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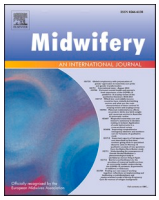

Journey toward Baby-Friendly Hospital Initiative designation: Healthcare professional's view on successful implementation process and maintenance of accreditation

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ABSTRACT

Problem: The Baby-Friendly Hospital Initiative has yet to achieve widespread global implementation.
Background: The implementation of the Baby-Friendly Hospital Initiative has been recognised as complex. The challenge has been to maintain accreditation.
Aim: To explore and gain a deeper understanding of the healthcare professionals' perceptions of the implementation process and the maintenance of the Baby-Friendly Hospital Initiative.
Methods: A qualitative descriptive study with focus groups ($n = 10$) of the nurses, midwives and unit leaders ($n = 43$) perceptions of the implementation process were analysed using inductive thematic analysis.
Findings: Analysis of the data revealed five main themes: groundwork for the baby-focused breastfeeding context, management support throughout the process, promoting baby-friendly practices, effective communication ensuring the right track, and supporting the maintenance of BFHI designation. The main themes describe the implementation as a journey of climbing a hill and after reaching the top trying to maintain their position.
Discussion: The starting point for implementation was an optimal environment supporting baby-friendly breastfeeding practices. The support of the management of the organisation was an important way of moving the implementation forward. Commitment to the common goal strengthened the baby-friendly approach and with concrete and immediate feedback the right pathway on a journey was ensured.
Conclusion: Practical ways to support the implementation journey include regular update education on breastfeeding and continuous monitoring, as well as providing statistics to health professionals. Global guidelines on how to sustain change are needed. This will ensure that the work done is not wasted.

Statement of Significance

Problem The Baby-Friendly Hospital Initiative has yet to achieve widespread global implementation. Its implementation has been acknowledged as complex. The challenge has been to maintain accreditation.

What is Already Known The challenge has been to achieve sustainable implementation and maintenance of the care practices. The coordinated implementation strategy, interprofessional education about breastfeeding, and multi-professional collaboration have supported the implementation, while lack of administrative support and high professional' turnover have been named as barriers to implementation.

What this Paper Adds Regular update education on breastfeeding and continuous monitoring alongside informing of statistics to healthcare professionals are practical ways to support the implementation journey.

Introduction

The benefits of breastfeeding for both maternal and child health are widely recognised (Victora et al., 2016). The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) jointly launched the Baby-Friendly Hospital Initiative (BFHI) to protect, promote and support breastfeeding in facilities providing maternity and

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newborn services worldwide (WHO and UNICEF, 2018). A version of the BFHI for neonatal intensive care units (Neo-BFHI) was launched in 2015 to address the specific needs of preterm and low-birthweight infants and their mothers (Nyqvist et al., 2015; WHO and UNICEF, 2020). The Ten Steps to Successful Breastfeeding (Ten Steps) is a set of evidence-based breastfeeding support practices that form the basis of the initiative (WHO and UNICEF, 2020). To become accredited "Baby-Friendly", an organisation's practices must comply with the "Ten Steps" and commit to the "International Code for Marketing of Breastmilk Substitutes" (Fair et al., 2021; WHO and UNICEF, 2018, 2020). Neo-BFHI assessments are recommended to be conducted at the same time as BFHI, but they are separate designations (Nyqvist et al., 2015).

The BFHI has been implemented in almost every country in the world, but the global coverage level remains low. Approximately 10 % of babies are born in facilities currently designated as Baby-friendly (WHO, 2017). Implementing the BFHI has been identified as complex (Esbati et al., 2019). The challenge has been to achieve sustainable implementation and maintenance of the BFHI (WHO and UNICEF, 2018). Neo-BFHI recommendations are partly implemented in many countries, however, hospitals that had ever-designated Baby-friendly were more compliant with the recommendations (Maastrup et al., 2019).

A variety of barriers and facilitators to BFHI implementation have been identified by different stakeholders (Esbati et al., 2019; Semenic et al., 2012; Walsh et al., 2023). Many factors have been identified both as facilitators and, in their absence, as barriers. Sociopolitical barriers include a lack of government direction and policy on BFHI and fragmentation of health services, whereas national collaboration promotes BFHI (Semenic et al., 2012). Traditional cultural practices have also been a barrier to implementation, leading to the creation of breastfeeding promotion programmes that do not meet international standards (Chen et al., 2020). At the organisational level, the coordinated implementation strategy, interprofessional breastfeeding education, and multi-professional collaboration have supported the implementation, while lack of administrative support and high professional turnover have been identified as barriers to implementation. Individual barriers and solutions are related to knowledge, attitudes, and care practices (Esbati et al., 2019; Semenic et al., 2012; Walsh et al., 2023). There is also a need for continuous work after the implementation, as BFHI standards may decline rapidly after the designation (Zakarija-Grković et al., 2018). Maintaining practices after designation is problematic, and facilities do not have internal monitoring systems to ensure that staff continue to comply with standards. One-third of the countries implementing BFHI had not reassessed the facilities (WHO, 2017).

Many countries have described problems with the process of assessing and designating facilities as Baby-friendly (WHO, 2017). A recent review identified the need for an advanced understanding of the implementation of the BFHI programme (Walsh et al., 2023). As the behaviour of health care professionals (HCPs) is difficult to change after years of implementing practices in a certain way (WHO and UNICEF, 2018), we need to know more about the implementation process and the key factors that influence it from the perspective of HCPs who work with families on a daily basis. This study aimed to explore the HCP's perceptions of the implementation process of the BFHI to gain an advanced understanding and recognition of the most effective approach to implementing BFHI. Other hospitals planning to achieve and maintain BFHI accreditation may benefit from the findings of important considerations in the process.

Methods

Design and setting

A qualitative descriptive study design was used, and the focus groups (Holloway and Wheeler, 2013) were conducted to gain a deeper understanding of the HCP's perceptions of the implementation and maintenance of the BFHI.

The study was conducted in a public, level II hospital in Western Finland with approximately 1700 childbirths annually and approximately 350 yearly admissions in the neonatal intensive care unit (NICU). The study units were 1) a maternity outpatient clinic, 2) a labour ward, 3) a maternity unit including both prenatal and postnatal patients, and 4) a NICU. The average hospital stay is two days for a vaginal birth and three days for a caesarean section (18 % in 2023). The exclusive breastfeeding rate at discharge is 89 % (2023). One midwife working in the study hospital is IBCLC accredited. The hospital premises enable infants to "room-in" with their mothers 24/7 also in the NICU and parents are encouraged to participate actively in the infant's care. The hospital is committed to family-centred care (FCC) policies and The Close Collaboration with Parents™ training programme which fosters the implementation of FCC (Ahlqvist-Björkroth et al., 2017) has been implemented in the NICU in 2010–2012 and the maternity unit in 2016–2018.

The BFHI and neoBFHI (WHO and UNICEF, 2018, 2020) implementation project began in the study hospital in early 2017 by establishing a project group of professionals from each study unit. Each participating unit also appointed mentors from all professional groups to support the implementation process. All professionals received education on breastfeeding and the code according to their job descriptions (Mäkelä et al., 2021). The hospital was awarded BFHI and Neo-BFHI designations by the Finnish Institute of Health and Welfare in 2019 and 2024.

Participants

The target population comprised the health care professionals and nursing managers working at the study units in autumn 2020. Midwives, nurses, and nurse leaders were recruited through convenience sampling. Participation requests were sent by e-mail and those interested in participating in the study indicated their willingness by replying to a message to the researcher or by contacting the head nurse of the unit. We included HCPs who (1) had been working in the units before the implementation, and (2) provided informed consent. The interviews were scheduled for the dates that midwives and nurses willing to participate were at work and the head nurse of each unit gathered the midwives and nurses available on that day for the interview. The groups were composed of professionals working in the same unit, except the nurse leaders were from different units. Separate focus groups were chosen to guarantee midwives and nurses the possibility to voice their opinions from their own unit's perspective and without managers' presence.

Ethical considerations

The study was conducted in accordance with the Helsinki Declaration of 2013 (World Medical Association, 2013). The study protocol had a favourable statement in September 2019 by the Ethics Committee of the University of Turku (statement 58/2019) and was approved by the Satakunta Hospital District administration (grant number SATSHP/321/13.01/2020) in March 2020. Participation in the study was voluntary. After verbal and written information was provided, written informed consent was obtained from each participant.

Data collection

A semi-structured interview guide was developed by the research team, including experienced qualitative researchers, and content experts on nursing. The use of the semi-structured interview guide fostered the emergence of relevant content from participants (Polit and Beck, 2021). Participants were asked to describe their perceptions of the BFHI and its implementation (Table 1).

The data were collected through semi-structured focus groups (n =

Table 1
The semi-structured interview guide.

Interview Questions
How has the Baby-Friendly Hospital Initiative (BFHI and Neo-BFHI) changed the care practices and policies in your unit?
As a professional, do you do things differently than before?
Has the role of parents changed in any way?
What did you think education and training were like?
What do you think supported or hindered the introduction of new practices?
If everything started now, would you do anything differently?

10) by one researcher (HM) (Table 2). The first author was familiar with maternity and neonatal care and the contents of the implemented programme, and she had previous experience conducting interviews. The external researcher did not participate in the training of the professionals. The focus groups were conducted between October and November 2020, 18 months after the hospital had been designated Baby-friendly. Each focus group was held in the study unit. With the participants' permission, the discussions were recorded. After, the recordings were downloaded to the locked study computer.

Data analysis

The data were analysed using inductive thematic analysis in six steps. Inductive thematic analysis was selected for its flexibility. It is not tied to a specific theoretical or epistemological position (Braun and Clarke, 2006). The analysis began by transcribing audio recordings verbatim by the first author. All personal data were deleted and replaced with a professional title (nurse/midwife). The transcripts were labelled with a group ID number and downloaded to QSR NVivo 12 Plus software for analysis. During the transcribing process, the first author (HM) familiarized with the data (step 1) and the initial ideas about the themes were noted.

The first author generated codes with NVivo (step 2) and as the process continued the codes were reviewed and potential sub-themes were generated (e.g., from routines to baby's schedule and sufficient resources) (step 3). To ensure the trustworthiness of the analysis, the other members of the research team (AA and HNV) familiarized themselves with the data and the codes. Based on the reflexive discussions within the research team, the potential sub-themes were reviewed and revised (step 4). After reaching a consensus, the final sub-themes (14) were condensed into five main themes; in addition, a thematic map (Fig. 1) for visualizing the data was created (step 5). After a critical review of the thematic map, the final sub-themes and themes were defined (step 6). Quotes were selected to strengthen the credibility of the analysis.

Findings

Participant demographics

In total, 43 HCPs participated in the focus groups ($n = 10$). Part of the participating midwives and nurses ($n = 10$) were also responsible for the implementation of BFHI, such as acting as a mentor. Seventeen participants were working in rotation between different study units (Table 3).

Analysis of the data revealed five main themes: 1. Groundwork for the baby-focused breastfeeding context, 2. Management support throughout the process, 3. Promoting baby-friendly practices, 4. Effective communication ensuring the right track, and 5. Supporting the maintenance of BFHI designation (Table 4). The main themes describe the implementation as a journey in which professionals are climbing a hill and after reaching the top try to maintain their position (Fig. 1).

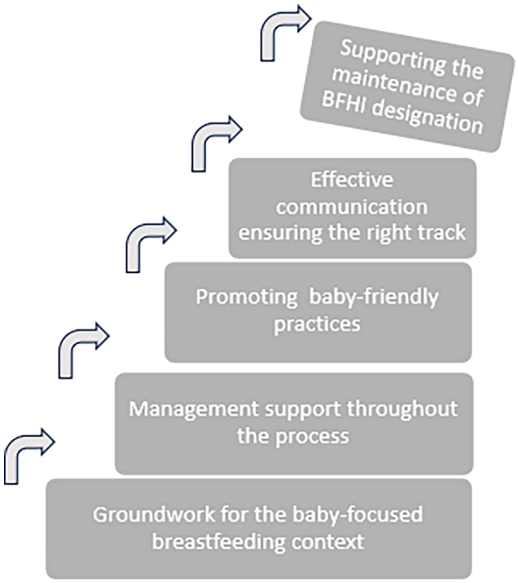

Fig. 1. The thematic map displaying the main themes shows findings of the key factors exploring the HCP's perceptions of the implementation journey as climbing a hill and trying to remain at the top.

Table 2
Description of the focus groups.

Unit	Participants	Focus group	Interview duration (min)
Maternity unit	5	G1	53
Maternity unit	2	G3	16
Maternity unit	4	G6	37
Maternity OP clinic[1]	8	G4	33
Labour ward	9	G8	23
Labour ward	2	G10	31
NICU	3	G5	37
NICU	2	G7	32
NICU	3	G9	37
Unit leaders	5	G2	53

[1] OP = outpatient.

Table 3
Healthcare professional's demographics.

Variable	n (%)	Median (range)
Healthcare professionals	43	
Midwives	29 (67%)	
Nurses	9 (21%)	
Nurse leaders	5 (12%)	
Age (years)		44 (25–63)
Main working unit		
Maternity OP[1] clinic	9 (21%)	
Labour ward	12 (28%)	
Maternity unit	12 (28%)	
NICU	10 (23%)	
Years in profession		16 (3–35)
Doing work rotation	17 (40%)	

[1] OP = outpatient.

Table 4
Main themes (5) and sub-themes (14) were created using inductive thematic analysis.

	Main Theme	Sub-theme
The implementation journey as climbing a hill and trying to remain at the top	Groundwork for the baby-focused breastfeeding context	New hospital premises
		Work rotation
		Changed professional role
	Management support throughout the process	Sufficient resources
		All professions' education
		Commitment
	Promoting baby-friendly practices	Getting to know the parents
		From routines to baby's schedule
		Promoting closeness and minimizing separation
	Effective communication ensuring the right track	Statistics information
		Parental response to change
	Supporting the maintenance of BFHI designation	Changing and new professionals
		Professional collaboration
		Ongoing education

Groundwork for baby-focused breastfeeding context

The new facilities and the organisation of the work rotation created an optimal environment and a starting point for the journey towards BFHI. The new way of involving parents changed the professional role and served as a good basis and foundation on which to build and successfully implement the BFHI and Neo-BFHI.

Prior to the implementation of the BFHI, the study units had moved to *new hospital premises*, including smaller rooms with only two mothers and more family rooms, allowing both parents to be more present with the baby and providing a peaceful space to guide families. In the new hospital, the maternity outpatient clinic, the labour ward, the maternity unit, and the NICU were administratively part of the same entity. Nursing leaders discussed that integrating families care into an administratively shared entity made it possible to manage change flexibly and use the HCPs' skills more efficiently.

In addition to the new facilities, the nurses and midwives started *work rotation*. The rotation of professionals working in the same administrative entity was possible and most worked in at least two different units. This allowed the nurses and midwives to see things wider and work for greater familiarity and coherence between the different units. The midwives who worked in the NICU supported seeing breastfeeding as a natural aspect of caring for a newborn who required intensive care. Similarly, understanding of the needs of newborns requiring special care in the maternity unit increased. Nurse leaders reported a work rotation as a supportive factor for common breastfeeding practices adoption in the different units. *"Our work rotation makes it so much easier to take this ideology and idea forward. Everyone knows where we are going and what we are doing" (G2, nurse leaders).*

Professionals felt that an important basis for baby-friendly practices was the Close Collaboration®(CC) training that the hospital staff had already received in the past. Through CC training HCPs learned to guide the parents to observe the baby's messages and care practices changed to support parental involvement in care in a new way. Midwives discussed that as a result, parental involvement *changed the professional role.* Professionals' attitudes were more breastfeeding favourable as care practices had changed towards a family-centred approach. The contents of the two different interventions supported and complemented each other, and the CC training created fertile ground for the implementation of BFHI practices. The nurses described that the preparation for the BFHI implementation and for the changes that were aimed at was important for the implementation. *"They [BFHI and CC] go hand in hand a lot and they are complementary" (G1, maternity unit).*

Management support throughout the process

The commitment of the organisation's management to support baby-friendly practices enabled sufficient resources and education for all professional groups. All professional groups' commitment to written care practice guidelines served as a strategy to move the BFHI implementation journey forward in a planned, step-by-step manner.

The organisation's management decided to implement the BFHI. Participants described that making that decision at a high enough level gave the project group a mandate and supported the engagement of all professional groups in the work required for implementation. In each interview, it was mentioned that the support of the organisation's management was an important way of moving things forward.

Based on the written infant feeding policy participants felt that the establishment of common guidelines for breastfeeding promotion in each unit, which everyone became aware of through education and to which everyone had to commit, supported the implementation. All professional groups' *commitment* to written care practice guidelines was supported by the fact that management was also committed to a common policy and designation became a shared mission for all.

Management commitment enabled the *sufficient resources* that were needed for implementation and education. Some professionals were given different responsibilities for implementation, and they acted, for example, as mentors. All professionals were allowed to participate in the mandatory education during working hours. Midwives discussed how the fact that everyone was given time for education and that all professionals received education with the same content made it easier to embed new practices. *"It was really good that time was set aside for education. All the professionalities were trained in the same way. Pediatricians, gynaecologists, obstetricians and others also attended. " (G8, labour ward).*

The availability of flexible breastfeeding *education for all professionals* (including unit managers and medical doctors) was identified as an essential element for improving breastfeeding knowledge, attitudes, and common practices that helped the adoption of the Ten Steps. Flexible education consisted of innovative teaching strategies alongside lectures and theoretical material, which were read independently by professionals. The education was supported with weekly briefings on the topic and facilitated by hands-on exercises which included practical training on parent guidance, breastfeeding observation, and interpreting baby's messages with a mentor trainee. Learning new things was sometimes felt to be a burden as there was a lot to learn, but working with a mentor enabled reflection on learning. *"I think the education was great. The work on the ward is quite lonely, but now you could share your*

thoughts with someone and work together. It was instructive to see other practices and discuss them. Quite rarely you discuss together how you discharge families and do different things" (G10, labour ward).

Promoting baby-friendly practices

The groundwork has facilitated essential changes to make the environment baby-friendly. This practice change was achieved through practising and commitment to care guidelines. New ways of guiding parents, getting to know the parents' and families' wishes, promoting parent-infant closeness, and moving from unit routines to the baby's schedule, were key changes that made the baby the main person and moved the HCP's away from the old practices and forward on their journey.

Professionals' attitudes toward baby-friendliness became more positive and care practices were done in a baby-centred way. As a result, care practices according to the unit schedules were eliminated and changed from the unit *routines to the baby's schedule*. Previously in the NICU, the baby was fed according to a specific schedule, the labour ward had always transferred families two hours after birth to the maternity unit where certain things had to be done during the morning shift. Now, breastfeeding was considered on an individual basis and enabled when the baby showed signs of being alert and willing to suckle. Families were transferred to the maternity unit after the baby had finished first sucking. Care activities were scheduled while the baby was awake and the baby was not, for example, woken from the mother's skin due to a nappy change.

Participants reflected that there was a need for trust that the practices were good and reliable. It was easier to commit to guidelines knowing that the BFHI care practices were based on evidence. As a result, professionals more often reflected on the basis on which their practice was based, and they more likely explained to parents the reasons behind different approaches. *"I tell parents why we're doing things and talk out loud about the benefits and why we're doing things this way. I also tell them how you [the parent] and the baby will benefit. Like more talking" (G8, labour ward).*

According to the professionals, baby-friendliness was promoted by *promoting parent-infant closeness and minimizing separation*. When there was more closeness between mother and baby, mothers could be taught to observe the baby's messages, and this supported breastfeeding. The professionals reflected a lot on their ways of doing things and the justifications behind their actions. They named the creation of a calm atmosphere as a key issue. They described doing things more by guiding parents instead of touching the baby themselves. *"It's positive to see that you can guide the parents without touching the baby. In breastfeeding guidance, it is sometimes difficult not to. However, I don't anymore touch the mother's breast. I have learned to guide the mother so that she can help herself the baby to latch" (G3, maternity unit).*

The families' wishes were appreciated in a different way than before. Active listening, based on asking open questions and ensuring understanding, was a basic tool for breastfeeding guidance. This helped parents to see the situation and generate solutions themselves. At the same time, the professionals gain insight into parents' resources, skills, and information needs. To provide individualized guidance to families, professionals felt that they had to *get to know the parents* differently than before, and as professionals, they could not assume what guidance parents needed at any given time.

Effective communication ensuring the right track

BFHI implementation is a long process. Getting feedback on the statistics and informing everyone about them helped to see that the journey was going in the right direction. In addition, the direct feedback from parents and seeing the parents' changed behaviour encouraged further progress and climbing to the top of the hill.

The progress of the implementation process was regularly evaluated by the project group. This helped to see where the process was and whether it was progressing according to the planned timetable. Professionals reflected that one key supporting factor in the progress was the adoption of continuous and systematic statistics. Indicators of BFHI, such as rooming-in, immediate and uninterrupted SSC, the rate of early breastfeeding, supplementary nutrition, and exclusive breastfeeding were recorded on a separate form for each family. Statistics were calculated monthly and regularly communicated to staff at weekly meetings. The progress made in practice, which was seen through *statistics*, made the changes visible and encouraged professionals to keep pushing forward. "*Starting to compile statistics, we got that feedback and we saw the progress on our exclusive breastfeeding rates. That encouraged even more" (G2, nurse leaders).*

Interviewees pointed out that another important feedback was *parental response to change*. Midwives observed that parents learned to attend to their babies' needs more swiftly and began to notice distinct aspects of their babies, recognizing their unique characteristics immediately. Professionals received feedback also from families who had given birth in the same hospital in the past and now noticed the changed practices.

Supporting the maintenance of bfhi designation

Good collaboration between professional groups supported continuous adherence to BFHI practices. However, the participants identified many threats to maintaining the new practices. Dwindling resources with changing and new professionals were seen as a threat to returning to old practices and the sustainability of the BFHI. This felt like struggling to stay on the top of the hill after the journey towards designation. There was a continuous need for further education to ensure that the new BFHI practices would be maintained.

Professionals reflected on the maintenance of BFHI practices because the new way of working takes more time than the old way and identified the new care practices as time-consuming. The length of care, especially for healthy newborn families, was short and with diminishing HCP resources, midwives and nurses were worried about reverting to old practices. A particular concern was the use of supplementary nutrition and bottle feeding, which was perceived as an easier solution in certain situations. Moreover, the participants questioned whether the *changing and new professionals* were trained well enough in the new practices and therefore engaged in baby-friendliness. The lack of commitment of some professionals to the agreed policies was considered another challenge. However, good *professional cooperation* as well as the ability to discuss practices even in difficult situations made daily work easier. *"There are still doctors with whom there are daily discussions about how things are done, how to feed the baby, and how much to give supplementary nutrition" (G9, NICU).*

As a solution to sustainability, interviewees pointed out that there was a need for *ongoing BFHI education*. Refresher education should be provided regularly. Old routines were difficult to get rid of permanently and continuous education would help to keep new ways of doing things in mind and reduce the risk of sustainability of the BFHI. Similarly, nurse managers felt that they played an important role in enabling continuous education. Even though the BFHI education was part of the orientation programme for the new staff, the nurse managers were concerned that additional training could not be organized and resourced sufficiently.

The participants considered the implementation process as a journey they were still on. Along the way they experienced successes, but it was also at times a difficult journey, where they felt they were climbing a hill. Even though nurses felt like they were trying to remain at the top of that hill, they highlighted they would start that same journey again. They felt rewarded every day for seeing how the new practices were supporting the families. *"How far along we are in this. Sort of like, seeing such victories every day" (G7, NICU).*

Discussion

This study aimed to understand the HCPs' perceptions of the BFHI implementation process. The study provided knowledge about the key factors in the journey towards a baby-friendly hospital. The HCPs' experience of the implementation process was a journey of climbing a hill and, once designated, trying to stay at the top. The journey's starting point was the groundwork that created an optimal environment for a baby-focused breastfeeding context. Support of the organisation's management was an important way to move things forward. Commitment to the common goal strengthened the baby-friendly approach and effective communication ensured the progress of the journey. However, maintaining the achieved changes was seen challenging, and required constant work to overcome.

Previously implemented Close Collaboration with Parents™ training programme for enhancing a family-centred environment (Ahlqvist-Björkroth et al., 2017) was a good basis for BFHI, especially in a NICU environment (Semenic et al., 2012). As care practices and attitudes had changed towards a family-centred approach, HCPs were ready for the BFHI intervention. Existing attitudes and motivations influence how new knowledge is assimilated at both individual and professional levels (Bergström et al., 2020). Supporting attitudinal basis for change requires ways (Kuo et al., 2012) like work rotation (Platis et al., 2021) which was an excellent way to create a consistent, new culture of care and support for common breastfeeding practices adoption between units in this study.

The organization's management was strongly committed to successfully implementing change by providing support and allocating resources (Esbati et al., 2019; Semenic et al., 2012; Walsh et al., 2023). The compact organisation in the study hospital enabled flexible planning and decision-making processes conducted in tight collaboration between management and staff. The commitment of management showed employees the importance of change and open communication created trust. Although this approach may be challenging in larger organisations, ongoing involvement of HCPs and open communication with management before and during implementation could be effective strategies. Nevertheless, such endeavours may require additional time and resources. Organisational management had a key role in the implementation of evidence-based practices and in promoting a culture that supports the changes. The management's role in the adoption of the new practice is to help staff understand its importance and potential and to promote staff competence in evidence-based care (Bianchi et al., 2018; Birken et al., 2018). Further, sufficient resources for comprehensive education for all professional groups (Walsh et al., 2023) served as a strategy forward the BFHI implementation process.

Our study highlighted that a multi-professional approach, where medical doctors, nurses and all other staff members were educated, was essential to successful implementation. The significance of a multidisciplinary approach has also been shown in implementation studies concerning family-centred care (Toivonen et al., 2019). However, complex interprofessional relationships and the hierarchy between medical doctors and nurses could hinder the implementation of new knowledge (Rycroft-Malone et al., 2013; Wieczorek et al., 2016).

Once the education had provided the knowledge and skills, HCPs had tools to provide families with professional breastfeeding support. The Ten Steps to Successful Breastfeeding is a set of evidence-based breastfeeding support practices including effective breastfeeding counselling. In this study, the key change described by the participants was a significant increase in verbal counselling of parents instead of hands-on counselling. However, the large workload in postnatal wards creates challenges for midwives trying to provide high-quality infant feeding counselling to mothers (Byrom et al., 2021; Havaei and MacPhee, 2020). It is important to identify and enable the time required for BFHI practices to support the sustainability of the BFHI.

Positive feedback from families reinforced the will to continue the implementation process. Moreover, feedback needed to be supported with statistics. The visible results have shown to be very significant for implementation success (Bergström et al., 2020; Esbati et al., 2019; Semenic et al., 2012; Walsh et al., 2023). Using statistics as a feedback mechanism in everyday work was seen as important in this study. The adoption of a continuous quality management approach to change (Semenic et al., 2012) and ongoing facility-level monitoring (Esbati et al., 2019) have also been identified to support the implementation. However, it is not enough to use statistics only to demonstrate the achievement of a particular breastfeeding target; the statistics must be communicated with staff members. Reviewing the statistics frequently enough will also indicate if care practices are starting to revert to old routines.

Despite education and training, HCPs' behaviour has been difficult to change when they have implemented practices in a certain way for years (WHO and UNICEF, 2018). In this study, HCPs were also concerned about the maintenance of new care practices. The resources allocated to implementation will not be sustained. While HCPs showed positive perceptions of the BFHI and commitment to it, time constraints may tempt them to take shortcuts. Efforts should be made to maintain current care practices. The baby-friendly journey does not end with accreditation and there is a need for a systematic plan after certification to keep up with the standards.

Strengths and limitations

Strengths and limitations are evaluated through credibility, dependability, transferability (Holloway and Wheeler, 2013) and reflexivity (Olmos-Vega et al., 2023). The findings represent the subjective experiences of nursing professionals as medical doctors were not included in the study. However, focus group interviews with many HCPs and nurse leaders provided rich data. Quite many of the participants in this study were working as responsible persons (mentors, nurse leaders) in the implementation process. Their experiences provide important information that can support successful implementation. In the focus groups, similar issues began to emerge, leading to data saturation, thereby reinforcing the trustworthiness of our findings. The interviews took place 18 months after accreditation, and experiences may be based on memories, which affects credibility. On the other hand, this time also gives perspective to bring up issues that were of concern in maintaining the changes. The participant quotations provide direct insights into experiences and enhance credibility. Dependability was addressed by using investigator triangulation and the research team discussed the emerging themes together to reach a consensus. The data were collected in one hospital in a small country thus the transferability of the findings is limited. However, there is potential for the findings to be applicable internationally. It is noteworthy that the researcher and the first author of this paper has a background as a midwife. Undoubtedly, her education and prior experience in midwifery may have shaped her views on breastfeeding and could have impacted the qualitative analysis. Additionally, other members of the research team have backgrounds in maternity and neonatal care. Recognizing how their breastfeeding-favourable attitudes influenced the research and reflective discussions during data analysis aided in maintaining reflexivity.

Conclusion

Globally, much work has been done to support the implementation of baby-friendly policies and practices. Because of the complexity of implementation, the process needs to be prepared by ensuring that the groundwork is in place to support baby-friendly breastfeeding practices. The support of the organisation's management is an important way of moving implementation forward. Maintaining established practices is challenging. Global guidelines and ways of sustaining change are needed to ensure that the work achieved is not wasted. Regular update education on breastfeeding, continuous monitoring and frequent review of statistics are practical ways to support the implementation journey.

Abbreviations

BFHI Baby-Friendly Hospital Initiative
NICU Neonatal Intensive Care Unit
HCP Healthcare professionals
CC Close Collaboration®

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This manuscript is a part of the PhD thesis of Heli Mäkelä (first author). HNV and AA are the supervisors of the PhD study.

CRediT authorship contribution statement

Heli Mäkelä: Writing – original draft, Visualization, Validation, Software, Methodology, Formal analysis, Data curation, Conceptualization. **Anna Axelin:** Writing – review & editing, Supervision, Project administration, Methodology, Formal analysis, Conceptualization. **Hannakaisa Niela-Vilén:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

The dataset used and analysed in this manuscript is available from the corresponding author upon reasonable request.

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