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How Does the United States Rank According to the World Breastfeeding Trends Initiative?

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ABSTRACT

The World Breastfeeding Trends Initiative is an assessment process designed to facilitate an ongoing national appraisal of progress toward the goals of the United Nations Children's Fund (UNICEF)/World Health Organization (WHO) Global Strategy for Infant and Young Child Feeding. More than 80 countries have completed this national assessment, including the United States of America. This article describes the process undertaken by the US World Breastfeeding Trends Initiative team, the findings of the expert panel related to infant and young child feeding policies, programs, and practices and the ranking of the United States compared with the 83 other participating nations. Identified strengths of the United States include data collection and monitoring, especially by the Centers for Disease Control and Prevention, the US Baby-Friendly Hospital Initiative, and the United States Breastfeeding Committee. The absence of a national infant feeding policy, insufficient maternity protection, and lack of preparation for infant and young children feeding in emergencies are key targets identified by the assessment requiring concerted national effort.

Key Words: breastfeeding, global strategy for Infant and young child feeding, WBT*i*

Optimal infant and young child feeding is an essential strategy toward the goal of reducing morbidity and mortality for infants and children younger than 5 years.[1] However, rates of breastfeeding vary widely from country to country. According to the *Global Breastfeeding Report Card,* published by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), data from 194 countries indicate that only 40% of infants meet the criteria of exclusive breastfeeding in the first 6 months.[2] The worldwide rate of breastfeeding at 1 year is 74%.[2] The United States' rate of exclusive breastfeeding for the first 6 months after birth, according to the Centers for Disease Control and Prevention (CDC), is 24.9%[3] and 33.7% breastfeeding at 1 year.[3]

More than a decade ago, UNICEF and WHO used a collaborative process to identify and disseminate interventions that had been shown to support women in their choice to breast-feed. The resulting publication, the *Global Strategy for Infant and Young Child Feeding*[4] suggests actions and activities as well as identifying problems and solutions for national and community programs. The *Global Strategy* also suggested mechanisms for first identifying and then increasing the commitment of stakeholders, including governments and healthcare systems, to ensure that mothers and other caregivers would be offered informed choices

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about optimal feeding practices for infants and young children.

The World Breastfeeding Trends Initiative (WBT*i*) was developed by the International Baby Food Action Network Asia as a tool to assess the progress of the world toward the actions outlined in the *Global Strategy*.[4] The purpose of this article is to describe the process and findings of the US WBT*i* Expert Panel. The investigation included the scoring and ranking of the US policies, programs, and practices related to infant and young child feeding compared with 83 other participating nations.

BACKGROUND

Optimal infant and young child feeding is defined as exclusive breastfeeding for the first 6 months after birth and then at around 6 months, but before 8 months, culturally appropriate family foods are added to the diet.[4] International recommendations from the WHO and the UNICEF are that, optimally, breastfeeding should continue until 2 years and beyond.[4] In the United States, the recommendation is for 1 year and beyond.[5]

Worldwide, if optimal infant and young child feeding were to be achieved, an estimated 823 000 deaths a year of children younger than 5 years, along with 20 000 deaths a year of women just from the disease of breast cancer could be prevented.[1] In the United States, "for every 597 women who optimally breastfeed, one maternal or child death is prevented."[6] The significance of breastfeeding optimally varies with each disease and condition, but with the case of necrotizing enterocolitis (NEC) in the United States, for example, for every 20 women who optimally breastfeed, 1 case is averted; for every 141 women who optimally breastfeed, 1 death that could be attributed to NEC is averted. Research suggests that if a preterm infant is fed a diet consisting of more than 98% human milk, the risk of NEC is 1.3% compared with a risk of 11.1% if fed a diet of preterm formula. The infant who receives both human milk and preterm formula has a risk of NEC of 8.2%.[7]

Beneficial maternal health outcomes for the woman who breastfeeds have been documented even beyond the recognized reduction of risk for breast cancer and include a significantly decreased risk for type 2 diabetes mellitus[8] and other aspects of metabolic syndrome.[9]

Within the construct that interventions make a difference to breastfeeding outcomes, there is acknowledgment that interventions are probably country specific and not generalizable.[10] Each country is, therefore, invited to participate in the WBT*i* and use a prescribed process to catalogue and document policy interventions and practice outcomes. Each national assessment is to be completed by a multisectoral, multidisciplinary team, the data and citations must be accessible on the Internet, and the data and citations must be national in scope. The use of a guide book and training materials ensures consistency from one nation to another.[11] After completing the assessment, the country's team self-scores the results and submits the assessment to International Baby Food Action Network Asia, which then validates the score and results before accepting the assessment and uploading it to the international WBT*i* web site. Comparison reports on the initiative can also be found on the world breastfeedingtrends.org web site.[12] Each nation is committed to repeat the WBT*i* assessment every 3 to 5 years in order to facilitate comparison over time and between countries.

The process of developing a national WBT*i* assessment includes analysis, scoring, and documentation of the state of the country according to 15 indicators related to the *Global Strategy for Infant and Young Child Feeding*. Part I of the WBT*i* national assessment examines the country's policies and programs that support optimal infant and young child feeding. Findings discovered in application of this section of the assessment tool will help identify gaps and achievements in areas of community-based action. Part II of the WBT*i* assessment tool examines specific numerical data extracted from national surveys. Indicators and key questions are listed in Table 1. Each indicator has a possible score of 10 points that are distributed among subquestions. The complete standards and criteria can be found in the WBT*i* Guide Book.[12] The total possible score is 150, 100 points for part I and 50 points for part II.

The 84-country synthesis, *Has Your Nation Done Enough to Bridge the Gaps?*,[12] presents the worldwide results of the WBT*i*. It highlights, for example, that Turkey, Sri Lanka, Malaysia, Kuwait, Gambia, Cuba, China, Brunei Darussalam, Brazil, Bolivia, Bahrain, and Afghanistan all scored the highest score, 10/10, on Indicator 1: National Policy, Programs and Coordination. The Seychelles, Portugal, Palau, São Tomé and Príncipe, and Cape Verde all scored the lowest score, 0/10, on indicator 1. For indicator 2, The Baby-Friendly Hospital Initiative, only Turkey scored 10/10 and São Tomé and Príncipe, Libya, India, Ethiopia, Cameroon, and Bhutan scored the lowest, with 0/10.

METHODS: THE US WBT*i* JOURNEY

The Healthy Children Project, Inc, a US nonprofit, nongovernmental organization, initiated the US effort by completing the prescribed training and planning as set forth by the WBT*i*. Healthy Children Project also provided funding and leadership for the assessment and, in the spring of 2016, a call was put forth inviting experts from all sectors involved in maternal child health to

Table 1. **World breastfeeding trends initiative: Indicators and key questions**[a,b]

Indicator no.	Part I: Policy and program indicators	Key question
1	National Policy, Programs and Coordination	*Is there a national infant and young child feeding/breastfeeding policy that protects, promotes, and supports optimal infant and young child feeding and the policy is supported by a government program? Is there a mechanism to coordinate like national infant and young child feeding committee and a coordinator for the committee?*
2	The Baby-Friendly Hospital Initiative	*What percentage of hospitals and maternity facilities that provide maternity services have been designated "Baby Friendly" based on the global or national criteria? What is the quality of BFHI implementation?*
3	Implementation of the International Code of Marketing of Breast milk Substitutes	*Is the International Code of Marketing of Breast milk Substitutes and subsequent World Health Assembly resolution in effect and implemented? Has any new action been taken to give effect to the provisions of the Code?*
4	Maternity Protection (Leave, Workplace Support)	*Is there a legislation and are there other measures (policies, regulations, practices) that meet or go beyond the International Labor Organization (ILO) standards for protecting and supporting breastfeeding for mothers, including those working mothers in the informal sector?*
5	Health and Nutrition Care Systems	*Do care providers in these systems undergo skills training, and does their preservice education curriculum support optimal infant and young child feeding; do these services support mother and breastfeeding-friendly birth practices, do the policies of healthcare services support mothers and children, and whether health workers' responsibilities to the Code are in place?*
6	Mother Support and Community Outreach	*Are there mother support and community outreach systems in place to protect, promote, and support optimal infant and young child feeding?*
7	Information Support	*Are comprehensive Information, Education, and Communication strategies for improving infant and young child feeding (breastfeeding and complementary feeding) being implemented?*
8	Infant Feeding and HIV	*Are policies and programs in place to ensure that HIV-positive mothers are supported to carry out the national recommended infant feeding practice?*
9	Infant Feeding During Emergencies	*Are appropriate policies and programs in place to ensure that mothers, infants, and young children will be provided adequate protection and support for appropriate feeding during emergencies?*
10	Monitoring and Evaluation	*Are monitoring and evaluation systems in place that routinely collect, analyze, and use data to improve infant and young child feeding practices?*
	Part II: Practice indicators	
11	Initiation of Breastfeeding	*What is the proportion of children born in the last 24 months who were put to the breast within 1 hour of birth?*
12	Exclusive Breastfeeding at 6 months	*What is the percentage of babies 0 to <6 months of age exclusively breastfed in the last 24 hours?*
13	Median Duration of Breastfeeding	*Babies are breastfed for a median duration of how many months?*
14	Bottle Feeding	*What is the percentage of breast-fed babies 0-12 months of age, who are fed with any foods or drinks (even breast milk) from bottles?*
15	Complementary Feeding	*What is the percentage of babies receiving solid, semisolid, or soft foods by 6-8 months of age?*

Abbreviations: BFHI, baby friendly hospital initiative; HIV, human immunodeficiency virus.
[a]Titles of policy and practice indicators as well as key questions are adapted from the World Breastfeeding Trends Initiative Assessment Tool.
[b]Adapted from IBFAN Asia.[11]

participate as members of the expert panel. The 15 volunteers represented public health policy, academic lactation, health communication, public policy, dietetics, anthropology, research, medical education, nursing education, advanced practice nursing, Baby-Friendly Hospital consultants, human immunodeficiency virus (HIV) education, maternal-child health education, medicine, public health education, mother-to-mother support, military families, public health employees, nutrition, nutrition education, and counseling.[13] The panel met in person in the spring of 2016 for 5 days with the task of describing US infant and young child feeding policies and outcomes, documenting and linking to the source material for the publically accessible data illustrating the responses, and assigning a score for each subsection of the 15 indicators. Gaps and recommendations were generated for each indicator and included in the draft report.

The draft report was circulated for feedback among the members of the United States Breastfeeding Committee (USBC) and 300+ participants of the National Breastfeeding Coalition Conference in August 2016. The finalized report was submitted to the World Breastfeeding Trend Initiative in September 2016. All documentation was reviewed and verified by the international organization before being accepted. The US report was included in the 84 country synthesis, *Has Your Nation Done Enough to Bridge the Gaps?*[12]

RESULTS

The US status on the WBT*i* indicators, as noted in Table 2, yielded a total score of 68, placing the United States in the low-middle grouping of nations, given the possible total score of 150.

The highest scoring US indicators—10 and 15

The maximum score of 10 was awarded to the United States in 2 areas, monitoring and evaluation (indicator 10) and complementary feeding (indicator 15). It was noted by the panel that the WBT*i* complementary feeding indicator is based on the child having started solid food by 8 months. The panel noted that the problem in the United States is not that children are offered solid foods late (after 8 months) but that they are started too early. This possibility, however, is not accounted for in the indicator score.

The lowest scoring US indicators

The lowest 2 scores received by the United States were for indicators that examined infant feeding in emergencies (indicator 9) and the implementation of the International Code of Marketing of Breast milk Substitutes, often referred to informally as "the code" (indicator 3).[14] Summaries of the tenets of the code are presented in Table 3.

In 2005, weaknesses in the care of infants and young children in emergencies, especially with respect to

Table 2. **The title of each WBT*i* policy, program, and practice indicator, and the United States' score for each**[a]

Indicator no.	Policy and program indicators	Score/10
1	National Policy, Programs, and Coordination	4
2	The Baby-Friendly Hospital Initiative	5
3	Implementation of the International Code of Marketing of Breast milk Substitutes	0.5
4	Maternity Protection (Leave, Workplace Support)	2
5	Health and Nutrition Care Systems	6
6	Mother Support and Community Outreach	4
7	Information Support	3
8	Infant Feeding and HIV	2.5
9	Infant Feeding During Emergencies	0
10	Monitoring and Evaluation	10
15	Practice Indicators	
11	Initiation of Breastfeeding	9
12	Exclusive Breastfeeding at 6 mo	6
13	Median Duration of Breastfeeding	3
14	Bottle Feeding	3
15	Complementary Feeding	10
Total score		68/150

[a]Adapted from IBFAN Asia.[13]

Table 3. **Summarization of the tenets of the International Code of Marketing of Breast milk Substitutes—"The Code"[a]**

1. Only certain products are covered by "The Code." They are breast milk substitutes such as infant formula (including follow-on formula) and any other foods or beverages that are represented or marketed to be suitable, with or without modification, for use as a partial or total replacement for breast milk. Other products covered by "The Code" are bottles and bottle nipples (teats).
2. None of the products covered by "The Code" can be advertised or marketed to the public.
3. There cannot be distribution of free samples or supplies of any of the products covered by "The Code."
4. Healthcare facilities may not promote any of the products covered by "The Code."
5. Company representatives should not have contact with or advise mothers.
6. Healthcare workers may not be given personal sample of products that are covered by "The Code."
7. The labels of products covered by "The Code" should not have words or pictures that idealize the products and should explain the benefits of breastfeeding and the risks of not breastfeeding.
8. Only scientific and factual information about the products covered by "The Code" may be given to health workers. Financial assistance may interfere with healthcare providers' unequivocal support for breastfeeding.
9. Unsuitable products should not be promoted for babies.
10. Products covered by "The Code" should be high in quality and take climate and storage conditions into consideration.
11. The standard of exclusive breastfeeding for the first 6 months and continued breastfeeding for 2 years and beyond should be promoted and supported.
12. Begin appropriate complementary feeding around 6 months recognizing that any food or drink given before it is nutritionally required may interfere with breastfeeding.
13. Complementary foods may not be marketed in ways that could undermine exclusive and sustained breastfeeding.

[a]Adapted from World Health Organization.[14]

feeding, were exposed in the United States by hurricane Katrina. The expert panel was unable to find that the United States has developed a cogent response to this issue. Two national offices (the National Commission for Children in Disasters, a presidential commission, and the National Council for Children in Disasters) have been created but remain unfunded by Congress and consequently no action has been taken. Likewise, multiple surgeons general's reports, blueprints, and Calls to Action have put the International Code of Marketing of Breast milk Substitutes on the national agenda, and yet, apart from the formation of a group or "constellation" of the USBC, no action has been taken.

Eleven indicators received an intermediate score

All 4 of the points awarded to indicator 1 (National Policy, Programs, and Coordination) were due to the existence of the USBC as the national committee. No points could be awarded for a national policy or national action plan as these are nonexistent. The US Dietary Guidelines do not address people younger than 2 years, although the 2020 revisions are expected to include 0 to 24 months.[15] The Healthy People goals, the Surgeon General's Call to Action, and the National Prevention Strategy provide rationale and guidance for infant feeding programs at the national, state, regional, and local levels.[16–18] However, they did not qualify as "national policy" for the purposes of this assessment.

The Baby-Friendly indicator 2 has 2 sections each with a possible score of 5 points. The first 5 points are awarded solely on the percentage of infants born in designated hospitals. At the time of the US WBT*i* national assessment (Spring 2016), the percentage of infants born in Baby-Friendly hospitals was in the range of 0.1% to 20% and so the award was for 1 point.[19] By 2017, more than 20% of infants are born in Baby-Friendly hospitals in the United States and this would increase the award to 2 points. Almost half of the infants born annually would need to be born in Baby-Friendly hospitals to increase the points awarded to 3. The second 5 points of indicator 2 are based on the Baby-Friendly program itself. A half point was lost in 2 subindicators: counseling for HIV-positive mothers for not being fully integrated into the US Baby-Friendly program and the integration of the Baby-Friendly Initiative into the National Infant and Young Child Feeding Policy. This cannot happen as no such policy exists in the United States.

Indicators 4 (Maternity Protection) and 6 (Mother Support and Community Outreach) received scores of 2/10 and 4/10, respectively. Health and Nutrition Care Systems (indicator 5) received a score of 6/10 and Information Systems (indicator 7) received 3/10. Two and a half points were awarded for Infant Feeding and HIV (indicator 8). Each of these 5 indicators would receive higher scores if existing programs were expanded. For example, the Special Supplemental Nutrition Program for Women, Infants and Children Program provides many of the scored elements for indicators 5, 6, and 7, but the indicator requires a broader scope of service than to only the families enrolled in the Women, Infants and Children Program. Similarly, testing for HIV

and infant-feeding counseling is not universal. There is research indicating that longer and paid maternity leaves would improve breastfeeding outcomes.[20] Of the 41 nations that comprise the Organization for Economic Cooperation and Development, the United States is the only country that does not mandate paid leave. The smallest amount of paid leave by any other country is about 2 months.[21]

The 5 indicators 11 to 15 are those that specifically examine infant and young child feeding practices. As described previously, indicator 15 (Complementary Feeding) was awarded 10 points because 94.1% to 100% of US infants have started solid foods by 8 months. Indicator 14 asks about the percentage of infants fed by bottle at 0 to 12 months of age. The United States falls into the 3-point range, 29.1% to 100%. Median duration of breastfeeding in the United States is between 0.1 and 18 months, thus 3 points were awarded for indicator 13. The percentage of infants exclusively breastfed at 6 months ranges from 11.1% to 49%, earning 6 points for indicator 12. For indicator 11, 9 points were awarded as early initiation of breastfeeding in the United States ranges from 49.1% to 89%.

International ranking of the US scores

Currently, 84 nations, including the United States, have completed the World Breastfeeding Trends assessment. The results are available on the worldbreastfeedingtrends.org web site and reports may be accessed in their entirety. Individual country submissions can be compared with those of other nations with comparison graphs and charts generated by the web site's program. Of the 84 countries reported, Sri Lanka has the highest score worldwide and Libya has the lowest score overall.[12] A summary of the US ranking for each of the WBT*i* indicators can be found in Table 4.

The United States scored in the first quartile for only 2 indicators on the WBT*i* comparative ranking. First quartile scores include indicator 10, Monitoring and Evaluation (largely due to the CDC's efforts), and indicator 15, Complementary Feeding.

In the comparison of 84 nations, the United States scored in the second quartile for 2 of the indicators—indicator 2 addressing the Baby-Friendly Hospital Initiative and indicator 11 addressing the percentage of mothers who initiate breastfeeding soon after birth. These 2 indicators are related, in that early initiation of breastfeeding is one of the 10 steps to successful breastfeeding that are the framework for the Baby-Friendly Hospital Initiative.

Three of the indicator scores placed the United States in the third quartile: Indicator 1, National Policy, Programs, and Coordination, Indicator 5, Health and Nutrition Care Systems, and Indicator 9, Infant Feeding in Emergencies. The scores on these indicators illustrate a partial commitment to the structures that support optimal infant and young child feeding but not fully executing the programs and policies that could make a difference in outcomes. For more than half of the indicators, the scores placed the United States in the lowest quartile among the 84 participating nations.

Table 4. **WBT*i* policy, program, and practice indicator scores and the United States' ranking for each vis-à-vis 83 other 2016 reporting countries**[a]

Indicator no.	Policy and program indicators	United States ranking out of 84 countries	Quartile
1	National Policy, Programs and Coordination	61	3rd
2	The Baby-Friendly Hospital Initiative	39	2nd
3	Implementation of the International Code of Marketing of Breast milk Substitutes	83	4th
4	Maternity Protection (Leave, Workplace Support)	80	4th
5	Health and Nutrition Care Systems	55	3rd
6	Mother Support and Community Outreach	73	4th
7	Information Support	76	4th
8	Infant Feeding and HIV	77	4th
9	Infant Feeding During Emergencies	62	3rd
10	Monitoring and Evaluation	1	1st
15	Practice Indicators		
11	Initiation of Breastfeeding	26	2nd
12	Exclusive Breastfeeding at 6 mo	64	4th
13	Median Duration of Breastfeeding	73	4th
14	Bottle Feeding	70	4th
15	Complementary Feeding	6	1st

[a]Adapted from IBFAN Asia.[12]

DISCUSSION

The US WBT*i* Expert Panel found both strengths and weaknesses in the US breastfeeding policies and programs. A commitment to effective, existing strategies could increase breastfeeding initiation, duration, and exclusivity.

Overall, strengths of the United States included the collection and monitoring of data, especially by the CDC, the structure and work of the USBC, and the progress of the Baby-Friendly Hospital Initiative. The United States has been identified by the WBT*i* with the number 1 ranking in the world for its indicator 10, Monitoring and Evaluation. A robust monitoring and evaluation system, led by the CDC and other federal partners, routinely collects, analyses, and uses collected data to encourage the improvement of infant and young childfeeding practices. However, without a national policy supporting infant and young child feeding, the continued funding for these federal partners cannot be ensured.

Linking professional and mother-to-mother support organizations, state and local breastfeeding coalitions, and federal and state governmental bodies, the USBC serves as the backbone of a constellation system wherein member organizations are stewards of various initiatives. A strategy to undertake full implementation of the International Code of Marketing of Breast-milk Substitutes is being considered by a constellation of the USBC.[22]

The nonprofit organization Baby-Friendly USA, Inc, is responsible for the designation process of the US Baby-Friendly Initiative. The expert panel found that although much of the global criteria set forth by WHO/UNICEF have been incorporated into the program, breastfeeding is contraindicated in the United States if the mother is positive for the HIV. Therefore, counseling related to HIV and breastfeeding is not mandated.[23] In addition, the global Baby-Friendly Hospital Initiative criteria established a minimum percentage of 75% of mothers' exclusive breastfeeding during the hospital stay, but this is not required for designation in the United States.[24] Baby-Friendly designated hospitals are expected to have implemented the International Code of Marketing of Breast milk Substitutes and Subsequent Resolutions (The Code) as apply to hospital settings. However, no other national action has been undertaken to implement the International Code of Marketing of Breast milk Substitutes.

The lack of a national policy on infant and young child feeding, including policies for the care of infants and young children in emergency situations, was identified as weaknesses. The expert panel found that no national infant and young child feeding policy has been officially adopted or approved by the US government. The US Dietary Guidelines do not address infants and young children, although it is expected that the 2020 revision will include the 0 to 2 years age group.

The United States has not enacted a federal paid maternity or family leave law, unlike virtually every other nation.[25] Only Lesotho, Swaziland, Papua New Guinea, and the United States do not mandate paid leave for mothers of newborns. Recently, Congress has shown some interest in putting forward legislation related to family leave and maternity protection. Currently enacted legislation cited by the United States Expert Panel includes the Family and Medical Leave Act, which provides for unpaid leave for up to 12 work weeks (applicable only to certain employees), the Pregnancy Discrimination Act, which makes discrimination illegal for "pregnancy or related conditions," and the Affordable Care Act, which allows hourly workers unpaid breastfeeding-related breaks at work for 1 year after the birth.[26–28]

The training status of healthcare staff related to infant and young child feeding can only be ensured at hospitals that have been designated as Baby-Friendly or are well on their Baby-Friendly journey. The Baby-Friendly USA web site reports that at least 450 hospitals have been designated. Only Baby-Friendly–designated hospitals, the Women, Infants and Children program, and other programs such as Head Start and Early Head Start reach discrete populations with commercial free materials and individual counseling.

The expert panel found that in spite of the clear need highlighted by hurricanes Katrina and Sandy, a comprehensive emergency plan addressing the needs of infants and young children has not been promulgated or implemented. At the time of submission of this article, Hurricanes Harvey, Irma, and Maria (and the devastation that has accompanied these storms) have had significant impact in many US states and territories. The expert panel was able to find policies for the care of exotic pets in emergencies but not for the feeding and care of infants and young children.

The United States Preventive Services Task Force (USPSTF) comprises experts in the fields of prevention and evidence-based medicine who make evidence-based recommendations about clinical preventive services, including breastfeeding. The Agency for Healthcare Research and Quality in the department of Health and Human Resources convenes and provides support to the task evidence-based strategies that work to promote optimal breastfeeding have been identified by the USPSTF[10] and include direct interventions for breastfeeding promotion and support including practical help. Evidenced-based system–level interventions described by the USPSTF include policies

and programs as well as hospital staff training. The Baby-Friendly Hospital Initiative was cited as the most widely implemented system-level intervention to support breastfeeding.[23] In addition, community-based strategies such as social marketing and workplace initiatives are suggested as additional means to improve breastfeeding outcomes in the United States. The analysis that formed the basis of the USPSTF conclusion confirmed the value of breastfeeding support interventions and their association with an increase in breastfeeding intensity—both duration and exclusive breastfeeding.[10] The initiatives outlined by the USPSTF are congruent with the WBT*i* findings and commitment to and implementation of the USPSTF findings would improve the Indicator Scores of the United States on the WBT*i* for 2019.

The Healthy Children Project plans to organize the repeat of the WBT*i* national assessment in 2019 in order to identify trends and progress. Meanwhile, a targeted assessment was conducted in the spring of 2017 of all 50 states, plus the District of Columbia and all US territories. Currently in draft form, the results are being circulated through the USBC and state and local coalitions for corrections and comment.

CONCLUSION

Suboptimal breastfeeding is expensive, costing the United States, conservatively, an estimated $3.0 billion annually in total medical costs and $13 billion in nonmedical costs.[29] The US participation in this methodical, guided approach of the WBT*i* allowed for a comprehensive assessment of infant and young child feeding policies, programs, and practices with the goal of identifying the strengths and weaknesses in the policies, programs, and practices related to optimal infant feeding. The WBT*i* national assessments are intended to afford a blueprint for country and global action in order to improve infant and young child feeding policies, programs, and practices. Realizing that the aim of the Global Strategies for Infant and Young Child Feeding was to prompt stakeholders to uncover problems, the assessment process of the WBT*i* has facilitated this endeavor in the United States. The next step is for the USBC and other organizations to utilize the findings of the expert panel to move optimal infant feeding forward in the United States.

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