

Inclusion Criteria

Mothers of neonates have been born in Benghazi.

Exclusion Criteria

Cases with missing data; mothers who refused to complete the form; and any misunderstood answers.

Data Collection

A standardized data collection form was used to assess the mother's knowledge, attitude, and practice. The data collected were divided into two-part first part about mothers' and neonatal demographic characteristics (age, sex, educational level, residency), and the second part includes Questions that assess knowledge, attitude, and practice about breastfeeding.

Quality Assurance and Validation

Before conducting this investigation, to ensure the accuracy and completeness of the data, a trained research assistant cross-checked a sample of 10% of the participants. (not included in the final sample) A pilot study was done among a sample of 30 of the mothers to evaluate the comprehensibility and the validity of the questions. Following this, no changes were made to the data collection form. Statistical Analysis: The data are reported as mean $\pm$ standard deviation (SD) and summarized frequencies and percentages. All analyses were performed using Statistical Package for the Social Sciences (SPSS) version 26 software, and data visualizations (e.g., graphs and charts) were created using Microsoft Excel 2019.

Ethical Considerations

The study protocol was reviewed and approved by the scientific committee at the BMC of the study and the use of de-identified patient data was approved. Strict measures were taken to ensure the confidentiality and security of the patient information throughout the study. All data were anonymised and de-identified to protect patient confidentiality.

Results

The study was conducted at a neonatal department in BMC and involved 305 participants. The age distribution of the mothers participating in the study ($N = 305$), in which the age distribution is $34.23 \text{ years} \pm 3.133$, which means that the group of women in question has a relatively concentrated age distribution ranging from the early to late thirties, as shown in (Figure 1). (Figure 2) illustrates the percentage representation of mothers by their educational background. The highest is that of college/diploma holders, which is 48.85%, and then the rest in the following order: secondary (31.15%), postgraduate (10.82%), elementary (7.869%), and illiterate (1.311%). The employment status of the mothers is illustrated in (Figure 3) which shows that most of the participants do not work and form 68.2% of the group, while working mothers constitute 31.8% of the group; that is shown in (Figure 3).

Approximately 85% of participants were from Benghazi, as shown in (Figure 4). The clustered bar chart presents the cross-tabulation of maternal employment status, grouped on the basis of place of residence. Mothers living in Benghazi have employment rates of 31.27% and unemployment rates of 68.73%, while mothers not living in Benghazi have employment rates of 34.78% and unemployment rates of 65.22%, as presented in (Figure 5). (Table 1) shows descriptive statistics about maternal knowledge, general information, infant benefits, and maternal health benefits about breastfeeding. There was an overwhelmingly large proportion of the sample who had very high knowledge about basic nutrition and protection provided by breastfeeding, as 92.5% knew that breast milk provides all nutrients needed and 93.1% knew that it protects the infant from infections and diseases. However, there was very high knowledge about bonding of the infant 88.9%, as well as reduced diarrhea and allergies 86.2%. However, there were some areas where knowledge was lacking, such as the function of colostrum as a vaccine (where 65.2% did not know) and birth spacing through breastfeeding (where 47.2% answered no and 23.9% did not know). Moreover, while 51.8% of the mothers were aware of the signs of a good breastfeeding latch, 37.7% did not know, and 60.7% correctly knew that feeling pain during breastfeeding is not normal.

Figure 6 illustrates the frequency of mothers' knowledge on the best time to initiate breastfeeding. The frequency of those who are wrong about the best time is 50.16% ($n=153$), who think that the right time to begin breastfeeding is after 4 hours. Those who know the best time is one hour are 27.87% ($n=85$). (Figure 7) displays the general percentages of the distribution of the participants based on their degree of knowledge on breastfeeding practices. Most of the mothers have fair knowledge of breastfeeding practices, which is 58.76%, while some have poor knowledge, 26.28%, whereas the rest have good knowledge, 14.96%. The main sources through which mothers gather information about breastfeeding. Family and friends form the main source of information overwhelmingly, accounting for 76.7%, followed by healthcare professionals 11.8%, internet/social media 9.51%, and TV or radio 1.97%; which is shown in (Figure 8).

Table 2 indicates the attitudes of the mothers towards various practices of breastfeeding. The majority of the participants had positive attitudes about the recommended practices, with (59.7%) agreeing that breastfeeding needs to be done until two years and (59%) supporting breastfeeding according to demand. In addition, optimal attitudes were observed through high levels of disagreement about the practice of stopping breastfeeding in cases of diarrhea (88.9%) and that formula feeding is better than breastfeeding (49.2%). On the other hand, significant misconceptions were observed, with (38.4%) of the mothers agreeing that pre-lacteal feeds need to be given and (32.8%) of the mothers agreeing that breastfeeding causes an increase in the weight of mothers, with (37.4%) being neutral about this. The classification of mothers' attitudes towards breastfeeding practices is generally suboptimal or moderate from the analysis of the results obtained. This is because the majority of the mothers, 44.6% ($n = 136$), showed a fair attitude, while the rest, 43.3% ($n = 132$), showed a poor attitude. On the other hand, only a small number of mothers, 12.1% ($n = 37$), had a good attitude, which is presented in (Table 3).

Table 4 highlights the self-reported breastfeeding practices among mothers related to the timing of breastfeeding initiation, frequency of feeding, counseling by health care professionals, and pre-lacteal feeding. Despite the encouraging number of women, 72.8% ($n=225$), who reported breastfeeding initiation in the first 24 hours of childbirth, there was inadequate practice in some other important aspects. In particular, more than half of the women, 52.5% ($n = 160$), provided pre-lacteal

feeds to their children, and most of them, 79.3% ($n = 242$), did not have counseling from lactation consultants before breastfeeding initiation. Also, there were the following distributions of frequency of daily feedings: 44.6% ($n=136$) of mothers fed every 2 to 3 hours, 43.3% ($n=132$) fed more often than every 2 hours, and 12.1% ($n=37$) had breaks of more than 3 hours. (Figure 9) demonstrates the general categorization of the actual breastfeeding behavior of the mothers. A remarkably high proportion of 60.00% of the participants are classified as poor breastfeeding behavior, while 34.10% of the participants have fair behavior and only 5.90% have good behavior.

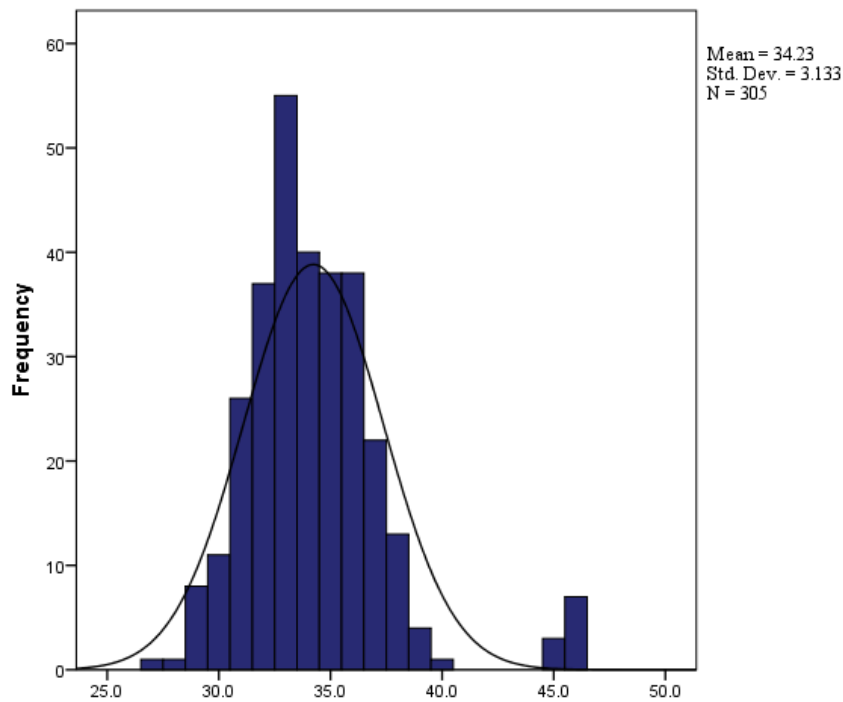


Figure 1. Histogram displaying the age distribution of Mothers

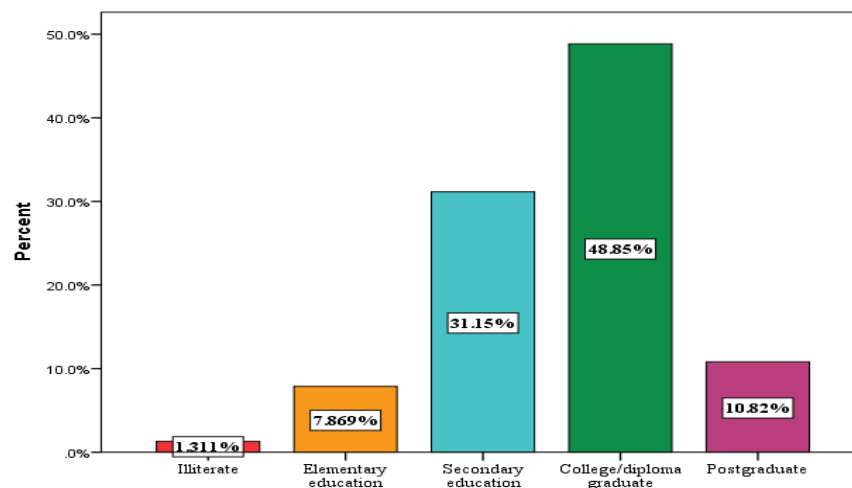


Figure 2. Distribution of mothers according to their educational level

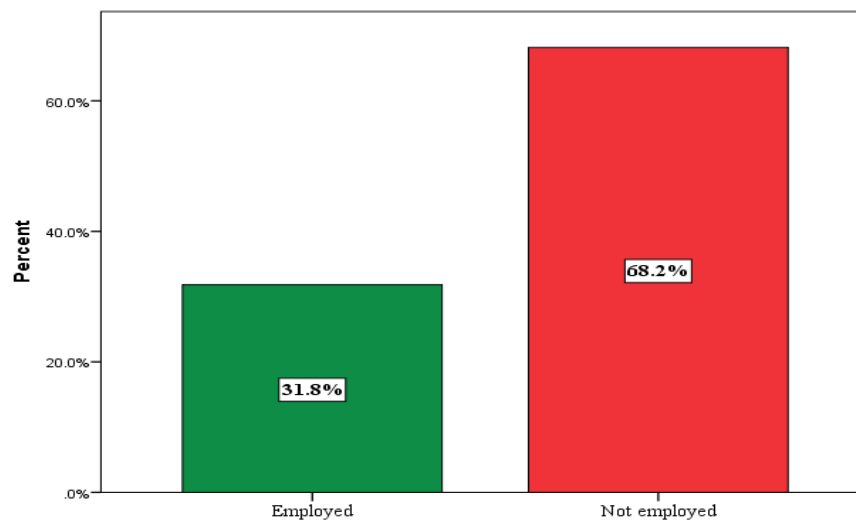


Figure 3. Distribution of mothers according to their employment status

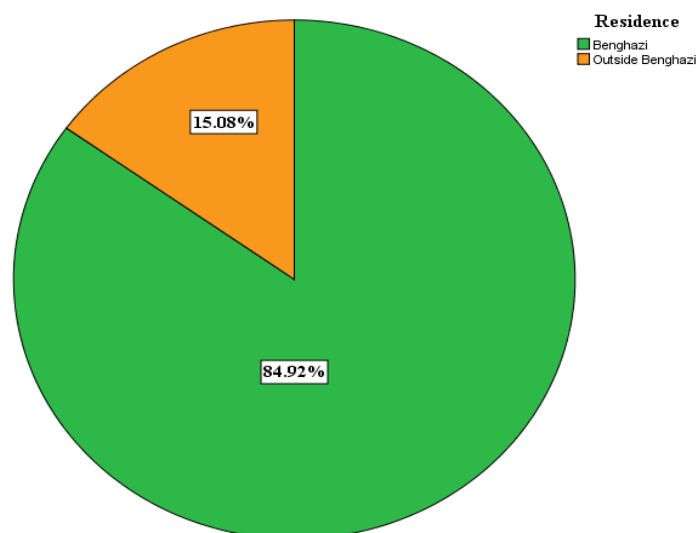


Figure 4. Distribution of mothers according to their residence

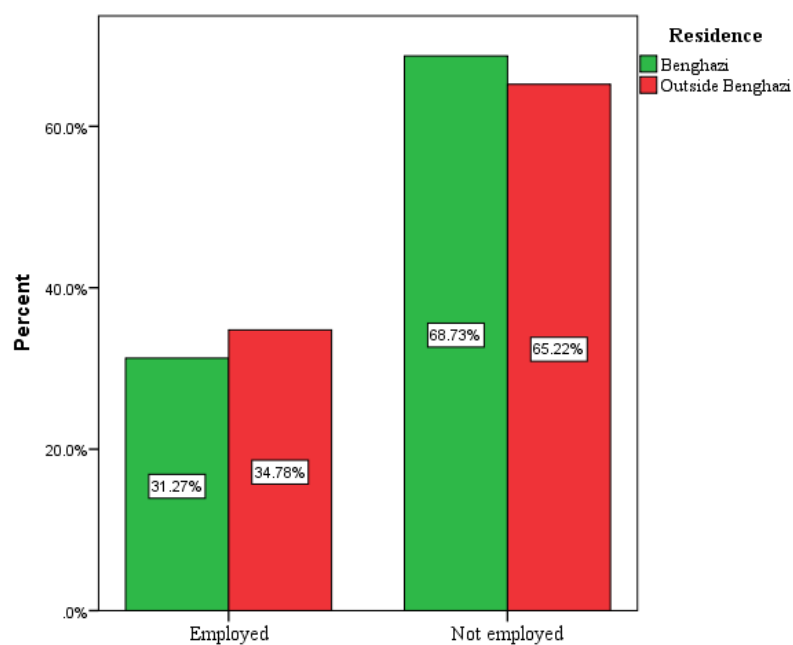
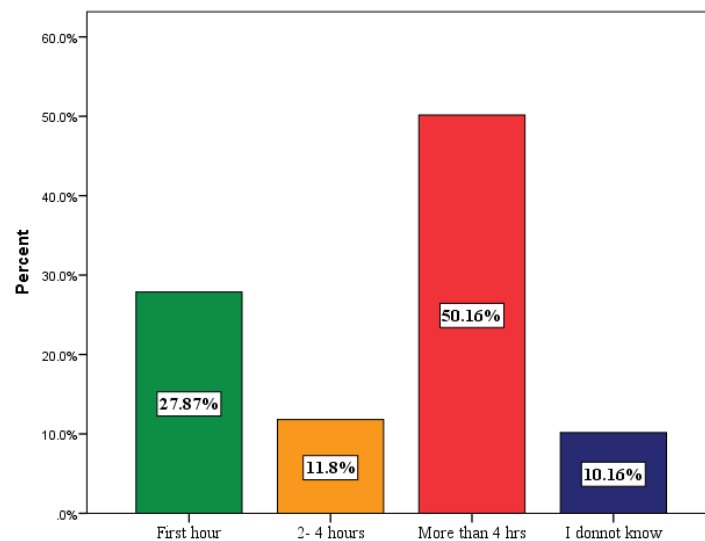
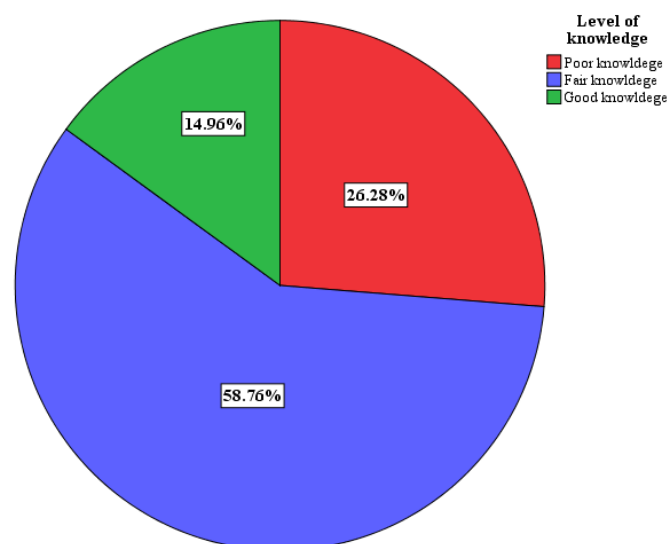


Figure 5. Clustered bar chart of maternal employment status cross-tabulated by residence

Table 1. Descriptive statistics of Maternal knowledge regarding general information and benefits of breastfeeding

Knowledge variables	Yes	No	Don't know
General information about breastfeeding:			
Breast milk has all the nutrients that the baby needs	282(92.5%)	8(2.6%)	15(4.9%)
Colostrum in breast milk works as a vaccine for the baby	94(30.8%)	12(3.9%)	199(65.2%)
Once solid foods are introduced, breastfeeding should be stopped	17(5.6%)	277(90.8%)	11(3.6%)
Breastfeeding mothers should eat healthy food to improve breast milk supply and secretion	214(70.2%)	64(21%)	27(8.2%)
Information about benefits of breastfeeding for baby			
Breastfeeding helps bonding between mother and child	271(88.9%)	13(4.3%)	21(6.9%)
Breastfeeding decreases diarrhea and allergies	263(86.2%)	12(3.9%)	30(9.8%)
Breastfeeding protects the baby from infections and diseases	284(93.1%)	6(2%)	15(4.9%)
Information about benefits of breastfeeding for mothers			
Breastfeeding prevents the mother from breast cancer	239(78.4%)	9(3%)	57(18.7%)
Breastfeeding prevents the mother from ovarian cancer	162((53.1%)	12(3.9%)	131(43%)
Breastfeeding is beneficial in spacing births	88(28.9%)	144(47.2%)	73(23.9%)
Do you know the signs of a good breastfeeding latch?	158(51.8%)	32(10.5%)	115(37.7%)
Is it normal for breastfeeding to be painful?	78(25.6%)	185(60.7%)	42(13.8%)

**Figure 6. Distribution of mothers' knowledge regarding the ideal timing for breastfeeding initiation****Figure 7. Percentage distribution of participants by level of knowledge regarding breastfeeding practices**

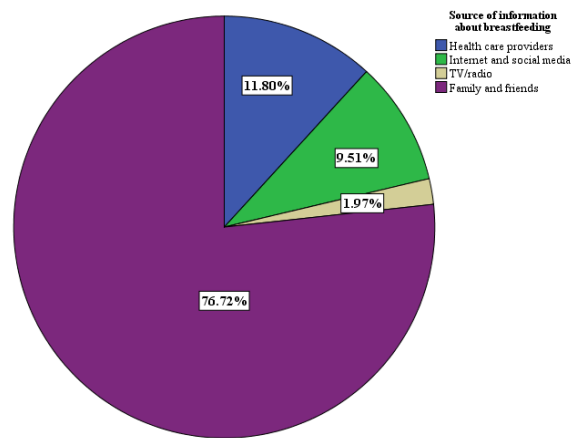


Figure 8. Distribution of mothers according to the primary sources of information regarding breastfeeding

Table 2. Description of mothers' attitudes toward various breastfeeding practices

Mothers' attitude towards breastfeeding practice	Agree	Neutral	Disagree
Breastfeeding should be continued up to 2 years	182(59.7%)	88(28.9%)	35(11.5%)
Do you think breastfeeding should be on demand	180(59%)	24(7.9%)	101(33.1%)
Do you believe in giving pre-lacteal feeds to babies	117(38.4%)	54(17.7%)	134(43.9%)
Do you think that breastfeeding should be stopped when a child has diarrheal episodes	20(6.6%)	14(4.6%)	271(88.9%)
Is formula feeding better than breastfeeding	77(25.2%)	78(25.6%)	150(49.2%)
Do you think that breastfeeding increases mothers' weight	100(32.8%)	114(37.4%)	91(29.8%)
Do you think that breastfeeding should be stopped if you take any medication?	72(23.6%)	72(23.6%)	161(52.8%)

Table 3. Mothers' attitude towards breastfeeding practices

Mothers' attitude towards breastfeeding practices	Frequency	Percentage
Poor attitude	132	43.3
Fair attitude	136	44.6
Good attitude	37	12.1

Table 4. Self-reported breastfeeding practices among mothers regarding initiation and frequency

Mothers' practice of breastfeeding			
When did you start breastfeeding after delivering your last child?	< 24 hours	24-48 hrs	>48 hrs
	225(73.8%)	60(19.7%)	20(6.6%)
How frequently do you breastfeed?	< 2 hrs	2-3 hrs	>3 hrs
	132(43.3%)	136(44.6%)	37(12.1%)
Did you take advice from a lactation counsellor before starting breastfeeding?	Yes	No	
	63(20.7%)	242(79.3%)	
Did you give pre-lacteal feeds to the infant?	160(52.5%)	145(47.5%)	

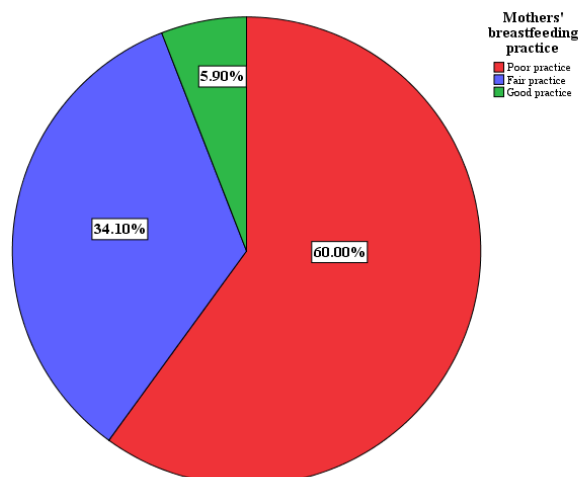


Figure 9. Pie chart of mothers' practice about breastfeeding

Discussion

Mothers' knowledge of breastfeeding

The descriptive statistics indicate that most respondents (92.5%) correctly identified breast milk as meeting all of an infant's nutritional needs, suggesting a generally strong grasp of its nutritional value. This is consistent with worldwide trends, which show that while breastfeeding is widely recognised as a basic nutritional practice, there is a dearth of more sophisticated information. According to research conducted at King Abdulaziz University Hospital in Jeddah, most mothers were aware of the vital advantages of breastfeeding for the health of their infants, but there were gaps in knowledge regarding exclusivity and duration [8]. In contrast, just 30.8% of respondents correctly answered that colostrum acts as a "vaccine" for the newborn, while nearly two-thirds chose "don't know." This disparity is frequently observed in the nursing literature and helps explain why colostrum disposal remains a common practice in many contexts. For instance, moms in Ethiopia who knew less about colostrum were more than three times more likely to throw it away than mothers who knew more.[9] The inadequate knowledge score on this item in the existing sample thus highlights a distinct and amendable objective for prenatal health education, given that counseling focused on colostrum instead of generic breastfeeding promotion is more helpful in altering this perception.

Additionally, 90.8% of respondents correctly disagreed that breastfeeding should cease when solids are introduced, demonstrating good knowledge. This is consistent with international guidelines that advise continuing breastfeeding well after the introduction of complementary foods. Maternal benefit knowledge was more consistent. The majority of women were aware that breastfeeding lowers the infant's risk of illness (93.1%) and reduces the risk of breast cancer (78.4%). Only 28.9% of respondents properly endorsed the birth spacing impact of breastfeeding, and 47.2% actively disagreed, indicating a rather low level of knowledge. This is a significant gap since, when used properly, the lactational amenorrhea technique (LAM), which involves complete or almost full nursing and amenorrhea during the first six months following birth, provides more than 98% protection against pregnancy [10].

Similar findings have been seen for primiparous women in the US, where understanding of the advantages of breastfeeding in decreasing pregnancy and delaying amenorrhea was also poor, especially among women who had not previously planned to use LAM.[11] The low level of awareness seen here implies that LAM is an underutilized counseling opportunity in postnatal education, particularly in situations where access to alternative forms of contraception may be restricted. Similarly, little over a quarter of respondents (25.6%) correctly identified that breastfeeding shouldn't typically be uncomfortable, and barely half of respondents (51.8%) said they understood the indicators of a healthy latch. This is a significant clinical finding: while some tenderness during the first few days of breastfeeding is typical as the mother and child get used to it, persistent or sharp pain is not physiologically normal and is typically caused by a shallow or incorrect latch, tongue-tie, or other treatable issues.[12]

Maternal Attitudes Toward Breastfeeding

The majority of mothers concurred that breastfeeding should continue for up to two years (59.7%) and should be offered on demand (59%), which is in line with international recommendations for nursing length and pattern. Less than one in eight mothers (12.1%) had a "good" overall attitude, according to the composite attitude, with the majority falling into the "fair" (44.6%) or "poor" (43.3%) categories. This distribution is generally consistent with other KAP (knowledge–attitude–practice) surveys, where positive attitudes regarding specific breastfeeding statements are frequently found. However, these attitudes do not always translate into a high composite attitude score, particularly when the items are related to culturally embedded practices such as pre-lacteal feeding or the use of medication during lactation.[8] Significantly, 38.4% of mothers supported pre-lacteal feeding, a practice that is discouraged by global health guidelines due to its displacement of colostrum intake, interference with the establishment of exclusive breastfeeding, and correlation with increased rates of respiratory illness and neonatal diarrhea.[13,14] This is consistent with the finding on colostrum knowledge above: It has also been repeatedly demonstrated that mothers who have unfavorable views or inadequate information about colostrum are more likely to accept pre-lacteal feeding[9], indicating that the two ideas are mutually reinforcing rather than independent. The views toward breastfeeding in the context of maternal sickness or medication usage were equally concerning from a therapeutic perspective. According to 23.6% of the mothers in this study, medicine should not be used during nursing. This result is in line with research done on 848 Saudi women by Alwelaie et al. (2010), in which 71.8% of the women said that discontinuing nursing was due to maternal sickness or the need to take medicine. Although the percentage in the current research was much lower, both results imply that worries about maternal sickness and drug use may be a significant barrier to sustained breastfeeding.[15]

Breastfeeding Practices

Initiation patterns are generally positive in the practice, with 72.8% of mothers initiating breastfeeding within the first 24 hours after delivery – a proportion that compares well with several regional benchmarks, although it is still below the WHO/UNICEF target of initiation within the first hour of life. Delay in initiation is one of the strongest predictors of colostrum avoidance and pre-lacteal feeding,[15] which are of clinical significance. This is supported by the internal pattern of this sample, where the significant minority of mothers who started breastfeeding later (19.7% at 24-48 hours, 6.6% over 48 hours) likely overlaps with the 52.5% of mothers reporting pre-lacteal feeds – a rate significantly higher than that seen in many regional surveys, where pre-lacteal feeding prevalence has more typically ranged from around 12% to 30% according to setting [16, 17], although similarly high rates have been reported elsewhere, for example in parts of South Sudan and

South Asia [18,19]. Merely 20.7% of women sought advice from a lactation counselor before initiating breastfeeding. The lack of breastfeeding counseling has been found in multiple studies to be a strong predictor of colostrum avoidance and pre-lacteal feeding, which makes this data worrying [15,20]. The sample's response distribution also seems to support the on-demand breastfeeding suggestion, with the majority of mothers (87.9%) reporting breastfeeding less frequently than every two hours or every two to three hours, while only 12.1% reported breastfeeding more frequently than every three hours. However, the fact that the majority of moms did not get lactation counseling before nursing raises the possibility that they were choosing their own breastfeeding habits rather than heeding expert advice. This might account for the sample's high incidence of breastfeeding problems, which may eventually lead to low breastfeeding rates or early breastfeeding cessation [12].

General Integration

The study sample currently has a reasonably good knowledge about the importance of breastfeeding, but there are specific and recurring omissions that logically can account for practice-related deficiencies of corresponding topics (e.g., the protective value of colostrum, the birth-spacing effect of breastfeeding, the proper technique for latching on, the safety of continuing breastfeeding during illness or medication use), particularly very low practice of pre-lacteal feeding and relatively low use of lactation counseling. This phenomenon is consistent with findings from the KAP literature, which show that knowledge, attitude, and practice scores usually do not move together and that topic-specific counseling rather than general breastfeeding promotion appears to be the most reliable predictor of change in high-risk behaviors like avoiding colostrum and using pre-lacteal feeding. [8,9] The low use of lactation services in this sample indicates that increasing mothers' access to and promotion of professional lactation services, particularly during the prenatal and early postnatal periods, may be one easily implemented factor for improving this population's knowledge and subsequent practice. [21]

Limitations

The research employed a cross-sectional design. As a result, it cannot establish causal relationships between mothers' social and demographic factors, their knowledge and attitudes, and their breastfeeding practices. Therefore, the findings only indicate associations and trends within this specific group of mothers. Another concern pertains to the method of data collection. The responses were self-reported, which can introduce recall bias, or individuals may respond in ways that appear more socially acceptable. This risk is particularly relevant when inquiring about breastfeeding behaviors, such as the provision of pre-lacteal feeds. Additionally, there is a concern regarding the sample size. The analysis involved 305 mothers, and the results may not be representative of all mothers within the broader study population. Factors such as cultural norms, access to healthcare, educational attainment, and family support can all influence what mothers know, believe, and practice. These elements can differ significantly across various populations. Finally, while the study identified variations in knowledge, attitudes, and practices, further statistical analysis is required to determine which factors are genuinely associated with breastfeeding outcomes.

Conclusion

This study shows a significant discordance between Breastfeeding knowledge, attitudes, and practices among mothers attending the neonatal department of Benghazi Medical Center. Maternal knowledge on the overall nutritional and protective value of breast milk was satisfactory; however, substantial deficits were seen in knowledge of colostrum, optimal time of initiation, birth spacing, and proper latch technique. This was evident in ambivalent attitudes, with only 12.1% of mothers having a favorable attitude in total. These gaps in knowledge were most apparent in practice, where 60.0% of mothers had poor breastfeeding behavior, although relatively high rate of early initiation. The persistence of pre-lacteal feeds and the low uptake of lactation counseling, as shown in over three-quarters of the sample, suggests that general awareness does not necessarily translate into evidence-based practice. Taken together, these findings underscore that intensive, structured education and awareness programmes targeting mothers at neonatology and maternity centers are urgently needed, delivered through sustained antenatal and postnatal counselling by trained lactation personnel rather than one-time or generalized health messaging. Institutionalizing such targeted interventions within neonatal care settings represents the most direct means of closing the knowledge-practice gap and improving breastfeeding outcomes in this population.

Recommendations

Based on the findings of the present study, the following recommendations are proposed: Give clear breastfeeding lessons during antenatal visits, and offer close breastfeeding support right after birth. Mothers need hands-on help early; expand services that rely on trained lactation counsellors. Correct wrong ideas about giving food before breast milk starts. Teaching should cover local customs and beliefs that push mothers to offer pre-lacteal feeds; for many mothers, family and close friends share most of the advice. If husbands, grandmothers, and others join the sessions, mothers may get steadier and more correct support. Boost the work of nurses, midwives, and other staff. Start breastfeeding awareness activities in the community. Health messages should not stay only in clinics or maternity wards. Local programs and suitable media can reach more mothers; future studies should use bigger and more varied groups. New work should include mothers from different cities and rural parts of Libya to better show what women know, think, and do about breastfeeding. Use studies

that test links between factors. Future research should look at how maternal education, work status, where mothers live, the source of information, counselling by professionals, knowledge, beliefs, and breastfeeding habits connect.

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