Working with Refugee Mothers around Infant Feeding Practices in the First Year of Life:
Findings from the Fairfield Refugee Nutrition Project

Between 2007 and 2010 the Fairfield Refugee Nutrition Project (FRNP) collected data on infant feeding of 461 children from 8 cultural groups: Arab Iraqi, Assyrian, Burundian, Chaldean, Congolese from the Democratic Republic of Congo (DRC), Iranian, southern Sudanese and Burmese. These findings are summarised here to aid health workers in assisting refugee mothers with infant feeding.

FRNP observed a strong culture of breastfeeding among all refugee groups, but there were substantial differences in practices of exclusivity, weaning, and the introduction of solids between groups.

Breastfeeding among refugee groups
A very strong culture of breastfeeding was observed among refugee populations compared to NSW averages1 (see table). This was particularly the case for people from Burundi, DRC, southern Sudan and Burma. The sharing of knowledge and support for a new mother was strongly apparent amongst these four groups, as was reverence for the practice of breastfeeding. These mothers generally demonstrated a strong understanding of the:

- nutritional superiority of breast milk over commercial formula
- physical, emotional and economic benefits of breastfeeding for mother and child
- importance of exclusive breast milk in the first 6 months of life
- importance of maintaining breastfeeding beyond 6 months of age.

Those women from Iraq, Iran and surrounding countries also demonstrated a strong culture of breastfeeding. Many infants however were not exclusively breastfed for the first 6 months of life and the use of commercial infant formula to supplement or replace breast feeding was more common.

Comparison of breastfeeding between the NSW averages and clients seen by FRNP by continent

<table>
<thead>
<tr>
<th></th>
<th>at birth</th>
<th>at 3 mths</th>
<th>at 6 mths</th>
<th>at 12 mths</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW averages</td>
<td>91%</td>
<td>69%</td>
<td>55%</td>
<td>28%</td>
</tr>
<tr>
<td>Middle East</td>
<td>95%</td>
<td>73%</td>
<td>68%</td>
<td>52%</td>
</tr>
<tr>
<td>Africa &amp; SE Asia*</td>
<td>100%</td>
<td>98%</td>
<td>97%</td>
<td>88%</td>
</tr>
</tbody>
</table>

*Burundi, DRC, Southern Sudan, Burma

Note: Due to small sample sizes of study, some differences may not be statistically significant.

Note that many of the infants for whom data were collected were not born or breastfed in Australia. It is possible that women’s confidence to continue breastfeeding here may be adversely affected by Australian culture, product marketing and the demands of migration.

Reasons for early cessation of breastfeeding among different refugee groups
Of those mothers interviewed, non-initiation of breastfeeding was related to illness or death of the child. Where breast feeding was not exclusive for the first 6 months of life or discontinued before 12 months the common reasons given included:

- perception of insufficient milk supply
- baby not satisfied
- baby’s interest in food
- baby’s refusal or disinterest
- mother’s fatigue
- pregnancy
- sore nipples.

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Tips for discussing breastfeeding with refugee mothers

• Explain how to determine if the milk supply is sufficient, including advice for maintaining sufficient supply and reassurance. If you are not skilled in providing breastfeeding support, please consider an appropriate referral, such as to the local child and family health nurse.

• Clearly explain why supplementing breastfeeding with water is not necessary.

• Encourage exclusive breastfeeding for infants under 6 months. Advice about exclusive breastfeeding can be misinterpreted and often conflicts with cultural beliefs and practices.

• Discuss services available for the support of breastfeeding, ask about social support, and offer opportunities for increasing social connectedness. Many refugees experience periods of social isolation during the years following resettlement in Australia.

• Other family members may need education as well, so they can provide appropriate support.

• If formula is being used, check that it is a commercial infant formula rather than milk substitutes such as skim milk powder. Ask about the preparation and quantity of infant formula, particularly if the client is not numerate.

• Discuss how the infant will be fed when the mother returns to English classes or work, including the practicalities of expressing milk and or the correct use of formula.

Tips for discussing the introduction of solids

• Ask the mother about her plans to introduce solid foods and what is normal cultural practice. Discuss current recommendations and provide the parents with as many practical resources of an appropriate literacy level as possible. Ideas for recipes are often very helpful.

• With regard to which solid foods should be introduced, find a balance between what is considered best practice in Australia and what is considered culturally appropriate – there are few rules regarding the correct and incorrect introduction of solids.

• Discuss the importance of textures for an infant including how to and when to modify textures. Texture modification may be a new concept and progression is often delayed.

• Discuss the importance of introducing a cup from 6 months, and learning to self feed.

• Ask whether children drink tea. Tea drinking is an important part of daily life for some groups and all family members, including infants, will consume tea. Tea contains tannins and other compounds that bind iron and other minerals, reducing their bioavailability. Tea for children, particularly under the age of 5 years, is not recommended. If it is being consumed, advise parents to wait 2 hours after a meal before offering tea.

Useful refugee-specific resources

ASeTTS’ Good Food for New Arrivals http://goodfood.asetts.org.au/ in particular:

• Guide to discussing infant feeding practices in newly arrived refugees
• Assisting Refugee Mothers with Infant feeding
• Bottle to Cup (multi-lingual resource)


Check vitamin D, iodine and iron levels. Refugees are often at increased risk of vitamin D and iodine deficiency, and anaemia. Note the cost of supplements may undermine treatment.

Introduction of solid foods

Of the 429 infants about whom the Project recorded feeding practices, 52% received solid food before the age of 6 months, compared to a NSW average of 48%. Thirty-four per cent were first introduced to solid foods at 6 months and 14% first received solid food after the age of 6 months.

First food choices included:

• rice cereal or porridge (54%, with 18% of these being iron fortified)
• fruit and vegetables (23%)
• dairy/eggs (18%)
• meat/chicken/fish (5%).

The use of eggs as a first food amongst Middle Eastern groups was the most significant difference between cultural groups. Assyrian, Chaldean and Arabic-speaking Iraqi children were more frequently offered egg and dairy (mostly custard) as a first food; this was often followed by meat and thought to increase the growth and intelligence of a child.