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"We All Believe in Breastfeeding": Australian Midwives' Experience of Implementing the Baby Friendly Hospital Initiative

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Abstract

Background: The education and support of new mothers during the in-hospital stay for childbirth is a critical time to establish breastfeeding. The Baby-Friendly Hospital Initiative was launched in 1991 to encourage maternity services to support and educate mothers to breastfeed by implementing Ten Steps to Successful Breastfeeding.
Research Aim: To explore midwives' experiences of implementing the Baby-Friendly Hospital Initiative in a Baby-Friendly accredited public hospital in Australia.
Methods: In this prospective, cross-sectional qualitative study we used focus groups to explore midwives' experiences. Midwives ($N = 26$) participated in two focus groups conducted between October and November 2019. Data were analyzed using thematic analysis.
Results: Time as a critical resource, and continuity of care, were crosscutting themes that framed midwives' experiences in supporting mothers to breastfeed their babies. Time constraints were experienced both through the health system structure and the BFHI accreditation process. Despite the challenges, the overarching theme—that we all believe in breastfeeding—fueled midwives' motivation.
Conclusion: Health services policy and practice need to consider ways to enable continuity of midwifery care and adequate time for midwives to support women to breastfeed their babies.

Abstract

Latar belakang: Dukungan dan edukasi pada ibu baru selama masa rawat inap setelah bersalin di rumah sakit merupakan kunci penting untuk membangun pondasi menyusui. Baby-Friendly Hospital Initiative (BFHI) disusun pada tahun 1991 untuk mendorong fasilitas layanan maternitas menyediakan dukungan dan edukasi pada ibu dengan cara menerapkan 10 Langkah Menuju Keberhasilan Menyusui (10 LMKM).
Tujuan penelitian: Tujuan penelitian ini adalah untuk mengeksplorasi pengalaman bidan dalam penerapan BFHI di sebuah rumah sakit umum yang terakreditasi BFHI di Australia.
Metode: Untuk studi kualitatif ini kami menggunakan Diskusi Kelompok Terfokus. Dua puluh enam bidan berpartisipasi dalam dua kelompok yang diadakan antara Oktober dan November 2019. Data dianalisis menggunakan analisis tematik.
Temuan: Waktu merupakan sumber daya yang penting dan pelayanan yang berkesinambungan, merupakan dua tema yang membingkai pengalaman bidan dalam mendukung ibu menyusui bayinya. Kendala keterbatasan waktu dialami baik dalam struktur sistem kesehatan maupun proses akreditasi BFHI. Terlepas dari kendala, tema utama, kami percaya pada menyusui, menjadi dorongan motivasi bidan dalam melaksanakan tugasnya.
Kesimpulan: Kebijakan layanan kesehatan perlu mempertimbangkan cara untuk mendorong terciptanya layanan maternitas yang berkesinambungan dan ketersediaan waktu untuk bidan untuk membantu ibu menyusui bayinya. Lebih lanjut, mencari solusi untuk menyederhanakan proses akreditasi BFHI dan beban biaya terkait dalam sistem kesehatan adalah penting untuk menurunkan biaya pada individual perempuan, baik yang bekerja sebagai bidan maupun yang melahirkan di fasilitas kesehatan.
Back translation by: Diana Amilia Susilo, MD, IBCLC

Keywords

Australia, Baby Friendly Hospital Initiative, breastfeeding, breastfeeding practices, focus group, health services research, midwifery, Ten Steps to Successful Breastfeeding

Background

The short- and long-term health risks for infants related to not breastfeeding as recommended by the World Health Organization (WHO), include increased risk of diabetes Type 1 and 2, obesity, hypertension, cardiovascular disease, and reduced cognitive development (Qu et al., 2018; Rameez et al., 2019). Longer durations of breastfeeding also have been associated with lower risk of maternal cardiovascular risk (Tschiderer et al., 2022) and postpartum depression, while breastfeeding difficulties predict depression symptoms (Del Ciampo & Del Ciampo, 2018; Figueiredo et al., 2021). Globally, the economic benefits of breastfeeding have been demonstrated, including savings of $53.7 billion USD in future lost earnings due to premature child and maternal death as well as $1.1 billion USD in healthcare treatment per annum (Walters et al., 2019).

The Ten Steps to Successful Breastfeeding (Ten Steps) was first launched in 1989 and revised in 2018 to ensure maternity facilities implement quality standards in supporting mothers to initiate and maintain breastfeeding (WHO, 2018b). These were incorporated into the Baby Friendly Hospital Initiative (BFHI) accreditation program (WHO, 2021). This provides a framework within which the Ten Steps can be implemented and maternity facilities, assessed by an external independent authority, can be awarded BFHI accreditation status. The United Nations Children's Fund (UNICEF) Australia passed governance of BFHI in Australia to the Australian College of Midwives (ACM) in 1995 (BFHI Australia, 2020a). ACM then changed the name to Baby-Friendly *Health* Initiative to incorporate the community role in supporting breastfeeding (BFHI Australia, 2020a).

BFHI accreditation in Australia is reassessed every 3 years over 2–3 days (depending on hospital size), against a list of ACM/BFHI Australia indicators based on the Ten Steps (Australian College of Midwives, 2016; BFHI Australia, 2020b). For example, in Step 4 (skin-to-skin contact), the assessor interviews senior midwives from the birthing service, postnatal services, and mothers. Accreditation is dependent on the midwives and at least 80% of the Group 1 and 2 personnel interviewed being able to outline the procedure and practices used in the facility to keep mother and baby together to initiate the first breastfeed, as well as at least 80% of interviewed mothers confirming that the baby stayed skin-to-skin without interruption for at least an hour. Group 1 personnel are those who provide breastfeeding assistance and/or education in any part of the maternity unit, antenatal clinic and/or neonatal nurseries. Group 2 are those who may provide general breastfeeding advice but not assistance, for example obstetricians and pediatricians. Group 3 are those who have contact with pregnant women but do not provide breastfeeding assistance and education as part of their role. (Further details are provided in Appendix 1.).

Key Messages

- Midwives have a key role in implementing the Baby Friendly Hospital Initiative.
- Time and continuity of care are critical resources for implementing the Baby Friendly Hospital Initiative.
- Midwives' unwavering belief in breastfeeding is a driving force underpinning their clinical practice.
- Baby Friendly Hospital Initiative accreditation processes need to be streamlined and associated costs allocated to the health system rather than to individual midwives.

The positive social value of maintaining BFHI accreditation has been demonstrated in one hospital in Australia and showed a AU$55 (or US$37) benefit for every AU$1 invested (US$ 1 PPP = AU$ 1.48) (Pramono et al., 2021). Despite evidence demonstrating positive associations between breastfeeding duration and maternal and child health (Kivlighan et al., 2020; Spaeth et al., 2018), only 10% of births occur in BFHI accredited hospitals globally (WHO, 2017) and only 26% of Australian hospitals are BFHI accredited (BFHI Australia, 2020a).

Barriers to BFHI implementation have been reported internationally, including resistance to change, lack of support from national health policy or health professional bodies, aggressive infant formula marketing, and inadequate pre-service breastfeeding education (WHO, 2017). Two Australian research teams have highlighted common barriers, including health care professionals' lack of breastfeeding knowledge (Holtzman & Usherwood, 2018), and different health professionals' perceptions, and cultural and organizational constraints (Esbati et al., 2019).

Midwives hold a key role in Australian maternity care. Attending most deliveries under the various models of care in Australia (Council of Australian Governments Health Council, 2019), they are specialists in maternal care, and offer the gold standard of continuity of care (Homer et al.,

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2019). They have unique skills and qualifications, and their role includes supporting women to breastfeed (Australian College of Midwives, 2021), meaning that their leadership in implementing BFHI at all levels of the health care system is crucial.

However, Walsh et al. (2011) surveyed South Australian maternity staff's attitudes towards BFHI and found that their understanding was at times contrary to the BFHI objectives. Perceived difficulties identified in six different hospital focus group interviews included hospital dynamics, the accreditation process and the Ten Steps implementation. These authors concluded that changes were needed to improve funding, policy, and management commitment, and that additional education and training to improve staff and mothers' understanding of the BFHI was necessary. Since then, no other researchers have examined midwives' perspectives and experiences of implementing the BFHI in Australian public hospitals. Our aim was to explore midwives' experiences of implementing the BFHI in a Baby-Friendly accredited hospital in Australia.

Methods

Research Design

We conducted this prospective, cross-sectional exploratory qualitative study using focus groups. Focus groups were considered the most suitable approach, as they enable researchers to explore a topic widely and encourage participation from a variety of participants, who can exchange viewpoints and discuss issues together.

Ethical approval was obtained from the Australian National University Human Research Ethics Committee (protocol number 2019/227) and the Calvary Public Hospital Human Research Ethics Committee (number 14-2019).

Setting and Relevant Context

While Australia has a mix of public and private healthcare, free universal healthcare, including maternity care in public hospitals, is provided through state and territory funding agreements with the federal government under Medicare (Callander et al., 2020). In the Australian Capital Territory (ACT), women can choose to use public or private care. Public maternity care may be provided by General Practitioners (GP) in a hospital shared care model, hospital-based midwifery led care, community health centers (postnatal care), or care at home (ACT Government Department of Health, 2021).

In the hospital-based setting, women can choose to give birth in the Birth Suite or the Birth Centre. The Birth Centre, designed for women who aim to have a non-medicalized pregnancy and birth, provides a continuity of care model, with one midwife for the duration of the antenatal through to the postpartum period, until the baby is around 1 week old. Women and their baby/babies are usually discharged from hospital within 24 hr. In the Birth Suite model, women receive care from a team of midwives throughout this period, and on average have 48 hr from birth until discharge. On a day shift, each midwife will have 3–5 mother-baby dyads to look after, which may increase up to 13 during the night shift; this may include post-Caesarean mothers. After discharge, routine follow-up includes daily visits by a midwife (Midcall) for 5 days. After this 5-day period, care is provided by a GP or by Maternal and Child Health (MACH) nurse at the government-run MACH clinic.

Calvary Public Hospital, Bruce, Canberra, was selected as the site for this study as it has been BFHI-accredited for 15 years. We also focused on public maternity care as 85.4% of mothers (approximately 4300 births) in this jurisdiction give birth in a public hospital (ACT Government, 2018; ACT Health, 2021). There were 1000 births in this hospital in 2019. Canberra is the country's capital city with a population of approximately 390,000 (Population Australia, 2021).

Sample

Two focus groups were conducted, consisting of midwives from all areas of the Maternity Unit: Postnatal Ward, Home-Visiting Program (Midcall), Special Care Nursery, and Birth Center. This purposively selected sample allowed us to capture perspectives from midwives working in all areas of the service. Participating midwives were recruited by the hospital Clinical Midwifery Educator and Clinical Midwifery Consultant. The inclusion criteria were midwives with more than 1 year of work experience specifically in the birthing room, maternity ward, and Special Care Nursery. Exclusion criteria included midwives with less than 1 year of work experience and those who worked outside the specified units. A total of 23 midwives, all female, participated in two focus groups. The two focus groups enabled us to achieve sample size adequacy through establishing data saturation.

Data Collection

Two focus groups were conducted and audio-recorded in October and November 2019, for 1 hr and 40 min respectively. Written informed consent was obtained prior to the focus group. Participant confidentiality was protected by de-identifying all names in transcripts. Data were stored on a password protected computer at the university and only accessible to the primary researcher.

The first focus group was facilitated by JD, SB, and AP, and the second focus group by JD and AP. A semi-structured focus group protocol was used (Table 1), at a time that was convenient for participants and during working hours. Questions 1–10 were directly adapted from a previous survey study (Walsh et al., 2011) and nine additional questions were developed by the team to explore participants' experiences of

Table 1. Focus Group Questions.

1	What is your opinion about the ideas behind the Baby Friendly Health Initiative?
2	What do you think about the Ten Steps to Successful Breastfeeding as a framework?
3	Why did your hospital decide to become baby friendly accredited?
4	When you decided to become baby friendly what set of circumstances prevailed?
5	Who initiated the uptake of the baby friendly accreditation process in your hospital?
6	What made your baby friendly accreditation process successful?
7	Were there any barriers encountered to becoming baby friendly accredited that were overcome?
8	How do you think baby friendly accreditation has affected maternity care specific to breastfeeding?
9	Are there any additional benefits of being baby friendly accredited?
10	Are there any unexpected drawbacks of being baby friendly accredited?
11	How much time does it take for each midwife to fulfil the requirements of the BFHI or Ten Steps?
12	How long does the training take?
13	Do you do the training in hospital time or your own time?
14	How often do you need to update?
15	Are there any costs associated with it?
16	Do you attend regular in-service education sessions about the BFHI or ten steps?
17	How difficult is it to implement these principles into practice?
18	What are some barriers to this?
19	What are some enablers in implementing it?

BFHI education and training in terms of time and costs, and barriers and enablers to implementation.

The research team was multidisciplinary, all female, and included clinical, academic, and policy expertise. AP is an International Board-Certified Lactation Consultant (IBCLC) and a PhD candidate; JS is an honorary associate professor, an experienced and qualified breastfeeding counsellor, and has expertise in breastfeeding economics, public regulation and policy, and gender analysis of policies; SB is a health economist and research fellow with expertise in economic evaluation and health services research, and JD is an experienced registered nurse and midwife, and a senior research fellow with expertise in qualitative research design and implementation. She has a professional network within this hospital. In light of this, she was careful not to share personal or professional experiences from this workplace. AP, JS, and JD were aware of their professional attitudes to breastfeeding and were mindful of the need to not convey this during the focus groups, or to let this cloud their approach to data analysis.

Trustworthiness was demonstrated through applying Lincoln and Guba's (1985) criteria: credibility, transferability, dependability, and confirmability. We achieved credibility through multidisciplinary investigator collaboration of practitioner (AP, JD, JS) and policy experts (JS), and through including one researcher with no breastfeeding expertise (SB). As our study was conducted in one Australian public maternity unit only, we cannot guarantee the transferability of the study findings. However, they might be transferrable to other Australian maternity units or in other countries with similar health systems. To demonstrate dependability, all raw data, transcripts, and team meetings were documented to provide an audit trail. Confirmability of the findings was established through repeated readings of the transcripts, multiple team meetings to discuss the analysis—including confirmation of the initial coding tree—subsequent themes derived from the data, and the relationships between the themes.

Data Analysis

Demographic data was derived from the informed consent forms completed by each participant. Audio recordings were professionally transcribed. Thematic analysis was conducted in line with the methods recommended by Braun and Clarke (2006), who describe six steps: (1) data familiarization (all authors); (2) initial codes generation (all authors); (3) themes search (AP, JD); (4) themes review (AP, JD); (5) themes naming and definitions (all authors); and (6) report production (all authors). All authors read the transcripts repeatedly and coded data individually. These were discussed, amended, and refined as a team. Potential themes were also discussed. Between Steps 2 and 3, AP input the data to NVivo to support analysis. After agreeing on the coding tree, AP and JD met to explore each code and ascertain that all data was placed appropriately. Themes were then agreed on (Table 2) and clarified with JS and SB, including the connections between themes (Figure 1).

Results

Characteristics of the Sample

Participants' ages ranged from 21 to over 60 years, and the majority had worked as midwives for 6–10 years. The majority of participants worked in the Birth Suite model of care (see Table 3).

Table 2. Data Analysis Structure.

Theme	Definition	Code	Definition
Overarching Theme We all believe in breastfeeding	Participants' perception on the reason of why they continue providing the optimal maternity care despite the challenges	Belief	Participants' reflection on their motivation in implementing BFHI and Ten Steps
Subthemes			
Time is a critical resource	Participants' reflection on one main factor that is affecting maternity care services provided, including BFHI implementation	Time related to BFHI accreditation process and requirements	Participants' experiences during BFHI assessment and in fulfilling BFHI requirements.
		Time related to maternity care services	Participants' experiences in providing maternity care services, including giving breastfeeding education and support to women and families
Continuity of midwifery care	Participants' perception on the continuity of care in the maternity care service	Information consistency	Participants' reflection on the information that were received by mothers, including from the community
		Duration	Period of time participants perceived as the optimal duration of maternity care
		Responsible person in care	Participants reflections on the responsible person in care from antenatal period until postpartum period
		What happens when there is enough time and continuity	Participants' perception on the impact when they have enough time and continuity of care
Maternity services structure	Participants' perception regarding Australian maternity services system structure	Other health care professionals	Participants' perception on other health care professionals' practice regarding breastfeeding support
		What happens when there is not enough time and continuity	Participants' perception on the impact when they do not have enough time and continuity of care
BFHI accreditation requirements	Participants' perception regarding accreditation requirements in general or specific Step	Impact on women and babies	Participants' perception regarding impact of BFHI accreditation on women and babies
		Skin-to-skin contact (Step 4)	Participants' perception on the implementation of Step 4
		Staff training (Step 2)	Participants' perception on Step 2 requirement

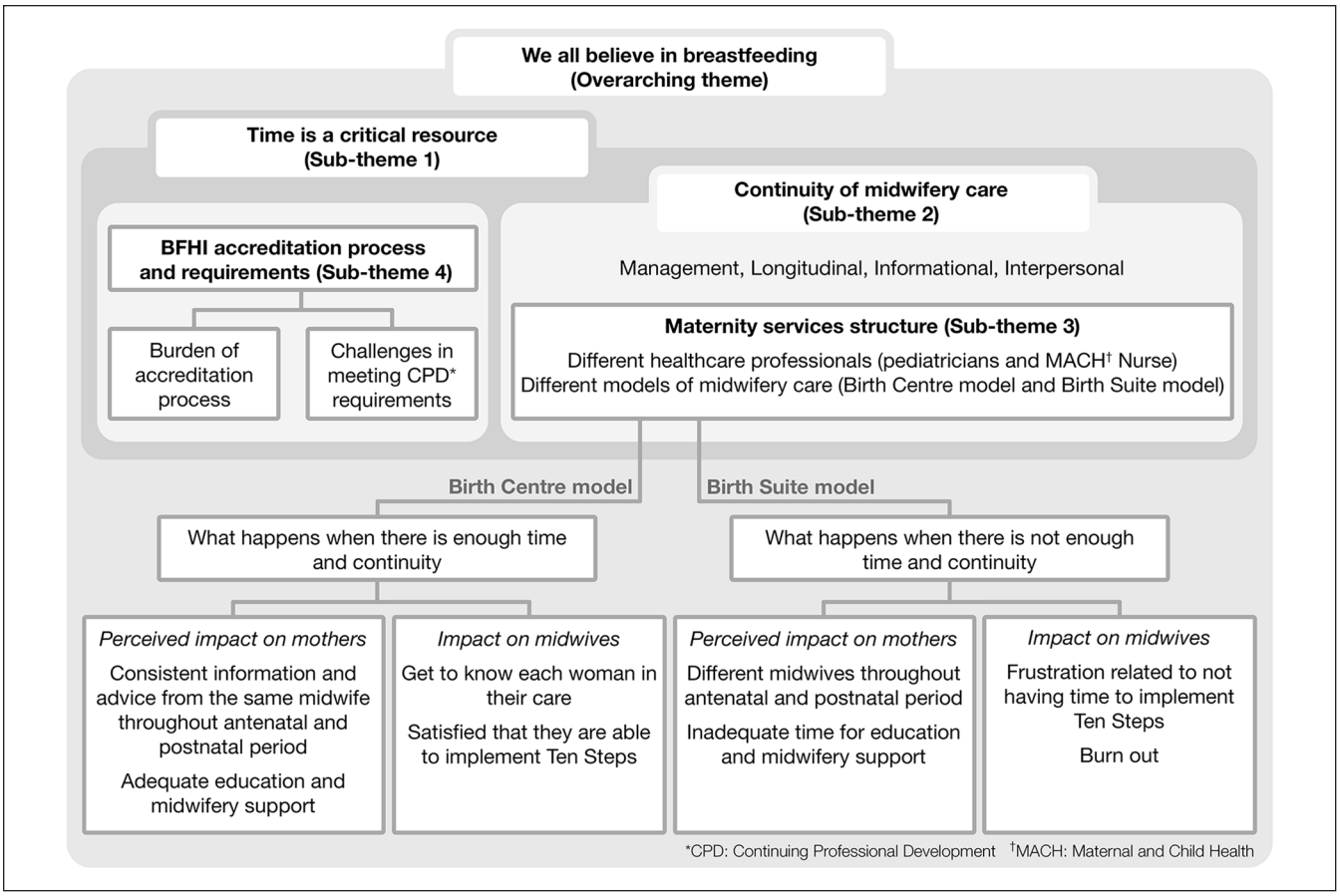

Figure 1. Conceptual Diagram of the Thematic Relationships.

Themes

We identified one overarching theme—that we all believe in breastfeeding—and four sub-themes, two of which were cross-cutting themes. Time as a critical resource was a cross-cutting theme in that it impacted implementation of the BFHI within each of the other three themes. In addition to time, Sub-Theme 2, continuity of midwifery care impacted midwives' capacity to implement the BFHI within different models of care in the maternity services structure (Sub-Theme 3). The processes and requirements of BFHI accreditation (Sub-Theme 4) were discussed by all participants BFHI accreditation in relation to the impact on their capacity to implement the BFHI. The relationship between themes is depicted in Figure 1.

Overarching Theme: We All Believe in Breastfeeding

We all believe in breastfeeding was the overarching theme identified. Participants in both focus groups stated that their education and support for mothers was underpinned by their belief in the importance of breastfeeding. "We all believe in breastfeeding as beneficial for health, so of course we're going to support something that implements it" (Participant FG1-2). Of great value to them was their perception that this belief also underpinned the actions of hospital management at all levels. "Yeah, the work culture, that's an asset" (Participant FG2-6). This support from management was a source of strength and optimism for the midwives.

Sub-Theme 1: Time is a Critical Resource

Having enough time was critical for participants to support women to breastfeed. This cross-cutting theme was reflected in every aspect of the focus group discussions: time from birth to achieving skin-to-skin contact or breastfeeding; how much time was available for women in hospital before being discharged to home; how much time was available during the working shift and, within this, how much time midwives had to allocate for each woman and baby in their care; how much time was available for home visits; how much time after birth until women and babies were transferred into the care of other healthcare providers; and within the available time, how much time they had to allocate to breastfeeding in addition to the other parental education needs. The in-hospital maternity care timeframe was perceived as short to prepare mothers to adapt with their new babies and to establish

Table 3. Focus Group Participants' Demography ($N = 23$).

Characteristic	*n* (%)
Age (years)	
21-30	1 (4.3)
31-40	5 (21.7)
41-50	10 (43.5)
51-60	2 (8.7)
>60	5 (21.7)
Time in midwifery profession (years)	
< 5 years	2 (8.7)
6-10 years	8 (34.8)
11-20 years	7 (30.4)
> 20 years	6 (26.1)
Work area	
Birth Center Model	6 (26.1)
Birth Suite Model	
Postnatal ward	2 (8.7)
Antenatal clinic	1 (4.3)
Midcall service	2 (8.7)
All areas of the maternity unit	6 (26.1)
Both Special Care Nursery and Postnatal ward	1 (4.3)
Both Postnatal ward and birth suite	1 (4.3)
Both Postnatal ward and Midcall service	1 (4.3)
Total Birth Suite Model	14 (60.9)
Serves both Birth Center and Birth Suite Models	
Special care nursery	3 (13)

breastfeeding. "Our women have short length of stay, so often they're home 6 hours post birth. And then we see them in their home for prolonged visits every day." (Participant FG1-2)

Sub-Theme 2: Continuity of Midwifery Care

The second sub-theme, continuity of care, was also a cross-cutting theme. This referred to continuity of care from one midwife over time, and continuity of information. Distinct differences in continuity were highlighted between the two models of care—Birth Suite and Birth Center—between midwives themselves, and between providers—midwives and pediatricians, and midwives and Maternal and Child Health (MACH) nurses.

Participants stated that a lack of time and continuity in the Birth Suite model of care increased their workload. It took more time to build good communication with women and, in turn, left less time to educate and support breastfeeding, especially around nursing and midwifery shift changes. In contrast with this, participants who worked in the Birth Centre model were able to provide continuity of care and had time available to implement the Ten Steps. When discussing the two models of care, participants agreed that the continuity model was ideal, "an ideal world, yes, continuity model" (Participant FG1-2). "Even that they know they can contact you, I think in itself is comforting as well. Like, they're confident to go home early because they know you're there if they need them" (Participant FG1-3). Participants stated that having enough time gave them the flexibility to arrange a schedule to assist mothers, which would not cause a negative ripple effect to other mothers; for example, they had flexibility to move appointments to enable them to assist mothers with complex breastfeeding issues if required.

Sub-Theme 3: Maternity Services Structure

Participants who worked in the Birth Suite model described challenges related to the structure and process of maternity care. They stated that the staffing ratios which were based on a midwife-mother ratio rather than a midwife-mother/baby ratio, made it very difficult to provide the standard of care required, including implementing the BFHI. Including babies in the ratios would make "a huge difference for midwife satisfaction and women's outcomes" (Participant FG1-2).

Participant FG1-4 described her experiences working in Midcall, "Five is generally do-able.. . . Up until recently, they were asking us to do seven. So, really, in an eight-and-a-half-hour shift, it's almost impossible." Consequently, she had to limit the time she dedicated to particular aspects of care. She believed that the lack of time to provide ideal care led to burn out.

Participants reflected on the fact that many new mothers were not used to seeing breastfeeding women in their community. Due to advertising and common practice, women and families could easily see formula-fed babies. Hence, shifting women's perception of natural infant feeding practices was an important part of their role: "A lot of people have made up their minds way before they're even pregnant and I think the education needs to start back even as far as primary school" (Participant FG2-6).

Participants described the challenge of implementing Step 9 related to the use of pacifiers. They stated that this concept was difficult to explain to mothers and families; and, similar to formula feeding in the community, mothers and families were used to seeing babies with a pacifier.

A 6-week period was perceived as the minimum duration for a woman to adapt to life with her newborn baby, and to establish breastfeeding, and participants believed continued midwifery support for this period of time was ideal.

> It's really difficult to change someone's way of thinking in a very short period of time when they're sleep deprived and they've got pain and they potentially might have had an instrumental delivery or a C section so like—and then their partner's going back to work or their baby has gone to the nursery and we're understaffed and we're—do you know what I mean? Like I think it's very easy to not breastfeed. (Participant FG2-2)

Participants discussed the fact that while women need at least 6 weeks to establish breastfeeding, the overlap during

this time when they transition from midwifery care to the MACH nurses, is often confusing.

> They have really different guidelines. Like, we tend to follow the Australian Breastfeeding Association guidelines on weight gain, and that says 400 g a month and it doesn't have to be linear, it can be really irregular. And the MACH nurses say 125 g a week and it has to be consistent.. . . And the ABA is exclusively breastfed babies, and MACH follows a [guideline] that's including formula. (Participant FG1-13)

Participants used this example to highlight the lack of continuity of information between the hospital midwifery care and community care. It also highlighted the importance of longitudinal continuity.

> I can only imagine the pressure that the MACH nurses feel. . . they're like, I don't know her history, I don't know what happened yesterday, I'm not going to know what's going to happen tomorrow. . .better just play it safe and give the baby comp feeds. (Participant FG1-2)

Sub-Theme 4: BFHI Accreditation Requirements

All participants agreed that the Ten Steps and BFHI were excellent and provided a clear and concise protocol to follow. The in-hospital BFHI accreditation process, which took place over a period of 2–3 days required a lot of preparation time, as well as time from individual midwives during that period, "it requires a lot of work from [name of the BFHI champion] the educator. It kind of becomes her life for a few months" (Participant FG2-4). They described the process as burdensome. The time required to respond to the BFHI accreditation assessment was discussed by many participants.

> I think it is sometimes, like it's a bit of a blitz. . .. There's pressure on to do all of that. And I just feel, like, that is a lot of extra work that doesn't really achieve any more people breastfeeding. It's just a tick all their boxes. . . (Participant FG1-3).

Some participants described how the assessment of one indicator with mothers was not appropriate as many of these mothers were fatigued and had given birth less than 24 hr previously. Nevertheless, the value of regular accreditation was acknowledged, if only it was made "more streamlined" and "less chunky" (Participant FG1-3).

Participants reflected on their perception that pediatricians and midwives work within different approaches to care. For example, participants stated that implementing Step 4 with babies born via Caesarean section was often a challenge, due to the difficulty that pediatricians perceived in managing babies' temperature in the operating theatre.

Another BFHI accreditation requirement that was seen to be difficult to achieve was 20 hr of staff education (Step 2), including 3 hours of supervised breastfeeding support and 8 hours of theoretical education.

> So, it's a bit of a worry if you're a midwife for 30 years and you still need supervising in what information you're giving women that breastfeed, when our stats show that 98% of women coming through the Birth Centre are breastfeeding after 12 months or something. . .. So, obviously the education we're providing is good. (Participant FG1-3)

Furthermore, Participant FG1-2 said "It's crazy, and it's a bit insulting, but it's—more than anything, it's just unrealistic that we would find the time to actually do that." Nevertheless, participants agreed that it is necessary to maintain the competency, and many described potential solutions, including more in-service education, weekly meetings, and handover to be counted as hours of staff training requirement. For a full list of the Ten Steps, see Supplemental Material 2.

Discussion

We identified four themes with one overarching theme. Participants discussed how time is a critical resource in their job. Time and continuity of midwifery care were identified as problematic within the current health system, where the predominant model of midwifery care does not support either. While BFHI accreditation was perceived as excellent in principle to ensure and maintain quality maternity care, the process and timing of onsite assessment was perceived as arduous.

Continuity of care, consisting of interpersonal, management, informational, and longitudinal factors (WHO, 2018a), is important in healthcare settings. Developing good communication and relationships with midwives as early as possible, as well as developing pregnancy and birth plans collaboratively, is ideal. Cummins et al. (2021) and Perriman et al. (2018) demonstrated that women receiving continuity of midwifery care value relationships with their midwives and had higher satisfaction rates.

In both models of care described by participants in our study, women were actively supported by midwives to breastfeed. However, information that women receive from the community may be less focused on supporting breastfeeding, especially as women receive unethical formula marketing and mixed messages. This hinders their capacity to make the best decision regarding their infant feeding method.

Participants in our study agreed wholeheartedly that the Ten Steps and BFHI was an excellent initiative to help mothers establish the foundation of breastfeeding journey. This aligns with several studies both in Australia and internationally (Amadhila & Van Rensburg, 2020; Atchan et al., 2018). However, the practice of skin-to-skin (Step 4) and prohibition of pacifier (Step 9) were mentioned by participants as challenging to implement. Healthcare staff are sometimes opposed to skin-to-skin contact, especially after a Caesarian

birth, and this was described by participants and in previous research (Balatero et al., 2019). For BFHI accreditation, a hospital must have procedures for skin-to-skin contact. This must be proven by Maternity Facility BFHI bi-annual data showing that at least 80% of term infants experienced the mentioned procedure and that at least 80% of interviewed mothers confirm (BFHI Australia, 2020b). The challenge for midwives lies in challenging other healthcare providers who are perceived as senior and in a position of power. This undermines their capacity to practice ideal midwifery care (Renfrew et al., 2019).

Using pacifiers interferes with babies' suckling and interrupts breastfeeding (Batista et al., 2018; Buccini et al., 2018). Participants stated that this was a difficult step to implement as mothers and families commonly saw babies with pacifiers in the community. They emphasized the risk of pacifiers to mothers and families in line with the requirements of the 2018 Ten Steps rather than full prohibition (Pramono et al., 2019).

The WHO/UNICEF BFHI requirement for 20 hr of staff training, including at least 3 hr of supervised clinical experience and 8 hr of theoretical education, was perceived as unfeasible and burdensome on midwives' time. Previously, Australian researchers found that midwives perceived that time pressures on staff were among the barriers to complying with BFHI's Ten Steps (Esbati et al., 2020). When midwives have insufficient time for training requirements, they must complete this outside work hours, also leading to burn out (Fenwick et al., 2018). The new *BFHI Australia Handbook* (BFHI Australia, 2020b) developed by the ACM based on the 2018 Ten Steps has changed the requirement to 8 hr of competency based in-service education for Group 1 personnel.

Lack of breastfeeding knowledge among health staff has been revealed by many research studies (Baranowska et al., 2019; Esselmont et al., 2018; Holtzman & Usherwood, 2018; Quinn & Tanis, 2020; Yang et al., 2018). Although provision of training interventions for health workers is known to improve knowledge and compliance with BFHI (Balogun et al., 2017), there is insufficient evidence of which specific training packages are most effective in increasing skills and knowledge, as well as breastfeeding outcomes. The WHO had identified evidence that breastfeeding training is helpful; however, it has often been given a lower priority due to competing priorities and resource implications. The WHO therefore no longer specifies the amount of mandatory training hours as a requirement, and instead encourages facilities to assess and verify their health staff competency and address knowledge gaps as necessary (Chapin et al., 2021). The WHO and UNICEF (2020) have recently launched a Competency Verification Toolkit. Importantly, the WHO and UNICEF (2018) recommends pre-service training for all health students in each country's national curricula. This requires new or stronger commitment from stakeholders, for example, ministries of education and health professional organizations (WHO & UNICEF, 2018).

Related to time and resource constraints discussed by participants were midwife-mother/infant ratios. Dani et al. (2020) assessed the influence of midwife-infant ratios on healthy term infant outcomes in an Italian BFHI hospital, finding that units with lower midwife-infant ratios (1:2.5–1:5 vs. 1:7–1:15) had higher exclusive breastfeeding. In Australia, the Queensland Nurses and Midwives' Union (2021) has encouraged every maternity facility to count babies separately from the mother in the workload design and resourcing. The current situation is argued to result in midwives having unrecognized and unreasonable workloads (Queensland Nurses and Midwives' Union, 2021).

The 2 days of hospital stay after birth is critical in developing a solid foundation for breastfeeding. It is essential for midwives to capitalize on this opportunity. Participants believed that BFHI goals were often hindered when mothers received advice from other healthcare providers. This particularly related to Step 6 on unindicated supplementation. In at least two states in Australia, around one third of babies were given formula before leaving hospital, which is very harmful to breastfeeding success (Centre for Epidemiology and Evidence, 2019; Maternal and Newborn Clinical Network INSIGHT Committee, 2018). Conflicting advice given, and differences in standards between guidelines used by pediatricians or MACH nurses, as well as from their families and community, could confuse new mothers (James et al., 2020).

Despite the challenges, similar to findings from previous researchers (Esbati et al., 2020), midwives in this study expressed a steadfast commitment to educate and support mothers in making the best infant-feeding decisions. Participants emphasized their belief in breastfeeding, which was strengthened by hospital management support, which further energized their commitment, as also shown by Esbati et al. (2020).

We have explored the midwives' experiences of implementing the BFHI. Understanding other healthcare providers' perspectives, such as pediatricians and MACH nurses, would provide important information that would assist in addressing barriers to implementation and find ways to scale up this program.

Limitations

This study was conducted in one Australian BFHI-accredited public hospital and the participants were all midwives. Participants may have been biased towards giving socially acceptable responses, particularly due to the focus group context. Another limitation was that the midwives in our study referred to the *BFHI Australia Handbook* (Australian College of Midwives, 2016) which still uses the 1989 Ten Steps. This handbook had been updated in 2020 to adapt the previous with 2018 Ten Steps, but had not been applied to

BFHI Australia at the time when the focus groups were conducted.

Conclusion

Time is a critical resource in the hospital maternity care setting, reflecting resource allocation decisions at the health care system and hospital level. Policy and practice need to be changed to ensure that women always receive continuity of midwifery care. Furthermore, it is very important to enable this quality assurance program to be streamlined, to integrate its associated costs within the health care and pre-service medical education system, and to limit the costs to individual facilities. We believe our findings amplify the importance of the WHO recommendation to integrate BFHI accreditation into national hospital accreditation.

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Author contribution(s)

Andini Pramono: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Visualization; Writing – original draft; Writing – review & editing.
Julie Smith: Conceptualization; Formal analysis; Methodology; Supervision; Validation; Visualization; Writing – review & editing.
Siobhan Bourke: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Supervision; Writing – review & editing.
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Supplemental Material

Supplementary Material may be found in the "Supplemental material" tab in the online version of this article.

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