

Breast feeding in refugee context: a scoping review

Juliana Vidal Vieira Guerra,*Valdecyr Herdy Alves, Audrey Vidal Pereira and Gabriela Cardoso Rodrigues Rangel

^aEscola de Enfermagem Aurora de Afonso Costa – Universidade Federal Fluminense, Rua Dr Celestino 74, Niterói. 24020-091, Brasil.

ARTICLE INFO

Article history:

Received 20210303

Received in revised form 20210313

Accepted 20210323

Available online 20210405

Keywords:

Breast feeding;

Refugees;

Human migration;

Involuntary Migration.

ABSTRACT

To map in the scientific literature the extent to which forced international migration changes the practice of breastfeeding. Method: Scoping review where the guiding question was: "Does forced international migration change the practice of breastfeeding in refugee women?" and searches were carried out between December 2018 and March 2019 in the databases: LILACS, MEDLINE, SciElo, BDEFN, Scopus and PubMed Central. Results: 8 studies were selected for the review. After the thematic analysis, 4 thematic categories emerged: knowledge versus breastfeeding practice; cultural and religious trends; performance of health services; and barriers to the practice of breastfeeding in resettlement. Conclusion: Forced migration alters the practice of breastfeeding in refugees, being intensified as a socio, ideological and culturally learned practice, or seen as primitive and non-normative conditioned to the destination country.

2021 Sciforce Publications. All rights reserved.

*Corresponding author. Tel.: +55-21 98485-8451; e-mail: julianaguerra@id.uff.br

Introduction

Breastfeeding (BF) is a secular and strategic practice of feeding newborns, which is related to the physiological, emotional, and social integrity of women. It also contributes to maintaining the healthy state of the child, regarding immunization and the consequent reduction in the risk of developing various diseases.¹⁻² In addition, breastfeeding, a safe and healthy food, promotes the bond between mother and baby and the child's food and nutritional security.³

The World Health Organization recommends that exclusive breastfeeding be established immediately after delivery, preferably within one hour of postpartum.⁴⁻⁵ And that it is carried out exclusively until the age of 6 months, and after that it is completed until the child's 2 years or more. Thus, as a practice solely related to the female gender, it requires knowledge, persistent learning, encouragement, and support, both by health professionals, civil society, and the family.⁶⁻⁷ EBF adherence rates up to six months of age vary between countries and appear to be related to health policies related to the support, promotion and protection of BF, the culture, and the financial income of families.⁸⁻⁹ Global rates of exclusive breastfeeding indicate that 43% of newborns are breastfed at 1 hour of life, while 41% are exclusively breastfed up to 6 months. As for the rates of BF in the 1st and 2nd year of life, they are 70% and 60% respectively.

However, these rates are below expectations, and it is desirable that by 2030, these rates should be boosted in order to obtain greater protection for women and children.¹⁰

When populations are forced to involuntary migration due to well-founded fears of persecution, which may be related to race, religion, nationality, social group or political opinion, to the widespread violation of human rights, violence, natural disasters and armed conflicts, migration to a new country is a condition for survival in refuge.¹¹ However, contact with new cultures can affect the ways, habits and practices of the populations that experience the refuge.

Thus, it is understood that the BF process experienced by women subjected to forced international migration may also differ from those found in their country of origin. Since women have the role of co-protagonist of breastfeeding, it is important to understand the reality presented at the refuge, regarding the possibilities of maintaining or starting the practice of breastfeeding. Therefore, the socio-economic-political-cultural factors related to the support, promotion and protection of breastfeeding can differently influence the practice of breastfeeding in the refuge. Thus, it is intended to map in the scientific literature the extent to which forced international migration alters the practice of breastfeeding.

Abbreviations

BF, breastfeeding. EBF, exclusive breastfeeding.

Material and methods

Scoping Review Study that aims to map the main concepts that support a given area of knowledge, examining the extent, scope and nature of the investigation, and synthesizing, propagating data, and identifying research gaps. The SR consists of distinct and integrated steps: elaboration of the research question, the search for studies, data extraction, analysis of the included studies with interpretation of results and presentation of the review.¹²⁻¹³

Therefore, the guiding question of this scope review was elaborated from the use of the mnemonic PCC,¹² which considered Population: refugee women, Concept: international migration and breastfeeding practice and the Context: health services and non-governmental organizations. Guiding question: "Does forced international migration change the practice of breastfeeding in refugee women?"

The databases where the searches were performed were: Latin American and Caribbean Center for Health Sciences Information (LILACS), US National Library of Medicine (MEDLINE), Scientific Electronic Library Online (SciELO), Nursing Database (BDFN), Scopus, US National Institutes of Health (PubMed Central). Descriptors were delimited for searches after consulting the trilingual dictionary Descriptors in Health Sciences (DeCS) and MeSH (Medical Subject Headings).

The surveys were carried out in December 2018 to March 2019 and the following descriptors were used, in Portuguese, English and Spanish: "Human Migration"; "Refugees"; "Infant Nutrition" and "Breastfeeding". The descriptors were combined in order to find studies that addressed breastfeeding or breastfeeding in refugees in the post-settlement. In the MEDLINE database, the descriptor "Infant nutrition" was used as "Infant food". The descriptors were combined as follows: "Human Migration AND Breastfeeding"; "Human Migration AND Infant Nutrition"; "Refugees AND Breastfeeding" and "Refugees AND Infant Nutrition". The searches in the databases were standardized with the same combination of descriptors, as for example in PubMed Central the search strategy: ("human migration" [MeSH Terms] OR ("human" [All Fields] AND "migration" [All Fields]) OR "human migration" [All Fields]) AND ("breast feeding" [MeSH Terms] OR ("breast" [All Fields] AND "feeding" [All Fields]) OR "breast feeding" [All Fields]) AND ("2013/01/01" [PubDate]: "2018/11/31" [PubDate]).

Articles were included that addressed the cultural, social, economic, political, and ideological aspects of breastfeeding in resettlement and that answered the study question, in the languages: English, Portuguese and Spanish, available in full and with free access, published between January 2013 and November 2018, the period following the outbreak of World Humanitarian Crises with intense migratory processes in the American, African and Middle East continents.

The analysis of the study was carried out in a descriptive manner aiming to answer the guiding question, considering the

ethical aspects, and respecting the authorship of the ideas, concepts and definitions present in the included articles. The studies were initially evaluated by titles and abstracts to improve the study considering only the articles that stood out for responding to the proposed objective of this review. In the subsequent phase, a full reading of each selected article was carried out, to broaden reflections on the health scenario, and seeking to recognize the aspects of interest that were recurrent or that stood out. Then, the articles were organized in an instrument prepared by the authors, for the extraction and collection of data for the construction of the scoping review, such as: year of publication, country where the study was conducted, authors, study population, objective and main information regarding the practice of breastfeeding. The analysis took place in detail, observing the subjects to which each article referred.

The initial search carried out by two independent reviewers, with a standardized protocol for using the descriptors and combinations in the databases. 916 articles were found. After applying the inclusion and exclusion criteria, there were a total of 30 studies that, after reading the titles and abstracts, 17 were thoroughly assessed, and those that showed some aspect of breastfeeding in refugee women, as well as 8 articles included in the review, as shown in Figure 1.

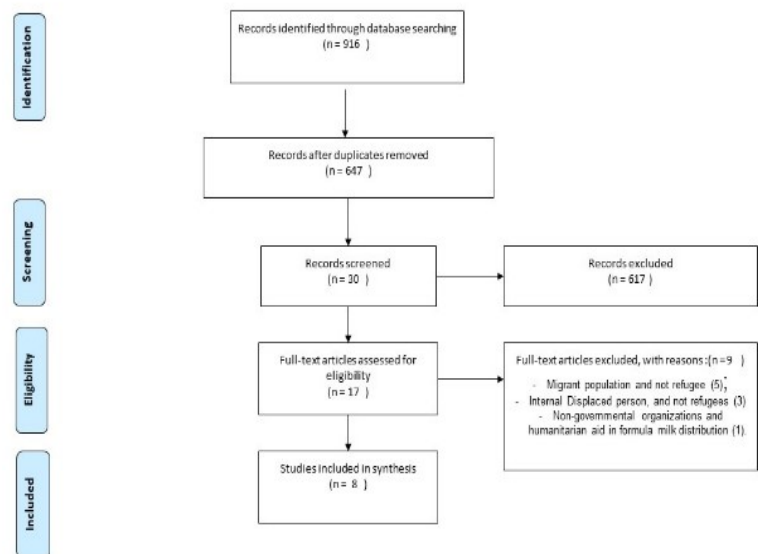


Figure 1. PRISMA de Scoping Review¹². Source: review data, Niterói, RJ, 2020.

Results

Of the 8 articles included in this review, all were in the English language, with 3 (37.5%) studies conducted in Canada,²

Table 1.

Identification	Author	Year	Country which study was conducted	Idiom	Population of the study
A1	Jino e col. ⁽¹⁴⁾	2013	Ghana	English	Refugees from Kigali and Rwanda
A2	Jessri e col. ⁽¹⁵⁾	2013	Canada	English	Migrants e refugees from Middle East
A3	Denis e col. ⁽¹⁶⁾	2014	Canada	English	Refugees and migrants living in Canada
A4	Gallegos e col. ⁽¹⁷⁾	2015	Australia	English	Refugees from Liberia, Sierra Leone, Burundi and Democratic Republic of Congo
A5	Jessri e col. ⁽¹⁸⁾	2015	Canada	English	Migrantes e Refugiadas Árabes e Iranianas
A6	Hufton e col. ⁽¹⁹⁾	2016	England	English	Refugees in Liverpool and Manchester
A7	Hunter-adams e col. ⁽²⁰⁾	2016	South Africa	English	Migrants And refugees from Democratic Republic of Congo Somalia e Zimbabwe
A8	Woldeghebric col. ⁽²¹⁾	2017	Ghana	English	Liberian Refugees

Source: review data, Niterói, RJ, 2020.

Knowledge versus Practice of Breastfeeding

(25%) conducted in Ghana, and 1 (12.5%) conducted in each of the respective countries: England, Australia and South Africa, as shown in table 1. The nature of the studies should be highlighted: 4 (50%) studies of a qualitative nature and 4 (50%) of a quantitative nature. After exhaustive reading of the studies, the thematic analysis of the studies was carried out, and the following thematic categories emerged: knowledge versus practice of breastfeeding; cultural and religious trends; barriers to the practice of breastfeeding in resettlement; performance of health services.

All studies signaled the influence of culture, on the breastfeeding of refugee women, even if comparing it to migrant women or to residents of the country of settlement itself. 14-21 However, culture is only one factor that relates to the practice of breastfeeding, especially in the refuge situation where the adaptation process also crosses barriers such as: the language, gender inequalities, and the previous knowledge of the breastfeeding mother, the performance of health professionals and services, and support, promotion and protection policies.

In study A1,¹⁴ low rates of BF were found, 34.4% (n = 31) among interviewed refugees resettled in Rwanda, mostly (90%) from the Democratic Republic of Congo. However, these data, as mentioned in the study, contradict the knowledge and attitudes rates of refugees 74% (n = 67) in relation to EBF in children aged zero to six months. Therefore, despite having high knowledge about the practice, encouraging other women, having beliefs that EBF up to six months is desirable and beneficial, the rates of adherence to the practice are low. It also mentions that these rates are below the rates found in the settlement country

itself, Rwanda, where the rate of EBF up to six months of age is 38%, and the rates presented in the Democratic Republic of Congo are 36.1% . (14) Thus, it is noted that the practice of BF is impacted by migration, even though the refugee population has knowledge and attitudes in favor of it.¹⁴

In study A8²¹, the context of the refuge in Ghana is presented, in particular that of Liberian refugees, resettled in the Buduburam camp and the rates of BF in comparison to those found in the native population. The study points out that of the 480 women participating: 239 were resettled Liberians and 241 Ghanaians. And that Liberians who resettled for eight years or more were significantly more likely to practice EBF when compared to Ghanaians.²¹ This suggests that the longer stay in Ghana, promoted greater adherence to the practice among refugees. It also points out that these findings may be related to the opportunities for education and support offered in the resettlement of refugees and that it was not accessible to native women.²¹ Therefore, it is essential that the entire population be supported with promotion, support, and protection to BF for the success of the practice of breastfeeding.

Cultural and Religious Trends

Study A2¹⁵ presents the perceptions and experiences of twenty-two immigrants and refugees of Iran (6) and Saudi Arabia (16) origin in AM in Canada. It is pointed out that breastfeeding has a strong relationship with the religious context. The interviewees were Islamic and recognized that since childhood, they were taught in the religious belief that children should be breastfed until the first two years of life, thus demonstrating the religious culture favorable to the practice of breastfeeding, even after settling in another country. And the

continuity of this knowledge in BF maintenance. However, they show that in their culture it is common to give food to the newborn, before BF, that is, they do not perform BF in the first 6 months, contrary to the recommendations of the World Health Organization.⁴

It is observed in study A5¹⁸ as to the practice of infant feeding of 22 women from the Middle East and resettled in Canada that all participants followed the Islamic religion and at the time of the study, all, with the exception of one, were breastfeeding. It also shows the clear influence of religion and cultural beliefs of these refugee women on trends in practices of early food introduction with herbal infusions and sweet drinks as beneficial to the health of their children. According to the culture of these women, the use of herbal infusions helps to prevent colic, and that sweetened drinks are recommended according to Islamic teachings as the first taste to be experienced by babies.¹⁸ The practice of early feeding is not recommended by the World Health Organization. However, health is common in the Islamic religion, and with that it is necessary that they are oriented in the settlement regarding the EBF, respecting the culture they have learned, and demonstrating the benefits of breast milk in relation to digestion, immunological properties, abdominal pain and composition.

Study A4¹⁷ presents the beliefs about breastfeeding and practices of 31 refugees of African origin, who had children in their country of origin and, or in the settlement in Australia. It is presented that the refugees recognize BF as a cultural tradition, but that in the refuge the options for infant feeding are varied and affordable, making BF optional, unlike what happened in the country of origin, where these foods are scarce and financially unviable, and EBF is the only option. Therefore, in the refuge, the large offer of affordable newborn food products is an intervening factor in the choice of infant feeding practices, even in refugees who culturally recognize the importance of EBF.¹⁷

Study A6¹⁸ presents the perceptions and practices of infant feeding of 30 refugees and asylum seekers from different nationalities resettled in Liverpool and Manchester, England and 5 health professionals. In this new context, the authors cite cultural influences (tradition), such as the support of the mother and mother-in-law in encouraging BF, even though they are not present, and religious influences. Most participants expressed that in their religion they should breastfeed until the two years of life of their children, and that it is a routine practice in the country of origin.¹⁸

Study A7¹⁹ presents the perception related to the practice of BF of 23 migrants and refugees of different nationalities from the African continent, such as Somalia, Zimbabwe and the Democratic Republic of Congo, resettled in the capital of South Africa. These expressed that although in the country of origin the practice of EBF is common, in the settlement there is the regulation of adherence to infant formulas. Therefore, they have low adherence to EBF, and the authors suggest that it is related to the factors expressed by the refugees: high workload, and housework, stress, inadequate maternal diet. The participants expressed that the resettlement place is considered to be the

place of work and prioritize work, which adds to the belief that the maternal diet is not adequate to produce sufficient milk and to adequate child development. In addition, the participants expressed appreciation for the babies' weight gain, as an essential factor in adhering to the formula. The belief that the introduction of the formula will accelerate weight gain, is combined with the appreciation of the baby with high weight. Demonstrating strong influence of the resettlement culture and the overlap of knowledge and practices from the original culture.¹⁹

Barriers to the practice of breastfeeding in resettlement

In study A2¹⁵ regarding the experiences of BF among Islamic refugees, the study points out as barriers the lack of support from local society in relation to the maintenance of BF practice. The study participants cited the lack of support for the practice through the perception that for Canadian society the practice of BF is outdated, and it is a practice that consumes the time of individuals and damages the aesthetics of women. Therefore, they also cited the lack of public places suitable for the practice, including in workspaces, where there is a lack of adequate places for women to perform the milking and storage of breast milk in ideal conditions. They also mention that, as a means of coping with the Canadian reality, to maintain the practice, they use the following strategies: they use cloths to cover their breasts and breastfeed in public, and when possible, they also introduce alternative foods such as rice porridge to replace the practice in public or perform the expressing and expressing of breast milk in advance. Thus, the participants also point out that infant formula is convenient for the Canadian population.¹⁵

In the A5¹⁸ study, the authors cite that barriers in relation to infant feeding recommendations in relation to BF and the introduction of complementary feeding for 22 refugees from the Middle East, and residing in Canada, are categorized into three groups: socio-cultural barriers, barriers of the health system itself in resettlement and personal barriers. Socio-cultural barriers refer to the beliefs of the culture of origin, the stigma of breastfeeding in public, the lack of appropriate public places to practice that does not expose the Muslim. In addition, the barriers of the health system mention the lack of appropriate resources for refugees to follow recommendations, such as the lack of audiovisual resources in the language of these mothers, the recommendation of financially inaccessible utensils and equipment for preparing food. Personal barriers, the authors cite the lack of knowledge, experience with infant feeding, making the most suggestive of the early introduction of homemade foods.¹⁸

Study A4¹⁷ presented the beliefs and practices of the AM of 31 refugees from African countries residing in Brisbane and Perth, Australia, and who had children in the country of origin and in the resettlement. These expressed the stigma of shame when breastfeeding in public. A sense emerged among them that they need to conform to the Australian culture of not breastfeeding in public due to primitive and vexatious beliefs. Therefore, they do not breastfeed in public, or when they

breastfeed, they cover themselves to avoid exposure and scrutiny. They also point to the ambivalence of BF, when they express that obtaining income makes them more resourceful and thus has the power to choose whether to breastfeed or introduce other foods to children. Thus, they believe that breastfeeding is conditioned by the lack of money and the scarcity of food in the country of origin, but not in resettlement.¹⁷

In A6¹⁹ it points to the perception of refugees resettled in England about the high valuation of BF and the benefits to health and child development, the recognition that breast milk is natural, better for the child's immunity. However, the health professionals participating in the study explained that they tend to use infant formulas when they are newcomers who are afraid, tired and when they are influenced by other residents. Or in the case of women who have lived in the resettlement country for years, they are influenced locally and use infant formulas.¹⁹

Health Services Performance

If, on the one hand, socio-economic-cultural barriers tend to influence the practice of BF, as well as religion, on the other hand the promotion, protection, and encouragement of health systems in resettlement are prerogatives that must be organized. However, studies point to the difficulties of health professionals in orienting refugees.^{15-16,21} In study A2, the participants indicate they are unaware of the existence of breastfeeding clinics in Canada, which promote and guide BF, and still demonstrate dissatisfaction with the attitude of health professionals who sometimes encourage the practice and sometimes assume that mothers will not be able to breastfeed. They also cite discontent with the local protocol that does not promote iron supplementation in the first four months of babies' lives, since specific foods for children are fortified, so infant formulas are more convenient for the local culture, that is, contrary recommendations of the world health organization.¹⁷

In the A3¹⁶ study on the practice of breastfeeding, the authors point to rates in Canada, among 1184 women, 374 native Canadian women and 810 migrant women, in the latter group it is emphasized that 16% (n = 127) were refugees and 36% (n = 288) asylum seekers. Regarding the evaluation of EBF rates between groups, which up to the 16th postpartum days were 50% in the group of migrant women and 70.9% in the group of native women. In addition, that in the group of migrant women, refugees were those with the lowest rates of EBF, especially those from African countries, which suggest the authors the need for support to minimize supplementation.¹⁶ Thus, it demonstrates the reduction in EBF rates by migrant mothers in Canada, with early introduction of dietary supplements, suggesting the need for greater support from health professionals to minimize supplementation and reinforce the encouragement of EBF practice.¹⁶

Study A4¹⁷ mentions that one of the barriers to adequate refugee guidance in Australia is language difficulties between health professionals and refugees. In addition, the study suggests that despite presenting many programs and actions aimed at promoting breastfeeding, there is a lack of integration between national and local governments, health organizations and support

groups. It also mentions that the little focus given to breastfeeding in Australia encourages the thought that in this country breastfeeding is considered shameful. In addition to denoting weaknesses in the health system in providing guidance in the native language without translation into the language of the refugees, that is, failure to ensure comparable access to health services.¹⁷

In study A5¹⁸, which was also conducted in Canada, it is pointed out that there are limitations of the health system in providing guidance in the language of refugees, and also the existence of contradictions between the advice of health professionals, which weaken the relationship with refugees and disbelief in the guidelines, and as a consequence do not reach the goal of protection, promotion and maintenance of BF.¹⁸

Discussion

The practice of breastfeeding is also characterized as a way of offering safe, healthy, high quality and accessible food at any time. Therefore, the practice of breastfeeding translates as an act that benefits the food and nutritional security of children aged 0 to 2 years of age or more, depending on the duration of the practice. In the refugee population, especially women and their babies, the practice of breastfeeding can have repercussions during the forced migration process.

Studies suggest that despite recognizing all the benefits of the practice of exclusive and complementary breastfeeding and having attitudes towards it, the refugee situation can denote low rates of exclusive breastfeeding when compared to the rates found in the countries of origin. However, when there is promotion of support education and support for this practice in the settlement country, there is evidence of greater adherence to breastfeeding, as demonstrated in Ghana, a country where Liberian women settlers had higher rates than Ghanaian women.²¹ which reinforces the need for constant education in the entire population and not only in vulnerable populations and yet another indication of the importance of actions in favor of breastfeeding.

Culture and traditions, including religious ones, also have an influence on breastfeeding, and as there is a custom of early introduction of foods held in populations, including refugees, of Islamic religion.¹⁵⁻¹⁸ Although studies point to respect for the tradition of religious scriptures that encourage breastfeeding until the child's 2 years of age, there is a belief that the practice of offering herbal infusions prevents colic in the baby and that before breastfeeding maternal, newborns must taste the sweet taste as the first flavor experienced in life.¹⁵⁻¹⁸ Therefore, exclusive breastfeeding is not a common reality in this population. This characteristic belief in some religions, such as in Islam, presents itself as a practice of early introduction of food, which contradicts international recommendations and denotes early complementary breastfeeding. If, on the one hand, there is recognition of the benefits, qualities, and importance of breastfeeding, on the other hand the practice does not stick to these, denoting the need to strengthen the promotion and protection of breastfeeding with the refugee population that practices food introduction early with newborns.

Knowledge is not related to the greater practice of breastfeeding, and in situations of humanitarian crises there are amenities of resources, difficulties in accessing institutional and political processes aimed at the population that may denote greater vulnerability, especially of the infant population, with fragility in food, especially when refugees do not have support from their mother-in-law, mother and other close relatives who encourage the practice.¹⁸ And that is why migration in refugee conditions can also be related to lesser breastfeeding practice, when there are beliefs that in the settlement, work, high domestic demands and inadequate maternal feeding add up to the possibility of acquiring infant formulas and they are motivations that make them choose not to breastfeed.^{15,17-19} But they recognize that access to infant formula is a financially viable strategy in the refuge, which does not occur in the country of origin.

Regarding barriers to breastfeeding, studies show that lack of support, promotion, and prevention of society in settlement countries, such as Canada and Australia¹⁷⁻¹⁸ where there is a belief that the practice is outdated and, therefore, to practice breastfeeding in public it is embarrassing for refugees who do not have specific places to do so in a protected way, not even in the workplace, and especially for Islamic ones. In addition, in countries like Australia, refugees see breastfeeding as an option due to the scarcity of resources, since they find a wide variety of products for infant feeding and prioritize accepting the local culture, fleeing the stigma of breastfeeding as a primitive and uncomfortable act in public.

In countries like England¹⁹ health professionals guide the practice of breastfeeding with formulas for refugees who arrive at the settlement with fatigue, fears or who are already influenced by other residents in the country, even recognizing the value of breastfeeding, denoting another barrier to adherence and fragility in health services that do not follow international recommendations. Still, there is an impasse in the language, since health centers do not have materials or professionals fluent in the languages of refugees,¹⁷⁻¹⁸ there is less link between refugees and health professionals, which does not generate trust, and incomprehension or even contradictions. In relation to the guidelines given, and there is a gap between the promotion of breastfeeding, protection, and support by health professionals.

Despite the studies focusing on the central theme of refugee breastfeeding in the global context, no studies were found that mentioned refugees resettled in Latin America, although it is a destination for refugees.

Conclusion

Forced migration alters the practice of breastfeeding in refugee women, making it possible to intensify it as a socioideological and culturally learned practice, or to be understood as a primitive and non-normative practice depending on the country of resettlement. The practice of breastfeeding in refugee nursing mothers differs when resettled in developed countries, contrary to the attitudes, culture and knowledge they have. Soon the complex influence of local culture and ideology, religion, imposing barriers in resettlement such as language and

financial resources, contradictions in the guidelines of health professionals and the difficulties of equal access to actions related to encouragement, protection are identified. , support and promotion of breastfeeding. It appears that the studies presented were all international, that is, they did not show the reality of refugee women in the Brazilian context, nor in Latin America, where there has been an intense process of forced migration since the socioeconomic crisis in Venezuela, which shows little production on the thematic and also the existing gap, especially in Brazil. It is important to note that the content of these studies and the relevance of the theme in the present is essential for the development of future studies nationally. Therefore, it is necessary that more studies be conducted that allow identifying in the Brazilian context, also in Latin America, how forced migration is reflected in the practice of breastfeeding.

There is a need to promote support materials translated into other languages for care actions in nursing and in the clinical management of breastfeeding as well as to improve the bond between refugee women and local health services. Regardless of the country of origin and settlement, it is essential that this population receives guidance on breastfeeding according to the recommendations of the world health organization, and that health professionals are sensitive and aligned with educational health work, mediating safe, up-to-date information and trying to create a bond with the population to strengthen the practice of breastfeeding, respecting different cultures, ideologies and traditions.

Acknowledgments

We acknowledge Universidade Federal Fluminense and Programa Acadêmico de Ciências do Cuidado em Saúde.

Conflicts of interest

Authors declare no conflict of interest.

References:

1. World Health Organization. Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services – the revised Baby-friendly Hospital Initiative. Geneva: World Health Organization; 2018. Último acesso em 03 de maio 2020. Disponível em: <https://www.who.int/nutrition/publications/infantfeeding/bf-hi-implementation/en/>
2. Maia, A. K.; Silva, B. Y. C.; Moreira, L. C. J. Effectiveness of educational interventions with pregnant women on the level of knowledge about breastfeeding. *Rev Bras Promoç Saúde*. 2019; 32: 9001. doi: 10.5020/18061230.2019.9001
3. Muñoz, S.L.; Mora, B.L.M.; Cubides, A.M.; Rodríguez, D.K.V.; Tapasco, H.C.; Marín, G. A. Aportes a la seguridad alimentaria a través de la lactancia materna en comunidades rurales. *Revista Médica Risaralda*. 2017, 23(2), 43-48. doi: 10.5020/18061230.2019.9001

4. Smith, E. R.; Hurt, L.; Chowdhury, R.; Sinha, B.; Fawzi, W.; Edmond, K. M. Delayed breastfeeding initiation and infant survival: A systematic review and meta-analysis. *PLoS ONE* **2017**, *12*(7), e0180722. doi: 10.1371/journal.pone.0180722.
5. Khan, J.; Vesel, L.; Bahl, R.; Martines, J. C. Timing of breastfeeding initiation and exclusivity of breastfeeding during the first month of life: effects on neonatal mortality and morbidity a systematic review and meta-analysis. *Maternal and Child Health Journal*. **2015**, *19*(3), 468–79. doi: 10.1007/s10995-014-1526-8.
6. Smith, R. L.; Lucas, R. Evaluation of nursing knowledge of early initiation of breastfeeding in preterm infants in a hospital setting. *J. Neonatal Nurs.* **2016**, *22*(03), 138–143. doi: <https://doi.org/10.1016/j.jnn.2015.07.009>
7. Balogun, O. O.; O'Sullivan, E. J.; McFadden, A.; Ota, E.; Gavine, A.; Garner, C. D.; Renfrew, M. J. Interventions for promoting the initiation of breastfeeding. *Cochrane Database of Systematic Reviews* **2016**, *11*, Art. No.: CD001688. doi:10.1002/14651858.CD001688.pub3
8. Cascone, D.; Tomassoni, D.; Napolitano, F.; Di Giuseppe, G. Evaluation of Knowledge, Attitudes, and Practices about Exclusive Breastfeeding among Women in Italy. *Int J Environ Res Public Health*. **2019**, *16*(12), 2118. doi: 10.3390/ijerph16122118
9. Tadele, N.; Habta, F.; Akmel, D.; Deges, E. Knowledge, attitude and practice towards exclusive breastfeeding among lactating mothers in Mizan Aman town, Southwestern Ethiopia: descriptive cross-sectional study. *Int Breastfeed J*. **2016**, *11*, 3. doi: 10.1186/s13006-016-0062-0
10. Global Breastfeeding Scorecard. Victora, C. G. Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *The Lancet*. **2016**, *387*(10017), 475–90. doi: [https://doi.org/10.1016/S0140-6736\(15\)01024-7](https://doi.org/10.1016/S0140-6736(15)01024-7)
11. Agencia, D.; ONU para Refugiados. ACNUR. Ministerio da Justica. Secretaria Nacional de Justica. Relatorio do Comite Nacional para os refugiados (CONARE). Refugio em Números. 3a Edicao. Brasil, 2018. Último acesso em 03 maio 2020. Disponível em: https://www.justica.gov.br/seus-direitos/refugio/anexos/refugio-em-numeros_1104.pdf
12. Peters, M. D. J.; Godfrey, C.; McInerney, P.; Baldini, S. C.; Khalil, H.; Parker, D. Chapter 11: Scoping Reviews. In: Aromataris E, Munn Z (Editors). Joanna Briggs Institute Reviewer's Manual. The Joanna Briggs Institute, 2017. Último acesso em 03 maio 2020. Disponível em: <https://wiki.joannabriggs.org/display/MANUAL/Chapter+11%3A+Scoping+reviews>
13. Tricco, A. C. PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Ann Intern Med*. **2018**, *69*, 467–473. doi: 10.7326/M18-0850.
14. Jino, G. B.; Munyanshngore, C.; Birungi, J. Knowledge, Attitude and practice of exclusive breast feeding of infants aged 0-6 months by urban refugee women in Kigali: a descriptive cross sectional study. *Rwanda Med. J.* **2013**, *70*, 1. https://www.researchgate.net/publication/289942736_Knowledge_attitudes_and_practices_of_exclusive_breast-feeding_of_infants_aged_0-6_months_by_urban_refugee_women_in_Kigali/link/5b903722299bf114b7f8b306/download
15. Jessri, M.; Farmer, A. P.; Olson, K. Exploring middle-eastern mothers' perceptions and experiences of breastfeeding in Canada: an ethnographic study. *Maternal and Child Nutrition*. **2013**, *9*, 41–56. doi:10.1111/j.1740-8709.2012.00436.x.
16. Dennis, C. L.; Gagnon, A.; Van Hulst, A.; Dougherty, G. Predictors of breastfeeding exclusivity among migrant and Canadian-born women: results from a multi-centre study. *Maternal and Child Nutrition*. **2014**, *10*, 527–44. doi: 10.1111/j.1740-8709.2012.00442.x.
17. Gallegos, D.; Vicc, N.; Streiner, S. Breastfeeding beliefs and practices of African women living in Brisbane and Perth, Australia. *Maternal and Child Nutrition*. **2015**, *11*, 727–36. doi: 10.1111/mcn.12034.
18. Jessri, M.; Farmer, A. P.; Olson, K. A. focused ethnographic Middle Eastern mother's infant feeding practices Canada. *Maternal and Child Nutrition*. **2015**, *11*, 671–86. doi: 10.1111/mcn.12048.
19. Hufton, E.; Raven, J. Exploring the infant feeding practices of immigrant women in the North West of England: a case study of asylum seeker and refugees in Liverpool and Manchester. *Maternal and Child Nutrition*. **2016**, *12*, 299–313. doi: 10.1111/mcn.12145
20. Hunter, J. A.; Myer, L.; Rother, H. A. Perceptions related to breastfeeding and the early introduction of complementary foods amongst migrants in Cape Town, South Africa. *International Breastfeeding Journal* **2016**, *11*, 29. doi: 10.1186/s13006-016-0088-3
21. Woldeghebriel, M.; Hromi, F.; Lartey, A.; Gallego, D. P.; Sandow, A.; Pérez, R. E. Length of time in Ghana is associated with the likelihood of exclusive breastfeeding among Liberian refugees living in Buduburam. *Maternal and Child Nutrition*. **2017**, *13*, e12363. doi: 10.1111/mcn.12363.