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Case study

A meta-ethnographic study of health care staff perceptions of the WHO/UNICEF Baby Friendly Health Initiative

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ABSTRACT

Background: Implementation of the Baby Friendly Health Initiative (BFHI) is associated with increases in breastfeeding initiation and duration of exclusive breastfeeding and 'any' breastfeeding. However, implementation of the BFHI is challenging.
Aim: To identify and synthesise health care staff perceptions of the WHO/UNICEF BFHI and identify facilitators and barriers for implementation.
Method: Seven qualitative studies, published between 2003 and 2013 were analysed using meta-ethnographic synthesis.
Findings: Three overarching themes were identified. First the BFHI was viewed variously as a 'desirable innovation or an unfriendly imposition'. Participants were passionate about supporting breastfeeding and improving consistency in the information provided. This view was juxtaposed against the belief that BFHI represents an imposition on women's choices, and is a costly exercise for little gain in breastfeeding rates. The second theme highlighted cultural and organisational constraints and obstacles to BFHI implementation including resource issues, entrenched staff practices and staff rationalisation of non-compliance. Theme three captured a level of optimism and enthusiasm amongst participants who could identify a dedicated and credible leader to lead the BFHI change process. Collaborative engagement with all key stakeholders was crucial.
Conclusions: Health care staff hold variant beliefs and attitudes towards BFHI, which can help or hinder the implementation process. The introduction of the BFHI at a local level requires detailed planning, extensive collaboration, and an enthusiastic and committed leader to drive the change process. This synthesis has highlighted the importance of thinking more creatively about the translation of this global policy into effective change at the local level.

1. Introduction

Protection, promotion and support of breastfeeding is a major public health issue. In recognition of this in 1991, WHO/UNICEF launched its global Baby Friendly Hospital Initiative,[1] now known in Australia as the Baby Friendly Health Initiative (BFHI). The purpose of the BFHI was to support the development of an infrastructure by maternity care facilities which enabled them to implement ten auditable standards, the 'Ten Steps'.[2] The BFHI was developed to reverse the medicalisation of infant feeding that occurred during the twentieth century, symbolised by rigid determination of the frequency and duration of feeds, separation of mothers and babies and unnecessary supplementation of breastfeeding with infant formula. WHO/UNICEF established national teams in participating countries to co-ordinate and monitor implementation in hospitals. BFHI accreditation is issued to those who reach a minimum externally auditable standard in relation to the 'Ten Steps'. Key aspects include health professional education, providing appropriate antenatal information, encouraging skin-to-skin contact, lactation support

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to include those mothers separated from their babies, avoiding unnecessary breast milk substitutes, keeping mothers and babies together, encouraging flexible, baby-led breastfeeding and offering mothers continued support once discharged from hospital.[3]

Implementation of the BFHI is associated with significant increases in breastfeeding initiation and duration of exclusive breastfeeding and any breastfeeding.[4] However, the actual process of implementation of such a comprehensive set of changes presents challenges including the need for endorsement from policy makers and local administrators, effective intra and inter-organisational leadership, staff training as well as the ongoing aggressive marketing of infant formula.[5] Semenic et al.[5] in an integrative review of BFHI implementation literature also noted that the individual characteristics of staff may impact on implementation. The lack of attention given to understanding how personal characteristics of staff may impact on the uptake of innovation by organisations has been criticised.[6,7]

There is a growing body of qualitative research exploring health care staff perceptions related to BFHI implementation and its impact on staff, practices, parents and infants. Useful insights can be gained from rigorous qualitative or mixed methods studies that have investigated in-depth the macro and micro features of health care organisations and professional practice that enable and constrain innovation and translation of evidence-based practice.[7–9] To develop an in-depth understanding of the factors influencing BFHI implementation, a meta-ethnographic study was conducted to identify health care staff perceptions of the BFHI and facilitators and barriers to implementation; this is reported on in this paper.

2. Methods

Meta-ethnographic investigation involves synthesising multiple qualitative studies focussed on a particular area of inquiry. The findings from each individual study are compared and contrasted against each other to synthesise a more nuanced understanding of the phenomenon. Noblit and Hare[10] developed an insightful approach to synthesising qualitative studies. This approach provides a framework for identifying 'reciprocal' and 'refutational' translations across findings in multiple studies. These techniques have been further developed by others[11,12] and qualitative syntheses are increasingly advocated, alongside meta-analysis, to inform health service policy and delivery.[13]

2.1. Search strategy

This search was conducted in May–June 2013 using the following databases: CINAHL, MEDLINE, Psychlit, PubMed, SCOPUS and the Cochrane Library. Search terms included: BFHI, BFHI, baby-friendly, baby friendly, ten steps, health service, maternity service, maternal health service, implement*, perceptions, attitudes, beliefs, experiences, practices, views. Included papers were published in English between 1991 (year the BFHI was launched) to May 2013, and needed to report on all or some of the following; staff attitudes and perceptions of the BFHI, their experiences of implementation processes and perceptions of constraints and enabling factors.

2.1.1. Exclusion criteria

Papers that referred indirectly to the BFHI, focused only on one step, focused on reporting outcomes of BFHI, or papers that related to experiences of mothers or families. Papers that explored health professional practices in maternity units related to breastfeeding (e.g. Burns et al.[14]) that did not specifically focus on BFHI implementation were also excluded.

2.2. Search results

The search resulted in 4577 papers (see Fig. 1). Following removal of duplicates (1345 papers), the titles of 3232 papers were reviewed and 2891 were removed as they did not meet the inclusion criteria. Abstracts of the remaining 341 papers were read and a further 295 papers were excluded. Forty-six papers were read in full. Of these 46 papers, a further 39 papers were excluded because they were quantitative studies or mixed methods studies that did not include qualitative data or address health care staff perspectives. Seven papers were identified and underwent a quality review (see Fig. 1).

2.3. Data quality

Seven papers were reviewed using the quality appraisal framework developed by Walsh and Downe.[15] Six papers were graded as B as they did not have a clear theoretical or methodological framework or did not demonstrate congruence between the findings and data presented. One paper by Thomson, Bilson and Dykes[16] was graded as A–. Of the seven papers, three[16–18] used a theoretical or conceptual framework to present or interpret the findings (see Table 1).

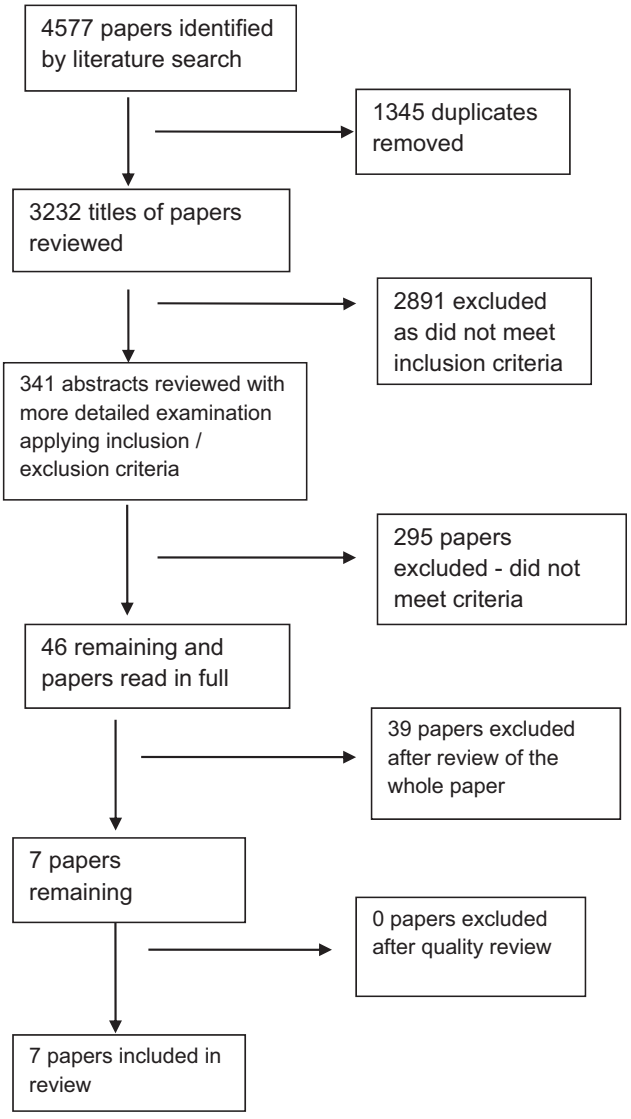

Fig. 1. Search results.