Evaluation of Sure Start on the Ocean bilingual breastfeeding support work

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Final Report

Shamoly Ahmed
Research Officer

Alison Macfarlane
Professor of Perinatal Health

Department of Midwifery
Philpot Street
London E1 2EA

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Introduction

In the late 1970's and early 1980's, the Ocean Estate in Tower Hamlets attracted an inflow of large numbers of people from minority ethnic communities, mainly people of Bangladeshi origin. Despite the current overcrowding of accommodation, with high levels of housing-related ill health and with high rates of consultation with GP's making increasing demands on the inadequate primary care provision, two-thirds of the tenants wish to stay in the area. This is because of improvements to housing as people are decanted out to new properties and because of the strong roots they now have in the community, with faith groups and local community and voluntary organisations playing a central role in the lives of the Ocean Estate residents.

Background to breastfeeding

Rates of breastfeeding initiation and duration of breastfeeding have declined in recent years in both developed and developing countries.[1, 2] In developing countries breastfeeding is a cultural norm and in western societies women from ethnic minorities turn to their families for breastfeeding support rather than to health professionals.[3, 4]

Breast-feeding is considered the optimum method of baby feeding. It is influenced by various physical, psychological, social and environmental factors.[5] In the past, women's knowledge about breastfeeding came from the experiences and accumulated knowledge of other women. Today women still value other women's knowledge of breastfeeding and have even requested to see women demonstrating breastfeeding and to be given the opportunity to speak with them in the antenatal period.[6]

Increasing the initiation and duration of breastfeeding is recognised as a national priority. Increased duration of breastfeeding offers health benefits to mothers and babies.[7] Benefits, compared to formula feeding, include optimal nutrition, reduced risk of infection and increased social interaction between the mother and her baby.[8] Advantages for the mother include increased maternal uterine tone, decreased risk of postpartum haemorrhage, return to pre-pregnancy weight more quickly, convenience and increased intervals between pregnancies. [9, 10]

Various factors contribute to the initiation and continuation of breastfeeding. These include the mother being educated about breastfeeding, embarrassment about breastfeeding in public, perceptions that breastfeeding is more restrictive than bottle feeding, lack of support or even active opposition by members of the mother's social network.[11, 12]

It is important to recognise that social factors play a significant role in influencing breastfeeding practice. Qualitative research suggests that social support and seeing other women breastfeed may be important determinants of breastfeeding behaviour. [13, 14]

Local studies have also looked at attitudes to breastfeeding, trends and decisions about infant feeding. A study of breastfeeding in East London found that decisions to initiate breastfeeding are influenced more by seeing other women breastfeeding than

by theoretical knowledge about its benefits.[14] It suggested that a woman's knowledge and confidence about breastfeeding and commitment to it can be gained more effectively through antenatal apprenticeship to a breastfeeding mother than from advice given in consultations or books.

A breastfeeding support centre was set up in Tower Hamlets in 1997 to improve the support breastfeeding women receive from health services locally. The work of the support centre was evaluated using qualitative methods. Although this used a very small sample, it is still important to note that all respondents valued the support received by breastfeeding supporters. In particular they appreciated the opportunity to share experiences and to discuss breastfeeding issues with other women. [15]

An audit of breastfeeding rates in Tower Hamlets in 1999 found that 61% of women intended to breastfeed their baby but only 23% actually breastfed them. The audit was unable to measure breastfeeding rates at intervals after the baby's birth due to poor recording of feeding information.[16] This study highlights the need to record routine information of this kind in order to monitor breastfeeding progress amongst women in the east end of London.

In Tower Hamlets, the difference between intention to breastfeed and actually breastfeeding is far greater for Bangladeshi women than for other women. Similar differences between Gujarati and Bangladeshi women were found in a study in Leicester. Although both groups are from the Indian subcontinent their intentions and actual feeding practices are quite different. This was especially surprising, given that many Bangladeshi women had recently arrived from Bangladesh where breastfeeding is the only viable option for most women.[17, 18] Further work is needed to understand the reasons behind such a change in breastfeeding trends and attitudes in women from a community where breastfeeding is well rooted in its own traditional culture.

Most of the studies in Tower Hamlets mentioned above looked only at the white population or included small numbers of Bangladeshis. This is disappointing as 61% of births in Tower Hamlets are to women of Bangladeshi origin* and many of the strategies used to promote breastfeeding will not apply to the Bangladeshi population. This is due to the differing levels of needs and access arising from the cultural and linguistic barriers unique to this population. Collecting information on feeding methods amongst the Bangladeshi community is the key to planning and delivering appropriate services to meet its needs.

* PRIDE database, Barts and The London NHS Trust

Sure Start on the Ocean breastfeeding support work

In 2000, the Eva Armsby Family Centre run by Tower Hamlets Social Services to provide parenting and family support to local residents, through one-to-one support and drop in groups, Tower Hamlets Healthcare Trust and the Breastfeeding Network obtained funding from the Sure Start programme to provide breastfeeding support and education to women in the local Sure Start area on the Ocean Estate. This is an extension to the ongoing work that two practice development midwives were already doing at the London hospital and through drop in sessions at the Eva Armsby Family Centre.

The aim was to improve uptake and duration of breastfeeding through antenatal and postnatal support and education for women living on the Ocean Estate.

The breastfeeding programme contributes to Sure Start objectives 1,2 and 4:

1. Improving social and emotional development - a satisfactory breastfeeding experience encourages early bonding between mother and child
2. Improving health - breastfeeding promotes healthy development after birth and will contribute to the reduction of hospital admissions for gastroenteritis
4. Strengthening families and communities - local breastfeeding mothers will be trained as breastfeeding friends to support new mothers.

An earlier project, which used information from the Royal London Hospital's Patient Administration System (PAS), the Child Health Computer System (RICHS), health visitors' records and work by two local practice development midwives showed that rates and duration of breastfeeding were low amongst Bangladeshi women. [16, 17] As a result, the breastfeeding project incorporated additional support for this group of women as part of its overall objectives, which were:

1. To provide training and supervision for a Bangladeshi breastfeeding supporter.
2. To train at least six local women volunteers who have breastfeed as peer supporters to act as positive role models for individual mothers.
3. To increase breastfeeding rates amongst the socially and materially deprived women on the estate by at least 10%.
4. To contribute towards a reduction of at least 10% in children admitted to hospital as an emergency with gastroenteritis or respiratory infection during their first year of life.

This report describes the evaluation of the first component of the project. The second component, in which six volunteers will be trained, has yet to take place.

Breastfeeding Support Worker

The two job share practice development midwives who work in Tower Hamlets Primary Care Trust and City University initiated the breastfeeding support programme in October 2000. The two midwives coordinated the programme in terms of its aims and objectives, finance, resources and the recruitment of the breastfeeding support worker. In order to be able to provide an effective support and education programme of breastfeeding to local Bangladeshi women, it was essential that the selected support worker had both commitment to and personal experience of breastfeeding, and was familiar with the language, social and cultural values and practices of the Bangladeshi women particularly in relation to breastfeeding. It is on this basis that the support worker, Janathara Uddin, was recruited in June 2001.

Initially she worked closely with the two practice development midwives who provided training and support. She also undertook a formal course of training under the auspices of the Breastfeeding Network to train as a Registered Breastfeeding Supporter. She worked independently under supervision from September 2001 to August 2002, at which point she went on her maternity leave. Her title was Breastfeeding Support Worker and she worked predominantly with women of Bangladeshi origin, but also saw a few women from other ethnic groups, notably Pakistanis and Somalis.

The support worker's aims were to make contact with as many pregnant women as possible both antenatally and postnatally, through home visits and telephone support. Women in the Sure Start area were identified by visits to the hospital wards and also through referrals made by midwives, Bangladeshi advocates and health visitors.

Women were given as much information as possible whilst in hospital and then at home on request. In order to establish on additional support network for women themselves, .support via home visits was encouraged to enable contact with family members, in the hope of getting them interested and educating them. The Eva Armsby Family Centre set up a satellite support centre on the Ocean Estate for women in the area. The support worker attended classes at this centre and provided support for breastfeeding.

The support worker worked independently under supervision for a year. This review will therefore focus on evaluating the work undertaken by the support worker and the value of this programme to the Sure Start women. This was to assess whether the programme succeeded in its objectives and which aspects of the way it functioned contributed, or detracted from, that success.

Evaluation of Breastfeeding Support work

Aim:

To evaluate the Sure Start on the Ocean breastfeeding support work.

Objectives:

1. To explore the effectiveness of the support work in the delivery of support and information to women in the Sure Start on the Ocean area to improve breastfeeding uptake and duration
2. To identify constraints and difficulties faced by local Bangladeshi women in relation to infant feeding
3. To explore whether local Bangladeshi women's needs in relation to breastfeeding were meet by the support worker.

Methodology

Sample

Women from the Sure Start Ocean Estate who had received some breastfeeding support from the support worker during the period September 2001 to August 2002 were identified from the client records maintained by all members of the breastfeeding support team. These records contained information on women's names, addresses, telephone numbers, ethnicity and language, child's date of birth, reasons for referral, notes on discussion with women during the support and date seen. Notes on the clients' record sheet were examined by one of the practice development midwife who had supervised the support worker.

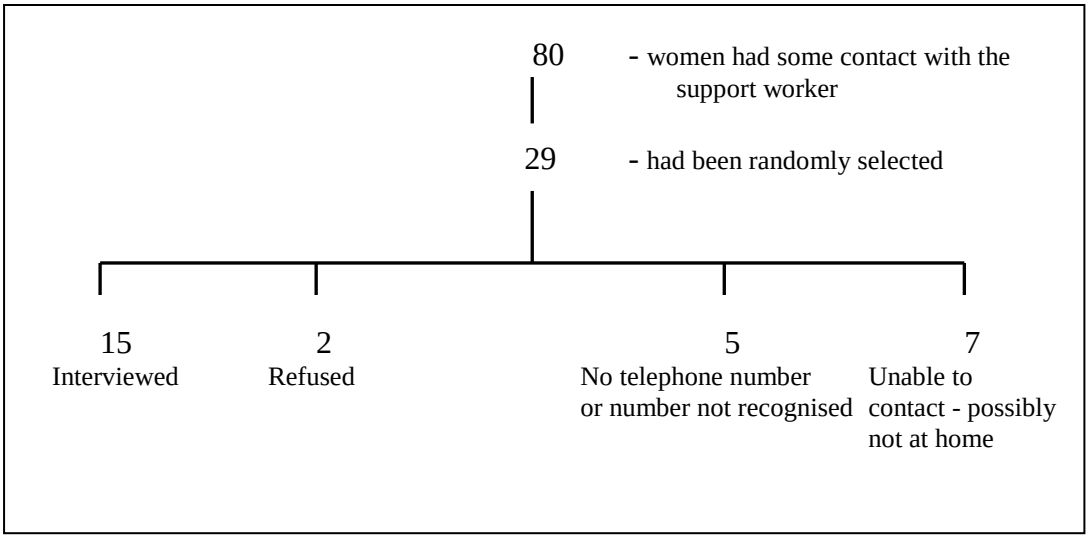
As a result, 80 women who had some contact, either face to face or via telephone contact only, with the support worker were identified. Fifteen of these women were randomly selected. Women were telephoned by a Sylheti speaking interviewer who invited them to participate in this study provided they met the study inclusion criteria. These were that women had to be over 18 years of age, have received breastfeeding support from the support work, and have a child of 4 months or over born since 2001. Due to the lack of information recorded it was not possible to use theoretical sampling in order to gain maximum variation in the sample. The sample size was determined by the resources available and hence used stratified sampling.

Because of the limited time available for this evaluation, the bilingual research interviewer contacted participants by telephone and obtained verbal consent. The decision not to produce a written study information pack in both English and Bengali was based on the time shortage, low levels of literacy among Sylheti women both in English and Bengali and the fact that Sylheti is a dialect that has no written format. Information about the project was given in Sylheti in a pre-prepared format. The women were invited to take part in the study. Those who agreed were interviewed, either straight away or at a later more convenient time.

Ethics approval was received from the East London and City Health Authority Ethics Committee. A total of 194 women gave birth from the Sure Start on the Ocean area during the period September 2001 to August 2002. Of these, 80 women received some contact from the support worker alone during this same period and a further 44

were seen by the rest of the breastfeeding team. For the evaluation, fifteen women who were seen by the support worker were randomly selected using a random number table created in Microsoft Excel. The sampling continued until acceptance to participate in the study by fifteen women was achieved. Figure 1 shows the process of random sampling of 15 women from those seen by the support worker.

Figure 1
Random sampling of the 15 women in the study



Survey

The survey included both closed and open-ended questions requesting information on women's intention to feed and current feeding methods, support and information received antenatally, during the hospital stay and postnatally, overall views on the information and support received in relation to breastfeeding as well as some baseline information. A major part of the questionnaire was adapted from a previously piloted and validated survey. [19] All questionnaires were completed over the telephone and took between 15 and 30 minutes to complete. Interviews were conducted in either Sylheti or English. Where Sylheti was used, translations of the response into English were recorded directly on the questionnaire.

The questionnaire was not designed to collect information solely on the support worker, but also on other support women had received. This was so that support from different areas could also be identified. It is known that members of minority ethnic communities are often reluctant to complain. [20] In particular if they were aware that an individual's work was being evaluated this may well have prevented Bangladeshi women from responding openly.

All data were entered into a statistical computer package using SPSS version 10. Descriptive statistics and univariate frequencies for all variables were used to analyse the data.

Results

Demographic characteristics of survey participants

Table 1 shows some baseline characteristics of the women in the sample. Over half the women were in their twenties, five in their thirties, one below 20 years and over 40 years of age. A quarter of the women were primiparae and a third multiparae. It seems that all those that were multiparae had some previous experience of breastfeeding. All except one woman was unsure of the feeding method her mother adapted to when feeding her, with eleven being feed breast milk.

All except one woman were of Bangladeshi origin, the other being Pakistani. Her survey was completed using the translation skills of one of her family members. Twelve of the women in the sample were not fluent in English, with same number educated in Bangladesh, 2 educated in the UK and 1 in Pakistan. Almost all women (13) were educated up to GCSE standard or less, with only 2 women with a degree or more. Both of these were of Bangladeshi origin. Thirteen were born in Bangladesh, 1 in the UK and 1 in Pakistan. Data on occupation of participants and their partners were also collected. The majority of the women were housewives with only two in other occupations. They were a bilingual instructor at a local school and a customer services advisor. Both these women had been educated in the UK, one up to degree level and the other up to GCSE level. More men than women were in paid employment, although just under half the partners were unemployed. Three worked in restaurants and the five others included one accountant, a taxi driver, a courier, a project worker at a local charity organisation and a retail worker. At the most recent birth, thirteen women had one baby and two had twins. The average number of children per participant was three.

Table 1
Demographic characteristics of participants

Variables	Number	*%*
Age of participant		
Less than 20	1	*7*
20 – 29	8	*53*
30 – 39	5	*33*
40 or over	1	*7*
Parity		
Primipara	5	*33*
Multipara	10	*67*
Previous experience of breastfeeding		
Yes	10	*67*
No	5	*33*
Number of babies at this delivery		
Singleton	13	*87*
Twins	2	*13*

Method of feeding own mother adapted to when feeding participant		
Breast	11	*73*
Bottle	0	*0*
Mixed	3	*20*
Not sure	1	*7*
Ethnicity		
Bangladeshi	14	*93*
Pakistani	1	*7*
Fluency in English		
Yes	3	*20*
No	12	*80*
Education – where?		
Bangladesh	12	*80*
UK	2	*13*
Pakistan	1	*7*
Education – to what level?		
Less than GCSE	6	*40*
GCSE or Equivalent	7	*47*
Degree or more	2	*13*
Country of birth		
UK born	1	*7*
Bangladesh	13	*87*
Pakistan	1	*7*
Occupation		
Mother:		
House wife	13	*86*
Other	2	*14*
Father:		
Unemployed	7	*47*
Restaurant	3	*20*
Other	5	*33*
Total number in sample	**15**	***100***

Intention to feed and current feeding method

Figure 2 shows intention to feed before birth and actual feeding method after birth. Twelve of the participants had decided on the method of feeding their baby before birth. Of these, nine had decided on breastfeeding their baby and three on mixed feeding. None of the participants had decided on exclusive bottle-feeding and three had not decided on any method of feeding before birth. This does not appear to relate to whether they had any discussions on feeding methods before giving birth or previous experience of feeding. Neither does it appear to relate to who provided support antenatally.

Nine of the women had stopped breastfeeding earlier than planned. Although nine women had intended to exclusively breastfeed, it appears that eleven had actually

exclusively breastfeed. Most had exclusively breastfed only up to three months, with the exception of two who did so up to seven months. Both those two women were in their twenties, one a primipara and the other a multipara. Both said that the decision to breastfeed was influenced by, for one, the support worker and for the other a midwife.

Figure 2
Intended feeding method before birth and actual feeding method after birth

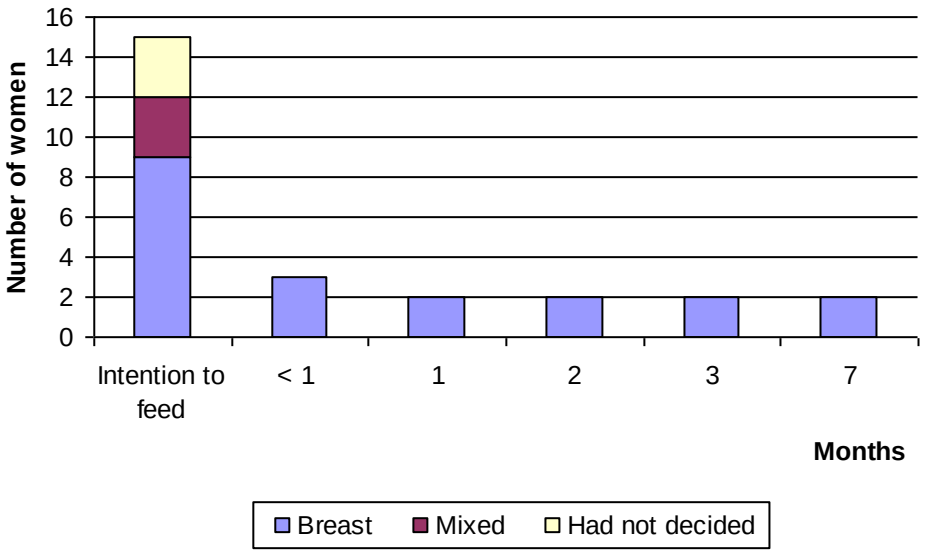


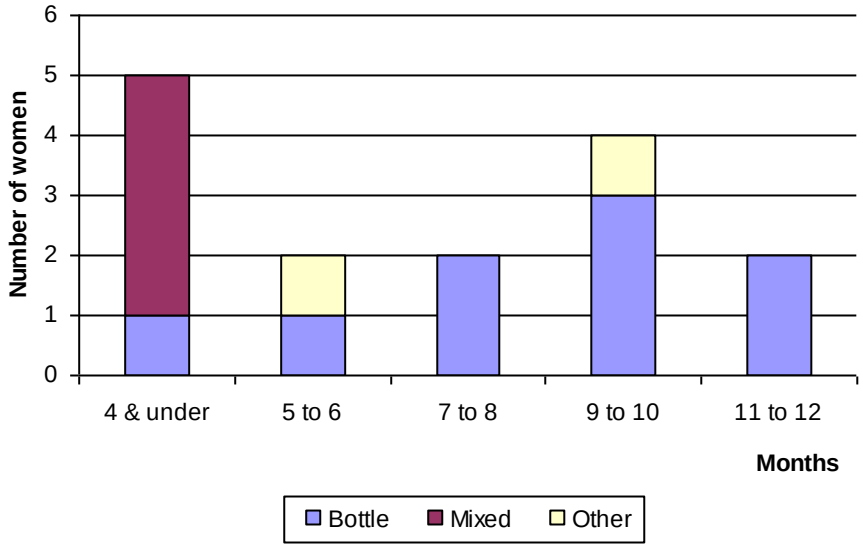
Table 2 **Reasons given for intention to feed before birth**	
Breast	Health beneficial to baby and mother, good for baby's brain and heart, creates bonding with baby, family advised good for baby, reduces mothers stomach and chemicals in bottles.*
Mixed	Because of previous experience, convenient as breast milk is not available all the time and also when busy they can get other children to bottle feed, embarrassing to breastfeed in front of visitors at home and at clinics.

* More than one participant cited each of these reasons, and the order in which they appear were the most mentioned by participants.

Figure 3 shows method of feeding at the time of interview by age of baby. At the time of the interview none of the women were breastfeeding exclusively. Nine women were bottle-feeding, four women were giving mixed breast and bottle feeding and two were feeding solid food. Of those that were feeding solid food, one child was 6 months old and the other 10 months old.

It is important to note that although at the time of interview nine mothers said they were bottle-feeding currently, all but one said this was not the method they used since birth.

Figure 3
Current feeding method by age of baby



Information was collected on the reasons for not continuing with intention to feed, Table 3 shows these reasons. All those that gave reasons for intention to feed were intending to breastfeed their baby, except one who had intended to mix feeds and was no longer breastfeeding because her baby "doesn't like breast milk". The most commonly cited reason for those who intended to breastfeed and were no longer doing so was "less/no breast milk" and "baby dislikes/not interested in breast milk". Again, more than one participant cited the same reasons.

Table 3
Reasons given for not continuing with intention to feed

Reason	*Number*
Less/no breast milk	4
Baby dislikes/not interested in breast milk	3
Because had caesarean	2
Pregnant again	1
Went back to work	1
Total women responded	**10**

Numbers added up to 10 as some women gave more than one response

Exclusive breastfeeding

Participants were asked whether there had been periods in which they had exclusively breastfeed their baby. Eleven had exclusively breastfeed while four had never exclusively breastfed.

Table 4 shows when mothers started and stopped exclusive breastfeeding. Of those that had exclusively breastfed, seven started to exclusively breastfeed from birth, and most stopped breastfeeding exclusively between one and three months. It seems that just over half of those that had exclusively breastfeed did so for only a period of within one month. Only two mothers exclusively breastfed for up to seven months.

Table 4
When mothers started, stopped and duration of exclusive breastfeeding

When started	*Number*
From birth	7
Within 2-4 days of birth	3
Within 5-10 days of birth	1
All	**11**
When stopped	
Within a week	2
Within a month	3
Within 2-3 months	4
At 7 months	2
All	**11**
Duration	
Within a month	6
Within 2-3 months	3
At Months	2
All	**11**

Nine of those that had exclusively breastfed had stopped earlier than planned. All of them had said no one or anything could have helped them to continue exclusive breastfeeding.

The two mothers with the twins had intended to exclusively breastfeed for as long as possible, but one was unable to do so after the birth and did not breastfeed exclusively at all due to *"not enough milk"*. This mother had a caesarean and report that this impacted on her ability to breastfeed, whereas the other mother had a normal birth and was able to breastfeed exclusively for up to three months.

Table 5 shows the reasons for stopping exclusive breastfeeding. It appears that the most common reason for stopping exclusive breastfeeding is "baby wouldn't take any milk/ find any milk".

Table 5
Reasons for stopping exclusive breastfeeding

Reason	Number
Baby wouldn't take any milk/ find any milk	4
Pregnant again	2
Difficulties with breastfeeding, pain	2
To get baby to bottle feed in case need to	2
To go back to work	1
No milk	1
No time	1
Taking contraceptive pills	1
Total women responded	**11**

Numbers add up to more than eleven as some women gave more than one response

Four mothers in the sample did not exclusively breastfeed. The most common reason given for not exclusively breastfeeding was "Not enough breast milk, baby cries", the other reason was "Due to caesarean".

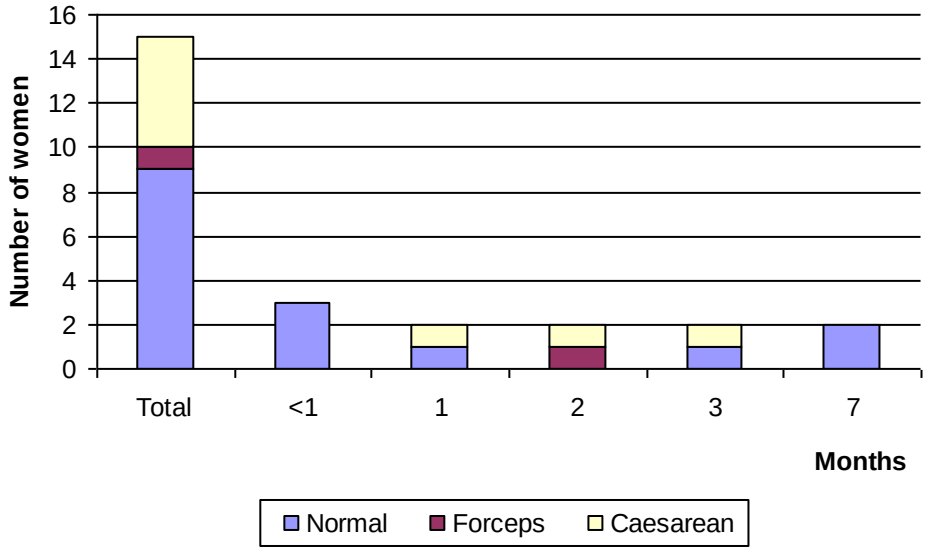
Solid food

Nine of the women in the sample had started to give their babies solid food. Most had started when baby was 3.5 to 4.5 months old. Only one started at seven months and another four when the baby was between nine and eleven months old. The solid food was the food that the family would have on a daily basis and consisted of rice, either plain or with vegetables or chicken, chapatti, and fruit, bananas, apples or oranges. One mother also mentioned solid food only if organic.

Type of delivery and whether influenced method of feeding

Nine participants had a normal delivery as Figure 4 shows, One had a forceps delivery and five had delivery by caesarean section. Of those that had a caesarean delivery, 4 out of 5 said that this had influenced the method of feeding they adapted to after delivery. Two did not exclusively breastfeed and those that did, did so for the first three months. Those that had a normal delivery exclusively breastfed, either for a month or less, or for seven months.

Figure 4
Method of delivery and exclusive breastfeeding



The following are reasons why their delivery affected how they fed their baby.

"Due to back pain did not breastfeed as planned, so bottle feed at hospital"

"If normal (birth) perhaps easier to breastfeed, pain, no help received at hospital with feeding baby"

"Problem with breastfeeding due to pain"

When support received and by whom

All participants had received some sort of antenatal care.
Table 6 shows when breastfeeding support was received and by whom. Nine received some support in the form of discussion, information and practical help about feeding method during antenatal care and nine received support during their hospital stay. More women received support postnatally, with 13 women receiving support at home from both health professionals and non-health professionals.

Participants received more support from the support worker both antenatally and postnatally at home than from any health professional. Four reported receiving help from midwives and three were helped by the support worker during their hospital stay. Equal numbers of participants reported receiving support from both the support worker and family members postnatally at home.

Participants who received breastfeeding discussion antenatally were asked whose discussions they found most helpful. Three named the Sure Start support worker, two named friends and one named the health advocate.

Table 6
When breastfeeding support received and from whom

From whom	When support received					
	Antenatally		During hospital stay		Postnatally at home	
	n	*%*	n	*%*	n	*%*
Support worker	6	*40*	3	*20*	8	*53*
Midwife *[1]	4	*27*	4	*27*	5	*33*
Health Advocate	1	*7*	2	*14*	0	*0*
Health Visitor	0	*0*	0	*0*	3	*20*
Family	0	*0*	1	*7*	8	*53*
Friends	2	*14*	0	*0*	3	*20*
Other *[2]	1	*7*	2	*14*	0	*0*
No help	6	*40*	6	*40*	2	*14*

Total number of women responding was 15.
*[1] Does not include Sure Start midwives
*[2] Participant who received antenatal support was not able to remember which health professional she received support from. Participants who received support during hospital stay had received support from hospital nurse on duty.

What were women told about breastfeeding

Table 7 summarises what women remember of the discussions about breastfeeding with health professionals and with members of their social network. These are summarised on the basis of most frequently remembered discussions, where the first summarised discussion on the list was the most mentioned by women. The numbers in brackets indicate how many women reported relevant discussions with a particular health professional or members of their social network.

It is clear that women are receiving a wide range of advice and discussion on issues related to breastfeeding from the Sure Start breastfeeding support worker. More theoretical information was generally given by health professionals and the support worker while practical support, like bathing the baby and other domestic help around the house came from members of their social network.

Table 7
Type of information and support women received about breastfeeding

Breastfeeding information/support received	Who from?
Good for babies and mothers health, for heart and brain	Support worker (7), Midwife (4) Mother-in-law (1)
Demonstrated how to feed baby	Support worker (2), Midwife (2), Mother-in-law (1), Mother(1), Friend(1)
Advantage/disadvantage of breastfeeding	Support worker (1), Midwife (2) Health Advocate (1), Friend (1)
Advised to attend workshop	Support worker (2), Midwife (1) Health Visitor (2)
Less chance of having cancer	Support worker(2),Midwife(1), Friend(1)
Help with looking after other children	Husband (3), Friend (1)
More you feed breast milk, more milk will be produced	Support worker (1), Friend (1)
Bangladeshi women breastfeed less, but you should	Support worker (2)
To drink from socked fennel seeds, help to produce breast milk	Support worker (1)
Reduces stomach to go back to normal	Midwife (1)
Relax while breastfeeding, will help baby to have More breast milk. Breastfeeding is easier than bottle feeding	Support worker (1)
Shared her own experience	Friend (1)
Bathing baby and cooking	Mother (1)
Understanding difficulties of feeding	Husband (1), Mother (1)

Two women reported that they had received conflicting advice about feeding their baby:

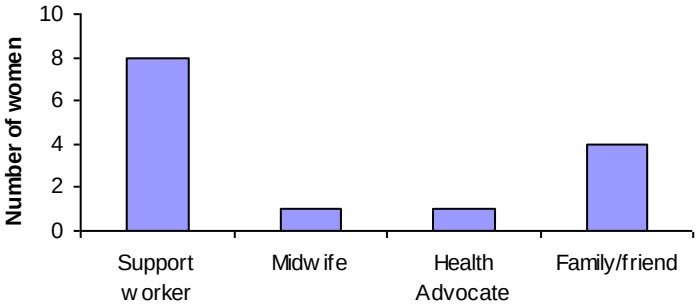
"Mother-in-law advised to bottle feed, thought baby will get less milk via breast, but client didn't listen to her"

"Friend said if baby doesn't won't breast milk leave it, Sure Start Bangladeshi Breastfeeding worker said to keep feeding breast milk this will help to produce more milk, but this is not always possible as have other children to look after"

Whose support was most helpful and why?

Figure 5 show that eight of the women in the sample found support received from the support worker to be the most helpful in terms of breastfeeding. Four reported that their family was the most helpful, with only one of each reporting a midwife or a health advocate to be the most helpful.

Figure 5
People from whom most helpful support was received



How much did the most helpful people influence mothers to breastfeed

Three participants reported being influenced to breastfeed "A lot" by the support worker. Those that received breastfeeding support from other health professionals reported being influenced "A lot" by them. Only one woman reported that her friend had not influenced her to breastfeed though she found her to be the most helpful support while breastfeeding. This shows the support worker influenced all women that found her most helpful in terms of support for breastfeeding Five women were influenced " A little" and only three "A lot" by the support worker. Two primiparous women and just one multiparous woman were influenced "A lot" by the support worker.

Of the ten participants in the sample who had other children, nine said they would have liked this type of breastfeeding support while feeding the other children. Only one refused.

Figure 6
How much the most helpful people influenced mothers to breastfeed

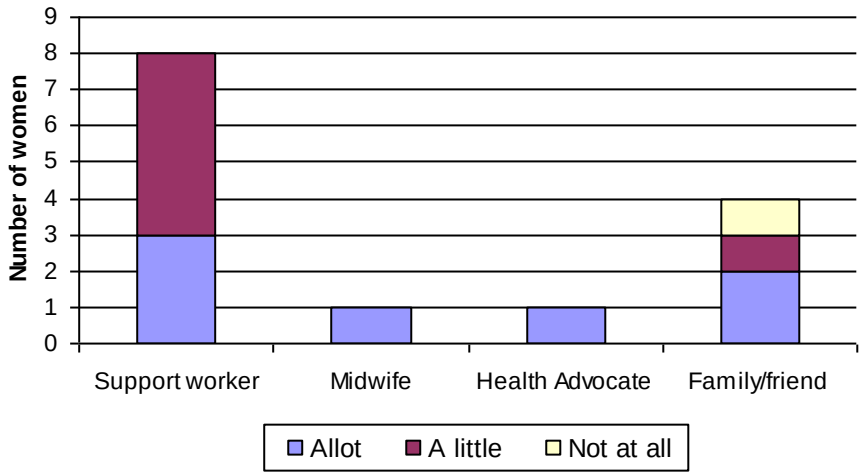


Table 8 gives the reasons why women found a particular person or group of people to be most helpful in term of breastfeeding. It seems that good communication skills, both verbal and practical, along with good knowledge of breastfeeding are attributes that women value most highly. Ease of access and an interest during the period of breastfeeding are the other two attributes that contribute highly to the needs of breastfeeding women. The most common reason given for finding family members most helpful in terms of breastfeeding was because they were accessible and they had a tendency to understand the difficulties of breastfeeding when there are other children to be looked after at the same time.

Table 8
What was so different about the most helpful person?

Gave good information about breastfeeding, Told me to relax while feeding baby I found that very helpful Only professional support and knew more than husband Rang few times and followed up Seems to know more and verbal information was good Spock in Bengali	Support worker
Always there and also demonstrated how to feed baby Always there and most caring People I knew well and could get in touch very easily They understood the complexity of having other children While breastfeeding	Family/ friends
More friendlier and more information about breastfeeding	Midwife
Nicer, friendlier, was like a friend not like a health professional	Health advocate

Ease of access to a health professional was asked to all participants if they needed any additional support. Only two women needed some support:

"…only when babies don't won't to drink (breast milk), especially the boy" (no. 7)

"Infection in both breast, blood from nipples…" (no. 8)

Despite the mothers having had contact details of the support worker, and having seen and received some support from the support worker, they still chose to contact other health professionals. One contacted a health visitor and the other contacted a doctor. This raises issues of confidence with and being able to recognise the support worker as a breastfeeding specialist from the view of the women themselves and their social network.

"Others advised best to see doctor" (no. 8)

Almost all women who had been seen by the support worker were left with a contact number if required.

Women who received breastfeeding support antenatally and postnatally at home solely from the support worker

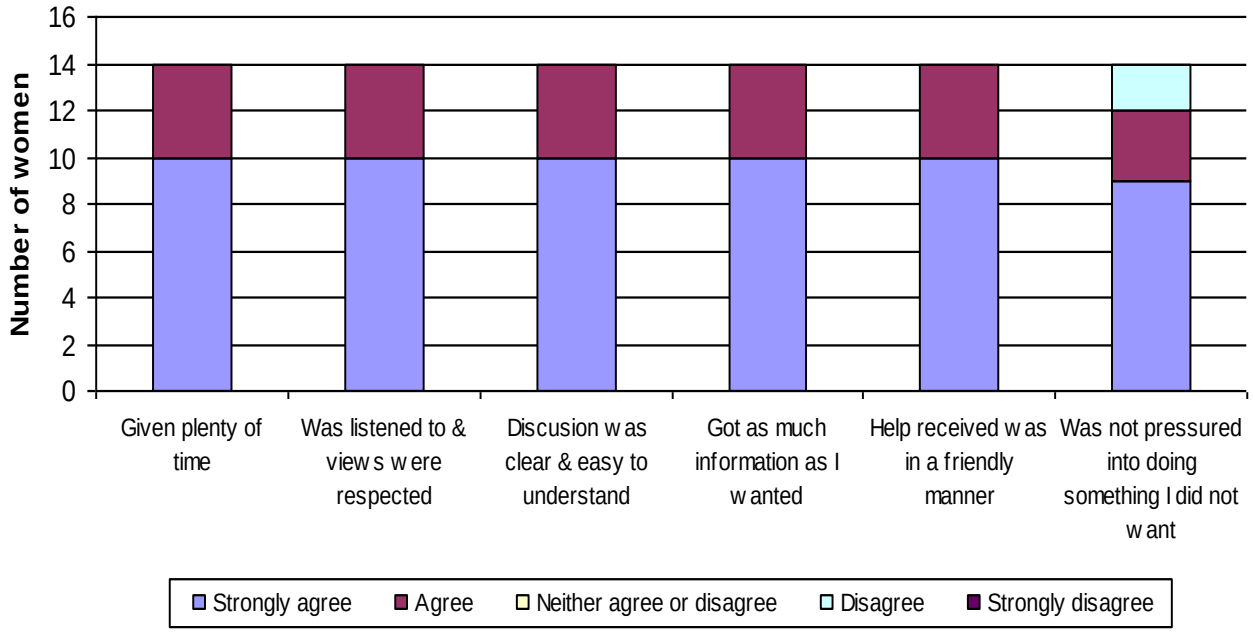
Three mothers had received support only from the support worker antenatally and "strongly agreed" with each of the following statements about the discussion they had about breastfeeding with the support worker:
I felt I was given plenty of time.
I felt I was listened to and my views were respected.
I felt the discussion was clear and easy to understand.
I felt I got as much information as I wanted.
I felt the help received was in a friendly manner
I felt I was not pressured into doing something I did not want.

Four mothers had received support postnatally at home only from the support worker. All had "agreed strongly" with all the above statements about the discussion on breastfeeding, except one who "disagreed" with the last statement "I felt I was not pressured into doing something I did not want".

Participants' views on the overall support received-

Of the 14 participants that responded to the question seeking their views on the overall support received in relation to breastfeeding, Figure 7 shows that ten participants "strongly agreed" and 4 "agreed" that they were given plenty of time, were listened to and their views were respected, the discussion was clear and easy to understand, they got as much information as they wanted, and the help was given in a friendly manner. When the same group of participants was presented with the statement " was not pressured into doing something I did not want", nine "strongly agreed" with the statement, three "agreed" and two "disagreed". This implies that at least these two mothers felt some degree of pressure to breastfeed.

Figure 7
Participants' views on the overall support received about breastfeeding



Problems encountered while feeding

Table 9
Problems encountered while feeding

	How many reported	What the problems were	Who they got help from
At hospital	7	Baby not latching to breast, Back, stomach, breast pain Breast milk did not come Not feed baby due to pain, Relative helped to bath baby Problem with setting and so With feeding baby	All asked hospital nurse, but no one got any help
At home	3	Baby has no food and lost Weight Infection on both breasts, blood on nipples Babies don't always have breast milk	Doctor, health visitor hospital A and E, Holy man All helped except hospital A and E

As can be seen from Table 9, ten women in total reported having problems with feeding their baby. Seven women reported having problems at the hospital but only three at home. A lot of women were having feeding problems at hospital but were not getting any help from hospital nurses on duty when requested. Women who had problems at home seem to have managed to get help except one woman when she

went to the hospital Accident and Emergency Department but this same women did receive help elsewhere from a Holy man:

"Didn't have any food from 4 months, "Nozor lagse" (some one's put an evil cast), *so got holy water which helped. Eats very little and weight is getting better now…hospital in emergency…hospital didn't give anything…and "feer"* (Holy man)*…yes, slowly he's beginning to gain weight."* (no. 9)

"Baby not latching onto breast…nurse (asked for help) *they gave express, wanted them to show me, but didn't show"* (no. 5)

Figures 8 and 9 show the length of stay in hospital after birth by method of feeding while in hospital. Six of the women in the study sample appear to have stayed for six days or longer at the hospital and all but one stayed two days or more. Staying in hospital for six days or longer is now unusual and is probably due to the higher than usual number of caesarean section deliveries.

Figure 8
Length of stay in hospital after birth by method of feeding while in hospital

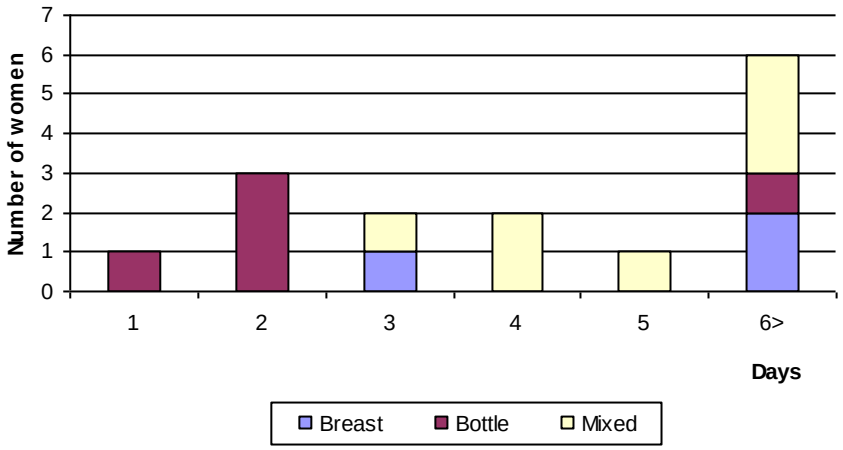
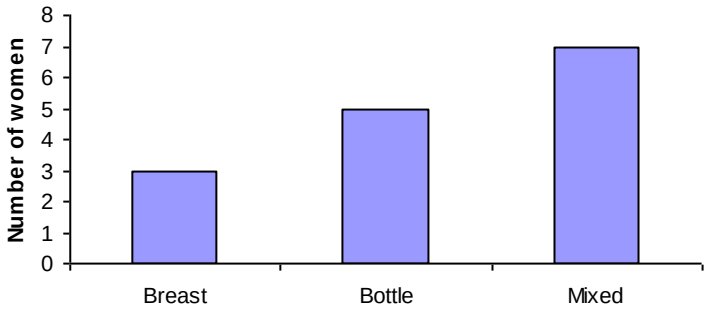


Figure 9
Method of feeding while staying in hospital



Fewer mothers were exclusively breastfeeding during their stay in hospital and the majority were mixed feeding apart from five who were bottle-feeding. It is worrying that only three mothers were exclusively breastfeeding while in hospital. Those who did started to exclusively breastfeed from their third day of stay at hospital or during stays of six days and over. This could be related to the lack of breastfeeding support received during this period, though it does happen that women are offered support but still choose to give a bottle. There is also a strong belief that colostrum is not sufficient for the baby and that giving bottles is acceptable. Perhaps the ready availability of bottles in the postnatal wards also has an influence on the method of feeding during the stay at hospital. On the other hand, the majority of the women we spoke to in our sample did suggest the lack of feeding support by hospital staff members is one of the reasons for women finding difficulties in exclusive breastfeeding. Women who stay in hospital as for only one to two days are bottle-feeding.

Information received

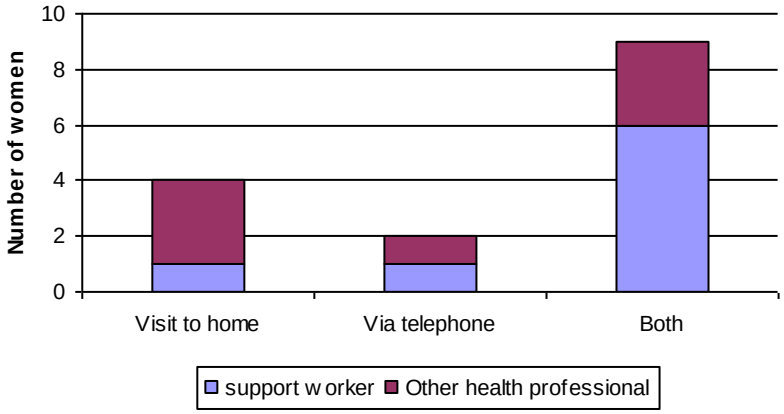
None of the participants had attended any breastfeeding classes or workshops, although six of them were informed about the workshops. Two participants reported elsewhere being informed about attending workshops by the support worker. On the other hand, when they were presented with the question about whether any one had told them to attend any breastfeeding workshops, they did not mention the support worker had informed them. There are three possible reasons for this. Firstly, they may not have remembered at the time of questioning. The support worker may have talked about x workshop other than breastfeeding, or the participants may have presumed it was another workshop. The other four women mentioned being informed by midwives and health visitors. Among women who were informed of the workshops but chose not to attend the reasons given were that they had housework and responsibility for looking after other children of their own, had experience of feeding babies and so did not see any reason to attend. One participant was not well enough to attend.

It is surprising that nine of the 15 women were not informed about the breastfeeding workshops. One the other hand, nine were given literature of some kind about breastfeeding. Eight women were given by information other health professionals and only two by the support worker. Only three reported not getting any information about breastfeeding in their own language.

How contact was achieved at home

The support worker seems to have made six of the contacts with women using both home visits and telephone calls, as shown in Figure 10. Contact was less likely to be made with women using just the telephone both by the support worker and by the other health professionals.

Figure 10
How contact was made at home by support worker and health professionals



What women would like to see in the future in relation to breastfeeding

As a last question, all women were asked if they could recommend anything else that would contribute to helping women breastfeed. Twelve women responded to the question in total. Two of those said they had received sufficient support and there was nothing they could see being improved. Of those that made suggestions, it is not surprising that as many as seven had requested breastfeeding support during their stay in the hospital. What they wanted was someone to help and show them how to breastfeed and simply to listen. Staff attitudes was another issue that women felt needed improving, as this impacted both on women feeling comfortable in seeking help as well as their confidence in feeding their baby.

Women would have welcomed more postnatal home visits and more flexible classes on breastfeeding. Women felt that ongoing support and follow-up, even through a quick phone call, would have helped them to breastfeed longer as this would remind them of breastfeeding as well as having the opportunity for a quick reminder of issues involved in breastfeeding and to tease out any concerns. There were also mentions of a video on breastfeeding issues, including demonstrations on how to breastfeed in women's own language, that they could take away home for viewing in their own time. The following captures some of these suggestions in women's own words:

"Help in hospital after delivery, demonstration on how to feed, position baby and myself...postnatal home visits" (no. 2)

" More social support while delivery and with actually feeding baby at hospital" (no.10)

"Home visits by health professional, classes for women (Breastfeeding) *and video to see at home in own language"* (no.9)

"Hospital support, more flexible classes for antenatal, especially in the evening" (no. 5)

" More ongoing support, telephone support to see how we are doing, allot of help is needed in hospital whether caesarean or not, staff attitude needs to be changed to good behaviour…puts strain while feeding" (no. 12)

Conclusions

Findings from this survey suggest that all participants received some kind of antenatal care. In terms of breastfeeding support, participants received more support antenatally and postnatally at home then they did during their stay in the hospital. More support was given by the support worker both antenatally and postnatally at home compared to support they received from any other health professional. Antenatally participants found it most useful to discuss breastfeeding with the support worker. Generally women received more breastfeeding support postnatally at home from the support worker, health professionals and from their social network.

Overall, the majority of participants in the sample found the support they received from the support worker to be the most helpful in terms of breastfeeding. The next most helpful were family members. The results suggest that all participants who found the support worker to be the most helpful were influenced to breastfeed. More women were influenced "A little" than "A lot". More primiparous women were influenced "A lot" by the support worker than were multiparous women. All women except one said that they would have liked this type of breastfeeding support while feeding their previous children. Good communication skills, both verbal and non-verbal, knowledge of breastfeeding, ease of access and an interest during the period while a women is breastfeeding are factors that contribute most highly to what women perceive as most helpful in terms of support during breastfeeding.

More women stayed in hospital for long periods of six days or more after birth, and more reported having problems while feeding at the hospital than at home. This along with fewer women exclusively breastfeeding during their stay in hospital explains the lack of feeding support received during this period. More work is needed in identifying strategies for helping women during this time in particular. An inability to get good support at such early stage can have huge impact on women's feeding methods postnatally at home and certainly does not give women a good start to exclusive breastfeeding.

Most participants had given some thought to feeding method before the birth of their baby, and many had decided on breastfeeding. In fact 11 of the 15 women had actually exclusively breastfed from birth but only did so for one to three months. Since the most frequent reason given for stopping was that "baby not willing or finding milk", it seems that continues support and contact with women may help them to increase the duration of exclusive breastfeeding, particularly since this was one of the suggestions made by women.

None of the participants had attended any breastfeeding classes or workshops. Less than half the women were informed of these and the support worker informed only two women. It appears that women are receiving literature of some kind about breastfeeding more from other health professionals than from the support worker. Support via workshops and literature should not be ignored. Instead more focus should be given on improving the current lack of publicity for breastfeeding through these two channels.

Just under half the women had caesarean sections and of those that had this type of delivery all except one said this had influenced the method of feeding they adopted after delivery. Two out of the five women who had caesarean section deliveries did not exclusively breastfeed. More support is needed to help these women break down the barriers to breastfeeding.

Although very few women needed additional support postnatally at home, it is striking that having received support from the support worker and finding her helpful, none had thought of contacting her for this additional support. Instead other health professionals such as the health visitor and doctor were consulted, and took a while to contact. All women had mentioned the support worker leaving a telephone number and yet did not consider contacting her. This raises issues of confidence with and lack of professional recognition for support worker as a breastfeeding specialist by women and those in her social network.

Recommendations

- More support should be available during the hospital stay. This could be by increasing number of hours spent at ward level by the support worker, along with increasing the visiting hours for women's supporters from their social networks.

- It is clear that women receive a lot of support with feeding their baby from their social networks. We therefore suggest that members of women's social network be invited and encouraged to participate in breastfeeding workshops. This may lead to an increase in the uptake of workshops by women, as this would improve women's social support during the workshop. There are issues around women not being allowed to attend workshops on their own and improve the chance of further discussion around breastfeeding with her own social network which clearly influences her decision to breastfeed.

- Only two women had reported being informed about breastfeeding workshops by the support worker, and fewer received literature of some kind from the breastfeeding support worker than from other health professional. We suggest any assumptions made on the basis that Bangladeshi women do not attend anta-natal classes or read literature be removed. Instead, efforts should be concentrated on actively promoting these workshops and distributing literature widely at hospital, GP premises or community, religious centres or even at women's own homes. This is because this evaluation clearly shows an interest in both participating in the workshops and receiving literature on breastfeeding.

- One way of solving the above is perhaps also through the wider use of videos in women's own language, which can be used during the workshops along with copies for women to take home. This would solve any problems with reading literature for some women and the issues around feeling embarrassed and shy in discussing issues of breastfeeding in front of others.

- It is clear that the support worker has had some influence on women's decision to breastfeed. In order for more women to benefit from this kind of support and for women in general to recognise this unique scheme, we suggest that work of this kind be promoted across Tower Hamlets. The aim of Sure Start is that the work should come from the local community and be sustainable once Sure Start finishes. In order to implement this, we suggest the health services employ more local women from different ethnic backgrounds to work across Tower Hamlets. In particular, they should work with the community so that women see the support worker as an expert in breastfeeding; who can give information and support about breastfeeding as well as any doctor or midwife or health visitor and should be the first port of call for women with breastfeeding difficulties.

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References

1. Emery JL, et al. *Decline in breastfeeding*. Arch Dis Child 1990; **65**:369-72.
2. Lawrence RA. *Breastfeeding trends: A cause for action*. Padiatrics 1991; **88**:867-68.
3. Thomas m, et al. *Infant feeding in Asian families*. London:ONS, 1997.
4. Baranowski T, et al. *Social support, social influence, ethnicity and the breastfeeding decision*. Soc Sci Ned 1983; **17**:1599-1611.
5. Kearney M. *Identifying psychosocial obstacles to breastfeeding success*. Journal of Obstetric, Gynaecologic, and Neonatal Nursing 1988; **17**:98-105.
6. Barclay L, et al. *Becoming a mother : an analysis of women's experience of early motherhood*. Journal of Advanced Nursing 1997; **25**:719-728.
7. Linda C. Pugh, et al. Breastfeeding Duration, Costs and Benefits of a Support Program for Low-Income Breastfeeding Women. Birth 2002; **29**:95-100.
8. Maclean H. *Women's experiences of breastfeeding*. Toronto, ON,Canada: University of Toronto Press, 1990.
9. Gonzales RB. *A large scale rooming-in program in a developing country: The Jose Fabella Memorial Hospital*. Int J Gynecol Obstet 1990; **31** (suppl 1):31-34.
10. McCann MF, et al. *Breastfeeding, fertility, and family planning*. Popul Rep J 1981; 24:J525-75.
11. Sullivan P. *Breast still faces many roadblocks: A national survey finds*. Can Med Assoc J 1996; 154:1569-70.
12. Marchand L, et al. *Infant feeding practices: Understanding the decision-making process*. Fam Med 1994; 26:319-24.
13. McIntosh J. *Barriers to breastfeeding: choice of feeding method in a sample of working class primiparae*. Midwifery 1985; **1**:213-224.
14. Hoddinott P, Pill R. *Qualitative study of decisions about infant feeding among women in east end of London*. BMJ 1999; **318**:30-34.
15. Hastings J, Trykozko H, Taylor J. *Evaluation of the Tower Hamlets Breastfeeding Support Centre.* 1999. Unpublished.
16. Kondel R. *Audit of breast feeding rates in Tower Hamlets*. 1999. Unpublished.
17. Hastings J, Naylor J. *Breastfeeding in Tower Hamlets: Evaluation of breastfeeding workshops.* March 2001. Unpublished.
18. Savita Katbamna. Book: *"Race" and Childbirth*. 1999.
19. Grant J, et al. *The South Thames Evidence Based Practice (STEP) Project*. June 2002. Unpublished.
20. Sure Start for all – Guidance on involving minority ethnic children and families planning pack. 1999.