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The impact of transnational migration on intergenerational transmission of knowledge and practice related to breast feeding

Alison McFadden, MA, Cert. Ed, RM, PhD (Research Fellow)[a,*],
Karl Atkin, BA (Hons), DPhil (York) (Professor)[b],
Mary J. Renfrew, BSc, RGN, RM, PhD (Professor of Mother and Infant Health)[a]

[a] School of Nursing and Midwifery, University of Dundee, 11 Airlie Place, Dundee DD1 4HJ, UK
[b] Department of Health Sciences, Seebohm Rowntree Building, University of York, Heslington, York YO10 5DD, UK

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ABSTRACT

Objectives: the aim of this study was to explore how migration from Bangladesh to the UK influenced the transmission of knowledge and practice related to breast feeding from one generation to the next.
Methods: this qualitative study used an ethnographic approach and comprised two focus group discussions with 14 grandmothers who had migrated from Bangladesh to the UK and in-depth interviews with 23 mothers of Bangladeshi origin who had breast fed in the UK within the previous five years. The focus group discussions and 10 of the interviews with mothers were conducted in Sylheti by a bilingual researcher. The study took place in four localities in northern England in 2008.
Findings: grandmothers and mothers of Bangladeshi origin emphasised the importance of intergenerational transmission of knowledge and practice related to breast feeding. However, migration disrupted this transmission through isolating women from their female kin, exposing them to a society in which breast feeding is mostly hidden and that privileges health professionals as an important source of information about breast feeding.
Conclusions and implications for practice: understanding how migration influences the knowledge and advice that grandmothers pass on to younger mothers could help health professionals facilitate family support for breast feeding. Health professionals could start by asking grandmothers about their experiences of breast feeding in their countries of origin and the host country. Where relevant, previous poor professional support for breast feeding should be acknowledged. Health professionals should not underestimate their role in influencing breast feeding decisions of mothers of Bangladeshi origin.

Introduction

This paper focuses on the intersection of ethnicity, family influence and transnational migration. More specifically it addresses how migration from Bangladesh to the UK influenced the role of grandmothers in the breast feeding practices of their daughters/daughters-in-law living in the UK, and the implications this may have for breast feeding promotion.

As way of background, most migrants from Bangladesh arrived in the UK in the latter half of the 20th century, commencing in the 1950s with unaccompanied men who were mostly employed in unskilled jobs in factories and textile mills (Peach, 2006). Migration of women and children increased in the 1970s and 1980s before tighter immigration controls were imposed (Peach, 2006). Women of Bangladeshi origin who are grandmothers today were likely to have been the first women in their families to arrive in the UK, and were thereby isolated from their female support networks (Katbamna, 2000). The relatively recent migration of families means that the Bangladeshi community in general have close links and emotional ties with Bangladesh (Katbamna, 2000). Many women arriving in the UK from Bangladesh had low levels of formal education and knew little English and this resulted in disadvantage and isolation (Modood et al., 1997). However, this may be changing now with evidence of increasing participation in higher education and paid employment in the UK (Dale et al., 2002a; Aston et al., 2007). Women of Bangladeshi origin who have grown up in the UK are likely to have very different experiences from their mothers, although the Bangladeshi population in the UK remains one of the most socio-economically disadvantaged of all groups (Dale et al., 2002b; Eade and Garbin, 2002; Barn and Sidhu, 2004).

National and international policy recommendations that infants should be exclusively breast fed for around six months (WHO, 2003; EU Project on Promotion of Breastfeeding in Europe, 2004; DH, 2012)

* Corresponding author.
E-mail address: a.m.mcfadden@dundee.ac.uk (A. McFadden).

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reflect robust evidence that breast feeding optimises health outcomes for infants and their mothers (e.g. Collaborative Group on Hormonal Factors in Breast Cancer et al., 2002; Horta et al., 2007; Ip et al., 2007; Quigley et al., 2007; Heikkila et al., 2011). Breast feeding has also been shown to contribute to reducing health inequalities (Field, 2010; DH, 2012) and health service costs (Renfrew et al., 2012). In the UK, whereas women from minority ethnic groups are more likely to initiate and continue breast feeding than the majority white population (Griffiths et al., 2005; Kelly et al., 2006; McAndrew et al., 2012), levels of exclusive breast feeding are low for all groups, with 23% breast feeding exclusively for six weeks and only 1% for six months (McAndrew et al., 2012). For mothers of Bangladeshi origin in the UK, over 90% initiated breast feeding compared to 70% of white British mothers but only 29% were predominantly breast feeding at three months (Kelly et al., 2006). Rates of breast feeding are higher in Bangladesh where it is reported that 98% of babies received some breastmilk, the median length of breast feeding was 33 months and 43% of infants less than six months old were exclusively breast fed (National Institute of Population Research and Training, 2009). This suggests that migration from Bangladesh to the UK has a potentially negative impact on breast feeding.

Other studies have reported similar reductions in breast feeding following migration from a low-income to a high-income country, for example, for Vietnamese women migrating to Australia (Rossiter, 1992; Nguyen et al., 2004), Mexican women to the US (Gibson-Davis and Brooks-Gunn, 2006; Harley et al., 2007), and women from India, Bangladesh and Pakistan to the UK (Hawkins et al., 2008; Twamley et al., 2011). This reduction in breast feeding following migration has frequently been explained by the concept of acculturation (e.g. Rassin et al., 1994; Gorman et al., 2007; Choudhry and Wallace, 2012), defined as the process by and extent to which migrants adopt the attitudes, values and behaviours of a new culture (Landrine and Klonoff, 2004; Manly and Mayeux, 2004). However acculturation has been criticised as offering essentialist explanations based on cultural stereotypes and ignoring the influence of contextual factors such as socio-economic status, history of migration and changing family norms, independent of acculturation, on health behaviours in the host country (Hunt et al., 2004). A study of breast feeding among Vietnamese women in Canada (Groleau et al., 2006) suggested that the cultural configuration of social space in Canada precluded maternal grandmothers from carrying out specific practices such as providing steam baths and massaging the new mother. In the absence of these practices mothers doubted the quality of their breastmilk and many chose to formula feed (Groleau et al., 2006). This suggests that explanations for changes in infant feeding practices following migration are more complex than the concept of acculturation would suggest and that family influence is a key factor.

Studies have shown that women's infant feeding decisions are strongly influenced by their social networks, chiefly female family members (Hoddinott and Pill, 1999; Whelan and Lupton, 1998; Ekstrom et al., 2003; Marshall et al., 2007; Grassley and Eschiti, 2008; Reid et al., 2010). Consequently there has been interest among health practitioners in involving grandmothers in breast feeding promotion activities (Ingram et al., 2003; Grassley and Eschiti, 2011). In many low-income countries such as Bangladesh, where extended, multigenerational families are the norm and older experienced women play a central role in the lives of mothers and children, the influence of grandmothers on infant feeding practices is particularly salient (Aubel et al., 2004; Masvie, 2006; Bezner Kerr et al., 2008; Aubel, 2012). It is unclear how the role of grandmothers in breast feeding changes when families migrate from a low-income to a high-income country and what implications this has for promoting breast feeding.

Our study of breast feeding practices of women of Bangladeshi origin living in the UK aimed to explore how migration from Bangladesh to the UK influenced the transmission of knowledge and practice related to breast feeding from one generation to the next. We were interested in the extent to which grandmothers maintained their central role as advisors and decision-makers in the face of professional information and advice related to breast feeding and the implications of this for supporting women of Bangladeshi origin to breast feed.

Methods

The findings reported here are drawn from a larger qualitative study exploring the breast feeding experiences of women of Bangladeshi origin living in the UK (McFadden et al., 2012). As well as the interviews with mothers and focus group discussions with grandmothers from which the data presented in this paper were drawn, the original study included one focus group discussion with fathers of Bangladeshi origin and five focus group discussions with health professionals. The study took place between 2008 and 2010 in four localities in northern England. Two localities were in large multicultural cities in West Yorkshire, whereas the other two localities were a city and a town in the north east of England, both of which have small minority ethnic communities. The study used an ethnographic approach to investigate how mothers and grandmothers ascribed meaning to their actions and how these were negotiated within social contexts (Spradley, 1979). The study was approved by a NHS Research Ethics Committee. Informed consent was obtained by the researchers and anonymity and confidentiality assured.

We conducted focus group discussions with grandmothers to explore normative values (Kitzinger and Barbour, 1999) and in-depth interviews with mothers to generate more individual narratives (Silverman, 2006). The samples of grandmothers and mothers were separately drawn and were not grandmother/mother pairs or related to each other. However, within the sample of mothers, there was one mother/daughter pair (M18, M10 respectively). Grandmothers and mothers were purposively recruited by bilingual development workers in four neighbourhoods In the first phase of the study, 14 grandmothers who self-identified as 'Bangladeshi' and had at least one grandchild who had been breast fed in the UK participated in two focus group discussions (see Table 1). The grandmothers were identified by community development workers from two inner city neighbourhood projects. One group of grandmothers attended a weekly lunch club for elderly women of Bangladesh origin whereas the other group was known to the community development worker through her work with local women.

The second phase of the study comprised individual interviews with 23 mothers of Bangladeshi origin who had breast fed at least one child in the UK in the previous five years. The mothers were purposively sampled for maximum diversity including place of birth, maternal age, parity, level of education and main language, to reflect the profile of the UK Bangladeshi population (Table 2). In the two localities in the north east of England, the women were recruited through Sure Start children's centres. Some of the women attended activities in the children's centres whereas others were identified by community midwives. In West Yorkshire the women were identified by the same community development workers who recruited the grandmothers. In one neighbourhood centre the women had attended health education sessions for pregnant women and new mothers whereas in the other, they were recruited from a child health clinic. Study information was translated into Bengali and checked by a bilingual community worker. Most of the grandmothers spoke Sylheti, a spoken dialect