Research Article

A Participatory Investigation of Breastfeeding Behavior in the Pakistani Community in the United Kingdom

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ABSTRACT

Objective: Pakistani women are more likely to exclusively breastfeed when living in Pakistan compared with when living in the United Kingdom. This study explored breastfeeding behavior in the Pakistani community living in the United Kingdom to understand why and to co-develop strategies to facilitate change.

Design: Participatory action research was used. Focus group data were collected from co-researchers. A co-produced community event, planned by co-researchers, facilitated the collation of creative consultation data from the wider community.

Setting: Stoke-on-Trent in the Midlands of the United Kingdom.

Participants: Fourteen co-researchers and 21 creative consultation contributions made by community members at a community event.

Phenomenon of Interest: Breastfeeding behavior.

Analysis: Co-researchers engaged in a workshop to produce a collaborative reflexive thematic analysis and action plan strategies for change.

Results: Three key areas (1) cultural context influences breastfeeding behavior, (2) education and awareness are essential, and (3) effective support must be culturally informed.

Conclusions and Implications: Breastfeeding was facilitated by the 40 days, a culturally accepted window following birth when the mother is relieved of other duties and able to focus on their newborn, after which mothers could struggle to balance conflicting demands and responsibilities. Improved education, awareness, and support should be offered prenatally and particularly targeted before the end of the 40 days. Faith-based interventions for mothers and the broader family unit are recommended to improve awareness and accessibility of support.

Key Words: breastfeeding, participatory action research, community research, Pakistani (*J Nutr Educ Behav.* 2026;000:1−15.)

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INTRODUCTION

The United Kingdom has one of the lowest rates of breastfeeding worldwide[1] especially among families from disadvantaged groups.[2] Women with lower income, job status, and educational attainment are less likely to intend to breastfeed, initiate breastfeeding, or maintain breastfeeding for long periods.[3] Furthermore, those residing in the most deprived areas of the United Kingdom exhibit a 40% lower likelihood of initiating breastfeeding compared with those residing in the least deprived areas.[4] Ethnicity and socioeconomic status are linked, with some ethnic minority groups being socioeconomically disadvantaged, for example, living in more deprived areas.[5] There are vast health inequalities between different ethnic groups within the United Kingdom, with South Asian individuals, particularly women of Pakistani and Bangladeshi heritage, more likely to experience poor health than White British individuals.[6,7] These inequalities are also exhibited in poorer maternity outcomes and experiences, with reduced access to and satisfaction with maternity services.[8]

The 2010 infant feeding survey in the United Kingdom reported that South Asian mothers have higher breastfeeding intentions than White mothers.[3] However, while the prevalence of exclusive breastfeeding at

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birth was higher in Asian mothers (75%) when compared with White mothers (68%), this difference was not maintained at 1 week, when 46% of White and 48% of Asian mothers reported exclusive breastfeeding.[3] Similarly, beyond exclusive breastfeeding, of those providing any breastmilk at birth, only 85% of White mothers and 86% of Asian mothers reported continuing to do so at 1 week.[3] The category of South Asian is not a homogenous group, and there are further variations within subgroups, for example Pakistani mothers have shorter breastfeeding durations than Bangladeshi and Indian mothers[9] and are less likely to intend to and initiate breastfeeding, breastfeed at 1 week and 6 weeks, and do so exclusively when compared with Indian mothers. Pakistani mothers are also more likely to hold the intention to formula feed and be less aware of the health benefits of breastfeeding than Indian mothers. Furthermore, a higher proportion of Pakistani mothers offer additional liquids to their infants (e.g., water, fruit juice) than Indian mothers (K. Choudry, PhD Thesis, 2018). This illustrates a need to further explore the breastfeeding experiences and perceptions of UK Pakistani communities.

Pakistani mothers are more likely to exclusively breastfeed when in Pakistan than when living in the United Kingdom.[10] Although breastfeeding rates in Pakistan are higher overall, several factors influence this pattern. For example, research in Pakistan reports that lack of formal education, working responsibilities, and cesarean deliveries can contribute to delays in initiating breastfeeding.[11] Cultural beliefs, such as the belief that colostrum is dirty and potentially harmful to newborns, can delay breastfeeding initiation.[12] In addition, prelacteal feeding is common in Pakistan.[13,14] This is when sweet foods, such as date are rubbed onto the newborn's palate before breastfeeding initiation, contributing to breastfeeding delay.[15] Breastfeeding is included in Islamic scriptures with one verse of the Qur'an commonly interpreted as the assertion that infants should be breastfed for 2 years; however, many Pakistani Muslim women may also be influenced by the Islamic concept of hay'a or modesty, which restricts how and when they breastfeed.[16] Mothers from an Asian background are significantly less likely than other mothers to breastfeed in public[3] and Muslim mothers often live with extended family, meaning privacy at home can pose an additional barrier.[16,17] In addition, exposure to the UK formula feeding culture[18,19] may contribute to reduced breastfeeding rates.[20]

Breastfeeding research in the United Kingdom must increase the diversity of participant populations, as current research models frequently employ self-selection recruitment approaches, resulting in a high proportion of White, highly educated participants. As a result, there is limited research evidence from other communities, both regarding challenges faced and reasons for higher breastfeeding rates in some populations. Specifically, there is a lack of research with the Pakistani community, for whom there are complex and interacting factors that influence breastfeeding behaviors.[21] Breastfeeding behavior in Pakistani communities differs between Pakistan and the United Kingdom[13] and acculturation, religion, and health care professional interactions all play a role in breastfeeding initiation and maintenance.[22,23]

Participatory methods recognize the value of experiential knowledge for challenging inequalities and advocate this to be the starting point for envisioning and actioning strategies for change.[24] This study employs participatory methods to explore and address breastfeeding inequalities in the Pakistani community in the United Kingdom. We address the research questions: (1) What are the barriers and facilitators to breastfeeding in the Pakistani community? (2) What strategies do the Pakistani community feel will improve breastfeeding support?

METHODS

Study Design and Setting

Participatory action research (PAR) facilitates engagement with underserved groups through co-production.[24] Pakistani women are underrepresented within research[25] and it is therefore essential that they are engaged in planning, implementing, and establishing processes that aim to bring about individual, collective, and/or social change.[24] Participatory action research requires collaboration between academics, co-researchers, and the wider community. Table 1 outlines the roles of the collaborators and contributors for this project. In this study, lived experience co-researchers (from here referred to as co-researchers) are members of the Pakistani community who worked in collaboration with the academic researchers. This means co-researchers contributed to the research beyond supplying data, as per traditional research, and were actively involved in data contribution, data collection, analysis, and decisions regarding recommendations arising from the study. Reference to community members indicates additional members of the Pakistani community who contributed anonymous data during a community event as research participants but were not involved in any other research activities.

The research was conducted in Stoke-on-Trent, located in the West Midlands of England, which has some of the poorest breastfeeding and infant mortality rates in the country.[26] The Pakistani community is the second largest group after the White British population and represents around 2.3% of the city population.[27] The local council identified concerns regarding low breastfeeding rates in the Pakistani community and commissioned this project to support the production of research evidence to inform their decision-making regarding addressing this issue. Full review board ethical approval was gained from the University of Staffordshire Health, Education, Policing and Sciences ethics committee. The research was conducted between January and July 2024.

Participants and Sample

The target number of co-researchers was determined by funding availability, which enabled 12–14 participants to be recruited. This number aligns with guidance for a medium-sized sample for interactive qualitative data collection approaches.[28] Adverts for co-researchers were placed on social media, in local Mosques and shared as flyers in local venues.

Table 1. Roles and Responsibilities of Collaborators and Contributors

Group	Key Roles and Responsibilities
Local council	Identification of the problem to be addressed
	Funding provision
	Actioning the recommendations made following the research
Academic team	Overall management and administration of the project
	Recruitment of co-researchers
	Planning, organization and management of workshops
	Devising the focus group questions and facilitating the discussion
	Transcription of the focus group data and preparation for analysis by co-researchers
	Proposal of potential creative consultation activities for a community event
	Organization and management of the community event
	Production of a written narrative of the findings and final reports
Lived Experience Co-researchers	Attendance at workshops
	Contribution to focus group discussion about breastfeeding
	Trialing and giving feedback on creative consultation activities for the event
	Making recommendations for format, catering, and event activities
	Volunteering time for event support and facilitation (optional)
	Raising awareness of the event within the community through word of mouth and distributing flyers
	Reading, discussing, and reflecting on focus group data and sticker board data collected at the community event to identify common facilitators and barriers to breastfeeding
	Reflecting on the facilitators and barriers identified and proposing potential solutions or strategies for change
	Reading and providing feedback on the written account of the research findings
	Providing feedback on their experience of being part of the project
Community members	Attendance at the community event
	Contribution of responses to sticker board questions (optional)
	Contributing thoughts and ideas on breastfeeding through the creative activities at the event (optional)
	Providing feedback on the community event (optional)

All local Pakistani adults were eligible, enabling a range of perspectives to be represented, including those with and without children and with and without experience of breastfeeding. Recruited co-researchers shared information about the opportunity with their networks through a snowball sampling approach. In total, 14 co-researchers were recruited, representing a range of ages from 18 to 60 years old, 11 had children, 5 had children aged under 5 years, and 10 had experience of breastfeeding. Pseudonyms and Full demographic information can be found in Table 2. All co-researchers provided written informed consent and have been allocated pseudonyms.

Data Collection

The Figure shows a diagram of the PAR process.

Workshop 1: focus group. The aims of workshop 1 were to (1) facilitate relationship building between co-researchers and the academic team, (2) explore the co-researchers' thoughts and experiences regarding breastfeeding via a focus group, and (3) co-plan a community event in which data regarding breastfeeding perceptions could be gathered from a wider range of community members. The workshop format created a welcoming environment, and co-researchers were reimbursed with a £60 voucher for their time, given all travel expenses, provided with refreshments, and offered child care.

After an initial icebreaking activity, thoughts about the facilitators and barriers to breastfeeding in the Pakistani community were explored using a focus group discussion. A question schedule (Table 3) was displayed on screen to remind the group of the discussion focus and was used flexibly by the moderator (AB), an experienced qualitative researcher, to ensure discussion was led by issues that were important to the co-researchers. All participants could speak and understand English; however, proficiency varied; to support engagement, another academic researcher (UB), who is fluent in both English and Urdu, co-moderated the focus group. This academic researcher took notes on the discussion points, and the focus group was audio-recorded.

Workshop 1: event planning. A community event was planned to facilitate data capture from the wider community members (as per the role of community members in Table 1). Any adult Pakistani community member would be eligible to contribute data at the event, regardless of parental or breastfeeding experience or status. These data were to provide a broader picture of community perceptions of breastfeeding rather than to gather specific individual experiences and were to be aggregated, reviewed, and interpreted by the co-researchers at a second workshop following the event.

Table 2. Co-researcher Demographic Characteristics (n = 15)

	Demographics				Workshop Attendance	
ID	Age, y	Children	Child Aged < 5 y	Breastfeeding Experience	1	2
Saima	41–50	Yes	No	Yes	Yes	Yes
Kam	18–30	No	No	No	Yes	No
Sonia	18–30	Yes	Yes	No	Yes	Yes
Haniya	41–50	Yes	No	Yes	No	No
Abeeha	41–50	Yes	No	Yes	No	Yes
Zara	31–40	Yes	Yes	Yes	Yes	Yes
Zoe	51–60	Yes	No	Yes	Yes	Yes
Sumaya	18–30	Yes	Yes	Yes	Yes	Yes
Alia	18–30	Yes	Yes	Yes	Yes	Yes
Mary	18–30	Yes	Yes	Yes	Yes	Yes
Samia	61–70	Yes	No	Yes	Yes	Yes
Nadia	31–40	No	No	No	Yes	Yes
Iram	51–60	Yes	No	Yes	Yes	Yes
Sana	31–40	No	No	No	No	Yes

Co-researchers planned the event structure and content, such as catering, venue, and activities. Sticky notes were used to record ideas, which were then discussed. As Eid was approaching, the group felt the event should be held on the second weekend after Eid to avoid any clash with individual family celebrations.

The academic researchers proposed creative methods for data capture from community members, which were informed by recommendations for creative community consultation with underserved populations.[29] The co-researchers trialed and approved the activities, which included sticker boards, a wishing tree, and paper and art materials. Sticker boards displayed closed questions about breastfeeding in both English and Urdu and asked respondents to place a sticker next to their answer. The wishing tree was positioned alongside hanging notes on which respondents could record and then hang their one wish to improve infant feeding support. Art materials were placed by an invitation to write and/or draw about infant feeding. Co-researchers agreed that all activities were appropriate to collect data from community members at the event.

To ensure inclusivity of all activities at the community event, it was agreed that any adults who attended, including those from non-Pakistani backgrounds, should be able to respond to the creative consultation activities if they wished to; only those from the Pakistani community would be relevant to the research aims. Therefore, to identify which contributions were made by Pakistani community members, the academic researchers suggested that different colored stickers could be used to represent the self-identified ethnicity of the respondents. Co-researchers felt that this would be an effective way to enable all community members to contribute, not be burdened with written demographic information, and maintain respondent anonymity. Co-researchers were invited to suggest alternative data capture questions or activities; no additional suggestions were made.

After the workshop, a Qualtrics survey containing the focus group and event planning activity questions was circulated to co-researchers by the academic researchers. This enabled those unable to attend the first workshop to add their thoughts, and for those who attended but did not feel confident or who had new ideas following the workshop, to contribute. The academic researchers reviewed all the responses and contacted the community groups, businesses, and caterers recommended by the co-researchers to arrange the event.

The community event. The community event was advertised via flyers in both English and Urdu on social media and in local venues. Co-researchers also circulated flyers to their networks. The event was open to adults and children from any ethnic background. Most adults registered themselves and their family members to attend via an online Qualtrics registration form, and some completed a paper form on the day. The registration form captured demographic information, including ethnicity, which was indicated by selecting a choice from one of the ethnic group options as used in the UK Census survey, and provided information about the event. An opt-in consent process was employed for the data capture activities at the event. Attendees were informed that by contributing to the data capture activities, they were consenting to the data being used for research purposes; however, they were also assured that they could attend the event and choose not to contribute. Signs reiterating this were displayed at the event.

The event included food from a South Asian catering company, refreshments, and family-friendly activities such as jewelry making, board games, Lego, reading corner, infant play area, arts and crafts, and Henna tasters. On request of the co-researchers, all refreshments and activities were offered free of charge. The event included stalls from a

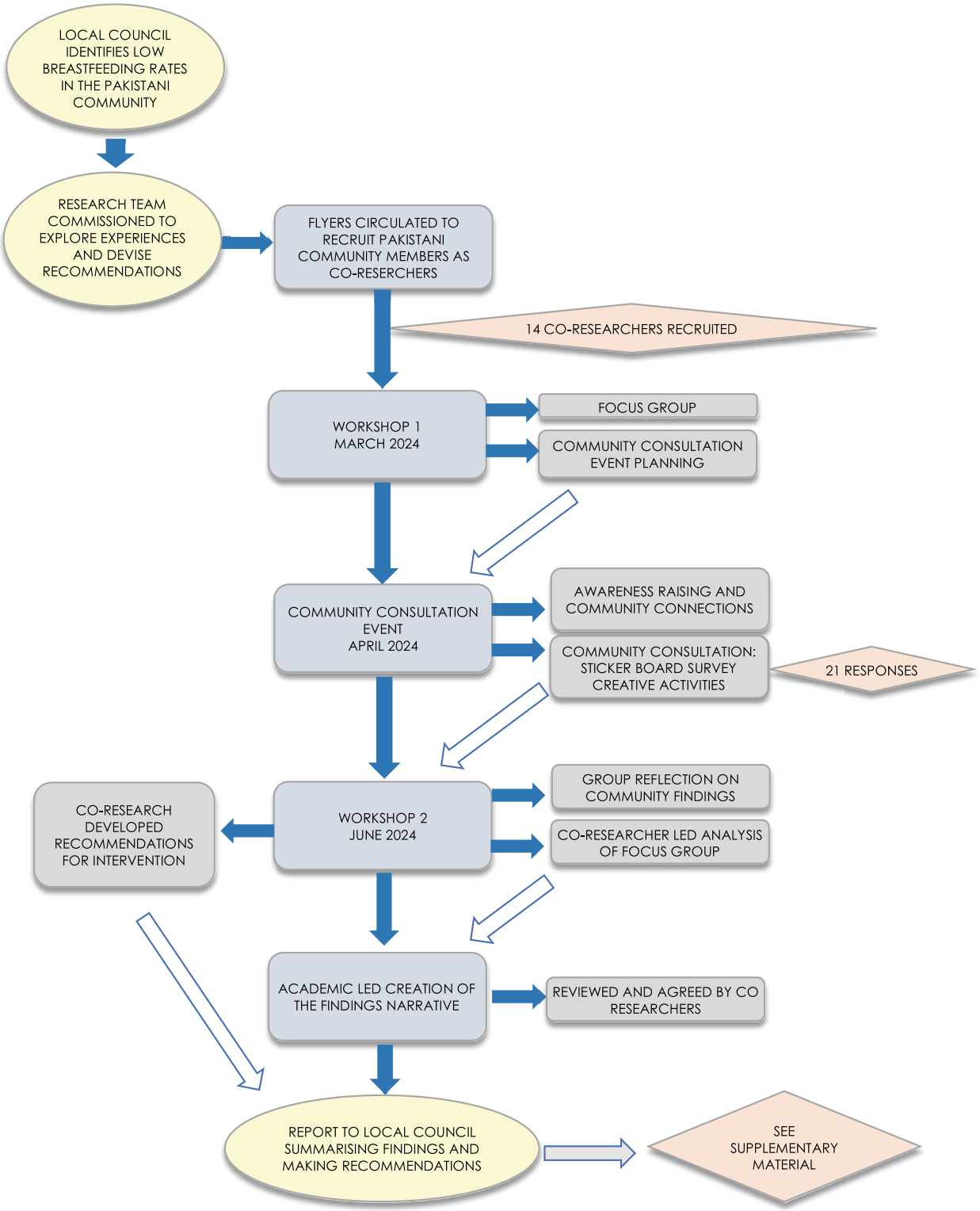

Figure. Diagram of the participatory action research process.

local breastfeeding support group and a community interest company, which offered support to local families. Co-researchers attended with their families, and some chose to support through running stalls, serving food, and supporting with activities. A total of 127 people attended; approximately 50% were adults and 50% were children, and at least 40% identified as Pakistani. The number of Pakistani attendees may have been slightly higher; however, some individuals chose not to disclose their ethnicity on the registration form.

Table 3. Focus Group Question Schedule Used in Workshop 1 to Explore Co-Researcher Breastfeeding Perceptions

Schedule
1. Thinking about the Pakistani community in particular, how do you feel most people like you, in your local community, feed their babies and infants?
a. What do you think are the reasons for people choosing to feed babies/infants using these methods?[a]
2. If you have children yourself, which methods did you use to feed your children, and what were the reasons for using these methods?
3. If you breastfed (or tried/intended to breastfeed), did you access any support services for this? If so, what support did you access?
4. What things influence how people in your community choose to feed their babies?
a. Any cultural influences?[a]
b. Any religious influences?[a]
c. Any influence from elders?[a]
d. Any influence from other family members?[a]
e. Any influence from friends or peers?[a]
f. Any environmental influences (e.g., set up of places where a person might feed their baby)?[a]
5. Thinking about breastfeeding specifically, what do you think helps women in your community to breastfeed?
6. What do you think can be barriers to being able to breastfeed?
7. What do you think might need to change to support those who want to breastfeed to be able to do so?
8. Is there anything else about breastfeeding in your community that we haven't talked about that you think it is important to share?

[a]Used as prompts when needed. These were not displayed during the focus group discussion

Data Analysis

Preparation of the focus group data. Focus group data collected during workshop 1 were transcribed verbatim by UB. Occasionally, during discussions, the group had short conversations in Urdu, and UB completed the translation for the transcription. AB and UB read through the transcripts and highlighted sections of text relevant to the research focus. Each section was extracted to produce a list of quotes for analysis. These quotes were translated into Urdu by UB, and a copy of the extracted quotes in both English and Urdu was circulated to the co-researchers.

Preparation of the event data. Numeric counts of the number of colored stickers representing Pakistani respondents for each sticker board question were made (Table 4). Because of the nature of the data capture method, it was not possible to identify how many respondents completed the sticker boards. This was because community members could choose to answer some, all, or none of the questions, and some questions required a response for each child. However, most single-response questions had 15-16 red stickers placed (the color chosen to represent respondents from the Pakistani community), and the highest number of red stickers was recorded for the question ascertaining age (n = 21). This represents responses to at least 1 sticker board question by approximately 42% of the Pakistani adult community members at the event. Counts were transformed into visual pie and/or bar charts by the academic researchers to be presented to the co-researchers for discussion during the second workshop. No written/drawn accounts were submitted by Pakistani attendees for the write or draw about your experience activity, and of the 5 wishing tree responses, it was unclear whether these were submitted by Pakistani attendees, as they had not been labeled with a colored sticker. It was therefore decided not to include these in the analysis.

Workshop 2: collaborative analysis. The aims of workshop 2 were to (1) review, explore, and co-analyze the data collated during workshop 1 focus group and at the community event, and (2) co-create action plans to recommend strategies to address any barriers to breastfeeding engagement or support identified during the analysis process.

> Co-researchers are able to collaborate with academic researchers to develop action plans for change.

First, co-researchers were presented with graphs depicting the data captured on the sticker boards at the community event (see Supplementary Data). Co-researchers discussed their perceptions of what the findings meant and the reasons they felt would explain the findings. All discussions were audio-recorded and transcribed verbatim by UB.

Co-researchers then analyzed the focus group data from workshop 1 using a method informed by reflexive thematic analysis (RTA),[28] which is a theoretically flexible method to identify patterns of meaning across a dataset and involves a systematic series of steps requiring data familiarization, coding, and theme development. The co-researchers had no prior experience with qualitative analysis and were not given detailed training in the use of RTA; however, the method was amended to support co-researcher engagement.

First, to facilitate the familiarization element of RTA, co-researchers read the focus group data before the workshop. Then, as the co-researchers had not engaged in qualitative analysis before, the author ran through a practice example by presenting a quote to be discussed by the whole group. Key issues in the example were discussed together and agreed on. Co-researchers were then divided into 2 groups to facilitate more focused discussions in which

Table 4. Community Member Sticker Board Question Responses

Question	Count
Age, y (n = 20)	6
18–30	2
31–40	8
41–50	3
51–60	1
61–70	0
≥ 71	
No. of children (n = 16)	
0	0
1	1
2	5
3	6
4	2
5	2
≥ 6	0
Fed (or intend to feed) colostrum (n = 16)	
Yes	15
No	1
Breastfed (or intend to breastfeed any child) (n = 15)	
Yes	13
No	2
Offered (or intend to offer) a prelacteal feed (n = 13)	
Yes	4
No	9
Offered (or intend to offer) a prelacteal feed (n = 13)	
Yes	4
No	9
How many children were breastfed (even only once) (n = 15)	
0	1
1	2
2	5
3	7
≥ 4	0
For parents: age of baby when first given formula (sticker for each child) (n = 16)	
< 1 wk	4
1–4 wk	0
5–12 wk	5
3–6 mo	2
> 6 mo	3
Never	2
For parents: age of child when breastfeeding stopped (sticker for each child) (n = 20)	
< 1 wk	1
1–4 wk	1
5–12 wk	6
3–6 mo	1
> 6 mo	11
Never had breastmilk	0
Who would you approach for breastfeeding advice (n = 12)	
Mother	4
Mother-in-law	0
Husband/partner	5
Sister/sister-in-law	2
Brother/brother-in-law	–
Midwife	3

(continued)

everyone could feel able to contribute. The groups were asked to continue the exercise by discussing the quotes and creating piles of quotes that they felt were examples of similar issues. Each quote was provided on a separate slip of paper to enable extracts to be physically sorted, discussed, and coded. Co-researchers reviewed the quotes and discussed what theme each example represented; this enabled coding to be conducted verbally. The groups marked all the examples collated together with a color to show they represented the same theme. Then, to facilitate the theme development and refinement, co-researchers were asked to give the collated extracts a name that explained why they had been grouped.

Co-researchers then engaged in reflexivity by discussing their themes and feeding back to the workshop facilitator, AB, who visually recorded ideas on a whiteboard. This approach aligns with strategies recommended for quality assurance in RTA, as discussing theme development with others supports exploration of different perspectives on the data and provides validation.[28] RTA quality is also enhanced by the involvement of an experienced supervisor,[28] therefore the discussion of theme development with AB, an experienced qualitative researcher, enabled interrogation and exploration of the theme ideas developed by the group as AB was able to ask questions which sought clarification and helped to explore alternative interpretations. This process led to a list of preliminary themes (Table 5).

Action planning. The final workshop activity invited co-researchers to reflect on the discussions and identify strategies for change. Co-researchers were provided with 'starburst' sheets (see Supplementary Data), informed by action planning theory that advocates the need to consider actions and intentions in detail to create achievable and actionable proposals for change.[30] For each of the identified themes, the sheets facilitated co-researchers to consider: Who needs to take this action? What does this person (or group of people) need to do? Where is the best place for this action to happen? When should this action

Table 4. (*Continued*)

Question	Count
GP	0
Health visitor	2
Breastfeeding network/other voluntary support	3
Other	0

Table 5. List of Preliminary Themes Developed Through Co-Researcher Discussions During Workshop 2

Theme	Subtheme
Social and cultural barriers	• Family pressures • Generational differences • Language • Modesty: body perception and sexualization of the breast in the United Kingdom culture • Returning to work
Need for improved breastfeeding awareness and education	• Antenatal support to prepare for motherhood • Improve understanding of health benefits • Facilitate informed personal choice
Perceived lack of support or lack of access to support	(No subthemes identified by the co-researchers)

happen? Why would this action help to address the barrier we have identified? How should this be done? What would the solution to the problem look like?

Creation of the findings narrative. The final stage of RTA is creating the theme narrative.[28] AB reviewed the initial theme list created by the co-researchers (Table 5), the piles of quotes collated by the co-researchers and their titles, and the transcribed discussion regarding the sticker board data alongside the action plans. These sources of data were triangulated by moving iteratively between the different examples to produce a descriptive narrative guided by the initial theme list and embedding extracts from the different data sources. A report on the findings was circulated to the co-researchers for review; no changes or alterations were requested.

RESULTS

The barriers and facilitators to breastfeeding identified by the co-researchers were grouped under 3 themes: (1) "It's much easier in Pakistan": Cultural context influences breastfeeding behavior, (2) "The reason I stopped was because I was never informed": Education and awareness is essential, and (3) "I feel as if culturally, midwives and health visitors are not trusted": Effective support must be culturally informed. The results narrative contains quotes from the focus group (workshop 1) and quotes in response to exploring the event data capture and action planning activities (workshop 2). Pseudonyms have been provided for quotes from the focus group discussion in workshop 1, when known. The activity-based format of the second workshop meant it was difficult to identify individual speakers from the recording, and therefore, pseudonyms for these examples are not reported.

It's Much Easier in Pakistan: Cultural Context Influences Breastfeeding Behavior

Co-researchers explained how women living in the UK Pakistani community breastfeed within a specific cultural context. The 40 days after birth are considered sacred and mothers are permitted the time, space and support needed to commit their full attention to their infant: "[In first 40 days after the delivery of the baby] you get time, you don't have to do other tasks. Yeah, your time, as you look after your baby that's all you are required to do" (Mary, workshop 1). This sacred time is temporarily supportive for breastfeeding and is often bolstered by their own mother or sisters joining them in the family home. However, when the 40 days end, this support is withdrawn, and many are left with full responsibility for the infant in addition to expectations around household duties (e.g., cooking, cleaning) and care of older children:

> *[5–12 weeks] is the point when you know, yeah, you've had your support, has gone back then. So, if your mom's come to stay, or you know, you've got, you know, sisters to help out. At that point, then you're on your own, you'd have to do the night feed, cooking, cleaning, everything else that goes will be done.* [workshop 2]

> Pakistani families in the United Kingdom breastfeed for shorter durations and are more likely to intend to formula feed than other South Asian groups.

This sudden withdrawal of support may explain why the sticker board data illustrated that breastfeeding cessation and formula introduction peaked at 5–12 weeks (35–84 days). The reintroduction of additional responsibilities could mean that mothers no longer feel they have the time to dedicate to breastfeeding:

> *I lived in a joint family at that time [when I was trying to breastfeed]. I had to look after the home and, you know, other stuff [after my baby was born]. So, it wasn't very, you know, I couldn't always be [breast]feeding my kid. So that's why I left the [breast]feeding. I started the formula milk.* [Alia, workshop 1]

As participants were also living in an economically deprived area, the cost of living was also perceived to be a barrier, with many mothers needing to return to work sooner than they would like to be able to financially support their family:

> *I think that's something that is an issue at the moment because a lot more women going [back to work] earlier there's a cost-of-living issue that you know especially because you know this area [Stoke-on-Trent] is massively deprived.* [workshop 2]

There was agreement that breastfeeding "is really hard for working parents," and one co-researcher summarized this as an almost impossible choice between breastfeeding a single child or working to support the whole family:

> *What do you do? Which one do you choose? Do you choose your child, or do you choose your work. [. . .] if you're gonna go to work of course it's going to benefit the whole family but then you leave the child with the bottle.* [. . .] [Pumping] *can be a lot of work for the third person who is going to feed the saved-up milk, if it's not saved-up in the bottles properly you know what I mean? A lot of time when you when you pump, you just keep all those refrigerated, and then the person who is gonna be* [feeding the milk is the] *mother-in-law. So, they think that's a hassle because one of them said to me is "I am not going to do that it's easier just to scoop shake [feed formula]"* [workshop 2]

The timing of support withdrawal may also align with other factors that present barriers to breastfeeding maintenance. For example, the onset of cluster feeding when a mother may begin to question their milk supply ("Four to six weeks is when the cluster feeding is really intense. And almost after six weeks, is there a perception that there isn't enough milk? Why [is my baby] still feeding so much?" [workshop 2]) and an increase in commentary on parenting decisions by wider family members, which added pressure and feelings of doubt:

> *Can I say around about five, six weeks? That's when you're then asked. Is your baby on a routine? Did your baby sleep through the night. Yeah. And I think then you just internalise that and think, why isn't my baby sleepy? Why aren't they on routine?* [workshop 2]

Pressure could also be amplified by an increase in exposure to narratives portraying breastfeeding more negatively, such as suggestions that a baby requiring lots of breastmilk may not be getting "full" or that breastmilk may not provide sufficient nutrition:

> *I think it's a lot of peer pressure from, like, your family relatives* [to use formula milk]. *They think that the baby is not full because I know in the first few weeks, baby is close to you for feed, then you have to keep putting them on the breast, and a lot of the Asian community thinks, that means that they're not full, that they haven't drunk enough milk so, that happened to me loads.* [Mary, workshop 1]

Some of these narratives reflected acculturation to UK norms. For example, breastfeeding may be seen by some members of the Pakistani community as an old-fashioned choice:

> *I feel that whole modern Asian culture is about keeping up appearances and facilitating that all that socializing. And even older ladies, the way they viewed breastfeeding was a burden. Lots of families and that now there's an alternative [of formula] so why would you go back to that prehistoric thing.* [Workshop 2]

In these cases, the formula may be perceived as representing affluence and therefore the visibility of formula use may present the family as higher status: "[Formula] shows that you're like, you got money. It shows you can afford it like a status [symbol]" (workshop 2). In addition, the cultural expectation for modesty was felt to particularly apply in a UK context, in which the female body is seen as sexualized. Some co-researchers compared this to spending time in Pakistan, in which they felt breastfeeding was more accepted:

> *Mary: I think it's much easier in Pakistan. I took my eldest, 3-month-old son; it was so easy*
>
> *Zoe: Because everybody knows it, they don't bother. They don't look in like that*
>
> *Mary: No one even cares, it's so normal. [. . .] I went to Pakistan when my son was almost three months old; I never went in a different room. All family was seen; I just covered a little bit. That's what we're saying is much more comfortable there. Because it's not from breasts sexualised as much as they are here. So it's normal to that's, I feel like that's what it's there for. So it's something I never felt uncomfortable about.*

In the United Kingdom, the need and expectation for modesty could prevent breastfeeding in several situations, for example, when visitors came to the home ("If you've got a baby and you're breastfeeding, you've got a lot of family around your baby, and your baby is unsettled and you want to [breast]feed, and you can't put the baby on the breast there" [Unknown, workshop 1]) or in hospitals ("Even now, in the hospital, you get babies that are born, and mums will say we want to breastfeed, but we'll do [it], when we go home. We don't want to [breastfeed] even in a private setting at the hospital, because they have got visitors coming and at home as well" [Zara, workshop 1]).

> Expectations of modesty are challenged by sexualisation of the breast in UK culture.

Concerningly, when not respected by health professionals, the absence of modesty in a health care context could also lead to extreme distress. One co-researcher, who gave birth in her early 20s, explained how after a

long labor the support she received conflicted with her need and desire for modesty as the health care professional placed her hands on her body without consent:

> *I heard somebody say to another lady [in the hospital], I'll just take your baby and give him a bottle. And I thought 'oh my God feeding' [. . .] I didn't know who to ask. And then there was a lady cleaning up in a purple uniform. And I just said to her, "excuse me, I think my baby's hungry. What am I supposed to feed my baby?" And she said, "do you want to breastfeed?" and that was the first time I'd thought. And then I thought, and then I said, "I don't know how to" [. . .] this lady in the purple uniform, healthcare, she was helping me. But I think it was so horrific for me personally, because she was touching me, and I didn't expect that. Yeah. And I was just like, "Oh, my God, where am I come to?"* [Unknown, Workshop 2]

The Reason I Stopped Was Because I Was Never Informed: Education and Awareness Are Essential

The co-researchers illustrated awareness of the benefits of breastfeeding and factors that might encourage breastfeeding by others, such as bonding and connection ("[Breastfeeding is] bonding with your child as well. You connect so well." [Iram, workshop 1]), and physical health benefits such as protection from infection ("Baby gets good health [from breastfeeding]; they don't get the sneezing one year. I think if you breastfeed him, to be honest, they go well, you know. No infections or anything" [Zoe, workshop 1]). Many also expressed awareness of the benefits of colostrum, and this was reinforced by the sticker board data, in which 87% had offered or intended to offer colostrum to their child. Co-researchers described colostrum as "liquid gold" (workshop 1) and, when considering the sticker board results, felt that some may not offer colostrum because of "not knowing the benefits, no knowledge" (workshop 2).

However, co-researcher discussions also highlighted several examples of misinformation in the ideas put forward, either co-researchers' own or examples witnessed in others. This included feeling uninformed:

> *I breastfed my three kids. But the reason I stopped doing that was because I was never informed. So ultimately, I would have to go back to the formula. And, as you know, giving a mixture of my [breast]feed and the formula feed, it wasn't making their health very good, they would keep throwing up. So, the doctor suggested to go with either your milk or the formula milk. So, whenever I fed my kid with my [breast] milk, half an hour or later, they were hungry again.* [Alia, Workshop 1]

In another example, one co-researcher expressed the belief that formula milk is more nutritious for the baby:

> *I strongly believe formula milk is more nutritious and covers all the necessary nurturing and somewhat naturing. When a mother breastfeeds, the mother chooses what to eat. The breastmilk may not necessarily be customised for a great taste and covers all nutrition involved for healthy growing.* [Nadia, Workshop 1]

Sticker board data suggested that around one-third of respondents offered, or had the intention to offer, prelacteal feeds (anything other than breastmilk or formula in the first 3 days after birth). Co-researchers felt that this choice reflected Islamic tradition, in which a small piece of softened date is gently rubbed on the child's upper palate soon after birth:

> *When baby born, they put honey or date, its religious tradition happens in first three days. It's like you get into a paste form. And then with your finger, just put it on the roof of the mouth of the child.* [workshop 2]

> Pakistani community members feel faith-linked interventions, delivered in religious settings, could be effective, and these should be co-designed with community members.

Some co-researchers were surprised that the number reported to be offering prelacteal feeds in the sticker board data was so low and speculated that this behavior is likely to be more common than had been represented. They suggested this might be due to parents not wishing to admit to the practice ("I think maybe the 'no's' are possibly people who don't want to own up to that cultural thing" [workshop 2]), or because it may happen without the parents' knowledge ("Sometimes as a mom, if you're out of it. Somebody else might do that [give a prelacteal feed]. And you weren't there, and you can't remember it, or you don't know that it happened" [workshop 2]).

I Feel As if, Culturally, Midwives and Health Visitors Are Not Trusted: Effective Support Must Be Culturally Informed

Advice, information, and practical support for breastfeeding were felt to be largely unavailable to Pakistani families in the United Kingdom. More support was perceived to be offered in Pakistan, where breastfeeding was easier:

> *I* [breast]*fed the* [babies] *in Pakistan that were born there because I had support. When I came here, she* [health care professional] *said it was just so much easier to give a bottle* [formula milk]. *[Saima, Workshop 1]*

Pakistani women often have a desire to breastfeed, but feel there is no practical help (My preferred method to feed my children is] breast first but [I] then resorted to mix

feeding because of social demands, no practical help what's so ever, then full formula" [Abeeha, workshop 1]) or information ("There is no information [about breastfeeding], no support [at hospitals]" [Haniya, workshop 1]) available to them. This problem was exacerbated by a lack of awareness of existing support options. For example, one co-researcher, who was active in the provision of support for local Pakistani women, attended the community event and provided feedback that, despite their role, they were unaware of many of the local breastfeeding support options and only became aware of some of these at the event:

> *Came [to the event] today and only became aware of the [volunteer-led] weekly breastfeeding sessions and antenatal sessions [at a local family hub] today. This needs to be regularly advertised on community groups, midwives must refer local mums to this initiative, and a sign containing activity details could be placed outside the centre—sharing all the activities offered inside, this should be prominently placed towards the pavement side so the local community can see.* [Abeeha]

Health care professionals were perceived to be a good source of support when they could be accessed, and sticker board data highlighted midwives and health visitors as good support options. However, there were also some expressions of doubt, for example, suggestions of a lack of trust in these health care professionals ("I feel as if culturally, midwives and health visitors are not trusted" [workshop 2]), and a feeling that health care professional guidance was inconsistent:

> *You can sit with a midwife who will tell you, you know, one year she'll be telling you that this is the guidelines and the next year telling you these are guidelines. Yeah, I think that creates a distrust because it's like, you were telling me this before. And now you're telling me this.* [workshop 2]

Furthermore, language barriers were presented as problematic for some in the community, increasing feelings of mistrust:

> *Recently, I was helping an immigrant, who can't [breast]feed and there was a language barrier [when talking to health care professionals], there was distrust the service even more, because you feel like they [health care professionals and services] don't know doing what you're doing.* [workshop 2]

These language barriers were perceived to be preventing effective communication: "For many people, English is not the first language. Women cannot communicate and cannot understand what's going on when support is offered" (workshop 2). One co-researcher was concerned that health care professionals may assume Pakistani women are unable to speak English and therefore not proactively offer support:

> *I remember asking* [my niece] *if she started breastfeeding a little one, and she said, "I want to; I had a section, but nobody come to show me." So, I remember talking to one of the midwives and say, "look, you know, she's in the ward, you know, or whatever. Can somebody just go over and speak to her?" She said,"would she speak English?" I was like, "she's born here; she speaks, reads, writes everything," I said. "How you've made an assumption that she doesn't, and you haven't gone to her."* [Saima, Workshop 1]

This experience was reflective of a wider feeling that support for Pakistani parents was inequitable, and a perception that health care professionals were acting on assumptions that Pakistani women already knew how to breastfeed and would get the support they needed from their family:

> *I do think there is a stereotype there that I think that we [Pakistani women] will know what to do [to be able to breastfeed]. And that the thing that we may have support from our parents and in-laws, and I do think sometimes they [health care professionals] think that we do know what to do, hence why they're not giving us the support.* [Unknown, workshop 1]

The group proposed some suggestions for how these negative perceptions and lack of trust in providers could be overcome. This included a need for more regular contact with health visitors to build relationships:

> *I think the health visitor thing, there was a time when the health visitor came to your home for regular weigh-ins, the services were there. And I think you create a bond where you get to know the health visitor, just break down that barrier.* [Workshop 2]

Co-researchers also suggested that support should be provided within Mosques and align with activities the community members were already engaged with:

> *Some Mosques now have education programmes and stuff, and making breastfeeding services making links with having regular, like breastfeeding clinics or whatever. And that way, if you're working with the mosque on the Friday sermon, the Mums can mention that any of you who have a breastfeeding mother in your house need to support. They do give sermon sometimes about marital advice and things like that* [workshop 2]

In the sticker board responses, there was no indication that parents would seek support from their mother-in-law, husband or partner, or sister/sister-in-law. Discussion around this highlighted that men were not perceived to be a source of support, and many co-researchers reflected that men in their community did not seem interested in breastfeeding:

> *Co-researcher 1: I think if you go to a man, because the solution we give you solutions don't they, and the solution that makes sense to them is give it formula because then [the baby will] go to sleep.*
>
> *Co-researcher 2: I think some of them [fathers/partners] are not interested in, they don't bother.*
>
> *Co-researcher 3: My ex-husband, he was not interested.*

Men were also thought to be reluctant to attend antenatal appointments because of cultural expectations and concerns about modesty, as discussed in the first theme:

> *I mean, at home, you know, we always cover our bumps and stuff like that. I think it's difficult to understand the levels of modesty, like when something [which is perceived not to be modest] comes onto the TV, as a family, you, you change the channel, you're bought up like that. So, you those things aren't openly, the reason partners wouldn't go [to antenatal appointments] as well is because it's gonna be a whole situation. It's not because they think it's something wrong with it or anything like that, or it's a modesty thing.* [Workshop 2]

Furthermore, a perception that antenatal appointments were for couples rather than the wider family created a perceived need to attend antenatal appointments alone when male partners refused, which was an additional barrier to support access:

> *My husband didn't want to go [to antenatal appointments]. Yeah, I didn't want to go on my own. I think a lot of antenatal and now geared towards couples. [. . .] I felt really self-conscious going.* [Workshop 2]

The preference for support from own mothers was felt to be tied to cultural expectations. This was helpful during the 40 days, but was a cultural barrier to support following this time, as mothers-in-law were seen to be responsible for supporting their own daughters rather than the daughters-in-law who may be sharing their home:

> *I think culturally, it's a weird setup that mothers are there to serve their own daughters, so each person is expected to go get those services given by their own mothers because mother-in-law is busy looking after her own daughters their own emotional needs and physical needs.* [Workshop 2]

DISCUSSION

In this research, we employed participatory methods to collaborate with members of the Pakistani community to better understand the facilitators and barriers to breastfeeding and how challenges identified could be addressed. Working with the community to collect and analyze breastfeeding-related data supported Pakistani women to share and identify participant-led understanding of breastfeeding and highlighted how Pakistani mothers in the United Kingdom often want to breastfeed but face several barriers.

Cultural factors were found to both support and hinder breastfeeding. The cultural practice of the 40 days initially facilitated breastfeeding. These benefits are advocated in Muslim teachings, which recognize motherhood as a major life transition and promote breastfeeding as a behavior which should be supported by the whole family to encourage mother-child bonding.[31] However, when the 40 days ended, the associated withdrawal of family support and renewed need to fulfill household duties was a barrier to breastfeeding maintenance. This phenomenon has been reported by the broader South Asian community[20] and therefore is not unique to Pakistani culture. South Asian families may benefit from more proactive and targeted support at around 5 weeks after birth, when additional family support may suddenly be removed, and home management expectations may increase.

> Support interventions should be prioritized within the first 40 days following birth and involve the whole family.

The UK formula feeding culture for infants[18,19,32] creates pressure for South Asian mothers to use formula, contributing to reduced breastfeeding rates.[20] Co-researchers in this study have expanded on this by proposing some reasons why formula may be preferred by Pakistani families. Some co-researchers spoke of the importance of keeping up appearances in Asian culture, which could indicate formula being perceived as a status symbol and a sign of wealth by older community members. This generational conflict regarding collectivist concerns about family status and prestige in South Asian families living in Western countries has been reported in research exploring education[33] and women's body image,[34] but this study highlights that these concerns also exist when considering infant feeding behavior. The influence of these generational pressures is exacerbated by evidence of insufficient awareness and knowledge of the benefits of breastfeeding, both by mothers and the wider family. There were reports of pressure from family members to offer formula, particularly during the peak of cluster feeding when infants' feeding cues were interpreted as signs that nutritional needs were not being met. In the general UK population, slow weight gain in babies is associated with breastfeeding cessation,[35] and studies exploring reasons for cessation commonly report concerns about supply as a contributing factor.[36] In intergenerational family homes, these social pressures can be amplified. Previous research has illustrated how grandmothers play an important role in influencing South Asian breastfeeding behavior[37] and the co-researchers in this study reaffirmed how comments from family could impact and exacerbate worries and concerns regarding breastfeeding. Evidence from Ireland suggests that mothers feel shame and judgment when breastfeeding in cultural settings, when formula feeding is considered preferable,[38] and our findings indicate this feeling of judgment could also contribute to infant feeding decisions within Pakistani family dynamics.

Cultural expectations for modesty presented a practical and confidence barrier to breastfeeding in a range of contexts. These findings help to explain the UK infant feeding survey evidence that Pakistani mothers are less likely to breastfeed in public than other mothers.[3] In line with

past research, the co-researchers drew comparisons to the ease of breastfeeding in Pakistan[10] and described a perceived need for increased modesty because of sexualization of the breast, a commonly reported challenge for breastfeeding uptake in the United Kingdom.[39,40] These observations support arguments that levels of acculturation are important contributors to breastfeeding behavior.[20] The co-researchers also expressed that they perceived that some men in the UK Pakistani community do not show an interest in breastfeeding or are reluctant to attend antenatal appointments because of concerns around modesty. This contrasts with research in Pakistan, in which fathers report positive attitudes toward, and knowledge of the benefits of, breastfeeding and express a responsibility to support ongoing breastfeeding through contributing to household chores.[41] This reasserts calls for increasing breastfeeding visibility in UK culture as a step toward challenging breast sexualization and normalizing breastfeeding behavior[21,42] and highlights the need for intervention approaches that engage the whole family to challenge assumptions, educate, and raise awareness of both the benefits of breastfeeding and how it can be supported.

Prelacteal feeding, a common practice in Pakistani culture, has been discussed in previous research.[13,14,43,44] Prelacteal feeding is associated with exclusive breastfeeding cessation and shorter breastfeeding duration[45] and therefore represents a barrier to breastfeeding. One-third of sticker board respondents reported actual or intended prelacteal feeding; the co-researchers suggested that this practice is likely to be more common than the event data suggested. This finding highlights a potential reluctance to publicly discuss or acknowledge prelacteal feeding practices, and that these practices may occur without parents' knowledge, presenting a challenge regarding identification and offering support. Prelacteal feeding represents a conflict between cultural practices and best-practice recommendations for ensuring newborn health. Much of the research on prelacteal feeding and the potential for negative health outcomes has been conducted in countries with low-middle income,[46] and the prevalence and impact on health outcomes in the UK context is unknown. This is an important area for further research.

Co-researchers also highlighted barriers regarding a perceived lack of health care professional support. Concerns were raised regarding a lack of trust, which was felt to be caused by variation in advice received, language barriers, and the perception that health care professionals make assumptions about breastfeeding knowledge or the availability of breastfeeding support from family members. These findings mirror those from research with health visitors and midwives, which reported that professionals hold assumptions about Pakistani breastfeeding behavior and may act on these assumptions rather than evidence-based guidance.[23] Trust is an important contributor to the uptake of routine postnatal care,[47] and therefore represents a barrier to accessing ongoing breastfeeding support. Furthermore, midwives and health visitors report a desire for cultural competence training,[48] which would help to address some of the sources of mistrust and the reports of assumptions made regarding English proficiency discussed by the co-researchers.

Co-researchers also highlighted dissatisfaction with support from health care professionals, something which has been reported in previous research with women from a range of ethnic backgrounds.[17] Co-researchers specifically requested more face-to-face support, which contrasts with previous research in which it was suggested that South Asian women are reluctant to discuss infant feeding with health care professionals.[22] However, it is important to note that this support also needs to be culturally competent. Co-researchers discussed experiences in which hands-on approaches to breastfeeding support could be distressing and conflict with cultural desires for modesty. This physical approach is also perceived negatively by other populations[49] and viewed as invasive and disrespectful of women's' bodies[50] highlighting a need for universal change to some breastfeeding support practices and improved training for health care professionals.

This research was conducted in collaboration with members of the Pakistani community, ensuring that findings were grounded in Pakistani women's understandings of breastfeeding. The co-researchers represented a range of generations, ages, motherhood statuses, and levels of breastfeeding experience, ensuring that several perspectives were contributed during data production and analysis. The use of PAR ensured that the voices of the community themselves were central to the research conducted and the findings produced. This differs from traditional researcher-led approaches, which create an inevitable power imbalance in the researcher-researched relationship, and recognizes the importance of lived experience and community member contributions for bringing about change.[24] As this research was conducted in a single city, these findings may not be transferable, and it is recommended that future research explores the applicability of these findings to other Pakistani communities in the United Kingdom. The city in which this research was conducted has particularly poor infant feeding rates and low levels of socioeconomic status, and therefore the challenges discussed are likely to be applicable to those who are most disadvantaged.

IMPLICATIONS FOR RESEARCH, PRACTICE, AND POLICY

One key recommendation for overcoming some of the challenges regarding current support provision was the delivery of support within Mosques, with teachings being linked to religious sermons. Faith-based interventions delivered in collaboration with Mosques represent a promising avenue for effective public health promotion.[51] Qualitative research with Muslim women has found Mosques to be perceived as a good setting for general women's health interventions, and that the inclusion of peer educators would be welcomed.[52] This approach could

increase exposure, encourage community awareness, and begin to normalize whole-family discussions regarding infant feeding. It is recommended that future research explore the feasibility and effectiveness of faith-based breastfeeding support interventions.

Breastfeeding rates in Pakistani populations in the United Kingdom are low, and this research has illustrated barriers to breastfeeding engagement, including the challenges of assimilating Pakistani and UK culture, gaps in knowledge and awareness regarding breastfeeding, and problems with the delivery of breastfeeding support. Co-researchers collaborated to agree on strategies to support breastfeeding in the Pakistani community, which highlighted the need for awareness raising, culturally sensitive intervention, faith-based intervention delivery, and a particular focus on support, which coincides with the end of the 40 days after birth, when barriers for breastfeeding increase and additional family-delivered support is often withdrawn. These findings support the recommendation for future collaboration with Pakistani community members to develop and evaluate intervention approaches delivered within places of worship.

CONFLICT OF INTEREST DISCLOSURE

Amy Burton has previously been a volunteer with The Breastfeeding Network. The authors declare no other declarations of interest.

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SUPPLEMENTARY DATA

Supplementary data related to this article can be found at https://doi.org/10.1016/j.jneb.2026.04.005.

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