Original Article

The education of health practitioners supporting breastfeeding women: time for critical reflection

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Abstract

The protection, promotion and support of breastfeeding has now become a major international priority as emphasized in the *Global Strategy for Infant and Young Child Feeding.* Health practitioners, such as midwives, nurses and doctors, have a key role to play in providing support to breastfeeding women. This paper provides a critical discussion of educational requirements of health practitioners to equip them for their supportive role. The effective integration of embodied, vicarious, practice-based and theoretical knowledge requires opportunities for deep critical reflection. This approach should facilitate personal reflection and critical engagement with broader socio-political issues, thus allowing for collective understandings and change. Practitioners also need to understand breastfeeding as a biopsychosocial process that is dynamic, relational and changes over time. Recommendations are outlined with regards to multidisciplinary undergraduate education; mentorship schemes with knowledgeable role models supporting student practitioners; involvement of voluntary and peer supporters; post-registration education; setting of national standards for breastfeeding education; tailored education for specific groups; designated funding; and involvement of breastfeeding specialists.

Keywords: breastfeeding, education, multidisciplinary, critical reflection.

Introduction

The protection, promotion and support of breastfeeding has now become a major international priority as emphasized in the *Global Strategy for Infant and Young Child Feeding* (WHO 2003). Within the Global Strategy, the statement is made that:

> Mothers should have access to skilled support to help them initiate and sustain appropriate feeding practices, and to prevent difficulties and overcome them when they occur. Knowledgeable health workers are well placed to provide this support, which should be a routine part not only of regular prenatal, delivery and postnatal care but also of services provided for the well baby and sick child. (p. 12)

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Breastfeeding women carry out a partially learned activity, which may be adversely affected by lack of exposure and low levels of knowledge and support within a given community. It is now well established that skilled support, proactively offered to women who want to breastfeed, can increase the duration of breastfeeding (Sikorski *et al*. 2004; Renfrew *et al*. 2005). It is also clear that a major reason for early cessation of breastfeeding relates to women's perceived difficulty with breastfeeding (Dennis 2002; Hamlyn *et al*. 2002; Renfrew *et al*. 2005).

Although health practitioners may positively influence breastfeeding women (Humenick *et al*. 1998; Kuan *et al*. 1999), they can also be a negative source of support when they provide women with inconsistent, inaccurate and/or inadequate information and recommendations. Conflicting information and indeed advice is repeatedly referred to in relation to hospital practices and, as Krogstad *et al*. (2002) reflect, it often relates to a lack of a common approach, coordination and cooperation among health practitioners. Conflicting information appears to be a continuing problem that undermines women's confidence in relation to breastfeeding (Garcia *et al*. 1998; Tarkka *et al*. 1998; Vogel & Mitchell 1998; Dykes & Williams 1999; Dykes 2005a).

It is axiomatic that provision of effective breastfeeding support is only possible if practitioners have the requisite skills for achieving this. Several key groups are engaged in supporting women with breastfeeding: (1) health practitioners, including midwives, maternal and child health nurses, medical doctors, healthcare assistants, neonatal nurses, community-based nurses, pharmacists, infant feeding specialists and lactation consultants; (2) trained breastfeeding counsellors from a breastfeeding support organization; (3) peer supporters; and (4) significant others such as family and friends. This paper focuses specifically on the educational needs of health practitioners. First, the cultural context of breastfeeding is discussed in order to set the scene for the subsequent focus upon educational issues.

The cultural context of breastfeeding

While the focus of this paper is upon the educational needs of practitioners engaged in aspects of supporting breastfeeding women, it is necessary to briefly consider the cultural context within which breastfeeding takes place. Only when this is understood can the constraints upon breastfeeding women *and* the educational needs of practitioners be appreciated. This cultural understanding is crucial in that many supporters of breastfeeding women will have been socialized through the same society as the women they support.

Infant feeding practices have undergone enormous changes in the past century, and these relate to a complex combination of factors such as medicalization of infant feeding, development of infant formulae, associated commercial activities and changing lives of women (Dykes 1997, 2002, 2005b; Dykes & Griffiths 1998). By the 1960s and early 1970s, breastfeeding rates had reached an all-time low in many communities across the globe. Ironically, this was the time when there was also a growing body of scientific research highlighting the nutritional and immunological benefits of breastfeeding for babies. A range of international initiatives were set up in response to this (WHO 1981, 1990;WHO/UNICEF 1989), and international breastfeeding rates started to rise again. However, there is now a predominant bottle-feeding culture in many communities around the world that is proving to be tenacious and persistent.

There is a growing body of research that highlights the reasons why women do not breastfeed at all, prefer to partially breastfeed or discontinue breastfeeding early (Tedstone *et al*. 1998; Fairbank *et al*. 2000; Renfrew *et al*. 2000, 2005; Dennis 2002; Hamlyn *et al*. 2002; Protheroe *et al*. 2003). Qualitative research illustrates the complexity and range of dilemmas and paradoxes surrounding breastfeeding (Dykes 2002, 2005a,b; Mahon-Daly & Andrews 2002). In some communities, a deeply entrenched bottle-feeding culture has existed for three generations, with children and adults rarely, if ever, seeing women breastfeed. Significant others who have generally been socialized through a similar culture play a key role in ongoing decision making related to infant feeding. Many women in the UK still feel uneasy about breastfeeding in public. This relates to the inherent ambiguities between breastfeeding as a maternal activity and breasts being increasingly, and ever more explicitly,

displayed throughout every media channel as sexual items (Dykes & Griffiths 1998; Pain *et al*. 2001; Mahon-Daly & Andrews 2002; Dykes 2003). Breastfeeding is still portrayed in the media and experienced by many women, particularly in socially deprived communities, as a marginal and liminal activity, rarely seen and barely spoken about (Hoddinott & Pill 1999; Henderson *et al*. 2000; Mahon-Daly & Andrews 2002; Dykes 2003).

Research also highlights that women continue to lack confidence in their ability to breastfeed (Hoddinott & Pill 1999; Blyth *et al*. 2002) and, in particular, their capacity to provide sufficient milk for their babies (Dykes & Williams 1999; Dykes 2002, 2005b). This body of research points to the need for understanding women's decisions related to infant feeding and indeed the educational needs of practitioners through a socio-cultural 'lens'. This has implications for the education of practitioners engaged in supporting breastfeeding women.

Knowledge, attitudes and practices of practitioners

Any interaction between a practitioner and a childbearing or breastfeeding woman will be influenced by the practitioner's attitudes, knowledge and skills. As these are key areas to consider in any educational programme, it is useful to briefly refer to the ways in which these are generated. It must, however, be stated that knowledge, attitudes and skills are very closely interconnected.

Knowledge

Knowledge of breastfeeding stems from several sources: (1) embodied knowledge; (2) vicarious knowledge; (3) practice-based knowledge; and (4) formal theoretical knowledge based on current research evidence. These forms of knowledge inevitably overlap but, for the purposes of clarity, they are briefly defined here. Embodied knowledge is a subjective knowledge acquired through a person's experiences and perceptions of his/her own body (Belenky *et al*. 1986; Hastrup 1995). Embodied knowledge of breastfeeding stems from personal experience of breastfeeding a baby. This has a most powerful influence upon attitudes, behaviour and personal confidence (Bandura 1977, 1986; Hoddinott & Pill 1999). Vicarious (cultural) knowledge stems from general learning experiences generated during one's life, for example, observing breastfeeding within one's own family or community (Bandura 1977, 1986; Hoddinott & Pill 1999). Practice-based knowledge is learned during a practitioner's experiences of observing other experienced practitioners and role models while in their own particular field of work. Formal knowledge generates from structured learning opportunities within the person's education. In the case of breastfeeding, this relates to the evidence base underpinning effective protection, promotion and support of breastfeeding.

The knowledge learned during a programme of education to prepare practitioners for their role will be paradigm specific. Kuhn (1970) was the first to highlight that for a given community or discipline, there develops a specific range of beliefs, values and methods of solving a puzzle. He referred to this way of 'seeing' the world by a specific discipline as a paradigm. A person's paradigmatic stance influences what he/she attends to and what is ignored or taken for granted. The paradigmatic stance of a medical doctor, whose educational programme stems from a scientific model, will inevitably be fundamentally different from that of a breastfeeding counsellor who has undertaken training based on a person-centred counselling model. While neither can be considered right or wrong, it is crucial that each discipline has some understanding of other paradigmatic stances.

The four forms of knowledge referred to above may, or may not, be integrated with each other, and this very much depends on the ways in which practitioners are enabled, through learning experiences, to connect these and develop coherence between them. It is acknowledged, for example, that informing practitioners on the evidence base for a subject, to include the provision of evidence-based guidelines, does not necessarily change practice (Bero *et al*. 1998; Haines & Donald 1998; Lawton & Parker 1999; Kirkham & Stapleton 2001; Grimshaw *et al*. 2004). This relates in part to constraints within the organizational culture (Kirkham & Stapleton 2001; Shaw *et al*. 2004; Dykes

2005c) and to formal teaching methods that fail to support critical reflection (Freire 1972; Peters & Lankshear 1994; Brechin 2000). These didactic models do not enable the integration of tacit forms of knowledge, i.e. those that remain largely outside our immediate awareness and explicit forms of knowledge that people communicate about with relative ease (Polanyi 1967; Spradley 1980).

Attitudes

Attitudes are enduring mental representations of various features of the social or physical world. They are acquired through life experiences, and they exert a direct influence upon behaviour (Breckler & Wiggins 1989). Attitudes stem from direct personal experiences that are the most powerful influences, vicarious experience, i.e. observation of others (role modelling) and the influences of others through verbal exchanges (Bandura 1977, 1986; Baron & Byrne 1991). Individuals appraise situations experienced and/or observed, and the resulting positive or negative appraisal influences their attitudes. Taking breastfeeding as an example, this appraisal takes place at a cognitive and affective (emotional) level. A person may therefore have a cognitive awareness of the health gains associated with breastfeeding but a negative affective response due to aversive experiences associated with it. As personal and vicarious experiences are the most powerful, they are more likely to influence behaviour (Bandura 1977, 1986; Baron & Byrne 1991). Hoddinott & Pill (1999) illustrated this negative reaction in a community in which breastfeeding was a marginal activity.

Skills

The development of skills with regard to supporting breastfeeding women relates to personal and vicarious experiences and direct experience of supporting women. The extent to which an individual's life skills, theoretical knowledge and practice-based skills are integrated is associated with the quality of the educational process (Freire 1972; Peters & Lankshear 1994; Brechin 2000; Clarke & Wilcockson 2001, 2002). Development and refinement of practice skills requires practitioners to critically reflect upon practice issues and related experiences. Operationalization of practice-based skills also relates to the personal confidence (self-efficacy) of the practitioner in their own abilities with regard to that skill (O'Halloran *et al*. 1996; Ford-Gilboe *et al*. 1997; Parle *et al*. 1997). This applies to practitioners supporting breastfeeding women (Burglehaus *et al*. 1997).

Self-efficacy (confidence) of practitioners

Self-efficacy theory was first defined by the social learning theorist Bandura (1977), and continues to be developed (Bandura 1982, 1986, 1995). Self-efficacy relates to the personal conviction that one can successfully carry out a particular activity to reach a personal goal. There are four influences upon self-efficacy for a given skill, listed from the most to least influential in terms of effect: (1) performance accomplishments – stems from direct experiences of success or failure; (2) vicarious experience (role modelling) – stems from appraisals following observing others in this situation; (3) verbal persuasion – relates to encouragement or discouragement from others; and (4) emotional arousal – associated with people's judgement of their physiological state and emotional feelings (Bandura 1977, 1982, 1986, 1995).

Bandura (1995) highlights the strong cultural component to self-efficacy, emphasizing the social construction of self-efficacy through transactional experiences with one's surroundings. Several studies have been conducted that focus upon breastfeeding women and their self-efficacy (Dennis 1999; Dennis & Faux 1999; Blyth *et al*. 2002). The collective findings suggest that women's confidence or self-efficacy with regard to breastfeeding influences the duration for which they breastfeed. With regard to health practitioners, it appears that when they are confident in their own skills to support breastfeeding women, they are more likely to positively promote breastfeeding and offer women support (Burglehaus *et al*. 1997). Thus, a belief in the importance of breastfeeding as a health-promoting behaviour needs to be balanced with a level of confidence related to carrying out the

skills required to support breastfeeding women. This has crucial implications for the educational process.

Breastfeeding education for practitioners

When focusing upon knowledge, attitudes and skills of health practitioners who support breastfeeding women and related educational initiatives, several areas warrant consideration:

Inadequate preparation in breastfeeding education for health practitioners

It is commonly reported that in industrialized countries, there are marked knowledge deficits about breastfeeding, ambivalent attitudes, low levels of skill and a lack of confidence among health practitioners. This has been reported in the USA (Schanler *et al*. 1999; Bernaix 2000; Guise & Freed 2000; Hellings & Howe 2000; Register *et al*. 2000; Arthur *et al*. 2003a,b; DiGirolamo *et al*. 2003; Power *et al*. 2003; Spear 2004), Australia (Cantrill *et al*. 2003a,b) and the UK (Jones & Brown 2003; Burt *et al*. 2006; Smale *et al*. 2006).

Breastfeeding education for health practitioners appears to be marginal in these countries, reflecting the relatively low priority often given to breastfeeding in general. There is a clear lack of formal undergraduate education in breastfeeding and subsequently inadequate knowledge and skills apparent across disciplines. These findings apply to nurses (Bernaix 2000; Register *et al*. 2000; Battersby 2002; Spear 2004) and midwives (Cantrill *et al*. 2003a,b, 2004). The exception appears to be nurses possessing the International Board of Certified Lactation Consultant (IBCLC) qualifications (Cantrill *et al*. 2003a,b) and those who possess qualifications with a voluntary breastfeeding support organization (Hall Moran *et al*. 2005; Smale *et al*. 2006).

The lack of knowledge appears to be particularly the case for practitioners who have a more marginal, infrequent or tangential role in supporting breastfeeding women, a key group being medical doctors, such as paediatricians (Schanler *et al*. 1999), physicians (Guise & Freed 2000), obstetricians (Power *et al*. 2003) and community doctors (general practitioners) (Burt *et al*. 2006).

The importance of embodied knowledge

Embodied knowledge gained from personal experiences of breastfeeding is both powerful and influential with regard to practitioners' knowledge, attitudes, practices and confidence in supporting breastfeeding women (Hellings & Howe 2000; Arthur *et al*. 2003a,b; Cantrill *et al*. 2003a,b; Power *et al*. 2003; Smale *et al*. 2006). Arthur *et al*. (2003a,b) conducted a survey with female physicians in Mississippi, USA, to explore practices related to breastfeeding women and personal breastfeeding behaviours. Their initiation rates were higher than average, but duration rates were comparable to the general population. Female physicians who had breastfed themselves were most comfortable supporting breastfeeding women.

Importance of cultural knowledge

Health practitioners are socialized in the same ways as those they care for, and the resulting sources of vicarious knowledge are influential upon their attitudes and behaviours (Kaewsarn *et al*. 2003; Smale *et al*. 2006). This was illustrated by Kaewsarn *et al*. (2003), who surveyed nurses in North Eastern Thailand regarding their beliefs related to breastfeeding. They reported that the cultural beliefs of nurses often clashed with contemporary evidence-based practices, with the former being a more profound influence upon practice. The authors conclude that peer review and mentoring are needed to enable practitioners to combine evidence-based practice with cultural beliefs in ways that prevent practices that are detrimental to breastfeeding.

Lack of integration of knowledge levels

Despite the growing evidence around the importance of personal and cultural experiences, there is often a lack of integration of the various knowledge forms for health practitioners in their undergraduate education, i.e. embodied, vicarious, formal and practice-based knowledge. In particular, there is inadequate

opportunity for practitioners to explore embodied and vicarious knowledge within formal educational situations (Hall Moran *et al*. 2005; Smale *et al*. 2006). Consequently, health practitioners may be unable to integrate their personal experiences effectively and appropriately in their encounters with clients. This may lead, on the one hand, to encounters that lack congruence and, on the other, to encounters in which 'self' is utilized inappropriately.

Negative or ambivalent attitudes

Practitioners commonly appear to hold ambivalent or negative attitudes towards breastfeeding (Register *et al*. 2000; Battersby 2002; DiGirolamo *et al*. 2003), and this appears to relate, in part, to levels and style of education (Register *et al*. 2000). The didactic teaching methods commonly utilized often do not facilitate incorporation of theory (evidence-based information) with practice. Thus, practitioners may experience dissonance between formal knowledge and practice-based situations. This again leads to a mismatch between cognition and affect. Health practitioners may have low levels of confidence in their ability to promote and support breastfeeding. This appears to relate to a lack of formal and practice-based knowledge and an inability to integrate the four forms of knowledge referred to above (Smale *et al*. 2006).

Organizational constraints in hospitals

Many health practitioners are based within hospitals where encounters with breastfeeding women occur mostly on post-natal wards. However, the general failure to meet women's needs on post-natal wards has been repeatedly highlighted (Bondas-Salonen 1998; Garcia *et al*. 1998; Yelland *et al*. 1998; Rice *et al*. 1999; Singh & Newburn 2000; Dykes 2005a, 2006).

Health practitioners are themselves affected by organizational constraints upon their ability to provide effective breastfeeding support. They report fragmented systems of care, shortage of time and staff, and senior staff with inadequate knowledge of and skills in breastfeeding support (Grant *et al*. 2000; Shaw *et al*. 2004; Dykes 2005a, 2006; Smale *et al*. 2006). Another aspect of organizational constraint relates to practitioners often working in a designated area or hospital setting and developing an understanding of breastfeeding issues only within that particular 'window' of time (Cloherty *et al*. 2004). This means that there is little understanding of the whole breastfeeding experience and long-term issues. As a result, health practitioners and service users continue to report: perpetuation of inappropriate routines and forms of care, inappropriate and inconsistent information and advice giving, and a low priority given to breastfeeding in relation to other aspects of care especially if circumstances become challenging (Garcia *et al*. 1998; Tarkka *et al*. 1998; Vogel & Mitchell 1998; Dykes & Williams 1999; Dykes 2005a, 2006).

Influences of breastfeeding education provided for qualified practitioners

A range of breastfeeding courses have been offered to qualified health practitioners and subsequently evaluated. WHO/UNICEF Baby Friendly Hospital Initiative (BFHI) courses appear to be the most commonly utilized. These consist of the WHO/UNICEF (1993a) 40 hour *Breastfeeding Counselling: A Training Course* and the WHO/UNICEF (1993b) *Breastfeeding Management and Promotion in a Baby Friendly Hospital* 18-h course for maternity staff. Various countries have adapted these courses for their own specific use; for example, UNICEF UK Baby Friendly Initiative has developed the UNICEF UK (2003) 3-day *Breastfeeding Management Course*. This is a UK adaptation of the WHO/UNICEF 18-h course. These courses are described in more depth by Lang & Dykes (1998). The 40-h course has more emphasis upon counselling approaches than the 20-h course, although both address this area.

These BFHI-based courses have been shown to positively influence knowledge (Hall Moran *et al*. 1999, 2000; Rea *et al*. 1999; Dinwoodie *et al*. 2000; Wissett *et al*. 2000; Cattaneo & Buzzetti 2001; Hillenbrand & Larsen 2002; Owoaje *et al*. 2002; Gau 2004), attitudes (Dinwoodie *et al*. 2000; Martens 2000; Wissett *et al*. 2000), practices (Rea *et al*. 1999; Hillenbrand & Larsen 2002; Durand *et al*. 2003; Gau 2004), confidence (Dinwoodie *et al*. 2000;

Hillenbrand & Larsen 2002) and breastfeeding duration (Martens 2000; Cattaneo & Buzzetti 2001; Gau 2004; Vittoz *et al*. 2004). These studies related to the specific evaluation of educational programmes or interventions. Other studies have been conducted in which the educational intervention was one part of a range of organizational interventions, for example, the Promotion of Breastfeeding Intervention Trial in Belarus, that involved an educational intervention along with implementation of a range of BFHI-based changes (Kramer *et al*. 2001).

Other approaches to education of staff include specialist courses; for example, Jones *et al*. (2004) provided an evidence-based module for neonatal staff and significantly improved practices that were supportive of breastfeeding. Burt *et al*. (2006) developed a course specifically for community medical doctors (general practitioners) that was very positively evaluated.

It seems therefore that education programmes have the potential to influence knowledge, attitudes and practices of practitioners. What is less clear is the most appropriate form that training should take, who should provide it, and for whom. It appears that a counselling component to the course may be important in supporting changes in practice (Rea *et al*. 1999; Cattaneo & Buzzetti 2001). It may also be the case that the style of education is more crucial than the actual content.

Recommendations for breastfeeding education

Development of courses that enable critical and reflexive integration of knowledge forms

There is a need for an educational process that enables integration of embodied, vicarious, formal and practice-based knowledge forms (Hellings & Howe 2000; Smale *et al*. 2006). This may be best achieved through programmes of education that incorporate opportunities for deep reflexive learning, personal debriefing, high levels of interaction and teaching of basic person-centred counselling skills. This should be offered during pre-registration programmes for all key health practitioners, including midwives, medical doctors, public health nurses (health visitors), neonatal and children's nurses. Those practitioners who are less central to breastfeeding support, such as social workers, pharmacists and childminders, still need opportunities to engage with this form of education.

This process of reflection may be considerably enhanced through effective educational methods and approaches. Reflection occurs at several levels (Freire 1972; Schon 1983; Peters & Lankshear 1994; Brechin 2000; Clarke & Wilcockson 2001, 2002): personal and vicarious experiences (Battersby 2002; Smale 2004; Smale *et al*. 2006); experiences in the practice settings and their links to theoretical knowledge (Cloherty *et al*. 2004); and broader socio-cultural issues (Freire 1972; Peters & Lankshear 1994; Brechin 2000; Clarke & Wilcockson 2001, 2002; Dykes 2006). The educational process also needs to facilitate an understanding of breastfeeding as a dynamic, relational experience that changes over time.

Biopsychosocial approach

Breastfeeding is clearly a biopsychosocial activity. Therefore, all practitioners need to develop an understanding of the physiological, socio-cultural and psychological aspects of breastfeeding. While education programmes for accredited breastfeeding counsellors and peer supporters do address this perspective, e.g. Smale (2004), health practitioners may tend towards one aspect to the exclusion of others. However, an inability to understand, for example, the cultural issues surrounding breastfeeding can lead to a profound ineptitude in meeting women's needs (Wright *et al*. 1997; Sellen 2001; Dykes 2005a,b, 2006). Understanding breastfeeding from a biopsychosocial perspective may support practitioners in providing the five types of support that women appear to need with regard to breastfeeding, i.e. practical, informational, esteem building, emotional and network (Dykes *et al*. 2003; Dykes 2005a,c, 2006).

Multidisciplinary education

An interagency and interdisciplinary collaborative model is crucial to developing a coherent and cohesive approach to education for those supporting

breastfeeding women and to the general support infrastructure for breastfeeding women. Given that much of the undergraduate education for a range of health practitioners takes place in universities, there is enormous scope for offering a basic module in breastfeeding that meets a cross section of needs, for example, Dykes (1995). UNICEF UK (2002) provide guidelines and learning outcomes for this development of undergraduate education in breastfeeding support. Universities may then apply for UNICEF accreditation, a process that involves formal assessment by UNICEF.

Involvement of voluntary and peer supporters

It would be particularly useful to involve accredited voluntary supporters in the delivery of education and secondly to invite peer supporters and breastfeeding women to speak to students. Remuneration for these groups should be provided. The programmes of education for breastfeeding counsellors and peer supporters (Smale 2004; Hall Moran *et al*. 2005) appear to offer enormous potential for health practitioners. The curricula include training in breastfeeding support, with particular emphasis upon listening and counselling skills and working within groups. Programmes of education aim to enhance self-awareness and provide opportunities for deep reflection on personal experiences and attitudes. The education programmes have a strong reflexive component, allowing trainees to debrief on their own experiences. The trainees are supported in gaining person-centred counselling skills (Rogers 1961), including empathic understanding, unconditional positive regard (non-judgemental acceptance) and genuineness. Central to this approach is active listening and validating women in making their own decisions. In this way, supporters combine a collective knowledge of the principles of effective breastfeeding with an individualized woman-to-woman approach that acknowledges a woman's experiential and embodied knowledge and her own unique circumstances.

Mentorship system

To facilitate effective role modelling and integration of the four knowledge forms, practitioners need to be supported adequately in practice areas by a mentorship scheme (Kaewsarn *et al*. 2003; Smale *et al*. 2006). With regard to breastfeeding, this requires facilitation by practitioners who have undergone education that supports integration of the four forms of knowledge and possess considerable expertise in breastfeeding. This scheme requires coordination by, for example, an infant feeding specialist or lactation consultant. This coordinator needs to have a senior status and management of change capabilities (Broome 1998).

Post-registration education

Until practitioners are receiving adequate pre-registration education in breastfeeding, there is a need to provide substantial post-registration education. As stated, currently this may involve purchasing a course, for example, the WHO/UNICEF (1993a) 40 hour *Breastfeeding Counselling: A Training Course* or the WHO/UNICEF (1993b) *Breastfeeding Management and Promotion in a Baby Friendly Hospital, an 18-Hour Course for Maternity Staff*. Alternatively, a course may be developed by the maternity service or local university (Dykes 1995). Again, it is crucial that these courses incorporate reflection upon and integration of the four levels of knowledge. Once practitioners are all receiving pre-registration education, there need to be practice-based opportunities for continued learning and integration of ongoing knowledge. Opportunities to reflexively explore practice-generated scenarios would be one way of providing this opportunity.

Setting of national standards for breastfeeding education

There is currently an absence of central coordination of breastfeeding education in many countries. It should be a requirement that national standards are set for pre-registration education for both key health practitioners and those with a more tangential responsibility. These standards should include broad learning outcomes, topic areas and hours allocated within the undergraduate curriculum.

Tailored education for specific groups

The training needs for post-registration practitioners should be fit for purpose. Adapted curricula are required for groups caring for women and babies with specific needs. Models for this education have been positively evaluated; for example, Jones *et al*. (2004) focused upon health practitioner needs for supporting women who were separated from their babies (on admission to neonatal unit) to initiate and/or maintain their lactation and to feed their babies optimally.

Designated funding

Designated funding should be made available to ensure that staff are prepared to support breastfeeding women both at the pre- and post-registration phases of their careers. Information needs to be collected and collated related to the costs of providing educational interventions.

Specialist groups

There are a number of groups that specialize in breastfeeding, in addition to the voluntary groups, for example, infant feeding specialists and lactation consultants. Further evaluation of the educational programmes provided for these groups is required. There may be elements of transferability between groups. On a broader note, given the evidence that additional, skilled support for breastfeeding women can influence breastfeeding initiation and duration rates, it seems timely to explore the possibility of routinely investing in specialists to act as a resource and support to both service users and staff. Ideally, these specialists should cross the hospital–community interface, providing continuity of support for service users.

Further research/evaluation

A number of areas require further work to include comprehensive evaluation of existing programmes of pre-registration education. Replication is required of studies that utilize the WHO/UNICEF BFHI courses. Controlled designs are needed to evaluate the effects upon a range of breastfeeding outcomes (e.g. Cattaneo & Buzzetti 2001). These studies should assess not only changes to knowledge, attitudes and practices, but also women's qualitative evaluations of the support they receive. Ultimately, a large multicentre cluster randomized controlled trial with additional qualitative research would enable evaluation of specific programmes of education in relation to providing appropriate support to breastfeeding women and increasing breastfeeding rates.

Controlled studies are required to evaluate educational programmes that incorporate elements of personal reflection and debriefing, reflective practice and basic person-centred counselling skills as compared with courses of the same length that are based on a more traditional knowledge transfer approach. Again, a range of outcomes should be measured, as above. Exploration is required related to who undertakes breastfeeding education for specific groups. Models that involve accredited breastfeeding counsellors as education providers, for example Spiby *et al*. (2002), require further evaluation.

There needs to be further research into a range of means for facilitating education, for example, use of multimedia (Jones *et al*. 1998), action research to support integration of theory into practice (Grant *et al*. 2000; Price & Johnson 2005), and interactive approaches such as the Bloomsbury workshops described by Jamieson (1995) in which staff and service users are facilitated in learning together and role play. Further research is required to identify the most appropriate models of staff training for different groups of practitioners. Studies such as Jones *et al*. (2004) for specialist groups require further funding, development and evaluation.

Conclusion

Health practitioner education in breastfeeding is a global priority. However, there is an absence of coherent international and national strategies to equip practitioners with the education they require to support breastfeeding women. There appears to be inadequate integration of embodied, vicarious, practice-based and formal knowledge. Health practitioners involved with supporting breastfeeding women need to learn from voluntary organizations. They

need to be facilitated in exploring their own personal and vicarious experiences of breastfeeding, so that they may use 'self' when appropriate and in ways that support, not undermine breastfeeding. Practitioners all need a working knowledge of basic person-centred counselling to include learning to listen to women and a concomitant knowledge of the principles underpinning effective breastfeeding. By combining person-centred counselling with supporting effective breastfeeding, women's individual needs may be met while at the same time evidence-based information is provided effectively.

The educational programme also needs to enable practitioners to critically reflect upon and integrate knowledge from their practice. The approach to this should facilitate not simply personal reflection upon practice but engagement with broader socio-political issues, thus allowing for collective understandings and change. The challenge ahead for educators is enormous.

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