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## **Bangladeshi women's experiences of infant feeding in the London Borough of Tower Hamlets**

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### **Abstract**

This study examined the main factors that influence Bangladeshi women living in London's decisions to partially breastfeed their children, including the influence of older women within the community. Fifty-seven women of Bangladeshi origin living in the London Borough of Tower Hamlets took part in seven discussion groups between April and June 2013. Five groups were held with women of child-bearing age and two groups with older women in the community. A further eight younger women and three older women took part in one-on-one interviews. Interviews were also carried out with eight local health care workers, including public health specialists, peer support workers, breastfeeding coordinators and a health visitor. The influences on women's infant feeding choices can be understood through a 'socio-ecological model', including public health policy; diverse cultural influences from Bangladesh, London and the Bangladeshi community in London; and the impacts of migration and religious and family beliefs. The women's commitment to breastfeeding was mediated through the complexity of their everyday lives. The tension between what was 'best' and what was 'possible' leads them not only to

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partially breastfeed but also to sustain partial breastfeeding in a way not seen in other socio-cultural groups in the United Kingdom.

**Keywords:** infant feeding, Bangladesh, migration, public health.

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### **Key messages**

- Bangladeshi women in London are choosing to partially breastfeed their children in order to manage the conflict between their desire to exclusively breastfeed and the complex reality of their daily lives, which makes this difficult to achieve.
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- Services may be more successful if they aim to recognise, harness and support women's intrinsic motivation and effort to maintain any breastfeeding, as opposed to focusing on a deficit model.
- Older women within the family are a key influence on women's infant feeding choices. Public health interventions should engage mothers, mothers-in-law and grandmothers.

### **Introduction**

Much concern has been expressed in the United Kingdom and internationally about the decline in rates of 'ever' breastfeeding and of 'exclusive' breastfeeding. Current evidence is clear that exclusive breastfeeding for at least the first 6 months of life has health and well-being benefits for the mother and child (Butte et al. 2002; Kramer & Kakuma 2012). The benefits are long as well as short term and they have

important and wide-ranging public health implications (WHO 2013). While babies who are partially breastfed receive some benefits from breastfeeding, such as antibody protection against certain infections, they are more at risk than exclusively breastfed babies of developing asthma, eczema, diabetes and of becoming obese (Owen et al. 2005). Exclusive breastfeeding may increase the rate of post-baby weight loss in women and prompt later resumption of periods, thereby offering a limited protection against further pregnancy (Kramer & Kakuma 2012).

Rates of breastfeeding initiation and continuation are low in many countries and mixed feeding is not only common but may also be a social norm. Rates of exclusive breastfeeding in the United Kingdom decline very rapidly after initiation, and younger mothers or those from low-income groups are more likely to introduce formula milk earlier than older mothers or those from managerial or professional groups (Bolling et al. 2007). A survey of women in 2000 found that 'use of formula milk in hospital was a strong indicator of mother giving up breastfeeding after leaving hospital' (Hamlyn et al. 2002).

Breastfeeding has a significant social dimension (Göksen 2002), as food and nurture are often culturally mediated. This means that what we eat, when, how and with whom are culturally defined and shaped practices (Hill 1990; Kershner 2002). Therefore, the social environment creates strong norms around infant feeding that influence beliefs, attitudes and practices (Göksen 2002). In the United Kingdom, breastfeeding rates are particularly low in certain regions [e.g. breastfeeding rates are lowest in Wales and Northern Ireland (McAndrew et al. 2012)], in certain social environments such as areas of high economic deprivation (McAndrew et al. 2012) and within white working class communities (Griffiths & Tate 2007). Research indicates that a norm of bottle feeding, which developed in the late 20th century, is a key barrier to breastfeeding for many women (Hoddinott & Pill 1999). In cultural groups where breastfeeding remains a social norm, the public health challenge is more often related to partial breastfeeding or mixed feeding, particularly with early introduction of formula or other substitute foods (Hashimoto & McCourt 2009). In addition to the importance of social norms and

environment, research indicates that many women do not feel supported effectively by health professionals (Beake et al. 2009).

Partial breastfeeding is common in some ethnic groups, e.g. 97% among Chinese, 96% for Black African Caribbean and 95% within Asian populations (McAndrew et al. 2012) and is higher than the national average in Tower Hamlets in East London (Tower Hamlets JSNA Reference Group 2014). Partial breastfeeding initiation rates are particularly high among mothers of Bangladeshi origin who accounted for approximately 46.5% of the births in the London Borough of Tower Hamlets (NHS North East London and the City 2012). Local midwives and breastfeeding support workers report that Bangladeshi women are more likely to breastfeed at night and bottle-feed during the day in order to accommodate domestic work during the day and because they have greater privacy at night (J. Rayment et al., personal communication).

There have been a number of previous studies of the infant feeding choices of South Asian women in the United Kingdom (e.g. Meddings & Porter 2007; Twamley et al. 2011). The evidence suggests that migration has a detrimental effect on women's breastfeeding status, especially when women move from a country with higher breastfeeding rates (e.g. Bangladesh) to a lower one (e.g. the United Kingdom) (Choudhry & Wallace 2012). Recently migrated women may be less affected by the dominant UK formula feeding culture than women who are more acculturated to the United Kingdom. However, Choudhry & Wallace (2012) found that recently migrated women gave formula rather than more breast milk in response to what they saw as their child's demand for more food or to reduce conflict with older members of the household.

Twamley et al. (2011) noted the need for further research exploring older women's views on breastfeeding and it is this intergenerational perspective of women in Tower Hamlets that this project sought to gain. Only one other study has specifically explored the intergenerational influence of South Asian (Bangladeshi, Pakistani and Indian) grandmothers on mothers' infant feeding choices. Ingram et al.

(2003) found that grandmothers said they supported their daughters' breastfeeding, were willing to take on household chores after the birth and respected the period of rest that traditionally follows after giving birth in many societies, as described by, for example, Woollett et al. (1995), during which time the new mother is excused from much of the domestic work. Griffith's (2005, 2010) ethnography of Bangladeshi women's experiences of becoming mothers in Tower Hamlets includes an analysis of the interplay of culture, religion, experience and health care in the borough and her work demonstrated how this kind of consideration of the influence of culture is crucial to understanding all women's infant feeding choices, not just those of Bangladeshi origin. These previous studies all noted the diversity of different South Asian women, which suggests that the experiences of Bangladeshi women may well be very different from those of Pakistani, Indian or other Bangladeshi women living in the United Kingdom, and different again from those of Bangladeshi women living outside London.

### **Breastfeeding and breastfeeding rates in Tower Hamlets**

In the United Kingdom, breastfeeding rates among minority ethnic groups are generally higher than the White British population, especially White British working class women who are still most likely to formula-feed their babies (Hoddinott & Pill 1999). London has one of the highest proportions of people from black and minority ethnic communities (Office of National Statistics 2012), and as a consequence, the breastfeeding rate in London is above the national average.

The initiation rate for breastfeeding in Tower Hamlets in 2012/2013 (86.8%) was the same as the London average (86.8%) and higher than the national average (73.9%) (Department of Health 2013). The number of women in Tower Hamlets who are exclusively breastfeeding at 6–8 weeks is approximately the same as the national average for England, but the rate of mixed feeding in the borough is around double the national rate and one of the highest of the London boroughs. Other data on infant feeding do not always distinguish between 'any' or 'exclusive'

breastfeeding and as a result obscures these differences in areas such as Tower Hamlets.

### **Aims of the study**

This study aims to determine the main influences on exclusive and partial breastfeeding rates in the Bangladeshi community in Tower Hamlets in order to inform efforts to increase the rate of exclusive breastfeeding within this community.

### **Objectives**

The study's objectives were as follows: to gain an understanding of the main factors that influence whether a mother breastfeeds exclusively or partially, including intergenerational influences; to explore insight into experiences of breastfeeding support in Tower Hamlets, what has worked well and what improvements could be made with recommendations for any changes; and to develop recommendations for service development to enable more mothers to breastfeed exclusively.

### **Design and methods**

A participatory approach was used, involving qualitative methods. A total of 57 women of Bangladeshi origin living in the London Borough of Tower Hamlets took part in a series of group discussions or individual interviews between April and June 2013. In addition, we interviewed eight local stakeholders involved in the design, commissioning and delivery of the Tower Hamlets breastfeeding support and other local services for child-bearing women. A stakeholder Bangladeshi women's experiences of infant feeding, including local public health professionals, breastfeeding support peer workers and midwives, met twice: once at the outset of the project to guide the data collection process and study questions, and again towards the end to discuss the emerging findings and participate in the analysis of the interview data.



## Discussion groups

Women were recruited through local services (primary school, community centres, the library, adult education classes, a local sheltered housing centre) and through personal contacts, with the help of a bilingual research assistant who was well known in the community. Efforts were made to recruit women outside of pre-existing groups to avoid overrecruitment of women who were well integrated into the local community. One group was held with women attending a course for recently migrated women at risk of social exclusion. Seven discussion groups were held in total.

<b>Groups</b>	<b>Location</b>	<b>Number of participants</b>
Younger women Group 1	Primary School	12
Younger women Group 2	Community Centre 1	5
Younger women Group 3	Private House	6
Younger women Group 4	Private House	6
Younger women Group 5	Community Centre 2	8
Older women Group 6	Sheltered Housing Centre	4
Older women Group 7	Private House	7
<b>Total</b>		<b>46</b>

Contemporaneous field notes (which did not identify individual participants) were taken of the group discussions and these notes were used in the analysis. The decision was taken to not record group discussions, as the groups were often noisy with talking and background sounds, compounded by participants speaking in two languages (English and Sylheti).

In order to engage participants, each group was asked to respond to a brainstorming exercise using the words 'breastfeeding' and 'bottle-feeding' to elicit the associations women made with those methods of feeding. The discussion then widened spontaneously to include women's individual stories. The facilitators (JR and SM) asked questions focusing on the key influences on their infant feeding choices, including the advice they had received from others (both family and friends and health care professionals). The discussions also covered the benefits and drawbacks of different infant feeding methods; the influence of local breastfeeding initiatives; the role of religion and culture on their feeding choices; generational differences between them and their mothers/daughters; the effects of migration on their way of life; and weaning and first foods. Older women were keen to speak about their own feeding experiences, as well as the advice they gave to their daughters and daughters-in-law.

### **Individual interviews**

A number of women (eight younger women and three older) and all of the stakeholders (n = 8) took part in semi-structured interviews carried out by JR, SM, CM and JC.

All the interviews with mother participants took place in the participant's house, with the exception of two of the three interviews with older women, which were carried out in a primary school and a friend's house.

Interviews with women were mostly recorded using contemporaneous notes, but those with stakeholders were audio recorded and transcribed verbatim. The use of notes rather than audio recording was a reflection of some women's unfamiliarity with the formality of an interview. Recruitment and interviewing needed to be flexible and informal in order to put women at ease, and it was felt that an audio recorder introduced an added unwelcome formality on top of the existing requirements for them to complete written consent forms. As most of the

interviews were carried out by both an English-speaking researcher (JR) and a Sylheti-speaking research assistant (SM), it was therefore easier to take detailed contemporaneous notes than it would have been for one researcher interviewing alone.

As relatively few interviews with women were recorded, quotes from these few interviews are used to illustrate a wider trend across the participant group and are only presented if they reflect a shared opinion with other participants. This strategy is reflected in the choice of quotes in this article.

The eight local stakeholders included public health specialists, peer support workers, breastfeeding coordinators and a health visitor. These interviews were carried out at their place of work, apart from one, which was carried out at City University London and one over the phone. Four participants were interviewed in pairs and the four remaining had one-phone conversations.

The presence of a bilingual research assistant was invaluable to the group discussions and interviews. As well as providing interpretation, the research assistant was able to act as a 'bridge' between the researcher (a White British, university educated woman) and the Bangladeshi participants. The presence of the research assistant, coupled with taking a flexible, informal and non-judgemental approach to fieldwork, helped participants to talk openly about their experiences, and as the researcher was of a similar age to the younger women participants, this also helped to break down other social barriers.

## **Analysis**

Rather than being an isolated event, the analysis of the data was ongoing throughout the development of the project, the fieldwork and writing and involved expert professionals and participants at each stage. A hypothetical, preliminary model of influences was produced based upon the existing literature before the beginning of the fieldwork (see Fig. 1) and was presented to and discussed by the

project stakeholder group. This model was then used as a framework to guide the later analysis of the data. Framework analysis allows for a structured analysis of fairly homogeneous qualitative data, such as this, on a single topic (i.e. infant feeding) (Gale et al. 2013). The framework is not however rigid and can be amended after data collection, if the data indicate that this is necessary.

Following transcription of audio-recorded interviews, the data from the transcripts and the notes from other interviews and discussion groups were sorted into the basic categories from the framework ('society', 'organisations' and 'individuals and interpersonal relationships'), but as the analysis progressed, these categories were subdivided and adjusted until they resulted in the five layers of the socio-ecological model (Fig. 2) described later in the article.

The participatory approach used during the discussion groups also meant that participants themselves contributed to the analysis of their own experiences. Each group was asked to rank their influences according to their importance, e.g. religion, husband and health visitor, and these lists were used to construct the final socio-ecological model.

At the end of the fieldwork period, the initial findings were shared with one of the final discussion groups of local Bangladeshi women. The women were asked to 'member check' these preliminary ideas by commenting on the extent to which they resonated or conflicted with their own and others' experiences. Notes were taken from this discussion and integrated into the development of the analysis. Finally, the research findings were presented to the stakeholder group at a second meeting. The group was asked to identify the priority issues and their application to policy and practice, and these thoughts were used to develop the final report, recommendations and this article.

## **Sample**

*Younger women*

Out of the total of 57 women, 46 were younger women with dependent children. Efforts were made to recruit as diverse a group of women as possible, particularly in terms of their English language capabilities and migration status.

The women were asked to fill in demographic information forms and 30 out of the 46 younger women did so.

Mean age of younger women	31 years (range 21-44)
Mean number of children	4 (range 0-5)
Mean age of youngest child	3 years (range 2 months - 11 years)
Number born in Bangladesh	24
Average age of migration	17 years (range 2-35)
First language Sylheti/Bengali	25
Fluent English	12
Functional English	8
Little or no English	7

#### *Older women*

All 11 of the older women participants provided demographic information

Total number of older women	11
Mean age of older women	61 years (range 53-77).
Number of children	Range 4-8
Age of youngest child	Range 17-39 years
Number of grandchildren	Range 3-26
Average age of migration	24 years (range 20-40).
First language Sylheti	11
Fluent English	1
Functional English	3
Little or no English	7

## **Ethical considerations and approvals**

The Bangladeshi community in East London is relatively small and tight-knit. This raised a central concern to ensure the confidentiality of participants. Names of participants were not recorded, instead we only made note of participants' age, number of children/grandchildren, English language ability, age of migration (if applicable) and basic household information (e.g. number of people in household and their relation to the participant). Participants were identified during analysis by numbered codes.

Women provided written consent to take part in the discussion groups or interviews and were free to leave the group at any time. At all times, the style of interviewing was open, flexible and informal so that women were free to choose to give, or withhold, information as they wished, which was particularly important to maintaining confidentiality within a group setting.

Ethical approval was granted by City University Senate Research Ethics Committee and the Ethics Committee of the London Borough of Tower Hamlets.

## **Findings**

The decisions that individuals make about their own health and that of their children are not made in isolation from those around them. People are influenced by their friends and family, the wider community, legal frameworks and by public policies. Bronfenbrenner's 'socio-ecological model' of human development proposed that individuals live within an 'ecological environment, conceived topologically as a nested arrangement of structures, each contained within the next' (1977, p. 514). These 'nested arrangements', which Bronfenbrenner names the micro-, meso-, exo- and macro-systems, encompass individual's relationships with family and peers, with institutions such as the workplace or school, with their neighbourhood, the

media and wider influences such as cultural norms and social and legal systems. This model of nested layers is useful for identifying and understanding how individuals are influenced to make decisions about their lives and highlights how far these individuals do not make decisions in isolation.

Beginning with Bronfenbrenner’s model, we proposed three nested layers: society (broad political and cultural influences), organisations (local community and health services) and individuals and interpersonal relationships (personal beliefs and family influences). Figure 1 shows how we hypothesised that these three layers of influence impacted on women’s infant feeding choices in Tower Hamlets.

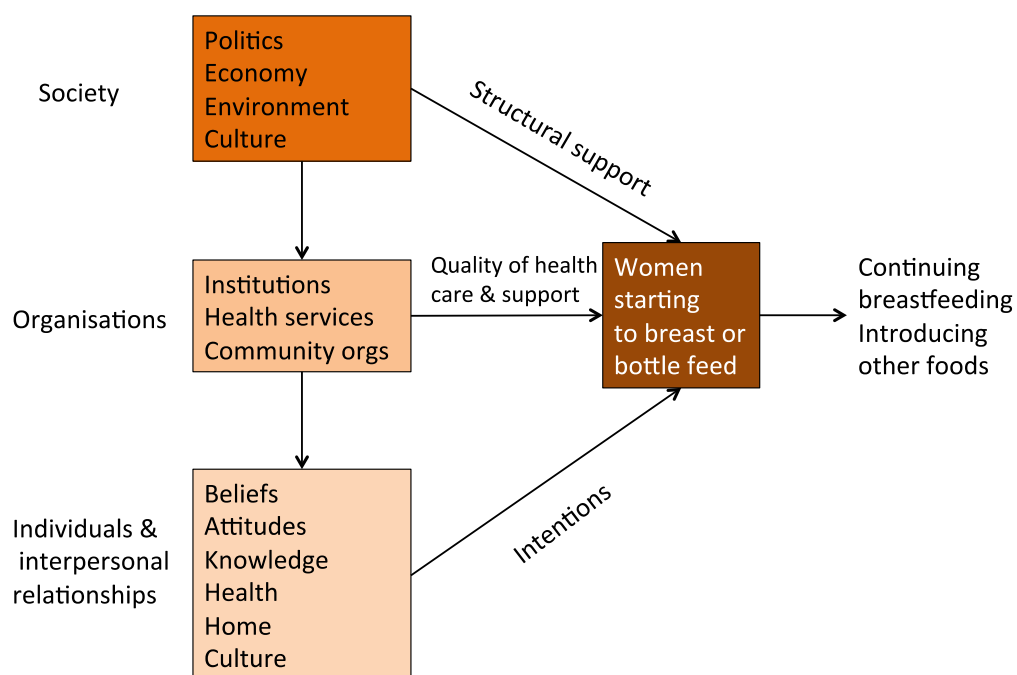


Figure 1: Simplified Ecological Model from Stakeholder Meeting January 2013

The findings from the focus groups and interviews broadly matched this kind of socio-ecological model, but the complexity of individual experiences called for a more sophisticated structure. In the following section, we outline the key findings

and then construct a new socio-ecological model that reflects the collective experiences of women in Tower Hamlets.

### **Public health messages**

Public health messages often try to change people's behaviour against the grain of the dominant social norms and structures. The influence of peoples' families, working lives, as well as media messages, or the marketing of corporations such as the food industry means that there is a significant effort needed to follow often conflicting advice (Foresight 2007, p. 50). People frequently make pragmatic choices to balance the costs and benefits of these often opposing influences.

The women who participated in this study had a good knowledge of the public health benefits of breastfeeding. They gave specific examples of improved immune systems, energy and general health for breastfed babies, and supported their beliefs by referring to the differences in health between babies they knew (including their own) who had been breastfed and not breastfed. They also valued the emotional benefits of breastfeeding, including a closer bond with their baby that they felt continued throughout childhood.

Discarding colostrum, which has been reported as common in many cultures (Liamputtong 2007), was not known about by most of the younger women we spoke to, and those who were aware of the practice considered it to be outdated. One breastfeeding peer support worker said:

*I remember when I first started mums used to say they chuck that [colostrum] away because that's what the mothers-in-law told them, because it was really vibrant yellow orange they thought it was pus. But with . . . through research now a lot of mums don't chuck that away, they are giving that to the baby because they know that it is really important with antibodies, things like that to give to the baby. (Breastfeeding peer support worker and younger woman 2)*



Studies of breastfeeding practices in Sylhet, Bangladesh, have also found that colostrum was not commonly actively discarded. Nonetheless, practices in London appeared to be different from the practices in Bangladesh reported in the literature, where breastfeeding was often delayed until the arrival of full milk at 3–5 days post-partum until which time newborns were fed with prelacteals such as sugar water, honey or banana (Winch et al. 2005; Sundaram et al. 2013).

## **UK Society and the Bangladeshi community**

### *Migration*

Migration has had a profound effect on all aspects of the women's lives, including their housing, food, health, education, social support, domestic workload, and personal and family aspirations. It appeared that older women who recently arrived, or still living in Bangladesh, were more supportive of breastfeeding than those who had been in the United Kingdom for longer period of time. This finding is supported by other studies (e.g. Bonuck et al. 2005) that found that assimilation into the UK society from a high breastfeeding country resulted in lower rates of breastfeeding. A move to the United Kingdom brought many changes and with it a desire to take on practices that were the norm in the United Kingdom. When women moved to London, they began to feed specialist formula and weaning foods that had not been available in Bangladesh, in combination with the family foods they would have given previously.

Migration and assimilation led people to make new norms in London. 'Bangladeshi' women, by which they meant women in Bangladesh, were seen as different from Bangladeshi women in London. One woman was teased by her brother for breastfeeding 'in public' at home because such behaviour was reminiscent of women in Bangladesh who were regularly seen breastfeeding outside the home:

*My brother used to walk into the room and say to me um . . . There is a word they use, it's like for Bangladeshi ladies, they say um . . . "freshie"<sup>2</sup>, so you just sit . . . I used to sit and feed anywhere in the room so they used to say, "Oh you are like these Bangladeshi ladies, you just feed anywhere, don't even care". (Breastfeeding support worker and younger woman 2)*

This 'othering' included creating a new set of purposively different norms for a new country. This meant that younger women were living with three, often conflicting, sets of expected behaviour: those from Bangladesh, from Bengali London and from dominant UK society. Younger women saw mixed feeding as a middle ground between the predominantly breastfeeding culture of Bangladesh and the predominantly bottle-feeding culture of the United Kingdom. Mixed feeding has become the norm in Tower Hamlets and most women followed their friends and peers to mix feed their babies.

Women did not appear to make a strong distinction between *exclusive* breastfeeding and *any* breastfeeding and took a positive view that any breastfeeding they could manage was incurring the benefits of breast milk to their children, without mentioning any possible risks of using formula milk:

*When we speak to them we ask them, "are you breastfeeding?" And they say, "yes, we are". Then we ask, "are you giving any other formula or bottle?" "oh, just one bottle at night time so baby will sleep". (Breastfeeding peer support worker and younger woman 1)*

Other studies of infant feeding practices in Bangladesh found very high rates of any breastfeeding but similarly low rates of exclusive breastfeeding. Women in urban areas of Dhaka frequently supplemented breastfeeding with water, and despite

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<sup>2</sup> 'Freshie' is a derogatory term used to describe someone 'fresh off the boat' or a new migrant from South Asia, particularly one who speaks poor English, or acts and dresses like someone from their country of origin.

doing this, they still viewed themselves as exclusively breastfeeding because they did not see water as a 'food' (Haider et al. 1999).

### *Infant feeding policy*

Although breastfeeding was the norm in Bangladesh, migration brought significant changes to all aspects of their everyday lives. Women's efforts to assimilate into their new societies as migrants included following UK infant feeding norms. One older woman explained what happened when she came to live in London, including the conflict between what is 'best' and what was 'possible':

*I breastfed my other three back home so it was no problem but bottles were available at the hospital [in London] and it was easier to feed so I gave a bottle. When I saw the nurses taking my baby and giving a bottle I started to do that. (. . .) God provided milk to us women to feed our children. I grew up seeing my women family members all breastfeeding. It came naturally, but we have got lots of help over there but here I didn't have time. My husband was at work all day and I was alone. Bottle is quick, no mess, easy. But breast milk is better. (Older woman 2, translated)*

Many of the older women we spoke to had given birth in the United Kingdom during the 1970s and 1980s and there was some evidence that the more proformula infant feeding policy of that period was still having an effect on the community today. Having formula fed their own children, older women may have been more likely to recommend to their daughters and daughter-in-laws to give formula to their children to help manage their domestic workload and promote weight gain in the baby, which was seen as a sign of good health. The influence of marketing from formula milk manufacturers remains powerful in the United Kingdom, despite legal restrictions (Brady 2012). In the following sections, we further discuss the influences of the older women on younger women in the community and their mothers' migration.

### *Influence of Islam on infant feeding*

Many women derived their commitment to breastfeed from their religious observance. Most of the women who took part in groups and interviews mentioned the Qu'ran's teaching that a child has a right to breast milk for two years. Breastfeeding for two years was an aspiration that motivated women to begin and continue breastfeeding, as this woman explained:

*I think the other thing that really encouraged me was you know, as Muslims in the Qu'ran it is told to us that we should breastfeed our babies, you know, suckle your child for two years if we can. So a lot of my friends they were doing it for that purpose and I had the same aim also because it is commanded by . . . from our religion. (Breastfeeding peer support worker and younger woman 1)*

The younger women participants recognised an increase in religious observance in recent years among the local Muslim community. Most of the women we spoke to did not consider themselves devout, but they respected the teachings of Islam and were committed to upholding them. As English translations of the Qu'ran and educational books on Islam had become more widespread, they felt that women of their generation had begun to engage more fully with the religion. They understood their new religious beliefs as part of a process of personal emancipation, through which they had learned to practise Islamic teachings, e.g. wearing hijab, for themselves and not because it was simply culturally expected of them. For some women, the Qu'ran provided them and their children with a moral compass and they were keen that their own children learned about Islam as a moral guide, particularly to encourage them to avoid alcohol and drugs. Islam was therefore a positive motivating factor in women's decisions to breastfeed their children and provided an aspiration, without dictating that it should be met.

### **Organisations**

### *Relationships with health professionals*

The women we spoke to often had had difficult experiences in the first hours after giving birth and were particularly critical of early post-natal care. This potentially had two main effects: firstly, that in many cases, breastfeeding was not established by the time they left hospital and, secondly, that their relationships and trust in the health care services were adversely affected:

*Midwives behave badly. They leave you to it. No one got any interpretation. (. . .) Sympathy and empathy are not there from professionals from when you arrive at the labour ward until you go home. Women are very vulnerable and no one comes to help. (Notes from Younger women's group 1)*

Some women who did not speak fluent English also felt that the staff did not take the time to communicate with them in the absence of professional interpreters, meaning they missed out on crucial health information, including breastfeeding. It should be noted that the youngest children of the (younger) women interviewed ranged from 2 months to 11 years (average 3 years) and so many of the comments would reflect experience of the service dating from several years ago.

The breastfeeding support service aims to see all women in the post-natal ward at the local hospital. Women often found it difficult to distinguish between different health care professionals, e.g. support workers, midwives and nurses, and so they were not clear as to whether they had had contact with a breastfeeding support worker while in the hospital.

Recent information from the re-assessment of the Royal London Hospital maternity service by the UNICEF UK Baby Friendly Initiative (2014) found that women who had seen a breastfeeding supporter or who had attended a breastfeeding workshop were pleased with the information they received, but those who had only seen a midwife did not always report having had a discussion about breastfeeding:

*By the time they left hospital virtually all mothers reported that they had received information and support to breastfeed according to their needs and the staff and breastfeeding supporters are commended for this. It was notable however, that those mothers who arrived on the ward later in the day which meant that their first opportunity to see a breastfeeding supporter was not until the following day sometimes did not receive as much proactive support. Consequently for some of these mothers, problems such as difficulty attaching their baby and sore nipples developed and this group of mothers were then more likely to go on to offer their baby a supplement. Developing a strategy which ensures that maternity ward staff do not rely too heavily on the peer supporters and ensure that mothers receive timely support is recommended. (UNICEF UK Baby Friendly Initiative 2014, p. 4)*

### *Interpersonal relationships*

Women's interpersonal relationships, particularly with peers, husbands, family and community elders, were all a significant influence in their decisions to continue breastfeeding. Whereas low-income women in the United Kingdom are the least likely social group to breastfeed (Kelly et al. 2006), low-income Bangladeshi women appear to persevere with (any) breastfeeding for longer periods of time.

One of the main motivators for breastfeeding was seeing other women breastfeed. While ongoing breastfeeding after initiation is not the norm in British society and breastfeeding women are rarely seen feeding in public, they did feed at community events within the Bangladeshi community in Tower Hamlets. A familiarity with breastfeeding started, for many, before they married and were pregnant. Seeing women breastfeed at family events, when meeting friends or at religious meetings, normalised it and demonstrated to them some of its benefits:

*It wasn't the information that I was getting from the professionals promoting . . . it wasn't all that so it was my friends, seeing them breastfeed encouraged me. You know, they are a few years older than me but I used to see them breastfeed and I used to go to, you know, gatherings and they would sit around and breastfeed and the same time just socialise with everyone, so I thought it was quite [a] normal thing to do. (Breastfeeding peer support worker and younger woman 1)*

A potentially negative influence however was the common practice of receiving a large number of guests in the first days after a birth as part of the family and community celebration of the occasion. The work that this demanded of new mothers may also have impacted on their ability to establish exclusive breastfeeding.

Older women in the family were also highly influential. Grandmothers' attitudes to their grandchildren's nutrition were directly influenced by how they had fed their young children. Many of the older women had breastfed their children, but those who had raised babies in the United Kingdom had, like their daughters, struggled to keep up with their domestic work and also breastfeed.

Women were frequently advised by older women in their family to give formula milk to tide their babies over the first days:

*I knew in the first few days it was colostrum, then I didn't know, I was just told by everyone, "You don't have any milk first few days so you have to give bottle, there is no milk," you know. But I know the small amount of colostrum but that is enough for them and I knew about hand expressing so I could massage and express to help her. (Breastfeeding peer supporter and younger mother 2)*

## **The challenges of breastfeeding**

### *Physiological difficulties*

The final 'layer' in the model relates to individual women's experiences. Like many other breastfeeding women, Bangladeshi women in Tower Hamlets found breastfeeding physically challenging, especially in the early weeks. They suffered breast pain and discomfort, nipple soreness, engorgement, mastitis and oversupply and leaking. Like many other women, this led them to introduce formula milk either to replace or supplement breastfeeding.

Women were frequently concerned whether breastfed babies were getting enough milk because they could not see the quantities the baby was drinking. This concern is, in part, a reflection of a wider Anglo-European culture, which has long privileged visual proof over other kinds of evidence (Aristotle 1986).

### *Returning to work*

Women who worked outside the home used formula milk to feed their babies while they were at work and some also continued to breastfeed at night.

Sometimes, women who knew they would be returning to work introduced a bottle early to acclimatise their baby and ensure that the baby would not refuse the bottle when it was needed.

### *Caring for an unsettled baby*

Women often associated formula feeding with a more settled baby and frequently attributed crying to babies being hungry because they were not getting sufficient breast milk. A health visitor commented that doctors may be increasingly medicalising 'colicky' or unsettled babies by prescribing medication, which may fuel parents' anxiety about the implications of infant crying. There may be a need for antenatal education for families to better understand when infant cues indicate hunger and when they do not and suggestions for non-pharmacological strategies for dealing with unsettled babies.



### *Internal conflict*

Many of the women we spoke to presented an internal conflict between their desire to do what they felt was best for their baby and the challenge of incorporating breastfeeding into their everyday lives. This woman's story represents this dilemma most clearly:

*I didn't breastfeed for very long, just about 6 weeks. I got married young – I was all over the place: emotions, responsibilities. I was scared. I found it very, very hard. My mum encouraged me but I found it hard. I did get advice at the hospital but it wasn't for me – the bottle worked for me – I know the benefits of breast milk. (Younger woman 7, translated)*

### **Discussion**

Within an often unfavourable social context, an emotional, spiritual or moral commitment to breastfeed was the biggest influence on continuing to breastfeed, either exclusively or in combination with formula. Often, women's commitment overrode their worries about breastfeeding in public and gave them the confidence to resist family pressure to give more formula than they were comfortable with.

All the women we spoke to, both older and younger, shared a commitment to the ideal of breastfeeding that was stronger than previous research has found in other low-income groups (Hoddinott & Pill 1999; Bolling et al. 2007). The women who were interviewed or who took part in the discussion groups were knowledgeable about the public health benefits of breastfeeding for them and for their baby. These benefits were an incentive to them to breastfeed but they were not enough on their own to enable them to exclusively breastfeed their infants.

While women understood the health benefits of breastfeeding, this did not always translate into breastfeeding their own children or sustaining initial breastfeeding beyond the first weeks. There were a number of competing factors at each of the socioecological 'layers' that made the difference between the 'ideal' of exclusive breastfeeding and the complex reality of how they fed their babies.

The socio-ecological model we hypothesised at the outset of project was generally supported, although the findings indicated that some model adjustment was required. The cultural and social influences on Bangladeshi women in Tower Hamlets came from the dominant UK society and from Bangladesh, and as such, the layer of social and cultural impact was subdivided to bring out the (often conflicting) distinction between these influences. In addition, the effect of public policy and public health provided different influences that were separate from other wider social and cultural norms. The socio-ecological model that emerged from our findings included the following five interconnected layers:

1. public policy, including public health campaigns;
2. the cultural and social norms of the Bangladeshi community in Tower Hamlets and the wider UK society;
3. local organisations including NHS hospitals, community midwifery and health visiting services and breastfeeding support;
4. the women's interpersonal relationships with their family and peers; and
5. the woman's individual experience of feeding, including psychological social and physiological challenges.

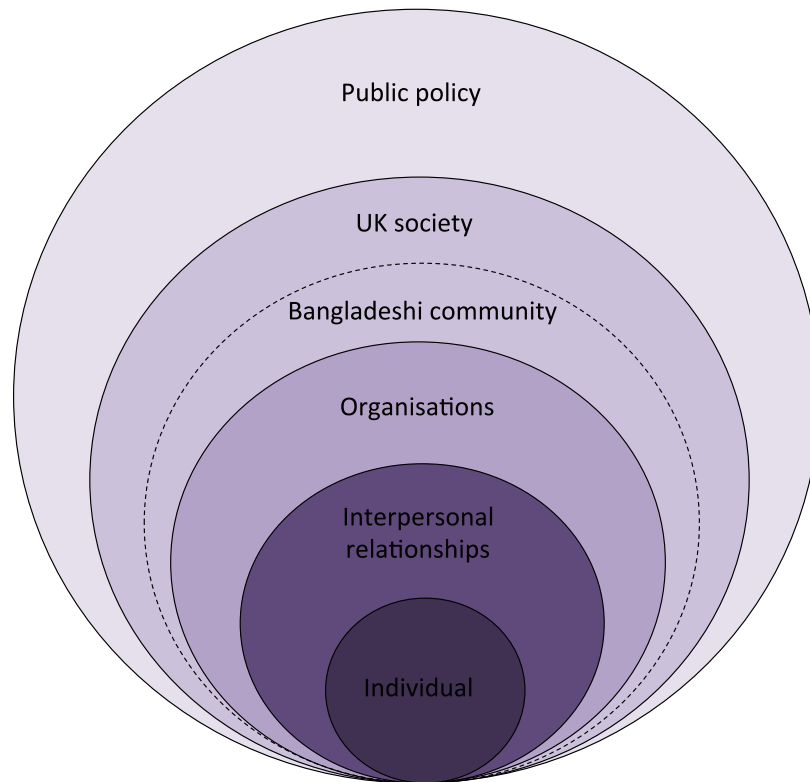


Figure 2: A socio-ecological model of Bangladeshi women’s infant feeding choices, adapted from Bronfenbrenner (1977)

The five layers of the socio-ecological model presented different challenges for women – and both positive and negative influences on their breastfeeding. The second and third ‘layers’ presented the most challenges, including the effects of migration, social support from elders, some fears about breastfeeding outside the house in a cultural environment in which bottle-feeding has been normalised and breastfeeding is associated with embarrassment, and difficult experiences with health services.

### *Commitment to breastfeeding*

Women were strongly influenced to breastfeed or mix feed by others around them, most notably their peers and older women in their family. Older women, such as

mothers and mothers-in-law, varied widely in their support for their daughters' breastfeeding.

Islamic beliefs were key motivators for breastfeeding, and the Qu'ran's explicit encouragement to women to breastfeed affected and supported many women's decisions. Most of the women believed that breast milk had been given to their child by God and that their child had a right to it for two years. Some women spoke of specific spiritual rewards that come from breastfeeding. The revival of Islam locally in the last 10 years is likely to have positively influenced women's decisions to breastfeed. While some women spoke about their concerns about breastfeeding in public, others did not see this as a problem and felt that their hijab was a useful tool to help them breastfeed discreetly in a public place. It is also important to note that concerns and embarrassment about breastfeeding in public are very socially widespread in countries like the United Kingdom (McFadden & Toole, 2006; Callaghan & Lazard, 2012).

#### *Diversity within the community*

Bangladeshi women in Tower Hamlets are as diverse a group of women as those anywhere else. Their diversity is not just in their age or migration history, level of education or knowledge of English, although these factors are important to their experience. Each woman had their own personal views, different levels of family support and different family relationships. This diversity is frequently invisible when South Asian British communities are so often seen as culturally homogeneous. As Alexander wrote:

*Where black/African-Caribbean identities have become defined as fluid, fragmented, negotiated and creative, Asian identities have been defined as static, bounded, internally homogeneous and externally impenetrable (2002, pp. 557–558).*

While women may have overarching experiences in common, such as migration and assimilation, their individual responses and pragmatic decision-making is different in each case. There may be a similar tendency among health professionals to view women's experiences as primarily influenced by being Bangladeshi women or Bangladeshi women in the United Kingdom, and to miss the specific diversity of individual experience (McFadden et al. 2012).

In her ethnographic study of health care in Tower Hamlets, Griffith suggested that the tendency to view the Bangladeshi population as homogeneous makes it impossible to decide what counts as 'authentic' cultural or religious practices:

*Many Bangladeshi workers in positions in Primary Health Care and the voluntary sector were called upon in my fieldwork to answer questions about cultural and religious practices. Determining what the cultural norms were in Bangladesh, or what was the "correct" Islamic practice, had within it a multitude of representational conflicts and concerns (2005, p. 19).*

#### *Personal difficulties with breastfeeding*

The women's personal difficulties with breastfeeding were very similar to the reported difficulties of most women in the United Kingdom: primarily, breast pain and discomfort; nipple soreness; the time that breastfeeding takes and the difficulty in keeping up with other domestic tasks such as cooking or cleaning the house, embarrassing feeding in front of others and lack of a socially supportive environment. These are not unique to Bangladeshi or to South Asian women, although they are likely to be magnified by the circumstances in which women live.

#### *Impact of migration*

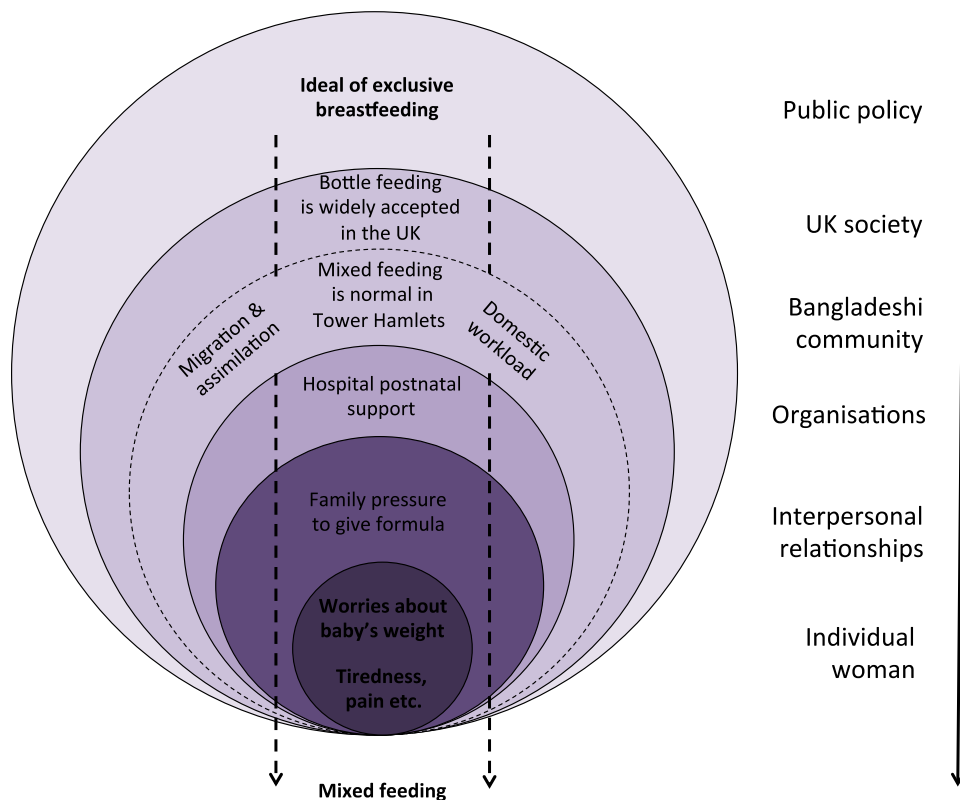
Unlike the indigenous UK population, migration has had a significant impact on these women's lives and the strategies that the Bangladeshi population in London have

used to distance themselves from those in Bangladesh have introduced new social norms. Younger women live with three, often conflicting, sets of social norms (Bangladeshi, London Bengali and dominant UK) that both facilitate and impede exclusive breastfeeding. In addition, while breastfeeding was described as commonplace and visible in Sylhet in a way that it was not in London, evidence from other cultures suggest that absolutely exclusive breastfeeding for 6 months is not common even in cultures where breastfeeding remains the norm.

'Any breastfeeding' had developed as a cultural norm in Bangladeshi London but while many women valued 'tradition': that is the practice associated with Bangladesh, being 'modern' and 'Western' was also prized. As bottle-feeding is so normalised in the UK culture, women often associated formula feeding with the status and benefits of being 'modern'.

The women who participated in this project appeared to find ways to persevere with breastfeeding where other groups of low-income women more commonly do not (Hoddinott & Pill 1999). This was more likely to be the case with second and subsequent babies as women developed confidence and a commitment to breastfeed as well as being more likely to live in a nuclear family and have more control over their environment and their time.

Figure 3 shows how each of the social/ecological layers acted as a filter of the ideal of exclusive breastfeeding and collectively led to the women's decision to mixed feed.



**Fig. 3. Influences on Bangladeshi women's infant feeding.**

### **Implications for clinical practice and policy**

Their perseverance in the face of multiple environmental 'layers' that often promoted and facilitated formula feeding deserves recognition. The women themselves saw their breastfeeding (whether exclusive or partial) as an effort that paid off for their child's long-term emotional and physical well-being. This should be viewed positively and pragmatic responses supported and not treated negatively. It is possible that the promotion of breastfeeding that similarly works with an asset rather than deficit model may prove to be effective. The public health focus could be as follows: to support and extend women's determination to breastfeed and to reduce practical barriers, as far as this is possible, which make it much more difficult to breastfeed exclusively, particularly with the aim of delaying the first formula feed.

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### **Conflicts of interest**

The authors declare they have no conflicts of interest.

### **Contributions**

JR contributed to the design of the research, coordinated and carried out data collection, analysed data and drafted the article.

CM contributed to the design, supervised data collection and analysis, and contributed to the drafting of the article.

LV commissioned the research and contributed to the design and the drafting of the article.

JC contributed to the collection of data and drafting of the article.

ETM commissioned the research and contributed to the drafting of the article.

All authors approved the final version of the article.

### **Ethical approval**



Ethical approval was obtained from the City University Research Ethics Committee and The London Borough of Tower Hamlets Research Ethics Committee.

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