Article

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.

Key words: Breastfeeding, Baby Friendly, Attitudes, Implementation, Health Professionals

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 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.

Method

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].

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.

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.

Search results

The search resulted in 4577 papers (see Figure 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 Figure 1).

Insert figure 1 about here

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 Table1). However, we found in the process of analysis that many of the themes

identified in the included papers were descriptive and were not adequately abstracted or conceptualised.

Insert Table 1 about here

Data extraction and synthesis

The framework developed by Noblit and Hare[10] guided data extraction and synthesis . This involved a seven phase approach including: identifying the area of interest, deciding what was relevant, reading and re-reading the studies, deciding how the chosen studies were related, translating the studies in relation to each another, synthesising translations and presenting the synthesis. Translating key concepts or interpretive metaphors from one study to another involved an idiomatic rather than a word-for-word translation. Two authors were assigned to read each paper and in addition the first author also read all of the papers. The themes reported in four papers[17, 19-21] were primarily descriptive for example, one paper[20] reported findings using each of the ten steps. Three papers[16, 18, 22] presented abstracted themes, using 'in vivo' codes or in a few instances a metaphorical statement for example*, 'the quick fix'*[18].

We began by synthesising the original researcher's interpretations of raw data, presented as themes in qualitative research papers, to facilitate the translation of one study into the next. The nature of the reported themes in the seven studies examined however, made it difficult to conduct reciprocal translation. Other authors have similarly reported this and Atkins et al. [23] and Dickson-Woods et al.[24] suggest in this instance that meta-ethnographic studies apply Schutz's[25] notion of first, second and third order constructs. First order constructs represent participants' perspectives of the phenomenon under investigation. Second order constructs are the thematic statements or abstractions reported as study findings by the original authors The first and second order constructs are then synthesised to produce third order constructs; hence the meta-synthesis findings. Applying this approach, the research team worked

systematically through the papers, reading and re reading papers to create a list of themes and or metaphors; these were juxtaposed and examined to see how they related to each other[10]. We then identified new integrative themes from the synthesised first order and second order constructs in each of the seven papers (see Table 2). Interpretations by the authors of individual studies were also utilised to ensure the quotes were examined in context.

Insert Table 2 about here

Results

The papers that were reviewed and synthesised were published between 2003 and 2013 with a notable increase in researchers studying professionals' perceptions of the BFHI since 2010. Four studies were conducted in Australia, one each in the UK, NZ and the USA. All seven studies were interpretive or descriptive qualitative studies. Three overarching themes were identified.

Theme 1: BFHI - Desirable innovation or an unfriendly imposition?

The studies included in this synthesis reported positive and negative staff attitudes towards the BFHI. From a positive perspective it was viewed as an intervention that would impact on the local level in healthier communities and a reduction in health care costs both locally and at a global level. These perceptions contrasted with other participants who held less favourable views towards BFHI in terms of 'other' workload commitments and priorities and concerns BFHI was 'mother unfriendly'.

Healthy lives, healthy communities

In UK and Australian studies, participants generally expressed a belief, commitment and passion towards breastfeeding and consequently valued the BFHI[16, 18]. The introduction of this award, and associated training, was perceived as important to enable staff to recognise

breastfeeding not just as a *'choice'* but rather the *'natural'* method of infant feeding[18]. In two Australian studies the BFHI was viewed as a key strategy to improve breastfeeding rates, change cultural perceptions and values and improve the health and well-being of families and communities[18, 21]:

> *If you breastfeed your baby, it doesn't just have benefits here and now, it has benefits for the whole community further along the track. Then that also impacts on how the country develops as a nation and then it snowballs into looking at how everything works in the world (FG 1)'*[18].

Empowering professionals and improving practice

The BFHI was considered to provide a clear direction for staff [21]. The requirements for training and education enabled staff to resolve their own personal experiences and prejudices around infant feeding as well as encourage and facilitate consistency and efficiency in providing breastfeeding support[16, 18, 21]. Participants identified how the training had enabled them to become *'better at what we do'* [22]; enhancing staff confidence in providing breastfeeding support, and helping women to resolve any concerns or issues[16, 17, 22]:

> *if somebody is perceived to have a breastfeeding problem they are passed to X or Y (different health professionals) so it's almost like the health visitors don't have, or don't feel they have, the skill to deal with it and I think going through the course, we let them see they do have the skill* [16, p.262].

Mother 'unfriendly'

Alternatively, in some studies negative views about the BFHI were expressed. In two studies undertaken in Australia and the USA, some viewed the ten steps as an '*imposition'* on women's choice[17, 18, 21]. Nickel et al[17] for example, described a *'lack of collective efficacy'* amongst staff who perceived they had to '*force breastfeeding'* against women's decisions

instead arguing, *'I think you have to adjust to the patient's needs'*[17, p.18]. One participant in the study by Schmied et al stated:

> *I have actually come to the point that we are imposing something on them because some of them really don't want to.... Yes, because I have actually seen some staff trying hard and no matter what, that woman has to breastfeed* [18, p.5].

Walsh, Pincombe and Henderson [21] also reported negative views held by participants from non-BFHI hospitals about the ten steps and the impact on staff and their influences on women. Phrases used included *'mother unfriendly'*, *'breastfeeding Nazi's'* or *'bullies'*.

Competing Priorities

It was also evident that the BFHI, when weighed against other areas of clinical practice, was not always prioritised or considered necessary. For example, some stated that the cost of BFHI attainment was problematic in the context of budgetary constraints[19, 21]. In the study by Walsh, Pincombe and Henderson [21], participants from non-BFHI hospitals questioned the value of the award as they were *'performing just as well'* (in relation to breastfeeding rates) as the hospitals that had BFHI status. The competing demands of clinical duties and prioritisation of administrative 'tasks'[18, 19], meant that BFHI was considered to be idealistic rather than realistic within practice[20]:

> *Because of time management…we are really having to get to grips with is [sic], once the baby is born, to get all the paperwork and computer work done, all the "important stuff"…I think that breastfeeding hasn't quite made it onto that more important than getting the paperwork done (sic) list just yet* [20, p.74].

Overwhelmed by Requirements

Within a number of the studies, the BFHI was considered to be an arduous process[16, 19, 21]; '*a mountain to climb'* [18] due to the constant need to train new staff members and the lack of skills and abilities in undertaking task requirements:

Producing a written breastfeeding and infant feeding policy (Step 1) was seen as a daunting task (many participants had no prior experience in this area) [21, p.601].

Theme 2: Cultural and Organisational Constraints and Obstacles

In all studies, no matter whether staff were generally positive towards the BFHI or not, many cultural and organisational issues or challenges to implementation were described.

Spatial and Resource Constraints

Staff described difficulties in BFHI implementation due to the geographical separation of mothers and infants (e.g. admission onto the neonatal unit); early discharge policies, inadequate staffing and busy units[16, 18, 20-22]. Others reported women's discomfort in establishing breastfeeding in the 'public' context of open bay postnatal wards[20]. Whilst practical problems emerged in terms of staff attending training events[21]; temporal and spatial constraints were considered to create '***quick fix'*** solutions through health professionals providing and/or encouraging formula milk:

You can give them the information to bottle feed really quick and then with breastfeeding they have to spend the time with them[22, p.29].

Resistance and Non-Compliance

Entrenched attitudes and practices towards care delivery led to *'resistance'* and lack of confidence amongst staff members to implement the BFHI[19]. A finding identified particularly amongst those who had more rather than less clinical experience in the study by Nickel et al.[17]; with some health professionals reliant on medical decisions for feeding practices. On occasion this led to staff giving babies bottles for example, babies with low blood sugars, as they were not confident in trying breastfeeding as a first option[19]:

Resistance…People are set in their ways

'I said we'll start breastfeeding, and it sucked beautifully, but the nurse by the bedside was so afraid. She insisted on giving [the hypoglycaemic baby] a bottle[22, p.29].

Staff members identified how they would not comply with some of the BFHI steps due to what they considered to be a weak evidence base for example, dummy use [21]. Others argued how compliance was not always possible due to the health status of the infant and/or mother, or the fact that neonatal infants had *'different'* needs[19, 22] which could result in health professionals providing formula milk against a mother's wishes. Whilst this practice is contrary to BFHI guidance, it also raises legal and moral issues. Reddin, Pincombe and Darbyshire [20] report how the loophole of medically indicated use in special care nurseries appears to be used to justify the use of formula for the convenience of staff as much as for the benefit of the baby.

Rationalising, excusing and blaming

In a number of the papers there was evidence of health professionals rationalising, excusing and blaming 'others' in relation to not adhering to BFHI implementation. It appeared that at times staff shifted responsibility for inaction on breastfeeding to the mother and to other staff or parts of the organisation[20]. For example, reasons cited for rooming-out included giving an *'exhausted mum a break'* and settling a fractious baby[18, 19]. Frustration was also expressed towards professionals not providing a consistent approach, and/or undermining the work undertaken to support a woman to breastfeed. Nickel et al[17], found that differences in attitudes, beliefs, and practices were considered to vary across day and night shifts:

> *On day shift, you can work and work and work with the mamma and not give it any formula and really work and she's breastfed all day. You give a report and you come in the next morning and they've had a bottle or formula during the night*[17, p.6].

Within other studies, staff members appeared to blame wider community and socio-cultural values[16, 17, 21, 22]. An entrenched bottle feeding culture and the fact that in western society babies are expected to follow routines according to what society thinks is *'correct'* were used to rationalise non-compliance with the BFHI policies and procedures. Comments such as *''not enough milk''*, *''your milk is not strong enough''*, *''bottle feeding is easier''*, *''bottle fed*

babies sleep longer", *''we can bottle feed while you have a sleep''* were reported to deflate a woman's confidence at a time when she is vulnerable.

Theme 3: Seizing the positive and being collaborative:

Despite the complexity of implementing BFHI and staff resistance, some studies reported more enthusiasm and optimism for BFHI implementation, as stated by participants in Schmied et al's study, *'staff are 100 percent behind it'*. The study by Thomson, Bilson and Dykes[16] in particular offers a fresh approach to BFHI implementation and emphasised the role of transformational leadership.

Building on the positive, one step at a time

Positive aspects of organisational culture in individual units were reported, for example:

> *one thing this unit's always had is its positiveness … and we are very good communicators with the mothers. And that's evident with the information that's passed onto them, and the sharing* [22, p.30].

Another participant in Moore et al's study stated, "*because of the camaraderie of the place*…because of that *I suppose we seem to have a good strategy* (for BFHI) *going." (Large hospital B)*[19]. Successes were also highlighted, *'I think now we do skin-to-skin better with our early, preterm babies*'[22, p.30]. Encouragement came from noting that some steps were easier to implement or were already in-situ. For example, demand feeding (step 8) [20] and 24 hour rooming-in (step 7)[20] were well established and almost taken for granted practices. Skin to skin at birth (step 4) was also perceived to be a popular and desirable practice by most mothers, and considered a *'time saver'* amongst staff:

> *It's [skin to skin] a time saver in the delivery suite as well because if you have your mother and baby skin to skin, that baby is safe with the mother,..., and more likely to latch on itself* [18, p.6].

A dedicated and credible leader

Leadership was seen as crucial. Most studies noted that having a dedicated and credible person to lead the change was essential, but many did not have this in place. At times leaders emerged 'ad hoc' simply because of their *'interest'* or position in the organisation. In NZ, Moore et al reported:

> *It was just the fact that there was a lactation consultant position here so therefore that was the function of the LC is to educate* wh*ich is one of the biggest things*[19, p.5].

The transformational approach reported by Thomson, Bilson and Dykes[16], stands out as unique. Here the infant feeding coordinators were community-based peer supporters. These two leaders had attained high regard from hospital and community health professionals and were valued due to their *'flexible'*, *'realistic'* approach and the fact that they were an *'invaluable resource'* for professionals:

> *Obviously they know about the issues regarding breastfeeding and getting mums going and supporting mothers and they have been doing that for years and years and plus they have got the commitment and the passion towards breastfeeding and really want this project to succeed* [16, p.260].

Top-down approach: 'A directive is needed'

High level management support was considered essential by some to implement BFHI, '*to be able to say we have been told we have to do this, so you (hospital management) need to support us*' [18, p.5]. In contrast Moore et al[19] and Nickel et al[17] report how the *'top down'* directive from management prompted staff to act:

> *my medical director communicated that this was what we want to do …as a result, people are committed because they 'have to be committed'*[17, p.6].

Caution was emphasised however, as taking a top down approach alone may increase the focus on measurement:

> *Well, things like audits, audits on breastfeeding stats, audits on skin-to-skin contact. Its measurements really we have them ongoingly*[19, p.6].

A 'softly-softly' collaborative approach

Although top down support to implement change was highlighted by some, the change process also needed to engage all stakeholders in a collaborative and respectful way:

> *(Infant Feeding Coordinators) are running this is a softly, softly approach and I like that: I don't like people telling me what to do, and I think that actually does engage because it makes us sit down and talk to them, they are approachable and available* [16, p. 260].

Thomson, Bilson and Dykes[16] also report how it was essential to engage all the key players in the implementation process, which included women and peer supporters. In Walsh, Pincombe and Henderson[21] one of the BFHI accredited hospitals had engaged the whole community with the support of the local peer support group from the Australian Breastfeeding Association[21].

Discussion

The BFHI is a complex, multi-faceted strategy now in place in over 152 countries[26, 28], however it remains challenging to implement and sustain in practice. The purpose of this meta-ethnographic study was to identify and synthesise health care staff perceptions of the BFHI and their views on the facilitators and barriers to implementation. The included studies were conducted in resource rich countries in over 30 facilities/sites and reported on various stages of BFHI implementation, including pre-implementation [17]. Sites where significant progress had been made in preparing for accreditation [18, 19, 21, 22] and sites that had achieved full BFHI accreditation [21] or part thereof [16] were also included. Some facilities included in the studies, while not accredited as BFHI, indicated they had already implemented a number or most of the steps; some non-BFHI facilities questioned the value of the award as they were *'doing it anyway'*[18, 21]. The findings highlight that BFHI was valued by many participating staff for its capacity to change perceptions and prejudices and improve health and wellbeing of families through its ability to promote consistency in care delivery as well as empowering

clinicians. However, others held more negative and sceptical views; a number of social, cultural and contextual barriers influencing BFHI implementation were identified.

Authors in the field of implementation science[6-8, 27, 28] have conceptualised the multi-faceted and complex nature of translating evidence into policy and practice. In this meta-ethnographic study, resistance and non-compliance with the BFHI was related to length of service, with younger and/or less experienced staff considered more ready to learn and amenable to change [17, 20, 21] and those who worked day shift perceived to be more committed than night staff [17, 18]. Words and phrases used by participants also demonstrated the passion or emotional connection some held to breastfeeding and the BFHI. Greenhalgh et al[7] and Cane et al[6] emphasised the importance of individual characteristics of staff as crucial to achieving attitudinal and behavioural change. Understanding the impact of individual skill and experience is important because the meaning attached to an innovation can be either positively or negatively reframed and negotiated through discourses within and between organisations[29]. Increasingly social media and incentives are being used to reframe health innovations such as the BFHI making them more attractive to consumers and professionals[30].

The context within which an innovation is implemented also impacts on practice. Rycroft-Malone et al[8, 9] identified culture, leadership and evaluation as core contextual elements that both influence and reflect the capacity of an organisation for change. Organisations characterised by a learning culture value individuals, attend to group processes and systems, and demonstrate decentralised decision-making that is facilitative rather than directive with an emphasis on the relationship between the manager and the worker[8]. In this context senior administrators and managers are responsible to facilitate access to the resources necessary for implementation. Such facilitative management was rarely reported in these studies with most staff describing that they did not have the time to develop and implement relevant policies or to access training and education.

Furthermore, some of the included studies reported an 'us and them' situation where other parts of the organisation such as theatre and recovery and NICU [18, 21, 22], and other professionals [18] were considered to be major obstacles to implementing BFHI. More concerning, in some studies, women themselves were blamed for the challenges to BFHI implementation[18]. It is evident from the work of Thomson, Bilson and Dykes[16] that an 'appreciative' or positive approach can be effective in achieving change. Change agents in this study successfully shaped the change process by framing and interpreting[29] aspects of BFHI implementation in ways that engaged health professionals in all parts of the organisation. BFHI implementation is a complex innovation and for some overwhelming. Participants therefore favoured an incremental 'one step at a time' approach to implementation.

Conclusion

This meta-ethnographic study has examined the perceptions of health staff towards the BFHI. Health care staff hold variant beliefs and attitudes towards the BFHI, which can help or hinder the implementation process. The introduction of the BFHI at a local level requires detailed planning, extensive collaboration, and enthusiastic and committed leader/s to drive the change process. This synthesis has highlighted the importance of thinking more creatively about the translation of this global policy for example, by starting from the community and using experienced peer supporters in collaboration with health professionals, to effect change at the local level.

References

1. WHO, UNICEF. *Innocenti Declaration. On the protection, promotion and support of breastfeeding*. Florence: UNICEF; 1991.

2. WHO. *Protecting, promoting and supporting breast-feeding: the special role of maternity services*. Geneva; 1989.

3. WHO., UNICEF. *Global Strategy for Infant Feeding & Young Child Feeding*. Geneva: World Health Organization; 2003.

4. Beake S, Pellowe C, Dykes F, Schmied V, Bick D. A systematic review of structured compared with non-structured breastfeeding programmes to support the initiation and duration of exclusive and any breastfeeding in acute and primary health care settings. *Maternal and Child Nutrition* 2012; **8**(2): 141-61.

5. Semenic S, Childerhose JE, Lauzière J, Groleau D. Barriers, facilitators, and recommendations related to implementing the Baby-Friendly initiative (BFI): An integrative review. *Journal of Human Lactation* 2012; **28**(3): 317-34.

6. Cane J, O'Connor D, Michie S. Validation of the theoretical domains framework for use in behaviour change and implementation research. *Implementation Science* 2012; **7**(1).

7. Greenhalgh T, Robert G, Macfarlane F, Bate P, Kyriakidou O. Diffusion of Innovations in Service Organizations: Systematic Review and Recommendations. *The Milbank Quarterly* 2004; **82**(4): 581-629.

8. Rycroft-Malone J. The PARIHS framework - A framework for guiding the implementation of evidence-based practice. *Journal of Nursing Care Quality* 2004; **19**(4): 297-304.

9. Rycroft-Malone J, Seers K, Chandler J, et al. The role of evidence, context, and facilitation in an implementation trial: Implications for the development of the PARIHS framework. *Implementation Science* 2013; **8**(1).

10. Noblit G, Hare R. Meta-ethnography: Synthesising qualitative studies. Newbury Park, CA: Sage; 1988.

11. Downe S. Metasynthesis: A guide to knitting smoke. *Evidence Based Midwifery* 2008; **6**(1): 4-8.

12. Finfgeld-Connett D, Johnson ED. Literature search strategies for conducting knowledge-building and theory-generating qualitative systematic reviews. *Journal of Advanced Nursing* 2013; **69**(1): 194-204.

13. Campbell R, Pound P, Morgan M, et al. Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment* 2011; **15**(43).

14. Burns E, Fenwick J, Sheehan A, Schmied V. Mining for liquid gold: Midwifery language and practices associated with early breastfeeding support. *Maternal and Child Nutrition* 2013; **9**(1): 57-73.

15. Walsh D, Downe S. Appraising the quality of qualitative research. *Midwifery* 2006; **22**(2): 108-19.

16. Thomson G, Bilson A, Dykes F. Implementing the WHO/UNICEF Baby Friendly Initiative in the community: A 'hearts and minds' approach. *Midwifery* 2012; **28**(2): 258-64.

17. Nickel NC, Taylor EC, Labbok MH, Weiner BJ, Williamson NE. Applying organisation theory to understand barriers and facilitators to the implementation of baby-friendly: A multisite qualitative study. *Midwifery* 2013.

18. Schmied V, Gribble K, Sheehan A, Taylor C, Dykes FC. Ten steps or climbing a mountain: A study of Australian health professionals' perceptions of implementing the baby friendly health initiative to protect, promote and support breastfeeding. *BMC Health Services Research* 2011; **11**.

19. Moore T, Gauld R, Williams S. Implementing Baby Friendly Hospital Initiative policy: The case of New Zealand public hospitals. *International Breastfeeding Journal* 2007; **2**.

20. Reddin E, Pincombe J, Darbyshire P. Passive resistance: Early experiences of midwifery students/graduates and the Baby Friendly Health Initiative 10 steps to successful breastfeeding. *Women and Birth* 2007; **20**(2): 71-6.

21. Walsh A, Pincombe J, Henderson A. An Examination of Maternity Staff Attitudes Towards Implementing Baby Friendly Health Initiative (BFHI) Accreditation in Australia. *Maternal & Child Health Journal* 2011; **15**(5): 597-609.

22. Taylor C, Gribble K, Sheehan A, Schmied V, Dykes F. Staff Perceptions and Experiences of Implementing the Baby Friendly Initiative in Neonatal Intensive Care Units in Australia. *JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing* 2011; **40**(1): 25-34.

23. Atkins S, Lewin S, Smith H, Engel M, Fretheim A, Volmink J. Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology* 2008; **8: 21**: 1-10.

24. Dixon-Woods M, Agarwal S, Jones D, Young B, Sutton A. Synthesising qualitative and quantitative evidence: A review of possible methods. *Journal of Health Services Research and Policy* 2005; **10**(1): 45-53.

25. Schutz A. Collected papers, vol 1. The Hague: : Martinus Nijhoff, ; 1962.

26. UNICEF. The Baby-Friendly Hospital Initiative. 2012. http://www.unicef.org/nutrition/index_24806.html (accessed July 30 2013).

27. Fixsen DL, Blase KA, Naoom SF, Wallace F. Core implementation components. *Research on Social Work Practice* 2009; **19**(5): 531-40.

28. Rycroft-Malone J, McCormack B, Hutchinson AM, et al. Realist synthesis: illustrating the method for implementation research. *Implementation Science* 2012; **7**(1).

29. Kezar A. Understanding and Facilitating Organizational Change in the 21st Century: Recent Research and Conceptualizations: ASHE-ERIC Higher Education Report; 2001.

30. Thomson G, Dykes F, Hurley MA, Hoddinott P. Incentives as connectors: Insights into a breastfeeding incentive intervention in a disadvantaged area of North-West England. *BMC Pregnancy and Childbirth* 2012; **12**.

Figure 1 Search Results

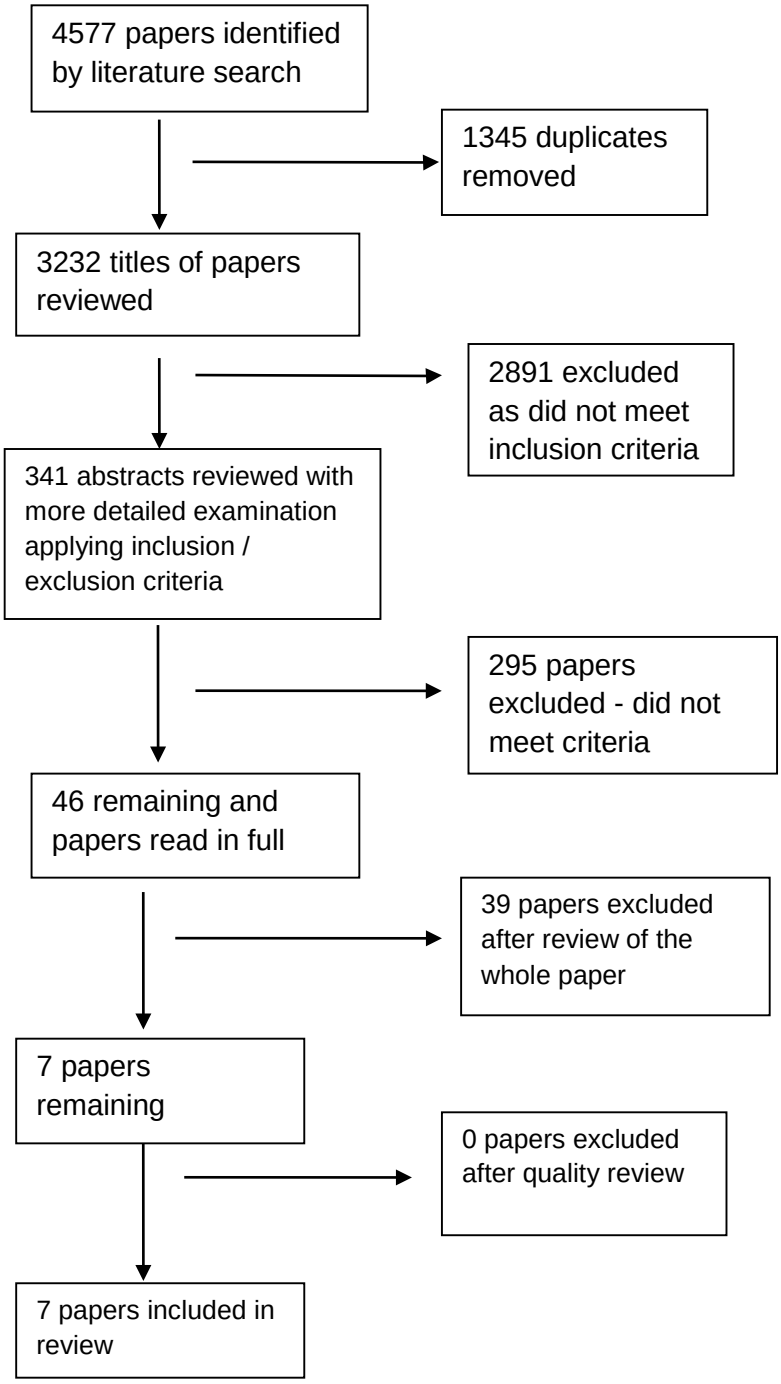

Table 1 – Included Studies

Author/ location	Aim	Participants	Methodology	Methods	Results
Moore, Gauld & Williams, 2007 (New Zealand)	To explore the processes and challenges of implementing National BFHI policy at the hospital level. The key focus being an examination of Steps 1 and 2 of the BFHI which involve developing a breastfeeding policy and training staff in order to be able to	Purposive sample of 6 lactation consultants from 6 public hospitals that represent the full range of public hospitals in New Zealand.	Qualitative descriptive study	Face to face Interviews Content analysis	8 descriptive themes presented: • Policy development • Relationship between hospital and government policy • Communicating policy • Overcoming barriers to communicating policy • Difficulty achieving exclusive breastfeeding targets • Policy evaluation • Discussing policy with other providers • Size matters

	implement the BFHI.				
Nickel et al, 2013 (USA)	To examine the application of an organisational pre-implementation theory (Organisational Readiness to Change) to identify and describe factors that impact on a hospitals readiness to achieve BFHI ten steps and to explore whether/how these factors vary between hospitals	Purposive sample of 34 health-care professionals (primarily maternity nurses, nurse practitioners, paediatricians, obstetricians and managers) from eight North Carolina hospitals planning to implement the BFHI ten steps.	Descriptive qualitative study	34 semi-structured interviews based on ORCs theoretical constructs Thematic and cross-site analysis	Factors influencing hospital readiness for change (arranged by the two dimensions of ORC: collective commitment & collective efficacy)- Related to collective commitment: • Night versus day shift • Management support • Change champions • Observing mothers utilising BF support Related to collective efficacy: • Staffing • Training • Visitors in hospital room Related to collective commitment and

					efficacy: • Perceptions of forcing versus supporting mothers • Perceptions of mothers' culture • Reliance on lactation consultants
Reddin, Pincombe & Darbyshire, 2007 (Australia)	To explore the factors that influence the development of breastfeeding support practice for beginning practitioner midwives in relation to the BFHI ten steps to successful breastfeeding.	17 newly graduated midwives about to commence a Graduate Midwifery Program (GMP) were recruited from two South Australian universities and one Western Australian hospital	Qualitative longitudinal study	3 semi-structured interviews using critical incident technique conducted with each participant over 1 year. Boyatzis' data-driven thematic analysis.	Participant experiences are presented under each of the ten steps to successful breastfeeding as the themes from the analysis. Overall findings suggest work and time pressures act as barriers to compliance with BFHI ten steps for both staff and newly qualified midwives.
Schmied et al 2011 (Australia)	To examine the perceptions of BFHI held by midwives and	132 health professionals including midwives, nurses, neonatal nurses	Qualitative interpretive study	10 focus groups Thematic analysis	Three main themes were identified: • Belief and Commitment • Interpreting BFHI

	nurses working in one area health service in NSW, Australia	and managers working across four maternity units, two neonatal intensive care units and related community services			• Climbing a Mountain
Taylor et al 2011 (Australia)	To explore the attitudes and opinions of hospital staff around the process of implementation of the BFHI in NICUs within the context of hospital environment.	Convenience sample of 47 participants; including nursing and midwifery staff and one paediatrician. Participants were recruited from 4 maternity units within one Area Health Service of NSW Australia, 2 of which included a NICU.	An exploratory study using naturalistic methods of inquiry.	5 focus groups – 2 NICU groups, 2 midwife groups, one BFI coordinators group and one interview with a paediatrician. Thematic analysis	Four major themes emerged: • It is a different world • Separate worlds: mother and infant • It is hard work • It can be done

Thomson, Bilson & Dykes 2012/(UK)	to explore the approach used to implement the community BFI award from the perspective of the professionals involved	Purposive sample of 47 participants from a variety of professional backgrounds including public health, local councils, maternity services, health visiting services and bf voluntary service.	a qualitative descriptive study	2 Focus groups 41 in-depth interviews. Thematic networks analysis	One global theme presented: Hearts and minds approach to BFI implementation. The 3 organising themes included: • Credible leadership • Engagement of key partners • Changing attitudes and practice
Walsh, Pincombe & Henderson, 2011 (Australia)	First of a 3 part study to examine the factors perceived to promote or hinder BFHI accreditation. Primary focus of this part was	31 health professionals including midwives, lactation consultants, managers and medical staff from six South Australian maternity hospitals. A selection	A qualitative descriptive study	Focus group interviews explored opinions of 31 participants, in differing roles and levels of employment. Thematic analysis	Seven descriptive themes presented outlining challenges/barriers associated with BFHI accreditation: • Participants understanding differed • Preconceptions and mothers' choice • The accreditation process • Intra-organisational difficulties

	to explore the attitudes and directives held by hospital staff towards BFHI accreditation.	from BFHI accredited and non-BFHI accredited hospitals included.	achieving BFHI accreditation • Implementing the ten steps • Bottle feeding culture • Continuation of breastfeeding and employment

Table 2 – Themes identified in each paper

	Moore, Gauld & Williams 2007	Nickel et al, 2013	Reddin, Pincombe & Darbyshire, 2007	Schmied et al, 2011	Taylor et al, 2011	Thomson, Bilson and Dykes, 2012	Walsh, Pincombe & Henderson, 2011
Desirable innovation or an unfriendly imposition?							
• ***Healthy lives, healthy communities***	✓	✓		✓	✓	✓	✓
• ***Empowering professionals and improving practice***	✓	✓	✓	✓	✓	✓	✓
• ***Mother 'unfriendly'***		✓	✓	✓			✓
• ***Competing priorities***	✓	✓	✓	✓			✓
• ***Overwhelmed by requirements***	✓		✓	✓	✓	✓	✓
Cultural and Organisational Constraints and Obstacles							
• ***Spatial & resource complaints***			✓	✓	✓	✓	✓
• ***Resistance & non-compliance***	✓	✓	✓	✓	✓		✓
• ***Rationalising, excusing, blaming***	✓	✓	✓	✓	✓	✓	✓
Seizing the positive and being collaborative							
• ***Building on the positive, one step at a time***	✓		✓	✓	✓		
• ***A dedicated and credible leader***	✓			✓		✓	
• ***Top-down approach: 'A directive is needed'***	✓	✓		✓			
• ***A 'softly-softly' collaborative approach***	✓					✓	✓