

Exploring Factors that Influence Adoption and Implementation of the Baby-Friendly Hospital  
Initiative in Washington State

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**Abstract**

Exploring Factors that Influence Adoption and Implementation of the Baby-Friendly Hospital Initiative in Washington State

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**Background:** The Baby-Friendly Hospital Initiative (BFHI) is a global initiative that is impacted by local context and systems. Research shows that BFHI has a positive impact on breastfeeding initiation and duration, however, there is limited adoption and implementation of BFHI. Despite several years of federal and state support, only five of 60 hospitals in Washington state are designated Baby-Friendly. A few hospitals are moving toward BFHI, but many more are not interested in pursuing the designation.

**Research Aims:** The purpose of this study is to identify the factors which positively or negatively impact adoption and implementation of BFHI in Washington state.

**Methods:** To conduct this qualitative secondary analysis, we read and summarized coded text from 18 hospital sector interviews using Greenhalgh's Diffusion of Innovations framework to identify themes and influences which help or hinder adoption and implementation of BFHI.

**Results:** Six key themes emerged as the major factors influencing adoption and implementation of BFHI: innovation, system antecedents, communication and influence, readiness, implementation, and outer context. Multi-level factors that help or hinder adoption and implementation of BFHI and BFHI-type policies include: written policy, time and funding, hospital administrator support, preexisting knowledge, knowledge sharing networks, physician support, training and education, community support, and external laws, policies, and standards.

**Conclusion:** Recommendations for improving BFHI adoption and implementation include appointment of a program coordinator to oversee implementation, lead multidisciplinary workgroups, and assure annual trainings for all staff at each maternity care site; community systems that build normative support for breastfeeding and assure that all families have access to prenatal education on breastfeeding; and state or national level initiatives that provide training, education, and technical assistance that includes developing model breastfeeding policies provided by Washington State Department of Health (WA DOH) and other stakeholders. Supportive systems and environments are built through effective policy adoption and implementation processes; knowledge about these processes can be applied to facilitate adoption and implementation of policies that support mothers in achieving their breastfeeding goals.

*(324 words)*

## Background

A gap has emerged between international evidence supporting implementation of the Baby-Friendly Hospital Initiative (BFHI) and integration into practice in Washington state. In 1991, World Health Organization/United Nations International Emergency Children's Fund (WHO/UNICEF) created BFHI, a quality improvement program intended to improve breastfeeding initiation, duration, and exclusivity and foster global breastfeeding culture. In order to be awarded a Baby-Friendly designation, birthing facilities must implement the Ten Steps to Successful Breastfeeding and comply with the International Code of Marketing of Breast-Milk Substitutes.<sup>1</sup> For the last ten years BFHI has enjoyed widespread support from the United States Department of Health and Human Services, where both the Centers for Disease Control (CDC) and the Surgeon General identified BFHI as a critical strategy for increasing high-quality maternity care.<sup>2</sup> In addition, prominent professional and academic organizations have endorsed BFHI, including the American Academy of Pediatrics and American College of Obstetrics and Gynecology.<sup>3,4,5</sup> At the Washington state level, Governor Jay Inslee launched the Healthiest Next Generation Initiative to help our next generation be the healthiest ever; supporting breastfeeding-friendly places is one of the initiative's three areas of focus.<sup>6</sup>

Though breastfeeding initiation rates are high in Washington state, outcomes for exclusivity and duration fall short of recommendations. Nearly 90% of Washington's mothers begin breastfeeding, but only 20% of babies are still breastfeeding at six months.<sup>7</sup> This is important because the health impacts of breastfeeding for both mother and baby are dose-dependent: the more the better.<sup>3-5,8</sup> One key predictor of long-term success with breastfeeding is getting

off to a good start during the hospital stay.<sup>9,10</sup> Research shows that BFHI increases initiation and duration of breastfeeding, however, implementation of BFHI is limited.<sup>11</sup> With only five BFHI accredited hospitals in the state, just over nine percent of births in Washington take place in Baby-Friendly facilities.<sup>12</sup>

Despite the benefits of BFHI in terms of initiation and duration of exclusive breastfeeding, staff from maternity care facilities pursuing the Baby-Friendly designation often come up against numerous barriers. Previously identified barriers to implementation in Washington include lack of funding, staffing limitations, and lack of education and training, both for staff and patients.<sup>13</sup> Other states have uncovered similar challenges such as difficulties garnering the administrative support to implement policy changes and changing the attitudes of staff nurses and physicians to overcome long-held beliefs regarding patient choice, as well as lack of knowledge that interferes with the implementation of best practices.<sup>14</sup> International literature confirms many of the same obstacles. Australian researchers have reported that barriers to BFHI adoption and implementation include lack of policy support, lack of funding, and misunderstanding of aims and outcomes of BFHI.<sup>15,16</sup> A recent Canadian study cited a lack of staff education and fear of stigmatizing women who do not breastfeed as further barriers to implementation.<sup>17</sup>

Established national and international facilitators to implementation of BFHI at individual hospitals include patient access to prenatal education about breastfeeding, the formation of multidisciplinary teams, and access to networks for information sharing.<sup>14</sup> The presence of a dedicated BFHI coordinator and/or team at a hospital has also been shown to facilitate

implementation, which points to the overarching need for time and financial resources. Finally, preexisting knowledge in the hands of champions tends to facilitate *adoption* of policies, whereas skills training for staff supports successful *implementation* of those policies.<sup>12-15</sup> BFHI implementation is also supported by actions taken by state health departments and monitoring efforts such as Maternity Practices in Infant Nutrition and Care (mPINC), a national survey of maternity care practices and policies conducted biannually by the CDC in all facilities with registered maternity beds, and the Joint Commission (TJC) that influences Medicaid payments and hospital accreditation.

The Washington State Department of Health (WA DOH) is committed to increasing breastfeeding rates, but also recognizes that there are very real administrative and financial barriers posed by the Baby-Friendly USA designation process. To circumvent these barriers, and at the same time incentivize more supportive breastfeeding policies and practices, WA DOH designed a voluntary recognition program called Breastfeeding Friendly Washington (BFWA) which can be used as a starting point towards receiving a Baby-Friendly designation.<sup>18</sup>

According to WA DOH, fourteen hospitals in the state are already designated BFWA, including the five that have achieved the full national Baby-Friendly designation (BFHI). Nineteen more hospitals are working towards BFWA recognition, including seven that are working towards BFHI. Among the hospitals not working toward BFWA, participants reported there were no resources or it was not a priority.

The purpose of this study is to identify the factors which positively or negatively impact adoption and implementation of BFHI in hospitals. Study findings can inform state and local public health agencies and practitioners as they work to increase breastfeeding rates through supportive breastfeeding policies and practices.

## **Methods**

### **Design**

This study is part of a larger parent study to examine breastfeeding policy adoption and implementation in various sectors (hospitals, childcare, worksites, clinics, coalitions, and state government). The research team was advised by the Washington State Department of Health (WA DOH) breastfeeding workgroup and key stakeholders from the hospital sector. Advisors reviewed the study design and interview guide, facilitated recruitment of study participants, and provided reactions to key study findings. The consolidated criteria for reporting qualitative research<sup>19</sup> and Greenhalgh's Diffusion of Innovations Framework<sup>20</sup> informed our study design. Greenhalgh's framework is based on a systematic literature review to identify influences of diffusion, dissemination, and implementation of innovations in health service delivery organizations. The University of Washington IRB determined this study exempt from human research review (May 2014).

### **Setting and Sample**

We conducted semi-structured interviews from August 2014 through January 2015. We recruited participants through purposive sampling. Advisory group members reached out to

individuals and organizations in their respective sectors via email. Potential participants for the hospital sector interviews included hospital birth unit directors and International Board-Certified Lactation Consultants (IBCLCs); researchers contacted interested participants via email and phone.

### **Data collection**

The BFHI Ten Steps to Exclusive Breastfeeding<sup>21</sup> informed the interview guide. We asked interviewees about key influences from Greenhalgh's framework to help us understand what factors helped or hindered breastfeeding policy adoption and implementation. Trained interviewers (V.B., L.S., K.F.) conducted phone interviews, obtaining verbal consent prior to each interview. Interviews lasted 45 minutes; we offered participants a \$35 gift card for participation.

### **Data analysis**

Interviews were recorded with permission and professionally transcribed verbatim (Proof Positive Transcriptions, Garland, Texas). We used qualitative data analysis software (Atlas.ti Scientific Software Development GmbH) to support coding and analysis. From a sample of 16 transcripts, research team members (V.B., L.S., L.P.W., D.J., J.O.) used thematic analysis to develop deductive codes based on the Greenhalgh framework. Two or more independent coders used this initial code list to pilot-code 10% of the interviews, reconcile codes, revise the code list and protocol, and create the final coding guide. We used this final coding guide to double-code one-third of the transcripts; we reached agreement for all coding discrepancies.

As stated above, hospital sector interviews were conducted as part of a larger parent study. To carry out this secondary qualitative analysis, we read and summarized coded text from hospital sector interviews to identify themes, facilitators, and barriers to BFHI implementation. We used these summaries to create a hospital specific diagram of key themes based on the Greenhalgh framework. The diagram helped us identify facilitators and barriers.

## **Results**

Of the 53 potential participants contacted from the hospital sector, 21 participants (from 19 hospital sector interviews) were included in the analysis. Our sample represented 18 hospitals across Washington state. The majority of Washington's population is in the North Western Region of the state, but our sample has strong geographic statewide representation.

Participants were predominately white and female, representative of those doing breastfeeding work in Washington state.

### **Ten Steps for Successful Breastfeeding**

We asked interviewees whether or not their organization met each of the ten steps for successful breastfeeding. Table 1 outlines all steps, and the percentage of organizations in our sample reporting meeting each step. These data show wide variance in the implementation of evidence-based best practices.

<b>TABLE 1. Percentage of Washington state hospitals reporting meeting each of the Ten Steps for Successful Breastfeeding (n=18)</b>
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<b>Ten Steps for Successful Breastfeeding</b>	Yes	No	Partially	Don't Know
1. Have a written breastfeeding policy that is routinely communicated to all health care staff	89	6	6	0
2. Train all health care staff in skills necessary to implement this policy	61	17	22	0
3. Inform all pregnant women about the benefits and management of breastfeeding	50	17	33	0
4. Help mothers initiate breastfeeding within one hour of birth	83	0	17	0
5. Show mothers how to breastfeed, and how to maintain lactation, even if they should be separated from their infants	83	0	17	0
6. Give breastfeeding newborn infants no food or drink other than breastmilk, unless medically indicated	44	11	44	0
7. Practice rooming-in—allow mothers and infants to remain together 24 hours per day	94	0	6	0
8. Encourage breastfeeding on demand	94	0	6	0
9. Give no artificial teats or pacifiers to breastfeeding infants	22	22	56	0
10. Foster the establishment of breastfeeding support groups and refer mothers to these groups on discharge from the hospital or clinic	50	11	39	0

### **Major Factors Influencing Policy Adoption and Implementation**

In our analysis we identified several factors that positively or negatively influenced adoption and implementation of BFHI in Washington state hospitals. We found the six Greenhalgh framework influences that most affect adoption and implementation of BFHI are the innovation itself, system antecedents for the innovation, outer context, readiness, communication and influence, and implementation.

### ***The Innovation Itself – Characteristics of BFHI***

**To receive Baby-Friendly designation, maternity care centers must have specific policies in place.** Respondents reported that having a written policy is essential to clinical practice.

Written policies provide clear expectations to staff and set a tone for the way care will be provided. They communicate to staff that messaging for patients should be consistent and always based on evidence-based guidelines. It also provides guidance for staff who haven't had adequate education around breastfeeding and validates the actions of trailblazers who may be going against the grain. One respondent memorably referred to supportive policies as "weapons for resistance." Another respondent stated that policy is important because staff are supported in honoring a mother's choice to exclusively breastfeed if a family member requests formula in the hospital.

**Respondents reported that BFHI policy is impractical for clinical use.** A policy needs to be concise and clear to be useful to staff. Some participants reported that the BFHI required policy is too long for practicality. One participant told us their policy was ten pages long when complete, thus not convenient for staff to reference in practice. Still others reported their dissatisfaction with the policy related to its rigidity, or lack of potential for reinvention. On the other hand, some respondents see a clear advantage in the 126-point policy checklist required by Baby-Friendly USA because they say it helped them identify gaps in their policy that they didn't know were there.

**Respondents reported that becoming Baby-Friendly is too expensive and too complex.** In addition to paying a large fee for initial designation, a fee for annual membership, and a fee to

become redesignated every five years, hospitals must pay for nurses and providers like physicians and midwives to receive initial mandatory training totaling 20 hours and three hours, respectively. Hospitals must also pay for annual breastfeeding continuing education for all maternity care staff. For many organizations, the financial barrier is insurmountable. The policy development and certification process is very detailed and generally takes over three years to complete. Participants expressed that they would like to be able to devote a full-time staff member to oversee and direct the process but simply cannot afford it. Many respondents commented that it takes too much time to create a detailed policy; it would be helpful for Baby-Friendly USA to create a model policy which could be adapted or used as a guide.

**Respondents reported widespread misinformation and misperceptions surrounding BFHI.**

While most hospitals in our sample reported having written policies, there were differences in the implementation of certain evidence-based best practices related to misinformation surrounding BFHI. Patients and staff perceive BFHI to be too restrictive, stripping mothers of their personal choice. Respondents reported that step six, which states that formula will not be given unless medically indicated, and step nine, which states that pacifiers will not be supplied, are met with the most resistance from patients and staff. Potential adopters may be under the impression that formula will not be allowed even if requested, and pacifiers will be taken away. There is also a perception that staff will need to be aggressive to implement the ten steps, and make mothers feel guilty if they are unsuccessful or choose not to breastfeed.

***System Antecedents for Innovation – What it takes to implement BFHI***

**Participants stated that time and financial resources allow hospitals to implement BFHI.**

Without adequate time and funding, hospitals cannot afford BFHI certification by Baby-Friendly USA, let alone carry out the staff training required to be in compliance. Hospitals that can afford to hire a program coordinator to oversee the adoption and implementation of BFHI tend to be more successful. If the hospital does not have time and money to channel into new projects, hospitals may have to rely on outside funding. Respondents reported that acquisition of funds, through a grant for example, can act as a catalyst to launch the process. Moreover, when resources are built into the annual budget this signals to the entire organization that supportive breastfeeding practices and policies are a priority.

**Respondents reported that administrators who are receptive to change tend to positively**

**influence implementation.** Without administrator support, a large-scale initiative like BFHI will run into endless roadblocks. Conversely, if administrators embrace policy adoption, the effort will become legitimized at the organizational level. Administrators often support breastfeeding policies and practices in theory, but it is hard to obtain the resources to support implementation. Many participants reported that hospital administration understands the health implications of breastfeeding, it is simply that the financial investment is difficult. In order to gain substantive financial support from hospital leadership, advocates must articulate the value of the investment in a way the “bean counters” can understand. Specifically, there is a need to quantify the cost savings that result from improving health for both mothers and babies and/or the extra patient income that is brought to the hospital by BFHI designation.

## ***Communication and Influence about BFHI***

**The presence of a champion with a preexisting knowledge and skills base tends to boost likelihood of adoption of BFHI.** Training and education is a prerequisite for adoption. Initially, it is typical for an International Board Certified Lactation Consultant (IBCLC) who has expert knowledge in lactation and lactation problems to spearhead the effort and bring others along.<sup>22</sup> Participants described organizational champions as being some of the earliest adopters. Internally, these champions work to give other innovators autonomy from organizational norm and systems. Champions also work in the role of network facilitator to develop cross-functional coalitions in the organization. That same champion may act as a boundary spanner to link the hospital to outside organizations.

**Knowledge sharing via internal and external networks supports BFHI.** Respondents told us that the formation of internal networks within the hospital helped to foster adoption and implementation of BFHI. Participants commented on the need for a multidisciplinary workgroup, or committee to tackle the process. They identified a need to hold regular meetings to find, interpret, recodify, and integrate new knowledge. Externally, hospitals feel supported in implementing BFHI when they work with other hospitals and outside organizations. According to one respondent, the Evidence-Based Hospital Breastfeeding Support Learning Collaborative (EBBS), a collaborative effort from WithinReach, the coordinator of the Breastfeeding Coalition of Washington (BCW), and WA DOH, was beneficial because hearing from other facilities and gave her the “fuel” to make something positive happen. The ability to share policies, lessons

learned, and resources creates strong social networks. One respondent expressed the desire to “ride in the ruts” of previous trailblazers when creating policy instead of “recreating the wheel”. Another respondent told us that there is no need for silos. Hospitals work closely with coalitions and government organizations like BCW and the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) for support in technical assistance, policy development, and education.

### ***Readiness of the facilities to implement BFHI***

**Participants reported that physicians greatly influence policy and patients.** Healthcare providers play a critical role in supporting mothers to learn about breastfeeding and meet their breastfeeding goals. When physicians and other providers give breastfeeding education to parents prenatally, the lactation staff’s job is easier. Nurses reported that the time immediately following the birth is too late to educate patients about the benefits of breastfeeding. At that time parents are overwhelmed and exhausted and sometimes not receptive to education. Ideally, the parents have been primed for breastfeeding, because they’ve received education from their physician or other provider and have had adequate time to make an informed, non-coercive decision. Respondents identified widespread gaps in breastfeeding education on the part of physicians. In addition, in every organization, pediatricians are directly involved in the policy adoption process therefore bringing physicians along is essential.

### ***Implementation of BFHI***

**Participants reported that training and education are necessary to support implementation of BFHI.** The staff need skills training to meet competencies and to feel confident in their ability to deliver evidence based care. Without the necessary training, nurses frequently resort to giving advice based on personal experience which can confuse new mothers. In a practical sense, respondents reported that nurses were not equipped with the skills to implement BFHI without training, and that nurses do not see breastfeeding support as medical advice unless they've received prior education.

***Outer Context – External factors that influence implementation of BFHI***

**Participants reported that consumer demand has the ability to shape hospital policy.**

Throughout the health care industry there is increased emphasis being placed on patient satisfaction. Hospital administrators know their patients have many choices when it comes to where they receive care, so in order to attract patients, the services offered must align with the community's expectations and values. If community members value breastfeeding they are more likely to see BFHI as supportive rather than restrictive. Numerous participants expressed that it is a priority of the community to have supportive policies and practices around breastfeeding, so the hospital is working towards it.

**Participants perceived federal and state laws, policies, and performance measures as motivation for becoming a Baby-Friendly facility and/or adopting BFHI-type policies.** The Joint

Commission, Medicaid reimbursement, and quality improvement efforts represent three areas which have particularly strong impact on whether hospitals implement BFHI. Interviewees commented that staying in compliance with The Joint Commission maternity care standards positively influenced practices and priorities and their importance within the organization. The financial incentive associated with Medicaid reimbursement was also a driver of supportive practices.

## **Discussion**

The Greenhalgh framework helps to identify important factors that need to be in place to move organizations to policy adoption and implementation. For example, if external laws and policies mandate that hospitals develop and implement supportive breastfeeding policies, they will likely be motivated to adopt breastfeeding policies, especially when those policies are tied to reimbursement. That said, hospitals are not likely to move toward becoming Baby-Friendly without a champion who possesses expert knowledge of the innovation and how to use it, generally an IBCLC. It is then up to the champion in many cases to bring powerful groups within the organization along. Respondents emphasized the importance of interdisciplinary committees and using a team approach to garner support and drive the process in its early stages. Staff will likely experience greater readiness in organizations that have established breastfeeding knowledge-sharing networks, or have a mission grounded in evidence-based science. Participants stated that administrator support can make the difference between organizational legitimacy or endless roadblocks. Likewise, participants emphasized the power

that physicians possess to shape both hospital policies and the values and beliefs of their patients.

During early implementation, influential factors include hospital staff access to information, sufficient training, and support. Data from the 2015 mPINC survey show that Washington state remains a national leader in supportive breastfeeding policies and practices, however, scores for staff training are below the national average and represent a clear area for improvement.<sup>29</sup> Hospitals will not be able to successfully implement policies without first providing the practical training needed to carry out the skills-based competencies. Participants told us that having a written policy was essential for standardized practice, but the rigidity of BFHI, which cannot be adapted or customized, is a barrier to implementation. Moreover, a long, complex policy is not pragmatic for clinical use, and the administrative burden to maintain compliance is excessive. Numerous participants echoed the need for a program coordinator to guide the very technical designation process. Lastly, the personal and emotional nature of breastfeeding must be acknowledged to effectively frame organizational breastfeeding policies and ensure staff feel comfortable in supporting mothers to achieve their infant feeding goals. In the organizational context of a hospital, Greenhalgh can help us explain why many hospitals are not interested in adopting and implementing the full BFHI and why a few hospitals are only moving towards it tentatively.

Other studies have identified similar facilitators and barriers to implementing breastfeeding policies. Both national and international studies have found that a champion with preexisting

knowledge will catalyze the process by advocating for more supportive policies and establishing multidisciplinary teams and networks for information sharing. Prerequisite knowledge at all levels of the organization, including hospital administration, is needed for system wide buy-in.

The benefit of support from leadership is undeniable. In addition, physicians greatly influence patients and policy, and their support is known to significantly impact breastfeeding success.<sup>22-</sup>

<sup>24</sup> Using the Greenhalgh framework, Schmied et al found that hospital staff held positive impressions of breastfeeding practices, but felt that policies could be too rigid and not account for individual mothers' needs.<sup>25</sup> Previous studies identified lack of nurse and provider time to support new mothers and a need for staff training as barriers, while facilitators include access to resources and technical assistance, and collection of data on breastfeeding outcomes related to external policies and mandates.<sup>7,13,26</sup>

There are limitations that restrict the generalizability of this study. Working through our advisory group, and recruiting from their networks most likely produced a sample of individuals already interacting within a supportive breastfeeding environment; the individuals we interviewed may have been inclined to support breastfeeding policies. One strength is our use of the Greenhalgh framework to specifically call out factors that help or hinder the adoption and implementation of evidence-based programs and policies, in order to guide recommendations for addressing these barriers.

Several recommendations emerged from common responses and suggestions from participants. At the hospital level, each hospital working towards the Baby-Friendly designation

should have a dedicated point person for communication with external organizations like WA DOH and Baby-Friendly USA. Our findings confirm that in order to help hospitals achieve success in implementation, technical assistance and administrative support from Baby-Friendly USA is invaluable. Also, implementation is much more likely when the organization can afford to employ a program coordinator to coordinate the process; to assure success, organizations who plan to go Baby-Friendly must carve out room in the budget for a program coordinator. In addition, hospitals should create organizational structures such as a Baby-Friendly hospital committee or workgroup to maintain momentum and garner widespread support. Furthermore, hospitals must devote time and money to annual training for staff at all levels of the organization. Building dedicated resources into the annual budget will help to improve routinization.

If the community values and prioritizes breastfeeding, a hospital is more likely to implement BFHI. Therefore, peer education, support groups, and pre-natal breastfeeding education should be a main priority. Time and again respondents told us that prenatal lactation classes, and breastfeeding education from the patient's physician and/or clinic staff increase support for, and rates of, exclusive breastfeeding. Given that hospital-based respondents in this study indicated that prenatal breastfeeding education would facilitate implementation of the 10 steps in their hospitals, and that breastfeeding support and education is associated with an increase in the duration of any and exclusive breastfeeding, this finding provides additional support for the recommendation to improve community systems (WIC, state and local public health departments, coalitions, etc.). In order to assure that prenatal care providers address

breastfeeding with their patients, we need to work to increase health care and community norms that support and value breastfeeding. For this reason, WA DOH and other state leaders should continue to provide and expand training, education, and technical assistance about breastfeeding for hospitals, clinics, and community organizations. At the national level, respondents told us it would be helpful for Baby-Friendly USA to create a model policy which could be adapted or used as a guide to save potential adopters precious time.

## **Conclusion**

In conclusion, rates of exclusive breastfeeding are most likely to increase when supportive environments extend across structural, organizational, and individual levels.<sup>27,28</sup> Supportive systems and environments are built through effective policy adoption and implementation processes; knowledge about these processes can be applied to facilitate adoption and implementation of policies that support mothers in achieving their breastfeeding goals.

**TABLE 2. Respondent quotations**

***The Innovation Itself – Characteristics of BFHI***

**To be Baby-Friendly, maternity care centers must have specific policies in place.**

Standardized, evidence-based care is predicated on it.

**Quote:** “I think that it is important. It does set a tone, and so as the lactation consultant I can use that in my arsenal to say, ‘Here, this is evidence-based information. We’re trying to give patients help to be the most successful that they can. We would like you all to be onboard with this.’ I think it’s important and helpful especially for new nurses coming in.”

**Quote:** “I think that a lot of the nurses feel like breastfeeding is not like the medical part of their job where if the doctor says that you have to give this medication, then they have to give it — or don’t give it, and so they don’t give it. With breastfeeding they feel like oh, you know, I know what I’m doing. I can help. This is fine. It’s hard, the patients will complain about getting different stories from different nurses.”

**Respondents reported that BFHI policy is impractical for clinical use.**

**Quote:** “Well, the Baby-Friendly USA has come out with policy requirements that in my humble opinion are absolutely ridiculous — and I’ve told them this. We went from a breastfeeding policy that was simply these are the Ten Steps as they’ve been identified through the Baby-Friendly Hospital Initiative that this is what we’ll follow to the policy that Baby-Friendly requires which is now about ten pages long, and there is no hospital policy that is ten pages long, you know? There just isn’t except for the breastfeeding policy.”

**Respondents reported that becoming Baby-Friendly is too expensive and too complex.**

**Quote:** “It does take somebody assigned to it, I’m afraid to say.”

**Quote:** “I think that it continues to be difficult for many organizations; for example, my facility has 200 nurses to train. Training 200 nurses in 20 hours of education — if you just average them with benefits and so forth and let’s say that they’re \$50 an hour — that is a \$200,000 investment. That is a significant amount of money. Balancing that type of an investment with the demands on healthcare organizations, it’s hard to get heard.”

**Respondents reported widespread misinformation and misperceptions surrounding BFHI.**

**Quote:** “The last things that we want to do is guilt our moms into feeling like they have no other choice but to breastfeed, or they’re a failure as a mother. I think that it’s important to be careful how far you push it, you know? I’m supportive of supporting the mom’s choice after giving her all of the information and education to make an informed decision.”

**Quote:** “I think the Baby-Friendly rules are pretty strict, and so again, because of the population that we work with, taking the change of formula away completely would likely decrease our breastfeeding numbers rather than increase them.”

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**System Antecedents for Innovation – What it takes to implement BFHI**

**Participants stated that time and financial resources allow hospitals to implement BFHI.**

**Quote:** “...In general, you know, the healthcare reimbursement costs have a big effect and play a big factor in our ability to do our jobs and give care in a way that we want to.”

Breastfeeding support takes time. So then anytime that our reimbursement is cut, you know, then potentially the staff cuts and different things like that. That can affect our ability to be supportive for sure.”

**Respondents reported that administrators who are receptive to change tend to positively influence implementation.**

**Quote:** “There are those who on the administration level are very, very supportive of breastfeeding and have supported our lactation program at significant cost to the hospital, because it hasn’t been a reimbursable service. We couldn't have done it without those individuals being our champions.”

**Respondents reported that a preexisting knowledge and skill base facilitate adoption of BFHI.**

**Quote:** “I think that it would be fair to say that when people aren't provided the appropriate education to support the policies that you might consider their, for lack of a better word, ignorance on the topic. I don't think that they’re necessarily intentionally resisting it, but sort of questioning it as sometimes appearing as if they’re not onboard. I don't think that they’re not onboard because they don’t have the value for breastfeeding. I think they're not onboard because they haven’t received the appropriate training.”

**Communication and Influence about BFHI**

**The presence of a champion tends to boost likelihood of adoption of BFHI.**

**Quote:** “I guess I was there from the beginning. We didn't have policies until like the early '90s. Yes, little by little and we were very inspired by Evergreen Hospital becoming the first Baby-Friendly hospital in the country, but it took us a lot longer... And then we tried to implement the Ten Steps...It took us still nine more years, but we worked on it in terms of trainings and just putting all the Ten Steps into place; teaching people why pacifiers should be avoided if possible, and no formula unless medically indicated. All that stuff and training the staff. Yes, I guess that I played a role in everything with writing policies and training the staff.”

**Enablement of knowledge sharing via internal and external networks tends to support BFHI.**

**Quote:** “...For people who are just starting out, it really does take a multidisciplinary committee. It takes having people who are absolute champions for this — administrator, director, physicians with both an obstetrician and a pediatrician — because you've got to have that, and then you've got to have a nurse leader who can really work with other nurses in terms of this. You've got to meet regularly, and you've got to really hammer out anything that's coming up on a regular basis for those places that are just getting started and having a lot of resistance. You've got to have that team approach.”

### **Readiness of the facilities to implement BFHI**

**Participants reported that physicians greatly influence policy and patients.** Respondents identified gaps in breastfeeding education on the part of physicians.

**Quote:** “They kind of treat it like, you know, are you going to breastfeed or bottle-feed? It’s kind of like do you want a Coke, or do you want a Pepsi?”

**Quote:** “...Our pediatrician several years ago felt like giving out the formula bags was confusing to patients. We’ve stopped doing that, and so we no longer offer really any formula information at all if they specifically are formula feeding. That has definitely had an influence, you know?”

**Quote:** “I really think that it takes one physician champion. Doctors have power, it’s true.”

### **Implementation of BFHI**

**Participants reported that training and education are necessary to support implementation of BFHI.** Without the necessary training breastfeeding support becomes inconsistent and confusing.

**Quote:** “I just want us to all have the same information so that our patients hear the same thing. I feel like that’s what makes things go sideways. [Different messaging?] Yes, the different messaging because they hear different from family, different from friends. And then if they hear differently from one nurse to the next, people don’t know what to do.”

**Outer Context – External factors that influence implementation of BFHI**

**Participants reported that consumer demand has the ability to shape hospital policy.**

**Quote:** “If people come wanting to breastfeed and we’re not supporting that, then there is definitely a push to make our policies so that we’re supporting what the mothers want. I mean, if we had a population of patients that were fighting, you know, and saying that we were pushing them into something that they didn't want to do, then that might be a different pace.”

**Participants perceived federal and state laws, policies, and performance measures as motivation for becoming a Baby-Friendly facility.** In conjunction, respondents identified financial reimbursement as incentive for supportive policies and greater priority within the organization.

**Quote:** “I do feel and think what drives this, sad to say, is reimbursement. I think that money talks. When JCAHO say that you’ve got to show us this, and this, and this, reimbursement talks. Of course, it does because that’s what keeps the hospital afloat. That helps to put some pressure and will kind of move the breastfeeding initiative higher up the scale, but it’s probably moderately so is my impression”.

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## **Well Established**

*The WHO/UNICEF Baby-Friendly Hospital Initiative is known to have a positive impact on breastfeeding rates and duration. Yet most Washington state hospitals have not fully implemented BFHI.*

## **Newly Expressed**

*We identified several factors that positively or negatively influence adoption and implementation BFHI in maternity care facilities, including presence or absence of staff training at all levels, misperceptions surrounding policies, and presence or absence of time and financial resources. Targeting these obstacles may result in greater acceptance of BFHI.*