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RESEARCH

Barriers and Facilitators to Implementing the Baby-Friendly Hospital Initiative in Neonatal Intensive Care Units

Britney Benoit and Sonia Semenic

Correspondence
Britney Benoit, RN, MSc(A)N, IWK Health Centre, 5850-5980 University Avenue Halifax, Nova Scotia Canada, B3K 6R8.
britney.benoit@iwk.nshealth.ca

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ABSTRACT

Objective: To explore manager, educator, and clinical leader perceptions of barriers and facilitators to implementing Baby-Friendly practice in the neonatal intensive care unit (NICU).

Design: Qualitative, descriptive design.

Setting: Two university-affiliated level-III NICUs in Canada.

Participants: A purposive sample of 10 medical and nursing managers, nurse educators, lactation consultants, and neonatal nurse practitioners.

Methods: In-depth, semistructured interviews transcribed and analyzed using qualitative content analysis.

Results: Participants valued breastfeeding and family-centered care yet identified numerous contextual barriers to Baby-Friendly care including infant health status, parent/infant separation, staff workloads and work patterns, gaps in staff knowledge and skills, and lack of continuity of breastfeeding support. Facilitators included breastfeeding education, breastfeeding champions, and interprofessional collaboration.

Conclusion: Despite identifying numerous barriers, participants recognized the potential value of expanding the Baby-Friendly Hospital Initiative (BFHI) to the NICU setting. Recommendations include promoting BFHI as a facilitator of family-centered care, interdisciplinary staff education, increasing access to lactation consultants, and establishing a group of NICU champions dedicated to BFHI implementation.

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Britney Benoit, RN, MSc(A)N, is a research nurse in the Centre for Pediatric Pain Research, IWK Health Centre, Halifax, Nova Scotia, Canada.

Sonia Semenic, RN, PhD, is an associate professor at the Ingram School of Nursing, Faculty of Medicine, McGill University, and a nurse scientist at the McGill University Health Center, Montreal, Quebec, Canada.

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Exclusive breastfeeding during the first 6 months of life provides optimal nutritional and immunological support for infant growth and development (American Academy of Pediatrics, 2012; Health Canada, 2012; World Health Organization, 2003). The health benefits of exclusive breastfeeding are particularly significant for hospitalized ill and premature infants, as the enzymatic, immune-modulatory, anti-infective, and anti-inflammatory properties of human milk provide protection against nosocomial infections, sepsis, necrotizing enterocolitis, and retinopathy of prematurity (El-Mohandes, Picard, Simmens, & Keiser, 1997; Furman, Taylor, Minich, & Hack, 2003; Patel, Meier, & Engstrom, 2007; Schanler, 2001). However there are significant physical, emotional, and logistical challenges to breastfeeding within the NICU setting (Dall'Oglio et al., 2007; Merewood, Philipp, Chawla, & Cimo, 2003; Renfrew et al., 2009), and studies suggests that initiation of lactation in the NICU population is lower than that in healthy infants born full-term (Flacking, Nyqvist, Ewald, & Wallin, 2003; Furman, Minich, & Hack, 2002).

Perceptions that the infant is too frail and/or medically compromised to breastfeed and maternal physical and emotional distress surrounding the experience of having a preterm infant have been identified as barriers to the establishment of breastfeeding and breast milk expression in the NICU (Callen, Pinelli, Atkinson, & Saigal, 2005; Renfrew et al., 2009). Mothers of ill and preterm infants who are dependent on pumping to establish maternal milk supply face additional challenges to maintaining adequate milk volumes until

their infants are capable of feeding at the breast. These include breast and nipple problems associated with pumping over long periods of time, delayed initiation of pumping, and the separation of mother and infant (Callen et al., 2005; McInnes & Chambers, 2008; Meier & Engstrom, 2007; Renfrew et al., 2009). Lack of privacy in the NICU setting (Nyqvist & Kylberg, 2008), disrespectful staff attitudes (Nyqvist & Kylberg, 2008), inconsistent breastfeeding support (Cricco-Lizza, 2009; Nyqvist & Kylberg, 2008; Weddig, Baker, & Auld, 2011), and implementation of strict breastfeeding regimens by health care providers (Boucher, Brazal, Graham-Certosini, Carnaghan-Sherrard, & Feeley, 2011) have also been documented as contextual and social barriers to breastfeeding in the NICU.

The World Health Organization (WHO)/United Nations Children's Fund (UNICEF) Baby-Friendly Hospital Initiative (BFHI) is a multifaceted, quality improvement program aimed at promoting, protecting, and supporting breastfeeding through transformation of health care structures, processes, and practices (WHO/UNICEF, 2009). Initially developed for regular maternity units, the BFHI includes Ten Steps for Successful Breastfeeding (Ten Steps), which aim to optimize breastfeeding outcomes through enhanced breastfeeding support and mother-infant skin-to-skin contact (WHO/UNICEF, 2009). In recognition of the unique challenges of breastfeeding and lactation for mothers with infants in the NICU, the BFHI has recently been expanded to neonatal settings by an international group of neonatal and breastfeeding experts (Nyqvist et al., 2013, 2012). Based on an extensive literature review and consultation with international colleagues, the expanded Neo-BFHI includes an adaptation of the BFHI's original Ten Steps tailored to the neonatal care context (Nyqvist et al., 2013) (Table 1).

The expanded BFHI also contains three guiding principles, the aim of which are to enhance breastfeeding support and mother/infant contact by focusing attention on the mother's needs, family-centered care, and continuity of care. These principles include the following: the staff attitude toward the mother must focus on the individual mother and her situation; the facility must provide family-centered care, supported by the environment; and the health care system must ensure continuity of care (i.e., continuity of pre-, peri-, and postnatal and postdischarge care) (Nyqvist et al., 2012). Emerging research indicates that adoption of the BFHI or breastfeeding promotion programs modeled from the BFHI's Ten Steps have positive effects on the rate of exclusive breastfeeding at NICU discharge (Bicalho-Mancini & Velasquez-Melendez, 2004; Dall'Oglio et al., 2007). However, to date there is little information on factors influencing the success of implementing Baby-Friendly practices in the NICUs that can be used to help plan initiatives to improve breastfeeding support in the NICU.

Table 1: Ten Steps to Successful Breastfeeding Expanded for Neonatal Wards

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Educate and train all staff in the specific knowledge and skills necessary to implement this policy.
3. Inform hospitalized pregnant women at risk for preterm delivery or birth of an ill infant about the management of lactation and breastfeeding and the benefits of breastfeeding.
4. Encourage early, continuous, and prolonged mother-infant skin-to-skin contact (kangaroo mother care) without unwarranted restrictions.
5. Show mothers how to initiate and maintain lactation and establish early breastfeeding with infant stability as the only criterion.
6. Give newborn infants no food or drink other than breast milk unless *medically* indicated.
7. Enable mothers and infants to remain together 24 hours/day.
8. Encourage demand feeding or, when needed, semidemand breastfeeding as a transitional strategy for preterm and ill infants.
9. Use alternatives to bottle feeding at least until breastfeeding is well established and only use pacifiers and nipple shields for justifiable reasons.
10. Prepare parents for continued breastfeeding and ensure access to support services/groups after hospital discharge.

Note. From Nyqvist, K. H., Häggvist, A. P., Hansen, M. N., Kylberg, E., Frandsen, A. L., Maastrup, R. . . . Haiek, L. N. (2013). Expansion of the Baby-Friendly Hospital Initiative ten steps to successful breastfeeding into neonatal intensive care: Expert group recommendations. *Journal of Human Lactation, 29*(3), 300–309. doi:10.1177/0890334413489775. Adapted with permission from Sage Publications.

Factors influencing successful implementation of Baby-Friendly practices in the NICU that can help plan initiatives to improve breastfeeding support have not been fully explored.