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Review Article

Self-efficacy for Women Breastfeeding as Migration Continues in Australia, A Review

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Abstract:

This article aims to raise awareness of the changes in the Australian population and globally. It aims to establish self-efficacy in understanding the environmental issues associated with breastfeeding women. Breast milk is a health value for babies and mothers who need support, as migration may interrupt women's traditional breastfeeding. Self-efficacy, such as self-confidence, is a significant topic in Canada. Macro layers are associated with microlayers for breastfeeding support, which differ in their host countries. Thus, in the early days, professional and community-based peers for social action faced psychological issues. This paper demonstrates that breastfeeding women require macro and local support. Relevance at macro levels influences the need for micro-level support, as assimilation is greater for Asian generations in Australia than European Countries. Many countries have yet to accept the World Health Organisation's CODE recommendations. Training needs for professional and community-based development training programs for immigrants. The Government must continue migration, implying that Society needs to accept population changes. Exclusive breastfeeding is low and requires more excellent knowledge of policies in Australia for immigrants as women are not a homogenous cultural group, and shared language can be effective and a trusting relationship around cultural topics. Australia's 60-year decline in fertility has implications for its migration projections, suggesting that higher migration rates may lead to a decline in fertility.

Key words: breastfeeding; self-efficacy; self-confidence; macro policies; peer support; training needs; cald women

Introduction

This article aims to understand the environmental issues affecting women's breastfeeding. A feminist view of breastfeeding argues for an "embodied activity with the lactating breast as its intelligence" [11]. Thus, the physiology of breastfeeding is an independent energy source, as [1] Hartmann (2007, p. 8) states, "the energy needs in the lactating breast are 30% and in the non-lactating breast are 23%". Others identify micronutrient energy intake items and show health benefits [2]. Thus, micro is a property that can overcome complications for those babies born early [3]. However, breastfeeding rates have "widened between high and low socio-economic populations" [4]. Others suggest [5,4] that peer support for breastfeeding may come from peers and social media [6]. There has been a global literature review to understand breastfeeding continuity [7]. The authors argue that fair support is vital as the migration of women has disrupted traditional breastfeeding practices (7), as a "quarter of all women giving birth in Australia are immigrants and around 18% are born in countries where English is not the principal language" [8]. Others say that "social media influences the life span of young women to overcome the notion that breastfeeding is difficult" [9]. We turn to a methodology to identify how women may be supported.

Method in Review Articles

Macro layers are associated with microlayers for breastfeeding support. A study [10] identifies that "breastfeeding has historical and cultural contexts and is not in host countries." Therefore, [11] Leeming et al. (2017) state that immigrants must be engaged in host countries. Others agree [12] Lysova et al. (2023, p. 714 that "education and counselling by professional and community-based peers can be effective". Thus, "community-based and health organizations need to understand meaningful work on ethics, settings and contexts" [12]. Teasing out education from cultural psychology is "situated action"[72], Tennant (2020, p. 3). Others suggest that motivation is the social problem-solving of volunteers [13]. Another suggests that "social practices are informed application of a specialized form of environment therapy that utilizes an intentional community to assist in theory" [14] (Velasquez et al., 2019, p. 259). We turn to self-efficacy as confidence.

Literature Self-efficacy for breastfeeding

Self-efficacy as self-confidence is a psychological issue [15]. Self-efficacy is a significant topic that has taken the view that breastfeeding research needs to be theory-led early in pregnancy and embedded in the breadth of self-efficacy theory [16]. Self-efficacy for breastfeeding has been developed in Canada and is effective in the early stages of pregnancy [17]. However, [16] McGovern identifies that "changes that occur over time are difficult to estimate." Therefore, self-efficacy has measured empowerment in individuals' actions [18]. Self-efficacy is a way to predict breastfeeding length [19]. Postpartum depression in breastfeeding mothers may mitigate breastfeeding [20]. Thus, this suggests that "common reasons are insufficient milk supply, infants not being satisfied with breast milk and issues latching to feed" [15] Reynolds. Of those "surveyed at five months, 29% were exclusively breastfeeding, which aligns with Australia's national rate of 35.4%" [15]. Others suggest personality typologies may be learned behaviour in various political-cultural areas [21]. A study on cross-cultural communication shows the need for Australian Chinese mothers in the early stages to gain knowledge [22]. Health literacy can be positive for self-efficacy in breastfeeding outcomes [23]. A midwife-led intervention increased self-efficacy and breastfeeding [24]. Others believe that a "psychological perspective is helping to improve relaxation in breastfeeding women as gaining satisfaction" [25]. A further study increases breastfeeding in psychosocial interventions [26]. Others take the Baby Friendly Health Initiative (BFHI) to train professional healthcare workers in Sweden, a multicultural population [27]. Many undertook the Training to provide the workforce with confidence. The physicians need to provide Training on the ten steps. However, the marketing of commercial milk formula is targeted at health professionals and involves high advertising [28]. We move to self-efficacy in non-English countries. Thus, self-efficacy is limited in non-English countries. A study across countries, including Australia, examined biopsychosocial factors [29]. Thus, the authors call for "support for breastfeeding as peer volunteer organizations and in the early days from health professionals" [28]. According to [25], growing acculturation psychology has a long-term definition: "When groups of individuals have various cultural backgrounds, then there can be an influence on each." Thus, adopting various values, lifestyles, and global cultures is a choice. Therefore, [30] that "assimilation is greater for Asian generations in Australia than in European Countries." We turn to the macro levels; thus, how will those support immigrants in Australia?

Macro Layers as Breastfeeding Policies

Internationally, a review study suggests that universal and targeted interventions identify social and cultural factors for further studies [32]. Others suggest that women are not a homogeneous cultural group [33]. According to research, the BFHI aims to increase breastfeeding rates in the 'Ten Steps' [34], which includes volunteer support and improving breastfeeding outcomes. However, there appear to be limited (70) accredited hospitals, maternal centres, and regional clusters in Australia, accounting for 23% of maternity facilities registered [35, 36]. Baby Friendly Hospital Initiative and Step Ten have been aligned with state leaders to improve breastfeeding rates [34]. Thus, "results indicate that implementing the Ten Steps and the BFHI is worth the investment; the social return received was significantly more significant than the investment." [37]. Many countries have yet to accept the World Health Organisation's CODE recommendations. The growing literature identifies the layers of macro influences on breastfeeding practice. Societal changes occur during migration for many women. Australian immigration is clustered in major cities [38]. Australia's 60-year declining fertility has implications for migration projections for its population, suggesting that more migrants will result in higher fertility [39]. A further implication is that new mothers born overseas are a trend that will continue. Many have suggested that formula marketing in Australia harms young children [40]. Thus, "accreditation is a way to ensure the equitable quality of maternity care, yet it lacks incentives for individual facilities in Australia's health financing system" (Baker et al., Furthermore, it is under the rights of children born in Australia [41]. Thus, human rights for children in infant marketing need greater action [42]. The health costs are for mothers, Society, and the environment due to the disposal of apparatus waste [43]. Moreover, for governments, exclusive breastfeeding is a promotion issue [44]. In conclusion, we seem to be in a problematic area for breastfeeding women. Community-based education can increase exclusive breastfeeding rates [45]. Others state that helping women to find ways to overcome barriers to exclusive breastfeeding, such as in the BFHI" [11]. As recommended by policymakers and the Innocenti Declaration meeting in August 1990, the aim is to protect and promote breastfeeding. Substitutes are, when necessary, based on sufficient information and through appropriate marketing and distribution [46]. The history of the WHO Code reflects activism for breastfeeding. In contemporary times, breastfeeding in (post-) industrialized nations has become a matter of statistical analysis globally and by countries themselves. For instance, the World Health Organization Global Data Bank provides published reports identifying breastfeeding trends in ninety-four countries. Breastfeeding rates in industrialized countries need to state membership in global initiatives such as the International WHO Code adopted by the World Health Assembly of the[46] WHO.

One issue in published breastfeeding rates is the disaggregation of numbers, which identifies specific patterns and trends among population variables, such as data in Australia. However, it is necessary to understand the health needs of immigrant women regarding language and cultural differences [47]. Thus, issues of support at the macro level have expectations at the local level. The following literature review aims to identify designed community-based development training programs for immigrants.

Training needs

A review of counselling interventions by [48] McFadden et al., in a meta-analysis, evaluated health promotions and found effective peer and health professional support. The authors conclude that antenatal and postnatal support requires certainty for mothers to find trained face-to-face breastfeeding support. Furthermore, the authors argue that health promotion is essential as it values the needs of targeted populations. This finding can be found in Agboado et al.'s [49] Study in multi-ethnic settings, suggesting maternal intentions are influenced by their socio-cultural environments during the antenatal period, thus suggesting peer support interventions need adoption during early decision-making time. Others suggest support for personal choices and ideology as a culturally sensitive approach." Others suggest information and individual support regarding personal choices and ideology as a culturally sensitive approach" [50]. A study found limited training efforts and the need for a peer supporter model for underprivileged mothers [51]. Furthermore, an Australian study by Rogers et al. of a health program for migrant and refugee women needing "peer groups and health professionals with lived experiences of migration helping mothers as gaining settlement" [52]. Thus, shared language was "an effective and trusting relationship around cultural taboo topics."[52] A further study [53] suggests "that settlement can lead to "isolation from support systems, such as formula feeding, which can be a sign of class or needs isolation from support systems taking up formula feeding, which can be a sign of class or need"[52]. These authors argue that there is a need to identify the current political and social context that influences mothers in a settlement context. A similar study [54], aimed to gain knowledge of "expectations and identify trusting relationships, which included general practice doctors, online information, and peer groups" [53] rather than less familiar and acceptable maternal and child health systems. Thus, immigrant women need language support and cultural understanding. Furthermore, a European country must provide cultural competence training [55]. The study was conducted in three countries as a two-day cultural competence training workshop [53]. Within ethnic groups, there is a diversity of languages and help-seeking behaviour. Training can be role-plays, simulations, and

experiential learning for health and community-based students. Contemporary pluralism in Australia, as immigrants, can be a resource as cognitive skills and competencies are used to think about language. A training package in three areas states: a study on cultural competence training in three European countries' ethnic groups shows a diversity of languages and help-seeking behaviour. Thus maternity care; and last challenges of and simulation of opportunities for effective communication and culturally competent care"[53]. The Training included role-plays, group discussions of case scenarios, personal experiential knowledge, and workshops" [53]. The Training was adapted from [56], including midwives and "maternity peer supporters" as providing "continuity of care and individual helping and social support" beyond professional help [53]. The evaluation was pre- and post-testing designed to assess compassion and cultural competence. Thus, immigrant women gained new health knowledge in their language and confidence in expressing themselves [53]. The knowledge, attitude and skills training program included reflective skills. Thus, adapting the training scheme for medically trained "individuals which gained low scores including taking the patient's and social context perspectives" [53]. Thus, training medical students was essential to the broader training needs.

Discussion

This study aimed to understand the issues between macro levels and how maternal peer support is in their Training. The Training was to develop and provide health care and community-based development programs. There is an ongoing global debate around the BFHI. These are "education in antenatal and postnatal, including organizational change and staff training or direct support to mothers as necessary" [56] and as "health professionals and peer supporters in groups, and individuals or family consultations was by media, face-to-face or in written information "gained knowledge [57]. The efficacy of peer support in public health strategies is to increase breastfeeding in attitude-based needs for ethnic and socio-economic groups—the Training " provided close cultural influences to match communities" [58]. Thus, peer support must have a relationship dimension that includes "individual attitudes as relaxed and caring while providing helpful and individualized support" [59]. Thus, "peer supporters supplement professional services, helping others and gaining social satisfaction" [60].

Training Implications

Can managers who train maternity peer supporters in these growing times of governments undertake the BFHI and Ten Steps and the social values of new immigrants? Thus, women or students may need a "formulaic utterance of conversational strategies and straightforward codes, such as everyday contacts" [61]. Therefore, not in Training but in oneness suggests that "preparing counsellors in multicultural training as authentic and direct about acknowledging requires passion as an educator" [62]. Therefore, developing trust in empathizing can lead to commitment. Sharing breastfeeding stories can be a relationship that needs a democratic organizational position in global times to gain self-reflection and move toward cultural empathy. Others, as assessments, need to "taking tendencies, rather than perceived abilities" in students' self-reports [62]. Therefore, as arguing for humility, empathy has a human understanding [63]. Thus, when Training, immigrant women may hold "alternative cultural values and norms related to social tendencies and emotional processes"[64]. Furthermore, there may be "individualized strategies when self-reflecting as reporting" in a pluralistic group [65]. Thus, influential "community members may give attention to organizations, and others may adjust their behaviour to be accommodating" [66]. Others suggest simulations, as cultural awareness is essential to nursing students [67]. Moreover, simulations to train community-based peers are needed. Others agree that student healthcare is in simulations to gain "medical terminology and ways to use for the patient" in their terms [68]. Thus, a study suggests that "person and patient-centred counselling needs constant and iterative aspects of dialogues" [69]. Thus, they need "authentic and listening skills, non-judgmental, and less clinical physically" [68]. Others suggest that a dialogical perspective is "respect for others and their human agency is democratic skills"[68]. Respect for others

requires educators to take their focus as "facilitators of learning rather than as executives of the policies of an organization and in social movement organizations" [70]. A New Zealand peer-supported intervention has been successful—the Training by the established La Leche League, NZ system, yet Indigenous women were limited in exclusive breastfeeding [71]. Another study suggests peer supporters were "role models, personally satisfied with their roles, and normalized breastfeeding in their communities" [69]. Parker et al. [71] state that Training needs to avoid "prejudices is to self-awareness and how cultural differences can influence ethical decision-making." Others suggest that the "human brain is open to change with new experiences" [72]. A review study of education needs to add "psychological components such as coping plans or, if available, personal support rather than telephone or text messaging" [73]. Others suggest that relational-cultural theory moves beyond self-reflection to grow and empower therapeutic relationships [74]. Thus, [75] "cultural intelligence for 'mythologies/constructs is learning from social experiences, appreciating critical differences in culture and backgrounds of self and others and being able to adapt.". Thus, training needs may include "broaching, curiosity, cultural humility, social justice and religious and spiritual training to practice gaining their self-awareness" [76], which may avoid burnout as a worker. Accordingly, [77], the need is increasing to gain "social justice knowledge to train by examining individuals understanding attitudes and beliefs, knowledge, skills, and actions."

Conclusion

This review aimed to identify societal macro and micro levels that influence how breastfeeding is supported. An implication is that new mothers born overseas are a trend that will continue [78]. Recent changes are the Government's view on more permanent residence visa situations for new immigrants [79]. We can understand this situation from Beck [80], who states that "the global and the local are mutually implicating principles rather than divergences." Others identify that exclusive breastfeeding is low and requires more excellent knowledge of policies in Australia for immigrants [22]. Studies have identified other issues implicating breastfeeding [29], such as maternal age, occupation, obesity, smoking, birth complications including caesarean, and maternal personality.

Limitations

The limitation of this review is its focus on Australia, Health, and peer students. Internationally, mixed migration is more significant than in Australia. The bias is that breastfeeding has a history in which not all women will have personal views on exclusive breastfeeding duration.

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