Baby-Friendly Hospital Initiative: A critical analysis within the nursing workforce

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A Critical Analysis Within the Nursing Workforce

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Abstract

Healthcare systems routinely frame breastfeeding as an ethical and clinical priority requiring institutional protection, particularly in maternity and newborn services. The Baby-Friendly Hospital Initiative represents a global effort to embed these commitments through policy, practice, and environmental support. While these protections are well established for patient-mothers, far less attention has been given to how they are applied to the nursing workforce responsible for enacting them.

The authors critically appraise an ethical contradiction experienced by lactating nurse-mothers. Breastfeeding is institutionally supported for patients but structurally constrained within nurses' own workplaces. Using relational ethics as the primary interpretive lens, supported by clinical and organizational ethics frameworks, the analysis positions nurse-mothers as embodied ethical agents whose experiences reveal systemic moral incoherence within maternal-centered institutions.

Evidence suggests that nurse-mothers frequently encounter delayed or denied pumping breaks, inadequate lactation facilities, stigmatization, and career penalties despite strong breastfeeding knowledge and commitment. These conditions generate ethical tension, moral distress, and professional disengagement. Achieving ethical integrity in Baby-Friendly Hospitals therefore requires enforceable structural protections that recognize maternal embodiment and caregiving as legitimate dimensions of ethically sustainable professional life.

Keywords: *nursing ethics, relational ethics, ethics of care, organizational ethics, nursing workforce, breastfeeding, nurse-mother, infant, newborn*

Introduction

Healthcare institutions routinely frame breastfeeding as an ethical good requiring structural protection, particularly within maternity and newborn services. When equivalent protections are not extended to lactating nurses within the same organizations, a structural asymmetry emerges. When healthcare institutions protect breastfeeding for patient-mothers but fail to extend comparable protections to nurse-mothers within their workforce, a form of role-based distributive injustice is produced.[1]

Because these institutions explicitly define breastfeeding as an ethical obligation, selectively extending protections to patient-mothers while withholding them from nurse-mothers results in an inequitable distribution of moral concern. This asymmetry reflects a breach of institutional ethical commitments rather than an inevitable feature of workplace organization. This paper does not critique the effectiveness of the Baby-Friendly Hospital Initiative (BFHI) as a policy intervention; rather, it examines how its ethical commitments are selectively applied within healthcare institutions.

Workplace constraints on breastfeeding are well documented across sectors, with many lactating individuals encountering inadequate facilities, inflexible scheduling, and organizational cultures that deprioritize caregiving needs. These challenges are not unique to healthcare and reflect broader structural tensions between productivity expectations and embodied caregiving. However, healthcare institutions, particularly those aligned with Baby-Friendly principles, occupy a distinct ethical position. By formally recognizing breastfeeding as an institutional obligation, these settings establish a higher standard of internal ethical consistency. When institutions fail to extend equivalent protections to nurse-mothers, this omission represents a breach of institutional moral commitments rather than a neutral workplace limitation.

As such, the authors undertook a critical ethical analysis of the asymmetry using relational ethics as the primary interpretive lens, supported by clinical and organizational ethics frameworks as complementary analytic tools. Within this analysis, BFHI is understood not simply as a clinical or policy initiative, but as an institutional articulation of breastfeeding as an ethical obligation requiring consistent and enforceable support. Nurse-mothers are conceptualized as embodied ethical agents whose lived experiences illuminate how institutional commitments are selectively applied across professional roles. Clinical and organizational ethics frameworks are used to examine how governance structures, policies, and workplace norms allocate protection and constraint. Accordingly, ethical integrity requires enforceable structures that recognize maternal embodiment and caregiving as legitimate dimensions of professional life within healthcare workforces. [2-3]

Within this analysis, the nurse-mother experience represents a form of embodied ethical tension in which maternal caregiving is institutionally valorized for patients yet constrained within the workforce. Work environments that explicitly promote breastfeeding as an ethical and clinical priority may intensify this tension, placing nurse-mothers in positions of moral dissonance. Nurse-mothers are expected to advocate for and model practices grounded in maternal-infant proximity and physiological responsiveness while navigating conditions that restrict their ability to sustain these same practices.

Moral dissonance may extend beyond individual experience to influence care delivery. When nurses are required to promote standards that they are structurally unable to uphold, their moral authority and experiential credibility are placed at risk, with implications for the consistency and sustainability of breastfeeding support provided to patients. Over time, these conditions may contribute to moral distress, professional disengagement, and workforce attrition,

with direct and indirect consequences for patient care quality, continuity, and the retention of experienced clinicians.

The result is a fracture in organizational moral coherence. Addressing this contradiction extends beyond workforce accommodation policy and raises questions about the ethical obligations healthcare institutions owe to those who sustain and deliver care. To further contextualize this ethical inquiry, the following section outlines the historical development and institutional evolution of the Baby-Friendly Hospital Initiative (BFHI).[4]

Background

The BFHI emerged in the early 1990s in response to hospital practices that separated mothers and infants, delayed breastfeeding initiation, promoted breast-milk substitutes, and undermined lactation. Evidence demonstrates that adherence to the 'Ten Steps' improves breastfeeding initiation, exclusivity, and duration, while reducing neonatal morbidity and improving maternal health outcomes.[4] Facilities achieving Baby-Friendly designation often report transformative changes, including more patient-centered care, improved staff competencies, and reduced formula use. [4]

The 2018 revision reframed BFHI as a systems-based approach emphasizing sustainability, universal coverage, monitoring, and compliance with the International Code of Marketing of Breast-milk Substitutes.[5-6] This shift clarified that breastfeeding protection is an ongoing structural obligation rather than a discrete accreditation outcome.[4] BFHI functions as an institutional commitment to maternal-centered care requiring structural support, extended through initiatives such as Baby-Friendly Community Initiatives across care settings.[7-9] Nurses play a central role in operationalizing these commitments. As BFHI principles are increasingly embedded in national standards, they represent baseline expectations for maternal

and newborn care rather than optional designation.[4] Consequently, institutions employing nurses in relevant settings participate in these commitments regardless of formal status, and the ethical claims of BFHI extend to the workforce responsible for delivering care.

The orientation aligns with ethics of care frameworks emphasizing relational responsibility.[10-11] However, when institutional support is inconsistent, responsibility shifts from organizations to individuals and informal networks, as reflected in working mothers' reliance on internet-based peer support.[12] Nurses, who are bound by professional obligations to advocate for vulnerable populations, remain central to implementing breastfeeding-supportive care.[1, 13]

Paradoxically, nurse-mothers returning to clinical practice while lactating frequently encounter workplace conditions that constrain breastfeeding, including delayed or denied pumping breaks, inadequate lactation facilities, rigid scheduling, managerial gatekeeping, stigmatization, and career penalties, despite strong breastfeeding knowledge and commitment.[14, 15] These constraints place nurse-mothers in ethically fraught positions. They are expected to uphold maternal-centered standards for patients [16] while lacking equivalent support for the caregiving relationships they sustain with their own children.[17-19]

In environments that explicitly promote breastfeeding as an ethical and clinical priority, this tension may intensify into moral dissonance. Nurse-mothers are required to advocate for and model practices grounded in maternal-infant proximity and physiological responsiveness while navigating conditions that prevent them from sustaining those same practices. When professionals are expected to promote standards they are structurally unable to uphold, their moral authority and experiential credibility may be undermined.

Over time, these conditions may contribute to moral distress, professional disengagement, and workforce attrition, with indirect consequences for patient care quality, continuity, and the retention of experienced clinicians. When workplace structures restrict breastfeeding, mothers often adopt compensatory strategies, including intensified feeding upon reunion or extended nighttime feeding, frequently at additional physical and emotional cost.[20] To move beyond identifying this inconsistency, the following section applies a relational ethics framework to examine how these tensions are produced, experienced, and sustained within everyday clinical environments.

Relational Ethics as an Interpretive Framework

Relational ethics focuses on how ethical meaning is produced within relationships shaped by environment, embodiment, mutual recognition, and engagement. [21] Rather than locating ethics solely in individual decision-making or rule compliance, this perspective situates moral agency within institutional and relational contexts that enable or constrain action. In Baby-Friendly Hospitals, nurses are positioned as ethical agents who assume responsibility for sustaining breastfeeding-supportive practices for patients. Relational ethics invites examination of whether those same institutional relationships sustain or constrain nurses as moral subjects. In foregrounding embodiment, relational ethics understands lactation as a time-sensitive physiological and relational process requiring structural accommodation. It also clarifies how respect and engagement are enacted or withheld across professional roles. Table 1 applies key elements of relational ethics to empirical accounts of nurse-mothers' workplace experiences, illustrating how institutional arrangements selectively distribute ethical protection. This framework enables analysis of the mechanisms through which institutional environments shape, constrain, and differentially distribute ethical action across roles.

Table 1. *Relational Ethics Analysis of Nurse-Mothers' Experiences in Baby-Friendly Hospitals*

Relational Ethics Element	Ethical Focus	Baby-Friendly Hospital Initiative (BFHI) Expectations for Nurse Employees	Workplace Conditions Reported in Nursing Literature	Relational Ethical Interpretation(s)
Environment	Moral action is conditioned by material, organizational, and cultural structures.	Nurses enact BFHI standards through patient education, protection of maternal-infant contact, and adherence to breastfeeding-supportive policy.	Delayed or denied pumping breaks; inadequate or inaccessible lactation spaces; rigid scheduling; managerial gatekeeping; stigmatization; career penalties.	Institutional structures predefine which bodies and caregiving relationships receive protection. Maternal embodiment is structurally supported for patients but operationally constrained for employees.
Embodiment	Ethical knowing arises through bodily experience, temporality, and vulnerability.	Breastfeeding support presumes time-sensitive physiology, proximity, and responsiveness; nurses are expected to model and teach these principles.	Nurses delay or forgo milk expression during clinical demands; suppress discomfort; absorb physiological and emotional consequences to conform to productivity norms.	Bodily distress functions as ethically significant evidence of structural misalignment. Lactation is reframed institutionally as disruption rather than legitimate caregiving labor.
Mutual Respect	Persons are recognized as moral subjects whose needs and voices carry ethical weight.	BFHI frames breastfeeding protection as an institutional obligation requiring consistent safeguards.	Nurse-mothers negotiate lactation privately through informal accommodations; needs treated as discretionary, stigmatized, or professionally risky.	Moral recognition becomes role contingent. Patient-mothers are institutionally affirmed; nurse-mothers are positioned as peripheral moral stakeholders within the same system.
Engagement	Ethical practice requires relational presence, responsiveness, and sustained attentiveness.	Nurses are expected to sustain therapeutic presence and actively support breastfeeding initiation and continuation.	Institutional conditions render self-directed caregiving engagement difficult or professionally penalized; structural barriers impede timely lactation.	Ethical engagement becomes asymmetrical. Nurses are required to remain present for others while their own caregiving relationships are structurally deprioritized, contributing to moral distress.

Environment as Moral Context

These conditions operate not incidentally but systematically, structuring when, how, and for whom ethical action is possible. From a relational ethics perspective, ethical action is inseparable from the environments in which it unfolds. Within Baby-Friendly Hospitals, nurses are positioned as primary agents responsible for enacting institutional commitments to breastfeeding. Expected behaviours include patient education, protection of maternal-infant contact, and adherence to policies prioritizing breastfeeding in the absence of medical contraindication. [4] The underlying assumption of the nurse's ethical duty here is that the organizational context supports both ethical responsiveness and moral agency.

For nurse-mothers, however, clinical environments frequently undermine the conditions required for ethical practice. [15, 17-18] Lactating nurses encounter delayed or denied pumping breaks, inadequate or inaccessible lactation spaces, discretionary managerial gatekeeping, stigmatization, and career penalties associated with breastfeeding at work. [14, 22] Such conditions persist even within institutions that publicly espouse maternal-centered values through Baby-Friendly designation. From a relational perspective, such environments function as moral signals, indicating which forms of care are institutionally valued and which are rendered marginal.

This reliance on informal substitution is echoed beyond the workforce. For example, Hiito et al. demonstrated that breastfeeding parents frequently rely on internet-based peer support communities for timely reassurance, practical guidance, and a sense of belonging, particularly when formal services are inaccessible or insufficient. [12] In both contexts, ethically significant care work is sustained through informal arrangements rather than guaranteed institutional support.

Embodiment and Ethical Knowing

Relational ethics foregrounds embodiment as a source of moral knowledge rather than a private or incidental experience. Lactation is a physiological, temporal, and relational process requiring bodily responsiveness and deliberate environmental accommodation. Nurse-mothers' ethical knowing arises through embodied experience, including physical discomfort, changes in milk supply, psychological distress, and the relational pull between professional and maternal responsibilities. [15, 18]

Qualitative accounts describe nurses delaying or forgoing milk expression during emergencies, suppressing bodily discomfort to avoid burdening colleagues, and internalizing guilt for attending to biologically necessary caregiving needs. [15, 19] These experiences render the nurse-mother's body a site of ethical tension. Within relational ethics, such bodily distress is ethically meaningful, signaling misalignment between institutional structures and lived realities of care.

Mutual Respect and Moral Recognition

Mutual respect requires recognizing persons as moral subjects whose needs, voices, and vulnerabilities carry ethical weight, even in asymmetrical relationships.[23] For nurse-mothers, this respect is often rhetorically affirmed yet practically withheld. While patient-mothers receive institutional protections for breastfeeding, nurse-mothers are frequently expected to negotiate lactation privately through personal sacrifice or informal workarounds. Although nurses possess strong breastfeeding knowledge and positive attitudes, their ability to sustain breastfeeding is shaped primarily by workplace conditions rather than individual motivation.[14, 17] When institutions fail to recognize nurse-mothers' caregiving needs as ethically legitimate, they erode nurses' moral subjectivity and weaken their sense of moral belonging within organizations that depend upon their ethical labor.[24]

Engagement and Ethical Presence

Engagement refers to active moral presence and responsiveness. Nurse-mothers are expected to demonstrate sustained engagement with patients, particularly in supporting breastfeeding initiation and continuation. At the same time, institutional conditions render similar engagement with their own caregiving needs functionally untenable. This asymmetry produces ethical dissonance, in which nurses recognize an appropriate course of action yet are structurally constrained from enacting it without incurring personal or professional costs. Such conditions align with descriptions of moral distress arising from institutional barriers to moral action.[25] In this context, moral distress can be understood as an institutional outcome of systematically constrained ethical engagement.

Ethics of Care and the Devaluation of Maternal Embodiment: A Four-Topic Ethical Analysis

While relational ethics illuminates how these tensions are experienced in practice, a structured ethical analysis is required to demonstrate how institutional commitments are selectively applied across roles. Jonsen et al.'s 'Four Topic Approach' provides a framework for examining how ethical criteria that justify breastfeeding protection for patients are differentially applied when the moral subject is a nurse.[26] Although typically used in bedside ethics, its extension to institutional contexts reveals how ethical reasoning can systematically privilege certain moral subjects while marginalizing others.[1] Applied at this level, the framework demonstrates how maternal embodiment is ethically recognized for patients but discounted within the nursing workforce. It further highlights how consistent ethical reasoning is disrupted by role-based distinctions in the allocation of protection and constraint. This analysis is summarized in Table 2.

Table 2. *Four Topic Ethical Analysis of Maternal Embodiment in Baby-Friendly Hospitals*

Four Topic Domain	Ethical Question	Application to Patient-Mothers	Application to Nurse-Mothers	Ethical Implications
Medical Indications	*What are the relevant physiological facts and risks?*	Breastfeeding recognized as medically and ethically indicated. Institutions provide protection, education, and environmental support.	Identical lactation physiology reframed as a logistical inconvenience. Pumping needs subordinated to staffing and productivity demands.	Physiological reality is treated as ethically relevant only when the mother is a patient.
Patient (moral) Preferences	*What does the individual value and choose?*	Preferences to breastfeed actively elicited, supported, and protected as expressions of autonomy.	Preferences to breastfeed treated as negotiable or optional and subject to managerial discretion.	Respect for moral agency becomes role-dependent rather than person-centered.
Quality of Life	*How do practices affect dignity, suffering, and well-being?*	Breastfeeding support framed as contributing to maternal well-being, bonding, and long-term health.	Physical discomfort, emotional strain, and guilt normalized as professional sacrifice.	Quality-of-life harms to nurse-mothers are rendered ethically invisible.
Contextual Features	*What social, institutional, and power factors shape the case?*	Institutional policies and leadership accountability mechanisms protect breastfeeding.	Productivity metrics, staffing pressures, and ideal-worker norms override ethical commitments.	Institutional interests are prioritized over ethical consistency and justice.

Across medical indications, patient preferences, quality of life, and contextual features, the same ethical criteria used to justify robust breastfeeding protections for patients are selectively suspended when the moral subject is a nurse. Lactation physiology is reframed as a logistical inconvenience, caregiving preferences are treated as negotiable, quality-of-life harms are rendered acceptable or invisible, and contextual pressures, including productivity and staffing demands, are prioritized over ethical consistency.

A parallel form of ethical displacement is visible in the wider breastfeeding support ecosystem. As Hiito et al. demonstrate, when formal institutional support is limited, responsibility for evaluating evidence, managing risk, and sustaining breastfeeding shifts onto

parents through reliance on online peer communities, the effectiveness of which depends on moderation and individual health literacy.[12] In both contexts, responsibility for an institutionally endorsed ethical good is transferred from systems to individuals. Selective reasoning devalues maternal embodiment and undermines the moral coherence of Baby-Friendly designation.

Ethical Implications for Nursing Practice and Workforce Sustainability: Indicators of Organizational 'Ethical Collapse'

These patterns extend beyond isolated inconsistencies and indicate broader systemic dysfunction. Viewed through Jennings' framework of organizational ethical collapse, the marginalization of nurse-mothers can be understood as a manifestation of institutional moral failure rather than a localized anomaly.[27] Key indicators include normalized deviance, role-based moral compartmentalization, instrumentalization of ethical language, suppression of ethical voice, displacement of responsibility onto individuals, erosion of moral community, and ethical myopia. The dynamics reflect patterns of institutional behavior that signal failures of ethical governance. Such conditions contribute to moral distress and professional disengagement, driving workforce attrition.[3, 19, 25] The loss of experienced nurse-mothers may undermine patient safety, continuity of care, and the retention of collective professional knowledge. Support for nurse-mothers should therefore be understood not as ancillary to ethical nursing practice, but as foundational to its ethical credibility. Without alignment between stated values and lived conditions, BFHI designation risks functioning as a symbolic marker rather than an ethically coherent practice. This misalignment signals institutional ethical fragility and an elevated risk of moral failure. These patterns are conceptually mapped in Table 3.

Table 3. *Mapping Jennings' Seven Signs of Organizational Ethical Collapse to Baby-Friendly Hospital Practices Affecting Nurse-Mothers*

Jennings' Sign of Ethical Collapse	Description (per Jennings)	Manifestation in Baby-Friendly Hospitals	Implications for Nurse-Mothers
Normalization of deviance	Ethically problematic practices become routine and accepted as normal.	Delayed or missed pumping breaks, lack of reliable lactation spaces, informal permission structures treated as standard.	Physiological harm, moral distress, and erosion of ethical expectations become normalized.
Role morality and compartmentalization	Ethical obligations are applied selectively based on role rather than moral status.	Breastfeeding protected when mothers are patients but not when mothers are nurses.	Nurses are expected to uphold ethics for others while excluded as moral subjects themselves.
Instrumentalization of moral language	Ethical rhetoric is used symbolically rather than enacted materially.	Baby-Friendly designation emphasized for reputation and accreditation while internal practices contradict it.	Maternal-centered care becomes performative rather than lived for the workforce.
Suppression of ethical voice	Dissent and ethical concern are discouraged or silenced.	Nurse-mothers remain silent about unmet lactation needs to avoid stigma or retaliation.	Moral agency is diminished and ethical concerns go unaddressed.
Displacement of responsibility onto individuals	Institutions shift ethical responsibility away from themselves.	Lactation framed as a personal accommodation rather than institutional obligation.	Costs of care are privatized through self-sacrifice, family substitution, or early weaning.
Erosion of moral community	Ethical failures undermine trust, integrity, and collective purpose.	Persistent moral distress contributes to disengagement, burnout, and attrition.	Loss of experienced clinicians weakens ethical and clinical capacity.
Ethical myopia and failure of moral imagination	Organizations fail to recognize morally relevant stakeholders.	Maternal embodiment recognized only in patients, not employees.	Caregiving labor by nurse-mothers is rendered invisible and ethically irrelevant.

From Ethical Contradiction to Institutional Integrity: A Way Forward

The ethical contradictions experienced by nurse-mothers within Baby-Friendly Hospitals call for more than recognition; they require principled realignment between stated institutional values and lived organizational practices. This analysis demonstrates that the problem is not a lack of evidence, professional knowledge, or moral commitment among nurses, but rather a systems failure within institutions to extend ethical commitments inward to the nursing workforce who are responsible for promoting Baby-Friendly care. Addressing this contradiction requires shifting from viewing breastfeeding support for staff as discretionary or auxiliary to recognizing it as integral to organizational ethical coherence.

Moral Symmetry and Distributive Justice

Ethical integrity depends on symmetry of moral obligation. If breastfeeding is protected as an ethical good for patient-mothers on the grounds of infant well-being, maternal embodiment, and relational vulnerability, these same grounds apply to nurse-mothers. Suspending this obligation based on employment status constitutes an inequitable distribution of moral concern and undermines claims that Baby-Friendly designation reflects a consistent ethical orientation. This asymmetry reflects role-based distributive injustice,[1] whereby institutional protections are allocated according to employment status rather than moral equivalence between mothers. Institutions must recognize nurse-mothers as ethical agents and moral subjects, not merely as workers whose caregiving needs compete with productivity demands.

Institutional Conditions and Moral Agency

Nursing ethics frameworks emphasize that moral agency is exercised within, not apart from, institutional contexts. When organizational structures systematically deny, delay, or

297 penalize biologically necessary caregiving practices such as lactation, nurses' capacity to act
298 ethically is constrained, producing moral distress and disengagement.

299 **Structural Responsibility and the Ethics of Care**

300 Healthcare organizations bear responsibility for creating conditions that enable, rather
301 than obstruct, moral action by their workforce. Breastfeeding support for nurse-mothers must be
302 understood as a structural responsibility rather than an informal accommodation. Reliance on
303 managerial discretion, peer goodwill, or individual negotiation signals ethical fragility rather
304 than genuine commitment. From an ethics of care perspective, institutional responsiveness
305 requires anticipatory structures that acknowledge dependency, embodiment, and relational needs
306 as predictable features of human life, including professional life. Support that is precarious,
307 stigmatized, or contingent fails to meet this standard.

308 **Protection from Moral and Professional Penalty**

309 Alignment also requires protection from moral and professional penalty. When nurse-
310 mothers incur career disadvantages, reputational harm, or implicit sanctions for attending to
311 lactation needs, institutions signal that caregiving is incompatible with professional legitimacy.
312 This message is ethically untenable within organizations that publicly affirm maternal-centered
313 care. Protecting nurses from such penalties is not a benefit or incentive but a matter of justice.

314 **Toward Ethically Coherent Institutions**

315 These considerations point toward a vision of Baby-Friendly Hospitals as ethically
316 coherent institutions in which caregiving, embodiment, and moral agency are recognized across
317 roles. Extending maternal-centered commitments inward is not an expansion of scope but a
318 fulfillment of ethical promise to patients, nurses, and communities. Without such alignment,

Baby-Friendly designation risks becoming symbolic: protective at the bedside, precarious in the workplace, and ultimately vulnerable as an ethical claim.

Implications for Institutional Practice

While this analysis does not prescribe specific policy solutions, it identifies key areas of institutional action. First, institutions should establish enforceable structural protections for lactation, including protected time and appropriate facilities that enable timely and dignified milk expression. Second, institutions should move beyond discretionary accommodation toward the systemic integration of maternal embodiment within workforce design, recognizing caregiving as a predictable and legitimate dimension of professional life. Third, institutions should ensure protection from professional or reputational penalty, so that nurse-mothers are not disadvantaged for engaging in biologically necessary caregiving practices.

Conclusion

Realigning Baby-Friendly commitments requires organizations to examine how workforce policies, staffing norms, and performance expectations either reinforce or contradict their ethical claims - not through prescriptive blueprints, but through institutional willingness to apply the same ethical scrutiny to internal practices as to patient care. Ethical credibility depends on consistency between values espoused and conditions enacted. Although BFHI frames breastfeeding as an ethical good requiring organizational protection, maternal embodiment protected for patient-mothers becomes precarious for nurse-mothers. Across ethics of care, relational ethics, clinical ethics, and organizational frameworks, productivity norms constrain ethical action and displace responsibility onto individuals. Nurse-mothers possess the knowledge and commitment to enact breastfeeding support, yet their embodied distress, moral silence, and personal sacrifice signal institutional failure. When identical ethical criteria applied to patient-

mothers are suspended for nurse-mothers, the Baby-Friendly designation risks becoming symbolic rather than lived ethical practice. True integrity demands enforceable structures that recognize caregiving and embodiment as legitimate dimensions of professional life, extending maternal-centered commitments inward as well as outward.

References

1. Butts JB, Rich KL. Nursing ethics: across the curriculum and into practice. Burlington (MA): Jones & Bartlett Learning; 2022.
2. Burns E, Gannon S, Pierce H, Hugman S. Corporeal generosity: breastfeeding bodies and female-dominated workplaces. Gender Work Organ. 2022;29(3):778-799. doi:10.1111/gwao.12821
3. Poeira A, Nunes L. Retaining those who care: ethical climate, leadership, and workforce sustainability in healthcare. Healthcare. 2025;13:3014. doi:10.3390/healthcare13233014
4. World Health Organization, United Nations Children's Fund. Protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: implementing the revised Baby-friendly Hospital Initiative. Geneva: WHO; 2018.
5. International Code Documentation Centre. International Code of Marketing of Breastmilk Substitutes and relevant WHA resolutions. 4th ed. Penang: IBFAN; 2022.
6. World Health Organization. The International Code of Marketing of Breast-milk Substitutes: frequently asked questions (2017 update). Geneva: WHO; 2017.
7. Fan YW, Fan HSL, Shing JSY, Ip HL, Fong DYT, Lok KYW. Impact of baby-friendly hospital initiatives on breastfeeding outcomes: a systematic review and meta-analysis. Women Birth. 2025;38:101881. doi:10.1016/j.wombi.2025.101881
8. Habte MB, Abdulahi M, Plusquin M, Cosemans C. Effectiveness of the Baby-Friendly Hospital Initiative on early initiation and exclusive breastfeeding practice: a systematic review and meta-analysis. Nutrients. 2025;17(14):2283. doi:10.3390/nu17142283

9. Lok KYW, Fan HSL, Ip HL, Leung ETY, Lau KW, Wong JYH, et al. Building a baby-friendly community: development, strategy, implementation and evaluation of a BFCI program. J Adv Nurs. 2025;81:7040-7051. doi:10.1111/jan.16267
10. Gilligan C. In a different voice: psychological theory and women's development. Cambridge (MA): Harvard University Press; 1982.
11. Tronto JC. An ethic of care. Generations. 1998;22(3):15-20.
12. Hiito E, Ikonen R, Niela-Vilén H. Internet-based breastfeeding peer support for breastfeeding parents: an integrative review. J Adv Nurs. 2024;80:4805-4824. doi:10.1111/jan.16221
13. International Council of Nurses. The ICN code of ethics for nurses. Geneva: ICN; 2021.
14. Iliyasu Z, Galadanci HS, Emokpae P, Amole TG, Nass N, Aliyu MH. Predictors of exclusive breastfeeding among health care workers in urban Kano, Nigeria. J Obstet Gynecol Neonatal Nurs. 2019;48(4):433-444. doi:10.1016/j.jogn.2019.04.285
15. Li S, Zhang W, Liu Y, Yu M, Yang S, Luo M, et al. Lactating nurses' experiences of return to work after lifting COVID-19 lockdown: a qualitative study. Heliyon. 2024;10:e23761. doi:10.1016/j.heliyon.2023.e23761
16. Gallagher TT, McKechnie AC. Missed care and equitable breastfeeding support: an integrative review of exposure to in-hospital care by patient characteristics and breastfeeding outcomes. J Adv Nurs. 2024;80:3086-3102. doi:10.1111/jan.16077
17. Nanthakomon T, Nukaw S, Kositamongkol S. Exclusive breastfeeding in health personnel: incidence and barriers. Children. 2023;10(8):1424. doi:10.3390/children10081424
18. Riaz S, Condon L. The experiences of breastfeeding mothers returning to work as hospital nurses in Pakistan: a qualitative study. Women Birth. 2019;32:e252-e258. doi:10.1016/j.wombi.2018.06.019

19. Watson AL, Peterson C, Gardner T, Young C, Houston G, Nelson B, et al. Exploring the impact of the motherhood penalty on critical care nurses: a hermeneutic phenomenological study. J Adv Nurs. 2025;82(2):1587-1600. doi:10.1111/jan.17075
20. Wood NK, Helfrich-Miller KR. Changes in breastfeeding relationships when frontline essential working mothers return to work during the COVID-19 pandemic: a longitudinal qualitative online study. J Adv Nurs. 2025;81:6709-6721. doi:10.1111/jan.16793
21. Bergum V, Dossetor JB. Relational ethics: the full meaning of respect. Frederick (MD): University Publishing Group; 2005.
22. Konlan KD, Pwavra JBP, Armah-Mensah M, Aryee R, Narkotey S. Challenges and coping strategies of nurses and midwives after maternity leave: a cross-sectional study in a human resource-constrained setting in Ghana. Nurs Open. 2023;10(1):208-216. doi:10.1002/nop2.1296
23. Seidlein AH, Kuhn E. When nurses' vulnerability challenges their moral integrity: a discursive paper. J Adv Nurs. 2023;79(10):3727-3736. doi:10.1111/jan.15717
24. Brewer KC, Dierkes AM, Norful AA. Organizational trust breaches among nurses and aides: a qualitative study. Nurs Ethics. 2024;31(8). doi:10.1177/09697330241230520
25. Jameton A. Nursing practice: the ethical issues. Englewood Cliffs (NJ): Prentice Hall; 1984.
26. Jonsen AR, Siegler M, Winslade WJ. Clinical ethics: a practical approach to ethical decisions in clinical medicine. 9th ed. New York: McGraw Hill; 2021.
27. Jennings M. The seven signs of ethical collapse. New York: St. Martin's Press; 2006