

Original Article

Exploring the infant feeding practices of immigrant women in the North West of England: a case study of asylum seekers and refugees in Liverpool and Manchester

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Abstract

Little is known about the infant feeding experiences of refugees residing in the UK. To enable successful health promotion for this population, such experiences must be understood. The study aimed to gain an understanding of infant feeding practices among a group of UK-based refugee mothers. Objectives were to explore mothers' perceptions and influences of infant feeding practices, to explore challenges faced by mothers in feeding their infants and to identify concerns and experiences of health care professionals with regard to caring for them. Fifteen semi-structured interviews and two focus group discussions with refugee mothers and five semi-structured interviews with health care providers were conducted in 2012. A framework approach was used to identify main themes. Overall mothers were dissatisfied with their infant feeding outcomes. A preference to exclusively breastfeed was often not achieved. Most resorted to using formula feed, perceiving that this was primarily due to a lack of support. Mothers who were positive to human immunodeficiency virus followed the UK guidelines of exclusively formula feeding for 6 months, but struggled with guilt of not being able to breastfeed. All mothers unable to exclusively breastfeed experienced a sense of loss. Lack of wider support services coupled with complex lifestyles appeared to create challenges in providing infant feeding support. The results highlight a need for an intensified response to facilitate these mothers to maintain their preferred infant feeding choices, or when required, to support them in the adoption of a new method. Using experienced refugee mothers to guide newer mothers, and integrating health and social care, would be positive starting points.

Keywords: refugee, breastfeeding, formula feeding, infant feeding, support, HIV.

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Introduction

Worldwide breastfeeding has long been recognised as the best way of ensuring a healthy start in childhood. Compelling evidence highlights the association of breastfeeding with a reduced risk of many diseases for infants and mothers (World Health Organization 2003; IP *et al.* 2007). Furthermore, in developed countries, the increased incidence of

illness associated with low rates of breastfeeding has a significant cost to health services (Dyson *et al.* 2006; Renfrew *et al.* 2012). The UK Department for Health has acknowledged the positive effect upon public health which could be gained by increasing breastfeeding rates, including financial implications and the long-term impact on the health of the population (Griffiths *et al.* 2005; Ingram *et al.* 2008).

Yet breastfeeding practices remain as precarious as they are powerful. Recent figures estimate that despite the overwhelming health benefits and cost savings of breastfeeding, rates in the UK are among the lowest in the world (IFS 2011; Bolling *et al.* 2007). The lowest rates of breastfeeding are in those from the lowest socio-economic groups, adding to inequalities in health and contributing to the perpetual cycle of deprivation (IFS 2011). Realistic alternatives exist and often women choose to formula feed (Taylor *et al.* 2010). Many British mothers regard formula feeding as more practical, less burdensome and more socially acceptable than breastfeeding (Erskine *et al.* 2010; Hoddinott *et al.* 2012).

Asylum seekers and refugees¹ residing in the UK are generally classed as being the most severely socio-economically deprived population (Refugee Council 2006), but in contrast to the impoverished white British population, the vast majority of this group originates from countries where breastfeeding is the accepted norm, indeed with limited access to clean water and sanitation it is often the only option (World Health Organization 2009).

Notwithstanding the high numbers of asylum seekers and refugees in the North West of England, initiation and continuation rates of breastfeeding are lower in Liverpool and Manchester than the national

averages (Berridge *et al.* 2004). The UK Infant Feeding Survey does not differentiate between women born in the UK and those born elsewhere, and hence breastfeeding rates and other socio-demographic patterns of infant feeding for refugee mothers are not available. Furthermore, despite the growing numbers of refugees in the UK, and the well-documented low breastfeeding rates within lower socio-economic groups, there is a gap in the literature about the infant feeding practices (IFPs) and influences on IFPs of this vulnerable group. There is also a dearth of research pertaining to the experiences of health care professionals (HCPs) in supporting refugee mothers with IFPs.

The gathering momentum of interest regarding infant feeding over the last two decades has predominantly focused on the safety, cost-effectiveness and child health outcomes of a given strategy, as well as the socio-demographic variables associated with IFPs. Less consideration has been given to the personal and socio-cultural implications of such practices, and to why mothers adopt a particular method of feeding. Of the research that does explore the complex motives for IFPs, most is centred on the behaviour and experiences of white British mothers, with little consideration given to women of ethnic minority, and even less to those dealing with the complexities of poverty and refugee status.

Little is known about the IFPs of refugee women, but for successful health promotion within this community, their experiences must first be understood. In resource poor settings, evidence suggests that adherence to the World Health Organization (WHO) Infant Feeding Guidelines has shown better responses when the voices and socio-cultural backgrounds of the mothers have first been considered

¹The term 'asylum seeker' is used for a person who has lodged an asylum claim with the Home Office and is awaiting a decision. Refugee status is gained when the application for asylum has been accepted and the individual then has to leave to remain in the UK for 4 years (Heptinstall *et al.* 2004). For the purposes of this study, the term refugee will be used synonymously to include both asylum seeker and refugee.

Key messages

- Refugee mothers in this study aspire to breastfeed, but many struggle with the realities of this.
- A sense of loss is felt by those who do not achieve their desired feeding outcomes.
- Refugee mothers who were positive to human immunodeficiency virus experience a sense of guilt at not being able to breastfeed and struggled with the cost of formula feed.
- Peer support would be beneficial for helping refugee mothers throughout infant feeding.
- Integrating health and social care would be beneficial in decreasing the burden for health care professionals and enhancing support for these mothers.

(Doherty *et al.* 2011). This has enabled context-specific approaches to be taken and promoted informed choice wherever possible (Desclaux & Alfieri 2009).

This study aims to explore an unmet need in understanding the issues surrounding IFPs of refugee mothers through investigating the beliefs and behaviours relating to IFPs of a small sample of refugee women in the North West of England and the experiences of HCPs in helping these women to reach the best outcomes for themselves and their infants. Understanding the issues relating to IFPs for refugee mothers can be used to inform the planning and implementation of inclusive and appropriate services delivered.

Materials and methods

Design

A qualitative methodology, comprising focus group discussions (FGDs) and semi-structured interviews (SSIs), was used to enable direct engagement with the participants and thereby to facilitate an effective exploration of women's attitudes and beliefs with regard to their IFPs, and an understanding of the perceptions and concerns of their HCPs.

Participants

Refugee mothers who resided in Liverpool or Manchester, had a child born in the UK in the last 4 years or were at least 6 months pregnant were purposively selected. These categories were designed in order to recruit women who were preparing to or had already encountered IFPs in the UK over the last few years. Given the vulnerability and accessibility of the (refugee) population of interest, the categories were necessarily broad in order to reach saturation on key objectives and to enable sufficient diversity of this heterogeneous group. Women who were positive to human immunodeficiency virus (HIV) were recruited as a large proportion of refugees in the North West are black African and this group is disproportionately affected with HIV compared with other ethnic minority groups in the UK. The feeding experiences of these

mothers have not been widely reported and their inclusion was therefore felt to add an important dimension to the study.

The researcher attended meetings of community-based groups offering support, advice and social contact for refugee women. This allowed an opportunity for familiarisation with the women, a chance to gain some insight into their circumstances and explain the study and invite their participation.

HCPs who were involved in maternal health (health visitors and midwives), had regular contact (weekly or more) with refugee women and had worked with them for at least 6 months were selected. A snowballing sampling approach was used to identify the HCPs; initial identification of participants was facilitated by the primary care trust (PCT), and those recruited were asked to identify other suitable professionals. Although the number of HCPs recruited did not meet the initial target, it was still possible to obtain data saturation on the major themes from the sample obtained.

Data collection methods

SSIs with refugee women and HCPs

Qualitative interviews facilitate key issues to be explored and give an opportunity to seek in-depth understanding of the meaning participants give to their experiences (Legard *et al.* 2003). This technique permitted detailed discussion about the feeding strategy a mother was using and what had influenced her decisions. For the HCPs, detailed discussion about their unique experiences of working with refugee women in a maternal health setting was enabled.

FGDs with refugee women

The key feature of the FGD is the interaction and generation of discussion between participants (Kitzinger 2006). Two FGDs were conducted with refugee women, each lasting approximately 1 h and providing an important social context to the topic. The diversity of information generated facilitated discussion of issues that may not have otherwise been considered by the researcher (Rupenthal *et al.* 2005), which helped to inform future interviews.

The topic guides, developed in collaboration with key managers in Liverpool PCT, covered areas such as UK feeding experiences compared with experiences elsewhere, knowledge and awareness of UK feeding recommendations, difficulties encountered with infant feeding methods and where help is sought (See Supporting Information Appendixes S1–S3 for the topic guides used).

All SSIs and FGDs were conducted in English by the first author, a female British student with a nursing background. Each interaction was held at a location deemed acceptable and convenient by the participant and suitable by the researcher. For the HCPs, this was a private office/clinic at their workplace, and for the refugee women, a private room or discrete area at the support venue they were attending (such as community centre or church hall). Dialogue was recorded using a digital Dictaphone (Personal equipment: Philips voice tracer 3400) following permission from each participant. Informed consent was obtained from each participant prior to starting the interviews and discussions.

Data analysis

Data were analysed by the first author using a framework approach, facilitating rigorous and transparent analysis (Ritchie *et al.* 2003). The transcripts were read to identify emerging themes; a coding framework was developed based on these themes and all transcripts were coded with this framework. Charts were created for all themes, and these charts were used to describe similar and divergent perceptions, develop explanations and find associations between them.

Liverpool School of Tropical Medicine Research Ethics Committee granted ethical approval for the study. The International Procurement Research Group (Mersey Deanery) and the Central Manchester University Hospitals NHS Foundation Trust (CMFT) Research and Innovation team also formally approved the study.

Results

A total of 30 mothers from 19 countries, and five maternal HCPs were recruited. The mothers were not

asked to divulge personal information about their health or asylum status, although some raised these issues of their own accord. The women who were HIV positive had been identified as such by the agencies they were attending. The rest of the mothers were not known to HIV support services, gave no indication of a positive HIV status in their interviews and were therefore presumed to be HIV negative. The codes and characteristics of each mother and codes and job title of each HCP are given in Table 1.

The themes and subthemes that emerged were categorised in order to capture the women's experiences of infant feeding as well as the experiences of their care providers, as illustrated in Table 2.

Infant feeding trends

All mothers were asked about the infant feeding strategy used for their most recent child. Of the 19 HIV-negative mothers, all had initiated breastfeeding of their newborn. Six mothers continued to exclusively breastfeed for 6 months (or were still exclusively breastfeeding at the time of interview), seven mixed fed (breastfeeding and formula feeding) and two started using formula feed within the first week and did not breastfeed again. All of the HIV-positive mothers had exclusively formula fed their UK-born infants for 6 months.

HCPs' views were similar to those of the mothers. They reported that the most HIV-negative mothers will attempt to breastfeed, and the vast majority of mothers with HIV will exclusively formula feed.

Awareness of feeding guidelines for HIV-positive mothers

The HIV-positive mothers reported that their decisions to formula feed resulted from the advice given by their HCPs. They all understood that by formula feeding they were avoiding the possible transmission of the virus to their babies through breast milk. This potential risk appeared to motivate them to adhere to the recommendations, although each HIV-positive mother expressed regret that they could not breastfeed.

Table 1. Characteristics and codes of study participant

	Participant code	Country of origin	Length of time in the UK	Parity	Husband/partner in UK	IFP of most recent child
SSI with mothers	R.1	South Africa	7 years	2	No	Exclusive FF (6 months)
	R.2	Ghana	5 years	2	No	Both BF and FF (6 months)
	R.3	Syria	3 years	3	Yes	Exclusive BF (6 months)
	R.4	Nigeria	2 years	3	Yes	Exclusive BF (ongoing)
	R.5	Zambia	3 years	1	No	Both BF and FF (6 months)
	R.6	Armenia	2 years	3	Yes	Exclusive BF (6 months)
	R.7	Iran	3 years	1	Yes	Exclusive BF (2 months) then only FF
	R.8	Gambia	2 years	2	No	Both BF and FF (6 months)
	R.9	Nigeria	10 years	1	No	Both BF and FF (6 months)
	R.10	Pakistan	15 years	4	No	Mainly BF (3 months) then only FF
	R.11	Pakistan	20 years	4	No	Initiated BF then only FF
	R.12	Nigeria	7 years	1	No	Exclusively BF (6 months)
	R.13	Malawi	4 years	1	No	Mostly BF (3 months) then only FF
FGD.1	R.14	Guinea	3 years	1 (+pregnant)	No	Exclusively FF (6 months)
	R.15	Somalia	9 years	0 (pregnant)	No	N/A (wants to BF)
	R.16	Somalia	7 months	1	No	Initiated BF then mainly FF
	R.17	Somalia	6 years	2	No	Exclusively BF (4 months) then BF and FF
FGD.2	R.18	Yemen	11 months	0 (pregnant)	Yes	N/A (wants to BF)
	R.19	Somalia	7 years	8	Yes	Exclusively BF (6 months)
	R.20–R.30	Nigeria × 2, Malawi × 2, Angola, Cameroon, Gabon, Togo, Uganda, Zimbabwe, South Africa	1–8 years	All have at least 1 child (<4 years old)	Majority No	All exclusively FF
SSI with HCP	P.1	Community midwife				
	P.2	Midwife specialist				
	P.3	Social inclusion specialist health visitor				
	P.4	Social inclusion health visitor assistant				
	P.5	Community midwife				

BF, breastfed; FF, formula fed; FGD, focus group discussion; HCP, health care professional; IFP, infant feeding practice; SSI, semi-structured interview.

The HCPs echoed the responses given by the mothers that UK guidelines are adhered to and breastfeeding is largely avoided in mothers with HIV.

However, a thread of perplexity was noted among the mothers as a result of recent speculation in the media that feeding guidelines may be revised in the future to enable HIV-positive mothers to breastfeed.

Mother 1: I don't know about now, but they say if your viral load is undetectable, you can breastfeed?

Mother 2: But is it safe?

Mother 3: There's an article, I can't remember where I saw it, they are saying something like, no, they are not saying 'yet', you know, they are now saying it's really good that HIV mums should now breastfeed and they came up with very convincing things.

Mother 1: I think that is also misleading because, you know for someone who don't have access to like, what we are doing here, they will think I will just go ahead and breastfeed. (FGD.2)

Similarities and differences between the IFP adopted in the UK compared with previous strategies

Table 2. Overview of the main themes and subthemes

Main theme	Subtheme
Infant feeding trends	
Awareness of infant feeding guidelines (HIV-positive mothers)	
Views on feeding methods	Health-related benefits of breastfeeding Creating a bond with the baby
Feeding influences	Religious influences and cultural traditions Influences of UK HCPs Support groups Western influences on IFP
Realities of following desired IFP	Negative feelings about method used Positive feelings about method used
Challenges to following desired IFP	Isolation and lack of support Lack of milk Asylum process Expense
Challenges of caring for refugee mothers	
Suggestions for improvement	

HCP, health care professional; HIV, human immunodeficiency virus; IFP, infant feeding practice.

used were widely discussed among HIV-positive mothers. Notably, mothers who had hitherto raised infants in Africa had all breastfed mainly because their HIV status was not then known.

Views on feeding methods

When asked for their views about IFPs, all mothers primarily discussed the advantages of breastfeeding.

Health-related benefits of breastfeeding

All mothers recognised the health benefits for the infant associated with breastfeeding. Words such as 'natural', 'good' and 'better' were commonly used in relation to breast milk and its comparison to formula milk. The majority opinion was that breastfeeding results in a strong child with good immunity.

My sister in law, she's give breast milk and baby's so health, so healthy! She's grown early teeth, walking, everything is fast. . . . Breast milk is too good for kids. (R.10)

If I have the chance to do it, I will give my child, my baby, six months [breast milk], that's fantastic because they will have strong bones, have strong everything. (R.9)

Creating a bond with the baby

Another perceived advantage of breastfeeding, expressed solely by HIV-positive mothers, was the bond created between the mother and her infant. These mothers expressed a sense of disappointment at not being able to create the same closeness to their infants as breastfeeding mothers.

So you feel all that, like the kid wont love you back, you know, that's what they put in our head. When you breastfeed, you know, even here you saw, you see it on the advertising on the TV, if you want to bond quicker with your child breastfeed and all those things. (R.14)

Feeding influences

Several influences were reported by the women: cultural and religious traditions were the most common influence; observed behaviours and expectations of family and friends; and having a named HCP and attending a peer support group.

Religious influences and cultural traditions

The majority of women referred to the breastfeed norms that existed within their countries of origin.

You know in our religion it says we have to feed the baby in breastfeeding, up to two years. (R.15)

Back home, that's all they do, they only breastfeed. They only breastfeed, they don't give milk. (R.8)

Women often referred to the behaviours they had observed among their friends and family 'back home', and in particular to the ways in which their own mothers had fed them. Mothers and mothers-in-law were considered to be particularly encouraging of breastfeeding, even without their physical presence.

My mum, she would make sure that she called every time and say; how many times are you breastfeeding in a day? At

six months; are you still breastfeeding? Don't stop until she is one! (FGD.2)

My husband mother tell me; please, everyday give baby breastfeed, because it's good for baby... She say me; please, do for two years! (R.6)

The HCPs recognised the importance of nurturing traditional family values and used it as a tool for encouraging breastfeeding.

I say, so you will be breastfeeding will you? I say don't adapt, in your own country what would you have done? And often they say breastfeed my baby, I say right, good... You have to feed the dream that this is the norm, that this is not the abnorm. (P.2)

Influences of UK HCPs

Most women could recall a midwife or health visitor who had given them practical support to breastfeed within hospital, or had encouraged them to continue breastfeeding within the community.

DVDs and booklets provided by HCPs were mentioned by several women as being useful for learning about correct positioning for breastfeeding.

Mothers with HIV who had received specialist support also described the benefit of having a named individual to help them come to terms with not being able to breastfeed and with the practicalities of formula feeding.

Support groups

Volunteer run support groups were viewed by the mothers as a valuable opportunity to meet and socialise with other refugee women. Only two mothers had heard of 'Sure Start' or other organisations specifically designed for feeding support.

Western influences on IFPs

The mothers did not recognise any influence of the Western IFPs on their own behaviours. Conversely, one HCP identified that some refugee mothers who have been in the UK for a number of years use formula milk 'because they've got into our system'

(P.1). The HCPs working with the newly arrived refugees revealed that these mothers, often exhausted and afraid, can be influenced into purchasing or borrowing formula feed from other women and staff encountered at the hostels.

Realities of following desired IFP

All mothers reported that they hoped to be able to breastfeed their infants. All HIV-positive mothers conveyed that if their health had allowed, or if future recommendations permitted, breastfeeding would be their preferred method.

Negative feelings about method used

Mothers used words such as 'stressful', 'difficult' and 'challenging' to describe their feeding experiences. Presumed HIV-negative mothers who had not breastfed expressed a strong sense of disappointment, often mixed with justification for their actions. HCPs reported that women were often disappointed when they struggled to breastfeed.

It upsets them, because they want to try, they want to carry on, but they just feel overwhelmed by the whole situation, everything that has happened to them... And I suppose sometimes they feel as if maybe they've failed. (P.3)

I stressed to give my child breastfeeding, but he didn't want it you know... I bottle feed him because there is no milk in my breasts, and then I regret it afterwards... I wanted to breastfeed him so bad, but you know he refused completely. (R.16)

For HIV-positive mothers, feelings of loss and guilt were also identified. The psychological impact of being unable to breastfeed was exacerbated by the discomfort and humiliation expressed by all but one of these mothers at having to lie to friends and families to avoid the stigma associated with HIV. Defending their IFPs without disclosing the truth was a constant reminder of their HIV status and left the mothers feeling culturally bereft.

I felt like I'm not a complete mum, like I'm not a good mother, cos I, in my culture, our parents breastfeed us, and I was expecting to do the same thing for my kids, which I can't

anymore so, it's hard, mentally you feel like oh I'm not a good mum, why am I doing this? You feel guilty, you blame yourself. (R.14)

The people from my church. . . . I lied to say the milk is not coming, so, they give me juice, they want to buy whatever they think can produce more milk, started massaging my breasts. . . . What other excuse could I give them? That sort of pressure is really uncomfortable, because [pause] sometimes you just want to scream and say, OK, I'm not breastfeeding because I'm like this, but you can't! (FGD.2)

Positive feelings about method used

Only one HIV-positive mother depicted a positive experience of formula feeding. In contrast to the other participants, she described being able to freely formula feed and her influence on a peer.

They don't realise why I don't breastfeed, because another one, she was pregnant after me and she said; oh ok, I will copy, I won't breastfeed, because I can see she is feeling well for not breastfeeding. (R.1)

A sense of pride as well as a feeling of achievement was apparent from the presumed HIV-negative mothers who had managed to exclusively breastfeed as intended.

Challenges to following desired IFP

The mothers described a number of challenges to achieving positive infant feeding experiences. Many of these factors were also recognised by the HCPs and were associated with the women's vulnerable circumstances.

Isolation and lack of support

The overwhelming reason for breastfeeding difficulties was linked to feelings of isolation. All but one of the six who exclusively breastfed lived with a partner, whereas each of the eight women who regularly used formula feed was a single parent. The responses indicated the difficulties of raising an infant in the absence of a support network.

If I can have another baby I will breastfeed, maybe if I have that chance, but it's difficult to have a baby, it's really difficult. . . . Both to raise the baby and look after the baby alone [crying]. (R.13)

If I had my mother here I think it would have been different. (R.16)

Lack of milk

Presumed HIV-negative women who were formula feeding often perceived their breast milk supplies as inadequate and believed their babies were 'too hungry' or 'too light' for them to continue breastfeeding without supplementing with formula feed. Several mothers with previous breastfeeding experiences explained that their milk supplies were less in the UK, or that their UK-born infants had refused the breast. Most could not explain why this was, but a minority recognised that differences in diet and lifestyle and increased levels of stress made it comparatively more difficult to breastfeed in the UK than in their home countries.

Asylum process

Mothers frequently mentioned concerns about poor housing, the dread of further dispersal/deportation, fear for their families' safety and sadness at the lack of rights disabling them from contributing to society or leading a normal life. They did not directly link these concerns to feeding difficulties, but HCPs described the struggle some mothers have in being physically and mentally relaxed enough to breastfeed.

Expense

The HIV-positive mothers frequently mentioned the expense of formula milk that makes it difficult for them to provide an ongoing supply for their infants. HCPs explained that a lack of benefits entitlement means that many mothers have to self-fund the milk, bottles and sterilising equipment. If unable to afford formula feed or equipment, most women reported that the child was their priority and they would

'manage' to provide milk even if it meant considerable suffering for themselves.

Mother 1: It's not everybody who can afford to buy the milk. I remember with my child you know, they said I should feed him, but I didn't have any money. . . . There was no formula in the house, so it will be better for me to open a can of soup and give to him.

Mother 2: Yes, sometimes you just take a cup of tea, in order to keep the money for the formula, that's what we do. . . . sometimes you will starve yourself to feed the baby. (FGD. 2)

HCPs echoed the extreme financial difficulties experienced by some refugee women and stressed the related vulnerability they face compared with other impoverished mothers in the UK.

Most people could find somebody who has a little bit [of money], even a poor family here. Where as if you are here as an asylum seeker, you have got no one to go to, and that's what I think is scary. (P.1)

Challenges of caring for refugee mothers

All HCPs discussed the challenges of focusing on IFP issues in the midst of a mother's frequently chaotic and precarious lifestyle. Words such as 'stressful', 'exasperating' and 'tiring' were used to describe their work. A common theme that emerged was the sense of responsibility that they felt for the vulnerable refugee mother.

Everything is so strange and so alien, and they don't know our system, you know they don't understand the NHS system, they don't know what support is out there and I think they can get very upset thinking nobody's there. (P.3)

Acutely aware of the lack of support afforded to this population, the HCPs' responses suggested that they were working with high levels of commitment and concern for these mothers, providing holistic support.

You deal with a lot of immediate and necessary things, and it could be medical things, it could be social, housing. . . . I suppose we advocate a lot for them really as well and, um, also with the border agency. (P.4)

The HCPs expressed unease at the ongoing governmental cuts to the health and voluntary sectors. It was felt that such measures were jeopardising the sparse funding available for refugee support and creating job uncertainties for those working with them. There was also a sense of frustration that this population was seen as 'bottom of the ladder', and that there was a lack of recognition and appreciation for the work being done for them. Most HCPs reported feeling unsupported and not valued in their work with refugees and almost all were concerned about their heavy caseloads and the subsequent shortage of time that could be afforded to supporting individuals with IFPs. They described their efforts to liaise with other agencies in order to share information and enhance the assistance available for the refugee mothers.

Suggestions for improvement

All HCPs discussed the need for increased local and national awareness, more support and resources for the maternal health of refugees.

There's no point having the best breastfeeding team in the hospital if they don't go and see people on the ward. . . . To be with women, to help them, to give them that time. . . . and I'm not saying that necessarily has to be a support worker or a trained midwifery staff, even like volunteers. . . . That's what we have to get in because I think their expertise within health would be a good thing. (P.2)

When asked about what would have helped with their IFPs, the desire for increased support was also highlighted by the mothers. One HIV-positive mother talked about the value of the peer support she had received. An interest in helping other women with maternal health issues was raised by an experienced mother during a FGD.

I had some mentoring you know from here, from other women and they really help me and that, even give me the courage to attend the training course. . . . When you hear from someone else who are in the same situation as you, even though you know they are not doctors. . . . You believe in them more that the consultant. (R.14)

R.16: For me, it's like how to hold the baby, to position, you know. . . . I had a specialist, she came to show me how to do it, but it's still difficult.

R.20: There is technique, how to do it, but first time mum. . . .

R.16: [Interrupts] But you need help with that you know.

R.20: I have that idea of Doula, but I don't know where I can go and try. . . . When she leave hospital and how they encourage, we have to help the mums! (FGD.1)

Discussion

Refugee mothers in this study perceive that it is advantageous to feed an infant breast milk rather than formula milk, and understand that this should continue for the first 6 months of life to ensure optimum health of the infant. The frequency of refugees breastfeeding in this study is higher than that supposed for the white British population.

Other studies have shown similar patterns where breastfeeding is more likely among ethnic minorities or women born outside of the countries they are living in (Bolling *et al.* 2007; Steinman *et al.* 2010).

In this study, cultural familiarity with breastfeeding appears to be an important factor influencing IFP and outweighs the normal demographic variables typically associated with breastfeeding. IFP among refugee mothers suggests that breastfeeding remains the common and expected method of feeding in their native countries. The mothers regularly described the expectation of their own mothers and mothers-in-law to breastfeed, highlighting that it remains a practice embedded in a deep-seated tradition reflecting socio-cultural values (Britton 2009; Cames *et al.* 2010; Van Hollen 2011). Furthermore, the precarious availability of clean water and sanitation in their home countries means the use of formula feed can greatly increase the risks of illness and fatality of the baby (Nduati *et al.* 2000; Kasinga *et al.* 2008). Although resources and infrastructures are already in place in the UK and the consequences of formula feeding are therefore not as critical, this backdrop may affect a refugee mother's desire to breastfeed and contribute to her feelings of guilt and shame when this is not achieved. This breastfeeding desire among refugee

mothers is in direct contrast to low-income white British mother's formula feeding preferences, which stem from a very different experience and attitude. Surveys with these women have consistently highlighted barriers to breastfeeding that include body image, perceived lack of freedom and the views of the main support person (Swanson *et al.* 2006; Erskine *et al.* 2010). This disparity indicates that it is not poverty per se that causes low breastfeeding, but the associated experience of a given practice.

This study found that knowledge and familiarity with breastfeeding among the refugee mothers does not equate to practice. Despite the intentions of the presumed HIV-negative mothers to breastfeed, less than half managed this exclusively. Many had replaced some or all breastfeeding with formula feeds within the first few weeks. In reality, it was a minority of the refugee mothers who managed to exclusively breastfeed, suggesting that the knowledge and understanding that they have about the benefits of breastfeeding is not enough for them to continue within their host countries. Responses from the mothers suggested that if they had been 'back home' they would have breastfed exclusively, and longer. These findings strongly indicate that the mothers felt their breastfeeding abilities had been compromised since arrival in the UK. Other qualitative research has similarly identified that British women of ethnic minority would have breastfed longer in their native countries than they had in the UK (Griffiths *et al.* 2005; Twamley *et al.* 2011). A study of British mothers and their maternal health care providers by Brown *et al.* (2011) suggests however that there may be an element of attributional bias among mothers in their given reasons for not breastfeeding. In the current study, it is important to consider therefore that despite the mother's clear views about breastfeeding attrition in the UK, achieving exclusive breastfeeding 'back home', although potentially easier for them, may still not have been as straightforward as imagined.

The theoretical concept of acculturation is often perceived as an inevitable and important part of adapting to a new country and might help individuals to gain a sense of semblance to conform in a new society (Landrine & Klonoff 2004; Bhugra & Becker

2005). In this study, this may not be the primary reason for women's breastfeeding attrition. This pattern of diminishing breastfeeding rates appears to be the result of multifaceted challenges faced by the refugee mothers, rather than conscious attempts to 'fit in' with the host population. It is not therefore their cultural beliefs that relinquish, but rather the mental and physical abilities to continue their cultural practices. In view of this, the concept of *deculturation* as opposed to *acculturation* is proposed as an alternative explanation for both cause and effect of unfulfilled breastfeeding aspirations among the mothers.

The principle is that an experience such as breastfeeding will be mediated through and influenced by cultural identity (Bhugra & Becker 2005), and hence deculturation is the loss of cultural identity and alienation, associated with guilt of abandoning these traditions that contributes to problems with self-esteem and confidence (Bhugra *et al.* 2011). Not having enough breast milk or that their children refused the breast – common perceptions among the women in this study – are therefore manifestations of this concept. The 'loss' of breastfeeding and the perceived necessity for the use of formula milk are experienced as cultural bereavement (Eisenbruch 1991), as these mothers struggle with the wider 'loss' of identity that relinquishing this traditional practice creates.

The study suggests that greater attention needs to be paid to the social determinants of health behaviour for this population. Lack of support was recognised by all mothers in this study to be the largest contributor to their breastfeeding challenges. Social support has been identified as having a significant positive effect on breastfeeding rates (Ingram *et al.* 2008; Hoddinott *et al.* 2012). Having a breastfeeding friend or relative has been shown to be the most significant predictor of breastfeeding initiation among low-income women in America (Bonuck *et al.* 2005). Confidence, self-esteem and the provision of practical help could be facilitated by the presence of a supportive other and may enable enhanced satisfaction with a feeding outcome. Practical and emotional support from a culturally matched breastfeeding peer is imperative for a single refugee mother struggling to breastfeed in an unfamiliar environment, especially as

the psychological implications of not breastfeeding may be intensified by her circumstances.

For the HIV-positive mothers in this study, dealing with the acceptability of formula feeding and coping with the guilt of not breastfeeding creates immense challenges. The ongoing anguish of not disclosing HIV status highlighted is a sad reflection of the worldwide stigma that still prevails. The findings of this study suggest that the support of a trusted individual or group that has experienced similar barriers is a fundamental part of decreasing this sense of isolation for such mothers. Chima (2010) found that peer support interventions in parts of Uganda decreased rates of mother-to-child transmission of HIV, and also had positive outcomes for mothers' psychosocial well-being. Introducing peer support programmes to refugee mothers in the UK may not only provide a valuable source of support for the mother, but may also be a way of increasing the self-worth and social interaction of the refugee women trained as peer supporters.

Financial constraint of obtaining formula feed was a concern raised by both HIV-positive mothers and HCPs in this study. In view of the limited access to benefits and levels of extreme poverty, it might be assumed that these mothers are left with no option but to breastfeed. Conversely, this study found that the determination of mothers to give their infants the best chance in life was enough to ignore the temptation to breastfeed or overdilute feeds, regardless of their significant physical and mental hardship. Infant formula milk is not universally provided to HIV-positive refugee mothers (Maternity Action 2010), and is a potential barrier to the successful implementation of the feeding guidelines. An ongoing supply of free formula milk as well as feeding equipment for all HIV-positive women should be negotiated at local and national levels.

Inherent in the asylum process are concerns for refugee welfare, including low self-esteem and mental stress (Reynolds & White 2010). In this study a cyclic scenario emerged in which a mother's circumstance affected her ability to succeed with her preferred IFP, further threatening her mental well-being and exacerbating her circumstances. HCPs in this study recognised that a sensitive approach is pertinent for

vulnerable refugee women who need empowering in their choice of IFP. This avoids infant feeding becoming a further test set up for them to fail. The idealism that breastfeeding is the norm needs to continue to underpin the messages given, but with the realism that for some women exclusive breastfeeding is not attainable (Hoddinott *et al.* 2012). Similarly, HIV-positive mothers need carefully delivered messages to encourage exclusive formula feeding, while avoiding them experiencing guilt and cultural bereavement associated with formula feeding.

The benefit of having maternal HCPs dedicated to working with the refugee populations was apparent. Those interviewed implicitly understood the depth of social and cultural problems faced by refugee mothers and were knowledgeable about the asylum process. Heptinstall *et al.* (2004) discuss the frequent experience of staff feeling overwhelmed with the complexity of each refugee client, which strikes resonance with the issues raised by the specialist HCPs in this study. The HCPs interviewed recognised that a lack of resources and personnel means they are also dealing with other urgent concerns such as housing and home office issues, allowing little opportunity for the time-consuming and sensitive communications required for IFP assistance. Such conflicting demands are commonly recognised for HCPs working with marginalised populations (Taylor 2009). This situation is exacerbated by the perceived lack of recognition of the important work being done. The paucity of funding to support refugees, and significantly the mothers of young children, was frequently mentioned by the HCPs in this study, and is highlighted elsewhere (Dumper 2002; Tribe & Patel 2007).

The ongoing reliance of the mothers on the HCPs, and the reciprocal responsibility felt by the HCPs for the mothers was clear. These factors reflect the inherent vulnerable lifestyles of the refugee mothers as well as the lack of wider services available for them.

The importance of HCPs networking with refugee community organisations has been reported (Heptinstall *et al.* 2004) and was recognised by the HCPs in this study. Integrating maternal health services into pre-existing community groups could be an

effective way of providing culturally normative, or where required, specialist IFP information at familiar locations for the refugee mothers. In this environment, the women may feel more at ease talking to HCPs about their health needs. The therapeutic value of group interaction was evident from the FGDs carried out in this study; the mothers were keen to share experiences with each other.

Further qualitative research on a larger scale could ensure that larger and more diverse samples of refugee mothers are recruited to better comprehend the complexities for these mothers and challenges for the HCPs who seek to support them. A deeper understanding is essential to help build and deliver effective and sustainable strategies to improve the infant feeding experiences for these mothers.

Study limitations

The exploratory nature of this study was such that the aim was not to generalise the findings but to highlight some of the key issues related to IFPs for refugee women in the UK and to contribute to our understanding of how best to support these mothers. Nevertheless, a number of limitations were encountered.

Although it was generally an advantage to evade translators, some of the participants did have limited spoken English, which may have prevented them from answering questions fully, and precluded detailed exploration of some topics.

The study only recruited refugee women who were known to HCPs or support networks and excluded non-English speaking women. Such criteria mean that the findings are not representative of the entirety of the refugee group researched. The study would undoubtedly have benefitted from the inclusion of these potentially most vulnerable women.

The participant numbers were not large enough to explore if any relationship between specific characteristics of refugee participants (such as country of origin, age of mother) and IFP existed. Instead, it focused on the findings for refugee participants as a homogenous group and the concepts that arose from this population. Larger studies would potentially benefit from further contextualisation of the data for more detailed findings.

Contact was made via email or phone call with a number of HCPs keen to participate in the research. In reality, it proved very difficult to schedule meetings with this group, which perhaps reflects their heavy workloads.

Conclusion

This study provides information and understanding about the IFP experiences of refugee mothers and the maternal HCPs working with them. The findings of the study suggest that while IFPs do change with arrival and habitation in the UK, refugee mothers are not consciously adapting their strategies to fit in with British maternal behaviours. The mothers involved were instead striving to hold on to their breastfeeding traditions in a predominantly formula feeding culture. Those turning to formula feed, through health status or personal struggle, feel a significant sense of loss and guilt for what they have left behind. The study suggests that isolation has a strong influence on the ability of a refugee mother to achieve a satisfactory IFP experience. Symbolic of the sense of well-being and ability to cope, IFP satisfaction has implications for the overall experience of the female refugee and her family.

At a local level, the involvement of peers could play an important part in increasing the well-being of the mothers and decreasing the burden for their maternal HCPs. On a national level, an augmented consideration and concern for this marginalised and vulnerable population is required, together with a focus on the merging of health and social care for a more holistic and efficient support service. Neglecting the need for IFP support among vulnerable populations has implications that touch upon human rights and create potential public health dilemmas.

The UK could learn from refugees' positive attitudes to breastfeeding, but must also take responsibility to aid their transition to the UK. Encouraging mothers to continue their traditions of breastfeeding is crucial, as is supporting those who can no longer breastfeed. The mothers involved in this study showed courage and determination to do the best they could for their infants in adverse circumstances. Understanding and commitment are required to help

them to retain, or to come to terms with the loss of, the few cultural values they have left in an unfamiliar world.

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Conflicts of interest

The authors declare that they have no conflicts of interest.

Contributions

EH designed the study, analysed the data and wrote the manuscript. JR contributed to the design, analysis and interpretation of data, and writing. All authors read and approved the final manuscript.

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Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher's web-site:

Appendix S1. Topic guide for semi-structured interview with refugee mother.

Appendix S2. Topic guide for focus group discussion with refugee mothers.

Appendix S3. Topic guide for semi-structured interview with health care professionals.