Original Article

'Informal' learning to support breastfeeding: local problems and opportunities

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Abstract

This study explored 'informal' learning opportunities in three health economies, both for National Health Service (NHS) staff and lay people wishing to promote and support breastfeeding and for new mothers wishing to breastfeed. The word 'informal' indicates local learning opportunities that are not part of recognized academic or professional training courses. Semi-structured telephone interviews were conducted with 31 key informants, including health visitors, midwives, infant feeding advisers, Sure Start personnel, voluntary organization representatives, Strategic Health Authority representatives, senior nurses and trainers. The results were analysed thematically. In each site, there were regular training events for NHS staff to acquire or update knowledge and skills. Training was provided by a small number of enthusiasts. Midwives and health visitors were the groups who attend most frequently, although many find it difficult to make time. Although many training events were multidisciplinary, few doctors appeared to attend. Individual staff also used additional learning opportunities, e.g. other courses, conferences, web-based learning, and training by voluntary organizations. Services offered to lay people by the NHS, Sure Start and voluntary organizations included parentcraft, antenatal and post-natal classes, breastfeeding support groups, 'baby cafés' and telephone counselling. Interviewees' organizations did not have a specific breastfeeding strategy, although action groups were trying to take the agenda forward. Local opportunities were over-dependent on individual champions working in relative isolation, and support is needed from local health economies for the facilitation of coordination and networking.

Keywords: breastfeeding, breastfeeding support, continuing professional development, informal training.

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Introduction

Although very basic information about and clinical experience of breastfeeding is likely to be a part of

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most relevant professional education, this is acknowledged not to be adequate to prepare health professionals to promote breastfeeding and to competently support breastfeeding mothers (Renfrew *et al*. 2005; Dykes 2006; Smale *et al*. 2006). It is important therefore that continuing professional development opportunities are also in place to enable all relevant health professionals to maintain, update and enhance their knowledge and skills.

Little is known about such arrangements that are usually offered at a local level, outside of formal accreditation systems, and provided by different organizations depending on the professional groups involved. We have called these arrangements 'informal'; this word is used to indicate all those learning opportunities, both for National Health Service (NHS) staff and for pregnant and breastfeeding women, that are not part of a recognized academic or professional training course. The term in no sense implies disparagement of this type of provision, which can and does make an important contribution to continuing professional development.

This study aimed to explore 'informal' learning opportunities in three health economies both for NHS staff and for lay people who wish to promote and support breastfeeding. By health economy, we mean the NHS and related services in one geographic area, including Primary Care Trusts (PCTs), acute trusts, Sure Start provision, the voluntary sector and other relevant services. This in-depth examination was intended to complement other phases of the national learning needs assessment. A review of 'informal' learning opportunities that existed in one health economy was conducted in each of three sites in England, selected to provide a range of different population groups. The populations served by the three participating health economies were:

- a very deprived population in inner London;
- a town-and-country population in the West Midlands; and
- a primarily suburban population in a northern metropolitan centre.

All three served a mix of ethnic groups.

Methods

Information was gathered early in 2005 by telephone contact with 10 or 11 key informants in each of the three sites. Permission to approach staff was gained from a key contact person in each of the three study sites (e.g. a senior staff member in the PCT or Strategic Health Authority). A list of roles held by staff in the PCT and associated organizations (e.g. hospital trusts, Strategic Health Authority, voluntary organizations) was drawn up by the study team, and these staff were identified through their organization's website. The professional lead for key professional groups in different sectors, individual health professionals and voluntary-sector representatives were all sought. Some roles did not exist in each locality, or individuals were not available during the information-gathering period. The list was therefore supplemented with nominations by those interviewed. A total of 31 informants participated in the study, and their roles included Strategic Health Authority Lead, Health Visitor Lead, hospital and community midwife, infant feeding adviser, Sure Start Lead and representative from a voluntary organization. In order to protect the confidentiality of the participants, the exact titles and locations of the informants have not been included in this report. Those identified were then invited by email or telephone to take part in the telephone interview at a time suitable for them. They were assured that all information would be anonymized.

All those approached agreed to be interviewed, although it proved impossible to arrange a telephone conversation with one person who had agreed to be consulted in principle by email. The questions included in the topic guide were developed by the team responsible for the overall planning of the learning needs assessment, and those involved in all of the elements, and included topics such as:

- existence of local strategies relating to promotion of breastfeeding;
- local learning opportunities for NHS staff at all levels (including further education colleges, professional organizations, PCTs, NHS trusts, Sure Start, voluntary organizations and private companies);

- learning opportunities for people outside the NHS (Sure Start volunteers/parents, childminders, peer supporters, etc.);
- local opportunities for multidisciplinary and multisectoral learning;
- formats and content of training; and
- gaps in informal learning opportunities, and desirable new provision.

Replies were recorded by hand during the conversation, and typed up immediately afterwards. Most interviews took between 20 and 30 min. The topics raised by the questions were used as categories to structure the summarizing of the information obtained.

Ethics approval was not sought for this exercise, which was conducted as a rapid learning needs assessment using senior staff who agreed to a short telephone interview.

Results

No informants felt that they had a complete picture of what was locally available, as they reported that work to promote and support breastfeeding was often somewhat fragmented. Despite the use of information from multiple sources, what follows may not be a complete picture. Key findings are summarized below.

Key findings

Local learning opportunities to promote and support breastfeeding, for professionals and lay people, are usually provided by a small number of enthusiasts.

Of healthcare professionals, midwives and health visitors are the most likely to attend, and doctors the least likely. Individuals find additional opportunities further afield.

Support for breastfeeding mothers is provided by the NHS, Sure Start and voluntary organizations. There is limited coordination between organizations.

The provision of local learning opportunities is over-dependent on individual champions working in relative isolation.

Learning opportunities provided for lay people

All three sites provided a range of services and learning opportunities for pregnant and breastfeeding women. These were always provided by local 'champions', both health professional (mainly midwives and health visitors) and members of voluntary groups (National Childbirth Trust and La Leche League), who had undergone additional, breastfeeding-specific training. Champions tended to work in relative isolation without the active involvement of many others.

Opportunities provided by the NHS

In all three sites, learning opportunities were provided in routine appointments between staff and new mothers or mothers-to-be, and written information was routinely given out. Staff displayed posters in clinical settings, and participated in Breastfeeding Awareness Week.

Site 1: A 'buddy' scheme had just started, in which unpaid community members were trained on a course accredited at a local college to support mothers in all aspects of antenatal and post-natal experiences, including breastfeeding. Particular efforts were being made to recruit women from minority ethnic groups for training. There was also a health visitor-led support group for breastfeeding mothers.

Site 2: Services included parentcraft classes, a health visitor-led support group, a hospital midwife-led drop-in centre and a joint stall with a voluntary organization at a farmer's market.

Site 3: Services included a baby café, led by a health visitor and members of voluntary groups; parentcraft classes; one-off sessions by the infant feeding adviser on request; and sessions specifically provided for teenagers.

Opportunities provided by Sure Start (including Sure Start Plus, Early Start)

Site 1: Opportunities included midwife-led antenatal, post-natal and breastfeeding support groups; health visitor-led support groups; a nutritionist-led breastfeeding and weaning group; and Meet and Eat groups (concerning diet and nutrition), which also covered breastfeeding.

Site 2: Relevant Sure Start activity was still at the planning stage at the time of information-gathering.

Site 3: Opportunities included support groups attended by midwives or health visitors but with a

self-help focus; an antenatal group; a Sure Start employed breastfeeding adviser; and a training course for peer supporters and a baby café.

Opportunities provided by the voluntary sector

In all three sites, at least one voluntary group was active, providing telephone counselling and ongoing coffee groups. NHS staff distributed literature to mothers-to-be, including contact details for voluntary counsellors. Other activities included voluntary counsellors visiting post-natal wards to discuss breastfeeding with mothers, and raising money to fund breastfeeding counsellor training for local women (site 1); collaborating with the PCT to run a stall at a farmer's market (site 2); and input by voluntary counsellors to ongoing study days (site 3). In site 3, a voluntary organization adviser worked with Sure Start, and the baby café was run jointly by a voluntary organization, Sure Start and the NHS.

Format of education for pregnant and breastfeeding women

For mothers and mothers-to-be, the topics included in breastfeeding education were less wide-ranging than those covered in training for staff. Content included the benefits of breastmilk, positioning and attachment, and common problems including those experienced by participants. It was reported to be particularly important to use a non-didactic approach with new mothers and mothers-to-be, e.g. discussion and small group work.

Learning opportunities provided for staff

In one study site, the infant feeding specialist who was based at the hospital trust did most of the training for both hospital and primary care staff. The main method of training was a periodic 1-day workshop, with a half-day follow-up. This was mainly attended by health visitors, midwives and healthcare assistants, although occasionally doctors and nutritionists attended. She also provided one-off sessions on request, and was available for consultation by individual practitioners with particular questions and concerns. For example, one informant had shadowed her as she talked with mothers on the wards. She also trained staff to set up and run breastfeeding support groups when required.

In the second study site, a regular 1-day and a half-day training event had been run by a team comprising two health visitors, one midwife working in both the community and hospital, and a dietician. However, the team was unable to meet the high demand for this event. The PCT therefore commissioned a local university to create a workbook which staff could work through at their own pace, to take the place of the training events. Respondents expressed the fear that the workbook would not provide opportunities for discussion and debriefing, although the training team planned to run occasional half-day sessions for this purpose.

In the third site, the infant feeding specialist based at the hospital trust ran monthly sessions. She also provided regular updates to maternity ward staff, and offered one-off sessions on request. An infant feeding group met every 3 months. Meetings included presentations, discussion and information-sharing, and were open to anyone with professional contact with pregnant or breastfeeding women. A quarterly meeting was also held for staff who had completed the breastfeeding module taught at the local university, for ongoing discussion and updating.

In all three sites, individual staff had identified additional learning opportunities for themselves, such as courses, conferences, briefings (for example, from the Community Practitioner and Health Visitors Association), web-based learning, and conferences and training with specialist voluntary organizations, such as the National Childbirth Trust and the La Leche League.

Format and content of education and training

Sessions were described as generally, comprising a mixture of methods including 'talk and chalk', videos, working in pairs, group work and hand-outs. A few informants suggested that while discussion and reflection were very important for staff new to

breastfeeding promotion and support, experienced staff needed brief updates rather than time-consuming discussion.

The content of training for staff included debriefing, the benefits of breastmilk, the physiology of lactation, positioning and attachment, expressing and storing breastmilk, best practice scenarios and resolving common problems.

Concerns about education and training for staff, locally and nationally

Informants identified issues and problems with education and training for staff, at both local and national levels. Although updating knowledge about breastfeeding was described as 'mandatory' for midwives, it was often not possible for these staff to attend because of pressures of work, staff shortages and restrictions on study leave. Respondents reported that many professionals in their area gave poor advice based on inadequate knowledge and understanding of the evidence, thereby deterring women unnecessarily from breastfeeding. Very few doctors appeared to take advantage of local learning opportunities. Informants noted that if health professionals have themselves had an unsatisfactory experience of breastfeeding, it was difficult for them to advise others to breastfeed. It was suggested that training should be thorough and sustained; short workshops such as those provided in these sites may not be adequate and may encourage poor practice. Champions of breastfeeding, whether in the NHS, Sure Start or the voluntary sector, were reported to be few and may work in relative isolation. Many respondents felt that professionals and lay supporters did not always understand the important difference between supporting women and giving advice. It was also noted that staff and pregnant women were already heavily burdened with information and advice, and breastfeeding education had to compete with other demands.

Most of the organizations whose personnel provided information to this study did not have a strategy for promoting breastfeeding. It was therefore difficult to establish breastfeeding as a priority in the range of organizations where staff needed additional training and support for service provision.

Strategies to address problems

Informants made a number of positive suggestions to address both local and national problems. These included:

1. Staff other than health visitors and midwives should be encouraged, or obliged, to attend breastfeeding training, including general practitioners, hospital doctors, dentists, children's nurses, school nurses, community development workers and healthcare support workers;
2. Breastfeeding education and training should include 'debriefing' to address difficulties that may result from a problematic personal experience of breastfeeding;
3. Local health economies should facilitate more cooperation between organizations and staff;
4. Several informants called for greater collaboration between professional groups and voluntary-sector organizations to enhance educational opportunities; and
5. Related strategies, such as health inequalities strategies, may offer opportunities to increase the profile and priority of breastfeeding both locally and nationally. There was evidence that strategy or action groups were taking the breastfeeding agenda forward, and for example, targets for breastfeeding were an integral part of Sure Start delivery plans.

Discussion and conclusions

This is a small study in three sites of 31 respondents, who may not be typical. Respondents were likely to be those with an interest in breastfeeding. The findings were, however, consistent across sites and between respondents, even those from very different backgrounds; and a clear picture emerged from all the interviews. This consistency is perhaps surprising given the diversity of the areas chosen. The findings are also consistent with the other parts of the breastfeeding learning needs assessment and with studies from this and other countries (Freed *et al*. 1995;

Hellings & Howe 2000; Cantrill *et al*. 2003; Dykes 2006; McFadden *et al*. 2006; Smale *et al*. 2006; Wallace & Kosmala-Anderson 2006, in press).

The contextual information of the breastfeeding services and learning opportunities available for pregnant and breastfeeding women in each of the three study sites demonstrates that breastfeeding services are evolving. This provides both challenges and opportunities for the education of practitioners. The current situation where breastfeeding support relies on a few highly motivated individuals is unlikely to be sustainable. The key challenge is to ensure that a wide range of practitioners have the skills to promote and support breastfeeding initiation and duration. Changing services can provide opportunities for innovative practice-based educational approaches which could be facilitated through mentorship.

'Informal' training to promote and support breastfeeding was generally provided by individuals or small groups of 'champions', whether in the NHS, Sure Start or the voluntary sector. The strength of this model is that it harnesses enthusiasm and commitment. The weakness is that local arrangements may become over-dependent on individuals who have limited capacity and may not always be available. The lack of an infrastructure to support such individuals also results in problems with disseminating information; even enthusiasts had only a partial picture of services locally. There is thus a need for increased collaboration between organizations. However, collaboration takes time and effort, and over-stretched staff, who may already have taken on additional, breastfeeding-specific work, should not be expected to create the necessary structures without extra resources.

Current demands on midwives and health visitors resulting from staffing shortages and restrictions on study leave (Ashcroft *et al*. 2003; RCM 2006) make it difficult to attend training, even for those who have a special interest. This limits education even where this is intended to be mandatory. On the other hand, where staff are able to attend, demand may exceed supply. The difficulties of attracting medical personnel to participate in both the uptake and the provision of local learning opportunities are even greater; we found no evidence of willingness of doctors from any speciality to attend education and training events on breastfeeding.

It is clear that the problems identified by informants cannot be addressed adequately by individuals. If services for women are to be extended and improved, NHS hospitals and PCTs and Sure Starts need to work together locally to support networks of individual enthusiasts, and allow them more dedicated time to create, sustain and extend the limited learning opportunities reported here.

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References

Ashcroft B., Elstein M., Boreham N. & Holm S. (2003) Prospective semistructured observational study to identify risk attributable to staff deployment, training, and updating opportunities for midwives. *British Medical Journal* **327**, 584–586.

Cantrill R.M., Creedy D.K. & Cooke M. (2003) An Australian study of midwives' breast-feeding knowledge. *Midwifery* **19**, 310–317.

Dykes F. (2006) The education of health practitioners supporting breastfeeding women: time for critical reflection. *Maternal and Child Nutrition* **2**, 204–216.

Freed G., Clark S., Cefalo R. & Sorenson J. (1995) Breast-feeding education of obstetrics-gynecology residents and practitioners. *American Journal of Obstetrics and Gynecology* **173**, 1607–1613.

Hellings P. & Howe C. (2000) Assessment of breastfeeding knowledge of nurse practitioners and nurse-midwives. *Journal of Midwifery and Women's Health* **45**, 264–270.

McFadden A., Renfrew M.J., Dykes F. & Burt S. (2006) Assessing learning needs for breastfeeding: setting the scene. *Maternal and Child Nutrition* **2**, 196–203.

Renfrew M.J., Dyson L., Wallace L., D'Souza L., McCormick F.M. & Spiby H. (2005) *The Effectiveness of Health Interventions to Promote the Duration of Breastfeeding: Systematic Review*. National Institute for Health and Clinical Excellence: London.

Royal College of Midwives (RCM) (2006) *Recruitment Shortages in Midwifery 'Threatens Service'*. Available at: http://www.rcm.org.uk/news/pages/newsView.php?id=111 (accessed 1 March 2006).

Smale M., Renfrew M.J., Marshall J.L. & Spiby H. (2006) Turning policy into practice: more difficult than it seems.

The case of breastfeeding education. *Maternal and Child Nutrition* **2**, 103–113.

Wallace L. & Kosmala-Anderson J. (2006) A training needs survey of doctors' breastfeeding support skills in England. *Maternal and Child Nutrition* **2**, 217–231.

Wallace L. & Kosmala-Anderson J. (in press) Training needs survey of midwives, health visitors and voluntary sector breastfeeding support staff in England. *Maternal and Child Nutrition* (in press).