The relationship between evidence and practice: some considerations in breastfeeding

This special issue of *Maternal and Child Nutrition* highlights two different but related problems: the declining numbers of women breastfeeding their babies in the United Kingdom and the difficulty of reversing that decline in spite of having plentiful evidence to bring to bear on the problem. The papers in this volume, in their different ways, address these two questions.

The relative decline in the numbers of women breastfeeding their babies will be familiar to readers of this journal irrespective of where in the world they work. There are a number of interlinked factors which the papers in this issue tackle. The public health importance of breastfeeding cannot be underestimated. The health benefits to mother and child of breastfeeding in the immediate and longer term are well documented. The problems associated with alternatives to breastfeeding are also well understood. So we have a paradox in that, while the evidence is clear and the win-win nature of breastfeeding is obvious, cultural trends, fashion, professional lack of involvement, as well as commercial interests have contributed to the decline. The health damaging effects of this decline to an individual and to the population will build up year on year until these trends can be reversed. The well documented problem of population obesity trends and the health inequalities gradient in relation both to breastfeeding and to obesity are evident and the nature of the association of these phenomena needs to be characterised: it seems to be more than coincidental.

Behind the top line problem, as these papers reveal, there are a series of factors which contribute. As the authors describe them here however, they are problems for which solutions exist. Again, as the papers demonstrate, the will to tackle the problems seems weak, or in more analytic terms, our ability to turn what we know into useful policy and practice to change things is flawed.

The explanations the authors variously record include professional unwillingness to get involved with the issue of breastfeeding. This takes a variety of

forms from indifference to the construction, in some professional discourses, of breastfeeding proponents as something akin to religious zealots. The authors also record lack of basic professional knowledge, highly variable professional education and training, inconsistency in the advice and messages provided by professionals. The authors highlight the gaps in the knowledge base of various professional groups. There is a catalogue of what is wrong and overall an inventory of what could be put right.

The papers also reflect on societal attitudes to breastfeeding which are at best ambivalent, and at worst hostile. This results in organisational and especially employment arrangements which embarrass women, and do very little to promote the health giving effects of breastfeeding. Another very important set of findings to which the papers refer relates to the importance of learning about breastfeeding in situations best described as informal. While this is clearly a very important potential part of the overall provision, we are equally clearly not making best use of the opportunities afforded by learning and knowledge which is not delivered top down by professionals.

The second very interesting and important question raised by all these papers, and confronted particularly by the final paper in the collection, is about the relationship between knowledge and practice and more broadly about getting evidence into practice. Mary Renfrew and colleagues (Renfrew *et al.* 2006b) describe a highly innovative practice development programme which she and colleagues around the country were involved in, and the ways that that network sought to bridge the barriers.

In short, across the field of health research, not just the topic of breastfeeding, a chasm exists between the findings of research and the practice on the ground. There are a number of reasons for this. The kinds of methods which we traditionally use in mainstream health research control out of the design what are often the most interesting practice questions. For example, designs used to answer the questions of effectiveness, like randomised controlled trials

(RCTs), while providing answers about whether something works, seldom provide answers as to *why* it did or did not work. This latter question is usually the more interesting practice question. And this is not a problem confined only to evidence drawn from trials. Qualitative methods are ideally placed to help us understand processes and how things work in practice. Unfortunately many researchers using qualitative methods are often more interested in questions of social construction and of representation, rather than in more practically useful questions. This is not, of course, to say that RCTs about effectiveness of particular interventions to promote breastfeeding or qualitative considerations of the social construction of breastfeeding are unimportant. Rather, it is to acknowledge that the way researchers traditionally ask questions is not always the way that the practitioners need to know the answer. Generally speaking scientific evidence from all sources provides a direction of travel. It will require further elaboration and refinement if it is to be put into practice (Kelly *et al.* 2004).

It is not just the fact that evidence is not always fit for practical purposes that is the problem. There are institutional barriers too and this issue uncovers the barriers and describes them in some detail. The group of researchers reporting in this issue are certainly not guilty of working at an esoteric and arcane level of little practical relevance to practitioners. Far from it. Yet their work and others like it, while acknowledged to be important, still struggles to bring about the kind of change which is so urgently required, because of the barriers here outlined. The structural barriers, the professional inertia, the lack of basic knowledge, the competition for other priorities within the service, the gaps between theory and practice remain to be confronted.

The view which has gained some currency in recent years is that we require an evidence based solution to these problems. However, evidence in this context means not evidence solely derived from the top end of the so called hierarchy of evidence, nor that which is confined to questions of effectiveness. What is required is a broad and inclusive evidence base which draws upon a variety of methodological traditions, asks questions which relate to the needs of

practitioners and the recipients of services with a view to transforming those services and to overcoming the problems which are so well laid out in this issue. It requires the imaginative use of the synthesis of those data. And it requires the involvement of professionals and users in the interpretation and use of the information. The practice development activities which are described in this issue provide us with some ideas about how this might look.

No doubt further methodological innovations are required and will be evolved in the future. However, the opportunities for such an evidence based approach are significant. One such opportunity, in England, is through the public health work of the National Institute for Health and Clinical Excellence (Kelly 2006). The former Health Development Agency funded the practice development work described here. It had the responsibility for implementing and monitoring the translation of evidence into practice. The next steps will be an evidence based solution, but evidence of a kind which is more practically relevant and solves some of the problems which the authors here so clearly describe. We know that the UK is not alone in facing these challenges, their context may vary according to societal, and socio-economic circumstances, but the Journal hopes that readers will be willing to submit their experiences and allow this to inform international practice in supporting breastfeeding.

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