

THE PROCESS OF IMPLEMENTING
A NEW BABY-FRIENDLY HOSPITAL INITIATIVE FOR NURSES: A
GROUNDED THEORY STUDY

By

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Abstract

Maternity nursing practice is changing across Canada with the movement toward becoming “baby friendly.” The World Health Organization (WHO) recommends the Baby-Friendly Hospital Initiative (BFHI) as a standard of care in hospitals worldwide. Very little research has been conducted with nurses to explore the impact of the initiative on nursing practice. The purpose of this study, therefore, was to examine the process of implementing the BFHI for nurses. The study was carried out using Corbin and Strauss’s method of grounded theory. Theoretical sampling was employed, which resulted in recruiting and interviewing 13 registered nurses whose area of employment included neonatal intensive care, postpartum, and labour and delivery.

The data analysis revealed a central category of resisting the BFHI. All of the nurses disagreed with some of the 10 steps to becoming a baby-friendly hospital as outlined by the WHO. Participants questioned the science and safety of aspects of the BFHI. Also, participants indicated that the implementation of this program did not substantially change their nursing practice. They empathized with new mothers and anticipated being collectively reprimanded by management should they not follow the initiative. Five conditions influenced their responses to the initiative, which were (a) an awareness of a pro-breastfeeding culture, (b) imposition of the BFHI, (c) knowledge of the health benefits of breastfeeding, (d) experiential knowledge of infant feeding, and (e) the belief in the autonomy of mothers to decide about infant feeding. The identified outcomes were moral distress and division between nurses. The study findings could guide decision making concerning the implementation of the BFHI.

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Chapter 1

Introduction

According to the Canadian Pediatric Society (2012), the benefits of breastfeeding are numerous, including a decrease among infants in the rates of respiratory tract infections, otitis media, urinary tract infections, and sudden infant death syndrome. The benefits for breastfeeding mothers include a decreased incidence of breast and ovarian cancers (Canadian Pediatric Society, 2012).

Data from Statistics Canada (Gionet, 2013) demonstrated that breastfeeding rates across Canada have increased in recent years. In 2003, 85% of Canadian mothers initiated breastfeeding. This number increased to 89% in 2011-2012. Exclusive breastfeeding has also increased, from 17% in 2003 to 26% in 2011-2012. A province-by-province breakdown of the numbers revealed a large variance between provinces. British Columbia has the highest rate of breastfeeding initiation, which was reported to be 41% in 2011-2012 and 28% in 2003. In the Atlantic provinces, the breastfeeding initiation rate was 11% in 2003, which increased to 23% in 2011-2012.

The Baby-Friendly Hospital Initiative (BFHI or BFI) was launched in 1991 through a joint partnership between the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF; WHO, 2009). This initiative was created in response to the Innocenti Declaration, which aimed to protect, promote, and support breastfeeding (WHO, 2009). The BFHI is a program with a plan to take these goals to a global level (WHO, 2009). A recently emerging trend in maternity nursing is the adoption of the BFHI into practice. As of December 2014, there were 29

health care facilities in Quebec designated as “baby friendly” and, in the rest of Canada, there were five hospitals and 14 community-based health care facilities with the designation (Breastfeeding Committee for Canada, 2014). Regions across Canada are currently working toward obtaining this designation in their hospitals and community health centers. For a facility to successfully obtain this designation it must have a 75% exclusive breastfeeding rate, follow the guidelines set forth by the WHO for the marketing of breast milk substitutes, and meet the requirements for the “seven points plan” for community health services or the “ten steps to successful breastfeeding” (WHO, 2009, p. 1).

The WHO (2009) outlined the process of becoming a baby-friendly hospital. The process begins with a minimum percentage of mothers that have exclusively breastfed their infants, which is 75%. This percentage was chosen by the WHO because to them it demonstrates that the facility has already taken some steps to protect, promote, and support breastfeeding. Seventy-five percent of mothers must have exclusively breastfed or fed their babies human milk unless there was an acceptable medical reason for the use of formula. One of the acceptable medical reasons is positive human immunodeficiency virus (HIV) status (WHO, 2009). Once the 75% exclusive breastfeeding rate has been met, an external assessment visit is arranged (WHO, 2009).

The second requirement to becoming a baby-friendly hospital is to refrain from the marketing practices prohibited by the International Code of Marketing of Breast-Milk Substitutes (WHO, 2009). This code states that having free or discounted formula available to newborns increases the likelihood they will consume it and, therefore, decreases what they determine to be optimal feeding practices. Hospitals must purchase

their formula at full retail price and if they do not comply with this step, then baby-friendly status cannot be achieved (WHO, 2009). In the publicly-funded, Canadian health care system, where increasing costs need to be curtailed (Chappell & Hollander, n.d.), this might be a significant issue.

The 10 Steps to Successful Breastfeeding

The 10 steps to successful breastfeeding are the standard criteria for baby-friendly hospital status (WHO, 2009). Step one is to have a written breastfeeding policy that is routinely communicated to all health care staff. At a minimum, the policy must contain guidance for the 10 steps and how they should be implemented, the International Code of Marketing of Breast-Milk Substitutes, and support for mothers with HIV. The policy must be posted in all areas of any facility that serves pregnant women, mothers, infants and children (WHO, 2009).

The second step is to train all health care staff in the skills necessary to implement the policy. This step means that all health care staff have received the appropriate orientation to the breastfeeding policy (WHO, 2009). Within Atlantic Canada, this step is being met through the WHO's classroom or online breastfeeding course. To successfully complete this step, 80% of staff employed for 6 months or more must have completed this course. Also, random staff members are selected during the certification process and at least 80% have to answer four out of five questions correctly about breastfeeding support and promotion. In addition, a minimum of 80% of staff have to adequately describe two issues that should be discussed with a pregnant woman who indicates that she is considering or has decided to formula feed (WHO, 2009).

Step three is to inform all pregnant women about the benefits and management of breastfeeding (WHO, 2009). There are specific topics that must be covered, which include the importance of breastfeeding, immediate/sustained skin-to-skin contact, early breastfeeding, 24-hour rooming-in, demand feeding, frequent feeding, proper positioning, exclusive breastfeeding for the first 6 months, the risks associated with formula, and the continuation of breastfeeding after 6 months, even when other foods are given. This step is evaluated for baby-friendly hospital status by randomly selecting women in their third trimester who have attended two antenatal visits, asking them if they have been spoken to about breastfeeding, and assessing their ability to describe two of the above mentioned topics with a 70% success rate (WHO, 2009).

Step four involves helping mothers initiate breastfeeding within 30 minutes of birth (WHO, 2009). The baby is placed skin-to-skin with the mother immediately after birth and they remain there for at least an hour. Assistance to breastfeed is offered when the newborn shows interest. A success indicator is 80% of women with vaginal and cesarean section (C-section) deliveries, without a general anesthetic, completed step four unless there was a medically justifiable reason. In addition, 80% of the new mothers also need to indicate that they were shown the signs that the baby was ready to feed and they were offered assistance. In cases where a general anesthetic was used, the percentage of new mothers that must report that skin-to-skin contact occurred, once they were responsive and alert, lowers to 50% (WHO, 2009).

Step five is to show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants (WHO, 2009). There are many success indicators for this step, some of which include instruction on hand expression, positioning

and attaching, and ways to determine if the baby is suckling well. At least 80% of mothers need to indicate that these topics were discussed with them (WHO, 2009).

Step six states that newborns have no food or drink other than breast milk, unless it is medically indicated (WHO, 2009). To successfully meet this step, the hospital must have at least 75% of newborns, within the past year, fed only breast milk from birth until discharge home. The facility should have the necessary equipment for demonstrating how to prepare formula, but this teaching must be done away from breastfeeding mothers (WHO, 2009).

Step seven involves the practice of rooming-in, which means the mothers and their infants remain together 24 hours a day (WHO, 2009). This step is met if 80% of mothers report that this occurred or if they were separated, that it was for a justifiable medical reason (WHO, 2009).

Step eight is to encourage breastfeeding on demand (WHO, 2009). Successful completion of this step is indicated when 80% of mothers have been informed about how to recognize hunger cues in their infants and the mothers can describe at least two feeding cues. The mothers must also state that they were directed to feed their babies as often and for as long as the babies would like (WHO, 2009).

Step nine is to give no artificial teats or pacifiers (soothers) to breastfeeding infants (WHO, 2009). This step is considered to be successfully met when at least 80% of all breastfeeding infants are not using bottles or soothers. If parents choose to use either a bottle or a soother, they must have been educated about the risks of doing so (WHO, 2009).

The tenth and final step is to foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic (WHO, 2009). To successfully complete this step, the facility must have provided at least 80% of randomly selected women with written information about where they can obtain breastfeeding help or who to contact if they have any questions after their discharge from hospital care (WHO, 2009).

In addition to the 10 steps, the WHO (2009) also included some global criteria targeted specifically to milk code compliance. In the criteria, it states that no employees of manufacturers or distributors of formula, bottles, nipples, and/or soothers can have direct contact with pregnant women or mothers. The hospital is prohibited from accepting any gifts, literature, materials/equipment, or support for in-service education from manufacturers or distributors of formula, bottle feeding supplies, and soothers. Mothers cannot receive samples or coupons for any formula, bottle feeding supplies, or soothers. Posters or any information related to formula cannot be displayed. The hospital cannot accept free or discounted formula or bottle feeding supplies. The global criteria also prohibit staff from teaching formula preparation to anyone that is breastfeeding (WHO, 2009).

Although there is a baby-friendly movement in Canada, very little research has been conducted with nurses, who are frontline workers in the BFHI, to explore the impact of the initiative on nursing practice. This study examined the transitional process associated with this program implementation from the perspective of registered nurses. Nurses need the opportunity to share their viewpoints on the process of implementing the initiative. It is important to understand the process of the program implementation and the

perspectives obtained from nurses. The study findings might identify strengths, challenges, and suggestions for policy makers to consider. Other researchers have noted that little qualitative research has been conducted on the implementation of the BFHI from the viewpoint of health care professionals, even though such research has the potential to provide valuable program development and delivery insights (Wieczorek, Schmied, Dorner, & Dür, 2015).

Purpose of the Study

The purpose of this study was to explore the process of implementing the BFHI for nurses.

Research Question

This research study was conducted to answer the following research question:
What is the process of implementing the BFHI for nurses?

Outline of the Thesis

Following this introductory chapter, chapter two is composed of a review of the literature. The literature review demonstrates that there is a gap in the research pertaining to exploring the process of implementing the BFHI for nurses.

Chapter three contains an overview of the study methods and methodology, which was grounded theory. The theoretical underpinnings of grounded theory are covered. A description of the study sample, setting, recruitment procedures, theoretical sampling, data collection, data analysis, rigor of the study, and ethical considerations are also addressed.

Chapter four includes a discussion of the study findings. First, the central category and the five conditions in which the central category arose are discussed, including (a) an

awareness of a pro-breastfeeding culture, (b) the imposition of the BFHI, (c) the knowledge of the health benefits of breastfeeding, (d) experiential knowledge of infant feeding, and (e) belief in the autonomy of mothers to decide about infant feeding. Shared actions/interactions and emotional responses were also identified, including (a) questioning the science and safety of the BFHI, (b) feeling empathy for new mothers, (c) having a limited impact on nursing practice, (d) talking minimally about the BFHI, and (e) anticipating reprimand from management. Two outcomes were moral distress and division between nurses. In chapter five, the findings are discussed.

Chapter six covers the implications that the study findings have for (a) nursing practice, (b) nursing education, and (c) nursing research. The limitations, as well as the strengths of the study, are also identified.

Chapter 2

Review of the Literature

Few published studies were found in the literature related to the aim of exploring the process of implementing the BFHI from the perspective of nurses. Databases searched included PubMed, CINAHL, and EBSCO using “breastfeeding, baby friendly, Baby Friendly Hospital Initiative, BFHI, maternal-child nursing, nurses’ experiences and breastfeeding, education initiatives and breastfeeding, nursing practice and breastfeeding, program evaluation, and implementing the BFHI” as key terms. The results included numerous studies on breastfeeding initiation rates, other education initiatives, and nurses’ attitudes toward breastfeeding in relation to their intention to support breastfeeding. I identified a very limited number of studies that were directed at nurses’ experiences and perspectives of implementing the BFHI. In this chapter, I provide an overview of the following two areas of research: (a) breastfeeding initiation, duration, and exclusivity rates in the BFHI; and (b) the effectiveness of BFHI training programs for health care professionals. Then, I discuss quantitative and qualitative research on the implementation of the BFHI for nurses.

Breastfeeding Initiation, Duration, and Exclusivity Rates in the BFHI

The majority of the results obtained from searching the above databases concerned breastfeeding success rates among baby-friendly hospitals. Measures of success generally included initiation rates, as well as the duration of exclusive breastfeeding. Abrahams and Labbok (2009) utilized demographic and health surveys from 14 developing countries to determine if the BFHI increased the rates of exclusive

breastfeeding. They looked at trends years before and after the implementation of the BFHI. Two specific age groups were chosen as exclusive breastfeeding milestones: children under the age of 2 months and children under the age of 6 months. The criterion the authors used for each age range was, “Who are exclusively breastfed as determined by the standards of the WHO?” (i.e., no food or drink other than human milk is provided). For both age groups, Abrahams and Labbok found a statistically significant upward trend in exclusive breastfeeding after, but not before, the BFHI implementation. Abrahams and Labbok acknowledged that their study had limitations. They recognized that 14 countries is a small number to represent developing countries and there are low rates of BFHI certification within the 14 countries. The authors also acknowledged that their study could not control or measure the ongoing adherence to the 10 steps nor the quality of the implementation. Abrahams and Labbok also noted that data on exclusive breastfeeding are not readily available and data were not collected solely for the purpose of this study, thereby limiting data points.

Although the majority of studies focused on developing countries, data exist on the intention to breastfeed, initiation rates, as well as exclusive breastfeeding rates across Canada. Chalmers et al. (2009) provided statistical data outlining these rates in province-by-province tables. Data were taken from the May 2006 Canadian census through telephone interviews conducted by Statistics Canada. The results obtained by Chalmers et al. indicated that 90% of women had the intention to breastfeed and 90% actually initiated breastfeeding. By 3 months of age, the researchers found a dramatic drop in exclusive breastfeeding, with 52% feeding human milk alone. At 6 months of age, the percentage decreased to 14%. Chalmers et al. had some suggestions as to why the rates of exclusive

breastfeeding decreased so rapidly: These suggestions included poor practice in delivering the 10 steps, especially those pertaining to early skin-to-skin contact, rooming-in, demand feeding, pacifiers, and formula samples.

Chalmers et al. (2009) documented the strengths and the weaknesses in regards to adherence to the BFHI. Atlantic Canada was strong in a couple of areas, including providing enough breastfeeding information (step three) and postpartum support (step 10). The areas of greatest weakness included putting the baby to breast shortly after delivery (step four) and encouraging the baby to feed on demand (step eight). Further research with nurses might uncover barriers to completing these steps effectively. The largest limitation of the study by Chalmers et al., as noted by them, was the data involved women's perceptions of the care they received, which is difficult to measure. Also, the interviews took place 5 to 14 months postpartum, so maternal recall might not be entirely accurate.

Some researchers, who examined rates of success for the BFHI, reported negative results. A longitudinal study conducted in the Czech Republic by Mydlilova, Sipek, and Vignerova (2009) indicated that the rates of initiation and exclusivity increased in the first couple of years, but 5 years after the BFHI designation, the rates began to decline. Their study looked at the time period of 7 years post-BFHI implementation. The results showed that the rate of exclusive breastfeeding improved in the early implementation stage from 84% to 91%. The authors hypothesized that the exclusive breastfeeding rate began to decline over time because adherence to the 10 steps might have decreased. Another noteworthy aspect of this study was the authors hypothesized that over the years of their study, as more hospitals obtained their BFHI designation, exclusive breastfeeding rates

would also increase; however, the opposite occurred even in hospitals with the BFHI designation. The authors offered some possible explanations for this decline, such as an increase in mothers with advanced maternal age, an increase in caesarean deliveries, and an increase in low-birth-weight newborns. The authors acknowledged that their study did not control for influencing factors, such as demographics, perinatal factors, and social support for breastfeeding. A previous study by Mydlilova, Sipek, and Wiesnerova (2008) examined how these factors can negatively impact successful breastfeeding.

Effectiveness of BFHI Training Programs for Health Care Professionals

Another area of research is the effectiveness of BFHI training programs for health care professionals. Martens (2000) looked at how an educational intervention for nursing staff affected beliefs, breastfeeding rates, and BFHI compliance. One specific area of education was the use of formula supplementation (e.g., the guidelines of the medical indications for formula supplementation). The study hypothesis was staff education on the medical indications for formula supplementation would result in an increase in BFHI compliance, an increase in staff attitude/belief scores, a decrease in bottle-feeding belief scores, and an increase in the number of mothers exclusively breastfeeding while in the hospital. The researchers used a survey and chart audits for data collection. The survey had four composite measures, namely BFHI Compliance, Breastfeeding Beliefs, Bottle Feeding Beliefs, and Breastfeeding Attitude. The results of the study showed that the educational intervention was associated with increases in BFHI compliance and breastfeeding-belief scores. The chart audits reflected this: There was a 23% increase in exclusive breastfeeding rates at the hospital that received the educational initiative. The

initiative had no effect on the breastfeeding initiation rate itself. The largest limitation of this study was the small sample size, consisting of 31 nurses.

OlaOlorun and Lawoyin (2006) also investigated the impact of BFHI staff education on breastfeeding rates. A survey was given to 386 Nigerian health care workers that consisted of 10 questions to assess breastfeeding knowledge. The results of their study suggested that when nurses have extensive and accurate knowledge of breastfeeding, there is an increase in the level of support for breastfeeding. In OlaOlorun and Lawoyin's study, the health care workers who had higher knowledge scores had higher level of support for breastfeeding than those with low to moderate scores ($p < .0001$).

Ingram, Johnson, and Condon (2011) examined the effects of BFHI training on breastfeeding rates, as well as breastfeeding attitudes, knowledge, and confidence in helping mothers to breastfeed among community health care staff. Their results demonstrated a positive impact across all of these aspects that was statistically significant ($p < 0.05$) post-training. Exclusive breastfeeding rates at the 8-week infant checkup increased from 32% in 2006 to 40% in 2009. Mothers who were combining breastfeeding with formula feeding rose from 15% in 2006 to 17% in 2009. Formula feeding exclusively decreased from 54% in 2006 to 43% in 2009.

Research on BFHI Implementation for Nurses

In recent years, some research has emerged in the literature on the implementation of the BFHI for nurses. In the following sections of the chapter, I discuss quantitative and qualitative studies in this area.

Quantitative Research

A quantitative study by Lillehoj and Dobson (2012) looked at the implementation of the steps of the BFHI in 53 hospitals in Iowa, United States. The researchers examined the extent to which the 10 steps were being implemented through the self-appraisal preassessment tool from the WHO. All of the data were collected from hospital administrators. Their results showed a low compliance with the 10 steps, with a median of three steps attained. In addition, they found a positive association between the number of steps successfully implemented and an increase in breastfeeding rates at discharge. The authors surmised that the low number of steps that were met was due to a lack of appropriate policies; however, further research is needed to explain why BFHI compliance was low.

A study by Chabot and Lacombe (2014) examined factors that influence the likelihood that perinatal nurses adopt the BFHI into their nursing practice. The strongest factors that were identified by their research included perceived behavioral control, subjective norm, and moral norm. Perceived behavioral control involved believing that one possesses the ability to overcome barriers and achieve success despite them. Some barriers that were specifically mentioned included the strict standards of the initiative, as well as a unique barrier not previously mentioned in any research, which was overcoming unfavorable remarks from the new mother's support system. Subjective norm involved the influence of the opinions of others in terms of the BFHI and how that can guide professional practice. For example, if a nurse thought that a mother was supportive of the BFHI, then the nurse was more likely to follow the guidelines. This extended to coworkers as well: Nurses were more likely to adopt the BFHI if their colleagues were in

agreement with its implementation. Moral norm was defined by the authors as how the implementation to adopt the BFHI corresponds with their own personal set of values.

In a study by Daniels and Jackson (2011), interviewer administered questionnaires were completed with eight managers and 45 staff nurses in non-BFHI maternity units to determine what the level of knowledge and attitudes were in terms of the BFHI. Questions were targeted toward the ability to define and demonstrate the skills and principles that are inherent in the 10 steps, as outlined by the WHO. The results revealed that the level of knowledge was acceptable, with particular competence identified in the areas of appropriately defining rooming-in and demonstrating correct breastfeeding positioning. Areas of needed improvement were identified as learning the correct technique for hand expression, as well as the management of sore nipples and engorgement. In terms of staff attitudes, the results demonstrated that the majority of nurses had a positive attitude toward the BFHI.

Qualitative Research

Barriers and facilitators of BFHI implementation. A study that included hospital managers as a source of data was conducted by Benoit and Semenic (2014). In their qualitative study, Benoit and Semenic explored barriers and facilitators to implementing the BFHI in two neonatal intensive care unit (NICU) settings in Canada. This study involved in-person interviews to determine management and staff opinions on the BFHI in the NICU setting in terms of relevance and feasibility. The participants shared that some barriers to implementing all 10 steps existed in the NICU setting; however, they placed great value on the BFHI, as it would facilitate the transition to family-centered care. Benoit and Semenic stated that their participants, who included

nursing managers, might not be representative of all practitioners in the NICU setting.

The authors recommended further research on this topic with bedside nurses.

Focus groups, consisting of staff working directly with the BFHI, were used in a qualitative study conducted by VanDevanter, Gennaro, Budin, Calalang-Javiera, and Nguyen (2014). The purpose of the study was to evaluate the implementation of the BFHI in a hospital in New York City. The authors identified strengths and challenges experienced in the implementation process and categorized them in terms of system-, provider-, and maternal-level factors. An example of a system-level strength was making the BFHI a visible priority through media and educational materials. A system challenge that was identified was staffing issues with regard to completing the available training and having adequate time to teach patients. Provider-level strengths included good staff resources, such as a lactation consultant, as well as adequate training opportunities. The inability to complete all of the training, particularly the hands-on portion, was a provider-level challenge. Maternal-level strengths were most mothers had the desire to breastfeed and many came prepared with knowledge and support. A maternal-level challenge was some mothers may have gone along with what they believed health care providers wanted them to do, but they had no intention of breastfeeding. VanDevanter and colleagues identified some study limitations. First of all, the focus groups took place in the workplace and the participants might have been hesitant to openly respond to the questions. Second, although there were 45 participants in the focus groups and six key informant interviews, the study took place in one hospital only.

Another qualitative study on barriers and facilitators to the implementation of the BFHI was completed by Nickel, Taylor, Labbok, Weiner, and Williamson (2013). They

focused on the preimplementation stage to determine factors that might impact a hospital's ability to carry out the 10 steps. The study participants were 34 health care professionals from eight different hospitals in North Carolina. It was conducted with a mix of staff, including pediatricians, obstetricians, nurse practitioners, administrators, and staff nurses. This study took place in an area with a large Latina population. Data were collected using a semistructured interview process. Nickel et al. coded the interview transcripts under two main constructs, which were collective commitment and collective efficacy. Some factors related to both constructs, including staff age and experience. Nickel et al. found that attitudes, beliefs, and experiences related to breastfeeding varied with age and experience: Participants that were younger and had less nursing experience held a higher commitment toward the implementation of the 10 steps.

In the study by Nickel et al. (2013), two other factors that were related to both collective commitment and efficacy were (a) the perception of forcing breastfeeding versus supporting mothers, and (b) the perception of mothers' cultural beliefs. Many participants expressed the belief that the 10 steps force breastfeeding on mothers, without respecting a mother's choice. The study participants expressed that it is a cultural norm to both bottle and breastfeed during the hospital stay because the Latina mothers do not believe that their milk has come in. The participants stated that they did not want to suggest to the Latina mothers that they go against their culture. The availability of an Internationally Board Certified Lactation Consultant (IBCLC) was also identified as a factor affecting both collective commitment and collective efficacy. If an IBCLC was available to help with difficult feeding situations, it increased staff participation in the 10 steps. However, if the IBCLC was solely responsible for all teaching, then participation

decreased, as patients refused help from the staff nurses and requested only the IBCLC to assist.

In the study by Nickel et al. (2013), factors related to collective commitment only included night versus day shift, management support, change champions, and observation of mothers utilizing breastfeeding support. Nickel and colleagues stated that night shift nurses did not provide breastfeeding support for three main reasons, which were (a) the belief that night is a time for the mother to rest, (b) the perception of no negative consequences of supplemental feeding, and (c) the belief that there were few benefits of exclusive breastfeeding during the hospital stay. With respect to management support, educational initiatives were routinely offered, managers consulted with nurses about patient experiences with breastfeeding support, and employee annual performance reviews included the topic of breastfeeding support. Change champions consisted of nurses who felt strongly about the BFHI and worked hard to obtain support from coworkers. The observation of mothers utilizing breastfeeding support was a factor in that nurses were encouraged by mothers who returned for additional assistance with breastfeeding.

Nickel et al. (2013) also reported factors that were related to collective efficacy only: These factors included staffing practices, mode of training, and visitors. If staffing was deemed to be inadequate, then practicing the 10 steps became less of a priority. Mode of training was an issue in regards to classroom versus hands-on training, with hands-on training being more valued by the participants. Finally, the presence of visitors in the room was also identified as a barrier to initiating feeding within the first hour and throughout the hospital stay because the baby was passed from visitor to visitor.

Furthermore, visitors would often encourage the mother to supplement with formula, particularly if they were older visitors. The researchers noted a limitation of this study, namely the participants knew the research team was part of an effort to implement the 10 steps. Therefore, the participants might have been reluctant to voice socially undesirable viewpoints.

A study by Wieczorek et al. (2015) used a qualitative approach to explore what the motives are for an institution to implement the BFHI. Their research question also examined how the BFHI is implemented and what factors facilitate or impede the implementation. Their findings showed that the decision to implement the initiative can be grouped into three main themes, including marketing, improving services, and improving collaboration among professional groups. In terms of marketing, the participants stated that obtaining the BFHI designation would give their facility good publicity, set their unit apart from others in the area, and attract more mothers. Some participants termed the BFHI designation a “calling card.” The findings related to improving services included beliefs that the initiative represented a true paradigm shift, in which the care was shifted from the staff looking after the baby to the mother caring for the baby. The final theme was the participants expected that the BFHI would improve collaboration among health care professionals.

Wieczorek et al. (2015) also examined how the BFHI was initiated once the decision was made to pursue implementation. The researchers discovered that among facilities that implemented the initiative, the process was very organized, with formally appointed groups of people directing the process. First, a project group was formed, which was typically comprised of managers from each discipline. Then, subgroups were

formed, with each assigned specific tasks such as statistics, workshops, and training. These subgroups had to work together to develop new work procedures, as well as standards of care.

A review of facilitators and barriers to the success of the BFHI was also examined by Wiczorek et al. (2015). They determined that facilitators to the operation of the BFHI included the skills of the staff, support from management, and staff support. The barriers included a lack of time and resources, old patterns of practice, lack of physician buy-in, tensions felt by nurses of caring for mothers and babies within the guidelines of the BFHI, breakdowns in consistency of care given by staff in relation to standards, and expectations that mothers and their extended families bring with them to the hospital.

A systematic, integrative review performed by Semenic, Childerhose, Lauziere and Groleau (2012) reviewed the literature for quantitative and qualitative studies related specifically to the barriers and facilitators faced while implementing the BFHI. Their review yielded 45 articles that were relevant to the topic. The amount of data was comprehensive, and the results were divided depending upon the group impacting the outcome, including the health care providers and the mother/family members. Within each group, key factors were identified: For health care providers, these included the knowledge/skills related to breastfeeding, staff attitudes, discomfort promoting breastfeeding, and the use of formula and pacifiers. For mothers and family members, the key factors included their knowledge about breastfeeding and the BFHI, their beliefs, their birth experience, and the level of family support.

Staff attitudes, perceptions, and experiences of BFHI implementation. Some studies have been conducted on staff attitudes, perceptions, and/or experiences of

implementing the BFHI. Schmied, Gribble, Sheehan, Taylor, and Dykes (2011) recognized the research gap concerning health professionals' perceptions of implementing the BFHI. To help fill this research gap, they recruited 132 health professionals, working in four maternity units and two NICUs, for their study. Three main themes were found: "belief and commitment," "interpreting BFHI," and "climbing a mountain." The participants were mostly keen and committed to achieving BFHI accreditation. They believed that the BFHI was a positive addition to practice because of the health benefits to both infants and women. The theme of interpreting BFHI highlighted some inconsistencies among health care professionals: Some participants viewed the initiative as a supportive tool that assisted in delivering the message of the benefits of breastfeeding, while others viewed it as a checklist of tasks to perform. Those that viewed it in a task-oriented frame of mind also expressed concerns about rigidity of the steps, leading mothers to feel pressured to breastfeed. For the third theme of climbing a mountain, all of the participants felt that the implementation process is hard work, regardless of their level of commitment or the amount of progress made to implement the initiative. A limitation of this study, which was noted by the researchers, was two of the participants had already worked in BFHI accredited hospitals and their experiences might have influenced the views of participants that were involved in BFHI implementation for the first time.

Researchers Walsh, Pincombe, and Henderson (2011) looked at maternity staff attitudes toward implementing the BFHI. Focus groups were held with 31 participants, who included midwives, nurses, qualified lactation consultants, and administrators. The findings consisted of seven themes in response to BFHI accreditation. The first theme was

participants' understandings of the initiative differed. Some viewed the initiative as robust and desirable, while others viewed it simply as an idealistic reward. The second theme was preconceptions and mothers' choices. Staff from baby-friendly hospitals felt they had superior skills and felt confident in their ability to support women to breastfeed.

Participants from non-baby-friendly hospitals expressed negative feelings about baby-friendly staff and described them as "mother unfriendly, breastfeeding Nazi's, or bullies" (Walsh et al., 2011, p. 599). The third theme was the accreditation process. In the non-baby-friendly hospitals, constraints were identified as budgetary as well as supportive. One participant stated that the director of nursing decided on becoming baby friendly, but the lack of consultation or input from staff led to resistance. In the baby-friendly hospitals, the approach was successful because it was collaborative and inclusive. The fourth theme was intra-organizational difficulties in achieving BFHI accreditation. It was identified that support from management and medical staff were needed in the process. The fifth theme was implementing the 10 steps. Most of the staff were unaware of the evidence behind the 10 steps. The sixth theme was a bottle-feeding culture: In Western society, bottle feeding is widely accepted and in prior generations, it was the norm. Theme seven was the continuation of breastfeeding and employment. The participants noted that when many women return to work, they cannot breastfeed; therefore, most switch to bottle feeding because it is easier than trying to pump and store breast milk.

The participants in Walsh et al.'s (2011) study identified challenges with implementing the BFHI steps. For step one, having a written breastfeeding policy was seen as an overwhelming task because most staff had no previous experience in policy development. For step two, attending the educational sessions during working hours or

unpaid time was a challenge. Also, for many participants the sessions were emotional, as they were ironically deemed to be baby-unfriendly. Step three, which is to inform pregnant women and their families about the benefits and management of breastfeeding, was well received by the participants. They pointed out that appropriate teaching was much easier if feeding decisions were discussed and finalized prior to delivery. Step four involves initiating breastfeeding within 30 minutes of birth and skin-to-skin contact immediately after birth. The participants indicated that step four was routinely difficult to accomplish due to C-sections, low staffing levels, routines, and the physical environment. There was a division between accredited and nonaccredited hospitals for step six, which is giving the infant no other food or drink other than breast milk: Those from accredited hospitals thought it was a challenge to deliver information in a way to guide mothers toward meeting step six of the BFHI. Those from nonaccredited hospitals were more willing to accept mothers' feeding decisions and they frequently provided formula supplementation. Step seven, which entails rooming-in 24 hours a day, was also managed differently in accredited versus nonaccredited hospitals. Those in accredited hospitals followed the step, whereas the participants from nonaccredited hospitals questioned whether the evidence on the benefits of this step outweighed the denial of an exhausted mother's request. For step nine on the use of pacifiers, baby-friendly hospital participants responded that parents focused on the short-term benefits of pacifiers, without much thought given to the long-term harm. The non-baby-friendly hospital participants questioned the scientific evidence of restricting pacifier use and deemed it to be a baby-unfriendly practice. Step 10, which covers breastfeeding support upon discharge, was viewed as an area that required improvement. Participants reported that mothers who

were doing well in the hospital would be seen a few days later giving the baby a bottle.

Walsh et al. did not comment on steps five and eight of the BFHI.

Taylor, Gribble, Sheehan, Schmied, and Dykes (2011) also examined staff perceptions, understandings, and experiences with the BFHI in the neonatal intensive care setting. Their work revealed four major themes, including it's a different world, mother and infant, it is hard work, and it can be done. Participants thought that the BFHI was different to implement in the NICU environment compared to the maternity floor setting, as this type of infant typically demands a different approach to care; consequently, there was tension between staff nurses on the maternity floor and staff nurses in the NICU. The reason cited for the tension was a lack of understanding of the other nurses' responsibilities, practices, and challenges. For the theme of mother and infant, the nurses acknowledged that the physical separation of the infant from the mother impacts their ability to implement the initiative. This led to the mother and the infant being treated as separate entities, rather than as one as per the goals of the BFHI. In terms of the theme of hard work, the main contribution to this theme was the identification of the challenges associated with the lack of resources and nurses reverting back to their old practices. Despite these challenges, the theme of "it can be done" emerged from the data, which illustrated the positive stance that the BFHI can be achieved.

Schmied et al. (2014) analyzed seven qualitative studies to identify health care provider perceptions of the BFHI, as well as facilitators and barriers to implementation. Three main themes that were identified in the literature were (a) the BFHI was viewed as either a desirable innovation or an unfriendly imposition, (b) cultural and organizational constraints, and (c) optimism for success in institutions with a strong and credible leader

to direct the change. Of interest in their study was the identification of perceptions among the health care providers. Those who viewed the initiative as a desirable innovation did so with the belief that it would create healthier communities; thus, they perceived a reduction in health care costs both locally and globally. Those who viewed the initiative as an unfriendly imposition did so because it was considered to be “mother unfriendly” (Schmied et al., 2014, p. 246). These participants thought that they had to force breastfeeding on mothers. Additional reasons for the viewpoint that it was an unfriendly imposition included competing priorities, such as financial resource allocation and time to perform clinical duties. Some nurses also expressed feelings of being overwhelmed by all of the requirements of the BFHI.

A study was conducted by Furber and Thomson (2006) to discover the views of midwives on baby feeding. They interviewed 30 midwives, who were employed in hospitals in North England; however, midwives that worked in neonatal units were excluded. In person interviews were utilized to explore their feelings in relation to infant feeding. Using grounded theory, Furber and Thomson uncovered a central category of “surviving baby feeding.” Four theoretical categories emerged, which included a) altering proximities of baby feeding, b) emotionalising feeding, c) struggling with feeding, and d) directing feeding. A common experience that the midwives reported was breaking the rules, specifically bottle feeding infants supplements by subtly helping the mother to make the suggestion herself. The rationale for ensuring that it was the mother’s request was their documentation could reflect that it was at the mother’s request, rather than the midwife’s suggestion. The midwives were concerned about being identified as an

unskilled practitioner by their peers and management, as well as by the parents themselves.

The BFHI is not limited to the hospital setting: It also has an equivalent plan of action to address the needs of nurses and physicians working with new mothers in the community setting. An accommodated version of the 10 steps exists to guide their practice. The seven point community plan includes having a breastfeeding policy, training for all community staff members that care for postnatal mothers, providing educational information to antenatal and postnatal women, and complying with the Code of Marketing of Breast Milk Substitutes in all community health care facilities (WHO, 2009).

A study by Thomson, Bilson, and Dykes (2011) utilized a qualitative approach to determine what the experience of the community aspect of the BFHI was like for community health care providers, including public health, local council employees, midwives, and members of a voluntary breastfeeding support organization in the United Kingdom. Participants were also asked questions to identify perceived facilitators and challenges faced throughout the process of implementing the initiative in the community. The findings of the study were similar to those found in the studies that took place in the hospital setting. Three primary themes emerged, which were credible leadership, engagement of key partners, and changing attitudes and practice. Credible leadership was demonstrated by having infant feeding coordinators that were well educated in breastfeeding management and had a passion and enthusiasm for the project. Engagement of key partners meant the involvement of as many people as possible that work with this population. The theme of changing attitudes and practices included giving

consistent information, engaging people on an emotional level, and appreciating that the implementation process is not going to be an instantaneous event, but rather a movement that will gain momentum over time. These three themes combined led the authors to describe the implementation process in the community as a “hearts and minds” approach, meaning that engagement needs to occur on both an emotional and a rational level to achieve successful implementation.

Conclusion

The literature review demonstrated that there is a gap in the research pertaining to exploring the process of implementing the BFHI for nurses. The literature review included studies examining breastfeeding rates among baby-friendly hospitals, in both developing and developed countries, and studies investigating the effectiveness of BFHI education interventions given to nursing staff. The chapter continued with a review of quantitative and qualitative research on BFHI implementation for nurses. Some of the reviewed studies included hospital managers and administrators along with nurses in the sample. None of the reviewed studies took a grounded theory approach to investigate the process of implementing the BFHI for nurses. In the present study, I explored the process for nurses of launching and implementing the new initiative into their health care system. In the next chapter, I outline the methodology and methods used in the research.

Chapter 3

Methodology and Methods

This qualitative study used grounded theory consistent with the approach of Corbin and Strauss (2008). The purpose of this chapter is to provide an overview of the methodology and methods used in this study. First, grounded theory is summarized. Then, the sample, setting, recruitment, sampling, data collection, and data analysis are described. The chapter ends with a discussion of the study rigor and ethical considerations.

Grounded Theory

Glaser and Strauss (1967) wrote extensively on grounded theory. They stated that grounded theory is the discovery of a theory from systematically obtained data. The generation of grounded theory enables the creation of a theory that is specifically suited to the investigated phenomenon. The derived theory should provide categories and hypotheses that can be verified not only in the present research, but in future research as well. Grounded theory produces a theory that is an appropriate fit to the phenomenon; it is applicable to the data under study. The goal of grounded theory is to have a meaningful theory that explains the phenomenon under study (Glaser & Strauss, 1967).

Theories resulting from grounded theory methodology are either substantive or formal (Corbin & Strauss, 2008). A substantive theory is the result when the theory is produced from and explains a specific phenomenon; consequently, it can suggest how to address the identified issues. A formal theory has a broader applicability because it is more abstract and it generally includes a range of topics (Corbin & Strauss, 2008).

The theoretical underpinnings of grounded theory include the concept of symbolic interactionism. Blumer (1986) stated that symbolic interactionism is comprised of three premises. The first is that humans act upon things based on the meaning that it holds for them. Second, meaning comes from the interactions that humans have in their environment and with each other. Beliefs and the meanings of things vary from society to society. Blumer stated that the third premise is an interpretive process used by humans: In the process, dealing with a situation leads to how meanings are handled and modified. Everyone responds to a situation based upon their world and history.

All research requires a research question, and it must be determined if it can be answered best by a qualitative or a quantitative approach. It was determined that my research question would be best answered by a qualitative approach. Corbin and Strauss (2008) stated that qualitative studies are generally exploratory in nature and more hypotheses generating, as opposed to testing. Qualitative studies allow the researcher flexibility to explore a topic in-depth. Another reason to choose a qualitative study approach is that all concepts pertaining to a phenomenon have not fully been explained, developed or understood; as a result, further exploration is needed to improve understanding. Typically qualitative research questions are broad, and their purpose is to lead the researcher to the data where issues important to the population in the study can be explored.

To answer the research question, Corbin and Strauss (2008) stated that there are many sources of data. Some suggestions of possible sources included interviews, observations, videos, drawings, diaries, newspapers, historical documents, and biographies to name a few. The authors noted that one of the most important factors to the

quality of the analysis is the quality of the materials that are being analyzed. For the purpose of this study, it was determined that the most valuable source of data would be an interview process with participants undergoing the experience of implementing the BFHI.

Sample and Setting

This study took place in hospitals in Eastern Canada. The sample was comprised of English-speaking registered nurses who worked in any maternity-related setting, including labour and delivery, postpartum, and the NICU. The study was open to both registered nurses and licensed practical nurses, but only registered nurses chose to participate. The participants were recruited until data saturation was achieved. A total of 13 female registered nurses participated in the study.

The ages of the participants ranged from 25 to 52 years of age (Mean [M] = 39; SD = 9.50). Years of nursing experience varied from 4 years up to 29 years (M = 15; SD = 11.13). Two of the 13 participants graduated from a college nursing program, and the remaining held university degrees, with two participants having completed some graduate studies. Two of the 13 participants were employed part-time, and the remaining participants held full-time positions. Five participants had employment solely in NICU, whereas the other eight nurses were cross-trained to work between labour and delivery, postpartum, and the NICU. At the time of the study, four participants had not yet completed the WHO breastfeeding course. A copy of the tool utilized to collect the biographical and sociodemographic data can be found in Appendix A.

Recruitment

Research posters displayed in maternity-related, staff areas of the hospitals were used to recruit the nurses in this study (see Appendix B). Also, nurses on these units were

invited to attend information sessions about the study that I held at each hospital. Information about the study as outlined in the consent form (e.g., the purpose of the study, study procedures, length of time, possible risks and discomforts, benefits, privacy and confidentiality etc.; see Appendix C) was verbally communicated during the information sessions for interested potential participants. Along with the invitation to contact me by phone or email as outlined on the research posters, the information sessions provided another opportunity for potential participants to ask me questions about the study. Permission to hold the information sessions and to display the study posters was obtained from the involved nurse managers at each hospital. Recruitment took place over a 1 year period of time. I continued to recruit participants and collect data until data saturation occurred.

Sampling

Theoretical sampling is used in grounded theory (Corbin & Strauss, 2008). The nature of theoretical sampling is such that the researcher simultaneously collects, codes, and analyzes the data. No more data are required once the researcher comes upon the saturation point in which no new codes emerge (Speziale & Carpenter, 2007). Theoretical sampling is responsive to data, and the number of participants cannot be established prior to commencing the research process (Corbin & Strauss, 2008).

Consistent with theoretical sampling, data analysis began with the initial piece of data collected. The analysis process began after the first interview. The process was circular in that the analysis led to concepts, the concepts generated questions, and the questions led to more data collection (Corbin & Strauss, 2008). This circular process was

repeated until all of the concepts were well defined and explained, meaning that the point of saturation was achieved.

Data Collection

Data collection was completed with registered nurses in interviews exploring their experiences with implementing the BFHI. All of the interviews were conducted by me.

The interviews were recorded and transcribed verbatim by the researcher.

The aim of the interviews was to examine the process of implementing the BFHI for the nurses. Broad and open-ended questions were used to gain a well-rounded understanding of the process. Some examples of the broad nature of the interview questions included asking about their thoughts and feelings about breastfeeding in general. A broad question was also asked about their thoughts and feelings concerning the BFHI. Some social aspects were also explored, asking about conversations that the participants had with coworkers, friends, and family about the initiative. The interview progressed to asking the participants about each of the 10 steps to successful breastfeeding. An interview guide was used, which can be found in Appendix D.

All participants were interviewed once, and the interviews took place face-to-face. All interviews were conducted in a private room or in the participant's own home. The interviews had a duration of 45-60 minutes. After each interview, notes were taken on nonverbal behaviours and the context of the conversation.

Data Analysis

Corbin and Strauss (2008) defined data analysis as examining a substance and its components, which then enables the researcher to determine their properties and functions, resulting in the acquired knowledge making inferences about the whole. The

process of analysis requires the use of analytic tools, which are defined by Corbin and Strauss as thinking devices and procedures that can facilitate coding. The process of analysis is dynamic as it involves brainstorming, trying out ideas, eliminating some of those ideas, while expanding on others. Corbin and Strauss identified the following 11 properties of data analysis in qualitative research:

1. Analysis is an art and a science.
2. Analysis is an interpretive act.
3. More than one story can be created from data.
4. Concepts form the basis of analysis.
5. Concepts vary in levels of abstraction.
6. There are different levels of analysis.
7. Analysis can have different aims.
8. Delineating context is an important aspect of analysis.
9. Analysis is a process.
10. Analysis begins with the collection of the first pieces of data.
11. A researcher can do microanalysis or more general analysis as the analytic situation demands. (Corbin & Strauss, 2008, p. 47)

Corbin and Strauss (2008) discussed various strategies for qualitative data analysis. Analysis involves coding, which is taking raw data and elevating it to a conceptual level. The action of coding produces codes, which are the names given to the concepts produced from coding. Corbin and Strauss explained the process of coding as interacting with the data, asking questions, making comparisons, and deriving concepts to

define that data. Then, the concepts are developed by looking at their properties and dimensions. Corbin and Strauss named the following 13 analytical tools that are useful for data analysis in grounded theory research:

1. The use of questioning.
2. Making comparisons.
3. Thinking about the various meanings of a word.
4. Using the flip-flop technique.
5. Drawing upon personal experience.
6. Waving the red flag.
7. Looking at language.
8. Looking at emotions that are expressed and the situations that aroused them.
9. Looking for words that indicate time.
10. Thinking in terms of metaphors and similes.
11. Looking for the negative case.
12. “So what?” and “what if”?
13. Looking at the structure of the narrative and how it is organized in terms of time or some other variable. (Corbin & Strauss, 2008, p. 69)

Next, is the consideration of context, process, and theoretical integration, as outlined by Corbin and Strauss (2008). The authors stated that context does not determine experience, but it does identify conditions in which problems and/or situations occur, which leads to responses and, in turn, leads to consequences that can impact conditions.

Context is based in symbolic interactionism and pragmatism. Analyzing data for context is similar to analyzing for concepts or categories. Process, as defined by Corbin and Strauss, is ongoing action/interaction/emotion in response to situations, often with the purpose of attaining a goal or handling a problem. Not all processes are developmental or progressive: They can be chaotic. Analyzing data for process encourages variation in the findings, can lead to pattern identification, and is essential to building a theory. Not all qualitative research builds theory, but for studies that do, theoretical integration is utilized. Corbin and Strauss stated the first step toward this goal is obtaining a central category, which represents the main theme of the research. The central category is the concept that all other concepts are related to. Corbin and Strauss listed five criteria for choosing a central category:

1. It must be abstract; that is, all other major categories can be related to it and placed under it.
2. It must appear frequently in the data. This means that within all, or almost all, cases there are indicators pointing to that concept.
3. It must be logical and consistent with the data. There should be no forcing of the data.
4. It should be sufficiently abstract so that it can be used to do research in other substantive areas, leading to the development of a more general theory.
5. It should grow in depth and explanatory power as each of the other categories is related to it through statements of relationship. (p. 105)

Corbin and Strauss (2008) named some techniques to help with integration. These included writing the story line, moving from the descriptive story to the theoretical explanation, using integrative diagrams, and reviewing and sorting through memos.

In my research, the process of implementing the BFHI for nurses was a purposely broad topic because it was intended to capture the entire process for nurses. As previously mentioned, coding began after the first interview. One to two interviews were conducted per day to allow for a first reading to take place, as per the method of Corbin and Strauss (2008). A first reading means that the researcher simply listens to the audio recording or reads all of the transcribed interview data without making any memos or notes. The researcher listens to the data, without any distraction.

After the first reading has occurred, Corbin and Strauss (2008) suggested taking a piece of the raw data and then beginning the process of memoing. Each memo is then labelled with a concept. Codes are not permanent through this process: They may change as more raw data are analyzed. As data analysis progresses, the memos become increasingly accurate, complex, and long.

A qualitative software program, such as NVIVO, was not utilized in my research. Each transcribed interview was printed on paper and a second piece of paper was attached to each page of data. Relevant text was highlighted and codes were written on the attached page. A colour coding system was utilized to categorize the data for easy access to the codes. After each interview, a list of concepts/codes was produced.

The production of codes involved three coding procedures: open coding, axial coding, and selective coding. These procedures are not a step-by-step process: They are achieved by moving back and forth between procedures. Open coding, as defined by

Corbin and Strauss (2008), is opening the data to all potentials and possibilities within them. This is achieved by examining the data line-by-line, looking for similarities and differences, not only within the participant interview, but also in comparison with all of the interviews. Once similar concepts were identified, they were grouped into abstract concepts known as categories.

Axial coding involved taking the pieces from open coding and linking categories to other categories. Corbin and Strauss (2008) stated that axial coding involves examining conditions, actions, interactions, and emotional responses, as well as the outcomes of these. Within this study, axial coding was utilized to determine the actions/interactions/emotional responses that nurses had with the implementation of the BFHI. Axial coding helped to determine what influenced their actions/interactions/emotional responses and the outcomes that were a result of their actions/interactions/emotional responses.

Selective coding involves refining categories to identify the central category (Corbin & Strauss, 2008). The 13 analytical tools, which were previously delineated in this chapter, were utilized throughout this process. The five criteria for choosing a central category, which were also previously outlined in this chapter, were utilized to determine the central category.

Once each interview had gone through the procedure of a first reading, line-by-line analysis, and coding/categorization, I used diagrams to help me understand the relationships between categories and subcategories. The diagrams changed over time, and the final diagram is displayed in the next chapter.

Rigor of the Study

Chiovitti and Piran (2003) discussed methodological issues concerning authenticity and trustworthiness of data in grounded theory studies. The authors suggested the following eight steps to enhance rigor, which I followed:

1. Let participants guide the inquiry process.
2. Check the theoretical construction generated against participants' meanings of the phenomenon.
3. Use participants' actual words in the theory.
4. Articulate the researcher's personal views and insights about the phenomenon explored.
5. Specify the criteria built into the researcher's thinking.
6. Specify how and why participants in the study were selected.
7. Delineate the scope of the research.
8. Describe how the literature relates to each category that emerged in the theory. (Chiovitti & Piran, 2003, p. 427)

Morse, Barrett, Mayan, Olson, and Spiers (2002) also discussed how to achieve rigor. One consideration is that the researcher impacts rigor through his or her creativity, sensitivity, flexibility, and skill using verification strategies. It is important that researchers be responsive to the data, ensure that categorization is appropriate, and if ideas are poorly supported, then they need to have the ability to resign those ideas. Morse et al. listed five specific verification strategies to ensure study rigor. The first is methodological coherence, meaning there is congruence between the research question

and the method. Second is that the sample is appropriate. In other words, the participants must have experience with the phenomenon under study. Third is collecting and analyzing data concurrently, with an appropriate pacing of data collection and analysis. The fourth strategy is thinking theoretically, which involves building a firm foundation of facts through constantly checking data as collection progresses. The final strategy to help ensure rigor is theory development, which means transforming data to a conceptual/theoretical level of understanding.

This study also achieved rigor based upon the verification strategies outlined by Morse et al. (2002). Grounded theory is often utilized to formulate hypotheses or theories based on an existing phenomenon, or to discover the participants' main concern and how they continually try to resolve it (Glaser, 1992). This is a perfect fit with the current study on implementing the BFHI and how nurses experienced that process. The second verification strategy, having an appropriate sample, was also achieved: This study was open to all nurses and licensed practical nurses who cared for newborns at any stage throughout their hospital admission from labour and deliver, neonatal intensive care, as well as postpartum units. Also, I achieved the third verification strategy by collecting and analyzing data concurrently. After each interview the coding and categorizing process commenced. An initial coding diagram was created, but as data were collected and categories were created, it evolved until the point of data saturation and a central category was easily discernible. Related to this verification strategy is thinking theoretically, in which I constantly checked the data as data collection proceeded. Finally, the last verification strategy to ensure rigor was theory development, in which the central

category, conditions, actions/interactions/emotional responses, and outcomes were identified.

Ethical Considerations

Informed, written consent was obtained from each participant prior to starting the first interview. The consent form (see Appendix C) was read out loud and reviewed by the researcher with each participant. A copy of the consent form was provided to each participant. The consent form included the contact information of the researcher and statements reminding the participants that they had the option to withdraw from the study at any time and they may review the study findings by contacting the researcher. The nurses in this study had the opportunity to share their thoughts, feelings, and experiences with the implementation of the BFHI, but it was not known if the study would benefit them. The only known potential risk for the participants was that some individuals may have found it upsetting to talk about the process of implementing the BFHI. The participants were aware that if speaking about the process did upset them, they could stop the interview, with the opportunity of rescheduling. Participants were also made aware of their right to refuse to answer any questions. None of the participants refused to answer the questions posed and none of them became visibly upset during the interviews. This study was granted approval by the Interdisciplinary Committee on Ethics in Human Research (ICEHR) at Memorial University of Newfoundland.

All interviews took place in a private area chosen by each participant. All participants were assigned a pseudonym. No identifying information appeared in the transcripts or other study documentation. The audio files, transcripts, and consent forms were stored in a locked safe in my locked home office. Study-related computer files were

password protected. My thesis supervisor, Dr. Cindy Murray, and I signed an oath of confidentiality, and we had access to the password-protected study transcripts. I am the only person who had access to the locked audio files and consent forms. Each participant was informed that: (a) the results of the study may be published or presented at conferences, but the utmost of care will be taken to eliminate or conceal identifying information; (b) the biographical/sociodemographic data will be reported as a group; and (c) the quotes will be anonymous.

Chapter 4

Study Findings

The process of implementing the BFHI was a very similar experience among the participants in this study based upon their stories, although one participant's experience in particular allowed for variation to be built into the process. The findings of this study (see Figure 1 on the next page) demonstrated a central or core category of resisting the BFHI. The identified conditions included an awareness of a pro-breastfeeding culture, imposition of the BFHI, knowledge of the health benefits of breastfeeding, experiential knowledge of infant feeding, and belief in the autonomy of mothers to decide about infant feeding. Within the process of implementing the BFHI, some actions/interactions/emotional responses emerged. These included questioning the science and safety of the BFHI, feeling empathy for new mothers, having a limited impact on nursing practice, talking minimally about the BFHI, and anticipating reprimand from management. Two outcomes were identified: moral distress and division between nurses. In this chapter, the study findings are presented with direct quotes from the participants.

Central Category

The central or core category “represents the main theme of the research. It is the concept that all the other concepts . . . [are] related to” (Corbin & Strauss, 2008, p. 104).

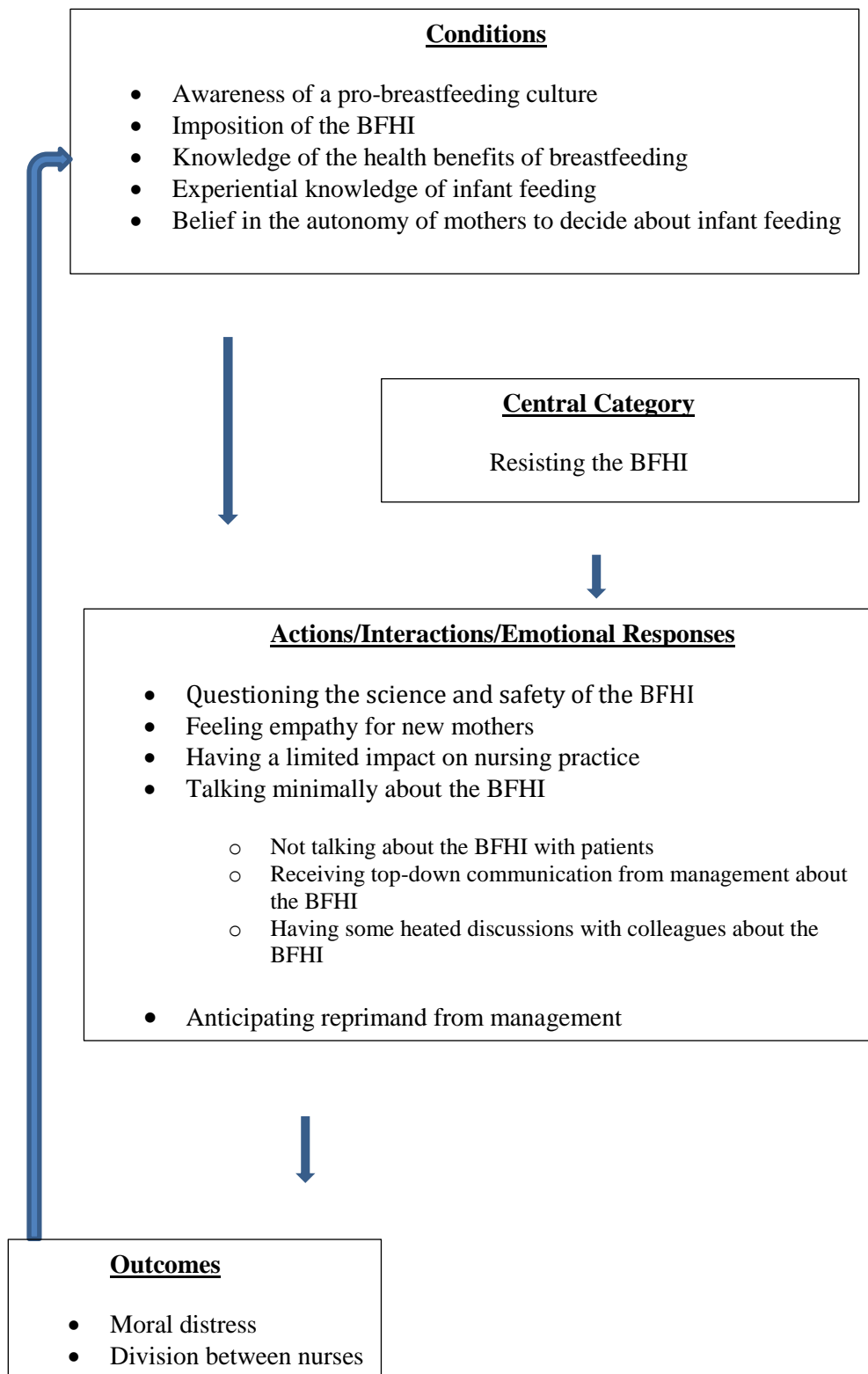


Figure 1. The process of implementing a new Baby-Friendly Hospital Initiative for nurses.

In this study, the central category was resisting the BFHI. All of the participants resisted the BFHI to various degrees. The following quotations are a couple of examples of resistance: “In any discussion I have had with people in consultation about it, it was [met] with great resistance.”

I feel that I do a really good job promoting breastfeeding the way I do it now. So, I don't like that a course that is offered and recommended by our hospital and our government . . . BFI endorses: [It's] outright lies and propaganda. [For example,] formula is not poison; it is made in a safe environment. Is it as good as breastmilk? No, but am I going to say that it is poison? That it could kill your baby or cause your baby to have . . . a problem? Like, no, I won't.

The central category of resistance was particularly evident when the participants were asked about their thoughts and feelings in relation to the 10 steps. Some steps were met with varying levels of support, while others were unanimously rejected. Step one (i.e., having a written breastfeeding policy that is routinely communicated to all health care staff) was generally accepted, as consistency in the education provided to mothers was a shared desire. For instance, one participant stated, “Yeah . . . that is a good idea because you need to be on the same page with what we're helping with and what we are offering.” Participants saw value in this step regardless of the hospital's BFHI status, “I think that's a beneficial thing and I think the hospital, whether it's BFI or not, should have a policy that outlines breastfeeding and how to go about that teaching and implementing those things in hospital.”

Some resistance started to emerge in the second step on training all health care staff in the skills necessary to implement the policy. One senior nurse expressed her dislike for how this was carried out within the BFHI, as breastfeeding mentors are utilized, "...the idea of . . . having to learn how to help a mom how to breastfeed by a maternity nurse after I have worked here . . . [for decades] is an insult. I do not wish to be a part of that." Another participant responded that they needed a breastfeeding policy, but disagreed with BFHI specific training, "Yes [a breastfeeding policy], but not within the initiative. No, I don't agree with that."

Step three (i.e., inform all pregnant women about the benefits and management of breastfeeding) received support and some resistance. Some participants questioned if informing would be taken too far, and that mothers would be made to feel that breastfeeding was the only option, in which case they would not support this step. One nurse stated the following:

They should know the benefits of breastfeeding, but what they do with that information should be their decision and . . . they shouldn't be coerced or made to believe that this is the only thing that they can do and that they have to breastfeed. That's my biggest problem.

Another participant expressed concerns about how this step would be accomplished based on her experience and perceptions of how the BFHI functions and its scientific basis:

No, see that's my huge issue . . . you can inform them about the benefits of breastfeeding, but it cannot be so 100% biased and . . . based on scare tactics . . . [and] guilt. If you want to present them with the factual information that you have,

[and] not anything that is loosely connected to one study with three babies, [then ok,] but not if we are talking about using guilt and fear to get women to breastfeed, then no.

Another participant expressed her concern that step three could lead to mothers being “brainwashed” into believing that they should not bottle feed.

Step four was also met with near unanimous resistance. Having the ability to help mothers initiate breastfeeding within 30 minutes of birth was viewed as nearly impossible to accomplish for many reasons. As one nurse shared:

Well sure, if it's a perfect world, but if they have had a caesarean section, if they're back in the [operating room] (OR) for a retained placenta, if their blood pressure is 200 over 110, I'm just thinking that you have to put that into perspective. That can be your goal, but again you have to allow for the outside. And some of the people that are really big on the baby-friendly thing make no allowances there.

Participants stated that circumstances, such as a C-section delivery, traumatic births, and/or the health status of either the infant or the mother, frequently led to this step being unattainable. Also, the participants noted that the culture of labour and delivery and postpartum has changed: In the past, there were visitor restrictions in terms of the number of visitors, as well as the time of visitation, but this is no longer the case. It is normal now for multiple family members to be present shortly after delivery and mothers are not always comfortable breastfeeding in front of them.

Step five (i.e., show mothers how to breastfeed and maintain lactation even if they should be separated from their infants) was well supported by the participants. This was due primarily to the fact that it is not a change from their current practice. As one participant stated, “We’ve always done that. We’ve always done anything we could.” However, the concern was raised that step five should only be done if this is what the mother wants. There were concerns that this step might be interpreted as a blanket statement for all mothers regardless of their feeding choice.

Step six (i.e., give newborn infants no food or drink other than breastmilk unless medically indicated) was met with resistance for multiple reasons. One issue was the participants believed strongly that formula should not be labelled as something that should only be used when medically necessary: Parents should be able to choose formula without feeling like it is wrong. One nurse said, “Well, I definitely agree with the medically indicated, [but] I disagree with the fact that you shouldn’t do it for other reasons.” Another issue was the clarity of what exactly met the criteria for medically indicated:

See, that one is open for interpretation. You can have a baby losing weight still at 5 weeks, or not at their birth weight at 5 weeks of age and still be told not to use anything. No, no, call it a day. That would be medically indicated to me after 2 weeks, or a week, but . . . it depends on their interpretations. [It] depends on what they feel.

Another participant was firm in her resistance to this issue:

Again, I would never tell a mom that. If a mother wants to give her baby a top-up of formula, I am not going to check with the doctors to find out if that's medically necessary or not. I mean, I feel that a woman's body, the body of her child, it's her business and you can inform her that she could pump if you want, but it's her business to give her baby a bottle and I am not getting in the way. I don't believe in it and I won't do it.

Step number seven (i.e., practice rooming-in, with mothers and babies remaining together 24 hours a day), was either cautiously accepted or rejected altogether. There were some questions concerning the scientific validity of the rationale for promoting rooming-in. One nurse said, "Whether it really affects bonding or not I question because we never had that in place before and do we have negative outcomes from that?" Most participants believed that the option of a nursery should still exist within the initiative for many reasons, including the ability to assess the baby in a more controlled environment and to offer the mother a break if she requests it. For example, a participant said:

Especially at night time, the lighting is terrible for doing a baby assessment, for doing a [phenylketonuria] (PKU) [screening test], for doing hearing [testing], for doing anything like that. Maybe the mom is exhausted and personally I think it's ok if mom says, "Do you mind taking this baby so that I can get a couple of hours of sleep?"

Some nurses, whose experience spanned decades, believed that the lack of a nursery was having a negative impact on mothers, and they questioned if there was a connection between that and mothers opting for earlier discharge home. As one nurse asserted:

This is going to sound old school, [but] to be honest I think that it is again putting expectations on parents that that's best. Who said that that was best? That babies couldn't leave their mothers side? Who, like where did that thought process come from? What happened to years ago when support people came and grandparents, grandmothers came and . . . let the mothers rest? They might have had a complicated C-section, they might have had a complicated delivery and we're expecting them to be superstars, to get up and take care of the baby and act like they didn't even deliver. So, I miss the nursery. I think there was a place for that, and I think that we had happier mothers that were more rested and more open to the teaching and more open to everything because they were rested before they went home. Now, I think we just have mothers that can't wait to get home because they want to go home and rest.

Another concern expressed about step seven was that it does not meet the needs of all families. Participants pointed out that rooming-in is supposed to occur with the father/support person also staying with the mother to help. There are situations, however, where there is not a present father, or the father is at home caring for the other children, so this is not always possible. Without a nursery, there is no safe place for the newborn to stay while the mother showers, for example. Due to this situation, participants shared stories of newborns being left at the nurses' station, which could become a safety/liability

issue. The majority of the participants stated that the nursery was a necessary part of safe nursing care and that it should be brought back into practice.

Step eight (i.e., encourage breastfeeding on demand) received mixed feedback: Some nurses supported this step, while the others would only offer support if it was clarified that babies should not be left for 4 hours or more without feeding to avoid poor infant outcomes.

I'm not going to let a baby go 6 hours without eating because it's not asking to [be fed]. I don't think that's reasonable. Certainly if a baby wants to eat every couple of hours, more frequently, that makes sense, but I think there still needs to be a timeframe in terms of a maximum amount of time in between feeds because then we just get into a whole bunch of issues like dehydration, jaundice, low sugars, [and] low temps.

One participant drew upon her experience encountering a mother in the community that demonstrated this issue:

I encourage breastfeeding every 3 hours. What drives me crazy is that, and I ran into a woman in the community this week, baby was extremely jaundiced. The baby was sleeping 6 hours a night and the clinic said, "Good job! Good job! [There's] no problem." The baby was only having three wet diapers a day and was obviously dehydrated, but yeah, so breastfeeding on demand, great, but if baby doesn't wake up and they are cycling into dehydration, then people need to understand that demand feeding doesn't mean that if they sleep for 6 hours, it's all good.

The ninth step was also met with universal resistance, which is to give no artificial nipples or pacifiers. One participant voiced, “I disagree: . . . there is a place for both if necessary. If a baby is very unsettled and unhappy and just needs to suck non-nutritiously, we know that babies need to do that. They do it in the womb.” Many stated that their experience in practice has never shown that an artificial nipple or pacifier interfered with feeding, which is the rationale for this step. “I disagree with that completely. Some babies just like to suck. I’ve never seen a soother or a bottle interfere with breastfeeding. I don’t agree with nipple confusion: I think that’s a crock.” One participant also thought that prohibiting soother use might be counterproductive to increasing exclusive breastfeeding rates:

Again, if we make the bar so high for these women that you can’t top them up, you can’t give them a soother, you can’t do anything like that, do we really honestly think that they are going to continue to breastfeed these kids? They are going to stop because they are going to be exhausted and rightfully so.

The final step (i.e., foster the establishment of breastfeeding support groups and refer mothers to them upon discharge from the hospital or clinic) provided varying opinions. An example of full support was, “Sure, why not? It would be like any support group. If you need that to allow things to keep happening and to cope and just get through, then absolutely.” A partially supportive sentiment was expressed by some participants, preferring that these groups be open to all mothers regardless of their chosen method of infant feeding: “I think that that’s beneficial to have those in place, but I think it doesn’t even have to be breastfeeding support groups: I think just mom support

groups.” This step also met some resistance, with the idea that community support groups may make mothers feel like a failure if things are not going well, rather than provide support and help.

Conditions

Awareness of a Pro-Breastfeeding Culture

The first condition in which the implementation of the BFHI, specifically the resisting of the BFHI, occurred was an awareness of a pro-breastfeeding culture. The participants expressed their concern that mothers are taught extensively in the prenatal period about dangers and risks of formula feeding to the extent that mothers come to the hospital with a negative connotation for any formula usage, even if medically indicated. They believed that the breastfeeding culture is pushing breastfeeding to the point of inducing fear. One of the participants remarked, “Just because they've had one feed of formula, their baby is not psychologically damaged or physically damaged in any way, but it's psychologically damaging for the mothers if they come in here with a negative association towards formula.”

Other nurses felt that the overemphasis placed upon breastfeeding, while an inpatient in the hospital setting, overshadows all of the other things that are important in a child's life or when teaching someone about how to care for their newborn. One nurse stated the following:

I do sometimes have a hard time saying breastfeeding is best because to me what's best for your baby is a loving and bonding relationship that encompasses your whole world, not just the breastfeeding experience. . . . You can have a baby that

breastfeeds and . . . in a toxic environment or you can have a baby that bottle feeds . . . [in] a loving nurturing environment.

The participants believed that the impact of a pro-breastfeeding culture was not only felt by the mothers prenatally and throughout their hospital stay, but also extended into the postpartum period, after their discharge from the hospital. The pro-breastfeeding culture fostered an increase in the presence of breastfeeding support groups. Participants suggested that while some of these groups can be very helpful and supportive, others might be contributing to the exclusive breastfeeding mindset. Some of the participants heard new mothers share their experiences of attending some community breastfeeding support group meetings. One nurse provided the following insights:

But I find that breastfeeding support groups are just a faction of what I kind of [refer to as], you know, the term “Nipple Nazis,” who just make mothers feel bad if it’s not going right. . . . It’s like they promote themselves as these super moms and make other mothers feel absolutely terrible if things aren’t going well. So, to me, that’s not supportive.

Imposition of the BFHI

The second condition identified was the imposition of the BFHI. This condition took on two meanings to the participants: how it was imposed upon them, as well as how it was imposed on mothers. The nurses expressed opposition and negative feelings concerning how the program was put into their practice without their support. One participant shared, “I don’t support the baby-friendly hospital. I don’t like the concept of

it. I don't like the radicalness of it and I don't like a government to mandate it. I don't like it government mandated."

Feelings of dislike toward the BFHI and the imposition of the program were readily expressed among the participants. One problem the participants had with the BFHI was its name. The participants believed that the "Baby-Friendly" name insinuates that everything they previously did in their nursing practice was not baby friendly.

I don't like how they are doing it. I don't like, if you look at what the term says, the fact that it's baby friendly and it implies that anything else is baby unfriendly, which I have a huge problem with. . . . It has been such a negative thing in our unit in my experience. There's no part of it, when I hear it, that I think is happy, positive, [or promotes,] "Oh great! Let's do this thing!" No, . . . from the beginning when it started, it's presented as this is good, this is what we are doing, everything else is bad. There is no leeway for anything else. There is no room for anything else. There . . . [are] no exceptions for anything else. No, . . . my gut when I hear it, it's like I said, my stomach clenches when I hear it. I don't like it. I don't like how they have done it. I don't like what it is doing with the parents and the babies.

Some participants broadened the sense of imposition to also reflect the impact they feel that it is having upon mothers. For example, one nurse shared, "Moms are not given the option of what they want to do. They are bullied into breastfeeding."

Knowledge of the Health Benefits of Breastfeeding

One thing that was abundantly clear in all of the participant interviews was the nurses appreciated and had knowledge of the health benefits of breastfeeding. For instance, one nurse voiced the following about breastfeeding:

For sure breastfeeding is great: It is [great]. I could even say that breastfeeding is best. Breast milk is terrific for so many reasons; however, the bottom line still for me is that our role as health care professionals, as nurses, physicians, neonatologists, pediatricians, whatever and maternity nurses is to allow parents to know that there are two ways to feed your baby and even though research indicates that breast milk and breastfeeding is best for all of these different reasons, formula feeding is an acceptable, other choice and we would be more than happy to teach whatever method they want to use and it's not our place to convince them one way or the other.

For the nurses in this study, the issue was not that they had a problem with breast milk or breastfeeding: The issue was program specific. All of the nurses expressed their support for breastfeeding. As one nurse proclaimed,

I'm actually pro-breastfeeding. I think it's wonderful and I think it's great; If it works for mom and baby, I'm all for breastfeeding. Studies have proven that breast milk is best and if that is what works, yes, I support breastfeeding.

Experiential Knowledge of Infant Feeding

Many of the study participants were nurses in the maternity setting for years. As such, they brought with them years of experiential knowledge of infant feeding. Some participants saw the BFHI approach as counterproductive to encouraging breastfeeding and used their experiential knowledge to handle situations or to suggest alternatives. The participants drew upon their past experiences of working with mothers coping with extreme fatigue, pain, and/or traumatic experiences, who were forced to a breaking point with frustrating breastfeeding experiences. These points are illustrated in the following quotation:

If you have a mom who has been up for 3 days, and we've all seen them, who have been in labour forever, they are absolutely exhausted. I think the worst thing that you can do is say, "Ok, there you go. You haven't slept for 3 days, but there's your baby." No, like, what is that mom going to do? She is exhausted, she is hormonal, [and] she is sore. . . . Considering the whole point of this process is to encourage breastfeeding, I think it's the worst think if they are not feeling up to it yet. If you give them a little time, let them get some sleep, offer to take the baby, they need to sleep, then you are going to have a much more rested, comfortable mom who is a lot more apt to breastfeed.

Some participants also struggled with the fact that the information presented to them in the BFHI conflicted with their experience. One example of this involved what they perceived as a strict rule in the BFHI that no infant shall receive a soother, as it will impede the infant's ability to breastfeed. Many nurses in the study expressed that this was

simply untrue based on their experience. One nurse asserted, “I have been a neonatal nurse for . . . [over 20] years and I have yet to see a case of a baby whom had an artificial nipple and then refused to breastfeed.”

Other participants questioned if the BFHI is truly needed, as breastfeeding is less about policy and rules, but about using trial and error, mentoring from senior staff, and learning through experience. Most of the nurses felt that it is not a skill that can be acquired through reading; rather, it is a skill that comes with time and experience.

I’m going to find it a huge challenge doing the . . . [breastfeeding] course because somebody with less experience than me is going to mentor me and tell me [what to do]. I think all of the healthy babies and moms that come up to me are proof positive that I already do a good job and I really don’t need somebody to test me on how I have taught breastfeeding when . . . I have helped hundreds of women successfully nurse.

The participants also reflected upon their experiences with infant feeding and came to the conclusion that the BFHI is regimented, and cares for every infant in only one way. It appeared to some participants that prenatal classes might be somewhat misleading as many mothers came into the hospital with the distinct impression that they will give birth and the baby will simply nurse. One participant stated:

I think it started right back with prenatal classes, where parents no longer talked about how to prepare formula if you need it. Prenatally they started implementing it [and] . . . they started talking about how breast is best; you don’t want formula [and] it has been referred to as poison. . . . Therefore, babies that get into trouble

and need formula for various reasons, and they do medically need it, those parents feel like they are failures.

Due to mothers' expectations that breastfeeding would be easy, the nurses frequently found themselves reassuring new mothers that it does not happen right away, it takes time and practice to figure out what is going to work for them, and assuring parents that formula is not dangerous and will not harm their baby.

There's not one other thing in our society that we do that the same approach is used for every child: It just doesn't work like that. So, the best thing that you can do to help them is to start off by telling them that this is going to be difficult. It is natural, but it doesn't come naturally. It's not necessarily going to work the very first time. We'll just figure it out together. . . . Then, if they start to hit a wall and you can see that they are hitting a wall, give them some options. Give them something to hang on to until they feel better, they get some sleep, milk comes in, and [the] baby is nursing. And, for that every-so-often one that you hit that this is just not working, then tell them that it's ok.

From the perspective of the participants, the BFHI's singular approach to every situation did not acknowledge individual needs or cases in which breastfeeding did not go well.

What I don't like is that there is no accommodation for any situation. There is no other part of nursing that I know about that there isn't some leeway based on the patient's experience: Some leeway based on individual situations, whether it's you

know a term baby, a prem [premature baby], a sick kid, a sick mom, a mom who has been in labour for 4 days, or a mom who had a 20 minute labour and delivered her baby. [There are] no soothers, no supplements, no anything, so all of a sudden, . . . you are looking at situations [with] . . . babies who are inconsolable, mothers who are inconsolable. . . . They are . . . being admitted to NICU because they are dehydrated, but yet they are not allowed to supplement or top up or do anything with them because it goes against the baby-friendly initiative.

Belief in the Autonomy of Mothers to Decide About Infant Feeding

Another condition identified in the data was the participants' belief in the autonomy of mothers to decide about infant feeding. The participants expressed concerns with rigidity in the BFHI that does not allow for choice, which they staunchly believed in. They maintained that breastfeeding was the only option offered with enthusiastic support. One nurse narrated the following:

People choose to formula feed or breastfeed for their own reasons. Do I support breastfeeding? [Yes,] 100%. Do I think that we should initiate breastfeeding? [Yes,] absolutely. Do I think that we should honour and respect individuals wishes and desires? [Yes,] absolutely. Do I think the baby-friendly initiative does that? [No,] absolutely not.

Some participants also expressed concerns about the BFHI in that once a mother arrives at the hospital, if she has checked off on her admission form that she wants to bottlefeed, the nurse is instructed to continue to try and convince the mother to breastfeed and that

breast is best. The participants did not agree with the instructions. A participant recounted the following:

If they have come into labour and delivery and they have checked off that they are bottle feeding, then no, I do not bring up breastfeeding with them. . . . I feel that as a woman she has made an informed choice. She has had 9 months to think about it. She has made a decision and that's none of my business.

Another dimension to the autonomy of mothers to make an informed decision was brought up by the nurses: By not respecting the choice to bottle feed, they believed that they would be sending a message that if you do not choose to breastfeed, then you are doing something wrong.

It totally ignores the fact as well that some of these women have made an educated decision not to do this. So, I don't think that they should be treated any differently or their children should be treated any differently in these hospitals – and they are. They have to be. . . . And it's the implication that what you are doing is wrong: That what you have chosen is wrong. . . . We have to have a policy that encompasses everybody – everybody and everybody's choices, and it doesn't [include everybody's choices]. . . . The other side of it is that, at some point, somebody has to sit back and say, "We have to respect the decisions that these intelligent and educated women have made to formula feed." There has to be another half to it.

Actions/Interactions/Emotional Responses

Questioning the Science and Safety of the BFHI

The implementation process of the BFHI also produced common actions/interactions and emotional responses among the participants. With respect to questioning the science and safety of the BFHI, participants expressed concerns about the scientific basis for the information they are directed to share with parents. This concern is voiced in the following quotation:

I will never make a mother feel badly because she is not going to breastfeed. I will never try to convince her to breastfeed. I will certainly never rattle off the big long list of all the things that are going to be wrong with her baby if she doesn't. I just won't. I think it's wrong. I think it's, don't even get me started. Most of it isn't even scientific. Right? I realise that we throw this information around, but we have very little scientifically-based studies to back it up.

As related in the following excerpt, some of the nurses looked into the information provided to them to share with parents:

Like I said, they are presenting fiction as fact in some cases, and I have gone to check on some of this stuff: I have looked it up. There is no scientific basis for some of the stuff. . . . Some of the connections that they make in terms of breastfeeding and outcomes are so loose.

The nurses were not resistant to any type of change. Many participants had been through changes in practice and procedure before; however, they believed in basing their

nursing care on evidence-informed practice, and to them, the scientific basis of the BFHI was questionable.

I'm still going to do what I think is best; . . . that hasn't really changed a whole lot. Has my practice changed some? Sure, when I started in nursing, I taught the women to put the babies to breast for 3 minutes at a time and then topped up with glucose and water and then we [changed that]. . . . So, we have learned over time . . . there was not that need for glucose and water. The science of what really happens in the baby's body with . . . breast milk, as opposed to formula and water has certainly become clear, but is that about the baby-friendly initiative? No, that's about research: That's about moving with research, and I much prefer to base my clinical practice based on research, rather than base my clinical practice on getting that certification, to become certified as a baby-friendly hospital.

In conjunction with questioning the science of the BFHI, the participants expressed concerns in regards to the safety of the program. One common response included noting the fear that some parents have of formula, as though it were poison. One participant shared that parents occasionally opt for an intravenous (IV) infusion, rather than formula supplementation as it is seen as having fewer risks. Another nurse stated:

I feel like the initiative presents breastfeeding as the only option, so there is no choice. And I've had moms, . . . especially in NICU where their babies are here and they are at home, . . . travel through snowstorms and put themselves at risk because they didn't have any pumped breast milk available for their baby overnight. And they've told me that giving one feed – one single feed of formula –

was like allowing your kid to eat junk food for a meal. And where that comes from? And where we see that I think is the fact that we don't promote feeding the baby; that we promote breastfeeding and solely breastfeeding, and they don't feel that there . . . [are] other options, or that the options that are available are bad for their child when that's not the case. We're not poisoning their baby! I've heard so many moms say that. They don't want their baby to have formula, which is fine if that's what they choose, but there's times when that is not possible.

The participants believed that in Canada we have great industry regulation and access to a safe water supply, and as such, formula is a perfectly safe and acceptable product to feed newborns.

Another aspect of the safety concerns is the lack of teaching provided to parents about safe formula preparation. According to the nurses in the study, if a mother is breastfeeding, formula preparation is not taught at all. Furthermore, if a mother is formula feeding, teaching is to take place in a private area away from breastfeeding mothers.

Another dimension to this issue was the nurses noted that some mothers breastfeed while in the hospital to avoid judgement, but then switch to bottle feeding once they are discharged home, with no safety instructions.

If they are just trying to please the nurses, and do what the nurses are telling them is best, and yet they know they are either uncomfortable with or incapable of breastfeeding and they're going to go home and formula feed their baby, I have not prepared them because they have been hiding the fact, so as not to be judged

here in the hospital, that they're going to formula feed. I haven't educated them on proper formula preparation, proper preparation of water, sterilization and whatnot.

Another safety issue was pointed out by participants: There are circumstances that can arise in which the mother can no longer breastfeed, which may be a crisis situation, and added to that situation is that no one else is safely prepared to feed the baby.

I think that all parents should know how to safely make a bottle. What if the mother ends up with a postpartum hemorrhage and is in the OR [operating room] and the baby needs to eat? Who's going to feed the baby? Dad doesn't have a clue: He's never been taught. So, I do think that there should be some guidelines so that . . . if I know you plan on exclusively breastfeeding your baby, but if life gets in the way and you need to do this, it would be really nice for you to have this information. Tuck it away someplace. Don't read it unless you have to. Even that is enough, but . . . I think we set a lot of moms up to fail.

The nurses mentioned their fear of parents preparing formula incorrectly, with known consequences.

We need to teach formula feeding because I know of cases that [were lethal]. One case in particular . . . was in Toronto one time where the mother didn't have any teaching and she went home and she gave straight concentrated [formula] and the baby died. So, I remember that, and I just think . . . it's too important, that everyone needs teaching.

For the participants in this research, another aspect of the concerns with the safety of the BFHI was the all-breast-and-no-supplementation approach that they believed does not work for everyone. If a mother's supply is not adequate, for one reason or another, and she feels that she cannot give formula, this can lead to problems.

Also, . . . my main safety concern is that moms who go home stressed are probably not in the best mental state, so they could be putting themselves at risk. I think a mom who is frustrated . . . has an increased risk for . . . getting frustrated with the baby and when you get frustrated with the baby, bad things can happen, and I think that those are inherent risks. I think physically toward babies dehydration is a huge risk: We see babies readmitted for jaundice and dehydration regularly in our NICU, even if those babies have been followed in the breastfeeding clinic. So, I do think that there are risks to babies if the mothers feel that they can't top the baby up, for sure.

Feeling Empathy for New Mothers

The participants in this study were empathic toward new mothers. They believed that society's expectations for these women were extremely high: In effect, they were expected to be "super moms," as one participant phrased it. The nurses also expressed empathy for mothers who formula feed. They were concerned about how they perceived the BFHI treats mothers who choose to formula feed.

I think that if a mother chooses to formula feed, that they shouldn't be made to feel guilty for their decisions. And I really think that the wording on a lot of the educational pamphlets that we're giving out is offensive in my opinion. I

personally would be offended if I was choosing to formula feed and I received the information pamphlet on formula feeding and the first phrase in the pamphlet was “breast is best.” I had already made that decision, that I wasn’t going to breastfeed, and I didn’t need any more guilt put upon me.

Nurses were troubled about the “unfriendly” and potentially harmful message they may be sending to mothers.

Formula is the worst thing that they can do, so for any of those mothers that have chosen to use formula, what are we doing to them? I mean these women are coming to the hospital, these are intelligent and educated women who have made a choice and the BFI initiative, which I think should be friendly to every baby not just the breastfeeding babies, you are now putting them into an environment where you are making it abundantly clear [that] yeah, we think what you are doing is wrong and we disagree with what you are doing. So, therefore, I don’t think that it is serving anybody. It’s certainly not serving the mothers whom have chosen to formula feed.

Having a Limited Impact on Nursing Practice

Many participants expressed that despite the implementation of the BFHI, they have made no changes to their nursing practice.

I would say not to [implement the BFHI; instead] . . . create your own kind of pro-breastfeeding environment without pigeon holing yourself into the baby-friendly initiative [and] all of the negativity that surrounds that and the stringent rules that

they have associated with that. I think that we were doing a great job promoting breastfeeding before BFI ever came in, and if you took it away from our hospital tomorrow, we would continue the same way that we do now.

The notion that despite policy change, their practice remained the same was echoed by many.

Honestly, I haven't changed what I do. Babies still need to be fed. Women still need to be supported, so I haven't changed: I do what I do. I have always supported a mother's right to breastfeed. If she wants to breastfeed, I will bend over backwards to help her. I will never make her feel badly if she doesn't. I will never make a mother feel like somehow she has made a bad decision.

Some of the participants changed their practice in limited ways. One of the nurses noted, "I'm trying to implement some of those changes in a positive [way]: like I'm trying to take the positives from it and do those positive things."

Talking Minimally About the BFHI

The nurses shared that their communities, particularly the prenatal population within their communities, were generally aware of the BFHI. The awareness was gained either through advertisements, discussions with family members or health care providers, or word of mouth through social networks that have experienced the program. Although the BFHI was only minimally discussed in and outside of the hospital, participants shared

what kind of conversations they had out in the community, and the impressions the conversations gave them.

We talk about the fact that it has made nursing look like the bad guys. We talk about the fact that it has absolutely increased the stress level of mothers. They come with a negative connotation toward the staff that we are going to shove breastfeeding down their throats and . . . we hear from mothers all of the time that they . . . just breastfeed in the hospital because they are too scared to admit to a nurse that they are not going to breastfeed. So, I think the implementation of the baby-friendly initiative has made our jobs harder, and it has made it harder to establish trust with our patients.

The implementation of the BFHI influenced how the nurses thought they are being perceived in the public eye. As pointed out in the quotation above, participants in the research believed that the implementation of the program was impacting the level of trust that the public has for nursing staff in the maternity setting. As a result, they thought it could be damaging professional-patient relationships. Some nurses shared stories of conversations they had socially in the community.

I have talked to people in the community . . . [and] when they realise where I work, they are careful: They stop what they are saying until I say, “Look, you know what? We’re not all fans of this program and then you hear the truth. . . . Then you hear them say that . . . the image in the public is that we’re going to make them do this [and breastfeed].

Not talking about the BFHI with patients. These community conversations impacted how the nurses interacted with their patients, once they were admitted to the hospital.

I went with one mom who was a mess: She was sobbing and finally, I stopped because I mean the baby wasn't nursing well and I said, "Did you plan [to breastfeed]? What do you want to do? This is your baby. It's entirely up to you. This is your decision." And she was sobbing. She was like, "I don't want to do this. I don't want to breastfeed. I just dread every time the baby comes in. I dread every time I have to feed him." And I said, "Then let's just stop." And she hugged me in tears. . . . She said, "I was just terrified to tell anyone." I mean how is this helping? How are we possibly serving the public if this is what we are doing to mothers in the hospital? So, . . . the conversation with the parents that they have to do this, and the conversation with the public . . . that they have to do this, [and] we're going to make them, it's ridiculous.

Because there appeared to be negative feelings within the community, it led to nurses avoiding the specific topic of BFHI. Some nurses also stated that they avoid specifically speaking with patients about the BFHI because they felt that it would only increase the stress level of an already stressed population.

They feel that they have to breastfeed, and they feel guilty if they choose not to or can't. . . . I feel it puts a lot of stress on mothers to have the designation hanging over them, which is probably why I don't discuss that BFI with patients because I don't want them to feel any undue pressure to breastfeed.

Receiving top-down communication from management about the BFHI. The participants thought that the mandated BFHI was implemented without any respect for them or any input or collaboration from them.

There was meetings and discussion. There wasn't any input from nursing. It was [presented as,] "The government has mandated [the BFHI]. This is what to do and your expertise doesn't matter." That's the way I felt. It was just like, "We're doing this. This is how it's happening, and . . . I appreciate that you have all of this experience, but I'm not going to ask you because you're just a nurse." . . . It wasn't like we were given a choice. . . . It was just there.

From the nurses' perspective, the fact that the BFHI was forced upon them, without their input, contributed to their resistance of the initiative. A participant summed up her experience with the implementation in the following remarks:

Personally, I'm not happy with it at all. I think it has been forced on staff. I think that it is something that [has been implemented] without any discussion, without any real [discussion]: I mean I know there have been meetings, [and] I know there was some consultation done, but not really consultation as much as, "This is what we are doing. This is the approach the hospital is going to be taking." Considering that the nursing staff are the ones that are implementing this process at the bedside, there was very little discussion that . . . I've ever seen with how it was being implemented. It was basically, "These are the courses you need to take. This is what we're doing. This is how we're doing it. This is the new policy and this is

what we have to do.” . . . It wasn’t something that was ever discussed. . . . It was [just] brought in across the board and started, so I don’t think it was handled well.

Having some heated discussions with colleagues about the BFHI. The implementation of the BFHI led to “heated” discussions among staff members as they reacted to the initiative in a passionate manner. As one nurse noted, “It’s a very passionate topic, so everyone seems to have an opinion, everyone.” Another nurse observed the following:

It seems heated here. And I don’t know if it’s just because it’s the [name of unit] environment, but there seems to be portions of the [BFHI] process or things that the hospital has to do and change in order to be considered BFI . . . [that] seem to be picking a bone with people.

One identified issue that caused “heated” discussions was the perception of the BFHI’s one-way, blanket approach to care. As one participant stated, “Anything else that you are going to do in the child’s life, you can’t have an all or none/there is no other way approach, so the conversations at the desk are heated.”

Anticipating Reprimand From Management

Since the participants never markedly changed their nursing practice on their units, the nurses expected a collective reprimand from management. Some of the participants were nervous or feared that suggesting supplementation would lead to an individual reprimand.

I still think that the way I'm teaching moms to breastfeed and [the information I'm giving on] what's right for their baby in terms of amount and quality and quantity hasn't changed, but there's always going to be the little "on edge" factor of, "Is someone going to be upset because I have tried to suggest that a formula product is needed or that a different type of feeding is needed?"

Many nurses shared their experience of censoring or slightly modifying their approach to conform with the guidelines of the BFHI.

I feel that as a nurse, when I am working with moms particularly out in postpartum, that I need to be very cautious in how I word things to moms . . . for fear of being chastised or judged for saying, "You know, it's ok if you don't want to breastfeed. Your baby will be ok."

Outcomes

The process resulted in two outcomes: (a) moral distress, and (b) division between nurses.

Moral Distress

One source of moral distress came from the nurses' inability to educate parents openly about safe formula preparation. They believed that the BFHI positioned them and mothers in a way that prevented them from providing necessary nursing care to mothers who decided to formula feed.

Like I feel like there's moral distress that comes with the BFI and the . . . breastfeeding course because as nurses we can support a mother's decision

without making her feel guilty, and I've heard stories from people . . . who have friends that have come into the hospital and felt that they needed to say that they would breastfeed and got all the information on breastfeeding and put the baby to breast for the 2 days or 24 hours in hospital and then went home and cracked open a bottle of Similac . . . or decided to pump and bottle feed. . . . It distresses me to think that these moms feel ashamed of giving a bottle, and if they're going to do both or if they're going to do one or the other, then we should be teaching them in hospital how to sterilize bottles, how to prepare formula, and at least giving them the information for when they are going home. And I think that that's the biggest problem with the BFI: . . . that population of people who never intend to breastfeed come in there and lie to us because they feel like they are a bad mother if they don't and then go home and are putting their babies at risk because they don't have the teaching that they should. And that's morally distressing to me as a nurse because it's my job to give them the information that they need to care for their baby properly at home.

Other participants viewed the BFHI as a potential case for negligence.

I think it can be kind of scary sometimes. I think it can set parents up for postpartum depression and [a] host of lots of things. . . . One of the scariest situations to me is . . . where the baby is not breastfeeding and goes home not breastfeeding well, not established, and then this carries on for a significant period of time and weight gain is an issue and failure to thrive becomes the case and then the mother just absolutely will not give a bottle. I think [it] is extremely scary and

I think and if we as health care providers allow that to happen, then we are negligent.

In the same sense, other participants expressed concerns about a balance between the BFHI and the health of the newborn.

I think that it is frustrating for a lot of us that work . . . here because we feel so much pressure to participate in this [BFHI], but we are a lot of the time more concerned about our babies because we see the low sugars and we know that there are consequences to these things. . . . It's hard for us to teach the moms these [BFHI] steps that they want us to and at the same time be able to maintain the health of the child.

Division Between Nurses

The perceived division between nurses was caused by the sense that different care areas of the maternity setting follow the BFHI to varying degrees.

In general, I have found that . . . it's caused a lot of controversy between the units; between the staff in the units in how much/how far we should be going with this: whether or not it's helpful, whether it's not helpful, which points of it some people feel need to be implemented, and which points . . . there needs to be some leeway on. So, in general, I don't see that it has been a positive experience so far.

Another participant acknowledged the imbalance of the application of the BHFI between nursing units, where the BFHI has not been enforced and nursing units where it has, and the negative feelings evoked by the division.

It's made me bitter. It's made it difficult with relations between the nurses who work on [name of nursing unit], which is the mother/postpartum area because, yeah, their hands are tied and it has changed the relationship between those two areas because . . . the nurses on those areas feel like their hands are tied and we do what we like in the neonatal unit.

Summary

This chapter provided an overview of the study findings. First, the central category and each condition that contributed to the central category were presented, including: (a) an awareness of a pro-breastfeeding culture; (b) the imposition of the BFHI; (c) the knowledge of the health benefits of breastfeeding; (d) experiential knowledge of infant feeding; and (e) belief in the autonomy of mothers to decide about infant feeding. Shared actions/interactions and emotional responses were also identified including: (a) questioning the science and safety of the BFHI; (b) feeling empathy for new mothers; (c) having a limited impact on nursing practice; (d) talking minimally about the BFHI; and (e) anticipating reprimand from management. Finally, two outcomes (i.e., moral distress and division between nurses) were described. A discussion of the study findings is found in the next chapter.

Chapter 5

Discussion of the Findings

In this chapter, the study findings are discussed. First, the findings related to the central category are considered. Then, the conditions, actions/interactions/emotional responses, and outcomes are discussed.

Central Category

Overall, the study findings indicated that there was very little support for the BFHI. A commonly mentioned issue was feeling disrespected from having a lack of input into both the program content and its method of delivery. Many felt that their years of experience were being ignored, along with believing that their previous practices were being viewed as “baby unfriendly.” Their resistance to the implementation of the BFHI is not unique. Researchers Walsh et al. (2011), who examined maternity staff attitudes toward implementing the BFHI, likewise reported that a lack of any consultation or input from staff led to resistance of the BFHI.

In this study, the 10 steps were reviewed with each participant to explore their thoughts, feelings, and experiences with implementing each step. In doing so, it was determined that there was resistance to several steps, particularly with steps four, six, seven, eight, and nine. Similar findings were obtained by Walsh et al. (2011) in Australia.

The findings in my study might help explain results obtained by Chalmers et al. (2009), who found that Atlantic Canada needed improvement with putting the baby to breast within 30 minutes of delivery (step four) and encouraging the baby to feed on demand (step eight). Step four met a great deal of resistance in this study. Most of the

nurses thought that it simply was not a practical expectation in the current labour and delivery environment. Chalmers et al. (2009) found that mothers were not routinely given the opportunity to feed their infants that early. With respect to step eight, nurses in my study would support the step if it was clarified that babies should not be left for four hours or more without feeding, as per the recommendation of the American College of Obstetricians and Gynecologists (2013).

The participants in my study did not share the concerns about formula that were stated by the WHO (2009). The participants believed that in Canada we have great industry regulation and access to a safe water supply, and as such, formula is a perfectly safe and acceptable product to feed newborns. The nurses in my research commented numerous times about how the WHO presented formula as “poison,” which puts nurses in a very difficult situation should a baby then need medically-indicated formula because some degree of fear has been instilled into parents.

Many participants in my study questioned why the WHO (2009) included step nine (i.e., give no artificial nipples or pacifiers), especially since research into sudden infant death syndrome has demonstrated that the use of soothers decreases the incidence (Alm, Wennergren, Möllborg, & Lagercrantz, 2016). A study by Kair, Kenron, Ethredge, Jaffe, and Phillipi (2013) examined if the argument that soothers interfered with infant feeding was valid. Their findings suggested that soothers, in fact, do not interfere with feeding, and actually increase exclusive breastfeeding rates. The nurses in my research encouraged a reexamination of this step. Limited pacifier use is supported elsewhere (Nyqvist et al., 2013).

Awareness of a Pro-Breastfeeding Culture

The participants in the current study believed that due to a predominance of the “breast is best” message sent to new mothers and the denigration of formula, pregnant women arrive in hospital with the preconceived notion that formula is harmful. The nurses were concerned about the impact of a strong pro-breastfeeding culture on those who do not breastfeed. In the literature, Crossley (2009) noted the large increase in breastfeeding promotion, and examined the influence that the promotion may have psychologically on new mothers. The author concluded that rather than breastfeeding becoming the empowering act that it is promoted to be, it is becoming a moral imperative where mothers are conflicted between their priorities and the expectations of society.

Imposition of the BFHI

The condition of the imposition of the BFHI was experienced and perceived by the participants in two different ways: how it was imposed upon them, as well as how it was imposed onto new mothers. The feelings expressed in this study are not unique. Walsh et al. (2011) also found that staff thought that the initiative was forced upon them, without any consultation taking place. Nurses in a study by Nickel et al. (2013) also voiced that they felt like they were imposing breastfeeding upon mothers and not offering them the choices that they should have. A study conducted by Knaak (2010) examined how mothers perceive risk as it pertains to the decision to breastfeed. The findings suggested that mothers make their decisions based upon a parenting culture that is guided by the advice of medical, psychological, and professional underpinnings. “Good” parenting is increasingly standardized and medicalized, within an ideological context (Knaak, 2010, p. 345). This is very similar to thoughts and feelings conveyed in my

study, in which it was felt that a universal approach was taken to care for all children, without taking any individual circumstances into consideration.

Experiential Knowledge of Infant Feeding

Many of the participants in this study expressed concerns about their ability to teach mothers who are exhausted as a result of experiencing childbirth and then, being responsible to care for their infant without any reprieve. A part of all nurses' basic education is to learn what circumstances are the best for optimal patient teaching. Participants in this study stated that they were concerned about the mothers' ability to learn all of the things that need to be taught prior to discharge under these conditions. Ward (2013) outlined some circumstances that are critical to effective patient teaching. Among them is providing a hospitable environment, including a comfortable patient who is rested and open to teaching. As the participants in the current study stated, this rarely happens in a maternity unit, as the mothers are offered no opportunity to rest.

Another issue that pertained to the experiential knowledge of infant feeding in this study was that participants whom had numerous years of experience all stated that they never personally experienced the effects of "nipple confusion." Therefore, their experience was in direct conflict with what the BFHI uses for the rationale for not allowing soothers or artificial nipples. A review of the literature completed by Zimmerman and Thompson (2015) found 14 articles that both support and refute nipple confusion. Their review concluded that it is very difficult to establish causality between these things: For example, is the baby preferring the bottle because there are physiological issues at the breast rather than confusion. It appeared that the majority of the "confusion" is related to bottles, not pacifiers (Zimmerman & Thompson, 2015, p.

895). This is consistent with the stories narrated by the participants in the current study: In their nursing experience, soothers never caused an issue, and any issues related to bottle versus breastfeeding were likely due to flow, not the actual artificial nipple itself.

Belief in the Autonomy of Mothers to Decide About Infant Feeding

The nurses in this study expressed concerns that breastfeeding was presented as the only infant feeding option in the initiative. This went against their beliefs that mothers have the right to make an informed decision about how they are going to feed their infant. In a British magazine, Traya (2012) recounted her personal experience with being an educated, middle-class mother that chose to bottle feed. She shared how she constantly felt judged by others. For example, other mothers would make comments like, “Isn’t it sad? Some mothers just don’t understand the importance of breastfeeding. Skin-on-skin contact creates such a bond. You just don’t get that with a bottle.” Traya asked herself how this has become the new social norm: Why have women, who frequently fight for the right to choose on so many issues, taken such a stringent view on this issue? Traya argued that the source of this is the inundation of the message that “breast is best” from health care, as well as the media. The message that the health care system is sending was actually in conflict with how the nurses in this study felt. The nurses in this study feared that mothers would interpret their message as “breast is best; therefore, formula is bad,” and Traya’s account demonstrated that this fear is plausible.

Research also supports that mothers feel judged for their decision to bottle feed. A systematic review of qualitative and quantitative studies examining mothers’ experiences of bottle feeding, which was completed by Lakshman, Ogilvie, and Ong (2009), revealed that many common emotions were experienced by bottle feeding mothers, including guilt,

anger, worry, uncertainty, and failure. Their review concluded that focusing on breastfeeding promotion may be detrimental to addressing the needs of mothers who were bottle feeding as they are not getting the time and teaching that they need. As cited in this review, a study by Lee (2007) found that mothers felt like failures when they did not breastfeed and 23% of the participants worried about what professionals might say about their decision.

Questioning the Science and Safety of the BFHI

Martens (2000) found that when nurses have extensive and accurate knowledge of breastfeeding, there is an increase in the level of support for the BFHI. Many of the participants in the current study expressed concerns in regards to the breastfeeding course that is a mandatory part of the BFHI implementation process. Specifically, participants cited concerns about the scientific validity of the information being presented to them in the course. There was satisfaction with the biological and physical information provided, such as the anatomy of the breast and the composition of breast milk. The information the nurses struggled with were some of the health benefits, such as an increased intelligence quotient (IQ) and lowered risk of diseases (e.g., obesity), because they perceived these claims to be questionable: The claims did not fit with the research they consulted. For example, a study by Hediger, Overpeck, Kuczmarski, and Ruan (2001) examined if there is a link between breastfeeding duration and risk of obesity in young children in the United States. Their findings indicated that there are inconsistent relationships between breastfeeding and obesity, and that familial factors had more of an impact. Another study by Colen and Ramey (2014) also examined the effects of breastfeeding on certain health outcomes including obesity, asthma, hyperactivity, attachment, compliance, academic

achievement, and competence. Their findings suggested that the currently promoted benefits of breastfeeding are overstated. Believing that the education provided is accurate and comprehensive has a large impact on how much support is given to a program (Sussman, 2001).

Another issue that was discussed at length among the participants was safety concerns. These concerns fell into three areas, which were (a) physical safety of the newborn, (b) mental health of the mother, and (c) a lack of preparation for caring for the newborn at home. Frequently cited concerns for the physical safety of the newborn were risks of dehydration and hypoglycemia.

Many of the participants felt that the guidelines of the BFHI set up safety concerns because of the opposition to providing supplementation, as well as their decreased ability to monitor newborns due to enforced rooming-in 24 hours a day. Prior to the implementation of the BFHI, the hospitals had a designated nursery where newborns would go for physical assessments and medical interventions, such as blood work and hearing tests, or it was simply used for mothers that wanted a break to get some rest. The nursery allowed nursing staff to assess the newborn in a one-to-one environment, which enabled them to put their entire focus on that patient. One participant also noted that in-room assessments are difficult with the BFHI because the lighting in the rooms is not optimal, and going in the room during the night shift and turning all the lights up seemed cruel to both the mother and the baby. The nursery allowed for more time to assess and observe the newborn. It also allowed for new mothers to have a break, which after being in labour for sometimes days is a much needed relief, since the labour and delivery process is physically demanding and can be traumatic. The nurses believed that the

nursery was needed to allow these mothers to rest and heal, which would enable them to become ready for caring for their newborn at home.

Another side to this issue was that because 24-hour a day care was promoted, infants tended to spend a great deal of time in beds with their mothers. A study by Thach (2014) collected data concerning the number of deaths of healthy infants while bed sharing on maternity units in the United States. Between 1999 and 2013, there were 15 fatalities and three near death incidents. Circumstances leading to the infant deaths included falling asleep while breastfeeding and falling asleep with the newborn in the bed. Additional risk factors noted in the study include obesity, swaddling the newborn, maternal sedation, maternal fatigue, pillows and soft bedding, and maternal smoking.

Compared to my study, Walsh et al. (2011) had similar findings in their study that assessed staff attitudes of implementing the BFHI. They found that participants questioned if the evidence of the reported benefits of 24-hour rooming-in outweighed denying a tired mother's request. Midwives in a study by Furber and Thomson (2008) also questioned the practice of 24-hour rooming-in. Participants in the current study thought that placing these mothers in this intense and stressful environment, with no offer of relief, was setting them up to experience postpartum depression. Participants suggested that the 10 steps set mothers up to feel like they have to be super moms right from delivery.

Concerns about safety and being well prepared for home also touched on the nurses' ability to teach proper formula preparation. Many nurses rejected the idea that families should not be shown how to prepare formula if they have chosen to breastfeed. A couple of participants were able to cite specific circumstances under which this avoidance

of providing information led to infant harm and death. A study by Daniels and Jackson (2011) echo the concern that parents and caregivers need to be provided with the correct information on formula feeding. Their study, which consisted of 45 maternity nursing staff, found that only 40% of that population could properly educate parents about formula. They hypothesize that this lack of knowledge may be in part due to the increase in BFHI training, particularly those that were BFHI trained early in the program's launch.

Feeling Empathy for New Mothers

The nurses in this study expressed concerns about the high expectations placed on mothers. The idea of the super mom and concerns about expecting women to do it all have been noted in the literature (Robinson & Hunter, 2008). In particular, the participants were empathic toward formula-feeding mothers. They were concerned that the message of "breast is best" was being interpreted as "formula is bad," which was a message that none of them wanted to give. Hehir (2005) wrote an article on the topic of how women that choose to bottle feed should not be made to feel like they are bad mothers, which is consistent with the current research. Hehir also noted that the support and advice that was offered in the past to mothers who were bottle feeding has basically disappeared. This is consistent with the current research in which participants explained that open teaching about bottle feeding is prohibited if the mother has indicated any interest in breastfeeding. If the mother indicated that she wished to bottle feed, her teaching had to take place in a secluded area away from any breastfeeding mothers. A review of postpartum care, as expressed by new mothers, in a study by Rudman and Waldenstrom (2007) found that breastfeeding support was sometimes inappropriate, as

there was too much focus on breastfeeding supervision, a lack of respect and understanding for the mother's decision, exaggerated claims on the advantages of breastfeeding, and tactics that made the mothers feel pressured and guilty. The mothers expressed a desire to be encouraged, rather than pressured. Nurses in my study did not want to make mothers feel guilty, add any pressure, or disrespect their decisions: They wanted the mothers to have a choice, and feel supported in that choice. The nurses believed that the BFHI made this challenging.

A study by Wirihana and Barnard (2012) examined the perceptions that women had toward their health care experience when they opted to bottle feed. Their research uncovered five unmet needs of mothers that choose to bottle feed, which were (a) equity, (b) self-sufficiency, (c) support, (d) education, and (e) to not feel pressured. Equity meant respecting the mother's choice, and to not prioritize her care second because she is not breastfeeding. The participants in my study expressed their desire to treat these women the same as the breastfeeding women; however, they did acknowledge that strictly following the BFHI made this very difficult, if not impossible. In the study by Wirihana and Barnard the mothers also expressed the desire to have the capability to be self-sufficient. Due to the BFHI, formula is no longer allowed to be within sight of breastfeeding mothers. It is hidden, typically in a locked room, so mothers have to ask a nurse to obtain formula, or in some hospitals, the mothers have to bring all of their own supplies. Wirihana and Barnard found mixed reviews of support, with some satisfied participants and others that were very dissatisfied. Those that were dissatisfied stated they did not receive adequate teaching about topics, such as the amount to feed the infant. They also perceived that their follow up after discharge home was less than that of

breastfeeding mothers. The findings related to education were somewhat related to support: They indicated that they did not receive enough written information, as well as verbal explanations on important topics, such as safe formula preparation. This was a topic of concern for the nurses in my research. The final theme discussed by Wirihana and Barnard was the desire not to feel pressured to breastfeed. Sources of pressure included health care professionals, other patients and visitors, and from the public in general, through advertising and promotion. This finding is in keeping with my research, as many participants thought that the BFHI, through the 10 steps, inherently placed pressure on mothers to breastfeed.

There is some evidence in the literature to suggest that breastfeeding messages need to be delivered with more empathy. A study by Fahlquist (2014) looked at the experiences of nonbreastfeeding mothers and how they are affected emotionally when they are told that breastfeeding is the safest and healthiest option. Fahlquist's findings uncovered the following themes: depression, anxiety and pain, failure as a mother and woman, loss of freedom, relief, and guilt. Fahlquist concluded that to help lessen or eliminate these issues, the message that is delivered to mothers needs to be more empathetic and inclusive, with attentive dialogue.

Limited Impact on Nursing Practice

Because so many participants resisted the implementation of the BFHI, this led to a limited impact on their nursing practice. None of the participants stated that the implementation of the BFHI largely or dramatically changed their nursing practice. A few participants took pieces of the BFHI and adopted them into their practice, such as early skin-to-skin contact, but the majority of their practice remained the same. This is similar

to the findings of Furber and Thomson (2006), in which midwives described how they simply ignored policy recommendations if they did not agree with them. Many of the nurses in this study could see value in parts of the BFHI, but struggled with its all-or-none approach. Rather than implementing all of the 10 steps, it may be more acceptable to have a policy in place that has greater flexibility. The nurses felt strongly that they have the education and the clinical skills to accomplish successful breastfeeding without being forced to utilize the 10 steps in the BFHI.

Talking Minimally About the BFHI

All participants stated that they spoke minimally about the BFHI with colleagues, friends and family, as well as with patients. The primary reason for this was they did not support the initiative. It was raised in the current study that the initiative might diminish trust and put strain on the nurse-patient relationship if mothers perceived that they were being forced into breastfeeding when they did not want to. A study by Belcher (2009) identified some circumstances that can affect trust in a nurse-patient relationship. In the findings it was brought up that if a patient does not have faith in your ability to care for her/him, it will put up a barrier to providing optimal nursing care. This may relate to the current study because many of the participants expressed concerns about mothers' perceptions that breastfeeding was going to be "shoved down their throats" in the hospital, which could put a strain on the nurse-patient relationship.

Many participants in the current study expressed their displeasure with the BFHI implementation process, as it occurred without any collaboration taking place. Research informs us that this goes against what we know works in terms of successfully implementing change in any organization: Staff input is extremely vital to the success of

any new initiative in the workplace (Cameron & Green, 2012). In the study by Thomson et al. (2011), the BFHI implementation process did not meet the resistance found in the current study. One possible reason is in the study by Thomson et al., the BFHI implementation process was done in consultation with the staff that would be implementing it. The health professionals in their study indicated that because it was done in an approachable and inclusive manner, they were made to feel like partners in the decision-making process, as opposed to simply being told what to do. A review of the literature that examined barriers and facilitators to the implementation of the BFHI by Semenic et al. (2012) also listed effective organizational strategies to the BFHI implementation process, which included avoiding a procedural/bureaucratic approach, involving the staff in the decision-making process, being flexible, implementing change gradually, maintaining a positive attitude, and taking into consideration any cultural or local needs that may impact how the change can occur.

Anticipating Reprimand From Management

The participants expected disciplinary repercussions if they deviated from following the 10 steps. Some referred to censoring their thoughts or cautiously wording what they wished to communicate to the mothers. This is not a unique finding. In a study by Furber and Thomson (2006), midwives discussed their experiences with the steps of the BFHI. The midwives stated that when speaking with patients about the possibility of supplementation, they used selective phrasing to ensure that the mother guides the conversation to supplementation, rather than it being a suggestion from them. The rationale for this “covering” was they would not be identified as poor practitioners by their peers, managers, and patients (Furber & Thomson, 2006, p. 369). In Furber and

Thomson's study, routine audits of charts fueled the concern that they would be reprimanded for not following the 10 steps.

Moral Distress

The nurses in this study were feeling moral distress. This is an important issue as Burston and Tuckett (2012) identified in their research that there are numerous and serious repercussions of moral distress: The repercussions included decreased quality of care, decreased workplace satisfaction, issues with high staff turnover rates, and negative impacts on physical well-being. One key issue related to these feelings of moral distress was the nurses in the study felt that they were forcing new mothers to breastfeed. Many of the nurses questioned the need for the BFHI, as they believed that the guidelines were rigid and perhaps not culturally appropriate to Canada, as Canadians value informed decision making and the right to make that choice without coercion.

Other research has raised similar concerns about the BFHI. Drglin (2005) questioned if the BFHI allows the nurse to provide his/her patients with the opportunity to make an informed decision about their method of feeding. Previous research demonstrated similar findings to this. Walsh et al. (2011) found that nurses from non-BFHI hospitals perceived those from BFHI hospitals as "mother unfriendly, breastfeeding Nazi's, or bullies," which are similar terms that were used in my study (p. 599). Graffy and Taylor (2005) found that misguided attempts to support mothers to continue to breastfeed despite difficulties may cross the line between encouragement and coercion. Participants in the present study expressed that they had no desire to push people to do something that they do not want to do. Ebersold, Murphy, Paterno, Sauvager, and Wright (2007) acknowledged that despite education and support, there will always be women

who choose to bottle feed. The participants in my study believed that this is overlooked in the BFHI, and the participants felt morally distressed due to that. In a study by Nyquist and Kylberg (2008), the researchers asked mothers for suggestions to improve the 10 steps, and among the suggestions was a respect for personal decision making. This suggests that the issue of respecting a mother's right to choose how she feeds her infant is an issue for both nurses and patients. Another study that examined the experience of non-breastfeeding mothers was completed by Fahlquist (2014). An online survey was given to non-breastfeeding mothers to capture the emotions that they experienced in a pro-breastfeeding culture. Some of the findings included feelings of depression, anxiety, failure, and guilt. These findings support some of the concerns expressed by the participants in the present study, as many had concerns about increasing the incidence of postpartum depression, as well as sending the message to new mothers that formula feeding is wrong, when in fact none of the nurses felt that way.

Many nurses in my study struggled with the manner in which the BFHI was being implemented, using fear, promoting questionable health benefits, and not offering choice. An article by Wolf (2007) looked at similar issues when the United States Department of Health and Human Services partnered with the Advertising Council to promote the message of the National Breastfeeding Awareness Campaign. This campaign warned mothers that not breastfeeding put infants at risk for a variety of health problems, and conveyed this message in advertisements with pregnant women riding mechanical bulls. The concerns with this advertisement campaign echo the concerns of the nurses in my study: It is a message of fear, with questionable scientific validity that portrayed infant

feeding in terms of safety versus danger, which ethically is a very questionable approach to allow for informed decision making.

A moral dilemma found in the review of the literature by Atchan, Davis, and Foureur (2013) was the conflict between a health care professional's beliefs and the right of the mother to choose her own method of feeding. The authors stated that there was a potential for feelings of conflict when the professional believed that they were morally obligated to promote breastfeeding because they felt it was in the best interest healthwise for all parties concerned, but they had to respect the rights of the woman to make her own decision. This was not an issue in the current research as all of the participants desired the mothers to have the opportunity to openly choose their method of feeding, and not feel that they were being judged because of that choice. On a final note, the American College of Obstetricians and Gynecologists (2016) recently released new guidelines recommending that doctors and other health care professionals respect and support the decision of women who choose to formula feed their babies. Mothers should not feel forced to breastfeed (Weeks, 2016).

Division Between Nurses

Another outcome of the implementation of the BFHI was the division felt among nurses. Participants reported that there was a different set of rules for the NICU versus the postpartum floor. There was a perception that the NICU nurses were free to loosely abide by the rules, while other nurses were expected to strictly follow the 10 steps. This became an uncomfortable situation, especially when nurses shared a patient, because different approaches and advice led to inconsistency in care, which led to frustration among all parties involved. An example cited of this would be with short-stay NICU admissions due

to gestational diabetes. If the baby experiences a period of hypoglycemia, supplementation with formula by bottle would routinely be provided. That baby would eventually be transferred to the mother's room, and at that moment the approach to care and the rules would change. Skin-to-skin contact, manual expression, pumping, and all other means would be utilized first. This may be confusing to the mother who already consented to supplementation, already fed her baby formula under similar circumstances, and in a short period of time would experience two diverse approaches to care.

Consistency is important, and the strict adherence to the 10 steps would make that impossible during this type of care transition. Similar findings were reported in the study by Taylor et al. (2011). Their study found tensions between NICU and maternity units due to a lack of understanding of the responsibilities and practices of the staff in the other area. These misunderstandings and miscommunication frequently led to feelings of hostility.

Chapter 6

Nursing Implications, Strengths, Limitations, and Conclusion

The purpose of this chapter is to discuss the nursing implications and limitations of the study. First, the implications for nursing practice, education, and research are outlined. Then, the strengths and limitations of the study are presented.

Implications for Nursing

This study demonstrated that nurses go through a process in the implementation of the BFHI. The findings from this study have various implications for the nursing profession, particularly in the areas of nursing practice, education, and research.

Nursing Practice

The findings of this study have implications for all nurses, as well as administrations who are contemplating the implementation of the BFHI, or who have just started the process. One key finding that this study revealed was that a lack of input or consultation during the implementation process may lead to resistance. If the process of program implementation begins by meeting resistance, the chance of timely success decreases dramatically (Mitchell, 2013). Nurses expressed the desire to share their experiences and their expertise, rather than have a program dictated to them. Therefore, I highly recommend that nursing administrators involve nurses in the change process early in order to improve nursing practice.

Another implication for nursing practice is to examine the frequency and causes of moral distress as described by the participants. Major sources of moral distress in this study included the nurses' belief that they were denying mothers the ability to make an

informed choice in terms of method of infant feeding. Others struggled with numerous safety concerns, such as the inability to teach formula preparation to breastfeeding mothers or the inability to provide formula easily, when their experience suggested that it is necessary. In terms of the impact on nursing practice, perhaps a modified implementation of the initiative could be utilized, so that the flexibility that all of the participants desired could be achieved and their moral distress could be addressed.

Of great importance to nursing practice is that nurses need to recognize the influences that their support and teaching have on the decision making of families. All of the participants stated that they support breastfeeding and will do everything that they can to help a mother successfully achieve that. Where it appears to get difficult is gauging when teaching is supportive and effective versus coercion. Nurses need to be skilled in the ability to assess how a mother is coping both through verbal and nonverbal cues. If nurses are attentive for signs of pushing breastfeeding, then they can assess the situation and adjust their actions accordingly to enable free and informed decision making.

A suggestion for nursing practice based upon this study is the creation of a Baby-Friendly committee that is comprised of nurses from all areas of maternal care, including labour and delivery, postpartum, and neonatal intensive care. This would allow for input from frontline nurses and demonstrate to them that their expertise is valuable. This group could also function to address the issue of staff division: They could provide the opportunity to bring the different areas together, so they could share with one another the unique challenges that the BFHI brings to their specific area that would otherwise be unknown. Collaboration is key to providing quality nursing care.

Along with frontline nurses, nurses in management positions need to be aware of some of the issues surrounding the BFHI. Many nurses cited specific safety concerns that span from hospital admission to the preparation of families to care for their newborn at home. From a risk management/liability perspective these concerns need to be addressed.

Another consideration for nursing practice is that nurses need to be well educated about the BFHI. Then, they can make a clinical decision about implementing steps into their practice. The BFHI has guidelines that are to be followed, but if they come into conflict with values or patient safety, then the nurse needs to be able to draw on her/his critical thinking skills, clinical experience, and expertise to safely navigate these situations. Many participants in this study reported doing this in their current practice.

Nursing Education

Research has demonstrated repeatedly the importance and the positive relationship between effective educational programs and the success of the implementation of the BFHI. Many participants reported feeling unsatisfied with the current breastfeeding course offered. Participants questioned the scientific validity of the information being provided. If nurses do not have faith in the educational base that this program is founded upon, how can they promote it to their patients? For the success of this program this issue needs to be addressed, and perhaps if the previously suggested Baby-Friendly committee were to be implemented, part of their mandate could be to update and revise the breastfeeding course to make it the research driven document that they desired. Also in terms of education, the mandate of the BFHI is to support, promote, and protect breastfeeding, which has to be done in such a manner that does not lead to alienating women that make the informed decision to bottle feed. This study has demonstrated that

how this mandate is delivered needs to be examined, and some education provided as to how to approach the teaching.

Nursing Research

Many nurses were interested in this research study. Through the interview and data collection process multiple other research areas to pursue were identified. One suggestion for nursing research would be to examine if the rates of postpartum depression increase in baby-friendly hospitals. Many nurses in this study reported that the BFHI “pushed mothers to the edge” because immediately after delivery, they are fully responsible for the care of their newborn. Furthermore, without the existence of a nursery, no breaks to rest and recover can be offered. Another aspect that the nurses in this study perceived may increase the rates of postpartum depression was concerning the population of women that simply do not have the physical ability or the desire to breastfeed. They are inundated with posters and handouts that state breastfeeding is best, but how does this affect those mothers in which circumstances do not permit them to breastfeed, or those that choose not to? Nurses also must attend to the needs of these groups.

Another potential for nursing research would be to examine how parents perceive formula. It seems to be an increasing perception that formula is “bad” or “poison,” which is a difficult circumstance to overcome if a baby needs medically-required supplementation. The degree of fear appears to be high for some parents. As one participant shared, parents occasionally opt for an IV infusion to avoid formula supplementation as it is seen as having fewer risks. It would be helpful to determine the source of this information: For example, is it health care groups, peer groups, or online information? A follow-up to this study may involve those that viewed formula as a

negative thing, if their baby had to be supplemented during their hospital stay. For instance, researchers could explore what the experience of the BFHI is like for them. Did the experience of the BFHI change their opinion on formula?

Another area for potential research would be to examine the views of coercion that the nurses in this study expressed, as well as the perspective of both mothers and fathers. This issue presented a significant source of moral distress to the participants in this study. More detail into the frequency in which mothers feel that they were coerced into breastfeeding would be of value, as perhaps it is not occurring as frequently as the nurses in this study perceived.

Strengths and Limitations of the Study

The purpose of this study was to examine what the process of implementing the BFHI was for nurses. I believe that this was achieved as a central category of resisting was uncovered, which was the core or main theme for the phenomenon under study. A limitation of this study, however, may be the small sample size. According to the guidelines of Corbin and Strauss (2008), data collection occurs until saturation has been achieved. In this study, participants expressed similar thoughts, feelings, and experiences of the implementation process, and one participant in particular provided variation, which was built into the process. Although the sample size was small, saturation was achieved in that no new data emerged in the latter interviews and categories and relationships between concepts were fully developed (Corbin & Strauss, 2008).

Another limitation of the study may be that nurses who held a negative view of the BFHI may have been more inclined to participate, as they may have felt that voicing their opinions could evoke change. Also, the study may have provided them with an

opportunity to voice their views, which they desired, but could not do in the BFHI implementation process. Therefore, although I sought participants with various viewpoints, it is possible that the findings only describe the process for nurses with a negative experience of the BFHI.

Another possible limitation of the study is that I am a neonatal intensive care nurse. As reported in the findings, the nurses anticipated being collectively reprimanded by management should they not follow the BFHI and there was division between nurses. Some responses may have been censored to avoid any conflict of opinion, although it was made clear to the participants that my role was that of a researcher, and all of their responses would be kept strictly confidential.

A primary strength of this study was the appropriate fit between the research topic, research participants, and the research methodology. The majority of researchers who previously investigated this topic did not utilize staff nurses as their only data source; rather, they included physicians and managers in the sample. Isolating the sample to only include staff nurses enabled this phenomenon to be examined solely from the perspective of nurses, which differed from the results of the studies that included other groups. The appropriate fit between the topic, participants, and the methodology was also demonstrated through the study's findings of consistent responses from staff nurses from different hospitals. As outlined by Glaser and Strauss (1967), the goal of grounded theory is to have a meaningful theory that explains the phenomenon under study, which was accomplished in this study.

Another strength of this study is that the one-to-one, face-to-face interview process allowed for the phenomenon under study to be examined with depth and detail.

The interview process that this study utilized, consisting of open-ended questions, enabled each participant to tell her story about their own unique thoughts, feelings, and experiences with the BFHI. This yielded large amounts of data in which categories and the relationships between them could be identified.

Conclusion

The BFHI is a program which numerous hospitals are working toward implementing. The objective of this study was to examine what that implementation process was like for nursing staff. A central category of resisting the BFHI emerged from the data. Conditions contributing to that included an awareness of a pro-breastfeeding culture, imposition of the BFHI, knowledge of the health benefits of breastfeeding, experiential knowledge of infant feeding, and a belief in the autonomy of mothers to decide about infant feeding. Actions/interactions/emotional responses identified included questioning the science and safety of the BFHI, feeling empathy for new mothers, having a limited impact on nursing practice, talking minimally about the BFHI, and anticipating reprimand from management. The identified outcomes included moral distress and a division between nurses. There was a great deal of dissatisfaction with the initiative, but this may be improved if staff input is sought, the breastfeeding course is improved, and there is a degree of flexibility with the 10 steps that is more in line with nurses' desire to provide safe and autonomous care to their patients.

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Appendix A

Biographical/Sociodemographic Data Record

Pseudonym: _____

I. Age _____

II. Gender

1. Male
2. Female

III. Years of Nursing Experience _____

Years of Nursing Experience in maternity/NICU _____

IV. Highest level of education:

1. College graduate
2. University graduate
3. Some graduate courses
4. Master's degree or doctorate

V. Employment Status:

1. Employed part-time
2. Employed full-time

VI. Occupation

1. Licensed practical nurse
2. Registered nurse

VII. Primary area of Practice

1. Postpartum
2. NICU

VIII. Have you completed the breastfeeding course?

1. Yes
2. No

IX. Have you completed any other continuing nursing education courses or certifications?

1. Yes (please specify _____)
2. No

X. When was the BFHI implemented in your hospital? _____

**Appendix C
Consent Form**

Consent to Take Part in Research

TITLE: Research Proposal: Nurses' Experiences of Implementing a New Baby-Friendly Hospital Initiative

INVESTIGATOR(S): Susan McCully, RN
scm384@mun.ca
(506) 454-1458

You have been invited to take part in a research study. It is up to you to decide whether to be in the study or not. Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

The researchers will:

- **discuss the study with you**
- **answer your questions**
- **keep confidential any information which could identify you personally**
- **be available during the study to deal with problems and answer questions**

1. Introduction/Background:

The World Health Organization recommends the Baby-Friendly Hospital Initiative (BFHI) as a standard of care in hospitals worldwide. This study will look at the implementation of the BFHI. This study will examine if the initiative impacts the care that nurses deliver to mothers and how nurses feel about any changes. This study is important as it will allow nurses to share their experiences and perhaps identify strengths and weaknesses in the implementation process and within the initiative itself.

2. Purpose of study:

The purpose of this study is to explore nurses' experiences of implementing a new BFHI.

3. Description of the study procedures and tests:

This study involves two audio taped conversations at a time and place that is good for you. The initial interview will take about 60 minutes, while the second interview will be closer to 30 minutes. In the first conversation, you will be asked to talk about your thoughts and feelings regarding the implementation of the BFHI. Also, you will be asked questions about your age, gender, education, occupation, and employment. The second conversation may be needed to confirm or make it clear what your experience with the implementation of the BFHI means for you. If you choose to withdraw from the study, at any point during the study, or choose not to answer all of the questions asked during the interviews, the questions answered will be included in the research. If you choose, however, not to have your responses included in the research, the researcher will immediately destroy the data.

4. Length of time:

The first interview will take approximately 60 minutes, while the second interview will last approximately 30 minutes.

5. Possible risks and discomforts:

There is one potential risk. Some individuals may find it upsetting to talk about their experiences and perceptions of the implementation process associated with the BFHI. If a participant does become upset, the researcher will ask the participant if he/she would like to stop or reschedule the session. Participants may refuse to answer any questions.

6. Benefits:

It is not known whether this study will benefit you.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights. Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

Protecting your privacy is an important part of this study. Every effort to protect your privacy will be made. However it cannot be guaranteed. For example we may be required by law to allow access to research records.

When you sign this consent form you give us permission to

- **Collect information from you**
- **Share information with the people conducting the study**

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will be kept for a minimum of five years.

If you decide to withdraw from the study, the information collected up to that time will continue to be used by the research team. It may not be removed. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored by Susan McCully in a locked safe in her home office. Susan McCully is the person responsible for keeping it secure.

Information collected from this study will be used to complete the requirements for Susan McCully's Master of Nursing degree. The findings from this study may be published in a nursing journal. Also, the findings may be presented at research conferences.

Your access to records

You may ask the researcher to see the information that has been collected about you.

9. Questions:

**If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is:
Susan McCully.
(506)454-1458
scm384@mun.ca**

The proposal for this research has been reviewed by the Interdisciplinary Committee on Ethics in Human Research and found to be in compliance with Memorial University's ethics policy. If you have ethical concerns about the research (such as the way you have been treated or your rights as a participant), you may contact the Chairperson of the ICEHR at icehr@mun.ca or by telephone at (709) 864-2861.

After signing this consent you will be given a copy.

Signature Page

Study title: Nurses’ Experiences of Implementing a New Baby-Friendly Hospital Initiative

Name of principal investigator: Susan McCully, RN

To be filled out and signed by the participant:

Please check as appropriate:

- I have read the consent. Yes { } No { }
- I have had the opportunity to ask questions/to discuss this study. Yes { } No { }
- I have received satisfactory answers to all of my questions. Yes { } No { }
- I have received enough information about the study. Yes { } No { }
- I have spoken to Susan McCully and she has answered my questions Yes { } No { }
- I understand that I am free to withdraw from the study Yes { } No { }
 - at any time
 - without having to give a reason
 - without affecting my future care
- I understand that it is my choice to be in the study and that I may not benefit. Yes { } No { }
- I agree to be video/audio taped Yes { } No { }
- I agree to take part in this study. Yes { } No { }

Signature of participant Date

Signature of witness (if applicable) Date

To be signed by the investigator or person obtaining consent

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of investigator/person obtaining consent Date

Telephone number: _____

Appendix D

Interview Guide

Opening Statement:

I am interested in your experiences with the implementation of the Baby-Friendly Hospital Initiative (BFHI). You can share any thoughts or feelings that you have about your experience. Could you please tell me about your experiences with the new initiative?

The following are examples of guiding questions/prompts that may be used during the interviews:

1. Could you please tell me your thoughts and feelings about breastfeeding?
2. Could you please tell me your thoughts and feelings about the BFHI? Please tell me your thoughts and feelings about the implementation of the BFHI.
3. Can you describe what the implementation process is like? How did you implement the initiative?
4. Could you please tell me about talking to your coworkers or hospital administration about implementing the initiative?
5. Could you please tell me about talking to patients or anyone else (e.g. family members or friends) about implementing the new initiative?
6. What advice, if any, would you give to nurses and policy makers at other hospitals considering the implementation of the BFHI?
7. (For participants who took the breastfeeding course) Could you please tell me about what the process of implementing the material covered in the breastfeeding course is like?

8. Has the BFHI changed your nursing practice in any way? If so, how? How do you feel about these changes?
9. Were you prepared for the implementation of the initiative? Who or what helped you the most to prepare for the implementation of the program? Who or what helped you the least?
10. (Review the 10 steps to successful breastfeeding) Could you please tell me about the process of implementing the 10 steps? Who or what helped you the most in the process of implementing these steps? Who or what helped you the least?
11. How can nurses promote and support breastfeeding in your view?

Interview Prompts

1. Could you tell me more about that?
2. Can you give me an example of that?
3. How did you feel about that?