Breastfeeding characteristics of Syrian refugees in Turkey

Siddika Songül Yalçın, Meryem Erat Nergiz, Suzan Yalçın, Kanuni Keklik
Abstract

Turkey currently hosts an estimated 3.6 million Syrian refugees, of whom 23% are reproductive-age women (15–49 years) and 14% are children aged 0–4 years. To achieve the best child survival and development outcomes, WHO recommends that infants start breastfeeding within one hour of birth and are exclusively breastfed for six months, followed by the timely introduction of adequate, safe and properly fed complementary foods with continued breastfeeding until at least 24 months of age. However, according to the 2019 Turkish Demographic and Health Survey, only 73% of Syrian babies are breastfed within one hour of birth, 24% of babies receive prelacteal food and only about half (51.6%) of children aged 0–5 months are exclusively breastfed. To understand the reasons for this, this study evaluated the perceptions and attitudes of Syrian refugee mothers on age-appropriate breastfeeding and the contributory sociocultural factors. Data were collected in September and October 2020. The study found that the short duration of breastfeeding is related to the cultural characteristics, migration experiences and low health literacy of mothers, and that health workers need further training in breastfeeding counselling, adapted to the cultural characteristics of Syrian mothers, to effectively support breastfeeding. Training and information campaigns for parents, mothers-to-be and other family influencers should aim to support mothers in optimal breastfeeding practices. Socially appropriate interventions are needed to support the continuation of girls’ education and prevent adolescent marriages and adolescent motherhood. Nutritional support could be provided for breastfeeding mothers.

Keywords

SYRIAN REFUGEES
TEENAGE PREGNANCIES
BREASTFEEDING
ANISE
SHORT BIRTH INTERVAL
MATERNAL NUTRITION
Breastfeeding characteristics of Syrian refugees in Turkey

Siddika Songül Yalçın,
Meryem Erat Nergiz
Suzan Yalçın
Kanuni Keklik
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Preface

The conflict in the Syrian Arab Republic has caused one of the world’s largest and most dynamic displacement crises, affecting millions of lives. WHO is supporting the response to the crisis through its operations in Turkey, which comprise a cross-border response from the field office in Gaziantep and a health response to refugees in Turkey, coordinated from the WHO Country Office in Ankara. In north-western Syrian Arab Republic, WHO is implementing interventions such as the delivery of vital medicines and medical supplies and providing support for the operational costs of health facilities and capacity-building of health staff. Through the Refugee Health Programme in Turkey, efforts have been made to strengthen the national health system through integrating Syrian health workers and translators, build capacity for mental health care, provide linguistic and culturally sensitive health services, and support home care for older refugees and those with disabilities.

Activities of the programme are defined within the scope of the Regional Refugee and Resilience Plan 2018–2019, a broad partnership platform for over 270 development and humanitarian partners to provide coordinated support in countries bordering the Syrian Arab Republic that are heavily impacted by the influx of refugees. This platform capitalizes on the knowledge, capacities and resources of humanitarian and development actors to provide a single strategic, multisectoral and resilience-based response. Supported by several donors, WHO’s activities are complementary to the Ministry of Health-implemented SIHHAT (Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities) project that is funded by the European Union (EU). This project operates under the EU’s Facility for Refugees in Turkey and focuses on strengthening the provision of primary and secondary health services to Syrian refugees, building and supporting a network of migrant health centres across the country, and employing additional health personnel, including Syrian doctors and nurses.

In November 2018 the Refugee Health Programme conducted the Workshop on Refugee and Migrant Health in Turkey: Survey and Research Consultation to identify gaps in the information and evidence required for programme development and adaptation and for informing policies on migrant health in Turkey. The Workshop brought together more than 57 national and international experts from academia, Ministry of Health, United Nations agencies and WHO collaborating centres and led to the formulation of the programme’s research framework. Within this framework, a series of studies were implemented in the fields of mental health, health literacy, women and child health, health workforce and noncommunicable diseases. This study, Breastfeeding characteristics of Syrian refugees in Turkey, is one of the studies implemented within the Refugee Health Programme research framework. It was implemented within the scope of the Improved access to health services for Syrian refugees in Turkey project with funding from the EU Regional Trust Fund in Response to the Syrian Crisis.
Acknowledgements

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Authors

Siddika Songül Yaşçın
Department of Paediatrics, Faculty of Medicine, Hacettepe University, Ankara, Turkey

Meryem Erat Nergiz
Department of Paediatrics, Yıldırım Beyazıt University, Yenimahalle Training and Research Hospital, Ankara, Turkey

Suzan Yaşçın
Department of Food Hygiene and Technology, Faculty of Veterinary Medicine, Selçuk University, Konya, Turkey

Kanuni Keklik
Department of Migration Health, General Directorate of Public Health, Ministry of Health, Ankara, Turkey

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Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FGD</td>
<td>focus group discussion</td>
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<tr>
<td>MHC</td>
<td>migrant health centre</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
</tr>
<tr>
<td>SIHHAT</td>
<td>Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities (project)</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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Executive summary

Refugee crises and disasters have a variety of adverse impacts on infant growth, development and survival. Breastfeeding plays a key role in improving infant health and well-being in these high-risk situations. Therefore, breastfeeding is a fundamental children’s right for achieving Sustainable Development Goal (SDG) 2 (zero hunger) and SDG 3 (good health and well-being), especially for those in adverse situations.

Breastfeeding is a natural process, but sociocultural factors and habits can influence the initiation and sustainability of breastfeeding. Ensuring age-appropriate breastfeeding and the proper transition to complementary feeding among migrants and refugees is still a challenge. Age-appropriate breastfeeding can be improved through anticipatory guidance for families and mothers through migrant health centres (MHCs). However, reasons for the low breastfeeding rate among Syrian refugees are unclear. The perceptions, attitudes and sociocultural factors that influence breastfeeding practices in Syrian refugees need to be well understood to support the development of recommendations for designing and implementing culturally acceptable and appropriate interventions to promote breastfeeding.

Therefore, WHO, the Ministry of Health of Turkey, and Hacettepe University jointly carried out a qualitative study using focus group discussions (FGDs) to identify how sociocultural factors influence breastfeeding in Syrian refugees. The study evaluated the perceptions and attitudes of Syrian mothers, fathers, grandmothers and pregnant women towards age-appropriate breastfeeding and the influence of sociocultural factors. The study also included both Syrian health workers who work at MHCs and Turkish health workers who work in hospital maternity wards.

A total of 46 virtual structured FGDs with 335 participants (262 Syrians and 73 Turks) were performed in four provinces (Gaziantep, Hatay, Istanbul and Izmir) that host about 31% of the total Syrian refugee population in Turkey. Six FGDs were with pregnant Syrian women, 12 were with Syrian mothers with at least one child under 24 months old, six were with Syrian grandmothers with at least one grandchild under 24 months old, six were with Syrian grandmothers with at least one grandchild under 24 months old, six were with Syrian grandmothers with at least one grandchild under 24 months old, eight were with health workers at MHCs and eight were with health workers who work in maternity wards in hospitals close to MHCs.

Although most parents agreed on the importance of breast milk and breastfeeding, some mothers reported that they bottle-feed their children. All of the mothers reported that they gave colostrum to their babies. However, one third of mothers said that they only breastfed for the first three days after birth. The most commonly used supplementary foods were baby formula, sugar water, anise tea, mint tea and chamomile tea. They said that they give these foods by bottle because they believe that newborns do not learn to suck immediately.

Only one third of Syrian mothers, one fifth of pregnant women and half of grandparents said that babies should be breastfed until the age of 24 months. The opinion of most fathers was that babies should be breastfed until the age of 2 years, but in practice mothers stop breastfeeding much earlier. Syrian parents thought that a long period of breastfeeding, especially for more than 2 years, would cause the child to become dependent on the mother, reduce their appetite and prevent adequate nutrition, as well as weakening the mother. The greatest obstacle to breastfeeding was poor maternal nutrition and health and short birth intervals. In addition, Syrian MHC health workers highlighted knowledge gaps related to breastfeeding counselling and requested that plans should be made to provide such training courses.

Establishing culturally and linguistically appropriate education and training programmes for both health workers and members of the Syrian refugee community would increase the effectiveness of breastfeeding and ensure healthy nutrition for babies.
Introduction

Breastfeeding is the simplest and cheapest intervention to reduce infant morbidity and mortality (1). Despite these advantages, rates of exclusive breastfeeding are low worldwide. In eastern Europe and the central Asia region alone, 33% of children are exclusively breastfed and the rate of early initiation of breastfeeding (i.e. initiating breastfeeding within the first hour of life) is 57%. The mortality rate is 33% higher among infants who do not start breastfeeding within the first hour of life than among those who do (2). WHO recommends early initiation of breastfeeding, exclusive breastfeeding for the first six months, and breastfeeding with complementary feeding for at least two years (3); following these recommendations could save the lives of 820 000 children every year (4). However, adverse feeding practices such as not giving colostrum to newborn babies, prelacteal feeding (giving something other than breastmilk to baby during the first three days of life) and the early introduction of complementary feeding are prevalent around the world (5,6). Adverse breastfeeding practices could be countered at primary health-care facilities by adopting the joint WHO–United Nations Children’s Fund (UNICEF) Ten steps for successful breastfeeding (7) and at community level through community health education interventions that promote breastfeeding.

Breastfeeding plays a critical role in the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) (8), which is part of the Every Woman Every Child movement (9). The Global Strategy highlights that both early initiation of breastfeeding and exclusive breastfeeding for six months are essential to achieve SDG targets on child survival, health and nutrition. Breastfeeding has a significant role in achieving SDG 2 (zero hunger) and SDG 3 (good health and well-being), which include the targets of ending hunger, improving nutrition, and promoting health and well-being. Breastfeeding also improves long-term health by decreasing the risk of noncommunicable diseases, including childhood asthma and obesity. It is also linked to critical health equity issues, including birth spacing and workplace rights, and promotes SDG 5 (gender equality). Other advantages of breast milk are that it is produced naturally by the mother with a minimal ecological footprint and, therefore, contributes to achieving SDG 12 (responsible consumption and production) (10–12).

However, breastfeeding is influenced by a variety of social determinants, sociocultural factors and habits (13–19). Lack of legislation to regulate the marketing of breast milk substitutes and to support working lactating women hinders mothers from choosing to breastfeed their infants. Furthermore, lack of support from family members and/or health professionals, issues with body image, and the role and low status of women in society can lead to the early cessation of breastfeeding. In addition, disaster situations and refugee crises have an adverse impact on breastfeeding and on infant feeding in general (20,21). However, it is especially important for mothers to maintain breastfeeding in disaster settings because artificial feeding increases the child mortality risk (22–25).

Rationale

As a fundamental children’s right, breastfeeding should be promoted and improved in all high-risk situations including migration, wars and natural disasters. However, to effectively promote breastfeeding, the perceptions, attitudes and sociocultural factors that influence breastfeeding practices in specific populations need to be understood. Breastfeeding studies among migrants and refugees have had contradictory results (26). In a Sahara refugee camp in Algeria, the rate of early initiation of breastfeeding was 65% and the rate of exclusive breastfeeding for the first six months was 11.7% (27). Another study reported that breastfeeding status varied by country (28). Breastfeeding counselling was reported to improve the breastfeeding rate among Liberian immigrants in Ghana (29). One study of Somali refugees living in Kenya found that, although breastfeeding was culturally supported and mothers gave colostrum to their newborn, shorter exclusive breastfeeding periods continued to present risks to infant and child health (30). A study in Jordan found that only three quarters of Syrian and Jordanian pregnant women were keen to breastfeed (31). Another study of Syrian refugees in Jordan found that the rate of early
initiation of breastfeeding was 24.2%, which is much lower than the rate (42.6%) reported in the Syrian Arab Republic before the refugee crisis (32). However, among Syrian refugee mothers in Turkey, the rates were 61.4% for early initiation of breastfeeding, 28.1% for exclusive breastfeeding for the first six months and 55.0% for continuing breastfeeding for 12 months (33). The Turkish Demographic and Health Survey reported that in the Syrian migrant population in Turkey 51% of mothers continued breastfeeding for 12–15 months and 15.2% continued for 20–23 months (34).

However, the breastfeeding practices of Syrian refugees in Turkey are poorly understood. This is a problem because, according to Ministry of Health statistics, Syrian refugees have the highest birth rate by far among all migrants and refugees in Turkey, at approximately 10 000 births per month.

In emergency settings, health workers should be mindful that mothers may experience difficulties in breastfeeding. However, proper encouragement and support can help mothers to overcome these. Breastfeeding is a safe, cheap, effective and sustainable way for women to feed their infants (22,24). Health workers in Turkish MHCs, where Syrian refugees access primary health-care services, indicate that women have short birth intervals and short breastfeeding durations.

The literature shows that breastfeeding practices vary among Syrians refugees, but does not explain the reasons. No comprehensive study has yet evaluated the perceptions, attitudes and sociocultural factors that influence breastfeeding practices among Syrian mothers. This qualitative study aimed to address this gap by identifying the problems that prevent mothers from properly feeding their babies to enable the development of socially and culturally appropriate interventions (including health education packages to promote breastfeeding).

**Methodology**

**Study population and sample size**

Seven groups of participants were targeted for this study: health workers at MHCs, health workers working in maternity wards in hospitals close to MHCs, pregnant women, mothers with at least one child aged under 6 months, mothers with at least one child aged 6–24 months, fathers, and grandmothers. FGDs were scheduled for each group according to the inclusion criteria. Data triangulation across the seven different focus groups was used to ensure the validity of collected data.

**Selection of participants**

The Ministry of Health of Turkey wrote to the health directors of the selected provinces to inform them about the research and provide contact information for the research team. The research team sent information to MHCs and maternity hospitals about the study aim and objectives, along with brief notes on the methodology, an invitation to participate in the study and contact information for the study team.

Inclusion criteria were:

- Syrian mothers: pregnant women, mothers with at least one child aged under 6 months, and mothers with at least one child aged 6–24 months;
- Syrian fathers: at least one child aged under 24 months;
- Syrian grandmothers: at least one grandchild aged under 24 months; and
- health workers: working in a MHC or in a maternity ward in a hospital close to a MHC.

**Aim and objectives**

This qualitative study is a joint project between WHO, the Ministry of Health of Turkey and Hacettepe University. The survey conducted structured FGDs in four provinces (Gaziantep, Hatay, Istanbul and Izmir) to collect community-based data to support the current scientific evidence on breastfeeding and breastfeeding practices in the Syrian community in Turkey. Its specific objectives were to support evidence-informed recommendations on the early initiation of breastfeeding and on exclusive breastfeeding by:

- evaluating the perceptions and attitudes of Syrian mothers on age-appropriate breastfeeding (specifically, the early initiation of breastfeeding, exclusive breastfeeding for the first year and continued breastfeeding for at least two years); and
- identifying the maternal sociocultural factors that influence age-appropriate breastfeeding.
Exclusion criteria were:

- women who were not pregnant or not the mother of a child aged under 24 months;
- parents whose children were cared for by someone else;
- health workers who do not provide maternal and child health services;
- individuals (mother, father, grandmother) related to the medical staff; and
- relatives of someone already participating in a FGD.

The research team asked community health support staff to help disseminate this information to recruit participants from the community. Community health support staff are trained bilingual community health workers who work in MHC teams. They are selected from the Syrian refugee population and trained by the WHO/Improving the health status of the Syrian population under temporary protection and related services provided by Turkish authorities (SIHHAT) project collaborative team as community liaison and support staff. As they are members of the Syrian community, they have close contact with the Syrian refugee population and can easily observe breastfeeding-related issues. During community visits, they distributed the study information leaflet and invited parents and family members to participate in the study. At MHCs, mothers, fathers and grandmothers were given information about the study and invited to participate; those who agreed and met the inclusion criteria were recruited by the research team and given a schedule for the relevant FGD (date, time and location). Other individuals interested in participating in the study could also contact the research team directly; those who met the inclusion criteria were sent a schedule for the relevant FGD.

Geographical area

FGDs were held in four provinces (Istanbul, Izmir, Gaziantep and Hatay) that together host about 31% of the total Syrian refugee population in Turkey. Istanbul and Izmir are large metropolitan cities with large populations and an advanced industrial infrastructure. Both cities host refugee groups with different characteristics, particularly Istanbul, which hosts the highest number of Syrian refugees in Turkey. Izmir is an attractive province for refugees because of the demand for agricultural workers. Gaziantep and Hatay are provinces near to the Syrian border and are key entry points for Syrian refugees into Turkey. These four provinces were included to capture the beliefs and attitudes of Syrian refugees with varying living conditions in order to obtain a better understanding of breastfeeding practices across the Syrian community. As more than 98% of refugees in Turkey live in urban areas within the local community, this study may make a unique contribution to the evidence base by revealing the perspectives of refugees living in urban settings.

Data collection

FGDs for pregnant women, mothers, fathers, grandmothers and health workers in MHCs were conducted in Arabic and FGDs for health workers in maternity hospitals were conducted in Turkish. Both sets of FGDs were conducted in September and October 2020.

Owing to the COVID-19 pandemic, virtual FGDs were conducted for both groups of health workers using an Internet-based videoconference platform: Zoom was selected based on its wide availability, intuitive interface, and additional functions that facilitate involvement and interactivity.

FGDs for all other focus groups were conducted in meeting rooms at MHCs to provide a safe, private environment that families could access easily.

FGDs in Arabic were facilitated by trained Turkish bilingual facilitators supported by trained interpreters. This was done because the study team was unable to find an Arabic-speaking qualitative researcher with experience in conducting FGDs in Syrian Arabic. A previous study had successfully shown that interpreters trained to work in health-care settings could help facilitators to collect qualitative data (35). Voice recordings and written notes were taken during the FGDs.

A short sociodemographic questionnaire (on age, gender, education level, number of children, breastfeeding status, etc.) was completed by each participant before the FGD. Most Syrian health workers were aged over 60 years and were not asked to state their exact age: instead, they were asked to indicate which age group they belonged to. For family members, the questionnaire asked for the exact age in years. Breastfeeding status is indicated by CBF+/- (i.e. continued or did not continue breastfeeding for two years).
FGDs
In total, seven types of FGDs were conducted (one for each type of focus group, listed above). Separate FGDs were conducted for each focus group in order to obtain a wide diversity of perspectives, enable data triangulation and reduce bias.

To allow sufficient time for everyone to express themselves, FGDs were limited to six to 12 participants. The duration of virtual FGDs was limited to 90 minutes.

As the data were compiled, the degree of saturation was checked and cross-checked with previous FGDs until data saturation was achieved.

Engagement
The purpose of the FGDs and intended use of the data were explained to participants in simple language. Before each FGD, the facilitators and notetakers were introduced and their roles were explained. After participants introduced themselves, the facilitators shared further information (including the expected duration of the FGD and the discussion plan) and emphasized the importance of participants interacting well and responding honestly, and that there were no right or wrong answers.

They then explained the ethical considerations, including confidentiality, the code of conduct, the steps taken to prevent stigmatization, the voluntary nature of participation, and the right to withdraw from the study, emphasizing that the latter would have no consequences. The facilitators then obtained written consent from all participants.

Exploration: thematic questions for FGDs
The facilitators developed a series of thematic questions after evaluating WHO indicators for infant feeding (36), WHO’s Guideline: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services (37), and other literature on breastfeeding (16,17,20,28,29,36). These thematic questions are shown in Annex 1. The semi-structured discussions included the questions “How do Syrian mothers feed their babies?”, “What is the value of breastfeeding in the Syrian culture?”, “What are the traditional foods and methods for infant feeding in Syrian society?” and “What is the impact of fathers, grandmothers and health workers on breastfeeding?” Illustrative statements made by participants in response to FGDs questions are included in the report.

At the end of each session, facilitators encourage participants to discuss and suggest solutions to the following statement: “International associations including WHO and UNICEF have recommended that babies should be breastfed for at least two years; how can we achieve this for Syrian babies?”

All questions were translated from Turkish into Arabic. Facilitators explained what would happen with the information shared in FGDs, answered any questions and gave the participants contact information in case they later wished to provide additional input or ask questions.

Data analysis
Data cleaning and analysis were performed by the research team at Hacettepe University under the supervision of WHO technical staff. Qualitative analysis was performed using MAXQDA 11 (VERBI Software, Berlin, Germany).

Three sources of data were used: (i) transcripts of FGD notes and (ii) voice recordings, and (iii) observations and insights captured during data collection and debrief meetings.

The master copy was developed into a matrix organized according to learning questions and subtopics. Raw data were coded into themes. Reading and coding of all notes started from the first FGD group and then moved through the others. During this process, the facilitators identified common phrases or ideas and assigned specific codes to highlight the main concepts.

Individual FGD responses and common themes identified within each comparison group were compared, and commonalities and differences were identified and recorded.

Ethical measures
Ethical approval for the study was obtained from the Ethical Board of Hacettepe University, the Public Health Institution of the Ministry of Health of Turkey, and the WHO Research Ethics Review Committee.

Participation in the study was voluntary and confidential; and no personal identifiers (e.g. name, national identity number) were collected from participants. Instead, all participants were assigned
a code number, which was used for recording data. Consent forms and all collected data will be securely stored in the WHO Country Office in Turkey for three years before being destroyed.

In consultation with Ministry of Health representatives, the research team ensured that there would be no legal, political, social, institutional, cultural or economic consequences or stigmatization for study participants. To ensure confidentiality, only one participant from each MHC was enrolled into each virtual FGD and each participant was alone in a MHC meeting room during the FGD. MHCs provided a child-friendly, comfortable environment for FGDs, with masks, disinfectant solution, snacks and drinks for participants. Mothers attended the FGDs with their infant and were encouraged to feed the child as necessary during the FGD. Breastfeeding mothers were provided with additional privacy using separator screens and time to attend to their babies.

Management and coordination
The study team from Hacettepe University implemented the study and produced the study report. In liaison with the Ministry of Health, the research team organized suitable meeting venues for data collection.

The Ministry of Health, through the Migrant Health department, was appointed a focal person to facilitate implementation of the study, disseminate the study findings and mobilize the support of provincial health directors to obtain permission for health workers to participate in the study. The Ministry of Health also participated in monitoring field data collection in the provinces.

WHO gave technical support and was responsible for obtaining approval from the WHO Research Ethics Review Committee.
Results

General characteristics of FGD participants
A total of 17 hospitals participated in the study: seven in Hatay, four in Gaziantep, and three each in Istanbul and Izmir. The total number of FGD participants was 335, comprising 262 Syrians (including 73 MHC health workers) and 73 Turks (all hospital health workers). Eight virtual FGDs were organized for hospital health workers (two for each province: one for physicians and the other for nurses). Of the 73 hospital health workers who participated in the FGDs, 69.9% were nurses.

Syrian health workers from 26 MHCs participated in the study: eight in Hatay and six each in Gaziantep, Izmir and Istanbul. Eight virtual FGDs were organized for MHC health workers (two for each province: one for physicians and the other for nurses); of the 73 MHC health workers who participated, 50.7% were nurses. Syrian MHC health workers were more likely than Turkish hospital health workers to be over 50 years old and to have more than four children (Table 1). Only 15.1% of the Syrian health workers said that they had received training in breastfeeding counselling, compared with 45.8% of the hospital health workers. In contrast, more Syrian health workers (88.6%) than Turkish health workers (56.3%) said that they were willing to receive such training.

Table 1. General characteristics of health workers in FGDs

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>MHC health workers: Syrians</th>
<th>Hospital health workers: Turks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants, n</td>
<td>73</td>
<td>73</td>
</tr>
<tr>
<td>Age (years), %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–29</td>
<td>19.2</td>
<td>27.4</td>
</tr>
<tr>
<td>30–39</td>
<td>30.1</td>
<td>41.1</td>
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<tr>
<td>40–49</td>
<td>23.3</td>
<td>26.0</td>
</tr>
<tr>
<td>≥ 50</td>
<td>27.4</td>
<td>5.5</td>
</tr>
<tr>
<td>Sex, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>61.6</td>
<td>82.2</td>
</tr>
<tr>
<td>Male</td>
<td>38.4</td>
<td>17.8</td>
</tr>
<tr>
<td>Profession, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse</td>
<td>50.7</td>
<td>69.9</td>
</tr>
<tr>
<td>Physician</td>
<td>49.3</td>
<td>30.1</td>
</tr>
<tr>
<td>Number of children, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>17.8</td>
<td>45.2</td>
</tr>
<tr>
<td>1</td>
<td>8.2</td>
<td>23.3</td>
</tr>
<tr>
<td>2–3</td>
<td>41.1</td>
<td>31.5</td>
</tr>
<tr>
<td>4–7</td>
<td>32.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Has attended a breastfeeding training course, %</td>
<td>15.1</td>
<td>45.8</td>
</tr>
<tr>
<td>Is willing to attend a breastfeeding training course, %</td>
<td>88.6</td>
<td>56.3</td>
</tr>
</tbody>
</table>

* In total, 70 Syrian health workers and 71 Turkish health workers responded to this question.
Six FGDs took place for each of the following groups: mothers with a child aged under 6 months, mothers with a child aged 6–24 months, and pregnant women. Data from the first two were combined and data for pregnant mothers are presented separately (Table 2).

Each FGD for mothers included six or seven participants. The proportion of adolescent marriages was similar for mothers (34.2%) and pregnant women (35.1%). Overall, 14.5% of mothers had two children younger than 24 months; 40.5% of pregnant women had a child under 24 months old (Table 2). Three quarters of mothers were currently breastfeeding their infant for less than two years. Only 39.5% of mothers reported receiving breastfeeding counselling during the postnatal period (i.e. the first 42 days after birth).

### Table 2. Characteristics of mothers and pregnant women who participated in FGDs

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>FGDs for mothers with a child aged under 24 months (n = 76)</th>
<th>FGDs for pregnant women (n = 37)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ± SD (range)</td>
<td>%</td>
</tr>
<tr>
<td>Age, years</td>
<td>27.1 ± 6.8 (17–45)</td>
<td>–</td>
</tr>
<tr>
<td>Age at marriage, years</td>
<td>19.5 ± 4.2 (11–39)</td>
<td>–</td>
</tr>
<tr>
<td>Married at age &lt; 18 years</td>
<td>–</td>
<td>34.2</td>
</tr>
<tr>
<td>Husband’s age, years</td>
<td>32.3 ± 8.0 (20–60)</td>
<td>–</td>
</tr>
<tr>
<td>Household size</td>
<td>5.6 ± 2.2 (3–13)</td>
<td>–</td>
</tr>
<tr>
<td>Family type**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple</td>
<td>–</td>
<td>76.3</td>
</tr>
<tr>
<td>Extended</td>
<td>–</td>
<td>19.7</td>
</tr>
<tr>
<td>Missing information</td>
<td>–</td>
<td>3.9</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>–</td>
<td>7.9</td>
</tr>
<tr>
<td>Can read and write</td>
<td>–</td>
<td>5.3</td>
</tr>
<tr>
<td>Primary school</td>
<td>–</td>
<td>15.8</td>
</tr>
<tr>
<td>Intermediate school</td>
<td>–</td>
<td>35.5</td>
</tr>
<tr>
<td>High school</td>
<td>–</td>
<td>21.1</td>
</tr>
<tr>
<td>University</td>
<td>–</td>
<td>14.5</td>
</tr>
<tr>
<td>Employed</td>
<td>–</td>
<td>5.3</td>
</tr>
<tr>
<td>Pregnant</td>
<td>–</td>
<td>3.9</td>
</tr>
<tr>
<td>Length of current pregnancy, months</td>
<td>4.7 ± 3.2 (1–7)</td>
<td>–</td>
</tr>
<tr>
<td>Number of living children</td>
<td>2.7 ± 1.6 (1–7)</td>
<td>–</td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>–</td>
<td>0.0</td>
</tr>
<tr>
<td>1</td>
<td>–</td>
<td>27.6</td>
</tr>
<tr>
<td>2–3</td>
<td>–</td>
<td>44.7</td>
</tr>
<tr>
<td>4–7</td>
<td>–</td>
<td>27.6</td>
</tr>
<tr>
<td>Age of youngest child, months</td>
<td>7.9 ± 6.5 (0.3–24.0)</td>
<td>–</td>
</tr>
<tr>
<td>Number of children aged under 24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>–</td>
<td>85.5</td>
</tr>
<tr>
<td>&gt; 2</td>
<td>–</td>
<td>14.5</td>
</tr>
</tbody>
</table>
Breastfeeding characteristics of Syrian refugees in Turkey

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>FGDs for mothers with a child aged under 24 months (n = 76)</th>
<th>FGDs for pregnant women (n = 37)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean ± SD (range)</td>
<td>%</td>
</tr>
<tr>
<td>Youngest child, ≤24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was breastfed within the first day Is currently breastfed</td>
<td>–</td>
<td>76.3 ± 77.6 (–)</td>
</tr>
<tr>
<td>Received breastfeeding counselling during pregnancy</td>
<td>–</td>
<td>35.5 ± 35.5 (–)</td>
</tr>
<tr>
<td>Received breastfeeding counselling in the postpartum period</td>
<td>–</td>
<td>39.5 ± 39.5 (–)</td>
</tr>
</tbody>
</table>

SD: standard deviation.
* Simple family: mother, father and children; extended family: mother, father, children, and grandparents or other relatives.

Almost one quarter (23.7%) of fathers had more than one child aged under 24 months (Table 3). Fathers reported that 65.8% of their children aged under 24 months were being breastfed.

Table 3. Characteristics of fathers who participated in FGDs

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean ± SD (range)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, years</td>
<td>30.8 ± 5.4 (22–43)</td>
<td>–</td>
</tr>
<tr>
<td>Age at marriage, years</td>
<td>24.8 ± 3.6 (19–33)</td>
<td>–</td>
</tr>
<tr>
<td>Household size</td>
<td>5.9 ± 2.3 (3–12)</td>
<td>–</td>
</tr>
<tr>
<td>Family type</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple</td>
<td>–</td>
<td>60.5</td>
</tr>
<tr>
<td>Extended</td>
<td>–</td>
<td>39.5</td>
</tr>
<tr>
<td>Education level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>–</td>
<td>7.9</td>
</tr>
<tr>
<td>Can read and write</td>
<td>–</td>
<td>5.3</td>
</tr>
<tr>
<td>Primary school</td>
<td>–</td>
<td>26.3</td>
</tr>
<tr>
<td>Intermediate school</td>
<td>–</td>
<td>15.8</td>
</tr>
<tr>
<td>High school</td>
<td>–</td>
<td>21.1</td>
</tr>
<tr>
<td>University</td>
<td>–</td>
<td>23.7</td>
</tr>
<tr>
<td>Currently employed</td>
<td>–</td>
<td>44.7</td>
</tr>
<tr>
<td>Number of living children</td>
<td>2.6 ± 1.7 (1–8)</td>
<td>–</td>
</tr>
<tr>
<td>Number of children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>–</td>
<td>23.7</td>
</tr>
<tr>
<td>2–3</td>
<td>–</td>
<td>52.6</td>
</tr>
<tr>
<td>4–7</td>
<td>–</td>
<td>23.7</td>
</tr>
<tr>
<td>Age of youngest child, months</td>
<td>10.2 ± 6.4 (0.1–24.0)</td>
<td>–</td>
</tr>
</tbody>
</table>
Table 4. Characteristics of grandmothers who participated in FGDs

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean ± SD (range)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of children aged under 24 months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>–</td>
<td>76.3</td>
</tr>
<tr>
<td>&gt; 1</td>
<td>–</td>
<td>23.7</td>
</tr>
<tr>
<td>Proportion of children aged under 24 months who are breastfed</td>
<td>65.8</td>
<td>–</td>
</tr>
</tbody>
</table>

\(^a n = 38.\)

A total of 38 grandmothers participated in six FGDs (Table 4). Data on the grandmothers’ own experiences of breastfeeding showed that the median duration was 12 months for the shortest period of breastfeeding and 20 months for the longest period. Grandmothers reported that 81.6% of their youngest grandchildren were being breastfed.
How Syrian refugee mothers feed their babies

More than half (59.4%) of Turkish maternity ward obstetricians who participated in FGDs reported that Syrian mothers breastfed their infants without any problem. However, some Turkish doctors said that Syrian mothers preferred infant formula to breastfeeding. The other 25% said that they had no opportunity to observe or no knowledge of the breastfeeding practices of Syrian mothers.

Since Syrians are not well off, they have no other choice but to breastfeed. But if you ask whether they make a conscious decision about this, we do not know, we can’t communicate with them anyway. In other words, we do not know whether they are breastfeeding because breast milk is beneficial or if they do it without thinking because they were raised that way.

Istanbul, female hospital physician, age group: 40–49 years

I worked in Gaziosmanpaşa. There, on my shift, I observed that patients tended to use infant formula, claiming that they could not breastfeed. They would always come for hot water. Whenever they could not breastfeed, they would quickly prepare infant formula instead of trying to breastfeed.

Istanbul, female hospital physician, age group: 40–49 years

Turkish maternity ward nurses who participated in FGDs reported (32 statements) that Syrian mothers were often unwilling to breastfeed, tended to give their infants formula milk, had low pain thresholds and tended to sleep more. In addition, mothers-in-law or other relatives helped to care for the babies, especially those of adolescent mothers. The nurses said that Syrian mothers did not report being unable to breastfeed as a problem and did not ask for help, but that their milk production was very good.

Syrian mothers fall asleep directly after giving birth and most tend to use infant formula.

Izmir, female hospital nurse, age group: 30–39 years

They breastfeed at our insistence; when we turn our backs, they give the baby formula again.

Gaziantep, female hospital nurse, age group: 20–29 years

Syrian mothers do not warn us even if they cannot breastfeed at all. If we are not aware or if the people in the next bed don’t warn us, maybe they will not breastfeed their baby at all until after they are discharged and go home.

Izmir, female hospital nurse, age group: 30–39 years

They are not willing to breastfeed, but I have seen that the oxytocin reflex works better in Syrian mothers, and their milk flow is much better compared with Turkish mothers. Although they might be expected to be more anxious [because of their young age], they actually seem less anxious; that’s how it happens. But they have less desire to breastfeed.

Izmir, female hospital nurse, age group: 40–49 years

Our common observation is that Syrian mothers have more milk, they have no worries or fears because they don’t hear or understand a lot of the negative things we say, that’s why they don’t worry.

Izmir, female hospital nurse, age group: 40–49 years

Half of the MHC health workers said that Syrian mothers are breastfeeding and have no problem breastfeeding. Others reported that Syrian mothers had to breastfeed for financial reasons but start complementary feeding very early.

Usually mothers prefer breastfeeding because they are under protection in Turkey, their finances are tight, and breast milk is less costly and more natural.

Gaziantep, male MHC physician, age group: 50–59 years
Usually everyone prefers to breastfeed but the new generation mothers especially tend to rely on infant formula. They feel lazy and are impatient; they are not patient, because breastfeeding requires a little patience.

Gaziantep, female MHC nurse, age group: 40–49 years

Previously, mothers were breastfeeding but, because of the economy, early marriages, living alone, having no grandparents, not getting support, being too young, poor nutrition of the mother, no breast milk comes after delivery; how can a baby be breastfed under these conditions?

Hatay, female MHC nurse, age group: 20–29 years

Almost all mothers said that breast milk is important for their baby’s nutrition. However, nine reported having problems with breastfeeding.

I wanted to breastfeed for two years; I planned for that. But as he is not full with my breast milk, I am currently both breastfeeding and bottle-feeding. I want to, but I can’t.

Hatay, FGD for mothers, 20 years old, one child: 2 months old/CBF+

Almost all fathers (34 out of 38) said that breast milk is the most important food. However, when mothers do not produce enough breast milk or the baby may not want to breastfeed, they said that it is necessary to supplement breastfeeding with infant formula and cow’s milk. They believed that breastfeeding should be discontinued if the mother becomes pregnant.

Although all grandmothers said breastfeeding is important, more than half (54.3%) reported that they bottle-feed their grandchildren with formula milk, cow’s milk, sugar water, anise tea and other herbal teas. They said that they also use a bottle to give complementary foods. Less than half reported that they had bottle-fed their own children.

My youngest grandchild is 9 months old. We give both infant formula and breast milk. We have also started giving complementary foods such as soup, tea and yogurt.

Gaziantep, FGD for grandmothers, 60 years old, seven grandchildren, youngest grandchild: 9 months old/CBF+

I was able to breastfeed all my children for up to almost three months. My children were not gaining weight with my milk. When I went to the doctor, the doctor said, “Your milk is not good for babies”, so I switched to complementary foods. When I gave the formula with a bottle, the baby got used to it and did not take breast milk at all.

Gaziantep, FGD for grandmothers, 51 years old, six grandchildren, youngest grandchild: 10 months old/CBF+

Most of the pregnant women said that they planned to breastfeed their babies. Those who had previously had problems with breastfeeding and those expecting twins felt anxious about breastfeeding.

I recommend breast milk. Since I’m pregnant with twins, I will have to give normal milk.

Gaziantep, FGD for pregnant women, 22 years old, first pregnancy

If the mother’s nutrition is not good, the milk she gives will not only harm the baby but also harm herself because the mother is not well fed. I had to wean a few of my children early because of my poor nutrition; I stopped breastfeeding some of my children after six, nine or 15 months. In such cases, we were buying milk from the pharmacy. When I went to a doctor in the Syrian Arab Republic, the doctor said that “the children are sucking in vain; they take the nutrients from your body and do not benefit from them” and suggested that I should return to baby food. This is my sixth pregnancy and my first pregnancy in Turkey.

Izmir, FGD for pregnant women, 39 years old, six children, youngest child: 11 years old
Early initiation of breastfeeding and prelacteal feeding

Maternity ward doctors said that Syrian mothers practise prelacteal feeding, by giving their babies sugar water, baby food and plain water soon after birth.

Most maternity nurses observed that Syrian mothers tried to feed their babies with something other than breast milk in the first three days: sugar water, packaged fruit juice, baby food, anise tea, dates and zamzam (blessed plain water; also called blessed water zamzam) were frequently given. They said that grandparents were asked for sugar and baby food. One nurse reported that some mothers believe that babies were fasting at birth and attempt to break the fast by giving the baby a piece of date, in accordance with their religious beliefs. Nurses said that they give the baby to the mother as soon as possible after birth, and that they generally monitor the baby and try to encourage breastfeeding.

I saw several times that they rub dates in babies’ mouth before breast feeding. When I asked why, they said that babies should break their fast with this food.

Hatay, female hospital nurse, age group: 40–49 years

More than half of MHC health workers (13 out of 19 statements) said that sugar water is traditionally given to infants in the Syrian Arab Republic; almost all mothers give it to their babies. They reported that dates, zamzam, honey, infant formula, anise tea and cumin tea are also given.

Some mothers give their babies dates to prevent iron deficiency. Some give sugar water to prevent jaundice. Some make the baby taste honey.

Izmir, male MHC physician, age group: 30–39 years

All of the mothers reported that they fed colostrum to their babies. However, only one third of mothers (16 out of 46 statements) said they breastfed exclusively for the first three days. The others also gave other liquids to their infants, most frequently infant formula (half of mothers), sugar water (half), anise tea (one third), and other teas (mint and chamomile; one fifth). The mothers were reported to give their baby sugar water, especially in the first three days, because they thought the baby could not learn to suck.

Since the baby could not learn to suck on the first day, I gave sugar water for the first three days. I started breastfeeding on the second day.

Gaziantep, FGD for mothers, 20 years old, one child: 5 months old/CBF+

I breastfed the baby one hour after birth. Then, for the first three days, I gave cumin, mint and chamomile tea with sugar water.

Gaziantep, FGD for mothers, 37 years old, five children, youngest child: 23 months old/CBF−

Only a third of fathers (4 out of 13 statements) said that their wife gave the baby breast milk exclusively; half said that their wife gave anise tea (n = 6), one quarter said sugar water (n = 3) and a few said dates. Fathers emphasized the pain relieving and calming effects of anise tea for both the mother and baby.

One fifth of grandmothers who commented on the early initiation of breastfeeding said they gave the babies breast milk only. More than half said that mostly they gave the babies sugar water, a quarter said anise tea, and a few said cumin tea, chamomile tea, rice water or baby food. These grandmothers believed that not enough milk will come in the first three days, so the baby should also be fed other liquids. They reported that sugar water was given to cleanse the baby’s intestines and prevent jaundice. One grandmother said that to prevent jaundice, the baby should be breastfed less and given sugar water instead.

In the first moments after birth, we boil anise until the breast milk comes and give it with sugar water. When the breast milk comes, we start the breastfeeding.

Gaziantep, FGD for grandmothers, 56 years old, one grandchild: 15 months old/CBF−

The pregnant women made 24 statements on this topic. Some said they would only give breast milk (14 statements), whereas others said they would also give sugar water and anise tea (five statements) or dates, cumin tea and chamomile tea (two statements). Those who used prelacteal feeding after previous
Breastfeeding characteristics of Syrian refugees in Turkey

deliveries said they would do so again because of problems such as low milk supply. They use baby bottles for prelacteal feeding. Sugar water is given for nutrition, protection from jaundice and cleansing the baby's intestines; anise tea is used for nutrition and pain relief and to calm infants and make them sleep. Anise tea is also given to the mother for pain relief and to increase her milk supply.

Since the mother is tired and in pain after birth, we give sugar water to the baby. We boil water with anise or other herbs such as chamomile or mint. Anise tea also allows baby to sleep calmly and peacefully.

Hatay, FGD for pregnant women, 26 years old, four children, youngest child: 16 months old/CBF−

Duration of breastfeeding
Maternity ward nurses said that Syrian mothers breastfeed for short periods because they have short birth intervals.

I don't think it can be very long because they get pregnant after 40 days and come back to the maternity ward within a year.

Hatay, FGD for pregnant women, 26 years old, four children, youngest child: 16 months old/CBF−

MF health workers reported that Syrian mothers usually stop breastfeeding when their child is 1–1.5 years old, but may stop even earlier, after 6 months, depending on the situation. Only a few said that they breastfed until the child was 2 years old.

One third of Syrian mothers said that babies should be breastfed until the age of 2 years, and one third said that breastfeeding could be stopped at 18 months on average or had done this themselves. In one fifth of statements, breastfeeding had continued up to the age of 1 year or less. Breastfeeding for long periods (especially until the child is 2 years of age) is thought to cause children to become dependent on mothers, and to reduce their appetite and prevent adequate nutrition.

Most fathers believed that babies should be breastfed until the age of 18–24 months, but their wives usually stopped breastfeeding much earlier (after less than a year). Even though mothers said that they had to stop breastfeeding because of a new pregnancy, with the necessary maternal training and antenatal care, such problems could be prevented in order to promote and continue breastfeeding.

I didn't breastfeed my son. I will not breastfeed my daughter until the age of 1 and a half years; that would be too long. I think it will be more beneficial if I breastfeed until the age of 1 year and then switch to home-made meals.

Izmir, FGD for mothers, 19 years old, two children, youngest child: 10 days old/CBF+

Of course, it is normal for us not to continue for up to two years, because at the age of 1 and a half years, all of the teeth have come through.

Izmir, FGD for fathers, 36 years old, five children, youngest child: aged 2 months/CBF−

Of course, it is normal for us not to continue for up to two years, because at the age of 1 and a half years, all of the teeth have come through.

Izmir, FGD for fathers, 36 years old, five children, youngest child: aged 2 months/CBF−

Half of the grandmothers said that babies should be breastfed until the age of 24 months and the other half said until the age of 1.5 years.

One fifth of pregnant women (seven out of 36 statements) said that they will breastfeed or that babies should be breastfed for 24 months. However, most had a negative attitude about breastfeeding for 24 months. They think that breastfeeding until the age of 24 months is unnecessary because it will weaken the mother and cause more harm than good to the child. Many pregnant
Breastfeeding characteristics of Syrian refugees in Turkey

© WHO
women were planning to stop breastfeeding at the end of the first year. Some pregnant women who had been unable to breastfeed their previous babies thought that they would also be unable to feed the new baby.

**Doctor, I will not tell you what it takes for a baby to be breastfed until the age of two, because in my opinion, a child should not be breastfed until the age of two. Because if a child gets used to breastfeeding, he or she will not accept additional foods. This might prevent him from sleeping through the night, and so it will be a problem.**

Istanbul, FGD for pregnant women, 32 years old, two children, youngest child: 6 years old

In my opinion, for the first six months breastfeeding is very important. In our mothers’ time, there were no such thing as infant formula. I think it’s very wrong to breastfeed for two years. I think at least six months to a year will be enough. I saw it in my nephews. They become weaker as they rely on their mothers for food. Mothers cannot do anything to help them either.

Izmir, FGD for pregnant women, 40 years old, no children

I think that she should be breastfed until the age of one or one and a half at most. Because after a year I do not think they will benefit much from breast milk. By the age of 1 year, the bond between mother and child is already strong. After the age of one, meals and complementary food will be more beneficial.

Izmir, FGD for pregnant women, 21 years old, one child: 4 years old

Syrian mothers reported that, although most start complementary feeding early, bottle-feeding and late weaning are also common. In addition, bottle-feeding with infant formula is common. Boiled rice, stewed fruit, cow’s milk and tea were the most commonly used complementary foods. In addition, babies were allowed to feed themselves using a spoon too late; mothers usually first put a spoon into their baby’s hand at the age of 18–24 months.

At 40 days after birth, I gave the baby ayran (basically, yogurt diluted with water) and, little by little, started to make him/her taste the family meals.

Gaziantep, FGD for mothers, 37 years old, five children, youngest child: 23 months old/CBF−

Now my baby is 13 months old. I recommend breastfeeding; I myself also breastfeed. I started giving my baby complementary foods after two months.

Istanbul, FGD for mothers, 24 years old, three children, youngest child: 13 months/CBF+

Pregnant women said that they had started giving complementary food (jarred baby fruit) to their previous babies when they were 3–6 months old.

Fathers made similar statements to mothers about complementary feeding and the types of complementary foods.

Grandmothers reported that complementary bottle-feeding of liquids (rice water, fruit puree, soup) can be started as early as two to three months after birth to get the infant used to a bottle. They said that solid foods are generally started later. Apart from bottle-feeding, children are allowed to use a spoon or cup or to eat with their hands from the age of 2–3 years.

**Complementary feeding versus exclusive breastfeeding for six months**

MHC health workers reported that Syrian mothers tend to start complementary foods after two to three months, but this could be as early as 40 days after birth. They generally started with foods such as rice water, diluted cow’s milk, pudding (any kind of rice or cacao pudding), yogurt and tea. It is very common to give boiled fruit. In regions where mothers are employed in agricultural work (e.g. Hatay), grandmothers are more likely to care for babies; in this situation, almost all of babies started complementary foods early. In one fifth of children, complementary feeding was delayed until the age of 1 year. Parents with a higher income usually use infant formula or cow’s milk because they want their babies to be chubby.

At 40 days after birth, I gave the baby ayran (basically, yogurt diluted with water) and, little by little, started to make him/her taste the family meals.

Gaziantep, FGD for mothers, 37 years old, five children, youngest child: 23 months old/CBF−
Determinants of breastfeeding

Observations of health workers

Maternity ward doctors (obstetricians) said that they do not ask mothers about the breastfeeding status of infants or problems with breastfeeding, but reported that Syrian mothers have a lot of social support and that the maternity ward is often crowded with family members. Doctors also observed that gender discrimination is prevalent: Syrian mothers prefer boys to girls. However, in general, they observed that gender did not affect nutritional practices. They also emphasized that adolescent mothers may find it more difficult to bond with the baby.

Half of maternity ward nurses reported observing gender discrimination in feeding practices: boys were breastfed and cared for more than girls. They learned that this was done so that girls would stay small and beautiful, and not grow big. They reported that mothers felt sad when they had a baby girl and weaned them early in order to try to have a baby boy. According to the maternity hospital nurses, the biggest obstacles to breastfeeding were frequent, recurrent pregnancies and adolescent pregnancies. The nurses also reported that mothers thought that breastfeeding adversely affected maternal health and placed a huge burden on the mother; they stopped breastfeeding in order to become pregnant again. When they became pregnant again, they tended to stop breastfeeding; those who continued breastfeeding, did so only for a short time. Nurses suggested that adolescent mothers do not know how to care for babies, but are unaware of this because they are still children themselves; they find it difficult to adapt to motherhood. Nurses observed that mothers who have many children are bored. According to the nurses, Syrians mothers have a low pain threshold and do not want to breastfeed due to breast pain or uterine contractions due to oxytocin release.

The nurses also observed that social support in Syrians families can sometimes be excessive – someone else often cares for the baby so the mother can rest. However, this can reduce contact and prevent bonding between the mother and baby. The nurses reported that mothers from higher-income families tend to use infant formula and those with a lower income are forced to breastfeed for financial reasons. They said that Syrian mothers have aesthetic concerns; they are afraid that their husband will bring another wife into the family home and consider the needs of their spouse before those of the child.

Whereas new Turkish mothers will strive to breastfeed their babies, a Syrian mother will put on make-up to see her husband and wear attractive clothes. Turkish motherhood is very different in this sense.

Istanbul, female hospital nurse, age group: 30–39 years

All except one of the MHC health workers said that the baby’s gender does not affect nutrition. There was a common opinion that boys were preferred but this did not affect their nutrition. They emphasized that the obstacles to breastfeeding were not eating well, poor health and tiredness in mothers, and a new pregnancy. Some participants said that other barriers to breastfeeding were feeling pain while breastfeeding in the first weeks (from cracked nipples), young maternal age, mother’s depression, changing conditions after the war, influence of the mother-in-law and neighbours, and aesthetic concerns.

In addition, since moving to Turkey, many Syrian women have started agricultural work and leave their babies in the care of their older children. Therefore, the mother’s work can significantly hinder breastfeeding and reduce nutrition for the baby.

Mothers-in-law were said to have a great influence on the breastfeeding practices of adolescent mothers, but fathers do not have much influence in this area. Mothers usually obtain information from grandparents, health workers and social media.

Observations of mothers

Syrian mothers reported that gender did not affect their decision to breastfeed or its duration. They suggested that first babies are generally unlucky because the second pregnancy usually occurs as soon as possible, causing the mother to stop breastfeeding. They also said that the baby can also determine the duration of breastfeeding. Babies can sometime reject the breast and, unfortunately, untrained mothers interpret this as a sign to stop or not to start breastfeeding. The main factors limiting breastfeeding were a new pregnancy, maternal malnutrition and maternal fatigue. Other factors were insufficient milk attributed to a caesarean
delivery, incubation of the baby, the mother working, and the cessation of milk production.

Approximately one third of mothers said that they experienced problems with breastfeeding (nipple cracks and breast congestion) and had treated these with olive oil or bought drugs from the pharmacy.

Although it is not mandatory for Muslim women to fast during Ramadan if they are breastfeeding, almost all mothers said that they can and do fast whether they are breastfeeding or pregnant. They said that they can start fasting after the baby is 40 days old, and that during fasting their milk production decreases (or even stops) and they become weak. They reported that they continued to fast even after their milk supply stops.

In all, 90% of mothers said that they consult their mother or mother-in-law about breastfeeding, and one third said that they consult a health worker.

When asked who decides about the duration of breastfeeding, everyone said the mother. Since mothers are responsible for household chores such as cooking and cleaning, the duration of breastfeeding will also be determined by the mother because she is the household manager. Breastfeeding was said to improve bonding between the mother and baby.

Mothers said that breastfeeding is beneficial for the baby’s health: the babies get sick less often, and grow and develop better. However, some mothers believe that breast milk may not benefit every baby in the same way. Breastfeeding was said to have a negative effect on maternal health by causing the mother to feel weak and tired, as well as maternal tooth decay and hair loss. Mothers reported that breastfeeding caused their breasts to get bigger, become lopsided and sag.

Mothers said that because only they can breastfeed, when a breastfed child cries the mother has to stop working and breastfeed her baby. Breastfeeding also prevents her from spending time with her other children. In contrast, anyone can feed a bottle-fed baby. Mothers also said that breastfeeding at night disrupts their sleep. Mothers said that they feel shy about breastfeeding outside the home and need to bottle-feed the baby when they go out.

- I had fasted in Ramadan when I was pregnant; I had no problems. But after fasting for a while, my breast milk became insufficient and then stopped when she was 2 months old. I had to return to bottle-feeding.

  Hatay, FGD for mothers, 37 years old, seven children, youngest child: 1 month old/CBF+

- At first, I didn’t like breastfeeding: I had a hard time. But when I saw that I established a connection with the baby, I started liking it very much. Then I got used to it. But after four months, my milk stopped.

  Gaziantep, FGD for mothers, 20 years old, one child: 5 months old/CBF−

- Of course, breastfeeding is a good thing; it is rewarding. It will have a beneficial effect on the baby. If the mother is well fed, the baby is also well fed from the milk.

  Hatay, FGD for mothers, 18 years old, one child: 18 months old/CBF+

- You see how many times the baby sucks during the day. That’s why the mother will be tired – because the baby pulls everything from her body. So, she needs to pay attention to her nutrition. If she pays attention, her problems will decrease; otherwise, breastfeeding will of course be too tiring for a mother.

  Hatay, FGD for mothers, 27 years old, two children, youngest child: 23 months old/CBF−

- Breastfeeding a child is a little difficult for me: it caused my teeth to break and caused me to lose a lot of weight. But, on the other hand, it helped my child a lot; it helped my child’s development, but it was very harmful to me.

  Istanbul, FGD for mothers, 34 years old, two children, youngest child: 19 months old/CBF−
Observations of fathers
In general, fathers said that the gender of the baby does not influence breastfeeding; however, one father said that gender may have an effect depending on the mother’s attitude. Fathers said that first babies may be breastfed less because the mother is inexperienced. Some babies may not prefer breast milk when they start to taste complementary food; therefore, breastfeeding may end at this stage, depending on the child. According to fathers, the main factors against breastfeeding are poor maternal health, poor maternal nutrition, the mother having a job, and the mother’s mood and fatigue; another factor was a new pregnancy.

Approximately half of the fathers reported that their spouses had experienced breast problems (e.g. cracked nipples, mastitis, fungal infection) and milk insufficiency during breastfeeding.

Fathers said that nursing mothers get tired and become weak; as the mother knows her own body best, she decides the duration of breastfeeding.

In fact, we compare breastfeeding for up to two years to a growing tree. In other words, a child who does not suck for two years is like a tree that does not give fruit. When we stopped breastfeeding, there is a lot of nutrient deficiency. I remember, for example, I was breastfed until the age of four or five. I even remember that period, I do not think I have ever been to hospital (laughing).

Izmir, FGD for fathers, 36 years old, five children, youngest child: 2 months old/CBF−

The Quran says up to two years; of course, this is the right of the child, but the mother also has a right. For example, if she gets weak after breastfeeding for a year and two months, or if she becomes pregnant, then she should stop breastfeeding.

Istanbul, FGD for fathers, 26 years old, two children, youngest child: 18 months old/CBF+

Observations of grandmothers
Although all grandmothers said that the gender of the baby does not influence breastfeeding, one participant said “sometimes girls want to be breastfed more”.

According to the grandmothers, the biggest obstacles to breastfeeding are the mother’s nutrition, the mother’s health and a new pregnancy. Grandmothers said that during Ramadan it is possible to fast if the baby is at least 2–4 months old; two participants said that they themselves had stopped producing milk because of Ramadan fasting.

Most grandmothers (21 out of 29 statements) reported having had breast problems themselves; almost all mentioned having had cracked nipples, and three statements mentioned breast congestion. To treat cracked nipples, they had bought medicine from the pharmacy or used creams and olive oil as recommended by MHC staff. One person had asked the imam to pray for her.

All of the grandmothers emphasized that breastfeeding is beneficial to the baby’s health. One grandmother said that the baby bottle is difficult to clean and should be used with care, but another suggested that it was easy to use.

Unlike fathers and mothers, most of the grandmothers reported that breastfeeding did not adversely affect maternal health and even had a positive effect; some suggested that breastfeeding can protect the mother from breast diseases. Others believed that breastfeeding helps to form a bond between the mother and child, is a blessing, and makes the mother happy while fulfilling her duty to the baby.

Bottle-feeding is convenient for the mother. When she goes out, she can leave the ready-made milk in the bottle and go. If the mother is a clean person, by God’s will, nothing will happen; but if the mother is not clean, anything can happen to the baby.

Hatay, FGD for grandmothers, 53 years old, two grandchildren, youngest grandchild: 15 days old/CBF+
Observations of pregnant women
In FGDs, pregnant women stated that the sex of the baby does not matter, but that breastfeeding also depends on whether the child accepts or rejects the breast. They reported that the most important factor in discontinuing breastfeeding is the mother’s poor health: if the mother feels weak or tired, or if her nutrition is poor, then she has the right to wean the baby. They said that another important factor was a new pregnancy.

Most of the pregnant women said that it is acceptable to fast during pregnancy and breastfeeding. Most had fasted during both pregnancy and breastfeeding. Only few said otherwise, for example “It is up to the mother; it affects me so much, I can’t fast”.

Most mothers received breastfeeding support from their mothers and mothers-in-law, whereas some also received support from their spouses, other relatives and older children. One fifth said that they did not receive any breastfeeding support.

Mothers indicated that they obtain information about breastfeeding from their mothers, mothers-in-law or other relatives. Some said that they consult health workers when they have a problem. A few consulted Arabic social media for information about breastfeeding and infant care.

Participants said that the mother decides the duration of breastfeeding. One participant said, “breastfeeding is a great burden on the mother, and occasionally affects her health, so the mother has the right to decide”. Three participants said that their husbands tried to persuade them to continue breastfeeding, but that the final decision was theirs.

Although most pregnant women made positive statements about the effect of breastfeeding on the baby, women in their first pregnancy said that they had no knowledge on this subject.

Most statements made by pregnant women about the effect of breastfeeding on the mother were negative and similar to those of mothers and fathers.
Whereas one third of the pregnant women did not think that breastfeeding had any effect on family relationships, half of the pregnant women highlighted that breastfeeding supports the family’s finances.

The father shouldn’t have much to do; this topic is a matter for the mother to decide. I think the father shouldn’t have anything to do with it because the mother knows how long her body can endure this.

Istanbul, FGD for pregnant women, 23 years old, one child: 16 months old/CFB−

With my first child, my husband asked me to breastfeed until the age of 24 months but when the child was a year and a half old, my body grew thin and I became weak. We also entered the month of Ramadan so I had to wean [the baby], but I don’t know what will happen with my second child.

Hatay, FGD for pregnant women, 18 years old, one child: 19 months old/CFB−

I am now six months pregnant and I’m still breastfeeding my 9-month-old baby. Of course, my baby is in very good health because I’m giving her/him breast milk. However, it has affected me: I get tired, I am weak. Actually, I am thinking of weaning, but I cannot do anything because the baby has become so used to it.

Hatay, FGD for pregnant women, 24 years old, two children, youngest child: 9 months old/CFB+

Overcoming the barriers to breastfeeding

In FGDs, the participants were asked to suggest solutions to overcome the barriers breastfeeding experienced by Syrian mothers living in Turkey.

In FGDs, the main solution suggested by Turkish health workers was to provide training courses on breastfeeding for both Syrian health workers and refugees. Their suggestions included providing training courses for health workers at primary health-care facilities and antenatal training courses from the start of pregnancy, including for spouses and grandmothers, at primary health-care facilities in both Arabic and Turkish, along with brochures and videos for Syrian refugees in Arabic. The second suggestion was to encourage family planning and the use of contraception. Health workers emphasized that Syrian refugees do not know much about family planning, but can use contraception if it is explained. They recognized that contraception is considered a sin in Syrian communities, but explained that many children are being born and so these beliefs need to be challenged. Turkish health workers said that to overcome these issues, language and communication problems must be resolved; there are too few interpreters, especially female interpreters, to explain issues such as contraception to Syrian women. In addition, nurses said that they had difficulty providing breastfeeding counselling owing to language problems; they had tried unsuccessfully to communicate with Syrian mothers using hand gestures. Less frequent suggestions were to improve the socioeconomic conditions for Syrian families and provide guidance via financial and behavioural incentive interventions.

In FGDs for Syrian MHC health workers, training was the most frequent suggestion. MHC health workers observed that some Syrian doctors working as general practitioners at MHCs had actually trained as specialists in areas such as general surgery, gynaecology and orthopaedics. Therefore, they lack up-to-date information on breastfeeding. Most MHC staff had not received training in breastfeeding counselling and most nurses said that, if possible, they would like to attend a training course on breastfeeding. In addition, MHCs were not baby-friendly centres, at least during the study period. The second most common suggestion by MHC health workers was to encourage family planning. Other recommendations were to improve maternal health, address language and communication problems, develop incentive interventions and adopt the use of reward–punishment methods.

I would suggest this: I would stop unconditional aid. For example, the Kızılay [Turkish Red Crescent] distributes aid cards. I wouldn’t give those cards unless mothers breastfeed for a minimum of two years.

Hatay, female MHC physician, age group: 30–39 years

Mothers, fathers and grandmothers all made suggestions to improve breastfeeding; the latter group emphasized that the main issue was to improve the health of the mother: the mother should eat well, pay
attention to what she eats and take her vitamins. When asked for suggestions to extend the birth interval, family planning was proposed as a solution. Whereas most participants used traditional family planning methods (i.e. withdrawal), a few said that they knew about and used modern methods. Women who were pregnant for the first time said that they could not express an opinion on this issue.

**Impact of the COVID-19 pandemic on child nutrition of Syrian refugees**

Turkish health workers at hospitals stated that Syrian women had been less likely than Turkish women to attend antenatal clinics before the pandemic; they only attended the hospital for emergency care and childbirth. The pandemic has not changed their behaviour: mothers’ visits and attendance at antenatal appointments (for health checks) and adherence to treatment/recommendations are closely related to their awareness level, which has not been changed by the pandemic. They said that they do not want to stay in hospital after the delivery, but want to be discharged immediately because of a fear of contracting COVID-19. However, they said that they did not know whether the pandemic has affected mothers’ breastfeeding behaviour.

Syrian MHC health workers said that at the start of the pandemic, families were hesitant about coming to the MHC they postponed their children's vaccinations and follow-up. However, they started to return after two or three months for catch-up vaccinations and follow-up checks. Most participants said that fathers had experienced financial difficulties during the pandemic, leading to food shortages at home and problems in obtaining complementary foods. In general, breastfeeding was not affected. One participant said that because of reduced nutrition, mothers had less breast milk, which had a serious impact on breastfeeding. A few participants said that financial difficulties had led mothers to stay at home more and, consequently, to breastfeed more.

Most family members said that they were afraid to leave home during the pandemic, but took the necessary preventive measures and continued attending the hospital for antenatal and child care. They said that they had experienced difficulties in getting appointments because of the reduced availability of hospital appointments. Therefore, they preferred to go to MHCs. They reported that when the MHC was closed, they went privately to Syrian doctors and bought drugs from other Syrians when needed; however, these practices are illegal in Turkey. They reported that breastfeeding and infant feeding had not been affected by the pandemic.
Discussion

This study has shown that the main factors responsible for the short duration of breastfeeding by Syrian refugees are likely to be cultural characteristics, migration and low health literacy in mothers (Fig. 1). The main cultural characteristics are:

- thinking that breastfeeding has a negative impact on the mother’s health;
- adolescent pregnancies;
- not using modern family planning techniques;
- wanting to have many children;
- Syrian mothers prioritizing caring for their husbands and themselves over the needs of their babies (e.g. by giving anise tea to calm the infant and not breastfeeding at night);
- prelacteal feeding, which decreases prolactin secretion and results in milk insufficiency; and
- strict social support, which limits mother–child interactions and bonding.

Factors such as not using modern family planning techniques and wanting to have many children result in short birth intervals.

In addition, migration was found to lead to increased:

- adolescent pregnancy
- poverty
- loss of social support
- maternal depression.

Adolescent pregnancies and poverty were associated with both low education levels and low health literacy in mothers.

Adolescent marriage is supported by tradition in the Syrian community and was also common in the pre-war period. However, since moving to Turkey for safety and security, teenage girls have been encouraged...
to marry at much younger ages than previously. Adolescent mothers cannot provide the necessary care and attention for their babies. Childbirth also causes physical and mental trauma for adolescents. Moreover, low school attendance due to pregnancy and early motherhood leads to low education and low health literacy levels.

Herbal teas such as anise and cumin are given to Syrian mothers to reduce postpartum pain and increase milk production. Anise tea is also given to babies to supplement breastfeeding in the first three days, and then later used to control crying and regulate night-time sleep. Herbal tea is commonly used to soothe infants in Arab communities (38,39). Night breastfeeding is perceived to be very tiring. Prelacteal feeding and limited nocturnal breastfeeding also reduce prolactin secretion, as well as the suppressive effect of lactation on ovulation (lactational amenorrhea). The latter is important because Syrian mothers rely on breastfeeding to protect them from becoming pregnant rather than modern family planning methods. However, because they do not exclusively breastfeed their babies, this contraceptive method is less effective. On the other hand, in Syrian families, a large number of children is a status symbol, and so many children are desired. They are accepted as "God given". The withdrawal method of contraception is also commonly used by those who say that they use family planning methods. The prevalence of these family planning methods explain the short birth intervals in the Syrian community.

Cultural factors can limit breastfeeding by Syrian mothers. Mothers prioritize fasting during Ramadan, which dehydrates them and probably reduces their production of breast milk. Moreover, the use of infant formula is considered a sign of wealth in families who have migrated from developing countries (where poverty is common) to developed countries (40,41). Breastfeeding rates are commonly reduced among immigrants and refugees (31).

In Syrian refugees in Jordan, low rates of early initiation of breastfeeding (32%), exclusive breastfeeding for six months (29%), and breastfeeding with complementary feeding in children aged 6–9 months (37%) have been reported (31). In contrast, the 2018 Turkish Demographic and Health Survey (Syrian migrant sample) found that more than seven out of 10 children (73%) were breastfed within one hour of birth, whereas 24% of breastfed children had received prelacteal feeding (34). This might be a consequence of the high proportion of hospital births among Syrian migrant women in Turkey (93% of live births) in the five years preceding the 2018 Survey (34). In 2019 98% of all births in Turkey took place in baby-friendly hospitals (42). In the present qualitative survey, all Turkish health workers were recruited from baby-friendly hospitals; these health workers were found to support early initiation of breastfeeding by mothers. The 2018 Survey found that half (52%) of Syrian children aged under 6 months in Turkey are exclusively breastfed; however, the proportion was lower for children aged 4–5 months (22%) and much lower for children aged 9–11 months (4.7%) (34). The present study also identified examples of shorter and longer periods of exclusive breastfeeding. In the 2018 Survey (Syrian migrant sample), the median duration of breastfeeding among children born in the previous three years was 13.7 months for any breastfeeding and 3.1 months for exclusive breastfeeding (34). Similarly, FGDs in the present study revealed the early introduction of complementary food and early cessation of breastfeeding.

The 2018 Survey showed that the birth interval is less than 24 months for nearly 38% of Syrian women. In addition, 39% of Syrian adolescents (aged 15–19 years) have had children, and for nearly half of this group the birth interval was less than 18 months (34). Similarly, the present study found that 40% of pregnant women also had a child younger than 24 months. In the 2018 Survey, the fertility rate in the Syrian migrant sample was 5.3 births per woman (34). The birth rate was similar for grandparents in the present study, at 5.2 births per woman.

This present study also found that, regardless of their family position (i.e. mother, father or grandmother), academic background and number of pregnancies (parity), participants considered that traditional practices are still acceptable. Moreover, a previous report found that maternal age and educational level did not correlate with breastfeeding rates in Syrian refugees in Turkey (33). Consistent with this, studies from other countries found that cultural beliefs and practices are predominant factors in infant care, even in well-educated mothers (43,44).
How to support breastfeeding in Syrian refugees living in Turkey

The present study revealed that health education combined with an evaluation of cultural characteristics and social norms is necessary to support breastfeeding in Syrian refugees living in Turkey (Fig. 2). Mothers are mainly responsible for making decisions about breastfeeding and most have negative perceptions about the effects of breastfeeding on their health. Initiatives, including health education packages, are needed to highlight the value of breast milk and promote breastfeeding in the Syrian population. Moreover, strategies are needed to encourage behavioural change in mothers to adopt the best breastfeeding practices.

In general, refugees prefer to receive health services from institutions that provide services in their own language. Currently, Syrian doctors and nurses are employed in MHCs through the Sihhat project, so there are no communication problems at these facilities. However, Syrian MHC health workers were found to have education gaps related to breastfeeding counselling. The study also found that most health workers are willing to undertake such training. There is, therefore, a need to plan and provide training in breastfeeding counselling. During the study period, the Baby-Friendly Hospital Initiative training programme (45) was translated into Arabic with the cooperation of the Ministry of Health of Turkey and UNICEF and training courses are being planned. The results of this study will be used for health education activities on breastfeeding to benefit the whole community (both Syrian and Turkish). Establishing culturally and linguistically appropriate education and training programmes will increase the effectiveness of breastfeeding and improve the health and nutrition of babies, as previously reported by a study of health-care utilization by Syrian refugees (46).

Health workers should be aware of the strong relationship between culture and breastfeeding behaviours in traditional Syrian families and should, therefore, ask caregivers about the use of folk remedies when assessing all breastfeeding problems.

Fig. 2. Actions to support breastfeeding in Syrian refugees in Turkey
**Strengths and limitations**

This is the first qualitative study to report on breastfeeding practices among Syrian refugees in Turkey. It reports the opinions of Syrian fathers and grandmothers (as well as those of pregnant women and mothers) about breastfeeding for the first time. The study identified the main groups that influence infant nutrition within the Syrian community and the opinions of these groups on breastfeeding practices in order to understand the breastfeeding challenges faced by mothers and possible solutions to these. The study outcomes will provide evidence to support the development of recommendations for culturally acceptable and appropriate behavioural incentive interventions to promote breastfeeding for Syrian refugees.

Separate FGDs were arranged for mothers with an infant aged under 24 months and for pregnant women. However, during the FGDs, some mothers of children aged under 24 months said that they were pregnant, and some pregnant women said that they had a child under 24 months of age. Despite these overlaps, the women remained in the FGD type to which they were originally assigned, and discussed the specific set of thematic questions for that FGD. Such overlaps are not uncommon in qualitative studies. Both groups said that the main problem for Syrian refugees was the short birth interval.

The study enrolled all mothers and fathers who were eligible. At the time of the study, all mothers and fathers included in FGDs had been living in Turkey for at least one year. As the study did not aim to detect changes in breastfeeding practices over time, no selection criteria were related to migration status. Following this study, antenatal and postnatal training at MHCs may be planned. As focus groups were not selected according to ethnicity, education level or age of participants, the findings cannot be differentiated by demographic group.

This study was conducted in four cities with a high Syrian refugee population in Turkey and the findings are, therefore, representative of Turkey. However, owing to the qualitative design, the evidence on breastfeeding may not be transferable to particular populations in other countries. Cultural differences between population groups will necessitate country-specific breastfeeding guidelines.
Conclusion

The study found that the short duration of breastfeeding is related to the cultural characteristics, migration experiences and low health literacy of mothers. To effectively support breastfeeding, health workers need further training in breastfeeding counselling adapted to the cultural characteristics of Syrian mothers. Training and information campaigns for parents, mothers-to-be and other family influencers should aim to support mothers in optimal breastfeeding practices. Socially appropriate interventions are needed to support the continuation of girls’ education and prevent adolescent marriages and adolescent motherhood. Nutritional support could be provided for breastfeeding mothers.

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Annex 1. Thematic questions for each focus group

The key questions for each focus group are given below.

**Thematic questions for breastfeeding mothers**
1. What type of feeding do you recommend for the healthy growth of babies?
2. How soon after birth did you start breastfeeding your youngest baby? How did you feed your baby in the first three days of his/her life?
3. How old is your youngest baby, how many times a day do you feed your baby, and which food do you give to your baby now? Did sex, birth order or any illness of your child affect his/her breastfeeding status?
4. What traditional methods are used for infant feeding?
5. Have you taken any nutritional supplements for yourself and your baby during the breastfeeding period? Could you explain?
6. Have you had any breastfeeding problems and how did you solve them?
7. Have you received support from any person (health-care provider, relative) about breastfeeding? What did your relatives and your husband advise you about infant feeding or breastfeeding?
8. Did health workers influence your breastfeeding practices?
9. What are the effects of your breastfeeding practices on your daily life?
10. How can breastfeeding affect infant and maternal health?
11. Has the COVID-19 pandemic affected how you care for and feed your baby?
12. What are the roles of women and children in your family? What do you expect from your child in the future?

**Thematic questions for pregnant women**
1. What type of feeding do you recommend for the healthy growth of babies?
2. What traditional methods and foods are used for infant feeding?
3. How long should babies receive breast milk to give them a healthy start to life? Can the gender, birth order or any illness of a child affect his/her breastfeeding status?
4. How long do you want to breastfeed your child? When will you start giving your child other milk and foods?
5. If you have another child, how did you feed your youngest baby for the first three days of his/her life? How long did you breastfeed your baby?
6. Have you taken any nutritional support for yourself during your pregnancy?
7. Who can help you raise your children?
8. What can be the impact of your breastfeeding practices on your daily life?
9. How can breastfeeding practices affect infant and maternal health?
10. Has the COVID-19 pandemic affected your postpartum care? Has the pandemic affected how you care for and feed your baby?
11. What are the roles of women and children in your family? What do you expect from your child in the future?
Thematic questions for fathers
1. What type of feeding do you recommend for the healthy growth of babies?
2. How old is your youngest baby and what is her/his gender? How do you feed your child now? Has the gender, birth order or any illness of your child affected her/his breastfeeding status?
3. What traditional methods are used for infant feeding?
4. Has your wife had any breastfeeding problems and, if so, how did she solve them?
5. How can breastfeeding affect infant and maternal health?
6. Did the health-care staff give you any help in breastfeeding your child?
7. Has the COVID-19 pandemic affected how you care for and feed your baby?
8. What are the roles of women and children in the family? What do you expect from your child in the future?

Thematic questions for grandmothers
1. What type of feeding do you recommend for the healthy growth of babies?
2. How many children and how many grandchildren do you have? How old is your youngest grandchild and what is her/his gender? How is your grandchild being fed now? Did birth order or any illness of your grandchild affect breastfeeding?
3. What traditional methods do you recommend for infant feeding? Do you provide any nutritional support for the mother and baby during the breastfeeding period?
4. Have you had any breastfeeding problems yourself and, if so, how did you solve them?
5. How can breastfeeding affect infant and maternal health?
6. Did health-care staff help you with breastfeeding?
7. Has the COVID-19 pandemic affected how you care for and feed your grandchild?
8. What are the roles of women and children in the family? What do you expect from your grandchild in the future?

Thematic questions for Syrian health workers at MHCs
1. How do Syrian mothers feed their babies?
2. How soon after birth do they first breastfeed their babies? When is complementary feeding started? For how many months do babies receive breast milk?
3. What is the value of breast milk and breastfeeding in your culture? What social and family support is available for breastfeeding? Can factors such as gender, birth order and disease status affect breastfeeding? What traditional methods for infant feeding are used in your society?
4. Do you have a breastfeeding counselling certificate?
5. If yes, do you have any specific challenges when providing breastfeeding counselling/training to Syrian refugees (i.e. different than those for the local population)? What are they?
6. If no, would you like to attend a breastfeeding counselling course?
7. Is there any difference between Syrian and Turkish mothers in terms of infant feeding patterns?
8. What is the sociocultural role of women and children in Syrian families? What are the expectations and roles of women and children in Syrian families?
9. Has the COVID-19 pandemic affected the care and type of feeding used for Syrian babies?
Thematic questions for Turkish health workers providing maternity care in hospitals

1. How do Syrian mothers feed their babies?
2. How soon after birth do they first breastfeed their babies?
3. How are breast milk and breastfeeding valued in their culture? What social and family support are available for breastfeeding? Can factors such as gender, birth order and disease status affect breastfeeding? What traditional methods for infant feeding are used in your society?
4. Do you have a breastfeeding counselling certificate?
5. If yes, do you face any specific challenges when providing breastfeeding counselling/training to Syrian refugees (i.e. different from those for the local population)? What are they?
6. If no, would you like to attend a breastfeeding counselling course?
7. Is there any difference between the Syrian and Turkish mothers in terms of infant feeding patterns?
8. What is the sociocultural role of women and children in Syrian families? What are the expectations and roles of women and children in Syrian families?
9. Has the COVID-19 pandemic affected the follow-up of Syrian pregnant women, the location and type of delivery, and infant care?
The WHO Regional Office for Europe
The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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World Health Organization
Regional Office for Europe
UN City, Marmorvej 51
DK-2100 Copenhagen Ø
Denmark

Tel.: +45 45 33 70 00
Fax: +45 45 33 70 01

Email: eurocontact@who.int
Website: www.euro.who.int