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Weaning Practices among Mothers Attending UNWRA Health Centers-Gaza Governorates

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Weaning Practices among Mothers Attending

UNWRA Health Centers-Gaza Governorates

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Dedication

I dedicate this work to

Those who I will always love

My parents who continuously encourage me for continuing learning

My lovely children for their patience love and support

Huda Sammour

Declaration

I certify that this thesis submitted for the degree of master is the result of my own research, except where other wise acknowledged, and that this thesis has not been submitted for a higher degree to any other university or institution.

Signed

Huda Sammour

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Abstract

Although breastfeeding (BF) and weaning are important domains in child nutrition, growth and health status in general, still weaning has gained little attention by health care providers, researchers and ordinary people. The overall aim of this study is to explore weaning patterns and practices among mothers attending United Nations Relief and Works Agency (UNRWA) health centers in the Gaza Strip, in order to provide information that could support child nutritional status and subsequently child health.

This study is a descriptive analytical cross sectional one, conducted on a sample of 6 UNRWA health centers in Gaza. A sum of 285 mothers, who had been chosen through a multi-stage sampling method were interviewed in the well-baby clinic through a self-constructed interviewed-questionnaire with a response rate of 95%. Data checked for validity and analyzed through the SPSS program.

The study findings revealed that the exclusivity rate of breast feeding for six months is 28.4%. The mean child age at weaning was 13.5, the median was 14 and SD was 4.76. The majority of the interviewed mothers had weaned their children suddenly (88.4%); from them, 65.3% used traditional methods for weaning. The researcher found that the most popular traditional methods used by mothers were putting substances with bad taste especially Aloe Vera (Subra Murra) on the nipples (39.6%), use of alternatives as pacifier (14.7%), putting red substance 11.2% and placing Coffee (8.8%) on the nipples. The magnitude of using the different traditional methods significantly varies according to the residency area. Coffee use was more prominent in Gaza and the south while red substance use was more prominent in Mid-zone. The study revealed that the usage of traditional methods was more associated with problems to the weaned children than the non-traditional method and the variations between the two groups were statistically significant (P value .002). Also, the less educated parents tend to use traditional weaning methods more than the educated ones and the variations among the two groups were statistically significant (Pvalue.003).

The study revealed that the main cause of weaning was pregnancy (42.8%) followed by improving child feeding (17.5%), and mothers chose the weaning approach which they think as good for their children. Interestingly, about 50% of mothers reported taken the decision to wean their children by themselves. The study revealed that weaning was not included as a component of health education. For the majority of subjects, the source of information about weaning was family in particularly from mothers in law and grandmothers (94%).

The study provided a set of recommendations that could improve weaning practices; including paying more attention to this important issue, promoting health care provider's skills and knowledge through providing training, strengthening the counseling and health education about weaning through different methods.

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Abbreviation

BF Breast Feeding

EBF Exclusive Breast Feeding

CPS Canadian Pediatric Society

DHSS Department of Health and Social Security

GG Gaza Governorates

MCH Mother and Child Health

MOH Ministry of Health

NECC Near East Council of Churches

LBW Low Birth Weight

NGOs Non-Governmental Organizations

PASSIA Palestinian Academic Society for the Study of International Affairs

PCBS Palestinian Central Bureau of Statistics

PHC Primary Health Care

PNGO Palestinian Non-Governmental Organizations

SPSS Statistical Package for Social Sciences

SSN Senior Staff Nurse

UNICEF United Nations International Children Fund

UNRWA United Nations Relief and Works Agency for Palestinian Refugees in the Near East

WHO World Health Organization

Chapter 1

1.1Research background

Early childhood feeding patterns and practices are important determinants of the nutritional status of children, which influence their health status (World Health Organization-WHO, 2002). A mother's nutritional well-being before and during pregnancy influences the health of her baby at birth, her ability to breastfeed successfully and her own general health. The health benefits of Breast Feeding (BF) for both the mother and the child are influenced by both the duration and intensity of BF and by the age at which the child receives supplementary food and weaning practices (Shaheen, 2007). Children are at greatest risk of nutritional deficiency and growth retardation between the ages of 6 and 24 months. Therefore, introducing complementary food along with BF is essential (Shaheen, 2007).

The criteria of appropriate weaning practices are, timely, gradually, adequate amount of food and safe preparation Shaheen, (2007). Timely means that, introducing food when the need for energy and nutrients can not be met through BF. Gradually means that, the number of BF meals should be decrease gradually. Adequate food provides sufficient energy, protein, and micronutrients to meet a growing child's nutritional needs. Safe meaning that foods are hygienically stored, prepared and fed with clean hands, using clean utensils and not bottles. Properly fed meaning that foods are given consistent with a child's appetite and feeding method actively encouraging the child to consume sufficient food using fingers, spoon or self-feeding that are suitable for age (Department of Health and Social Security-DHSS, 1988).

As difficult as it is for some women to begin BF, it is even harder for others to wean at the same time, some babies may feel rejected when mothers initiate the weaning process, especially if co-sleeping was part of BF time (O'Brien, 2007). Sometimes the child will get so angry and feel so deprived. When nursing stops they can become very irritated with mother (Sears, 2003). Some women decide to quit BF suddenly, offering a baby milk substitutes at once. As in fact, we should say that, there are variations in babies' reaction to weaning as many babies can pass this period quite calmly and others will prefer to reduce quantity of nursing gradually (Sears, 2003). This variant will give

the baby possibility of rearranging himself/herself stage-by-stage, but on the other hand, it can turn to be more difficult for a baby (Daniel, 2001).

Many of the reported reasons for early BF cessation are similar despite enormous differences in geography, culture, environment and social conditions. Researchers have reported that mothers' plans to return to work or school are associated with a shorter duration of BF (Jane, 2006). Maternal demographics such as age, income, and ethnicity also are strongly associated with BF duration among women throughout the world (Daniel, 2001). Certainly, there are barriers to continued BF that need to be addressed through institutional and social change. Fortunately, there are other factors associated with BF duration that lactation consultants can address. In fact, it is widely known that perceived insufficient milk, nipple and breast pain and poor suckling are common reasons for early BF termination (Jane, 2006).

Many mothers are relieved to learn that they don't need to totally wean their children until both mother and child are ready. Partially nursing, such as before naps, bedtime, and/or in the morning, can alleviate some of the stress that comes from a frequently nursing toddler or older child (Juniper, 2009).

The main purpose of the study is to explore positive and negative weaning practices among mothers of children aged 6-24 months. For weaning to be successful, not only proper foods and nutrients must be available in the household or community but also feeding behavior must be appropriate to ensure that food is delivered successfully to the child (WHO, 1998). What people actually do may or may not be consistent with patterns of reported behavior. Shaheen, (2007) represented that complementary food plays important roles in the diets of children, especially fruits, vegetables, and meats, expose the child to a wide variety of flavors, and provide essential vitamins and minerals. Appropriate weaning involves a combination of practices to maintain breast milk intake and, at the same time, improve the quantity and quality of foods children consume (WHO, 2002).

In the next paragraphs the researcher will illustrate about the research problem, the justification of the study, research objectives and the context of research.

1.2Research Problem

Weaning is the stage in baby's life when he or she passes through transitions from breast milk to other sources of nourishment. Whenever the mother decides to wean her baby it is important to understand that weaning is a gradual process that calls for patience and understanding from both the mother and her child. She must know when and how to wean as there are many perceived malpractices related to cultural and traditional issues, which may affect the physical and psychological status of the child. There, are many studies, which discussed BF, but until now, very little studies explored weaning practices, especially weaning malpractices. In Gaza, no studies have been conducted to assess weaning practices and this left to informational gaps related to weaning practices. We need to know what are the methods used in weaning in Gaza governorate. Are they dangerous? In addition, the study explores how these practices can affect child health? This study assesses weaning practices and the prevalence of malpractices; it explores factors related to weaning and suggests solutions to improve weaning malpractices. The study may lead to improve child mortality and morbidity. It is designed to gather and present relevant information from nursing mothers to determine the strengths and weaknesses of the relevant policies and programmes, which can help in protecting, promoting and supporting appropriate weaning practices, and in deciding what improvements needed to improve child health.

1.3Justification of the study

There is no doubt that exclusive breast-feeding (EBF) is the best feeding for infant until the age of 6 months (WHO, 2002). The pattern and duration of BF is one of the most important determinants of the child health status (WHO, 2002). As mentions before, in recent decades, numerous studies have documented the importance of BF and complementary feeding but little of them discussed weaning, although weaning is very important stage in infant's life and has a critical impact on child health. For weaning to be successful, not only proper food and nutrients must be available in the household or community but also feeding behavior must be appropriate to ensure that the food is delivered successfully to the child and gradual cessation of BF (Shaheen, 2007). This has highlighted the importance of studying this topic.

Since nursing is not only a source of food for a baby, but also a source of security and emotional comfort as well, abruptly withdrawing the breast can cause emotional trauma to the baby and can be very disturbing. There is absolutely no way to explain to the baby why he/she suddenly cannot nurse anymore (Ingram, 2004). Weaning gradually substitute other kinds of attention to help compensate for the loss of the closeness of nursing. This implies how we can prevent these emotional effects by proper weaning practices (Ingram, 2004). The assumption that in the Palestinian community there are have bad practices in weaning from the researcher's observation beside the lack of information; therefore, we need to explore in depth weaning practices, as mothers know a lots about breastfeeding, but they misunderstand weaning. They think that weaning means stop breastfeeding. They do not know how and when to wean. In addition, some cultural, social and economical factors lead to weaning malpractices.

Assessing weaning practices to recognize the different methods of weaning which the mothers do is very important to improve child health. Beside that, we cannot ignore the psychological impact of weaning on children and mothers. Moreover, weaning practices may influences infant growth rate, which have an important consequences on the child health. Thus, it is important to have weaning policy based on outcome studies in this area, which are currently lacking.

The value of studying weaning practices gains more importance in the Palestinian community which characterized by low food security level, high prevalence of malnutrition and bad sanitary condition. BF provides safe, hygienic, available and appropriate feeding sources. Appropriate patterns and practices of weaning in the Palestinian community and avoiding the factors which lead to unhealthy mothers, infants, families and society, will contribute to child health. This study will fulfill an important gap of information to improve maternal and child health.

1.4 Research Objectives.

1.4.1 General objective.

To explore weaning patterns and practices among mothers attending UNRWA health centers in Gaza Strip, in order to provide information that could support child nutritional status and subsequently it may impact the child health.

1.4.2 Specific objectives.

1. To assess weaning related to knowledge, attitude and practices among mothers attending UNWRA health centers in Gaza Governorates (GG).
2. To explore variation in weaning practices in relation to the family characteristics.
3. To identify the main gaps of weaning practices.
4. To provide recommendations and suggestions for improving healthy weaning practices.

1.5 Research questions

1. How mothers in GG are conceptualizing weaning?
2. What are the features of weaning practices in GG?
3. What are the dominant weaning malpractices in GG?
4. Do mothers initiate weaning early?
5. Do mothers start weaning gradually?
6. Are the social factors affecting the weaning practices?
7. What are the demographic factors that lead to weaning malpractices in GG?
8. Are there gaps in mothers' knowledge in relation to weaning practices?
9. How can we improve weaning practices?

1.6.1 Demographic context

The Gaza Strip is a narrow band of land located on the south of Palestine, constituting the coastal zone of the Palestinian territory along the Mediterranean Sea between Egypt and Israel. It is 45 Kilometers long and 6-12 kilometers wide with an area of 365 square kilometers (Palestinian Academic Society for the Study of International Affairs-PASSIA, 2008). Currently, the Gaza Strip is composed of five governorates: the North, Gaza City, the Mid Zone, Khan Younis and Rafah**.** The total population in the West Bank and Gaza is 3,761,646 million of them 1,416,543 million (67.9% are refugees) are living in Gaza Strip with a population density of 3988 persons/Km2 (Palestinian Central Bureau of Statistics-PCBS, 2009). The Palestinian society is considered a young population with 49.3% under 14 years (PCBS, 2009).

1.6.2 Political and economical context

The political and economical situation for around 1.5 million Palestinians in the Gaza Strip became worse than it has ever been since the start of the Israeli military occupation in 1967. However, Israel still holds overall control, over the Gaza Strip. It has the upper hand over borders, movement of goods and travelers in and out of Gaza, particularly the Palestinian themselves. It also controls trade, the commercial market, water, the main sources of energy the means of communications and the overall security. Hence, it still has a hold over the Palestinian economy. The war on Gaza that started on December 27 2008 has further deteriorated the already miserable situations (Palestinian Non-Governmental Organizations-PNGO, 2009). This situation has manifested itself in an increased unemployment rates-more than 50%. Poverty continues to affect large numbers in Gaza Strip and West Bank. As at the third quarter of 2008, 51% of Palestinians were living below the poverty line (48% in the West Bank and 56% in the Gaza Strip) and about 19% lived in conditions of extreme poverty and therefore were unable to meet their basic needs in terms of food, clothing and housing (WHO, 2009).

The described above situation has negatively affected the health status of the population including increasing poverty related diseases, malnutrition, anemia. In addition, the unprecedented division of Palestinians resulted in further mudding the waters and negatively affected the ability of health providers to meet the increasing needs and

demands of the population (NECC, 2008). This political and social deterioration affect the child health and have a role in mothers' decisions of pregnancy, breast-feeding and weaning practices.

1.6.3Health care context

Palestine experience in health care system is rather unique and complicated. The several years of occupation and the following unilateral withdrawal of the Israeli occupation while maintaining the siege did strongly influence the health care system in Palestine. The consequences of closures and separation constructed a great challenge for the MOH as it created obstacles regarding the accessibility to health care services, availability of drugs and food security level which affects the unity of the health care system in all Palestinian governorates (PNGO, 2009).

In Palestine, there are 4 major health provider; MOH, UNRWA, Non-Governmental Institutions (NGOs) and Private sector. MOH is the main health care provider; it provides primary, secondary and tertiary services. The secondary health care delivery system is a mix of governmental, UNRWA and private sectors. There are 24 hospitals in Gaza (general, specialized, rehabilitation, maternity) of which 12 are managed by MOH, 10 by Non Governmental Organization and two private. The total number of hospital beds is 1917 of which 1462 are managed by MOH, 416 for NGOs and 39 for private. The population per hospital ratio is 57,098 that are considered very low. This level of capacity makes it difficult for people to receive sufficient and adequate services (MOH, 2006).

The numbers of the primary health centers in Gaza are 45 governmental centers, 20 UNRWA centers and 31centers owned by NGOs. (MOH 56.5%, UNRWA 7.3% and 36.3% NGOs) (WHO, 2009). The UNRWA mainly provides primary health care services to the refuges population. It operates 20 health centers distributed all over Gaza governorates as follows :in Sorth Gaza there are 2 health centers Gaza there are 4 health centers and 4 in the Mid Zone,in Khan-Younis 4 health centers, in Rafah there are 3 health centers and 3 sub centers distributed in all areas (UNRWA, 2009).

Registered refugees in GG who served by the UNRWA are 838500 (about 80% of the total population). From them the estimated No of surviving infants are 36241; from

them 35783 infants are below one year and 97026 from 0-3 years. The total child health coverage rate is 95.3. Registered children 1<2 years are 31964; from them regular attendance are %63, Registered children 2<3years are 30531; %39 of them are regular attendance (UNWRA, 2008).

1.6.4Child Health Context

There is coordination between UNRWA and MOH services especially in the vaccination program, which is one of the most successful programs in Palestine with vaccination coverage 100% (PCBS, 2006). Child health indicators and their trends demonstrate the change of child health status over time. Infant mortality rates (IMR) are the most health indices that reflect socioeconomic level and status of a community. IMR in Palestine scored 25.2 deaths per 1000 live births in 2008 (UNRWA, 2008). The leading causes of IMR were low birth weight and prematurely (28.6%), congenital malformation (27.8%) and acute respiratory infections (18.2%). The cause of death in 7% of reported cases could not be ascertained. Around 40% died during the early neonatal period, 20.2% during the late neonatal period and 40.2% between 29 days and one year of age. IMR was higher among males than females, at 55.9% and 44.1% respectively. About 27% of children who died during 2008 were not hospitalized; this could be explained by the increased difficulties facing refugees to access hospital services due to limited funds allocated to subsidize hospitalization (UNRWA, 2008). .

Acute malnutrition is low, but stunting is increasing and levels of anemia remain very high. In 2006, wasting levels in children aged 6-59 months remained insignificant at 1.2% and stunting levels were at 13.2%, slightly above the threshold of 10% that is considered a public health problem, according to WHO standards (WHO, 2008). Anemia increased from 37.9% in 2002 to 47.9% in 2007, affecting nearly half of children aged under the proportion of children exclusively breastfed at 5 months in Gaza is 26.6%, although the proportion of children ever breastfed is as high as 97 %; initiation is not a problem while continuation is (WHO, 2009).

Regarding the psychological status of the Palestinian children, they have been exposed to a wide range of traumatic events since September 2000, Rate of Post traumatic syndrome in Palestinian children ranged from 40% after the stop of the first Intifada during the peace period to 10% during the peace process to 39% during this Intifada

(Thabet et al 2006) and up to 70% due to current shelling of Gaza Strip (Thabet and Vostanis, 2007). All these events affect the children behaviors.

The results of a research, conducted in Gaza in 2004, indicated that 32.7% of the children started to develop acute post traumatic symptoms that need psychological intervention, while 49.2% of them suffered from moderate level of post traumatic symptoms. Also the results showed that the most prevalent types of trauma exposure for children are for those who had witnessed funerals (94.6%), witnessed shooting (83.2%), saw injured or dead who were not relatives (66.9%), and saw family members injured or killed (61.6%) (Qouta, 2004). All the mentioned above issues must be considered in planning for weaning, as an appropriate weaning technique has an impact on the psychological status of the children.

The prevalence of exclusive breast-feeding among Palestine refugee infants is generally low (19.5% in Gaza). The mean duration of EBF was 2.7 months. BF and weaning have an important role in child health. A lot of studies discuss BF and its affect on the child health but till know no studies discuss weaning practices and its effect on the child health. In this study, we will discuss the weaning practices and how to improve the child health**.**

1.7 Operational Definitions

Weaning is gradual process of cessation of BF and introducing of complementary feeding. It is the provision of any nutrient containing foods or liquids other than breast milk and includes both solid food and infant formula (WHO, 2005)**.**

Breastfeeding: BF can be defined as a child has received breast milk direct from the breast or expressed from the mother's breast (WHO, 1994)**.**

Exclusive breastfeeding: No other liquid or solid from any other source enters the infant s mouth except BF (WHO, 1994).

Practice: Do or perform often, customarily, or habitually, style of behavior regarding breastfeeding (Brunner, 1996).

Malpractice: may arise from a person's misconduct or failure to use adequate levels of care, skill or diligence in the performance of any duties that causes harm to another.

Feeding practice: the techniques that are used to feed babies (WHO, 1994).

Complementary feeding: It is any additional food given to the breastfeed infant

Knowledge: Refers to the state or condition of understanding that fact or subject and being able to apply it (UNCIEF, 1992)

Attitude: Favorable or unfavorable evaluative statement concerning object reflecting how one feels about it.

Subra Murra is a plant that grows in the Middle East .It is over green one and scientifically known as (Aloe, Vera). It has no poisonous extraction**.**

Isolation: The child stays away from his mother more than 24 hours and does not sleep with her in the same house

Large clinic: The clinic which has afternoon shift or its staff is more than 50 employee

Small clinic : The clinic which dose not have afternoon shift or its staff is less than 50 employee

Chapter 2: Literature review

2.1 Conceptual framework

The conceptual framework is the conceptual map that guides the implementation of the study and it is an efficient mechanism for illustration and summarizing the study variables in a figure.

This chapter describes the factors that influence the weaning process which are the main variables of the study. The identification of these variables was based on researcher's experience and the literature review. These factors are related to the cultural factors, the socio-economic factors, the economic factors and the health services.

2.2 Components of the conceptual framework

2.2.1 The socio-demographic and economic related factors:

The study assumed that the socio-economic related factors have a direct impact on the weaning process. These factors include mother's age and education, father's age and education, type of family social relationship, mother's occupation, number of children and family size. The economic factors which include the income, the relation between the economic factors, the decision of weaning and weaning practices all these variables may have an important role on the weaning process.

2.2.2 The cultural related factors:

The cultural factors explain the relationship between the culture, weaning practices and the decision about weaning. These include mothers' believes and attitudes toward weaning practices, the role of the gender, the role of mother in law and her knowledge about weaning and the usage of alternatives and its effect on the approach of weaning. At least hypothetically, one can say that the cultural factors are very important in weaning practices.

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2.2.3 The health services related factors

No one can deny that one of the most important keys to improve weaning is the health care providers who should have knowledge, experiences and training. In additions to the role of counseling in the MCH related to the BF, complementary feeding, weaning approach, time and the technique of weaning is crucial.

2.2.4 Mothers' knowledge, attitude and practices

Mothers' knowledge about BF and weaning affect their attitude and practices. The technique of weaning, which used by the mothers reflects their background, culture and knowledge.

Finally, all the above components and their related factors work together affecting weaning practices.

2.3 Literature review

This chapter the researcher presented the reviewed literature regarding to BF, complementary feeding, weaning definition, weaning approach, factors affect weaning, causes of weaning, the effect of weaning in child health and weaning in Islam.

2.3.1 Breast feeding

BF is recommended as the preferred infant feeding method because of the nutritional value and health benefits of human milk (Labbok, 2000). Exclusive BF is recommended for the first 6 months of life with continued BF supplemented with appropriate solid food till the infant's second birthday (Labbok, 2000). BF has benefits for the baby and for the mother. The benefit of BF for the baby go beyond nutrition; human milk provides different kinds of defense against disease as intestinal and respiratory diseases; in addition, the bond that develops between the mother and the child during BF, is fundamental to the child's overall physical and psychological growth (Bennett and Brown, 1993).

BF not only has benefits for the child but also has benefits for the mother, as it decreases the risk of postpartum hemorrhage, early returned to pre pregnancy weight as

well, reduces the risk of ovarian and breast cancer and help in family planning. Also, it has an economical benefit (Labbok, 1994).

The duration of BF should be 2 years. All studies that include the duration of BF as a variable; show that, the longer a baby is nursed, the better its health and cognitive development will be. For example, breast-fed children have fewer allergies, fewer ear infections, less diarrhea and lower risk for sudden infant death syndrome (a rare but devastating occurrence). Breast-fed children also have higher cognitive test scores and lower incidence of attention deficit hyperactivity disorder (Dettwyler, 1997).

2.3.2 Complementary Feeding

Feeding baby in the first year of life is an exciting adventure for parents and babies alike. It is about development, nutrition, exploration, sharing and learning. Mothers can help their babies develop a lifetime of healthy eating habits with the right start (CPS, 2005).

At 6 months, most babies cannot get everything they need from breast milk or formula alone. Though mother can continue to breastfeed until her baby is 2 years and beyond, at 6 months she will start to introduce other food to her baby (Lanigan, 2001). Baby is ready to start other foods when he/she: seems hungry earlier than usual, can sit up without support, has good control of his neck muscles, holds food in his mouth without pushing it out on his tongue right away, shows interest in food when others are eating, and opens his mouth when he sees food coming on his way. The child can let his mother know that he/she does not want food by leaning back or turning his head away. There are many ways to introduce solid food (Lanigan, 2001). The first food usually varies from culture to culture and from family to family (Shurbasi, 1994).

There was strong association between nutrients intake and growth. Early introduction of formula to the infants may lead a mild degree of stunting. Mothers should be educated on the appropriate feeds for each stage in the growth of the infant and the appropriate time for introduction of such food （Abidoye, 2000）.

The choice of complementary food are affected by factors like family dietary pattern, influence of elders, culture and customs, beliefs of food taboos, previous experience of parents, agriculture, geography and climate. In developing countries, the age of

introduction of complementary food to breast fed infants has public health importance because of the risk of diarrhea from contaminated weaning food, and the potential risk of growth faltering if appropriate food is delayed (Shurbasi, 1994).

In addition, some types of food are not recommended in child feeding. Avoid using sugary drinks or foods, such as candies, soda/pop or energy drinks and honey to babies under 1 year old, as there is a risk of infant botulism (food poisoning). To reduce the chances of an allergic reaction, avoid giving egg whites until your baby is 1 year old. If you have a family history of allergies, you may want to wait until your baby is 3 years old before introducing peanuts, tree nuts (such as pecans or walnuts) or shellfish (Lanigan, 2001).

A rapid assessment survey was undertaken in Bahrain related to complementary feeding. It finds out the current practices of infant feeding and the impact of educational level of the mothers on these practices. Among 2000 Bahraini mothers of children less than 2 years, the researcher found that highly educated mothers tended to introduce rice, wheat, infant formula and fruit at an earlier age of the infant's life than lower educational groups. In addition, infant cereals are used more often in urban than in rural areas of low socioeconomic status. Moreover, other studies found that working mother seems to cause earlier introduction of complementary food. The type and location of women's work may affect child-feeding practices (Shirley, 1998**).**

Good complementary feeding depends on nutritional quality of complementary foods, access to and control of cash income. Most mothers think of complementary feeding as a replacement of breast milks not an adding up to it. They usually replace BF with whole meals and decrease the frequency of BF instead of maintaining it (Lanigan, 2001).

2.3.3 Weaning

Although weaning practices are very important topic related to child health, there are a few regional studies related to it. These studies discussed how to introduce complementary feeding only and no regional studies explain how to stop breast feeding.

Weaning is defined as‘‘ the introduction of solid feeding and the gradual replacement of BF by solid food as the main source of nutrition"(WHO, 2002). In a publications about

BF the WHO uses the term weaning in a more limited sense to indicate gradually cessation of BF and introducing of complementary feeding which is the provision of any nutrient containing foods or liquids other than breast milk and includes both solid food and infant formula. When starting to give foods other than breast milk, it is called weaning. Most parents consider weaning to mean completely stopping BF (WHO, 2002).

Attempted weaning referred to an event of purposefully not BF with the intention of completely weaning the child, or carrying out an action (e.g., placing bitter substances on the breasts) that the mother assumed would lead to complete weaning. A weaning event was not defined by a specific time and might have ranged from less than a day to 3 months or more. Relactation involved the reintroduction of BF to the child after weaning. Here, the intention of mothers reintroduced BF not to appease the child momentarily but to continue BF for nourishment, comfort, and other benefits for an unspecified duration (Marquis, 1998).

2.3.4 Causes of weaning

The major reasons why mothers stop BF at various times during their child's first year should be useful to health professionals when attempting to help mothers overcome BF barriers. The decision to stop BF is often complex. Research on BF cessation has been limited with regard to the social and economic issues that may influence the behavior of low-income women. The results support the need to develop interventions and policies to improve weaning practices (Dettwyler, 1997).

The perception that infant was not satisfied by breast milk alone was cited consistently as 1 of the top 3 reasons in the mothers' decision to stop BF regardless of weaning age. Mothers' concerns about lactation and nutrition issues were the most frequently reasons for stopping BF during the first 2 months (Obrien, 2007). Starting from the third month, self-weaning reasons were increasingly cited as important, with the statements "My baby began to bite "My baby lost interest in nursing or began to wean himself or herself, and "Breast milk alone did not satisfy my baby" cited as the top 3 reasons at > or = 9 months of age (Obrien, 2007)

As for mothers' reasons behind stopping BF, they mentioned child's biting of nipple; mothers' need to sleep at night, mothers' pregnancy and child's refusal of breast milk. In general, women agreed that no one affects their decision on how or when to stop BF their children, however sometimes they listen to their husbands and mothers in law which can make an effect on how to breastfeed children (Shaheen, 2007).

In a study about BF and weaning in a poor urban neighborhood in Cairo, Egypt about maternal beliefs and perceptions, the researcher found that weaning is ideally related to developmental milestones (walking, complete dentition) but often occurs early due to a variety of factors including maternal illness, desire for another pregnancy, and perceptions that breast milk may be inadequate. Weaning is perceived to be a difficult and dangerous transition. The timing of weaning may be influenced by perceptions of summertime as a time of heightened risk of diarrhea by the mothers' decision regarding fasting during Ramadan, and by a desire to minimize the period of vulnerability to illness (Harrison, 2006).

In a study sought to identify the reasons provided for BF cessation among women who switched to formula feeding during the first six months postpartum, and to investigate the socio-demographic characteristics of weaning showed that women who ceased BF before six months postpartum, were concerned with insufficient milk supply, baby weight gain and the baby not sleeping through the night. Additionally, the likelihood of selecting a particular reason for weaning was influenced by the woman's demographic and psychosocial characteristics. The main reasons included the mother's and father's usual occupations, maternal age, parity and obtaining BF information before pregnancy. Two components, maternal comfort and Infant comfort were identified as the main reasons for weaning. Reasons for stopping BF are frequently associated with the mother's confidence in her BF ability, and her perception of the impact of BF on the comfort and wellbeing of both herself and her infant (O'Brien, 2007).

Sometimes a mother is pressured to wean, even though both she and her baby are enjoying BF. She may wean for one of the following reasons: milk quality or quantity**,** going back to work**,** sick baby or mother, troubles with biting, refusal to suck**,** return of menstrual cycle**,** pregnancy and still BF**,** community pressure and BF Problems **(**Australian Breastfeeding Association, 2003**).**

Working women is one of the main cause of weaning .Women who work outside the home have a shorter duration of BF, and intentions to work full time are significantly associated with lower rates of BF initiation and shorter duration. Working women who are faced with too many barriers to continue BF take off more sick days for their children as compared with women who continue to breastfeed while back to work. Several studies indicate that support for lactation at work benefits individual families as well as employers (Eglash, 2007). The women did not go to work in the fields farthest away from the house as long as their child was less than a year old (Sears, 2003).

A paper presents the qualitative part of a traditional community in East Bhutan, investigates the effects of BF, weaning and subsequent pregnancy of the mother on child health. Quantitative data have shown that children who are weaned during a subsequent pregnancy of the mother have a reduced weight gain and an increased incidence of infectious diseases during weaning, while this is not so for children weaned from non-pregnant mothers. In-depth interviews with 35 women with experience from BF were carried out in order to obtain qualitative data regarding the processes underlying the mothers decisions during weaning (Bohler, 1999).

2.3.5 Appropriate time of weaning

There was a major change to the age of weaning during the period 1975–1980, after publication of the 1974 infant feeding practice report, recommended "about four months" as the minimum age for the introduction of solids. Before the later report, weaning often occurred at younger ages. Interestingly, in 1980 and 1988, the WHO suggested "few infants should require solids before 3 months and most by 6 months". Then, in 1994, the WHO report about weaning and the weaning diet suggests that mothers should begin to introduce solid foods at 4–6 months of age. However, despite a movement towards later introduction of solids between 1995 and 2000, many mothers seem still either unwilling or unable to follow the WHO recommendations. Recently, the recommendation of WHO is exclusive BF for at least six months as the optimal mode of infant feeding, with the introduction of solid food (WHO, 2002) .

The key to understanding infant feeding policy is an important issue for the age for the first introduction of solids food. Early diet has an immediate effect on the health of infants in economically developing countries because of factors such as the lack of

availability of suitable alternatives to breast milk, microbial contamination of food and fluids, displacement of breast milk by less nutritious alternatives, and return to fertility associated with the cessation of lactation. In fact, there is evidence to support the continuation of exclusive BF in early life to reduce morbidity and mortality among infants in economically developing countries (WHO, 1998).

Data from the 2000 Infant feeding survey in Johannesburg have been published and showed a movement towards later introduction of solids, with 24% of mothers weaning by 3 months of age compared with 56% in 1995. However, 85% of mothers in 2000 had still introduced solids before 4 months (Tjale, 2001).

Another important determinant of the appropriate age for weaning is the physiological maturity of gastrointestinal and renal function. Foot in 2003 said that there are concerns, firstly, that the high permeability of the young infant is digestive tract may permit large foreign proteins to penetrate and provoke immune sensitization. Secondly, that food with a high solute load may result in the need to concentrate urine to a degree that exceeds the capacity of the young infant's kidneys. This second concern would be especially relevant in the presence of diarrhea. However, this concern seems unfounded in relation to the early provision of solid food to infants in western industrialized countries because hypernatraemia is rarely seen in the first six months of life since the reduction in the use of cows' milk and high osmolar formulas. A further consideration in determining the optimum age to introduce solids is the interference of non-breast milk foods with the bioavailability of important nutrients found in breast milk, including iron and zinc (Foote, 2003).

In a study about weaning, mothers were asked also an imaginary question, assume that all influencing factors were removed, when and how they would wean their children. Most of the mothers agreed that they would follow optimal BF practices i.e. practice EBF from birth to 6 months of age, and introduce complementary foods at 6 months of age while continuing to breastfeed up to 2 years and stop BF gradually. However, few of them insisted on practicing sudden weaning and to continue BF up to one year only (Dettwyler, 1995).

A small-scale, prospective study of BF and weaning practices was conducted in northern Tanzania, focus group participants suggested that weaning patterns are strongly

influenced by seasonal factors, and mothers often stated an intention to introduce adult staple food and terminate BF at the end of the long rains. However, a combination of maternal self-perception, assessment of infant well-being, and indicators of household food supply influenced the actual progression of weaning for individual children. The results of a study conducted in rural East African pastoral populations suggest that interventions to promote EBF and improve complementary feeding practices could build on maternal attention to infant centered cues and address household-level constraints on caregivers making decisions about young child feeding (Daniel, 2001).

The consequences of inappropriate weaning carry a lot of risks. Too early initiative of weaning is a risk factor for both increased morbidity due to diarrhea and food allergies, as external challenges are introduced into the immature digestive tract, and of infant malnutrition set in due to the normal decrease in maternal milk production as the baby is withdrawn from the breast. On the other hand, too late weaning can lead to faltering growth, decreased immune protection, and again increased diarrhea disease and malnutrition when exclusively BF becomes inadequate. Inappropriate choice of weaning foods can lead to protein energy malnutrition and an array of micronutrient deficiencies (Foot, 2003).

A study was conducted to describe the weaning practices of women resident in the inner city of Johannesburg, whose babies were between the ages of 6 and 9 months show that BF was initiated by most women at birth. By four months only 25% of women were exclusively BF. Early weaning was associated with poor quantity and poor quality of breast milk. Partial BF is practiced and women use a variety of milk formulas to substitute breast milk. Dissatisfaction with milk insufficiency was the reason for stopping breast feeds. The research findings suggested that the information given by women on appropriate time of introducing solids differs from that of health professionals (Tjale, 2001).

Most primates wean their young when the first permanent molars begin erupting. Some scientists have suggested that this is because a child's immune system reaches maturity at about this same time; a possible indicator that full immune protection was in breast milk. Although children at this age receive little immune protection from breast milk

because of changes in our biology, some advocates of extended BF feel that this is still an emotionally natural weaning age (Juniper, 2009).

In a study in Gaza and West Bank about BF, most of the mothers agreed that BF must last for one to one and half year. Few groups especially in Jenin mentioned that it should last up to two years while a few women in Gaza said that the decision to stop BF depends on their circumstances and there is no specific rule for them (Shaheen, 2007) .

2.3.6Weaning approach

When the mother and her baby are ready to wean, there are few things to remember that will make the experience a more positive one for both. It is easiest for mother and her baby if weaning is gradual – over several weeks, months or even longer. A sudden, abrupt wean should only be considered in extreme circumstances and is hard on both of them (Foote**,** 2003)**.**

According to Canadian Pediatric Society (CPS) Public Education Subcommittee the transition to weaning may be easier if introduce the baby to a cup instead of a bottle. Breastfed babies easily learn to drink from a cup as early as six months of age start by substituting one feed, the least 'favorite' one of the day. Someone else may need to offer this feed for the baby to accept it. The next least favored feed at the opposite time of the day. Continue this way, substituting one feed at a time, the slower the better. Waiting at least a few days in between each new feed before substituting another one (CPS, 2005).

A partial weaning can be used, this means substitute one or more BF with a cup or bottle and breastfeed at other times. This can work well if mothers are going back to work but still want to breastfeed. During this, make sure checking baby's weight gain regularly. If breasts are uncomfortable while weaning, cold compresses or gel packs applied to the breasts can also give some comfort. Some drugs like acetaminophen or ibuprofen can also help (Daniek, 2001).

Some mothers choose what is called 'infant-led weaning'. This means watching the baby's cues and weaning at his pace (that is, never refusing the breast but also not offering the breast when the baby is not interested). With infant-led weaning, BF may

continue for two to four years. This type of weaning is practiced by many non-western cultures (Foote**,** 2003).

Juniper, (2009) in his research about weaning, said that the mother must be sure to involve baby's feelings in all steps. The breasts have become the baby's main source of comfort, so wean slowly is important. It is also better for mother to go slowly, as her breasts would become much engorged otherwise, possibly leading to infection. She cans try to start the process about two months before her desired cut-off date. Beginning by substituting one meal a day with a bottle or cup is good. (A cup is probably better, as she will only have to break him of the bottle habit soon, anyway). Reduce feeding to sleep are generally the hardest to drop as it may be the only way the child will have a nap, go to sleep at night, or settle again in the middle of the night. Plan a change of routine gradually so not feeding to sleep (e.g. feed in another room), but give as much time, love and comfort as you can when putting your child to sleep, singing, rocking, reading a story, patting her, whatever helps. Gradually reduce the time at the breast to just enough to settle, placing the emphasis on the story, song etc rather than on the breastfeed.

Gradually weaning can be done by stretching out daytime feeds and gradually increasing the time between the sleep-time feed and actually putting him to bed, so that they are no longer associated, and then the feed can eventually be dropped. Distractions and persuading the child to take substitutes seem to be the most satisfactory answers for weaning off daytime feeds. Having set times for feeding e.g. only at home, only after lunch, no in-between snacks, anticipate boredom, restlessness and the need for a change of activity (Juniper, 2009).

Offering something novel as Ice blocks, ice in a mug, frozen yoghurt, drinks or favorite snacks can help to distract him. Avoid morning feeds. If the mother shares her bed with her child and she usually has an early morning feed, she could try getting up before he/she wakes. The mother should be already dressed, so he/she may forget about the breast, and go to breakfast and play. And, use older children or father to help distract him/her (Tjale, 2001*).*

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In addition, avoid wearing clothes that allow easy access to the breasts, and avoid undressing in front of the child, as this tends to be a reminder. Changing the routine and using helpful friends or relatives may be able to look after the child during the day to help change a routine, with mother close by if needed. A child usually reacts differently with people he/she knows well and will take substitute drink and food and forget a favorite breastfeed. Also, cutting out night feeds may be the hardest to stop because of convenience. The mother must try all the ideas that suggested sleep without a feed and be prepared for a very gradual changeover from feeding for comfort (Rhona, 2003).

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Discourage long feeds if the mother has always left her baby at the breast until she has finished the feed by herself, or fallen asleep, it may take time for her to accept that making feeds shorter. Mother can try to substitute something interesting e.g. *'Come on, get down, we'll go for a walk.' Or, 'We will just have a little feed and then we will go and see if Grandma is home.' An older toddler might like to count the sucks* (Tjale, 2001*).*

According to Dr. Shaheen study, (2007) almost all mothers accept to wean their children gradually. Few mothers in Halhoul and Arraneh agreed that complete weaning of BF should be done suddenly. Mothers mentioned several reasons behind why they prefer gradual weaning over sudden and they are mainly: better for the mother's and child's health and his psychology, prevent breast from becoming engorged, sore and decrease breast milk gradually, prevent pregnancy, keep strong bonds between the mother and her child and give mothers chance to find different alternatives to feed their children. On the other hand, women who were in favor of sudden weaning came up with different reasons where they claimed that gradual weaning: makes the baby upset and cranky most of the time, causes breast pain, psychologically is not good for the child, if the mother is pregnant, sudden weaning is better for her and it keeps the beauty of her body.

2.3.7 Traditional methods

Regarding weaning practices, because of children's attachment to BF and to their mothers, they face difficulties to wean their children completely so they put some thing bitter "*sabra mura*"or red substance on the nipple. This practice is very traumatizing to the weaned children and usually they develop sickness after that (Shaheen, 2007).

The pacifier, a non-nutritive sucking device, is commonly used for calming infants. The WHO/United Nation's Children's Fund (UNICEF) initiative recommends avoiding pacifiers in breastfed term infants because it is thought to lead to early weaning. Most studies that found early weaning to be associated with pacifier use were observational in design. The results of researche imply that pacifier use may be a marker of BF difficulties or decreased maternal motivation to breastfeed, as opposed to being the causal agent in early weaning (Marilyn, 2002)

BF mothers may be confused and flustered by pressure from outside groups and their families to wean prematurely (Dettwyler, 1995). Many of the mothers described difficulties with termination of BF. Some had tried several times before they managed to stop. Often this was described as a kind of negotiation between the mother and her child, where different methods, verbal and physical "arguments" were used (Bohler, 1999)

Bohler (1999) said that, when the mother felt it was time for weaning she would often tell the child that her milk had "gone bad", in order to discourage BF. For the same purpose, it was common to paint the breasts with the juice of a species of chrysanthemum much used in local traditional medicine. The juice is black and has a bitter, nauseating taste (Bohler, 1999). Some also painted the breasts with a mixture of ashes and water. Usually it was sufficient to do this for one day, but one mother told she had done it for three days. The child vomited, but continued to try to drink, so in the end the mother gave in and let it continue. Some mothers had been separated from the child for one night or more in order to make the child stop BF. The use of physical means as mentioned here, were reported by mothers who had been pregnant (Marquis, 1998). The use of similar means for weaning as in our study has also been reported in neighboring.

2.3.8 Effect of weaning on child's health

The process of weaning is often associated with an elevated risk of infant mortality and morbidity because infants no longer receive passive immunity from their mothers, and they are exposed to new sources of infection through the weaning diet (WHO, 2002). The process of weaning has also been tied to the duration of the contraceptive effects of

nursing and the return of fecundity, which in turn provides information about birth spacing and population growth. Some of the basic assumptions about nursing and weaning, and their effects on morbidity, mortality and population growth, have been challenged, based on new technical and cross-cultural information (Marquis, 1998).

There is also interest in the nutritional implications of the transition from breast milk to solid foods (Katzenberg, 1995). Weaning too early, before the age of 4 months, is associated with an increased rate of minor morbidity, and jeopardizes the continuation of lactation. On the other hand, delaying the introduction of solids beyond the age of 12 months has been associated with increased risk of malnutrition (WHO, 2002).
Weaning before 12 months was associated with short-term negative and traumatic consequences. These included a reversal in motor and language development (walking, speech acquisition, eating skills), emotional disturbances (intense sorrow, resentment, crying, and temper tantrums), learning difficulties, and physical problems (illness, weight loss, loss of appetite and sleep). The consequences that worried mothers the most were crying, loss of appetite, and weight loss. Crying was reported to go on for a few days, a week, or even more. Mothers frequently spoke of the sorrow that they experienced when their children cried during weaning (Marquis, 1998).

BF was found to fulfill a valuable social function in addition to its biological and emotional properties. The breastfed child had an indubitable “right of access” to the mother's care, not only her breast, whenever she wanted, but to all that the mother can provide of warmth, care and comfort. To some children the "loss of breast means loss of mother too" (Jane, 2006).

This child also assumed a status in the family in which its vulnerability, its special needs and its value were clearly recognized. The mothers expressed a basic motivation to breastfeed “as long as possible”. There were, however, important limitations as to how this was manifested in the practical weaning process. If the mother was pregnant at the time of weaning, these limitations tended to be mother-centered (Chen, 2008).

Children at the same age who were not breastfed were often taken further away by their caretakers, and the mother would not know exactly where the child was. BF thus provides the child with an indubitable right of access to the mother, irrespective of its

age. This "right of access" is not only to the breast. It can be hard to balance the needs of mother and child in the cooperative venture of weaning. Many mothers find themselves thinking about weaning before the child is ready, while others experience disappointment when their baby initiates weaning earlier than expected (Bohler, 1999).

Small children always slept together with someone, both for warmth and for comfort. All the breastfed children, even the oldest ones, slept with their mother, and had "free access" to the breast at night. Their BF at night was said not to disturb the mother much; she would fall asleep again while the child was BF. After BF was terminated, most of the children stopped sleeping with their mother. If the mother was pregnant, this happened more often than if she was not. A few continued sleeping with their mother also after birth of the younger child, but the mothers who reported this said that the elder child was now "moved from sleeping in front of me to sleeping behind me"(Sears, 2003).

A breastfed child always asked for breast milk, even if the mother is busy. A child who was weaned did not have this indubitable right to her. Its needs could always be handled by others, for example, elder children. This was reflected in the situation we usually met when coming to a house with a small child. Often the child was looked after by its elder children. If the child was still breastfed, it would seldom be far away from its mother, and she would always know where it was (Sears, 2003).

2.3.9 Factors affect weaning practice

International studies have identified certain factors that affect weaning such as employment, social attitudes, culture and the variable standard and content of the advice given to mothers by health workers. Some common factors identified from previous studies include personal perceptions, employment and employer support, husband involvement, social attitudes, social support, public facilities and advice given by health workers. Mothers, knowledge and attitudes followed by husbands support were identified as important in influencing infant feeding choice too (Ingram, 2004).

If the mother and her child both enjoy nursing, and her only reason for weaning is that she is under pressure from other people who think she should, then she need to look

further for outside support of her decision to continue nursing. If the mother no longer enjoys nursing, or if there are legitimate pressing reasons for her to wean, should do it and feel good about the time she did nurse, without feeling guilty about what might have been (Smith, 1998).

In addition, inexpererienced mothers, mothers education, culture and nature of the family, health status of the infant and environmental factors and others traditionally, mothers in law possess significant authority over child weaning practices as they claim to represent the credible and authoritative reference for newly married couples within the extended family structure. Although the influence of mothers in law is rather changing, it is still believed by many professionals that mothers in law are still playing a crucial role in how children are fed, reared and raised specially in the early years of children's lives (Dettwyler, 1995).

In a study done by Shaheen, in 2007 mothers in law indicated that weaning should start around the age of 1.5 years of the child age. Other women indicated that mothers should continue BF if there are no other reasons to prevent them such as becoming pregnant. Some women indicated that women stop BF in order to get pregnant as they believe that BF can delay pregnancies. Mothers in law think that mothers should start early before weaning her child by introducing other foods so it can make weaning easier. In general, the interviewed mothers in law were in favor of extended BF from year and half to two years as long as the mother is not pregnant, while the child can still receive other available foods prepared by the family.

Moreover, the interviewed UNRWA staff mentioned the workload does not allow them to give the mother the needed time for counseling about different BF and weaning problems and constrains. In general and with some variations, the interviewed health care providers have reasonable level of knowledge concerning BF, complementary feeding, weaning, and growth monitoring and most of the time they used the phrase of “according to WHO recommendations” (Shaheen, 2007).

In a paper presents the qualitative study in a traditional community in East Bhutan, which, among other items, investigates the effects on child health of BF, weaning and subsequent pregnancy of the mother. Quantitative data from the study have shown that children who are weaned during a subsequent pregnancy of the mother have a reduced

weight gain and an increased incidence of infectious diseases during weaning, while this is not so for children weaned from non-pregnant mothers (Smith, 1998).

The interaction between the child and his/her mother during the complex process of weaning, and the change in social status, which the child goes through, show considerable variation between cultures. There are indications that one of the most influential factors is whether or not the mother is pregnant at the time of weaning Children who are weaned during a subsequent pregnancy have a reduced weight gain and an increased incidence of infectious diseases during weaning, while this is not so for children weaned at the same age from non-pregnant mothers. Effects on child health of weaning from pregnant vs. from non-pregnant mothers have rarely been compared in other studies. However, in Senegal, weaning from pregnant mothers was more closely associated with increased child mortality. The quantitative data have also shown that the presence or absence of a new pregnancy significantly influences the time and mode of weaning. However, such data give little information about the mother's decisions during weaning, or the relationship between the mother and her child at the time of weaning. Qualitative data are needed to investigate in greater detail the dynamics of the weaning process (Raphael, 2003).

There are many reasons you may need to wean your child. Women who choose to let babies wean themselves often become extended breast feeders, sometimes nursing their child for several years. Although that is perfectly healthy, many women may feel that is a long time to be tied down BF. Also, a mother who is returning to work may not be able to keep her supply up with pumping alone. It is also hard for many women to get pregnant while nursing, so fertility issues may be the reason behind weaning (Raphael, 2003).

Researchers have normally considered weaning to be a non-reversible event. Factors that influenced feeding decisions were primarily related to maternal and child health, and maternal time commitments. Children were weaned when there was a perceived problem of maternal health or time commitments and child health was not at risk of deterioration. Mothers postponed weaning because of poor child health. The primary reason for relactation was a child's negative reaction to weaning (e.g., incessant crying or refusal to eat). Personalities of the mother and child were important determinants of feeding decisions. These results demonstrate that maternal and child factors jointly

influence child-feeding decisions and that these decisions are easily reversed. As relactation is culturally acceptable, health practitioners should consider recommending relactation when children have been prematurely weaned and human milk would improve their nutritional and health status. Health professionals should recognize that relactation is a feasible and culturally acceptable recommendation for young children who have been prematurely weaned. Relactation, therefore, is an feeding option that can be recommended to mothers when human milk would continue to be beneficial to the young child (Marquis**,** 1998).

2.3.10 Weaning and Islam

The Islamic religion through Qur'an and Prophet Mohammad's sermons (PBUH) encouraged mothers to breastfeed strongly for two years. The religious leaders agreed that nowadays, mothers do not breastfeed frequently because they are forced to go outside for work even if women are not educated, for instant they go to farming or trading. Almost all of them mentioned they proactively counseling mothers about BF benefits because it is mentioned in Quran and they believe that at the human level, families should secure enough proper food for their children and BF is the first and the best for children (Sharwy, 1991).

Islam emphasized weaning and BF. The Holy Quran endorses the BF and weaning (*Mothers shall breastfeed their children for two whole years ;(that is) for those who wish to complete the BF. The duty of feeding and clothing nursing mothers in a seemly manner is upon the father of the child*)(The holy Quran, Al Baqara 233) *,"We have enjoined man to show kindness to his parents ,with much pain his mother bears him ,and with much pain she brings him into the world. He is born and weaned in thirty month*"(The holy Quran, 15 Al-Ahqaf15,). All of versus mentioned that absolute weaning should not happen before the two years of the child age as mentioned in the Quran as long as the mother has no contraindications such as pregnancy and sickness.

When probing and asking about given fluids or foods long with BF, Gaza religious advisors and one from Hebron were knowledgeable about the need to breastfeed exclusively up to six months. While the rest mentioned several inaccurate responses such as the child should be given water starting the first few weeks of life and up to 8

months and then add food since water is essential for life and juices have important multivitamins, others mentioned exclusive should last to 4-5 months and then add food (Shaheen, 2007).

(If they both decide on weaning, by mutual consent, and after due consultation, there is no sin on them.) (The holy Quran, Al Baqarah, 233). This verse indicates that if the father and the mother decide on the weaning before the two years (of BF) end, and for a benefit that they duly discuss and agree upon, then there is no sin in this case. So, the verse indicates that one parent is not allowed to make this kind of decision without duly consulting the other one, as stated by Ath-Thawri. The method of mutual consultation protects the child's interests. It is also a mercy from Allah to his servants, for his legislation the best method for parents to rear their children, and his legislation guides and directs the parents and the children to success. Similarly, Allah then said: (And if you decide on a foster breastfeed-mother for your children, there is no sin on you, provided you pay (the mother) what you agreed (to give her) on a reasonable basis.) meaning, if the mother and the father both agree that the father assumes custody of the child due to a circumstance that compels her or allows him to do so, then there is no sin in this case. Hence, the mother is allowed to give up the child and the father is allowed to assume custody of the child. The father should kindly give the mother her compensation for the previous period (during which she reared and breastfeed the child), and he should seek other women to suckle his child for monetary compensation (The holy Quran, At-Talaq, 6).

(And (the period of) his gestation and weaning is thirty months,) `Ali Ben Aby Talleb may Allah be pleased with him, used this verse along with the following two verses to prove that the minimum period of pregnancy (gestation) is six months (And his weaning is in two years.) and (The mothers breastfeed their children two complete years -- for those who desire to complete the term of BF.) (Sharwy, 1991).

" Ibn Abi Hatim related from his father that Farwah bin Abi Al-Maghra' told them that `Ali bin Mushir narrated to them from Dawud bin Abi Hind, who narrated from `Ikrimah that Ibn `Abbas, may Allah be pleased with him, said, "When a woman delivers after nine months, the baby will only need twenty-one months of BF. When she delivers after seven months, the baby will need twenty-three months of BF. When she delivers after six months, the baby will need two full years of BF, because Allah says,

(and his gestation and weaning is thirty months, till when he/she attains full strength)." meaning, he/she becomes strong, youthful, and attains full ability (Islahi, 1986).

Luqman said to his son when he was advising him: "O my son! Join not in worship others with Allah. Verily, joining others in worship with Allah is a great Zulm (wrong) indeed.") (And we have enjoined on man (to be dutiful and good) to his parents. His mother bore him in weakness and hardship upon weakness and hardship, and his weaning is in two years -- give thanks to me and to your parents.

In Surah Baqarah, the directive of weaning has been mentioned in detail: And [after divorce also] mothers shall breastfeed their offspring for two whole years, for those who desire to complete the term. And the child's father [in such a case] shall have to bear the cost of their food and clothing according to the norms. But if they both decide on weaning by mutual consent and after due consultation, there is no blame on them. And if you decide to engage someone else to suckle your offspring, there is no blame on you, provided you pay [the mother] in accordance with the norms [of the society] what you promised. But fear Allah and know that Allah sees well what you do (The holy Quran, Surah Baqarah , 233)

Imam Amin Ahsan Islahi, while summarizing the explanation of BF that these verses mention, said that it is the responsibility of a divorced lady to breastfeed her child for two full years in case the husband wants her to complete the total BF period. During this period, it is the responsibility of the father to provide his divorced wife with food and clothing, keeping in view the norms of the society. In other words, the status of the husband, the needs of the divorced wife and her own status shall be kept in consideration while providing her this maintenance.

If through mutual consent and consultation, the estranged husband and wife decide to terminate the BF period before two years, they can do so. If the child's father or, in his absence, the heirs of the child want to breastfeed the child through some other lady instead of the mother, they are authorized to do so provided what has been agreed with the mother regarding her maintenance is fully honored (Islahi, 1986).

Chapter 3: Methodology

This chapter presents the study methodology, demonstrates study design, type of study sample, study population and ethical issues considered. In addition, it presents the instrument, which was used in the study, its validity, data collection process, data processing and analysis. Finally, it presents selection criteria

3.1 Study design

The design of this study is a cross sectional descriptive analytical one as it describes weaning patterns and practices among mothers in the Gaza Strip UNRWA clinics. Cross sectional design were chosen because it is useful for descriptive and analytical purposes. It is less expensive than other designs and enables the researcher to meet the study objectives in short time. In this research, cross sectional design allows to provide an over all picture about the examined phenomenon by using the relationship among the variables and to compare differences among the study variable groups.

3.2 Study population.

The target population is mothers attending MCH with their children; mothers with their children of age group 6-24 months who visit the UNRWA primary health care centers in Gaza for immunization or medical advice, the number of mothers attending the UNRWA health centers for vaccination are nearly 35000 women in the year 2009 according to physical check out.

3.3 Period of the study

The study was conducted in February 2009 through November 2009, the researcher wrote the proposal through February and March. Then the researcher conducted the questionnaire in April. In May, ethical approval from Helsinki Committee was obtained. Piloting and data collection was done in September for 3 weeks. Than, one week for data entry and analysis. Writing the research results and the discussion were done in October. Submission was done in November 2009.

3.4 Setting of the study

Since the study was conducted in Gaza Strip, 6 primary health care centers are randomly chosen as described in sampling process to be the work field in the UNRWA health centers since which was the major sector that covering MCH services.

3.5 Sampling process

To select the clinics from where the sample was drawn the researcher used multistage sampling approach. The Gaza Strip is divided into three strata as follows North and Gaza, the Middle, and the South. Using another stratification layer, the clinics were divided and listed into 2 categories; large and small clinics according to UNRWA classification. Through a stratified random selection, 6 clinics was then selected (3 large and 3 small).

To select subjects from clinics, the researcher calculated the average number of women attending the clinics to receive well baby care services. Based on the calculated average and the calculated sample size, 300 clients were divided into 6 clinics in the 3 areas 60 mothers with their children was the proposed study sample in every large clinic and 40 in the small clinic.

Depending on visits schedule-two days a week, one busy day and another regular day, the research selected all the mothers presenting to clinics at the day of data collection in case of their children met the criteria (child's age was from 6 to 24 months, and the child was already weaned).

3.6 Sample size:

The researcher used the statistical calculator of the Epi –Info to determine the sample size (Annex 4). A propositional sample of 238 mothers with their children of age group 6-24 months registered in UNRWA health centers during the year 2009 were selected randomly from the study population. The researcher increased the sample size to be 300 subjects to compensate for non-respondents.

3.7 Eligibility criteria

3.7.1 Inclusive criteria

Subjects should meet the following criteria

- Mothers with children between 6-24 months age presenting to the well and sick baby clinic.
- Mothers had weaned their babies.

3.7.2 Exclusive criteria

1- Nursing mothers who still breastfeed their children in the will and sick baby clinic.

2- Nursing mothers with their children in the well and sick baby clinic who were visiting the center for reasons other than receiving child care.

3.8 Ethical consideration

- Approval of Helsinki Committee in Gaza to conduct the study was obtained (Annex 5).
- Approval of UNRWA to carry out the study was obtained (Annex 6).
- Mothers of concern were informed through a written and oral consent about the purpose of the study and their right to optional participation (Annex 7).

3.9 Data collection tool

The researcher used self constructed questionnaire based on the literature review and field observation with consultation of experts in this field (Annex 8). The questionnaire was divided to three parts:

The first part included characteristic data about the participant such as child's age, sex; mother's age, education, occupation; father's education, occupation; family type, size, house ownership; family problem and child problem.

The second part included information related to BF and weaning such as EBF, duration of EBF, weaning age, reasons of weaning, weaning approach, traditional

method use, practices and believes about traditional methods, problems related to weaning, feeding before and after weaning and practicing gender discrimination.

The third part contained information related to mother's knowledge about weaning practices.

3.10 Pilot study

Piloting was done on 20 mothers with their infants who were selected through a convenient sampling from the three centers in the North of Gaza. Such procedure was done to test recruitment, response rate, validity and suitability of the questionnaire. Some revisions and modifications were introduced as a result of the piloting process. The pilot subjects were not included in the study sample.

3.11 Data collection

A face-to-face interviewed questionnaire was implemented for 300 mothers with their infants of age 6-24 months in the 6 health centers. The researcher collects the data by herself. After verifying the infant's age from child file, the researcher explained briefly the purpose of the study to each mother and confirms her right to accept or refuse the participation before filling the questionnaire. After obtaining informed consent (Annex 7), mothers were interviewed, and privacy and confidently was maintained all the time. After filling each questionnaire the researcher reviewed it, and checked the completion of the information. Additionally, to check the nutritional status of the concerned child, and the child's file checked for information about the child anthropometric to check weather the child is underweight or not.

3.12 Response Rate

Of the enrolled mothers, 285 have participated, and 15 of them refused to participate. The represented sample of the mothers in the study was 95%.

3.13 Validity and reliability

Many researchers have stressed on the importance of validity of an instrument. Validity is defined as "the extent to which a measuring instrument measures what it is supposed to measure" (Mark, 1996). In fact, when instruments measure what they are designed for, this is considered to be of great importance for their reliability and this start with conceptual relevance and simplicity of the instrument (Fagerstorm et al., 2000).

In this study Content Validity Index (CVI) were used to rate the relevance of the questionnaire. The technique of measuring variables must be reliable as this reflects the extent to which an operational definition, questionnaire or other instruments is stable and consistent (Mark, 1996). So, a measure is reliable, if it gives the same results each time the situation or the factor is measured. General measures of reliability and validity were implemented including*;*

reliability

- Standardization of data collection tools.
- Standardization of implementation methods.

validity

- Systematic checking and follow up of data collected.
- Data collection was done by the researcher herself.
- Data cleaning and checking.
- Use the child record to check of the information

3.14 Plan of data management

After collecting and revising the questionnaire, the next step was coding this questionnaire using the computer software Statistical Package for Social Science (SPSS) version 11. Then, the coded questionnaires were entered into the computer by the researcher with the help of the academic supervisor. Data cleaning was done through checking out a random number of the questionnaires and through exploring descriptive statistic frequencies for all variables. Means and stander deviations were computed for the continuous numeric variables and than coded. In addition, chi square

was used to examine the statistical relationships between the categorized variables and malpractices pertain to weaning.

3.15 Limitations of the study.

The researcher's place of work gave her more flexibility to face fewer limitations. However there are some limitations

- Lack of resources and materials about the study of concern.
- Frequent cut offs of the electricity.
- The effect of political diversion and Gaza war on the participants
- The design of this study is cross sectional. Carrying out cohort study ,taking mothers and their babies since birth and following them could produce more reliable information. Potentially recall bias could occur.

Chapter 5: Results and Discussion

This chapter describes the results and findings of the study, and it presents and discusses the analyses of the data. The results shows the characteristics and the distribution of the respondents of questionnaires from the 6 HCs included in the study concerning to weaning practices. In addition, the analyses illustrate relationship between some variables in regards to weaning practices. Some findings were also compared with other studies' finding.

5.1 Socio-demographic characteristics

Table1 shows that the weaned babies' age ranged between 6 months and 24 months with a mean of 17.5 months olds. The criteria of the sample regarding the age was designed to be between 6 month and 24 months as this is the expected period of weaning for children. The study finds that the age of 81.4% of the participants was more than one year and 18.6% aged from 6 months to 12 months. It is related to the inclusive criteria as mention before the child must be weaned.

Table 1 Distribution of respondents by child characteristics variables

N=285

Characteristics	No	%	Mean	MD	SD
Baby age group					
6-12months	53	18.6%	17.56	18	4.78
13-24months	232	81.4%			
Sex					
Male	132	46.3%			
Female	153	53.7%			
Weight					
Normal weight	250	87.7%			
Under weight	35	12.3%			

The study shows that 53.7% of the children were females, while 46.3% were males. Females were slightly more than males that mean that the females were weaned earlier than males and this could be a cultural oriented behavior. Also, about 87.7% of the children were normal weight and 12.3% were under weight which is more than the growth failure prevalence rate of children under 3 years in Gaza (7.8%) (UNRWA,

2008). The under weight in this research is being judged according to the UNRWA standard for under weight (weight by age). However, the percentage of children under 5 years who moderately suffering from under weight in Gaza was 2.4 (PCBS, 2008). But in this study the children less than 6 months, more than 24 months and children between 6-24 months who still breastfeed not included in the percentage of under weight. According to annex 9 there is no statistical difference between the child weight and weaning approach.

Table 2-Distribution of subjects by certain Characteristics variables N=285

Characteristics	**No**	**%**	**Mean**	**MD**	**SD**
Mothers age					
Up to 20 years	25	8.8%	29.9	30	3.43
21-30 years	139	48.8%			
31-40 years	113	39.6%			
More than 40	8	2.8%			
Mothers' years of education					
Less than 6 years	65	22.8%	10.23	12	3.67
7-12 years	195	68.4%			
More than 12 years	25	8.8%			
Fathers' years of education					
Less than 6years	40	14%	11.67	12	3.67
7-12 years	172	60.4%			
More than 12years	73	25.6%			
Mother's occupation					
Not Working	269	94.4%			
working	16	5.6%			
Father's occupation					
Not working	125	43.9%			
Employee	116	40.7%			
Laborer	44	15.4%			
Income					
Less than 1000	185	64.9%			
More than1000	36	12.7%			
Refuse to answer	46	16.1%			
Don't know	18	6.3%			

The age of participating mothers ranged between 15 and 47 years with a mean of 30 years. The majority of mothers' ages were found to be between 21-40 years about 48.8%of mothers' ages were between 21-30years and about 39.6% of mothers' ages were between 31-40 years. The majority of mothers' education years ranged from 7 to 12 years (68.4%) and 8.8% had more than 12 years of education. The majority of the fathers' education years (60.4%) ranged from 7-12 years, 14% were less than 6 years. These findings are nearly similar to findings of El Najjar (2008) as the mean educational years of the women and their husbands were 11.6 and 11.8 years respectively, the median was 12 years for both.

The majority of mothers (94.4%) at the time of data collection were housewives, yet about 5.6% were employed which mainly around the MOH findings where the percentage of employed women was and 4.4% respectively (MOH, 2006). The finding regarding husband's employment status shows that the percentage of employed husbands was higher than that of women and reached 56.1% of them, but it is worth to mention that many of them were working as unskilled worker at the time of the study. Also, the percentage of not working fathers was 43.9%. This result is similar to the unemployment rate in Gaza which was 45% according to UN report which is the highest rate in the world (UN, 2008).

In addition, 64.9% of the participants' income was less than 1000 NIS. About 40.7 % of the working fathers were employees, about 10.9% of the participants' income ranged from 1000 to 3000 NIS. The World Bank and the PCBS reported that poverty is common in Gaza Governorates and poor tend to have larger family size and lower level of education (PCBS and World Bank, 2004). This means that the majority of the participants were living below the poverty line specified by the World Bank for West-Bank and Gaza which was specified as 2$ /person per day (PCBS and World Bank, 2004) and the rest of the participant were living at or around the poverty line taking in consideration the size of the family.

Table 3 Distribution of subjects by family related variables N=285

Characteristics	No	%	Mean
Family type:			
Nuclear family	152	53.7%	
Extended family	133	46.6%	
Nuclear Family size:			
Less than 5 members	66	43.4%	2.6
6-10members	70	46.1%	
More than11 members	16	10.5%	
Extended Family size			
Less than 5 members	5	3.7%	1.7
6-10members	44	32.8%	
More than11 members	85	63.4%	
Marital status			
Married	282	98.9%	
Widowed	3	1.1%	
House ownership			
Family owned extended	162	56.8%	
Self owned	108	37.9%	
Rented	10	3.5%	
Destroyed during war	5	1.8%	

Of the subjects, 53 % were living in nuclear families, while 47 % were living in extended families. Within this family, 3.7 % had less than 5 children. The extended family size ranged from 6-11 persons per family was 32.8 %; the majority was more than 11 persons per family (63.4%). This increases the burden of child care on the mother and reduces her time to BF and facilitates early weaning; in addition, extended family and large family size may lead to increase in the interference from family members in weaning approach and duration. From the nuclear families, 43.4% had less than 5 children, 46.1% ranged from 6-11 persons per family and 10.5% were more than 11 persons per family. The reported figures about Gaza average household size to 6.5 individuals (PCBS, 2007). This is a relatively large family size which increases the family's economic burden, and the household duties of the mothers.

Regarding the house ownership, 56.8% of the participants had family owned house and 37.9% had their owned houses. While 3.5% had rented apartments and 1.8% were homelessness as their homes was destroyed during the war. From the participant,

98.9% were married and 1.1% was widows. These together give a large sign about the interference of the other family members in weaning decision and weaning practices, as nearly half of the participants live in nuclear family in family owned houses, and 29.5% of the family size more than 11 members. The health provider should consider this information in planning for health education about weaning especially to include other family members in health education.

5.2 Breast feeding practices

Table 4 shows the distribution of mothers by breastfeeding practices. We can say that 79.6% of the participants use EBF but at different periods from one day to 6 months, and 20.4% of them use additional fluids or foods beside BF; most of them use formula or herbs especially working mothers. Moreover, 66.3% of those who use EBF use it for less than 4 months, and 28.4% of them use EBF from 4 to 6 months, but only 5.3% of them use it for more than 7 months**.** These results are not similar to the result which found about BF at Ard El Insan which showed that 71.2% of mothers use EBF for 6 months, 22% for 4-5 months and 6.8% for 3 months (Abu Hasan, 2008). If we compare these results by a BF study which done before 15 years in Gaza, we can see the improvement of the EBF rate (4-6 months) as it was 12.3% in 1994 (Shurbasi, 1994).

Table 4 Distribution of subjects by breastfeeding practices of the concerned child N=285

Variables	**No**	**%**
Exclusively breastfeeding		
Yes	227	79.6%
No	58	20.4%
Duration of exclusive breastfeeding		
Less than 4months	189	66.3%
From 4-6months	81	28.4%
More than 7 months	15	5.3%

The rate of EBF was 28.4%, which is around the data obtained from the 2000 Infant feeding survey which have been published and showed a movement towards later introduction of solids, with 24% of mothers weaning by 3 months of age compared with 56% in 1995. However, 85% of mothers in 2000 had still introduced solids before 6

months (WHO, 2002). According to study carried in UNRWA in 2001 found that 25.8% of mothers used EBF for 4 months. According to MOH report in 2004, the national EBF rate is 25.5% and Gaza EBF rate is 23.5% (MOH, 2004). In recent study in UNRWA health centers, the prevalence of EBF up to 4 months in Gaza was 33.3%, but the percentage of infant breastfeed (not EBF) for at least one year was 65% (UNRWA, 2008).

According to Sharwy, the Islamic religion through Qur'an and Prophet Mohammad's sermons encouraged mothers to breastfeed strongly for two years. The religious thinkers agreed that nowadays, mothers do not breastfeed frequently because they are forced to go outside for work even if women are not educated. For instant, they go to farming or trading. Almost all of them mentioned they proactively counsel mothers about BF benefits because it is mentioned in Quran and they believe that at the human level, families should secure enough proper food for their children and BF is the first and the best for children (Sharwy, 1991).

Weaning too early, before the age of 4 months, is associated with an increased rate of minor morbidity and jeopardizes the continuation of lactation (Dettwyler, 1997). On the other hand, delaying the introduction of solids beyond the age of 6 months has been associated with increased risk of malnutrition (WHO, 2002).

5.3 Weaning Practices

Table 5 shows that the main cause of weaning is pregnancy (42.8%). This is related to our culture which encourages high fertility and considers large family size as an advantage. So counseling about family planning will improve weaning age and BF. The second cause of weaning is to improve the child's feeding (17.5%), as the main complain of the mothers was that their children refuse food and prefer suckling and BF. The third cause was the child age which is more than 18 months (13.3%); which considers the ideal time of weaning from 18-24 months. The next cause represented 11.2%, was the baby weans him/herself, which can be seen in young mothers or in large families and those mothers need counseling related to BF and weaning. Also, 8.4% of the participants preferred to wean their children for their comfort; they feel that BF interrupts their daily activity and their sleeping. About 3.5% of the causes is related to mothers' illness. In Shaheen study about infant feeding, mothers' reasons behind

stopping BF were child's biting of nipple; mothers' need to sleep at night, mothers' pregnancy and child's refusal of breast milk (Shaheen, 2007).

Table 5 – Distribution of mothers by their weaning practices N=285

Variables	**No**	**%**
Causes of stopping BF		
Pregnancy	122	42.8%
Improving child feeding	50	17.5%
The child more than 18 months	38	13.3%
Baby wean him/herself	32	11.2%
Mother's comfort	24	8.4%
Mother's illness	10	3.5%
Social pressure	8	2.8%
Doctor's advice	1	.4%
Weaning approach		
Sudden	252	88.4%
Gradual	33	11.6%
Causes of choosing the weaning approach		
Pregnancy	118	41.4%
Improving the child health	87	30.5%
Mother's comfort	60	21.1%
Others	17	6%
Doctor's advices	3	1.1%
Weaning age		
Less than 6 months	33	11.6%
From7-12 months	89	31.2%
More than 13 months	163	57.2%
The usage of traditional methods		
Yes	186	65.3%
No	99	34.7%
Decision to stop breastfeeding(one choice)		
Mother	145	50.9%
Mother in law	89	31.2%
Husband	28	9.8%
Dr order	11	3.9%
The child	10	3.5%
Child's grandmother	2	.7%
Gender discrimination		
Yes	4	1.4%
No	262	91.9%
Not applicable	19	6.7%

About 2.8% of the causes is related to social pressures which mostly appear in extended family and when the husband and mother in law interfere in the weaning decision and weaning practices. It is very important point to consider in health education. Finally

.4% of them related to Dr order which rarely due to mother or child illness. All this finding reflects the need appropriate counseling about BF and weaning.

Obrien, 2007 in his study about BF and weaning said that, the perception that infant was not satisfied by breast milk alone was cited consistently as 1 of the top 3 reasons in the mothers' decision to stop BF regardless of weaning age. Mothers' concerns about lactation and nutrition issues were the most frequently reasons for stopping BF during the first 2 months. Starting from the third month, self-weaning reasons were increasingly cited as important (Obrien, 2007). In addition, a study about BF and weaning in a poor urban neighborhood in Cairo, Egypt: the researcher found that weaning occurs early due to a variety of factors including maternal illness, desire for another pregnancy, and perceptions that breast milk may be inadequate (Harrison, 2006).

In addition, Sometimes a mother is pressured to wean, even though both she and her baby are enjoying BF. She may wean for one of the following reasons: milk quality or quantity**,** going back to work**,** sick baby or mother, troubles with biting, refusal to suck**,** return of menstrual cycle**,** pregnancy and still BF**,** community pressure and BF Problems **(**Australian Breastfeeding Association, 2003**).** Other studies showed that working women is one of the main cause of weaning .Women who work outside the home have a shorter duration of BF, and intentions to work full time are significantly associated with lower rates of BF initiation and shorter duration (Eglash, 2007**).**

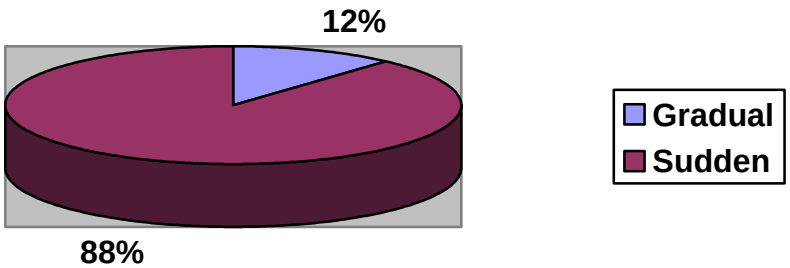

Figure 1 Weaning Approach

The study shows that 88.4% of the mothers use sudden weaning, while only 11.6 % of them use gradual weaning. This reflects the information gap and the need of counseling. The majority of mothers who used sudden or gradual weaning about 41.4% due to pregnancy, as mentioned before it is due to cultural factors. While 30.5% of mothers think that it was better for child health, and 21.1% of them think that it was better for mothers' health. About 1.1% of the causes related to Dr Order; in case of mother and child illness. And only .6% related to other causes**.** In addition, the study shows that the majority of weaning age was from 13 to18 months (43.9%), and 31.2% from 7 to 14 months. While 13.3% from them was more than 19 months and 11.6% was less than 6 months. The mean of weaning age was 13.5 while, the median was 14 and SD was 4.76. This needs more effort from the decision makers to improve the counseling about weaning.

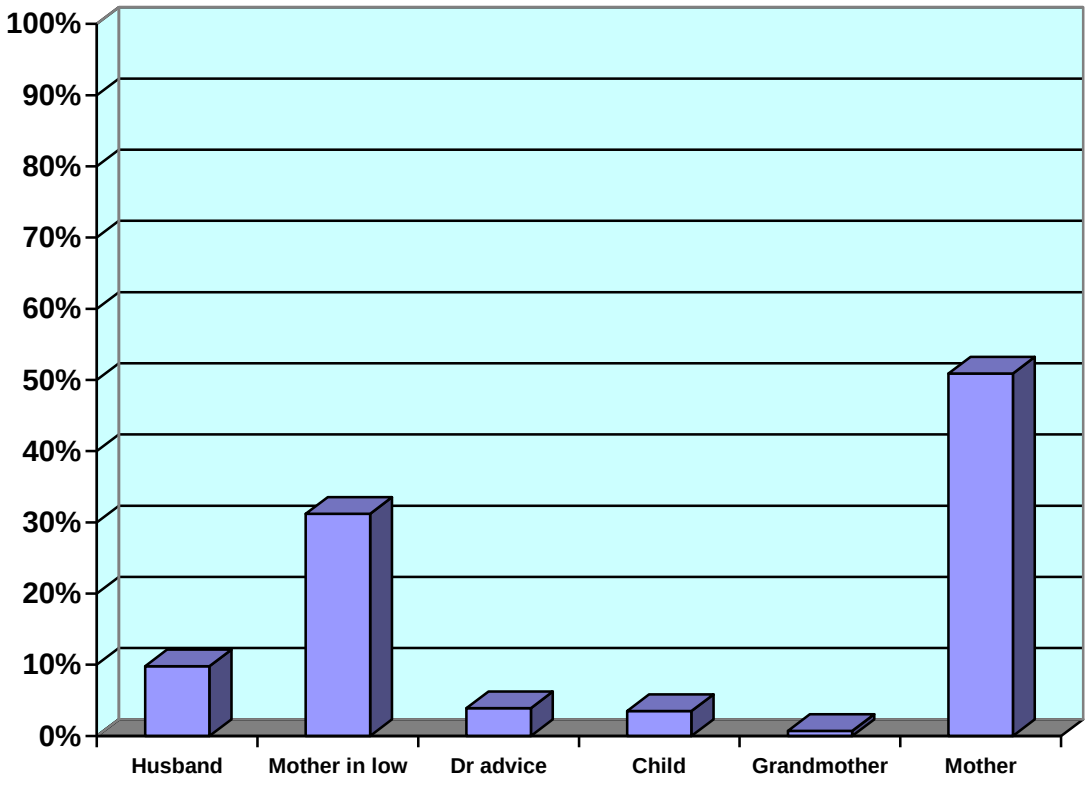

Figure 2 distributions of people who influence weaning decision

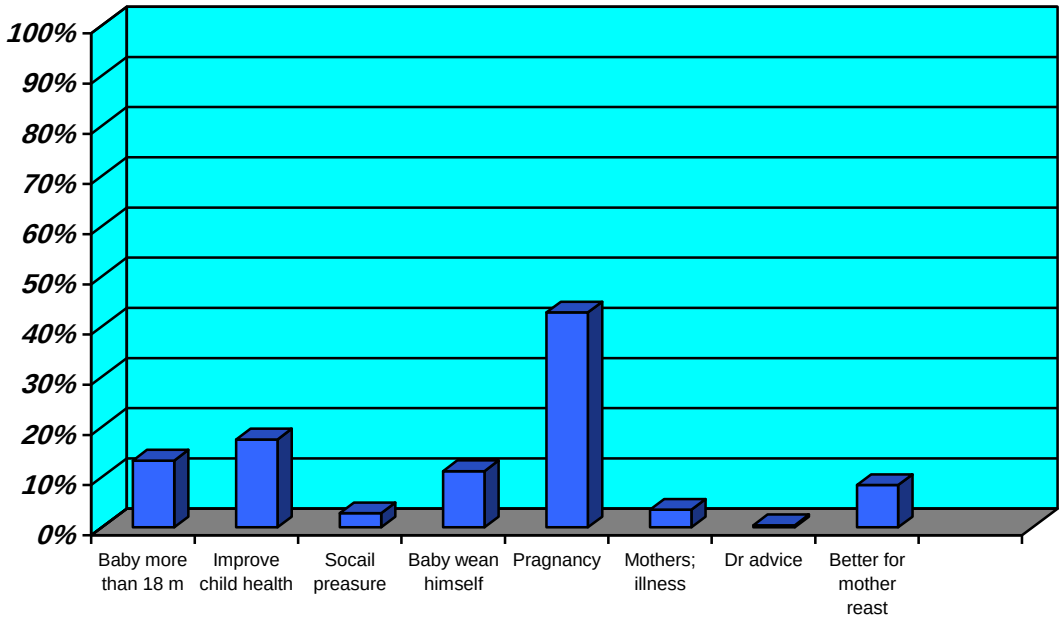

Figure 3 the cause of choosing weaning approach

In another study mothers were asked also an imaginary question, when and how they would wean their children. Most of the mothers agreed that they would follow optimal BF practices i.e. practice exclusive BF from birth to 6 months of age, and introduce complementary foods at 6 months of age while continuing to breastfeed up to 2 years and stop BF gradually. However, few of them insisted on practicing sudden weaning and to continue BF up to one year only (Dettwyler, 1995).

Table 6 shows that 65.3% of the participants used traditional methods, and 34.7% of them did not use traditional methods. Again, this is related to cultural factors. In addition, the majority of the mothers tacked their decision to stop BF by themselves (50.9%). This means that health education must focus on mothers. While 31.2% of mothers in law had a role in weaning decision especially in extended families. The husbands represented 9.8% of the decision makers in weaning, and 3.9% related to Dr Orders. The child himself represented 3.5%, while the child grand mothers' represented .7%. These results must be considered in planning health education for weaning; health

providers must include the other family members in health education. However, this results against Islamic rules as the Quran said in Surah El Baqarah, verses 233 that If through mutual consent and consultation, the estranged husband and wife decide to terminate the BF period before two years, they can do so. If the child's father or, in his absence, the heirs of the child want to breastfeed the child through some other lady instead of the mother, they are authorized to do so provided what has been agreed with the mother regarding her maintenance is fully honored (Islahi, 1986).

Also, the study shows that the differences between male and female in weaning practices are not significant. About 91.9% of the participants think that there were no differences between males and females, when only 1.4% of them think that there were difference; they think that males need more care than females in weaning (gender discrimination), and 6.7%of the cases not applicable. Some mothers think that the differences between males and females not in weaning approach but in child reaction to weaning. For example, females' weaning is easier than males' weaning.

Table 6 Distribution of mothers by their believe and practices of traditional methods No 285

Variables	**Believe**		**Practices**	
	N	%	N	%
Substances with bad taste on the nipple	118	41.4%	113	39.6%
Use of alternatives	79	27.7%	42	14.7%
Isolation	55	19.3%	35	12.3%
Red substances on the nipple	31	10.9%	32	11.2%
Coffee on the nipple	28	9.8%	25	8.8%
Alternative breast	28	9.8%	24	8.4%
Drug	18	6.3%	22	7.7%

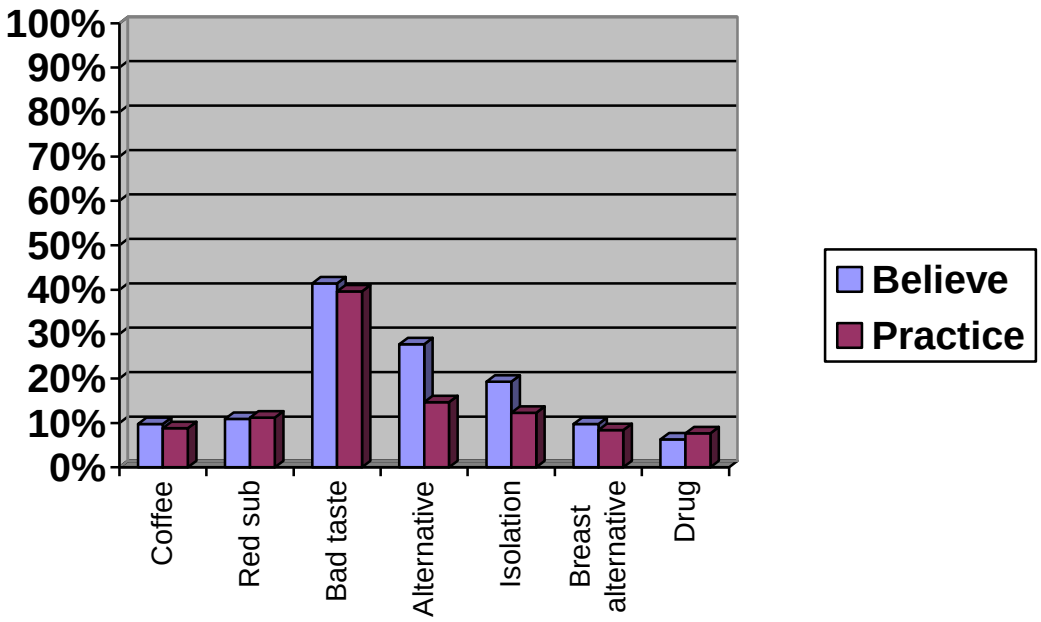

Figure 4 Distribution of mothers by their beliefs and practiceing different traditional methods

As shown before in table 5 about 65.3% of mothers used traditional methods. Table 6 shows the distribution of mothers by the methods. As the percentage of mothers who believe in using substances with bad taste on the nipple like Subra Muura is 41.4% which still less than the mothers who do not believe in it (58.6%), and the percentage of mothers, who use substances with bad taste on the nipple, is 39.6%. In addition the percentage of mothers who believed in using alternatives such as formula feeding and pacifier is 27.7%, while the percentage of mothers who use alternatives is 14.7%. Also the percentages of mothers who believe in isolation is 19.3%, and the percentage of mothers use isolation is 12.3. The percentage of mothers believes in alternative breast or usage of coffee in the nipple is 9.8%. The percentage of mothers who use alternative breast or use coffee in the nipple is 8.8%. And 10.9% of mothers believe in usage of red substances in the nipple; 11.2% of them use red substances in the nipple. There are 6.3% of mothers believe in usage of drug to make the baby calm or sleep most of the time during weaning.

Annex 10 shows that the usage of traditional methods is different according to the area; as we can say that the highest percentage of using coffee in the breast was in Rafah

(42.9 %). Also the majority of the mothers using bad taste and red substances in the nipple is in Nuserate (27.1%) (32.3%). In addition, the highest rate of using drug and isolation is in Rimal (52.6%) (30.9%). The majority of mothers use alternative is in Beit Hanoun (31.6%) (Annex 10). These reflect the effect of the culture and environment on weaning practices, and the need to tailor the health education plans according to the geographic disturbance.

This result is similar to a study done about the struggle of weaning**.** Many of the mothers described difficulties with termination of BF. Some had tried several times before they managed to stop. Often this was described as a kind of negotiation between the mother and her child, where different methods, verbal and physical "arguments" were used (Marquis, 1998). When the mother felt it was time for weaning she would often tell the child that her milk had "gone bad", in order to discourage it from BF. For the same purpose it was common to paint the breasts with the juice of a species of chrysanthemum much used in local traditional medicine. The juice is black and has a bitter, nauseating taste. Some also painted the breasts with a mixture of ashes and water. Usually it was sufficient to do this for one day, but one mother told she had done it for three days. The child vomited, but continued to try to drink, so in the end the mother gave in and let it continue. Some mothers had been separated from the child for one night or more in order to make the child stop suckling. The use of similar means for weaning as in our study has also been reported in neighboring (Marquis, 1998).

5.4 Mothers' knowledge about weaning practices

In general and according to the finding in table 7 there is still a gap between the different kinds of the information; not all the women understand the information they receive. About 76.8% of the women know that she must be patient with her baby during weaning, followed by 77.9% of them know that the child may be irritable, restlessness and anxious during weaning, and she must avoid making her child see her breast. In addition, 71.9%of the participants understand the need of the child to be close to his/her mother during weaning. About 68.1% of mothers began feeding with food other than breastfeeding; 59.6% of the participants know that she must not use any substances on the nipple during weaning. Also, 53.3% of them think that weaning in winter is better than weaning in summer, and 44.9% of them see that weaning must be gradually.

Table 7 Distribution of mothers by their knowledge about weaning practices N 285mothers

Variables	Yes		No	
	N	%	N	%
Mothers' knowledge about weaning				
Weaning should be gradually	128	44.9%	157	55.1%
Appropriate start of weaning	152	53.3	133	46.7%
Feeding should begin with food than breastfeeding	194	68.1%	91	32.9%
Traditional methods should not be use on nipple	170	59.6%	115	40.4%
Avoid isolation for a long time.	205	71.9%	80	28.1%
Providing psychological care during weaning.	219	76.8%	66	23.2%
Knowing the psychological changes of weaning	222	77.9%	63	22.1%
Avoid seeing the breast.	222	77.9%	63	22.1%
The source of mothers' knowledge				
Family	266		94%	
Friends	12		4.2%	
Doctor	5		1.8%	

Indeed, for the majority, the source of the information about weaning was from the family in particularly from mothers in law and grandmothers about 94%. Only 4.2% of participants received the information from friends, and 1.8% from private doctor. It is surprised to say that all mothers in the study reported not receiving counseling about weaning in health clinics or from the media.

These findings indicate that women did not receive appropriate knowledge about weaning. It is worth to mention that the technical instructions of UNRWA stress on breastfeeding and not highlighted the weaning practices. Moreover, according to the study mothers did not receive health education about weaning in health centers. All their information from their mothers in law or from mothers is important to improve the health education and counseling about weaning. This imply the mothers in law should involved in campaign to learn appropriate feeding practices and also, counseling should promoted at the clinics.

5.5 Family's problems related variables

Table 8 shows that at the time of weaning 57.2% of the families under study did not have family problems and 42.8% of them had family problems. From the families which had family problems 12.3% had social problem, 79.5% had economical problems as mention before the majority of the participants' income were less than 1000 NIS. And 8.2% had political problems, due to coup or Gaza war. From those who have social problems, 86.6% of these problems due to husband's family, 13.3% due to the husband and the children. The family problems special social problems affect weaning process. Again, nearly half of the participants live in extended family in family owned houses which may lead to social problems. When there are problems between the mother and her husband or mother in law, she can not take right decision about weaning**.** Weaning is easier in families that did not have family's problems; as there is not a conflict between mother and father in weaning approach. This explained in Quran as versus indicates that if the father and the mother decide to wean their child before the two years end, they must discuss and agree upon. So, the Ayah indicates that one parent is not allowed to make this kind of decision without consulting the other parent. The method of mutual consultation protects the child's interests.

Table 8 Distribution of Family's problems related variables N=285

Variable	**No**	**%**
Experiencing family problems during weaning		
Yes	122	42.8%
No	163	57.2%
Types of family problems		
Social	15	12.3%
Economical	97	79.5%
Political	10	8.2%
Nature of social problem		
With husband's family	15	86.6%
With husband and children	2	13.3%

5.6 Children experiencing health problems during and after weaning

Table 9 shows that during weaning, 64.1% of the children had psychological problems and 51.9% of them after weaning had the same problems. In addition, 20.5% of the children loss their appetite during weaning, and 19.6% of them had the same problem after weaning. Also, about 5.1% of the children loss their weight during weaning, and 23.5% of them had the same problem after weaning. Finally, about 10.2% of them before and 5.9% after weaning had other problems as fainting attacks and anemia**.**

These findings were similar to Shaheen study 2007 regarding weaning practices, because of children's attachment to BF and to their mothers, they face difficulties to wean their children completely, so they put some thing bitter "*sabra mura*"or red substance on the nipple. This practice is very traumatizing to the weaned children and usually they develop sickness after that. Also this is what Marquis, (1998) said about weaning after 12 months was associated with short-term negative and traumatic consequences. These included a reversal in motor and language development (walking, speech acquisition, eating skills), emotional disturbances (intense sorrow, resentment, crying, and temper tantrums), learning difficulties, and physical problems (illness, weight loss, loss of appetite and sleep). The consequences that worried mothers the most were crying, loss of appetite, and weight loss. Crying was reported to go on for a few days, a week, or even more. Mothers frequently spoke of the sorrow that they experienced when their children cried during weaning.

Table 9 Distribution of mothers responses about expecting health problems during and after weaning

Health problems	**During weaning**		**After weaning**	
	N	%	N	%
Psychological problems	25	64.1%	26	51.9%
Loss of appetite	8	20.5%	10	19.6%
Loss of weight	2	5.1%	12	23.5%
Others	4	10.2%	3	5.9%
Methods of dealing with these problems				
Increase the amount of food	192	67.4%		
Increase the number of meals	56	19.6%		
Relactation	29	10.2%		
Others	8	2.5%		

Regarding how to deal with these problems the majority of mothers about 67.4% increase the amount of food; and 19.6% increase the number of meals. Only 10.2% of the mothers increase breast milk which means relactation. Health professionals should recognize that relactation is a feasibly and culturally acceptable recommendation for young children who have been prematurely weaned. Relactation, therefore, is a feeding option that can be recommended to mothers when human milk would continue to be beneficial to the young child (Marquis**,** 1998). Lastly, 2.5% of the participants use other methods as recreational activities.

Weaning before 12 months was associated with short-term negative and traumatic consequences. Again, as mentioned before these included a reversal in motor and language development, crying, loss of appetite, and weight loss. Crying was reported to go on for a few days, a week, or even more (Marquis, 1998).

Table 10 Distribution of child's complementary feeding before and after weaning

Variables	**Before**		**After**	
	N	%	N	%
Quantity of complementary feeding				
Normal	80	28.1%	233	81.7%
Few	205	72%	52	18.2%
Quality of complementary feeding				
Normal	77	27%	236	82.8%
Poor	208	73%	49	17.2%

This table describes the quantity and quality of feeding before and after weaning. 72% of the children feeding quantity of the participants are few before weaning and 18.2% after it. Also 28.1% of them had normal quantity of food before weaning, but 81.7% of the children had normal quantity after weaning. The majority of children had poor feeding quality before weaning 73%, but normal feeding quality after weaning 82.8%. The percentage of children who had normal feeding quality before weaning is 27% which rises to 82.8% after weaning. The change of percentage of quality and quantity of feeding before and after weaning is very important indicator about the cause and the technique of weaning.

A study was conducted to describe the weaning practices of women resident in the inner city of Johannesburg, whose babies were between the ages of 6 and 9 months show that BF was initiated by most women at birth. By four months only 25% of women were

EBF. Early weaning was associated with poor quantity and poor quality of breast milk. Partial BF is practiced and women use a variety of milk formulas to substitute breast milk (Jane, 2006).

Table 11 Distribution of mothers' practice of different traditional methods by geographic area

Variables	Gaza		Middle		South		Total		X^2	P
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**		
Bad taste as Subra Murra										
Yes	36	38.3	53	54.6	29	30,9	118	41.4	11.7	.003
No	58	61.7	44	45.5	65	38.9	167	58.6		
Alternatives as pacifier										
Yes	41	43.6	8	8.2	30	31.9	79	27.7	31.04	0.00
No	53	56.4	89	91.8	64	68.1	206	72.3		
Isolation										
Yes	31	33	3	3.1	21	22.3	55	19.3	28.21	0.00
No	63	67	94	96.9	73	77.7	230	80.7		
Using red substances										
Yes	6	7.4	14	14.4	10	10.6	31	10.9	2.41	.299
No	87	92.6	83	85.6	84	89.4	254	98.1		
Using coffee										
Yes	13	13.8	2	2.1	13	13.8	28	9.8	10.01	.007
No	81	86.2	95	97.9	81	86.2	257	90.2		
Breast alternative										
Yes	8	8.5	2	2.1	18	19.1	28	9.8	16.01	0.00
No	86	91.5	95	97.9	76	80.9	257	90.2		
Drug										
Yes	11	11.7	4	4.1	4	4.3	19	6.7	5.71	.057
No	83	88.3	93	98.9	90	95.7	266	93.3		

Table 11 shows that the number of mothers who used substance with bad taste as subra muura in weaning in all Gaza Strip was 118 mothers which represent 41.4% from the total participants who used traditional methods. About half of the middle camp participants used substance with bad taste (54.6%) which was in used more than other areas, as 38.3% of mothers within Gaza used substance with bad taste, and 30.9% of the participants from the south used substances with bad taste. The number of mothers who used alternatives as formula, juice, and pacifier in weaning in all Gaza Strip were 79 mothers which represented 27.7% from the total participants who use traditional methods. About 43.6% of the participants within Gaza used alternatives, and 31.9% within south used this method. While, 8.2% of mothers within the Middle Zone used alternatives. The pacifier, (a non-nutritive sucking device), is commonly used for calming infants. WHO and UNICEF initiative recommends avoiding pacifiers in breastfed term infants because it is thought to lead to early weaning (WHO, 2002). Most studies found that early weaning is associated with pacifier use (Marilyn, 2002)

Regarding isolation, as a traditional method, about 19.3% of the total number of participants used it. About 33% of mothers within Gaza used this method, and 22.3% of mothers within South used it. While only 3.1% within the Mid Zone used it. Isolation is very dangerous method of weaning. Children at the same age who were not breastfed were often taken further away by their caretakers, and the mother would not know exactly where the child was. BF thus provides the child with an indubitable right of access to the mother, irrespective of its age. This "right of access" is not only to the breast, but to all that the mother can provide of warmth, care and comfort. To some children the "loss of breast means loss of mother too" (Jane, 2006).

The next method was red substances as make up, tomatoes and nail color which represented 10.9% from the total methods. About 14.4% of the mothers within Mid Zone used this method, while 10.6% within South used it. About 7.4% within Gaza used it. The study found that 9.8% of the participants used sudden weaning from alternative breast which distributed according to the areas 19.1% of South subjects, 8.5% from Gaza subjects and 2.1% from Middle Zone mothers. In addition, the number of mothers who used coffee in weaning in all Gaza Strip was 28 mothers which represent 9.8% from the total participants who used traditional methods. We found that 13.8% of mothers within Gaza and 13.8% within South used coffee in weaning, while

2.1% of the mothers within the Mid-Zone used coffee in weaning. The last method was drug which represented 6.7% from the traditional methods. The main area which used drug in weaning was Gaza (about 11.7% of their mothers), 4.3% within South and 4.1% within the Middle used drug in weaning.

We can see that the difference between areas in each method is statistically significant except in the use of red substances. Each area has its own characters and culture. In Gaza the main method was using alternatives, then substances with bad taste, isolation, coffee, drug, breast alternatives and red substances. In the Mid Zone the main methods was substances with bad taste then red substances, alternatives, drug, isolation, breast alternatives and coffee. So it is recommended to consider the culture of each area in health education about weaning .Each area need specific education according to the method which used in this area.

Table 12 shows that 28% of mothers and 18.3% of fathers whose education less than 6 years used traditional methods, which means that traditional methods were used more by the low education parents. Also, 66.1%of mothers and 59.7% of fathers whose education from 7 to 12 years used traditional methods. In addition, 5.9% of mothers and 22% of fathers whose education more than 13 years use traditional methods (P value .003). This means that the use of traditional methods within the low educational parents is more than highly educated parents. That's means that we must improve the health education and counseling about weaning age for those with low education level.

In relation to occupation 4.3% of working mothers and 51.6% of employee fathers used traditional methods. While both of 95.7% of non working mothers and 48.4% of non working fathers used traditional methods. Women who work outside the home have a shorter duration of BF, and intentions to work full time are significantly associated with lower rates of BF initiation and shorter duration. Working women who are faced with too many barriers to continue BF take off more sick days for their children as compared with women who continue to breastfeed while back to work (Mcinnes, 2008).

Table 12 Distribution of mothers by using traditional methods by certain parents characteristics

Variables	Using of traditional methods							
	Yes		No		Total		X^2	P value
	N	%	N	%	N	%		
Mothers' education								
Less than 6y	52	28%	13	13.1%	65	22.8	11.62	.003
From7-12y	123	66.1%	72	72.7%	195	68.4		
More than 13y	11	5.9%	14	14.1%	25	8.7		
Fathers' education								
Less than 6y	34	18.3%	6	6.1%	40	14	9.58	.008
From7-12y	111	59.7%	61	61.6%	172	60.1		
More than 13y	41	22%	32	32.3%	73	25.6		
Mothers' occupation								
Working	8	4.3%	8	8.1%	16	5.6	1.74	.147
Not working	178	95.7%	91	91.9%	269	94.3		
Fathers' occupation								
Working	96	51.6%	64	64.6%	160	56.6	13.04	.001
Not working	90	48.4%	35	35.4%	125	43.8		

In table 13, we can see that there are significant relationships between the usage of traditional methods and problems during and after weaning (P value .002, X^2 14.42). The table shows that 13.3% within the cases which had loss of appetite during weaning use traditional methods in weaning, while 14.3% of participants had loss of appetite after weaning. This is due to the way of weaning or the psychological effect of traditional methods. Also, 16.7% of the participant had loss of weight after weaning while no one had weight loss during weaning. Furthermore, 76.7%of the children who had psychological problem during weaning use traditional methods, and 61.9% of the children had psychological problems use traditional methods. Lastly 10% of the cases who had insomnia during weaning and 7.1% after use traditional methods. These mean that the usage of traditional methods has bad effect on child health, and we need to consider these in heath education plans. This point must consider when we give

counseling to mothers; the mothers must know the bad effect of traditional methods on their children.

Table 13 Distribution of mothers using traditional methods by types of problems affect the child during (N=39) and after weaning(N=51).

Variables	Using traditional methods							
	Yes		No		Total		X^2	P
	N	%	N	%	N	%		
During weaning								
Loss of appetite	4	13.3%	4	44.4%	8	20.5	13.14	.004
Loss of wt	0	0%	2	22.2%	2	5.1		
Psychological problems	23	76.7%	2	22.2%	25	64.1		
Insomnia	3	10%	1	11.1%	4	10.3		
After weaning								
Loss of appetite	6	14.3%	4	44.4%	10	19.6	14.42	.002
Loss of weight	7	16.7%	5	55.6%	12	23.5		
Psychological problems	26	61.9%	0	0%	26	51		
Insomnia	3	7.1%	0	0%	3	5.9		

In studying the relation between weaning approach and the causes of weaning the researcher found that there were a statistical significant difference between them (p .006, X^2 12.44). About 27.4% of the mothers who think that weaning was better for the children used sudden weaning while, only 22.6% whose causes were better for mother used sudden weaning. In addition 42.1% of whose causes were pregnancy used sudden weaning. As mention before, this due to gap in the weaning information which needs more effort in counseling and health education. Related to the type of the family, 51.2% of the nuclear family used sudden weaning, and 48.8% of the extended family

used sudden weaning. The extended families gave chance to the other family members to interfere the weaning decision and weaning technique**.**

Table 14 weaning approach by the causes of weaning

Variables	Weaning approach						X^2	P
	Gradually		**Sudden**		**Total**			
	N	**%**	**N**	**%**	**N**	**%**		
Causes of using this approach								
Better for mother comfort	3	9.1%	57	22.6%	60	22.1%		
Better for child	18	54.5%	69	27.4%	87	30.5%		
Pregnancy	12	36.4%	106	42.1%	118	41.4%	12.44	.006
Dr advice	0	0	20	7.9%	20	7%		
Type of the family								
Extended	9	27.3%	123	48.8	132	46.3%		
Nuclear	24	72.7%	129	51.2	153	53.7%	5.44	.020

Harrison 2006 said that the causes as 1 of the top 3 reasons in the mothers' decision to stop BF regardless of weaning age. Mothers' concerns about lactation and nutrition issues were the most frequently cited reasons for stopping BF during the first 2 months. Starting from the third month, self-weaning reasons were increasingly cited as important, with the statements "My baby began to bite "My baby lost interest in nursing or began to wean himself or herself", and "Breast milk alone did not satisfy my baby" cited as the top 3 reasons at > or = 9 months of age.

In-depth interviews with 35 women with experience from BF were carried out in order to obtain qualitative data regarding the processes underlying the mothers decisions during weaning, shown that children who were weaned during a subsequent pregnancy of the mother had a reduced weight gain and an increased incidence of infectious diseases during weaning, while this was not so for children weaned from non-pregnant mothers (Bohler,1999).

Table 15 Distribution of weaning approach by experiences problems after weaning

Variable	Gradual		Sudden		Total		X^2	P
Problems after weaning	**N**	**%**	**N**	**%**	**N**	**%**		
Psychological	2	33.3%	24	53.3%	26	50.9	1.746	.627
Loss of wt	2	33.3%	10	22.2%	12	23.5		
Loss of appetite	2	33.3%	8	17.8%	10	19.6		
Others	0	0	3	6.7%	3	5.8		

Table 15 shows that, 53.3% of the children had psychological problems after weaning due to sudden weaning. While 22.2% of them who's had loss of weight after weaning, use sudden weaning. In addition, 17.8% of them who had loss of appetite use sudden weaning. These mean that sudden weaning may lead to problems affect the child health. In fact, we could say that, there are variations in babies' reaction to weaning as many babies can pass this period quite calmly and others will prefer to reduce quantity of nursing gradually. This variant will give the baby possibility of rearranging himself stage-by-stage, but on the other hand, it can turn to be more difficult for a baby (Daniel, 2001). Therefore, our religion advices us to use gradual weaning. "We have enjoined man to show kindness to his parent, with much pain his mother bears him, and with much pain she brings him into the world. He is born and weaned in thirty month"(Al-Ahqaf15, The holy Quran). This versus explain that weaning period must not be sudden but in 24 months period. As mention before sudden weaning has bad impact on the child health. So mothers should know throw health education the dangerous of sudden weaning and how to wean their children gradually.

Table 16 distribution of weaning approach by geographic area

Variable	Gradual		Sudden		Total		X^2	P
	N	%	N	%	N	%		
Area								
Gaza	15	45.5%	79	31.3%	94	33	4.64	.098
Middle	6	18.2%	91	36.1%	97	34		
South	12	36.4%	82	32.5%	94	33		
Health center								
Beat Hanoun	14	42.4%	23	9.1%	37	13	37.5	0.00
Rimal	1	3%	57	22.6%	58	20.3		
Burej	4	12.2%	34	13.5%	38	13.3		
Nuserate	2	6.1%	56	22.2%	58	20.3		
Maen	7	21.2%	27	10.7%	34	12		
Rafah	5	15.2%	55	21.8%	60	21.5		

Regarded to the geographic distribution the majority of cases who use sudden weaning from Mid Zone about 36.1%, while South and North 31.3% and 32.5%. The distribution according to health centers, 22.6% of Rimal mothers, 22.2% of Nuserate and Rafah use sudden weaning. Also 13.5% of Burej, 10.7% of Maen use sudden weaning. The least rate which uses sudden weaning is from Beat Hanoun about 9.1%. This differences between the 2 groups according to geographical areas reach the statistical significant level (p value .098, X^2 4.645 for areas) (p value 0.00, X^2 37.52 for health centers) which related to cultural difference. And as mention before health providers need to consider the culture of each area in counseling about weaning. Health educators should explain to the mothers the dangerous of using traditional methods; each health educator should know the popular method of weaning which used in his area and consider that in his educational plan.

Many mothers are relieved to learn that they don't need to totally wean their children until both mother and child are ready. Partially nursing, such as before naps, bedtime, and/or in the morning, can alleviate some of the stress that comes from a frequently nursing toddler or older child (Mcinnes, 2008)

Table 17 distribution of usage of traditional methods by problems after weaning

Variables	**Traditional methods**				**X^2**	**P**
	Yes		**No**			
	N	**%**	**N**	**%**		
Problems after weaning						
Loss of appetite	6	14.3%	4	44.4%	14.416	.OO2
Loss of wt	7	16.7%	5	55.6%		
Psychological	26	61.9%	0	0		
Others	3	7.1%	0	0		

Table 17 shows that all the cases which had psychological problems used traditional methods in weaning. Almost all the cases which used red substances on the nipple as make up or tomatoes had psychological problems; all of them said that the child screamed, caught his/her hair and hit his head in the wall. The health workers should explain to the mothers the psychological importance of BF and how to minimize the effect of weaning on the child. In addition, 14.3% of children who had loss of weight and 16.7% who had loss of appetite used traditional methods in weaning. These results are similar to the results of using sudden weaning. The differences between the usage of traditional method and not usage according to psychological problems are statistically significant (p value .002, X^2 14.416). So it is important to consider that in health education about weaning. The best way to wean the children is gradually weaning without using any traditional methods. In addition, the mothers must consider the psychological status of the children during weaning because weaning period is very critical period in the child life.

Chapter (6) Conclusions and recommendations

This chapter explains the study conclusions that are drawn from the study and the recommendations made to improve the breast feeding and weaning practices in the study areas.

6.1 Main conclusions

The aim of the study was to assess weaning patterns and practices among mothers attending UNRWA health centers in Gaza Strip, in order to provide information that could support child nutritional status and its impact on the child health. It was done also in order to identify socio-demographic factors affecting weaning practices, and to identify the main gaps of weaning practices; Moreover, to provide recommendations and suggestions for improving weaning.

A self conducted questionnaire was used for the mothers attending the UNRWA health centers whose children age was from 6 to 24 months. A multi-stage sampling method was used for the mothers' sample resulting in high response rate of 95%.

The study showed that the majority of the study population use EBF (79.6%), but the duration of exclusive BF is not the same as only 28.5% of them use EBF for 6 months. The findings of the study also showed that the majority of the mothers use sudden weaning (88.4%); from them 65.3% use traditional methods in weaning. The researcher found that the main cause of weaning was pregnancy (42.8%), and the mothers chose the weaning approach which she thinks that was better for the child .Beside that the majority weaned their children from 13 to 18 months (43.9%). Moreover, about 50% of the mothers tacked the decision of weaning by themselves, while 30% of the mothers in low decide when and how to wean. The study shows that the differences between male and female are not significant. About 91.9 % of the participants think that there were no differences between males and female in weaning.

The study revealed that the most popular traditional method used by the mothers was the substances with bad taste especially subra murra. The usage of traditional methods differs according to the area; as we can say that the highest percentage of using coffee in the

breast is in Rafah (42.9 %). Also the majority of the usage of bad taste in the nipple is in Nuserate (27.1%) and red substances (32.3%).In addition, the highest rate of use of drug is in Rimal (52.6%) and isolation (30.9%).The majority of mothers use alternative is in Beit Hanoun (31.6%).

Concerning the health information and advices received, the result of the study revealed that there was not health education about weaning in the health centers indeed, the majority of the source of the information about weaning was from the family in particularly from mothers in low and grandmothers about 94%. And it is worth to mention that the technical instruction stress on breastfeeding and ignore the weaning practices. Moreover, according to the study all the mothers said that they did not receive health education about weaning in health centers, and all their information from their mothers in low or from mothers.

According to the study results, 66.7%of the children feeding quantity under the study are few before weaning and 14.7% after it. In addition, the majority of children had poor feeding quality before weaning (68.1%), but normal feeding quality after weaning (67.7%).

As it shown in the study, the usage of traditional methods differs according to the area. The majority of mothers use coffee on nipple for weaning were 13.8% from Gaza, south and north within the total mothers use coffee (28mothers), and the highest percentage of using red substances on nipple as make up, tomatoes and nail color were from the mid zone(14.4%). Moreover, regard usage of alternatives in weaning as formula, pacifier and juices the highest rate from Gaza (43.6%) from79 total mothers. Also, the highest rate of usage breast alternative was from south (19.1%).

The study showed that 80% of mothers and 85% of fathers whose education less than 6 years use traditional methods. This means that the use of traditional methods within low educational parents is more than high educational parents.

The study revealed that There are a significant relationship between the usage of traditional methods and problems during and after weaning (P value .002, X^2 14.45). As 92.3%of the children who had psychological problem during weaning use traditional methods, and 100% of the children had psychological problems after weaning use

traditional methods. Moreover, 92% of the children under study had psychological problems after weaning due to sudden weaning. These mean that sudden weaning may lead to problems affect the child health; therefore, our religion advices us for gradual weaning.

6.2 Recommendations

The mother and child care services provided to mothers and their children at UNRWA health centers in Gaza cover the important point of breastfeeding and child nutrition. However, further efforts are needed to strengthen the weak points and to bridge the gaps in this regard. The researcher suggests some recommendations that could improve the services through considering the findings of the study as follows:

- Because weaning is important stage which affects the child health, policy makers and health programs managers are required to pay more attention to this important issue and to continuously support it.
- Coordination between the different health providers such as UNRWA, governmental and NGOs is essential to provided appropriate unified message about weaning.
- Policy development about weaning practices is essential. Such policy should be followed by appropriate implementation and monitoring. Development of performance indicators about weaning practices is essential which could help in evaluating weaning practices and linking them to child health.
- Revision and updating of the technical instructions to include weaning practices is essential.
- Upgrading health provider's skills and knowledge about weaning is essential possibly through practical training, workshops and continuing education activities.
- Weaning practices must be included in any workshops or training about breastfeeding.
- Weaning need to be included in the counseling and health education services particularly during well baby visits.

- Counseling session about weaning should focus on
    - Complementary feeding
    - Honest of weaning
    - Traditional methods and its negative impact
    - How weaning should take place
- Health awareness campaigns about weaning should be organized focusing on the addressing traditional weaning practices accompanied by the usage of pamphlets and audiovisual materials about weaning in health centers.
- Influential persons such as mothers in law, family members, community leaders and religious persons should be included in the campaigns to support appropriate weaning practices.
- Efforts aiming to induce social change for promoting appropriate weaning practices could be launched out through the usage of media (T.V, Radio), advocacy and lobbying.

Recommendations for further studies

- A study to find out if exclusive breastfeeding continues up to 6 months age, and what is the factors and barriers affect EBF.
- Conducting a study to find the effect of traditional methods on the psychological status of the child.
- A study to find the compliance of the health provider in MCH to weaning and BF education.
- A study at national level including other health providers such as MOH, NGOs related weaning practices is needed.

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Annex1

Map of Palestine

PCBS, 2007

Annex 2

البقرة 233

وَالْوَالِدَاتُ يُرْضِعْنَ أَوْلَادَهُنَّ حَوْلَيْنِ كَامِلَيْنِ لِمَنْ أَرَادَ أَنْ يُتِمَّ الرَّضَاعَةَ وَعَلَى الْمَوْلُودِ لَهُ رِزْقُهُنَّ وَكِسْوَتُهُنَّ بِالْمَعْرُوفِ لَا تُكَلَّفُ نَفْسٌ إِلَّا وُسْعَهَا لَا تُضَارَّ وَالِدَةٌ بِوَلَدِهَا وَلَا مَوْلُودٌ لَهُ بِوَلَدِهِ وَعَلَى الْوَارِثِ مِثْلُ ذَلِكَ فَإِنْ أَرَادَا فِصَالًا عَنْ تَرَاضٍ مِنْهُمَا وَتَشَاوُرٍ فَلَا جُنَاحَ عَلَيْهِمَا وَإِنْ أَرَدْتُمْ أَنْ تَسْتَرْضِعُوا أَوْلَادَكُمْ فَلَا جُنَاحَ عَلَيْكُمْ إِذَا سَلَّمْتُمْ مَا آتَيْتُمْ بِالْمَعْرُوفِ وَاتَّقُوا اللَّهَ وَاعْلَمُوا أَنَّ اللَّهَ بِمَا تَعْمَلُونَ بَصِيرٌ

الطلاق 6

ۦأَسْكِنُوهُنَّ مِنْ حَيْثُ سَكَنْتُمْ مِنْ وُجْدِكُمْ وَلَا تُضَارُّوهُنَّ لِتُضَيِّقُوا عَلَيْهِنَّ وَإِنْ كُنَّ أُولَاتِ حَمْلٍ فَأَنْفِقُوا عَلَيْهِنَّ حَتَّى يَضَعْنَ حَمْلَهُنَّ فَإِنْ أَرْضَعْنَ لَكُمْ فَآتُوهُنَّ أُجُورَهُنَّ وَأْتَمِرُوا بَيْنَكُمْ بِمَعْرُوفٍ وَإِنْ تَعَاسَرْتُمْ فَسَتُرْضِعُ لَهُ أُخْرَى (٦) لِيُنْفِقْ ذُو سَعَةٍ مِنْ سَعَتِهِ وَمَنْ قُدِرَ عَلَيْهِ رِزْقُهُ فَلْيُنْفِقْ مِمَّا آتَاهُ اللَّهُ لَا يُكَلِّفُ اللَّهُ نَفْسًا إِلَّا مَا آتَاهَا سَيَجْعَلُ اللَّهُ بَعْدَ عُسْرٍ يُسْرًا ٧

الاحقاف 15

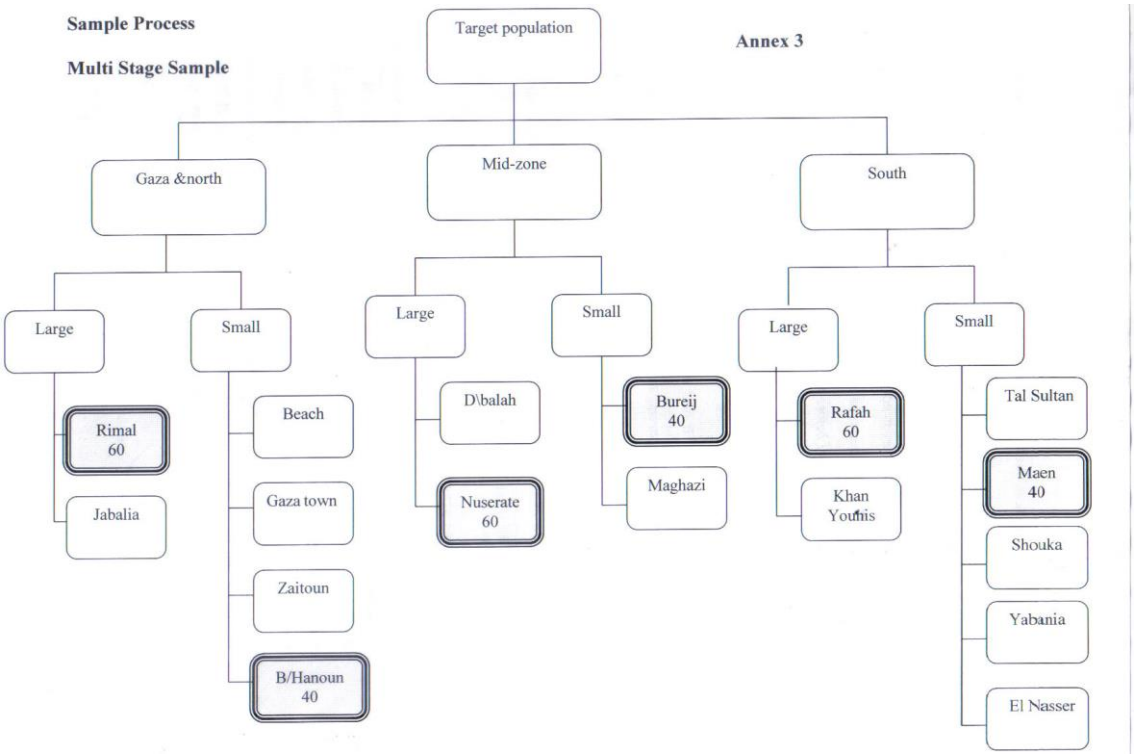
وَوَصَّيْنَا الْإِنْسَانَ بِوَالِدَيْهِ إِحْسَانًا حَمَلَتْهُ أُمُّهُ كُرْهًا وَوَضَعَتْهُ كُرْهًا وَحَمْلُهُ وَفِصَالُهُ ثَلَاثُونَ شَهْرًا حَتَّى إِذَا بَلَغَ أَشُدَّهُ وَبَلَغَ أَرْبَعِينَ سَنَةً قَالَ رَبِّ أَوْزِعْنِي أَنْ أَشْكُرَ نِعْمَتَكَ الَّتِي أَنْعَمْتَ عَلَيَّ وَعَلَى وَالِدَيَّ وَأَنْ أَعْمَلَ صَالِحًا تَرْضَاهُ وَأَصْلِحْ لِي فِي ذُرِّيَّتِي إِنِّي تُبْتُ إِلَيْكَ وَإِنِّي مِنَ الْمُسْلِمِينَ 15

لقمان 14

وَوَصَّيْنَا الْإِنْسَانَ بِوَالِدَيْهِ حَمَلَتْهُ أُمُّهُ وَهْنًا عَلَى وَهْنٍ وَفِصَالُهُ فِي عَامَيْنِ أَنِ اشْكُرْ لِي وَلِوَالِدَيْكَ إِلَيَّ الْمَصِيرُ ١٤

Annex 3

Sample process



Annex 4

B D:\E| · jDjx

Epilofo y ft *- :· L on ^ Statcalc **Novewber 1993**

Population Survey OF Descriptive Study l)r ing Randon <Not Cluster) Sanpling

Population Size : 33.HUH

Expected Frequency : 90.00 *y.*

Worst Acceptable OTFTC x

Confidence **Level** Sanple Size

80 /. 90 /. **102**
•5 / 99 /. **168**
99.9 *y.* 238
99.99 *y* **408**
661
917

Change value of Population. Frequency, or Worst Acceptable to recalculate.

Annex 5

Palestinian National Authority
Ministry of Health
Helsinki Committee

السلطة الوطنية الفلسطينية
وزارة الصحة
لجنة هلسنكي

Name:

التاريخ2009/6/3

I would like to inform you that the committee has discussed your application about:
Weaning Practices among: Mothers attending UNRWA Health Centers-Gaza Governorates

الاسم: هدى خليل طه سمور
نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-

In its meeting on June 2009 and decided the Following:-
To approve the above mention research study.

و ذلك في جلستها المنعقدة لشهر 6 2009
و قد قررت ما يلي:-
الموافقة على البحث المذكور عاليه.

Signature
توقيع

Member
عضو

Member
عضو

Chairperson

Conditions:-
- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Annex6

Al-Quds University
Jerusalem
School of Public Health

جامعة القدس
القدس
كلية الصحة العامة

2009/6/30

الأخ/د. محمد المقادمة المحترم
مدير دائرة الصحة–وكالة الغوث
تحية طيبة وبعد،،،

الموضوع: مساعدة الطالبة هدى سمور

تقوم الطالبة المذكورة بأعلاه بإجراء بحث بعنوان :

"Weaning Practices among Mothers attending UNRWA Health Centers in Gaza Governorates"

كمتطلب للحصول على درجة الماجستير في الصحة العامة–مسار إدارة صحية و عليه نرجو التكرم للإيعاز لمن تروته مناسب لتسهيل مهمة الطالبة في جمع البيانات اللازمة من عيادات الرعاية الأولية التابعة لإدارتكم الموقرة .
علماً بأن المعلومات ستكون متوفرة لدى الباحثة و الجامعة فقط.

و اقبلوا فائق التحية و الاحترام،،،

د. بسام أبو حمد
منسق عام برامج الصحة العامة

Approved
OLC HP
30/6/09

نسخة:
- الملف

cc: HCs

Jerusalem Branch/Telefax 02-24799234
Gaza Branch/telefax 08-2884422-2884411
Sphealth@admin.alquds.edu
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ص.ب/51000-القدس

Annex 7

Informed consent

Research title: Weaning practice of nursing mother at UNRWA health centers in Gaza strip

Hello, my name is Huda sammour I am master student of public health at Al Quds University-Palestine.

I am conducting my research as a part of my study requirement at the university.

The study aims to evaluate **the weaning practice of nursing mother at UNRWA health centers in Gaza strip** The study will help illustrating tools for improvement thus could lead to more adherence, less complications, and better outcomes of child health

I highly appreciate your participation in this study.

The questionnaire takes 10 to 15 minutes, if you feel tired or uncomfortable please ask to hold the interview.

Participation in this study is voluntary and you have the right to withdraw at any time. Confidentiality will be provided, no need to write down your name.

Please answer the questions you as feel, and practice in reality.

Thank you very much in advance for your co-operation.

Huda sammour **9849300**

Annex 8

Questionnaire about Weaning In UNRWA Health Clinics in Gaza

Serial number…..	Area…..	Date …… Clinic name….

FIRST	**Personal Characteristics**	
1.	Child's name	
2.	Date of birth of the last child	/ /
3.	Child age in months	**……**m
4.	Sex	□ Male □Female
5.	Current weigh	…….. gm □Normal wt □ under wt
6.	Infant's order among his brothers and sisters	
7.	Mother's age	……years
8.	Total Study years for mother	**……..** years
9.	Total Study years for father	……..years
10.	Mother's occupation	
11.	Father's occupation	
12.	Type of family	□ Nuclear No…….persons □ Extended No…….persons
14.	Marital status	□Married □ Divorced □Separated □ Widowed □Others Specify……..
15.	House ownership	□ Completely owned □Family owned □ Rented □ Destroyed during war □Other Specify……..
16.	Are you facing/Have you faced family problems during weaning? If no skip toQ21 If yes:	□ Yes □ No □ Refuse to answer
17	What are the nature of these problems?(you can chose more than one) prompted	□ Social □ Economical □ Political □ Other Specify……..
18.	If it is social problem, with whom**?**	□ Husband □ Childern □ husband's family □ relatives' □ friends' □Others Specify……..

	If you are a **working woman** answer Q21,Q22	
19	Where do you leave your baby when you go to work?	□ With your family □ With you in the work field □ In nursery □Others Specify……..
20	For how long do you leave your child?	……hr/day
21	Was your baby born with health problems? If yes	□ Yes □ No
22	What was the problem?	
23	Family income	□Less than 1000 □more than 3000 □From 1000 to 3000 □ refuse to answer □Don't know
Second	**Breastfeeding and weaning practices**	
24	Do you breastfeed your baby?	□ Yes □ No if no skip to 28
25	Do you breastfeed exclusively?	□ Yes □ No
	If yes	
26	How long have you breastfeed exclusively?	…….m
27	If you have already stopped breast feeding When did you stop breastfeeding?	.....age in month
28	What are the reasons for weaning?	□The baby is more than18 months old. □To improve child feeding □Social pressure □Pregnancy □Better for the mother to rest □Baby weaned himself /herself □ Illness of the mother □ Others Specify…
30	What is your approach in weaning?	□Gradually □ Sudden
31	Why do you prefer that approach**?**	□ Better for the mother's health □Better for the child's health □ pregnancy □Keeps strong bonds between mothers and children □Other Specify……
32	How long dose the weaning process take? (From decreasing B F to complete stoppage BF).	
33	Do you use any traditional methods in	□ Yes □ No

	weaning?			
	If yes			
34	Do you believe in these methods?(you can chose more than one) prompted	Yes	No	
	□ Coffee on the nipple			
	□ Red substance on the nipple			
	□Other substances with bad taste on the nipple (salt, lemonic acid,sabra murra,paper)			
	□Use of alternatives as formula, juices..etc			
	□Isolation For how long?			
	□Alternative breast one after another			
	□Others			
35	Do you practice any of the following methods?(you can chose more than one) Prompted	Still Practice	Used to practice	Never Practiced
	□ Coffee on the nipple			
	□ Red substance on the nipple			
	□Other substance with bad taste on the nipple (salt, lemonic acid,sabra murra,paper)			
	□Use of alternatives as formula , juic			
	□Isolation For how long?			
	□Alternative breast one after another			
	□Others Specify…			
36	Do you know the following aspect about weaning practices?	Yes	No	
	□Start to decrease breastfeeding gradually			
	□Try to start in the winter not in the summer.			
	□ Begin feeding with food than breastfeeding			
	□Never use any substances on the nipple as……..			
	□Don't let your baby away from you during weaning for a long time.			
	□Be patient with your baby during weaning.			
	.□ Baby may be irritable , restlessness, anxious			
	.□ Avoid making your child see your breast.			
37	What is the source of your information about weaning?	□ Family □ Health educators' □ MCH nurse	□ Media	

		□ Friend □ Others Specify…
38	Did you have any problem with your children **during** weaning?	□ Yes □ No
39	What was this problem?	□Loss of appetite □Loss of weight □Psychological problems □Insomnia □Others Specify…
40	Did you have any problem with your children **after** weaning?	□ Yes □ No
41	What was this problem?	□Loss of appetite □Loss of weight □Psychological problems □Insomnia □Others Specify…
42	what do you do with this problem?	□Increase breast feeding □ Increase the amount of food □ Increase the No of meals □Others Specify…
43	How do you describe your baby food before stopping breastfeeding?	Quantity □ Normal □ Good □ Few □ Very few Quality □ Normal □ Good □ Poor □ Very poor
44	How do you describe your baby food after stopping breastfeeding?	Quantity □ Normal □ Good □ Few □ Very few Quality □ Normal □ Good □ Poor □ Very poor
45	Do you emphasize on certain food during weaning?	□ Yes □ No
	If yes	
46	What is this food?	
47	When do you give weaning food?	□ Before Breast feeding □ After breast feeding □ No relation to breastfeeding
48	Who influenced your decision about stopping breastfeeding?	□The husband □The mother experience □The mother in law □The child □ No one □Child grandmother

49	Are there any differences in weaning practices between male and female children?	□ Yes □ Not applicable		□ No	
50	if yes specify				
51	. What do you use for male children?	Specify			
52	. What do you use for female children?	Specify			
53	During your visit to MCH did you receive counseling about weaning?	□ Yes		□ No	
54	When did you receive this counseling?	. □During immunization visit □During treatment □During health educational sessions inMCH			
55	Who gave you counseling about weaning?	□Nurse □SSN		□Dr. □Health educator	
56	How many times did you receive counseling about weaning?	……..			
57	Did you receive any education material about weaning?	□Yes □ Don't remember		□No	
58	Which of the following aspects of weaning were discussed with you during your visits to MCH?	□Yes spontaneously	□Yes after asking	□No	□Don't remember
	□Start to decrease breastfeeding gradually				
	□Try to start in the winter not in the summer.				
	□ Begin feeding with food than breastfeeding				
	□Never use any substances on the nipple as……..				
	□Don't let your baby away from you during weaning for a long time.				
	□Be patient with your baby during weaning.				
	.□ Baby may be irritable , restlessness, anxious				
	.□ Avoid making your child see your breast.				

Annex 9

Distribution of weaning approach by child weight

Variables	Gradual		Sudden		Total		X^2	P
	N	**%**	**N**	**%**	**N**	**%**		
Normal weight	**29**	**87.9**	**221**	**87.7**	**250**	**87.7**	**.001**	**.976**
Under weight	**4**	**12.1**	**31**	**12.3**	**35**	**12.3**		

Annex 10

Distribution of mothers' practice of different traditional methods by health centers

Variables	BH		Rimal		Brej		Nuserate		Maen		Rafah		Chi-square	P – value
Used to practice	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**		
Coffee	3	10.7	10	3507	0	0	2	7.1	1	3.6	12	42.9	19.36	.002
Red substances	2	6.5	5	16.1	4	12.9	10	32.3	3	9.7	7	22.6	4.62	.54
Bad taste substances	12	10.2	25	21.2	20	16.9	32	27.1	9	7.6	20	16.9	12.539	.28
Alternatives	15	31.6	16	20.3	4	5.1	4	5.1	18	22.8	12	15.2	60.62	0
Isolation	14	25.5	17	30.9	3	5.5	0	0	9	16.4	12	21.8	30.08	0
Drug	1	5.3	10	52.6	4	21.1	0	0	0	0	4	21.1	18.84	.002
Alternative breast	7	25	1	3.6	0	0	2	7.1	10	35.7	8	28.6	30.12	0

دراسة الممارسات والعادات المتبعة عند الفطام لدى الأمهات المترددات علي عيادات وكالة الغوث في قطاع غزة

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ملخص الدراسة

اهداف الدراسة:

على الرغم من أن الرضاعة الطبيعية والفطام لهما أدوار هامة في مجال صحة و نمو الطفل ، إلا أن كثير من الناس لا تعطي فترة الفطام قدرها من الأهمية. إن الهدف العام من هذه الدراسة هو استكشاف أنماط وممارسات الفطام بين الأمهات اللواتى يحضرون إلي مراكز الرعاية الأولية التابعة لوكالة الغوث في قطاع غزة ، من أجل توفير المعلومات التي يمكن أن تدعم تغذية الأطفال وأثرها على صحتهم .

منهجية الدراسة:

إن هذه الدراسة هي وصفية تحليلية نفذت في مراكز تابعة لوكالة الغوث الدولية في قطاع غزة لقد اختيرت عينة الأمهات البالغة 285 أم باعتماد الطريقة الطبقية النسبية المتعددة وتمت مقابلتهم مباشرة في محطات التطعيم وذلك بتعبئة استبانه تم إعدادها بواسطة الباحثة وكان معدل الاستجابة 95% .

نتائج الدراسة:

كشفت نتائج الدراسة أن متوسط سن الفطام 14 شهر وان الغالبية العظمى من الأمهات يستخدمن الفطام المفاجئ (88.4 ٪) ، منهم 65.3 ٪ يقمن باستخدام الطرق التقليدية في الفطام. وكشفت الدراسة عن أن الأسلوب الأكثر شعبية(التقليدية) التي تستخدمها الأمهات كانت المواد ذات المذاق السيئ خصوصا الصبرا المرة. واستخدام الأساليب التقليدية تختلف وفقا للمنطقة. حيث أن غالبية الأمهات اللاتي يستخدمن القهوة على الحلمة كوسيلة للفطام (46.4 ٪) كانت من قطاع غزة والجنوب والشمال في إطار مجموع الأمهات اللاتي يستخدمن القهوة ، وأعلى نسبة مئوية لاستخدام المواد ألحمراء على الحلمة مثل احمر الشفاه والطماطم وطلاء الأظافر كانوا من المنطقة

الوسطي ويشكلون (45.2 ٪). وعلاوة على ذلك ، نعتبر استخدام البدائل في الفطام مثل اللهاة والمصاصة و العصير موجودة بأعلى نسبة في مدينة غزة (51.9 ٪) ، و أعلى معدل لاستخدام طريقة التبادل بين الثديين من الجنوب (64.3 ٪).

ووجدت الباحثة أن السبب الرئيسي للفطام كان الحمل (42.8 ٪) ، والأمهات يخترن طريقة الفطام اللاتي يعتقدن أنه من الأفضل لأطفالهن ، إلى جانب أن الأغلبية يفطمن أطفالهم من 13 إلى 18 شهرا (43.9 ٪). وعلاوة على ذلك ، 50 ٪ من الأمهات يتخذن قرار الفطام من تلقاء أنفسهم.

بشأن المعلومات الصحية والنصائح التي تتلقاها الأمهات عن الفطام ا كشفت الدراسة أن الطريقة الصحيحة للفطام لم تكن مدرجة في خطة التثقيف الصحي في المراكز الصحية. والواقع أن الغالبية العظمى من مصدر للمعلومات حول الفطام كان من العائلة وخاصة من الأمهات والحموات حوالي 94 ٪. وأظهرت الدراسة أن 80 ٪ من الأمهات و 85 ٪ من الآباء الذين حصلوا علي مستوى تعليمي أقل من 6 سنوات يستخدمون الأساليب التقليدية. وهذا يعني أن استخدام الطرق التقليدية يكون أكثر عند الآباء ذو مستوي تعليمي منخفض أكثر من الآباء ذو مستوي تعليمي عالي. وكشفت الدراسة عن أن هناك علاقة كبيرة بين استخدام الأساليب التقليدية والمشاكل أثناء وبعد الفطام.

التوصيات:

وقدمت الدراسة مجموعة من التوصيات الأولية التي يمكن أن تحسن ممارسات الفطام مثل زيادة اهتمام واضعي السياسات ومديري البرامج لهذه النقطة الهامة ، وذلك باستمرار الدعم والمراجعة والتحديث الدوري للإرشادات الفنية و التقنية ، ورفع مستوى تقديم الخدمات الصحية والمهارات والمعارف و زيادة معارفهم من خلال التدريب العملي ، وتعزيز الإرشاد والتثقيف الصحي حول الفطام لا سيما في الدورات التدريبية واستخدام الكتيبات والمواد السمعية والبصرية اللازمة حول الفطام في المراكز الصحية. تقديم تدريبات عملية عن الفطام بشكل خاص للموظفين والموظفات الجدد, دعم وتشجيع تقديم المشورة الفعالة للأمهات , الاهتمام بالمتابعة و تقوية نظام المتابعة . إن مديري الصحة وصانعي القرار بإمكانهم تحسين ممارسات الفطام بتبني علي الأقل بعضا من هذه التوصيات وتطبيقها.