Examining the Application and Use of the Baby-Friendly Initiative within Rural and Urban Health Facilities in Canada among Indigenous Mothers

by

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A thesis

presented to the University of Waterloo

in fulfillment of the

thesis requirement for the degree of

Master of Science

in

Public Health Sciences

Waterloo, Ontario, Canada 2023

Author's Declaration

This thesis consists of material all of which I authored or co-authored: see Statement of Contributions included in the thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners. I understand that my thesis may be made electronically available to the public.

Statement of contributions

I, Meagan Bacciaglia, was the sole author on all the chapters written within this thesis. Dr. Elena Neiterman and Dr. Warren Dodd are members of the thesis committee, and assisted with the overall study design, as well as reviewed and revised the final thesis content.

Dr. Hannah Neufeld as the supervisor on this thesis, had a large contribution on every aspect of the research. Dr. Neufeld assisted with the creation of the research questions, study design, interview guides, selection of the theoretical frameworks, assisted with making connections with potential research participants, along with revising the final thesis content.

Abstract

Background: To prevent infant mortality and morbidity, WHO and UNICEF established the Baby-Friendly Hospital Initiative (BFHI) to support breastfeeding initiation and duration by improving the quality of care provided in health facilities globally. Indigenous communities across the world report lower breastfeeding rates compared to non-Indigenous populations. There is very limited research surrounding the implementation of the BFI (Baby-Friendly Initiative) within Canada to support Indigenous women.

Research Questions: This study sought to answer: 1) How is the BFI implemented and utilized among health facilities that service Indigenous women in Canada? 2) What is the availability and utilization of the BFI among Indigenous women? 3) Are there differences in the uptake of the BFI between rural and urban health facilities?

Methods: Qualitative methodologies and methods, including semi-structured interviews, case study research, and document analysis were implemented to examine the experiences of policymakers, health service providers, and health organizations. Seven participants were recruited from international and national health organizations, bodies of the Canadian government, and Canadian health facilities. Inuvik Regional Hospital and Grey Nuns Hospital were reviewed as the case studies through using documentary analysis. The Interactive Theory of Breastfeeding was used to inform the study design and frame the results.

Results: A conceptual model utilizing the social-ecological framework was created to expand the Interactive Theory of Breastfeeding, and contextualize the participant experiences of implementing the BFI, decisions to breastfeed, and the cultural appropriateness of the BFI for Indigenous women. Through the adapted model, a unique contribution includes the incorporation

of Indigenous traditions and context. Previous models have not specifically examined policy and environmental influences relating to breastfeeding and Indigenous women within Canada.

Conclusion: There is an opportunity for the BFI to be a culturally appropriate initiative for Indigenous mothers if the facility/health center implementing the initiative understands and incorporates the local context at a variety of levels, including interpersonal, organizational, and in the environment and policy layers. Collaborating with key stakeholders and the community is one method to understand and incorporate local context. The BFI as a stand-alone initiative is not culturally appropriate, and steps need to be completed to ensure that during implementation there is a focus on empowering women with education and informed choice in their infant feeding decisions. There are a variety of factors that influence an Indigenous women's decision to breastfeed, and there is a need for culturally appropriate and gender inclusive educational materials, supports, and health services to be available.

Acknowledgments

Dr. Neufeld, thank you for your continued and unwavering support throughout this process. It's hard to place into words the gratitude and appreciation I have for your guidance and help over the last few years. Your kindness, patience, and encouragement kept me feeling motivated and inspired throughout the duration of the program. Thank you for always offering a listening ear and being available to brainstorm ideas, discuss research directions, and explore different avenues. I've truly enjoyed exploring this research topic with you and will carry the lessons you've taught me forward in my academic journey. I am extremely grateful for my committee members, Dr. Dodd and Dr. Neiterman. Thank you for participating in my research journey and providing your guidance and direction. It was an honor to learn from you both.

I am immensely grateful for my friends and family and their support over the past few years. My grandparents, Nelson, Velma, Doris, and Robert taught me at a young age the importance of critical thinking and asking the question why. Thank you for being a sounding board throughout my research process, and always listening and asking questions about my research topic. To my partner Matt, thank you for offering an ongoing, tremendous amount of support and confidence. I appreciate your willingness to listen to my presentations, and review conference posters. To my mother Ann, thank you for always lending a listening ear if I wanted to go through my research. Your ongoing love and support have been a staple I am eternally grateful for.

I am grateful for the support I was provided financially through the University of Waterloo Graduate Research Assistantship, and the Global Health Policy and Innovation Research Centre for providing me with the Global Health Policy and Innovation Funding.

Dedication

To my late father, Darin Bacciaglia who instilled in me that there is lightness in every situation and my late uncle, Denis Montgomery who taught me the power of optimism and bravery.

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List of Abbreviations

COVID-19	Coronavirus disease 2019
ITB	Interactive Theory of Breastfeeding
BFHI	Baby-Friendly Hospital Initiative
BFI	Baby-Friendly Initiative
UNICEF	United Nations Children's Fund
WHO	World Health Organization
The Code	International Code of Marketing of Breastmilk Substitutes
UN	United Nations
SIDS	Sudden Infant Death Syndrome
NGO	Non-governmental organization
INFACT	Infant Feeding Action Coalition
SEM	Socio-ecological model
IK	Indigenous Knowledge

Chapter 1: Introduction

1.1 Introduction

Breastfeeding has been shown to provide positive health outcomes in both the mother and infant (WHO, 2021). Despite strong evidence of the benefits, there are still issues with the uptake and support of the initiation of breastfeeding (WHO, 2021). To help promote and support breastfeeding, the World Health Organization (WHO), and the United Nations Children's Fund (UNICEF) released a number of global guidelines on breastfeeding and best practices in infant care, including the International Code of Marketing of Breastmilk Substitutes (the Code) in 1981, a joint statement titled "Protecting, Promoting, and Supporting Breastfeeding" which contained the 10 steps to successful breastfeeding in 1989, the introduction of the Baby-Friendly Hospital Initiative (BFHI), also known as the Baby-Friendly Initiative (BFI) in 1991, and the updated revision of the BFHI in 2018 **(**Aryeetey & Dykes, 2018; WHO & UNICEF, 2009; WHO, 1981).

The international breastfeeding guidelines outline directions for how facilities can provide high quality birthing care and highlight how government and authority bodies can be involved in the process through creating policies on infant feeding, restricting the marketing of breastmilk substitutes, and eliminating the offering of free samples in health facilities (WHO & UNICEF, 2009). The international guidelines highlight that infants should engage in breastfeeding within the first hour of birth (WHO, 2021). Mothers are also encouraged to provide breastmilk exclusively to their infants for the first 6 months of life (UNICEF, 2018). The BFI was created with the intent to increase the quality of postnatal clinical care provided to mothers and infants,

as well as increase breastfeeding support provided during hospital stays (Aryeetey & Dykes, 2018).

Despite the global guidance, breastfeeding rates are still varied across the world, with the lowest rates found within higher resource countries. For example, among lower- and middle-resource countries 4% of infants are not breastfed, however, this number is seen to increase to 21% within higher-resource countries (UNICEF, 2018). The largest variation of breastfeeding is seen within higher-resource countries (UNICEF, 2018). In addition, Indigenous communities across the world report lower breastfeeding rates compared to non-Indigenous populations along with having some of the lowest access to health services (Sheppard et al., 2017).

This thesis aimed to explore why there has been limited uptake in the BFI specifically among health centers providing care to Indigenous mothers primarily within the context of Canada. This research set out to explore whether or not the BFI has been implemented as a culturally appropriate initiative for Indigenous mothers. The study design incorporated semi-structured interviews, case study methodology, and document analysis to better understand how rural and urban health care facilities within Canada progressed in their journey to obtain the BFI designation.

This thesis includes 4 chapters and begins by providing an overview on the global guidance on breastfeeding, history of the BFHI, and present context on breastfeeding among Indigenous communities within Canada. The second chapter explores the methods, and how they were applied in this research. The third chapter focuses on the results and will present an adapted

model of the Interactive Theory of Breastfeeding (ITB) that draws on the social-ecological model of health (SEM). The final chapter of this thesis will present a summary of the findings, recommendations, limitations, and areas of future research.

1.2 Background

Annually, 2.7 million child deaths occur globally due to undernutrition (WHO, 2021). To prevent infant morbidity and mortality due to undernutrition and promote infant and maternal health it is imperative for breastfeeding to be encouraged (WHO, 2021). It is widely reported in the academic literature and in global guidance documents that breastfeeding promotes positive health outcomes in both mother and infant postpartum and later in life (WHO, 2021). However, there are still issues with the uptake and support of the initiation of breastfeeding, as well as increasing breastfeeding duration and exclusivity (Pramono et al., 2021). Despite global guidance that exists on infant and young child feeding, approximately 2 out of 3 infants are not exclusively breastfed for the outlined 6 months[1] (WHO, n.d). Internationally, 3 in every 5 infants do not engage in the early initiation of breastfeeding within the first hour of life [2] (WHO, n.d). If all children between the ages of 0-23 months were breastfed according to the global guidelines, it is estimated that 820,000 children's lives could be saved annually (WHO, 2021).

1.2.1 International Guidance

[1] Global guidance outlines that mothers should exclusively breastfeed their children for the first 6 months of life. By exclusive breastfeeding, the infant's diet is restricted to breastmilk only (WHO, 2021). While engaging in exclusive breastfeeding, the infant's diet should not include water, or any other substance until after the infant reaches 6 months of age (WHO, 2021).

[2] WHO recommends that mothers and infants engage in early and uninterrupted skin-to-skin contact as soon as possible after birth (WHO, 2021). In addition, there should be support provided to mothers to engage in breastfeeding either as soon as possible, or within the first hour after birth (WHO, 2021).

To promote the health of both the infant and the mother, WHO and UNICEF established global guidelines on the marketing of breastmilk substitutes in 1981(Aryeetey & Dykes, 2018) (see figure 1). The guidelines became more specific to the promotion and support of breastfeeding in 1989, with the publication of the "Protecting, Promoting, and Supporting Breastfeeding" statement. Under the statement it is recommended that mothers engage in the early initiation of breastfeeding (Aryeetey & Dykes, 2018). This is when the infant is breastfed within the first hour of birth (WHO, 2021). Mothers are encouraged to breastfeed their infant, without the use of bottles, teats, or pacifiers in the early stages of breastfeeding (WHO, n.d). In addition, mothers are advised to exclusively breastfeed for the first 6 months of life. Uptake of these guidelines is varied. Out of 123 countries, approximately 95% of babies have been fed breastmilk at least once (UNICEF, 2018). Unfortunately, this high rate of breastfeeding is not equally observed across countries or income groups within the same country (UNICEF, 2018). For example, among lower- and middle-resource countries 4% of infants are not breastfed, however, this number increases to 21% within higher-resource countries (UNICEF, 2018). The largest variation of breastfeeding is seen within higher-resource countries. In Sweden, it is reported that almost all infants are breastfed, however, in the United States, it is noted that only 74% of infants are fed breastmilk (UNICEF, 2018). Within countries, breastfeeding rates vary greatly among income levels. For example, within higher-resource countries breastfeeding rates are lower among mothers who have a lower income status (UNICEF, 2018). In addition to income levels, Indigenous status has also been associated with lower breastfeeding rates within Australia, Canada, and the United States (Sheppard et al., 2017). Jaime Cidro, an anthropology professor at the University of Winnipeg, highlights this may be due to a lack of family support and the

experience of discrimination during the birthing process and hospital experience (Cidro et al., 2015).

Figure 1. Timeline of key moments involving International Guidance on Breastfeeding (Aryeetey & Dykes, 2018; WHO & UNICEF, 2009; WHO, 1981)

1.2.1.1 International Code of Marketing of Breastmilk substitutes

WHO and UNICEF published the International Code of Marketing of Breastmilk Substitutes (the Code) in 1981 **(**WHO & UNICEF, 2009; WHO, 1981). The Code aims to restrict the marketing and misleading advertising of infant formula (Appendix A) (WHO & UNICEF, 2009). The goal of the Code is to ensure that breastmilk substitutes are being used properly and safely. The Code outlines that advertising material related to infant feeding and breastmilk substitutes must be clear and free from misinformation (WHO, 1981). Moreover, the Code states that manufacturers and distributors should not provide pregnant women, mothers, or members of their families' samples of products (WHO, 1981). The Code also provides responsibilities for health workers not to promote the use of infant formula feeding (WHO, 1981). On a global scale,

many countries have adopted the principles outlined in the Code. However, Canada, Australia, New Zealand, and the United States have not (WHO et al., 2020).

1.2.1.2 Protecting, Promoting, and Supporting Breastfeeding - The Ten Steps to Successful Breastfeeding

In 1989, WHO and UNICEF acknowledged the benefits of breastfeeding by releasing a joint statement entitled "Protecting, Promoting, and Supporting Breastfeeding" (Aryeetey & Dykes, 2018). Within the statement, UNICEF and WHO outlined the "Ten Steps to Successful Breastfeeding" (Appendix B). In 1991, WHO and UNICEF continued their work on increasing the practice of breastfeeding through the global introduction of the Baby-Friendly Hospital Initiative (BFHI) (Aryeetey & Dykes, 2018). The BFHI was created to increase the quality of clinical care provided to mothers and infants, as well as increase the support provided during the hospital stay (Aryeetey & Dykes, 2018). One component of the BFHI is the promotion of the practice of breastfeeding among mothers and their newborns.

1.2.1.3 Protecting, Promoting and Supporting Breastfeeding in Facilities Providing Maternity and Newborn Services – The Nine Key Responsibilities

In 2015, WHO and UNICEF examined the format of the BFHI and determined it required a restructuring on a national level, directed toward policymakers and governmental bodies (WHO, n.d B). In 2017, WHO released a new guideline titled "Protecting, promoting, and supporting breastfeeding in facilities providing maternity and newborn services", which was incorporated into the BFHI requirements in 2018 (WHO, n.d B). The updated BFHI implementation guide included aspects related to sustainability and the focus on ensuring

universal coverage (WHO, n.d B). Through the updated national BFHI, WHO requested that countries include 9 key responsibilities (in addition to the 10 steps previously outlined and adhering to The Code) in the program implementation (Appendix C).

To reach the goals of the BFHI, WHO and UNICEF encouraged health providers and clinical institutions to provide maternity care that treats mothers and newborns in line with the Ten Steps outlined in the 1989 statement. While the initiative was introduced in 1991, it has had limited implementation within Canada, Australia, and the United States (Pramono et al., 2021; Baby-Friendly USA, n.d; Breastfeeding Committee for Canada, 2021).

For a health center or hospital to receive the Baby-Friendly designation, they must provide maternity services that are in line with the expectations of the Ten Steps (Aryeetey & Dykes, 2018). Moreover, the health center must also act in accordance with the Code (WHO & UNICEF, 2009). The center will start by doing a self-assessment of the care and services provided, if they are eligible for the designation, an external review will then be conducted (Aryeetey & Dykes, 2018). As of 2015, more than 20,000 hospitals across 156 countries have received the Baby-Friendly designation (Pound & Unger, 2015). Unfortunately, it is estimated that only 10% of children globally are born within health centers that have received the Baby-Friendly designation (Aryeetey & Dykes, 2018).

1.2.2 Baby-Friendly Hospital Initiative on a Global Scale

WHO released a report in 2017 that examined how the BFHI was implemented on a global scale and indicated that only around 13% of births within the Americas occurred in a center that held

the Baby-Friendly designation (WHO, 2017). The highest percentage of births occurring in designated centers was in Europe, with approximately 36% of births occurring in Baby-Friendly facilities, although there is a range reported across countries (WHO, 2017). In Albania for example, 80.4% of births occur in designated hospitals, compared to only 9.4% reported in Belgium (WHO, 2017). The number of facilities receiving the Baby-Friendly designation varies significantly across regions of the world. For example, the United States currently has 590 Baby-Friendly facilities that provide care and services to 1,060,309 mothers and babies annually (Baby-Friendly USA, n.d), while Cuba has 49 designated Baby-Friendly maternity facilities (Pound & Unger, 2015).

A report completed by WHO and UNICEF in 2020 reviewed the implementation of the Code among 194 countries and found that 136 countries have created legal policies, regulations, or legislation in accordance with the Code (UNICEF, 2020). However, it was found that the level of coverage within these legal measures greatly varies across countries (UNICEF, 2020). Only 19 countries discuss restricting the sponsorships from companies selling breastmilk substitutes during meetings with health professionals (UNICEF, 2020). Moreover, 51 countries have reported creating regulations surrounding the restriction of providing supplies, such as formula at either low cost or free in health facilities (UNICEF, 2020). To promote the principles outlined in the Code, it is necessary for parents to be protected from manipulation from company advertisements and misleading health providers (WHO et al., 2020). Canada, New Zealand, Australia, and the United States have no legal measures implemented in response to the principles outlined in the Code (WHO et al., 2020). While Canada does not explicitly adhere to

the Code, it does have some governmental measures in place, which will be discussed later in this thesis.

1.2.3 Baby-Friendly Hospital Initiative and Indigenous Communities

Indigenous communities across the world report lower breastfeeding rates compared to non-Indigenous populations along with having some of the lowest access to health services (Sheppard et al., 2017). Within Canada, the breastfeeding rate among non-Indigenous mothers is 88.0%, however, among Indigenous communities, the breastfeeding rate is 77.8% (Romano et al., 2019). Moreover, the rate of exclusive breastfeeding is lower among Indigenous populations in Canada compared to non-Indigenous populations. For non-Indigenous mothers, the rate of exclusive breastfeeding for up to 6 months is 26.7%, while the rate for Indigenous mothers is 16.5% (Romano et al., 2019). This difference is problematic since breastfeeding decreases the risk of the infant developing infections and chronic disease conditions (Romano et al., 2019). In addition, mothers also experience health benefits from engaging in breastfeeding. Mothers who breastfeed are seen to decrease their risk of developing both ovarian and breast cancers (Romano et al., 2019).

Unfortunately, the resources and efforts put forward to implement the BFHI have overlooked Indigenous communities. The literature that has been published on the BFHI is currently lacking research on the progress of the BFHI implementation for Indigenous women in these higher-resource colonized nations. As such, this research aimed to examine how the BFI has been implemented within Indigenous communities in Canada. Colonized nations have historically provided health resources and services disproportionately among Indigenous women compared

to non-Indigenous women (Smylie et al., 2010). Through processes of colonization, there has been a loss of culture among Indigenous Peoples, and a history of targeted discrimination and violence (Cooke et al., 2007). Indigenous mothers and their children experience more adverse health outcomes compared to the general population (Sheppard et al., 2017). Canada does not provide adequate health services and resources to Indigenous mothers and infants (Smylie et al., 2010). Moreover, in Canada, Indigenous populations have lower levels of access to health services due to structural issues such as confusion with jurisdictional health service provisions, and a lack of funding and dedication of resources (Gardiner-Garden & Dow, 2014).

Infants who are exclusively breastfed are seen to have a decreased risk of developing a range of life-threatening diseases, infections, and chronic conditions including respiratory tract infections, obesity, type two diabetes, diarrhea, bacterial meningitis, and urinary tract infections (Romano et al., 2019; Pound & Unger, 2015). Prior studies have revealed that formula-fed infants are at an increased risk of developing more severe respiratory illness compared to infants who were exposed to exclusive breastfeeding (Pound & Unger, 2015). Breastfeeding has also been shown to decrease the risk of sudden infant death syndrome (Pound & Unger, 2015). Moreover, formula-fed infants also face an increased risk of developing gastrointestinal illness (Koopman et al., 1985). A study conducted on infant formula use and the occurrence of gastrointestinal illness revealed that infants who received formula were at a 6 times greater risk of developing an acute gastrointestinal illness, compared to infants who ingested breastmilk (Koopman et al., 1985). In addition to acute gastrointestinal illness, formula-fed infants face the risk of developing deadly diarrheal illness due to exposure to unhygienic and contaminated water sources (Marino, 2007). When an infant is formula fed, sometimes the formula requires the addition of water, the bottle

and the bottles teat also must be washed prior to being used (Marino, 2007). If contaminated water is used throughout this process, the infant's risk of developing diarrhea doubles (Marino, 2007). The concern of the use of unhygienic water in the preparation of infant formula is greatly justified within Indigenous reserves due to the lack of availability of clean water (Bradford et al., 2016). Among Indigenous communities, waterborne infections occur more commonly compared to the national average (Bradford et al., 2016). Moreover, 30% of Indigenous community water systems have been deemed "high risk", with 138 drinking water advisories in 94 First Nations communities (excluding British Columbia) (Bradford et al., 2016). The lack of availability to access clean water is problematic overall but can be deadly when infants are formula fed.

In addition to infant health benefits, mothers also experience positive health outcomes from engaging in breastfeeding. The practice of breastfeeding has been shown to decrease the incidence of ovarian cancer and breast cancer (Pound & Unger, 2015). For each year of lactation, women who practice breastfeeding reduce their risk of breast cancer by 4% (Marinelli et al., 2019). The risk of ovarian cancer is seen to decrease by 24% (Marinelli et al., 2019). Breastfeeding has also been shown to help with postpartum weight loss (Pound & Unger, 2015). Moreover, breastfeeding promotes the strengthening of a social connection between the mother and the infant (Public Health Agency of Canada, 2022). The action of breastfeeding involves skin-to-skin contact between the infant and the mother. This physical connection can help promote physical and emotional bonding between the pair (Cleveland Clinic, n.d). The process of breastfeeding can also improve maternal self-efficacy, as breastfeeding can promote the regulation of sleeping patterns for the infant and the mother (Rivi et al., 2020).

1.3 Study Context

1.3.1 Indigenous Maternal Health within Canada

When examining the maternal health outcomes in Canada among Indigenous women, compared to non-Indigenous women, there are clear differences in the results. Indigenous women within Canada report having more negative health outcomes after giving birth (Sheppard et al., 2017). Indigenous pregnant women tend to be younger, have fewer educational opportunities, and less reliable access to prenatal care compared to non-Indigenous women (Sheppard et al., 2017). Infant mortality rates are twice as high (Sheppard et al., 2017). The occurrence of sudden infant death syndrome (SIDS) is reported to be more than 7 times higher among Indigenous infants, compared to non-Indigenous infants (Sheppard et al., 2017). In non-Indigenous groups, SIDS accounts for approximately 7% of infant deaths (Sheppard et al., 2017). However, this number drastically increases when examining Indigenous populations. It was reported that 24% of First Nations infant deaths and 21% of Inuit infant deaths were due to SIDS (Sheppard et al., 2017).

Indigenous infants are less likely to be breastfed compared to non-Indigenous infants (Romano et al., 2019). In Canada, approximately 88.0% of women initiate breastfeeding, however, this percentage is seen to decrease to 77.8% when examining breastfeeding initiation rates among Indigenous mothers (Romano et al., 2019). While WHO recommends that children be exclusively breastfed for the first 6 months, this does not appear to be the common trend in Canada, with 16.5% of Indigenous women practicing exclusive breastfeeding for up to 6 months, while the rate among non-Indigenous mothers is 26.7% (Romano et al., 2019).

It is important to note that the health disparities being experienced by Indigenous women go beyond health behaviours and are rooted in the history of colonization and collective experiences of intergenerational trauma (Sheppard et al., 2017). It is essential that Canada acknowledges and recognizes the ongoing impacts and the lingering effects of colonization on the physical, mental, spiritual, and emotional health of Indigenous women and their families (Sheppard et al., 2017). There is an urgent need for additional resources, funding, and support to be provided to Indigenous mothers within Canada. The BFI provides an opportunity to ensure that mother-centered care, resources, knowledge, and training are provided to Indigenous mothers. This additional support can help improve infant and maternal health outcomes among Indigenous mothers by empowering them to make informed decisions on their care and feeding practices.

1.3.2 The Baby Friendly Initiative

Within Canada, the national average breastfeeding rate is 88.0% (Romano et al., 2019). However, the breastfeeding initiation rates range across the provinces. In Prince Edward Island, the breastfeeding rate is approximately 72.2% (Chalmers, 2013). The national average for women who exclusively breastfeed for 6 months is only 26.7% (Romano et al., 2019). The 6-month exclusive breastfeeding rate also greatly ranges across provinces with 5.8% in Newfoundland and Labrador, to 34.2% in the Yukon (Chalmers, 2013). The vast difference in breastfeeding rates is proposed to be due to differences in resources, training, and institutional practices (Chalmers, 2013). Some health facilities, for example, may promote the use of infant formula for feeding. A study published in 2013 revealed that in Ontario, it was found that some hospitals were providing mothers with a public health document that encouraged formula feeding for children during the first 6 months of life (Chalmers, 2013). This action directly violates the

rules established in the Code. The Canadian Hospital Maternity Policies and Practices Survey reported that in 2007, 68% of hospitals examined held exclusive contracts with formula companies (Public Health Agency of Canada, 2012).

Canada does not currently have any binding regulations, legislation, or policy that outlines a legal requirement and responsibility for health facilities, companies, and health professionals to adhere to the Code. Instead, Canada has the Competition Act, as well as sections B.25.061 (2), B.01.503 (2), B.01.601 (1) (i) of the Food and Drug Act (INFACT, n.d). The purpose of the Competition Act is to create restrictions within marketing practices and outline that companies may not advertise misleading information (INFACT, n.d). If companies are found to violate the Competition Act, they can be fined up to $1,000,000 (INFACT, n.d). The policies and acts implemented within Canada are problematic as they are not comprehensive. Current Canadian policies permit violations of the Code to occur and mothers to receive breastmilk substitute advertisements, as well as samples from health providers (Monsebraaten & Javed, 2010**)**. According to a Toronto Public Health report, 40% of new mothers leave the hospital with free infant formula (Monsebraaten & Javed, 2010). On paper, the current policies restrict marketing practices and limit the spread of misinformation, however, some health facilities and health providers are still advertising and encouraging breastmilk substitutes (Chalmers, 2013). In an interview with a news outlet, Linda Young, the director of maternal newborn and child health at Michael Garron Hospital, reported that “strains on health care budgets have led health care facilities to depend on formula company donations as though there are no alternatives” (Monsebraaten & Javed, 2010). In this same article, Younge shares that hospitals may be provided a signing bonus between $130,000 and $150,000 when they sign contracts with formula

companies (Monsebraaten & Javed, 2010). The financial incentive is a possible reason why health providers continue to provide free samples to mothers in Canadian hospitals. In Canada, the implementation of the BFI has been limited, with 153 facilities holding the Baby-Friendly designation throughout the country (Haiek, 2021) (See table 1). As of 2021, Canada has 1,300 hospitals throughout the country, however the total number of health facilities is unavailable (Michas, 2022).

The Breastfeeding Committee for Canada is responsible for monitoring the implementation of the BFI. However, each province or territory also has its own specific breastfeeding committee for its region. For example, in British Columbia, the BC Baby-Friendly network aims to increase breastfeeding by supporting the implementation efforts of the BFI (BC Baby-Friendly Network, 2021). The network in British Columbia was created by the BC Minister of Children and Families in 1991 (BC Baby-Friendly Network, 2021). The BC Baby-Friendly network is made up of health providers, representatives of the ministry, as well as advocates interested in the promotion and protection of breastfeeding (BC Baby-Friendly Network, n.d).

The Infant Feeding Action Coalition (INFACT) is a non-governmental organization (NGO) that monitors companies and organizations that violate the Code in Canada and internationally (INFACT, n.d). However, upon examination, this organization has not recently posted any updated information on its website and does not provide any indication that they are still actively publishing Code violations. A document published by INFACT recommends that Canada must apply pressure on industries that do not comply with the principles of the Code and implement legal action to deter future violations (INFACT, n.d). Moreover, they suggest that governmental

agencies must enforce marketing regulations to ensure that manipulative advertisements and marketing are not influencing and misleading mothers (INFACT, n.d).

Table 1. Breakdown of BFI designated facilities in Canada

Province/ Territory	**Number of Facilities with BFI designation**	**Location of facilities**
Alberta	4 (Appendix D)	West Edmonton, High River, South East Edmonton, Bonnyville (Haiek, 2021)
British Columbia	3 (Appendix E)	Vancouver, Maple Ridge, Chilliwack (Haiek, 2021)
Manitoba	4 (Appendix F)	Steinbach, The Pas, Thompson (Haiek, 2021)
New Brunswick	0	N/a (Haiek, 2021)
Newfoundland and Labrador	1 (Appendix G)	Labrador City (Haiek, 2021)
Northwest Territories	1 (Appendix H)	Inuvik (Haiek, 2021)
Nova Scotia	2 (Appendix I)	New Glasgow, Halifax (Haiek, 2021)
Nunavut	0	N/A
Ontario	30 (Appendix J)	Hamilton, Toronto, Mississauga, Ottawa, Owen Sound, Palmerston, Mount Forest, Oakville, Sault. Ste Marie, Chatham, North Bay, Kingston, Waterloo, New Market, Clinton, Pembroke, Rockland, Sudbury, New Liskeard, St. Jacobs, Barrie, Windsor, Cambridge, Simcoe, Brockville, and Port Hope (Haiek, 2021)
Prince Edward Island	0	N/A
Quebec	107 (Appendix K)	Bas-Saint-Laurent region, Capitale- Nationale region,

		Mauricie, Centre-du-Quebec Region, Outauais Region, and Chaudiere - Appalaches region, Estrie region, Montreal region, Laurentians region, Monteregie region (Haiek, 2021).
Saskatchewan	1 (Appendix L)	Saskatoon (Haiek, 2021).
Yukon	0	N/A

1.3.3 Study Rationale

There is very limited research examining the implementation of the BFI among rural, and remote facilities, compared to the strategies deployed in health facilities located in large cities. Moreover, there is also very limited research looking at how the BFHI has been implemented and utilized among health facilities that provide care to Indigenous mothers. From the minimal research published, there is limited number of Baby-Friendly designated facilities within rural, and remote facilities. Moreover, this research aimed to address this research gap and highlight the present situation surrounding the application and utilization of Baby-Friendly designated services among Indigenous mothers in Canada.

The overall aim of this research was to explore the barriers, challenges, and experiences of policymakers and health providers in the implementation of the BFI among Indigenous women within Canada. The study objectives were to explore and understand the experiences and barriers for BFI implementation through using the Interactive Theory of Breastfeeding (ITB). This study sought to explore the following research questions within the Canadian context: 1) How is the BFI implemented and utilized among health facilities that service Indigenous women? 2) What is

the availability and utilization of the BFI among Indigenous women? 3) Are there differences in the uptake of the BFI between rural and urban health facilities.

Chapter 2: Methods

2.1 Study Design

To investigate this under-researched topic, qualitative research methods have been selected. Specifically, semi-structured interviews, case study research, and document analysis. Qualitative research methods were utilized to gain a deeper understanding of a participants' experiences and explore research questions aimed to address research gaps in the literature and research using "how" and "why" questions (Cleland, 2017). Moreover, the research aimed to explore participant experiences and analyze inductive reasoning and evaluate interpretations (Harrison et al., 2017). Semi-structured interviews were selected as one of the methods of data collection, as it allows for participants to discuss their experiences, beliefs, and attitudes with the topic being examined (DeJonckheere & Vaughn, 2019). Semi-structured interviews allow for participants to discuss topics that deviate from the questions and prompts being asked, allowing for researchers to uncover additional codes and themes that were not originally anticipated (DeJonckheere & Vaughn, 2019).

Given the challenges of engagement due to the public health restrictions associated with the COVID-19 pandemic, in addition to semi-structured interviews, the study incorporated document analysis. Document analysis provides a method to systematically examine and explore content provided in publicly available documents (Bowen, 2009). Glenn Bowen (2009), outlines that there are five specific functions that the document material can play throughout the research process. Firstly, documents can provide context and background information on where participants and programs operate (Bowen, 2009). The second function of the document is to suggest gaps in the current research and highlight future research areas (Bowen, 2009). The third function is to provide additional research data which can aid in the overall results (Bowen,

2009). The fourth function is to review the changes that have been made over time within the documents, as these details can highlight important shifts in priorities (Bowen, 2009). The final function is to use documents to verify findings that have been uncovered through other sources (Bowen, 2009).

Document analysis was selected for this research since this method can help the process of triangulation and provide context on situations where interviews or field observations cannot be conducted (Bowen, 2009). Triangulation is the process of combining methods to improve the credibility of the results (Bowen, 2009). Triangulation is an important process as it allows researchers to relate findings across different sources and determine credibility, gaps, and help reduce the bias that may be present with the examination of one source of the data set (Bowen, 2009). Overall, through engaging in triangulation, the results from this research will have more credibility and a stronger context. Document analysis is commonly used in partnership with an additional qualitative research method, in the case of this research, this is appropriate as the primary source of data is the content provided in the semi-structured interviews.

A case study research design was utilized to explore the experiences of policymakers, health service providers, and health organizations in implementing the BFHI in maternal health facilities servicing Indigenous women. Case study methodology was selected as it aims to examine issues that occur within real-life settings (Harrison, et al., 2017). Case study research involves researchers exploring a chosen case, or multiple cases (Harrison, et al., 2017). The case studies are examined through detailed data collection which includes a variety of sources of information, including but not limited to observations, interviews, documents, and reports

(Harrison, et al., 2017). Through examining case studies, the researchers can create a case description and case-based themes (Harrison, et al., 2017). By utilizing case studies on this topic, I gained an understanding of the situation examined and the associated behaviors, attitudes, and practices, and provided context to understand relationships related to breastfeeding practice and health care provision across contexts and geographics (Harrison, et al., 2017). Case study methodologies have been used to explore research either on Indigenous topics or with Indigenous participants. In most of the published literature, case study research is used for cross-community analysis, where the researchers are comparing the health status of Indigenous communities compared to non-Indigenous communities across different geographical locations (Lemchuk-Favel & Jock, 2004). Case study analysis has also been used to explore research and its [research] relationship with Indigenous cultures (Vakalahi & Ihara, 2011).

The cases selected for this research fall directly in line with the research questions and objectives, as the selected case studies are examining facilities that have the Baby-friendly designation and provide care to Indigenous mothers. There is very limited research surrounding the implementation of the BFI within Indigenous communities and the use of the program by Indigenous women, the cases present important data on geography and the health services available across different contexts. For the locations where the information was lacking with Indigenous populations, large urban hospitals in city settings were selected. These larger institutions tend to have significant resources that could have been dedicated to the implementation of the project, and as such, allows the health facility to be in a unique position compared to other health facilities in the country. Larger hospitals are expected to have more financial resources, as well as more staff that can be dedicated to providing care and program

support implementing the BFHI. Including large hospitals in the case studies allowed for comparisons to be drawn on the availability of resources among hospitals and health facilities within large, urban locations, compared to what is available in rural, remote facilities to Indigenous women and their families.

2.1.1 Reflectivity and Positionality

When examining research conducted, it is important to evaluate the positionality of the researcher. Through positionality, the researcher has to examine their individual worldview, and the perspectives and practices they implement in their research in the current social and political context (Holmes, 2020). Using the positionality process, the researcher must examine three areas, including the subject under investigation, the research participants, and the research context and process (Holmes, 2020).

Throughout the process of engaging in this research, it was important to reflect on my identity. I am a white female that has not experienced the effects of colonization, racism, or discrimination. Being an outsider to Indigenous culture is something I continuously reflected on throughout this process. I strongly respect Indigenous cultures and traditions and have reflected on my personal feelings and assumptions throughout the entirety of this research. It is incredibly important that any unconscious biases are addressed and uncovered throughout this process to ensure that the information provided by the participants is showcased in an accurate light. To do so, I have read through the results multiple times to ensure that the data is interpreted and presented in an accurate and representative manner. Given the history of how Indigenous communities have been treated in Canada, it is imperative that any research done on the topic is presented in a

culturally sensitive and meaningful manner that recognizes previous and present trauma, discrimination, colonization, and racism. Through the research, I journaled my thoughts, feelings, and perspectives to ensure my opinions and feelings did not influence the interpretation of the results.

I first became interested in the topic of Indigenous maternal health through courses I took during my undergraduate degree. I found it confusing to learn that Indigenous women and their infants experienced increased negative health outcomes compared to non-Indigenous populations. I found it concerning to learn that many of the causes of death, disease, and illness, were entirely preventable with the already existing resources and services in place. This highlighted a large disconnect between Indigenous mothers, service delivery, and utilization of maternal and infant health services, and I was driven to understand why. Through my curiosity on the topic, and discussions with my Master's supervisor, we were able to narrow down the focus of my research to look at the BFI and its application to Indigenous mothers within Canada.

2.1.2 Study Sample

Study participants were employed in the government, BFI-designated health facilities and/or community organizations. They were based in Canada or could speak to BFHI on an international scale. Participants therefore either had a strong knowledge of the BFHI at a policy or community organization level or provided maternal care in practice. This was to ensure that the participants had the relevant knowledge and/or experience to answer the questions posed. The final study sample included 7 individuals.

With the exception of one participant, all resided in Canada and had knowledge of the Canadian context. Study participants had diverse occupational backgrounds and were located in different geographical areas to approach the research questions from a range of perspectives. I aimed to understand, for example, how the perspectives of a policy worker may be different from someone providing BFI care in practice. Case study research was used to provide insight on implementing the BFI at an urban health facility and rural health location. The case studies selected for this research included Grey Nuns Hospital located in Edmonton, Alberta, and Inuvik Regional Hospital located in the town of Inuvik in the Northwest Territories.

Grey Nuns Hospital was selected as the case study to represent the urban health facility as it received the Baby-Friendly designation in 2017 and is the largest full-service hospital to receive the designation in Canada. Therefore, it was anticipated that the information provided through this case study would provide insight on the experience of a hospital with a large number of staff and resources available. Moreover, the hospital is located in Edmonton, where approximately 5.8% (58,165) of the population identifies as Indigenous (Government of Canada, 2022).

Inuvik Regional Hospital was selected to be the case study to represent the rural health facility as it was the first hospital in the Northwest Territories to receive the Baby-Friendly designation. With 51 beds, the Inuvik regional hospital is small, and it was assumed the facility has fewer resources and staff compared to a hospital located in a large urban location (Health and Social Services Authority, n.d). Moreover, the Northwest Territories has a large Indigenous population to similarly provide insights on providing care to Indigenous mothers (Government of Canada, 2022 B).

2.1.3 Theoretical Framing - Interactive Theory of Breastfeeding

The Interactive Theory of Breastfeeding (ITB) was used as a theoretical framework to help guide the study design, act as a lens to approach and frame the research results. The aim of this theory is to contextualize factors affecting breastfeeding to describe, explain, predict, and prescribe breastfeeding practices (Primo & Brandão, 2017). The ITB was created from the foundations of the King's Conceptual system that includes three interactive systems (Primo & Brandão, 2017). The first system is the personal system, under this category, there are seven aspects examined, including perception, self, body image, growth, development, time, and space (Primo & Brandão, 2017). The second focus is geared toward the interpersonal system, this includes human beings who communicate within the system and the role they play (Primo & Brandão, 2017). Lastly, the social system is explored. A person's social system consists of a combination of interpersonal systems that include concepts such as organization, power, authority, decision-making, and status (Primo & Brandão, 2017).

The goal of the ITB is to assist in contextualizing the phenomenon of breastfeeding and explain why it occurs including examining factors that are present before and during the breastfeeding process (Primo & Brandão, 2017). The theory aims to explore breastfeeding factors by creating a range of theoretical concepts that are deemed important to the breastfeeding process (Primo & Brandão, 2017). According to the theory, the factors influencing breastfeeding include a variety of considerations, including and extending beyond the mother-child dynamic, women's biological conditions, perceptions of breastfeeding, as well as time, and space (Primo & Brandão, 2017). Drawing from King's Conceptual System, the ITB has a similar outline of interactive systems. However, the format of the model was altered by Primo and Brandão (2017).

In the outer circle (see Figure 2), the system focuses on the mother's role, the space for breastfeeding, the organization system for the protection, promotion, and support, family and social authority, as well as the women's body image (Primo & Brandão, 2017). Moving inwards, the next circle examines women and children's biological conditions, women's and children's perceptions and women's decision-making (Primo & Brandão, 2017). Lastly, the most inward circle discusses the dynamic interaction between mother and child, time of breastfeeding and stress (Primo & Brandão, 2017). While these combined complex considerations are important in predicting the engagement in breastfeeding, the ITB emphasizes that the main barrier to breastfeeding is time and stress (Meyer, 2019).

The theory does not discuss the experience of Indigenous women; however, the model can be used to explore more complex factors or determinants such as the influences of historical trauma on knowledge perceptions and ability (Meyer, 2019). Meyer adapted the ITB to examine the promotion of breastfeeding with Indigenous mothers within the United States (Meyer, 2019). His research included conducting a literature review and applying the ITB to the research findings. Meyer determined that there were many aspects of the ITB that could be applied to researching Indigenous breastfeeding practices (Meyer, 2019). For instance, the study noted the legacies of residential schools has led to a loss of Indigenous Knowledge (IK) around food provisions and the roles of Indigenous women influencing breastfeeding practices (Meyer, 2019). In addition, social cohesion within families and communities was found to play a key role in providing breastfeeding support for Indigenous women (Meyer, 2019). The ITB is therefore applicable and adaptable to this study as this theoretical framework considers a vast range of factors that influence decision-making processes and experiences.

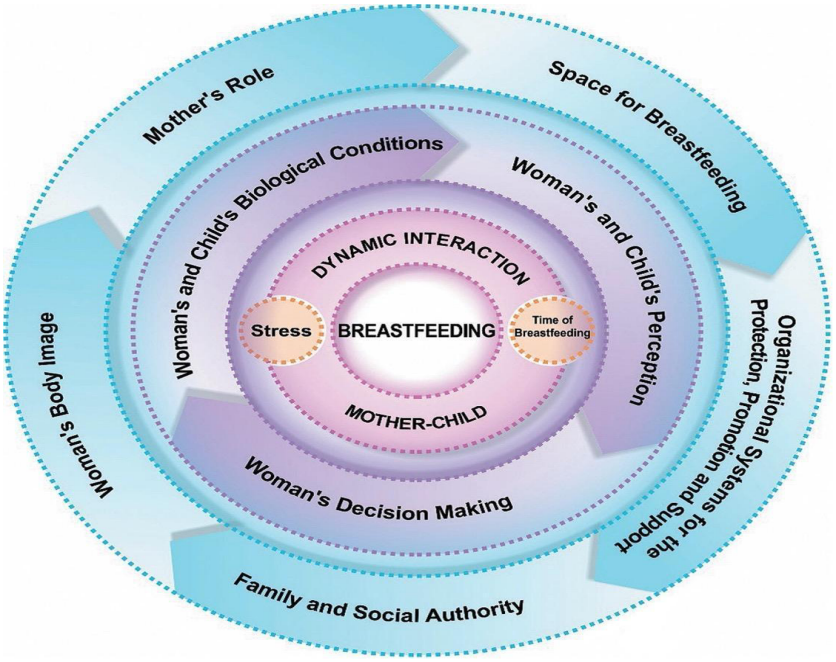

Figure 2. Interactive Theory of Breastfeeding Framework created based on the Foundation of the King's Conceptual System (Primo & Brandão, 2017)

2.1.3.1 Interview guide development

When creating the semi-structured interview guides, three separate documents were created to reflect the context and occupation of the individual being interviewed (Appendices M,N,O). Three different interview guides were prepared for policymakers, health providers, and hospital/organization administrators. The questions were open-ended to encourage participants to provide an in-depth description of their experiences with the BFHI (both at a policy level, and in practice), and incorporate the theoretical components of the ITB. The interview questions overall

aimed to be open-ended and had a number of prompts included to ensure that participants were able to expand on answers and share their experiences.

The ITB was incorporated into the development of the semi-structured interview guides. I ensured that some of the questions asked in the interview touched upon the factors listed in the ITB. I aimed to understand if the barriers listed in this theory are observed barriers for Indigenous mothers engaging in breastfeeding. Moreover, the concepts brought up in the theory were used to help design potential prompts to be used in response to questions listed in the interview guide. In addition, the ITB was used to help frame the results as an adapted version of the model is introduced.

3.2.3 Participant Recruitment

To recruit participants for this research, several health facilities holding the BFI designation, and Indigenous organizations were contacted by email. An individual was deemed eligible to participate in the study if they worked in or with a facility that held the BFI designation or had knowledge and experience with the BFI. Recruitment began in May and continued to December 2022. Overall, 7 participants were included in the study (Table 2).

Inuvik Regional Hospital and Grey Nuns Hospital were selected as Canadian case studies. The international case study included the experience implementing and developing the BFHI on a global scale. Grey Nuns Hospital, operated through Covenant Health is the largest hospital in Canada to receive the BFI designation and is located in the city of Edmonton, Alberta also with a significant local Indigenous population. Covenant Health's objective is to provide care that goes

beyond physical health, and treats people as a whole, including their minds and spirit (Covenant Health, n.d.). The Grey Nuns Hospital was selected as it is the largest full-service hospital to receive the Baby-Friendly designation in Canada, holding 984 acute care beds, and 1,600 continuing care beds, employing 11,076 staff, the Grey Nuns Hospital saw 8,452 deliveries from 2020 to 2021 (Covenant Health, 2021). Moreover, data from the 2021 census highlighted that 5.8% (58,165) of the population in Edmonton identified as Indigenous, as such, it was hopeful that the health facility would be able to provide context on providing care to Indigenous mothers (Government of Canada, 2022). People who identify as Indigenous make up approximately 5% of the overall Canadian population (Government of Canada, 2022).

Inuvik Regional Hospital was chosen as the rural location, as it is a BFI-designated facility within a small town in the Northwest Territories (Health and Social Services Authority, n.d), serving a large Indigenous population. The Department of Health and Social Services is responsible for assisting in the implementation of the BFI within the Territory that services (Health and Social Services, n.d). With 51 beds, the Inuvik Regional hospital is smaller than Grey Nun's hospital and has fewer resources compared to a health facility located in a large city. According to the 2021 census data, 20,035 Indigenous people reside in the Northwest Territories, accounting for 49.6% of the population in the NWT (Government, 2022 B).

Table 2. Characteristics of participants who participated in the interviews conducted in this study (n=7)

Participant Number	**Pseudonyms**	**Occupation**	**Location**

1	Jane	Employee at National Organization Previously a Doula Indigenous Mother	British Columbia, Canada
2	Emma	Employee at National Organization Previously a Nurse	British Columbia, Canada
3	Charlotte	International Policy Expert on BFI Previously worked at an international organization that led BFI.	South America
4	Hayley	Works at the Government in the Northwest Territories	Northwest Territories, Canada
5	Alice	Works at the Government in the Northwest Territories	Northwest Territories, Canada
6	Olivia	Works at the Government in the Northwest Territories	Northwest Territories, Canada
7	Carly	Works at the Government in the Northwest Territories Registered Midwife at a health facility working towards BFI designation	Northwest Territories, Canada

2.1.4 Funding and Research Ethics

This study was supported by the University of Waterloo Global Health Policy and Innovation Research Centre's Global Health Scholarship. Prior to data collection, ethical approval was received from the Research Ethics Board at the University of Waterloo, along with the government research authorities that were included in the research. The initial ethics approval from the University was provided on May 5th, 2022, File #44051. (Appendix P). The Aurora Research Institute used by the government in the Northwest Territories issued the research license for this research on November 1st, 2022.

2.2 Study Participants

To recruit participants for this research, a recruitment script and organizational letter were first emailed to the eligible facilities and organizations. After potential participants indicated they were interested in participating in the study, they received a recruitment email, along with an electronic letter of information and consent form. Participants provided consent to participate in this study by reading through the consent form and signing the document. Recruitment began in May 2022 and continued until December 2022.

Overall, 7 participants were included in this study. Two of the participants were health providers and discussed their experience providing maternal care. Both of these participants also had additional responsibilities, one working at a national health organization, and the other worked with BFI policy through her role at the Northwest Territories government. In total, 4 participants were able to speak about the government's role and their experience with BFI policy. Two of the 7 participants worked in a national health organization and were able to speak about providing

resources to their communities, and their knowledge surrounding the BFI. Out of these two individuals, one was an Indigenous mother who shared their personal experience assessing culturally safe resources. Lastly, one of the participants worked at an international health organization. The participants mostly resided across Canada, with one policy-level participant located in South America (See table 2).

2.3 Data Collection

2.3.1 Semi-structured interviews

Interviews were conducted over an eight-month period (May to December 2022). Due to the public health restrictions associated with the pandemic and logistical challenges, all of the interviews were conducted virtually via Zoom. Rather than phone calls, the Zoom platform was selected to build rapport with the participants and make the virtual experience more personal. At the start of the Zoom call, prior to beginning the recording, each participant was asked if they had any questions or concerns related to the study. At this time, the participant and I would speak off record about any concerns. At the end of the interview, after the recording was completed, the participant was then thanked again for their participation and reminded to keep an eye out for the gift card email and to reach out if they had any questions or concerns. Participants in this research were provided with a $100.00 VISA or Amazon gift card.

The interview times ranged from 24 minutes and 38 seconds to 1 hour and 10 minutes and 21 seconds. The average length of the interviews was 42 minutes and 22 seconds. The range in interview time was due to additional questions being asked in response to the answers provided by participants. In situations where participants had a range of experiences and examples with

the BFI, I would ask additional questions specific to these experiences. When conducting the interviews, the first questions asked to participants was for them to explain their experience with the BFI, and what their organization's experience has been with the BFI. Throughout the interview process, question prompts were used to try and obtain a deeper understanding of the content being provided.

2.3.2 Document Analysis

Document analysis was utilized to obtain more context surrounding the use of the BFI within Canada, specifically in one rural hospital, and one urban hospital. When using document analysis, it is imperative that two sources are used (Bowen, 2009). For this study, the data collected through document analysis is be considered one source, and the data from the semi-structured interviews would be the second source. There are 5 functions that documents can play (Bowen, 2009). For this study, the functions of the document fell under category one (provide data on context and background information) to help provide additional background information surrounding the BFI implementation in Canadian rural and urban hospitals.

When completing document analysis, the researcher must undergo the analytic procedure, this includes finding, selecting, appraising, and synthesizing the data within the document (Bowen, 2009). When finding documents, the researcher analyzes the content available on the topic by looking through publicly available outlets, such as libraries, educational institutions, or government websites (Bowen, 2009). The next step includes selecting documents that are relevant to the research question. After selecting the document, the next stage is to appraise the content, by superficially examining the material. This involves briefly reviewing the material and

engaging in content analysis (Bowen, 2009). The purpose of the initial read-through is to determine that the overall content is relevant and to establish preliminary categories. Next, the documents are synthesized by critically reviewing the content, and interpreting the document to understand the direct and indirect message being portrayed (Bowen, 2009). This includes reading through the document material multiple times using different lenses to determine possible categories, patterns, themes, and codes (Bowen, 2009).

Therefore, to conduct the data collection process for document analysis, I followed the 4 steps, including finding, selecting, appraising, and synthesizing documents (Bowen, 2009). To ensure transparency, I kept track of all of the phrases and internet platforms explored (Appendix Q). When searching for documents, I looked through key terms on internet platforms (Google, news outlets, and health facility websites) and then reviewed relevant websites and educational materials. These platforms were established to containing the most relevant information pertaining to the research questions. The next step in the data collection process involves selecting the documents. To select documents, I first ensured that the content was based on social facts and had not been created with a researcher's intervention and originated from a reliable source (Bowen, 2009). Accordingly, the documents selected included news articles, press releases, educational presentations, and health facility web pages. These forms of documents questions and topic being examined. During the appraisal and synthesis stage, the content that was selected was further analyzed, and will be described in more detail under the data analysis section of this thesis. Overall, 13 documents were synthesized and included.

2.4 Data Analysis

2.4.1 Semi-Structured Interview Data

Thematic analysis was chosen to analyze the interview data as it allowed for theoretical flexibility to integrate different theories and perspectives, which in turn helped create a more meaningful analysis (Lester et al., 2020). To begin, I followed the 7 phases outlined by Lester and colleagues (2020). Thematic analysis includes using different approaches with the goal to identify patterns across qualitative datasets (Lester et al., 2020). The most commonly cited approach to conducting thematic analysis is Braun and Clark (2006) (Lochmiller, 2021). However, the roadmap provided by Lester and colleagues (2020) was chosen due to its flexibility and to assist in the development of descriptive broad statements representative of the research questions that drove the study. The overall focus and aims of this research were broad and examined a range of influences on breastfeeding and BFI.

There are a number of similarities between the approaches presented by Braun and Clarke (2006), and Lester et al (2020). Both approaches include the phases of becoming comfortable with the data set through transcribing the data, and reviewing the data for codes and themes, however, the completion of these steps differ (Braun & Clarke, 2006). Between the two approaches, the main difference is the coding process. Coding begins in phase 2 (generating initial codes) (Braun & Clarke, 2006) when the researcher has an initial list of ideas about what the data is, and what stands out to them; this is further developed in phase 2, as the initial codes are created (Braun & Clarke, 2006). Themes are then developed in phase 3, and further refined in phase 4 and then defined in phase 5 (Braun & Clarke, 2006). In Lester et al, the coding process begins in phase 5 (coding the data) and follows 3 phases. The 3 phases are introduced to help researchers examine the data set a number of times to ensure accuracy and relevance to the

research objectives (Lester et al., 2020). The codes are further developed and refined into categories and themes in phase 6 (moving from codes to categories and categories to themes) (Lester et al., 2020).

The first phase introduced by Lester and colleagues, included preparing and organizing data for analysis (2020). During this stage, I gathered the interview audio and field note journal files along with creating a master list in Excel containing the participant's name, occupation, and interview date. The second phase involved transcribing the data (Lester et al., 2020). I manually transcribed the audio verbatim from the interview recordings into a MS Word document. Completing the transcripts manually presented the opportunity to engage in the third phase, which included becoming familiar with the data (Lester et al., 2020). During this stage, I listened to the audio recordings and made notes on the general messages and highlighted gaps shared by the participants.

During the fourth phase, I created a personal journal outlining the main messages conveyed during the interview, my personal thoughts, biases, and opinions. This phase assisted in positioning myself in the research to ensure that I was looking at the data without assumptions, and biases. At this phase I began to relate the interview and document data to the ITB.

The fifth phase included coding the data in an inductive manner (Lester et al., 2020). I followed the 3 phases of coding presented by Lester et al (2020). The first phase of the coding process involved creating codes throughout the entire interview transcript (Lester et al., 2020). During this stage, I engaged in line-by-line coding to ensure each sentence was reviewed for any

potential significance and relevance to the research questions and objectives. During the first phase, the created codes were more descriptive in nature. After the completion of the initial coding period, I had 104 codes. These codes were placed in a Word document and continuously reviewed and refined throughout the thematic analysis. During the second coding phase, I reviewed the initially created codes and worked to refine, further develop, and pull out the relevant data contained in the interview transcripts (Lester et al., 2020). During the second coding phase, I aimed to relate the content and created codes back to the research questions (Lester et al., 2020). After the second phase of the coding process, I had 55 codes. Next, I engaged in the third phase of coding, where the aim was to relate the transcript data to the ITB. In addition, during this phase, I aimed to further develop the code complexity and how they related to one another (Lester et al., 2020). During this phase, I related 55 codes directly and indirectly to the framework provided by the ITB. At the end of the coding process, there were a total of 30 codes.

During the sixth phase, I examined the codes established in phase five, and created categories (Lester et al., 2020). The categories were created based on how the codes contrasted and related to each other (Lester et al., 2020). I critically examined how the established codes could interact with each other, and how this could translate into categories to further classify the data. I reexamined the created categories three times to ensure that it was reflective of the data and refined the content when necessary. Overall, there were eight categories that were established based on the 30 codes for the interview data. After refining the categories, I developed key themes, as a first step by connecting related categories by examining how they were similar and different (Lester et al., 2020). Next, I translated my analysis of the categories into themes that

were descriptive and reflective of the previously established categories (Lester et al., 2020). To ensure accuracy, I continuously reviewed the interview transcripts and related content back to the developed themes and overall research questions and objectives. The last phase included making the analytic process transparent (Lester et al., 2020). In this phase, I prepared an audit trail to show the connections between the interview transcripts original codes, and how this developed further into categories and themes.

2.4.2 Document Analysis

Throughout the process of conducting the semi-structured interviews, I worked concurrently on the data analysis of the documents selected by engaging in both content and thematic analysis (Bowen, 2009). To conduct content analysis, I completed an initial review of the document material. During this review, I engaged in reflexivity and made notes on my assumptions, feelings, and reactions that occurred. In addition, I made notes of the content's relevancy to the research question being examined. In order for the document to be included in the analysis, it had to mention the BFI and be based in Canada at one of the case study locations (Grey Nuns Hospital, or Inuvik Regional Hospital). Moreover, the document had to be published from a credible organization, news outlet, institution, or government agency. This was to ensure that the content was credible, accurate and reflective of the context being examined. During the initial review, I made notes of possible categories that could be further explored in the next phase of the analysis. Based on the content included in the documents, a total of three categories were created.

Next, I conducted a thematic analysis on the content within the documents. I reviewed the document content twice to look for patterns related to the research questions. While the aim of content analysis was to establish categories, thematic analysis brings the content review one step deeper to determine themes (Bowen, 2009). The categories created during the content analysis were further examined to understand the interaction between the categories, their similarities and differences (Bowen, 2009). After connecting the categories, 12 themes were identified. I reexamined the created themes four times to ensure that the categories accurately reflected the content and related back to the research objectives.

During the synthesis of the document material, I looked to evaluate the content provided (Bowen, 2009), by making note of the document objective, purpose, or aim. If the document objective was not explicitly stated, I made an assumption based on the content, platform of publication, and tone of the material. If I assumed the objective, I indicated this through incorporating an asterisk in the document analysis table (Appendix R). For example, a news article titled "*Grey Nuns Hospital Leads in being 'Baby-Friendly'* published by Grandin media, contained information related to the archival of the BFI designation at the hospital, but did not explicitly state in the document the objective, goal, or purpose of the article (Ehrkamp, 2017). As such, based on the content, and the tone of the article, I assumed the objective was to discuss the designation process of the BFI at Grey Nuns Hospital (Ehrkamp, 2017).

Moreover, I indicated in the document analysis table whether or not the document is relevant to the question being examined. For a document to be considered relevant, the content had to speak to the perceptions/opinions, use, and/or implementation of the Baby-Friendly Initiative in

Canada. Next, I reviewed the credibility and authenticity of the document. To ensure credibility, I only included documents that were published on government, institutional, or news websites. During the review of the document, I made any notes of vagueness contained in the content, along with the intended audience. based on the availability of the document, the published platform, and the tone of the content.

Chapter 3: Results

3.1 Results

To frame the results, an adapted model of the ITB was created that incorporated components of the Socio-ecological Model (SEM). Under the SEM, there are 5 levels of influence that may impact an individual's health and wellbeing directly/indirectly, including individual/intrapersonal, interpersonal, Institutional/organizational, community factors, and public policy (RHI Hub, n.d). In the 1970s, Urie Bronfenbrenner created the SEM as a conceptual model to explore child development and understand how factors beyond the immediate environment can impact development and growth (Kilanowski, 2017; Evans, 2020). In the 1980s, the model was formalized into a health behaviour theory that explored an individual's interaction with a variety of different systems (Kilanowski, 2017). The SEM theory was incorporated into this research after the results were obtained, due to its unique consideration of health and how it is impacted by interactions of factors both distal and proximal to the individual (Kilanowski, 2017). Through the SEM theory, researchers can explore a wide variety of factors and influences that may be excluded if using a narrower theory. This expanded model (Figure 3) therefore incorporates the macro levels of influence that can impact BFI implementation and therefore Indigenous women's decision-making processes and experiences breastfeeding. The SEM of health was selected to assist in framing the results as it considers factors beyond what is presented in the ITB (personal, interpersonal, and social), which were found to be aligned with the policy and larger organizational issues discussed by the participants. The data obtained from the semi-structured interviews informed the majority of the model, however, document analysis was used to inform the outer layer addressing space and place reflective of both urban and rural environments.

Figure 3. Adapted ITB model showcasing different levels influencing BFI and breastfeeding among Indigenous Women

3.1.1 Individual Influences on Indigenous Breastfeeding Practices

Participants were asked to discuss barriers related to the implementation of BFI along with accessing designated facilities. They were not explicitly asked about personal barriers to breastfeeding, but the topic surfaced during interviews with the majority of the 7 participants. When looking at the elements that support or present challenges to breastfeeding for Indigenous

mothers, participants discussed a number of themes including family and peers, educational materials, representation, accessibility, mental health, and substance use. The most commonly discussed theme was the influences of family and peers. Emma, a nurse at a Baby-Friendly health facility in a large Canadian city, and an employee at a national health organization commented, "*their families would be number one, right? Especially those maternal roles, grandmothers, mothers, and aunties. Second, would probably be their peers. Maybe depending on age, peers might come first, family might come second."*

The availability and quality of educational materials was the second most commonly discussed theme. Charlotte, an international expert on BFHI policy, talked about literacy levels for mothers across cultural settings, stating *"...you have to see how you adapt* [resources] *and not assume…. that people are reading and writing in that language, they might only be speaking".* Participants also spoke about the importance of representation in educational resources and service delivery. Representation in service delivery was described as beneficial in promoting breastfeeding as it brings a sense of cultural awareness and comfort to mothers. With the history of colonization and blatant disregard for Indigenous cultures within the medical system, having representation can help Indigenous women feel that their cultures will be respected, acknowledged, and incorporated into their care. Accessibility was also acknowledged as a factor that can both support and hinder an individual's choice to breastfeed. There are also common situations where the mother requires additional support for physiological challenges such as latching and medical treatment for conditions that arise.

3.1.2 Interpersonal Care

3.1.2.1 Cultural Practices, Healing, and BFI: "*I think that* [breastfeeding] *is culturally appropriate because traditionally, we have always mothered through breastfeeding."*

When participants were asked if the BFI is a culturally appropriate program for Indigenous women, responses varied. While there was some agreement that the BFI was effective within their cultural contexts, participants outlined criticisms and recommendations that could improve the sensitivity of care. Jane, an Indigenous mother who previously provided birthing support as a doula, felt, for example, that breastfeeding is aligned with traditional healing methods, and stated:

> "*In my culture we talk about breastfeeding, and breastmilk as medicine and baby's first medicine. I think that the promotion of more breastfeeding initiatives is important to Indigenous cultures and I do think it's aligned."*

However, not all participants felt that BFI was a culturally appropriate program. Emma indicated that the incorporation of traditional healing is missing from the current system. Emma felt very strongly about the topic and her experience in the health system as a health provider, indicating that the current policies do not support traditional healing. She said:

> *"Because there's all these policies and procedures that are logical when you read them on paper, but when you really start learning about people, including Indigenous people, and really how we're doing so much harm by not letting people, all people, including Indigenous people, practice their beliefs and their ways of healing we're really*

actually, creating harm."

Similar to Emma, Hayley, an employee in the Northwest Territories government, discussed the missing incorporation of traditional knowledge in the BFI implemented in the Northwest Territories when they first began their career. She said:

> *"[The BFI] wasn't inclusive of all families experiences in the Northwest Territories. In particular, it didn't centre in Indigenous knowledge and Indigenous families in the care. There was a lot of work that had to happen to understand BFI firstly."*

Hayley went on to discuss the structure of the BFI in Canada. Noting that there were questions on the cultural appropriateness of the BFI and how tradition and culture were involved in the structure in the BFI. She explained:

> *"It wasn't clear originally from just speaking with the breastfeeding committee for Canada. It's a southern based organization. It did have very few members across the Territories. And so, it wasn't clear how voices from the north were actually being represented at that forum either. When we were looking at whether or not to implement BFI, one of the first steps we actually took was to support a local institution to conduct research and to support the understanding of cultural practices around infant feeding."*

To improve the options communicated to mothers, Emma indicated that there should be a resource available that clearly outlines what breastfeeding looks like in different communities and what is involved with traditional healing. As she said:

> *"I would say a list or a booklet or whatever, really recognizing, really digging in, and talking more about what breastfeeding looks like in communities where traditional basic healing and being are really prominent. To try and help those front line professionals open up their eyes. Maybe we need to explore if there are other people who should be supporting those families other than our nurses and lactation consultants."*

3.1.2.2 Choice and Autonomy: *"they're the experts in their lives and their babies. And us as health care professionals are not"*

Throughout the interviews, participants highlighted components missing in the BFI, and adjustments that could be made to make the system more reflective of Indigenous cultures and traditions. One of the commonly discussed topics throughout the interviews was the concept of informed choice. With a history of colonization, it was emphasized that the Canadian healthcare system needs to allow Indigenous mothers to have a choice in the care they receive, including circumstances where mothers may want to use formula over breastfeeding. This was discussed in an interview with Emma who explained:

> " *If we have a family going home, we always want people to initiate breastfeeding, but*

if we want to talk about harm reduction and breastfeeding and someone has the potential to, let's say, relapse on a street level opioid, which includes fentanyl, you then want to, in best practice, to encourage a family to be ready for that potential relapse, which means having stuff on hand whether it's formula or pumped milk when you're not using and all the apparatus which might include spoon feeding, bottle feeding, whatever that looks like. Baby friendly, I think, it feels like it's working against that. Because there are some families for sure. And even families who come in third, fourth. I've had families that have come into the acute care setting who CLEARLY have made the decision to formula feed and yet there's still this like whole system working against them for sure…"

Emma also highlighted that health providers do not always know what happens behind closed doors. They are not always privy to the patient context and situation. As such, she suggested that health providers need to provide education on alternative feeding methods so mothers can make an informed decision on the type of feeding they would like to practice.

Carly, a registered midwife in the Northwest Territories similarly discussed in her interview the importance of informed choice. When asked about the BFI, Carly indicated that:

"Overall, I think Baby-Friendly is great. I think it's a really good initiative. I think it promotes a lot of good things. At the end of the day, it's about informed choice. So, I think what they're missing is a bit of that informed choice. That really everyone should be provided with all of the information. Hiding the information for formula or

formula feeding isn't providing informed choice at the end of the day. You're only providing one side of the story."

Throughout the conversation with Emma, the topic of health provider autonomy surfaced. Emma highlighted that there should be more autonomy offered to health providers, where the providers have more control over the care provided to patients, depending on the unique circumstances. Emma indicated that there is a push for a standardized approach in the healthcare system, as she said:

" *I feel like there's such this push to always have an algorithm or you know blanket statements for standardization, but part of decolonizing work is getting away from that idea and really trusting that the practitioners who we hire - who have a professional designation, also have critical judgment that they use every day in all other areas"*

To make care more personalized and relevant for Indigenous mothers, Emma suggested that health providers ask more questions throughout the process since it is important for health providers to understand the values, and goals of the patient and respect their decisions. Emma indicated while there will be an opportunity to provide education towards the decisions being made, there is a need to respect the decision of the patient.

"*Definitely to ask more questions about what their values and intentions are in the beginning of labour. Or if it's a quick labour, as soon as possible after. Then to support those plans, even if we have to offer some education. Fine, pros and cons, but*

still be able to support those plans no matter what"

The conversation with Emma showcased how BFI provides a strict framework for how mothers should be treated when they are receiving care and information pertaining to infant feeding. Through Emma's experience as a nurse, she recommends that BFI be used as a tool to provide education and resources surrounding infant feeding practices, but the infant feeding decision is in the hands of the mothers.

3.1.2.3 Language and Tone: *"Even the name of the program, right? Baby Friendly, promotion of breastfeeding. So, what's not breastfeeding? Not Baby-Friendly?"*

When asked questions related to how the BFI could be improved, participants highlighted language as an important consideration. The tone, words, and photos used in educational and health materials can influence how people interact with the content. For example, when looking at language and Indigenous material relating to BFI, Emma noted an important consideration and made the recommendation, *"I'm always huge on gender-inclusive language….so I would change all the things all over the place and include Two Spirits specifically for Indigenous people as we*ll."

As participants previously mentioned, there are reasons mothers may not breastfeed. The name BFI, as Emma stated above, can insinuate that alternative feeding options are not necessarily friendly to infants which can further stigmatize mothers who face difficulty breastfeeding or choose an alternative feeding method. Emma and Carly indicated that the BFI was a positive

initiative, however, it takes on an anti-formula approach that interferes with resources provided to families that make the decision not to breastfeed. The BFI in Emma's workplace was perceived as creating barriers for families that decide breastfeeding is not an appropriate feeding method for their particular context. As Emma highlighted:

> *"Baby-friendly initiative sometimes can get in the way of the intent of the resource for families who maybe need to make a healthy choice to engage with formula feeding. For reasons maybe like substance use. Sometimes, although fantastic on a framework level, as an acute care nurse in the hospital, I think it also isn't taking into considerations those special circumstances where formula feeding is healthy."*

> *"...I understand where they're [Baby-Friendly Initiative] going with not talking about formula, and how it's not really presented until someone asks about it. But I do think it's a bit of hiding something. Right? Where people don't feel like they're getting any information on formula. Or because we aren't talking about it, it's a bit more like something that's stigmatized and there's already so much stigmatization in terms of how you feed your baby, and where you feed your baby."* Carly

Charlotte also discussed the importance of language and communication with the BFI, and noted that:

> *"So we are teaching, in my case teaching medical students, I mean, communication is VERY important. Because I mean you have to put yourself in the shoes of the patient.*

And you need to be communicating. Those things are the ones that have to be promoted so the hospital can keep the BFHI status."

In addition to the tone and words used, participants Charlotte and Alice, an employee at the government in the Northwest Territories, indicated that part of the BFHI is to communicate the ten steps in the local Indigenous languages. Charlotte recalled a situation she encountered while working with the BFHI on an international scale, where people could speak the local language fluently, however, they could not read it, "*so we said we have to have images, so that was an adaption to the to the local situation. With the image you don't have the confusion."* Alice also suggested:

"I think ensuring that language-in the NWT there are nine official languages along with English and French, so ensuring that resources are available in different languages. A lot of times too, our designs and information that are put out have graphics and stuff that are very culturally safe in the NWT, including different Indigenous groups, and even we have a food chart that includes things like Caribou. A lot of graphics do include feeding and different graphics."

3.1.2.4 Fear and Embedded Racism: *"they're not our people, then there's a sense of weariness, right? Because it's scary."*

Several participants indicated that there needs to be an acknowledgment that the BFI as a policy was created from outside of Indigenous communities, lending a sense of wariness, hesitation, and

fear. According to Jane, *"the medical system and clinics and doctors, and nurses even and you know very all well-meaning people, but there's so much embedded racism and it's really scary."* When asked how Indigenous people perceive the BFI, Emma indicated that she does not believe they know about the initiative and the focus is more surrounding systematic racism, stating, *"I think there is so much larger issues around systematic racism, you know? And like just not recognizing traditional parenting. I think there was just such bigger issues among Indigenous families"*

To improve the implementation of the BFI, Jane suggested the use of anti-racism training to uncover internal biases among health care providers. Jane also discussed the importance of examining the system as a whole to recognize the historically racist roots in the following quote:

> *"... so again, it comes down to that training, right? I think it really does start with the fact that there needs to be foundational learning around anti-racism and internal bias and those types of things. I think – you know there's no safety net. You know when we're doing- when we have a doctor or nurse or somebody going into the health care, there isn't any explicit anti-racism training, there just isn't. And I'm not saying they don't cover multiculturalism and I'm not saying they don't take oaths, and I'm also not saying that everybody is a bad person, or you know.. But the problem is with that we live in a racist society and so a lot of the policies that are created have been created from a system that is racist, or has been, has a history of really bad racism and it kills our people, right? It kills our people. We see that. We see the maternal death rates, you know?"*

3.1.3 Institutional and Organizational Challenges

3.1.3.1 Lack of Capacity: *"It's a lot of steps, I think it's hard for these smaller health centers if they want all of Canada to become Baby-friendly"*

When examining how the BFI has been implemented and delivered in different health facilities, it is crucial to also examine the state of the health care system itself to understand the challenges and barriers that may be present. Health care systems are facing a current crisis in terms of capacity with staffing and workload. Hayley, Alice, and Carly discussed this topic in depth, explaining how the resources required to implement the BFI acts as a barrier. As Alice described:

> *"It does look like there is some work involved. I know they do chart audits, and report on numbers for certain things such as how long skin-to-skin happened after birth, and breastfeeding when they left the hospital, and initiating breastfeeding. So it does take some man hours for somebody to actually do that."*

When looking at implementing the BFI, Carly indicated that a large barrier she faces in her rural health facility, is the educational component of the BFI. Noting that her staff will have to complete a 20-hour breastfeeding course, and then attend an in-person supervised practice, however, in her location, there is no breastfeeding clinic. Hayley highlighted that due to the staffing crisis there is a burden on health care providers and expressed her discomfort adding responsibilities because "*when we're asking them to do something where they feel might be*

additional demand on their jobs, I think that could affect whether facilities move forward with it."

3.1.3.2 Missing Local Context: *"We have one hospital designated a few years ago, and they had no understanding of our context."*

In Canada, to become BFI designated, a health facility must be reviewed by the Breastfeeding Committee for Canada. Hayley discussed during her interview that the members of the committee tend to be from the south, with few members representing the northern context, resulting in a lack of understanding for the local contexts outside of their jurisdiction. She explained:

> *"Even going through that designation process um because often the people conducting the audits and designation are from the south, their traveling up here. So, it seems like there's also a need on a national level for like cultural safety training and like a commitment to that if you're going to travel to a different jurisdiction to designate a hospital, what are your responsibilities before you come, so you're also respectful of the cultural practices and the attempts that are being made to make sure the program fits appropriately."*

3.1.3.3 Rigid and Inflexible: *"There was a hesitancy with the program itself being rigid, and not inclusive of all families and experiences in the Northwest Territories or anywhere really."*

When implementing the BFI in the NWT, one of the barriers experienced was the perception of the health initiative. People working in health organizations and local government positions in the NWT were concerned with the policy being firm and rigid. Hayley described the concerns:

> *"If you plan on just implementing BFI as is, it's unlikely it will be successful or taken on both by health care providers, but also by the clients taken on by the health care system and families we service. So, unless it is adapted for a regional or local context, I think a huge barrier is just coming at it as a 10 clinical steps and policies that you implement with no recognition of the context."*

3.1.3.4 Commitment from Leadership: ***"But one of the things that created so much momentum is that we had a signed letter of commitment from the department and all three health authorities to participate in BFI."***

Hayley, an employee in the Northwest Territories, also shared during her interview the importance of having a commitment from leadership in the implementation of BFI. Having a signed letter of commitment helped ensure that staff were aware of the priority and felt inspired and encouraged to be a part of the work. She said:

> *"It [signed letter of commitment] was something that we leaned on throughout, since it's so easy to where other things become prioritized over this initiative."*

Moreover, Hayley highlighted how having this letter of commitment can help maintain the designation as well, as there is support for the continuous providing of resources and services in BFI.

3.1.3.5 Community-Based, Representation, and Indigenous-Led: *"I think that if a culturally appropriate initiative is going to be community-based it's going to be led by other Indigenous folks"*

The BFI is provided in health facilities; however, the policy does not outline or require any incorporation of the community. The decision of community involvement is determined by the health facility implementing the BFI. Incorporating community was mentioned throughout all 7 interviews, but in different contexts. Community was discussed as important for the delivery, organization of maternal services, and representation. Jane emphasized:

> "*Because there is a very particular way, I think of going about teaching about cultural practices because ultimately, breastfeeding is a cultural practice for Indigenous people around the world and when I say Indigenous people, I include people of colour for their dysphoria, so Black folks as well. And I think that for me it would look like making that really accessible, like making sure that there are folks that can come into homes, maybe go into the Community. You know I think there needs to be more reaching in and reaching out to other communities. If I was planning an initiative, I would go there. I would go to these communities. I would go to these* [reserves]*, I would go into places where it's inaccessible. Also, making sure again that there is*

representation because I think that is really important. Having other Indigenous doulas or having Indigenous midwives."

To improve the BFI at a policy level, Hayley highlighted using community-based research to understand the current context to ensure that the creation of the BFI in the NWT moved from a policy developed by the Territory to an initiative created in collaboration with the community to be reflective of current context and values and "*centering our people that lived here*". She went on to illustrate:

"…my main experience with BFI, so the actual need to change the narrative of it to fit the local context of the ways that people can do that. It's still invaluable to have a global set of standards that are well recognized and a designation process, but it has no meaning for health care providers or families if it isn't in the context in the area you're located in."

Emma also highlighted an important consideration when looking at the involvement of Indigenous communities and indicated that health providers and policymakers need to do more prior to the involvement of Indigenous communities. Key stakeholders need to look and read through the toolkits and recommendations that were already provided and incorporate these suggestions. Emma noted that far too often policy makers, health providers, and organizations ask for input or suggestions on what to do, and then this guidance is ignored and not reflected in programming. As she explained:

> *"Indigenous people are being exhausted, when we go to Indigenous people and say teach us what to do. And now the responsibility needs to be put back on policymakers, organizations, employees who experience white privilege to find the information themselves. So instead of being like well we definitely need Indigenous people to tell us what to do, and to inform us and to teach us, I think there needs to be more work put into finding out ourselves. There's so many like toolkits, and recommendations, and elder toolkits and so much knowledge out there, as to how Indigenous people can be supported better. But there's really a lack of implementation…".*

Community was mentioned by Charlotte as well, who indicated that on an international scale, BFHI has incorporated the community in different manners. She gave the example of a Baby-Friendly initiative in Gambia where the work was done and implemented at the community level and went on to indicate that when, *"it's closer to the community [the] mother feels more comfortable with the health care provider that's closer to them. So those are the types of activities that you have to involve the community because otherwise, it's quite difficult."*

Charlotte and Hayley both mentioned the importance of having the initiative at the community level as that is where a lot of the activity occurs with the mother. According to Hayley:

> *"...we support local committees to actually take ownership and champion the work, versus us if we can hold the work, and we can do some of the administrative, there's a lot of administrative pieces of it, and more at a systemic level, but at a community and facility level, they really have to lead the work, and want to do the work."*

3.1.3.6 COVID-19's Impact on BFI: *"You don't allow breastfeeding mothers, for instance, to breastfeeding their babies, because you said they [infants] were going to get infected through breastmilk"*

This study took place during the COVID-19 pandemic. From the interviews conducted, participants highlighted the impact of the COVID-19 pandemic and how it influenced breastfeeding rates, access to services, the service delivery of maternal health, and the offering of the BFI. Due to misinformation and a lack of understanding of COVID-19, traditional healing was not respected throughout the pandemic as rooming-in, skin-to-skin contact, and breastfeeding were all adversely impacted. According to Jane, for example, throughout the pandemic, individuals had even more limited access to breastfeeding support:

> *"…I think that it's so hard, it's so hard to get any type of care. Actually, and I'll add this right now, and I know that we aren't as new as in the pandemic as we are now, but even now, going to try to see a doctor at the clinic…And it's really hard to access, really hard…"*

Charlotte highlighted the barriers to providing traditional healing and standard BFHI care during the pandemic. Indicating that during the pandemic, the world was scared, and unsure what to do. This resulted in misinformation and quick action fueled by fear. For example, Charlotte discussed how due to the pandemic, mothers were advised not to breastfeed as there was worry

the infection would travel from the mother to the baby. In addition to being discouraged from breastfeeding, mothers were also separated from their babies and did not engage in rooming-in, and skin-to-skin contact immediately after birth. Charlotte went on to discuss this experience:

> *"As soon as baby was born you had to separate mother and baby because the mother COULD have COVID. Not even if the mother was positive, she could have COVID. So, you had to separate them. They couldn't have contact with their babies, and they couldn't breastfeed their babies. It also affected Baby-Friendly because they didn't want to do the rooming in for instance. They didn't want to have skin-to-skin contact, they didn't want to have rooming in, they didn't' want to have the breastfeeding"*

Both Emma and Charlotte described what the experiences might have been like for the mothers who had a plan and gave birth during the COVID-19 Pandemic:

> *"Well, it could be grandmothers and aunties they've known their whole life and that was always the plan, and we rip that away from them. For like actual truth."* Emma

> *"...and also, if you already let's say you were covid positive, you're already scared because you're positive."* --- *"on top of that they separate you from your baby. They make you feel that you're worthless, terrible"* Charlotte

3.1.4 Implementing the BFI: Context-Specific Policy Environments

Results from the semi-structured interviews provided some context of the BFHI from an international perspective, however, participants did not touch upon the comparison between rural and urban facilities within Canada. Document analysis was therefore utilized to fill in these gaps and inform the Canadian urban and rural case studies. The first case study, focusing on the international perspective, was informed by Charlotte's interview. As someone who was involved with the BFHI at a global level, her contributions to the study highlighted a number of factors that were critical to the successful implementation of BFHI in a variety of cultural settings. Important factors to consider included the facilities' intention, participation in evaluation and monitoring, financial resources, facility coordination and collaboration, and perspective surrounding control. Charlotte also provided insight as to why there is such a variation in the uptake of BFHI, explaining that intention for implementation drives this gap, she explained *"I mean I think the variation has come because of the interest in the plates [*BFHI designation plates]. *If you were in a country that had more of a focus on care, those were doing okay. If you had a country where the whole interest was to have a plate, for instance, the interest died once you had the plate."*

The Canadian urban context focuses on the experience of Grey Nuns Hospital operated through Covenant Health. Covenant Health is a Catholic-based health organization based in the province of Alberta (Covenant Health, n.d). After reviewing seven publicly available documents, including one news article, one educational resource, and five organizational webpages, patterns and themes emerged surrounding the hospital's implementation of the BFI program. The BFI focused on patient autonomy, informed infant feeding decisions, and resulted in an overall positive experience for mothers and staff. Based on the sourced documents, however, there was a

lack of culture, Indigenous representation, and diversity discussed in the documents and educational material. While there was limited information pertaining to the barriers faced by Grey Nuns Hospital, it was mentioned that a particular challenge was staff knowledge and ensuring everyone was aware of the BFI.

The third case study examined the Canadian rural context at Inuvik Regional Hospital. The Inuvik Regional Hospital was selected as the only hospital facility located in the Beaufort-Delta region in the Northwest Territories (Health and Social Services Authority, n.d). From reviewing five relevant documents, including 4 webpages, and 1 news article, through document analysis, there were additional themes and patterns that emerged from the hospital's implementation of the BFI, including the intention to improve the quality of care, emphasis on patient autonomy, and uplifting experience for mothers and staff. The tone of the documents reviewed spoke highly of the BFI, which is similar to the information provided by the participants who reside in the NWT. There were parallels between what was found in the documents, and the data provided by the participants, primarily focusing on the necessity of informed choice.

The case studies presented an opportunity to highlight positive experiences and challenges faced when implementing the BFI within Canada, and on an international scale. Moreover, the findings of this research also point to the many gaps in public information on this topic nationally within Canada, compared to internationally. Between the three case studies, there were a number of parallels that will be illustrated according to the categories and themes presented in the next section.

3.1.5 Place-based Policy Positives

3.1.5.1 Intention to improve quality of care: *"The goal should be to improve the care of mothers and babies in the facilities and to do an ongoing improvement"*

All three case studies mentioned the importance of the intention driving the implementation of the BFHI internationally and the BFI within Canada. Facilities were seen to be successful in the implementation of the BFHI when the goal was not to become recognized as BFHI designated, but instead to improve the quality of care for mothers and babies. Charlotte highlighted the intention from the international perspective as, *"WHO and UNICEF also said that the goal shouldn't be being assessed or being recognized as a Baby-Friendly hospital".* The intent to implement to improve care was further showcased in both Canadian case studies, where the hospitals highlighted that the BFI designation was a representation of their focus on improving care for their mothers and infants. According to Gail Cameron, the Senior Director of Operations, Women's & Child Health at Covenant Health, achieving the BFI designation was a *"testament to the commitment and dedication of our nurses, leaders and the organizations for improving care and support for all mothers"* (Kim, 2017). Sue Cullen, the CEO of the NWT Health and Social Services Authority shared a similar statement when announcing their archival of the BFI designation, stating that receiving the BFI, *"demonstrates our commitment to supporting maternal and infant care. Across the NWTHSSA we are committed to providing the best care and services to all residents."* (Health and Social Services Authority, 2018).

3.1.5.2 Staff Participation: *"It doesn't matter if they don't work in the maternity unit or newborn unit, they should be aware of BFHI."*

In the successful implementation of the BFHI, the participation of the staff is a key factor. It is important that everyone in the hospital is aware of the initiative, while they don't have to be trained in BFHI, they need to be aware of the initiative due to hospital attrition. As Charlotte indicated:

> *"Okay, one of the things, as I've said, participation of the staff. Because, for instance, attrition is a problem you have in most places. So, you do have a person that is well trained, and then that person suddenly goes to other service etcetera, and then you have new staff that has no idea…. so that's one of the problems. What [is] said that everyone that who works in a facility, it doesn't matter if they don't work in the maternity unit or newborn unit, they should be aware of BFHI."*

3.1.5.3 Community Participation: *"You pay attention to somebody who went through what you are going through."*

The community was mentioned to play a critical role in implementing the BFHI across different countries. The community can be used to help provide additional support to mothers that offer insights from lived experience. Charlotte explained that she worked with a hospital in Pakistan that used peer support to assist mothers in the discharge process by having mothers who were about to be discharged paired with a mother who was recently in neonatal care. Charlotte

indicated that offering peer support to mothers is a helpful and impactful way to provide guidance and advice to mothers:

> *"You pay attention to somebody who went through what you are going Through, because I mean the doctors tells you everything or the nurses tell you Everything and you say what does she know! [laughs]."*

3.1.5.4 Patient autonomy: ***"Mothers have a choice. The best thing you can do is provide them with information that they can make the informed choice."***

Through reviewing the content for Grey Nuns Hospital, and Inuvik Regional Hospital, patterns surrounding patient autonomy and informed choice among mothers and their infant feeding decisions were identified. Margret Salopek, clinical nurse educator with Grey Nuns Hospital, for example, indicated that through BFI*, "they're still going to make the best decision for them and their family because that's what they do."* (Ehrkamp, 2017). A similar finding was reported at Inuvik Regional Hospital, with patients reporting they are, *"very pleased with the care they received, stating they received consistent infant feeding education and support, regardless of if they chose to breast or bottle feed"* (Health and Social Services Authority, 2018).

While mothers are supported to breastfeed, they have the choice to explore alternative feeding options as well. By giving patients choices, there is a recognition that there are contexts and factors that make breastfeeding not the safest and most appropriate feeding method. It is acknowledged that there are situations where mothers may choose not to breastfeed for personal

preferences. Margaret Salopek, showcased the acknowledgment of patient choice by highlighting "*Grey Nuns Hospital will continue to respect the choice of mothers."* (Ehrkamp, 2017). Meghan Scott, the chair of the BFI at the Inuvik Regional Hospital shared a similar sentiment towards patient choice through stating, *"They* [Inuvik Regional Hospital] *will also support mothers who choose to feed them baby with formula"* (Scott, 2018).

3.1.5.5 Uplifting experience for mothers and staff: *"[My baby] Riley has been with us the whole time."*

Across the documents, a pattern that was highlighted discussed how the BFI implementation created a shift in service delivery surrounding how care was provided to mothers. Focusing on keeping the baby and mother together and promoting skin-to-skin contact has been identified by mothers who received care from the Grey Nuns Hospital and Inuvik Regional Hospital. Kathleen Martyshuk a mother of two children, indicated in an interview with *The Vital Beat* that she noticed a difference in the care provided during the birth of her most recent child at Grey Nuns Hospital:

> *"The nurses bathe the baby at 24 hours instead of six hours. The lab testing is done skin-to-skin. It's been good; I feel like I can comfort him, instead of watching him scream in the little bassinet."*

Catarina, a mother of four, shared she had her most recent child at Inuvik Regional Hospital. In an interview with CBC, Catarina indicated that the biggest change she noticed was that the

hospital left her alone with her husband and their child for a long period of time (Scott, 2018). Through doing this, the family was able to bond. In addition, Catarina indicated that:

> *"Not only were they encouraging me to breastfeed … They were also letting me know about programs for once I go home".*

3.1.6 Global Policy Challenges

3.1.6.1 Intention Driving Implementation: *"The bad thing in terms of that, was that the countries were, and the hospitals were implementing BFHI to get the plate and to get the things."*

At the international level, a few key components were uncovered across the course of the interview. First, for countries to successfully implement the BFHI, there had to be a genuine interest in improving the quality of postnatal care. Charlotte explained that through the designation process, once the hospital implemented all of the BFHI requirements, they would receive a plate to showcase their achievement and share their commitment to providing Baby-Friendly services. However, if facilities were focused on the perceived benefit of the designation or looking only to obtain the plate to showcase their designation, then they would ultimately fail due to the monitoring and evaluation components implemented in the updated version of the BFHI. As Charlotte indicated, *"in many countries, there was not real involvement in the process. It was more doing something for final goal was to get the plate, as recognition of being a Baby Friendly Hospital. And then that was the end of the story."*

3.1.6.2 Lack of engagement with evaluation/monitoring: *"Being recognized as a Baby-Friendly Hospital is not the end of the story. You do have to make sure you're keeping what you need and that you are improving whenever it's not going okay."*

To respond to the concern surrounding a facility's intention for implementing the BFHI, WHO and UNICEF created an updated version of the BFHI which included the need for monitoring tools. According to Charlotte, *"noticing that WHO and UNICEF made the second version BFHI that inputted monitoring tools."* Through implementing monitoring tools, the aim was to ensure that receiving the plate of designation was only one part of the BFHI journey, and that ongoing improvements and evaluation are required.

However, there were a number of barriers to implementing the monitoring system among countries. Charlotte also highlighted that some institutions did not engage in evaluation because they were used to the "*status quo*" and did not view the monitoring of the BFHI within their facilities as beneficial. One of the barriers identified by Charlotte was that the evaluation was conducted from the outside and applied to the facility and this was problematic for the facilities as they were not used to measuring themselves.

3.2 Discussion

The centre of the adapted model (Figure 3) situates the individual or personal influences that may impact an Indigenous women's decision to breastfeed. At the individual layer, proximal factors are examined. This would include an individual's beliefs, personality, and knowledge (RHI Hub, n.d). The academic literature has showcased that there are a number of individual

factors that can impact Indigenous women's decision-making processes and experiences breastfeeding, such as substance use, cultural beliefs, or breastfeeding knowledge (Schroeder et al., 2019). Breastfeeding practices were investigated among urban Indigenous women in Regina, Saskatchewan (Schroeder et al., 2019). Findings suggest that through promoting cultural beliefs regarding breastfeeding, they were able to see an increase in community awareness and support of breastfeeding practices (Schroeder et al., 2019). Another Canadian study similarly highlighted that Indigenous women who had Elders in their lives to share teachings about breastfeeding, were reported to breastfeed the majority of their children (Moffitt, 2018). Mothers from this study also discussed how alcohol use among family members negatively impacted their support system and can be a driving factor in a women's choice to bottle feed (Moffitt, 2018).

These findings directly relate to the representation influence, as well as the context of mental health and substance use that was referenced by Emma in our study. During the semi-structured interviews, participants discussed their perspectives on the factors that influence Indigenous women's individual decisions to breastfeed. Through these discussions, the main influences were family and peers, educational materials, representation, accessibility, along with mental health and substance use. According to the ITB, these influences would fall under the interpersonal system and the social system (Primo & Brandão, 2017). Most of the influences mentioned in these results discussed influences that happened beyond the women's personal system. The women's personal system includes influences such as perception, self; body image, growth, development, time, and space (Primo & Brandão, 2017). Instead, the participants in this study focused more on factors outside of the personal system, including the Indigenous women's interactions, experiences, and exposure to the established social network around them, and available health resources (both service delivery and educational materials), reflective of the

participants' backgrounds and perspectives as service providers, government workers and policy experts rather than Indigenous mothers.

When examining factors relating to the decision to breastfeed, it is imperative that interpersonal influences are acknowledged and explored (Meyer, 2019). Through examining interpersonal influences, there is a focus on an individual's interaction with other people and systems, and how this may translate into barriers or supporting factors (RHI Hub, n.d). Interpersonal influences described by participants included themes of cultural practices, choice, language and tone, fear, and racism. Breastfeeding as a cultural practice has been described within the academic literature[3] (Moffitt, 2018; O'Driscoll et al., 2011; Cidro et al., 2018). The traditional practice among Indigenous populations includes breastfeeding for approximately 2 years (O'Driscoll et al., 2011). Breastfeeding directly after birth is very much emphasized, as it builds emotional and physical connectivity (O'Driscoll et al., 2011). The information presented in the literature is similar to what was found in this research. Through this research, a few participants in the interviews mentioned that breastfeeding is a part of Indigenous traditions, meaning that the BFI is culturally appropriate. Moreover, traditional birthing practices in some Indigenous cultures include a large emphasis on community participation (O'Driscoll et al., 2011). For example, in Northwestern, Ontario Elders discussed how when birth occurred, experienced women living in the community would help assist (O'Driscoll et al., 2011). After birth, the placenta would then be wrapped in either birch bark or cloth, and buried or hung in a tree, as it was considered sacred (O'Driscoll et al., 2011). Interestingly, throughout this research, there were parallels between

[3] It's important to note that traditions and practices vary among different Indigenous communities. For the purpose of this thesis the most commonly discussed practices and traditions will be mentioned, with some specific practices highlighted for examples. However, the reader should be aware there are no standardized Indigenous traditions, the practice is unique to the community and its context.

what was found in the literature, and examples provided by participants. For example, Charlotte discussed her experience with BFHI and traditional healing, showcasing the importance of asking families if they wished to keep the placenta. Other participants in this research highlighted how aspects of the BFI are already in alignment with some Indigenous postnatal birthing practices. For example, skin-to-skin contact is a requirement under the BFI and been observed to be an Indigenous birthing practice among Elders in the Northwest Territories (Moffitt, 2018). However, some participants indicated that the BFI is not a culturally appropriate policy for Indigenous mothers. These participants noted that when examining the BFI, there are areas for improvement to make the program more culturally sensitive for Indigenous women. For example, to make the BFI more culturally sensitive and align with Indigenous culture, health facilities could incorporate smudging, and drumming, increase the number of people allowed in the room, and incorporate Indigenous knowledges and families in the care being provided.

Previous research has highlighted that some women who formula feed experience shame and guilt associated with their feeding choice, with those who use formula, reporting feeling guilt linked to experiences with health providers (Jackson et al., 2021). Women who breastfeed still experience guilt and shame, however, these experiences can be due to stressors from family and peers (Jackson et al., 2021). Concerns were voiced among a few participants in this study, that the BFI could be used to spread anti-formula messaging. This was indicated by the participants to increase the stigma surrounding formula feeding, and guilt women into choosing to breastfeed, even if it was not the most appropriate choice for their specific context. This finding was not surprising and has also been reported in the literature surrounding BFI (Jackson et al., 2021).

It is imperative that education is provided to all women on a variety of feeding methods, so they are able to make an informed and safe choice when feeding their infants (Daniel, 2020). The topic of education and informed decision was brought up numerous times throughout the interviews, and case studies. The health facility websites and news articles that discussed the BFI implementation highlighted that the facilities provided education for families to make informed decisions (Kim, 2017; Health and Social Services Authority, 2018; Ehrkamp, 2017; Scott, 2018). Providing information, and highlighting the choice mothers have, helps move away from the medical paternalistic health system that carries the narrative that health providers know best (Barnabe, 2021).

Language used can influence a woman's feeling surrounding breastfeeding and their feeding options. A recent article, for example, discussed concerns surrounding the use of the slogan, “breast is best” (Daniel, 2020). Using this expression, implies a sense of social pressure associated with bottle feeding even though, in some cases the decision to bottle feed is due to a health context or concern (Daniel, 2020). The authors of this article suggest that in order to see increased breastfeeding rates there has to be a supportive environment overall, not just targeted to those who breastfeed (Daniel, 2020). Participants in our study similarly discussed the use of language and tone. One participant specifically highlighted that the name “Baby-Friendly” insinuates that feeding methods outside of breastfeeding are not friendly to the infant.

An interesting observation that emerged through this study was the use of language surrounding chest feeding and breastfeeding. In the official BFHI literature published by WHO and UNICEF, there is no mention of chest feeding with most sources exclusively using the term breastfeeding

(UNICEF Canada., n.d; UNICEF, n.d; WHO, n.d A; WHO, n.d B). There is some available literature that describes using inclusive language when discussing and providing birthing care, but it does not appear to be discussed in policy documents or at a national level (Duckett & Ruud, 2019); García-Acosta et al., 2019). During the semi-structured interviews, some of the participants repeatedly used both terms chest feeding and breastfeeding consistently when discussing infant feeding and stressed the importance of inclusive language.

When examining interpersonal influences on breastfeeding within Indigenous communities, a critical consideration is the impact of residential schools. Previous research has described how residential schools have impacted breastfeeding, as Indigenous women reported being told to feel ashamed of their bodies within the schools (Moffitt, 2018). These negative feelings and learnings contributed to barriers in breastfeeding and knowledge transfer by being separated from their mothers, grandmothers, and aunties (Moffitt, 2018). This showcases the impacts of intergenerational learning and how it can be incorporated in breastfeeding awareness. This topic was rarely discussed among the participants in this research. While participants throughout the interviews acknowledging the history of colonization and its impact on current hesitations and fears with utilization of health programs and government policies, there was rarely any mention of residential schools specifically.

Similar to what participants discussed in the results, studies have showcased that the current health policies and systems are based on racial oppression and colonial practice (Coen-Sanchez et al., 2022). To help reduce racism in health care, Jane indicated there needs to be a larger shift that goes beyond just providing training on racism and bias. Jane suggests while the training

could be helpful, there needs to be an examination of the foundation of the policies and the roots of the system. This finding is supported in academic literature, with one study suggesting that for there to be trust in the healthcare system, there needs to be restructuring of current practices with health providers that are informed on how to provide culturally appropriate care and hold a dedicated commitment to creating and delivering programs that highlight socioeconomic determinants that disproportionately affect Indigenous populations (Coen-Sanchez et al., 2022).

Through COVID-19, there was an abundance of confusion on what the best practices were in the delivery of health programs. Participants highlighted frustration and difficulty with accessing health services and breastfeeding support. There was also an emphasis on how disconnected birthing was during the COVID-19 pandemic, with quickly changing recommendations, mothers in some cases were discouraged to breastfeed, unable to engage in skin-to-skin contact after birth and limited the number of people allowed in the room. The feelings and experiences reported by participants were showcased in the literature (Flaherty et al., 2022). Considering the chaos that COVID-19 evoked, it is not surprising to find that the pandemic had such a large impact on health care provision in a variety of settings. An interesting topic that was missing from the interview data, but what was found in the literature was the concern of what the long-term impact of the COVID may be on infant bonding, resilience, and coping (Flaherty et al., 2022).

Organizational influences include examining regulations, policies, and informal structures that may support or present barriers towards engaging in healthy behaviors (RHI Hub, n.d.). In this research, organizational influences include institutional challenges, involving lack of capacity in health providers, missing local context, perception of rigid and inflexible policies, commitment

from leadership, and involvement in the community. The academic literature examining the experience of implementing BFI within institutions in Canada is limited. One study examining the perception of the BFI across nursing staff in Canada found that perceived difficulty and staff workloads played a large role in if facilities faced barriers in implementation (Benoit & Semenic, 2014). An interesting finding reported in the academic literature that was not discussed in the results of this study was how a mother can influence the perspective of the nurse on the BFI (Benoit & Semenic, 2014). Nurses reported being concerned that they would be regarded as a health provider who imposed breastfeeding on the mother which could act as a barrier to implementation of the BFI (Benoit & Semenic, 2014). Nurses also reported being heavily influenced by the opinions of their colleagues, holding the values and knowledge of their nursing colleagues at a higher regard than their education (Chabot & Lacombe, 2014). This example from the literature showcases barriers that can be presented when facilities try to implement BFI without staff collaboration and participation (Chabot & Lacombe, 2014). Similar findings were reported in this research with a focus on perceived difficulty, missing local context, lack of capacity, time pressures, and resources.

Environmental and policy factors include local, national, and international policies and laws surrounding health (RHI Hub, n.d.). Participant interviews highlighted issues pertaining to access to health facilities that incorporate Indigenous healing practices, which has also been discussed within the academic literature. Asamoah and colleagues (2022) investigated Indigenous healing practices on an international scale and found extensive barriers present in health facilities worldwide (2022). Internationally, there are a number of policies and recommendations available, however there has been a lack of enforcement. For example, under article 24 of the

United Nations Declaration on the Rights of Indigenous Peoples, Indigenous Peoples have the right to access traditional medicines and engage in their own health practices (Asamoah et al., 2022). In 2014, the West Australian Mental Health Act, under principle 7, highlighted that mental health services aligned with cultural and spiritual practices and beliefs must be available for people of Aboriginal or Torres Strait Islander descent (Asamoah et al., 2022). In addition, the Truth and Reconciliation Commission's Calls to Action includes the recognition for the Canadian healthcare system to understand and recognize the value of Indigenous healing practices (Asamoah et al., 2022; TRC, 2015). Moreover, if requested by the patient, care must be provided in collaboration with Indigenous healers and Elders (Asamoah et al., 2022). While there are international policies to protect and promote the access of traditional medicine and practices among Indigenous Peoples, there is a lack of uptake and support within countries (Asamoah et al., 2022). We see a similar narrative, of barriers and lack of implementation, when examining the enforcement of legal regulations following the Code, and Ten Steps to breastfeed.

Through looking at the environmental/policy layer of the model, it is important to examine what resources and structures are available nationally and internationally on the topic of breastfeeding support provided to Indigenous women. This includes looking at what academic literature is available on the implementation process of the BFI, and similar breastfeeding programs. However, there was very limited academic literature available on this topic. When examining situations of successful implementation of the BFI in Canada and internationally, there were a number of patterns reported by participants and the themes found through document analysis. Most commonly found, was an emphasis on intention. Health facilities and policy makers had to implement BFI with the intention of improving the quality care provided, and not to receive the

perceived benefits associated with the BFI designation. When BFI implementation was successful, there was collaboration with staff members as well as the community. The process took time, but it is imperative for the BFI implementation to be successful, it must be an uplifting experience for mothers and the staff providing care (Benoit & Semenic, 2014). Moreover, the BFI must be adjusted to reflect the context of the community it will be implemented in. In addition, there is a need for staff and the community to see a commitment to implementation from leadership. Hayley highlighted how having a signed letter of commitment from senior leadership assisted with highlighting this area as a priority and helped receive buy-in from key stakeholders.

3.2.1 Strengths and Limitations

A strength of this study was the use of multiple sources and methods, referred to as triangulation (Bowen, 2009). Through using document analysis and the data collected from the semi-structured interviews, I was able to present evidence from a number of sources to establish credibility (Bowen, 2009). Document analysis is an efficient and cost-effective method to obtain data and fill in some of the gaps associated with data collection challenges (Bowen, 2009). Moreover, the study used a variety of perspectives to try and obtain an understanding of the BFI from multiple levels. Using this approach gives a more complete understanding of BFI from a policy, health provider, and community organization levels by adapting and expanding the ITB to incorporate more distal social-ecological influences.

There are limitations, however, to this study. Many hospitals and health facilities were contacted to participate in this research; however, the response rate was extremely low. Document analysis

was therefore utilized to inform the case studies. Publicly available resources, however, were limited. Richer data would have been obtained if additional interviews were conducted. Due to time constraints and complications with the COVID-19 pandemic, Indigenous mothers were not interviewed. Their direct insights and experiences are missing from the development of the expanded framework, and the interpretation of the results. Ideally future research will draw on the framework presented and will further refine highlighting Indigenous mothers' voices.

3.3 Conclusions

According to the results of this exploratory study, there are opportunities for the BFI to become a culturally appropriate initiative for Indigenous mothers if the facility/health center incorporating the initiative works towards incorporating the local contexts. As a stand-alone initiative, there are steps that need to be taken to ensure that there is a focus on empowering women with education and choice in their infant feeding decisions and experiences. There are a variety of personal, interpersonal, organizational, and policy factors that influence Indigenous women's decisions to breastfeed, and there is a need for culturally appropriate educational materials to be available to support this process. Within institutional settings, health care providers can provide education, support, and resources, but Indigenous women best understand their cultural context.

Health facilities that have implemented the BFI can provide important insights into the influences and resources required for the initiative to be successful, and what barriers may arise. The barriers reported at an international level have strong parallels to those present within Canadian health facilities. Accordingly, these findings represent an opportunity to share collective implementation experiences across cultures to learn from others how to adapt the BFI

to fit local contexts and incorporate Indigenous knowledges into breastfeeding support programming delivered to Indigenous women. Beyond individual experiences, it is also essential that policies and programs are developed in a collaborative manner with the support of community to ensure service delivery is reflective of local contexts including social and ecological environments.

Chapter 4: Conclusions and Recommendations

4.1 Study Summary

The aim of this research was to explore the barriers, challenges, and experiences of policymakers and health care providers in the implementation of the BFI among Indigenous women within Canada. Study objectives were to interview participants who had firsthand experience with trying to implement, improve access, or provide the BFI among Indigenous women, and to explore and understand the experiences and barriers for BFI implementation through using the Interactive Theory of Breastfeeding (ITB). Moreover, this study sought to explore the following research questions within the Canadian context: 1) how is the BFI implemented and utilized among health facilities that service Indigenous women? 2) what is the availability and utilization of the BFI among Indigenous women? 3) are there differences in the uptake of the BFI between rural and urban health facilities? Through the semi-structured interview process and incorporation of document analysis, data collected contributed towards the outlined aims and objectives of the study.

To frame the individual influences of breastfeeding among Indigenous mothers, and the impacts of the BFI, the ITB was adapted and expanded by incorporating components of the SEM. When we reviewed the results, we recognized that the majority of the factors discussed by participants related to interactions with influences that resided within the interpersonal, organizational, policy/environmental layers. As such, we determined it would be appropriate to expand the ITB model, based on the macro level influences included in the SEM (Figure 3). The SEM was selected to aid in the framing of the results, as it highlights and recognizes distal factors that go

beyond the more proximal influences presented in the ITB. Specifically, the SEM acknowledges the influences of larger organizational issues and the role of policy.

The inner layer of the adapted model frames the individual influences on breastfeeding among Indigenous mothers. Participants provided insights on the influences that promote and discourage breastfeeding among Indigenous mothers, including family and peers, educational materials, representation, accessibility, mental health, and substance abuse. The most commonly discussed influence was family and peers, along with educational materials. Moving outwards in the model, the second most inner layer includes interpersonal influences. Under the interpersonal considerations, participants highlighted cultural practices, choice, language and tone, fear, and racism as impacting the BFI.

By utilizing the SEM, additional layers were added to the ITB, including a focus on the macro levels of influence, such as organizational challenges, and environment / policy (see figure 3). Under organizational challenges, participants shared examples of how their specific facility implemented the BFI and the barriers they faced. Across the majority of the interviews the challenges included a lack of capacity, missing local context, impacts of COVID-19, as well as the perception that the BFI is a rigid and inflexible policy. Successes associated with BFI implementation included commitment from leadership, and involvement of the community.

The most outer layer of the model reflects the interactions with the environmental and policy influences including intention for implementation, and engagement with evaluation and monitoring. The central theme appeared to be the intent in which the policy was designed and

implemented. Both the interviews and data collected through document analysis highlighted if health facilities and policymakers implemented the BFI with the intent to improve the quality of care provided, then they appeared to have more success with their implementation. However, if a health facility implemented the BFI with the intent to reap the perceived benefits, they were seen to face barriers in designation as well as maintenance. Issues relating to engagement with evaluation and monitoring of BFI progress was highlighted as a barrier. In addition to barriers, research results emphasized the successes in implementation, noting the significance of staff and community participation, focus on patient autonomy, and ensuring an uplifting experience for mothers and staff.

Research results shed light on the availability and accessibility of the BFI among Indigenous women. Through examining where the BFI-designated facilities are located, it is more likely to find a BFI facility in a well-populated location, rather than a rural town. However, it was difficult to explore the utilization of the BFI among Indigenous mothers, as Indigenous mothers were not included in the study sample. Results obtained through document analysis showcased important successes in the implementation of the BFI in. rural and urban health facilities and highlighted some of the resources required. However, the documents accessed did not discuss the challenges related to implementing BFI within the Inuvik Regional Hospital or Grey Nuns Hospital. As such, the findings of this research are unable to discuss the place-based differences between rural and urban health facilities.

It therefore appears that there is an opportunity for the BFI to be culturally appropriate within a range of settings for Indigenous women, if processes and resources are in place to understand the

local culture, and the initiative is used to empower mothers with education and choices. However, the BFI can also overlook culturally appropriate components if the initiative is implemented with rigid guidelines, and the inability to highlight contextual factors that may influence a woman to formula feed. Moreover, there is also a need to ensure that the focus of BFI is to provide mothers with the education, resources and perhaps most importantly support to make an informed infant feeding plan and choice that fits their specific context. At the same time, there needs to be a shift away from a paternalistic top-down perspective, and move towards personalized care that is reflective of local contexts and available resources.

4.2 Study Strengths and Limitations

This study included a variety of perspectives from policymakers, health care providers, health advocates, and community organizations to try and obtain an understanding of the implementation and cultural appropriateness of BFI across multiple levels. This approach provided a comprehensive understanding of BFI from a policy, health provider, and community organization level. The research also employed qualitative methods including semi-structured interviews to provide an in-depth understanding on a topic (Kakilla, 2021). Overall, there has been very limited research conducted examining the BFHI and the BFI, and no research has explored if the BFI is a culturally appropriate policy for Indigenous mothers. Using qualitative research methods, specifically semi-structured interviews, assisted in documenting the experiences of policymakers, health providers, and health organizations in the delivery and implementation of the BFI policy. The results of this research contribute to filling the current research gap surrounding the BFI and its cultural appropriateness and adds to the literature discussing experiences implementing the policy.

Utilizing document analysis in addition to semi-structured interviews, I was able to triangulate my data to present a confluence of evidence to establish credibility (Bowen, 2009). Document analysis therefore contributed to the strength of the study as it provided a method to analyze the grey literature available on the topic of BFI in Grey Nuns Hospital, and Inuvik Regional Hospital. Document analysis also provided an opportunity to incorporate and explore social facts to supplement the interview data.

There are, however, a number of limitations associated with this study, many associated with constraints associated with the on-going COVID-19 pandemic. The main challenge was participant engagement that negatively impacted recruitment. The COVID-19 pandemic impacted essentially every crevasse of the healthcare system across the globe. In March 2022 the Canadian Medical Association announced that "Canada's health system is on life support" (Canadian Medical Association, 2022). Staffing shortages are cited for causing mass burnouts and long backlogs among health workers (Canadian Medical Association, 2022). Through trying to recruit participants for this study, I received responses from potential participants that similar issues were noted in Australia as well. As such, there were on-going challenges in the recruitment of health care providers for this study.

The initial research design aimed to look remotely at the BFHI in Australia along with the BFI in Canada, however, due to a lack of response from Australian facilities, and a lack of available literature, Australia was omitted from the study. Canadian rural and urban health facilities were also contacted to participate in this research. Unfortunately, due to a lack of engagement

virtually, limited capacity, and lengthy institutional ethics processes, we were unable to receive approval in time to include the participation of individuals from these health facilities. In response, the initial research design was adapted to include document analysis to provide supplemental results for the case studies. Initially, it was anticipated that 15-20 interviews would be included to provide the perspectives of approximately 5 hospital administrators, 5 health care providers, 5 policymakers, and 5 community leaders across Canada and Australia in rural and urban locations. However, due to complications with virtual recruitment, overall, only 7 participants were interviewed over the eight-month recruitment period.

Using a case study research design also carries limitations to the study's generalizability (Crowe et al., 2011). The narrow focus of the case study implies that the results cannot be generalized. However, the objectives of the research were to shine a light on the experiences of the specific health facilities servicing Indigenous women and families. Case study research has also been criticized due to its lack of transparency (Crowe et al., 2011). To counter this, quotations were used to outline the content incorporated and provide context. There are also limitations associated with document analysis. Articles included in document analysis are not created for the purpose of research, and therefore do not necessarily provide sufficient data (Bowen, 2009). To address this limitation, I drew on a number of articles to provide a variety of perspectives. Biased selectivity can also be a limitation (Bowen, 2009). To reduce its occurrence, I made the selection process transparent through the inclusion of keywords and search platforms and kept a journal throughout to ensure I was reflective through the process.

Lastly, when conducting document analysis to inform the case studies, the number of relevant documents were very limited. As such, the case-based descriptions and data can appear to be thin, and lacking substance. However, high quality documents were included to inform the case studies and did shine light on part of the implementation process within Grey Nuns Hospital, and Inuvik Regional Hospital.

4.3 Research Contributions and Implications for Future Research

This study is the first to my knowledge to examine the BFI in Canada as a culturally congruent policy for Indigenous mothers. It is also the first to highlight the experiences of both healthcare providers and policymakers in the delivery and implementation of the BFI within Canada. Moreover, this study builds on the ITB framework through incorporating the SEM. An additional unique contribution to this area of research is the use of document analysis in combination with qualitative interviewing methods. While this study only included data from document analysis on the Inuvik Regional Hospital, and the Grey Nuns Hospital, it still included a small number of documents that were meant to reflect social facts. Focusing on documents that have been created without the intervention of a researcher, is intended to provide insights into the social beliefs, behaviours, and attitudes towards the BFI within the locations selected.

This research further builds on studies that examine the role of fear and racism within health care settings (Moffitt, 2018). Participants in this research illustrated that fear and racism play a role in the utilization of government run health services. With the history of colonization, discrimination, racism and abuse, there are still tensions and fears associated with health programs that are coming from outside of the local community (Moffitt, 2018). As a blanket

global policy initiative, BFI is not culturally appropriate for Indigenous mothers, as it is missing the incorporation and inclusion of the local context present within the communities it services. According to study participants the local Indigenous context needs to be taken into consideration along with a focus on informed choice, along with recognition of the presence of fear and systemic racism in the health system. Participants suggested that the creation of training surrounding anti-racism and internal bias as one possible way to address within health facilities serving Indigenous mothers and their families.

Within the BFI policy, there should be a more wholistic approach to breastfeeding, incorporating the perspectives from a spiritual, emotional, mental and physical lens (Moffitt, 2018). The educational materials and resources (including breastfeeding curriculum) provided through the BFI, should include Indigenous cultures, traditions, language, and positive Indigenous and gender representation. This could be achieved through using graphics and photos that are positive, inclusive, and relevant to the local context. Moreover, the language and tone should be considerate of gender inclusivity, and the stigma associated with formula feeding.

One of the main findings that continuously was showcased in the academic literature, and the data collected for this study was the theme of participation from community and staff to ensure successful policy implementation. There needs to be collaboration with key stakeholders (including staff and community members) to work towards improving health outcomes in Indigenous maternal and child health (Moffitt, 2018; Scott, 2018; Asamoah et al., 2022). The results of this study highlight that collaboration including a range of stakeholders is possible in Canada when implementing the BFI, and further expands on previous research to showcase how.

Participants in this study present several examples of collaboration in the creation and delivery of the BFI, including the use of community created toolkits, community ownership and championing, staff knowledge on BFI, as well as the use of staff and community quality committees. By sharing the results of this study through publications, conferences, along with knowledge dissemination platforms, it is hopeful that this will encourage and spark collaboration across policymakers, health providers and community organizations.

Due to time constraints and challenges associated with the COVID-19 pandemic, Indigenous mothers were not interviewed for this study. While one Indigenous mother was interviewed, the perspectives she provided was as an employee working at a health organization, not her personal experiences as an Indigenous mother. As such, the specific insights and experiences of Indigenous mothers is missing from the development of the adapted framework, and the interpretation of the results. It is hopeful that future research will draw on the framework presented and further refine it using Indigenous perspectives and experiences through further engagement and storytelling.

Within Canada there has been limited research on Indigenous maternal health care (Bacciaglia et al), particularly within the postnatal period. There is a need therefore to further examine how Indigenous women perceive the BFI within Canada, as well as internationally. In-person community-based engagement on this topic could be achieved by working directly with health facilities providing BFI, including methods such as participant observations and perhaps arts-based methods such as photovoice combined with sharing circles. Participatory research could

assist with participant engagement and bridge opportunity for wider knowledge translation and integration of research recommendations.

As we also described in this study, COVID-19 was found to have had a large impact on the delivery of BFI services in Canada, as well as internationally. Academic literature also discussed the continuously changing recommendations, reporting that health care providers were unsure how to provide safe birthing care under the unknown circumstances (Flaherty et al., 2022). Participants in this study, showcased that due to COVID-19, a number of BFHI guidelines were ignored, including skin-to-skin immediately after birth, and rooming in. A possible future research area could retrospectively explore the short-term and long-term health and social impacts of changing the birthing practices due to COVID-19. Moreover, research should be conducted to review how Indigenous women experienced giving birth during the COVID-19 pandemic. With the history of residential schools, intergenerational trauma, and discrimination, they may have experienced and perceived the restrictive COVID-19 birthing practices differently compared to non-Indigenous women.

At the global level further research is necessary to compare and contrast across countries that have the BFI/BFHI designation. Due to the limitations previously discussed, this research was unable to present a comparison of circumstances within institutional settings in Australia and Canada. However, future research comparing the implementation of the BFI across international settings could provide meaningful insights into the similarities and differences in experiences, perspectives, and resources required throughout the designation and implementation processes.

Lastly, future research needs to provide a more in-depth examination of the language and tone used within the BFHI material to determine areas of improvement for inclusivity of all genders and orientations. In this study, the majority of participants consistently used gender inclusive language, referring to chest feeding, and person who gave birth. Comparatively, none of the official BFHI policy information includes gender inclusive language, exclusivity using terms such as breastfeeding, and mother, women. Future research is required to examine what updates can be made to the documents to promote gender inclusivity internationally.

To conclude, the body of this thesis centred on exploring how the BFI has been implemented within facilities along with examining the availability and utilization of the BFI among Indigenous women. The results of the research suggest there is a need to ensure that health policies and programs providing care to Indigenous women are centered in local knowledge, co-developed, and co-led by community. The BFI as a health policy presents an opportunity to inform mothers of best practices related to infant feeding, however as this research has revealed, it can also be inflexible and restrictive if not adapted to the needs and values of the communities it is serving including diversity in culture along with gender.

The results of this research highlighted influences that can contribute towards the success of a health facility in implementing the BFI, along with circumstances where barriers arose. Through analyzing these influences as case studies, it was clear that there are common themes between Canadian and international contexts, suggesting there needs to be stronger knowledge dissemination and sharing on the topic of the BFI such as a virtual platform to share knowledge, perspectives, and experiences of implementing the BFI. As the process of document analysis

revealed, there is limited information published on this topic highlighting community-based examples and incorporating local contexts, particularly Indigenous communities. Transparency in the implementation process can help aid those who are looking to implement the BFI, and allow for those in diverse communities to voice concerns. The current lack of transparency surrounding implementation, language, and learning, is problematic and restricts continued growth and cultural evolution in the promotion of breastfeeding in all its forms.

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Appendices

Appendix A: Summary of the Top 10 Key Points of the International Code[4]

Summary of the top 10 key points of the code, created by Breastfeeding Committee for Canada
1. No advertising of products under the scope of the Code to the public.
2. No free samples to mothers.
3. No promotion of products in health care facilities, including the distribution of free or low-cost supplies.
4. No company representatives to advise mothers.
5. No gifts or personal samples to health workers.
6. No words or pictures idealizing artificial feeding, including pictures of infants on the labels of products.
7. Information to health workers should be scientific and factual.
8. All information on use of breastmilk substitutes, including the labels, should explain the benefits of breastmilk and all costs and hazards associated with artificial feeding.
9. Unsuitable products such as sweetened condensed milk should not be promoted for babies.
10. Products should be of a high quality and take into account the climatic and storage conditions of the country where they are used.

[4] Breastfeeding Committee for Canada. (2022, September 26). *Baby-Friendly Initiative*. Breastfeeding Committee for Canada. Retrieved from https://breastfeedingcanada.ca/en/baby-friendly-initiative/

Appendix B: The Baby-Friendly Hospital Initiative implementation guideline (Ten Steps) outlined by WHO and UNICEF.[5]

STEP	Original version (1989) 'Every facility providing maternity services and care for newborn infants should':	Revised version (2018)
1	Have a written breastfeeding policy that is routinely communicated to all healthcare staff.	(a) Comply fully with the International Code of Marketing of Breast-milk substitutes and relevant World Health Assembly resolutions. (b) Have a written infant feeding policy that is routinely communicated to staff and parents. (c) Establish ongoing monitoring and data-management systems.
2	Train all healthcare staff in the skills necessary to implement the breastfeeding policy.	Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding
3	Inform all pregnant women about the benefits and management of breastfeeding.	Discuss the importance and management of breastfeeding with pregnant women and their families
4	Help mothers to initiate breastfeeding within half an hour of birth.	Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
5	Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants	Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6	Give newborn infants no food or drink other than breastmilk, unless medically indicated.	Do not provide breastfed newborn infants any food or fluids other than breastmilk, unless medically indicated
7	Practice rooming-in, allowing mothers and infants to remain together 24 hours a day.	Enable mothers and infants to remain together and to practice rooming-in 24 hours a day.
8	Encourage breastfeeding on demand	Support mothers to recognize and respond to their infant's cues for feeding.
9	Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.	Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
10	Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.	Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

[5] Aryeetey, R., & Dykes, F. (2018). Global implications of the new WHO and UNICEF implementation guidance on the revised baby-friendly hospital initiative. *Maternal & Child Nutrition*, *14*(3). https://doi.org/10.1111/mcn.12637

Appendix C: The 9 Key Responsibilities Included in BFHI Implementation[6]

Countries are called upon to fulfill nine key responsibilities through a national BFHI program:
1. Establish or strengthen a national breastfeeding coordination body.
2. Integrate the Ten Steps into relevant national policy documents and professional standards of care.
3. Ensure the competency of health professionals and managers in implementation of the Ten Steps.
4. Utilize external assessment systems to regularly evaluate adherence to the Ten Steps.
5. Develop and implement incentives for compliance and/or sanctions for non-compliance with the Ten Steps.
6. Provide technical assistance to facilities that are making changes to adopt the Ten Steps.
7. Monitor implementation of the initiative.
8. Advocate for the BFHI to relevant audiences.
9. Identify and allocate sufficient resources to ensure the ongoing funding of the initiative.

[6] WHO. (n.d.)B . *Promoting baby-friendly hospitals*. World Health Organization. Retrieved from https://www.who.int/activities/promoting-baby-friendly-hospitals

Appendix D: BFI Designated Facilities in Alberta[7]

Hospital Name /Community Centre	**Designation**
1. High River General Hospital, High River Alberta	2017
2. Grey Nuns Community Hospital, Edmonton, Alberta	2017
3. Bonnyville Healthcare Centre, Bonnyville Alberta	2017
4. Misericordia Community Hospital, Edmonton, Alberta	2018

[7] Breastfeeding Committee for Canada. (2021, January). Baby-Friendly Facilities in Canada. Canada; Breastfeeding Committee for Canada. Retrieved from https://breastfeedingcanada.ca/wp-content/uploads/2021/01/2021-January-Designated-Facilities-in-Canada-en.pdf

Appendix E: BFI Designated Facilities in British Columbia[8]

Hospital Name/ Community Centre	**Designation**
1. B.C. Women's Hospital and Health Centre, Vancouver, British Columbia	2008
2. Chilliwack Public Health Unit, Chilliwack, British Columbia	2018
3. Maple Ridge Public Health, Maple Ridge, British Columbia	2019

[8] Breastfeeding Committee for Canada. (2021, January). Baby-Friendly Facilities in Canada. Canada; Breastfeeding Committee for Canada. Retrieved from https://breastfeedingcanada.ca/wp-content/uploads/2021/01/2021-January-Designated-Facilities-in-Canada-en.pdf

Appendix F: BFI Designated Facilities in Manitoba[9]

Hospital Name / Community Centre	**Designation**
1. Bethesda Regional Health Centre, Steinbach, Manitoba	2014
2. The Pas Primary Health Care Centre, The Pas Manitoba	2015
3. Flin Flon Primary Health Care Centre, Flin Flon, Manitoba	2017
4. Thompson Public and Community Health Services, Thompson, Manitoba	2017

[9] Haiek, L. N. (2021). Annual General Meeting: Breastfeeding Committee for Canada: Report 2021. Canada; Breastfeeding Committee for Canada. Retrieved from https://breastfeedingcanada.ca/wp-content/uploads/2022/04/BCC-AGM-2021-Report.pdf

Appendix G: BFI Designated Facilities in Newfoundland and Labrador[10]

Hospital Name / Community Centre	**Year of Designation**
1. Labrador West Health Centre Labrador City, Newfoundland, 2018	2018

[10] Haiek, L. N. (2021). Annual General Meeting: Breastfeeding Committee for Canada: Report 2021. Canada; Breastfeeding Committee for Canada. Retrieved from https://breastfeedingcanada.ca/wp-content/uploads/2022/04/BCC-AGM-2021-Report.pdf

Appendix H: BFI Designated Facilities in Northwest Territories[11]

Hospital Name / Community Centre	**Year of Designation**
1. Inuvik Regional Hospital, Inuvik Northwest Territories	2018

[11] Haiek, L. N. (2021). Annual General Meeting: Breastfeeding Committee for Canada: Report 2021. Canada; Breastfeeding Committee for Canada. Retrieved from https://breastfeedingcanada.ca/wp-content/uploads/2022/04/BCC-AGM-2021-Report.pdf

Appendix I: BFI Designated Facilities in Nova Scotia[12]

Hospital Name / Community Centre	**Year of Designation**
1. Aberdeen Hospital, New Glasgow, Nova Scotia	N/A
2. IWK Health Centre, Halifax, Nova Scotia	N/A

[12] Breastfeeding Committee for Canada. (2021, January). Baby-Friendly Facilities in Canada. Canada; Breastfeeding Committee for Canada. Retrieved from https://breastfeedingcanada.ca/wp-content/uploads/2021/01/2021-January-Designated-Facilities-in-Canada-en.pdf

Appendix J: BFI Designated Facilities in Ontario

Hospital Name / Community Centre	**Year of Designation**
1. St. Joseph's healthcare, Hamilton	2003
2. Michael Garron Hospital, Toronto	2007
3. Grey Bruce Health Services, Owen Sound, Ontario	2015
4. North Wellington health Centre - Palmerston and District Hospital in Palmerston Ontario	2017
5. North Wellington Health Care - Louise Marshall Hospital, Mount Forest, Ontario	2017
6. Trillium Health Partners - Credit Valley Hospital, Mississauga, Ontario	2017
7. Trillium Health Partners - Mississauga Hospital, Mississauga Ontario	2017
8. Halton Regional Health Department, Oakville, Ontario	2009

9. Algoma Public Health Sault Ste. Marie, Ontario	2010
10. Chatham-Kent Public Health Service, Chatham, Ontario	2010
11. North Bay Parry Sound District Health Unit, North Bay, Ontario	2011
12. Centretown Community Health Center, Ottawa, Ontario	2012
13. Toronto Public Health, Toronto, Ontario	2013
14. Kingston, Frontenac, Lennox & Addington Public Health, Kingston, Ontario	2013
15. Region of Waterloo Public Health and Emergency Services, Waterloo, Ontario	2015
16. York Region Community and Health Services Newmarket, Ontario	2016
17. City of Hamilton Public Health	2016

Services, Hamilton, Ontario	
18. Huron Perth Public Health, Clinton, Ontario	2016
19. Renfrew County and District Health Unit, Pembroke, Ontario	2016
20. Eastern Ontario Health Unit, Rockland, Ontario	2016
21. Public Health Sudbury and Districts, Sudbury, Ontario	2016
22. Timiskaming Health Unit, New Liskeard, Ontario	2017
23. Woolwich Community Health Centre, St. Jacobs, Ontario	2017
24. Simcoe Muskoka District Health Unit, Barrie, Ontario	2017
25. Windsor-Essex County Health Unit, Windsor, Ontario	2017
26. Carlington Community Health Centre, Ottawa, Ontario	2017

27. Two Rivers Family Health Team, Cambridge, Ontario	2018
28. Haldimand Norfolk Health Unit, Simcoe, Ontario	2019
29. Haliburton, Kawartha, Pine Ridge District Health Unit, Port Hope, Ontario	2019
30. Leeds. Grenville & Lanark District Health Unit Brockville, Ontario[13]	2019

[13] Breastfeeding Committee for Canada. (2021, January). Baby-Friendly Facilities in Canada. Canada; Breastfeeding Committee for Canada. Retrieved from https://breastfeedingcanada.ca/wp-content/uploads/2021/01/2021-January-Designated-Facilities-in-Canada-en.pdf

Appendix K: BFI Designated Facilities in Quebec

Region	**Name of Hospital / Community Centre**
Region 01-Bas-Saint-Laurent	Our Lady of Fatima Hospital CLSC Saint-Pascal Our Lady of Fatima Hospital Villa Maria Residential Centre CSSS de La Mitis CLSC of The Heights Birth Centre Colette-Julien
Regional 03 - Capitale- Nationale	CLSC Donnacona CLSC CLSC of Pont-Rouge Portneuf CLSC CLSC of Riviere-a-pierre CLSC Saint-marc-des-carrieres CLSC Saint-Ubalde Saint-Raymond CLSC
Region 04- Mauricie and Centre-du-Quebec	Birthplace of the Daughters of Wisdom
Region 05-Estrie	Brome-Missisquoi-Perkins Hospital

	Cowansville South CLSC Cowansville CLSC Farham CLSC CLSC Brome Lake Sutton CLSC Bedford CLSC and accommodation centre Asbestos Hospital, CLSC and residential centre Valcourt residential centre Windsor residential centre Richmond clsc Bromont clsc Clsc saint-joseph Waterloo clsc CLSC Notre Dame CLSC Robinson South CLSC Saint- Charles CLSC Yvan Duquette CSSS Of the MRC-de-Coaticook Memphremagog CSSS Mansonville CLSC Memphremagog CSSS- Stanstead service point

Region 06- Montreal	CLSC De LaSalle Dorval-Lachine CLSC Pierrefonds CLSC CLSC Lac-Saint-Louis Saint-Charles Metal Health Ambulatory Service Centre CLSC Lac-Saint Louis Birth Centre St. Mary's Hospital Centre CLSC of Cote-des-neiges CLSC and GMFU Cote-des-neiges Parc-extension multi-service health and social services centre CLSC and GMFU Metro CLSC union Birth Centre Cote-des-Neiges CLSC Saint-Leonard CLSC Saint Michel CLSC des faubourgs Visitation CLSC and GMFU CLSC and GMFU of the Faubourgs CLSC and GMFU Sainte-Catherine CLSC du Plateau-Mont-Royal CLSC Staint-Louis-du- Parc

	CLSC Saint- Urbain Jeanne-Mance Birth Centre
Region 07- Outauais	Outaouais Birth Centre
Region 12 - Chaudiere - Appalaches	Mimosa birth centre
Region 15 - Laurentians	Laurentian Hospital CLSC of Sainte-Agathe-des-Monts Mont-Tremblant CLSC CLSC De Labelle CLSC of Therese-de blainville CLSC Saint Joseph Argenteuil multi-service health and social service centre Grenville CLSC and Day centre Mary Street CLSC and Ambulatory Services Centre Kanesatake Heath Centre
Region 16 - Monteregie	CLSC des Patriotes CLSC Saint-Bruno-de-Montarville CLSC of Mont-Saint- Hilaire Boucherville CLSC

	Saint-Amable CLSC CLSC of Sainte-Julie Varennes CLSC CLSC of Vercheres CLSC des Seigneuries and residential centre of Contrecoeur CLSC des Seigneuries CLSC simonne-monet-chartrand CLSC de longueuil-Ouest Anna Laberge Hospital CLSC Kateri CLSC Chateauguay Residential centre and CLSC of Coteau-du-lac Rigaud CLSC CLSC Saint-Polycarpe CLSC and ambulatory services centre of Vaudreuil-Dorion CLSC of the Valley of the Forts Henryville CLSC Chaplain Street CLSC Saint-Jean-sur-Richelieu Service point Richelieu CLSC CLSC Saint-Cesaire

	Birthplace of Richelieu[14]

[14] Quebec. (2022, September). *Information pour les Professionnels de la Santé*. Allaitement et alimentation. Retrieved from https://www.msss.gouv.qc.ca/professionnels/perinatalite/allaitement-et-alimentation/initiative-amis-bebes

Appendix L: BFI Designated Facilities in Saskatchewan[15]

Name of facility	Date of designation
1. West Winds Primary Health Centre, Saskatoon, Saskatchewan	2011

[15] Haiek, L. N. (2021). Annual General Meeting: Breastfeeding Committee for Canada: Report 2021. Canada; Breastfeeding Committee for Canada. Retrieved from https://breastfeedingcanada.ca/wp-content/uploads/2022/04/BCC-AGM-2021-Report.pdf

Appendix M: Semi-Structured Interview guide: Health Providers

Semi-Structured Interview Guide for a Healthcare provider in a Hospital Setting

1. Can you please tell me about your role here at the hospital?
2. How long have you worked for this health facility?
3. How has your role changed over the years?
4. What do you know about the Baby-Friendly Initiative (BFI)/ Baby-Friendly Hospital Initiative (BFHI)?
5. What is your opinion of the BFI/BFHI?
6. What was your reaction to the adoption of the BFI/BFHI?
   Prompt: What was the reaction of other staff members?
7. What was your experience like when the hospital became BFI/ BFHI designated?
   Prompt: Was it a negative or positive experience? Was it a long process? Was it confusing? Did you feel supported during the adoption of the program?

8. Can you tell me a bit about how and why the health facility decided to become BFI/ BFHI designated?
   Prompt: Who led the implementation of the program? Who initiated the program? Who was involved in terms of their roles? How were people selected to be a part of the implementation of the program, were people selected, did the hospital put a flyer asking for volunteers to participate?

9. How long have you been providing care under the BFI/BFHI?
   Prompt: Personal experience? Providing care at this specific hospital? Providing care at additional health facilities?
10. What has your experience been like providing care under the BFI/BFHI?
11. Can you tell me about any other health initiatives that are similar to the BFI/ BFHI?
12. What was the training process like when the hospital incorporated the BFI/BFHI?
13. How did the implementation of the BFI/BFHI change your workload?
    Prompt: Did the workload increase/decrease? Did the individual notice that they were spending more time doing some particular tasks that they might not have been responsible for before?

14. Have you seen a change in the number of patients you help with birthing since the adoption of the BFI/BFHI?
15. Have you seen a change in the number of patients you help with antenatal care since the adoption of the BFI/BFHI?

16. Are there Indigenous women who are supported by the BFI/BFHI program within your facility?
    Prompt: What do you believe is the overall proportion of Indigenous women who access these supports?
17. How do you think the BFI/BFHI received among Indigenous patients generally?
    Prompt: Do you feel that the BFI/BFHI supports Indigenous women and their families locally?

18. Do you have any advice for any health providers that will be joining a facility that offers BFI/BFHI services?
19. In addition to the BFI/BFHI, do you have recommendations for the adoption of a maternity-based health initiative?
20. Has the pandemic impacted the hospital's ability to implement the BFI/BFHI?
21. From your experience, do patients face any barriers when trying to access BFI/BFHI services?

    Prompt: If yes, what? If not, would you anticipate any barriers?

22. How do you think your facility could be improved for Indigenous women and their babies?

23. Are there other programs you believe are better suited to address the maternal health care needs of Indigenous patients during pregnancy? Postpartum?

24. Is there anything else you would like to share?

Appendix N: Semi-Structured Interview guide: Hospital Administrator

Semi-Structured Interview Guide for a Hospital Administrator Role

1. Can you please tell me about your role here at the hospital?
2. How long have you been in your position?
3. What do you know about the Baby-Friendly Initiative (BFI) / Baby-Friendly Hospital Initiative (BFHI)?
4. Does your hospital offer any other services that are similar to the Baby-Friendly Initiative?
5. What has your experience been with the Baby-Friendly Initiative?
   Prompt: How long have you been involved with the BFI/ BFHI? Prior to your current position, have you had any experience with the BFI/ BFHI?

6. Can you tell me how your facility incorporated the BFI/BFHI designation?
   Prompt: Was the experience negative, positive, any barriers? How long did the process take?

7. In your experience what kinds of resources or supports are necessary to implement the BFI/ BFHI, and to also maintain the designation?
   Prompt: number of staff involved, training sessions (education resources, flyers, etc.), cost of the program.

8. Can you explain what is involved in the maintenance of the BFI/BFHI designation?
   Prompt: How often does the re-designation process occur? What does the process include?
9. Was there any change in community support, or patient load when your facility became BFI/BFHI designated? f
   Prompt: increase/decrease in patients; support from the wider community

10. How did your position play a role in the adoption of the BFI/ BFHI, or the maintenance of the program?

11. If another hospital was planning on adopting the BFI/ BFHI program, would you have any advice for them?

12. How did the hospital staff, including administration, care staff, and board members react to the adoption of the program?
    Prompt: Was the staff okay with the implementation of the program? Were there any concerns with the adoption?

13. What kind of results has the hospital seen since the implementation of the program?
    Prompt: Has there been any change in patient satisfaction/dissatisfaction? changes in health outcomes, breastfeeding rates, etc

Appendix O: Semi-Structured Interview guide: Policy or Government Employee

Semi-Structured Interview Guide for a Policymaker at an International Organization or Local/Federal government

1. Can you please tell me about your role at the organization/government?
2. How long have you been in your position?
3. What do you know about the Baby-Friendly Initiative/ Baby-Friendly Hospital Initiative?
4. What has your experience been with the BFI/ BFHI?
   Prompt: How long have you been involved with the BFI/BFHI? Prior to your current position, have you had any experience with the BFI/BFHI?

5. What has your organization's experience been with the BFI/BFHI?
   Prompt: what kind of policies have they implemented surrounding BFI/BFHI? Who led the initiative and why and when was it created?

6. In your experience what kinds of resources or supports are necessary to implement the BFI/BFHI?
7. In your experience what kinds of resources or supports are necessary to maintain the BFI/ BFHI designation?
8. What type of barriers did you and your organization face when trying to implement the BFI/BFHI?
9. How was the BFI/BFHI received when it was first created?
   Prompt: Were they supportive and/or excited? Were there any concerns with the creation of the policy?
10. Why do you think health facilities may neglect implementing the BFI/BFHI?
11. How do you think the uptake of the BFI/ BFHI could be improved?
12. How do you think the overall BFI/BFHI policy can be improved? Internationally? At the local level?

13. Why do you believe there is such a variation in the uptake of the BFI/BFHI within countries, as well as internationally?
14. Can you explain how the BFI/BFHI has been implemented within different cultures?
15. Can you explain if you believe the BFI/ BFHI provides culturally appropriate support to Indigenous mothers and their babies? If yes, why? If not, why?
16. How has COVID-19 impacted the implementation of BFI/BFHI policy?
17. Is there anything else you would like to share?

Appendix P: Research ethics approval: Research Ethics Board, University of Waterloo

Dear Hannah Tait Neufeld and other members of the research team:

Your application has been reviewed by Delegated Reviewers. We are pleased to inform you the **Initial application for 44051 Examining the application and use of the Baby-Friendly Hospital Initiative within Rural and Urban health facilities in Canada and Australia among Indigenous Mothers** has been given ethics clearance.

Note: Due to the current COVID-19 situation, research activities that require face-to-face/in-person interactions cannot be conducted until all procedures (e.g., safety plan approval) have been completed. For on campus research, all research team members and participants must complete the campus check in before coming to campus and be full fully vaccinated or have received an accommodation as per the University of Waterloo's vaccination policy. Please review processes and forms, vaccination confirmation guidance, and templates and guidance to use when conducting in-person research activities. Direct any inquires to researchethics@uwaterloo.ca.

This research must be conducted in accordance with the most recent version of the application in the research ethics system and the most recent versions of all supporting materials.

Ethics clearance for this study is valid until Thursday, May 4th 2023.

The research team is responsible for obtaining any additional institutional approvals that might be required to complete this Expedited study.

University of Waterloo Research Ethics Boards operate in compliance with the institution's guidelines for research with human participants, the Tri-Council Policy Statement for the Ethical Conduct for Research Involving Humans (TCPS, 2nd edition), Internalization Conference on Harmonization: Good Clinical Practice (ICH-GCP), the Ontario Personal Health Information Protection Act (PHIPA), and the applicable laws and regulations of the province of Ontario. Both Boards are registered with the U.S. Department of Health and Human Services under the Federal Wide Assurance, FWA00021410, and IRB registration number IRB00002419 (Human Research Ethics Board) and IRB00007409 (Clinical Research Ethics Board).

Appendix Q: Words and Platforms used During Documentary Analysis Search

Phrase	**Platform**	**Resources Found**
BFI Grey Nuns Hospital	Google	Congratulations - Covenant Health - Covenant Health Covenant Health - Grey Nuns Community Hospital Grey Nuns Community Hospital Earns Baby-Friendly Designation by - Covenant Health Grey Nuns Receives 'Baby-Friendly" by designation by Covenant Health
Baby Friendly Initiative Grey Nuns Hospital	Google	Helping moms and babies at Grey Nuns by Covenant Foundation International accreditation for

		promoting breastfeeding for new mothers by Grandin Media
Indigenous Baby Friendly Initiative Grey Nuns Hospital	Google	Covenant Health Grey Nuns Community Hospital , followed links on the web page to get the following resources from The Vital Beat: Indigenous People are at much higher risk for Diabetes
Indigenous	Webpage at Covenant Health Grey Nuns Community Hospital	Covenant Health Grey Nuns Community Hospital - Main Page 11 results came up, of which 4 are relevant: Aboriginal Liaison The Path to Reconciliation Child Health Clinic Diversity & Inclusion at Covenant Health

Inuvik Regional Hospital Baby Friendly Initiative BFI Inuvik Regional Hospital Indigenous Inuvik regional hospital baby friendly initiative	Google	Inuvik Regional Hospital First Arctic Hospital to receive Globally Recognized Baby-Friendly Designation by Health and Social Services Authority Baby Friendly Initiative by Health and social services Inuvik Hospital becomes 1st in territories to get 'baby-friendly' designation by CBC news Inuvik Hospital Received Baby-friendly Designation by True North Best Health|Best Care| Better Future by PracticeNWT

Appendix R: Sources Reviewed and Coded for Document Analysis

Name of Document	Type of Document	Is Previous research included in the content?	Is the author drawing from first-hand experience? If not, where is the data from?	Who was the article intended for?	What content is detailed? What content is vague?	What is the overall purpose of the document?	Is the author listed?	Findings/ Themes/ Categories
Grey Nuns Hospital leads in being 'Baby Friendly'	News Article	No	Yes. The content involved in this document draws on information obtained through interviews with staff and patients who had experience with receiving BFI care.	Mothers	Detailed	*To discuss the designation process of the BFI at Grey Nun Hospital.	Author Listed	Choice, informed decision, learned behaviour, educational materials, perception that breastfeeding is easy, breastfeeding support from health providers, support for infant feeding formula, respect for mothers, feeding choice, mothers know best, lack of mention of culture or traditional healing, lack of representation.
Name of Document	**Type of Document**	**Is Previous research included in the content?**	**Is the author drawing from first-hand experience? If not, where is the data from?**	**Who was the article intended for?**	**What content is detailed? What content is vague?**	**What is the overall purpose of the document?**	**Is the author listed?**	**Findings/ Themes/ Categories**
Grey Nuns Receives "baby-friendly' designation	Webpage	Yes	Yes, interviews with hospital staff and mothers	Public	Includes details	*To share the story on how BFI was implemented in Grey Nuns Hospital	Yes.	No mention of culture, no representation, shift in care, skin-to-skin, rooming in, breastfeeding, protect families against commercial pressures from formula companies, support, choice,
Helping Moms and Babies at Grey Nun	Webpage	No	Drawing on experiences from staff	Public	Short, slightly detailed	*To discuss the implementation of BFI	No, posted by the hospital foundation	Collaboration with health providers, 15-minute tutorial, bonding between mother and baby
Covenant Health Grey Nuns Community Hospital	Webpage	No	Research is not presented on this webpage	General Population	Slightly detailed, vague in particular parts	*To provide general information on the services available at the hospital.	No	Lack of culture, lack of representation, mention of Indigenous people in paragraph on the bottom on land acknowledgement, spiritual care

Name of Document	Type of Document	Is Previous research included in the content?	Is the author drawing from first-hand experience? If not, where is the data from?	Who was the article intended for?	What content is detailed? What content is vague?	What is the overall purpose of the document?	Is the author listed?	Findings/ Themes/ Categories
Congratulations on the anticipated arrival of your baby!	PDF Presentation	No	Hospital Resources	Pregnant People	The document is detailed about the resources available at the hospital. But is vague about benefits / risks.	The purpose of the document was to answer questions pregnant people may have about giving birth at the Grey Nuns.	No, published by the hospital.	Lack of representation, No mention of culture or traditional healing, Does not use inclusive language, limitations on number of people in the room, mentions skin-to-skin, respects feeding decision, staff one-on-one conversations to result in informed feeding, recognition of context.
Grey Nuns Community Hospital Earns Baby-Friendly Designation	Webpage	No	Draws from employee experiences	Public	Relatively Detailed	*To share information surrounding the BFI designation	No, published by Covenant Health	Positive intention, education,

Name of Document	Type of Document	Is Previous research included in the content?	Is the author drawing from first-hand experience? If not, where is the data from?	Who was the article intended for?	What content is detailed? What content is vague?	What is the overall purpose of the document?	Is the author listed?	Findings/ Themes/ Categories
Inuvik Hospital becomes 1st in territories to get 'baby-friendly' designation	News Article	No	Interviews with staff and patients of Inuvik Hospital	General Population	Detailed	*The purpose is to announce that Inuvik Regional Hospital received the BFI designation, and share positive experiences from staff and patients.	Yes.	Collaborative process, time, community, breastfeeding support, choice, support infant formula feeding, positive experience with mothers, peer support, home support, positive patient experience, promotion of breastfeeding, community services
Health Services in the Beaufort Delta Region	Webpage	No	Information from Inuvik Regional Hospital	General Population	Detailed in terms of the different departments, located in the hospital. However, missing specific information on services offered within different departments at the hospital.	*Provide resources for the health services available within the facilities located in the geography.	No.	Lack of resources

Name of Document	Type of Document	Is Previous research included in the content?	Is the author drawing from first-hand experience? If not, where is the data from?	Who was the article intended for?	What content is detailed? What content is vague?	What is the overall purpose of the document?	Is the author listed?	Findings/ Themes/ Categories
Aboriginal Liaison	Webpage	No	Research is not presented on this webpage	Indigenous patients receiving care from Grey Nun Hospital	Detailed	*To provide information on the Aboriginal Liaison service available at the hospital	No	Culture, compassionate, traditional healing, smudging, trust, communication
Inuvik Regional Hospital First Arctic Hospital to receive globally recognized baby-friendly designation	Webpage	No	Interviews with staff, incorporates additional resources, including government webpages, and information provided by Breastfeeding Committee Canada	General Population	Detailed	*To announce that Inuvik Regional Hospital received the Baby-Friendly Designation	Yes	Time, Positive patient experience, education to mothers, breastfeeding support, support for formula use, choice, lack of mention about culture
Baby Friendly Initiative - Health and Social Services	Webpage	No	Draws on publically available resources, to provide an overview on BFI in NWT.	General Population	Detailed	*To provide information on BFI in the NWT.	A specific person is not listed, however the Health and Wellness Promotion Department of Health and Social Services is listed.	Resources surrounding breastfeeding, skin-to-skin, supportive infant formula feeding, community health centre

Name of Document	Type of Document	Is Previous research included in the content?	Is the author drawing from first-hand experience? If not, where is the data from?	Who was the article intended for?	What content is detailed? What content is vague?	What is the overall purpose of the document?	Is the author listed?	Findings/ Themes/ Categories
Health Services by the Town of Inuvik	Webpage	No	Information from the town of Inuvik	People who live within Inuvik	Provides an overview of the hospital facility and the different departments available.	*Provides an outline of the health facility located in the area, and the services offered.	No	provides background information on the topic of breastfeeding, but nothing relevant to the study.