Title: An historical document analysis of the introduction of the Baby Friendly Hospital Initiative into the Australian setting.

Abstract:

Background: Breastfeeding has many known benefits yet its support across Australian health systems was suboptimal throughout the 20th Century. The World Health Organization launched a global health promotion strategy to help create a 'breastfeeding culture'. Research on the program has revealed multiple barriers since implementation.

Aim: To analyse the sociopolitical challenges associated with implementing a global program into a national setting via an examination of the influences on the early period of implementation of the Baby Friendly Hospital Initiative in Australia.

Methods: A focused historical document analysis was attended as part of an instrumental case study. A purposeful sampling strategy obtained a comprehensive sample of public and private documents related to the introduction of the BFHI in Australia. Analysis was informed by a 'documents as commentary' approach to gain insight into individual and collective social practices not otherwise observable.

Findings: Four major themes were identified: *"a breastfeeding culture"; "resource implications"; "ambivalent support for breastfeeding and the BFHI"* and "*business versus advocacy"*. *"A breastfeeding culture"* included several subthemes. No tangible support for breastfeeding generally, or the Baby Friendly Hospital Initiative specifically, was identified. Australian policy did not follow international recommendations. There were no financial or policy incentives for BFHI implementation.

Conclusions: Key stakeholders' decisions negatively impacted on the Baby Friendly Hospital Initiative at a crucial time in its implementation in Australia. The potential impact of the program was not realised, representing a missed opportunity to establish and provide sustainable standardised breastfeeding support to Australian women and their families.

Keywords: Baby Friendly Hospital Initiative, Baby Friendly Health Initiative, Australia, midwifery, case study research, document analysis

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Introduction

Summary of Relevance

Issue	Sociopolitical challenges exist with regards implementing a global program in a national setting to support breastfeeding.
What is already known	Systems-level and attitudinal barriers have been identified affecting the uptake and development of the Baby Friendly Health Initiative in Australia. Research is lacking to shed light on observable challenges to implementation.
What this paper adds	A clear mapping of the early implementation period and influencing factors. The Commonwealth government's decision not to enact international Declarations despite being a signatory had a negative effect on breastfeeding support. Local advocacy efforts were hampered by availability of resources and governance issues at national and international levels.

The events leading to the development and release in 1991 and official launch and implementation in 1992, of the Baby Friendly Hospital Initiative (BFHI) by the World Health Organization (WHO) and the United Nations Emergency Children's Fund (UNICEF) represented landmark policy decisions by international agencies in advocating for women's and children's rights. The BFHI is a global, evidence-based, public health initiative and advocacy activity that supports practices promoting the initiation and maintenance of breastfeeding and encourages women's informed infant feeding decisions[1].

A positive association between the BFHI and breastfeeding prevalence has been demonstrated[2]. Nevertheless, the variance of 'baby friendly' accredited hospitals across Australian States and Territories reveals only nominal uptake of BFHI accreditation nationally[3]. Research is lacking on the early BFHI implementation period in Australia. The aim of this paper is to examine the introduction of the BFHI into the Australian setting through a focused historical document analysis of the factors that influenced the BFHI's early implementation period in Australia, from1992 to 1995. An understanding of the contextual

factors surrounding this period will increase stakeholders', researchers', midwives' and policy makers' appreciation of issues identified in recent literature such as the significant variation in women's experience of breastfeeding support from health professionals, including midwives[4].

This paper may also be relevant to researchers in other national settings who are examining the history of the BFHI in their own country. Comprehension of how global initiatives translate into a national setting and are impacted by local context will be enhanced. Understanding the application of knowledge translation from evidence to practice has relevance beyond breastfeeding and the BFHI. Challenges with translating evidence into national policy and maximising funding opportunities have also been observed in the prevention of non-communicable chronic health conditions such as diabetes[5] and obesity[6].

Implementation of the BFHI globally and in Australia was complex. Reviewing relevant international and national events will contextualise and increase the understanding of subsequent influences on the uptake and development of the BFHI in Australia.

Contextualising the BFHI in Australia

Throughout most of the twentieth century support for breastfeeding was eroded at all levels of the health care system and women did not receive consistent, timely or accurate advice and assistance[7]. Mothers and babies were routinely separated; babies were fed according to a predetermined schedule with liberal artificial supplementation. The presence of free and/or highly subsidised formula milks in the hospital environment was seen as a major barrier to exclusive breastfeeding [8] and the situation required high level action.

Insert Table I here

Table I maps the Declarations and actions that informed and represented international aid agencies' pro-breastfeeding policy statements from 1981 to 1992. The policy statements

acknowledged breastfeeding as the most appropriate nutrition for babies and introduced the health promotion concept of breastfeeding as a human right. The creation of a global breastfeeding culture was a clearly desired outcome. International Declarations clarified the key concepts, actions and resources required to reorient health care delivery into a social model of health framework to support culture change.

The *Innocenti Declaration on the protection promotion and support of breastfeeding* (the *Innocenti Declaration*) set the goal of increased support for breastfeeding. The culmination of many years planning the *Innocenti Declaration* described four operational targets to achieve its goal. World Health Assembly (WHA) member states, including Australia, were expected to implement any international conventions they ratified by strengthening local standards through the development of national policy[9]. The BFHI was the *Innocenti Declaration's* second target.

The BFHI accreditation program was conceptualised as a global recognition of excellence and designed to act as an incentive for maternity facilities that implemented and practised all of the *Ten Steps to Successful Breastfeeding.* Between June 1991 and March 1992 the BFHI was announced, developed, field tested and launched[10]. Phase 1 field-testing (June 1991 to February 1992) focused on creating capability in twelve specifically chosen 'early starter' low-income nations, with a significant number of pilot hospitals designated as 'baby friendly.' Whilst field testing was underway, all UNICEF offices were contacted via an Executive Directive that outlined the Initiative and presented a 'suggested' implementation schedule[8].

Insert Table II here

Table II reveals the actions recommended to occur in 1992[8]. The anticipated result was a rapid embedding of the BFHI program. Table II also presents a timeline of the significant events that occurred in Australia in comparison with the UNICEF targets. Over a three-year

period, a number, but not all of the recommended actions were implemented. A national authority (National Steering Group [NSG])[11] assumed responsibility for a number of achievements as described in Table II. Targets identified in the projected timeline[8] that were not realised during the initial implementation period included a national survey of maternity facilities to inform a baseline assessment of the country's situation and the establishment of a 'lead training facility' to act as a 'train the trainer' for breastfeeding.

UNICEF Australia Executive made internal decisions about its relationship with the BFHI, commissioning an options paper and making the ultimate decision to cease governance. UNICEF Australia received expressions of interest from a consortium of breastfeeding advocacy groups: the Nursing Mother's Association of Australia, Australian Lactation Consultants Association, Lactation and Infant Feeding Association, Aboriginal Birth and Breastfeeding Association plus a separate bid by the Australian College of Midwives (ACM)[12]. The ACM bid was submitted without the knowledge of the other NSG members[13] who had assumed that the ACM was part of the consortium. The ACM was announced as the successor body of BFHI in Australia[14] with the transfer of responsibility occurring in November 1995. A critical component of the BFHI's transfer to a new successor body was a financial agreement that was part of the tender process[14]. UNICEF's provision of $25,000 in total over two years to support the ACM take over did not eventuate[15], leaving the College in an unforeseen financial deficit situation.

How international and national events ultimately impacted on the implementation and uptake of BFHI across Australia is arguably a crucial element of what has emerged as the breastfeeding culture in Australia. Better understanding of the influences on the current translation of evidence-based breastfeeding knowledge into practice in Australia is required. An exploration of factors that influenced the BFHI during its early implementation phase and later development and uptake appears justified. An instrumental case study[16] was undertaken, which was informed by a Knowledge Translation theoretical framework[2].

Methods and analysis

'The case' in this study is the quality assurance program known as *BFHI Australia*. The case explores the introduction and implementation of this global program into the Australian setting. In instrumental case study research investigating 'the case' also serves to facilitate understanding of an intimately related issue. In this study the focus was the support of breastfeeding in Australia. Case Study Research (CSR) has been shown to be an applicable methodology for midwifery research[17]. Case Study Research is an appropriate approach to reveal the highly complex contexts surrounding the development and implementation of a clinical, quality assurance program such as the BFHI.

The CSR design required the collection of data from National policy documents, government reports, organisational minutes and correspondence. Field notes taken when reviewing documents were also utilised. This paper presents an in depth analysis of public and private documents published and in use leading up to and around the time of initial implementation in Australia. These documents shed light on the challenges of implementing a global program into a national setting, namely the initial uptake of the BFHI in Australia.

There are good rationales for using document analysis. Documents are distinctive in so far as they exist before the researcher seeks to use them as data[18] and may contain far more information than would be gained from an interview or survey. Documents uncover meaning, develop understanding and help the researcher discover new insights about the research problem. The background information as well as historical insights that are obtained can help researchers understand the roots of specific issues. The capacity for triangulation, namely using a variety of sources to strengthen findings, makes document analysis very valuable to case study research[16].

This paper contributes to a larger doctoral research study. Ethics approval from the University of Technology Sydney Human Research Ethics Committee was obtained for what was regarded as a low/negligible risk project. Support from the current custodians of *BFHI Australia* included access to private archival documents. Access to publicly available documents did not require ethical approval.

Sampling Strategy

A purposeful strategy was used to obtain a comprehensive sample of information-rich documents. The selection strategy was based on each document's importance and relevance to breastfeeding, the BFHI implementation process and reliability of authorship. A finite number of documents resulted (Table III). Knowledge of the situation assists in setting the text in its context of production to identify richness and limitations[19]. The first author had extensive prior knowledge, understanding and experience with breastfeeding support issues and the BFHI in Australia, facilitating a deeper understanding of relevant interrelated events and documents. The first author was also mindful to acknowledge the existence of prior knowledge and engagement during analysis to ensure the situation did not arise where assumptions and presuppositions could interfere with the findings generated.

Documents are categorised as personal, private or public, depending on who wrote them rather than ownership or availability to the wider population[20]. Archival documents may be more personal, individual and private, thus more reflective of 'real life'[19]. Published material may also be polished to be strategic in nature, consequently unpublished material was included to ensure anything relevant to the BFHI implementation period and process was drawn upon. Private documents accessed from the archives of the Australian College of Midwives (ACM) revealed a unique insight into decision-making processes and outcomes. Public documents were accessed from the Internet or via the University's document delivery service. The date range of 1980 to 1996 was specifically chosen as it was considered to be highly influential in the development of the support of breastfeeding in Australia. Table III

identifies the documents which exerted an influence on the BFHI's Australian implementation and uptake in the early 1990s, which is the period under examination.

Analysis Framework

A context analysis framework and a 'documents as commentary' approach[18] informed the iterative analysis process. Analysis should seek to locate documents within their social as well as textual context[21]. Documents are not produced in isolation; they both refer and are connected to other documents, with meanings that are socially situated. How they are authored, produced, used and consumed reflects social reality. The 'documents as commentary' approach provides insight into individual and collective social practices and structures that are not otherwise observable. The analytical approach for data analysis included careful attention to contrary or alternate examples or explanations and the use of multiple types of documents[16]. Documents were initially 'skimmed' and examined superficially. Meaningful and relevant data were identified and separated out. Close critical reading probed the precise language use and organisation of the whole text[19] facilitating deeper understanding of the context in which the document was produced. The text was reread and examined thoroughly. A number of interrelated themes emerged that demonstrated an influence on the BFHI's uptake in Australia during the early implementation phase.

Findings and Discussion

Using a purposive sampling technique nine National policy reports and twelve organisational archival documents dated between 1982 and 1996 were chosen for analysis. These documents contained references to the support of breastfeeding and or the BFHI. They each contributed to each other and provided an understanding of the national policy and social context in which the support of breastfeeding was practiced during the 1980s and early 1990s. Table III identifies the documents accessed, rationale for their selection and data analysed.

Insert Table III here

Overall there were differing perceptions and valuing of breastfeeding. There were also different views of the BFHI's role in Australia, its desirability and capacity to create change plus debate about an appropriate governance structure. Four discrete themes were identified: "*a breastfeeding culture,*" "r*esource implications,*" *"ambivalent support for breastfeeding and the BFHI*" and *"advocacy versus business*". Each of the four themes is explored and discussed in detail below. A key issue identified in the document analysis was the relationship between the two tiers of government that co-exist in Australia (national and state levels). It is therefore important to begin the presentation of the findings by providing further contextual information about the way national and state-based governments co-exist within Australia and set policy.

Australia operates as a federal system due to its colonial history. There is a two-tiered government structure with an overarching central (Commonwealth) and eight independent state/territory bodies. Each State/Territory has its own constitution, parliament, government and health system. The Commonwealth establishes national priorities and directions in public policy, for example in education and health. Competition for power exists. The States/Territories provide most of the services despite the Commonwealth having financial control due to its income taxing powers. The 1986 *Looking Forward to Better Health Report* [22] identified that new Commonwealth initiatives were potentially seen as a threat by the States/Territories; national policy-making was regarded as "an exercise in conflict management" (p.50).

The Australian Commonwealth's representation on international meetings and ratification of Declarations described in Table I is an example of national policy-making. At a national level, health policy documents and reports record the progress of support of breastfeeding and the BFHI in Australia. While pursuing a national agenda Australia's policy documents were also

a response to the requirement for action from the international Declarations. How the support of breastfeeding and a global strategy, the BFHI, were handled is further explored within each of the four themes.

"A breastfeeding culture"

A breastfeeding culture is one where breastfeeding is the norm. The total environment supports women to breastfeed: socially, politically and culturally. Policy documents traced the efforts made at a national level to promote the concept of an Australian culture of breastfeeding. In Australia the National Health and Medical Research Council (NHMRC) is a national organisation that uses expert panels and public consultation processes to develop health standards and disseminate advice for the community, health professionals and government public policy. Positive rhetoric underpinned the public policy stance for breastfeeding in 1996 as the following quote reveals:

"The Commonwealth Government is committed to protecting, promoting and supporting exclusive breastfeeding for at least the first four to six months of life. Australia is one of the few developed countries in the world to include a guideline on breastfeeding in its dietary guidelines for adults." Infant Feeding Guidelines for Health Workers 1996[23] (p.2)

Closer scrutiny of the policy and context exposes significant gaps in the translation of evidence to practice. Four subthemes were identified: *"reporting breastfeeding prevalence and practice", "goals and targets", "limiting applicability"* and *"supporting the BFHI"* which will be discussed in greater detail.

"Reporting breastfeeding prevalence and practice"

Accurate data about trends in breastfeeding prevalence and practice, which are essential for informed policy formation were lacking. The seeming absence of concern for accuracy and

an inflated sense of achievement were exhibited in the language of an early government report:

"The Working Party noted that the incidence of breastfeeding observed among Australian women now ranked among the highest in the Western world and exceeded those reported from several less developed countries." Report of the Working party on Implementation of the WHO International Code of Marketing of Breast-milk Substitutes 1985[24] (p.14)

The incidence of breastfeeding referred to by the Working Party was drawn from a 1982 survey of 'national averages [25]. Data were collected from 83,987 live births from fifty-five representative hospitals; state and territory administrative figures, health department surveys and independent surveys. The survey estimated breastfeeding rates as: 72% at 6-8 weeks; 54-55% at 3 months; 40-42% at 6 months and 10-12% at 12 months. Critical examination has revealed significant methodological flaws, limiting applicability[26]. Bias included staff's estimation rather than a true quantitative survey of the number of women 'fully' breastfeeding at discharge. With regards to determining duration, the lack of homogeneity, namely inconsistent definitions and methodologies, different infant age groups and reporting periods reduced reliability and meaningfulness of the findings.

The results of a subsequent national survey in 1989 by the Australian Bureau of Statistics (ABS) revealed a different picture[27]. The self-reported overall percentage of breastfeeding at hospital discharge of 77% was gathered from a participant-completed questionnaire returned by12,820 women aged 18 to 50 years. Similar to the 1982 survey significant flaws in methodology were revealed [28]. Small sample sizes, lack of clear definitions of breastfeeding and age specific rates meant only the percentage of women who had ever breastfed were able to be calculated, not breastfeeding intensity (degree of exclusivity). Exclusion of mothers aged less than 18 and respondent fatigue were further confounders not accounted

for. Reporting errors such as respondents not understanding the questions, missing questions or following incorrect sequence guides also survived into the final data set. Secondary analysis of the same data by the ABS[29] revealed that despite overestimation there remained a decrease in rates from the 1982 figures at 3 months (originally 54-55% now 28%) and 6 months (originally 40-42% now 23%).

Unlike the 1992 *Dietary Guidelines*, that reproduced Palmer's (1985) survey results, *Australia's Health 1994*, reported the 1989 figures[27]. *Australia's Health* is a biennial report on health published by the Australian Institute of Health and Welfare (AIHW). An independent statistics and research agency within the Commonwealth government, the AIHW's mission is to support public policy-making on health and welfare issues by coordinating, developing, analysing and disseminating national statistics on the health of Australians. *Australia's Health 1994* acknowledged the limitations of current data collection processes while also concluding that the trend to increased breastfeeding prevalence had ceased. Despite long standing proposals to establish a coordinated national monitoring system[24,28] recommendations for future data collection to ensure the accuracy of the trend were absent. The differences in definitions and methodologies of successive surveys and studies and inconsistency of reporting data meant that the Commonwealth government's claims could not be substantiated. The data's lack comparability and usefulness also impacted on the development and assessment of any national goals and targets.

"Goals and targets"

Goal and target setting to increase the prevalence and duration of breastfeeding did not contain mechanisms to assess progress. Health goals and targets are used to indicate the direction and pace of change of health in populations. Goals represent a vision for the future; targets are specific and measurable. The Better Health Commission, chaired by a medical expert with assistance from a panel of professionals established taskforces to investigate

morbidity and mortality in the community. *Looking Forward to Better Health* published in 1986[22] set the first goal for breastfeeding, namely increasing the duration of breastfeeding. The specific target was to increase rates at 3 months from 50% to 80% by the Year 2000. Using 50% as a baseline figure again suggests the use of the 1982 inflated figures rather than the 1989 survey findings. Using 50% would also mean that less improvement would be required to reach the target. However strategies to measure progress towards the targets were absent from the Report. A caveat was also included with language that clearly removed any governmental responsibility for implementation:

"The taskforce recommendations are not necessarily those of the Better Health Commission: they are the results of independent inquiries undertaken in the interest of improving the health of all Australians." Looking Forward to Better Health Volume 1 Final Report[22] (p.xii)

A subsequent expert panel developed and published revised goals and set new targets for Australian health standards in 1993. *Goals and targets for Australia's health in the year 2000 and beyond*[30] included breastfeeding under the nutrition umbrella. The targets were specific for hospital discharge plus full and partial breastfeeding up to 2, 3 and 6 months of age however they also did not include any measurable strategies. The expert panel clearly identified that there were insufficient current data on which to base the targets, which is incongruous with the process undertaken. Nevertheless, the goals and targets were referred to in a variety of public documents[23,28,31] suggesting the Australian government did not see any incongruence in endorsing the setting of non-measurable outcomes. Embedding the goals and targets in dietary guidelines also demonstrated the Australian government's view that breastfeeding was a nutritional issue.

"Limiting applicability"

Situating the support of breastfeeding and (later) the BFHI in nutrition policy and dietary guidelines negatively impacted its subsequent applicability to a wide range of potential

stakeholders. Australia had previously decided breastfeeding 'belonged' in food and nutrition policy[32]. Dietary guidelines are designed to provide advice from health professionals to the general population about healthy food choices. The progression of the Australian government's conceptualisation of breastfeeding is discernible through the progression of published dietary guidelines.

The linkage of the health promotion strategies of breastfeeding and nutrition were observable in the earliest guideline:

"Breastfeeding provides the best nutritional start in life." Dietary Guidelines for Australians 1982[33] (p.5)

The recommendations of the 1990 *Innocenti Declaration* (ratified by Australia) clearly situated the support of breastfeeding in a separate dedicated national multisectorial national breastfeeding committee. However the NHMRC continued to locate breastfeeding in a nutrition framework with the following justification:

"The inclusion of breastfeeding as a dietary guideline is a recognition of the nutritional, health, social and economic benefits of breastfeeding to the Australian community." Dietary Guidelines for Australians[34] (p. 87)

Not only did the Commonwealth government not demonstrate fulfillment of the international recommendations it had previously endorsed the following quote also suggests the beginning of a conceptual shift of onus to the community to support breastfeeding:

"The health of Australians begins with a good diet in infancy and community education should contribute to increasing breastfeeding rates and education in future generations of Australians." Dietary Guidelines for Australians 1992[34] (p. 87)

This theme was further developed in a subsequent guideline:

"Support and encouragement are necessary at all levels of the health system and in the wider community if the contribution of breastfeeding to the health of Australians is to be recognised and the prevalence and duration of breastfeeding are to be increased." Dietary Guidelines for Children and Adolescents[31] (p.3)

The onus of responsibility and sense of obligation was clearly no longer a national government issue as demonstrated by the contrast between language and context. Policy statements are situated within a highly specific framework yet breastfeeding is more than the provision of nutrition and diet-related disease risk reduction[35]. Dietary guidelines encourage eating patterns to reduce the risk of diet-related disease and improve population wellbeing. The guidelines failed to adequately describe the complex interrelationships that exist between mother, baby, the family and society at large to facilitate breastfeeding 'success' and long-term health outcomes.

Policy language clearly recommended uptake by a range of stakeholders for a successful outcome. One might argue the panel recognised the limitation of the policy's placement and was attempting to demonstrate wider applicability. A guideline format for policy has limitations however. While the guidelines referred to goals and targets published elsewhere[30] the absence of actionable items meant progress evaluation was not possible and potentially not anticipated or desired. The lack of a consistent system for monitoring clearly impacted on the assessment of targets. The guideline's capacity for demonstrating relevance to a widespread audience was further diminished as it was not possible to establish an accurate picture from which to draw conclusions to inform future direction. The issues faced by policymakers also reached the BFHI.

"Supporting the BFHI"

The BFHI experienced an extension of the unique policy and implementation challenges already observed in the support of breastfeeding. The NHMRC expanded policy to create companion documents[23,31]. The two expert panels only shared three members, the rest were drawn from a wide range of key stakeholders. The *Dietary Guidelines for Children and Adolescent's* section on breastfeeding was informed by a background paper written by the peak breastfeeding support organisation, the (former) Nursing Mothers of Australia[31]. The "*Ten Steps to Successful Breastfeeding*" was included, but direction and/or encouragement for implementation were absent. The *Infant Feeding Guidelines for Health Workers* development process included the expert panel, submissions and a public consultation process[23]. The following statement was included:

"Australian hospitals are encouraged to actively adopt the Ten Steps to Successful Breastfeeding." Infant Feeding Guidelines for Health Workers 1995[31] (p.1)

If a mandate represents official permission for something to happen the language of the above statement fulfills that criterion with the government seeming to give 'permission' for the BFHI's uptake. Contrasting issues are observable however. This policy may have represented the strongest stance possible at the time however 'encouraged to actively adopt' is not a robust statement of national intent. It does not support the impression of absolute endorsement of the BFHI. The language does not represent an indication by the Commonwealth government of a requirement for action by the States to commit to implementation/accreditation. 'Adoption' may also be subject to a different interpretation to 'implementation'.

At a local level responsibility for the BFHI was clearly placed on the individual hospital, further weakening the persuasive value of 'in principle' support. The BFHI program includes accreditation as a natural end point to publicly demonstrate achievement of the standards.

Any guidance for achieving the BFHI's goals or tangible support for implementation and accreditation was absent thus limiting the policy's (and the Commonwealth Government's) potential capacity to drive change. Given the known financial tensions that existed between Federal and State[22] the view of policymakers may have been that the BFHI was not seen either as an effective or an economically feasible strategy to be pursued at a national level.

"Resource implications"

The provision of resources to implement or evaluate the recommendations for the support of breastfeeding and the BFHI was a recurrent theme observed through a range of documents from key stakeholders.

The following quote clearly identifies the lack of financial assistance UNICEF could expect from Head Office to implement the BFHI:

"At country level, activities should be funded from existing country-level budgets." Executive Directive Re: Baby-Friendly Hospital Initiative[8] (p.6)

The Executive Directive mandated the BFHI's implementation yet UNICEF did not equip its offices with resources to achieve its execution in an optimal manner. The implications for Australia were immediately apparent. UNICEF Australia did not enact the highly detailed and resource intensive 'suggested' implementation schedule described in Table II. UNICEF's available financial and human resources determined their reaction to unforeseen internal and external challenges and out of necessity adaptation of the schedule occurred, also described in Table II. The resource allocation required for the 'suggested' implementation may well have negatively impacted on usual UNICEF business activities, namely fund raising for low-income nations. A balance between the two priorities needed to be achieved. The language of the following quote in an internal Discussion Paper implies a warning,

concern, perhaps a degree of resentment towards the resources required for program sustainability:

"Considerable time and effort is involved in the BFHI." Baby Friendly Hospital Initiative Discussion Paper[36]

Governance was complex as the BFHI was a national program operating out of the UNICEF Victoria branch office. Internal operational issues were identified, including a lack of clarity around budget, communication, responsibility and policy by the 'in house' Discussion Paper[36]. The tensions arising from the ongoing resourcing requirements may well have contributed to the de-prioritisation of the BFHI and reinforced the intent to find an alternate governing body in the 1995/1996 financial year. External challenges included key stakeholders' apparent lack of interest in governing the BFHI, presumably due to the financial implications. As the BFHI did not receive public policy attention till 1995[31] it can be assumed that in Australia in the early 1990s the commitment to breastfeeding support and the BFHI was confined to a fairly narrow sector of the health community. Reviewing UNICEF correspondence reveals multiple attempts to transfer governance of the BFHI. Repeated requests to the Commonwealth government, both by Head Office and Australia[11,37,38] to discuss taking up implementation responsibility were not actioned. UNICEF Australia also enquired whether other national associations had an interest in the BFHI[39]. The lack of uptake further supports the suggestion that the BFHI was not widely seen as a desirable or financially viable program in the Australian context.

Actioning recommendations have resource implications. Where action was taken in the support of breastfeeding the Commonwealth government appeared to use a cost minimisation approach to policy implementation, namely the least expensive method was chosen. The Dietary Guidelines[31,33,34] represented one aspect of the policy response to the *WHO Code.* A 1993 Steering Committee reviewed the implementation of the *Who Code* and

made specific recommendations to government[40] which contrasted with previous recommendations[24]. The resulting policy response, *The Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement – the MAIF Agreement* and Advisory Panel[41] was voluntary, narrow in scope and the Advisory Panel included industry representation, a potential conflict of interest. To enact all the targets of the *Innocenti* Declaration additional legislative and structural changes were required. The lack of tangible resourcing indicated attitudinal issues were also present.

"Ambivalent support for breastfeeding and the BFHI"

A sense of ambivalence with regards the importance of support for breastfeeding and the BFHI was also evident from various stakeholders.

The following quote from UNICEF's Executive Directive (1991) demonstrated an assumption of BFHI knowledge at country level prior to its development and launch yet did not suggest an extensive prior communication or consultative process had occurred:

"... a new global effort you have probably heard of by word of mouth or reports from Headquarters." Executive Directive Re: Baby-Friendly Hospital Initiative[8] (p1)

However Head Office also held the positive opinion that all country offices would enthusiastically embrace the BFHI as identified in the following quote:

"The BFHI should fit naturally with your current field program aims, since it will give strong lift towards several World summit goals." Letter to country office heads[42] (p.2)

UNICEF Australia may well have felt they had few options initially considering the manner in which the program was communicated and delivered, which is in contrast with the recommended social model of health framework and health promotion principles. Examination of UNICEF correspondence revealed a number of issues:

*"In response to some community pressure and from New York, UNICEF Australia set up a national task force in mid-1992, with representation from a number of national organisations and with support from others."*Correspondence to the President of UNICEF Australia [43]

The existence of ambivalence from several areas can be interpreted in the language used: from the identified 'pressure' to set up the task force from various groups and a clear distinction between representation and support from committee members. Some degree of ambivalence is understandable given that UNICEF Australia staff may have held opinions typical of high-income nations at the time. A positive perception existed of formula milk's comparability to breastmilk[44]. A limited awareness and understanding that the benefits of breastfeeding applied equally to all babies was also present. One influencing factor for this attitude could have been an unintended effect of the success of the international advocacy campaigns against formula companies in the 1970s.The campaigns highlighted the dangers associated in low-income nations rather than the risks incurred for any mother and baby regardless of demographic. A sense of complacency and naivety existed amongst many people living in conditions of relative prosperity, namely that their children were immune from risk[45]. The attitude that the BFHI was more applicable to low-income nations may also have been present in the Commonwealth government, with the perception influencing policymakers' prioritisation of the program.

Further examples of ambivalence towards the BFHI from key stakeholders were observed, for example the peak body of Obstetricians in Australia was moved to record the following complaint in a letter to UNICEF Australia:

"*Some of your strategies are too restrictive for Australian women and Australian hospitals.*" Correspondence to the President of UNICEF Australia[46]

Support for breastfeeding by the Royal Australian College of Obstetricians and

Gynaecologists (RACOG) clearly did not extend to the BFHI; presumably "strategies" refers to the "*Ten Steps to Successful Breastfeeding.*" This assumption is supported by RACOG's exception to the term 'baby friendly hospital' in the same document stating it suggested discrimination. The RACOG subsequently opted out of physical representation on the NSG[47]. The RACOG's view represented a lack of understanding of the BFHI philosophy, where women are enabled to freely make informed infant feeding decisions[1]. The historical subordination of midwives to doctors in Australian maternity services described in the literature[48] may also have reinforced obstetricians' desire for and decision to maintain political distance.

A subtle ambivalence with regards to the Commonwealth government's unqualified support for breastfeeding and later the BFHI can also be seen in the language used for recommendations, particularly the inclusions and exclusions. The *Innocenti Declaration* set a goal for achieving optimal health for infants and mothers by clearly describing a recommended standard of breastfeeding practice as follows:

"...all women should be enabled to practise exclusive breastfeeding and all infants should be fed exclusively on breastmilk from birth to 4-6 months of age. Thereafter, children should continue to be breastfed, while receiving appropriate and adequate complementary foods, for up to two years of age or beyond." Innocenti Declaration 1990[49]

Observation of the use of language reveals a significant point of difference in policy. The Dietary Guidelines[23,31,34] concurred with the WHO on exclusivity however they carefully avoided the topic of duration as the following quote reveals:

"Breastfeeding from a healthy well-nourished mother is adequate as the sole source of nutrients for full-term infants from birth until four to six months of life." Dietary Guidelines for Australians[34] (p.87)

The lack of specificity regarding duration was potentially because some groups in the Australian community at that time may have reacted negatively to the suggestion of breastfeeding for two years[26].

The lack of clear policy and direction to support the BFHI also suggests a sense of ambivalence. Potentially its inclusion in policy was meant to signify the BFHI's importance to the wider Australian community. The Commonwealth government could have considered their public position as a reasonable compromise, one that also demonstrated a positive response to their international and national obligations. The lack of national standardisation and clear endorsement of international policy with regards the support of breastfeeding and the BFHI can also be viewed as further examples of a prevailing ambivalent attitude that provided support for the stance of other national organisations. It can also be argued that public policy demonstrated little evidence of advocacy for the women and children of Australia.

"Advocacy versus business"

A final theme highlighted in the document analysis was the tension between advocacy and business priorities. The BFHI aims to influence decisions and practices within the health system. As previously identified such change has funding implications that may not be appealing to policymakers. The tension between advocacy and business was observed in documents at national and (international) local level.

It was optimistic and perhaps naïve of UNICEF to assume or even hope that all governments would decide to implement the actions of the *Innocenti Declaration* in full considering local resource and legislative implications. Australia for example was undergoing a period of economic rationalisation. Health care became an industry and a neoliberal market state evolved with deregulation, privatisation and deletion of government intervention occurring.

The economic rationalist agenda impacted on healthcare policy. There was a shift to performance indicators with greater measuring of outputs and outcomes as well as drugs and dollars and minimising bureaucracy. Health care became centralised and privatised. The introduction of new initiatives that had recurrent resource implications and no proven outcomes had little likelihood of uptake in a climate experiencing wide ranging tax reforms and program reviews to reduce current spending.

The following quote from the report of the UNICEF Australia's external review of the BFHI in 1995 is revealing:

While strongly supporting the philosophy and basis for establishing the BFHI in Australia and acknowledging the powerful and rapid impact that has been made to date, UNICEF Australia is unable to justify major financial and administrative support of this project when faced with the considerable demands of other vital international initiatives in support of needy women and children in the world's poorest countries." Report for UNICEF Australia Baby Friendly Hospital Project[50] (p.4)

The direct outcome of having the contrasting priorities between advocacy and business resulted in tension experienced by an international aid agency prioritizing business on the one hand to support advocacy activities elsewhere. UNICEF Australia was also unused to and inexperienced with governing an unfunded domestic program. It is safe to assume that their actions would also have been influenced by the BFHI's business model at the time of early implementation. Support is also lent to the argument that UNICEF staff did not have a full appreciation of the importance of breastfeeding to the health of women and their families in Australia. The language suggests an attitude that the needs of women and children in low income nations outweighed the needs of Australian women and children, which is arguably a form of reverse discrimination.

The NSG's reaction to UNICEF's decision to withdraw from the BFHI was captured by the Minutes immediately following the announcement:

"The National Steering Group members present expressed deep regret at the decision taken." BFHI National Steering Group Minutes[14] (p.2)

UNICEF's resolve to withdraw from the BFHI and to find an alternate governing body was a business decision; however it was conceptually foreign to the NSG. National Steering Group members were volunteers who fitted BFHI work in around their substantive positions. They shared a belief in the long-term measurable difference to prevalence, duration and health outcomes for society as a whole that could be achieved through the active support of breastfeeding and the BFHI. Similar to UNICEF's view regarding country-level engagement the NSG may also have had an expectation that UNICEF Australia would naturally embrace the BFHI. The NSG were not privy to the inner workings of the UNICEF Australia Board however. Given more time the BFHI may have become self-sustaining however in the short term it was optimistic of the NSG to assume that UNICEF Australia would continue to fully support a program that was in deficit.

Similarly the ACM identified a distinction between altruism and business as revealed in the following reflection recorded immediately after the transfer of governance:

"I am really beginning to think we may have taken on the wrong thing business wise." ACM interoffice memo[15]

The College had committed significant resources in its bid to secure sole governance rights of the BFHI. The UNICEF Australia funding agreement did not eventuate, leaving the College in an unforeseen financial situation, which would have far-reaching consequences.

Strengths and Limitations

The construction of a different and deeper understanding of the issues under examination has been achieved using the 'documents as commentary' approach (Miller & Alvardo, 2005). The international imperative to develop the BFHI and influences on its uptake in Australia has been mapped and analysed. Breastfeeding support has been tracked through the examination of breastfeeding policy documents.

Strengths of this documentary research process included access to a wide range of public and private documents. Methods to enhance trustworthiness in data analysis were employed. A clearly identifiable process using quality criteria was utilised as a means to ensure rigour. The documents and evidence were verified as genuine due to access from official websites, the presence of official letterhead and verifying signatures (authenticity). The documents were free from obvious bias as they were produced for information dissemination rather than personal use (credibility). Public documents analysed reflected current government policy and reports contained recommendations for government action (representativeness). The access to private documents may not have been representative of the totality of the entire set of relevant documents though, impacting on the authors' subsequent capacity to reveal all aspects of the 'story'. However, the evidence contained within all the documents was clear and comprehensible (meaning). 'Source criticism' strategies to ensure quality were also employed[18]. External critique reinforced quality control with the establishment and credibility of documents verified. Internal critique uncovered how a source can inform the analysis through a consideration of the intentions and abilities of the document's producers and access to events. All documents were clearly linked to events surrounding the early implementation of the BFHI and or the support of breastfeeding in Australia. Individuals, organisations or government departments that were either associated with or had some responsibility for the events produced the documents. The sampling strategy was chosen to minimise any potential for bias. Data analysis was undertaken by the first author, a doctoral candidate. Close collaboration with the supervisory panel ensured potential bias did not influence the analysis.

Reflexivity was a further method used to encourage rigour. Knowledge production is neither an external process nor is it objective; interpreting data is influenced by the intrinsic qualities and interests of the researcher[51]. It was an advantage to have knowledge of the situation to better contextualise the texts under analysis[19]. Deep previous engagement with the BFHI, occupying an 'insider' position[51] was seen as an advantage as the actual policy environment was known. There was a degree of familiarity with a number of the public documents and key stakeholders displayed trust by providing access to private documents. Care was taken not to make assumptions, as they would threaten validity. Any presuppositions on the part of the investigators, due to their prior knowledge were also suspended in order to minimise bias in reporting.

The capacity for influence from interview participants for example was not applicable, as a document exists before the researcher[18] although the issue of power remained[52]. Reflexivity of the power relationship resulted in care being taken to avoid any exertion of authority by authoring a particular version of the text; the use of triangulation lessened this potential bias.

Conclusion

The challenges to implementation identified through the document analysis were many and varied, yet interrelated. The Australian two tier government system added to the complexities of attempting to translate evidence, namely changing the prevailing infant feeding culture through policy and practice. There was little persuasive effort by the Commonwealth government to the States and Territories. Ambivalence towards the importance of support for breastfeeding and the BFHI from several key stakeholders was also observed, with the underpinning thread of resource limitations evident. Consequently the BFHI was unable to gain good early traction. The support of breastfeeding and the BFHI in Australia was conceptualised as part of and subsumed within a food and nutrition policy rather than a standalone program and primary health care initiative as per international recommendations.

While providing policy responses the Commonwealth still essentially distanced itself from fulfilling its obligations as a signatory of the *Innocenti Declaration*. Recommendations included the creation of a multisectorial national committee to take carriage of breastfeeding in Australia, which included the BFHI. By not actioning these recommendations the Commonwealth government demonstrated a lack of specific direction in the active support for breastfeeding. Furthermore the provision of a clear mandate for nation-wide full implementation the BFHI and accreditation of maternity facilities was absent. However, the missed opportunity to gain an early understanding and appreciation of breastfeeding as a contextual activity, with interrelationships between social, economic and environmental factors and translate this into policy has had long term impact on the capacity for Australia to develop a comprehensive supportive breastfeeding environment for women, babies and their families.

This analysis has highlighted lessons that could be useful to the implementation of other national health promotion activities. There are a number of recommendations. To effect the translation of evidence into practice carriage of the program by a dedicated multisectorial national committee to oversee all aspects of implementation, evaluate progress and ensure accountability is essential. An initial mapping exercise will determine the current situation as a baseline and identify enablers and barriers. In conjunction with the mapping exercise an economic model of the proposed program with short and long term projections is required. Clearly worded policy that is applicable to a wide range of stakeholders with specific and tangible incentives will be persuasive to the program's uptake. The establishment of goals and targets informed by current data will indicate the desired direction, pace of change and measure outcomes. Finally a communication policy and process across all government departments with an ongoing funded national campaign will demonstrate the translation of evidence into practice, unqualified nature of support offered throughout the health system and wider population to facilitate the desired culture change.

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1981	1989	1990	1991	1992
21 May: Resolution by World Health Assembly WHA 33.32: The *International Code of Marketing of Breast-milk Substitutes* passes by 118 votes to 1 and is ratified by Member States of the World Health Organization (WHO) including Australia	Publication of "*Protecting, promoting and supporting breastfeeding: the special role of maternity services. A joint WHO/UNICEF statement*". The "Ten Steps to Successful Breastfeeding" makes its print debut **20 November:** At the General meeting of the United Nations the Member States adopted by acclamation i.e. without a vote and ratified the *Convention on the Rights of the Child* (UN Resolution 44/25). Article 24 reveals agreement by Member States, including Australia, to provide information and support for breastfeeding	**30 July-01 August:** Breastfeeding into the 1990s: A Global Initiative, Florence, Italy. Adoption of the *Innocenti Declaration on the protection promotion and support of breastfeeding*. Endorsed by the World Health Assembly (which includes Australia) and Executive Board of UNICEF providing increased status. The "*Ten Steps to Successful Breastfeeding*" are embedded in policy **30 September:** World Summit for Children held at the United Nations. Adoption of the *World Declaration on the Survival, Protection and Development of Children* and a related *Plan of Action*. Point 3 of 'The Commitment' clearly states breastfeeding will be promoted	**14 February:** World Alliance of Breastfeeding Action (WABA) formed with the purpose of achieving the *Innocenti Declaration's* operational targets **15 May:** WHA 44.33 request to UNICEF's Director General to accelerate planned implementation actions following on from the World Summit for Children **June:** Operational launch of the WHO/UNICEF Baby-Friendly Hospital Initiative and field testing begins **30 August:** Joint WHO-UNICEF letter to all Heads of state/Government, on the Baby Friendly Hospital Initiative (BFHI) **26 September:** Official letter to all UNICEF offices informing and advising of BFHI implementation **30 December**: Executive Directive to all offices providing further information, goals, objectives and guidelines for country-level actions	**February:** Field-testing completed. 52 hospitals in twelve low-income nations designated as 'baby friendly' and 15 received a "*Certificate of Commitment*". Wellstart International hold UNICEF sponsored "Master Trainer/ Assessor" workshop in San Diego with representatives from 24 countries, including Australia **March:** Official global launch of the WHO/UNICEF Baby-Friendly Hospital Initiative **1-7 August**: WABA "World Breastfeeding Week" observed for the first time, celebrating the anniversary of the *Innocenti Declaration*

Table I: Timeline of the international Declarations, decisions and actions preceding (and including) the global launch of the Baby Friendly Hospital Initiative

1992	1993	1994	1995
UNICEF: (By December) ✦ Perform baseline survey to identify country-level goals. ✦ Identify a national BFHI body. Distribute hospital self –appraisal. ✦ Assess hospital conformity with assessment criteria. Identify first and second tier hospitals, a lead BFHI training facility, develop training strategy. ✦ Coordinate on-site appraisals. Award BFHI achievement awards and certificates of commitment.	✦ Hand over BFHI to government/national body. ✦ Continue representation on national body.		
Australia: ✧ *February*: Australian representative attends Wellstart Int. BFHI Master Trainer/Assessor workshop in USA ✧ *April*: UNICEF hosts preliminary meeting (Melbourne). Formation of National Consultative Group (NCG) and Taskforce to develop implementation strategies. ✧ *May*: The Marketing in Australia of Infant Formulas (MAIF): Manufacturers and Importers Agreement signed and ratified by the Federal govt. ✧ *September*: Adaptation of global documents. Field-testing at a Melbourne hospital.	✧ *February*: "BFHI in Australia and New Zealand": an invitation-only free workshop to introduce the BFHI to key stakeholders held in Melbourne. ✧ *April*: UNICEF Australia dissolves NCG and Taskforce → National Steering Group (NSG). ✧ *August*: First 'Certificate of Commitment' awarded (Royal Women's Hospital, Melbourne). ✧ *October*: UNICEF Australia provides part-time secretariat support in the form of a Program Manager. Work demands soon outstrip capacity.	✧ *March*: First successful hospital accreditation (Mitcham Private Hospital, Melbourne). ✧ *April*: Formal commitment from every state and territory to establish a BFHI (State) Committee. ✧ *September*: Second successful accreditation (Royal Women's Hospital, Melbourne).	✧ *January*: Review of BFHI by UNICEF Australia (external process). ✧ *February*: UNICEF Australia decision to cease BFHI governance. Call for tenders for successor body. Funding agreement identified. ✧ *July*: Expressions of interest received. ✧ *August*: Australian College of Midwives (ACM) announced as successor body. ✧ *November*: Responsibility transferred to ACM (minus funding). UNICEF Australia withdraws from any further Committee representation.

Table II: UNICEF International recommended and Australian actual implementation timeline