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Baby-Friendly Hospital Initiative's Benefits, Effectiveness, and Relevance to Internship at a Women's Hospital

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Abstract

Background: This review was conducted to analyze the benefits and effectiveness of the Baby-Friendly Hospital Initiative and compare it to my internship at a Baby-Friendly designated women's hospital.

Purpose: The purpose of this review was to compile and compare existing research on Baby-Friendly Hospital Initiative to determine its benefits, effectiveness, and relevance to my internship.

Method: Two databases, CINAHL Complete and MEDLINE, were used to find a total of 18 peer-reviewed journal articles on Baby-Friendly Hospital Initiative benefits and effectiveness. Key words consisted of "baby friendly," "hospital," and "benefits or advantages."

Results: The Baby-Friendly Hospital Initiative has been found to increase initiation of breastfeeding; however, it has not been proven to increase duration of breastfeeding enough to get to the United States Healthy People 2030 goal of exclusive breastfeeding of 42.4% of infants through six months of life.

Conclusion: The Baby-Friendly Hospital Initiative practices that have been analyzed were seen in my internship with a women's hospital. I was able to witness a lot of these benefits firsthand and see many of the challenges that go along with Baby-Friendly practices.

Introduction

The Baby Friendly Hospital Initiative (BFHI) was created by The World Health Organization and The United Nations Children's Fund to increase breastfeeding worldwide in 1991 (Nobari et al., 2017). This initiative was adapted into The United States healthcare due to the Healthy People initiatives continuing goal of increasing breastfeeding infants. Healthy People 2030 initiative set a public health goal that 42.4% of infants in the US be breastfed exclusively through six months (Gyamfi et al., 2021). In an evaluation of prenatal breastfeeding in 2018, only 24.9% of US infants were exclusively receiving their mother's milk for the recommended six months, which was down 0.7% from 2017's evaluation of exclusive breastfeeding through six months of age (Parry et al., 2018; Mieso et al., 2021).

The BFHI is implemented in The United States through registration with Baby-Friendly USA. It includes Ten Steps to Successful Breastfeeding. Step one requires a written breastfeeding policy that is routinely communicated to all healthcare staff. Step two requires the training of all health care staff in the skills necessary to implement this policy. Steps three, five, and ten inform pregnant women about the benefits and management of breastfeeding; demonstrate to mothers how to breastfeed and how to maintain lactation; provide resources of breastfeeding support groups and refer mothers to them on discharge from the hospital or birth center. Steps four, seven, and eight require helping mothers initiate breastfeeding within one hour of birth, practice rooming-in, and encourage breastfeeding on demand. Step six recommends infants have no food or drink other than breast milk unless medically indicated. Step nine states that no pacifiers or artificial nipples should be given to breastfeeding infants (Gomez-Pomar & Blubaugh, 2018). Implementation of the ten steps is associated with a positive,

dose-response relationship with breastfeeding initiation, exclusivity, and duration and is considered to be part of evidence-based, family-centered care (Parry et al., 2018).

These Ten Steps are implemented by the 4-D Process. The first phase is the Discovery Phase when staff learns what BFHI practices include, and the facility registers with Baby-Friendly USA. The second phase is the Development phase when the facility plans how to implement and sustain the Ten Steps, forms a committee, and develops policies and staff training. The Dissemination Phase is when the staff receives orientation. This establishes the breastfeeding education that will be given to pregnant women and new mothers. Breastfeeding data will also start to be collected at this time. In the final phase, the Designation Phase, the facility submits a "Request to Move Letter" to Baby-Friendly USA and includes data demonstrating the facility meets specific guidelines (Cardaci, 2017).

The women's hospital I interned at has implemented The Ten Steps to Successful Breastfeeding to become designated as a Baby-Friendly hospital. Through this review, Baby-Friendly practices are analyzed to recognize how beneficial they have been for both the mother and baby, which then allows determining of how it will impact patients I interact with.

Methods

This review was executed with the scoping review method in order to provide an overall evaluation of how effective the Baby-Friendly Hospital Initiative has been in The United States. The research question to be addressed was "What are the benefits and effectiveness of implementing the Baby-Friendly Hospital Initiative in The United States?" After doing this initial search, it came to light that there are minority groups that have not received the benefits of Baby-Friendly Hospital Initiative in The United States; therefore, another review was done to

determine why these minority groups are not having the same positive results of the Baby-Friendly Hospital Initiative.

Articles were selected based on relevance to the topic from the databases CINAHL Complete and MEDLINE. The articles were filtered by selecting specific criteria to be included. While searching these databases, the key terms used for the review were: Baby-Friendly, hospital, benefits or advantages. Limiters included were: published date between 2017 and 2022, academic journals, and geographic location of The United States. Having these specific terms and limiters allowed for a narrowed number of articles that proved to be more relevant to the research question.

Eligibility for this literature review was determined by the use of the Baby-Friendly Hospital Initiative in pregnant and/or postpartum women. Excluded articles did not involve or relate to Baby-Friendly practices, did not have results that matched the research question, had inconclusive results, covered Baby-Friendly practices in the NICU, focused on a geographical region that could not relate to The United States, or included too specific of a population. Studies and reviews that included information from outside of The United States but could be applied to The United States were included. After assessing which articles were appropriate to include or exclude, 23 articles were included in this review.

The search of these two databases led to the retrieval of 39 articles, 20 from CINAHL Complete and 19 from MEDLINE. Duplicate articles from the two databases were removed, leaving a total of 34 articles. After reviewing these articles, six were excluded for not focusing on the research question, three were removed for not focusing on Baby-Friendly practices, one was excluded for inconclusive results, two were removed for Baby-Friendly practices in the

NICU, two were removed for geographical regions that could not be related to The United States, two were removed for being too specific of a population.

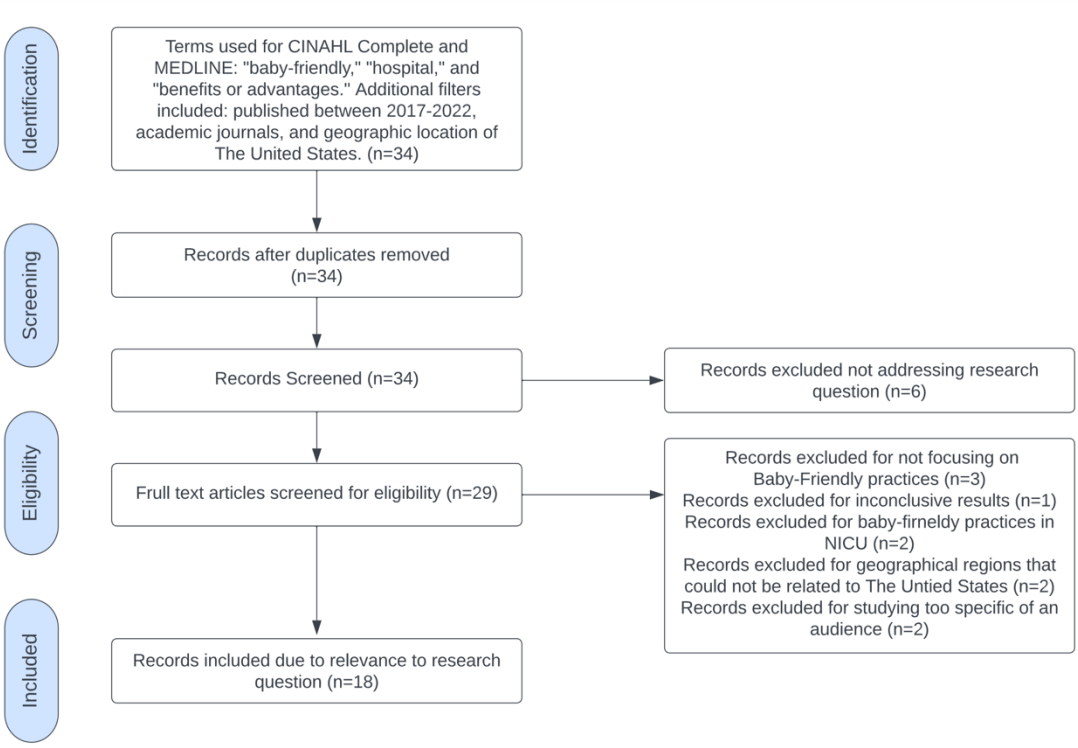

Figure 1: PRISMA Flow Diagram

Results

All journal articles that were included in this review had the same study subjects of mothers and their over 35 week old healthy babies. This excluded premature newborns and newborns that were taken to intensive care. All of these studies used Baby-Friendly practices as described by WHO. Although not every study occurred in The United States, they were able to be applied due to enough similarities in application of Baby-Friendly practices.

Skin-to-Skin

Skin-to-skin contact benefits mothers by shortening the third stage of labor, leading to more complete placental separation, and decreasing delivery blood loss. In the long term, skin-

to-skin contact improves the mother's breastfeeding self-efficacy, which leads to optimal sucking and this initiated bond has been proven in some studies to increase the likeliness of mothers changing their plans from formula to exclusive breastfeeding (Cadwell et al., 2018; Ward et al., 2017). Skin-to-skin can also decrease maternal stress (Gomez-Pomar & Blubaugh, 2018). Benefits to infants by providing skin-to-skin contact include stabilization of their temperature, facilitating initial breastfeeding, decreasing stress, decreasing crying, improving cardiopulmonary dynamics, and resulting in more optimal blood glucose (Steinhorn, 2020; Cadwell et al., 2018). Rooming-in allows mothers and infants to remain together 24 hours a day, which has improved the initiation of and length of breastfeeding. The infants cry less, get soothed quicker, and take more breast milk (Gomez-Pomar & Blubaugh, 2018).

Not practicing skin-to-skin increases the chance of the newborn not being fed within the first hour of delivery. When latching does not occur in this first hour, it hinders the production of milk and lengthens the time for lactogenesis II to occur, which is the process that provides a copious amount of milk production. When latching does occur within the first hour, the onset of lactogenesis II is decreased and the production of milk is increased by 130% by three weeks postpartum. Sometimes the newborn is unable to latch within the first hour for many reasons, but an example would be exposure to pain medications or epidural anesthesia, which reduces their sucking reflexes. When this happens, a solution is to hand express rather than pump because in the first 48 hours expression has been shown to have an increased colostrum volume removed rather than pumping (O'Sullivan et al., 2015). Other consequences of not initiating breastfeeding within the first hour was found in a review of high and low income countries that infants who initiated breastfeeding between 2 and 23 hours after birth had a 33% increased risk of neonatal mortality versus newborns that fed within the first hour (Cadwell et al., 2018).

Exclusive Breastfeeding

In The Ten Steps for Successful Breastfeeding, step six recommends that infants have no food or drink other than breast milk unless medically indicated (Gomez-Pomar & Blubaugh, 2018). Exclusive breastfeeding for the infants' first six months of life reduces diseases and illnesses common in infancy (otitis media, respiratory infection, gastroenteritis, urinary tract infection, conjunctivitis, and thrush), SIDS, and later risk of obesity, cancers, and other chronic diseases for infants (Parry et al., 2018; Gyamfi et al., 2021; Cardaci, 2017). For breastfeeding mothers, there are health benefits that happen in the postpartum period such as decreasing depression, anxiety, and stress symptoms, and breastfeeding increases maternal self-efficacy. Health benefits of breastfeeding for 12 months or more decrease the mothers' risk for breast and ovarian cancers, diabetes, hypertension, cardiovascular disease, and returning to pre-pregnancy body shape (Gyamfi et al., 2021).

There has been an increase in hospitals that have been avoiding formula; for example, 7.4% of hospitals in 2009 did not accept free infant formula whereas 28.7% in 2015 no longer accept free infant formula (Nelson & Grossniklaus, 2019). This is because formula has been found to have some disadvantages in the newborn microbiome. The gut microbiome of a formula-fed infant demonstrates adult patterns with increased proinflammatory bacterial taxa, increased gut permeability, and lower concentrations of fecal short-chain fatty acids compared with exclusive breastfeeding. This exposure to proinflammatory bacteria and antigens during the neonatal period may profoundly influence oral tolerance and have long-term consequences on immune health (O'Sullivan et al., 2015). While there are some disadvantages to formula-feeding newborns, 24% of pediatricians find that formula-fed infants will be just as healthy as breastfed infants in the long run (Feldman-Winter et al., 2018).

Baby-Friendly practices increase breastfeeding initiation but do not always ensure increased exclusive breastfeeding duration. Many studies showed an increase in breastfeeding initiation; however, no study showed results that imply that the Healthy People 2030 initiative goal of 42.4% of infants in the US being breastfed exclusively through six months will occur based on current Baby-Friendly practices (Gyamfi et al., 2021). The PRAMS data did not find baby-friendly designated hospitals to be associated with increased exclusivity at more than four weeks (Nobari et al., 2017).

Support while Breastfeeding

Many women lack support in their postpartum period; however, this support has been proven to be needed to have a successful breastfeeding experience. A great source of support is the woman's family; involving her family in prenatal education can improve breastfeeding initiation, duration, and exclusivity (Wouk et al., 2016). Another source of support is healthcare workers and specifically, International Board Certified Lactation Consultants (IBCLC). Yourkavitch and Hall Smith (2022) demonstrated a 5% increase in the rate of exclusive breastfeeding at six months and a 4% increase in the rate of breastfeeding at 12 months with each additional IBCLC per 1000 population, suggesting that each IBCLC provides a significant impact of support to the women of their community. Lactation consultants involvement should continue after discharge from the hospital as breastfeeding concerns expressed such as "feeding difficulty" peaked on day 7 and concerns regarding "milk quantity" peaked on day 14 (O'Sullivan et al., 2015). In a study with 27 first-time mothers, lactation consultants made weekly phone calls for three months postpartum, and then, monthly calls during four to six months postpartum or until the infant was weaned. At six months postpartum, 73% of women were still breastfeeding exclusively, compared with the hospital's baseline breastfeeding rate of

38% (Cardaci, 2017). Peers have also been proven to be a significant support system to breastfeeding mothers. In Michigan's Special Supplemental Nutrition Program for Women, Infants, and Children, 990 women received services. Women who participated in peer-counseling breastfeeding support programs in addition to receiving prenatal services were significantly more likely to initiate breastfeeding and to continue it for six months than were those in a control group who received prenatal counseling (Cardaci, 2017).

Reasons for Not Breastfeeding

Many women have misconceptions revolving breastfeeding that makes formula feeding more appealing to them. For example, many mothers believe that breastfed infants become overly dependent on their mothers, so formula usage is seen as quick and supportive of women's social lives (Gyamfi et al., 2021). Another issue in maintaining breastfeeding is the perception of insufficient milk supply (Gomez-Pomar & Blubaugh, 2018).

Effectiveness of Baby-Friendly Practices

Overall, many researchers have proven an increase in breastfeeding due to the implementation of the Baby-Friendly Hospital Initiative. For example, in Los Angeles County, infants fed only human milk at Baby-Friendly Hospitals increased 77% from 2008 to 2014. By 2014, 84% of these infants breastfed at one month, 66% at three months, and 48% at six months. Exclusive breastfeeding had lower rates but still improved with approximately 30% exclusively breastfed for one month, 20% at three months, and 8% at six months (Nobari et al., 2017). This increase in breastfeeding encourages maintenance of Baby-Friendly practices. In a study of pregnant incarcerated women, a program was initiated that provided each woman with a doula to help guide them through their pregnancy and delivery with Baby-Friendly practices. In the beginning, 45.5% of women reported that they intended to breastfeed in the hospital; upon giving

birth, 64.1% of the women initiated breastfeeding. In this study, the women felt breastfeeding increased the bond they felt with their newborns during the hospital stay (Shlafer et al., 2018). This study proves that women who encounter Baby-Friendly practices are more likely to at least attempt breastfeeding once in the hospital setting. This is encouraging to increasing breastfeeding rates with Baby-Friendly because it has been found that the mother's intention to breastfeed was the strongest predictor of breastfeeding duration (Nobari et al., 2017).

A significant aspect of the Baby-Friendly Hospital Initiative is education. It has been proven that prenatal education that includes both informational materials and interpersonal support increases breastfeeding initiation, duration, and exclusivity. More specifically, education with breastfeeding workshops, additional tools such as dolls, videos, and group discussions increased self-efficacy; this verbal education has been proven important but less common (Wouk et al., 2016; Nelson & Grossniklaus, 2019). With technology advancing, it has also been proven effective to post education for patients and hospital staff to learn from (Nelson & Grossniklaus, 2019). There have been various programs to educate mothers during pregnancy and postpartum. For example, Ready Set BABY has a 28-page color patient booklet, an educator flipchart with suggested text, and a digital file to show portions of the flipchart on a screen for use in group settings. This particular education program has culturally diverse images and the ability at a sixth-grade level, which makes education much more inclusive. Ready, Set, BABY was proven to be effective education due to women's Infant Feeding Intentions (IFI) scores increasing from 14.0 to 15.5 (out of 16) after training, which was significant (Parry et al., 2018). Not only is prenatal education important, but throughout the hospital stay, education on breastfeeding has been needed because breastfeeding is a learned behavior (Eckenrode, 2018). In a study in a large multicenter medical institution in Chicago, rates of exclusive breastfeeding throughout the

hospital stay rose from 38.6% to 53.5% over a four-month period after nurses completed a 20-hour education program (Cardaci, 2017).

Healthcare Team Education

Breastfeeding education is also for health staff. During Baby-Friendly training nurses are taught different breastfeeding techniques (breastfeeding positions, cup-feeding, syringe-feeding, finger feeding, etc.) and strategies to correct breastfeeding techniques and assist with any problems that mothers have. While there is some resistance to this level of involvement in breastfeeding, it has been shown that one on one assistance can increase a woman's likeliness (up to seven times) of breastfeeding their infant (Eckenrode, 2018; Shlafer et al., 2018). Baby-Friendly Initiative requires all staff to be educated on their policies, but a profession that still needs education on Baby-Friendly practices are pediatricians. In 2014, 75% of pediatricians reported that they advise exclusive breastfeeding during the first month, up from 66% in 1995 (Feldman-Winter et al., 2018).

Economic Influence

The benefits of baby-friendly practices and policies not only improve infants' and mothers' health but can also contribute positively to the economy. By not implementing Baby-Friendly practices, there is a public health burden of a global gross expenditure of $341.3 billion. These expenditures come from multiple different factors such as formula, costs of infantile diseases and health visits, and lost wages (Gyamfi et al., 2021). If 90% of mothers in the U.S. exclusively breastfed their infants for at least six months after birth, it would prevent more than 900 deaths per year and save The United States approximately $13 billion in annual health care expenditures (Cardaci, 2017). On the other hand, there is research that demonstrates Baby-Friendly designated hospitals are more expensive. For example, in the US the cost per birth

ranged from 7.27 (which were obstetric level two, large hospitals with minimal training) to 125.39 (which were obstetric level one, small hospitals with comprehensive training). There are ways to make Baby-Friendly implementation more affordable; for example, WHO/UNICEF have free teaching materials that have been shown to be effective in improving staff knowledge of Baby-Friendly practices. Also, these smaller institutions could combine together for their training in order to be more cost-effective (Arslanian et al., 2022).

Baby-Friendly and Minorities

While Baby-Friendly implementation has benefitted many, it is not accessible enough to benefit everyone. BFHI-designated facilities are disproportionately less accessible in neighborhoods of color (Mieso et al., 2021). CDC's 2011 Maternity Practices in Infant Nutrition and Care Survey revealed that facilities in communities with >12% Black residents were significantly less likely to implement even half of the supportive breastfeeding recommendations (Mieso et al., 2021).

There are many reasons as to why the Black population has lower breastfeeding rates. For example, there are negative attitudes toward breastfeeding and sexuality, a lack of role models, and disproportionate exposure to formula feeding versus breastfeeding (Hemingway et al., 2021). While it is common for lower socioeconomic status (SES) women to have lower breastfeeding rates, it has been proven that black women in high socioeconomic status or with advanced degrees have worse obstetric and neonatal outcomes than do non-Black women of low SES or those without high school diploma (Hemingway et al., 2021). This proves that there is a standing racial gap when it comes to obstetric and neonatal care even in a study at a Baby-Friendly Hospital when 84.6% of non-Black breastfeeding-initiating mothers sustained breastfeeding, while only 69.5% of Black breastfeeding-initiating mothers sustained breastfeeding (Hemingway

et al., 2021). This emphasizes that Baby-Friendly Hospital Initiative improves breastfeeding success in the Black population but still does not provide equal results to all.

Limitations to Baby-Friendly

There are many limitations in providing Baby-Friendly care including potential harm to infants, benefits of discouraged interventions, and staff resistance. Baby-Friendly highly emphasizes the importance of rooming-in; however, there has been evidence that rooming-in has potential risks. For example, rooming in has led to an increase in accidental suffocation of newborns and unexpected postnatal collapse (Steinhorn, 2020; Gomez-Pomar & Blubaugh, 2018).

Step nine of The Ten Steps to Successful Breastfeeding discourages the use of pacifiers and artificial nipples. This is a challenge to enforce because there are potential medical benefits such as providing comfort, contributing towards neurobehavioral organization, and reducing the risk of SIDS (Gomez-Pomar & Blubaugh, 2018).

Another obstacle to the successful implementation of Baby-Friendly in many hospitals is the hospital staff themselves. There have been five main themes with nurse obstacles to implementing Baby-Friendly: resistance, culture, investment in the journey, teamwork, and source of pride (Eckenrode, 2018). Resistance was found to be common in many nurses due to their opposition to change and lack of confidence in their breastfeeding knowledge. Culture includes the nurses' history of having babies spend more time in the nursery. Adaptation to practice changes of having newborns room-in would take nurses approximately two years. In order to make these changes, the staffing education needed to be appealing with engaged stakeholder involvement. Effective leadership was also found to be essential in implementing changes (Eckenrode, 2018).

Discussion

The Baby-Friendly Hospital Initiative has proven itself to improve many beneficial aspects of the labor and delivery and postpartum experience. Skin-to-skin care provides many benefits to both the mothers and babies, most notably the increased success of breastfeeding. Therefore, it is important to try to use different strategies, such as expression, to give newborns breastmilk within the first hour of delivery and promote lactogenesis. Breastfeeding provides many benefits for newborns by decreasing common newborn illnesses and complications and decreasing later health risks (ex: obesity). Avoiding formula will help the newborn prevent any harm to their gut microbiome. Mothers also have medical benefits to breastfeeding such as decrease mental illness and stress and increased maternal self-efficacy. Baby-Friendly practices increase breastfeeding initiation but do not always ensure increased exclusive breastfeeding duration. Therefore, there is still more intervention and education that needs to occur with breastfeeding mothers in addition to current Baby-Friendly practices to have true success in the long duration of exclusive breastfeeding.

Many women hold beliefs about breastfeeding that hold them back from being successful (they won't be able to provide enough milk, it is inefficient and/or isolating, etc.). While many women hold these views, it is imperative for nurses and other healthcare professionals to educate these women on how to be cost-effective, efficient, and socially active while breastfeeding. One of the main healthcare professionals that can do this are International Board Certified Lactation Consultants (IBCLCs). By providing follow-up phone calls throughout the postpartum and breastfeeding period, lactation consultants are able to address and assist with concerns and stressors that typically result in mothers giving up on breastfeeding before six months. Having this additional follow-up has shown a significant increase in exclusive breastfeeding success.

An issue that needs to be addressed more in the future to improve success rates with the Baby-Friendly Hospital Initiative and Healthy People 2030 goals is educating pediatricians in order to increase their amount of support toward exclusive breastfeeding. Not enough pediatricians educate mothers on long-term exclusive breastfeeding. Commonly, young pediatricians do not stress this education due to their decreased confidence in managing breastfeeding problems and adequately addressing parents' questions about breastfeeding (Feldman-Winter et al., 2018). Having pediatrician support would result in increased continued breastfeeding because pediatricians are commonly seen more often than women's OBGYN doctors after birth.

Another issue that needs to be addressed to continue the success of the Baby-Friendly Hospital Initiative is implementing ways to make Baby-Friendly practices more affordable. There are many resources that have free teaching materials, such as WHO/UNICEF, which have been shown to be effective in improving staff knowledge of Baby-Friendly practices since staff education can be a financial burden on hospitals trying to become Baby-Friendly designated. Also, smaller institutions could combine their training in order to be more cost-effective (Arslanian et al., 2022).

While Baby-Friendly implementation has benefitted many, it is not accessible enough to benefit everyone. The Black population is a minority group with a lower percentage of breastfeeding and especially exclusive breastfeeding compared to the White population; therefore, this is a population that should not be overlooked in the Baby-Friendly Hospital Initiative. To reach the United States' Healthy Initiative breastfeeding goal for 2030, minorities also need assistance in improving their breastfeeding rates.

Rooming-in is a Baby-Friendly practice that still has lots of hesitation due to potential risks the newborn would encounter. To minimize these potential negative outcomes, it is important to assess the individual newborn's risks. For example, if an infant received extensive resuscitation, low APGAR scores, delivered at late preterm or early term, had a difficult delivery, or received codeine or other medications that may affect neonate and sedated mothers or sleeping mothers and newborns it would be important to have extra monitoring for these dyads during the rooming-in process (Gomez-Pomar & Blubaugh, 2018). It takes clinical judgement on part of the healthcare staff to determine if rooming-in is beneficial or not on a case-to-case basis.

Step nine of The Ten Steps to Successful Breastfeeding discourages pacifiers and artificial nipples, which causes some controversy in the neonatal community on the pros and cons of pacifier use. Baby-Friendly USA has said that pacifiers can be used once breastfeeding is established; however, this is difficult to implement due to no definition of what established breastfeeding entails (Gomez-Pomar & Blubaugh, 2018).

Resistance from staff is a common obstacle that is important for institutions to overcome when implementing Baby-Friendly policies. Being prepared to acknowledge the resistance, change of culture, and provide passionate and motivated stakeholders in the journey that is supported by many others is essential to the process.

Limitations of this paper include possibly not including all up to date Baby-Friendly Hospital Initiative peer reviewed journal articles. Also, hospitals that conducted some of these studies may not have perfectly followed Baby-Friendly Hospital Initiative steps or been in the process of being designated as Baby-Friendly.

Conclusion

My internship at a USA Baby-Friendly designated hospital allowed for me to see many of the benefits and challenges of the Baby-Friendly Hospital Initiative previously reviewed. I participated in many trainings over Baby-Friendly practices and other education opportunities with my colleagues during our monthly staff meetings.

A Baby-Friendly practice that I saw very often was skin-to-skin contact immediately after delivery along with latching and breastfeeding within the first hour of delivery. This was something that occurred in majority of deliveries of a healthy newborn and mother. Whenever there was a complication with the newborn and/or mother, once the complication was solved, the skin-to-skin contact would begin. An important note on this is that I only witnessed vaginal deliveries; therefore, I cannot speak to the skin-to-skin and latching practices after cesarean deliveries. Many mothers were able to successfully latch within the first hour and if they couldn't many nurses would assist in teaching the mothers how to hand express their milk in order to help the newborn latch and get their first colostrum.

During my internship, every mother was asked about her intention to either breastfeed or formula-feed their newborn when admitted for labor. Breastfeeding was highly encouraged; however, when medically indicated or requested, formula-feeding was an option. Majority of the mothers would initiate breastfeeding and breastfeed exclusively throughout their hospital stay due to the support of their nurses and lactation consultants. When breastfeeding became a challenge for the mothers, I got to participate in teaching them different methods of expressing their milk and pumping. They then were able to provide their breastmilk to their infant with syringe feeding, finger feeding, and paced bottle feeding. Having these other solutions to the traditional latching method allowed for many mothers to continue their breastfeeding success.

My internship experience allowed for me to be a part of the in-patient hospital portion of Baby-Friendly practices. There are many more steps of Baby-Friendly prior to in-patient care that I did not witness. Throughout this experience, I was able to see some trends that I believe need more attention in order to improve the implementation of Baby-Friendly policies. For example, as stated in this review, minorities are known for having a lower percentage of breastfeeding for various reasons. In Northwest Arkansas, there is a large population of Marshallese. Through my personal experience, I have noticed many of them choosing to formula-feed their infant. Through a re-evaluation on how this population is educated on breastfeeding, hopefully misconceptions and other challenges in breastfeeding initiation can be clarified and solved in order to increase their breastfeeding rates.

The women's hospital I interned at demonstrated Baby-Friendly protocols, which allowed me to observe the benefits and challenges of this approach. This internship broadened my understanding of The Baby-Friendly Hospital Initiative that I can now use in my future career as a Registered Nurse.

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