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Author(s): Huda Diab

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MSc Public Health Nutrition

**The study of factors affecting breastfeeding uptake
and duration within Somali Women**

Huda Diab : 0721362

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Abstract

It is widely recognized that human breast-milk is optimal for the normal healthy growth and development of the infant. A wide range of literature is available with evidence clearly demonstrating the benefits of breastfeeding and the impact of exclusive breastfeeding on the baby. Despite this breastfeeding initiation rates in the UK remain amongst the lowest in Europe and especially in the North West of England. The basis of this research was to unveil the factors which relate to breastfeeding uptake and duration, and also to find out whether or not these agree with previous findings. Participants were recruited from 'Somali Women's' community centres in Liverpool. Results were obtained through two focus groups. Findings from focus group 1 show that although most women choose to breastfeed initially, half of the participants had to stop within six months due to starting another pregnancy. In some cases the women felt mix-feeding was more efficient because the baby appeared to remain hungry between feeding times when fed solely on breast milk. A combination of both self determination and family support lead to a longer breastfeeding duration amongst this group. Results from focus group 2 were similar but most participants spoke very poor English leading to a language barrier between them and the hospital staff. All participants were of Muslim faith; and religion played a key factor in their determination to continue breast feeding up to six months and longer. Findings from this study in line with previous investigations, illustrated the need for better communication, with and education of, pregnant mothers to give them a greater understanding of the benefits of breast feeding. Findings show that there are many determinants to long-term breastfeeding and parents need to work together when infant feeding choices are made. Antenatal support influences long-term decisions. Private places for women need to be made more readily available for

breastfeeding women outside of their homes, and further flexibility provided for working mothers.

Abbreviations

NHS – National Health Service, LA’s- Local Authorities, LSP’s –Local Strategic Partnerships, BFI- UNICEF UK Baby Friendly Initiative, Doh- Department of Health, LA -Local Authority, NCT- National Childbirth Trust, NHS -National Health Service, NICE- National Institute for Health and Clinical Excellence, PCT- Primary Care Trust, UNICEF- United Nations Children’s Fund, WHO- World Health Organization

Declaration of original work

I hereby declare that work contained herewith is original and is entirely my own work (unless indicated otherwise). It has not been previously submitted in support of a Degree, qualification or other course.

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Signature:

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Chapter 1

Introduction

This chapter gives an overview on the benefits of breastfeeding and addresses governmental recommendations on optimal number of months to breast feed. It also discusses current breastfeeding uptake and duration in the world in comparison to the UK and then Liverpool. As well as factors affecting breastfeeding uptake including ethnicity and religion, and study designs previously incorporated in this area. Finally, the aims of the study will be presented.

1.1 Background on breastfeeding

Every child has the right to adequate nutrition and access to safe and nutritious food. The World Health Organisation (WHO) recommends breastfeeding to be initiated within the first hour after the birth of a child and exclusive breastfeeding is recommended up to 6 months of age. It is considered the ideal way of providing young infants with the nutrients they need for healthy growth and development. It is the natural and most beneficial way to feed. Virtually all mothers can breastfeed, provided they have accurate information, and the support of their family and the health care system (WHO, 2009).

A systematic report on the ‘optimal duration for exclusive breastfeeding’ has evidence showing that, on a population basis, exclusive breastfeeding for 6 months is the optimal way of feeding infants (WHO, 2001). Thereafter infants should receive complementary foods with continued breastfeeding up to 2 years of age or beyond (WHO, 2009).

It has been stressed that all governments should ensure that breastfeeding is facilitated in every society to encourage the development of each child to its full potential (WHO, 2009). This is a

major public health concern, with the addition of breastfeeding inequalities perpetuated in societies around the globe (WHO, 2003).

Government intervention schemes have been set up to suit the needs of individual populations. In 2002, WHO and UNICEF jointly endorsed the ‘Global Strategy for Infant and Young Child Feeding’ which focused world attention on the impact that feeding practices have on the nutritional status, growth and development, health, and thus the very survival of infants and young children (WHO, 2003). The Global Strategy renewed commitment to continuing joint action consistent with the Baby-friendly Hospital Initiative (BFHI), the International Code of Marketing of Breast-milk Substitutes, and the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (WHO, 2003). Countries are urged to formulate, implement, monitor and evaluate a comprehensive national policy on infant and young child feeding (WHO & UNICEF, 2008). [Table 1]

This includes ensuring sufficient maternity leave to promote exclusive breastfeeding and provision of publications on infant feeding practices for different regions (WHO, 2002).

Table 1: UNICEF & WHO recommendations

WHO and UNICEF recommendations for enabling mothers to establish and sustain exclusive breastfeeding for 6 months.	
1	Initiation of breastfeeding within the first hour of life
2	Exclusive breastfeeding – infant only receives breast milk without any additional food or drink, not even water
3	Breastfeeding on demand – that is as often as the child wants, day and night
4	No use of bottles, teats or pacifiers

1.2 Current breastfeeding uptake and duration in the world in comparison to UK and Liverpool

Previous statistics show that barely one in three children are breast fed exclusively for the first four months of life, and only one in five receives breast milk at six months of age (WHO, 2006).

According to UNICEF (2005) more than 3,000 babies are dying every day from infections caused by bottle feeding, and 1.5 million children are dying each year because they are not breast fed. These statistics can be altered by reducing the health risks with exclusive breastfeeding continuing alongside complementary food for up to two years (WHO, 2009 United nations Children's Fund, 1999). Rates of breastfeeding cessation remain high i.e. 42% up to 6 weeks and 21% at 6 months, which remains disappointing (Hamlyn, Brooker, Oleinikova & Wands, 2002).

There are fewer than 25 percent of babies in the UK being exclusively breastfeed for up to six months (Hamlyn et al. 2002). Although the most recent infant feeding survey for the UK shows that the incidence of exclusive breastfeeding is on the rise (Bolling & Grant, 2007). However, the overall breastfeeding initiation and duration rates in the North-west of England in the UK remain low (Berridge, 2005).

In the North West, 66% of babies were breastfed at birth compared to 78% for the whole of England – the second lowest rate in the country (Bolling, Grant , Hamlyn & Thornton , 2007) and only 17% of babies were still breastfed at six months compared with 25% for England (Bolling et al. 2007). The region also has wide variations in breastfeeding initiation rates between different primary health care trust (PCT) areas ranging from 33% to 73% (Hussey, 2008).

The graph [figure 1] indicates that despite UK initiation rates being amongst the lowest in the Europe the percentage of breastfeeding rates between the years 1995-2000 have been gradually increasing. (National Statistics, 2006)

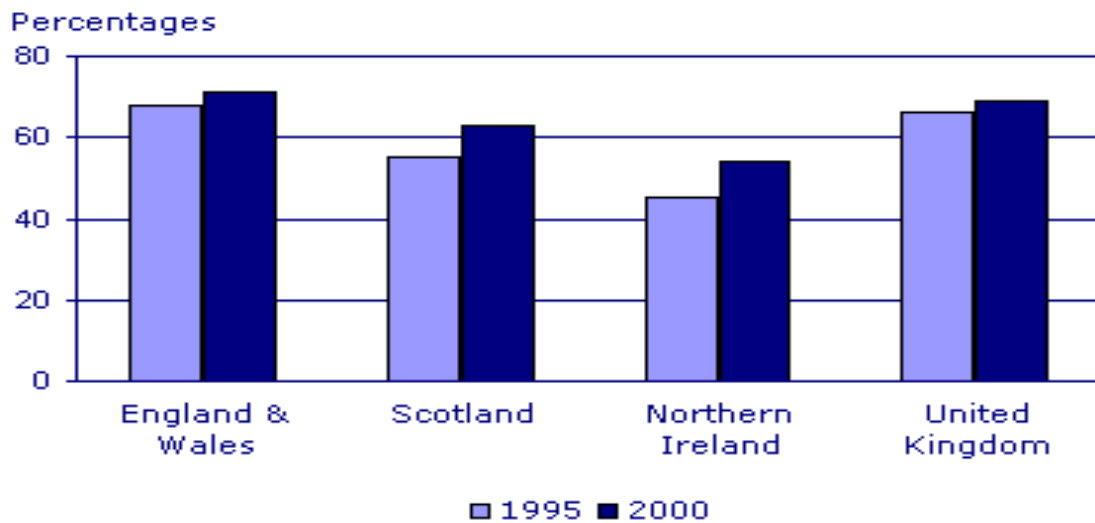


Figure 1: The rate of breastfeeding at birth in the UK rose from 66 per cent to 69 per cent. (National Statistics, 2006) The graph however fails to show the percentage increase of babies exclusively breastfed for up to six months.

1.3 Government intervention schemes

At present Liverpool PCT and Liverpool City council are working together to put the ‘North West Breastfeeding Framework for Action’ into action in order to achieve the UNICEF UK Baby friendly Community award. This framework provides the strategic action plan (Table 2, Table 3) for all local government schemes i.e. NHS, local strategic partnerships and other local organisations which need to adopt this strategy in order to increase initiation and duration rates of breastfeeding in the North West. The aim is to encourage more women to breastfeed by providing an environment which makes breastfeeding easier and more comfortable to do and to

improve the health of mothers and children, particularly those of low socioeconomic backgrounds. By facilitating an increase in breastfeeding initiation and duration rates it aims to reduce some of the health inequalities in the community. This thesis is aimed at finding the extent to which governmental schemes have been successful in achieving what they have initially set out to do.

Table 2: Main goals of the 'North West Breastfeeding Framework for Action'

(Hussey, 2008)

	Goals
1	To generate an environment that enables women to make informed decisions about optimal feeding practices
2	To provide accurate and impartial infant feeding information and support to all women and families
3	To raise awareness of the short and long term health and economic disadvantages related to not breastfeeding
4	To protect a mother's right to breastfeed her baby in public
5	To ensure that robust infant feeding data is collected and shared across the North West
	To engender a culture of continuous improvement and sharing of good practice across the North West

Table 3: 'North West Breastfeeding Framework for Action' recommended priorities

(Hussey, 2008)

	Priorities for Action
1	All NHS/LAs/LSPs to have a local action plan in place, which demonstrates a multifaceted approach and/or a coordinated programme of interventions across settings to increase breastfeeding rates
2	Access to effective breastfeeding peer support programmes in all PCTs/LAs, particularly in areas where breastfeeding initiation and duration rates are low
3	Appointment of an Infant Feeding Coordinator, in a senior position, in each health economy area
4	The collection of accurate and timely data on breastfeeding initiation and duration
5	Gain UNICEF BFI accredited status, if appropriate
6	Ban promotion and advertising of infant formula (includes no display, distribution or use of leaflets, posters, charts, educational materials or any other materials and equipment produced by infant formula manufacturers)

Faulty feeding practices begin with giving any nourishment other than breast milk before complementary feeding is nutritionally required or by entirely substituting breast milk, which places babies at risk of illness and even death. When complementary feeding begins, uninformed decisions can also interfere with good nutrition in terms of which foods are given, how much and how often and whether breastfeeding continues, as it should (Kruger & Gericke, 2002).

Nutritionally inadequate or contaminated food and starting complementary feeding too early or too late are major causes of malnutrition in infants and young children (WHO, 2001). Therefore obtaining the right balance is important and ensuring expectant mothers have this knowledge is vital (Sargent, Dalton, Schwartz & Kramer, 2001).

Breastfeeding is not only an unequalled way of providing ideal food for the healthy growth and development of infants; it is also greatly beneficial to the health of the mother, as an integral part of the reproductive process (WHO, 2009).

1.4 Breastfeeding Benefits

The mother's breast milk has many more benefits such as promoting sensory and cognitive development, and protecting the infant against infectious and chronic diseases (Sargent, Dalton, Schwartz & Kramer, 2001). Infant mortality rate is reduced with exclusive breastfeeding as it protects against common childhood infections such as diarrhoea or pneumonia, due to the antibodies passed from the mother to baby during feeding it assists in a quicker recovery during illness (Sargent et al. 2001).

The benefits of breastfed infants and children include a lower incidence of otitis media, (Chantry, Howard & Auinger, 2006) atopic dermatitis, and gastroenteritis as well as lowering the risk of obesity (Horta et al. 2007). Additional benefits include a reduced incidence of sudden infant death syndrome, type 1 and 2 diabetes mellitus, and childhood leukaemia (Pediatrics. 2005). A study by Bai, Middlestadt, Peng & Fly (2009) found an association between not breastfeeding and postpartum depression.

Breast feeding benefits the mother as well as the baby, it reduces the risk of ovarian and breast cancer, assists with family planning by helping with the spacing of children and it reduces the risk of type 2 diabetes. In addition, breastfeeding is also more economical (WHO, 2009).

1.5 Breastfeeding Nutritional Benefits

Breast milk contains all the required nutrients for the healthy growth of the baby, including; proteins, fat, carbohydrates, calcium phosphorus, vitamins and fluid. The breast milk also contains a rich supply of antibodies (Mainstone, 2008).

The Baby Friendly Health Initiative has been implemented in about 16,000 hospitals in 171 countries and it has contributed to improving the establishment of exclusive breastfeeding world-wide (UNICEF, 2009). While improved maternity services help to increase the initiation of exclusive breastfeeding, support throughout the health system is required to help mothers sustain exclusive breastfeeding (WHO, 2009).

Although breast feeding has many benefits, there are challenges to overcome, the greatest being within the first few days when milk synthesis is being established, for example a sleepy baby that feeds infrequently leads to reduced stimulation and hormonal responses and subsequent involution in the mother. Management of infant feeding is required by waking the infant every two- three hours in order to reduce the risk of jaundice. If the infant is not feeding well, mothers need to provide a supplement by expressing their breast milk through a feeding cup, finger feeder or supplementary nursing system until the infant is able to feed well and empty the breast (Hilton, 2008).

Other challenges to infant feeding can come from the baby being lactose intolerant (Infacol, 2000). Specialist formulas have been designed to overcome this problem.

Mothers with lactose intolerant infants should feel confident that their midwife can give sound advice and recognize specific symptoms (Infacol, 2000).

1.6 Factors affecting breastfeeding uptake

Patterns of breastfeeding vary considerably across different racial/ethnic groups. However, little is known about factors that might explain differences across and within different racial/ethnic groups. The initiation and maintenance of breast feeding is determined by a range of clinical, personal, social, cultural and environmental factors (Kelly, Watt & Nazroo, 2006).

A study which investigated the patterns of breastfeeding initiation and continuation among racially/ethnically diverse mothers assessed different factors which may contribute to breastfeeding uptake and cessation. These included demographic, social, and cultural factors on racial/ethnic differences in breastfeeding practices. The data was obtained from the first survey of the UK millennium cohort study (Kelly et al. 2006). In this study, it was found that Indian, Pakistani, black Caribbean, and black African mothers were more likely to initiate breastfeeding compared with white mothers. They were likely to continue breastfeeding at 3 months compared to white mothers. However, different cultural groups assessed were found to have varied rates of breastfeeding uptake and cessation between each other, and in comparison with white mothers. Therefore culture has an impact on breast feeding duration, and the highest breastfeeding rates were found among black and Asian mothers; where breastfeeding was continued up to 4 and 6 months (Kelly et al. 2006).

A large sample size of over 17,000 was used to assess contributing factors. Therefore the results are more likely to be reliable with data obtained from the millennium cohort, and less likely to be imprecise (Kelly et al. 2006).

Another UK study analysed data from the millennium cohort study in relation to breastfeeding initiation and duration and social class (Kelly & Watt, 2005). Results show that breastfeeding rates peaked and then dropped dramatically with time, with the initial rate starting at a high 71% and then dramatically decreasing to just 3% and lower after 4-6 months. Social class was found to be a factor that influenced breast feeding initiation. Women of lower social working class were four times less likely to initiate breastfeeding compared to higher class working mothers.

It was also stated that it is vital for the development of public policies and supportive health services to promote breastfeeding in order to increase uptake and duration for up to 6-months Kelly & Watt (2005). Whilst Kelly & Watt (2005), discussed various quantitative studies, they failed to make any qualitative exploration of the data within this cohort study.

1.7 Ethnic groups

Griffiths, Tate, Dezateux & the millennium study health group (2006) investigated variations in early infant feeding practices by maternal ethnic groups. White mothers were more likely to discontinue breastfeeding (62%) and introduce solids early (37%) than most other ethnic minority groups, which included whites from other European countries, Black African, Black Caribbean, Indian, Pakistani and Bangladeshi participants.

Hawkins et al. (2008) also analysed data from the Millennium Cohort study and compared health behaviours during pregnancy and after birth. Several health behaviours were observed including initiation and duration of breastfeeding. Participants included predominantly British/Irish white mothers and a small sample of mothers from other ethnic backgrounds including: - Pakistani, Bangladeshi, Indian, Black, other white and mixed groups. It was found that mothers from ethnic backgrounds were more likely to initiate breastfeeding and to breastfeed for at least up to four

months (40%) compared to white British/Irish mothers (27%) (Hawkins, Lamb, Cole, & Law, 2008).

First and Second generation mothers from ethnic groups were found to alter their breastfeeding habits after living in the UK to resemble those of the resident population. The likelihood of mothers from ethnic groups changing their breastfeeding habits, and adapting them according to British culture, was found to increase every five years, from their UK residence (Hawkins et al. 2008). The data was obtained over time and changes were assessed increasing the reliability of the findings in the long-term.

The results however, did not provide a complete summary of all the ethnic groups in England. In some cases smaller numbers of participants were combined for the purpose of statistical adjustment. However combined groups may have been heterogeneous with respect to maternal characteristics related to acculturation and health behaviours (Hawkins et al. 2008).

These findings indicate that ethnic background and culture can have an influence on breastfeeding uptake and duration. However there is little research to date on the factors which might influence breast-feeding uptake and duration among ethnic groups. Gaining an even further understanding into the factors which influence infant feeding choice is vital to assist in future health promotion. There is little known about the influence of Western culture on breast feeding behaviours among recent migrants to the UK (Hawkins et al.2008).

1.8 Islam and breastfeeding.

Breastfeeding has a religious basis in Islam. It is recommended in the Holy Quran that the mother continues to breastfeed her baby for up to two years, stating that “Mothers shall suckle their children for two whole years... [in the case of] those who wish to complete the suckling” (Quran, verse 2:233). The Quran also describes the dependency of the foetus on nutrition obtained from the mother from the developmental stage up until the child is born. It emphasises the special connection formed between mother and baby, and how this dependency continues for the first 30 months of the infant’s life, “and the bearing of him and the weaning is thirty months” (Quran, verse 46:15) (Shaikh & Ahmed, 2006). This is also within congruence of the WHO recommendations (WHO, 2009). However maternity leave is only granted for up to nine months in the UK making it very difficult for working mothers to breastfeed for longer than six months (Gatrell, 2007). It would be useful to investigate the impact of other faiths and cultures. To find out the extent to which the UK government has considered the social and cultural factors of other women who have migrated to the UK, when implementing their health campaigns in a more multicultural society (Gatrell, 2007).

The Islamic religious scripture also mentions that the breastfeeding mother receives the reward of a good deed for every drop of breast milk she feeds her child. As Islam encourages breastfeeding there is great emphasis in Islam on privacy and modesty when breastfeeding, which stems from the Islamic belief that there are parts of the body of which both men and women should cover at all times in front of non-family members. (Shaikh & Ahmed, 2006) However the general societal attitude on breastfeeding women in the UK can make women feel restricted when they intend to feed outside of the home. Breastfeeding is no longer perceived as an ordinary everyday experience within UK society (Carter, 1996).

Previous research implies that the breastfeeding attitudes have changed in contemporary Western society. Research suggests that women have very little visual experience of breastfeeding, and this influences both initiation and duration (Dykes & Griffiths, 1998).

Participants from a qualitative study (Earle, 2002) involving women recruited through 12 antenatal clinics in the UK who chose to formula feed, stated their concerns with breastfeeding. The majority of participants mainly white residents expressed concerns for not wishing to expose private parts of their bodies to feed in public places, and even feeling uncomfortable to feed in front of family relations. The sexualisation of breasts within western society has raised the issue of the function of breasts and how they are perceived by the public (Carter, 1996). It is highlighted in Carters research the tension which exists between the breasts function as a symbol of sexuality and the function of the breast as an organic source of nutrients for the infant (Carter, 1996). Participants from Earle (2002), study said they had observed other mothers feeding however they could not see themselves happy and comfortable to feed publicly, one participant quotes “It’s the way society looks at it as well, the way people see things like that. They’d think it was wrong. A lot of people think that you should do that sort of thing in private” (Earle, 2002, p.210).

In some cases negative public attitudes towards breastfeeding were found to be a factor in the mother’s decision to stop breastfeeding early on. A study on the attitudes of teenagers towards breastfeeding in Liverpool surveyed 400 pupils from 10 different comprehensive schools and found that embarrassment was one of the main reasons for pupils not wanting to breastfeed in public. Some 15% of pupils agree that breastfeeding makes people think of ‘page three girls’ and

8% of the pupil's perceived breast feeding as rude (Gregg 1989). These aspects to infant feeding need to be considered as well as religious, ethnic, and cultural backgrounds which may also restrict public feeding.

1.9 Aim

This research will further contribute to these findings on Somali women and infant feeding choices. The aim is to understand the factors which contribute to breastfeeding uptake and duration. The study will also explore infant feeding practices and concerns among two groups of Somali women from the North West, as well as any issues behind these infant feeding choices. The findings may be used to improve the contribution of health care professionals, and to improve future practices particularly in relation to reaching government targets of increased breastfeeding uptake and duration rates in the UK. This research will highlight whether or not these factors exist in the UK and even in an area of Liverpool with a high percentage of Somali residents. It will also explore the Western Cultural influence on Somali women in relation to their breastfeeding habits. Results on the patterns of infant feeding in women of different ethnicity are complex and diverse; the literature review indicated that more work needs to be done in order to increase our understanding of this area.

Chapter 2 Methodology

2. Introduction

This chapter provides justification for the methods used, research design, participant recruitment, interviewing methods, data collection, data analysis and finally ethical considerations.

2.1 Research questions

Do socio-cultural factors have an impact on breast-feeding uptake and duration, and if so to what extent has this occurred? To what extent have governmental intervention schemes been successful in achieving their goals? Did the participants in this research feel they had a safe environment for them to breastfeed? Has there been accurate support to all women and families? Has awareness of the short and long-term health and economic advantages been raised? Is there still room for further improvement? Did results indicate that women felt they had received effective breastfeeding support?

2.2 Justification for the Methodology

2.21 Qualitative Research

Qualitative research will allow for the investigation of the extent to which culture and ethnic background can influence infant feeding choice (Green & Thorogood, 2005).

A qualitative study explored women's views on how they felt health care professionals communicate with them (Haddinott & Pill, 2000). Adequate results were obtained from a study on white low-income mothers. They effectively communicated their need for further support, through breastfeeding demonstration rather than verbal communication. However semi structured face to face interviews were conducted by a GP specialist and participants were aware

of this. Perhaps this may have affected their responses. The data obtained was transcribed and shown to participants who then signed to confirm the data was correct and thus should have reduced bias. The setting for data collection was perhaps inadequate. The interviews were taken at the home of the participants. If breastfeeding cessation from a parent or partner who may have been present at the time of the interview, then the participant may have been unlikely to report this for the purpose of the study. This means there may have been report bias (Haddinott & Pill, 2000). The data for this thesis was obtained using different methods in a more appropriate environment, which participants were familiar and comfortable.

Due to the diversity among ethnic groups the aim of this study is to gain an in depth insight into the contributing factors for breastfeeding uptake and cessation in just one ethnic group.

Qualitative research would be highly beneficial to this study. Qualitative research focuses on understanding the world from the point of view of participants in the study. This form of research is an attempt to present the social world, and it's perspectives in terms of behaviours, perceptions and accounts of the people who inhabit it. Interviewing current mothers on their previous experiences and the factors which lead to their final decisions can provide a useful insight into research today, in order to improve available facilities for these women (Green & Thorogood, 2005).

The Somali community is one of the most established ethnic minorities in the UK. The health needs of this group particularly with respect to the information and support they receive during pregnancy, labour and post-natal care is poorly understood. Research is required in order to facilitate information to birthing mothers and to support maternal decision-making among Somali women (Davies & Bath, 2001).

This study will allow further investigation into the issues behind infant feeding choices within the Somalian community. It will allow a better understanding to the needs of these women and whether racial bias or inequality still exists within this community.

Such factors may have contributed to the decisions they made, from experiences at the hospital through to family. Peer pressure can be a major contributing factor to the infant feeding choice. (Herrel et al, 2004).

A previous investigation on Somali refugee women in the United States found that women reported racial bias and stereotyping, (Herrel et al, 2004). This research aimed to incorporate a study design which further explored contributing factors associated with breast feeding uptake and cessation.

2.22 Focus Group

It was important when conducting the study that optimum conditions were provided for participants, these included the group meeting in a quiet place, with comfortable seating arranged. Hence permission was obtained for focus groups to take place at the Somali Women's Group (Appendix G). Participants should have had a clear understanding of everything involved in the focus group before the study commenced (Burns & Grove, 2009).

The research of Kruger and Gericke (2002) showed that reasonable analysis could be conducted on data obtained by applying focus group interviews. This method facilitates group discussions in identifying problems and making suggestions as to a solution.

Focus groups usually consist of a small group of people (6-12) therefore each group contained between 4-6 participants (Green & Thorogood, 2005). Focus groups could take place on the condition that this number of participants had been obtained.

Participants in focus groups can present their own views and experience; they are given a chance to hear other participant views at the same time. In response to what they hear they can be encouraged to contribute any additional concerns. During discussions participants can ask questions of each other, seek clarification, comment on what they have heard and prompt others to reveal more. As the discussion continues the researcher should find individual responses becoming sharpened and refined and moved into a deeper and more considered level (Lewis & Ritchie, 2003)

Previous research has found Somali women to have reported communication issues. It is argued that, for Somali women, language barriers are the biggest hurdle for contact with maternity services in the UK (Bulman & McCourt, 2002). A study found 53% of Somalis in London have limited or no access to interpretation services (Islington Somali Community, 2000). Even if interpretation services were made more easily accessible, this improvement in isolation may fail to overcome other problems, the study also found that many Somali women are reluctant to use interpreters for fear of misinterpretation and lack of confidentiality (Davies & Bath, 2001)

2.23 Semi-structured Interviews (pros and cons)

Although interview methods would also have been advantageous to the study, they are time consuming. Focus groups will encourage participants to contribute information when they are reminded of their own personal experiences through the answers given by other people in the same focus group, whereas face-face interviews only have the researcher and participant therefore information may not be recalled as well. At the same time semi-structured interviews are at an advantage to focus groups as they allow a more intimate focus between the researcher and participant. The participant may feel more inclined to share information if they are alone with the researcher (Ritchie & Lewis, 2003). However the structure of the focus group

questions incorporated in the study were tailored in a way that did not place the subject in a position to answer any personal questions. Participants were not obliged to contribute to every question, but they were encouraged.

2.3 Research Design

This research incorporated a focus group with non-English speaking Somali participants and a group of Somali English speaking. The aim was to find out whether prejudices exist against other ethnic groups as well as health inequalities with patients whom are unable to communicate with healthcare specialists. Focus groups were conducted separately.

2.31 Recruitment

The women were recruited from pre-existing social groups or venues within the area, where Somali Community Centres were located. Participants recruited through pre-existing groups are less likely to suffer from non-attendance during sessions (Bloor, Frankland, Thomas & Robson, 2001).

The study was advertised using posters being placed within the area. Participant information sheets (Appendix B1) were left alongside poster advertisements (Appendix C), explaining the purpose of the study. Employees at the Community centre were also given copies of the poster and participant information forms; they could then mention the study after group meetings with Somali women.

Participants contacted the researcher from the contact details on the poster; the researcher could then make record of their contact and get back to individuals to arrange an appropriate date and time for the focus group. Participant's who were interested were free to ask questions and identify other people they knew who fitted the appropriate criteria. This process is known as

snowballing. This allowed the researcher was able to obtain more information on suitable participants if only a small number of individuals contacted the researcher (Ritchie & Lewis, 2003). The poster placed at the community centre was aimed to encourage individuals to identify other individuals who could take part. The researcher also recruited by being present at community centres and areas which were found to be densely populated by Somali residents. An interpreter was also present who assisted in ensuring clear verbal communication was provided. The interpreter was not paid for her time or contribution. Once participants were recruited, data was collected through two topic guided focus group sessions.

Figure 4 shows: inclusion & exclusion criteria included in the participant information sheet.

Inclusion	Exclusion
Somali women	Women from other cultural backgrounds
Somali women who have had a baby/babies in the UK	Women who have had their babies outside of the UK
	Men are excluded from attending focus group sessions to protect the confidentiality of participants and ensure they are comfortable to freely express personal experiences

2.4 Moderators guide

The researcher selected questions which aimed to investigate factors related to breastfeeding which had previously been addressed in other studies. The practicality of these questions was tested prior to research using a pilot study. A group of four women took part in the pilot study. Participants were aware that results would not be included in the final write up of the study. The pilot study was useful in sharpening focus group questions and creating a more concise set of questions. Questions were altered and modified.

These questions were a useful guide to the researcher. Set questions allow the interview to be steered in a way which enables participants to contribute their opinions freely (Morgan, 1997)

2.5 Focus group procedure

This qualitative study included 12 participants, with four Somali speaking mothers and eight Somali-English speaking mothers. Originally six participants were recruited for the Somali speaking focus group; two of the participants however did not meet the inclusion criteria. They had not had children in the UK and this was the main reason why they were excused from the research. The researcher wanted to base the study in the UK on Somali women in the North West. Focus groups were conducted on two separate days. The researcher spoke to the participants in English on both occasions; however the interpreter was available to translate during focus group 2.

Participants were reminded that all sessions would be digitally recorded. They were reassured that recordings would soon be deleted once data was transcribed. Participants gave informed consent. Focus group sessions took place once all queries were addressed.

Participants were informed that complaints could be referred to the Dean of the School of Applied and Health Sciences if they could not be dealt with by the researcher or faculty supervisor. The advantage for the participant was that focus groups were conducted in a professional setting, in an environment which they were used to, had they wished to do so they could complain to staff available at the community centre at any point.

Focus group sessions lasted between an hour up to an hour and a half at the latest. Once the discussion was concluded, the researcher made every effort to thank individuals for participating.

2.6 Consent Form

Informed written consent was needed in order to permit the researcher to store and use data from focus group sessions. This was obtained by asking participants to sign a consent form (Appendix E). The interpreter was required to assist non/poor English speaking participants. The researcher did not identify individuals by their names in the written report to maintain participant anonymity.

2.7 Translation and Transcription

Once the researcher had been through all recordings and the data was fully transcribed. Recordings were easy to dispose of once they were of no further use. It would have been unethical to store the data, as individuals could be identified from their voices on the recordings. All provision complied with the requirements of the UK Data Protection Act (1998).

2.8 Data Analysis (Appendix D)

The researcher applied thematic framework analysis to the transcribed data. This involved deciding upon themes or concepts, under which the data could then be labelled, sorted and

compared. Recurrent themes were drawn upon from the issues raised during the interview process. Raw data was then applied to the framework. The final stage of analysis involved summarising and synthesising the original data (Ritchie & Lewis, 2003). Dominating themes were then discussed further (**Chapter 3**).

2.9 Ethical Considerations (Appendix A)

Group members were able to voice opinions that were upsetting to them and other participants. A related problem was that participants may actually provide each other with misinformation, in such cases the researcher had to take responsibility of providing accurate information (Holloway, 2005). Any information, which was irrelevant, was not included in the data analysis.

2.10 Potential risk factor or hazards

Subjects did not take any supplements or undergo any physical examination. Focus group participants could not be given absolute guarantee that confidences shared in the group would be respected.

2.11 Any inconveniences or changes in lifestyle

It was ensured that the focus group took place at a time convenient for all participants to ensure sessions did not cause any inconvenience to the participant's daily routine. During the group discussion sensitive issues were discussed so the researcher had to maintain anonymity when transcribing data.

2.12 Potential benefits for participants

Participants were told they were making a vital contribution to this area of research with the hope that further improvements to the current health care system could be made.

2.13 Potential for any adverse effects

Participants may have felt restricted to freely discuss all related issues as they were selected from a pre-existing social group. Confidentiality could only be guaranteed amongst researcher and interpreter but not amongst participants involved. This is why it was important that subjects were made fully aware of the questions involved in the study and the implications of their involvement, e.g. how it may benefit future practice (Holloway, 2005).

2.14 Relationship between participant and researcher

The study was open to mothers who met inclusion/exclusion criteria. Equality had to be maintained between researcher and participant to ensure no power imbalance during the study.

2.15 Measures taken to protect the confidentiality of participants.

Collection of participant personal information is justified by potential benefits of this research to society and wider scientific knowledge (Information Commissioners Office, 1998). Participants were informed about the purpose for their data and the extent to which data would be shared. Following this, they were given genuine and free choice to give consent on data sharing of their personal information (ICO, 1998). Participants were told that they could have access to the information about them, and were informed about the precautions that were taken to protect their confidentiality (CIOMS, 2002). Quality and security of data was maintained by ensuring information was up to date and recorded in compatible format, and inaccurate data was corrected (ICO, 1998).

Information sharing was limited to purposes of the research if required external supervisors (the interpreter, academic supervisor) were allowed to view the information to assist in drawing conclusions.

The following safeguards ensured information protection:

- 1) Each participant was given a code instead of using their name
- 2) Drop-outs' information was discarded when data was transcribed.
- 3) Digital recordings were deleted once the study was complete.
- 4) Only the researcher and interpreter had access to names and contact information of subjects.

The interpreter needed to be the one who communicating with non-English speaking participants and therefore had their details.

- 5) Consent forms containing any signatures were locked in a secure cabinet at the researcher's residence.

The research was monitored by the supervisor involved who provided an oversight of the research conduct and act in a scientific advisory capacity. Regular meetings were scheduled with the academic supervisor.

Chapter 3

Results

Introduction

The results chapter discusses the central themes found from the qualitative data analysis for both focus groups, which can be closely referred to in **Appendix D**. It then goes onto incorporate individual participant quotations and to discuss what they imply to research findings.

3.1 Central themes from thematic analysis (focus group 1 &2)

The central themes identified from the thematic chart suggest the majority of Somali women breastfed for up to six months. All participants intended to breastfed for up to six months however it was found they were not always able to carry out intentions due to varying complications. These findings suggest that long-term support is required from health professionals. It is important to establish community centre's for women, so they can have access to the knowledge and information they need.

Participants involved appeared to be highly motivated and determined when it came to long-term breastfeeding. This determination was re-enforced when participants had knowledge from either health care professionals or family that they were doing what was best for their baby, at the time. Therefore knowledge is a key factor. Family planning is important to Somali women and they appeared comfortable with the idea that breastfeeding was a natural form of contraception; this was a motivating factor for some participants. Religion and culture had more of an influence on infant feeding decision than western popular culture.

3.2 Focus Group 1

There were eight participants involved in this focus group. All participants chose to breastfeed.

Three of the participants, breastfed exclusively for up to six months.

“When I had my first baby, I wanted to breastfeed, but I went through complications and was told to bottle-feed, but I persisted and carried on breastfeeding”

“Knowing that it is the best thing for your child keeps you going with breastfeeding”

“Breastfeeding is better for the health of the child and health of the mother; I wanted to breastfeed and then found it easier to continue from this point onwards. When I had my first baby I didn’t have much of an idea about how important it is to breastfeed, but then after this I went to breastfeed my baby and after this I carried on breastfeeding my children”.

Mothers who were unable to continue breastfeeding up to six months had experienced complications. These were mostly related to health, having difficulty with breast feeding technique or unplanned pregnancy.

“With my second baby, it did want the breast, and the doctor said you have to stop at three months, because I had low calcium level”

“I breastfed my first baby till she was five months, but then I stopped as I was pregnant with another, the second baby I breastfed for two years”

“My children were born about four months apart so I only got to breastfeed for four months and then another I was pregnant with another child and then another, so I was unable to feed for longer”.

Participants used breastfeeding as a form of contraception.

‘Breastfeeding gave me a break between my children instead of using other forms of contraception, so it was good in a way. My child was healthy and I didn’t get pregnant that quickly, these are the reasons of why I wanted to breastfeed’

This participant then goes on to say *“I breastfed my first baby till she was five months, but then I stopped as I was pregnant with another, the second baby I breastfed for two years”* she became pregnant after five months of her first baby, which was the cause of her early cessation.

Another participant had the same problem, but still supported breastfeeding as a form of contraception; combining her opinions with her religious beliefs.

“My children were born about four months apart so I only got to breastfeed for four months and then another child came and then another, so I couldn’t really breastfeed for longer, all women are a different situation’ ‘Islam encourages breastfeeding, it is a safer option for you to not rely on pills or injection in terms of family planning, they all have side effects where as this is natural you don’t need to take drugs or anything thanks to God, and if you do have another child praise God, it’s a good way of dealing with it and either way you get benefit and your child gets benefit, it’s the right way of doing things so thank God!”

Two of the participants introduced mix feeding within the six-month period; they felt it necessary to supplement breast milk, in response to the behaviour of the baby during that time.

“I felt that when I fed with just the breast milk, the baby would cry more and it became uncomfortable so I mix fed at that time”.

“I choose to do both breast and bottle. I breastfed for 3 months then the baby preferred to bottle feed rather than breast feed”.

Three of the participants breastfeed after it was recommended by healthcare professionals, participants felt encouraged to continue and they were well supported.

“The midwife told me it would be best to breastfeed, my mum also helped, she told me to give the baby breast milk, and my family supported me”.

“As far as I know the many health professionals, here encourage the mothers to breastfeed the babies”

“I was offered support for four weeks, at the time I felt reassured and well supported when I was in hospital”

Two of the participants felt discouraged by family, family felt they knew what was best for ‘mother and baby’; participants also experienced difficulty with breastfeeding.

“I was still drugged up when the midwife just threw the baby at me and said you have to breastfeed, so I had a hard time because my mother was there and she had to take the baby off me and say to them ‘listen I’m going to bottle feed this baby because she’s in no state to be breastfeeding”

“ I tried and tried and tried, I didn’t have any support because my mother wasn’t with me, so after a few weeks I just gave up because the baby wasn’t latching on and my second preferred the bottle rather than the breast”.

“ my mum was the opposite when I was in hospital, she didn't want me to breastfeed , she felt that it was traumatizing when she saw me with the baby , I'd just been through the caesarean I was very tired the midwife asked me breast or bottle I said breast and she just put the baby on straight away . So my mum came from the other side of the room and tried to pull the baby away as she was worried about me she felt it was abuse towards me when she could see the state I was in at the time ”

Three of the participants felt that support outside of the hospital was vital to the continuation of long-term breastfeeding. Participants agreed that “the first couple of days were the most challenging” continuous support is required while the bond between mother and baby is still at a vulnerable during this time.

“They show you how to feed the baby the first day and then that's it, they should help you for a couple of days or a week at least”

“We should have something where support is offered after breastfeeding and not just before...and more local groups in the communities, where women can drop in, more mother and baby groups, where people can go in and just drop in and just talk about their issues in the communities”

“If you don't have anyone there then it becomes very hard. I feel that there should be someone on there to support breastfeeding women’

‘Sometimes the baby refuses the breast and just wants a dummy there rather than the breast, so support is important”

Participants felt that health visitors needed to be more involved in order to impact the mother's infant feeding habits.

“They do say to you ‘breast is best’ but they don’t give you any other support, also they come and go the health care visitors so they don’t know what your daily life is and then you don’t have any other support”

“If there was something like a clinic at the women’s say you can go if you had any problems you would get that help. Otherwise there’s no support as soon as you leave you are left by yourself and it’s not nice because you get so much help to breastfeed but when you want to wean them off you are by yourself”

Participants were unable to find suitable private spaces to breastfeed outside of the home. This was a limiting factor in terms of where they could breastfeed, because the women were concerned with maintaining modesty outside of the home for religious and cultural reasons.

“The only place that I could feed in town is maybe boots and maybe next but unless you have that, I wouldn’t go to feed on the bus or at the park or anywhere to breastfeed so it would be nice if there were more places available you would then be able to breastfeed the baby outside of the home”

“You are limited in a way because you are Muslim you can’t have your breasts out”

“You have to have somewhere private and suitable to breastfeed”

Working mothers found governmental regulations in the UK had an influence on their decision to breastfeed as they had to return to work after the six-month period even if they felt they were not ready. Pressure is placed on working mothers to return to work.

“You have to get back to work as well and then everything is a rush and so it’s a challenge, whereas my mum the reason she could breastfeed for up to two years was because she used to stay at home. Whereas her you have a baby and then after nine months it’s back to work, what do you do then? I felt pushed back into work”

“Even with maternity leave here you are on full pay for six months and then after that you may receive £400/month and this isn’t enough you can’t live on this especially when you have a big family and you have young children”

“If you do take the time out it’s going to be really hard for you to get back into it once more and to start where you left off”

“Even myself at the time I was a student and I went to take 10 months maternity leave and then. I went back to my studies before the two weeks before the baby turned 6 months old. I still continued with breastfeeding I would go to university and then in the hour break time I would go home and breastfeed, so I was backwards and forwards and it’s exhausting”

One participant felt compared to other countries, that the UK provides a wider range of infant feeding choices.

“There’s a lot of milk available free milk, in Somalia and Africa there is not that much, in Yemen not a lot of free milk, another thing is you are set in classes as well, but that’s how it used to be

years ago here that people who had money bottle-fed and people who didn't, they didn't have money to buy the milk"

"In Somali don't think they have buy much milk as they have animals such as goats and so the milk is always available for them"

Healthcare professionals would encourage feeding, however long-term support was not provided. Work and lack of privacy affected infant- feeding choice, participants had to sacrifice life outside of the home in order to feed in the long term. The dominating factors in this group were: – self-motivation, knowledge, confidence and religion. Women agreed that breastfeeding was the healthier option, and the most beneficial to mother and baby. As well as the best way to form a bond between mother and baby, in accordance to religious ethic and the easiest, natural way to feed. It was also agreed that without love and support from family and friends it would have been really difficult and they may not had the strength to continue for up to six months.

3.3 Focus Group 2

There were four participants involved in this focus group 2. All participants chose to breastfeed, exclusively for up to six months.

"I preferred to breastfeed I was breastfeeding when I had the baby"

"I had a lot of milk feels she was very blessed and found it very easy to breastfeed"

"Breastfeeding helped me also in the night time, when you make a bottle of milk you have to get up, in the night the milk is already in my breast, I only give it to my baby, it's not cold or hot, I'm not awoken fully to boil the water, put the milk and then make it cool again no it's not like that, that's why I like the breast, when you are breastfeeding you feel more love for your baby, when

you are breastfeeding and you feel the milk coming down you have more love for the baby, you feel like there are things you didn't know you feel love, forms a special bond between me and the baby glory to God! God give us special milk in our breasts to feed the baby, why do we need the bottle?"

All participants felt well supported at the hospital. However lack of understanding through available interpreters lead some to feel disrespected, isolated and unsupported. Women felt that the hospital was short staffed and wanted better communication during hospital stay.

"I couldn't sleep with the baby crying, one night at the hospital I placed the child between my legs and sleep upright the midwife came in and tells me off, she says 'you're naughty' but I explained I can't take anymore and I'm tired and I can't carry on like this, there was no support and I felt alone. I did not feel that they respected me during my stay"

"It's always the persons who cannot speak English nobody gives them full respect"

"When I had my last baby, I requested for them to look after the baby during the night, however they refused to help and so I locked the room on myself, I also felt unsupported"

"It was difficult for me here because at the time I didn't speak English. There was a translator but felt helpless not being able to communicate at the time of labour, experienced complication with the delivery, had a caesarean with her last baby. I think that they should improve what they communicated to me through the translator".

Participants breastfed as a natural contraceptive form.

"Religion says to breastfeed for two years, I decided for personal reasons to breastfeed for a year and was told by friends that this is a good natural way of contraception and helps to pace

the family. I feel my friends assisted me, who had children before. It's also easier to breast feed rather than bottle feed. I'm not working but it would have been harder if I was in work"

In this case the participant felt that personal choice and social influence directed her infant-feeding choice more so than religion.

Participants in this group were unemployed and this gave them freedom and flexibility with their time. It was agreed that community centres are useful and provide a private space for women that is clean and safe.

"I am housewife so I am staying at home even if I went to the shop I would come back and feed them at home , especially at that time I wanted to be a housewife and stay with my kids at home, I took on full responsibility of my children, the chores cooking and cleaning taking them to school .I always fed at home. Western culture had no influence on what she wanted to do"

Participants experienced difficulty in finding a private space, when needing to breastfeed outside of the home.

"It's difficult for Muslim women to breastfeed outside of the home or in a public place, but sometimes there would be places for me to feed, there was a room for women to breastfeed, found other women using the facilities also of mixed cultures, clean and nice room"

"I had to breastfeed at home, I feel like community centres such as the Somali women's are useful there are facilities provided at centre's such as this for breastfeeding women and we feel safe and confident to use them, it is a private space to breastfeed"

Rather than knowledge, Confidence and self-motivation being the dominating factors, it was religion and self-motivation, which encouraged long-term breastfeeding in focus group 2.

However better family planning is needed, if women are expected to exclusively breastfeed for up to six months. Focus group 1 and 2 both agreed that family support is a major contributing factor to long term breastfeeding, as well as love and support from their partner. Participants also felt that breastfeeding helped to create a special bond between them and the baby.

3.4 Focus Group 2 Non-Supportive Partner

“At the time I didn’t have my family here, just myself and my husband, my husband was very busy with work , but I still breastfeed all of my children”

3.5 Focus Group 2 Supportive Partner

“I wanted to breastfeed, my husband encouraged me to breastfeed and I wanted to, I felt happy to continue with breastfeeding and felt happy to always breastfeed”

3.51 Focus group 1- Supportive Partner

“My husband was also there supporting me during the night; they tell you that you are doing something good you feel really encouraged. Sometimes I would think why do I continue? I look a mess and I’m tired but knowing you are doing the right thing keeps you going”

Health visitors should make the effort to understand other cultures in order to support individual mothers, and to maintain equality in the care they provide them with.

“I think if you are healthy and you can do it everyone has different circumstances breastfeeding is a beautiful thing but, if you do have a child that is sick or is born prematurely then you need support and looking after both mother and baby, mother is overcoming shock. It depends on whatever position you are in life and what you are faced with that influences you the most”.

Chapter 4

Discussion

4.1 Introduction

The literature review has well established that breastfeeding rates vary according to ethnic group and that factors contributing to infant feeding choice need to be further explored. This discussion aims to identify how results from this thesis compare with other findings. Theories behind these findings will also be implemented within this discussion.

4.2 Breastfeeding factors (duration variables)

Islam is the predominate religion in Somalia, therefore all the participants involved in this thesis were Muslim (SOMALIA UNICEF, 2002). From the results of the 12 participants, breastfeeding was the most popular form of infant feeding. Participants felt that health care professionals were dominantly supportive with earlier breastfeeding decisions, rather than during the later months. Coinciding to this participants complained that hospitals were short staffed and that midwives should have been more attentive to individual needs.

Health practitioners, such as midwives, nurses and doctors, have a key role to play in providing support to breastfeeding women (Dykes, 2006). Research shows that there are some organizational constraints in hospitals and there is a general failure to meet the needs of women on post-natal wards (Dykes, 2006). Previous findings have repeatedly highlighted this problem (Dykes, 2005; 2006).

However the role of healthcare professionals in supporting breastfeeding mothers should be improving with midwives incorporating a 'hands on role' (Marshall, Godfrey & Renfrew, 2007). The 'Managing Breastfeeding and Merging Identities Paper' - states "hands on care" (Marshall,

Godfrey & Renfrew 2007, p.2152) is a common form of help given by hospital midwives. This is a direct approach, where the midwife directly helps the baby latch onto the breast. This can provoke various reactions from the mother such as: that of a participant from Marshall, Godfrey & Renfrew's (2007, p.2152) Study, "It was helpful but a bit of a shock ...they just got a hold of your boob and they put it. It felt a bit like a cow".

Other studies also imply that the 'hands on' approach is invasive and embarrassing (D'Anzi, 1998).

The role of health care professionals was also explored in a study by Furber & Thomson (2008), on breastfeeding practice in the UK, which looked at things from the perspective of the midwives themselves. It found that whilst breastfeeding was on the increase, many mothers still expressed dissatisfaction in the level of support they were given. The research suggested that although the level of support from midwives was adequate, that some midwives still failed to communicate with mothers in a friendly manner. Some had an authoritative approach which may be discouraging to the mothers concerned. Health care professionals and midwives need to be trained so that they can educate and support others in the best possible way (Furber & Thomson, 2008).

Health care professionals should consider the feelings of the mothers they are dealing with.

Whichever approach is incorporated- 'hands on/off', it is important that appropriate supervision be provided to ensure that the correct breastfeeding technique is well adopted (Furber & Thomson, 2008).

The level of support received by Somali participants needed furtherer investigation. However, the results suggest that women successfully breastfed due to self-sufficiency and determination rather than having had an informal demonstration from the midwife at hand. In some cases

participants reported problems with the baby not latching on correctly, this led to early cessation. Cases such as these reinforce the importance of the mother establishing the correct breastfeeding technique. Another mother reported feeling that her breast milk was insufficient for the needs of her baby. There are biological variables which influence breastfeeding duration this was identified by a review paper examining variables associated with breastfeeding duration (Thulier & Mercer, 2009).

In some cases Somali participants reported their milk supply as insufficient (results chapter 3). Insufficient milk supply, either real or perceived, is described as a mother feeling that her milk supply is inadequate to either satisfy her infant's hunger or support adequate weight gain (Hill & Humenick, 1989). The problem of insufficient milk supply can be related to primary or secondary causes. A primary inability to fully lactate is related to anatomic breast abnormalities or hormonal aberration. These problems may affect up to 5% of women. Secondary causes of inadequate milk production are associated with problems in breastfeeding management and are much more common (Neifert, 2001).

The Somali participants felt isolated and in need of further support, this again highlights the importance of external supervision and support during early infant feeding, by health care professionals. It can be suggested that problems with breast feeding management lead to early cessation, which is a secondary rather than a primary cause (Neifert, 2001). It should be considered that breastfeeding management is dependant on the mother, and how she is influenced by external factors.

Culture is an impacting variable on breastfeeding duration. The Somali women felt that breastfeeding could be considered as a natural and reliable contraceptive. However results show some participants became pregnant whilst still breastfeeding their previous baby, and so were

forced to discontinue breastfeeding that baby before the end of the six month period. This suggests that breastfeeding may not be a reliable form of contraception after all (N.B: Breastfeeding as a contraceptive form is discussed in section 4.3).

The Somali Health Care Initiative (SHCI) (2002) launched a qualitative research project in the Somali community in Minnesota (USA). This study was developed to investigate and to better understand breastfeeding practices among Somali women. It was found that there was a large amount of misinformation in relation to breastfeeding and that there needs to be more accurate information available for both Somali women and healthcare professionals (MIHV, 2005).

Although there is little research on the topic of breastfeeding in Somali communities there is evidence available which has shown that women in Somalia breastfeed their children for an average of 19.5 months. It was also found that cow's milk was given by a cup to all infants from the day they were born, along with energy supplements, e.g. sugar and oil which were given during the early days of infancy (Ibrahim, Persson, Omar & Wall, 1992). These results relate to faulty feeding practice (Ibrahim, Persson, Omar & Wall, 1992). It was also found that 40% out of a sample of 25 participants said that they supplement their breast milk with other liquids, such as plain water, infant formula or other types of milk (MIHV, 2005). Results from this thesis also show that Somali women reported mix feeding in some cases; however the types of supplementation which were given within the first six months were not mentioned. Greater effort needs to be made to discuss breast-feeding options during antenatal care (Oweis, Tayem & Froelicher, 2008). Research implies that antenatal teaching increases the chance of women obtaining the relevant information they need to support them with long-term breastfeeding (Oweis, Tayem & Froelicher, 2008).

In another study by Marshall, Godfrey & Renfrew (2007), it was suggested in the results that breastfeeding intention may come at a later stage of pregnancy, whilst attending antenatal classes, one participant quotes “I hadn’t really thought about it early in my pregnancy, it was when I went to antenatal classes that I made up my mind” (Marshall, Godfrey & Renfrew, 2007, p.2050), other participants in this same study were found to perceive breastfeeding as natural as this was the chosen method by their own mothers. This was a UK study and even though the majority of participants involved were white British, the findings parallel with the results on Somali women.

The Scientific Advisory Committee on Nutrition (SACN) (Subgroup on Maternal and Child Nutrition (SMCN)) has reviewed the findings of the 2005 Infant Feeding Survey. This review recommends options to improve infant feeding practice. The survey shows that antenatal care and support are related to breastfeeding outcome in the UK. Mothers who attend antenatal check ups were more likely to initiate breastfeeding than those who had not (IFS commentary, 2008). However the results from this thesis show Somali women perceived breastfeeding as the ‘normal’ thing to do rather than relating the decision to breastfeeding antenatal support. Some suggested that they had been exposed to the breastfeeding technique from the way their mothers breastfed other siblings. Somali women mentioned they would consider advice from their close friends during infant feeding, which indicates the degree of social influence.

This indicates how they were influenced by their peers. The Infant feeding survey (2005) found a correlation between infant feeding practices of mothers themselves and their friends.

Breastfeeding initiation and continuation rates were higher among mothers who had been breastfed themselves as infants, and who had friends who breastfed compared to mothers who

were surrounded by friends and family who had/were bottle feeding. Most communities in the UK still have a very strong bottle feeding culture (IFS commentary, 2008).

The report on Somali women in Minnesota also shows that Somali Women rely heavily on their families for support (MIHV, 2005). This is concurrent with research findings in this thesis; the women were more successful with long-term breastfeeding when they were well supported by family. Other research papers have identified how culture can influence infant feeding practice. Bangladeshi women were found to delay breastfeeding due to reluctance to give newborn infants colostrum. It was found that these women perceived colostrum to be poisonous or harmful to the baby (Littler, 1997). A similar finding was seen in Pakistani women, where it is not uncommon for a grandmother to encourage her daughter- in-law to discard the colostrum. However these women were also identified to show non-compliance to the available information to them, even after interventions were aimed at correcting these faulty practices (Ingram, 2003; Meddings & Porter (2007)). This contrasts with the general attitude of the Somali participants whom were keen to obtain information from health care professionals, and would feel encouraged to see an expansion and development of community centers, which could then be available to provide appropriate services for new and current mothers.

This is why the role of health care professionals is so important in giving women the confidence and advice they need to persist in the long-term. Further research is needed to clarify the needs and expectations of breast feeding mothers (Furber & Thomson, 2008).

The Somali participants felt disrespected at times, particularly when they spoke poor English and had experienced complications after labour. They felt socially isolated and felt they had not received adequate information from health professionals. These findings relate to a report on Somali women in the United States. Somali women felt they wanted a greater input from health

care professionals, women wanted more information about events in the delivery room, pain medications, prenatal visits, interpreters, and roles of hospital staff. It appears that the most desirable educational formats were videotape, audiotapes, printed materials, and birth center tours (Herrel et al.2004). Governmental schemes need to consider the individual needs for different groups of women. If guidance and information for those involved in peer support is to be provided, it is vital to understand and to take into consideration the views of individual women, to find out the level of support which they require (Graffy & Taylor, 2005).

Communicating information clearly at a level adapted to suit individuals is also important as misinterpretation is seen as an underlying problem in Somali women (Davis, 2001). This may have also been the reason why poor/ non-English speaking Somali women may have experienced communication problems while dealing with health care professionals.

4.3 Breastfeeding and Contraception

Results have identified breastfeeding as an unreliable contraceptive form. There is however evidence to suggest that natural methods play an important role in the regulation of human fertility, and for some couples this might be the only option for cultural or religious reasons and for some women maybe the most appropriate method for women during post-natal period.

Natural methods can assist in the control of population growth rates particularly in developing countries where other methods of contraception are not always readily available. The WHO previously established a Task force on ‘Methods for the regulation of fertility’ and attention was drawn to lactation amenorrhoea. Natural methods were found effective in developing countries more so than artificial contraceptives (Howie, 1993). In spite of this research also shows that many still become pregnant when applying this method, and in developed countries service providers are sometimes reluctant to allow women to rely on breastfeeding for pregnancy

protection. Breastfeeding has even been discouraged in favour of initiating a modern method of contraception. Women who are interested in using the natural protection of breastfeeding should have access to information about LAM (Lactational Amenorrhea Method) and about other available family planning methods suitable for breastfeeding women (Labbok et al. 1994). Therefore if Somali women are found to rely on breastfeeding as a form of contraception, and they feel it is the most appropriate method to suit their needs, it is vital that they are informed of the pros and cons with this method. They should also be introduced to other contraceptive forms, which can then be taken into consideration. At the same time other contraceptive forms maybe disliked or rejected by Somali women, although it was never directly stated thesis results imply LAM complied with religious and cultural beliefs and that they were happier with a natural, non-invasive contraceptive method.

4.4 Breastfeeding and Sexuality

4.41 The role of the father

Previous research shows that male attitudes can impact breastfeeding decisions in women (Marshall, Godfrey & Renfrew, 2007) it has been suggested that they act as key supports for breastfeeding (Scott & Binns, 1999; Arora McJunkin, Wehrer & Kuhn, 2000; Scott, Landers, Hughes & Binns, 2001).

A study examining the degree to which varying factors can influence incidence and duration of breastfeeding, including marital relationships, found that husbands could be the providers of emotional and instrumental support. Long-term breastfeeding mothers were found among those who had adjusted their lifestyle to pregnancy and motherhood. These mothers were more likely to describe their marriages as satisfying and loving during the prenatal period and throughout the first postpartum year. They were content with the nature and extent of support received from

husbands (Isabella & Isabella, 1994). Results on Somali participants were similar; mothers who were successful with long-term breastfeeding had also described love and care from their husbands as a strong form of encouragement to them during the postnatal period.

If governmental schemes aim to encourage breastfeeding exclusively for six months (WHO, 2009) the role of the father and the extent of influence they have should be considered. Fathers should be encouraged to support their partner in the best way, 'The Fatherhood Institute' is calling for universal breastfeeding education from the NHS to include fathers, and for the national breastfeeding helpline to include fathers as well as mothers in supporting breastfeeding (Fatherhood Institute, 2007). In some cases it has been found that mothers prefer to feed via bottle as well as breast to allow a way for their partner to be a part of infant feeding times (Kamilloson, 2008). In this case, health care professionals can implement advice on expressing milk.

4.42 Negative impacts on breastfeeding mothers

A study on Canadian women explores the impact of breastfeeding on sexuality. It was found that breastfeeding can have a negative impact on sexuality, this can be related to the following factors; lactating women have elevated prolactin levels that are maintained by breastfeeding (Rowland, Foxcoft, Hopman & Patel, 2005). The latter leads to low gonadotropin levels and consequently low estrogen and progesterone levels due to suppressed ovarian activity. Vaginal dryness is one consequence of this hypo-estrogenized state (Rowland, Foxcoft, Hopman & Patel, 2005). It was also found that the likelihood of resuming intercourse was pro-longed with women who had chosen to breastfeed in comparison to those who had not. The average time for resumption of intercourse has been found to range between 5-8 weeks (Barrett, Pendry, Peacock, Victor, Thaker, & Manyonda, 2000).

From the results Somali participants did not describe any similar negative impacts on sexual relations during breastfeeding, attitudes towards breastfeeding were highly optimistic. This suggests they may not have experienced the same anxieties found in Canadian women with breastfeeding and the pro-longing resumption of intercourse. It is a possibility with the participants being Muslim that pro-longing intercourse was not viewed as problematic with Islamic law stating the prohibition of sexual intercourse before postnatal bleeding has ceased, with post-natal bleeding usually lasting up to 40 days (Al-Aytah, 1999). Although it cannot be determined whether the women had resumed intercourse during this time as this aspect of their infant feeding choice was not investigated, therefore no conclusions can be determined, further investigation into this aspect of infant feeding is required.

Other studies have shown that breastfeeding women are significantly more likely to report lack of sexual desire than non-breastfeeding women (Avery, Duckett, & Frantzich, 2000; Glazener, 1997; Byrd, Hyde, DeLamater, & Plant, 1998; Alder, Cook, Davidson, West, & Bancroft, 1986; Alder, & Bancroft, 1998). Reduced interest in sex may increase the prevalence of postnatal depression (Brown & Lumley, 2000) which can cause adverse effects on both mother and infant. A cohort of 1745 women in Australia found that postnatal depression has a significant negative impact on breastfeeding duration. Assistance with breastfeeding issues should be included in the management of postnatal depression (Henderson et al. 2003).

It can be suggested that statistics from the Millennium Cohort Study (Kelly et al. 2006), show that western mothers are less likely to breastfeed in the long-term because of the negative impacts breastfeeding can have on them sexually.

4.43 Couples

Healthcare professionals should take on board these factors when advising couples. Couples need to be informed of the impact which breastfeeding may have on them both. They should also be informed of the difficulties and challenges they may encounter and how they can overcome them. In the executive summary of the World Health Organization guide on postpartum care of the mother and newborn, information and/or counselling on sexual life is identified as one of the needs of women, as this time represents an ideal opportunity to address existing problems related to sexual health and functioning (WHO, 2010). Governmental schemes also need to act to tailor to the needs of possible problems that may be encountered by different couples. They need to consider that ideals cannot be enforced and opinions on the matter should be balanced depending on the mother's circumstances.

4.5 Changing male attitudes

Recent polls have shown an improvement on male attitudes in the UK today compared to that of the 1990's (Kamilloson, 2008). Male attitudes towards breastfeeding have positively evolved over the last 15 years. The 21st century man proves a much more relaxed and comfortable attitude towards breastfeeding, with 72% of mums claiming their partner is happy for them to breastfeed not only at home but also in public. The survey shows a significant change in attitude when compared to a survey conducted by Royal College of Midwives (RCM) in 1993, which revealed that 50% of men thought women should not breastfeed in a public place (Response Source, 2008).

Despite the findings suggesting male attitudes have improved in western society this does not apply to Somali women or address the issues Somali women encounter, as they were found to experience complications with public feeding and the majority were found to prefer feeding at

home, for reasons of comfort and privacy. However another study which assessed male attitudes on breastfeeding on men who spoke either English or Spanish, also shows that men of different cultural backgrounds are also greatly keen to encourage their partners to breastfeed, and that they see it as the best infant feeding choice for their child. The study also addresses that men can have strong positive attitudes towards breastfeeding which can often remain disregarded by healthcare professionals (Pollock, Forest, & Giarratano 2002).

4.6 Public attitudes & Media

Participants struggled in finding a private place to breastfeed outside of their homes. Muslim women are required to maintain a certain level of modesty at all times, therefore they may feel restricted to expose parts of their bodies, in public, to breastfeed . This would explain why the Somali participants found it difficult to feed outside of their homes. This also shows how religion and culture can influence the way in which breastfeeding is carried out.

A paper on factors affecting the initiation rates of breastfeeding, also gives the impression that women feel embarrassed to feed in front of others or outside of the home, even when they are not Muslim (Earle, 2002). A breastfeeding mother may fear others opinions, being frowned upon by the public, and feel embarrassed to breastfeed in public. In Western Society breasts are highly sexualized, which discourages women from breastfeeding, in public (Earle, 2002). Whether women are modest as a part of religious practice or they are not, all women can feel uncomfortable when needing to breastfeed in a public place or anywhere where there is little privacy to do so (Dykes, 1998).

Research examining how breast and bottle feeding are promoted through the British media found that positive images on breast feeding are rarely seen through the mass media. This may be

related to media coverage reflecting the reality of what is publically visible, the reality being that many women do not, or do not feel that they can breast feed in public. Limited portrayals may also perpetuate a lack of acceptance of breast-feeding in public. This may also sustain the idea that breast feeding is an arduous task and likely to fail, or it is only an option for certain types of women. The generally more expected promontory images for infant feeding are usual of a woman bottle-feeding her baby (Henderson, Kitzinger & Green, 2000).

However more recent visual campaigns such as the 'be a star campaign' have incorporated the image of a modern trendy western woman who has adopted celebrity status because she is breastfeeding (BFBAS, 2008). Images such as this should encourage women to feel comfortable with the idea of breastfeeding, as it is portrayed as fashionable, honourable and even heroic, unlike previous images promoting only bottle feeding. The 'be a star campaign' gives an optimistic portrayal of a vital aspect of motherhood and can influence women away from misconceptions they may have on status and motherhood (BFBAS, 2008).

In spite of this the campaign can still fall short of universal influence. Migrants to the UK, may not relate to Western ideals and popular culture, they may feel excluded from the campaign. The media has to work at targeting all mothers in the UK and relating the images to women of other cultures and ethnic background to attract them to what they intend to promote. Somali women's views and attitudes towards breastfeeding should also be explored in greater depth

It can be argued that it would be unfair to criticise UK governmental schemes aiming to encourage women to breastfeed, when immigrants here, particularly those who have come from developing countries, will only be adopting a better way of life and diet for themselves and their baby. The level of treatment through health care is at a much higher standard than what it would

have been in Somalia. Thus women have a better chance of receiving the guidance and support they need to feed the recommended six-month period of exclusive breastfeeding. In any case culture and ethnic background should still be considered an important influencing factor. Somali participants spoke of adopting social habits from family members so breastfeeding was a natural choice, with little hesitation. Therefore the women wanted to breastfeed, this decision then combined with governmental schemes highly recommending breastfeeding have assisted in increasing breastfeeding duration, whether they felt they were able to access all the information at the time needs to be further examined. Even so participants felt they had not been well supported from health professionals. Participants, who were successful in long-term breastfeeding, implied that family were a great source of influence and support, particularly during the vulnerable stages of breast-feeding.

4.7 Breastfeeding and work

For the working mother, returning to work inevitably creates difficulties towards long term breast-feeding. In spite of the attempts from the National Childbirth Trust for expressing breast-milk for later feeding, it is most likely that babies are switched to formula-feeding. A study taken in North West England showed that from a sample of 149 women between the ages of 18-43, 70% of women who were still breast-feeding (either partially or exclusively) intended to switch to bottle feeding while on maternity leave in preparation for returning to work. This caused anxiety among these working mothers and was the main reason for early cessation (Berridge, Hackett, Abayomi, Maxwell, 2004).

Somali women in focus group, one who were employed, discussed the pressures that working women in western society are faced with. They felt that nine months maternity leave, set by the government, was too short a time in relation to personal and religious breastfeeding aims. If

women wish to breastfeed for longer than the optimum six months and to spend quality time with their baby before having to return to work, they have to face consequences. It is evident that Somali participants made many sacrifices to maintain breastfeeding in the long term. Somali mothers juggled feeding times around work and this enabled them to maintain their breastfeeding habits, stating that they would rush home to breastfeed whenever they would have time to leave work during breaks.

Hawkins as well as Kelly & Watt found that migrants who spoke the English language were more likely to adopt British cultural practices, including common infant feeding practice (Hawkins, 2008). However results showed that even when women had attained the ability to communicate at a reasonable level of English, they stayed true to what they felt was best for them and their baby, so if they had intended to breastfeed they would make every effort to breastfeed.

Participants stated that they were unaffected by Western culture and that it had not impacted their way of life, however the results indicate that Somali working mothers had to sacrifice a lot in order to continue breastfeeding for up to six months, and they had to return to work after nine months, even when they had intended to breastfeed for up to two years.

This problem can also be found with western women who have also been found to experience difficulty in finding a balance between their responsibilities as a mother and those of a working woman. A qualitative study explored the conflict between health advice and organizational practice regarding breastfeeding. It focused on a group of mothers who had the highest rates of both breastfeeding initiation and of continuous employment following maternity leave: specifically, educated mothers in managerial and/or professional occupations. It was investigated, through in-depth interviews, the embodied experiences of 20 heterosexual UK mothers, qualified to degree level, who returned to professional employment within 1 year of

childbirth. The study observes that mothers who attempted to combine breastfeeding with paid work did so with difficulty because the material activity of breastfeeding was tabooed within the workplace. Thus, the requirement to conform to organizational expectations regarding suitable embodied behaviour contradicted health advice about what was best for infant children. In order to comply with workplace requirements, mothers in the study were obliged either to cease breastfeeding or to conceal breastfeeding activities. In relation to the mothers experiences the study suggests that breastfeeding duration rates among professionally employed mothers can only be improved if negative attitudes about maternal bodies and employment are challenged and if employers, as well as mothers, are the focus of health initiatives aimed at promoting breastfeeding (Gatrell, 2007).

These findings should highlight a problem for governmental schemes and encourage an extension on the current nine month period; particularly for women who feel it is a religious requirement to breastfeed for up to two years.

4.8 Baby bonding skin-skin contact

Early skin-to-skin contact between mother and baby at birth reduces crying, improves mother-baby interaction, keeps the baby warmer, and helps women breastfeed successfully (Kostyra, Mazur & Boltruszko, 2002).

In many cultures, babies are generally cradled naked on their mother's bare chest, at birth.

Historically, this was necessary for the baby's survival. Nowadays with the increasing number of hospital births and a decrease in home births, particularly in developed countries, (Telegraph, 2007) (Wax, Pinette, Cartin, 2010) it is common practice that babies are separated or dressed before being given to their mothers. It has been suggested that in industrialized societies, hospital

routines may significantly disrupt early mother-infant interactions and have harmful effects (Bystrova et al. 2009).

A prospective cohort study followed a group of 1250 Polish children for 3 years from birth in order to study the influence on breastfeeding of skin-to-skin contact after birth. Skin contact significantly increased the mean duration of exclusive breastfeeding by 0.39 months and overall breastfeeding duration by 1.43 months. The infants kept with the mothers for at least 20 minutes were exclusively breastfed for 1.35 months longer and weaned 2.10 months later than those who had no skin-to-skin contact after delivery. The difference was significant after controlling for other hospital practices including rooming-in and breastfeeding within 2 hours of delivery (Kostyra, Mazur & Boltruszko, 2002).

Establishing a bond between mother and baby was important to Somali participants. Somali participants described breastfeeding as a highly rewarding experience in the long-term. They felt a special connection with their baby whilst breastfeeding, establishing this connection between mother and baby is important particularly during the vulnerable i.e. early stages of breast feeding; women need to be encouraged to have early skin-skin contact with their child, to establish better feeding (Bramson et al.2010).

Somali women also discussed relating infant feeding choice to what they had previously done or to what they were advised was best from their mothers. Past experiences of breastfeeding play a significant part in whether or not women choose to continue with breastfeeding as their infant feeding choice. Therefore women should be more aware of the important impact skin-skin can have on them for long-term feeding.

Encouraging skin-skin contact between the mother and baby during the after birth period known as the sensitive period may encourage a long term positive effect between mother and baby (Bystrova, et al. 2009).

4.9 Limitations of the study

With a total of twelve participants and only two focus group sessions, an extensive amount of research is harder to obtain, the descriptive data was not sufficient enough to generalize the entire Somali population. If there had been more focus group sessions this would have been useful in raising further issues worth considering. There were few participants whom responded to the poster advertisement; this indicated a poster may not have been the most suitable tool for advertisement in this case. Participants were more interested in taking part when the researcher advertised verbally within the community along with the interpreter.

It would be difficult to confirm all data as accurate in every case with some participants discussing the experiences they had from the nineteen eighties, which may have affected data reliability. Data collected retrospectively is subject to recall bias.

The researcher only allocated the two slots participants had agreed to, therefore if there had been some participants who were unwell or who had decided to withdraw from the study, the researcher would have then had a hard time trying to compensate any drop-outs.

Primary research can be very limiting especially as the research for this data was not compared with trends in Somalia. A further exploration of Somalia culture would have aided in understanding the reasoning behind infant feeding practices. Faulty feeding practices were implied with participants mentioning mix feeding before the end of the six month exclusive

breastfeeding period; however this needed to be further examined to understand the type of supplement and reasons for supplementing breast milk.

The language barrier with non-English speaking participants (focus group two) was challenging because there may have been some misunderstandings between the researcher, interpreter or participant. Misunderstandings were detected when there were two participants who could not be considered for the study, it was found that neither had a baby in the UK and one had not even had children, she had understood the study was just about discussing infant feeding beliefs for future reference. This stresses the importance of clear communication when recruiting for any form of research.

It was also difficult to clearly distinguish between participants at times when two three participants were talk together during the transcription stage of the information; this stresses the importance of creating a code of conduct for participants to keep statements made clear.

Although most statistics for the literature review are obtained from well renowned governmental organizations such as the WHO and DoH there are still limitations with current surveys and statistics as it is not possible to get full access to all populations and obtain data on them.

It was highly important that the participants maintained a copy of PIS forms and had fully understood the consent forms given to them, even if it meant that focus groups took longer than expected, the interpreter had to take caution and time to explain all the information and assist in answering any enquires participants had at the time. If the PIS and Consent forms had been written in Somali this would have posed an advantage and perhaps saved time, however it would not have worked practically as the majority of Somali speaking participants involved were illiterate. Again clear communication is vital to obtaining accurate and reliable data. This is an

important factor which should be considered by governments as all intended new mothers need to have access to the information available on breastfeeding benefits, however if the information is all written in English, not all new mothers will be able to read and understand the information available. Therefore it is important to have the information available in different forms in order for women to take a more independent role when choosing the best for their child, public health campaigns that focus on increasing the social acceptability of breastfeeding may prove effective in addressing this cultural barrier (Dykes & Griffiths, 1998).

The aim of the thesis was ‘The study of factors affecting breastfeeding uptake and duration within Somali women’ it is difficult to come to a definite conclusion and make a generalization on factors affecting Somali women, as the researcher had such a small sample of Somali women.

In order to gain a better understanding of Somali women and African culture the researcher would have had to go to Somalia, this way a much greater understanding of the normal cultural practices related to infant feeding would be gained. The researcher could then continue research in the UK this time focusing on a much larger sample of Somali women from various communities. However when considering the funding and timescale for this thesis it was found that the data was better obtained locally.

The governmental laws in Somalia are appropriate to the needs of the women who live there. For example UNICEF has taken action to ensure mothers in Somalia who are malnourished, are provided with supplemental vitamins and minerals, to benefit both mother and baby (SOMALIA UNICEF, 2008). The Somali mother’s diet was not investigated during focus groups, which limits the researchers general understanding of whether mothers were conscious of the importance of healthy eating. The Food Standards Agency has set guidelines for breastfeeding

mothers, to give them a clear idea of how to go about obtaining a healthy varied and balanced diet (FSA, 2010). It is important that new mothers are made aware of these guidelines and given flexible ways to incorporate them into their daily routine.

Results from this thesis have re-enforced what previous studies have noted that further investigation into the contributing factors of infant feeding is required.

Final Chapter 5

5.1 Conclusion

“The act of breastfeeding is not simply about meeting the nutritional requirements of the baby, it is imbued with social, emotional, sexual and cultural meaning for mothers, for ‘significant others’ and for those within the wider social and cultural milieu” (Maher, 1992; Vincent, 1999; Marshall, Godfrey, & Renfrew, 2007, p.2147-2148)

5.2 Introduction

This conclusion shows the main findings of the study obtained from both focus groups. The conclusion summarizes the main findings and goes on to suggest how findings may impact future practice as well as addressing whether or not the study established reasonable answers to previous research questions.

5.3 Summary of research findings

From the results it can be concluded that it is important for health professionals to understand the needs of the mother to promote breastfeeding. Somali women appear to be confident and independent in their personal feeding choices, however they are influenced by friends and family to an extent. Family contributed positively to breastfeeding practice as women were more confident when encouraged to continue breastfeeding in the long-term.

Islam played a part in breastfeeding decision women were aware that Islamic law recommends breastfeeding for up to two years, and tried to abide by religious beliefs as much as they could.

Breastfeeding as a form of contraception is not ideal, although the women held the view that it was the best contraceptive form for them and it was found a contributing factor to early cessation. It is important to educate women on all forms of contraception, so they can consider a more reliable form of family planning. Somali women would prefer long term support outside of the hospital, and to feel health care visitors take time to establish a better understanding of their situation and individual needs. Somali women feel there is room for improvements with the current health care system, and feel there should be more health clinics available to suit their personal needs.

It is important to establish local community centres in order to provide a secure environment for women to obtain information and a place where they feel they can breastfeed outside of the home. Having a private space to breastfeed was a major concern for participants and women felt there were no private spaces outside of the home to feed, so they were found to stay at home during feeding times.

Somali women felt the impact of western society when they had to return to work after nine months, maternity leave, especially if they had intended to breastfeed for up to two years.

Working women had a difficult time and were encouraged to continue with the support of family and friends. Developing countries give women a choice between breast and bottle feeding.

It was the mother's determination which got her through the first six months and further with their infant feeding decision. All participants had the initial intention to breast feed and only a minority were unable to continue to do so due to health complications or changing circumstances, moving away from family and lack of support from health care professionals lead bottle feeding instead. A common cultural practice found was for mothers to mix-feed if they

felt the baby was underweight with the breast milk, they would try both. Cultural background and religion was found to be a major contributing factor towards breastfeeding for up to six months in this case.

With the non-English speaking group of Somali women it was found that they had experienced communication problems during their hospital stay and were unaware of what was happening to them all the time. Changes are required for both healthcare professionals and staff. In spite of language and cultural barriers participants in this study were still found to have a strong determination to breastfeed, it appeared to be the first choice without question or doubt.

Breast feeding was found to be prematurely ended when the patient had experienced complications, such as a major operation or through lack of social support. Results indicate that women take on the responsibility of breastfeeding on themselves and then attempted to overcome the challenges they were faced with.

Healthcare professionals need to put out adequate information to patients so as to avoid cultural practices leading to poor quality feeding practices, such as inappropriate mixed feeding. Just as Kruger & Gericke (2002,p.217) found in their study “Nutrition knowledge needs to be changed in a first step towards implementing improved feeding practices” they also found that, facilitated group discussions could focus on possible solutions for the identified nutrition-related problems.

Participants stated that it was hard going mostly with the first couple of days; they needed support during this vulnerable time in order for them to be encouraged to continue for at least up to 6 months. Governmental schemes should aim to target both men and women in the promotion of breastfeeding.

The results from the perceptions of Somali women give an overall sense of optimism in relation to breastfeeding benefits. It can be concluded that strong determination, love and support from their partner, family and social units in combination with the close bond established by mother and baby maintains long-term and successful breastfeeding. It can also be identified that these women were willing to sacrifice time and energy to give the best for their babies and this was enhanced with the knowledge of breast milk benefits, for both mother and baby.

5.4 Final Conclusions

By relating the previous research questions to focus group findings the researcher can conclude that socio-cultural factors do have an impact on breastfeeding uptake and duration and that the extent to which this occurs varies between ethnic groups. Governmental schemes have been successful in breast feeding promotion as there has been a positive increase in statistics, at the same time they need to work at understanding the needs of mothers further to establish the best way to communicate their ideals. Participants in this research felt safest to feed within their own homes, safer environments need to be established outside of the home. It is important to have an understanding of parental dietary habits and how this can impact infant feeding habits. Further education is needed as does the positive re-enforcement from health care professionals.

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References Conclusion

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Appendix A

2.9 Ethical Considerations

This research incorporated the basic ethical principles according to the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1979). It also put into consideration the major ethical concerns in research and when dealing with human subjects. Basic ethical considerations were given, including respect for persons beneficence and justice.

The principle of respect for persons was incorporated, as the subject's participation was voluntary with no influence or coercion, thus, authenticating valid consent. Adequate information about the research was provided prior to commencement. The information was concisely communicated to all participants and had to be adapted to the subjects' capacity to ensure full comprehension of the details provided.

Group members were able to voice opinions that were upsetting to them and other participants. A related problem was that participants may actually provide each other with mis-information, in such cases the researcher had to take responsibility of providing accurate information (Holloway, 2005). Any information, which was irrelevant, was not included in the data analysis.



Participant Information Sheet

The study of factors affecting infant feeding among Somali women.

Why is this research being done?

This study is being carried out to look at socio-cultural factors and their effect on infant feeding choices.

The purposes of this study are:

To find out how much cultural, social and religious factors have an impact on infant feeding choices.

What kind of study is this?

This is a social study to explore your infant feeding experiences and what led you to make certain choices. All the information obtained depends on what you are willing to share through the interview process. Each group session should not take longer than 60 minutes maximum of your time. Your participation in this study could help others in a similar situation as well as allowing a time for self-reflection on your own experiences.

Who can take part in the study?

Somali women who have had a baby in Britain can take part in this study. It is important to note that only women are allowed to attend focus group sessions to ensure that everyone is comfortable to answer the questions freely.

How many people will take part in the study?

There will hopefully be around 10-12 women taking part altogether.

What is involved in the study?

The study will involve a group talk.

Example questions to expect

Interview.

1. What method/plan of infant feeding did you have in mind before having your last baby?
2. Did anyone at the hospital offer advice on the best way to feed your baby?

3. Did you feel confident to ask questions in relation to infant feeding?
4. Were family members with you offering to support you when you decided to breast/bottle feed?
5. Did you feel assured that you could contact health professionals for further support if you needed help?
6. What do you feel should be improved with the current health care system?

Potential risks

You will not be taking any supplements or undergo any physical examination. Great care will be taken during the interview to ensure that you are comfortable and confident to give answers with the questions asked. If you are not happy to answer a certain question you can let me know during the time of the group discussion.

Potential benefits

You should feel that you could freely express any concerns, which you may have. The information you give should provide good reason for further improvements to the current health care system; which can benefit people in the future if the article is published. This will assist in improving current facilities available for your needs in the future if any of the results are later published in a midwifery journal.

Confidentiality

Your name and personal details will be kept completely confidential by the researcher. Any information given will be recorded under a different name rather than the actual name of the participant. Anything that is recorded will be later deleted when the study is complete.

Participants' Rights

- Your participation is voluntary.
- You can choose not to take part or leave at any time without giving a reason.
- Any new information that may affect your participation will be shared with you at the group session.

Who has reviewed this study?

The Faculty of Applied and Health Sciences, Research Ethics Committee has reviewed and approved this study.

Who is funding this study?

This study has been self-funded and applied for through the University of Chester.

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Huda Diab Appendix B

Concerns

Should you have any concerns/complaints about any aspect of the way you have been approached or treated during the course of this study then be sure to contact Professor Sarah Andrew Dean of the faculty of Applied and Health sciences at University of Chester (Tel: - 01244 513119 ext: 3119)

Thank you for taking the time to read this information sheet. If you do decide to take part you will need to sign the consent forms provided to you on the day.

Somali Mothers your voices are needed !

APPENDIX C

Huda Diab
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Have you had a baby in the UK?

If **YES**, then pay attention! There may be a way that **YOU CAN HELP** by attending a friendly chat with other Somali women .



If you would like a chance to discuss your previous infant feeding experiences then be in touch.... Tel:- 07919184957

If you know other women who can help then **PLEASE SPREAD THE WORD !**

Research is expected to be between November-December 2008 .



Why is this study being done ?

This is a study to find out about Somali women and their infant feeding choices. The chat will take place at the Somali Women's group. This study is **ONLY** for women and their babies.

The researcher of this study is from the University of Chester. All contributions to this study will be highly valued and respected

Appendix D

Thematic Chart. (Focus group2 Somali speaking women)

Infant feeding method 1	1.1 Breastfed	1.2 Bottle-fed	1.3 Mixed fed	1.4 Bf for less than six months	1.5 Bf for more than six months	1.6 Experienced complications
Participant 1a	Had my mind set on breastfeeding					
Participant 2a	Breastfed					
Participant 3a	Breastfed		One of children mix fed after 6 months		Bf all children for up to a year solely on breast milk except for one	
Participant 4a	Breastfed				Bf some for up to nine months, 7,8,6, some for a year and half (had nine children ,4 in England)	Had a caesarean with last baby complicated delivery, didn't fully understand what was happening.

Support 2	2.1 Health professionals	2.2 Husband/partner	2.3 Family	2.4 Healthcare professionals/family discouraged breastfeeding	2.5 friends	2.6 Contacted health care professionals for further help (useful)	2.7 Contacted for further help but was not useful
Participant 1a	Encouraged and advised by doctor to breastfeed rather than family					During stay in hospital felt like the midwife gave advice	
Participant 2a	In hospital for a month, they bathed the baby, gave lots of support and looked after the baby well						
Participant 3a							
Participant 4a	I did have advice from the health visitor who encouraged me to breastfeed	Husband encouraged me to breastfeed and I wanted to	Mum was always with me				No, not really

Improvements 3	3.1 short staffed	3.2 Facilities	3.3 Support Groups	3.4 Communication issues	3.5 Felt disrespected
Participant 1a	There was a point after delivery where I was given drugs and taken to the ward, was not a 100% sure what was going on and was taken to the ward, not even able to hold the baby, nobody was there to help.				It's always the persons who cannot speak English nobody gives them full respect
Participant 2a	Only one midwife to 12 women, people complain , they have to change and improve the health care system			Felt unsupported and experienced translation difficulties	
Participant 3a	No support felt left to own devices, less time for patients				Didn't feel respected at the time
Participant 4a				There was a ...translator but felt helpless not being able to communicate at the time of labour	

Western Culture and Social Factors 4	4.1 Limited to feeding at home	4.2 Lack of public facilities	4.3 Facilities available with private spaces	4.4 Used support groups or women's health centres	4.5 Willing to take on full mothering role/unaffected by society
Participant 1a	Had to breastfeed at home			Community centres such as the 'Somali women's' are useful there are facilities available for breastfeeding women and we feel safe and confident to use them, there are private spaces for breastfeeding	
Participant 2a					
Participant 3a					I wanted to be a housewife and stay with my kids at home, I always fed at home. Western Culture had no influence on what I did.
Participant 4a	It's difficult for Muslim women to feed outside of the home or in a public place		Sometimes there would be places for me to feed, Boots has a room for breastfeeding, other women were using these facilities also of mixed cultures, the room was nice and clean		I'm not working but it would have been even harder if I had to work.

Rational behind breastfeeding 5	5.1 Religion	5.2 Self motivation	5.3 Knowledge and Confidence	5.4 Told to feed by healthcare professionals/family	5.5 Breastfeed as a form of contraception	5.6 found it to be the natural and easy way to feed	5.7 It forms a special bond between mother and baby	5.8 Encouraged by friends
Participant 1a	My Religion says it's better to breastfeed		Breast milk is healthier and protects the baby from the many illnesses there are					
Participant 2a						I had a lot of milk, feel I was very blessed and found it very easy to breastfeed		
Participant 3a	Allah (God) give us special milk in our breasts to feed the baby, why do we need the bottle?					Breastfeeding helped me also in the night time, when you make a bottle of milk you have to get up, in the night the milk is already in my breast, I only give it to my baby , it's not cold or hot , I'm not awoken fully to boil the water , put the milk and then make it cool again no it's not like that, that's why I like the breast	when you are breastfeeding you feel more love for your baby, when you are breastfeeding and you feel the milk coming down you have more love for the baby, you feel like there are things you didn't know you feel love, forms a special bond	
Participant 4a		happy to continue with breastfeeding and felt happy to always breastfeed, decided for personal reasons to breastfeed up to a year			Followed advice and breastfeed	It's easier to breastfeed than bottle		Friends told me it was a good natural way of contraception and helps to pace the family

Appendix D**Results 2****Focus Group 1 (Somali women, English speaking)**

1 Infant feeding	1.1 Breastfed	1.2 Bottle-fed	1.3 Mix feed	1.4 Less than six months	1.5 Six months or more	1.6 Experienced Complications
Participant 1b	breastfed				at the end my baby was breastfeeding for about one year and two months and I didn't bottle feed at all I only breastfed	
Participant 2b	breastfed				I bf all mine for a year and half, my baby was about 7 months at the time	
Participant 3b	breastfed				You need to breastfed for at least six months. With ten months you are a winner. I breastfed my son for a year. When he refused to bottle-feed it was two years in total. My second child after I fed him for 11 months was able to give the bottle after this.	I was trying to bottle-feed him but the child was unwell and refused to be weaned off the breast earlier
Participant 4b	basically I breastfed all my kids				I breastfed my first baby till she was five months, but then I stopped as I was pregnant with another.	
Participant 5b					My children were born about four months apart so I only got to breastfeed for four months and then another I was pregnant with another child and then	

				another, so I was unable to feed for longer.		
Participant 6b		The first baby I didn't feel confident with my plan, he didn't want to breastfeed at home, and he refused the breast, I could only feed him for two months and then he stopped, not sucking at the breast properly and could only then bottle-feed		I could only feed my first baby for two months and then he stopped. ... With my second baby, it did want the breast, and the doctor said you have to stop at three months, because I had low calcium level		I had low calcium/calcium levels were low
Participant 7b			I mix-fed because I felt that when I fed with just the breast milk, the baby would cry more and it became uncomfortable so she mix fed at that time.			
Participant 8b			I choose to do both breast and bottle	I breastfed for 3 months		With my first they should have kept me in for longer after a major operation the baby was also premature, with my second baby which was also premature ,I had a long labor and a cesarean and then I was still drugged up when the midwife just threw the baby at me and said you have to BF. I started to express my breast milk , while the baby was still in hospital the baby was in hospital for four weeks and so I had to express the milk take it to her and then , express at home or express in the hospital which was really difficult , then after she got discharged from the hospital she did not latch onto the breast at all , I tried and tried and tried

2 Support	2.1 Health professionals	2.2 Husband/partner	2.3 Family	2.4 Healthcare professionals/family discouraged breastfeeding	2.5 friends	2.6 Contacted health care professionals for further help (useful)	2.7 Contacted for further help but was not useful	2.8 Support groups at the hospital
Participant 1b	I feel that here, mothers are taught how to hold and position the baby while breastfeeding, and how often can they breastfeed and things like that		my mother in-law was with me and she, encouraged me not to give up because my daughter didn't like(latch on)	I wanted to continue with the breast milk but my husband and my mother in-law both tried to persuade me to give up because the baby didn't like it				
Participant 2b	I got told to breastfeed	My husband supported me which really helped me carry on breastfeeding... My husband didn't want me to bottle feed at all; he just wanted me to breastfeed, so he didn't want me to bottle. My husband was also there supporting me during the night , they tell you that you are doing something good you feel really encouraged	I can honestly say that if I had not had family support I would not have continued with breastfeeding. It's esp. challenging when you have other children in need	My mother discouraged me from breastfeeding as I had a cesarean at the time with my baby, she wasn't happy with me you know the late nights, the stress, I had already been traumatized going through the whole labor process, but because I was like no, no I want to do this I want to, my mum in the end she supported me, more so with my second child than with my first child. She didn't want me to suffer				There was a breastfeeding group in the women's so we used to go
Participant 3b			..nice if you have the support from family & friends to breastfeed because it helps you to put				Feel the support groups at the hospital were useless.	

			your feet up and probably the only time you breastfeed might be the only time to sit down.					
Participant 4b						I felt happy to contact them, at first it was difficult because none of my family live here, so it was difficult for me to ask for help but I managed somehow		
Participant 5b								
Participant 6b	The midwife told me it would be best to breastfeed		my mum also helped, she told me to give the baby breast milk, and my family supported me					
Participant 7b								
Participant 8b			I felt well supported with my first baby, my mum would get up in the middle of the night with me and help me to feed this encouraged me , she was very concerned at the time after I had a cesarean she was very affected by the sight of all the blood and she passed out , ever since that day she was more determined to help me	I had a hard time with my first, because my mother was there and she had to take the baby off me and say to them 'listen I'm going to bottle feed this baby because she's in no state to be breastfeeding'				

3.Improvements	3.1 short staffed	3.2 Facilities	3.3 Support Groups	3.4 Communication issues	3.5 Felt disrespected	3.6 Need continued support outside of the hospital	3.7 Content with health care
Participant 1b			Young women should be targeted with these groups				
Participant 2b			There need to be more local groups in the communities, where women can drop in, more mother and baby groups, where people can go in and just drop in and just talk about their issues in the communities.. for young women esp. because they need to talk to people ,so that if there are people who want to give up and they've been bf for nine-ten months they can't really cope because they have no one to turn to. But they've successfully breastfed for ten months then that's enough			I think they do support you, but they also leave you to get on with it ,so if you're a first time mum, for the first couple of days which you know are the hardest , I don't think that you get the support, and that's why a lot of people either mix feed/ leave hospital just bottle feeding because the first couple of days are the hardest, and you think it is going to be like this forever but it's not.	
Participant 3b						You do get so much support and encouragement when you are breastfeeding but when you want to stop breastfeeding and things like that , there is no support and I think that the support can be increased , (my friend was there for me)	When you leave the hospital and they've shown you how to breast feed if you haven't got the support at home then, you are just left on your own where you are waiting for family and friends to come We should have something where support is offered after breastfeeding not just before. I think if you had the support to help you wean the baby onto the bottle then this would be nice, you wouldn't feel the pressure to run around everywhere
Participant 6b						They show you how to feed the baby the first day and then that's it, they should help you	
Participant 8b						I was in the hospital two days after they kicked me out so no support	I didn't have any support because my mother wasn't with me a ever gave up because the baby wasn't latching, I gave up

4. Western Culture and social factors	4.1 Limited to feeding at home	4.2 Lack of public facilities	4.3 Facilities available with a private space	4.4 Used Support groups/women's health centres	4.5 Willing to take on full mothering role/unaffected by society	4.6 Felt encouraged to breastfeed in western society	4.7 Reference made to the differences between Somali and UK	4.8 Social class/economic factors
Participant 1b		There should be somewhere private and suitable to breastfeed.				as far as I know the many health professionals, here encourage the mothers to breastfeed the babies	In Somali I don't think they have buy much powdered milk as they have animals such as goats and so the milk is always available for them to get the milk from.	
Participant 2b	you are limited in a way because you are Muslim you can't have your breasts out						I think back home in Somali a lot of women breastfed and it was normal for them to bf, however in this country because they have the free milk and the bottle milk they don't feel like they have to breastfeed. There's a lot of milk available free milk here, in Somalia and Africa there is not that much, in Yemen not a lot of free milk	You are set in classes (in U.K). well that's how it used to be years ago here that people who had money bottle-fed and people who didn't, they didn't have money to buy the milk. Even with maternity leave here you are on full pay for six months and then after that you may receive £400/month and this isn't enough (others agree) you can't live on this especially when you have a big family and you have young children. I found with being a working mum, - it becomes a case of wherever we put you you'll be placed there so it was a case of deciding that way, however because I had such good support I continued working and bf and I took my holidays before and so when I did go back there was a lot of pressure on me as a working mother, I was

								using my lunch hours to go home and feed
Participant 3b	I was at home feeding my 1 st baby a lot	sometimes you are limited depending on where you can feed as well , you can't just feed your baby anywhere, you want to feed where a young Muslim mother can feel comfortable feeding even if you are out with your baby/whatever, you have to choose where you breastfeed.				yes I think it encouraged quite a lot	breastfeeding is not the only choice...you've been given other choices , which its easier to bottle feed, breastfeeding's very hard , mentally, physically and it's a beautiful thing that only you can do once for your child.	At the time I was a student and I went to take 10 months maternity leave and then I went back to my studies before the two weeks before the baby turned (6 months) old . I still continued with breast-feeding, I would go to university and then in the hour break time I would go home and bf, so I was backwards and forwards and it was exhausting
Participant 4b	I would always stay at home				I didn't really feel affected in anyway to be honest because well I was breastfeeding I would always stay at home , so I didn't go out , it would have affected me if I went out or if I was working or outside all the time but I was in my house and so it did not affect me .			
Participant 5b								
Participant 6b					I just continued with the breast milk when I could, I'm not really working so I didn't feel affected by the people here			
Participant 7b	I didn't really feel I had to change my plan here , but I can't be feeding outside in public as							

	I am Muslim woman, so I can only feed when there's only women, so mostly fed my babies in the home								
Participant 8b							I had to get back to work as well and then everything is a rush and so it's a challenge, whereas my mum the reason she could bf for up to two years was because she used to stay at home. Here you have a baby and then after nine months its back to work, what do you do then?	I feel mothers are pushed back into working this is why the culture has affected us because of work, and if there are mothers who are not working you are then made to feel that you are doing something wrong. If you do take the time out it's going to be really hard for you to get back into it once more and to start where you left off and after -you don't feel guaranteed the same position in your job if you take time out to support your baby for longer, e.g. 2 yrs	

5. Rational behind breastfeeding	5.1 Religion	5.2 Self-motivation	5.3 Knowledge and confidence	5.4 Told to feed by healthcare professionals/family	5.5 Breastfed as a form of contraception	5.6 Found it to be the natural and easy way to feed	5.7 It forms a special bond between mother and baby	5.8 Encouraged by friends	5.9 Just did what felt most adequate for the baby	6.0 assisted with a healthier diet plan (mother & baby benefits)
Participant 1b		When I had my first baby I didn't have much of an idea about how important it is to breastfeed, but then after this I went to breastfeed my baby and after this I carried on breastfeeding my children. .. in terms of my first baby , it was hard for me to breastfeed because she refused to breastfeed, and my mum wasn't	Better for the health of the child and health of the mother, I wanted to breastfeed and then found it easier to continue from this point onwards, even though you might be							

		with me at that time , but my mother in-law was with me and she, encouraged me not to give up because my daughter didn't like(latch on) breastfeeding and you know but I stick to breastfeeding and it took nearly about a month to breastfeed properly but I tried and I kept trying till the end...refused to give up	young and an inexperienced first time mother you still have some experience from your background you know your.. mother and so you already have some experience							
Participant 2b	Islamically you should breastfeed for up to two years. So this had an influence on my decision to bf	You have to just sit down with the baby in spite of everything, it's harder and you just carry on ... Otherwise you would be like no that's it I will bottle-feed	.. the benefits for the baby keep you going, I found that the longer I breastfeed the easier it became, after four months that's when the ease starts coming in and that's the time when you need to be encouraged from your mother to keep going because it does get easier and when you pursue it it's one of the easiest and loveliest things				I loved every min of it, it's a lovely thing. It's such a blessing that a baby can be soothed on the breast after crying but I struggled and even at work my manager was very understanding with my choice and she supported me also which I won't forget , sometimes when she would see how tired I was she would send me home , I think this too was a factor and it's true that if you don't have the right support you can't continue		I think if you are healthy and you can do it everyone has different circumstances bf is a beautiful thing but, if you do have a child that is sick or is born prematurely then you need support and looking after both mother and baby, mother is overcoming shock . It depends on whatever position you are in life and what you are faced with that influences you the most. I think most Somali women would love to Bf but the baby might not like it, my sister tried to Bf	I felt that my uterus and everything came back better and I have had friends in a similar situation who have had a harder time, but my body healed quicker I felt , I felt stronger and more confident with time

									for three months but he would refuse after this he didn't want it and she was devastated she had the intention but he didn't want the breast so it depends on your situation and circumstances	
Participant 3b			I was confident but it was really hard but you know you are doing something better for your child and you protect the baby against infections or whatever else			When you sit down to breastfeed it's a way of relaxation for you and the child, it's nicer when you sit down you've got someone to make you a drink			I think just because you have had one or two kids before it shouldn't be expected that you will breastfeed because every child is different , sometimes they refuse the breast and they just want a dummy there rather so support is important	Breastfeeding helps you to get the right diet, because for me I found I didn't have that and so I would double check with family and friends that I was having the right diet and this made a huge difference for me then and so I changed my mind and made the decision then to breastfeed longer. When you get extra support, and you feel you are doing something good and you can see that the baby is gaining weight each week then this encourages you to continue
Participant 4b	My religion supported my decision to breastfeed, so it was good	I don't think anybody asked me how I was going to do it, I just came home and decided then and there , I wouldn't say that I didn't get support but I have never asked for advice or anything I just did it	It was something that I wanted to do and so I just did it. I knew it was right for me and for my kids and so I just did it		Breast- feeding gave me a break from having kids so close because my first two babies were only a year apart and so breastfeeding gave me a break between my	I felt it was just there, all you have to do is eat or drink and you give your child the breast and you don't have to make anything and it's easier , no need to				

					children instead of using other forms of contraception, so it was good in a way. My child was healthy and I didn't get pregnant that quickly, these are the reasons of why I wanted to breastfeed	sterilize bottles				
Participant 5b	I feel that religion supported my decision, Islam encourages breastfeeding		breastfeeding for me felt good ,this is the healthier way to feed		It's a safer option for you to not rely on pills or injection in terms of family planning, they all have side effects where as this is natural you don't need to take drugs or anything, thanks to God.. .. I Feel strongly that it was the right way of doing things, and that breastfeeding is the best form of contraception for me		You feel love between you and your child, when you breastfeed your child, there's more love because when you put the baby in your heart and breastfeed, your child will love you more so it's Thanks to God , it's a way to create a connection with the baby			if you do have another child well you're still breastfeeding, praise God, it's a good way of dealing with it and either way you get benefit and your child gets benefit, it's the right way of doing things so thank God!
Participant 6b										
Participant 7b									For me I think it's more about what the baby wants as well as religion sometimes the baby wants, so you can give, some babies want more than just milk, so it just depends on what felt right for the baby at the time	

Participant 8b									..the baby preferred to bottle feed rather than breast feed	
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Appendix D1

Framework for Descriptive analysis.

(Focus group 1 Somali English speaking women)

1. Detection
2. Categorisation
3. Classification

Participant	Column A	Column B	Column C
	Data charted in column 2.3 about the impact of family on breastfeeding duration Group 1	Elements /dimensions identified	Categorised/classes
P1b	Mother in-law was present& encouraged longer duration even when the baby did not initially latch on to the breast	Family had an impact on the mothers decision, the mother was happy to take on board what was advised through the family	Needed encouragement to continue
P2b	If had not had family support would not have continued with breastfeeding, it's especially challenging when you have other children in need	Family support assisted in the continuation of breastfeeding	Needed encouragement to continue & support in this case provided a strong foundation for a longer duration of breastfeeding at the time
P3b	It's nice if you have the support from family and friends because it helps you put your feet up, might be the only time you get to relax when you sit to breastfeed	Enjoyed the support given by family and friends, helped the mother to have mother and baby time when they would help with other daily duties	Stressed the importance of having moments with her baby and found breastfeeding relaxing when supported by others

Participant	Column A	Column B	Column C
	Data charted in column 2.4 about whether family/health care professionals discouraged breastfeeding Group 1	Elements /dimensions identified	Categorised/classes
P1b	Wanted to continue breastfeeding for longer but husband and mother tried to persuade her to give up because the baby didn't like it	Family trying to intervene with feeding process as they feel they know what's best	Family advice can be taken on board at any stage of the infant feeding process even if it's not necessarily the best step to take. This participant feed for over 6 months in spite of this

P2b	Mother tried to discourage from breastfeeding as P2b had undergone a caesarean, mother felt unhappy with P2b's choice, particularly with her dealing with late nights, stress. Already been traumatized going through the whole labour, because I wanted to breastfeed no matter what mum supported me in the end, she just didn't want her daughter to suffer. More support with the second child	Mother tried to be involved as she had concerns for her daughter (P2b) However daughters determination to breastfeed meant more in the end and so the mother was forced to support that decision	Participant had made her decision to breast feed and stuck with this in spite of her mother's disapproval
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Participant	Column A	Column B	Column C
	Data charted in column 3.6 About whether continued support outside of hospital is required	Elements /dimensions identified	Categorised/classes
P2b	You are supported but they also leave you to get on with it, so if you're a first time mum, the first couple of days which are hardest not enough support there possible why lots opt for mix feeding' or leave hospital bottle feeding, after the first couple of days feel it will remain difficult but this is not the case	Only felt supported within the hospital setting then left to own devices outside of that	Support outside of the hospital is important as the first couple of days are the hardest for a new mother and this is a venerable stage.
P3b	Much support and encouragement when at the hospital but more is needed for when you want to stop breastfeeding. Once you leave the hospital if you haven't got the support at home then you are left on your own, think it would be nice if further support was given outside of hospital.	Much support within the hospital setting, but felt like there should be consistent or long term support outside of the hospital to advise on the best way for the next stages of infant feeding	Support provided in the hospital is good, but there still needs to be support outside of this to encourage the best way to feed in the long term.
P6b	Only shown how to feed the first day and that's it, extra help should be there for a couple of days or even a week at least.	Only felt supported within the hospital setting , felt there should be more help outside of the hospital	Supported within the hospital, however further support is required when the patient leaves.
P8b	In the hospital for two days, then felt like she was kicked out after that and there was no support what so ever. I didn't have support because my mum wasn't with me all the time needed her more. Thus gave up after a few weeks as the baby was not latching on. Given initial advice at the hospital 'breast is best' but not enough!	Not supported well within the hospital setting, no sufficient family support , struggled with the baby feeding , gave up breast feeding altogether	Had a negative experience within the hospital setting and left to own devises outside of the hospital, discontinued with breast feeding.

Participant	Column A	Column B	Column C
	Data charted in column 4.8 about the impact of social /economic factors	Elements /dimensions identified	Categorised/classes
P2b	You're set in classes in the UK, this is how it was people who had money would bottle feed and those who didn't breastfeed. Even with maternity leave you're on full pay for six months then after this you may receive about £400 monthly which isn't enough. Have to decided between your position at work and whether or not you want to continue feeding with a longer maternity leave, still continued but went back to work and found a lot of pressure as a working mother, using lunch hours to feed the baby.	Found it hard to cope with the pressures of the work ethic in the UK, felt obliged to go back to work even though had opted to feeding for longer than six months.	Pushed into working after six months
P3b	Took leave 10 months, was a student and went back to studying continued breastfeeding before the baby turned 6 months. Exhausted going backwards and forwards between home and uni to feed the baby within the lunch hour	Struggled with going back to being a student and having to feed at certain times , choose to feed for longer than 10 months	Needed to go back into university to continue but struggled to find a balance between this and nurturing her baby .
P8b	Feel mothers are pushed back into working , so western culture has an affect on working mothers, if there are mothers who choose not to work they're made to feel wrong. It's hard to get back into work once you've left, not guaranteed the same job position if you take longer than 6 months maternity leave.	Felt pressured to go back into employment , felt threatened to loose a good position in her career if she had opted for a longer maternity leave	Pressured back into working after six months.

Participant	Column A	Column B	Column C
	Data charted in column 5.2 self-motivation	Elements /dimensions identified	Categorised/classes
P1b	With the first baby didn't have much of an idea of the importance of breastfeeding, but after this was confident to breastfeed anyway and did so with all her children, although the baby didn't latch on I continued to breastfeed and refused to give up.	Determined to breastfeed even though it was hard, didn't have the knowledge initially	Determined
P2b	You have to just sit down with the baby in spite of everything and you find it hard but carry on anyway , otherwise it's easy to give up and say no I want to breastfeed.	Struggled but carried on	Determined
P4b	Nobody really asked me how I preferred to feed; I just came home from the hospital and chose to breast feed, never really received support or asked for any.	Did what she felt was best for her	Comfortable with personal choice

Participant	Column A	Column B	Column C
	Data charted in column 5.3 Knowledge & Confidence	Elements /dimensions identified	Categorised/classes
P1b	Better health for both mother & baby, helps when you have an idea from what your family chose to do before you. Wanted to breastfeed initially and then just continued to do so	Had the knowledge that this was the healthier option & confident to do what her mother had done before	Knowledge and confidence
P2b	Benefits for baby keep you going, after the initial struggle becomes easier and so you gain confidence to continue, and it's a lovely thing.	Knowledge helped in spite of struggle and then found it to be an enjoyable experience	Knowledge and confidence
P3b	Was confident but it was really hard, know you are doing the best for your child to protect them against infections and whatever else.	Knowledge of the benefits although it wasn't the easiest option for her	Knowledge and confidence
P4b	Knew it was right for me and my kid and what I wanted to do so I just did it.	Confident to breastfeed	Knowledge and confidence
P5b	Felt good and was the healthier way to feed	Felt right and had the knowledge it was healthier	Knowledge and confidence

Categories

Health professional s role – level of support

Role of Family /impact – positive or negative influence, Personal preference with knowledge was found to over ride any outside factors which may have lead to the discontinuation of breastfeeding otherwise.

Employment impact on breastfeeding duration – participants were forced to conform to the six months of maternity leave provided if they were to consider coming back to the same position in their career.

Personal experiences and choices – Knowledge and Confidence played a large role in deciding to breastfeed as all found it to be a struggle but chose to continue when they knew they were doing the right thing.

Appendix D2

Descriptive Analysis focus group 2 (Somali Speaking women)

Participant	Column A	Column B	Column C
	Data charted in 2.1 Healthcare professionals	Elements /dimensions identified	Categorised/classes
P1a	Encouraged and advised by the doctor rather than family	Support from GP	GP advice had an influence
P2a	Lots of support was given during stay at the hospital and they looked after the baby well	Positive feedback on the role of healthcare professionals during stay at the hospital	Felt content with hospital services

Participant	Column A	Column B	Column C
	Data charted in 3. 1 Short staffed	Elements/dimensions identified	Categorized/classes
P1a	Given drugs after delivery and taken to ward, wasn't a 100% sure what was going on, nobody was there to help	Better communication and reassurance was required	Communication is vital to patients comfort
P2a	There was only one midwife to 12 women, people complained , the health care system should be improved	Hospital was short staffed, patients left unhappy at the time, subject feels the health care system needs improving	Need more staff on wards to assist women and reassure them
P3a	I was left to my own devices, felt unsupported, wasn't given the time I needed from the staff	Subject left on her own to feed, lack of support from staff	Unsupported patient left to feed alone

Participant	Column A	Column B	Column C
	4.1 Limited to feeding at home	Elements/dimensions identified	Categorized/classes
P1a	I had to breastfeed at home	Feed at home with no other choice	Restricted feeding
P2a	I was always feeding at home	Always fed in the comfort and privacy of the home	Never made attempt to feed outside of the home
P4a	It's difficult for Muslim women to feed outside of the home or in a public place	Experienced difficulty attempting to feed in places other than the home	Difficulty experienced outside of the home due to religious ethic

Participant	Column A	Column B	Column C
	4.5 Willing to take on full mothering role/unaffected by society	Elements/dimensions identified	Categorized/classes
P3a	Wanted to be a house wife& stay at home. I always fed at home Western Culture had no influence.	Content to take on full mothering role and to feed within the home therefore there was little or no influence on her infant feeding choice	Unaffected by western society
P4a	I'm not working , it would have been harder if I had to work	Unaffected by western society but admits this would have impacted her infant feeding choice had she been working	Unemployed mother felt less restricted with Infant feeding

Participant	Column A	Column B	Column C
	Data charted 5.1 Religion	Elements/dimensions identified	Categorized/classes
P1a	My religion says it's better to breastfeed	Religion had an influence on infant feeding choice	Religion positive impact
P3a	Allah (God) give us special milk in our breasts to feed, why do we need the bottle?	Views breast milk as Gods blessing to the mother	Subject felt grateful and find it logical to want to breast feed her baby

Participant	Column A	Column B	Column C
	Data charted 5.6 Found it to be the natural & easy way to feed	Elements/dimensions identified	Categorized/classes
P2a	I had a lot of milk, I feel I was v.blessed and found it very easy to breastfeed	Felt the breastmilk was a great blessing and found breastfeeding came easily to her	Natural way to feed came easily to subject
P3a	Breast feeding helped me in the night time , when you make a bottle of milk you have to get up, in the night the milk is already in the breast ..it's too hot or cold...I'm not woken fully	A reference to the pros of breastfeeding is made	Subject feels breast is best
P4a	It's easier to breastfeed than to bottle feed	Found breastfeeding to be the easier option between the two breast/bottle	Breastfeeding came easily and naturally to the subject

Categories

Healthcare professional's attitude- encouraged breastfeeding, mothers took onboard the advice

Staff assistance- Patient felt lonely, better support needed and improvement on staff communication

Private spaces/Facilities unavailable for breast feeding outside the home- Mothers chose to stay at home and feed, not really anywhere available for feeding outside of the home, lack of privacy is significant limiting factor to women wanting to breastfeed outside of the home.

Impact of Western Society-Western society had little and no impact on mother's infant feeding decision when they were unemployed and staying at home.

Religion- religion had a positive influence and encouraged women to breastfeed

Choosing Breast over bottled milk – felt that breast was best, found it easier to feed this way rather than to bottle fed.

Summary Women here also express a strong determination to breast feed as did focus group1. Except here the subjects were mostly unemployed and so they felt unaffected by western society. Religion was found /detected as a positive factor. The women here felt that they were not communicated to properly at the time of delivery.



Title of Project: The study of factors affecting infant feeding choices amongst Somali women.

Name of Researcher: Huda Diab

Please tick the box if you agree with the statement:

1. I confirm that I have read and understood the participant information sheet for the above-named study, and have had the opportunity to ask the lead researcher any questions.
2. I understand that my participation is voluntary, and that I am free to withdraw from participating in the study at any time, without giving any reason and without my rights being affected.
3. I agree the focus group being audio-recorded for the purposes of this research project.
4. I agree to take part in the above study.

Participants Name Signature Date

Researchers Name Signature Date

Appendix F

Example Transcript Focus group 2 (5/2/09)

Participants (4) Participant 1B :- 1 What method/ plan of infant feeding did you have in mind before having your baby ? last baby ? prefer to breastfeed/breastfeeding when she had a baby, (1.1)

felt confident with her plan . (1.6) Participant (advice) asked which type of method they would prefer, then asked how they would cope with that method Were you assisted ? Yes - when she had her first baby it was a caesarean and but because she was determined to give breast milk so she would pump the milk and fed the first three months this way , (small baby born at 7 months , she had high blood pressure (first baby was born in Holland –no family at the time of the first baby to offer support)(4 children here in the UK and 3 in Holland-(2 died) she said it didn't matter where she had her babies she already had the mind set that she was going to breastfeed. (2.7)

5. Advice? - was advised by her doctor and so as a consequence he had encouraged her to breastfeed at the time. Rather than family. (2.2)

6. Contacting health professionals for help/support? When she went to hospital her midwife advised her(2.2), and also my religion(4.2) says it's better to breastfeed, also the breast milk is healthier and protects the baby from the many illness there are. (4.3)

Improvements? Yes the health care system does need in improving in what way ? there was a point after delivery where she had to take drugs (ventalin/bentaleen), and she's not 100% sure what was going on and she was taken to the ward and she couldn't even hold her baby and no body was there to help her, they should help her. (3.1)

Did you feel with not being able to speak fluent English that you received the same level of respect as an English speaking woman ? No , it's always the persons who cannot speak English nobody gives them full respect. (3.4)

Did she feel influenced by western culture ? Had to breastfeed at home(5.1), feel like community centers such as the Somali womens are useful there are facilities provided at centre's such as this for breastfeeding women and we feel safe and confident to use them , private space to breastfeed. (5.3)

P2B – felt with her first baby that she had a lot of support, she was in hospital for 1 month , also had high blood pressure (300bp) wed-Friday Lots of support a lot, gave her bath, took care of the baby looking after the baby (2.1)

She had a lot of milk feels she was very blessed and found it very easy to breastfeed. (1.1)

Even the labor three days three different women helped alot looked after alot mom was in Somali ..al in the womens hospital , situation has changed now , sister had a baby 1 or 2 midwives , changed every 3-6 hrs 1996 ...2002....7 months labor ...didn't know when she was having baby ...labor two hours ...easy labor ...2-3 days ..now only one midwife 12 women ...come in every 5-10 mins feels the system is terrible . 1-2 women ..change everybody complaining , They have to change and improve the health care system (3.1)

Encourage family ? some people don't feel supported with their feeding , last lady she was with calling , only there two people mum and her , she felt her sister was unsupported with labor ..

P3B – also when i had my babies here , I had seven children here , during the night they would take the baby to the nursery and this would give a chance to relax and sleep . Last two babies since they take me to the ward , no nursing for babies during the night now, told her she must look after her own child, (asha joins in –this is rude)-

however i was very tired and couldn't even get up , but the baby was crying and i just say I need sleep , but I couldn't sleep with the baby crying, one night places the child between her legs and sleeps upright the midwife comes in and tells her 'you're naughty ' but mariam explains I can't take anymore and I'm tired and I can't carry on like this , no support felt left to their own devices .(3.1) Doesn't feel that they respected her . (3.5)

P2B – when she had her last baby, she requested for them to look after the baby during the night , however they refused and so she locked the room on herself , also felt unsupported(3.1) , translation difficulties etc ...(3.4)

P3B– when she had her first baby(1980) gave her nappies, clothes to change the baby , washed the baby first time round, then after this they bring the baby for me when it's clean and nice and well presented... after this they say I have to wash my own baby(1993) , have to bring your own pyjamas, own nappies (other women can relate), own washing soaps . Nobody helped me , less time. She has ten children 7 were born in England, (2.1)

Family support? At the time I didn't have my family here, just myself and my husband, my husband was very busy with work , but I still breastfeed all of my children(4.1) , except 1 baby who refused the breast, happier and more comfortable with the bottle before this she was crying , I would breastfeed all my babies for up to a year(1.4) , but for one child I stopped after 6 months , breastfeeding alone , after this I started to feed and continue with the breast milk. Would always have to breastfeed at home always,(1.2) I am housewife so I am staying at home even if I go to the shop I would come back and feed them at home , especially at that time I wanted to be a housewife and stay with my kids at home, took on full responsibility of her children chores cooking and cleaning take them to school . always fed at home . (5.1) Western culture had no influence on what she wanted to do ,

Breastfeeding helped me also in the night time, when you make a bottle of milk you have to get up, in the night the milk is already in my breast, I only give it to my baby , it's not cold or hot , I'm not awoken fully to boil the water , put the milk and then make it cool again no it's not like that, that's why I like the breast, when you are breastfeeding you feel more love for your baby, when you are breastfeeding and you feel the milk coming down you have more love for the baby, you feel like there are things you didn't know you feel love, forms a special bond between me and the baby subhanallah, Allah give us special milk in our breasts to feed the baby, why do we need the bottle? (6.5)

Religion ? P4B – wanted to breastfeed(1.1) , husband encouraged her to breastfeed and she too wanted to(2.2) , felt happy to continue with breastfeeding and felt happy to always breastfeed(4.1) , breastfed some children for nine months, some 7 , 8 , 6 but never below that ,some one year and a half (nine kids -4 in England) just breast milk on its own (1.4) Family support? yes, my mum was always with me(2.3) ,Did you feel like you could contact health professionals when you needed ? No, not really (2.6) How did you feel when you were having your babies here in the hospital? it was difficult for me here because at the time I didn't speak English . there was a translator but felt helpless not being able to communicate at the time of labor, experienced complications with the delivery, had a caesarean with her last baby. I think that they should improve what they communicated to me through the translator.

I did have advice from the health visitor, who encouraged me to breastfeed, told me that breastfeeding was healthier, Western culture affected you? Its difficult for Muslim women to breastfeed outside of the home or in a public place, but sometimes there would be places for me to feed, there was a room for women to breastfeed, found other women using the facilities also of mixed cultures, clean and nice room.

Religion? Religion says to breastfeed for two years, I decided for personal reasons to breastfeed for a year and was told by friends that this is a good natural way of contraception and helps to pace the family. I feel my friends assisted me, who had children before. It's also easier to breast feed rather than bottle feed. I'm not working but it would have been harder if I was in work.