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# Factors influencing the implementation of the Becoming Breastfeeding Friendly initiative in Ghana

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## Abstract

Becoming Breastfeeding Friendly (BBF) is an initiative designed to help countries assess their readiness to scale-up breastfeeding programs and develop key recommendations to strengthen their breastfeeding environment. In 2016, Ghana was one of two countries to first pilot BBF. In applying BBF, a committee of 15 Ghanaian nutrition, health, and breastfeeding experts implemented the BBF toolbox over 8 months. Following implementation, semistructured interviews were conducted with 12 committee members (CMs) to (a) identify facilitators and barriers to implement BBF and (b) determine factors needed to strengthen the breastfeeding environment in Ghana. Using a grounded theory approach, five domains were identified. First, a dynamic committee of key stakeholders drove the implementation of BBF. Second, CMs faced some logistical and methodological challenges, including difficulty accessing data and the need for strong in-country technical support for adhering to the BBF process. Third, CMs felt well positioned to facilitate and lead the dissemination and implementation of recommendations. Fourth, accountability would be essential to properly translate recommendations. Fifth, to move recommendations to action, advocacy would be a required first step, and BBF was proposed to facilitate this step. BBF provided an in-depth analysis of Ghana's current breastfeeding environment to help Ghana strengthen its breastfeeding governance, policies, and programs while informing CMs' government and nongovernmental organizations' breastfeeding efforts.

**KEYWORDS**

breastfeeding, health policy, implementation science, nutrition, qualitative research, scale-up

## 1 | INTRODUCTION

Benefits of breastfeeding on the immediate and long-term physical and cognitive health of mothers and infants have been well established (Rollins et al., 2016; Victora et al., 2016). However, exclusive breastfeeding rates remain low at 37% globally and continued breastfeeding at 12–15 months has declined (76% to 73% in 2013; Development Initiatives, 2017; Victora et al., 2016). The scaling up of breastfeeding protection, promotion, and support globally has the potential to save the lives of over 800,000 children younger than five annually (Victora et al., 2016). However, without evidence-based frameworks to guide countries in strengthening their breastfeeding-friendly environment (i.e., where breastfeeding is protected, promoted, and supported), scaling up progress is limited (Pérez-Escamilla & Hall Moran, 2016).

In 2016, the Becoming Breastfeeding Friendly (BBF) initiative was developed to assist countries in (a) measuring their current breastfeeding-friendly environment and (b) developing an evidence-based plan to implement recommendations to guide the scaling up of national breastfeeding protection, promotion, and support efforts (Pérez-Escamilla et al., 2018). BBF is grounded in the breastfeeding gear model (BFGM), which takes a complex adaptive systems

  

approach to scale-up breastfeeding programs and policies. The BFGM posits that eight gears (advocacy; political will; legislation and policy; funding and resources; training and program delivery; promotion; research & evaluation; and coordination, goals, and monitoring) must be present and working harmoniously to enable countries to achieve successful scaling up of breastfeeding programs and initiatives (Pérez-Escamilla, Curry, Minhas, Taylor, & Bradley, 2012). To operationalize the BFGM into a useful tool to help countries assess, plan, and track breastfeeding scale-up, BBF provides a multisectoral country committee of nutrition, health, and breastfeeding experts with a systematic toolbox. The BBF toolbox includes (a) the 54-benchmark BBF Index (BBFI), which assesses the eight gears of the BFGM to score the country's enabling breastfeeding environment; (b) case studies, which illustrate how countries have created enabling breastfeeding environments; and (c) a five-meeting process, which guides countries in the breastfeeding scaling up process by utilizing the BBFI to assign their country's readiness "score" and develop priority recommendations (Pérez-Escamilla et al., 2018; Hromi-Fiedler, Dos Santos Buccini, Gubert, Doucet, & Pérez-Escamilla, 2018). Country committees then disseminate these policy recommendations, calling on decision makers to implement them.

The feasibility of the BBF toolbox in guiding the national scale-up of breastfeeding programs was initially piloted in two countries, including Ghana (Aryeetey et al., 2018; Hromi-Fiedler et al., 2018). Since the early 1990s, Ghana has demonstrated strong political will to promote, protect, and support optimal breastfeeding. Over the last 25 years, Ghana has implemented policies and strategies dedicated to improving exclusive breastfeeding, including the Baby Friendly Hospital Initiative, maternity protection, safe motherhood, newborn health care, infant and young child feeding, and adoption of the International Code of Marketing of Breastmilk Substitutes (code; Table 1; UNICEF & WHO, 2017). Breastfeeding is practiced almost universally in Ghana with approximately 98% of Ghanaian mothers choosing to breastfeed their infants (Ghana Statistical Service (GSS) et al., 2015). However, optimal breastfeeding behaviours, such as initiating breastfeeding within the first hour of birth, are not widespread (56% early initiation; Ghana Statistical Service (GSS) et al., 2015). Although exclusive breastfeeding rates have risen steadily since the 1990s, reaching 63% in 2008, they have recently fallen to rates similar to those documented a decade ago (53%; Ghana Statistical Service (GSS) et al., 2015; Ghana Statistical Service (GSS), Ghana Health Services (GHS), & ICF Macro, 2009; Ghana Statistical Service (GSS), Noguchi Memorial Institute for Medical Research (NMIMR), & ORC Macro, 2004).

Ghana was well positioned to pilot the BBF toolbox given its unwavering commitment to understand and address declining exclusive breastfeeding rates (Aryeetey et al., 2018). With strong government support, Ghana convened a BBF committee that consisted of 15 nutrition, health, and breastfeeding experts from nine institutions representing government, academia, and civil society (hereinafter referred to as the "country committee"). This country committee of key stakeholders applied the BBF toolbox between July 2016 and February 2017 to determine the current scaling up environment and provided recommendations to address identified gaps in breastfeeding policy, programs, promotion, and initiatives. Between the five scheduled BBF meetings, four smaller teams, each with a membership of three committee members (CMs), collected data and assigned benchmarks scores within the eight gears (Aryeetey et al., 2018). The BBFI score for Ghana was 2.0 out of 3, indicating a moderately strong environment for scaling up breastfeeding programs (Aryeetey et al., 2018). Additionally, the country committee prioritized four recommendations from an initial list of 46 recommendations committed to strengthening breastfeeding advocacy efforts, maternity protection, training, and promotion (Aryeetey et al., 2018).

As previously reported (Hromi-Fiedler et al., 2018), the breastfeeding environment can be strengthened through policy, and implementation of BBF can help identify factors influencing the breastfeeding environment through the nonlinear heuristic policy model (Darmstadt, et al., 2014) to promote change. Although the final scores and recommendations put forth by the BBF committee in Ghana demonstrate the feasibility of utilizing BBF as a tool to assess and guide countries in scaling up breastfeeding nationally (Aryeetey et al., 2018), the CMs' experiences carrying out BBF remain unknown. In this qualitative study, we sought to identify (a) facilitators and barriers to implementing BBF and (b) factors needed to strengthen the breastfeeding environment in Ghana considering the input from BBF CMs.

**Key messages**

- Careful selection of committee members is needed to maximize the quality of the BBF process and uptake of the policy recommendations resulting from BBF.
- A data gathering plan should be clearly established early on in the BBF planning and implementation process.
- A clear plan for translating BBF recommendations into actions should be developed at the outset.
- Involving key stakeholders early in the BBF process has the potential to strongly improve the breastfeeding environment in Ghana.
- Advocacy is a core ingredient for improving breastfeeding scale-up via BBF.

**TABLE 1** Current policies, legislation, and strategies relevant for breastfeeding promotion in Ghana

| Year | Policies, legislation, and strategies |
|---|---|
| 1993 | Official adoption of the Baby Friendly Hospitals Initiative |
| 2000 | Breastfeeding Promotion Regulation (Legislative Instrument 1667) |
| 2003 | National Breastfeeding Policy |
| 2003 | Labour Act endorses ILO provisions on maternity protection |
| 2007 | National Infant and Young Child Feeding Strategy document |
| 2008 | National Under-Five Child Health Policy 2007–2015 |
| 2008 | National Under-Five Child Health Strategy 2007–2015 |
| 2015 | Ghana National Newborn Health Strategy and Action Plan 2014–2018 |
| 2016 | National Nutrition Policy, 2016 |

Adapted from UNICEF and WHO (2017).

## 2 | METHODS

### 2.1 | Description of participants

Semistructured, in-depth interviews were conducted with 12 of the 15 BBF Ghana CMs. The remaining three CMs were unable to participate in the interview due to time constraints. Participating CMs composed of Ghanaian nutrition, health, and breastfeeding experts working in institutions implementing breastfeeding programs. Fifty percent were from government institutions across health and law enforcement sectors, whereas 33% were from non-governmental organizations comprising of international development agencies, and 17% were from academia. Ten CMs included in this study were women, and two CMs were men.

### 2.2 | Data collection

Semistructured interviews were conducted between May and September 2017 (Table S1), approximately 3 months after the last BBF meeting when recommendations were disseminated. The BBF director and project associate in Ghana contacted CMs to solicit their participation in and schedule the interviews. All CMs who agreed to participate signed consent forms and were interviewed.

The interview guide included questions that assessed participants' (a) work experience and how they became involved in BBF; (b) expectations prior to implementing BBF; (c) experiences and challenges implementing BBF; (d) recommendations on ways to improve the BBF toolbox; (e) assessment of how to translate recommendations into actions; and f) impact of BBF toolbox on their work environment.

Interviews were conducted in English and lasted between 32 and 67 min each. All but two of the interviews were audio recorded; because workplace policies restricted the use of audio recorders in these situations, extensive notes were taken instead. Interviews were conducted face-to-face with the exception of one, which was recorded over the phone for a CM who was travelling. Interviews were completed primarily by a project associate, trained and supervised by Ghana's BBF director who conducted four of the interviews while training the project associate. The interviews were transcribed verbatim by two team members in Ghana. Transcripts were deidentified and reviewed against the audio by two research associates to ensure the quality of the transcripts.

### 2.3 | Data analysis

Techniques from grounded theory (Corbin & Strauss, 2014) were used to develop themes based on the interview data. First, two team members independently read one transcript. Then, an open coding process was applied to that transcript, where codes were added to represent ideas in the text. Next, an initial codebook was developed based on code usage and structure. Redundancies and clarity of codes were discussed, and inconsistencies between coders were resolved through consensus. This process of independently reviewing, independently coding, and discussing the code application was repeated three times using a different transcript each time to define additional codes that represent a wider range of ideas discussed in the interviews. The codebook was revised after each discussion of the code application. After four transcripts were coded and discussed, no new themes emerged and thematic saturation of the data was reached.

Final coding was conducted using Dedoose (SocioCultural Research Consultants, 2018), an online qualitative coding program. One investigator applied the codebook, and a second investigator reviewed the code application. Discrepancies in code application were minimal but resolved through discussion and consensus. Excerpts that most accurately represented the domains were extracted and reviewed within the full transcripts to contextualize these excerpts within participants' broader experiences with the BBF process.

### 2.4 | Ethical approval

Ethical approval for this study was obtained from the Ethics and Review Committee, Research and Development Division, Ghana Health Service. The study was exempted from Yale University's International Review Board approval because it was based on interviews with CMs to improve the quality of the BBF process.

## 3 | RESULTS

Five domains were identified that describe facilitators and barriers to implementing BBF and factors influencing breastfeeding environment in Ghana: (a) dynamic BBF committee, (b) implementation of BBF toolbox, (c) BBF outputs, (d) breastfeeding governance, and (e) enabling breastfeeding environment (Table 2).

### 3.1 | Dynamic BBF committee

A dynamic committee of experts representing multiple sectors across maternal and child health and nutrition backgrounds drove the implementation of BBF. Members brought years of professional expertise and knowledge about the breastfeeding environment and maternal and child health issues within Ghana to BBF. As one CM described,

> *Being in a committee with people who work regularly on breastfeeding was really learning for me and working with people from different backgrounds … So, it was really a balance of the theory, research and the implementation aspect of breastfeeding (CM6).*

The CMs' diverse and complementary backgrounds fostered enriching discussions around current problems within the breastfeeding environment in Ghana. CMs were also "in the field and very realistic about the challenges and the difficulties," (CM8) they faced with improving breastfeeding outcomes in Ghana. CMs brought different perspectives to the committee, which helped them work together to identify gaps, fully inform the development as well as prioritization of recommendations, and how they should be addressed.

CMs worked in various government and non-government sectors, representing gears within the BBFI. Their knowledge and positions allowed them to readily figure out if data were available to score benchmarks in the BBFI:

**TABLE 2** Definition of domains and summary of findings

| Domain | Definition | Summary of findings |
|---|---|---|
| Dynamic BBF Committee | The composition of the country committee that implemented BBF toolbox. | A dynamic committee of experts from government and non-government sectors with backgrounds in maternal and child health and nutrition program implementation and evaluation drove the implementation of BBF. Participation provided professional enrichment for CMs while also strengthening collegiality among members, which provided a platform for discussions, networking, and facilitated information sharing. |
| Implementation of BBF toolbox | The process implementing the BBF toolbox in Ghana, which included the five-meeting process, application of the BBFI, and use of case studies. | CMs faced logistical and methodological challenges with implementing BBF, the BBF toolbox, including difficulty accessing or lack of data, the time and work commitment to complete the BBF process, and difficulties applying the BBFI, a standardized metric, in the country context of Ghana. Feeling the process was too academic. In-country technical support was needed for adhering to all BBF implementation steps. However, some challenges enhanced CMs understanding of the current breastfeeding environment and bolstered discussions around strategies needed to strengthen the breastfeeding enabling environment. |
| BBF outputs | Outputs from implementing BBF, which included a country's readiness "score" and priority recommendations to scale-up breastfeeding. | CMs felt the final BBF score was an accurate reflection of the enabling breastfeeding environment, but some felt it was a little lower due to data challenges. CMs called for additional stakeholders to be engaged early and throughout the BBF process, not only at the fifth meeting. CMs recommended the dissemination of recommendations needed to be a continual process to help encourage implementation at the country level. |
| Breastfeeding governance | The need for consistent and sustained executive (e.g., government) support in order to maintain momentum to implement BBF recommendations and strengthen enabling breastfeeding environment.[a] | Executive leadership from government actors will be needed to implement and sustain BBF recommendations. CMs identified that accountability will be essential to ensure recommendations were being translated properly, such as inclusion of action into work plans, having an independent, overseeing advisory group to guide scaling up and sustainability of breastfeeding programs and initiatives. Some CMs felt well positioned to facilitate the dissemination, take key leadership roles to implement and communicate progress of recommendations. |
| Enabling breastfeeding environment | Structural factors that create an enabling environment for women to breastfeed.[b] | CMs agreed that moving recommendations to action requires advocacy as the first step and identified BBF to facilitate this. Building country capacity will also be critical for scaling up the breastfeeding environment in Ghana. |

*Note*. BBF, Becoming Breastfeeding Friendly; BBFI, Becoming Breastfeeding Friendly Index; CMs, committee members.

[a]Definition adapted from Sarkies et al. (2017).

[b]Definition adapted from Rollins et al. (2016).

> *It is important to identify the correct group of people and because here in Ghana, the kind of people we had in our committee helped a lot [with data collection]. For most of the questions we had to ask [when implementing BBF] we did not have to step outside the committee to ask, we could find answers from within the group (CM11).*

CMs also described how they were connected to key stakeholders who would be integral in implementing the recommendations.

Working with the CMs on BBF helped foster collaborative partnerships between representatives from various institutions working towards improving breastfeeding outcomes. Participation in BBF generated an understanding and appreciation for work conducted by different sectors. As a respondent said, BBF "had given me an insight into the level of work that everybody is contributing to achieve improved breastfeeding rates" (CM2). CMs felt interactions between institutions provided a platform for discussions and networking across various sectors that were not part of BBF.

## 3.2 | Implementation of BBF toolbox

The CM composition helped facilitate the implementation of the BBF toolbox, which included the five-meeting process, application of the BBFI, and use of the case studies for recommendation development. However, CMs faced logistical and methodological challenges with implementing BBF. CMs felt well positioned to drive the BBF process forward, but in some cases, limited access or lack of data was a barrier for the scoring process. Although CMs often knew where to find data required for scoring the BBFI, in some cases, some CMs were uncertain about information-sharing agreements or willingness from their agencies:

> *There were a couple of people who were not 100% sure whether they had the right to be sharing this information because many of them were from agencies and the ministries and they did not have access to some information about breastfeeding … yes, they were not clear whether they were allowed to share certain information (CM8).*

In other cases, data did not exist at all. Lack of data to score benchmarks raised CMs' awareness of gaps in documentation of key breastfeeding indicators and monitoring systems of breastfeeding programs. Some documentation gaps were immediately addressed following implementation of the BBF: "We were not capturing continuous breastfeeding in the national survey but now we have put it in our routine system to do that" (CM12).

Another logistical challenge was the time and work commitment to carry out BBF tasks (i.e., data collection, scoring, and small gear team meetings). Respondents expressed challenges they faced balancing BBF commitments with their full-time positions. CMs addressed some logistical challenges independently to save time. For example, several conducted small group meetings over phone or video conferencing rather than travelling to meet in person. Additionally, support from the country staff leading the BBF implementation was deemed essential to ease logistical challenges, such as with data collection, as well as strengthen the CMs' understanding of the BBF process.

Methodological challenges were also experienced applying the standardized BBFI to the context of Ghana. On occasion, CMs had some difficulty scoring specific benchmarks that they felt could not easily be "tailored to [Ghana's] environment" (CM5). Although scoring of some benchmarks was challenging, it was understood that BBF "is being done all over the [world] so it's difficult if you change [benchmarks] around, then comparison is going to be difficult [between countries]" (CM8).

Piloting the feasibility of the BBF toolbox required extensive documentation in order to assess the performance and validity. Some CMs felt the documentation process was repetitive, making it feel more like an academic exercise than a programmatic assessment:

> *The part about documenting everything, documenting the process, writing notes I thought that there was some repetition. I think there was justification on your side on why we should do those things but I just felt that there was some kind of duplication so but you know when academic processes feel that they should ask the same question in a different way. Yes, it has to be done so you insisted you have to do it (CM1).*

A suggestion was made to reduce the intensive documentation to make the process more "user friendly" for CMs (CM10).

Some of these BBF implementation challenges were important to identify as they enhanced CMs' understanding of the current breastfeeding environment and generated discussion around strategies needed to strengthen it. In other words, CMs were able to identify the systematic and large amount of work that needs to be done to address gaps in the breastfeeding environment.

## 3.3 | BBF outputs

BBF outputs included the final score and priority recommendations. Although several CMs believed the final BBF score was an accurate reflection of the current enabling breastfeeding environment, others felt the data challenges they faced resulted in a final score that was a little lower than what they would have expected the current scaling up environment in Ghana to be scored.

Through the BBF process, CMs tended to align themselves with recommendations central to activities linked to their current positions:

> *It was a very good opportunity for me to learn what practically I can do on breastfeeding through [organization]. So, meeting the other committee members from different backgrounds it helped me to learn a bit more about breastfeeding, the materials that were shared by the PI. [Being on the BBF committee] also helped me to understand also a bit more about breastfeeding and also to make a conscious effort to incorporate breastfeeding into the work that I do (CM6).*

Recommendations were disseminated and discussed with attendees of the fifth meeting, including technical staff from key organizations and institutions as well as key policymakers and high-level administrators. CMs agreed that these stakeholders should be engaged early and throughout the BBF process, not just the fifth meeting, in order to maintain investment in actions to improve the breastfeeding environment. CMs also acknowledged that dissemination of recommendations needs to be a continual process to help encourage implementation at the country level.

## 3.4 | Breastfeeding governance

CMs acknowledged that strengthening the enabling environment in Ghana will require strong breastfeeding governance, which necessitates executive leadership to implement and sustain BBF recommendations. This included having a role in engaging influential, high-level decision makers: "We need to identify some other people and get the message to them, we need to get some forum for discussion and concrete decision making about what to do to improve [breastfeeding]" (CM12). Accountability would also be essential to ensure recommendations were being translated properly, such as including actions into current work plans or having an independent advisory group, like the BBF committee, guiding the scale-up and sustainability of breastfeeding programs and initiatives:

> *I think that is the starting point if this [committee] should be formalized so they have a proper term of reference and have scheduled meetings and can make proposals or suggestions or whatever recommendations to the bigger [health sector] on where breastfeeding is (CM6).*

To facilitate government leadership, some CMs felt they as well as others were well positioned to continue facilitating the dissemination of recommendations, take key leadership roles to implement recommendations, and communicate progress for implementing recommendations. Some CMs felt they were already beginning to assist with the initiation of activities to address gaps in the enabling breastfeeding environment identified in the BBF process, such as contributing to a breastfeeding social media promotion campaign, incorporating key breastfeeding indicators into the national survey, and monitoring breastfeeding training for health professionals.

## 3.5 | Enabling breastfeeding environment

As breastfeeding governance continues to gain strength, priority recommendations can continue to be implemented, subsequently strengthening the enabling breastfeeding environment in Ghana. CMs discussed the importance of advocacy to move

recommendations into action and build country capacity to scaling up breastfeeding programs.

CMs agreed that moving recommendations into action requires advocacy and identified BBF as an initiative to facilitate this step. Advocacy was seen as a necessary first step towards generating change within key areas of the enabling environment, including enhancing expressed commitment by key decision makers, strengthening breastfeeding policies (e.g., the code), and funding breastfeeding programs. CMs also recognized the importance of leveraging high-level breastfeeding supporters, such as the First Lady of Ghana, as champions to help strengthen breastfeeding polices:

> *There were so many recommendations in the area of advocacy, the whole point of identifying champions in breastfeeding. That should not be difficult to do, I mean [the] First Lady has shown her face very strongly [for breastfeeding], I wonder whether anybody is seriously engaging her, and saying, "we need you to do this, do that" (CM8).*

CMs discussed the need to build country capacity for scaling up breastfeeding programs in order to strengthen the enabling breastfeeding environment in Ghana. This included updating and strengthening the training curriculum for health professionals: "The Ministry of Health training institutions need to factor in more breastfeeding information for trainings so when [trained health professionals] come out they will be more better equipped to promote breastfeeding" (CM5). Although the current government budgeting system did not earmark funds directly to breastfeeding, CMs felt they still had the capacity to carry out recommendations but would require continued support from key development partners.

## 4 | DISCUSSION

This study demonstrates that CMs consider BBF an important process for guiding the scale-up of breastfeeding policies and programs in Ghana. The study identified important underlying facilitators and barriers that need to be addressed to enhance its implementation and modifiable factors to strengthen the enabling breastfeeding environment in Ghana. These lessons learned are currently being addressed through the ongoing second application of the BBF process in Ghana, which began in March 2018 and completed October 2018.

A key factor for successful BBF implementation in Ghana was the ability to identify and include a dynamic and motivated country committee devoted to improving breastfeeding. These qualities were considered critical drivers for implementing BBF. CMs felt better equipped to (a) understand issues within the current breastfeeding environment and (b) to come together to develop a shared vision for improving breastfeeding outcomes. Ideally, the selected CMs should have a good understanding of the country's breastfeeding environment and be willing to spend time working as members of a team seeking to generate the BBF outputs and develop a shared vision (Sarkies et al., 2017) needed to inform decision making. One of the strengths observed in the piloting of BBF in Ghana and one that should be considered in subsequent assessments was that the committee of experts were drawn from multiple sectors. An additional strength was that some of the experts have had opportunity to previously work together on breastfeeding activities. Our study confirms that multisectoral committees formed by experts with program implementation and evaluation experience can foster collaborations, enhance partnerships, and encourage the translation of recommendations into actions. Moving forward, findings also indicate that strengthening breastfeeding governance in Ghana calls for consistent executive support from the government to maintain project momentum and support (Sarkies et al., 2017).

Logistical and methodological challenges influenced the BBF process for CMs, primarily with respect to data availability and accessibility, as well as the time and effort required. Despite these challenges, the BBF process improved CMs understanding of the breastfeeding situation in Ghana and motivated CMs to continue contributing towards improving the breastfeeding environment. Further, technical guidance to assist countries on implementing BBF, such as on the size and composition of the BBF country committee, is cited in previous publications and can be adapted by countries based on individual country needs (Hromi-Fiedler et al., 2018). With regard to size, it is recommended there are 10 to 12 CMs. In the case of Ghana, additional CMs were needed to step in for members with time constraints (e.g., assistants who worked closely with CMs), resulting in a larger committee size (Aryeetey et al., 2018; Hromi-Fiedler et al., 2018). It should be noted, CMs who filled in for others played an active role in the implementation of BBF (Aryeetey et al., 2018).

Engaging additional stakeholders and decision makers early in the BBF process can play an important role in preparing them for the data needs of BBF and garnering support to share data for the sole purpose of scoring BBF benchmarks. Additionally, evidence has demonstrated that involving and engaging more decision makers in processes, like BBF, can increase the likelihood that outcomes are translated into policy and action (Murphy & Fafard, 2012).

Some CMs felt BBF implementation was an academic exercise due to the rigorous and stringent nature of the BBFI scoring procedures. Continual reporting of the CMs' implementation of BBF was required for validating BBF. Considering this, transferring BBF from academic-led to government-led institutions with works within a programmatic lens may ensure sustainability, greater buy-in from stakeholders, and create stronger opportunity to impact implementation practice in Ghana (Brownson, Chriqui, & Stamatakis, 2009; Sarkies et al., 2017).

CMs considered BBF as a tool for enabling environments through improved advocacy. In the BFGM, the framework on which BBF is developed, advocacy serves as the initial "gear" for initiating scaling up activities in a given country (Pérez-Escamilla et al., 2012). Consistent with this view, in Ghana, advocacy was deemed vital to placing breastfeeding on the public agenda and driving recommendations forward (Aryeetey et al., 2018). Encouraging additional stakeholders and decision makers early on to engage with breastfeeding protection, promotion, and support can facilitate this process (Sarkies et al., 2017). Indeed, decision makers can positively influence the composition of the country committee, and thereby, strongly affecting the translation of recommendations, and thereby influencing policies effecting the breastfeeding environment (e.g., maternity leave and

the code). In Ghana, key stakeholders were instrumental in selecting CMs, which were composed of diverse influential experts within BBF key areas with the potential to drive recommendations forward (Aryeetey et al., 2018; Hromi-Fiedler et al., 2018). Combined with sustained efforts from breastfeeding advocates, sufficient political can be generated, improving the breastfeeding environment in Ghana in the long term (Pelletier et al., 2012; Pérez-Escamilla et al., 2012).

This study may be limited because it could not include the perspectives and experiences of three CMs who were not available for an interview. Despite this, as thematic saturation was reached after four interviews were coded in the analysis, for this reason, we assumed that similar themes would have emerged with the three additional interviews.

This study represents an in-depth examination of the experiences of a country committee shortly after they completed piloting the BBF toolbox. Findings show that BBF can inform government and non-governmental organizations breastfeeding efforts and help Ghana strengthen its breastfeeding governance, policies, and programs. Given that results are consistent with the BBF findings from interviews with the BBF-Mexico CMs (Safon, Buccini, Ferre, Gonzalez de Cosio, & Pérez-Escamilla, 2018). BBF is a key initiative that countries can implement with success to strengthen their breastfeeding governance and enabling environments.

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## CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

## CONTRIBUTIONS

All authors contributed to the study design development. CS led the development the interview guide, AAY and RA conducted interviews, and AAY transcribed the interviews. GC and AAY developed the codebook and coded the transcripts. GC, AAY, and AHF analysed the data with feedback from RA and RPE. GC led the development of manuscript with contributions from AAY and AHF and critical feedback from RA, CS, and RPE. All authors reviewed and approved the final manuscript.

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## SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

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