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Citation: Ahmed, S., Macfarlane, A. J., Naylor, J. & Hastings, J. (2006). Evaluating bilingual peer support for breastfeeding in a local Sure Start. *British Journal of Midwifery*, 14(8), pp. 467-470. doi: 10.12968/bjom.2006.14.8.21640

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**Title of article: Evaluating bilingual peer support for breastfeeding in a local
Sure Start**

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Abstract

In Tower Hamlets, the Bangladeshi women have a very low rate of breastfeeding and the difference between their intentions to breastfeed and actually breastfeeding is far wider than for women from other ethnic groups. In Bangladesh, breastfeeding is well rooted in its own traditional culture. A Sure Start local programme funded a Bangladeshi support worker to work with childbearing Bangladeshi women in the area; many of who are not fluent in English. A short evaluation of this work was conducted to assess the impact of bilingual breastfeeding support to women's uptake and duration of breastfeeding. The majority of women found the support worker to be the most helpful breastfeeding advisor and felt she influenced them to breastfeed. Despite this, a minority of women exclusively breastfed and most reported having problems feeding during hospital stay. This evaluation highlighted the need for further work in this area.

Introduction

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 (Baranowski et al, 1983).

The national UK Infant Feeding Survey showed that between 1995 and 2000, there was an overall increase in breastfeeding incidence in the United Kingdom (Infant feeding, 2000). It also showed that mothers from Asian and other ethnic minority groups were more likely to breastfeed at birth compared with white women. A survey of breastfeeding in South Asian families in 1994 found that 90 per cent of Bangladeshi mothers at all birth orders breastfed initially compared with 82 per cent of Indian, 76 per cent of Pakistani and 62 per cent of white mothers. (Thomas, 1997).

This was not surprising, given that many women were likely to have recently arrived from Bangladesh where breastfeeding is the only viable option for most women. In a study of Gujarati and Bangladeshi women in Leicester there were differences in breastfeeding rates between the two groups despite their being from the same subcontinent (Katbamna, 2000).

In the 2001 census, 33.4 percent of the population of the London Borough of Tower Hamlets was Bangladeshi. In the three year period, 1999-2001, 58.1 per cent of births to Tower Hamlets residents were to Bangladeshi mothers (Macfarlane et al, 2005). Many were not fluent in the English language.

Unpublished data from the Royal London hospital, where the majority of these Bangladeshi women delivered showed low rates of breastfeeding which were markedly different from the national level in the mid 1990s. (Table 1) Furthermore,

the difference between intention to breastfeed and actually breastfeeding was far greater for Bangladeshi women than for other women. It is difficult to explain this large difference however one reason could be due to inadequate communication resulting in poor understanding for non-English speaking women.

Table 1. Intention to breastfeed and actual breastfeeding by ethnicity

	<i>Percentage of respondents in each group</i>		
	Intention	Actual	Difference
Bangladeshi	62	18	44
White	67	45	22
African	80	43	37
Other	73	41	32

Source: Unpublished data from Royal London Hospital, 2000.

The bilingual breastfeeding programme

As one response to this, a bilingual breastfeeding programme was developed. The first stage was a project to provide extra breastfeeding support and education to Bangladeshi women, funded by a local Sure Start programme. Two specialist midwives provided training and supervision for a Bangladeshi breastfeeding supporter. The aim was to provide help and support with breastfeeding to as many Bangladeshi women as possible within the Sure Start area. Most importantly, someone familiar with service users' language, social and cultural values and practices offered the services.

Postcodes were used to identify women who lived in the Sure Start area. The support worker made contact with the women by means of hospital ward visits and referrals made by midwives, advocates and health visitors. She then provided one-to-one support including home visits and telephone support.

This paper reports a short evaluation of this first phase of the bilingual breastfeeding programme. The work described was used to assess the need for a second phase. The evaluation was commissioned by the local Sure Start programme.

Methods

Sample

The two midwives and the support worker had provided breastfeeding support to 194 women during the one year period, September 2001 to August 2002. Of these, 80 women received help from the support worker alone. The majority of these 80 women were Bangladeshi. For the evaluation, fifteen women were randomly selected from these women.

Women who were not contactable by telephone, under 18 years of age, had not received services from the support worker and women whose child or children were aged 4 months or over were excluded from the sample.

At the time of the study North East London Strategic Health Authority Research Ethics Sub-Committee was the local research Ethics committee, and approval was gained from them.

Survey

The survey questionnaire included some open and closed questions about women's intention to feed and their current feeding methods, breastfeeding support and information received antenatally, during the hospital stay and postnatally, overall

views on the information and support received, and some demographic details. A major part of the questionnaire was adapted from a previously piloted and validated survey (Grant et al, 2000).

Eleven interviews were conducted by SA by telephone in Sylheti, a dialect that has no written format, three in English and one in Urdu, using a female family member to translate. Interviews took between 15 and 30 minutes to complete. Where Sylheti was used, the responses were translated directly into English for recording on the questionnaire.

Data were entered into a computer and analysed using SPSS version 10. Descriptive statistics were used for the quantitative questions and thematic analyses were used for the qualitative questions.

Results

Table 2 shows some of the demographic characteristics of the sample. Only three women were fluent in English with the rest being educated in Bangladesh with either GCSE equivalent or less. Seven of their partners were unemployed and 13 women were not employed outside the home. All the women that were multiparae had some previous experience of breastfeeding. The majority of women had been breastfed by their own mother.

Table 2 Demographic characteristics of participants

	Percentage	Base
Age of participant		
Less than 20	7	1
20 – 29	53	8
30 – 39	33	5
40 or over	7	1
Parity		
Primipara	33	5
Multipara	67	10
Previous experience of breastfeeding		
Yes	67	10
No	33	5
Fluency in English		
Yes	20	3
No	80	12
Feeding method participant's mother adopted when feeding her		
Breast	73	11
Bottle	0	0
Mixed	20	3
Not sure	7	1
Method of feeding by participants while staying in hospital		
Breast	20	3
Bottle	33	5
Mixed	47	7
Total	100	15

Table 3 shows when breastfeeding support was received and from whom. All women received breastfeeding support at some stage of their maternity care. Women received more support postnatally, and less support during their hospital stay. More of them received support from the support worker both antenatally and postnatally than from other health professionals. The “Other” category represents women who received antenatal support but were unable to remember which health professional gave it. Those who received support during hospital stay had received support from the hospital nurse on duty.

Table 3 When breastfeeding support received and from whom

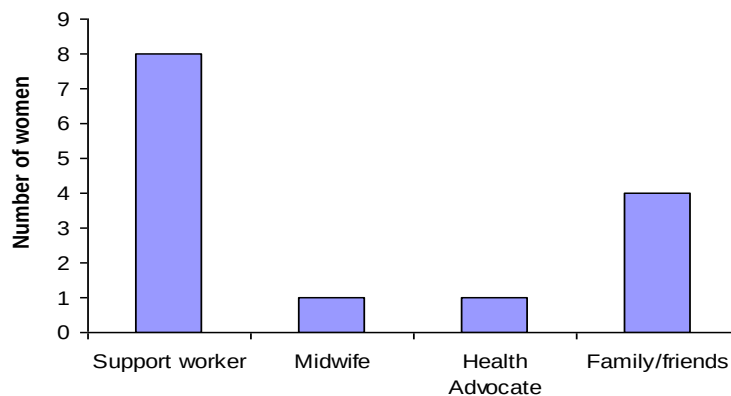
Source of support	<i>When support received</i>					
	Antenatally		During hospital stay		Postnatally at home	
	Percentage	Base	Percentage	Base	Percentage	Base
Support worker	40	6	20	3	53	8
Midwife *	27	4	27	4	33	5
Health Advocate	7	1	14	2	0	0
Health Visitor	0	0	0	0	20	3
Family	0	0	7	1	53	8
Friends	14	2	0	0	20	3
Other	7	1	14	2	0	0
No help	40	6	40	6	14	2
Total	100	15	100	15	100	15

* None of these were Sure Start midwives

Some women received help from more than one source at each stage, so the totals do not add up to 100.

Most women identified the support worker to be the most helpful in terms of breastfeeding (figure1), and reported that she had influenced them to breastfeed. Of these women, five were multipara and all mentioned they would have liked this support while feeding their previous child or children. More primiparous women were influenced “A lot” by the support worker than were multiparous women.

Figure 1. Who did women find most helpful in terms of support with breastfeeding.



Only two women said they needed further support with breastfeeding in addition to the help they had been receiving. Despite having contact details of the support worker, having seen and received some support from her, and found her to be supportive they decided to contact other health professionals such as the health visitor or doctor for queries. This was because their social networks advised them that other health professionals would be able to advise better than the support worker. This raises issues of lack of confidence in and professional recognition of the support worker as a breastfeeding specialist by women and those in their social network.

None of the women attended breastfeeding classes. Only six women reported being informed about the classes and none of those reported being informed of the breastfeeding classes by the support worker. It is possible that women may not have remembered being informed by the support worker at the time of questioning or may have presumed that the support worker was discussing a different workshop. Women wanted videos of breastfeeding education in their own languages, to be used in the workshops and copies for them to borrow to watch at home in privacy.

The qualitative elements in the questionnaire showed one of the reasons most women found difficulties in exclusive breastfeeding during their hospital stay was lack of support by hospital staff. Just under half the women had caesarean sections. This was quite high compared to the overall rate of 18 per cent in the same hospital in the same year. All except one of those who had caesareans said this had influenced the method of feeding they adopted to after delivery. They said they found breastfeeding difficult due to general pain and back pain. As one woman said:

“Due to back pain did not breastfeed as planned, so bottle fed at hospital.” (Q2)

Two women, who had caesarean sections, described the kind of support they would have liked during their stay at the hospital.

“Help in hospital after delivery, help with demonstrating how to position baby on breast, how for me to position myself...physical demonstration rather than talking...”
(Q2)

“To have continued support with feeding baby at hospital, especially...who have operation (caesarean). Then when they get home it would be easier...” (Q15)

Good communication skills, both verbal and non-verbal, knowledge of breastfeeding, ease of access and an interest during the period while women are breastfeeding are factors that contributed the most highly to what women perceived as most helpful in terms of support during breastfeeding.

Discussion

The sample is too small to carry out statistical tests and no comparative data were collected from women who did not receive help from the support worker, but the data suggest the benefits of the additional support worker. The majority of women found the support worker to be the most helpful breastfeeding advisor with whom they had contact. This evaluation highlighted the need for further work in this area. By 2005, Tower Hamlets had similar breastfeeding projects in each of the seven Sure Start areas, employing seven part-time support workers and four part-time project coordinators.

The success of the scheme also suggests that other existing services are failing to offer adequate support to this group of women. A number of strategies could be adopted. Increasing time spent at ward level by a support worker and longer visiting hours may improve the support available during hospital stay. Women's social networks provide a lot of support with feeding; the involvement of these networks in breastfeeding workshops could improve attendance.

The availability of videos in women's own languages can help to remove barriers associated with literacy and act as another tool for educating women in particular those who feel embarrassed and shy to be involved in an open discussion regarding breastfeeding. Since the end of the project, videos have been introduced. Careful distribution and monitoring of their impact on women's breastfeeding patterns and knowledge may enable the usefulness and practicality of such material. The Sure Start programmes are reaching their final stages and it is anticipated that successful projects will continue to be supported by Children Centres. On a larger scale, both health and

economic evaluation of the second phase will need to be conducted to assess the implications of these programmes for women and their families, health care providers and whether these should or can be incorporated within the mainstream health services or the Children Centres once Sure Start ends.

Conclusion

This evaluation was conducted to make a preliminary assessment of the impact of bilingual breastfeeding support work on Bangladeshi women and inform decisions about extending this service to other areas. The apparent success of the scheme suggested that there was a need to continue to employ local women to work as support workers.

Key Points

- A majority of participants found the bilingual breastfeeding support worker to be more helpful than other professionals
- Women reported they were influenced to breastfeed by the bilingual support worker.
- Further work is required to assess the views of service providers and the contribution such programmes can make to mainstream services.

We would like to thank Stephen Abbott from Public Health and Primary Care Unit, City University, for his advice during the preparation of this paper.

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