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The Barriers and Facilitators to becoming a Baby-Friendly Hospital

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Breastfeeding is the gold standard of nutrition for newborn babies. However, lack of interest, knowledge, and resources to new mothers could cause the natural habit of breastfeeding to decrease and the use of formula supplementation to increase. In order to assist hospitals in providing the essentials to promote breastfeeding as the best choice of nutrition for newborn babies, the United Nation's Children's Fund (UNICEF) paired with the World Health Organization (WHO) to launch the Baby-Friendly Hospital Initiative (BFHI) (Baby Friendly USA Incorporated, 2012).

What is the Baby-Friendly Hospital Initiative?

The Baby-Friendly Hospital Initiative is a program for hospitals to implement in order to achieve Baby-Friendly certification (BFUSAI, 2012). BFHI follows an evidence-based, ten-step process that hospitals use as their protocol when supporting breastfeeding and bonding between the mother and new baby. Hospitals who have gained this designation have successfully implemented the Ten-Steps to Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes (BFUSAI, 2012).

History. In 1991, UNICEF and WHO began the BFHI in order to encourage all birthing hospitals and centers to be "centers of breastfeeding support" (BFUSAI, 2012). To execute this initiative, the United States Department of Health and Human Services paid an Expert Work Group to create evaluation tools that would carry out the BFHI assessment procedure (BFUSAI, 2012). Wellstart International was the first to test out the assessment tools. UNICEF requested Healthy Children Project Inc. to generate an organization to be responsible for the BFHI; they created Baby Friendly USA Inc.

(BFUSAI, 2012). In August of 1997, Baby-Friendly USA, Inc. (BFUSA) was a non-profit, designated leader for the BFHI.

There are a plethora of "major maternal and child health authorities" that sanction and support the Ten Steps to Successful Breastfeeding (BFUSAI, 2012). The endorsers include the American Academy of Family Physicians, American Academy of Nurses, American Academy of Pediatrics, American College of Nurse-Midwives, Academy of Breastfeeding Medicine, Academy of Nutrition and Dietetics, Association of Women's Health, Obstetric and Neonatal Nurses, Centers for Disease Control and Prevention, National WIC Association, U.S. Breastfeeding Committee, U.S. Preventive Services Task Force, and U.S. Surgeon General.

Elements of the Baby-Friendly Hospital Initiative

The Ten Steps to Successful Breastfeeding were established by examining evidence-based practices that support an increase in breastfeeding initiation and duration (BFUSAI, 2012). Baby-Friendly hospitals are required to adopt and maintain the ten steps to uphold the designation. These are as follows:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.

5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.

6. Give infants no food or drink other than breast-milk, unless medically indicated.

7. Practice rooming in- allow mothers and infants to remain together 24 hours a day.

8. Encourage breastfeeding on demand.

9. Give no pacifiers or artificial nipples to breastfeeding infants.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center.

(BFUSAI, 2012).

To be considered Baby-Friendly, a hospital not only needs to follow the Ten Steps but it also needs to implement the International Code of Marketing of Breast-milk Substitutes (1981). This code was proposed to encourage safe nutrition for infants, recognizing that breastfeeding is optimal but also giving guidance when a breastmilk substitute is necessary. Breast-milk substitutes of interest in the code include infant formula, other milk products, foods and beverages, including bottle administered complementary foods. In addition, the code is concerned about the marketing of substitutes for "use as a partial or total replacement of breast milk; feeding bottles and teasts" (International code of marketing of breast-milk substitutes, 1981). Basically, the

code addresses what information about formula should be communicated and how it is taught and solicited to new mothers.

Incidence. In the United States, California has the most BFHI designated hospitals at seventy-seven. There are a handful of states that only have one baby-friendly hospital; they are Wyoming, Vermont, Utah, Tennessee, North Dakota, Nebraska, Mississippi, Kansas, Idaho, and the District of Columbia. Michigan is about average in having twelve baby-friendly designated hospitals (BFUSAI, 2012).

Purpose

The purpose of this paper is to examine the Baby-Friendly Hospital Initiative and focus on the facilitators and barriers as to why some, but not all, hospitals choose to pursue this designation. There were interviews conducted of leaders in hospitals with the designation and without it, to further understand the barriers of attaining this designation.

The Ten Steps to Successful Breastfeeding

The first step of the Ten Steps to Successful Breastfeeding is to have a written breastfeeding policy that is routinely communicated to all health care staff (BFUSAI, 2012). This involves the facility making a written, evidence-based policy stating the implementation of steps two through ten and the International Code of Marketing of Breast Milk Substitutes (1981). The policies should include the importance of mothers rooming with, caring for, and feeding their own well infants and how newborns are protected from the promotion of breastmilk substitutes. The policies created should be in effect in any area of the hospital that serves childbearing women and babies. The Ten Steps and institutional philosophy regarding breastmilk substitutes should be prominently

displayed in these areas. The policies should be created in the languages spoken most by patients and available for the visually and hearing impaired. Different departmental policies may not override the facility's breastfeeding policy. New employees must receive orientation to the policies set in place. Each facility should have a means of measuring effectiveness of the policies and how they have been incorporated into routine quality improvement procedures. All of these guidelines are to ensure that every health care provider is educated enough on breastfeeding to advocate for it and that universal support for breastfeeding throughout the health care facility can be provided to mothers to promote adherence of the policies.

The second step is to train all health care staff in the skills necessary to implement this policy (BFUSAI, 2012). This step involves appointing a health care professional as the responsible party for assessing needs, planning, implementing, evaluating, and periodically updating competency-based training in breastfeeding and parent teaching for formula preparation and feeding. This applies to all health care staff that interacts with mothers, infants and/or young children. There should be documentation to show that staff has achieved essential skills. For maternity staff specifically, they will need 20 hours of training, including 15 hours of in-class sessions and five hours of supervised clinical experience (BFUSAI, 2012). Training on other units will vary depending on how exposed they are to mothers and babies. Physicians, midwives, physician assistants and advanced practice registered nurses specializing in mother/baby care should have a minimum of three hours of breastfeeding management education, tailored to their role in the care that is to be given. Clinical competency verification should be a focus of all staff training (BFUSAI, 2012). Maternity staff should receive education on counseling the feeding

decision, teaching and assisting mothers with hand expression of milk, and many other skills that accompany the Ten Steps. Providing training to all staff members is important to implementing the Ten Steps correctly and ensure the most effective outcome of exclusive breastfeeding.

Step three is to inform all pregnant women about the benefits and management of breastfeeding (BFUSAI, 2012). This step includes starting education as early as possible by individually counseling mothers about breastfeeding. This step can take place in the facility or its associated clinics that are providing prenatal care. Education includes non-pharmacologic pain relief methods for labor, feeding on demand or baby-led feeding, and many other topics important to the BFHI vision. Contraindications to breastfeeding, as with some special medical conditions, should be documented. Both individual and group counseling should be available through the facility that provides inpatient services. The importance of this step is to educate women as early as possible on breastfeeding to increase the likelihood of new mothers breastfeeding.

After a baby is delivered, step four addresses helping mothers initiate breastfeeding within the first hour after birth (BFUSAI,2012). This step involves keeping the baby skin-to-skin with mother as soon as it is born and for the first hour. If medical justification is provided to delay contact of mother and baby, skin-to-skin should be performed as soon as possible. All needed neonatal procedures should be done while skin-to-skin with mother. Procedures requiring the baby to separate should wait until after the first hour after birth. If a mother is to have a cesarean birth, she should have the baby placed skin-to-skin as soon as the mother is responsive and alert. The baby should feed as soon as possible after birth. Mothers should be encouraged to look for signs that

their babies are ready to feed; (BFUSAI, 2012). For mothers whose babies are in a neonatal intensive care unit or special care unit, they are to practice kangaroo mother care as soon as the baby is ready for that kind of contact. The importance of this step is to initiate mother-baby bonding with skin-to-skin contact in order to promote breastfeeding.

Step five is to show mothers how to breastfeed and maintain lactation, even when they are separated from their infants (BFUSAI, 2012). This step involves assessing mothers' breastfeeding techniques and determines what help she needs with positioning and attachment within three hours, and no later than six hours after birth. Before discharge, mothers should be educated on: exclusive breastfeeding, maintaining lactation for six months, assessing if the baby is getting enough breastmilk, expressing (including manual expression) and storing breast milk, and sustaining lactation when separated from the baby. Mothers should be educated on how to express milk beginning within six hours of birth. The importance of giving the breast milk to the infant as soon as they are able should be emphasized. Mothers who choose not to breastfeed should be given non-branded information about formula and how it should be prepared, handled, stored, and fed to the infant (BFUSAI, 2012). This information should be individualized to only the mothers who choose not to breastfeed or chose to mix feed. As defined by UNICEF (2015), mixed feeding is "giving other liquids and/or foods together with breast milk to infants under 6 months of age". Step five is crucial for maintaining breastfeeding with high risk mothers or neonates.

The sixth step of the Ten Steps to Successful Breastfeeding is to give infants no food or drink other than breastmilk unless medically indicated (BFUSAI, 2012). This involves health care professionals exploring reasons why a mother may choose not to

breastfeed and then educating her on why it is healthy and what consequences can come from not breastfeeding. If she chooses not be breastfeed after being educated, her decision must be documented. The main goal of the BFHI is to promote breastfeeding as the only method of infant feeding, unless medically indicated. Therefore this step is important in informing mothers who may not choose to breastfeed why they should.

Step seven is to practice rooming-in, which allows mothers and infants to remain together twenty-four hours a day (BFUSAI, 2012). This step is implemented, regardless of feeding choice, so long as the baby is healthy. If a mother requests her child be put in the nursery, it is the health care professional's responsibility to explore the reason for that request and educate the patient on why rooming in is the healthiest option for the newborn. The mother has the choice whether to place her baby in the nursery; that decision should be documented. Any routine infant procedure should be done at the mother's bedside whenever possible and the baby should never be apart from the mother for more than an hour (BFUSAI, 2012). If a baby has a medically indicated nursery stay, the mother should be allowed access to feed at any time. The importance of step seven is to facilitate mother-baby bonding.

Encouraging breastfeeding on demand is step eight (BFUSAI, 2012). This can be applied to all mothers, regardless of feeding method, the infant provides feeding cues, which the mother can observe. This step helps mothers understand there are no restrictions when it comes to frequency or length of feeding. Newborns feed a minimum of eight times in 24 hours. Feeding cues that infants use to signal readiness to begin and end feeding should also be taught to mothers and health care personnel. Last, mothers

need knowledge about the importance of physical contact and infant nourishment. Feeding on demand is significant to infant health and continued breastfeeding.

Step nine requires no pacifiers or artificial nipples be given to breastfeeding infants (BFUSAI, 2012). The importance of this step is that providing other resources that resemble breastfeeding can actually interfere with optimal development of breastfeeding. If a mother requests the use of a bottle or pacifier for her infant, a health care professional should educate her on why it is not a good choice and provide different alternatives to soothe the child. Mothers always have a choice about whether an artificial nipple or pacifier should be given; the counseling, education and decision should be documented. Any supplementation that is medically indicated should not be given by an artificial nipple: instead, a tube, syringe, spoon, or cup should be used (BFUSAI, 2012). Pacifiers should not be given by any health care professional and are only to be used to sooth a baby during painful procedures when the baby is unable to be held or breastfed, and discarded shortly after procedure completion. The ease of breastfeeding will be more successful if artificial nipples and pacifiers are avoided.

The last step in the Ten Steps to Successful Breastfeeding is to foster breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center (BFUSAI, 2012). The benefits of these groups should be discussed in depth by a health care professional with the new mother and a supporting friend or family member before discharge. Discharge planning should include information on the importance of exclusive breastfeeding for about six months and availability of culturally specific breastfeeding support services without ties to commercial interests (BFUSAI, 2012). An early post-discharge follow-up appointment with the mother's pediatric care

provider should be scheduled. The hospital should provide some sort of in-house breastfeeding support if there are inadequate support services for referral. Providing support to new mothers outside the hospital will encourage continuation of breastfeeding.

Process of Becoming Baby-Friendly

To achieve the Baby-Friendly Hospital Initiative accreditation, there is a system of phases that need to be fulfilled. The facility must register with Baby-Friendly USA, Inc first. Once the facility has refreshed their current practices with baby-friendly ones, they can request an on-site assessment. Baby-Friendly USA Inc staff performs this assessment and determines if that facility has successfully implemented all steps of the Ten Steps to Successful Breastfeeding. After that, the facility receives quality checks every five years to ensure their accreditation is still being practiced and achieved.

Baby-Friendly USA has created a 4-step implementation process to further break down the process of applying and meeting the standards for accreditation. The steps help facilities achieve Baby-Friendly status with ease. MacEnroe (2010) of Baby-Friendly USA Inc calls it the “4-D Pathway to Baby-Friendly Designation”.

The 4-D Pathway to Baby-Friendly Designation involves Discovery, Development, Dissemination, and Designation. The first phase, the Discovery Phase, is when the facility examines the benefits of achieving Baby-Friendly status and investigates what it will involve to become qualified. Next is the Development Phase, which is when the facility creates multiple plans for each hospital unit that will be involved, to implement the Ten Steps to Successful Breastfeeding. MacEnroe (2010) states the different aspects that need to be developed are “a Baby-Friendly committee,

Baby-Friendly work plan, comprehensive breastfeeding policy, staff training curriculum/plan, prenatal, impatient, and postpartum teaching plans, and a quality improvement plan" (p. 247). To assist the prospective facility with implementation, Baby-Friendly USA provides a series of tools and templates to assist with a smoother execution. In order to move onto the next phase, the Dissemination Phase, Baby-Friendly USA, Inc must approve all plans created by the facility. The Dissemination Phase is the "rolling out" of the plans developed during the Development Phase. The Designation Phase is last and involves the facility receiving designation and licensure to use the Baby-Friendly certification mark. This can only be done after passing the on-site assessment performed by a team from Baby-Friendly USA, Inc. A review is also conducted by the External Review Board to determine that the Ten Steps to Successful Breastfeeding were properly implemented (MacEnroe, 2010). Then a designation agreement is carried out by the facility.

There are costs involved in this process. Baby-Friendly USA Inc. has laid out a schedule depending on what stage of the 4-D Pathway is completed and what type of facility is trying to achieve designation. There is also a continuous annual fee for remaining Baby-Friendly after the certification is achieved. The fees are per phase so as the facility continues through the four phases, they will have to pay the fee listed as the facility reaches each new pathway phase. For the on-site assessment, there is a travel fee; for multiple-site assessments, there is an additional fee. The facilities are assumed to move through the 4-D Pathway within a year of starting or there is an additional fee for taking longer (see Table 1).

Review of Literature

Barriers to Implementing the Baby-Friendly Hospital Initiative

One of the first barriers that hospitals encountered while implementing the BFHI was adherence to all ten of the Ten Steps. Fifty-three hospitals in Iowa were examined and none met more than seven of the ten steps consistently (Lillehoj & Dobson, 2012). The same research found that the most difficult step to achieve was in fact the first, which is to create a written breastfeeding policy that is communicated to all health care staff. The reason for the difficulty in fully achieving the first step was its multiple components that needed to be met. Most facilities did not have a mechanism of evaluating the breastfeeding policy effectiveness (Lillehoj & Dobson, 2012). This makes evaluating physician and nursing practices pertaining to the BFHI complicated. Without evaluations, there is no way to measure whether improvements need to be made or to identify problem areas. In another study performed by interviewing forty-five participants who worked directly with the BFHI, it was found that even though there were written policies for each of the steps, steps 4 and 6 were not consistently followed (Vandevanter, Gennaro, Budin, Calalang-Javiera, & Nguyen, 2014). Improper implementation of the Ten Steps will hinder hospitals chances of achieving and maintaining certification.

Another aspect that slowed down the implementation was staffing insufficiencies. Often, nurses felt they did not have time to finish the five hours of supervised clinical experience required for BFHI if their units were running short. This in turn caused some nurses to lack the skills to assist and educate patients in proper ways to breastfeed. Staffing also tends to be lower during the evening and night shifts, which causes challenges to implementation as well. It could take a nurse 20-45 minutes to teach or assist a new mother on breastfeeding. When there is less staff on the evening and night

shifts, a nurse may feel pressured and just hand the mother a bottle to save time. Short staffing and the absence of an on-site Clinical Lactation Counselor (CLC) at times were also issues impacting prenatal breastfeeding classes (Vandevanter et. al, 2014).

There were multiple issues that were experienced at the provider level, which slowed the implementation of the BFHI. Some physicians felt they had little formal training in helping mother's breastfeed (Vandevanter et.al, 2014). One nurse felt that the skin-to-skin contact between mother and baby within the first hour was difficult because of the hospital procedures needed following a delivery. Some nurses also felt some frustration in having a heavy workload, personal beliefs, and not "wanting to fight with the mother." (Vandevanter et. al, 2014). Old patterns were difficult to break in seasoned nurses. They may not have agreed with the new ways of the BFHI and therefore felt they did not need to change. If a nurse or provider had a bad experience with breastfeeding, that often was portrayed in how they practiced the BFHI principles.

Another barrier was the financial and facility support needed for BFHI. When hospitals become baby-friendly, they no longer receive free formula. Trying to convince hospitals that purchasing formula is better than getting it free is difficult. No one wants to pay for something that they can get for free. Also, physician support was often lacking. Staff should be encouraged to refer doubtful physicians to IBCLC-certified staff rather than providing inaccurate information (Wieczorek, Schmied, Dorner, & Dur, 2015). Anesthesiologists did not prefer skin-to-skin contact immediately after a C-section because it confined them to monitoring one mother for a longer period of time (Wieczorek et al., 2015).

Facilitators to Implementing the Baby-Friendly Hospital Initiative

A facilitator for most hospitals was that the certificate itself was a marketing tool. It was seen as a credible, quality label that would support maternity units in fulfilling mothers' or parents' expectation of high-quality service delivery on maternity units (Wieczorek et al., 2015). BFHI may draw more patients in and provide a positive corporate image of maternity health, which is a benefit to any community and hospital.

Implementing the Baby-Friendly program worked best when project management was involved. Weiczorek et al. (2015) suggests that this group be responsible for all overall BFHI-certification processes and that they meet once a month for a period of one to two years for successful implementation. From the main project management groups, sub-groups were created. The sub-groups purpose was to work on particular requirements by the BFHI and to encourage staff commitment on the unit. The sub-groups were responsible for disseminating the BF standards for the facility through face-to-face interactions and written communications during intra-professional team meetings (Weiczorek et al., 2015). With the division of work and splitting of responsibilities, groups of people will focus on each different part of the Baby-Friendly Hospital Initiative, making it easier to focus on the larger picture when putting all the parts together.

The 4-D Pathway was specifically created for the purpose of directing the process of becoming Baby-Friendly. As described by MacEnroe (2010), it is a "method to assist facilities with self-evaluation and planning for incorporating all necessary changes, high-standards set by the team of global experts, breaking down the process into manageable

and achievable tasks" (p. 247). The four D's are phases labeled as Discovery, Development, Dissemination, and Designation. Further information about the 4-D Pathway can be found on the Baby-Friendly USA website.

Overall support by management and the staff workers trained and implementing the Ten Steps could be seen as the most important facilitator. Ongoing encouragement and flexible time management to complete the required in-class and skill hours for the certification is crucial. Wieczorek et al. (2015) explains that "presenting the evidence of health benefits through breast-feeding to staff, showing positive outcomes of Baby-Friendly practices already implemented by statistics as well as ongoing discussion during team-meetings, helped to increase commitment" (p. 8). As with any new change, continuing promotion of the Baby-Friendly practices will certainly keep the momentum up.

Report of Interviews

Two nurse administrators were selected from Michigan hospitals to be interviewed about their experiences with BFHI. The interview process involved a non-Baby-Friendly certified hospital (Hospital A) from Southwest Michigan and a Baby-Friendly certified hospital (Hospital B) from the Metro Detroit area in Michigan. A Nurse Manager from the Labor and Delivery unit of Hospital A was interviewed and a Director of Clinical Operations Specialty Units was interviewed from Hospital B. Before any interviews were performed, Western Michigan University's HSIRB was queried about the need for HSIRB review and responded that the project did not require IRB review (see Appendix A). Interview questions were developed (see Appendix B). Although the

planned interview questions were asked, further clarifying questions and discussions developed during the interview process.

Hospital A

Facilitators. Although this hospital does not have the BF designation, the facility was already implementing some of the Ten Steps to Successful Breastfeeding. They promoted skin-to-skin contact immediately after birth for the first hour (step four). The facility also provided continued support after discharge, similar to step ten. Many of the staff were trained on how to educate mothers on breastfeeding as well, which is promoted through the BFHI. Not only were they implementing steps but the hospital's overall exclusive breastfeeding rate was exceptionally high (personal communication, March 10, 2016).

Another facilitator for this hospital was that the staff was pro-breastfeeding. The nursing staff understood that the facility supported breastfeeding over bottle-feeding. There were also specific doctors who were pro-breastfeeding and encouraged it throughout the hospital. Even if the hospital was not designated as Baby-Friendly, they had many attributes similar to designated hospitals.

Barriers. The largest, and most recurrent barrier for this hospital was financial. Because the certification involves fees, it can be seen as a road block to achieving the designation. Hospital A explained that, at one time, they had a grant to use to become Baby-Friendly, however the money fell through at the last minute (personal communication, March 10, 2016). Also, I got the impression that the facility was not interested in paying for formula. It was a large facility that supported a labor and delivery

unit, a NICU, and a pediatrics floor. I believe their impression was that they were unsure of how they would pay for formula to cover all of their specialty facilities.

The surrounding community was another barrier that Hospital A identified. In following some of the steps of the Ten Steps to Successful Breastfeeding, they felt that the community would not be happy about the changes, such as removing pacifiers (personal communication, March 10, 2016). During the interview, Hospital A gave me the impression that they felt there was a fine line between promoting breastfeeding and forcing breastfeeding, as portrayed by patients. I had a perception that Hospital A felt they encouraged breastfeeding enough already to patients and that becoming baby-friendly to them would pressure patients more. That is never the intention of the Baby-Friendly Hospital Initiative to force breastfeeding but to encourage it.

Hospital B

Facilitators. Being in a place of change was a facilitator for Hospital B to implement the Baby-Friendly Hospital Initiative right from the beginning. They appreciated the idea that the designation would set them aside from the other birthing facilities in the area and enjoyed the "shininess" of being a Baby-Friendly hospital. Hospital B was undergoing growth of the facility and changes in protocol so the Director felt it was the right time to start implementing the BFHI. They also had received a collaborative from Baby-Friendly USA Inc. and the Center of Disease Control to guide them through the process of becoming Baby-Friendly (personal communication, March 8, 2016). They stayed in contact often with BFUSA Inc. for assistance on their next steps to take and received financial aide through the collaboration.

Within the facility, there was an immense amount of support to become Baby-Friendly. Hospital B had a particular pediatrician who was all for becoming designated BFHI. She was a great early adopter and spread the word to other healthcare staff to build support. Hospital B involved the use of their project management team and identified that as a large facilitator. The team essentially constructed a blue print using the 4-D Pathway and broke the implementation process into smaller pieces to be completed more efficiently. Hospital B reported that incorporating the Ten Steps to Successful Breastfeeding was not as drastic of a change as some would think (personal communication, March 8, 2016). No one ever objected or thought they simply could not do this.

Barriers. The collaboration was a huge help financially to Hospital B, however, trying to convince the Hospital's financial committees that buying formula was logical rather than receiving it for free was another story. The Director from Hospital B reported that she felt she needed to present the idea "thousands of times" before the financial officers understood that the idea would be buying *less* formula as more and more mothers chose to breastfeed (personal communication, March 8, 2016).

Although there were many staff members supporting the designation, knowing that more than just the nurses and physicians needed training was a bit overwhelming. There needed to be support from the facility coordinators to the environmental service workers. When it comes to getting a large number of people on board too, there is always the barrier of personal opinion. If staff members did not view breastfeeding as a priority, or if they themselves had a bad experience with it, it made implementing the new pro-

breastfeeding practices difficult. Hospital B reported keeping personal opinion out of practice as a factor that slowed down implementation.

The project management team was a wonderful resource to use but it is no secret that the Baby-Friendly Hospital Initiative is a complex project. Hospital B felt that working on all steps at once was difficult. Through the implementation process, it was a topic talked about every single day to make sure everything was on track and what the next step was. Incorporating the steps into the hospital policies and protocol was one change, although the electronic medical records (EMR) were another system that needed to become Baby-Friendly as well. The Director from Hospital B reported that the facility needed to create prompts in their EMR system to facilitate the changes that Baby-Friendly involves (personal communication, March 8 2016). This was a barrier that is, to this day, on which they are still working.

Reflection

There were a couple of factors found through the interviews that were not identified in the literature review. Two facilitators established through the interviews were the collaborations that were available and being in the right time and right place. Information about collaborations was not reported in the literature. In addition, a hospital undergoing change may be a perfect time to implement the change of becoming Baby-Friendly. Some barriers that were discovered during the interview process were community, patient education, and electronic medical records. The literature did not mention surrounding communities as being skeptical or perceived as “not ready” for a Baby-Friendly change. Getting the impression that hospitals may perceive the initiative

as persuasion rather than encouragement towards their patients was also a newly discovered barrier. Last, the literature never mentioned anything about electronic medical records and having to tailor them to be Baby-Friendly as well.

In summary, I felt that the Baby-Friendly Hospital implementation process is perceived differently for different hospitals. There are circumstances that can facilitate the journey such as collaborations, project management teams, and knowledge. There are modifiable barriers that slow the process as well. I learned that collaborations are huge and can make the decision for hospitals to pursue BFHI designation. With that, there needs to be more knowledge in both the community and the facility itself. If the community can become aware of the advantages BFHI brings to facilities, there may be donors who would choose to fund this kind of project. I got the impression that hospitals that are not Baby-Friendly could use more knowledge on the initiative and how realistic it could be to pursue the designation. Project management is a facilitating force that can help ease the implementation process and is highly recommended by Baby-Friendly hospitals to facilities that plan to implement the BFHI. Hospitals that are Baby-Friendly may be open to sharing their implementation plan's with other facilities as well (personal communication, March 8 2016). The location of the facility can influence an organizations choice to pursue designation or not. Communities with different socioeconomic levels may feel impacted by Baby-Friendly changes in different ways. I got the impression that facilities wanting to change need to be either all in or not at all. Factors within the environment of the organization, such as misconceptions about BF intentions or getting ready to make facility-wide changes are influences that effect how smoothly implementation will proceed. There will always be facilitators and barriers to

any facility change and there will be similarities and differences from one organization to the next. There are resources available and knowledge to share to help ease the implementation process of the Baby-Friendly Hospital Initiative.

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Table 1.

4-D Pathway Phase Fees

Phase	Hospitals	Free Standing Birth Centers & Hospitals With Fewer Than 500 Births Per Year
Discovery	$0 Fee	$0 Fee
Development	$3,600	$2,800
Dissemination	$3,900	$3,000
Designation	$4,200	$3,200

From Baby Friendly USA Incorporated (2012)

Appendix A

WMU Human Subjects Institutional Review Board

Hello Mary Ann,

The HSIRB Chair reviewed to determine this does not require IRB oversight; it does not meet the federal definition of human subject research.

45 CFR 46.102 (f) Human Subject
(f) *Human subject* means a living individual about whom an investigator (whether professional or student) conducting research obtains
(1) Data through intervention or interaction with the individual, or
(2) Identifiable private information.
Intervention includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes. Interaction includes communication or interpersonal contact between investigator and subject. *Private information* includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.

Best,
Julia

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Appendix B

Interview Questions

Hospital A:

1. Can you take me through the thoughts and process that went into deciding that Baby-Friendly was not an option to pursue at this time?
2. What are some of the deterrents in choosing to become a Baby-Friendly Hospital?
3. Would you consider becoming Baby-Friendly in the future?
4. What resources would you need to become Baby-Friendly?
5. Have you had patients or staff members approach you about becoming Baby-Friendly?
6. Do you think the size of the facility affects the ease of implementation process to becoming Baby-Friendly?
7. Do you think the benefits outweigh the disadvantages of being Baby-Friendly?

Hospital B:

1. What are the benefits to becoming a Baby-Friendly Hospital?
    a. To the Hospital as a whole?
    b. To the patients?
    c. To the providers?
2. Do you find any disadvantage of being a Baby-Friendly Hospital?
3. What made you decide to pursue the Baby-Friendly Initiative?
4. Can you identify any barriers that you encountered while becoming Baby-Friendly?
5. Can you identify any facilitators that encouraged the Baby-Friendly Hospital Initiative?
6. Could you describe the overall process you encountered while implementing the Ten Steps to Successful Breastfeeding?
    a. Were any steps easier/harder than others?
7. What are the steps you have to take to maintain a Baby-Friendly Hospital?
8. What are some of the struggles in maintaining a Baby-Friendly Hospital?

9. Do you have any ideas to encourage other hospitals to become Baby-Friendly?