

Implementation of Family Centered Care (FCC) to Improve Maternal and Infant Health: Systematic Literature Review

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Abstract. The global MMR in 2023 is 197 per 100,000 live births. The causes include hemorrhage, infection, pre-eclampsia and eclampsia, complications during childbirth, and abortion. The Family-Centered Care (FCC) model is a collaboration between medical professionals, patients, and families to address the emotional, social, and developmental needs of the patient. This study aims to determine the impact of FCC on maternal and infant health. A systematic literature search based on PRISMA in the Scopus, PubMed, and ScienceDirect databases yielded 13,301 articles (Scopus 270, PubMed 5,071, ScienceDirect 7,960). Screening of publications from the past 5 years (2020 – 2025) resulted in 3,895 articles, abstract identification (n=11), and full-text review. Based on eligibility criteria, 11 articles were deemed suitable for analysis. The implementation of FCC is beneficial for improving the quality of life of infants, motor development, and neurological behavior in very premature babies, the role of parenting and parents' sense of competence, family care without causing harm, effectively reducing the length of care for premature babies, and increasing parental satisfaction. In conclusion, the implementation of FCC has a positive impact on improving the health status of mothers and infants. It is hoped that healthcare workers will apply FCC in every care service.

Keywords: implementation, family centered care, maternal health, infant health

1 Introduction

According to the WHO (2023), the global Maternal Mortality Ratio (MMR) in 2023 is 197 per 100,000 live births. Approximately 92% of all maternal deaths occur in low- and lower-middle-income countries, which is still far from the global MMR target of below 70 by 2030. Women die from complications during and after pregnancy and childbirth. Most of these complications develop during pregnancy and are largely preventable or treatable. Other complications may exist before pregnancy but worsen during pregnancy, especially if not managed as part of a woman's care. The main complications contributing to approximately 75% of all maternal deaths are: severe haemorrhage (mostly postpartum haemorrhage), infection (usually postpartum), high blood pressure during pregnancy (pre-eclampsia and eclampsia), and complications from unsafe childbirth and abortion [1]. There are nearly 1.9 million stillbirths each year, with more than 40 per cent of all stillbirths occurring during labour. One foetal death occurs every 16 seconds. This means that each year, approximately 2 million babies are stillborn. Most stillbirths can be prevented with quality and respectful care during labour [2].

The WHO's efforts to reduce MMR include improving maternal and infant health, strengthening research evidence, providing clinical guidelines and evidence-based programmes, setting global standards, and providing technical support to Member States in developing and implementing effective policies and programmes. As defined in the Strategy to End Preventable Maternal Deaths (EPMM) and Ending preventable maternal deaths: a new focus on improving the health and well-being of mothers and newborns, WHO works with partners to support countries in addressing inequalities in access to and quality of reproductive, maternal and newborn health services; ensuring universal health coverage for comprehensive reproductive, maternal and newborn health care; addressing all causes of maternal mortality, reproductive and maternal morbidity, and related disabilities; strengthening health systems to collect high-quality data to respond to the needs and priorities of women and girls; and ensuring accountability to improve the quality of care and equity.

The Family-Centred Care (FCC) model is a comprehensive approach that emphasises collaboration between medical professionals, patients, and families to address the emotional, social, and developmental needs of paediatric patients and individuals with serious or chronic illnesses. FCC aims to improve health outcomes for patients and their families. FCC is built on four core principles: Respect & Dignity, Information Sharing, Participation, and Collaboration. These principles ensure that families are active partners in their child's care, leading to improved outcomes for patients and families.

Family-Centred Care (FCC) is a care model that involves planning, implementing, and evaluating care for children in various settings [2]. FCC, which includes evidence-based interventions, is defined as a multidimensional approach that encompasses the planning, delivery, and evaluation of health services based on collaboration between health teams and families, and adopts the philosophy that parents' health issues affect children's health. Although it follows a set of principles based on its philosophy, it should be noted that there are institutional-based differences in its implementation process. According to the FCC [3] philosophy, the family is the primary source of strength and support for the infant. Its main principles include respecting the values, beliefs, and preferences of the family; sharing complete, reliable, and non-judgmental information on a regular basis; encouraging parents to be involved in the care of their children; supporting and facilitating parents in making decisions about their own health and that of their children; and considering the needs of all family members and ensuring cooperation between the healthcare team and the family throughout the entire process in [4].

The aim of this study was to explore the benefits of implementing Family Centred Care (FCC) in all care provided to mothers and babies, which can improve the health of both mothers and babies.

2 Methods

2.1 Protocol and Registration

This literature review aims to provide an overview of the implementation of Family Centred Care (FCC) to improve the health of mothers and babies. The study selection process followed a systematic flow based on the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines. This flow included the identification, screening, eligibility, and inclusion of articles.

2.2 Database and Search Strategy.

Three databases (Scopus, PubMed, and Science Direct) were searched for articles published in the last five years, namely from 2020 to 2025. The keywords used were 'Family Nursing', 'Family Nursings', 'Family-Centred Maternity Care', 'Family Centred Care', 'Family-Centred Nursing', 'Health Women's', 'Womens Health', 'Woman's Health', 'Infant Baby Health', 'Baby Newborn Health', 'Newborn Infant Health', 'Health Of Newborn Infant', 'Newborn Infant Health', 'Health of Newborn Infants', as well as MeSH terms and their subsets, combined with Boolean operators. Quotation marks and Boolean operators (AND, OR) were used for more specific filtering.

2.3 Eligibility Criteria

Each article was screened based on the Population (P), Intervention (I), Comparison (C), Outcomes (O), and Study Design (S) (PICOS) criteria, as presented in Table 1 by at least two researchers independently (T, WH). Articles must include: (1) pregnant women, women in labour or postpartum women, and infants under 1 year of age; (2) interventions developed or implemented, namely Family-Centred Care (FCC); (3) maternal and infant health outcomes; (4) quantitative, qualitative, mixed methods, or literature reviews; and (5) written in English. We excluded studies with populations other than mothers and infants.

2.4 Inclusion and Exclusion Criteria

Table 1. Inclusion and Exclusion Criteria

Criteria	Inclusion	Excklusion
<i>Population</i>	Mother and/or baby	Individuals other than the mother and/or baby
<i>Intervention</i>	<i>Family-centred care or family nursing approach</i>	<i>Interventions that are not family-based (such as focusing only on the mother and/or baby without family involvement)</i>
<i>Comparison</i>	No maternal health services or no maternal health services compared with Family-Centred or Family Nursing approaches	Studies without controls or without comparisons with Family-Centred or Family Nursing approaches
<i>Outcomes</i>	Improving the health of mothers and/or babies	Studies that do not measure the impact on maternal and/or infant health
<i>Study Design</i>	Studi kuantitatif, kualitatif atau mix- method yang dipublikasikan dalam jurnal <i>peer-reviewed</i>	Studies in the form of opinions, editorials, or articles without peer review

2.5 Data Extraction

A data extraction instrument was developed to tabulate several characteristics and details of all included studies, including (1) author and year, (2) country of origin, (3) study design, (4) data source, (5) single or multi-centre, (6) population profile (including number of patients, age, and proportion of males).

2.6 Risk of Bias Assessment

The included studies were conducted by a single researcher (T), so there is still a possibility of bias.

3 Results And Discussion

Result

Study Characteristic

The study selection process began with the identification of articles through Scopus, PubMed, and Science Direct. These three databases yielded 13,301 articles, with 270 articles from Scopus, 5,071 articles from PubMed, and 7,960 articles from Science Direct. Screening of publications from the last five years, from 2020 to 2025, yielded 3,895 articles, with 210 articles from Scopus, 1,430 articles from PubMed, and 2,255 articles from Science Direct. Duplicate screening identified 21 duplicate articles (n=3877). Title screening excluded irrelevant articles (n = 188), leaving 9 articles. Based on abstract identification of these 11 articles, all abstracts were relevant (n=11). Based on full-text examination and eligibility criteria for the remaining 11 articles, 11 articles were eligible for further analysis. Study quality analysis was performed using a relevant critical appraisal checklist, in which the 11 articles analysed scored more than 70%, indicating high validity and relevance, so that the total number of articles used in the data synthesis was 11 articles.

Characteristics of Study Respondents

Most studies involved families with infants under 1 year of age. Sample sizes varied from small groups of 45 to 765 infants and 654 mothers. The research was conducted in community-based health facilities and hospitals, with interventions in the form of Family Centred Care.

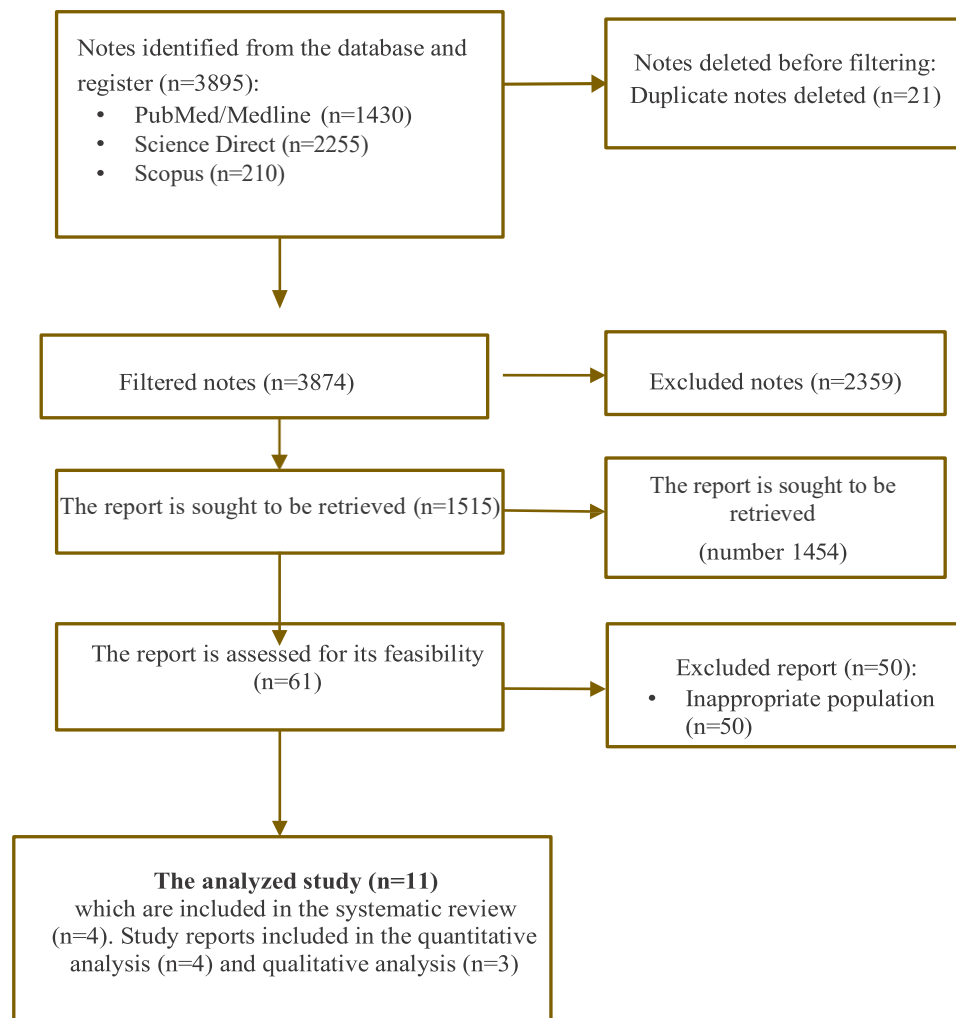


Figure 1. PRISMA flow diagram of the study selection process

Quality Study and Research Selection

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checklist, where the 11 articles analysed scored more than 70%, indicating high validity and relevance, so that the total number of articles used in the data synthesis was 11 articles.

Discussion

Various studies show that the Family Centred Care (FCC) approach plays an important role in improving maternal and infant health. The results of the study are as follows:

Improving the Quality of Life of Infants

The results of a study conducted by [5] show that nutrition education provided to families of infants (between 0 and 12 months of age) can reduce malnutrition, as evidenced by low to moderate certainty evidence for improvements in weight and height during the first two years of life. Based on the reviewed studies, the clinical significance of improvements in growth parameters is small and should be interpreted with caution due to inconsistencies between studies, which may be partly due to differences in study design and in the delivery of nutrition education. Low to moderate certainty evidence suggests that nutrition education aimed at improving feeding practices related to weaning improves weight and height in the first two years of life.

Nutrition education on appropriate complementary feeding practices during infancy can be an effective tool for reducing the risk of malnutrition in children, particularly in low- and middle-income countries. Although only slight improvements in growth parameters are seen during the first two years of life, it is unclear whether these improvements can be sustained into later life, leading to greater differences in long-term growth parameters.

Improving Motor Development and Neural Behaviour in Very Premature Infants.

Research conducted by [6] shows that through FCC, health professionals guide programmes and work with parents to support and guide infants' motor and neurological development in order to improve their abilities. Providing care to premature infants through a family-centred approach can improve the overall development of infants.

Through FCC, healthcare professionals guide programmes and collaborate with parents to support and guide infants' motor and neurological development in order to improve their abilities. Providing care to premature infants through a family-centred approach can improve the overall development of infants and, in turn, reduce the burden on caregivers and increase their capacity. The findings of this review will provide an understanding of the effectiveness of FCC components and their benefits for very preterm infants and thus assist policymakers and healthcare professionals in adopting evidence-based FCC decision-making and practices. This systematic review will guide clinicians on the feasibility of practising FCC that can support and promote parental integration into various rehabilitation settings.

Effective in Reducing the Length of Stay for Premature Infants in Level II NICUs

The results of a study conducted by [7] show that Alberta FICare Standard Time is effective in reducing the length of stay for premature infants in Level II NICUs, without an increase in the number of readmitted patients or visits to the emergency department. A small number of locations within one jurisdiction and specific groups of infants limit the generalisability of the findings. The length of hospital stay for infants was measured from the date and time of birth to the date and time of discharge from the hospital. Secondary infant outcomes were the proportion of infants requiring readmission at 2 months of age, the proportion of infants requiring emergency department care at 2 months of age, and the type of feeding at hospital discharge (breast milk only, combination of breast milk and formula, or formula only). Secondary maternal outcomes were psychosocial stress (anxiety, depressive symptoms, and stress) and parental self-efficacy at hospital discharge.

The goal of Alberta FICareWaktu Standar is to change the culture and practices that involve and support parents in their role when their babies receive care in a Level II NICU. Alberta FICareWaktu Standar is a theoretically and dynamically driven psychoeducational care model that empowers parents to build their knowledge, skills, and confidence in caring for their babies in the NICU to

prepare for early discharge. This model has three main components: Relational Communication, Parent Education, and Parent Support. Relational Communication is based on family systems theory and uses circular pattern diagrams and questioning practices to negotiate the roles of parents and HCPs as parents gain confidence in providing care. As partners in the healthcare team, parents are encouraged, as they are ready and willing, to introduce and share information about their baby during bedside visits, and are empowered to participate in decision-making and care planning.

Praise is used as positive feedback to parents. Parent Education is based on adult learning and self-efficacy theory, and includes Parent Education Pathways, bedside individual teaching, group parent education sessions, and the Life's Little Love app (© 2015 Alexiatek). The multimodal evidence-based education approach provides consistency across HCPs. Parental Support is based on stress and coping theory. Professional support includes postnatal depression screening and referrals to ensure mothers receive timely psychological support. Family Mentors, parents who have experience with premature babies in the NICU, provide peer support.

Improving Cognitive, Motor, and Language Development in Premature Children.

Research conducted by [8] shows that family-focused interventions have a positive effect on the cognition of premature children. The effect on motor development is smaller, possibly because the intervention emphasises family-child interaction. The effects of intervention on the development of children at social risk and on language skills are inconclusive, due to the scarcity of research in this area.

Early intervention focused on the family compared with usual care improved the motor development of children born prematurely; however, when the analysis was performed at different ages, the effect was only observed up to 12 months of age. Similar results were observed in a meta-analysis by Spittle et al.,¹⁸ although they did not specifically discuss family-focused interventions, and by Vanderveen et al., who found positive effects on motor outcomes only up to 12 months. The interventions analysed in this study, which provided greater benefits in motor development, were those based largely on the synchronous-active theory.

Although most of the programmes analysed did not specifically focus on motor development, early intervention elements based on the synchronous-active theory help explain the overall positive effects of early intervention on motor outcomes in the sample of premature infants. When social risk was added to biological risk, no positive effects of intervention were observed on motor and cognitive development, even when children with high social risk were compared with those with low social risk. It should be noted that the meta-analysis was conducted by pooling data from only two studies of moderate methodological quality; therefore, the results should be interpreted with caution. There is evidence that more intensive and long-term programmes, such as Early Head Start,⁴¹ conducted in the United States with more than 3,000 children from low-income families in the first 3 years of life, have a positive impact on cognitive development. It is possible that the number of sessions³¹ and intensity⁵ of the interventions conducted were not sufficient to influence the motor and cognitive development of children with associated social and biological risks.

Enhancing the Role of Parenting and Competence in Parents of Premature Babies.

The results of a study conducted by [9] show that after family-centred care intervention, the experimental group showed a relatively higher increase in competence scores (83.42 ± 6.66) compared to the control group (57.60). Similarly, the experimental group had a higher average parenting role score (87.95 ± 6.45) compared to the control group (54.77 ± 11.80), which means that the implementation of a family-centred care programme developed a training package based on the principles of family-centred care for nurses working in neonatal intensive care units. This training will help parents of babies being treated in hospital to increase their sense of competence and enhance their role as parents.

Our study identified several barriers related to access, engagement, and implementation of FCSUT, including challenges for children related to the facility environment, lack of support for family-centred care among other family members, isolation for some people undergoing treatment during the 'blackout' period, the limited involvement of male partners and/or fathers due to facility

regulations, restrictions imposed by facilities on the age or number of children who can attend, and logistical barriers (e.g., distance of the facility from family members or community services) that limit access to FCSUT. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides resources on family-centred care for women that outline best practices, key elements, and challenges to family-centred care (Werner et al., 2007). Findings from this study support the guidance outlined in these resources, which note that individuals receiving FCSUT services should determine how their family is defined and which family members and other significant persons (e.g., children, partners, and household partners) should participate in treatment. In families with a history of violence, facilities and service providers should work with clients to determine the appropriate level of involvement of partners or other family members. In addition, SAMHSA notes that FCSUT can also be flexible and adaptive and can empower parents to create a safe, stable, and supportive environment for their children and families. FCSUT facilities may need to adjust their policies regarding family member involvement in the care of each client to provide them with the most beneficial services for them and their families. FCSUT facilities may also need to consider the ages of the children in their care in order to offer activities appropriate to their developmental stages, as well as parenting classes for parents, which can enable pregnant and postpartum mothers and their children to feel safe and included while undergoing treatment.

Preventing Intergenerational Transmission of Adverse Childhood Experiences

Research conducted by [10] shows that a family-centred approach to substance abuse treatment provides a range of prevention services for individuals and their family members that focus on improving outcomes for parents, children, and other family members (National Centre on Substance Abuse and Child Welfare, 2021). In turn, FCSUT can prevent ACEs and their transmission from generation to generation (Centres for Disease Control and Prevention, 2019; Zhang et al., 2023). Pregnancy and the postpartum period may be an opportune time for FCSUT to provide early interventions to stop the intergenerational transmission of ACEs. This study identified perceived benefits of FCSUT, including improved parenting and communication skills, promotion of healthy relationships with infants and other children, partners, and other family members, and facilitation of support systems for long-term recovery. However, the programme may face barriers in integrating family members, particularly young children and fathers and/or partners, into care. In addition, pregnant and postpartum individuals may experience difficulties accessing and/or engaging in care when families are not fully integrated. Meeting the needs of all family members affected by SUD and strengthening families can help break the intergenerational transmission of ACEs through the creation of safe, stable, and supportive relationships and environments for children and their families.

Empowering parents by providing family integrated care (FICare)

The results of research conducted by [11] reveal five themes of parent empowerment (results), namely Feeling Respected, Acquiring Self-Management Tools, Insight into Newborn Conditions, Perceived Control, and Self-Efficacy. For each theme, participants reported facilitating and hindering experiences (mechanisms) that were initiated and influenced by a combination of single family rooms, paired care, rooming-in, and FICare (context). Unlimited physical proximity to their newborns, 24 hours a day, in a safe private environment offered parents an intensive learning experience through active participation in care. This helps them achieve independence as parents upon discharge from the hospital, but also poses challenges such as power conflicts with staff; prioritising care for themselves, siblings, or the newborn; feelings of isolation; and sleep deprivation. Providing FICare to mother-newborn pairs in single family rooms offers an intensive learning context for parents to become independent parents upon discharge from hospital. Healthcare professionals should be aware of the challenges and facilitators experienced by parents in the context of 24-hour physical closeness with their newborns in single family rooms. This awareness will enable them to better support parents in their empowerment process towards becoming independent parents upon discharge from the hospital.

Improving Parental Readiness

The results of a study conducted by [12] show that the total average scores of mothers and fathers in the intervention group regarding readiness to go home and care at home were higher than those in the control group, and a significant difference was observed. Statistically significant differences were found in terms of weight at discharge, the first day of enteral feeding, and the first breastfeeding. This means that the FICare Model was observed to improve the readiness of mothers and fathers to return home and provide care at home, and had a positive impact on infant weight gain, breastfeeding status, and nutritional continuity.

Five themes related to parental empowerment (outcomes) and the underlying mechanisms and contexts were identified: Feeling Respected, Acquiring Self-Management Tools, Insight into Newborn Conditions, Perceived Control, and Self-Efficacy. Most participants began by saying how they felt respected as a whole and real family because they could stay together while being treated at the hospital. This sense of respect seems to have created a basis for participants to acquire self-management tools and gain insight into the condition of their newborn babies. This, in turn, contributed positively to the participants' feelings of control and self-efficacy.

Discharge training for parents with babies in the NICU is the most important component of FICare. Discharge training for babies should begin as soon as possible after the baby is admitted to the unit and continue until the parents are ready to take their baby home. It is important to assess the parents' readiness to ensure that they can provide the necessary care for their baby independently and safely. A reliable tool is needed to provide a comprehensive pre-discharge assessment of parents' readiness to take their babies home. Thus, the parents' needs can be determined before discharge, and the necessary preventive interventions can be planned and implemented accordingly. Given the nature of discharge training, it is emphasised that the strongest predictor of discharge readiness is a comprehensive discharge preparation programme. Parents should be given an individualised and systematic educational approach. This will help especially high-risk infants to have a healthier home care process after discharge from the NICU [27]. In one study, it was emphasised that parents are generally not prepared for the transition from hospital care to home care, and situations such as physical exhaustion, lifestyle changes, and adaptation to the role of parent are sources of stress. High-quality discharge training, which is the most important component of the discharge preparation process and is provided by nurses, will help moderate the transition process at home and help parents prepare for the discharge of premature babies [29]. The FICare model makes it easier to identify their training needs and provide the support they need [26]. In evaluating the effectiveness of the FICare care model, the programme can be evaluated using a scale. The use of a practical scale will help us to objectively evaluate parents in questioning their readiness to go home and care for their baby at home. In line with the low scores received from the scale items, parents can be supported in areas they feel are inadequate.

Improving the quality of life of parents of premature babies

The results of the study [12] showed that the quality of life of participants before and after the intervention was assessed and observed that the Quality of Life score and all its dimensions were higher in fathers than in mothers ($p < 0.001$). Furthermore, after the intervention, Quality of Life and all dimensions except (social function $P = 0.127$) and (environmental health ($P = 0.098$)) were significantly higher in fathers than in mothers ($p = 0.098$) and significantly higher in fathers than in mothers ($p < 0.001$). It was also found that fathers' physical health after the intervention decreased significantly compared to before the intervention ($p < 0.001$). Changes in Quality of Life and its dimensions were examined. There was an increase in scores at the end of the study for both fathers and mothers, but this increase was significant in all dimensions except social functioning in the mothers' group. This increase was greater than that of the fathers' group ($P < 0.001$). The data were analysed using SPSS v.16, T-test and covariance analysis with a significance level of 0.05. Family-centred education, particularly the simultaneous education of fathers and mothers, improved the quality of life of fathers. Family-based education, particularly the simultaneous education of fathers and mothers, was effective in improving quality of life.

The family-centred educational intervention studied in this research resulted in an improvement in the quality of life of mothers and fathers with premature babies. A study by Peterson showed that fathers with premature babies had a lower quality of life six weeks after the birth of their premature babies compared to fathers with full-term babies and required intervention and educational programmes to address this issue (Petersen and Quinlivan, 2020). Current research shows that an improvement in the quality of life of fathers can be achieved through educational interventions. In the study by Ionio et al., it was observed that both fathers and mothers were negatively affected by the birth of a premature baby. Therefore, family-centred care from the outset is essential to involve parents in caring for their premature babies and to minimise these negative effects. In this study, it was observed that the quality of life of parents after family-centred care improved significantly, consistent with the results of Ionio's study (IONIO et al., 2016). In the study by Qiu et al., family-centred interventions for parents of premature babies with grade 4 intraventricular haemorrhage improved the parents' quality of life, consistent with the results of this study (Qiu et al., 2020).

Improving Care for Families Without Causing Harm

The results of research conducted by [13] show that parents and doctors report many benefits for families. They are all enthusiastic about FiCare for non-medical matters such as changing nappies and skin-to-skin care; for more medical matters, such as conducting routine examinations, being present during resuscitation or procedures, most doctors want more parental involvement, more than other professionals, even parents. All parents described how FiCare benefited them, empowered them, helped them feel like parents and become a family; but some parents, who were unable to participate as much or did not want to take on a clinical role, reported feeling guilty. Having a flexible yet transparent FiCare philosophy is key, rather than having a homogeneous goal. For example, the goal of having all parents present at routine check-ups in a quality improvement initiative could be detrimental to some families. We suggest ways to ethically enhance FiCare in the best interests of families while minimising harm. It is important for FiCare not to become 'Family-Imposed Care.' Optimising FiCare can only be achieved if parental priorities guide our actions, while also considering the doctor's perspective and respecting the realities of each NICU.

This highlights the importance of personalising our approach, that making parental participation in some interventions a positive thing does not mean it becomes an obligation and a 'QI goal' for all parents. We must always think carefully when implementing training programmes for parents aimed at getting 'all parents' to participate. Since not all parents participate in these QI initiatives (75% response rate for parents who meet the recruitment criteria), it is likely that FiCare losses (or less FiCare) are not reported and many ethical issues go unreported.

Improving nurses' attitudes towards parental involvement and increasing parental attachment to infants, parental satisfaction, and infant weight gain.

The results of a study conducted by [4] show that nurses' attitudes towards parental participation scores obtained immediately after and one month after training were higher than pre-training scores, while scores one month after training were lower than those immediately after training. The results indicate that infant weight gain upon discharge from the hospital in the experimental group was significantly higher than infant weight in the control group, and there was no significant difference between the two groups in terms of length of stay in the neonatal intensive care unit. The attachment and satisfaction scores of mothers in the experimental group were significantly higher than those in the control group. This means that the implementation of family-centred nursing care interventions, developed based on unit needs and supported by managers, with trained neonatal intensive care nurses, has a positive impact on parental attachment, parental satisfaction, and infant weight gain.

This study shows that training nurses for NCC improves their attitudes towards parental participation in the care process. Oude Maatman et al. (2020) reported that the most important factor influencing the implementation of FCC is whether there is a change in mindset among health professionals, in terms of parents being seen as primary caregivers and, therefore, health professionals being required to receive training and observe efficient implementation. In the same study, it was emphasised that there is a need to improve the communication skills of health professionals in understanding and meeting the needs of parents, and to arrange the environment to facilitate the implementation of FCC (Oude Maatman et al., 2020). Trajkovski et al. reported that

although education is important, it is not necessarily sufficient (Trajkovski et al., 2012). Grol and colleagues (2013) reported that FCC policies must be established to change nurses' mindsets, and that barriers must be removed to implement effective training to improve communication techniques. Considering that employees' attitudes guide their behaviour, it can be concluded that training provided to nurses supported by arrangements in the NICU environment (e.g., creating physical space for parents, establishing FCC-related procedures, arranging staff to provide psychological support and breastfeeding counselling for parents, and documentation and planning for training programmes, etc.) is effective in implementing FCC initiatives.

4 Conclusion

The implementation of Family Centred Care (FCC) has a positive impact on the health of mothers and babies. Some of the beneficial effects of implementing FCC are improved quality of life for infants, improved motor and neurological development in very premature infants, effective reduction in the length of stay for premature infants in level II NICUs, and improved cognitive, motor, and language development in children -Children Born Prematurely, Enhanced Parenting Roles and Sense of Competence in Parents of Premature Infants, Prevention of Intergenerational Transmission of Adverse Childhood Experiences, Empowering Parents by Providing Family Integrated Care (FICare), Improving the quality of life of parents of premature babies, improving care for families without causing harm, and improving nurses' attitudes towards parental involvement and increasing parental attachment, parental satisfaction, and infant weight gain. We recommend implementing Family-Centred Care in all care provided to mothers and babies to improve the health status of both mothers and babies.

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