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Research

An exploratory analysis of infant and young child feeding perceptions and practices among South Asian women living in London

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Background

Breastfeeding and complementary feeding are crucial in early life nutrition. In the UK, only 1% of mothers exclusively breastfeed at six months. Data from England (2020-21) show that at six to eight weeks, breastfeeding rates were lower among white mothers (49.8%) than among Asian or Asian British mothers (69.0%). However, exclusive breastfeeding rates in the home countries of UK minority groups are higher than those of their counterparts in the UK.

Objective

This study explores the perceptions and practices of South Asian mothers in London regarding infant and young child feeding (IYCF), identifying socio-cultural and environmental influences.

Methods

A qualitative study recruited eleven South Asian mothers of children under five living in London through purposive convenience and snowball sampling. Semi-structured online interviews were conducted, and data were analysed following an inductive thematic approach.

Results

Three themes emerged: (1) maternal practices shaped by religion, culture, and social support; (2) lack of support in managing IYCF challenges; and (3) practical support needed to enhance exclusive breastfeeding: cultural and religious beliefs, emotional bonding, and convenience motivated breastfeeding initiation. However, mixed feeding and early solid food introduction occurred due to perceived milk insufficiency and misinformation. Mothers relied on social circles and digital sources due to cultural and language barriers. Inadequate maternity leave policies were perceived to lead to shorter breastfeeding durations, particularly among recent immigrants.

Conclusions

Addressing milk supply misconceptions and providing information on infant needs are essential. Policy changes offering flexible work conditions could support breastfeeding among immigrant mothers.

INTRODUCTION

Breastfeeding and complementary feeding are essential components of early life nutrition. Breastfeeding is widely recognised as the optimal source of infant nutrition, supports ideal growth, protects against Type 2 diabetes and obesity, and promotes long-term health (Kramer and Kakuma, 2012; Michels et al. 2017; Peregrino et al. 2018; Zivkovic et al. 2010). The World Health Organisation (2023b) recommends initiating breastfeeding within the

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first hour of birth and maintaining exclusive breastfeeding (EBF) for the first six months. Early initiation of breastfeeding, for newborns within an hour, has been associated with a 29% lower risk of infant mortality (NEOVITA Study Group, 2016) and universal EBF from 0 to 6 months could prevent up to 820,000 deaths annually among children under five (WHO, 2020). From six months up to 24 months of age or beyond, breastfeeding should be complemented with appropriate solid foods to meet infants' growing nutritional needs (WHO, 2023a; WHO, 2023b; NHS, 2023). However, introducing solids too early can increase the risk of infections and obesity (Brown and Rowan, 2015). It also reduces exclusive breastfeeding, depriving infants of essential nutrients (Morales et al. 2023). So-called baby-led weaning (BLW) has emerged in recent years as an alternative approach to introducing solid foods at six months. This method enables babies to self-feed using finger foods, promoting autonomy in eating rather than caregiver-led spoon-feeding (NHS, 2020).

GLOBAL AND NATIONAL EFFORTS TO PROMOTE BREASTFEEDING

In 2015, the United Nations designated 2015-2025 as the Decade of Nutrition. In 2012, 194 member countries participating in the 65th World Health Assembly committed to six global nutrition targets, including raising EBF rates by 50% (WHO, 2014; UN, 2016; Krivtsova and Keith, 2021). The UN has also included the target of 75% EBF by 2030 as part of their Sustainable Development Goal 2 indicators (UN, 2016). UNICEF's Ten Steps guidelines to enhance successful breastfeeding, known as the Baby Friendly Hospital Initiative (BFHI) (UNICEF, 2018a; WHO, 2018) were revised in 2018.

Despite the UK's strong national commitment to promoting breastfeeding, there are still numerous gaps in the availability of breastfeeding support (WBTI, 2016). Breastfeeding rates in the UK remain low, with 34% breastfeeding at six months (UNICEF, 2021), compared to 80% in Norway and 78% in Sweden (Häggkvist et al. 2010; Cato et al. 2020). In 2010, the prevalence of breastfeeding in the UK was 81% at birth, falling to 69% at one week, and decreasing further to 55% at six weeks, and by six months, the prevalence of EBF was only 1% (McAndrew et al. 2010). Data in England in 2020-21 show that for breastfeeding at 6 to 8 weeks, mothers with white ethnicity were less likely to breastfeed (49.8%) than mothers from an Asian or Asian British (69.0%) ethnic group (OHID, 2O23). However, EBF rates for infants under the age of six months in the home countries are far higher than the breastfeeding rate from the UK study group, for example, 46% in India, 37% in Pakistan, and 43% in Bangladesh (WHO, 2010).

FACTORS INFLUENCING FEEDING PRACTICES

Research highlights several individual, socioeconomic, cultural and structural factors that influence infant and young child feeding practices, including exclusive and breastfeeding duration. At the individual level, many mothers face physical challenges when initiating breastfeeding, such as fatigue, sore and cracked nipples, breast abscess and poor latching (Chang et al. 2019; Gianni et al. 2019; Tarrant et al, 2014; Moss et al, 2021). Perceived milk insufficiency is also frequently reported and remains one of the leading reasons for early discontinuation of breastfeeding (Gatti, 2015; Olare and Harley, 2024). In the UK, Page et al. (2021) identified breastfeeding difficulties as key determinants of cessation. However, their impact varied depending on the specific nature of the problem and the type of support received. This underscores that while breastfeeding challenges are widespread, their influence can be moderated through adequate social and professional support (Page et al. 2021). Hospitals' implementation of the BFHI and support from partners, family and health professionals are crucial for breastfeeding success (Perez-Escamilla et al. 2016; Ingram et al. 2002). However, inconsistent advice from healthcare providers and limited access to evidence-based breastfeeding support contribute to early cessation or mixed feeding practices (Fox et al. 2015; Grant et al., 2017). Brown et al. (2015) further emphasised the need for better prenatal education on infant and young child feeding (IYCF) due to widespread misinformation. Structural challenges also play a role in influencing breastfeeding continuation. Skafida (2011) found that returning to work within six months postpartum significantly decreased the likelihood of EBF at six months, while Ogbuanu et al. (2011) showed that extended maternity leave is associated with longer breastfeeding duration.

Infant feeding practices are rooted in the context of ethnic and cultural beliefs (Tarrant and Dodgson, 2007). In South Asian countries, early initiation of complementary feeding is common practice (Chandrashekhar et al., 2007; Faruque et al., 2008; Hazir et al., 2011). Upon emigration, this context changes for people who migrate to a new country or culture where infant feeding customs might differ substantially (Choudhry and Wallace, 2010). In the UK, breastfeeding is not commonly witnessed or openly discussed, leading to a lack of practical experience among new mothers (Binns and Scott, 2002; Williamson et al., 2012). South Asian women born in the UK are less likely than migrant women to initiate and continue breastfeeding for at least four months (Twamley et al., 2010). Therefore, this study aimed to explore infant and young child feeding perceptions and practices, factors that influence them, and challenges faced by first-generation South Asian women living in London.

METHODS

STUDY DESIGN

This study followed an interpretive qualitative approach to explore first generation South Asian mothers' lived experiences of IYCF. Semi-structured telephone interviews were chosen as a data collection method for this research, as they offer flexibility and ensure participants' convenience. The semi-structured interview method included open-ended questions using a topic guide and probing.

PARTICIPANTS

The target population for this study consists of mothers from first generation South Asian ethnic backgrounds (i.e., women born in South Asia) who reside in London. London was chosen as a city to conduct this study as it is one of the most diverse cities in the UK and a home to a significant proportion of the UK South Asian population (ONS, 2024). The criteria for inclusion were as follows: a woman from a

first generation South Asian ethnic background must be over the age of eighteen, must have a child aged between 6 months and 5 years, living in London and has not been diagnosed with mental health conditions or experienced post-natal depression, fluent in English or Bangali.

Purposive convenience and snowball sampling strategies were used. This approach ensured a relevant and diverse sample that aligned with the research objectives. A combination of recruitment methods was utilised to reach the target population effectively. Initially, flyers were posted online via social media platforms, such as Facebook, Instagram, and WhatsApp, for South Asian communities living in London. Focusing on those who were easily accessible and willing to participate. Afterwards, snowball sampling was used, where early participants referred researchers to others who met the study's criteria. Data were collected until saturation when additional data no longer provided new insights or perspectives (Saunders et al., 2018). A total of 11 women were interviewed in this study.

DATA COLLECTION AND INTERVIEW GUIDE

Participant recruitment and data collection began in May 2023 and continued through June 2023. Participants were given the opportunity to select the time that best suited their preferences and convenience. The telephone interviews were conducted by AW (female) and lasted between 20 and 54 minutes. Interviews were conducted in English or Bengali (Bangla), depending on each participant's language preference. AW is from a Bangladeshi background and has a positive view towards breastfeeding, which is shaped by upbringing and cultural and personal experiences. All interviews were audio-recorded with the participants' consent.

The research team developed a topic guide based on the study's aims and objectives. The topic guide was pilot tested by conducting mock interviews using feedback from fellow South Asian colleagues. The mock interviews aimed to help the interviewer refine the technique and ensure the questions were clear and culturally appropriate.

DATA ANALYSIS

The interviews were transcribed verbatim, translated into English, and analysed by AW. Data analysis followed Braun and Clarke's (2006) six-phase inductive thematic analysis framework. The analysis involved an in-depth engagement with the data, involving a thorough and reflective reading of the transcripts to ensure familiarity and immersion in the content. During the second phase, known as "coding", significant features within the data were systematically highlighted, and relevant information was grouped under preliminary codes (Braun and Clarke, 2006; Clarke and Braun, 2017). The third phase focused on "theme development", where related codes were combined into broader thematic categories and all corresponding data were organised under each potential theme. The fourth and fifth phases involved reviewing and refining these themes, ensuring their clarity and coherence, and assigning distinct names to each theme (Braun and Clarke, 2006; Clarke and Braun, 2017). After that, the generated themes were reviewed by AW and her supervisor, MK, to reach agreement.

ETHICAL CONSIDERATIONS

Ethical approval was obtained from the University of Westminster before data collection (ETH2324- 2990). Before the interviews, informed consent was obtained from all participants, ensuring they understood the research's purpose and procedures before agreeing to participate. Participation was voluntary, and participants could opt out of the study until data analysis. The interviews, transcripts, and data were anonymised and stored using a code to ensure participant confidentiality and anonymity. Data were stored on a password-protected laptop.

RESULTS

STUDY PARTICIPANTS

Eleven mothers from South Asian ethnic backgrounds living in London participated in this study. The participants' countries of origin include Bangladesh (n=5), India (n=3), and Pakistan (n=3). Most had one child (n=6), followed by two (n=4), and three (n=1). Childbirth experiences included natural delivery (n=6) and caesarean section (n=5). Employment status varied, with four employed, six unemployed, and one combining part-time work with studies.

THEMES

Three major themes and their respective sub-themes were generated from the gathered data through an inductive thematic analysis (Table 1). Quotes from participating mothers relating to each theme are presented in Tables 2-4.

Table 1. Themes and sub-themes

Themes	Sub-themes
Maternal practices are influenced by religion, culture and social circle	• *Religion and culture;* • *Breastmilk is best;* • *Sources of information;*
Infant and young child feeding challenges	• *Caesarean section birth;* • *Pain and latching;* • *Perceived inadequate quantity* • *Baby's rejection of breastmilk;* • *Lack of clarity regarding complementary feeding;*
Practical support improves adherence to exclusive breastfeeding	• *Inadequate Breastfeeding guidance and support;* • *Financial struggles, maternity leave and employment policies;* • *Advocacy to encourage breastfeeding;*

MATERNAL PRACTICES ARE INFLUENCED BY CULTURE, RELIGION, AND SOCIAL CIRCLE

RELIGION AND CULTURE

All participants perceived breastfeeding as a biological act and a cultural ritual embedded with deep significance. Breastfeeding was seen as a duty and an essential part of motherhood, influenced by cultural norms, religious teachings in Islam, and the collective wisdom passed down through generations.

BREASTMILK IS BEST

Most participants preferred breastfeeding, as breast milk was perceived as highly nutritious, convenient, does not require sterilisation, and is cost-effective. All the mothers also said

breastfeeding contributed to a deeper connection with their baby and a range of positive emotions such as fulfilment, pride, closeness, joy, appreciation, and satisfaction. These emotions contribute to the overall positive perception of breastfeeding and highlight its importance beyond nutritional benefits.

SOURCES OF INFORMATION AND EXPERIENCE

Participants stated that their mothers, mothers-in-law, friends and cousins were primary sources of information regarding IYCF. Mothers also relied on sources like YouTube and Google search because the content was available in their first language. Only one mother mentioned attending antenatal classes, while others said they could not join due to work or study commitments. Some participants explained that personal experience and lessons learned from their previous child significantly enhanced the breastfeeding experience with the subsequent child.

Table 2. Quotes, Theme 1. Maternal practices influenced by culture, religion, and social circle

Subtheme	Quotes
Religion and Culture	*"I was determined to breastfeed; as you know, it's a normal tendency we Asians have" (P 2)* *"I breastfed my child for two years because it's good for the baby, and also, as a Muslim, I'm bound to breastfeed for two years" (P1)*
Breastmilk is the best	*"For me, it's the miracle superfood which doesn't require sterilisation or extra work, and most importantly, it costs you nothing" (P9)* *"I know formula doesn't provide all the nutrition a baby requires" (P 3)* *"The baby hears your heartbeat which is like a rhyme to his ears, and when the baby is close to you, you get to make a really special connection which only a mother and child can feel" (P4)*
Sources of Information	*"When my baby was 6 months old, my mother came here from India, and we started weaning together" (P8)* *"We were constantly connected with our parents; they told us what to give and what not. I was also watching videos on YouTube, as I can't read English and in YouTube, they've many contents in Gujrati language" (P 07)* *"Knowledge and education are different things and experience is different thing. I made a mistake giving my first child a bottle, in the case of my second child, I didn't make this mistake, and I was able to breastfeed her for 2 years." (P01).* *"When I had my first two child, I was shy to breastfeed in public places but now with my third baby, I'm doing it in public places without hesitation." (P09)*

INFANT AND YOUNG CHILD FEEDING CHALLENGES

MODE OF DELIVERY AND PHYSICAL PAIN

More than half of the participants who had a caesarean section birth stated that they had experienced delayed lactation because of anaesthesia, the physical stress of surgery, back pain, seating and moving issues, and holding and positioning the baby on their own. Consequently, early breastfeeding initiation within one hour was not possible, and early bottle feeding was introduced. In contrast, most of the mothers who gave birth vaginally stated they could breastfeed their baby with fewer challenges. However, some mothers said the initiation of breastfeeding was not within the first hour because they were tired, and one participant mentioned it depends on practices that vary from midwife to midwife. Most participants reported that midwives did not suggest early breastfeeding initiation within the first hour. A few participants stated that they had experienced issues regarding sore and swollen nipples, dryness and pain in the breasts. However, none stopped breastfeeding or switched to formula milk because of these problems.

PERCEIVED INADEQUATE QUANTITY

Many mothers who breastfed expressed concerns that they were not producing enough milk to satisfy their baby's needs, which commonly influenced their decision to supplement with formula, and in some cases, to stop breastfeeding altogether and rely solely on formula. They reported feelings of anxiety, stress, and inadequacy when they believed they were not producing enough breast milk. Some participants were told by family members and midwives that sometimes mothers do not produce enough milk to meet their baby's needs. Therefore, mixed feeding is acceptable if the baby is still hungry. However, others reported that support from family members and midwives significantly enhanced breastfeeding success by reassuring mothers and teaching them how to assess their milk production, such as checking for breast fullness (feeling fuller, heavier, or firmer) and confirming milk flow by observing if milk comes out easily during hand expression or pumping.

BABY'S REJECTION OF BREAST MILK

Several mothers reported that due to unavoidable circumstances, such as returning to work or experiencing health issues, they introduced bottle feeding to their infants. Subsequently, they observed that their babies began to reject breastfeeding, showing a preference for formula milk. Many mothers believed this was because their infants liked "the taste" of formula more. This shift often led some mothers to discontinue breastfeeding earlier than they had intended.

LACK OF CLARITY REGARDING COMPLEMENTARY FEEDING

Most mothers reported receiving breastfeeding information from midwives, but did not receive any guidance on complementary feeding. Although the National Health Service (NHS) provided leaflets or booklets, most mothers reported needing more time to read these materials. Most participants stated they initiated complementary feeding at five to six months. However, a few mothers stated that they started solid food at four months, either because they perceived the child was not satisfied after breastfeeding, or because they had returned to work. Also, one participant explained that she was influenced by a supermarket's brand of infant food, which indicated that the brand was suitable for infants aged three to four months. Most mothers practised both traditional and Western complementary feeding practices, giving their country's traditional food such as Khichuri (Bangladeshi), Dal Ka Pani (lentil soup, South Indian), Kahwah (Pakistani drink), along with boiled and blended potatoes, tomatoes, rice, apple and carrot puree without salt and sugar. Two mothers followed BLW, while the rest were unfamiliar with this method of introducing solid foods.

Table 3. Theme, 2 Quotes - Infant and young child feeding challenges

Subtheme	Quotes
Caesarean section birth	*"I couldn't sit without a cushion. Otherwise, I was getting severe back pain, and I was only sleeping on a flat surface. The situation was out of control; however, I still tried to breastfeed but couldn't manage. Consequently, my husband had to give the formula to the baby" (P 07).* *"As I had a C-section when the baby was born, I didn't have the strength to feed him, and we started giving him a bottle" (P 05)* *"The midwife came to me two hours later with the baby to breastfeed. I said I couldn't; I was tired. She asked "should I give the baby formula milk that we have then", I said "yes", and she gave the baby ready-to-use formula they had" (P09)* *"The initiation, you know, depends on midwife to midwife. When I had two of my daughters, although the midwives did skin-to-skin, they didn't start breastfeeding at the same time. But when I had my son, the midwife said 'let's try breastfeeding mommy' and she put the baby to my breast while doing the skin to skin, and the baby sucked for an hour" (P09)*
Pain and latching	*"It was hard, like there were some soreness and nipple pop-down issues at the beginning but now everything is going smooth" (P10)* *"My nipples were sore and dry, and that lasted one full year. During that period, I used an ointment on the nipples before breastfeeding the baby. This practice helped to lessen the pain." (P09)*
Perceived inadequate quantity	*"After four months, my milk production became slow; I wasn't producing milk in good quantity. So, I quit breastfeeding and switched to bottle feeding." (P11)* *"My cousin told me that sometimes, a baby's stomach doesn't get filled with only mother's breast milk, so giving formula is a good thing. I thought: "why not give it a try and start giving formula." (P08)* *"After ten days of delivery, I started doing the mix-feeding. My baby was crying; when I consulted with my midwife, she said I should do formula feeding, because I wasn't producing enough milk for her." (P02)* *"I thought I'd do formula feeding as I thought I wasn't producing enough milk. Fortunately, my mother came to the UK one month before the delivery, she said it is normal that first few days milk production isn't that much but gradually it'll increase only then I could relax." (p03)* *"I was worried that my milk wasn't enough for my baby. But then mid-wife came for home visit and I told her about my concern. She showed me how to express our milk like with one hand and how to check whether my breast is full or not. I did it and I was satisfied that I'm producing enough milk for my baby." (p08)*
Baby's rejection of breastmilk	*"He was looking for the formula milk only, like the way he was behaving, we understood that he wasn't happy with the breast milk" (P06)* *"Although I initiated the breastfeeding within 1 hour but you know first few days the milk production is not that much, so the baby was crying and my mother-in-law give her formula out of affection. I think she liked the taste of formula and only wanted it and kept rejecting breastfeeding. Eventually after 3 months I had to stop breastfeeding as my milk dried out" (P01)*
Lack of clarity regarding complementary feeding	*"When I started complementary feeding, I was confused what to or what not to give her, and what would be good for her. Then, I watched some videos online and then I started giving her complementary foods." (P 03)* *"I got some booklets from hospital about breastfeeding and complementary feeding. I didn't read the booklets; they were given to me as a package. I have no support here and I am on my own to take care the baby and have no time to read them." (P 06)* *"I started solid food for my first child at the age of six months, but for my third child, I started at four months as XXX [supermarket in the UK] sells baby food for 3-4 months old. Here in the UK, like Bangladesh, you cannot just sell anything if it is not according to guidelines." (P09)* *"I gave him solid food at four months old because he was a hungry baby." (P04)* *"Before going back to work, I wanted to reduce the baby's dependency on breastmilk, so I introduced weaning at four months". (P10)* *"We started giving complementary food in our traditional way, dal ka pani (lentil soup) like the liquid protein one and then basic things without salt and sugar." (P07)* *"I introduced many different foods as such mashed fruits and potatoes, and also some finger shaped veggies. Like finger foods, so, that he can eat on his own, trying to be independent little man." (P04)*

PRACTICAL SUPPORT IMPROVES ADHERENCE TO EXCLUSIVE BREASTFEEDING

INADEQUATE BREASTFEEDING GUIDANCE AND SUPPORT

Many mothers reported that their primary source of guidance and direct support came from family members. While some guidance was provided by midwives at the hospital initially after birth, many mothers noted that after being discharged from the hospital, the support they received from midwives became limited, and they did not receive any home visits from a midwife. Participants believe it is important to receive consistent follow-up care and support after discharge; such measures could provide new mothers with the essential help needed to establish and sustain breastfeeding. Furthermore, they perceive that restrictions on home visits by midwives, lactation specialists, and health visitors may reduce opportunities for personalised support in IYCF.

FINANCIAL STRUGGLES AND MATERNITY LEAVE POLICIES

Most participants perceived adequate maternity leave allows mothers to establish and maintain breastfeeding without work pressures. The mothers' breastfeeding duration differed between mothers who received paid maternity leave and those who had to work or did not receive paid maternity

leave. On one hand, the participants who received an extended maternity leave explained how it helped them to initiate and continue breastfeeding. On the other hand, many participants, specifically those who are new immigrants in the UK, have mentioned that the UK's maternity leave policies contribute to insufficient support for breastfeeding as they were not eligible for certain government benefits and support programs, such as maternity allowances, Universal Credit, or Child Benefit, due to visa limitations and other criteria. Consequently, financial instability and the need to return to work quickly impacted their breastfeeding ability. Some mothers also mentioned that paid paternity leave was not long enough.

Work or study schedules were also perceived to impact IYCF practices. Women in education explained that their busy university schedule and balancing studying and household duties made breastfeeding difficult. Therefore, they had to give supplemental formula milk early. One participant explained that free school meals provided for her older children was an indirect yet meaningful form of support as it alleviates financial pressures for mothers in low-income households and enables them to concentrate more fully on caring for their infant.

ADVOCACY TO ENCOURAGE BREASTFEEDING

Mothers highlighted the lack of breastfeeding promotion on social media platforms in the UK compared to their countries of origin, where advertisements are widespread. They expressed concern that young women in the UK may avoid breastfeeding due to misconceptions, such as fear of physical changes like "*sagging breasts*". Participants emphasised the need for early education to address these myths in order to encourage breastfeeding or for breastfeeding to thrive.

Table 4. Quotes, Theme 3. Practical support improves adherence to exclusive breastfeeding

Subtheme	Quotes
Inadequate Breastfeeding guidance and support	*"I didn't get any visits from midwife at home. Only once a health visitor came. Just for the first visit, I requested the midwife to come to my house. As it was raining heavily; my husband was at work; I had a C-section, and I wasn't able to move properly, and my room was also upstairs. Besides, to go to the hospital I had to take the bus since we don't have car. But the midwife said I need to manage anyway and hung up the phone. For a minute I was shocked, I looked outside and started crying…" (P10)* "*I think more visits from midwives* are *really necessary to support breastfeeding because this was the only help, I got here in UK, and it was really helpful. But it was just once or twice." (P08)*
Maternity leave and employment policies	*"After coming to the UK, you have to work in a company for nine months before you can apply for paid maternity leave. When I came here, I was already two months pregnant, so, I wasn't eligible for paid maternity leave. When the baby was born, my husband was working 16 hours a day to meet our expenses, we were going through a huge financial and mental stress" (P02)* *"As I got 52 weeks paid maternity leave and my husband was getting a good salary, I didn't struggle with anything and my child's 11 months old and I'm still breastfeeding my child." (P03)* *"In our visa, it's mentioned that no public funds. But I think that for the sake of the baby, it should be open for everyone." (P08)* *"My husband got 2 weeks paid paternity leave but I think it needs to be at least 4 weeks, you know here all you have is yourself and your husband*" (P02) *"The first 4 months were the most traumatic and very difficult phase of my life. Due to financial issues, my husband and I'd a lot of fights and arguments. We even started weaning at 4 months as I had to go back to my job to fulfil our requirements" (P10)* *"I've a flexible work schedule- I work from 7am to 10pm and it doesn't affect my breastfeeding in any way." (P01)* *"I had to go to the university and during that time my husband used to give her the bottle" (P10)* *"I had to go to the university and do the cooking, household chores and everything, it was very difficult for me to do the breastfeeding, so after 4 months I converted her to bottle feeding." (P11)* *"I'm grateful that my daughter is getting free meals at school. They provide halal food like chicken, cheese, fries and fruit. She really loves it and because of that I had more time to breastfeed and money to spend on my two-year old" (P01)*
Advocacy to encourage breastfeeding	*"In the UK, most young girls are using social media but there is no content related to breastfeeding on these platforms. But, in Bangladesh, you will see everywhere advertisement related to breastfeeding." (P03)* *"Here girls don't breastfeed thinking it will make their breasts saggy. It is a misconception, and it needs to be corrected at a very early stage. Like mothers should tell their girls that breastfeeding will not harm their physical beauty." (P02)*

DISCUSSION

This study explored the perceptions and practices of IYCF among first-generation South Asian women living in London, highlighting the cultural, structural, and personal factors shaping their experiences.

PERCEPTIONS AND PRACTICES OF INFANT AND YOUNG CHILD FEEDING

Breastfeeding was widely perceived as a cultural and religious duty and played a role in participants' identity as mothers. Also, some mothers reported that positive emotional experiences, such as joy, pride, and fulfilment reinforced breastfeeding practices. Similar findings were

found in studies by Keith et al. (2019) and Cook et al. (2021). Moreover, most mothers recognised the nutritional and health benefits of breastfeeding and described it as cost-effective, convenient, and important for bonding. However, traditional and modern weaning practices were blended. Participants introduced foods like *Khichuri* and *Dal Ka Pani* alongside pureed fruits and vegetables, which offered cultural comfort while adhering partially to international recommendations. This aligns with the findings of Keith et al. (2018), who observed similar dual practices in immigrant communities. Despite these positive practices, the study found limited awareness of BLW. Furthermore, the introduction of complementary foods often occurred earlier than the NHS and WHO-recommended six months, primarily influenced by cultural norms, perceived insufficient milk supply, pressure to return to work and education, and misleading marketing by food brands. Similar findings were found by Vitctora et al. (2016), who identified similar patterns globally.

FACTORS INFLUENCING IYCF PRACTICES

This study found that breastfeeding is shaped by a complex interplay of factors beyond individual choice. Cultural norms, religion, family dynamics, and broader social influences play significant roles, as do the availability of supportive environments, the quality of healthcare services, and enabling policies. Mothers often emphasised the importance of practical support from partners, relatives, and healthcare professionals in sustaining breastfeeding. Such support helps during feeding and provides emotional reassurance about milk adequacy and efforts to alleviate maternal stress, all of which contribute to greater maternal confidence. These findings are consistent with those of Leahy-Warren et al. (2012), who found a strong association between social support and maternal breastfeeding self-efficacy.

Family members, particularly mothers and mothers-in-law, were often viewed as primary sources of advice who reinforced traditional feeding practices. While healthcare professionals such as midwives provided initial breastfeeding guidance, however their limited post-discharge support was a significant barrier to sustained breastfeeding. Participants highlighted the need for consistent follow-up care, a finding consistent with Renfrew et al. (2012). Many participants preferred increased midwife visits, perceiving them as a source of essential medical care and as providers of emotional and psychological support. This support positively influenced their well-being, self-assurance, and adaptations to significant life transitions. This is consistent with Renfrew et al. (2012), who found that strategies relying primarily on face-to-face support are more likely to succeed. Similarly, Sinha et al. (2015) identified that social and community-based interventions are key to improving EBF rates.

Digital platforms such as YouTube and Google were widely used for accessing language-appropriate information. In contrast, NHS-provided leaflets and booklets were underutilised due to time constraints and workload, similar to findings in Keith et al. (2019) and Brown and Lee (2011). This underscores the need for NHS to utilise more accessible, culturally sensitive, and time-efficient informational resources in different languages.

CHALLENGES IN IYCF PRACTICES

PHYSICAL AND MEDICAL CHALLENGES

Although participants perceived physical challenges such as sore nipples and breast pain as contributing to delayed lactation, these difficulties did not lead to avoidance or the cessation of breastfeeding. Instead, the participants described a strong resilience and commitment, which enabled them to continue breastfeeding despite discomfort, contrasting with the findings reported by Li et al. (2008). Tiredness, pain and inability to breastfeed, particularly among mothers who underwent caesarean sections, were notable barriers to early and exclusive breastfeeding. Many participants reported that midwives did not promote early initiation, which contravenes the Baby Friendly Hospital Initiative Step 4. Delays disrupted early feeding patterns, leading to formula introduction, consistent with findings by Rowe-Murray and Fisher (2002). Immediate postnatal support from healthcare providers remains crucial to address these gaps.

PERCEIVED INSUFFICIENT MILK SUPPLY

A dominant theme was the mothers' perceptions of insufficient breast milk supply. Family members, friends, and even healthcare professionals were also perceived to be reinforcing this concern at times. This perception was frequently driven by misinterpreting typical infant behaviours as signs of hunger, contributing to the early introduction of formula. Improving education for both mothers and midwives on infant feeding physiology, including concepts such as newborn stomach capacity (Bergman, 2013), is essential to address these misconceptions.

SOCIOECONOMIC AND POLICY BARRIERS

Socioeconomic challenges were significant. Participants highlighted a lack of societal promotion of breastfeeding in the UK, contrasting with their countries of origin, where media campaigns normalised and celebrated breastfeeding. Misconceptions about physical changes, such as breast ptosis, deterred some women from breastfeeding, echoing the findings of Victora et al. (2016). Participants who lacked access to maternity leave and government benefits due to visa limitations struggled to sustain breastfeeding. Financial instability and the pressure to return to work further compounded these challenges. These findings align with Skafida (2011), who demonstrated that shorter maternity leave durations correlate with earlier cessation of breastfeeding. Adequate parental leave policies played a critical role in supporting sustained EBF, mirroring findings from Heymann et al. (2013), emphasising the importance of national policies and workplace accommodations.

Interestingly, free school meal programs were identified as an indirect yet impactful support mechanism, enabling mothers to allocate additional time and resources to breastfeeding. This novel finding suggests that expanding such initiatives could positively influence IYCF practices. Further research is needed to explore the specific impact of free school meals on breastfeeding mothers.

STUDY STRENGTHS AND LIMITATIONS

Using a qualitative approach is a strength of this study as it offers deeper insights into the cultural and social factors that influence IYCF practices among first generation South Asian women living in London. One of the limitations of this study was that all the interviews were performed using mobile phones. Online interviews often fail to facilitate in-depth qualitative analysis due to various factors, such as difficulty building trust and rapport, which is more easily achieved in face-to-face interactions. However, this approach increased participants' interest because they could schedule their participation at their convenience. Another limitation of this study is that demographic factors that may influence maternal practices, such as educational level and socioeconomic status, were not collected from the study participants. It also did not explore the influence of bed-sharing, co-sleeping, or room-sharing practices on breastfeeding. These practices have been shown to extend the duration of breastfeeding, are cultural norms in many parts of the world, and represent a crucial element in breastfeeding promotion (McKenna et al., 2007; Ball, 2003). Therefore, further research is needed to investigate these aspects more thoroughly.

CONCLUSION

The study highlights the need for a comprehensive, culturally sensitive, and supportive approach to promote and sustain optimal infant and young child feeding practices in the UK. Midwives and healthcare providers can play an important role in addressing these misconceptions by offering ongoing lactation support and accurate information. Such interventions can help reassure mothers about their milk supply and enable them to manage breastfeeding-related challenges more effectively, thereby promoting the practice of exclusive breastfeeding. Furthermore, financial constraints and inadequate government support significantly impacted mothers' ability to sustain breastfeeding. Issues such as insufficient maternity leave, lack of immediate eligibility for benefits, and limited paternity leave contributed to financial and emotional stress affecting IYCF practices. Therefore, there is a need for more inclusive and supportive policies for all mothers, regardless of their immigration status. A policy change to extend maternity leave, improve eligibility for benefits, and offer more flexible working conditions could significantly support breastfeeding among immigrant mothers in the UK.

AUTHOR CONTRIBUTIONS

All authors contributed to defining the research aims and methodology. AW recruited participants, conducted interviews, prepared transcriptions, and performed the initial coding. AW conducted the analysis and developed the themes. MAK reviewed the themes. AW initially drafted the discussion and subsequently refined by MAK. All authors approved the final version of the manuscript.

CONFLICT OF INTEREST

The authors declare that they have no other potential conflicts of interest.

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