



Building the competency of health professionals in the Kyrgyz Republic for the Baby-Friendly Hospital Initiative

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Abstract

Health professional competency building is one of nine national responsibilities (to achieve universal coverage and sustainability) described in the 2018 World Health Organization/UNICEF implementation guidance for the Baby-Friendly Hospital Initiative (BFHI). Skilled breastfeeding support as a standard of newborn care is critical to the establishment of lactation and exclusive breastfeeding. This qualitative case study describes the Kyrgyz Republic's experience with health professional competency building related to breastfeeding counselling and support. We interviewed 38 key informants and reviewed national policies and international guidelines related to BFHI. The study found that although the country has a new policy reflecting BFHI global standards and guidance, the policy has not been disseminated nationally. Additionally, the policy lacks guidance on competency monitoring and verification and does not mention preservice training, even though preservice training on breastfeeding support exists. To achieve universal coverage for health professional competencies, the Kyrgyz Republic uses preservice, in-service and refresher training. However, the main limitations to aligning with the new guidance are a lack of preservice BFHI- and breastfeeding-specific curricula, experienced trainers and sufficient time and funding to dedicate to practical skill development. Conducted during the COVID-19 pandemic, this study confirmed disruptions to BFHI training and service delivery but also documents the Kyrgyz Republic's resilient strides to mitigate impacts on breastfeeding support through facility-level individual champions and adjustments to training such as going online. Opportunities exist for strengthening the competencies of service providers through strengthened preservice training, comprehensive and consistent in-service training, solutions for overworked service providers and clear and sufficiently funded monitoring guidance.

KEYWORDS

Baby-Friendly Hospital Initiative, breastfeeding, breastfeeding support, breastfeeding training, health professional, qualitative methods

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1 | INTRODUCTION

The Baby-Friendly Hospital Initiative (BFHI) helps facilities providing maternity and newborn services to support breastfeeding and ensure that mothers and newborns receive timely and appropriate care to establish optimal feeding (UNICEF and World Health Organization (WHO), 2018). Launched in 1991 by UNICEF and the WHO, it includes Ten Steps for facilities to support caregivers by promoting breastfeeding-friendly antenatal, maternity and newborn care practices. By 2018, only 44% of newborns globally were initiating breastfeeding within the first hour after birth, and 40% of infants under 6 months of age were exclusively breastfed. In response, WHO and UNICEF updated the Ten Steps and provided guidance on new strategies for countries to improve BFHI implementation and breastfeeding practices (Box 1). The new guidance moved away from external baby-friendly facility designation towards institutionalizing the Ten Steps into national standards of care. It added nine national responsibilities for universal coverage and sustainability (Figure 1) (UNICEF and WHO, 2018).

The 2018 guidance revised step 2 from 'train all health care staff in skills necessary to implement this policy', (1991) to 'ensure that

BOX 1 Ten Steps to successful breastfeeding

Critical management procedures

1.
 - a. Comply fully with the International Code of Marketing of Breast Milk Substitutes and relevant World Health Assembly resolutions.
 - b. Have a written infant feeding policy that is routinely communicated to staff and parents.
 - c. Establish ongoing monitoring and data-management systems.
2. Ensure staff has sufficient knowledge, competence and skills to support breastfeeding.

Key clinical practices

3. Discuss the importance and management of breastfeeding with pregnant women and their families.
4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.
5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.
6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.
7. Enable mothers and their infants to remain together and to practice rooming-in 24 h a day.
8. Support mothers to recognize and respond to their infant's cues for feeding.
9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.
10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care.

(UNICEF & WHO, 2018)

Key messages

- The Kyrgyz Republic government has proactively enacted policies (Order 1078) reflecting the updated Baby-Friendly Hospital Initiative (BFHI) guidance and has demonstrated a commitment to institutionalizing BFHI.
- Insufficient funding and the COVID-19 pandemic derailed plans for implementing the new policy and guidance beyond the regional levels.
- There remain gaps in prioritizing, funding, and monitoring breastfeeding counselling and support competency building for both preservice and in-service.
- Multi-sectoral advocacy for BFHI is needed to secure national and local commitment and funding across and beyond the health system.



FIGURE 1 Nine Key National Responsibilities for Baby-Friendly Hospital Initiative.

staff has sufficient knowledge, competence and skills to support breastfeeding' (UNICEF and WHO, 2018, p. 39). This shift reflected concerns that the required 20-h training was not sufficient to ensure health care professionals developed and implemented behaviours essential to successfully implement the Ten Steps. According to the 2018 guidance, individual facilities should assess staff competencies and take steps to strengthen deficits (UNICEF and WHO, 2018; WHO and UNICEF, 2020).

National Responsibility 3 (health professional competency building) requires that national governments support service providers to develop the knowledge and skills to implement the Ten Steps. This responsibility includes adapting, updating and developing curricula and materials; ensuring teaching staff are qualified and conducting training for service providers working with pregnant and post-partum women and newborns. Facilities should appoint qualified teaching staff to teach, adapt or develop new materials and curricula; and the guidance suggests a train-the-trainer approach. Preservice training should be a cornerstone of competency building

for all professionals and should include theoretical and practical sessions. As many countries have inadequate preservice training on breastfeeding, new competency-based national curricula may need to be developed. In these countries, working health professionals need in-service training until enough newly trained professionals graduate. In-service training should be a short-term solution, and it should be competency-based, and focus on practical skills and theoretical knowledge (UNICEF and WHO, 2018; WHO and UNICEF, 2020). Countries are encouraged to develop and implement their own approaches how to integrate BFHI into their systems; however, there is no specific guidance.

The Kyrgyz Republic, in Central Asia, has been working to strengthen and support breastfeeding practices for many decades, and this case study looks at their work related to national responsibility 3, health professional competency building. The country has a number of policies in place to protect and support breastfeeding; however, less is known about how these policies have been implemented at the facility level, or how health worker competencies are strengthened, supported and monitored during preservice or in-service training.

1.1 | Objective

The objective of this qualitative case study is to explore how the Kyrgyz Republic codifies and carries out national responsibility 3, health professional competency building. The case study explored the following research questions:

1. What are the government and stakeholders doing to build and ensure the competency of health professionals to implement the Ten Steps at the national, regional and facility levels?
2. What efforts are underway at the national level to achieve universal coverage and sustainability of health professional competencies? What challenges have been encountered?

3. What lessons learned could strengthen universal coverage and sustainability of health professional competency building within BFHI in other countries?

2 | METHODS

2.1 | Study design

This qualitative case study is part of a two-country case study of the Kyrgyz Republic and Malawi (Mukuria-Ashe, Klein, et al., 2022). This paper focuses on the findings from the Kyrgyz Republic, selected because of the government's commitment and political will, US Agency for International Development's (USAID) strong support for BFHI in the country and USAID Advancing Nutrition's existing work related to BFHI in the Kyrgyz Republic.

2.2 | Site selection

USAID Advancing Nutrition and the USAID Mission selected facilities in four districts for data collection: Jalal-Abad, Naryn, Sokuluk and Leilek (Figure 2). The first two districts received technical assistance for BFHI from the USAID-funded Strengthening Partnerships, Results and Innovations in Nutrition Globally (SPRING) project between 2014 and 2017, and the second two did not. Selected facilities were certified baby-friendly or working towards certification at the time of this case study.

2.3 | Data collection

The case study included key informant interviews and a review of national policies and international guidelines related to BFHI and



FIGURE 2 US Agency for International Development Advancing Nutrition's presence in the Kyrgyz Republic.

specifically to service provider competency building. We tailored the interview guides to respondent type and used open-ended and probing questions focusing on their role and experience with BFHI competencies, specifically policies, training, monitoring and financing. We contracted a local research firm to conduct semistructured interviews using guides developed by USAID Advancing Nutrition. The firm pretested the guides and we updated them to reflect feedback. Interviews took place between 4 February and 22 April 2021, with a purposive sample identified in consultation with the USAID Mission in the Kyrgyz Republic, the Kyrgyz Ministry of Health (MoH), and the USAID Advancing Nutrition Kyrgyz Republic chief of party. A two-person team of an interviewer and a note-taker conducted interviews in Kyrgyz or Russian and translated their notes before submitting them to the USAID Advancing Nutrition team for coding and analysis. Due to the COVID-19 pandemic, we conducted interviews by phone.

2.4 | Data analysis

We used ATLAS.ti 9 for coding and qualitative data analysis. A two-person team coded 38 interviews using a codebook with 37 codes. The team developed initial codes deductively using the interview guides and added to or replaced them with inductive codes created from the interview data. We categorized the interviews by district, respondent level, and type. We then analyzed data using the analysis functions on ATLAS.ti to identify and explore responses related to the key themes of competency and capacity, training, training content, policy, assessment and monitoring, barriers and challenges and COVID-19 challenges within each of those categories.

2.5 | Ethical considerations

The JSI Institutional Review Board determined the study to be exempt from human subjects research oversight. The Institutional

Review Board of the American University of Central Asia in the Kyrgyz Republic approved the study. All participants provided written or verbal consent for participation and recording of the interview. Declining to record the interview did not affect participation.

3 | RESULTS

3.1 | Document review

We identified 23 documents for review, including Kyrgyz government policies and regulations, country health statistical reports and UNICEF and WHO BFHI guidance documents.

3.2 | Study participants

We interviewed 38 key informants, 18 of whom were national level; the other 20 were located in the regions of Chuy, Batken, Naryn and Jalal-Abad. For each of the four district facilities, we interviewed one administrator and three service providers, 10 of whom were doctors and two were maternity ward department heads (Table 1). All 12 service providers were women, and all four facility administrators were men. Two of the 12 service providers had less than five years of experience, and the other 10 had between 13 and 38 years.

3.3 | Kyrgyz republic breastfeeding practices and policy environment

In the Kyrgyz Republic, in Central Asia, 46% of children under 6 months are exclusively breastfed, and 22% of children 20–23 months continue to receive breast milk (National Statistical Committee (NSC) and UNICEF, 2019). Nationally, 81% of children are breastfed within 1 h of birth; however, this varies regionally from 65% to 95%. Exclusive breastfeeding of children under 6 months ranges regionally

TABLE 1 Respondents by location.

Participants	National	Regional	Facility	Subtotal
Policy makers (National Center for Maternal and Child Health Protection, MoH, Primary Health Care and Drug Policy Department, Republican Center for Health Promotion)	6	4	-	10
Mandatory health insurance fund	2			2
Professional medical associations	2			2
Health professional training institutes	2			2
Donors and implementing partner staff	6	-	-	6
Facility administrators and programme managers	-	-	4	4
Service providers	-	-	12	12
Total	18	4	16	38

from 24% to 71% (NSC and UNICEF, 2019). Urban areas have higher levels of exclusive breastfeeding, while rural areas have a higher prevalence of early initiation and longer average durations (UNICEF, 2019). Additionally, 82% of women receive at least four prenatal care visits and skilled health personnel attend 100% of deliveries (NSC and UNICEF, 2019).

The Kyrgyz Republic implemented a policy supporting exclusive breastfeeding in health facilities in 1996 with Order N19. This policy includes rooming-in, initiation of breastfeeding within 1 h after birth, a ban on prelacteal feeding of infants, and a call to breastfeed exclusively and on demand until 4–6 months of age (UNICEF and WHO, 2017). In 2000, the Kyrgyz Republic adopted BFHI and accredited the first hospital (UNICEF and WHO, 2017). The percentage of baby-friendly facilities peaked in 2010 at 76%, declining to 42% by 2015 due to a lack of funding for recertification and training challenges (UNICEF and WHO, 2017).

The MoH created the National BFHI Coordination Committee (NCC) between 1992 and 1995 to manage accreditation. This committee of medical and health experts coordinates the accreditation process, awards BFHI status, reviews breastfeeding promotional materials and training programmes and adapts breastfeeding regulations (UNICEF and WHO, 2017). The MoH's National Center for Maternal and Child Health coordinates it, and the Deputy Minister of Health chairs it, although it has often relied on donor funding (SPRING, 2018). The NCC paused activities early in 2020 due to the COVID-19 pandemic and had not restarted at the time of the study.

Order 1078, or 'On the protection, promotion and support of breastfeeding in institutions providing services for the protection of mothers and children' was enacted in 2019 and adopted the 2018 BFHI guidelines (MoH Kyrgyz Republic, 2019). The Order provides guidance on institutionalizing the Ten Steps within public and private facilities and gives direction for in-service health professional competency building for implementing the Ten Steps. It was passed before the 2020 release of the WHO and UNICEF Competency Verification Toolkit. The Order states that facilities should train all medical personnel in a 20-h programme within 6 months after they enter the workforce (MoH Kyrgyz Republic, 2019). Preservice training in the Kyrgyz Republic has been supported by donors, and the Order does not provide guidance for it.

Order 1078 aligns with the global standards for monitoring step 2 of BFHI to ensure competencies. It mandates that each facility create a committee on breastfeeding promotion that monitors two outcome indicators—early initiation of breastfeeding and exclusive breastfeeding for each mother and infant pair—at least every 6 months using mothers' statements. Additionally, the policy mandates that facilities conduct a self-assessment of current activities related to implementing the Ten Steps, carry out a detailed analysis of the result and develop an action plan (MoH Kyrgyz Republic, 2019).

In 2019, the MoH started to roll out the updated guidelines specified in Order 1078, but regions could not complete training sessions due to a lack of trainers and funding. Although Order 1078 states that the NCC will gradually shift away from certifying facilities for BFHI status, as of early 2022 there was no implementation plan

(personal communication, implementing partner, April 27, 2022). In 2020, the COVID-19 pandemic added an additional barrier to disseminating guidelines and training, and at the time of the study, it was unclear when this will continue. The facility staff interviewed had not yet adopted the guidelines and did not mention them. One implementing partner respondent said 'In 2019 when the new guidelines were published, certification stopped. There was supposed to be a roll-out of new training to all the regions but there is a lack of trainers and funding so this roll-out has not been accomplished. The pandemic has also caused delays'.

3.4 | Current implementation of competency strengthening for breastfeeding

3.4.1 | Facility in-service and refresher training

While there are national policies, regulations, committees and plans for rolling out competency strengthening at facility and service provider levels, key informants explained how facilities implemented training varied in length, frequency and location; the curricula used and types of trainers. This variability was due to budgets, priorities, staffing and other factors.

Service providers at one facility said they conducted in-service training using an adapted version of the 2009 WHO 20-h course on breastfeeding counselling and support. They provided training in modules, so it did not interfere with service provision and incorporated practical skills into sessions. Another facility had not had externally provided in-service training since receiving BFHI certification 8 years before the study, and internal facility doctors provided monthly in-service training that included practical skills building. Another BFHI-certified facility reported that the Kyrgyz State Medical Institute provided them with in-service training using the WHO 20-h course. A different BFHI-certified facility reported that they had off-site training at Osh State Medical University, and that on-site, facility doctors trained new employees and other doctors on the wards. A few service providers said that government and health facility leadership did not prioritize breastfeeding practices or training them to provide counselling and support.

Doctors in multiple facilities were torn between leaving their patients and receiving training. A service provider explained 'We do not have enough time because training conflicts with doing the job. We need to do our work. We stay until 6–7 pm. Usually, training is conducted during work hours'. While some felt that it would be best to have training after work, others preferred breaks from work to attend training. Trainers reported a lack of time to prepare and conduct training. Respondents said there were not enough staff to conduct training, and more than one facility relied on a single trainer. Interviewees repeatedly mentioned staff turnover after training as a barrier to maintaining trained service providers.

Facility directors in all four districts did not have funding for breastfeeding training in their budgets. They were unable to send service providers to paid training unless a training institute provided

free spots or a donor provided funding. One director said they could hardly cover salaries and medicines. Donors and policymakers also mentioned that medical facilities or the MoH do not fund training programmes. Respondents in all four districts mentioned a shortage of materials including demonstration dolls, counselling cards, flip calendars, curricula and event space.

Donor organizations also support breastfeeding training on a project-by-project basis. For example, UNICEF provides resources to train medical professionals involved in breastfeeding counselling and support, and medical staff involved in BFHI implementation. USAID-funded projects provide resources for breastfeeding training for medical personnel of all levels, and WHO provides resources for breastfeeding training for medical professionals on a national level. Aga Khan Foundation plans to develop mixed-method breastfeeding courses for doctors and nurses with KSMA or Kyrgyz State Medical Institute for Retraining and Continuing Education that includes video materials, exams and mentoring.

The COVID-19 pandemic moved training online or paused it at the time of data collection. Participants had trouble due to a lack of computers, internet, working microphones or knowledge of how online platforms work. The COVID-19 pandemic caused other challenges as facilities sent trainers and service providers into the 'red zone' to treat COVID-19 patients. The need to redirect finances to fighting COVID-19 left fewer resources for breastfeeding training.

In summary, barriers to the provision of consistent, sustainable and quality training to support breastfeeding counselling included high staff turnover; time constraints of staff and trainers; lack of available skilled trainers, incentives for trainers and funding and a shortage of training materials and low prioritization by facility administrators and staff.

3.5 | Preservice training

Some medical universities provide preservice training on breastfeeding counselling and support for health professionals. For example, KSMA provides preservice nutrition curricula that include BFHI during the third and sixth years of medical school. One implementing partner said that this includes lectures and practice. The breastfeeding topics covered during preservice training include breastfeeding challenges; correct positioning; the Ten Steps; counselling skills; the International Code of Marketing Breast Milk Substitutes; the advantages of breastfeeding; and prenatal, post-natal, and neonatal care. The USAID SPRING project provided a 5-day introductory training to preservice training institutions on nutrition programmes, including BFHI, and nutrition programme curricula to all preservice institutes in the country using the nationally adapted BFHI 2013 materials.

Ten of the 12 service providers interviewed completed preservice education more than 10 years ago and many only ever received in-service training on breastfeeding. One service provider said, 'There was no training at all. We did not give much thought to breastfeeding. We did not have that. I asked fellow students. I am

surprised that we did not'. Another said there was 'no preservice training that included breastfeeding counselling and support'. Another added that while there were no separate lessons on breastfeeding counselling and support, the children's diseases course covered topics related to breastfeeding and the marketing of breast milk substitutes. A respondent at a training university said that even today universities are sometimes unable to provide preservice training on breastfeeding-related topics due to limited time and instructors' technical capacities. A professional association member said teaching tools do not include interactive learning. Additionally, due to the COVID-19 pandemic, preservice training occurred virtually.

Multiple respondents mentioned a shortage of study hours related to BFHI and breastfeeding at the preservice stage. A number of service providers considered the incorporation of breastfeeding in preservice education essential for implementing and maintaining high-quality breastfeeding counselling and support.

3.6 | Monitoring of competencies

Respondents described the systems and processes used for monitoring competencies in different facilities. Before Order 1078, there was no checklist. A respondent at one facility reported conducting internal self-assessments using their own questionnaire to interview staff about whether they follow the Ten Steps. They said, 'everyone must show how to properly attach to the breast, the correct position of the baby at the breast, and how to express milk properly. In our department, we use breast dummies and puppets to conduct training and certification'. If there is a gap in knowledge or practice, they arrange additional training. Another facility also mentioned using their own questionnaires and that their maternity unit manager assesses the competencies of facility medical personnel by evaluating mothers' breastfeeding practices.

Service providers at facilities in two districts reported that they did not conduct regular assessments of the breastfeeding competencies of medical professionals. Instead, they report quarterly on how many women are admitted, have given birth and are nursing. They ask mothers who gave birth the previous day:

1. if they had consultations in prenatal departments;
2. if maternity ward doctors and midwives counselled them about the importance of breastfeeding;
3. about their experiences after delivery such as when the baby first breastfed and did skin-to-skin contact and
4. whether they can demonstrate breastfeeding correctly and explain the importance of breastfeeding.

One implementing partner said maternity hospitals were more likely than primary care departments to assess the breastfeeding competencies of service providers. However, even then it is often with financial support from donors such as UNICEF, and not through the MoH. A donor said conducting regular monitoring requires time, and financing is often dependent on support.

At a non-BFHI certified facility, a service provider commented that monitoring activities were intermittent, and completed for reporting, not for improving performance. The director of one BFHI-certified facility reported that there was no national follow-up monitoring after obtaining certification; instead, the facility monitored competencies based on posttraining test scores, and a doctor reported that they were solely responsible for conducting surveys of mothers after birth to assess whether they received adequate breastfeeding counselling.

4 | DISCUSSION

Decades of policies related to protecting, promoting and supporting breastfeeding reflect a national commitment to breastfeeding counselling support. Despite strong policy commitments to breastfeeding, this case study affirms that translating policy into practice (especially at scale) is challenging. Supporting health workers to develop and maintain strong competencies has been difficult due to insufficient preservice and irregular in-service training. This study additionally found there are few skilled trainers, time constraints, a lack of incentives for health workers and trainers, a shortage of funding and other resources, a lack of prioritization of breastfeeding by facility directors and irregular monitoring. Further, the COVID-19 pandemic disrupted the dissemination and implementation of Order 1078 and placed many activities on hold. While the Order aims to strengthen the training and monitoring of service providers, the challenges noted by respondents will likely require additional funding and significant support to overcome. This case study documented key changes that the Order intends to achieve, but challenges remain to build and verify competencies; these lessons could be helpful for other stakeholders working on BFHI. Additionally, though Order 1078 is aligned with the 2018 Implementation Guidance to move away from facility designation as baby-friendly, and towards institutionalizing the Ten-Steps into standards of care, the NCC had not yet created an implementation plan for doing so. At the time of this case study, respondents still spoke only of facility designation.

The Kyrgyz Republic's approaches to in-service training provide interesting lessons. The mandate of Order 1078 to train all providers entering the workforce within 6 months, and the suggestion to hire a training specialist indicates a continuing reliance on in-service training, which the 2018 guidance discourages, and which may be costly. Reliance on in-service training for BFHI is common and was also found in Malawi (Mukuria-Ashe, Nyambo, et al., 2022). The parliament passed Order 1078 before WHO released the updated BFHI training course and competency verification toolkit, so one aspect of the in-service training that needs further assessment is whether the updated courses reflect competency-based training, and to what extent in-service training includes skills assessment or verification. Additionally, national preservice and in-service training curricula and materials for all facilities and institutions could make competency building for service providers more consistent.

Most respondents described in-service training including practical, face-to-face training, which Terzioğlu et al. (2016) showed increased providers' confidence. Like in other countries, the COVID-19 pandemic forced facilities in the Kyrgyz Republic to transition to in-service training online (Palmquist et al., 2020). The revised BFHI guidance suggests online courses may be a low-cost approach for building competencies; however, in this case study, this transition was challenging and costly for both facilities and service providers. Facilities should consider potential positive and negative outcomes of online or hybrid online/in-person training; providers in this study felt they learned more practical skills through in-person training but appreciated the flexibility online courses offer. A recent study looking at surgical skill acquisition through online training found no significant difference in knowledge transfer between online and traditional training methods (Feeley et al., 2022).

The revised global guidance emphasizes the sustainability and national responsibility of ensuring service provider competency through preservice education. Respondents' views and experiences with preservice training for BFHI varied, though most received their education before the 2018 update. Reviews of preservice education curricula in other countries identified gaps in health care students' or residents' knowledge and skills (Campbell et al., 2022; Meek et al., 2020). This study found that breastfeeding education in preservice curricula was mostly theoretical, which is common in other countries as well (Campbell et al., 2022). One resource for preservice education is the WHO and UNICEF (2020) BFHI course, which is competency-based and includes both theoretical and practical clinical sessions. Additionally, the WHO (2009) infant and young child feeding model chapter for medical students is currently being updated.

Assessing or verifying the competencies of service providers was a critical change to step 2 of the Ten Steps, along with the addition of the national responsibility to ensure competence (Chapin et al., 2021). Order 1078 aligns with the new global standards; however, respondents across the country described multiple processes of monitoring and reporting. Because verification of competence is new for BFHI, this could be a challenge for facility administrators and national monitoring. Despite this, some facilities in this case study described using observation tools or oral interviews to assess service providers' competencies, which the WHO/UNICEF Competency Verification Toolkit recommends. Though the toolkit provides methods of identifying gaps even after staff have undergone training, it does not provide recommendations on effective approaches to fill them. Facilities and programme managers should consider using effective methods of ensuring competencies beyond training—for example, through supportive supervision, mentorships, and coaching—to avoid inadvertently promoting reliance on in-service training.

This case study documented challenges in the context of shifting the implementation of BFHI from designation to standards of care. For example, national-level respondents described processes for facilities to implement and monitor in-service training; however, facility-level respondents revealed different lived experiences, highlighting disconnects between national-level policy and actual implementation at scale. This is possibly due to the delayed rollout

of Order 1078; facilities were training with previous materials or unaware of changes. Funding remains another key challenge, and it was unclear whether additional funding for training or monitoring would accompany implementation. Respondents also cited the lack of prioritization of breastfeeding as a challenge, which highlights the need for continued advocacy nationally and with facility administrators.

4.1 | Limitations

This case study had some limitations. Due to the COVID-19 pandemic, the study designers could not collect data directly, and deeper probes may have been missed which could have resulted in richer findings. However, using data collectors who spoke Kyrgyz and Russian was an advantage. While nuances may have been lost in the translation of data, the wide array of informants allowed us to triangulate the data. Because curricula for preservice or in-service training were unavailable for review, some findings could be subject to recall bias or outdated. Furthermore, while the design intended to sample a diverse range of respondents, each group was small and lacked diversity in terms of gender and provider occupation. A strength of this study is that it documents a critical component that inhibits the implementation of the clinical steps of BFHI—the national responsibility to ensure the competencies of service providers. The paradigm shift to ensuring and verifying competencies is a key change, and sharing approaches and lessons from countries, while maybe not generalizable, are important for others attempting to achieve this shift.

5 | CONCLUSION

Order 1078 demonstrates the Kyrgyz Republic's commitment to institutionalizing BFHI. The order is in place and includes some resources, but facilities and training institutions need to do more to implement procedures and make resources available. Additional advocacy and dissemination to multiple sectors, including education, is necessary to strengthen implementation. Ensuring service provider competencies requires commitment from the government, educational institutions, and medical facilities. Policies need a coordinated, well-funded roll-out plan, combined with adoption mechanisms for medical institutions and facilities to enact changes. This collaborative effort should have shared goals to commit to funding, strengthen preservice training, implement comprehensive and consistent in-service training, find solutions for overburdened service providers and develop clear guidance for and sufficiently fund monitoring. As one service provider noted 'We need to promote breastfeeding. We should not forget breastfeeding, so children grow up healthy and strong. They are the future'.

AUTHOR CONTRIBUTIONS

Altrena Mukuria-Ashe and Jeniece Alvey designed the study with US Agency for International Development support; Alyssa Klein

and Charlotte Block adapted it for the Kyrgyz Republic, oversaw data collection, conducted data analysis and wrote the manuscript. Nazgul Abazbekova and Jeniece Alvey contributed to the writing. Adil Mansimov and Samat Okenov collected data conducted high-level analysis and drafted an overview of Kyrgyz Republic results.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy.

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