Using qualitative research findings to analyse how breastfeeding public health recommendations can be tailored to meet the needs of women of Bangladeshi origin living in England

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Abstract
Breastfeeding, by improving health outcomes and life chances for women and children, is a key strategy for addressing health inequalities. National evidence-based public health recommendations for breastfeeding exist in the UK (NICE (2008) Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households. NICE public health guidance 11. London: National Institute for Health and Clinical Excellence). The need to tailor interventions to the needs of diverse disadvantaged population groups is an overarching principle informing these recommendations. However, there is little evidence on how to achieve such tailored services. This qualitative paper examines the breastfeeding experiences of 14 grandmothers, 23 women of Bangladeshi origin and 28 health practitioners to illuminate how public health recommendations can be modified for diverse populations. The findings suggested that while many of the women’s needs were similar to the majority population, much current breastfeeding support is not culturally sensitive. These findings were used to interrogate barriers
to implementation of national public health recommendations to promote and support breastfeeding for women and babies from ethnically diverse communities. These included services that do not consider women’s individual needs and expectations, and practitioner stereotypes and assumptions. In addition to informing recommendations for service provision and the education of health practitioners, this analysis offers an example of using qualitative research to scrutinise how national public health recommendations might work for different population groups.

**Keywords**

breastfeeding, public health recommendations, ethnically diverse populations, qualitative research, culturally sensitive services, health practitioners

**Introduction**

Breastfeeding can make an important contribution to public health by reducing health inequalities through prevention of disease for mothers and babies across the life course, and by maximising infant growth and development (Ip et al., 2007; Quigley et al., 2007; Heikkila et al., 2011). Exclusive breastfeeding is recommended for around the first six months of life, with continued breastfeeding alongside appropriate solid foods for as long as the mother and baby wish (DH, 2003; WHO, 2003).

International infant feeding policies (WHO, 2003; EU Project on promotion of breastfeeding in Europe, 2004) and the global UNICEF Baby Friendly Initiative (BFI; WHO/UNICEF, 1989) provide a positive framework for promoting and supporting breastfeeding, and successive UK governments have recognised the importance of breastfeeding for public health (DH, 2004; HM Government, 2010). There is a need for effective breastfeeding services and support for women who are least likely to breastfeed and those most at risk of poor health outcomes (DH, 2009). To achieve this, a series of guidance documents have been developed that highlight evidence-based interventions that have the potential to tackle the complex challenges inherent in increasing breastfeeding rates in the UK (Dyson et al., 2006; NICE, 2006, 2008; DH, 2009).

Despite this positive policy context and encouraging increases in the number of women initiating breastfeeding (The NHS Information Centre, 2011), low rates of continuing breastfeeding persist in the UK, especially among young mothers and women from low-income groups (Bolling et al., 2007). Women from minority ethnic groups have higher rates of breastfeeding initiation and continuation than the majority population, but rates of exclusive breastfeeding are low in all communities (Kelly et al., 2006). Rates also differ within and between diverse ethnic groupings (Thomas and Avery 1997; Kelly et al., 2006). The reasons for these diverse patterns of breastfeeding are complex and indicate the need for different strategies to promote and enable breastfeeding within different population groups.

The aim of this paper is to examine national public health recommendations for breastfeeding (NICE, 2008) in the light of qualitative research of women’s and practitioners’ experiences of breastfeeding support to illuminate how such recommendations can be tailored to meet the needs of diverse populations. These public health recommendations drew on a series of systematic reviews (Tedstone et al., 1998; Fairbank et al., 2000; Protheroe et al., 2003; Renfrew et al., 2005), and were informed by
a national consultation with practitioners, service managers, policy makers and service users (Renfrew et al., 2008; Dyson et al., 2010a). Key recommendations suggest that information, education and support should be provided in a setting and style that meets women’s needs, and that women whose first language is not English should receive appropriate information and support. The public health recommendations include implementation of the WHO/UNICEF BFI as the intervention most likely to achieve increases in breastfeeding for all women. In this paper, the public health recommendations are mapped to the relevant WHO/UNICEF BFI 10 steps (WHO/UNICEF, 1989).

One challenge is achieving the right balance between focussing on mainstream services that will improve support and breastfeeding outcomes for all women, and providing targeted services tailored to the needs of diverse groups (Dyson et al., 2006). This is particularly complex in the case of women from minority ethnic backgrounds where mainstream services may not meet health needs because they are not culturally appropriate (Atkin, 2004). However, focussing on cultural differences in planning targeted services risks making assumptions about women’s needs based on lack of understanding of diversity within and commonalities across population groups (Culley, 2001), and ignoring the role of socio-economic circumstances and racism in an individual’s ability to access health services (Nazroo, 2001). Ethnographic research can contribute towards better understanding of these complex issues through providing detailed accounts of the meanings participants attach to their experiences and actions in specific situations (Hammersley and Atkinson, 2007).

The ethnographic research reported here explored breastfeeding support for women of Bangladeshi origin living in England from the perspectives of grandmothers, childbearing women and health practitioners. Women of Bangladeshi origin were chosen because they are the most socio-economically deprived group in the UK (White, 2002) and experience poor health outcomes (Fitzpatrick and Jacobsen, 2005; ONS, 2005). Patterns of breastfeeding among women of Bangladeshi origin are characterised by high initiation rates, rapid decrease in any breastfeeding and low rates of predominant breastfeeding (Kelly et al., 2006). For women of Bangladeshi origin, unlike the majority population, breastfeeding rates are not strongly associated with socio-economic status (Kelly et al., 2006).

Methodology

This paper is based on re-analysis of research material from the original study (paper submitted for publication), which comprised three cumulative phases exploring the views and experiences of grandmothers, breastfeeding women and practitioners. The study was approved by the North West National Health Service (NHS) Research Ethics Committee. The researchers obtained written informed consent and confidentiality and anonymity were assured.

The study took place in four localities in Northern England in 2008. Purposive sampling was used to recruit 14 grandmothers who had at least one grandchild who had been breastfed in England, 23 women of Bangladeshi origin who had breastfed at least one child in the previous three years and 28 healthcare practitioners (see Table 1 for a summary of participant characteristics). Recruitment of women and grandmothers was facilitated by community projects and Sure Start Children’s Centres. As most of the grandmothers did not read any language, a researcher working with a project worker as an interpreter explained the study a week prior to each focus group discussion. The focus
group discussions with grandmothers and 10 individual interviews with women were conducted in Sylheti by a bilingual researcher. Thirteen interviews with women and five focus group discussions with practitioners were conducted in English by the lead researcher. Research encounters took place in community venues, women’s homes and healthcare facilities.

All focus group discussions and interviews were facilitated using topic guides developed from the research objectives. The interviews with women were informed by preliminary findings of the grandmothers’ focus groups and the focus groups with practitioners were informed by findings of the women’s interviews. Topics for grandmothers and women included experiences of breastfeeding, breastfeeding support provided by family and health services and differences between breastfeeding in England and Bangladesh. For health practitioners, key topics were providing breastfeeding support for women of Bangladeshi origin, the role of families and social networks and issues raised by women, such as the high number of formula feeds given to breastfed babies in hospital. Focus group discussions with grandmothers lasted around 90 minutes, individual interviews with women ranged from 40 to 80 minutes and focus group discussions with practitioners lasted around one hour.

All research encounters were audio-recorded and transcribed. Translation by the bilingual researcher focussed on conveying meaning rather than literal translation, keeping as close as possible to participants’ words. We indicate throughout where quotes are translated.

Analysis of research material

The original analysis of the research material used Atlas Ti software™ to perform open and inductive coding. The complete data set was structured around women’s journeys from

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Mean (range)</th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grandmothers (n = 14)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>58 (43–73)</td>
<td></td>
</tr>
<tr>
<td>No. of years living in UK</td>
<td>27 (12–40)</td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td>6 (3–11)</td>
<td></td>
</tr>
<tr>
<td>Number of grandchildren</td>
<td>10 (1–30)</td>
<td></td>
</tr>
<tr>
<td>Women (n = 23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>28.5 (21–40)</td>
<td></td>
</tr>
<tr>
<td>Born in Bangladesh</td>
<td>83% (19)</td>
<td></td>
</tr>
<tr>
<td>Age at migration</td>
<td>12 (1–25)</td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>52% (11)</td>
<td></td>
</tr>
<tr>
<td>Number of children</td>
<td>2.7 (1–6)</td>
<td></td>
</tr>
<tr>
<td>First child</td>
<td>30% (7)</td>
<td></td>
</tr>
<tr>
<td>Practitioners (n = 28)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td>50% (14)</td>
<td></td>
</tr>
<tr>
<td>Health visitor</td>
<td>18% (5)</td>
<td></td>
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<tr>
<td>Number of years in current role</td>
<td></td>
<td></td>
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<tr>
<td>&lt;5 years</td>
<td>29% (8)</td>
<td></td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>50% (14)</td>
<td></td>
</tr>
<tr>
<td>Ethnic origin: white British</td>
<td>82% (23)</td>
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</table>

Table 1. Summary of participant characteristics
before their first pregnancies until they ceased breastfeeding. For the purposes of the work reported here, public health recommendations for breastfeeding (NICE, 2008) were scrutinised in the light of the main themes of this original analysis and recommendations that reflected themes raised in the qualitative findings were identified (see Tables 2–4). The themes ‘provision of antenatal education’ (recommendation (R) 9) and ‘positioning and attachment of the baby to the breast’ (R10) mapped directly to the public health recommendations and to Step 3 of the WHO/UNICEF BFI. The theme ‘giving breastfed babies no formula feeds’ is an important element of Public Health recommendation seven and WHO/UNICEF UK BFI Step 6. An iterative process took place in which the interview and focus group transcripts were re-analysed to ensure all relevant content was included. For each theme, the research material was categorised by importance to participants, current service provision, barriers and strategies for implementation and examples of good practice, and relevance to each of the public health recommendations was identified (Tables 2–4).

Findings

Theme 1: Provision of antenatal breastfeeding education

Public health recommendation: A midwife or health visitor trained in breastfeeding management should provide an informal group session in the last trimester of pregnancy. This should focus on how to breastfeed effectively by covering feeding position and how to attach the baby correctly (R9) and WHO/UNICEF BFI Step 3, ‘Inform all pregnant women of the benefits and management of breastfeeding’.

Of all three public health recommendations, participants in our study had most to say about this one. Clearly, the women, grandmothers and practitioners felt that provision of antenatal information about breastfeeding was important, and most women and grandmothers suggested that it should be provided by health practitioners.

G5: It is really the midwives or nurses that the mothers would like to listen to more, not only hospital even before that when they go for checkups, whilst pregnant.  
G3: Yes they would say about us what do they know. They are ancient people from olden days. You see these people [practitioners] are educated. (Translated exchange between grandmothers in focus group 1)

Only two women had attended breastfeeding group sessions during pregnancy and four felt they had no opportunity to discuss infant feeding with a health practitioner. Most women received some information from midwives during individual antenatal appointments. All practitioners reported providing opportunities for antenatal group discussions; in two localities it was recognised that these were inappropriate for many women of Bangladeshi origin.

P3 (health visitor): Well, I think if you can’t understand the language then you think what’s the point of going? So, I think there’s also although the group might be welcoming, it’s how the person sees things.
P1 (health visitor): Feels, yes.
P3: How they perceive it. And we’ve got to think that people don’t only live in groups. They’re out in the community and in the community they don’t feel welcome so the coming into a group is kind of frightening for most. People wouldn’t come on their own or whatever. (Practitioner focus group 1)
## Table 2. Theme 1 – provision of antenatal breastfeeding education

**Recommended actions**

A midwife or health visitor trained in breastfeeding management should provide an informal group session in the last trimester of pregnancy. This should focus on how to breastfeed effectively by covering feeding position and how to attach the baby correctly (R9).

**WHO/UNICEF BFI Step 3:** Inform all pregnant women of the benefits and management of breastfeeding.

### Women Grandmothers Practitioners

| Importance | Most women wanted more practical information about breastfeeding during pregnancy from health professionals | Women need information during pregnancy about potential problems and how to prevent them to encourage breastfeeding. | Practitioners recognised the importance of providing antenatal information and some saw it as the answer to some of the problems they encountered postnatally. |
| Current provision | Several women had no opportunity to discuss infant feeding during pregnancy with a health professional. Two women had attended antenatal sessions about breastfeeding | No comments | All localities provided some variation of antenatal group discussions for breastfeeding women but these were not necessarily for women of Bangladeshi origin. Provision for women of Bangladeshi origin was more likely to be through one-to-one discussions. |
| Barriers | Some women found discussing breastfeeding antenatally embarrassing, particularly during a first pregnancy. Barriers to attending group sessions included inaccessible venue, embarrassment, household duties, lack of confidence outside the home, working during the day and language barriers. | Too embarrassing to talk about breastfeeding during pregnancy | Practitioners thought language was the main barrier to providing antenatal sessions on breastfeeding. Practitioners appeared to be unaware that women might find discussing breastfeeding during pregnancy embarrassing. Practitioners suggested women may not attend group sessions because of language barriers, having support at home, husbands and grandmothers won’t allow women to attend, they don’t feel welcome or they have too many household tasks. |

(continued)
<table>
<thead>
<tr>
<th>Strategies/suggestions</th>
<th>Women</th>
<th>Grandmothers</th>
<th>Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Antenatal information should be realistic and include potential problems, such as sore nipples. Including grandmothers and other family members would benefit women. Women preferred group sessions for 'Bangladeshi' or 'Asian' women only. Provide sessions in the evening for women who are in paid employment. Offer group sessions alongside antenatal appointments in health centres. Many women would prefer a one-to-one discussion with a health professional in their own home.</td>
<td>Classes are best way to provide information. Grandmothers would like more information themselves to pass on to their daughters and daughters-in-law.</td>
<td>Include families, especially grandmothers. Provide sessions for different communities. Provide groups that are not just about breastfeeding.</td>
</tr>
<tr>
<td></td>
<td>Examples of good practice: One woman had attended an antenatal workshop at a neighbourhood project for Asian women facilitated by a health professional with an interpreter. The project staff invited women and telephoned them to encourage them to attend.</td>
<td>No comments</td>
<td>Antenatal sessions provided alongside postnatal breastfeeding group with peer supporters. Joint groups involving voluntary sector. Links between antenatal breastfeeding session and follow-up support on a hospital postnatal ward. Project providing continuity of care, including antenatal sessions for women of Bangladeshi origin (no longer running due to lack of funding).</td>
</tr>
</tbody>
</table>
Table 3. Theme 2 – positioning and attachment of the baby at the breast

Recommended actions
Ensure a mother can demonstrate how to position and attach the baby to the breast and can identify signs that the baby is feeding well. (R10).
WHO/UNICEF BFI Step 3: Inform all pregnant women of the benefits and management of breastfeeding

<table>
<thead>
<tr>
<th>Importance</th>
<th>Women</th>
<th>Grandmothers</th>
<th>Practitioners</th>
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<tbody>
<tr>
<td>Women thought positioning and attachment for breastfeeding was a necessary skill for new mothers to learn and that it should be taught by health professionals</td>
<td>Grandmothers thought women need support for positioning and attachment from health professionals, especially when they are in hospital and when the mother has few female relatives close by</td>
<td>Practitioners thought that women of Bangladeshi origin had the same need for support for effective positioning and attachment as other women</td>
<td></td>
</tr>
<tr>
<td>Current provision</td>
<td>Women appreciated being shown positioning and attachment, many of whom valued physical support</td>
<td>Grandmothers described examples of practitioners helping women with positioning and attachment</td>
<td>No comments</td>
</tr>
<tr>
<td>8 women suggested they were not given any or insufficient support for positioning and attachment</td>
<td>Grandmothers commented on variations between individual practitioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 women commented on variation between individual practitioners relating to attitudes, skill or conflicting information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Several women had experienced sore nipples, suggesting they had not achieved effective positioning and attachment</td>
<td></td>
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<tr>
<td>Barriers</td>
<td>Barriers included practitioners were too busy, made assumptions about women’s feeding preferences or did not consider women’s individual needs</td>
<td>No comments</td>
<td>Workload and lack of time</td>
</tr>
<tr>
<td>Women felt too tired, ill or needed interventions in the early days after birth and some women clearly expected ‘hands on’ support</td>
<td></td>
<td>Assumptions about women not wanting to put the baby to the breast</td>
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<tr>
<td></td>
<td></td>
<td>Women’s embarrassment and reluctance to allow practitioners to support them to achieve effective positioning and attachment</td>
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<thead>
<tr>
<th>Strategies/suggestions</th>
<th>Women</th>
<th>Grandmothers</th>
<th>Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women suggested practitioners should offer timely and proactive support for positioning and attachment and spend time observing women breastfeed, provide sufficient interpreters and ask women about their individual needs</td>
<td>Teach and demonstrate positioning and attachment</td>
<td>Recognise individual needs</td>
<td>No comments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Examples of good practice</th>
<th>Women</th>
<th>Grandmothers</th>
<th>Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>One mother described how physical support for positioning and attachment was provided in a sensitive manner</td>
<td>No comments</td>
<td>No comments</td>
<td>No comments</td>
</tr>
</tbody>
</table>
Table 4. Theme 3 – giving formula feeds to breastfed babies

<table>
<thead>
<tr>
<th>Recommended actions</th>
<th>Women</th>
<th>Grandmothers</th>
<th>Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Implement a structured programme that encourages breastfeeding using UNICEF UK Baby Friendly Initiative (BFI) as a minimum standard (R7) that includes UNICEF UK BFI Step 6: Give newborn infants no food or drink other than breastmilk, unless medically indicated</strong></td>
<td>No comments related to the importance of abandoning this practice</td>
<td>No comments related to the importance of abandoning this practice</td>
<td>Recognised the importance of this action for initiation and duration of breastfeeding</td>
</tr>
<tr>
<td><strong>Importance</strong></td>
<td>No comments related to the importance of abandoning this practice</td>
<td>Grandmothers thought giving formula milk to breastfed babies could be an important survival strategy in the UK</td>
<td></td>
</tr>
<tr>
<td>Several women felt giving formula feeds to breastfed babies was important to ensure adequate nutrition</td>
<td>Grandmothers thought giving formula milk to breastfed babies could be an important survival strategy in the UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current provision</strong></td>
<td>13 infants were fed infant formula in hospital</td>
<td>Assumption in grandmothers accounts that many breastfed babies in the UK need infant formula and grandmothers were often the ones feeding this to babies</td>
<td>Recognised the implications of giving formula feed to babies.</td>
</tr>
<tr>
<td>None of the 6 infants born in the UNICEF BFI-accredited hospital were fed infant formula in hospital</td>
<td>Suggested formula feeds were only given at women’s or their families’ request</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td>Barriers included expectations that it is routine practice, doubts about the adequacy of colostrum and breastmilk, the impact of birth experiences, difficulties with positioning and attachment</td>
<td>The main barrier was doubts about the adequacy of colostrum and breastmilk to meet babies’ needs</td>
<td>Practitioners reported many barriers, including women’s cultural beliefs about colostrum, women’s unwillingness to breastfeed in hospital due to embarrassment and needing to recover from the birth, influence of grandmothers and husbands and language barriers</td>
</tr>
<tr>
<td>Women reported that some practitioners routinely gave formula feeds to breastfed babies in hospital</td>
<td>Grandmothers may also have been influenced by their own experiences of infant feeding in the UK</td>
<td>Practitioners’ workloads, lack of interpreting services and lack of understanding of ‘cultural factors’ were also cited as barriers</td>
<td></td>
</tr>
<tr>
<td><strong>Strategies/suggestions</strong></td>
<td>No comments</td>
<td>No comments</td>
<td>Getting grandmothers ‘on side’</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>More antenatal education for women</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Training in cultural issues for practitioners</td>
</tr>
<tr>
<td><strong>Examples of good practice</strong></td>
<td>No comments</td>
<td>No comments</td>
<td>No comments</td>
</tr>
</tbody>
</table>
Women and practitioners discussed many barriers to women of Bangladeshi origin participating in antenatal group discussions about breastfeeding. A key barrier from women’s and grandmothers’ accounts was that women are embarrassed, especially during their first pregnancy. However, practitioners seemed to be unaware of this. Other barriers highlighted by women included inaccessible venues, lack of confidence outside the home, too many household tasks and language barriers. Practitioners recognised many of these, although from their perspective language was the main barrier. Some practitioners also suggested that women’s husbands and mothers-in-law would not allow them to attend group sessions. This appeared to reflect stereotyping of women of Bangladeshi origin as lacking autonomy.

Community midwife: I think there’s the permission thing, as well. Often you have to go by custom, you know, mother-in-law for them to get permission to go to things. (Practitioner focus group 4)
Hospital midwife: I mean a lot of the time they seem to seek their spouses’ approval to do something. (Practitioner focus group 5)

None of the women reported needing permission from families to attend antenatal sessions, but many spoke of not having time or of access being difficult.

W12: They had a session, a Bangla class where midwives came in to tell women how to feed their children breastmilk. When women have babies what to do and how to feed or what not to do, things like that. You see they rang me to come but I didn’t attend because I didn’t have much time. (Translated)
W2: [...] To have classes in the [community] centres it’s really good because this local area people would go there. If it’s far away nobody would go, especially when you are pregnant you don’t want to go walking far away, anything like that.

A common theme in practitioners’ narratives was that they had insufficient time to provide antenatal information about breastfeeding and examples were given of successful initiatives that had ceased because of lack of funding. This applied to providing breastfeeding support for all women and is likely to be exacerbated in the current fiscal climate.

Women and practitioners suggested how culturally appropriate group sessions for women of Bangladeshi origin could be provided. The two common themes were to provide sessions that were specifically for women of Bangladeshi origin and to include other family members, especially grandmothers. For many women it was crucial that any information should be realistic about how challenging breastfeeding can be and prepare them for potential problems. One strategy suggested by several women and one practitioner group was to combine breastfeeding education with antenatal appointments in local health centres. One woman who had attended a hospital antenatal breastfeeding workshop commented:

W23: I can drive and I knew where the (hospital) was so it was easier for me to get to but I thought the local women would never be able to get to that I mean yeah if they need a scan their husband will take them [...] but just for a workshop, their husbands are not going to get up and take them to a workshop, wait outside, I think it was 2 or 3 hours, pick them up. [...] I always think, do you know how we go to your appointment every month, things like that, if they had sessions on, in the surgery like the hall or one room you know on breastfeeding and things like incorporated into the nine months of pregnancy I think it would be a lot better.
Many women, especially those interviewed in Sylheti, stated a preference for one-to-one discussions with health practitioners in their own homes. The research interview was used as an example:

W9: Like today you people [researchers] have come and are asking me, well like this if other people who come and advise me more about how to breastfeed or what the benefits are I am willing to learn. Yes I would like to know new ideas that have come out. (Translated)

From women’s accounts, an example of good practice was an antenatal education session about breastfeeding provided by health practitioners in a women’s neighbourhood project. The session was interpreted by a health development worker who knew many families in the locality. Staff at the project telephoned women to encourage attendance. Health practitioners cited several examples of good practice (see Table 2), although none of the women interviewed had experienced these.

**Theme 2: Positioning and attachment of the baby at the breast**

Public health recommendation: Ensure a mother can demonstrate how to position and attach the baby to the breast and can identify signs that the baby is feeding well (R10) (see also Step 3 WHO/UNICEF BFI).

Women had more to say about this topic than grandmothers or practitioners. Positioning and attachment for breastfeeding, termed ‘latching on’ by participants, was a frequent theme in women’s narratives and felt to be essential for breastfeeding.

Q: What could the health service do to make breastfeeding easier for women?  
W11: Well if they came and helped them by practically showing them to hold the baby to the breast. There are some who cannot get them [baby] to hold onto it [breast]. So if they came to give that kind of support then it would be good for them [mothers]. (Translated)

Women appreciated support from health practitioners to achieve effective positioning and attachment and appeared to value practical help, especially in the early days after birth.

W15: In the night I wasn’t able to breastfeed the baby as I had problem and so I called the nurse and she came to me and held the baby onto the breast. (Translated)

Evidence suggests effective positioning and attachment is best achieved using an enabling approach in which women learn to breastfeed with support, guidance and confidence-building rather than having it done for them (Dyson et al., 2006). Eight women reported none or insufficient support for positioning and attachment.

Q: What was it like when you were first trying [to breastfeed]?  
W4: I wished someone could help me, explain more, show me how to hold the breast or how to hold the baby.

Several of these women recounted experiencing sore nipples, suggesting that effective positioning and attachment had not been achieved.

A frequently mentioned barrier from women’s perspectives was that practitioners were too busy to spend time helping them breastfeed. Practitioner assumptions about women’s feeding preferences and lack of consideration of individual needs, especially relating to women having their second baby, were also cited as barriers.
W1: They didn’t help you second time because they think you, you have the first baby and you know everything. They wasn’t very helpful as they were with my first child even though it was a different experience than what I had with my daughter.

A further theme relating to women’s expectations that they would receive practical help for positioning and attachment was the impact of their birth experiences. The following quotes contrast women’s experiences, both of whom wished to breastfeed.

W2: The midwives they fed him with a bottle because I had to have blood transfusion and my iron level was so down I couldn’t even get up and I was having problem with I had one side I had this blood, blood drops going down so many hours and so the midwives they fed him and they looked after him and everything.

W22: As soon as she was born they just put her onto the breast straight away and because they have put injection [epidural] on me I couldn’t really move at all so I was just lying down. I could move my arms but not my legs so they just sort of put her onto the breast and they just held her there

Grandmothers acknowledged differences in women’s needs for support.

G5: There are difference in mothers, like for example there are some mothers who after five hours later is well enough to look after her baby and some mothers sometimes don’t even have the strength to pick up their baby, she is weak, so the support they should give in hospital is to get the baby to latch onto the mother’s breast. (Translated from grandmothers’ focus group 2)

Some practitioners commented that supporting women of Bangladeshi origin to breastfeed was no different from other women. However in one discussion (FG5), staff on a hospital postnatal ward said they found supporting women of Bangladeshi origin challenging. This appeared to be based on misunderstandings and assumptions that women did not want to initiate breastfeeding in hospital.

Postnatal midwife: Sometimes they will reluctantly put the baby to the breast but they won’t actually fix the baby to the breast. [...] They just go through the motions because they know that’s what you expect them to do, not that they want to do that. (Practitioner focus group 5)

These practitioners interpreted women’s expectations of practical help as evidence of passivity. Consequently, practitioners were frustrated in their attempts to support breastfeeding and along with more time, suggested that training would help them to understand this client group.

Postnatal midwife: They’re very hard work to look after and I think if we had some training on why they’re like that, that would probably help it because it’s in a very busy unit and you’ve got somebody who’s physically well but won’t do anything. (Practitioner focus group 5)

The most important strategy suggested by women to achieve effective positioning and attachment was that practitioners should proactively offer support and spend time observing women feed.

W7: So I would have liked the help in the sense of not feeling a burden but having help oh come on let us give you a hand and get some cushions under and hold her like this and try and keep her latched on and let’s get your back supported and see how far you can feed her for.
An example of good practice was one woman’s description of a community midwife’s sensitive approach:

W5: And so first of all I felt uncomfortable because showing yourself in front of somebody else, a stranger, it’s quite uncomfortable but she was reassuring and said look it’s OK and she wouldn’t touch you unless you said you know you gave permission. She said can I touch you to show you how to do it and she moved the baby around so that it’s more comfortable.

Theme 3: Giving formula feeds to breastfed babies

Public health recommendation: Implement a structured programme that encourages breastfeeding using the UNICEF UK BFI as a minimum standard (R7) that includes Step 6: Give newborn infants no food or drink other than breastmilk, unless medically indicated

Participants’ accounts overlapped in relation to supporting positioning and attachment and to giving formula feeds routinely. This included the impact of women’s birth experiences and their expectations of support from practitioners. Neither the women nor grandmothers suggested that abandoning this practice was important, rather it appeared to be accepted as necessary to meet infants’ nutritional needs.

G1: So now I want to breastfeed my baby and he is not getting any milk in the two days then how would that baby survive? In this [breastfeeding] I know it is good and they are advising me it is good but the baby is not consuming it.

G8: Yes for this reason you have to give bottle milk. (Translated exchange among grandmother in focus group 2)

Thirteen babies had at least one formula feed in hospital but this did not include any of the six babies born in a UNICEF Baby Friendly accredited facility. This supports evidence that fully implementing the BFI can result in changes in breastfeeding behaviours. Practitioners recognised the implications of giving formula feeds but felt constrained by women’s choice.

From women’s and grandmothers’ comments, the main reasons for introducing formula feeds to breastfed babies were doubts about the adequacy of colostrum, the impact of birth experiences and difficulties with positioning and attachment. This appeared to be underpinned by expectations that giving formula feeds was routine practice.

Q: You said you expected they would do a bit of bottle feeding and a bit of breastfeeding when you were in hospital.

W23: I suppose because, I don’t know because everywhere I heard people say it could take 3 to 4 days for your milk to come through. First of all you get your colostrum and then so it takes 3 to 4 days for your milk to come through so I thought 3 to 4 days babies can’t starve probably they’ll give a bit of milk (formula) as well.

Many women reported instances when formula feeds had been given because they were too tired to breastfeed following the birth. Several grandmothers reported that they had been discouraged from breastfeeding in the UK and this may have influenced their expectations.

G2: In this country they use to feed my child in the beginning. So later I hid and breastfed. I’m thinking what is this? So when my second son was born I breastfed without telling them. They used to bottle feed then.
G3: In those times they didn’t give much importance to breastfeeding. (Translated exchange among grandmothers in focus group 1)

Practitioners’ discussions of routine supplemental feeds for breastfed babies focussed on assumptions concerning cultural and religious beliefs and families’ influence. Thus practitioners appeared to feel they had no option.

Postnatal ward healthcare assistant: A lot of the time there is, like you say, the language barrier and maybe the young girl may sit on the bed and not say a right lot and the mum may just come up the corridor and say, ‘She wants to bottle feed now, can we have a bottle for baby?’ We now have forms that have to be signed, you know, mother’s consent and a lot of the time, some mums are reluctant to sign it because it’s the grandparent that’s asked for the bottle, but then it’s just, I don’t know, it’s almost as though it’s taken out of our hands sometimes, you know, because you feel well, right, you don’t want to be intrusive if it’s a religious thing because some mums don’t like to give the baby colostrum. They’ll wait while day three, you know. (Practitioner focus group 3)

There was no indication from women’s or practitioners’ accounts that practitioners explored women’s understandings about colostrum or discussed the implications of giving formula feeds for breastfeeding.

Only practitioners suggested strategies for abandoning the routine practice of giving formula supplements to breastfed infants. These included better antenatal information for women, getting support from grandmothers and staff training.

Discussion

The most striking feature of our detailed analysis of women’s, grandmothers’ and practitioners’ comments relevant to public health recommendations for breastfeeding was that breastfeeding experiences of women of Bangladeshi origin are largely similar to those of many women. For example, many women have difficulties with positioning and attachment for breastfeeding (Renfrew et al., 2005; Bolling et al., 2007). Providing accessible antenatal information is also an issue for young, single, white women (Raleigh et al., 2010). Similarly, the influence of families on breastfeeding and women’s embarrassment have been shown to be barriers to breastfeeding for many low-income and young women (Marshall et al., 2007; Dyson et al., 2010b; Hoddinott et al., 2011). This suggests that focussing on getting mainstream services right for all women, which is the approach of the UNICEF UK BFI, will improve support for women of Bangladeshi origin, although there are some important cultural differences to consider. Nonetheless, many of the implications of our work discussed below may be relevant for women from many different backgrounds.

Implications of our work that were relevant for all three recommendations were the need for practitioners to involve families, especially grandmothers, and practitioner workloads. A key barrier to providing culturally sensitive services were practitioners’ assumptions and stereotypes based on understandings of cultural groups as fixed and homogenous. This appeared to prevent practitioners from providing breastfeeding support based on individual needs and expectations: an overarching evidence-based action identified by Dyson et al. (2006).
Theme 1: Provision of antenatal breastfeeding education

In our study only two women had attended antenatal breastfeeding sessions and several were not given an opportunity during their pregnancies to discuss infant feeding with a health practitioner as recommended by BFI Step 3. Our analysis suggested specific issues that need to be considered when planning group sessions for women of Bangladeshi origin. Women were unlikely to attend unless sessions were specifically for women from similar ethno-religious backgrounds, confirming findings by Ingram et al. (2008), and the venue was close to where women lived and felt confident. Many women found discussing breastfeeding embarrassing, especially during a first pregnancy. Many women also reported not having time to attend group sessions. One suggested strategy to overcome this was to offer breastfeeding group sessions alongside antenatal appointments, as women and their families prioritised these. This could have potential advantages for practitioners, such as streamlining services and more efficient use of bilingual workers. An interesting model for providing group care during pregnancy and involving families in ‘conversations’ about breastfeeding, ‘Centering Pregnancy’ (see, for example, Gaudion and Menka, 2010), could be explored for this population of women. However it was clear that many women neither could nor wished to attend antenatal group sessions and that all pregnant women should be offered the opportunity to discuss infant feeding with a health practitioner. Clearly, adequate levels of appropriately trained staff are required to achieve this (Dyson et al., 2010a).

Theme 2: Positioning and attachment of the baby at the breast

Effective and pain-free positioning and attachment are widely recognised to be critical to enabling women to breastfeed (Renfrew et al., 2005) and there is evidence that many practitioners lack knowledge and skills to support women to achieve this (Renfrew et al., 2006; Wallace and Kosmala-Anderson, 2007). Experiences of women and practitioners in our study were no different. Barriers identified by women and grandmothers included health practitioners being too busy to spend time helping women, variations in their attitudes and skills and giving inconsistent information (Renfrew et al., 2005; Dykes, 2006; Bolling et al., 2007). The women appeared to have a strong expectation and preference for practical support for positioning and attachment from practitioners, which included physical help. The approach currently favoured is one in which practitioners guide women but do not physically touch the mother or baby (Wallace et al., 2006; NCT http://www.nct.org.uk/in-your-area/bristol/breastfeed/BFCs), possibly in response to previous approaches where some practitioners insensitively attached the baby to the breast without helping the mother to learn to do this for herself. Our participants indicated that some physical help could be helpful, particularly in the early days while women were recovering from their birth experiences, and especially if they were unwell. It is unclear whether this is something other women would welcome. The women in this study did not report experiencing other support strategies included in the BFI, such as facilitation of skin-to-skin contact, and being taught hand expression of breastmilk. Possibly, if the women in this study had experienced these support strategies and an enabling approach to positioning and attachment, they would not report needing physical help. However, practitioners appeared to make assumptions that women of Bangladeshi origin preferred not to initiate breastfeeding until the third postnatal day and that they were too embarrassed to accept help with positioning and attachment. To implement this recommendation requires all women, regardless of
background, to be offered timely and sensitive support to achieve effective positioning and attachment. Antenatal information could help women make informed decisions about when and how they commence breastfeeding and to know what support to request from practitioners.

**Theme 3: Giving formula feeds to breastfed babies**

Many women in our study reported that their infants had received formula feeds in hospital; this appeared to reflect assumptions on the part of both women and practitioners. From women’s perspectives, like many women in the UK (Bolling et al., 2007), the assumption was that there was insufficient colostrum to meet the infant’s needs and therefore formula supplements were required. This was also linked to the impact of their birth experiences and their struggles with achieving effective positioning and attachment. Practitioners understood women’s or their families’ requests to give breastfed infants formula supplements as confirming both cultural attitudes towards colostrum as unclean and stereotypes of women as passive. Similar to the strategies suggested above, implementing this recommendation requires practitioners to have better understanding of women’s needs and expectations and to provide antenatal information for women and their families to challenge perceptions that colostrum is insufficient to meet babies’ needs.

An important aspect of the accreditation process for BFI is that all women should receive appropriate care, regardless of their socio-economic or ethnic background (UNICEF UK BFI, 2001). Our research indicated that the BFI was effective in challenging practitioner assumptions around women’s attitudes to colostrum and initiating breastfeeding soon after birth. However, women in this locality were just as likely as those in the other localities to comment on variation between individual practitioners relating to attitudes, skill or conflicting information as reported under the previous theme. This suggests that the BFI is an effective framework for achieving minimum standards, but more needs to be done to prepare practitioners to provide sensitive, culturally appropriate care based on individual needs. However it should be noted, as discussed below, that the practitioners participating in this study were not working in BFI-accredited organisations.

**Strength and limitations**

We believe that our study is unique in using ethnographic research to scrutinise how public health recommendations for breastfeeding might work for different population groups. Strengths include comparisons of perspectives of women, grandmothers and health practitioners and giving voice to disadvantaged and vulnerable women. We endeavoured to avoid essentialist conclusions through highlighting likely similarities between population groups and where socio-economic factors were key. The main limitation is that participants were not systematically asked about the public health recommendations and potentially important contributions may have been missed. The issues concerning practitioners’ experiences of providing breastfeeding support in hospital are drawn mainly from one focus group of postnatal ward midwives. The fact that the women reported similar hospital experiences regardless of locality gives us some confidence that these practitioners were typical. However, it would have been illuminating to elicit the experiences of practitioners working in the BFI-accredited maternity hospital. This may have allowed us to challenge the notion that giving babies formula feeds in hospitals is based on
cultural practices. It may also have further illuminated the expectations of women that they would receive physical help with breastfeeding. Nevertheless, our findings raise important issues for practitioners, service providers and commissioners responsible for implementing public health recommendations for breastfeeding.

**Key points**

- Qualitative research findings can be valuable to raise questions and suggest strategies for how policy recommendations might work for different population groups.
- Focussing on getting mainstream services right for all women is likely to improve breastfeeding support for women from diverse ethnic backgrounds, although there may be important cultural differences to consider.
- Approaches to antenatal breastfeeding education for women from diverse backgrounds should consider how it is delivered, including accessibility of venue, and women's embarrassment and household duties.
- Full implementation of the WHO/UNICEF BFI 10 steps to breastfeeding may provide an effective framework for ensuring all women are offered practical support to achieve effective positioning and attachment of the baby to the breast based on individual need, and for reducing the number of breastfed babies of Bangladeshi origin given formula feeds without medical indication.

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None declared.

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