Befriending breastfeeding: a home based antenatal pilot for South Asian families.

Naomi Douglas  MSc, GDip PHN, RHV, B Nurs, RGN
Children’s Centre Health Visitor
Mary Seacole Development Award Winner 2010
Final Report October 2011
Acknowledgements

Born in 1805 to a Scottish father and a Jamaican mother Mary Seacole was an accomplished and tenacious nurse and healer whose dedication to inclusivity continues to inspire the nursing profession and many others. It is a privilege to be granted an award in honour of Mary’s work, and to continue to work towards enhanced health for Black and Minority Ethnic groups. I would like to thank the Mary Seacole Steering Group for granting me the opportunity to embark on this journey and am especially grateful to my mentors for their valuable advice and guidance. While this project was conceived of and conducted by myself, its undertaking and completion would not have been possible without the support of committed colleagues. I would particularly like to acknowledge the support of my managers Jane Morley and Sian Taylor from Oxford Health NHS Foundation Trust for allowing me the time and flexibility to focus on this project. I am also indebted to my colleagues from Oxfordshire Children’s Centres, East Oxford Children’s Centre, Florence Park Children’s Centre and Rose Hill Children’s Centre, for not only their partnership, but also their unwavering belief in the project. Their conviction ensured I never lost my vision. They include:-

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vicky Hatch</td>
<td>Operational Manager, East Oxford Children’s Centre</td>
</tr>
<tr>
<td>Merlyn Mistry</td>
<td>BME Health Advocate, Oxfordshire PCT</td>
</tr>
<tr>
<td>Imelda Ryan</td>
<td>Muslim Befriending Network, Family Action</td>
</tr>
<tr>
<td>Norma Thompson</td>
<td>Manager, Florence Park Children’s Centre</td>
</tr>
<tr>
<td>Lynda McKean</td>
<td>Outreach Worker, Florence Park Children’s Centre</td>
</tr>
<tr>
<td>Aurelia Donniselli-Morgan</td>
<td>Children’s Centre Health Visitor</td>
</tr>
<tr>
<td>Tracey Russell</td>
<td>Extended Services Co-ordinator, East Oxford Children’s Centre</td>
</tr>
<tr>
<td>Sakina Butt</td>
<td>Children’s Centre Worker, East Oxford Children’s Centre</td>
</tr>
<tr>
<td>Farhat Abbasi</td>
<td>Children’s Centre Worker, East Oxford Children’s Centre</td>
</tr>
<tr>
<td>Hafsa Akkas</td>
<td>Children’s Centre Worker, Rose Hill Children’s Centre</td>
</tr>
</tbody>
</table>

Above all I am grateful for the support and patience of my fiancé who has been ever present with his wisdom and a listening ear.
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>1</td>
</tr>
<tr>
<td>1. Introduction</td>
<td>3</td>
</tr>
<tr>
<td>2. Context and Background</td>
<td>4</td>
</tr>
<tr>
<td>2.1 Health benefits of breastfeeding</td>
<td>4</td>
</tr>
<tr>
<td>2.2 Breastfeeding rates</td>
<td>5</td>
</tr>
<tr>
<td>2.3 Barriers to breastfeeding</td>
<td>5</td>
</tr>
<tr>
<td>2.4 Ethnic differences in breastfeeding behaviour</td>
<td>6</td>
</tr>
<tr>
<td>2.5 Ethnicity Data</td>
<td>7</td>
</tr>
<tr>
<td>2.6 Support for South Asian families</td>
<td>8</td>
</tr>
<tr>
<td>2.7 South Asian Families in Oxford</td>
<td>9</td>
</tr>
<tr>
<td>3. Aim</td>
<td>10</td>
</tr>
<tr>
<td>3.1 Aim</td>
<td>10</td>
</tr>
<tr>
<td>3.2 Objectives</td>
<td>10</td>
</tr>
<tr>
<td>3.3 Methods</td>
<td>10</td>
</tr>
<tr>
<td>3.3.1 Data collection</td>
<td>12</td>
</tr>
<tr>
<td>3.3.2 Data analysis</td>
<td>13</td>
</tr>
<tr>
<td>3.3.2.1 Questionnaires</td>
<td>13</td>
</tr>
<tr>
<td>3.3.2.2 Evaluations</td>
<td>13</td>
</tr>
<tr>
<td>4. Ethical considerations and information governance</td>
<td>14</td>
</tr>
<tr>
<td>4.1 Ethical approval and consent</td>
<td>14</td>
</tr>
<tr>
<td>4.2 Information governance</td>
<td>14</td>
</tr>
<tr>
<td>5. Limitations of the Study</td>
<td>15</td>
</tr>
<tr>
<td>6. Findings</td>
<td>16</td>
</tr>
<tr>
<td>6.1 Sample</td>
<td>16</td>
</tr>
<tr>
<td>6.2 Knowledge Questionnaires</td>
<td>17</td>
</tr>
<tr>
<td>6.3 Breastfeeding data</td>
<td>18</td>
</tr>
<tr>
<td>6.4 Evaluation results</td>
<td>19</td>
</tr>
<tr>
<td>6.4.1 Reasons given for choice of feeding method</td>
<td>19</td>
</tr>
<tr>
<td>6.4.2 Perceived influence of project on feeding decisions</td>
<td>20</td>
</tr>
<tr>
<td>6.4.3 Would you tell other people to breastfeed?</td>
<td>20</td>
</tr>
<tr>
<td>6.4.4 As part of this project have you heard about the following?</td>
<td>20</td>
</tr>
<tr>
<td>6.4.5 If we hadn’t come to visit would you have had this information from anywhere else?</td>
<td>21</td>
</tr>
<tr>
<td>6.4.6 What were the good things about the project?</td>
<td>22</td>
</tr>
<tr>
<td>6.4.7 Where to go for further support</td>
<td>23</td>
</tr>
</tbody>
</table>
6.5 Staff evaluations
   6.5.1 Ease of integrating with routine work 24
   6.5.2 Themes identified from staff evaluations 24

7. Implications of findings 25
   7.1 Implications for practice 25
      7.1.1 Bilingual Staff 25
      7.1.2 Wider networks 25
      7.1.3 Professional training, diversity and cultural competence 25
      7.1.4 Flexible service 26
   7.2 Implications for research 26
      7.2.1 How to engage with families 26
      7.2.2 Cultural influences 27
      7.2.3 Confidence in breast milk 27

8. Recommendations 27

9. Reporting and Dissemination 28

10. Conclusion 28

References 29

Appendices
   Appendix A  Letter from Chair of Ethics Council A
   Appendix B  Information for clients regarding their voluntary participation in the project
   Appendix C  Letters of introduction
Executive Summary

In the last decade recognition of the impact of social inequalities on health has resulted in a refocus of the public health agenda, with health visitors having a pivotal role (Smith, 2004). The recently elected Coalition government has strengthened this emphasis by specifically underlining a commitment to the redevelopment of the health visitor workforce and strengthening the health visitor position (DH, 2010). While this involvement is in the form of family-centred public health, it is also intended to involve work with the wider community (DH, 2011), and primarily focuses on beginning to address the injustice of inequality before a child is born, acknowledging that early intervention is key to breaking the cycle of deprivation (DH, 2011). The Marmot Review (2010a) clearly acknowledged that inequalities across all areas of life, but particularly in employment, education and skills, impact on life choices and long term health outcomes. These inequalities can be passed on by way of inadequate maternal and child health and so the cycle repeats itself. Such inequalities disproportionately affect those from black and minority ethnic groups (BME) who are more likely to report long-term ill health than their white counterparts due to various contributing factors such as differing attitudes to ill-health, differing function of family units and inequity of access to health care services (Harris & Salway, 2008). Access to health care services is restricted not only by family choices but also by difficulties of location and language.

Numerous initiatives to address these issues have been implemented in the last ten years, from Sure Start centres to reforms within the maternity services, but the level of engagement from women from BME groups such as South Asian is not equal to that of their counterparts. In the locality of Iffley/Cowley in Oxford, there is a high concentration of families from Pakistan and Bangladesh which, despite concerted efforts, have remained hard to reach. This has been evidenced in the very poor uptake of antenatal breastfeeding information services offered routinely to all families. Anecdotal local reports demonstrate that breastfeeding support and information is provided by family members, particularly the mother-in-law, and choices about breastfeeding are made by the wider family. Consequently families...
often choose to mixed feed rather than exclusively breastfeed, often under the misconception that the benefits are equal or that providing formula presents health advantages.

The long term public health advantages conferred by exclusive breastfeeding of infants until the age of 6 months are widely known (Bick, 1999, UNICEF, 2009) but unfortunately breastfeeding figures in the UK are inversely associated with levels of deprivation (McInnes, et. al., 2001) indicating this to be a necessary area of focus for the public health agenda.

This project attempted to redesign current service, and aimed to produce evidence to guide practice to better connect with this group. The review considers evidence provided by the literature base and utilises a home visiting approach to investigate the topic. Results are correlated and compared, and considerations and recommendations for the future are presented.
1. Introduction

In 1990 the Innocenti Declaration recognised exclusive breastfeeding for 4-6 months as the optimal form of nutrition for infants. The Declaration was renewed in 2005 and recommendations were extended to exclusive breastfeeding for 6 months (UNICEF, 2005). The WHO defines exclusive breastfeeding as when an “infant only receives breast milk without any additional food or drink, not even water”. Partial breastfeeding is when a child receives some formula milk and artificial feeding when a child receives only formula (WHO, 2010). As a contributing member state to the Declaration the United Kingdom Department of Health (DH) also advises exclusive breastfeeding for the first 6 months of life (DH, 2010b) yet the 2005 Infant feeding survey found that by 6 months only 25% of babies were breastfed (Bolling et al., 2007). Research into the benefits of ante-natal breastfeeding education produces varied conclusions regarding its efficacy in increasing exclusive breastfeeding (Su et al., 2007, MacArthur et al., 2009). Nevertheless the Oxfordshire Integrated Care Pathway for breastfeeding states that all women should be offered the opportunity to attend an antenatal breastfeeding information session by 26 weeks of pregnancy.

In the locality of Iffley/Cowley in Oxford, there is a high concentration of families from Pakistan and Bangladesh which, despite concerted efforts, have remained hard to engage. This has been evidenced in the very poor uptake of the antenatal breastfeeding information services.

This report presents the methods and results of a pilot project undertaken to redesign current service provision and access the South Asian community of Iffley/Cowley. The intention was to provide them with routine information and empower them to make informed infant feeding decisions. The project was financed by the Mary Seacole Development Awards Scheme, and undertaken in partnership with staff from Oxford Health NHS Foundation Trust (known as Community Health Oxford when the project began) and Oxfordshire Children’s Centres, with contributions from Oxfordshire PCT and the voluntary sector in the planning phase.
2. Context and Background

2.1 Health benefits of breastfeeding

The literature examining the benefits of breastfeeding is extensive and a thorough review is not possible within the confines of this report. However the superiority of breastfeeding over other forms of infant nutrition is clearly demonstrated. A search of the literature base will reveal positive associations with a reduction in childhood cancers (Greaves, 1998), a reduction of atopic disease in the early years of breastfed infants (Kull, et al., 2002). Small significance but repeated associations between breastfeeding and blood pressure (Lawlor, et al., 2004), breastfeeding and obesity (Twell & Newhook, 2010), and an overall associated reduction in the risk of developing type 2 diabetes (Owen et al. (2006). Investigations continue in to associations between breastfeeding and behaviour (Heikkilä et al., 2011).

While health promotion pays much attention to broadcasting the many health benefits conferred by breastfeeding, the importance of exclusive breastfeeding can be overlooked despite clear evidence that the greatest benefit is conferred by exclusive breastfeeding. The Dundee Infant feeding Study conducted by Howie, et al. (1990) compared the incidence of gastro-intestinal infection amongst fully and partially breast fed, and formula fed babies up to 13 weeks and found that breastfeeding significantly reduced illness. This large study was important not only because it was methodologically sound, but also because it examined western children, and compared exclusive and partial feeding.

The recent Duijts, et al., (2010) study from the Netherlands has further strengthened these conclusions by revealing an association only between exclusive breastfeeding and respiratory infection to a minimum of 4 months, whilst partial breastfeeding did not significantly lower infection.

The importance of exclusivity also extends to the health of the mother. In fact the association between breastfeeding and a reduction in the risk of breast cancer is sufficiently strong that in 2007 the World Cancer Research Fund advocated exclusive breastfeeding.
breastfeeding for 6 months as one of its 10 expert panel recommendations for cancer prevention (WCRF, 2007, p.13). The report referred not only to the link between breastfeeding and a reduced relative risk of breast cancer, but also of ovarian cancer.

2.2 Breastfeeding rates

Vital Signs Monitoring Return (VSMR) collects breastfeeding data at birth and six weeks. Local data is also collected at Primary Birth Visit (PBV) between 10 and 14 days post delivery.

![Chart One: Breastfeeding drop off rates from initiation to 6-8 week for Q3 2010/2011](chart.png)

Data above indicate that breastfeeding rates in the project locality are above the national and county averages, although all are still well below 100%. Data pertaining to breastfeeding initiation rates is not available at a locality level.

2.3 Barriers to breastfeeding

A variety of factors influence a woman’s feeding choice ranging from demographic, such as socioeconomic position (McInnes, et. al., 2001) to societal. Britain has a strong formula feeding and weak breastfeeding culture. The normalisation of
artificial feeding begins in childhood and is compounded by aggressive advertising. Unfortunately breastfeeding is often seen as embarrassing, and as a result women are not often openly seen feeding.

For those who do try to breastfeed, establishing effective feeding can be challenging and many give up early due to difficulties (McLeod, et.al, 2002). In reality many of these may be easily overcome but mothers do not receive the correct information from health professionals, or feel they have inadequate support. The National Institute for Health and Clinical Excellence (NICE) recommendations for the provision of both professional and peer support have, in many areas, been shown to be effective (Britton, et al., 2001). However clinical support currently offered is provided by midwives and health visitor teams, who are often highly stretched and may not be able to visit at home when mothers need early intervention.

Social and peer support is more freely available but usually requires women to seek it out in unfamiliar establishments which may not be close to the family home. Indeed leaving the house at a time of perceived crisis, i.e., a baby not feeding, is often unrealistic for many women. Therefore support from within the family or the woman’s close network is crucial for successful breastfeeding, however this is dependent on positive partner and family attitudes to breastfeeding (Swanson & Power, 2005).

2.4 Ethnic differences in breastfeeding behaviour

Despite ethnic disparities in health, which are usually associated with other health inequality determinants such as income, ethnicity tends to be positively associated with breastfeeding initiation (Aspinall & Jacobson, 2004). There is, however, some disagreement on the longer term feeding practices of mothers from minority ethnic backgrounds. In 1997 Thomas and Avery found that although south Asian women were more likely to initiate feeding, they were also more likely to give up by 6 weeks. Yet Kelly, et al., (2006) found in their review of all singleton mothers who participated in the first United Kingdom Millennium Cohort Study Asian women were more likely to breastfeed to 3 months than white women. Other investigations in to
the relationship between ethnicity and breastfeeding have acknowledged that ethnic
groups are not homogenous. Griffiths et al. (2006) noted that Bangladeshi, Pakistani
and white mothers were more likely to stop breastfeeding before 4 months than
black African mothers and those from ‘other white’ or ‘other ethnic’ groups. Thus
broad generalisations about ethnicity and breastfeeding should be made with
cautions. Nevertheless a repeated pattern of behaviour observed in women of ethnic
origin, is decreased breastfeeding with increased acculturation. In their 2008
Hawkins, et al. found that for every 5 years a woman had spend in the UK her
likelihood of breastfeeding to 4 months decreased by 5%. This pattern suggests that
moving from a culture of high breastfeeding to low breastfeeding is likely to have a
negative effect on feeding practices rather than immigrant practices influencing local
culture.

Reduced access to services may also affect breastfeeding practices in this group,
although there is limited data surrounding access to information, due to inconsistent
collection of ethnicity data in primary care. Nevertheless a 2004 NHS review
reported that women from minority ethnic groups used antenatal services less
intensively than their white counterparts (Aspinall & Jacobson, 2004). These results
are repeated in a survey published in 2010 indicating little change in behaviour
amongst this group (Raleigh et al., 2010). Aspinall et. al’s report (2004) highlights the
use of bilingual workers as one means of addressing such difficulties of access.

2.5 Ethnicity Data

Data from 2001 census

<table>
<thead>
<tr>
<th>Ethnicity Compared</th>
<th>White</th>
<th>Asian/Asian British</th>
<th>Black/ Black British</th>
<th>Mixed</th>
<th>Chinese/Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iffley/Cowley Children’s Centres</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001 Census Data</td>
<td>84.7%</td>
<td>7.36%</td>
<td>2.2%</td>
<td>2.7%</td>
<td>3.04%</td>
</tr>
<tr>
<td>Oxford City 2001 Census Data</td>
<td>87.3%</td>
<td>4.8%</td>
<td>2.6%</td>
<td>2.4%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Oxfordshire 2001 Census Data</td>
<td>94.0%</td>
<td>2.2%</td>
<td>1.1%</td>
<td>1.3%</td>
<td>1.4%</td>
</tr>
<tr>
<td>England (2006)</td>
<td>88.7%</td>
<td>5.5%</td>
<td>2.8%</td>
<td>1.6%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
Data from 2009 census of under 5s in Foundation Stage Units

<table>
<thead>
<tr>
<th>Children in BME groups</th>
<th>Asian/Asian British</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iffley/Cowley CCs</td>
<td>22.2%</td>
</tr>
<tr>
<td>Oxford City</td>
<td>13.0%</td>
</tr>
<tr>
<td>Oxfordshire</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Number of children born between January 2010 and June 2010 in East Oxford, Florence Park and Rose Hill Children’s Centre catchment area

*Source: RiO system (extracted on 18/08/2010)*

<table>
<thead>
<tr>
<th>Broad Ethnic Group</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian or Asian British</td>
<td>65</td>
<td>18.1%</td>
</tr>
<tr>
<td>Mixed - White &amp; Asian</td>
<td>10</td>
<td>2.8%</td>
</tr>
<tr>
<td>White - British</td>
<td>141</td>
<td>39.3%</td>
</tr>
<tr>
<td>White - Other</td>
<td>62</td>
<td>17.3%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>22</td>
<td>6.1%</td>
</tr>
<tr>
<td>Mixed - Other</td>
<td>20</td>
<td>5.6%</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
<td>5.3%</td>
</tr>
<tr>
<td>Not stated (Not Requested)</td>
<td>20</td>
<td>5.6%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>359</td>
<td></td>
</tr>
</tbody>
</table>

2.6 Support for South Asian families

Unfortunately there is little literature to address the breastfeeding support mechanisms specifically used by South Asian women, although Swanson & Power (2005) assert that support from within the family or the woman’s close network is crucial for successful breastfeeding. This is reinforced by Twamley et. al (2010) who found that grandparental pressure to introduce formula was a key issue for South Asian women.

Despite these enduring issues there appears a paucity of studies which attempt to redesign health care to more culturally appropriate standards. The exceptions to this are two studies carried out by Ingram, et al. (2003, 2004) in Bristol which examine
interventions aimed at the mother and wider family and reveal a positive association between their involvement and duration of breastfeeding. Both are small studies which limits their external validity, but they offer opportunities for further research in this area.

2.7 South Asian Families in Oxford

In the Iffley/Cowley locality of Oxford there is a high concentration of families from Pakistan and Bangladesh which have remained hard to reach. This has been evidenced in the very poor uptake of ante-natal breastfeeding information services offered routinely to all families. To offer women enough information to enable them to make an informed choice, all women are invited to attend an informal information session about breastfeeding. This session discusses the benefits of breastfeeding, how it works and what mums can expect in the early days and weeks after birth. From April 2009 to April 2010 there was zero attendance by South Asian women and health visitors often find that at the primary birth visits families have already introduced formula. Attendance at the East Oxford Baby Café is approximately 1 per month and attendance at Rose Hill Baby Café is approximately 25% Asian mothers.

In discussion with new parents health visitors identified the following contributing factors:

- Lack of access to traditional networks which support mothers in the perinatal period
- False perception that formula milk is best
- Impact of marketing formula milk, (in country of origin as well as UK)
- Lack of accurate information on breast feeding.
- Lack of understanding of infants’ behaviour in early weeks.
- Feeling that formula feeding is less time consuming
- Perception of healthy weight for babies (chubby babies are healthy babies)
- This is often a perception shared by the father and the extended family that will encourage the introduction of formula feeding.
- With the exception of essential appointments, e.g. GP appointments, it is traditional for mothers to stay in the home (Muslim can be up to 40 days, Hindu 10-14 days)
- Current service provision relies on mothers accessing services outside the home e.g. Breastfeeding clinic, Baby Cafes Current service does not cater for mothers with insufficient knowledge and low motivation to breastfeed
3. Aim

3.1 Aim

To increase the provision of breastfeeding information to women from the South Asian Community in the Iffley/Cowley area of Oxford, during the ante natal period and thereby increase rates of exclusive breastfeeding until 6 months.

3.2 Objectives

3.2.1 Effectively engage with South Asian women and their families in the antenatal period.

3.2.2 Increase knowledge and understanding of breastfeeding, to enable an informed choice.

3.2.3 Support women to exclusive breastfeed to 6 weeks.

3.3 Methods

Target group: South Asian women living within a defined postcode area.

Practitioners: UNICEF trained Children’s Centre (CC) workers of South Asian origin
Children’s Centre Health Visitors (CCHV)
Trained South Asian volunteers

All families were to be offered a set schedule of care, as outlined in the following table.
Identification of appropriate women from local Health Visitor team antenatal lists by designated CCHV.

Allocation to appropriate CC worker.

Once referral is received CC worker sends letter introducing service at approximately 22 weeks gestation.

1 week later CC worker telephones to arrange appointment to visit to discuss service and give knowledge pre-test questionnaire.

CC worker visits according to following schedule:

- 25 weeks gestation – Visit to introduce programme, assess baseline knowledge with questionnaire.
- 27 weeks - Discuss previous breastfeeding (bf) experience/knowledge- importance of support, especially importance of grandmother if present.
- 29 weeks - Visit to discuss benefits of bf, risks of formula, importance of exclusive bf, accessing support.
- 30 weeks - Telephone call to maintain contact.
- 31 weeks - Home visit to discuss positioning and attachment – problem solving
- 33 weeks - Home visit- watch DVD (Bump to breastfeeding) and answer any questions.
- 36 weeks - Telephone call.
- 38 weeks - Telephone call.
- 40 weeks - Telephone call.
- (42)weeks - Telephone call.
3.3.1 Data collection

A variety of data collection methods were used to evaluate the project. Information on breastfeeding status at initiation, primary birth visit and 6 weeks was collected by both health visitors and CC outreach workers, enabling the verification of information and improving the reliability of data collection. The definition of breastfeeding status was as per Department of Health guidelines.

A pre and post test was given to mothers and their mother/mother-in-laws, to assess knowledge and understanding of breastfeeding, and where to access support should they wish to. This questionnaire was presented at the first visit, and the 6 week post-natal visit. Participants were informed that the data collected would be anonymised and that the results of the pre-test would have no effect on the care they received through their pregnancy or in the post-natal period.

Both client and staff experience participating in the project were asked to complete final evaluations regarding their experiences.

Post natal visiting schedule

Day 2 - Telephone call
Day 7 - Home visit
Week 2 - Home visit
Week 3 - Home visit
Week 4 - Telephone call (Home visit)
Week 5 - Telephone call (Home visit)
Week 6 - Home visit and evaluation, breastfeeding data collection and post-test.
3.3.2 Data analysis

3.3.2.1 Questionnaires

Pre-study data was organised under the following headings and each given an aggregate score of 1.

- Knowledge about benefits of breastfeeding
- Knowledge about benefits of formula
- Knowledge about benefits of skin-to-skin contact with babies
- Components of colostrum
- Practical knowledge about breastfeeding (attachment, position, frequency, milk supply)
- Knowledge about breast feeding support

Correct answers from the questionnaire received a score of plus 1 and incorrect answers received a score of -1.

The same aggregate scores were generated from the post study questionnaire, and were then used as comparisons to observe whether there was a difference in knowledge base.

3.3.2.2 Evaluations

Evaluation information regarding family experience of the project was hand coded and then reviewed for recurring themes using a meta-synthesis approach as suggested by Aveyard (2007), which encompasses a thematic analysis. Single word codes are applied to the results section of each paper, and codes are then grouped into themes. Themes are analysed for patterns or contradictions across all evaluation forms and conclusions can be drawn. The process should be repeated at least one to ensure that all codes and themes are identified. This was especially important in this review as it was undertaken by a single novice researcher. Despite repeating the process I am aware it was possible for me to impose bias on the
findings as a result of my personal perspective on the topic of research, and important contradictions in the evidence may have been overlooked.

Quantitative data was generated through closed questions regarding the content of pilot.

Participating staff were also asked to complete evaluation forms, to provide insights into practical issues which may influence planning of future projects or services.

4. Ethical considerations and information governance

4.1 Ethical approval and consent
The Committee Chair of Oxfordshire Research and Ethics Council A was consulted regarding the need for ethical approval for this project. She was satisfied that the initiative fell firmly within service improvement and audit and did not require ethics review by a Research Ethics Committee. An official letter to this effect was received from the Chair and is included in appendix A.

Participants of the pilot were not required to sign a consent form, as the pilot was a redesign of current service. However all participants were informed on their first face to face visit that they could leave the project at any time, without affecting their routine care. This was reinforced with a leaflet, included in appendix B.

4.2 Information governance
Information pertaining to pregnant and expectant women requiring extra support is routinely passed from midwives to health visitors in the ante-natal period, as part of the Healthy Child Programme (DH, 2009). All midwives in the defined catchment area were made aware of the project via leaflets, and emails, and were asked to advertise it to their patients. The project lead also attended a midwife locality meeting to discuss the project with midwives and a midwife representative formed part of the initial working group. Individual midwives provided client contact details to the CCHV managing the project. Families were then sent an introductory letter, constructed with input from Asian workers, from the CCHV in English, Urdu and
Befriending breastfeeding: a home base antenatal pilot for South Asian Families.

Bengali to introduce the pilot and invite them to participate. The letters were translated by the Oxford County Council translation department and are included in appendix C.

All records generated by the project were kept in locked storage as per Oxford Health NHS Foundation Trust and Oxfordshire Children’s Centres policy. Clients’ confidentiality was maintained in accordance with The Caldicott Principles (DH,2003), and all clients were assured that data generated for the project report would remain anonymous.

5. Limitations of the Study

This project had a number of limitations. The duration was very short and results are difficult to achieve in a short time span. The results do not necessarily indicate that the methodology is ineffective, but any repeat of the project should be for a longer period. However the small sample size and lack of control group does limit the external validity of the study.

A number of difficulties throughout the duration of the project required the proposed schedule of care to be altered. Initial discussions with midwifery colleagues proposed that midwives would introduce the project to families and then refer on an opt-out basis. Due to staffing difficulties and time pressure during consultations this did not happen, and client details were then obtained from health visitor ante-natal lists. The impact this had on recruitment to the project is unclear but it is possible that the less personalised method subsequently adopted, whereby families were contacted by letter, may have reduced participation by clients, thus reducing sample size.

Shortfalls in staffing were also experienced by Children’s Centre colleagues, who were including project work as part of their routine outreach services. Reductions in staff numbers, and requirements to support other ongoing Children’s Centre services during the project resulted in some participants not receiving the proposed schedule of care at the allotted times. This may have impacted on the feeding choices families
made as evidence currently suggests that beyond 34 weeks of pregnancy women are less receptive to information about feeding as they are focussed on the birth (DH, 2010).

The lack of standardisation of awareness and knowledge regarding data collection amongst Children Centre workers, resulted in late acquisition and compilation of all questionnaires and evaluation forms. As a result data were subjected to hand coding and rudimentary comparison of mean aggregate scores rather than sophisticated statistical analysis by a computer programme. This limits reliability of the findings.

6. Findings
6.1 Sample

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Approached</td>
<td>23</td>
</tr>
<tr>
<td>Declined</td>
<td>8</td>
</tr>
<tr>
<td>Participated</td>
<td>15</td>
</tr>
<tr>
<td>Withdrew</td>
<td>4</td>
</tr>
<tr>
<td>Completed</td>
<td>11</td>
</tr>
</tbody>
</table>

Families not included:- 4 families identified from the initial Health Visitor antenatal lists were not contacted. 2 of these due to incorrect contact details, 1 moved out of area, and 1 referral was not followed up by CC staff due to resourcing issues.

Reasons for declining or withdrawing:- Most families who declined felt they did not need the service as they would get support from within the family, and they had older children. Some of the families contacted were not able to engage as they were still working and the service was provided within office hours. Other families did not decline, but blocked contact with the mother or were evasive and did not keep appointments. One of the workers on the project explained that culturally to decline might appear impolite whereas not keeping appointments was acceptable and should be taken as a sign the family did not wish to participate.
Prior to the project no South Asian women were attending breastfeeding sessions provided at the children’s centres. Therefore, although the sample contacted is small this does show an increase. 47% of those approached completed the pilot. As the project became known in the community families began to request the service. Language, or literacy barriers and a lack of cultural competence are frequently cited as the largest causes of inequality of access to services for clients from black and minority ethnic backgrounds (Latif, 2010). Yet our pilot indicates that other factors, which may be less easy to define, also impact on client engagement. The difficulties expressed by staff, of keeping appointments indicates a mismatch of values and expectations with regards to appointments and to the service itself. Furthermore clients are expected to keep appointments in “office hours” which may not meet the needs of the family. One of the children’s centre (CC) workers offered to hold a group in her home in the evening as a way of engaging the grandmothers. She explained that this would be acceptable within the community, and would also be considered “neutral” to families who may have contentions between them. Due to professional boundaries and insurance issues, this option could not be pursued. Unfortunately the service in its current form did not have great success in engaging other family members.

6.2 Knowledge Questionnaires

8 families who completed the pilot were asked to complete a pre-test questionnaire to ascertain their knowledge about breastfeeding. 3 families were not asked. This appeared to be due to miscommunication between managers and those completing home visits. Of the 11 families who finished the pilot 9 also completed post-test questionnaires, however these were not all the same families as the pre-tests. Average aggregate scores were compared between the pre and post-test to indicate any improvement in knowledge. These however are not robust and have not been subjected to rigorous statistical analysis so can not be considered empirical evidence. Never-the-less they indicate an increase in the knowledge for the families involved. Scores are shown below.
Mean Aggregate Knowledge Questionnaire Scores

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean Aggregate Score</th>
<th>Benefits of Breastfeeding</th>
<th>Benefits of Formula</th>
<th>Skin-to-skin</th>
<th>Colostrum</th>
<th>Practical Knowledge</th>
<th>Where to get support</th>
<th>Total Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before</td>
<td></td>
<td></td>
<td>2.44</td>
<td>4</td>
<td>3.11</td>
<td>2.55</td>
<td>11.11</td>
<td>3.11</td>
</tr>
<tr>
<td>After</td>
<td></td>
<td></td>
<td>4.55</td>
<td>5.77</td>
<td>3.77</td>
<td>2.55</td>
<td>16.33</td>
<td>3.88</td>
</tr>
</tbody>
</table>

6.3 Breastfeeding data

Comparison of 6 week data with antenatal feeding intention demonstrated that more women were giving formula than had specified antenatally. These data are compromised as many women who stated they intended to breastfeed did not specify whether they intended to do this exclusively.

Antenatal feeding intention

- Totally Breastfeed: 22%
- Partially breastfeed: 22%
- Breastfeed: 45%
- Formula feed: 11%

Total intending to give some breast milk 89%.

Feeding method at 6 weeks

- Totally breastfeeding: 36%
- Partially breastfeeding: 46%
- Formula feeding: 18%

Total giving some breast milk 82%.
6.4 Evaluation results

10 families completed evaluation forms for the pilot. Results are shown and discussed below.

6.4.1 Reasons given for choice of feeding method.

Categories as defined by the WHO (2010) and Department of Health (2010b).

<table>
<thead>
<tr>
<th>Totally Breastfeeding</th>
<th>Partially Breastfeeding</th>
<th>Artificial feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthier for the baby</td>
<td>“Just in case”</td>
<td>Staff gave a bottle</td>
</tr>
<tr>
<td>Protection against</td>
<td>Not enough milk</td>
<td>Staff advised not to give breast milk</td>
</tr>
<tr>
<td>diseases</td>
<td>Family pressures</td>
<td></td>
</tr>
<tr>
<td>Convenience</td>
<td>Easier</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sleeps better</td>
<td></td>
</tr>
</tbody>
</table>

Coding and analysis of evaluations revealed clear themes surrounding feeding choices. Awareness of the health benefits was the primary reason for totally breastfeeding. It was also felt to be more convenient.

Conversely ease was a theme identified by those who partially breastfed. However it was unclear if this referred to physical feeding, or accommodating it with demands of family responsibilities. Family pressures featured strongly and these were also linked to the baby sleeping better, as a sleeping baby released time for women to do other household jobs. Family pressures also encouraged the sharing of feeding with other family members, and were embedded in a belief that breastmilk wasn’t enough for the baby, or that perceived frequent crying indicated insufficient milk supply. Such beliefs suggest that families were unable to accept information explaining the supply and demand nature of milk production. This also influenced their choice to supplement “just in case”.

The circumstances under which families perceived hospital NHS staff to have recommended they gave a bottle were unclear. However once they had received this information from a professional they were reluctant to accept any information.
suggesting they should do otherwise. This highlights the importance of consistent messages being conveyed by professionals across agencies, and reinforces the regard families hold for professional staff.

6.4.2 Perceived influence of project on feeding decisions
Most participants did not feel able to verbalise how the project had influenced their feeding decisions. However those who did exclusively breastfeed stated it was due to reassurance from the project. There was also some reduction in the frequency of formula being given to the babies as a result of the project. Some of the women defied family instructions and one secretly give breast milk to her baby via a bottle, when family members wanted her to give formula.

6.4.3 Would you tell other people to breastfeed?
All participants felt they would tell others to exclusively breastfeed, some had already encouraged others to try breastfeeding despite previous formula feeding. The superiority of breastfeeding over formula feeding was clearly acknowledged at an intellectual level. However there is a clear discrepancy between this and actual behaviour.

6.4.4 As part of this project have you heard about the following?

![Bar chart showing number of families asked and issues discussed.](image)
The importance of enabling informed choice through the provision of appropriate information is fundamental to health promotion and a key facet of client empowerment (Tones, 2001). At 6 weeks post-partum the majority of families were able to recall receiving key messages regarding breastfeeding. Raw results from the questionnaires and evaluations demonstrate increases in knowledge for almost all areas, yet very few women exclusively breastfed to 6 weeks. The implication is thus that increased knowledge is not sufficient to bring about behaviour change. Or indeed that increased knowledge may result in an informed choice, which may still not be that desired by professionals. Certainly the decision making process for infant feeding is complex, and many women indicated that balancing the work of feeding a baby with their other responsibilities was demanding. Additionally women of childbearing age, living in an extended family context, were frequently not in a powerful enough position to determine their child’s feeding method. Yet all acknowledged the ideal of exclusive breastfeeding and were prepared to recommend it to others. The potential for a ripple effect to be seen amongst other women who did not participate, or indeed in their daughters should not be overlooked when considering the value of projects such as this

6.4.5 If we hadn’t come to visit would you have had this information from anywhere else?
6.4.6 What were the good things about the project?

- There is always someone available to help
- Resources
- Demonstrations of positioning and attachment
- Delivered at home
- Skin-to-skin
- Friendly staff
- How information was explained

No families gave feedback regarding content to be removed from the pilot. Suggested changes were that sessions should be delivered in Children's Centres so they could talk to other mothers and watch the DVD together. This option had been trialled originally, however attendance was very poor. Another family suggested sessions be offered at the time Bounty Packs are distributed. However this suggestion raises a number of issues. Bounty Packs are distributed via midwives, who were unable to engage with this project, and who are restricted in their ability to participate in partnership ventures in Oxfordshire, due to capacity difficulties. It is therefore currently unclear to HV teams and CCs if packs are distributed in a routine fashion. The distribution of advertising material within a service aimed at increasing the provision of free nutrition for infants might also open up an ethical debate.

Certainly those women who did participate clearly identified that they would not have received the information from other sources, or would have received very little. Participants were enthusiastic about the project and appreciated receiving information in a variety of formats, in their home environment. The ability to communicate in their own language and ask questions was highlighted as important, as were the staff themselves. The importance of the relationships that were built over time cannot be underestimated when considering the efficacy of engaging with these families. Cultural traditions and roles continue to strongly influence behaviours. New information must be provided in line with this and requires confidence and respect for the information provider by the family. The intensity of
contacts enabled, CCs, via the workers, to attain an “acceptable” status with the families and as a result of the home visits, some have begun to attend the centres.

6.4.7 Where to go for further support

All families indicated they knew where their local Children’s Centres were and that they planned to attend. While very few women exclusively breastfed to 6 weeks more women utilised the support available than prior to the pilot. Children’s centre (CC) workers completed home visits in the post natal period to support with positioning and attachment, loaned breast pumps and liaised with community midwifery staff to ensure women had the support they wanted. Some women also attended the CCs for support and one woman expressed her milk at the centre and then returned home to her mother-in-law who gave it in a bottle, under the guise of formula. Such action demonstrates the commitment of the mother to provide her child with her own milk. Although a testament to the CC workers of their success in working with the family, this situation also raises ethical issues, particularly surrounding the potential safety of women who go against their families’ wishes.

All participants were confident about where they could obtain breastfeeding support if they wished, and particularly cited CCs as venues for this. Interestingly women still considered their GP as an option for support with breastfeeding difficulties, despite never receiving this information from the CC workers.
6.5 Staff evaluations

6.5.1 Ease of integrating with routine work

Average amount of time spent on visits 45-60 minutes
Average amount of time spent on calls 2-3 hours
Average time for documentation 10-15 minutes per visit

6.5.2 Themes identified from staff evaluations

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff enjoyed the project.</td>
<td>Not enough time available/time consuming.</td>
</tr>
<tr>
<td>Learned a lot about other agencies.</td>
<td>Difficulties of families receiving conflicting advice from midwives in the very early days.</td>
</tr>
<tr>
<td>Consolidated breastfeeding knowledge.</td>
<td>Needed a longer project.</td>
</tr>
<tr>
<td>Benefits of taking information in to the community.</td>
<td>Difficult to address cultural issues such as the requirement to be “doing something”.</td>
</tr>
<tr>
<td>Benefits of building early relationships with families.</td>
<td>Difficult to engage family members.</td>
</tr>
<tr>
<td>Word of mouth –other families began to request service.</td>
<td>Families had different values regarding keeping appointments.</td>
</tr>
<tr>
<td></td>
<td>More joint working with Health Visitors would improve engagement due to “medical” status.</td>
</tr>
</tbody>
</table>
While staff reported high job satisfaction when delivering this service such intensive contact was very difficult to integrate with regular work. This reduced the likelihood of effective engagement if they were under time pressure. Ultimately the service was deemed to be unsustainable past the end of the pilot, due to personnel constraints.

7. Implications of findings

7.1. Implications for practice

7.1.1 Bilingual Staff
As recommended in the literature base, bilingual staff are essential to providing an equitable service to families (Aspinall & Jacobson, 2004). However breastfeeding is a complex issue which has many cultural influences. To address these effectively the breastfeeding support workforce needs to reflect multi-cultural population we serve and be culturally competent. Such staff need to be sufficient in number, and have enough available time to provide a consistent service and acquire the confidence and trust of communities, before they will be able to achieve long term behaviour change in their clients. Equally programmes require a realistic timeframe to have an impact. The longevity of a project or programme of this nature will affect how well information becomes embedded in a community.

7.1.2 Wider networks
Conflicting messages regarding breastfeeding and cultural expectations of women’s roles which impact on the ability of women to exclusively breastfeed, require health promotion to be communicated by a wider network. Professionals should engage in partnership working with local mosques, community champions and other organisations to achieve wider understanding and long term behaviour change.

7.1.3 Professional training, diversity and cultural competence
The high regard shown to health visitors and GPs as medical professionals highlights the need for more training in the area of breastfeeding, so consistent messages can be relayed to families. It is important to engage GPs in such training programmes as
they do not traditionally receive in depth breastfeeding education, but are identified by clients as resources for support. The care of families should be conducted under models of transcultural medicine or nursing incorporating cultural understanding and context into care. It would be an advantage for professional staff in areas of high ethnicity to be equipped with some skills in the majority languages of the area, and professionals from BME backgrounds should be actively recruited to reflect the diversity of the population.

7.1.4 Flexible service
The difficulties of accessing families highlight issues of social isolation. In Oxford there is no longer a place for women to gather which is considered culturally acceptable. Previous women’s groups held at the local Asian Cultural Centre were poorly attended, and the South Asian community is not homogenous, yet feedback indicates that women would have liked to discuss issues with their peers. While home visits are clearly well received, consideration should also be given to the possibility of providing groups in family homes at a time which is convenient to clients. Certainly pre-test market research should be undertaken for the communities staff are trying to access to determine where they are most likely to attend, rather than only offering services at Children’s Centres or health care facilities.

7.2 Implications for research
7.2.1 How to engage with families
Results of this project indicate significant areas for research. The gatekeepers to women are the elders (Becher & Husain, 2003), particularly the grandmothers. Projects which address behaviour will always be limited in their success if they cease to work within this construct. Therefore a primary area for further research must be around how and where to engage the senior women in communities. Questions which examine why families and communities remain reticent also need investigating. Despite addressing language and cultural understanding by utilising South Asian workers, this project continued to experience difficulties engaging with
families, suggesting there are other unidentified factors which contribute to health access inequalities, continued research in this area is required.

7.2.2 Cultural influences
All the women involved with the project were aware that breastfeeding was good for their baby, but found it difficult to juggle with other household responsibilities. This was particularly evident in multi-generational households. A question thus arising from this project is “How does breastfeeding fit into cultural roles and expectations of women?” and where should information be targeted?

7.2.3 Confidence in breast milk
Despite demonstrating an increase in knowledge and understanding of breastfeeding, there was still an underlying lack of confidence that breast milk is sufficient. This question needs further exploration to determine how health promotion should communicate messages about breast milk to families.

8. Recommendations
On completion of this project the following recommendations are made:

- Health and Social Care services should actively recruit and train more South-Asian women to specific breastfeeding support posts, and as part of the strategy to increase the health visitor workforce the Department of Health should specifically target nurses of South-Asian origin to become Health Visitors.

- To achieve breastfeeding behaviour change Public Health England should implement long-term initiatives not subject to review at each end of financial year.

- Appropriate breastfeeding training should be included in training of GPs.

- Community and Health services should consider alternative locations and timings, acceptable to target communities, for information sessions.
Organisations, such as Children’s Centres, responsible for the promotion and training of breast feeding should recruit breastfeeding peer supporters and peer champions from local BME communities.

Targeted packages of breastfeeding education within ‘Universal plus’ and ‘Universal partnership Plus’ should be explored within the new service model for health visiting.

Further research is needed to understand how to best meet the needs of South-Asian communities in Britain.

9. Reporting and Dissemination

The findings of this report will be used to inform the development of an outreach programme to deliver ante-natal breastfeeding information to hard-to-reach groups. They will also enlighten the development of any further breastfeeding support worker roles.

This detailed report will be submitted to the Mary Seacole Steering group, presented at a gathering of project contributors and presented to Children’s Centre and Oxford Health (NHS) operational managers. Findings will be presented at local and national conferences and be submitted for publication in an appropriate professional journal.

10. Conclusion

The introduction of a small service redesign pilot has demonstrated an ability to increase knowledge and understanding about breastfeeding among South-Asian women, but this did not of itself result in behaviour change manifested by increased rates of exclusive breastfeeding at 6 weeks. Provision of a home-based visiting service did increase the numbers of women from this community accessing ante-natal breastfeeding information, and was very well received by participants, however the project was not successful in engaging with family members and less than 50% approached accepted the service. The results of this project highlight further areas of research regarding engagement with this community and reinforce the need for long-term public health issues to be addressed by long duration public health initiatives.
References


World Health Organisation (2010) Exclusive breastfeeding. Available at:
Appendices

Appendix A  Letter of opinion from Chair of Ethics Council A
Appendix B  Information for clients regarding their voluntary participation in the project
Appendix C  Letters of introduction
Appendix A  Letter of opinion from Chair of Ethics Council A
24 November 2010

Dear Sir/Madam

Chair’s opinion            Mary Seacole Award Project
Naomi Douglas, Children’s Centre Health Visitor

*Befriending Breastfeeding: a home based antenatal pilot for South Asian families*

I have reviewed the project proposed, to increase the provision of breastfeeding information to women from the Asian Community in a specific area of Oxford, during the antenatal period, and thereby increase rates of exclusive breastfeeding until 6 months.

I am satisfied that the initiative falls firmly within service improvement and audit and does not require ethics review by a Research Ethics Committee.

Should you require further information, please do not hesitate to contact me.

Dr Karen Melham
Committee Chair, Oxfordshire REC A

Email: karen.melham@dphpc.ox.ac.uk
Tel: 01865 287890

Researcher in Ethics,
HeLEX, Centre for Health Law and Emerging Technologies
University of Oxford
Richards Building, Old Road Campus
Oxford OX3 7LF

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics committees in England.
Appendix B  Information for clients regarding their voluntary participation in the project
Befriending Breastfeeding: a home based antenatal pilot for South Asian families.

You are invited to take part in a pilot service to be made available to women of South Asian origin in the East Oxford, Florence Park, and Rose Hill areas of Oxford. This pilot is offered in addition to your routine maternity care. The purpose of the pilot is to offer breastfeeding support to women and learn about breastfeeding in the South Asian community.

This service will be offered to all South Asian pregnant women and their senior female support person. This might be your mother, mother-in-law, sister, or any person you think will be most influential for you once the baby is born. We strongly encourage you to have your support person with you at as many contacts as possible during the pilot.

During the course of this pilot you can expect to receive:

- 3 home visits from your support person to discuss breastfeeding, learn what you know and discuss any questions you may have.
- Telephone contact until your baby is born.
Contact from your support person every 2 weeks between 30 weeks of pregnancy and birth.

Contact at 2 days, 9 days and weekly until 6 weeks after the baby is born to offer support and information about breastfeeding.

At your 6 week post natal visit, we will ask you to complete an evaluation to let us know what you think about the service.

Your participation in this pilot is optional and you are entitled to leave the pilot at any time. Withdrawal will not affect your maternity care in any way.
Appendix C   Letters of introduction
East Oxford Children’s Centre
The Union Building
Collins Street
OX4 1EE
07768 641 637

Dear ,

There is a new breastfeeding service we have designed especially for South Asian families living in the East Oxford, Florence Park, and Rose Hill areas of Oxford. This service is part of your routine maternity care and we are asking you to participate. The best for you and your baby is to give only breastmilk for 6 months and is important for long term health and well being.

This service will be offered to all South Asian pregnant women and Their senior female support person. This might be your mother, mother-in-law, sister, or any person you think will be most influential for you once the baby is born.

Your midwife provided me with your contact details as she felt you might be interested in participating. One of the Children’s Centre workers who is supporting this project will contact you to arrange a visit to discuss it more.

I hope you will consider taking part.

Yours thankfully

Naomi Douglas
Health Visitor
East Oxford Children’s Centre
(Naomi Douglas)

Children's Centres
For families in Oxfordshire

Oxfordshire Community Health

07768 641 637

OX4 1EE

A childminder's job is to care for children in their own home, to provide a safe and stimulating environment for the children to play and learn. The role of a childminder is to provide a loving, caring and safe environment for the children, to help them develop their skills and abilities, and to support their overall development. Childminders are responsible for ensuring the children's physical and emotional well-being, and for providing a nurturing and supportive environment. They are also responsible for ensuring that the children are safe and happy, and for ensuring that they are provided with a healthy, nutritious and balanced diet. Childminders are expected to be knowledgeable in all aspects of childcare, including helping children to learn to interact with other children and their environment, and to develop their independence and confidence. They are also expected to be able to work effectively with parents and other professionals, and to be able to maintain a positive and professional relationship with all those involved in the children's care. Childminders are expected to be able to work alongside other professionals, such as doctors, nurses, and social workers, to ensure that the children's needs are met in the best possible way. Childminders are also expected to have a good understanding of the children's development and learning, and to be able to provide a stimulating and challenging environment for the children to learn and develop. They are also expected to be able to work effectively with parents and other professionals, and to be able to maintain a positive and professional relationship with all those involved in the children's care. They are also expected to be able to work alongside other professionals, such as doctors, nurses, and social workers, to ensure that the children's needs are met in the best possible way. Childminders are also expected to have a good understanding of the children's development and learning, and to be able to provide a stimulating and challenging environment for the children to learn and develop. They are also expected to be able to work effectively with parents and other professionals, and to be able to maintain a positive and professional relationship with all those involved in the children's care. They are also expected to be able to work alongside other professionals, such as doctors, nurses, and social workers, to ensure that the children's needs are met in the best possible way. Childminders are also expected to have a good understanding of the children's development and learning, and to be able to provide a stimulating and challenging environment for the children to learn and develop. They are also expected to be able to work effectively with parents and other professionals, and to be able to maintain a positive and professional relationship with all those involved in the children's care. They are also expected to be able to work alongside other professionals, such as doctors, nurses, and social workers, to ensure that the children's needs are met in the best possible way. Childminders are also expected to have a good understanding of the children's development and learning, and to be able to provide a stimulating and challenging environment for the children to learn and develop. They are also expected to be able to work effectively with parents and other professionals, and to be able to maintain a positive and professional relationship with all those involved in the children's care. They are also expected to be able to work alongside other professionals, such as doctors, nurses, and social workers, to ensure that the children's needs are met in the best possible way. Childminders are also expected to have a good understanding of the children's development and learning, and to be able to provide a stimulating and challenging environment for the children to learn and develop. They are also expected to be able to work effectively with parents and other professionals, and to be able to maintain a positive and professional relationship with all those involved in the children's care. They are also expected to be able to work alongside other professionals, such as doctors, nurses, and social workers, to ensure that the children's needs are met in the best possible way. Childminders are also expected to have a good understanding of the children's development and learning, and to be able to provide a stimulating and challenging environment for the children to learn and develop. They are also expected to be able to work effectively with parents and other professionals, and to be able to maintain a positive and professional relationship with all those involved in the children's care. They are also expected to be able to work alongside other professionals, such as doctors, nurses, and social workers, to ensure that the children's needs are met in the best possible way.
শ্রেয় শ্রেয়, 

শিশুদের সন্তানের বিষয়ে আমরা নতুন একটা সেবা ব্যবস্থা চালু করেছিলি যা অক্সফোর্ড শহরের ইটন অক্সফোর্ড, ক্লারসেড পার্ক এবং রোজ হিল এলাকায় বসবাসকারী দক্ষিণ এশিয়ার পরিবারগুলির জন্য বিশেষভাবে পরিকল্পনা করা হয়েছে। সম্ভবতেও রূপান্তরিত হয়ে আমরা আপনাকে দেখতে চাইতে অংশগ্রহণের জন্য আমাদের সামর্থ পূর্ণ করে। শিশু জন্মাবার পরে গ্রীষ্মকালে তাদের শুধু রুটের ধরা খাওয়ানো। আপনার ও আপনার শিশু দুইজনের জন্য এই সব থেকে ভালো এবং ভাবনায় স্বাস্থ্য ভালো রাখার জন্য প্রতিষ্ঠানের সরাসরি সহায়তা গ্রহণ করার জন্য আমরা অনুমোদন করি।

দক্ষিণ এশিয়ার পরিবারগুলিতে সন্তানসমূহের সব মা, কোন সব মহিলা তাদের সাহায্য করে থাকেন তাদের সকলের জন্য এই সেবার ব্যবস্থা করা হয়েছে। এই বয়স্ক মহিলা হয়তো আপনার আমা, শাস্ত্রী, বোন, বা অন্য যে কোনও মহিলা যিনি বাচ্চা তুলিয়ে হার পরে আপনাকে সব থেকে দেশি সাহায্য করেন বলে আপনি মনে করেন।

আপনার সাথে যোথোপো করবার চিকিৎসা আমাকে জানিয়েছেন আপনার মিডিয়ার কারণ তার মনে হয়েছে যে আপনি হয়তো এতে যোগ দিতে পারেন। চিল্ডসেন্টার (Children's Centre) বা শিশুদের সেটারের কথা যা এই প্রকল্পে কাজ করছে, তাদের মধ্যে একজন আপনার সাথে যোথোপো করেন ও এই বিষয়ে আরও আলোচনা করবার জন্য আপনার বাসায় নিয়ে দেখা করবার ব্যবস্থা করেন।

আশা করি যে আপনি এতে যোগ দেবার বিষয়ে ভিত্তি দেখবেন।

ধনাদার,

নেওমি ডগ্ল্যাস
হেলথ ডিভিশন
ইটন অক্সফোর্ড চিল্ডসেন্টার সেন্টার

Naomi Douglas
Health Visitor
East Oxford Children’s Centre
Funded by the Department of Health

Supported by Oxford Health NHS Foundation Trust and
Oxfordshire Children’s Centres