Exploring the barriers to exclusive breastfeeding in black and minority ethnic groups and young mothers in the UK

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Abstract

UK health policy for many years has been to increase rates of breastfeeding because of the health benefits conferred on mothers and babies. World Health Organization recommends that babies should be breastfed exclusively for 6 months (without water or other fluids) and the National Institute for Health and Clinical Excellence promotes the provision of peer supporters or breastfeeding support groups to increase breastfeeding rates. This study aimed to explore the barriers to exclusive breastfeeding to 6 months with black and minority ethnic groups and with young mothers, and the strategies for overcoming these barriers, including peer support. Twenty-two mothers from Somali, Afro-Caribbean and South Asian communities or young mothers groups attended five focus groups. Transcripts were analysed using thematic and framework methods. There was enthusiasm for breastfeeding support groups, but with a wider remit to discuss other baby-related issues and provide general social support as well as support for breastfeeding. The Somali and South Asian women preferred the groups to be for their ethnic group, Afro-Caribbean women were keen that they should be open to all cultures and young mothers would like groups for their peers only. Encouraging mothers to breastfeed exclusively to 6 months should be promoted more and emphasized by health professionals when supporting women post-natally, and good support with breastfeeding management should be given to enable mothers to achieve this goal. Breastfeeding support groups may play a part in increasing breastfeeding continuation of breastfeeding, but for the groups studied this was not the greatest influence, with families and older women in the community having more influence in changing practice.

Keywords: exclusive breastfeeding, peer support, minority ethnic groups, young mothers.

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Background

UK health policy for many years has been to increase rates of breastfeeding because of the health benefits conferred on mothers and babies (Department of Health 1995). The Department of Health has recognized the potential impact upon public health to be gained by increasing breastfeeding with particular focus upon socially excluded groups. As part of delivering the National Health Service plan Primary Care Trusts (PCTs) are required to increase support for breastfeeding and raise breastfeeding rates by 2% per year, particularly among families from disadvantaged groups (Department of Health 2002).

The UK National Infant Feeding Survey 2005 (Bolling *et al.* 2007) has shown that breastfeeding rates for black and South Asian groups are higher overall for both initiation and duration than for the white majority, with some individual variation between ethnic groups. However, exclusive breastfeeding as defined by World Health Organization (without water) for the recommended 6 months, even among women from minority ethnic groups, was less common and very similar across ethnic groups.

Families of South Asian origin are often among the poorest in the UK with 45% of Pakistani and Bangladeshi and 21% of Indian households on Income Support (Thomas & Avery 1997). The UK national survey of Infant Feeding in Asian Families reported that even though more South Asian women started to breastfeed than white women, Pakistani and Bangladeshi mothers were three times more likely than white mothers to leave hospital bottle feeding and by 8 weeks over 50% of them had stopped breastfeeding. Mothers in all minority ethnic groups received most advice about infant feeding from their own mother or mother-in-law (Thomas & Avery 1997).

In Bristol, in one area with high health needs and a large multi-ethnic population, 32% of the women having babies in 2000/2001 were South Asian (approximately one-third each Indian, Bangladeshi and Pakistani). Despite relatively high rates of breastfeeding initiation, local health professionals report that mixed feeding was commonly practised, with many South Asian mothers introducing bottles of

formula milk very early, which contributed to the rapid decline in breastfeeding in these communities (Ingram *et al.* 2003).

Higginbottom's (1998) study of women from Somali and Afro-Caribbean backgrounds suggests positive attitudes to breastfeeding among this combined group, but younger women showed less commitment to breastfeeding than older women. She also indicated different perceptions of the acceptability of breastfeeding in the UK compared with their country of origin, which impact upon women's breastfeeding practice. Condon *et al.* (2003) confirmed that black women experience significant difficulties in fitting breastfeeding into their family and social lives. Condon *et al.* (2003) also described how Bangladeshi and Pakistani women found it difficult to breastfeed outside the home, and this was cited as a disadvantage. Breastfeeding in the UK causes a problem to Muslim groups because of the unacceptability of exposing the body and because of the lack of public provision for breastfeeding. Afro-Caribbean women appeared most confident about putting the needs of the baby above social approval, but also described situations where they were openly criticized for breastfeeding in public.

Teenage mothers in the UK are less likely to breastfeed than older women with only 51% initiating and the fall-out rate is also greater than for older mothers, particularly in the first week (Bolling *et al.* 2007). There is evidence to suggest that they decide on their chosen method of feeding later than other mothers (Cruikshank & Regis 2005) and they often need a lot of support to continue breastfeeding. The document 'Every Child Matters' (Department of Health 2004) outlines the importance of personalizing services and developing strategies to meet the needs of teenage parents, one aim being to increase breastfeeding rates.

Social support has been found to have direct and positive effects on mothers' relationships with their infants and on breastfeeding rates. Studies have shown that a supportive environment is related to successful lactation for economically disadvantaged women (Marchand & Morrow 1994). Studies in the USA have also shown that volunteer peer supporters, who provide low-income women with role models,

accurate information, support and encouragement, have helped to increase breastfeeding duration in these communities (Morrow *et al.* 1999). The National Institute for Health and Clinical Excellence has recommended that peer support programmes should be offered to provide information about breastfeeding and counselling support to women on low incomes in the antenatal and post-natal periods (Dyson *et al.* 2005). A peer support scheme in a predominantly white Sure Start area in Bristol was evaluated in 2002 and this showed an initial increase in breastfeeding rates at 2 months from 17% to 25% (Ingram *et al.* 2004). However, peer support schemes may not be acceptable or successful in all communities. Culturally sensitive support for breastfeeding women begins with an awareness of the differences among cultural groups and breastfeeding educational programmes are more effective when they emerge from the culture itself (Riordan & Gill-Hopple 2001).

The aims of the current study were to:

1. explore the barriers to exclusive breastfeeding to 6 months with minority ethnic or socially disadvantaged groups of women, and
2. ascertain what strategies would help to overcome these barriers, including peer support schemes.

Methodology

Mothers who had had a baby within the previous 10–18 months and who had breastfed for at least a few weeks were purposively sampled and approached. Mothers with a range of breastfeeding experiences were also included.

A senior linkworker, from Health Links, contacted mothers in the South Asian communities, to explain the study and invite them to attend a focus group at the health centre. To ensure good attendance, she reminded all those who had agreed on the day of the focus group about the time and venue, and arranged transport for those who needed it. The Somali community was approached through the Barton Hill Settlement (a community resource centre and charity for Barton Hill – a diverse inner city area in the east of Bristol). Mothers who attended the Settlement were asked to come to a focus group by a Health Visitor

(B.P.) or Somali Family Support Worker, who is part of the health visitor team. The Afro-Caribbean community was approached by a Health Visitor, who had links with one of the local day nurseries where a parent/child group is held. Permission had been sought from the manager of the nursery and the group was to be held over lunchtime. Teenage mothers were approached through a Connexions Worker and Teenage Pregnancy Midwife, also through a mother and baby unit, organizations who provided accommodation for young mothers and a Young Women's Christian Association (YWCA) training centre where activities, teaching and training for teenage mothers are run. Consent was then obtained from the mothers for their contact details to be given to the Health Visitor leading the research study (K.C.).

All participants were invited to lunch before each session to provide a relaxed atmosphere, were offered transport to the health centre or other venue and given a baby-related gift token in thanks at the end.

For groups whose first language was not English, a linkworker and two researchers were present at each focus group. Information about the study was given in written and verbal format as participants arrived and consent forms were completed in the relevant languages. Each group was facilitated by one researcher (J.I.) with questions and responses translated by a linkworker into Punjabi, Bengali, Urdu or Somali as appropriate. The other researcher took detailed notes during the group to record information at the time. After the group the linkworker and researchers discussed the topics again, referring to the notes taken and recalling any other points made. The discussions were recorded with a digital recorder and compared with the notes taken and the researchers summarized the common themes arising out of each topic.

The teenage mothers' focus group was facilitated by one researcher and another took notes to aid transcription. The transcript was coded and analysed using a thematic approach of sorting quotations into themes and subthemes (Silverman 2000). Framework analysis comparing the responses on each topic or theme for each group was subsequently carried out.

Some basic demographic information was collected from each woman and the groups started with a discussion about family size and how each child had

Table 1. Demographic characteristics of the 22 women in the study

	Somali	South Asian (two groups)	Afro-Caribbean	Single young mothers
Numbers who agreed to attend	7	12	4	11
Numbers attended	5 (71%)	9 (75%)	3 (75%)	5 (45%)
Mother's age (years), range (mean)	25–40 (30)	20–40 (31.3)	22–30 (24.7)	16–23 (18.2)
Number of children	1–4	1–6	1–2	1–3
Age of the youngest babies	7–11 months	4 months to 2 years	17–19 months	7 weeks to 8 months
Breastfeeding experiences	3 exc BF for 5–6 months then solids; 2 mixed fed from birth	3 exc BF for 6 months; 5 exc BF for 4 months then solids; 1 BF to 4 weeks	2 exc BF for 5–6 months then solids; 1 BF to 3 months	2 exc BF to 5 months then solids; 2 BF to 3 months; 1 BF to 5 weeks

exc BF, exclusive breastfeeding (no water or fluids other than breast milk).

been fed from birth. At the beginning of the discussion about breastfeeding, a definition of 'exclusive breastfeeding' (i.e. feeding without any other drinks of water, formula, tea or juice) was given, so that everyone knew what was being discussed.

Ethics permission was granted by Southmead Research Ethics Committee in June 2006.

Results

The focus groups were held between July 2006 and January 2007 and 22 women attended the groups. More women had been contacted and had agreed to attend but because of illness or other family reasons were not able to come on the day. In total, 23 black and minority ethnic women agreed and 17 (74%) attended, 11 single young mothers agreed but only 5 managed to attend the group (45%) (see Table 1). Some demographic details for the women in the study are also shown in Table 1.

Feeding experiences and cultural or family influences on breastfeeding

Somali

Three of the Somali women breastfed exclusively for 4 or 5 months and then introduced solid food, the other two supplemented with formula from birth because they were unaware that breast milk was suf-

ficient for their babies. The women stated that they were informed by their general practitioner that they could introduce other drinks and/or solids between 4 and 6 months. The message from the Somali community, mainly from women with older children, is that breast milk alone is insufficient for the baby, and supplements are needed. 'Healthy women should have healthy big babies.' They are told that their children will not grow tall and large if they do not supplement.

Family members and friends will visit following the birth of a baby, bringing with them 'a gift and a piece of information'. There is a lot of pressure to follow the advice of others and stigma and criticism can be experienced if you do not. Since there are more options for supplementing here in the UK, there is no excuse not to have a large healthy baby and the women said that they felt a lot of pressure to offer supplements. Traditionally in Somalia they would breastfeed exclusively for 6 months.

South Asian

Most of the South Asian women had breastfed exclusively to 4 months, some to 6 months. One mother gave her baby water from when it was 3–4 days old on a 2–3 hourly basis; this was her own personal feeling and not family or religious pressure (she only breastfed for 1 month). Most of the other women introduced water at 4 months old, with a few waiting until

5 or 6 months, when solid food was also introduced. The majority however introduced solids from 4 months old. The South Asian women all agreed that breastfeeding was 'best for baby' and it was very good nutritionally to offer 'purely mother's milk'. Their culture and religion encourage them to breastfeed for at least 2 years. Families are also an important source of advice for mothers on how to feed and there are usually many family members living close by. There is always family support in Bangladesh and in the UK the in-laws are supportive and offer help. Partners were not seen as a main support for breastfeeding – 'they encouraged with words, but nothing else'.

Afro-Caribbean

Two women breastfed exclusively for 5 and 6 months, respectively, and the other introduced formula milk at 3 months. Mothers had been advised by health visitors and other health professionals to introduce formula in addition to breast milk when their babies had been slow to gain weight. One chose not to do this and the others found that their babies put on weight more rapidly when they introduced formula at 3 months and 5 months respectively. The group suggested that mothers from the Afro-Caribbean community were more likely to breastfeed than white women. Culturally it is generally the family that influences the woman's decision to breastfeed and how much support she gets and none of the women felt that they had received much help or support from their partners.

Young mothers

Two of the young mothers breastfed exclusively for 5 months and then introduced solids, two others breastfed for 3 months before giving some solid food or formula and the fifth breastfed for 5 weeks. A range of different advice had been received on the use of water and when to give solids, with health professionals telling them not to give water, but family members encouraging them to do so, either to relieve wind, to extend the time between feeds, or if their baby seemed thirsty. This conflicting advice caused uncertainty as they had often followed what their family

had told them to do. They had all introduced solid food before 6 months, some from about 5 months.

All the young mothers felt that the attitudes and support from partners and family influenced how they fed their babies. Some said that their partners had not been too keen for them to breastfeed initially as they wanted to be involved with feeding the baby '... until the novelty wore off'! Others mentioned that family members commented about breastfeeding in public, and about not knowing how much milk the baby had taken, whereas some family members (particularly a grandmother) guarded their privacy by stopping men from visiting or coming into the room when they were feeding. Most felt that it was difficult to feed in front of men (friends' boyfriends, brothers and their friends).

Breastfeeding outside the home

Somali

Most of the women stated that they would feed anywhere and felt that their clothing assisted this. They would use the baby changing rooms, for example, in stores in town, but would find a place where they felt comfortable. Fathers accessing these rooms would not prevent them, but they would seek the best place where they could not be seen by men.

South Asian

All the South Asian women agreed they would breastfeed before they went out and then know they would have 1–2 h out with their baby before they had to get back home to breastfeed. Privacy and 'female-only' places to breastfeed were important; one said she would like to be able to feed in more places. All agreed that a *separate father's area* for nappy changing would 'make life much easier to breastfeed'.

Their reasoning for introducing formula, other drinks and solids earlier than 6 months of age was reported to be a direct result of being unable to 'expose' themselves and breastfeed in public places.

Afro-Caribbean

Generally this group felt there were not enough places to breastfeed, and where there were facilities,

they were often inadequate and inappropriate. They wanted a warm comfortable room with a chair and not to have to use the toilet. They felt that there needed to be a room for feeding, with separate nappy changing facilities.

They had strong views about the importance of being able to feed their babies when and where they needed to. One mother felt very strongly that the child's needs are paramount, and she would not let others' views prevent her from feeding her baby if she required feeding.

Young mothers

All agreed that it was difficult to breastfeed a baby when out shopping, particularly in smaller shopping centres, where there were few suitable and available facilities for breastfeeding. With support from other family members, a few had breastfed in cafes or on park benches, but they all felt that men get offended when women are feeding in public places.

Exclusive breastfeeding to 6 months

Somali

One of the women said that if she had known that her breast milk was sufficient, she would have breastfed exclusively for longer. Although the midwives advised them that breast milk was sufficient, most of the women did not feel confident enough to override the advice and information from the women in their community telling them to supplement.

They felt that they needed 'concrete' information and advice, as it takes time to establish breastfeeding to ensure a good milk supply. The whole issue of 'supply and demand' needed to be understood better, as many women found it easier to give a bottle, but may persevere if they had this information. Antenatal advice was felt to be vital, as many women will supplement from birth. The women felt that the whole Somali community needed educating in breastfeeding management, particularly women and family members with older children and experience of motherhood. Grandparents were said to be generally supportive of breastfeeding.

South Asian

Self-confidence, experience and encouragement from family were important for some mothers to keep breastfeeding. They said that life in England for Asian women is 'too hard' compared with back in their home countries. They could not carry on fully breastfeeding over 6 months, even though they would like to, as there was no support with housework, getting other children to school and their many family commitments. Breastfeeding up to 6 months is manageable as long as mothers know their babies and their patterns of feeding, enabling them to go out and still breastfeed within the home only. They felt that having a private area to enable them to feed in public places would help, but this private place should only be accessible to women, and this is not always easy to do.

Afro-Caribbean

The women in the group did not have any strong views about how long babies should be breastfed for, but only one breastfed exclusively for 6 months. Those who had continued to breastfeed beyond 6 months had done so because they felt it was important for their babies' health.

Young mothers

The young mothers discussed how others might be helped to breastfeed exclusively for longer and to 6 months if possible. Some of their thoughts on this topic included banning bottles and advertising, clearer explanation of the health benefits of breast milk from health professionals and more guidance about managing breastfeeding in the early days.

Everyone knows about the nutrition, but not the other stuff.

Managing breastfeeding in the early days puts people off, with frequent feeds and sore nipples and breasts.

I'd say to others, try breastfeeding first, and then decide how you feel.

Peer support or breastfeeding support groups

Somali

There was a lot of heated discussion and interest in a breastfeeding support group for Somali women and also in peer support. The women felt that they would like their own group as opposed to accessing a group with women from other cultural backgrounds, as language barriers played a large part in not accessing existing antenatal or post-natal groups. They felt that some sort of group for both antenatal and post-natal women would be helpful, with linkworker support, where a range of issues around feeding and child care could be discussed. They highlighted the following points:

That there should be experienced mothers at the group who had breastfed exclusively (as role models); someone with expertise should be present (to answer questions) and translation available; pregnant women should also attend to gain the information about exclusive breastfeeding and that it is good for babies.

They felt that English women are able to access other groups, are given information, decide what they want to do and go home and do it. Somali women need more confidence to oppose the Somali community views and influences.

South Asian

One mother felt that if she had received more support and encouragement, perhaps from a group, this would have helped when breastfeeding her first two sons (she only breastfed her first two children for a short period and was currently breastfeeding her third at 8 months). Another felt that a group to discuss breastfeeding in the antenatal period would have been encouraging and she would have used it. Others agreed that a breastfeeding support group from 32 weeks of gestation and a person able to speak in their mother tongue would be helpful. However, most of the mothers that attended the focus groups agreed they were too busy with family commitments to be involved in running a group. When asked about sup-

porting other mothers (peer support) they said that they were all so busy that they would not have time to do this on a regular basis.

However, linkworkers are key to information dissemination throughout the South Asian community. They see all ages of women, from young mothers to grandmothers, so it was agreed that this would be the best way to get new evidence-based information out to the community. Those giving breastfeeding training to linkworkers need to know about cultural influences and make it relevant to the community. It is important that the linkworkers for all minority ethnic groups have up to date information about breastfeeding, so that they can assist and support community health professionals.

Afro-Caribbean

The mothers were not aware of any breastfeeding support groups and did not think that they would go to such groups, as they relied on family and friends for support. They may consider going to a group to socialize and to find out about other topics, but the group should be open to all women and not be culturally specific. They recognized that some women do need support and that a group could therefore be useful for some, with peer support.

Young mothers

Some mothers had attended an antenatal group, but they were

all a lot older – like 40 something, with lots of married couples

and another felt

it seemed that everyone was looking down on me.

They suggested that maybe at the Mother and Baby Unit or the education unit for young parents, a group could be held specifically for young mothers. Two mothers had had experience of attending such a group that had been set up and established by the Teenage Pregnancy Midwife. People had started coming to the group antenatally and then continued meeting post-natally. They reported that they did not

feel embarrassed when the group was for young people only, as being around people of the same age was important. They suggested that posters in general practitioner surgeries could advertise the group.

Discussion

This study specifically explored two recent recommendations for improving breastfeeding rates with black and minority ethnic groups and with young mothers. The recommendations discussed were exclusive breastfeeding to 6 months (without water or other fluids) and the provision of peer supporters or breastfeeding support groups. There was some enthusiasm for breastfeeding support groups, but perhaps with a wider remit to discuss other baby-related issues and provide general social support as well as support for breastfeeding. The Somali and South Asian women would prefer the groups to be for their ethnic group, whereas the Afro-Caribbean women were keen that they should be open to all cultures. Exclusive breastfeeding to 6 months was achieved by very few women in the study and this seemed mainly due to a lack of information in some minority ethnic groups, a busy lifestyle or different advice from health professionals. However, three-quarters of them breastfed exclusively for 4 months and half of them to 5 months. The focus groups were held in 2006 when the recommendation to breastfeed exclusively to 6 months had been current practice for about 3 years, but some mothers with older babies may not have received this advice. It is therefore important that reasons for the change are given to multiparous mothers in terms of health benefits and cost savings.

The study was limited by the small numbers who attended the focus groups, particularly by Afro-Caribbean women, but running focus groups for these communities was always going to be challenging. However, we felt that this was the best way to stimulate discussion on these topics, rather than doing individual interviews. We held two groups for the South Asian women which were attended by Pakistani, Bangladeshi and Indian women and the findings were similar in both. The study may have been strengthened by trying to run repeat groups for the other

communities, but we were not able to contact any more women in the time available.

Our study confirms findings from larger surveys in the UK that women from minority ethnic groups breastfeed more exclusively and for longer than the single young mothers and than white mothers in the UK (Kelly *et al.* 2006; Bolling *et al.* 2007). The largest group in the study was from the South Asian community and these mothers were older, had more children and more experience of breastfeeding than the other groups and they reinforced the cultural and religious reasons for breastfeeding for up to 2 years. They still found it difficult to breastfeed outside the home, which sometimes caused them to use formula when out, since for Muslim women it is unacceptable to expose the body and there are few acceptable places to breastfeed. Discomfort at feeding in public was also noted by Potter (2005) as a risk factor for mastitis because of delayed or hurried feeds. She concluded from this that cultural values relating to breastfeeding in public were equal to physical and pathological risk factors for mastitis. Afro-Caribbean women appeared most confident about putting the needs of the baby above social approval when out and breastfed in more places, as also found by Condon *et al.* (2003).

Cultural and family influences were important for all the groups in the support for breastfeeding and the advice given about the introduction of other foods and drinks. A previous study with South Asian families (Ingram *et al.* 2003) has shown how family members can influence practice and this was reinforced with the other groups, especially the recently arrived Somali women. The Somali group was the most interested in having a breastfeeding support group for their community and this may be influenced by the more recent establishment of this community in Bristol, compared with the long-established South Asian and Afro-Caribbean communities, who all seemed to have good family networks to provide this support. The only women interested in peer support were also from the Somali community. When commissioning community health services, it is important to take account of the complexity and diversity of cultural values, to be able to provide the most appropriate models of care.

The role of linkworkers in providing up-to-date information to all the minority ethnic groups is highlighted in this study as it has been in a previous study (Ingram *et al.* 2003). Linkworker training in breastfeeding needs to be refreshed at regular intervals so that they can support health professionals in disseminating current information about exclusive breastfeeding and when to introduce solids to their respective communities.

The young mothers in the study suggested that educational sessions about the benefits of breastfeeding particularly for young mothers and given by known individuals would be valued, which is confirmed by a recent review of studies by Hall Moran (2007). They also liked the idea of groups for young mothers only, which would enable them to feel more confident and relaxed about breastfeeding.

Conclusion

Encouraging mothers to breastfeed exclusively to 6 months should be promoted more and emphasized by health professionals when supporting women post-natally, and good support with breastfeeding management should be given so that mothers are enabled to achieve this goal. Breastfeeding support groups may play a part in increasing the continuation of breastfeeding, but for the minority ethnic communities studied this was not seen as the greatest influence, with families and older women in the community having more influence in changing practice.

Future research could explore how to identify and develop strategies to educate older women within minority ethnic communities, while valuing their traditional practices that are helpful to breastfeeding duration.

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Key messages

- Culturally specific breastfeeding support groups may be a goal to work towards, but encouraging discussion and giving evidence-based information at existing minority ethnic support groups may be more feasible in practice.
- Linkworkers are important and influential resources who can change opinions and beliefs in minority ethnic communities, so their training should be kept up to date to reflect the latest breastfeeding evidence.
- Educational sessions and support groups specifically for young mothers should be run by known individuals with expertise to encourage and support their breastfeeding needs.

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