Addressing the learning deficit in breastfeeding: strategies for change

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Abstract

This paper summarizes the findings of the learning needs assessment described in this issue. Limitations and strengths are discussed. The paper describes a national, multi-sectoral, multi-disciplinary picture. Our respondents may over-represent those with an interest in breastfeeding; if so, the true picture may be even more problematic than described here. Major deficits were identified in the knowledge and skills of practitioners from all backgrounds and all sectors. Many professionals report poor knowledge about breastfeeding and have low levels of confidence and clinical competence. Organizational constraints and barriers to effective education and practice include fragmentation of care and education, lack of facilities, and a low priority being given to breastfeeding. There is a range of current educational provision, although not all is fit for purpose. Voluntary organizations seem to have higher standards than do some current professional learning opportunities. Preferred methods of training include practical observation and mentorship, volunteer counsellor involvement in training programmes, as well as self-study and online opportunities. Recommendations include: a funded, mandatory, inter-agency and multidisciplinary approach; appropriate content; support at local and national levels; breastfeeding education to be included in clinical governance and audit mechanisms; and further research and evaluation to examine optimum ways of providing education and training. Organizational barriers could be addressed through a public health policy and evidence-based approach.

Keywords: breastfeeding education, breastfeeding training, learning needs assessment, breastfeeding recommendations, breastfeeding policy.

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Introduction

The work presented in the series of papers in this journal issue (Abbott *et al.* 2006; Dykes 2006; McFadden *et al.* 2006; Wallace & Kosmala-Anderson 2006) and in a forthcoming issue (Wallace & Kosmala-Anderson *in press*) paints a picture of a large and complex problem. This paper presents an analysis of results from a large programme that mapped the learning needs of professionals, identified education and training opportunities, and explored the organizational barriers to the provision of quality breastfeeding promotion. This paper discusses overall findings and implications for education, practice and policy. First, the strengths and limitations of the exercise conducted need to be examined.

The learning needs assessment conducted had five component parts, and aimed to make an assessment of the issues across England and Wales taking a multidisciplinary perspective. We are not aware of work on a similar scale in the UK or other countries. In addition to the scoping work on the literature (Dykes 2006) and on current accredited provision, we examined the views of 19 national stakeholder organizations (McFadden *et al.* 2006), 752 survey respondents (Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson *in press*) and 31 telephone interviewees (Abbott *et al.* 2006). Full details are in the relevant cited papers. These represented all relevant health professions from a wide range of levels of seniority, as well as consumer representatives and practitioners from social and voluntary sectors. The study examined issues in areas that served families experiencing deprivation, and we achieved good cooperation from health economies in three areas that served urban, rural and multicultural deprived populations.

The approach was deliberately multi-method and examined both formal and informal learning, and issues broadly for a large sample as well as in-depth for a smaller sample. The programme was supported by a range of professional and consumer organizations, which helped us to achieve a large-scale and active response. Participants engaged not only in answering our specific questions about education and training, but also in exploring some of the related

organizational and policy issues. Responses came from across the UK and reflected consistent views of the problem and possible solutions.

However, caution is needed when interpreting these results. This was not a fully funded research study, but rather an assessment of learning needs conducted over a few months. There was no specific attempt to recruit representative samples, and there was uneven representation of disciplines among our respondents.

There were limited opportunities to assess women's views in this exercise. Their voices were heard only through participating consumer organizations. Three national consumer organizations responded to the stakeholder survey (McFadden *et al.* 2006), one representative from a consumer organization from each site was included in the review of informal learning opportunities (Abbott *et al.* 2006), and 40 voluntary breastfeeding supporters responded to the survey (Wallace & Kosmala-Anderson *in press*). It may be that recent developments are improving the situation for women, and that women's experiences in different parts of the country vary considerably. We may have missed some important aspects by not seeking the views of a larger number of women with recent experience. The respondents in Abbott *et al.*'s study (2006) indicated that breastfeeding services for women and their families in the UK are developing rapidly. Initiatives we are aware of across the UK include peer support and buddy schemes, baby cafés and breastfeeding support groups, breastfeeding workshops for women and involvement of a wide range of support staff, such as healthcare assistants and early years practitioners in supporting pregnant and breastfeeding women (Dykes 2003). It would appear that currently these initiatives are being introduced piecemeal across the country and are more commonly found in Sure Start Local Programmes where funding is available. These initiatives are particularly important in addressing breastfeeding rates in socio-economically deprived populations (Renfrew *et al.* 2005). A recent National Institute for Health and Clinical Excellence (NICE) document on breastfeeding (Dyson *et al.* 2006) will recommend widespread adoption of many of these interventions. Capacity to implement these recommendations will depend on a wide range of practitio-

ners equipped with the necessary knowledge, skills and attitudes to support breastfeeding.

We did not directly seek the views of educators or of the Workforce Development Confederation/Directorates, who are influential stakeholders. A drawback of training needs analyses can be a failure to address how educators' needs should be identified (Gould *et al.* 2004). Related work conducted by this group (Smale *et al.* 2006) did directly seek the views of educators; that study showed that those responsible for breastfeeding education for a range of professional groups reported gaps in provision and for many educators, breastfeeding education was not viewed as a priority issue.

Large-scale learning needs analyses have the problem that recommendations for future training provision do not belong to any one organization with authority to act on them. The potential for generating real change thus remains limited (Gould *et al.* 2004). This work was initially planned as a precursor to a national programme of practice development (Renfrew *et al.* 2006), and had that work been conducted, it would have provided a valuable foundation. The funding for the practice development work was, however, withdrawn as a result of changes in government agencies. The lack of such follow through, at least on a national scale, seriously limits the potential for change.

In spite of these limitations, there is much food for thought in the findings presented here. The possibility that those practitioners who were most interested in the topic were most likely to respond means that the results are likely to reflect a rather better assessment of the situation than it really is; there is no comfort to be gained from that methodological criticism. Further, a clear and consistent picture emerged from each stage and across all respondents; there was widespread agreement about the extent and nature of the problems.

This paper summarizes the key findings, and examines the implications for education and for practice.

Summary of key themes and recommendations

Evidence of learning deficits

There are major deficits in knowledge, skills and attitudes of many health practitioners, including core

professions in this field: medical practitioners, midwives, health visitors, neonatal nurses and others (Abbott *et al.* 2006; Dykes 2006; Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson in press). Eighteen out of 19 stakeholder organizations agreed that care provided by their members could be enhanced by greater knowledge and expertise in the field of breastfeeding (McFadden *et al.* 2006). Consequently, professionals report that they provide poor information based on inadequate knowledge of the evidence (Abbott *et al.* 2006) and have low levels of confidence in their abilities to promote and support breastfeeding (Dykes 2006).

Specific areas where there are knowledge and skill gaps relate to knowledge of policy and guidance (all groups but especially medical practitioners), and formal antenatal education and socio-cultural aspects (midwives, health visitors and other non-medical practitioners). There is a particular need for breastfeeding training to prepare practitioners to work with diverse and disadvantaged groups, including those on low-income, adolescent mothers and minority ethnic groups. A significant proportion of medical practitioners have deficits in key areas where other health professionals may rely on them for information, such as detecting abnormal growth rates in babies, prescribing to breastfeeding mothers and managing mastitis (Wallace & Kosmala-Anderson 2006).

Barriers to effective education and practice

Organizational constraints occur in a range of health-care settings. These include inappropriate routines and forms of care (Dykes 2006), lack of a common approach, leading to conflicting and inconsistent information and practice (Abbott *et al.* 2006; Dykes 2006; Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson in press), poor facilities for breastfeeding women in hospitals (Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson in press), and the fragmentation of care so that practitioners do not develop an understanding of the whole breastfeeding experience (Abbott *et al.* 2006; Dykes 2006). The system seems to rely on breastfeeding 'champions', who are relatively few and isolated (Abbott *et al.* 2006). Workload demands on

midwifery and nursing staff, even those interested in breastfeeding, make it difficult to attend training, even where this is supposedly mandatory (Abbott *et al.* 2006).

Policy constraints include practitioners not having access to, or having difficulty in implementing, local breastfeeding guidelines (Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson in press), and the low priority given to breastfeeding support and education (Abbott *et al.* 2006; Dykes 2006). No one appears to have a full picture of what is happening with regard to breastfeeding within a health economy (Abbott *et al.* 2006). This finding is especially troublesome in relation to a topic that needs multifaceted, multi-sectoral input.

Current provision of breastfeeding education and training

There are no national standards for pre-registration breastfeeding education in the UK, although the introduction of the UNICEF UK Baby Friendly Initiative (BFI) best practice standards for breastfeeding education (2002) for student midwives and health visitors is likely to provide a framework for those delivering pre-registration education to address this issue. In the meantime, post-registration education will have to fill the gap to address the long-standing lack of education and training for existing practitioners.

A range of providers offer relevant formal and informal post-registration education, including universities, Royal Colleges, voluntary organizations, and Trust-based training delivered by local practitioners (Abbott *et al.* 2006; Dykes 2006; McFadden *et al.* 2006). However, not all professional groups access it. More motivated practitioners are more likely to recognize the importance of updating and seek learning opportunities (Abbott *et al.* 2006; Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson in press). Many practitioners appear to recognize the value of regular updating (Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson in press), but education and training would appear to be accessed mainly by midwives, health visitors and voluntary supporters; there is a need to

engage with a wider range of health professionals, especially medical practitioners (Abbott *et al.* 2006; Dykes 2006; Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson in press).

However, not all current education and training is fit for purpose (Dykes 2006; Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson in press). There is a lack of integration of the different forms of knowledge needed to understand breastfeeding, including biopsychosocial perspectives (Dykes 2006). There appears to be some consensus around the content that is appropriate for key practitioners such as midwives, health visitors and general practitioners (Abbott *et al.* 2006; Dykes 2006; McFadden *et al.* 2006); content must also be tailored to meet the needs of specialist groups such as neonatal nurses and paediatricians (Abbott *et al.* 2006; Dykes 2006; Wallace & Kosmala-Anderson in press).

Voluntary organizations seem to meet the educational needs of their members better than educators of health practitioners (Dykes 2006); this is in agreement with previous work conducted by this group (Smale *et al.* 2006), where voluntary counsellors were reported to be prepared to a higher standard than any other group. This is likely to lead to tensions between volunteers and professional staff.

Preferred methods of training and learning approaches

Training that involves practical observation or actual practice and some mentorship are the preferred methods of learning for many practitioners (Abbott *et al.* 2006; Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson in press), rather than the use of traditional didactic methods (Wallace & Kosmala-Anderson 2006; Wallace & Kosmala-Anderson in press). Self-study is an approach that many practitioners would find helpful, and online information is suggested to be particularly helpful for medical practitioners (McFadden *et al.* 2006; Wallace & Kosmala-Anderson 2006). There is likely to be a problem with quality control of learning online, unless specific packages, endorsed by relevant professional bodies, are developed. Some voluntary organization training is found to be particularly helpful (Dykes 2006; Wallace

& Kosmala-Anderson in press), as is training that includes the combination of professional and voluntary perspectives (Abbott *et al.* 2006).

Recommendations and strategies for change

The following strategies are based on the findings of this work:

A funded, mandatory, interagency and multidisciplinary approach

1. Funding should be designated for breastfeeding education and training by educational commissioners; in England, this is currently the Workforce Development Confederations and National Health Service (NHS) Trusts.

2. A systematic approach to establishing the training needs of staff is required for all health professionals working in all healthcare sectors. Reliance on self-assessment is insufficient to identify those in need of update; more rigorous knowledge and practice-based assessments are needed.

3. Breastfeeding education should be mandatory for staff at all levels.

4. Education about breastfeeding at post-registration levels should be provided on a health economy-wide basis using an inter-agency and interdisciplinary collaborative model to facilitate a coherent and cohesive approach and a support infrastructure for women.

5. Universities are key to offering pre- and post-registration education to meet a cross-section of needs.

Appropriate content of education and training

6. Accredited voluntary support organizations should be actively involved in the education of health professionals at both pre- and post-registration levels.

7. Courses should enable reflexive integration of forms of knowledge and use a biopsychosocial approach. A wide range of skills should be covered, as well as current local, national and international policy and guidance.

8. Education and training should involve more practice-based learning with observation of mothers and skilled practitioners facilitated through mentor-

ship. Such an approach will require the practice of breastfeeding promotion and support in each Trust to be improved, so that learners experience a learning environment in which high standards of care are provided. This would be helped by the implementation of UNICEF UK BFI in acute and primary care NHS Trusts; ensuring post-registration and training for staff is one component of that accreditation process.

9. Training should be tailored to the needs of different practitioner groups.

10. Higher education institutions should be encouraged to adopt the UNICEF UK BFI best practice standards for breastfeeding education for student midwives and health visitors.

Support for education and training at local and national levels

11. Education in local health economies might be best coordinated by infant feeding specialist(s) who are credible with all professional groups, who have senior status and management of change capabilities, and who work across the hospital–community interface.

12. National stakeholder organizations should be involved in supporting educational developments, including identifying ways of encouraging their members to attend training, and accrediting education and training for their members.

Clinical governance and audit

13. The standard of education and training for breastfeeding should be monitored through NHS Trusts' clinical governance mechanisms, and should become a component of Healthcare Commission inspections.

14. Action at executive level in NHS Trusts is required to address organizational barriers to breastfeeding; the UNICEF UK BFI best practice standards will be a relevant tool in addressing these issues.

Further research and evaluation

15. Staff experience of breastfeeding training and objective assessment of learning achieved should be evaluated and changes implemented accordingly.

16. Further evaluation of the education of specialist groups, such as lactation consultants and infant feeding specialists, is needed, along with an assessment of routine investment in these roles.

17. More information is needed on the differential cost-effectiveness of a range of educational interventions.

Conclusion

The situation described here indicates an extensive failure of the educational system for health professionals, and it will trouble all educators, practitioners, managers, policymakers and consumers with an interest in breastfeeding and in public health more generally. It is crucial that this issue is addressed if government targets for tackling health inequalities in England and Wales are to be met. Several generations of practitioners, families and the wider public have been exposed to artificial feeding as the norm, and turning to bottle feeding when breastfeeding proves problematic has been a simple solution for families and professionals alike (Renfrew *et al.* 2005). Addressing this problem will not be simple, as the educational deficit is profound and the numbers of those who are able and prepared to educate professionals to a proper standard are limited. A forthcoming NICE document on breastfeeding (Dyson *et al.* 2006) may provide the impetus for such change, as it will become a priority for all NHS Trusts.

Educational strategies will need to be accompanied by changes in practice and policy across the health economy. Unless the whole healthcare system provides accurate care and helpful support, women's experience of breastfeeding is unlikely to improve, and staff are unlikely to learn how it can be different.

Improvement is unlikely unless breastfeeding becomes a priority for senior managers in across health economies, in Workforce Development Confederations, Strategic Health Authorities, Primary Care Trusts and acute Trusts, as well as in higher education institutions, Royal Colleges and other professional organizations, to develop the integrated system required. The involvement of the voluntary sector, and in particular accredited volunteer counsellors, is crucial to properly inform approaches to education

and training. This multi-sectoral and multidisciplinary approach is likely to be relevant for other countries. It may also apply to other public health priorities; developing a learning network for breastfeeding may have other benefits for public health more widely.

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