

## Practice report

# Embracing diversity in community healthcare settings: developing a client-centred approach to weaning support

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### ABSTRACT

Embracing diversity within a multi-ethnic and multi-faith population is an ongoing challenge for healthcare practitioners who seek to deliver patient-centred care. This paper presents an account of a pilot scheme intended to provide client-centred help with weaning to 30 British Bangladeshi families through a specially trained support worker (infant feeding advisor).

The infant feeding advisor visited each family at their home a minimum of five times during the weaning period, the final visit being when the child was one year old. Following the completion of the intervention, each family was visited by the project health visitor to evaluate progress. Evaluation showed that, in the majority of families, the pilot scheme was helpful. Parents' responses appeared to indicate that one of the benefits of employing infant

feeding advisors who were empathetic and knowledgeable about the culture of the families, and who had the relevant language skills, was a more effective exchange of health information and improved dialogue between the client and practitioner. Women, both mothers and grandmothers, showed an increased acceptance and use of health information, suggesting that the encouragement of a client-centred approach should be given priority in the development of new services. This pilot demonstrates that the development of patient-centred services achieves not only improvements in health but also increased awareness of health issues among a diverse population.

**Keywords:** Bangladeshi, client-focused, feeding advisor, support worker

## Introduction

There is increasing recognition that nutrition in the early years of life is an important contributory factor to both short- and long-term health. In order to ensure that nutritional advice is responsive to new evidence and best practice, the Department of Health is informed and advised by the Food Standards Agency (FSA) and the Scientific Advisory Committee on Nutrition (SACN). In May 2003 the UK issued guidelines initially recommended by the World Health Organization that infants should be exclusively breast-fed for the first six months (26 weeks) of life. More recently, the Department of Health revised its guidelines to include delaying the introduction of

solids to six months for both breast and formula-fed babies (Department of Health, 2004).

## Communication

A key challenge for health professionals is the communication of best practice to clients. This challenge becomes more complex in situations in which clients and professionals do not share the same language, or those in which clients may not readily have access to written sources of information. Many of the British

Bangladeshi community living in the UK do not speak English and are thus disadvantaged in their encounters with the health service. A significant part of the community originates from the district of Sylhet in the north-east corner of Bangladesh close to the hills of the Indian state of Assam. Many Bangladeshi women have, at most, received a few years of primary school education, which enables them to read simple Bengali but not the equivalent of an English broadsheet, the form often used for health information. The mother tongue spoken in the Sylhet district of Bangladesh is Sylheti, a dialect which has no written form and which is quite distinct from Bangla. Many members of the British Bangladeshi community who originate from Sylhet therefore struggle to understand the educated Bangla language.

Most Bangladeshi women therefore do not have ready access to health information in English or their mother tongue. In their meetings with health professionals an interpreter can minimise difficulties, but cannot remove them. Consequently, Bangladeshi mothers may not be able to find the information and advice they need, for example, in relation to child health. A national survey found that Bangladeshi parents expressed the highest levels of concern of all groups in relation to their children's feeding (Thomas and Avery, 1997).

## Weaning patterns

Studies about weaning from the point of view of parents are relatively rare, particularly when seeking parents' perceptions in the South Asian community. One such study by Sarwar (2002) investigated feeding practices by Pakistani women both in the UK and in Pakistan. However, there is an extensive literature from the 1970s to the present day that records health professionals' concerns and observations relating to weaning practices and children's feeding patterns within the South Asian community in the UK. The literature often describes feeding practices that result in an inadequate diet and, by implication, the failure of health visitors to effect change in the family's management of the weaning period (Griffiths, 2000). The prolonged and excessive use of milk, as well as dependency on sweetened weaning foods, are consistently cited as contributory factors to the high levels of iron deficiency anaemia found in children from South Asian ethnic backgrounds (Daly *et al*, 1996; Lawson *et al*, 1998). However, such studies, generally, do not engage with the reasons why health professionals might be ineffective in their advice, or explore why families offer their children a diet that relies heavily on milk and sweetened baby foods extending into the toddler period. Yaha (2001) provides an exception in

writing frankly and sympathetically about her experiences both as a daughter and mother in a Bangladeshi family and as a health visitor working in Tower Hamlets. She mentions the difficult problem of force feeding, which 'good' mothers do to ensure that their children eat well. Fat children are seen as healthy and a sign of good parenting. The health professional, however, may perceive the situation differently as she sees a child, who is force fed, food averse and crying at the sight of a spoon. Yaha (2001) also recognises the effect of spiritual beliefs on weaning practices, and their relevance to data analysis will be referred to later.

During the last 20 years, a number of studies have concluded with fairly general recommendations for improving weaning practice; for example, the use of pictorial charts, and the need for cultural sensitivity and using interpreters. These rather vague observations give justification to Bhopal and White's (1993) identification of the need for research within the field of health promotion for ethnic minority groups that has clear measurable objectives. Similarly Randhawa *et al* (2000) suggest the advantage of a focused approach is, 'to make progress in a handful of target areas – with the option to evaluate, and the possibility of identifying workable models for successful action ...'

Two specific areas of interest emerge from this review. First, there is a dearth of evidence exploring the experiences of British Bangladeshi families, and other South Asian families in general, of feeding their children. Studies are usually from the health professionals' perspective, noting the child's diet and feeding practices. Second, in the various approaches that have been adopted in the promotion of healthy feeding practices, there is a need to identify processes that make interventions effective, from both the service provider's and the service user's viewpoint. This paper addresses this second issue by presenting an evaluative account of a client-centred intervention for Bangladeshi families with children of weaning age. The next section explains the intervention. This explanation is followed by an account of the evaluation of this intervention and the outcomes achieved. The paper closes with a discussion of the need for health services that are client centred, and suggests that the weaning intervention shows some evidence for increasing access to health services for a particular client group.

## The intervention

Earlier studies involving South Asian communities tended to refer to Asians and South Asians as a homogenous unit; for example, Jivani (1978) discusses feeding practices in relation to 'Asian infants', while Duggan *et al* (1991) refer to 'young Asian children'.

However, more recent studies have attempted to distinguish between different ethnic groups within the South Asian community (Khan and Randhawa, 1999). This study sought to make a contribution to the literature concerning weaning by focusing on the experiences of the Bangladeshi community living in one UK town. A number of local health visitors working with Bangladeshi families had acknowledged the limitations of the weaning advice they were able to offer, due to the challenges of communication that arose despite the use of interpreters. The health visitors identified an urgent need to develop an intervention that enabled the Bangladeshi families to access and utilise weaning information in a culturally competent manner. The key aim of the intervention was to employ the skills of specially trained support workers, infant feeding advisors, in offering a client-centred weaning service to Bangladeshi families.

## Recruiting and training the infant feeding advisors

The proposed intervention was based on work carried out with Pakistani families (Smith and Randhawa, 2004). It aimed to be sensitive to the specific needs of the community, attempting to overcome the challenges of communication described earlier. The infant feeding advisors were integral to this intervention, and therefore careful thought was given to personal characteristics of individuals who were to be recruited to these posts. The infant feeding advisors were specially trained support workers who shared a similar linguistic and ethnic background with the clients they visited. The criteria for selection were community work experience, fluency in the relevant South Asian languages, as well as English, and empathy with their ethnic community. The infant feeding advisors had all been employed as linkworkers in the primary care trust and were therefore accustomed to working with a wide range of health professionals. The infant feeding advisor role involved managing a caseload of families, delegated by the family health visitor, and undertaking home visits independently of other health professionals. The work required up-to-date knowledge of current weaning advice, including the ability to support the maintenance of breast-feeding during the weaning period. The infant feeding advisors undertook training courses to prepare them for home visiting and offering weaning advice and support. These courses, each of 30 hours' length, were accredited by the Open College Network ([www.ocnotc.com](http://www.ocnotc.com)). The subject areas covered included topics such as working alone, confidentiality, accountability and communication skills, as well as an in-depth examination of the weaning process.

## Key components of the intervention

The intervention provided for continuity of information giving by offering visits to the client's home at monthly intervals during the weaning period (Box 1). The frequency of visits enabled the infant feeding advisor and the family to build a relationship, which was considered essential to the success of the intervention. The initial visit was made when the baby was three months old, and the intervention was completed following the baby's first birthday. The infant feeding advisor's role was to support, to encourage and to provide evidence-based information. At each visit the feeding advisor completed a questionnaire, which was designed to enable the mother to articulate her experience of feeding her child before the infant feeding advisor formulated her advice. This was considered pivotal to the intervention as it ensured that the client's needs were heard and addressed. Although the intervention allowed for monthly visits to the client's home, the frequency of visits was flexible depending on the individual client's needs and circumstances, and visits were initiated by either the client or the infant feeding advisor.

### Box 1 Core components of weaning intervention

- Intervention offered by specially trained bilingual support workers
- Monthly home visits to families with babies aged three months to one year
- Emphasis on relationship building and evidence-based advice
- Infant feeding cups given when babies aged six months

The importance of building a rapport with the client as well as offering evidence-based weaning information was fundamental to the weaning intervention. The focus of this intervention was always concerned with effective communication. From other studies that describe health visiting interventions to improve weaning practices (Childs *et al*, 1997; Griffiths, 2002), and our experience locally, it was apparent that health visitors had often been unsuccessful in providing appropriate feeding advice. Crucially this was not simply an issue of speaking the same language as the client. The importance of rapport and relationship between the client and the caregiver was fundamental to offering support and advice that was personal and sensitive to the individual's situation (Randhawa *et al*, 2003). Rapport and relationship were recurrent themes throughout the training of the infant feeding advisors, and during their ongoing mentorship and supervision. Effective communication using evidence-based weaning information was core

to the intervention. A part of this process was the use of the written word. Weaning information provided by the infant feeding advisors, who were able to speak with the families in their preferred language, was supported by double-sided A5 leaflets written in plain English. The development and use of audiotapes was not considered to be particularly advantageous. The results of a study undertaken in Birmingham, in which the use of audiotapes was incorporated into a dietary health education programme, did not appear to demonstrate their effectiveness (Childs *et al*, 1997).

## Methodology

The intervention was introduced as a pilot scheme in 2003/2004 and was offered to Bangladeshi families with children aged three months, who were registered with identified general practitioners (GPs). Premature babies and families with complex medical and social needs were excluded from the study. There were no other inclusion or exclusion criteria.

Formal evaluation of the pilot was undertaken using a broadly qualitative methodology. Following the child's first birthday the intervention was completed, with the infant feeding advisor undertaking her final visit. She reminded each family that the project health visitor would contact them in order to arrange a mutually convenient time to complete a questionnaire about the intervention. A linkworker, who worked independently of the intervention, was appointed to undertake joint visits with the project health visitor to those families whose preferred language was Sylheti or Bangla. The linkworker was prepared for this role by discussion regarding the purpose of the evaluation, and in particular the translation of the questionnaire into Sylheti or Bangla as appropriate. Without a written translation, this process was especially important, as the linkworker needed to familiarise herself with the questionnaire, ensuring that she was able to offer conceptually equivalent questions, in a consistent form. The semi-structured questionnaire was therefore administered verbally by the project health visitor. Families' answers were written down at the time of the interview, with simultaneous translation by the linkworker where necessary. Quantitative data were recorded using Excel, and the remaining data themed.

The evaluation sought the women's perspective on their children's feeding. Their responses indicated the extent to which the intervention had achieved its objectives. In addition the questionnaire asked the parent/carer's views on the intervention. Questions were designed as recommended by Bowling (1997) to elicit the study's effectiveness, enabling an assessment to be made of the child's feeding, and its appropriateness,

in this instance, the receiving of advice from a support worker in their own home.

Ethical approval for the study was sought and given by the chairperson of the local research ethics committee (LREC). Additional to the issues that govern all ethical research was the challenge of working in a cross-cultural setting, where some of the participants did not speak English. Enabling the clients to give informed consent was of particular concern.

## Obtaining consent for the intervention

A staged process was developed to obtaining consent. This enabled the participants to have at least three opportunities to seek information regarding the study, and to decide to accept or decline participation in the intervention. Initially, the family health visitor discussed the proposed intervention with the family at the child's six-week development check and offered written information regarding the study. When the child was three months of age, the infant feeding advisor contacted the family by phone to discuss participation in the weaning intervention, and, if the family were still interested, an appointment for a home visit was made. At this visit, undertaken by both the project health visitor and the infant feeding advisor, participation in the intervention was discussed again and written consent sought. At this point four families, for various reasons, ranging from a planned trip to Bangladesh to feeling the family did not require this level of intervention, declined to participate.

## Evaluating the intervention

Following the child's first birthday the project health visitor visited the families to evaluate the intervention (Box 2). Parental and professional concerns around feeding were grouped around certain themes, and these informed the basis for choosing the objectives. Parents frequently reported that 'my child doesn't eat'. The reason for the concerns often stemmed from an excessive milk intake, resulting in a lack of appetite for food. Typically such a child will be fed sweetened baby foods and possibly some cereal. In consultation with a dietitian, it was decided to make the first objective family food, the five food groups as appropriate to a one year old, and milk intake not exceeding 750 ml in 24 h. Families were offered a feeding cup when their child was six months old, and as part of promoting good oral health the use of a cup or beaker was encouraged. Many families offered water from a glass but followed UK culture in using a baby bottle for milk and other drinks. Drinking from a cup or beaker tends to prevent the overfeeding of milk in the older child.

### Box 2 Objectives for a child aged one year

- Eats family foods – measured by:
  - three meals a day
  - five food groups appropriate to a one year old
- Drinks less than 750 ml milk in 24 h
- Drinks from a cup/beaker for drinks other than milk
- Finger feeds

Long-term health concerns that may result from prolonged bottle-feeding are discussed in a Briefing Paper from the Community Nutrition Group of the British Dietetic Association (1997). Traditional Bangladeshi food is easily adaptable to enable young children to self-feed using their hands. Parents who reported feeding problems in older toddlers often said they did not allow self-feeding because of the amount of mess this created. In order to encourage the development of self-feeding skills, a child finger feeding at one year formed the final objective.

The questionnaire, including a 24-h food recall diary, consisted of three broad topic areas, namely the parent's perception as to how the child was feeding; the family's, usually the parent's, opinion of weaning support as offered through the weaning intervention; and lastly their use of the written information on weaning that had been given to them. The questionnaire allowed the collection of qualitative data, particularly in relation to the parent's perceptions of their child's eating. In addition, numerical data, for example about the number of children drinking from a cup rather than a bottle, were measured. The information obtained from the food diary, supported by the response to a question eliciting the range of foods eaten, indicated whether each child's diet included the five food groups, appropriate to the needs of a one year old. The possible effect of cultural beliefs was recognised in the analysis of the data. For example, one of the linkworkers suggested that the parents would be reluctant to say their child was feeding very well, because of *nazar* or the evil eye, 'otherwise he'll stop eating, he'll lose weight'. This phenomenon is not unique to this study population, and has been discussed previously by Yaha (2001).

## Outcomes of the evaluation

Twenty-four families completed the intervention, twenty-two of whom were visited for the evaluation (Figure 1). Four mothers thought their children fed very well, with an equal number who considered that

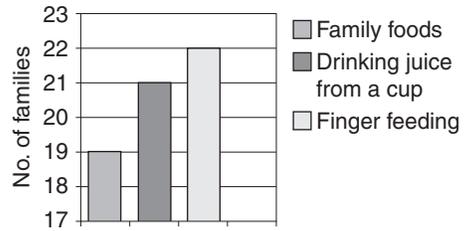


Figure 1 Results of the pilot study

their children did not feed well. The remainder were satisfied with how their child was eating. The use of cups/beakers for drinks other than milk had been encouraged throughout the intervention, and with the exception of one child, everyone was using a cup for drinks other than milk. However, all the children continued to drink milk from a bottle although one child sometimes drank milk from a cup. Two children were breast-fed. All the families reported that the children were finger feeding.

The weaning intervention was well received by clients. They reported increased knowledge about the weaning process and often used this knowledge to inform their friends and relatives. Clients suggested the service should be expanded beyond the pilot, and also asked for leaflets to be available in Bangla as well as in English. The women spoke confidently about their own knowledge and how their children were feeding. English-speaking mothers appeared to gain as much benefit from the intervention as those who were non-English speaking. A mother who was also a nursery nurse said:

'I didn't know what to feed him but with [the infant feeding advisor's] help I knew exactly what to do.'

Similar views were expressed by many of the women and are reflected by this Sylheti-speaking mother:

'She has everything on time, everything she is given. When I first started weaning I gave her food without salt. With my three other children I didn't know what to do, no feeding advisors were available. I wasn't aware what foods to give or not to give like rice pudding. This time I didn't buy jars, I bought the fresh vegetables and boiled them. She hasn't fallen ill since I've been boiling vegetables. I was advised not to give sugary drinks. I cut down on sugar and salt. You can obviously feed the child anything, but what is right for the child it's crucial to know. If I went into the chemist before I'd buy egg custard and rice pudding, I never gave fresh vegetable. It's good for other mothers especially if it's the first or second child. If a woman is on her own she doesn't know what to do. I suffered a lot with the eldest.'

Over 80% of the women preferred to speak Sylheti, a factor that demonstrated this client group's vulnerability to missing key health messages. Repeatedly, women, including English-speaking mothers who had had previous children, indicated that the weaning knowledge they had gained was new information. The parents' responses in this small study appear to indicate that one of the benefits of employing feeding advisors who are empathetic and knowledgeable of the culture, as well as possessing the relevant language skills, is a more effective exchange of health information and improved dialogue between the client and practitioner. Women, both mothers and grandmothers, showed an increased acceptance and use of health information, suggesting that the encouragement of a client-centred approach should be given priority in the development of new services. The infant feeding advisor was reported to be a key person who intuitively knew what advice and support were acceptable in certain situations. She was able to break down barriers that were independent of language. The acknowledgement by a number of the mothers that they had gained new knowledge was associated with a rise in confidence because they knew what to give their children. One mother commented that she looked forward to the infant feeding advisor's visit each month, and liked being praised for the way she weaned her child.

## Conclusion

The importance of nutrition in the first year of life and its effect on health and development of children and in later life are increasingly recognised (Subgroup on Maternal and Child Nutrition of the Scientific Advisory Committee on Nutrition: [www.sacn.gov.uk](http://www.sacn.gov.uk)). The current study showed that, notwithstanding a primary healthcare system that offers a universal health visiting service, mothers often expressed their lack of knowledge concerning weaning. The majority of mothers would have received routine feeding advice through child health clinics and at developmental checks but, for many, this information seems not to be transferred into practice. This appears to be supported by the continued interest of health professionals in relation to the weaning diet in the South Asian community (Yaha, 2001; Griffiths, 2002; Sarwar, 2002). Uncertainty about which commercially produced baby foods are *halal*, or lawful in terms of Islam, means that there has traditionally been a greater use of sweetened baby foods as well as an apparent lack of confidence in the use of family foods (Sarwar, 2002).

The need for a culturally competent client-based service that ensures that families are able to access and utilise weaning information is clearly apparent. Within the intervention described, the emphasis on relationship

building, as well as offering staged advice through visits to the client's home by support workers from a similar ethnic and linguistic background, seemed to demonstrate that the manner in which information was offered through the weaning intervention enabled most of the mothers to assimilate and put it into practice. This reflects the evidence for the role of care in nutrition programmes recognising the importance of the interaction between carer and child (Engle, 2000). Engle (2000) describes nutrition programmes that focus only on advice, *without care*.

It is not known whether families will be able to maintain healthy feeding practices, particularly when their children want greater independence and choice. It is possible that dependency on milk will increase, particularly if children are not encouraged to use beakers or cups. However, a long-term evaluation is planned for when the children are two years old.

## REFERENCES

- Bhopal R and White M (1993) Health promotion for ethnic minorities: past, present and future. In: Ahmad W (ed). *'Race' and Health in Contemporary Britain*. Buckingham: Open University Press, pp. 137–66.
- Bowling A (1997) *Research Methods in Health*. Buckingham: Open University Press.
- British Dietetic Association (1997) *From Bottle to Cup*. A Briefing Paper from the Community Nutrition Group. [www.s125758931.websitehome.co.uk/news\\_page.htm#bottletocup](http://www.s125758931.websitehome.co.uk/news_page.htm#bottletocup) (accessed 9 May 2006).
- Childs F, Aukett A, Darbyshire P, Ilett S and Livera LN (1997) Dietary education and iron deficiency anaemia in the inner city. *Archives of Disease in Childhood* 76:144–7.
- Daly A, MacDonald A, Aukett A *et al* (1996) Prevention of anaemia in inner city toddlers by an iron supplemented cows' milk formula. *Archives of Disease in Childhood* 75: 9–16.
- Department of Health (2004) *Infant Feeding Recommendation*. London: Department of Health.
- Duggan M, Steel G, Elwys G, Harbottle L and Noble C (1991) Iron status, energy intake, and nutritional status of healthy young Asian children. *Archives of Disease in Childhood* 66:1386–9.
- Engle P, Bentley M and Peltó G (2000) The role of care in nutrition programmes: current research and a research agenda. *Proceedings of the Nutrition Society* 59:25–35.
- Griffiths B (2000) Improving infant nutrition: a health visiting intervention. *Community Practitioner* 73:432–4.
- Griffiths B (2002) A health visiting intervention to improve the outcome of weaning. *Community Practitioner* 75: 420–3.
- Jivani S (1978) The practice of infant feeding among Asian immigrants. *Archives of Disease in Childhood* 53:69–73.
- Khan Z and Randhawa G (1999) Informing the UK's South Asian communities on organ donation and transplantation. *EDTNA/ERCA Journal* xxvi:12–14.
- Lawson MS, Thomas M and Hardiman A (1998) Iron status of Asian children aged 2 years living in England. *Archives of Disease in Childhood* 78:420–6.

- Randhawa G, Owens A, Fitches R and Khan Z (2003) The role of communication in developing culturally competent palliative care services in the UK. *International Journal of Palliative Nursing* 9:24–31.
- Sarwar T (2002) Infant feeding practices of Pakistani mothers in England and Pakistan. *Journal of Human Nutrition and Dietetics* 15:419–28.
- Smith S and Randhawa G (2004) Extending the role of the linkworker in weaning support. *Community Practitioner* 77:146–9.
- Thomas M and Avery V (1997) *Infant Feeding in Asian Families*. London: The Stationery Office, p. 80.
- Yaha H (2001) Weaning in the Bangladeshi community: problems observed. *Community Practitioner* 74:299–301.

#### CONFLICTS OF INTEREST

None.

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