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Weaning Problems among Palestine Arab Refugees

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In the refugee community, as in other communities, breast-feeding and weaning practices depend on such factors as cultural, religious, social and economic. These practices are not unchangeable and one should not ignore the increasing tendency to follow the western pattern of infant feeding and weaning under the influence of commercial advertisements.

Most refugees living in camps are economically unprivileged and depend, for their living, on the services provided by UNRWA, the United Nations Relief and Works Agency. Camp refugees live under unfavourable environmental conditions, about 20% of refugee houses do not have private latrines and about two thirds do not have private water connections and electricity is available only to the minority. Overcrowding with 5 or 6 family members living in one room of about 10 m^2 is the usual finding. Under these conditions one should not be surprised to find a relatively high incidence of gastro-intestinal and upper respiratory infections. Consideration of breast-feeding and weaning problems should therefore be considered within the above context.

Data from a recent study in the refugees camps in Jordan and Gaza show that about 23% of the babies are completely weaned from the breast by the age of 3 months, 11% are weaned between 4 and 6 months, 27% are weaned between the 7th and 12th month, 27% are weaned between the 13th and the 18th and 12% are breastfed for more than 18 months.

The trend has been changing over the last 10 years towards early weaning. In 1963 only 13% were completely weaned by the 3rd month compared to 23% in 1974. In 1963, 41% were weaned before the first birthday while in 1974 the figure is 61%.

Refugee mothers tend to breast-feed males longer than females. This is consistent with the refugees culture which favours males for social and economic reasons. Our data show that about 30% of the males are weaned before the age of 6 months compared to 39% of the females; before the age of 12 months 56% of the males and 67% of the females are weaned; and by the 18th month 82% of the males and 95% of the females are weaned.

It also shows that about 18% of the males are breastfed after 18 months compared to 5% only of the females. About three percent of males are breastfed after the age of 2 years but none of the females.

Most refugee women consider lactation a good contraceptive and therefore tend to prolong breast-feeding. But on the other hand if they get pregnant, they suddenly stop breast-feeding. The majority believes that when they get pregnant their milk becomes of no value to the baby although some of them even believe that it becomes harmful to the baby.

Refugee mothers tend to introduce mixed feeding early during the first 6 months of life. Water and sweetened tea are usually given as early as the first month of life especially during the hot season, oranges and tomato juice between the fourth and sixth month; yoghurt, starch pudding and cereals between the 6th and 8th, while cooked vegetables, eggs and meat are usually given around the first birthday. Supplementation with milk, either from UNRWA sources or purchases, usually starts by the 6th month. This supplementation of breast milk should not, however, be considered adequate since in most cases the quantities of food given are usually small and the frequency is low. Because of economical limitations, gradual weaning in many cases is directly from the breast to the family food. The use of special weaning foods by the refugees is rather very limited. The mother usually starts offering her child a bit of what the family eats early during the first 6 months of life, starting by the fluids and semi-solids. Gradually the child gets used to the family food and the time comes when the child weans himself from the breast.

Gradual weaning is the most widespread practice among the refugees. Abrupt weaning is the commonest during the first 6 months of life.

Causes of abrupt weaning from the breast as stated by the mothers in descending order of frequency are:

A. Maternal factors:

1. Psychological and emotional factors. This is important because failure of lactation may be repeated with subsequent babies. One mother gave her story of having been satisfactorily breast-feeding her baby for about two months and one day she received some shocking sad news about the death of her father. Her milk suddenly failed, and although afterwards she got five more babies, she never had milk since then.

2. Local breast ailments including mastitis breast abcess, inverted nipples or fissures.

3. Sickness or hospitalization of the mother.

4. Onset of pregnancy.

5. Employment of mothers, although this accounts only for a very low percentage.

6. Some mothers reported the spontaneous drying of their milk for no apparent reason.

B. Infant factors:

1. Sickness or hospitalization of the baby. It is customary among refugee women to stop breast-feeding when their children get measles or prolonged high fever. A child with stomatitis or thrush will reject the breast.

2. Rejection of the breast for unknown reasons. Abrupt weaning was reported to be associated with irritability, sadness, crying, poor appetite, diarrhoea and loss of weight. The loss of weight is probably due in part to the diarrhoea but is also attributed to the smaller quantities of food consumed by the child. Until recently the common practice among refugee mothers when their babies get diarrhoea was to put them exclusively on water or much diluted rice water until they recover. These observations were noted to be more frequent and severer among the children who were exclusively on the breast and among children weaned after one year of age. About 40% of the cases had diarrhoea after abrupt weaning associated with fever and sometimes vomiting. Maternal deprivation with its subsequent psychological trauma, seriously affects the babies if weaning takes place around the sixth month it being the time of rapid growth and teething which is usually accompanied by loss of appetite.

Gradual complete weaning which usually comes late around the first birthday and during the second year was stated by mothers to be due to the following reasons, in this order of frequency.

A. Maternal factors

1. Onset of pregnancy
2. Milk inadequacy
3. Illness of mothers and the feeling of general weakness.
4. Psychological or emothional factors.
5. Child becoming old enough
6. Breast milk considered to be not good at that time.

B. Infant factors

1. Sickness of the child
2. Child gets used to the bottle and refuses the breast
3. Child rejecting the breast for no apparent reason.

Few mothers were seen breast-feeding their children exclusively into the second year of life. In all these cases the growth rate was retarded and the greatest retardation was around the sixth month, which shows the importance of supplementation at this age.

Something should be mentioned here about the use of dry powder milk which is becoming more popular now among the refugees who can afford to buy it, either for supplementation of the breast milk or for its replacement. In almost all these cases the milk is reconstituted in wrong proportions, either more concentrated but usually more diluted. Fortunately most of the mothers are now using the cup for feeding their children and not the bottle, probably as a result of the long health education campaigns UNWRA has been undertaking over the last 20 years. The use of feeding bottles under the prevailing conditions in the refugee camps exposes the babies to tremendous risks of contamination and gastro-intestinal infections. Among the groups who still use the bottle, unsatisfactory practices were noted in respect of the infrequent boiling and cleaning of the bottle, of the improper boiling of the water for reconstitution and the keeping of the unconsumed part of the milk for future use after some hours.

As mentioned earlier, there are no special weaning foods used by the refugees, the child is gradually trained to eat from the family food. But, during the last few years and among the groups who are economically better, the use of commercial baby cereals is receiving more popularity.

As part of UNRWA's nutrition education programme, the mothers have been encouraged to use as a weaning and an infant food a certain cereal-pulses mixture based on local products and known as the burghol-hommos pudding. Although the mixture was based on scientific knowledge and was used satisfactorily in the UNRWA Supplementary Feeding Centres, yet its use by the refugees at home is very limited. This is probably tue to financial limitations but may also be due to the amount of work and fuel involved.

Recently UNRWA started to distribute WSB (wheat, soya blend) to refugee infants between the ages of 4 and 24 months. It was meant to serve as a weaning and an infant food. The product was received very well at the beginning but the acceptability has been noticed to be decreasing lately. Efforts are being made to teach the mothers more ways of using the WSP in order to break the monotony and improve the acceptability.

The UNWRA Supplementary Feeding programme also makes available a daily issue of whole and skim milk mixture (30 gms dry powder of each) in reconstituted form to all eligible infants between the 6th and 12th months of age and to non-breast-fed babies under 6 months. A daily portion of reconstituted skim milk (40 gms dry powder) is also made available to all eligible refugee children from 1 to 6 years of age, as well as to pregnant and lactating women for 12 months after birth.

In the UNRWA Supplementary Feeding Centres, where hot meals are served daily to pre-school and school children and to a group of sick adults, special menus are also prepared for infants from 4 months up to 2 years of age. Regrettably the attendance of this group is very poor because the infant has to come to the feeding centre with his mother or elder sister and this is not usually feasible. To overcome this difficulty, the intention at present is to distribute to mothers certain food commodities that they can prepare at home, coupled with an intensive nutrition education programme geared towards improving infant feeding and weaning practices.

In conclusion, it is recommended that in dealing with groups of people living under conditions similar to that of the refugees, with unfavourable ervironmental conditions, with low social, economic and educational standards, one should encourage prolonged breast-feeding and complete weaning from the breast, initiation of mixed feeding by the fourth month, intensive health education of mothers on hygiene preparation and administration of the baby food, nutrition education aiming at improving the feeding and weaning practices; discourage the use of feeding bottles and encourage the use of the spoon and cup. Care should also be directed towards the proper feeding of mothers during pregnancy and lactation in order to ensure adequate breast milk. The phenomenon of early spontaneous or gradual drying of breastmilk requires further investigation. Efforts should be made to avoid or counteract the influence of commercial advertisement which encourage mothers to abandon breast feeding.

Table 1

Breastfeeding and weaning by age and Sex

Age in months	MALES		FEMALES	
	Breastfed	Weaned	Breastfed	Weaned
0-3	22	1	13	2
4-6	26	4	18	8
7-9	19	5	22	5
10-12	20	10	12	6
13-18	25	16	11	17
19-24	6	24	1	25
25 & above	2	59	0	42

Table [illegible]

Age of [illegible]

Age in months	Number	Percentage	Cumulative
0-3	44	22.7	22.7
4-6	22	11.3	34.0
7-9	19	9.8	43.8
10-12	33	17.0	60.8
13-18	52	26.8	87.6
19-24	21	10.8	98.4
25 & above	3	1.6	100.0

Table 3

Age of vomiting by Sex

Age in months	MALES			FEMALES		
	No.	%	Cumulative %	No.	%	Cumulative %
0-3	21	19.3	19.3	23	27.1	27.1
4-6	12	11.0	30.3	10	11.8	36.9
7-9	11	10.1	40.4	8	9.4	46.3
10-12	17	15.6	56.0	16	18.8	67.1
13-18	23	25.7	81.7	24	28.2	95.3
19-24	17	15.6	97.3	4	4.7	100.0
25 & above	3	2.7	100.0	0	0.0	
	109	100.0		85	100.0	