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Review article

Applying a knowledge translation model to the uptake of the Baby Friendly Health Initiative in the Australian health care system

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ABSTRACT

Background: The Baby Friendly Hospital Initiative is a global, evidence-based, public health initiative. The evidence underpinning the Initiative supports practices promoting the initiation and maintenance of breastfeeding and encourages women's informed infant feeding decisions. In Australia, where the Initiative is known as the Baby Friendly Health Initiative (BFHI) the translation of evidence into practice has not been uniform, as demonstrated by a varying number of maternity facilities in each State and Territory currently accredited as 'baby friendly'. This variance has persisted regardless of BFHI implementation in Australia gaining 'in principle' support at a national and governmental level as well as inclusion in health policy in several states. There are many stakeholders that exert an influence on policy development and health care practices.
Aim: Identify a theory and model to examine where and how barriers occur in the gap between evidence and practice in the uptake of the BFHI in Australia.
Results: Knowledge translation theory and the research to practice pipeline model are used to examine the identified barriers to BFHI implementation and accreditation in Australia.
Conclusion: Australian and international studies have identified similar issues that have either enabled implementation of the BFHI or acted as a barrier. Knowledge translation theory and the research to practice pipeline model is of practical value to examine barriers. Recommendations in the form of specific targeted strategies to facilitate knowledge transfer and supportive practices into the Australian health care system and current midwifery practice are included.

What is already known on the subject:

- The full range of breastfeeding support nationally in Australian maternity facilities is unknown.
- Organisational and individual attitudinal barriers to implementation and accreditation of BFHI have been identified.

What this paper adds:

- A conceptual model utilising knowledge translation theory provides a structured framework for the translation of knowledge into the Australian health care system and midwifery practice with regards to BFHI implementation and accreditation.
- Recommendations arising from the conceptual model may lead to higher levels of implementation of the 'Ten Steps' and BFHI accreditation.

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1. Introduction

Protecting, promoting and supporting breastfeeding is an important public health strategy. There is international evidence that implementation of the global strategy known as the Baby Friendly Hospital Initiative and accreditation of maternity facilities as 'baby friendly' has positively influenced breastfeeding initiation and short-term duration.[1,2]

In Australia the Initiative changed its name in 2006 to demonstrate its inclusion of the community and is now known as the Baby Friendly Health Initiative (BFHI). Implementation of the Initiative in maternity facilities has been variable indicating an evidence-practice gap at all levels of the health care system. Although the Initiative is supported 'in principle' in Australia, studies have identified organisational and cultural barriers to implementation.[3] Barriers include a lack of policy support and funding as well as a misunderstanding of the aims and outcomes of the Initiative. This theoretical paper seeks to provide a model for understanding the issues influencing the translation of knowledge into the Australian health care system and midwifery practice with regards to BFHI implementation.

This paper is organised in four sections. A brief description of the BFHI and the evidence supporting its implementation is presented, namely the positive association between the Initiative's practices and breastfeeding prevalence. The BFHI is then situated in the Australian context. Knowledge translation theory is proposed as a means of understanding the issues that influence the translation of knowledge into practice in healthcare. Finally an adaptation of a knowledge translation conceptual framework,[4] which also considers the process of change management is utilised to explore issues that influence the translation of evidence underpinning the BFHI into the Australian healthcare system and midwifery practice. Recommendations in the form of specific targeted strategies to facilitate knowledge transfer and supportive practices into the health care system and current midwifery practice are included.

2. The evidence supporting the implementation of the BFHI

The BFHI is a multifaceted intervention. "The Ten Steps to Successful Breastfeeding"[5] are intended to present the complexities of the strategy in a simple, easy to understand format. Each "step" comprises a minimum quality standard to achieve and maintain. Full implementation is designed to provide a framework for clinical practice and enable a breastfeeding culture in maternity facilities. The expectation is that hospital policies that do not support breastfeeding are replaced with evidence-based strategies to promote best practice and facilitate maternal informed infant feeding decision-making and practices. The anticipated result is an increase in breastfeeding and breastfeeding-related health outcomes at a local and national level.

Impact studies to demonstrate the effectiveness of the Initiative have been undertaken internationally at population, national and local levels. There are a number of complexities in researching infant feeding. The sum of research findings however provides enough weight of evidence to strongly suggest an ongoing positive relationship between the Initiative, changes in practice and breastfeeding prevalence.[6] When added to the well documented health outcomes BFHI implementation and accreditation is a desirable strategy for policy makers and health service managers to actively pursue and implement.

The evidence supporting the benefits of implementing the BFHI has been drawn from a single large randomised controlled trial (the PROBIT study). The PROBIT study[7] minimised multiple sources of potential bias to provide robust evidence of the impact of the Initiative with follow-up data on breastfeeding and health outcomes. This study, together with two large systematic reviews and meta-analyses of many small, individual studies of breastfeeding have established there are clinically and statistically significant health benefits for breasteeding.[8,9]

The World Health Organization (WHO) has made strong recommendations for exclusive breastfeeding for the first six months of life followed by continued breastfeeding (with the addition of nutritious family foods) until well into the second year or beyond.[10] In Australia, despite national health policy endorsement[11] the WHO recommendations are not being met.[12] One reason may be that commercially produced artificial baby milks have been identified as being an attractive or at least a comparable alternative to breastfeeding. The marketing practices of the breastmilk substitute industry promote and maintain a high public opinion of their products[13] and encourage uncritical acceptance of their health statements.[14,15] Therefore the efficacy of the voluntary regulation to protect breastfeeding that currently exists in Australia is questionable.[16] Since infant feeding is highly emotive and contextualised for each woman and her family, women turn to midwives for advice and support with their decisions and practice. However it is clear that midwives are also subject to situational influences. It is within this context that the Baby Friendly Health Initiative in Australia is operationalised.

3. The Baby Friendly Health Initiative in Australia

The Initiative in Australia is supported 'in principle' at a national level.[11] BFHI implementation is also encouraged through its inclusion in health policy in several states. Similar to other middle and high-income nations[17] accreditation of Australian facilities has been protracted and implementation varied. Currently 74 or approximately 19% of the 394 maternity facilities in Australia are accredited as 'baby friendly'.[18] The number of maternity facilities applying for re-accreditation appears to outnumber those seeking accreditation for the first time.

Currently it is not possible to determine the extent to which a consistent standard of BFHI practices is provided across Australia, irrespective of accreditation status.[19] Published data on implementation are found in the Victorian maternity service performance indicators.[20] The internal audit process and report indicates a high level of implementation is achieved in the majority of Victorian maternity facilities. If researchers, policy makers and health service managers are unable to determine the degree of impact of the BFHI in Australia this may further hamper its uptake. What is apparent is the existence of a gap between the international evidence supporting the Initiative's implementation and its integration into Australian practice. In order to increase our understanding of why the gap exists and how to address it the following section examines the problems associated with, and barriers to, the translation of evidence into practice.

4. How does evidence translate into practice in healthcare settings?

The aim of evidence-based practice is to provide clinicians and patients with choices about the most effective care based on the best available evidence. However, a gap exists between acquired knowledge and actual practice. The progress of adopting evidence-based therapies and implementation of guidelines has been described as both slow and random.[21] Results of the ensuing gap are poorer health outcomes, health inequalities and wasted time and money.[22] Both time and resources have been invested in studies attempting to ascertain why the introduction of new technologies and practices are not readily integrated into the practice of most workers.[23] To successfully introduce a new innovation that involves practice change, strategies that address