



World Breastfeeding Trends Initiative (WBTi)

# Assessment Report United States of America 2019





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# USA Report 2019



Academy of  
Nutrition  
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# The World Breastfeeding Trends Initiative (WBTi)

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## United States of America 2019

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## Background

The *Global Strategy for Infant and Young Child Feeding* was developed jointly by WHO and UNICEF and published in its final form in 2003 after being adopted by the World Health Assembly (WHA) and the UNICEF Executive Board. The aim was to “improve - through optimal feeding - the nutritional status, growth and development, health, and thus the very survival of infants and young children.”

*The Global Strategy's specific objectives are:*

- *to raise awareness of the main problems affecting infant and young child feeding, identify approaches to their solution, and provide a framework of essential interventions;*
- *to increase the commitment of governments, international organizations and other concerned parties for optimal feeding practices for infants and young children;*
- *to create an environment that will enable mothers, families and other caregivers in all circumstances to make - and implement - informed choices about optimal feeding practices for infants and young children.*

The *Global Strategy* was designed as a guide for action by identifying proven impact interventions especially those that support mothers and families. The strategy also sets forth the role of governments, civil society and other concerned parties.

The World Breastfeeding Trends Initiative (WBTi) was developed by IBFAN Asia in order to provide a platform for the assessment of achievement and progress toward the goals of the *Global Strategy*. The WBTi process builds on the GLOPAR (Global Participatory Action) initiative of the 90's in that it encourages careful self-assessment of the strengths and weaknesses of policies and programs toward the goal of “strengthening and stimulating breastfeeding action worldwide.” Currently 107 countries have completed their assessment. This draft represents the United States' progress toward submission.

The WBTi process has three phases:

1. A National Assessment of the implementation of the *Global Strategy*. In this phase, multiple partners analyze and document the situation in their country and identify gaps according to 15 indicators.
2. The scoring, rating, grading and ranking of each country or region according to the findings of the national assessment.
3. The repetition of the assessment after 3-5 years to analyze trends.

## Assessment Process

The National Assessment in the United States has been conducted according to the activities set forth by the WBTi Guide Book. Karin Cadwell PhD, Kajsa Brimdyr PhD, Anna Blair, PhD, and Cindy Turner-Maffei MA (from the Healthy Children Project) served as Assessment Coordinators. Holly Hansen is the Assessment Editor. Funding was provided by the Healthy Children Project. After an orientation meeting and training, a work plan was developed. The Expert Panel with representatives from key sectors was assembled and met for 5 days to collect information and draft a preliminary report. The Expert Panel members represented public health policy, academic lactation, health

communication, public policy, dietetics, anthropology, research, medical education, nursing education, advanced practice nursing, HIV education, maternal-child health education, medicine, public health education, mother-to-mother support, military families, public health employees, nutrition, nutrition education, counseling.

The report went through 4 rounds of editing resulting in the June 2019 draft.

# World Breastfeeding Trends Initiative (WBTi)

## Background

The World Breastfeeding Trends Initiative (WBTi) is an innovative initiative, developed by IBFAN Asia, to assess the status and benchmark the progress of the implementation of the Global Strategy for Infant and Young Child Feeding at national level. The tool is based on two global initiatives, the first is WABA's (GLOPAR) and the second the WHO's "Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". The WBTi is designed to assist countries in assessing the strengths and weaknesses of their policies and programmes to protect, promote and support optimal infant and young child feeding practices. The WBTi has identified 15 indicators in two parts, each indicator having specific significance.

Part-I deals with policy and programmes (indicator 1-10)	Part –II deals with infant feeding practices (indicator 11-15)
<ol style="list-style-type: none"> <li>1. National Policy, Programme and Coordination</li> <li>2. Baby Friendly Hospital Initiative (Ten steps to successful breastfeeding)</li> <li>3. Implementation of the International Code of Marketing of Breastmilk Substitutes</li> <li>4. Maternity Protection</li> <li>5. Health and Nutrition Care Systems (in support of breastfeeding &amp; IYCF)</li> <li>6. Mother Support and Community Outreach</li> <li>7. Information Support</li> <li>8. Infant Feeding and HIV</li> <li>9. Infant Feeding during Emergencies</li> <li>10. Mechanisms of Monitoring and Evaluation System</li> </ol>	<ol style="list-style-type: none"> <li>11. Early Initiation of Breastfeeding</li> <li>12. Exclusive breastfeeding</li> <li>13. Median duration of breastfeeding</li> <li>14. Bottle feeding</li> <li>15. Complementary feeding</li> </ol>

Once assessment of gaps is carried out, the data on 15 indicators is fed into the questionnaire using the WBTi web based toolkit© which is specifically designed to meet this need. The toolkit objectively quantifies the data to provide a colour- coded rating in Red, Yellow, Blue or Green. The toolkit has the capacity to generate visual maps or graphic charts to assist in advocacy at all levels e.g. national, regional and international.

**Each indicator used for assessment has following components;**

- The key question that needs to be investigated.
- Background on why the practice, policy or programme component is important.
- A list of key criteria as subset of questions to be considered in identifying achievements and areas needing improvement, with guidelines for scoring, colour-rating, and ranking how well the country is doing.

**Part I:** A set of criteria has been developed for each target, based on Global Strategy for Infant and Young Child Feeding (2002) and the Innocenti Declaration on Infant and Young Child Feeding (2005). For each indicator, there is a subset of questions. Answers to these can lead to identify achievements and gaps in policies and programmes to implement Global Strategy for Infant and Young Child Feeding. This shows how a country is doing in a particular area of action on Infant and Young Child Feeding.

**Part II:** Infant and Young Child Feeding Practices in Part II ask for specific numerical data on each practice based on data from random household survey that is national in scope.

Once the information about the indicators is gathered and analyzed, it is then entered into the web-based toolkit through the 'WBTi Questionnaire.' Further, the toolkit scores and colour- rate each individual indicator as per **IBFAN Asia's Guidelines for WBTi.**

## Indicator 1: National Policy, Programme and Coordination

**Key question:** *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 programme? Is there a mechanism to coordinate like National infant and young child feeding committee and a coordinator for the committee?*

<b>Guidelines for scoring</b>		
<b>Criteria</b>	<b>Scoring</b>	<b>Results</b> ✓ <i>Check any one</i>
1.1) A national infant and young child feeding/breastfeeding policy has been officially adopted/approved by the government	1	
1.2) The policy recommended exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	1	
1.3) A national plan of action developed based on the policy	2	
1.4) The plan is adequately funded	2	
1.5) There is a National Breastfeeding Committee/ IYCF Committee	1	✓
1.6) The national breastfeeding (infant and young child feeding) committee meets, monitors and reviews on a regular basis	2	✓
1.7) The national breastfeeding (infant and young child feeding) committee links effectively with all other sectors like health, nutrition, information etc.	0.5	✓
1.8) Breastfeeding Committee is headed by a coordinator with clear terms of reference, regularly communicating national policy to regional, district and community level.	0.5	✓
<b>Total Score</b>	<b>_/10</b>	<b>4/10</b>

### Information Sources Used (please list):

1. <https://www.dietaryguidelines.gov/>
2. <https://www.fns.usda.gov/cnpp/center-nutrition-policy-and-promotionhttp://www.ncbi.nlm.nih.gov/pubmed/25911339>
3. <http://health.gov/dietaryguidelines/2015-BINDER/meeting1/birthTo24Months.aspx>
4. [www.usbreastfeeding.org](http://www.usbreastfeeding.org)
5. <https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-childhealth/objectives>
6. <http://www.surgeongeneral.gov/priorities/prevention/strategy/>

7. <http://www.surgeongeneral.gov/library/calls/breastfeeding/index.html>
8. <http://www.usbreastfeeding.org>

**Conclusions** (*Summarize which aspects of IYCF policy, program and coordination are appropriate; which need improvement and why; and any further analysis needed*):

The Dietary Guidelines for Americans (DGA) are recognized as the national policy for individuals 2 years of age and above, however the 2014 Farm Bill mandated that future recommendations include nutrition guidelines throughout the lifecycle. Appointments to the 2020 Dietary Guidelines Advisory Committee (DGAC) (<https://www.usda.gov/media/press-releases/2019/02/21/members-2020-dietary-guidelines-advisory-committee-announced>) were recently announced and include nationally recognized experts in infant and child feeding including breastfeeding. In addition, the research questions published by the U.S. Health and Human Services reflect the intent to include early infant and child feeding recommendations into the revised recommendations. (<https://www.dietaryguidelines.gov/work-under-way/review-science/topics-and-questions-under-review>)

In addition to the future recommendations of the DGAC regarding IYCF, the major health organizations in the US currently have published position statements that support exclusive breastfeeding until 6 months of age with continued breastfeeding through at least one year of age. An expert panel was convened by Robert Wood Johnson Foundation Healthy Eating Research to publish “Feeding Guidelines for Infants and Young Toddlers: A Responsive Parenting Approach” evidence-based guidelines to provide as interim to DGA for programs serving infants and young children <https://healthyeatingresearch.org/research/feeding-guidelines-for-infants-and-young-toddlers-a-responsive-parenting-approach/>. An National Institute of Health task force on Research Specific to Pregnant Women and Lactating Women (PRGLAC) has been renewed for two more years to provide guidance to the HHS Secretary on the implementation of the task force's recommendations for addressing gaps in knowledge and research on safe and effective therapies for pregnant women and lactating women (<https://www.nih.gov/news-events/news-releases/nih-led-task-force-pregnancy-lactation-receives-two-year-renewal>). Despite the lack of a national plan pending the anticipated release of the DGAs in 2020, these organization policy recommendations have been integral to development and goals of the Healthy People 2020 Report, the U.S. Surgeon General’s Call to Action (SGCTA) to Support Breastfeeding, and the National Prevention Strategy also released by the Surgeon General. Collectively, these documents provide rationale and guidance for breastfeeding programs at the local, regional, state, and national levels; however, these recommendations do not constitute national policy for the purposes of this evaluation.

*Healthy People 2020* is the federal government’s prevention agenda for building a healthy nation. It is a statement of national health objectives designated to identify the most significant preventable threats to health and to establish national goals to reduce these threats. The agenda is revised every ten years with input from cross sector stakeholders in a public and transparent process. The Healthy People 2030 (<https://www.healthypeople.gov/2020/About-Healthy-People/Development-Healthy-People-2030/Framework>) process for reviewing and established public health recommendations and metrics is in progress. Stakeholders have provided significant content recommendations related to maternal and child health. The current objective, MICH-21 ([https://www.healthypeople.gov/node/4859/data\\_details](https://www.healthypeople.gov/node/4859/data_details)), is to increase the proportion of infants who are breastfed. While the systematic collection of data on IYCF practices is addressed in subsequent indicator responses, it is important to note that the establishment of this objective sets the expectation for such data to be gathered.

The U.S. Preventive Services Task Force recommends interventions during pregnancy and birth to promote and support breastfeeding

(<https://www.uspreventiveservicestaskforce.org/Page/Document/final-recommendation-statement154/breastfeeding-primary-care-interventions>). This grade B recommendation is instrumental in ensuring inclusion of the recommendation in not only Healthy People agendas, but also in third-party payer systems and publically funded health care such as the Medicaid program.

The Affordable Care Act expands coverage and is intended to help narrow longstanding disparities of health coverage for people of color and low income individuals. In addition, services for pregnant women or women who may become pregnant include breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies for pregnant and nursing women. (<https://www.healthcare.gov/coverage/breast-feeding-benefits/>)

Recently passed legislation will allow stakeholders to convene to address causes and solutions to the disparate prevalence of maternal morbidity and mortality that exists in the U.S. The identification of trends and proposed solutions will shape policy and increase the likelihood of the adoption of national goals and objectives including breastfeeding as a preventive measure. (<https://www.dol.gov/wb/maps/4.htm>)

Concern has been raised regarding the influence of industry on the DGAs in the past regarding recommendations for consumption of foods such as meat and dairy. Previous efforts to incorporate global recommendations that promote food system sustainability were thwarted during the 2015 process. It is likely that the inclusion of the zero to two recommendations will receive focused attention by the infant formula industry.

The United States Breastfeeding Committee (USBC) functions as the national breastfeeding committee. The USBC meets, monitors and reviews breastfeeding policy on a regular basis and links effectively with all major sectors. The chair of the USBC leads the efforts to regularly communicate national policy to national, regional, district and community entities, however is not a government-appointed national breastfeeding coordinator. State and tribal coalitions are members of the USBC and are charged with communicating back to local coalitions and are seen as a strength to the public health and breastfeeding infrastructure. The USBC coordinates bi-monthly teleconferences for state and tribal coalitions as a tactic to disseminate important information and to build capacity to influence geographical and culturally specific public policy. The constellation infrastructure of the USBC provides a learning community that facilitates communication and the exchange of ideas and is based on the Collective Impact Model. More information can be found in the annual USBC report reference. (<http://www.usbreastfeeding.org/annual-reports>)

In the absence of a plan, there is no funding for a national strategy at this time. The government does not currently fund all of the aspects of the implementation of the dietary guidelines and will likely not fund implementation even after the adoption of the birth to 24 months component. Congress appropriated funds for the first time in 2019 specifically for development of the guidelines. Funding for breastfeeding related initiatives is currently a component of the appropriations budget adopted by Congress. At present, funding is appropriated for the Special Supplemental Nutrition Program for Women, Infant and Children (WIC) and the Centers for Disease Control and Prevention (CDC). The Maternal and Child Health Bureau's Title 5 block grant funding to states identifies breastfeeding as a priority area for states to choose as a focus area; all 50 states have selected breastfeeding as a priority to target funding. Additional funds for breastfeeding programs and services are included in the

health care delivery system through the ACA and Medicaid program yet many states have not implemented policies that realize this opportunity.

Child Nutrition Reauthorization occurs approximately every 5 years and defines specific aspects regarding the administration of all federal school meal and child nutrition programs such as the Child and Adult Care Food Program, and WIC. WIC provides breastfeeding support and counseling, nutritious foods, nutrition education, and access to health care to low-income pregnant women, new mothers, infants, and children up to age 5.

**Gaps** (*List gaps identified in the implementation of this indicator*):

1. There is no government appointed national breastfeeding coordinator.
2. USBC focuses on the protection, promotion and support of breastfeeding, as opposed to comprehensive infant and young child feeding and nutrition.
3. There is currently no identified implementation plan for the DGA. Implementation of the DGA needs to frame messages that are culturally relevant to populations experiencing disparities.
4. Economic goals and practices of industry may not be congruent with national public health goals, and are especially concerning to groups experiencing health inequities.
5. Analyses and reports about food access often don't include or may undervalue the importance of breastfeeding, and do not advocate for longer duration or exclusivity as one of the solutions for food security.
6. Breastfeeding can play an integral role in sustainability, especially as more attention is being paid to environmental impacts and policies related to climate change.
7. There is disconnect between government agencies and the work of organizations that address infant and young child feeding resulting in inconsistent policies, communication and messaging to the public.
8. Health care workers will need training to support implementation of the IYCF guidelines.

**Recommendations** (*List actions recommended to bridge the gaps*):

1. USBC or other stakeholder petition the Federal government to appoint a national breastfeeding coordinator.
2. USBC to endorse WBTi, and collaborate with partners/stakeholders to advocate for improving national breastfeeding policies, including the development of a national advocacy agenda.
3. Efforts must be made by public health stakeholders throughout the Dietary Guidelines for Americans process to ensure that the recommendations are evidenced-based and free of economic or political influence.
4. USBC should encourage the national Breastfeeding Public Health Partners to outline a DGA implementation plan for 0-2, with particular attention to populations experiencing disparities.
5. USBC and stakeholder organizations identify and participate in U.S. Health and Human Service advisory committees to inform national policy, including but not limited to those associated with Minority Health, Department of Defense, Women's Health and Fetal, Infant and Maternal Nutrition.

## Indicator 2: Baby Friendly Care and Baby-Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding<sup>1</sup>)

### Key questions:

- What percentage of hospitals and maternity facilities that provide maternity services have been designated as “Baby Friendly” based on the global or national criteria?
- What is the quality of BFHI program implementation?

### Guidelines – Quantitative Criteria

2.1) 564 out of 3000+ total hospitals (both public & private) and maternity facilities offering maternity services have been designated or reassessed as “Baby Friendly” in the last 5 years: (27.71% of births occur in a Baby-Friendly designated facility)

Guidelines for scoring		
Criteria	Scoring	Results
		✓ Check only one which is applicable
0	0	
0.1 - 20%	1	
20.1 - 49%	2	✓
49.1 - 69%	3	
69.1-89 %	4	
89.1 - 100%	5	
<b>Total rating</b>	<b>___ / 5</b>	<b>2/5</b>

<sup>1</sup> **The Ten Steps to Successful Breastfeeding:** The BFHI promotes, protects, and supports breastfeeding through The Ten Steps to Successful Breastfeeding for Hospitals, as outlined by UNICEF/WHO. The steps for the United States are:

1. Maintain a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breastmilk, unless medically indicated.
7. Practice “rooming in”-- allow mothers and infants to remain together 24 hours a day.
8. Encourage unrestricted breastfeeding.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

## Guidelines – Qualitative Criteria

*Quality of BFHI programme implementation:*

<b>Guidelines for scoring</b>		
<b>Criteria</b>	<b>Scoring</b>	<b>Results</b> ✓ <b>Check that apply</b>
2.2) BFHI programme relies on training of health workers using at least 20 hours training programme <sup>2</sup>	1.0	✓
2.3) A standard monitoring <sup>3</sup> system is in place	0.5	✓
2.4) An assessment system includes interviews of health care personnel in maternity and post natal facilities	0.5	✓
2.5) An assessment system relies on interviews of mothers.	0.5	✓
2.6) Reassessment <sup>4</sup> systems have been incorporated in national plans with a time bound implementation	1.0	✓
2.7) There is/was a time-bound program to increase the number of BFHI institutions in the country	0.5	✓
2.8) HIV is integrated to BFHI programme	0.5	
2.9) National criteria are fully implementing Global BFHI criteria (See Annex 2.1)	0.5	
<b>Total Score</b>	<b>____/5</b>	<b>4/5</b>
<b>Total Score</b>	<b>____/10</b>	<b>6/10</b>

### Information Sources Used (please list):

1. Baby-Friendly USA. (n.d.). Baby-Friendly USA ~ More than a million babies each year off to a great start. Retrieved March 22, 2019, from <https://www.babyfriendlyusa.org/>
2. Baby-Friendly USA. (n.d.). Baby-Friendly USA ~ Baby-Friendly Facilities A-Z and by State. Retrieved March 22, 2019, from <https://www.babyfriendlyusa.org/for-parents/baby-friendly-facilities-by-state/>

<sup>2</sup> IYCF training programmes such as IBFAN Asia's '4 in1' IYCF counseling training programme, WHO's Breastfeeding counseling course etc. may be used.

<sup>3</sup> **Monitoring** is a dynamic system for data collection and review that can provide information on implementation of the *Ten Steps* to assist with on-going management of the *Initiative*. It can be organized by the hospitals themselves or at a higher level in the system. Data should be collected either on an ongoing basis or periodically, for example on a semi-annual or yearly basis, to measure both breastfeeding support provided by the hospitals and mothers' feeding practices.

<sup>4</sup> **Reassessment** can be described as a "re-evaluation" of already designated baby-friendly hospitals to determine if they continue to adhere to the *Ten Steps* and other baby friendly criteria. It is usually planned and scheduled by the national authority responsible for BFHI for the purpose of evaluating on-going compliance with the *Global Criteria* and includes a reassessment visit by an outside team. Because of the human and financial resources required, in many countries it may be feasible to reassess hospitals only once every three years, but the final decision concerning how often reassessment is required should be left to the national authority.

3. Baby-Friendly USA, Inc. (2018, July 16). Guidelines and Evaluation Criteria for Facilities Seeking Baby-Friendly Designation. Baby-Friendly USA, Inc. Retrieved from [https://babyfriendlyusa.org/wp-content/uploads/2018/10/GEC2016\\_v2-180716.pdf](https://babyfriendlyusa.org/wp-content/uploads/2018/10/GEC2016_v2-180716.pdf)

**Conclusions** (*Summarize which aspects of IYCF policy, program and coordination are appropriate; which need improvement and why; and any further analysis needed*):

The number of births in Baby-Friendly designated facilities has increased sharply over the past several years. Every U.S. state and the Commonwealth of Puerto Rico has at least one Baby-Friendly designated birth facility.

A number of federal and foundation-funded state, regional and national collaborative endeavors have increased the spread of Baby-Friendly practices in underserved areas, aiming to reduce racial disparities in breastfeeding and increase equitable distribution of supportive maternity care practices. While the U.S. does not implement the Global BFHI criteria for a baseline requirement of >80% EBF prior to BFHI assessment, it is clear that working to decrease unnecessary supplementation will also decrease disparities in BF rates. The US does not disregard the importance of EBF; rates of exclusivity are of concern, and lowering in-hospital supplementation is a Healthy People 2020 objective, and anticipated to carry-over to HP 2030. In addition, the addition of a Joint Commission core measure anticipating increased rates of exclusive breast milk feeding has increased awareness of unnecessary supplementation.

The U.S. has not integrated the HIV counseling component of the 2009 Global BFHI Criteria since the U.S. CDC advises against breastfeeding for several conditions, including among HIV+ mothers. Therefore, training staff about how to counsel HIV+ mothers regarding infant feeding would be counter to national recommendations (see Indicator 8).

The U.S. has not yet adopted the Mother Friendly Care component as described in the 2009 Global BFHI Criteria.

**Gaps** (*List gaps identified in the implementation of this indicator*):

Disparities in racial/ethnic breastfeeding rates are now examined in greater detail in governmental surveillance (see chart below). Initiation rates are lowest among non-Hispanic Black and Non-Hispanic Native American/Alaskan Native peoples. Birth facilities located in communities with higher proportion of black residents are less likely to practice the Ten Steps to Successful Breastfeeding (Lind et al., 2014).

Rural/urban diversity in breastfeeding rates is complicated by uneven distribution of Baby-Friendly designated facilities. Data from North Carolina suggests that implementing the BFHI decreases the rural/urban breastfeeding rate disparity (Liberty, Wouk, Chetwynd, & Ringel-Kulka, 2019).

## Breastfeeding Rates (Data from National Immunization Survey, Children born in 2015)

Rate	Overall	Hispanic	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian	Non-Hispanic Hawaiian / Pacific Islander	Non-Hispanic Native American / Alaskan Native	2 or more races
<b>Ever BF</b>	83.2%	84.6%	85.9%	69.4%	89.3%	83.0%	76.4%	82.5%
<b>BF @ 6 m</b>	57.6	54.1	62.0	44.7	72.2	57.8	55.0	55.5
<b>BF @ 12 m</b>	35.9	32.6	39.8	24.0	50.3	24.4	31.3	35.9
<b>EBF @ 3 m</b>	46.9	42.2	53.0	36.0	45.7	45.3	44.6	46.5
<b>EBF @ 6 m</b>	24.9	20.9	29.5	17.2	30.1	29.0	19.6	21.9

### Recommendations *(List actions recommended to bridge the gaps):*

1. Continue funding for collaborative endeavors to implement the BFHI, targeting underserved communities where breastfeeding rates are lowest.
2. Continue state and local endeavors designed to increase the spread of BFHI practices.
3. Increase spread of innovations to address economic disparities, as well as others.
4. Continue to track EBF rates as a gateway to getting more facilities working toward full implementation of the BFHI.
5. Continue to officially support the BFHI.
6. Request that Baby-Friendly USA, Inc. implement the WHO/UNICEF Mother-Friendly Care standards.
7. Adopt evidence-based maternity care practices in birth facilities and health systems such as the Mother Friendly component of the BFHI.
8. Increase availability of training programs for health care providers and hospital staff to assist in the spread of knowledge and skill supportive of the BFHI.
9. Encourage the implementation of additional quality improvement measures in support of the BFHI.
10. Encourage states to align model breastfeeding policies with the BFHI.

### References

1. Baby-Friendly USA, Inc. (2019, January 31). Baby-Friendly Practices Help Reduce Racial Gaps in US South. Retrieved March 22, 2019, from <https://www.babyfriendlyusa.org/news/baby-friendly-practices-help-decrease-racial-gaps-in-breastfeeding-in-the-us-south/>
2. Centers for Disease Control and Prevention. (2019, January 25). National Immunization Survey, Rates of Any and Exclusive Breastfeeding by Socio-demographics among Children Born in 2015. Breastfeeding Rates | Breastfeeding | CDC. Retrieved March 22, 2019, from [https://www.cdc.gov/breastfeeding/data/nis\\_data/rates-any-exclusive-bf-socio-dem-2015.htm](https://www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-socio-dem-2015.htm)
3. Liberty, A. L., Wouk, K., Chetwynd, E., & Ringel-Kulka, T. (2019). A Geospatial Analysis of the Impact of the Baby-Friendly Hospital Initiative on Breastfeeding Initiation in North Carolina. *Journal of Human Lactation*, 35(1), 114–126. <https://doi.org/10.1177/0890334418776645>
4. Lind, J. N., Perrine, C. G., Li, R., Scanlon, K. S., Grummer-Strawn, L. M., & Centers for Disease Control and Prevention (CDC). (2014). Racial disparities in access to maternity care

practices that support breastfeeding - United States, 2011. *MMWR. Morbidity and Mortality Weekly Report*, 63(33), 725–728.

5. Merewood, A., Bugg, K., Burnham, L., Krane, K., Nickel, N., Broom, S., ... Feldman-Winter, L. (2019). Addressing Racial Inequities in Breastfeeding in the Southern United States. *Pediatrics*. <https://doi.org/10.1542/peds.2018-1897>
6. Procaccini, D., Curley, A. L. C., & Goldman, M. (2018). Baby-Friendly Practices Minimize Newborn Infants Weight Loss. *Breastfeeding Medicine*, 13(3), 189–194. <https://doi.org/10.1089/bfm.2017.0182>

## Indicator 3: Implementation of the International Code of Marketing of Breastmilk Substitutes

**Key question:** *Is the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolution are in effect and implemented? Has any new action been taken to give effect to the provisions of the Code?*

<b>Guidelines for scoring</b>		
<b>Criteria</b> (Legal Measures that are in Place in the Country)	<b>Scoring</b>	<b>Results</b>
<b>3a: Status of the International Code of Marketing</b>		✓ (Check that apply. If more than one is applicable, record the highest score.)
3.1) No action taken	0	
3.2) The best approach is being considered	0.5	✓
3.3) National Measures awaiting approval (for not more than three years)	1	
3.4) Few Code provisions as voluntary measure	1.5	
3.5) All Code provisions as a voluntary measure	2	
3.6) Administrative directive/circular implementing the code in full or in part in health facilities with administrative sanctions	3	
3.7) Some articles of the Code as law	4	
3.8) All articles of the Code as law	5	
3.9) Relevant provisions of WHA resolutions subsequent to the Code are included in the national legislation <sup>5</sup>		
a) Provisions based on at least 2 of the WHA resolutions as listed below are included	5.5	
b) Provisions based on all 4 of the WHA resolutions as listed below are included	6	

<sup>5</sup> Following WHA resolutions should be included in the national legislation/enforced through legal orders to tick this score.

1. Donation of free or subsidized supplies of breastmilk substitutes are not allowed (WHA 47.5)
2. Labeling of complementary foods recommended, marketed or represented for use from 6 months onward (WHA 49.15)
3. Health and nutrition claims for products for infants and young children are prohibited (WHA 58.32) are prohibited
4. Labels of covered products have warnings on the risks of intrinsic contamination and reflect the FAO/WHO recommendations for safe preparation of powder infant formula (WHA 58.32, 61.20)

<b>3b: Implementation of the Code/National legislation</b>		✓ <i>Check that apply</i>
3.10) The measure/law provides for a monitoring system	1	
3.11) The measure provides for penalties and fines to be imposed to violators	1	
3.12) The compliance with the measure is monitored and violations reported to concerned agencies	1	
3.13) Violators of the law have been sanctioned during the last three years	1	
<b>Total Score (3a + 3b)</b>	<b>___/10</b>	<b>0.5/10</b>

**Information Sources Used** *(please list):*

1. <https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm048694.htm>
2. <https://www.cdc.gov/breastfeeding/pdf/strategy9-addressing-marketing-infant-formula.pdf>
3. <https://www.unicef.org/programme/breastfeeding/innocenti.htm>
4. <https://www.fda.gov/food/guidanceregulation/guidancedocumentsregulatoryinformation/infantformula/default.htm>
5. <http://www.lexjuris.com/lexlex/leyes2004/lexl2004079.htm>
6. <https://www.cdc.gov/breastfeeding/data/reportcard.htm>
7. [https://www.cdc.gov/breastfeeding/data/mpinc/state\\_reports.html](https://www.cdc.gov/breastfeeding/data/mpinc/state_reports.html)
8. <https://www.ncbi.nlm.nih.gov/pubmed/21452448>
9. <https://www.citizen.org/sites/default/files/report-successful-initiatives-formula-marketing.pdf>
10. <https://banthebags.org/bag-free-hospitals/>
11. <http://www.fao.org/fao-who-codexalimentarius/en/>

**Conclusions** *(Summarize which aspects of IYCF policy, program and coordination are appropriate; which need improvement and why; and any further analysis needed):*

1. Many more hospitals are implementing the Code and resolutions through the BFHI with consequences for violations as described in Baby-Friendly USA internal policies.
2. Progress is being made at the state and local levels, which can be a pathway to establishing federal laws.
3. USBC has a Code Committee (Constellation) and is considering the best approach; many state coalitions are implementing Code-relevant practices.
4. A Final Rule was set forth by the FDA in 2014.
5. Within the US, there are significant disparities related to the implementation of the WHO Code, when considering policies for implementation, these disparities should be considered along with solutions to create equitable implementation.
6. The Joint Commission has indicated the importance of exclusive breastfeeding by including exclusive breastfeeding in the perinatal core measure set with the expectation of 100 percent of babies will be exclusively breastfed during the hospital stay, with a few exceptions.

**Gaps** (*List gaps identified in the implementation of this indicator*):

1. The US does not have federal legal measures at this time to address the International Code and Resolutions, nor the Global Strategies for Infant and Young Child Feeding.
2. Federal directives have strongly cited and recommendation implementation of the Code since around 1984, however little progress has occurred.
3. Food and Drug Administration (FDA) regulations address formula labeling, labeling claims, and manufacturing/processing requirements, but not the Code and Resolutions.
4. There are significant disparities in rates of formula use by hospital, race and ethnicity, maternal education and poverty level.
5. There is a lack of access to Baby-Friendly designated hospitals in many communities. There is variation among hospitals as to their implementation of the WHO Code. Hospitals in primarily African American communities are less likely to be Baby-Friendly (and potentially may not be as WHO Code compliant).
6. Some areas and regions have more hospitals designated as Baby-Friendly. Hospitals that were owned by the City of New York were mandated to become designated as Baby-Friendly, this is a model for other communities. Some multi-hospital health systems have also made the decision to work on and become designated. Indian Health Service also facilitated the IHP hospitals through the designation process.
7. While some hospitals, regions, and states have banned the distribution of hospital discharge bags, this is not the case in all states.

**Recommendations** (*List actions recommended to bridge the gaps*):

1. Implement Action 6 of the Surgeon General's Call to Action to Support Breastfeeding (2011) by holding marketers of infant formula, bottles and teats, and follow-on milks accountable for complying with the WHO Code.
2. Strengthen federal agency regulations that address any part of the Code, including the FDA and Federal Trade Commission (FTC) (SGCTA) and enact legislation that would legally codify the Code and create enforceable consequences for manufacturers and distributors that do not uphold their obligations.
3. Ensure that health care clinicians in both hospital and ambulatory clinics do not serve as advertisers for infant formula (SGCTA).
4. Establish and fund a Code-monitoring organization or collaborative agency.
5. Develop and disseminate guidelines and reporting procedures.
6. Improving hospital policies and practices could help reduce the disparity gap and decrease non-medically indicated formula supplementation.

## Indicator 4: Maternity Protection

**Key question:** *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?*

<i>Guidelines for scoring</i>		
Criteria	Scoring	Results ✓ <b>Check that apply</b>
4.1) Women covered by the national legislation are allowed the following weeks of paid maternity leave a. Any leave less than 14 weeks b. 14 to 17 weeks c. 18 to 25 weeks d. 26 weeks or more	0.5 1 1.5 2	
4.2) Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily. a. Unpaid break b. Paid break	0.5 1	
4.3) Legislation obliges private sector employers of women in the country to <i>(more than one may be applicable)</i> a. Give at least 14 weeks paid maternity leave b. Paid nursing breaks.	0.5 0.5	
4.4) There is provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector. <i>(more than one may be applicable)</i> a. Space for Breastfeeding/Breastmilk expression b. Crèche	1 0.5	
4.5) Women in informal/unorganized and agriculture sector are: a. accorded some protective measures b. accorded the same protection as women working in the formal sector	0.5 1	
4.6). <i>(more than one may be applicable)</i> a. Information about maternity protection laws, regulations, or policies is made available to workers.	0.5	✓

b. There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.	0.5	✓
4.7) Paternity leave is granted in public sector for at least 3 days.	0.5	
4.8) Paternity leave is granted in the private sector for at least 3 days.	0.5	
4.9) There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.	0.5	✓
4.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	1	✓
<b>Total Score:</b>	<b>___/10</b>	<b>2.5/10</b>

#### Information Sources Used *(please list)*:

1. <https://www.entrepreneur.com/slideshow/249467>
2. [https://www.nursingoutlook.org/article/S0029-6554\(17\)30213-0/fulltext](https://www.nursingoutlook.org/article/S0029-6554(17)30213-0/fulltext)
3. <http://breastfeedingincombatboots.com/military-policies/>
4. <http://www.techrepublic.com/article/10-things-you-need-to-know-about-maternity-leave-in-the-us/>
5. <http://www.dol.gov/asp/policy-development/PaternityBrief.pdf>
6. <http://www.theatlantic.com/technology/archive/2015/03/the-best-and-worst-companies-for-newmoms-and-dads-in-silicon-valley/386384/>
7. [http://www.edd.ca.gov/pdf\\_pub\\_ctr/de2511.pdf](http://www.edd.ca.gov/pdf_pub_ctr/de2511.pdf)
8. <http://paidfamilyleave.org>
9. <https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter484>
10. [http://www.dlt.ri.gov/lis/pdfs/medicalleave\\_rr02.pdf](http://www.dlt.ri.gov/lis/pdfs/medicalleave_rr02.pdf)
11. <http://lwd.dol.state.nj.us/labor/fli/fliindex.html>
12. <https://osha.europa.eu/en/legislation/directives/10>
13. <http://www.cdc.gov/niosh/topics/repro/employers.html>
14. <http://advocatesforpregnantwomen.org/06CFinalDraft.pdf>
15. <http://www.dol.gov/whd/nursingmothers/>
16. <http://www.google.com/about/careers/lifeatgoogle/benefits/>
17. <http://benefits.adobe.com/what-happens-when/im-taking-a-leave-of-absence#Maternity>
18. <https://www.facebook.com/careers/benefits/>
19. <http://appleinsider.com/articles/14/10/02/apple-overhauls-employee-benefits-with-longer-parental-leave-improved-education-reimbursements>
20. <http://www.blognj.com/2015/04/jj-and-the-21st-century-working-family/>
21. <http://www.goldmansachs.com/careers/why-goldman-sachs/compensation-andbenefits/compensation-and-benefits-us.html>
22. <http://careers.bankofamerica.com/us/working-here/benefits-advantages.aspx>
23. <http://www.ncsl.org/research/health/breastfeeding-state-laws.aspx>
24. <http://www.ncsl.org/documents/health/smartinvestments914.pdf>

25. <http://www.ncsl.org/research/labor-and-employment/state-family-and-medical-leave-laws.aspx> 20
26. <http://www.rwjf.org/en/library/research/2016/03/workplace-and-public-accommodations-for-nursingmothers.html>
27. [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2016/rwjf427667](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf427667)
28. <http://nwlc.org/issue/pregnancy-parenting-the-workplace/>
29. <http://nwlc.org/press-releases/new-report-reveals-violations-affordable-care-act%E2%80%99sbreastfeeding-benefits/>
30. Healthy People 2020 MICH-22 is measuring workplace support for breastfeeding mothers <https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-childhealth/objectives>
31. <https://www.osha.gov/>
32. <https://genesishrsolutions.com/peo-blog/paternity-leave/>

“Eighty-nine percent of all fathers took some time off after their baby’s birth, but almost two-thirds of them took one week or less, according to a study by two professors of social work, Lenna Nepomnyaschy of Rutgers and Jane Waldfogel of Columbia. Low-income and minority fathers are least likely to take leave, it found. And men often use sick or vacation days and cite work pressure and unwritten expectations as reasons for not taking longer leaves, according to a study published this year by the Boston College Center for Work & Family and sponsored by EY, the global parent company of Ernst & Young.” <https://www.nytimes.com/2014/11/09/upshot/paternity-leave-the-rewards-and-the-remaining-stigma.html>

<https://www.aclualabama.org/en/cases/hicks-v-city-tuscaloosa-alabama> Lactation is covered under the Pregnancy Discrimination Act as of Feb 2017. However, women may not know about this protection, especially marginalized women working in vulnerable, low-wage positions.

**Conclusions** (*Summarize which aspects of IYCF policy, program and coordination are appropriate; which need improvement and why; and any further analysis needed*):

The United States has recently demonstrated an increased interest in improving our maternity/paternity protection. Changes have been made in certain public sectors such as the Department of Defense (DOD), a few states including California, Puerto Rico, and public corporations (Google, Bank of America, etc.). In Puerto Rico a full-time worker (7.4 hours) get two 30 minutes or three 20 minutes paid break. Since 2017, a part-time worker get a 30 minutes paid break for each 4 hours of work.

Absence of policy and education puts the onus on the woman herself to advocate to her employer, potentially putting her livelihood at risk, vulnerable women are most at risk.

Only hourly workers are covered by national legislation and breaks are unpaid. “Section 7 of the Fair Labor Standards Act (FLSA) requires employers to provide reasonable break time for an employee to express breast milk for her nursing child for one year after the child’s birth each time such employee has need to express the milk. Employers are also required to provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.” <https://www.dol.gov/whd/nursingmothers/>

**Gaps** (*List gaps identified in the implementation of this indicator*):

The US has no federal paid maternity leave law, no paid family leave law. Family and Medical Leave Act (FMLA) provides unpaid leave for up to 12 work weeks, and is only applicable to employees of companies with more than 50 employees who have been at their jobs at least a year and have completed at least 1250 hours of work within the previous 12 months. Fewer than 50% of US families qualify for FMLA. Minority, lower wage and vulnerable employees are less likely to be covered by FMLA.

“On the other hand, black working parents have relatively high eligibility rates (54%), reflecting the fact that a disproportionate share of black workers are employed in the public sector (all public agencies are covered by the FMLA regardless of size, unlike in the private sector). Nevertheless, while relatively high eligibility rates are a positive sign for black working parents, many working parents – both black and Hispanic – struggle to afford unpaid FMLA leave.”

<http://www.diversitydatakids.org/files/Policy/FMLA/Capacity/Inequities%20in%20FMLA%20eligibility.pdf>

Under FMLA, when leave is used for the birth or adoption of a baby/child, the business may determine whether the FMLA must be taken consecutively or incrementally. Determination of maternity/family leave benefit is left to employers. Some private sector companies are generous, but this is typically only offered to salaried employees, leaving gaps for hourly employees, informal economy (unregulated workers), part-time employees, etc. The Patient Protection and Affordable Care Act (ACA) Reasonable Break Time for Nursing Mothers law does not apply to all workers, only protects breaks until the child’s first birthday and does not require paid breaks. <https://www.dol.gov/whd/nursingmothers/faqBTNM.htm>  
<https://www.dol.gov/compliance/guide/minwage.htm>.

ACA only protects breaks for expressing breast milk; actual breastfeeding is NOT protected. <https://www.bostonglobe.com/lifestyle/health-wellness/2013/08/18/new-hampshire-woman-fired-after-fight-with-employers-over-breast-feeding/HpoMceGCBxojIyK2nrFRNJ/story.html>

The overtime law expansion expands break time coverage under ACA.

<http://www.epi.org/publication/who-benefits-from-new-overtime-threshold/>

The expansion of the law governing which workers are salaried (i.e. do not qualify for overtime pay) and which are hourly (i.e. do qualify for overtime pay) would not only expands the number of parents who are eligible for break time coverage under the Affordable Care Act (ACA) but “4.2 million parents and 7.3 million children (under age 18), 1.5 million blacks (who make up 8.9 percent of the salaried workforce but 12.0 percent of directly benefiting workers), and 2.0 million Hispanics (who make up 11.8 percent of the salaried workforce but 16.0 percent of directly benefiting workers) will be paid more when classified as hourly compared to salaried workers.

<http://www.epi.org/publication/who-benefits-from-new-overtime-threshold/>

**Recommendations** (*List actions recommended to bridge the gaps*):

1. Establish federal paid family leave law compliant with ILO MPC 183 recommendations providing a minimum of 14 weeks paid maternity leave following a birth, family leave for nonbirth partners, adoptive parents. Federal paid family leave law should be applicable to 100% of the U.S. workforce, with no exceptions or exemptions. 21

2. Enact legislation that would make it illegal to fire any employee for breastfeeding or expressing breast milk. <https://www.dol.gov/wb/maps/> <https://www.dol.gov/wb/maps/4.htm>
3. Strengthen Break Time for Nursing Mothers provision to cover reasonable accommodations for breastfeeding a child at breast on breaks when reasonable.
4. Develop public awareness campaigns expanding on “The Business Case for Breastfeeding” that demonstrate to employers how accommodating breastfeeding is good for their employees and good for their bottom line; showcase examples of how employers have successfully integrated strategies for supporting breastfeeding employees, create resources for employers and employees to find solutions to common concerns.  
<http://www.womenshealth.gov/breastfeeding/employer-solutions>
5. Continue the development of policies in individual states as a tool to incubate potential federal policy.
6. Advocate for changes to the FMLA statute that would allow workers to take family leave incrementally rather than requiring consecutive days so that women can choose to return to work part time. [From the US breastfeeding website:] State Legislation If a state provision is stronger, it supersedes the federal provision. There are several sources of information on state legislation: · The National Conference of State Legislatures provides compiled listings of breastfeeding related state legislation; · The U.S. Department of Labor Women's Bureau publishes a map with details of employment protections for workers who are pregnant or nursing; and The National Partnership for Women & Families maintains a work and family policy database with an overview of bills proposed and laws passed in various states.  
<http://www.nationalpartnership.org/issues/work-family/paid-leave.html>
7. Unions and other labor advocates should embrace and support maternity and paternity legislation.
8. State and local coalitions have a role to play now that breastfeeding in public is legal in all 50 states. Lack of awareness of the laws perpetuates discrimination, especially for vulnerable workers.

## Indicator 5: Health and Nutrition Care Systems (in support of breastfeeding & IYCF)

**Key question:** Do care providers in these systems undergo skills training, and do their pre-service education curriculum support optimal infant and young child feeding; do these services support mother and breastfeeding friendly birth practices, do the policies of health care services support mothers and children, and whether health workers responsibilities to Code are in place?

<b>Guidelines for scoring</b>			
<b>Criteria</b>	<b>Scoring</b>		
	✓ Check that apply		
	<b>Adequate</b>	<b>Inadequate</b>	<b>No Reference</b>
5.1) A review of health provider schools and pre-service education programmes for health professionals, social and community workers in the country <sup>6</sup> indicates that infant and young child feeding curricula or session plans are adequate/inadequate	2	1	0
	✓		
5.2) Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care. (See Annex 5b Example of criteria for mother-friendly care)	2	1	0
	✓		
5.3) There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers. <sup>7</sup>	2	1	0
	✓		
5.4) Health workers are trained on their responsibility under the Code implementation / national regulation throughout the country.	1	0.5	0
		✓	
5.5) Infant feeding and young feeding information and skills are integrated, as appropriate, into training programmes	1	0.5	0

<sup>6</sup> Types of schools and education programmes that should have curricula related to infant and young child feeding may vary from country to country. Which departments within various schools are responsible for teaching various topics may also vary. The assessment team should decide which schools and departments are most essential to include in the review, with guidance from educational experts on infant and young child feeding, as necessary.

<sup>7</sup> The types of health providers that should receive training may vary from country to country, but should include providers that care for mothers and children in fields such as medicine, nursing, midwifery, nutrition and public health.

focusing on (diarrheal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, breast cancer, women's health, NCDs etc.)		✓	
5.6) In-service training programmes referenced in 5.5 are being provided throughout the country. <sup>8</sup>	1	0.5	0
		✓	
5.7) Child health policies provide for mothers and babies to stay together when one of them is sick.	1	0.5	0
		✓	
<b>Total Score:</b>	<b>8/10</b>		

### Information Sources Used (please list):

- <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pqc.htm>
- <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Breastfeeding/Pages/Residency-Curriculum.aspx>
- <https://www.acog.org/About-ACOG/ACOG-Departments/Toolkits-for-Health-Care-Providers/Breastfeeding-Toolkit?IsMobileSet=false>  
<http://www.cdc.gov/breastfeeding/data/mpinc/index.htm> (mPINC Survey, CDC)
- <http://www.jointcommission.org/assets/1/6/aroamapforhospitalsfinalversion727.pdf>
- <http://www.cdc.gov/breastfeeding/pdf/BF-Guide-508.PDF> (evidence based practice)
- Bipartisan Policy Council; Nursing School Expert Panel
- BFHI-27.7% of nation's births are at Baby Friendly Hospitals; training is required of Baby Friendly Hospitals (<https://www.cdc.gov/breastfeeding/data/reportcard.htm>)
- Trust for America's Health publishes yearly reports (<https://www.tfah.org/>)
- There is a range of some nutrition pre-service, conducted by NGOs, public health, especially WIC, and hospitals. NICHQ provides training and technical assistance with policy development. Healthy Children Project is the largest NGO providing lactation education <http://www.centerforbreastfeeding.org>
- WIC provides benefits to about 1.7 million infants each month; slightly less than half of all infants in the US participate in WIC.  
([https://fns-prod.azureedge.net/sites/default/files/pd/37WIC\\_Monthly.pdf](https://fns-prod.azureedge.net/sites/default/files/pd/37WIC_Monthly.pdf))
- Every state WIC program is required to have a Breastfeeding Coordinator that oversees the promotion and management of breastfeeding to staff at local agencies. The Coordinator identifies or develops resources and educational materials for local agencies. Each local agency must have a designated staff person to coordinate breastfeeding activities and incorporate breastfeeding training into orientation programs for new staff.  
(<http://www.fns.usda.gov/wic/breastfeeding-promotion-wiccurrent-federal-requirements>)
- Type of breastfeeding promotion and support women receive in WIC can be found at <http://www.fns.usda.gov/wic/breastfeeding-promotion-and-support-wic>
- Child care workers play an important role in supporting breastfeeding women, especially since there is no national paid leave policy so women return to work early. USDA has childcare feeding regulations which include increased support for breastfeeding women.  
([https://fns-prod.azureedge.net/sites/default/files/cacfp/CACFP\\_InfantMealPattern\\_FactSheet\\_V2.pdf](https://fns-prod.azureedge.net/sites/default/files/cacfp/CACFP_InfantMealPattern_FactSheet_V2.pdf))

<sup>8</sup> Training programmes can be considered to be provided "throughout the country" if there is at least one training programme in each region or province or similar jurisdiction.

14. As part of the Child and Adult Care Feeding Program (CACFP) training materials supporting breastfeeding and appropriate complementary feeding are available online to child care workers (<https://www.fns.usda.gov/tn/feeding-infants-child-and-adult-care-food-program>) States determine training requirements for providers who participate in CACFP.
15. National Child Care Development Block Grant (CCDBG) <https://www.acf.hhs.gov/occ/ccdf-strengthened-regulations> and require states to describe in their plan how nutrition and breastfeeding training will be addressed.
16. Head Start—has pre-service and in-service staff training requirements for health and safety, which includes breastfeeding <https://eclkc.ohs.acf.hhs.gov/policy/45-cfr-chap-xiii/1302-44-child-nutrition> and <https://eclkc.ohs.acf.hhs.gov/nutrition>
17. Healthy Kids Healthy Future is a national resource that has online training resources and tools for child care providers. <https://healthykidshealthyfuture.org/>
18. MCH Workforce Development Center is one of many options to support pre-service training in breastfeeding (<http://mchb.hrsa.gov/training/projects.asp?program=29>)

**Conclusions** (*Summarize which aspects of IYCF policy, program and coordination are appropriate; which need improvement and why; and any further analysis needed*):

Core curriculum for health professions in the U.S. include infant and young child feeding at a level to ensure basic knowledge and entry level competency. While the content is included, it is understood that there is significant variation within and between professions regarding the amount of time and the depth of training to apply the knowledge and advance competency. Reviews of medical school education have been completed by the Bipartisan Policy Council; currently, no systematic and continual review process is in place at the institution level. Major professional organizations such as the American Academy of Pediatricians (AAP) and American College of Obstetricians and Gynecologists (ACOG) and others have post-degree breastfeeding curriculum recommendations for their members.

Standards and guidelines for mother friendly childbirth procedures have been developed by AWHONN (Association of Women’s Health, Obstetric and Neonatal Nurses) and ACOG (American College of Obstetricians and Gynecologists), and are disseminated nationally.

Data is collected as part of the evidence-based Maternity Practices in Infant Nutrition and Care (mPINC) monitoring system to all U.S. hospitals providing maternity care. More than 80% of facilities complete the survey and reports are generated for each facility, state and at the national level. The reports delineate recommendations for improvement at each level and highlight areas of achievement. This allows hospitals to identify training and resource requirements in order to improve future mPINC scores.

In-service training on the 20-hour course and orientations for new staff have been provided in hospitals awarded the Baby-Friendly USA designation. At a minimum, in-service training programs occur periodically at Baby-Friendly hospitals. There are more than 500 Baby-Friendly designated facilities in the United States covering 27.7% of US births. Although the mPINC survey assesses and determines if some elements of the code are followed, there is no mechanism to determine what changes in practice or training occur as a result of participation and there is no report of specific outcomes.

The adoption of The Joint Commission measures by some facilities surrounding breastfeeding and the related guidance documents demonstrates that those facilities that adopt the measures have prioritized infant feeding within their systems.

National programs have policies that support breastfeeding and breast milk feeding in child care and Head Start settings. The Childhood and Adult Care Food Program supports breastfeeding including the education and training of care providers and reimbursement for direct breastfeeding and by the parent and breast milk feeding by the care provider to support the provision of breastmilk in child care.

In addition to the delivery of primary care, community based programs such as WIC and Ryan White Comprehensive AIDS Resources Emergency (CARE) Act offer education and training to professionals delivering care.

Policies are not in place at a national level to ensure mothers and babies who are sick remain together either in the hospital or post-discharge throughout breastfeeding duration.

**Gaps** (*List gaps identified in the implementation of this indicator*):

1. Education and training of clinicians is at a basic competency level and may not include more advanced training in lactation for clinicians that serve pregnant and lactation women.
2. There is inconsistency across federal programs that serve women, infants and children in the type of breastfeeding training offered.
3. There is inconsistency across states related to statewide programs and the support of breastfeeding or breastmilk feeding in child care settings.
4. The Joint Commission has included exclusive breastfeeding in its Perinatal Core Measurement set, however, other healthcare agency accreditors have not recognized breastfeeding outcomes as a quality standard.
5. Health care providers need focused training on racial bias, stigma and cultural humility in order to deliver quality care to populations from different geographical, age and gender classes.

**Recommendations** (*List actions recommended to bridge the gaps*):

1. Require professional staff in federally funded programs serving mothers and children to meet evidence-based core competencies in breastfeeding care and support as described by the USBC.
2. Increase the complexity and competency levels of education of healthcare providers and include the promotion and management of breastfeeding in health professional coursework and accreditation / licensing exams.
3. Advocate for national sick leave policy and paid family leave.
4. Advocate for a national initiative that would address the need for consistent and required training for Early Care and Education providers regarding breastfeeding and breast milk feeding.
5. Encourage all health care agency accreditors include breastfeeding outcome as a quality improvement standard.
6. Revise education and training materials to incorporate content related to reduce racial bias, sigma and other forms of discrimination.

## Indicator 6: Mother Support and Community Outreach - Community-based support for the pregnant and breastfeeding mother

**Key question:** Are there mother support and community outreach systems in place to protect, promote and support optimal infant and young child feeding.

<b>Guidelines for scoring</b>			
<b>Criteria</b>	<b>Scoring</b> ✓ Check that apply		
	Yes	To some degree	No
6.1) All pregnant women have access to community-based ante-natal and post -natal support systems with counseling services on infant and young child feeding.	2	1	0
		✓	
6.2) All women receive support for infant and young child feeding at birth for breastfeeding initiation.	2	1	0
		✓	
6.3) All women have access to counseling support for Infant and young child feeding counseling and support services have national coverage.	2	1	0
		✓	
6.4) Community-based counseling through Mother Support Groups (MSG) and support services for the pregnant and breastfeeding woman are integrated into an overall infant and young child health and development policy IYCF/Health/Nutrition Policy.	2	1	0
			✓
6.5) Community-based volunteers and health workers are trained in counseling skills for infant and young child feeding.	2	1	0
		✓	
<b>Total Score:</b>	<b>4/10</b>		

Information Sources Used (*please list*):

1. [PRAMS](#)
2. [WIC Infant and Toddler Feeding Practices Study](#)
3. [Infant Feeding Practices Study II](#) (IFPS-II)
4. [mPINC](#)
5. [BFUSA](#)

### **Indicator 6.1**

While currently non-existent, national policy on infant and young child feeding is anticipated to be in place with the 2020 Dietary Guidelines for Americans. Approximately 50% of pregnant parents and new infants are eligible to participate in the USDA Special Supplemental Nutrition Program for Women, Infants and Children (“WIC”). Rates of WIC participation have been decreasing, due to concern about potential deportation among undocumented immigrants. Pregnant women participating in WIC receive counseling on infant and young child feeding. Federal law under the ACA requires insurers to provide pregnancy care and breastfeeding support. However, 8.8% of Americans (28.5 million individuals) were not insured in 2017 (Berchick, Hood, & Barnett, 2018, p. 1). This is another area where racial and ethnic disparities abound; in 2017, 93.7% of non-Hispanic White Americans were covered by health insurance, followed by Asians (92.7 percent), Blacks (89.4 percent), and Hispanics (83.9 percent) (Berchick, Hood, & Barnett, 2018, p. 15).

### **Indicator 6.2**

Significant progress has occurred in uptake of the 10 Steps to Successful Breastfeeding as documented through an increase in births in Baby-Friendly designated birth facilities from 18.3% in 2016 (Centers for Disease Control & Prevention, 2016) to 27.7% as of 3/19/2019 (Baby-Friendly USA, Inc., 2019). However, a number of birth facilities are clinging to old practices, which negatively impacts breastfeeding initiation for many new families. Of particular concern: hospitals based in neighborhoods with a high percentage of black residents are less likely to be compliant with the 10 Steps of the Baby-Friendly Hospital Initiative than those serving white communities (Lind et al., 2014).

### **Indicator 6.3**

While there are no data to support this, Expert Panel members believe that most or all families have access to IYCF counselling support, most frequently through pediatric care, family and friends. However, there is no nationwide service network for such support.

In addition to family medicine, pediatric, obstetric, and women’s health medical clinicians, known resources for community lactation support include care providers such as lactation counselors, consultants, educators and specialists doulas, birth workers, childbirth educators, and M2M counselors (detailed under 6.4 below).

### **Indicator 6.4**

Known Mother-to-Mother (M2M) support groups working on a national level include:

- [BabyCafé USA](#)
- [Black Mothers’ Breastfeeding Association](#)
- [BreastfeedingUSA](#)
- [La Leche League](#)
- [Mom2Mom Global](#) (military communities)

- [Reaching Our Sisters Everywhere \(ROSE\)](#)
- [Human Milk Banking Association of North America](#)

In addition, a number of powerful local/regional models for M2M support include:

- [Appalachian Breastfeeding Network](#)
- [Breastfeeding M.A.F.I.A](#) (Oakland, CA)
- [Brown Baby Brigade](#) (Tampa, FL)
- [BSTARS](#) (Memphis, TN)
- [CinnaMoms](#) (Los Angeles)
- [Indiana Black Breastfeeding Coalition](#)
- [Pittsburgh Black Breastfeeding Circle](#) (PA)

### Indicator 6.5

All existing community-based volunteers and health workers that Expert Panel members are aware of are trained in counselling techniques. Models and content of services vary, but individual care providers are trained to the standards and specifications of the organization they work for or by which they are accredited, for example:

- Birthing Project
- Doulas
- HealthConnect One
- Healthy Start grantees
- Healthy Children Project, Inc.-trained Lactation Counselors (CLCs)
- Home Visitors
- International Board Certified Lactation Consultants (IBCLCs)
- Individuals trained by a number of NGOs delivering M2M support (La Leche League, Mom2Mom Global, Nursing Mothers Counsel, ROSE Community Transformers, etc.)
- REACH grantees (CDC)
- National Association of County and City Health Officials (NACCHO) grantees
- Nurse-Family Partnership
- WIC breastfeeding peer counselors

All indicators: The Expert Panel members note a tendency to focus on individual providers/streams of community support (e.g. specific types of Lactation Care Providers, or M2M programs, etc.) Reminder to all that there is a broad spectrum of community education/support activities ranging from grassroots to treetops, from in-home to virtual support, etc.)

**Conclusions** (*Summarize which aspects of IYCF policy, program and coordination are appropriate; which need improvement and why; and any further analysis needed*):

1. No national data sources confirm that community education and support is available to all parents. Beyond that, there is no data examining how parents rate the community education/support they do receive, nor exploring what unmet education/support services exist. The general trend to design services without asking what is needed must be reversed. However, US families participating in the WIC family (roughly 50% of childbearing families) receive education and support through this community-based program.
2. Disparities abound in access to community services; the needs of single-parent families, teen parents, parents separated from their babies due to work/school, and underserved communities are less likely to be met.
3. Beyond WIC, the most prominent community sector providing IYCF education and support is pediatric care.
4. There is no national data indicating the prevalence or coverage of M2M services.
5. A growing number of millennial parents utilize social media communities and groups as a primary source of peer support (Audelo, 2014; Mahurin-Smith, 2016). Qualitative and quantitative data regarding these resources is needed.

**Gaps** (*List gaps identified in the implementation of this indicator*):

1. National infant feeding policy, while not yet implemented, is anticipated by the end of 2020. It is not known to what extent community support will be addressed in that document.
2. Undocumented immigrants are less likely to have access to health insurance and breastfeeding support.
3. Disparities in community support include cultural humility; restrictions to access (e.g. meeting times may limit access to parents who have returned to work/school, transportation issues, ability to bring other children, etc.); the preponderance of white, female, English-speaking individuals among lactation care providers does not best serve multi-ethnic, multilingual clientele.
4. Fiscal barriers continue to be a challenge to the ongoing provision of services.
5. The visibility of community education/support has improved with more women seeking services for self-determined needs (e.g. Serena Williams), spread of implementation of Step 10 of the BFHI has increased referrals. However, there is still a need to build cross-sectoral awareness of community education/support resources. [Some tools for increasing this include the provider resources being developed by ACOG/AAP, the referral form developed for this project under USBC/LSP constellation, work of the currently-forming USBC/Continuity of Care constellation]
6. The WBTi tool envisions a “system” of community support, which is challenging in the U.S. due to fragmentation of the health care “system” (i.e., infants are cared for by a pediatric specialist, mother by an obstetric one, little transfer of information between woman’s primary care provider to obstetric, etc.). Fragmentation of the larger health system is reflected in the lactation support system, with non-articulation of medical and community breastfeeding/parenting helpers, etc.
7. Data Gaps include how health care providers make referrals, which resources they refer to; which resources health care providers are aware of; the extent to which families accessing support feel supported; definition issues (e.g. IFPS interprets M2M support as support from friends/family); lack of data about donor milk availability/use in the community.
8. Perception Gaps include the lack of recognition of the importance of M2M support (powerful education/support device, not just social).

## Recommendations *(List actions recommended to bridge the gaps):*

1. Fund and support development of community educators/supporters in rural, military, multiethnic, multilingual and other underserved communities.
2. There is a crucial need to expand the number of new care providers, and build the skill of existing providers from under-represented communities (economic, ethnic, religious, etc.)
3. Develop and disseminate a national online referral tool for community support; consider the model provided by the USBC Lactation Support Provider constellation.
4. Broaden the framework of community education/support to include online social media and telemedicine platforms.
5. Examine qualitative aspects of education/support: what do families think of existing services? What services are missing?
6. Develop data-tracking systems on community services, expand tool utilized by NACCHO
7. Increase awareness of virtual support systems, including online resources
8. Raise awareness among prenatal, obstetric, postpartum, and pediatric health care professionals of community support endeavors as a vital to increasing breastfeeding initiation and duration rates, and integrate them as a bridge between health care and community services (e.g., invite community LCPs into hospital, etc.)
9. Healthcare inequities in the US are a longstanding issue that, if addressed would eliminate healthcare disparities and improve the health and wellbeing of all Americans.
10. Race is associated with breastfeeding intensity and outcomes in the US. Systemic racism should be acknowledged and addressed in order to confront this disparity.

## References

1. Audelo, L. (2014). Connecting With Today's Mothers: Breastfeeding Support Online. *Clinical Lactation*, 5(1), 16–19. <https://doi.org/10.1891/2158-0782.5.1.16>
2. Baby-Friendly USA, Inc. (2019). Baby-Friendly USA ~ More than a Million Babies Each Year Off to a Great Start: Baby-Friendly Designated Facilities. Retrieved Marhy 19, 2019, from <https://www.babyfriendlyusa.org/>
3. Barron Smolinski, A. (2016). Boobs, Babes and Boots. In B. Martin & L. B. Arnold (Eds.), *Taking the village online: mothers, motherhood, and social media*. Bradford, Ontario: Demeter Press.
4. Berchick, E. R., Hood, E., & Barnett, J. C. (2018). *Health Insurance Coverage in the United States: 2017*. Retrieved from <https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-264.pdf>
5. Centers for Disease Control & Prevention. (2016). Breastfeeding Report Card: 2016. Centers for Disease Control & Prevention, Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. Retrieved from <http://www.cdc.gov/breastfeeding/data/reportcard.htm>
6. Lind, J. N., Perrine, C. G., Li, R., Scanlon, K. S., Grummer-Strawn, L. M., & Centers for Disease Control and Prevention (CDC). (2014). Racial disparities in access to maternity care practices that support breastfeeding - United States, 2011. *MMWR. Morbidity and Mortality Weekly Report*, 63(33), 725–728.
7. Ray, J. A. (2013). Family Connections: Today's Young Families: Successful Strategies for Engaging Millennial Parents. *Childhood Education*, 89(5), 332–334. <https://doi.org/10.1080/00094056.2013.830920>

## Indicator 7: Information Support

**Key question:** Are comprehensive Information, Education and Communication (IEC) strategies for improving infant and young child feeding (breastfeeding and complementary feeding) being implemented?

<i>Guidelines for scoring</i>			
Criteria	Scoring		
	✓ <i>Check that apply</i>		
	Yes	To some degree	No
7.1) There is a national IEC strategy for improving infant and young child feeding that ensures all information and materials are free from commercial influence/ potential conflicts or interest are avoided.	2	0	0
			✓
7.2a) National health/nutrition systems include individual counseling on infant and young child feeding	1	.5	0
	✓		
7.2b) National health/nutrition systems include group education and counseling services on infant and young child feeding	1	.5	0
	✓		
7.3) IYCF IEC materials are objective, consistent and in line with national and/or international recommendations and include information on the risks of artificial feeding	2	1	0
			✓
7.4. IEC programmes (e.g. World Breastfeeding Week) that include infant and young child feeding are being implemented at local level and are free from commercial influence	2	1	0
		✓	
7.5 IEC materials/messages to include information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula (PIF). <sup>9</sup>	2	0	0
			✓
<b>Total Score:</b>	<b>3/10</b>		

<sup>9</sup> to ensure that clinicians and other health-care personnel, community health workers and families, parents and other caregivers, particularly of infants at high risk, are provided with enough information and training by health-care providers, in a timely manner on the preparation, use and handling of powdered infant formula in order to minimize health hazards; are informed that powdered infant formula may contain pathogenic microorganisms and must be prepared and used appropriately; and, where applicable, that this information is conveyed through an explicit warning on packaging;

**Information Sources Used** *(please list):*

1. [https://www.ecfr.gov/cgi-bin/text-idx?SID=a42889f84f99d56ec18d77c9b463c613&node=7:4.1.1.1.10&rgn=div5#se7.4.246\\_111](https://www.ecfr.gov/cgi-bin/text-idx?SID=a42889f84f99d56ec18d77c9b463c613&node=7:4.1.1.1.10&rgn=div5#se7.4.246_111)  
(section 246.11)

**Conclusions** *(Summarize which aspects of IYCF policy, program and coordination are appropriate; which need improvement and why; and any further analysis needed):*

**7.1**

1. The US does not have a national strategy for improving infant and young child feeding. In addition, the US does not enforce the Code, nor is it Code compliant. Countries are not required to comply with the Code, but encouraged instead to enact legislation and policies that enforce compliance from distributors, manufacturers, and healthcare workers.
2. The current WIC program in the United States provides information about formula and risks associated with formula to eligible mothers. However, since the program is income based, not all mothers have access to this information. The WIC model could be used to create ways to reach all expectant families to assure that everyone has education around formula and safe formula use.
3. The United States does not have a national IEC strategy for improving infant and young child feeding. Therefore, there is no assurance in said policy that all information and materials are free from commercial influence/potential conflicts of interest are avoided. The United States does implement the International Code of the Marketing of Breastmilk Substitutes.

**7.2**

1. The U.S. has national programs that require individual or group counseling on IYCF, but they serve participants that meet certain criteria and thus do not reach all segments of the population. The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a public health nutrition program administered by the USDA that serves slightly less than half of all infants born in the US. Eligibility is based on income guidelines and nutrition risk criteria. Immigration policy enforcement has led to a decrease in participation in WIC as well as other health and social service programs. Other programs administered by other government agencies have less population reach, such as Healthy Start, Early Head Start, Maternal, Infant and Early Childhood Home Visit Program (MIECHV) and infant mortality reduction programs. These are not nutrition programs however they may provide counseling about breastfeeding and infant nutrition.
2. Since programs are administered by different federal agencies, health care provider training and messages to families may not be consistent due to possible lack of coordination. Training in breastfeeding and nutrition is not explicitly required at the federal level for the home visiting programs and is up to individual states how health care providers are trained. This may result in disparities among states and within states in that education services may not adequately address infant feeding needs.

3. Breastfeeding and nutrition education may also be subject to provider bias and cultural and linguistic barriers that prevents patient – provider communication. People of color may face significantly more barriers to access nutrition counseling.
4. Electronic health record implementation in the U.S. may assist in the gathering of data regarding IYCF practices including whether individual counseling was provided.

#### 7.4

1. WIC programs by definition must provide information absent of commercial influence; WIC is available in all states, territories and tribal nations but may not cover every community and is income based nutrition program so is not inclusive of all mothers. There are nationally developed materials for WIC but there is no requirement to use them.
2. Other programs such as Healthy Start, Healthy Families (or other home visiting or community health worker programs) are supposed to be absent of commercial influence. It is not clear what policies are in place or what materials these programs use.
3. World Breastfeeding Week (WBW) and Black Breastfeeding Week (BBW) initiatives are held across the country in many local communities. A site to register events is sponsored by WABA for WBW (<http://worldbreastfeedingweek.org>) and BBW (<http://blackbreastfeedingweek.org>). While WBW events are to be free from commercial interest, BBW has no such mandate.

#### 7.5

1. At BFHI accredited hospitals the standard of practice includes discussing the risks of artificial feeding. While there are over 500 BFHI accredited hospitals (an increasing number) they are disproportionally located under-represented in communities of color and underserved communities (e.g. rural).
2. FDA recommends following manufacturer’s guidance (on formula preparation) that may or may not be consistent with the CDC or WHO guidelines.

#### **Gaps** (*List gaps identified in the implementation of this indicator*):

**7.1/7.2:** WIC serves slightly less than half of all infants born in the US. Eligibility is based on income guidelines and nutrition risk criteria. There is not a system in place that serves every infant in the US regardless of income.

#### **7.4/7.5**

- USBC and federal agencies should recognize and endorse the Global strategy for IYCF
- Not only have we not agreed on whether to have a policy but what that policy should be
- There is no evidence about how best to communicate about complementary feeding including timing, content and who/how.

#### **Recommendations** (*List actions recommended to bridge the gaps*):

**7.1** The US should develop and implement a national IEC strategy for improving infant and young child feeding and include the establishment of a National Breastfeeding Coordinator. Incorporated in to the policy should be assurance that all information and materials are free from commercial influence/potential conflicts of interest are avoided. The WHO Code should be implemented and enforced.

**7.2** Government agencies that administer programs providing nutrition counseling need to collaborate to provide consistent training of health care providers, such as home visit nurses, and messaging to families about IFYC feeding.

#### **7.4/7.5**

- USBC and its partner organizations should implement collaborative efforts to advocate for federal and other agencies to recognize and endorse the Global Strategy for IYCF
- The federal government should adopt the WHO Code (International Code of Marketing of Breast-milk Substitutes) and enforce/implement
- FDA should regulate infant formula (e.g. ingredients) according to WHO standards; adopt WHO guidelines so FDA, USDA and formula companies are held to the same standards
- US should establish interdisciplinary group to develop a national communication strategy to effectively promote, support and protect breastfeeding
- Professional organizations that have components of IYCF feeding should be mandated to adopt WHO guidelines inclusive of the WHO feeding hierarchy.
- All families should be eligible for education similar to that made available to WIC clients.
- Infant feeding guidelines being promulgated; the above recommendations should be reviewed in light of these guidelines to identify consistencies, gaps and inconsistencies.
- Identify effective strategies for communicating about risks of artificial feeding need to be identified
- Determine what data are available on how information about risks of artificial feeding is being disseminated (what, by whom and to whom).

## Indicator 8: Infant Feeding and HIV

**Key question:** Are policies and programmes in place to ensure that HIV - positive mothers are supported to carry out the national recommended Infant feeding practice?

<i>Guidelines for scoring</i>			
Criteria	Results		
	✓ <i>Check that apply</i>		
	Yes	To some degree	No
8.1) The country has a comprehensive updated policy in line with international Guidelines on infant and young child feeding that includes infant feeding and HIV	2	1	0
			✓
8.2) The infant feeding and HIV policy gives effect to the International Code/ National Legislation	1	0.5	0
			✓
8.3) Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.	1	0.5	0
		✓	
8.4) HIV Testing and Counselling (HTC)/ Provide Initiated HIV Testing and Counselling (PIHTC)/ Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.	1	0.5	0
	✓		
8.5) Infant feeding counselling in line with current international recommendations and appropriate to local circumstances is provided to HIV positive mothers.	1	0.5	0
			✓
8.6) Mothers are supported in carrying out the recommended national infant feeding practices with further counselling and follow-up to make implementation of these practices feasible.	1	0.5	0
			✓
8.7) HIV positive breastfeeding mothers, who are supported through provision of ARVs in line with the national recommendations, are followed up and supported to ensure their adherence to ARVs uptake.	1	0.5	0
			✓

8.8) Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.	1	0.5	0
			✓
8.9) On-going monitoring is in place to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status.	1	0.5	0
	✓		
<b>Total Score:</b>		<b>2.5/10</b>	

**Information Sources Used** (please list):

1. Center for Disease Control and Prevention, (2018) *HIV Among Pregnant Women, Infants, and Children*. Retrieved from <https://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html>
2. Center for Disease Control and Prevention. (2018). *Breastfeeding – HIV* Retrieved from <https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/maternal-or-infant-illnesses/hiv.html>
3. American Academy of Pediatrics. (2013) *Infant Feeding and the Transmission of Immunodeficiency Virus in the United States*. Retrieved from <https://pediatrics.aappublications.org/content/131/2/391>
4. United States Department of Health and Human Services. (2019) *Guidelines for Use of Antiretroviral Agents in Pediatric HIV infection* <https://aidsinfo.nih.gov/guidelines>
5. Global Breastfeeding Collective (2018) *Breastfeeding and HIV* Retrieved from <https://www.unicef.org>nutrition>files>
6. American College of Obstetrics and Gynecology. (2016) *Gynecological Care for Women and Adolescents with Human Immunodeficiency Virus* Retrieved from <https://acog.org>
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- Possible Racial Disparities in NICU Breast milk Use January 2018 Hospitals located in zip code
9. United States Department of Health and Human Services. (2018) *Postpartum Follow-up of Women Living with HIV Infection* Retrieved from <https://aidsinfo.nih.gov>
10. <https://www.ncbi.nlm.nih.gov/pubmed/22945404>
11. United States Department of Health and Human Services (2018) *Recommendations for the Use of Antiretroviral Drugs in Pregnant Woman with HIV Infection and Interventions to Reduce Perinatal Transmission in the United States*. Retrieved from <https://aidsinfo.nih.gov/guidelines>

12. Center for Disease Control and Prevention (January 24, 2018) Contraindications to Breastfeeding or Feeding Expressed Breast milk to Infants <https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/contraindications-to-breastfeeding.html>
13. Human Immunodeficiency Virus (HIV) Infection: Screening (April 2013) <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/human-immunodeficiency-virus-hiv-infection-screening>
14. U.S. Department of Health and Human Services Preventing Mother-to-Child Transmission of HIV (December 18, 2018) <https://aidsinfo.nih.gov/understanding-hiv-aids/fact-sheets/20/50/preventing-mother-to-child-transmission-of-hiv>
15. American College of Obstetrics and Gynecology (June 2015) <https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Prenatal-and-Perinatal-Human-Immunodeficiency-Virus-Testing?IsMobileSet=false>

**Conclusions** (*Summarize which aspects of IYCF policy, program and coordination are appropriate; which need improvement and why; and any further analysis needed*):

1. The United States has not developed nor implemented a comprehensive, evidence-based national infant and young child feeding policy in line with the Global Strategy for IYCF and including infant feeding and HIV. The AAP, CDC, US DHHS, and ACOG recommend that HIV-infected women not breastfeed their infants or provide their milk to their infants regardless of maternal viral load and AVR therapy. The Centers for Disease Control and Prevention (CDC) has advised health services to counsel HIV-positive mothers to avoid all breastfeeding as the strategy that will most likely give infants the greatest chance of survival and remaining HIV-negative. The United States Department of Health and Human Services (US DHHS) recommends that mothers with confirmed or suspected HIV infection not breastfeed because safer alternatives are available.
2. In 2016, as reported by the CDC, 65% of the diagnoses of perinatal HIV infections in the US were in the Black/African American population. In the same year, percentages of diagnoses for other races/ethnicities were as follows: Asians 3%, Hispanic/Latino 15%, White 13%, and Multiple Races 4%. In addition, the CDC states, “Social and economic factors, especially poverty, affect access to all health care, and disproportionately affect people living with HIV.” Furthermore, it has been shown that hospital in a zip code with an above average percentage of black residents are less likely to use breastmilk in the neonatal intensive care units. Many of the infants born to mothers who are HIV positive would be cared for in the NICU. (*Possible Racial Disparities in NICU Breast milk*)
3. As it is the standard of practice to recommend that mothers who are HIV-positive not breastfeed, health staff and community worker receive training only on that aspect of breastfeeding and HIV. Various other options are taught to health staff or community workers and women are not counseled on these options. In most cases, the option of banked donor milk is not discussed with women.

4. The United States does not have a national policy for adherence to the International Code of the Marketing of Breastmilk Substitutes. The AAP recommends that in the case where a mother is HIV-positive physicians recommend formula feeding and assist families to access formula when the family lacks financial resources.

5. Confidential HIV testing and counseling for pregnant women and their partners is universally offered in the US. Opt-out testing is recommended whereby a pregnant woman will be tested unless she refuses.

6. The CDC has developed a framework intended to guide federal agencies and other organizations in their efforts to reduce the rate of perinatal transmission of HIV. In addition, the CDC funds the Integrated Human Immunodeficiency Virus Surveillance and Prevention Programs for Health Departments.

7. In the document, *Infant Feeding and the Transmission of Immunodeficiency Virus in the United States*, from AAP (2013), there is offered a plan of counseling and support for the HIV-positive mother who is taking ARTs and has repeatedly undetectable HIV viral loads. It is stated that this circumstance not provide ground for an automatic referral to Child Protective Services.

8. In the document, *Recommendations for the Use of Antiretroviral Drugs in Pregnant Woman with HIV Infection and Interventions to Reduce Perinatal Transmission in the United States*, the HHS Panel on Treatment of Pregnant Woman with HIV Infection and Prevention of Perinatal Transmission states that breastfeeding is not recommended for women living with HIV in the United States. However in the section, *Guidance for Counseling and Managing Women Living with HIV in the United States Who Desire to Breastfeed*, the panel recommends the following:

- Women who have questions about breastfeeding or who desire to breastfeed should receive patient-centered, evidence-based counseling on infant feeding options.
- When women with HIV chose to breastfeed despite intensive counseling, they should be counseled to use harm-reduction measures to minimize the risk of HIV transmission to their infants.

**Gaps** (*List gaps identified in the implementation of this indicator*):

1. In the United States, despite current evidence-based global recommendations, HIV-positive women are being counseled to not breastfeed their infants.

2. Formula is the current recommended substitute for infant feeding when the mother is HIV-positive. Donor milk is offered in most counseling situations.

3. Disparities in access to care and support exist regarding the HIV-positive mother and her infant.

4. Social media and the Internet serve as a source of misinformation about infant feeding options that

are not safe for HIV-positive women.

5. U.S. Department of Health and Human Services does not recommend donor milk for infants who are born to HIV positive mothers.

6. Hospitals located in zip codes with an above-average percentage of black residents are less likely to use breast milk in their neonatal intensive care unit (NICU), a recent CDC **study** found.

Reference:

- Journal of American Medical Association (JAMA) (January 23/30, 2018)  
<https://jamanetwork.com/journals/jama/article-abstract/2670264>
- Center for Disease Control and Prevention (December 8, 2018)  
<https://www.cdc.gov/mmwr/volumes/66/wr/mm6648a1.htm>

**Recommendations** (*List actions recommended to bridge the gaps*):

1. A national IYCF policy should be developed and implemented with inclusion of the current evidence-based of evidence-based guidelines for mothers who are HIV-positive. In the document, *Breastfeeding and HIV* (Nov 2018), the Global Breastfeeding Collective, states, “Mothers living with HIV can breastfeed without negative consequences for their own health and the health of their children. When these mothers take antiretroviral medicine consistently throughout the breastfeeding period, the risk of transmitting to their infants is extremely low.”
2. Women who are HIV positive should universally have access to antiretroviral medications, beginning at the time when a positive status is discovered and continuing as long as is prescribed by current research.
3. Health care staff and community workers should be trained to understand the infant feeding options for women living with HIV and counsel women appropriately.
4. A plan of intense follow-up and support should be designed nationally to offer support for breastfeeding women who are HIV-positive. The plan should include universal accessibility to this support.
5. Donor milk should be included as a feeding option for infants whose mothers are HIV positive. There should be at the national level, an effort to increase the availability of donor milk in communities. Accessibility to the donor milk should be inclusive of all mother and infants, regardless of race, ethnicity, socioeconomic status or geographic location.
6. When developing programs of support for breastfeeding women who are HIV-positive, the International Code of the Marketing of Breastmilk Substitutes should be upheld.

## Indicator 9: Infant and Young Child Feeding during Emergencies

**Key question:** *Are appropriate policies and programmes in place to ensure that mothers, infants and young children will be provided adequate protection and support for appropriate feeding during emergencies?*

<b>Guidelines for scoring</b>			
<b>Criteria</b>	<b>Scoring</b>		
	✓ <b>Check that apply</b>		
	Yes	To some degree	No
9.1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance	2	1	0
			✓
9.2) Person(s) tasked with responsibility for national coordination with all relevant partners such as the UN, donors, military and NGOs regarding infant and young child feeding in emergency situations have been appointed	2	1	0
			✓
9.3) An emergency preparedness and response plan based on the practical steps listed in the Operational Guidance has been developed and put into effect in most recent emergency situations, and covers:  a) basic and technical interventions to create an enabling environment for breastfeeding, including counseling by appropriately trained counselors, support for relactation and wet-nursing, and protected spaces for breastfeeding  b) measures to minimize the risks of artificial feeding, including an endorsed statement on avoidance of donations of breastmilk substitutes, bottles and teats, and standard procedures for handling unsolicited donations, and procurement management and use of any infant formula and BMS, in accordance with strict criteria, the IFE Operational Guidance, and the International Code and subsequent relevant WHA resolutions	1	0.5	0
			✓
	1	0.5	0
			✓

9.4) Resources have been allocated for implementation of the emergency preparedness and response plan	2	1	0
			✓
9.5) a) Appropriate orientation and training material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel.  b) Orientation and training is taking place as per the national emergency preparedness and response plan	1	0.5	0
			✓
	1	0.5	0
			✓
<b>Total Score:</b>	<b>0/10</b>		

**Information Sources Used** *(please list):*

1. <http://getreadyforflu.org/hurricanes.htm>
2. <http://napplsc.org/page-18105>
3. <https://sph.unc.edu/cgbi/cgbi-resources-l-i-f-e-support-basic-kit/>
4. <http://www.usbreastfeeding.org/emergencies>
5. <http://www.alimentacionsegura.org/>
6. <https://www.lli.org/breastfeeding-info/infant-feeding-emergencies-multilingual/>
7. <https://www.lli.org/breastfeeding-info/infant-feeding-emergencies-multilingual/>
8. <file:///C:/Users/pamphlet/Downloads/InfantNutritionDisaster.pdf>
9. Centers for Disease Control and Prevention. (2019, March 26). Proper Storage and Preparation of Breast Milk | Breastfeeding | CDC. Retrieved March 30, 2019, from Breastfeeding website: [https://www.cdc.gov/breastfeeding/recommendations/handling\\_breastmilk.htm](https://www.cdc.gov/breastfeeding/recommendations/handling_breastmilk.htm)

**Conclusions** *(Summarize which aspects of IYCF policy, program and coordination are appropriate; which need improvement and why; and any further analysis needed):*

1. Hurricane Katrina demonstrated the cracks and weaknesses in the US system of emergency response to disasters. Unfortunately those cracks have continued to be exposed by further emergencies such as Hurricane Maria, Hurricane Harvey, Hurricane Michael, and the Flint Michigan water crisis.
2. There is no national policy or procedure in place to address IYCF during emergencies. However there are several grassroots and organizational efforts being made such as USBC, Alimentacion Segura Infantil (ASI), Carolina Global Breastfeeding Institute Initiative LIFE (Lactation and Infant Feeding in Emergencies), Safely Fed USA, NAPPLC statement on infant feeding during disasters, Save the Children, Well Start International.

3. The current lead for emergency response in the United States now rests with Health and Human Services: the Office of the Assistant Secretary for preparedness and response.
4. The overall response to emergencies in the United States is inequitable in that communities of color and underserved populations are often the last to receive care and help and the help they do receive is substandard.
5. Some states do make mention of breastfeeding and human milk as important during disasters but it is inconsistent from state to state.

**Gaps** (*List gaps identified in the implementation of this indicator*):

1. This entire topic is a gap in that there is no current policy or procedure in place to address IYCF during emergencies.
2. People most impacted by disasters are often underserved communities and communities of color and poor communities because they are unable to leave during a crisis.
3. Policy and strategy documents do not address breastfeeding and relactation in emergencies
4. Policy and strategy documents do not address donor milk use in emergencies.
5. Policy and strategy documents do not address a safe alternative for those who are feeding formula already such as ready-to-feed.
6. Policy and strategy documents do not address proper preparation, storage, and handling of infant formula and there is no distribution plan for donated formula.
7. Policy and strategy documents do not address stocking emergency supplies of donor milk.

**Recommendations** (*List actions recommended to bridge the gaps*):

1. Establish a National Infant Feeding Coordinator in the office of the Surgeon general. Job description should include, but not be limited to:
  - a. Permanent position within the surgeon General's office. Report to the Surgeon General.
  - b. Documented training in lactation.
  - c. Coordinate/implement all policies related to IFE.
  - d. Coordinate all other agencies/NGO's with any responsibility for infants and young children
2. Training of response personnel and HHS staff, responders, medical reserve corps (active duty, reserve, and National Guard), and volunteers is needed. Both medical and other corps that respond during disasters (logistics, communications, etc.), should be cross trained in IFE Operational Guidance, as well as culturally sensitive situational awareness and should evaluate and revise best practices as far as collaborating with NGOs.
3. Ensure that all training and care is culturally appropriate and trauma informed for the impacted communities
4. Examine critical supply lists, procurement, and stockpiling policies for IYCF
5. Breastfeeding and IFE should be included in preservice education of all health care providers.
6. Include peer and professional lactation care givers as members of emergency response teams.
7. Incorporate HMBANA's Emergency Plan for delivering donor milk to areas of need.
8. Ensure there are safe and secure areas in shelters for breastfeeding mothers. This includes disaster shelters as well as immigration shelters.

## Indicator 10: Mechanisms of Monitoring and Evaluation System

**Key question:** Are monitoring and evaluation systems in place that routinely collect, analyse and use data to improve infant and young child feeding practices?

Guidelines for scoring			
Criteria	Scoring		
	✓ Check that apply		
	Yes	To some degree	No
10.1) Monitoring and evaluation components are built into major infant and young child feeding programme activities.	2	1	0
	✓		
10.2) Data/information on progress made in implementing the IYCF programme are used by programme managers to guide planning and investments decisions	2	1	0
	✓		
10.3) Data on progress made in implementing IYCF programme activities routinely collected at the sub national and national levels	2	1	0
	✓		
10.4) Data/Information related to infant and young child feeding programme progress are reported to key decision-makers	2	1	0
	✓		
10.5) Monitoring of key infant and young child feeding practices is integrated into the national nutritional surveillance system, and/or health information system or national health surveys.	2	1	0
	✓		
<b>Total Score:</b>	<b>10/10</b>		

### Information Sources Used (please list):

1. <http://www.cdc.gov/prams/questionnaire.htm>
2. <http://www.cdc.gov/prams/>
3. Regarding the previous links, core questions include education about breastfeeding (#19), childbirth classes (#25), home visit (#26 & 49), WIC participant (#27). Standard questions are optional so states may add questions of interest that are standardized across the country. There are lots of categories—to call out a few: B series about BF and what happens in the hospital, early introduction of solid foods; C questions about time off from work, paid time; and there are questions about labor, HIV etc.

4. Title V <http://mchb.hrsa.gov/programs/titlevgrants/index.html> Breastfeeding is a national performance measure - 49 states selected BF as a performance measure (unchanged from 2016). <https://mchb.tvisdata.hrsa.gov/>
5. <https://www.fns.usda.gov/wic/breastfeeding-priority-wic-program>
6. Home visiting programs funded through the Affordable Care Act (MIECHV) require annual reporting on breastfeeding as one of their mandatory systems outcomes (Percent of infants (among mothers who enrolled in home visiting prenatally) who were breastfed any amount at 6 months of age performance). <https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/pdf/programbrief.pdf>
7. [Prevention strategies](#)
8. A variety of training programs from pre-service to in-service <https://mchb.hrsa.gov/maternal-child-health-initiatives/mchb-programs/programs-initiatives-z> (breastfeeding is not a singular training program but would be embedded in a program as appropriate). Training programs are also available through state, local and tribal organizations/agencies, and through organizations such as American Public Health Organization, National Association of County and City Health Officials and through health professions associations (e.g. American Academy of Pediatrics; Association of Women's Health, Obstetric and Neonatal Nurses).
9. NIS data describing disparities [https://www.cdc.gov/breastfeeding/data/nis\\_data/rates-any-exclusive-bf-socio-dem-2015.htm](https://www.cdc.gov/breastfeeding/data/nis_data/rates-any-exclusive-bf-socio-dem-2015.htm)
10. mPINC (see table)
11. National Conference of State Legislatures tracks progress on breastfeeding related legislation; a summary was posted in n018; <http://www.ncsl.org/research/health/breastfeeding-state-laws.aspx>
12. <https://fns-prod.azureedge.net/sites/default/files/ops/WIC-ITFPS2-Year2Report.pdf>
13. Donor milk distribution <https://www.hmbana.org/news/blog.html/article/2018/03/14/nonprofit-donor-human-milk-distribution-reaches-record-high-in-2017>
14. <https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/pages/2018-employee-benefits.aspx>
15. [Harvard School of Public Health includes a number of relevant databases.https://web.sph.harvard.edu/mch-data-connect/?sfid=1730&sf\\_database\\_keyword=breastfeeding&sf\\_paged=2](https://web.sph.harvard.edu/mch-data-connect/?sfid=1730&sf_database_keyword=breastfeeding&sf_paged=2)
16. Economic costs of not breastfeeding have been studied at the national level; Bartick M. Breastfeeding and the U.S. economy. Breastfeed Med. 2011; Oct;6:313-8. doi: 10.1089/bfm.2011.0057. PubMed PMID: 22007819.
17. <https://www.ncbi.nlm.nih.gov/pubmed/27837954>

**Conclusions** (*Summarize which aspects of IYCF policy, program and coordination are appropriate; which need improvement and why; and any further analysis needed*):

1. The US has one infant and young child feeding program, the Special Supplemental Nutrition Program for Women, Infants, and Children, referred to as WIC. This program is implemented in all 50 states and the District of Columbia, US territories, tribal lands, and US military installations outside the US through local agencies. WIC provides a prescriptive food package of healthy foods (through an electronic benefit card) to eligible pregnant and lactating women and children up to the age of 5. Eligibility based on poor income or at risk for poor nutritional status. The program supports breastfeeding through classes, individual counseling and support. The latter includes designated breastfeeding peer counselors who are typically former WIC clients who engage with pregnant women to encourage them to intend to breastfeed and postpartum provide support and encouragement to continue breastfeeding.

Until the Affordable Care Act, depending on the agency breast pumps were also available through WIC. The redesigned WIC food packages were implemented by 2014 across the US with the goal to further incentivize women to breastfeed, offering them a more desirable postpartum maternal food and additional baby food starting at month 7 if they breastfed. While the bar for eligibility is relatively low, compared to other state and federal entitlement programs such as Medicaid (health insurance) only about 50-60% of eligible mothers participate in WIC, thus limiting its reach and potential impact on mothers. By contrast approximately 50% of US born infants receive WIC benefits. (10.1)

2. Pertinent to this indicator the WIC program collects data from each participant upon enrollment and at subsequent visits (and at reauthorization). Data include demographics, weight and height and breastfeeding outcomes (initiation, duration and exclusivity). These data are collected by local programs, aggregated by states and submitted to the national WIC program. Both state and national level reports are created annually that provide for comparisons overtime. WIC-IFPS study (nationally representative data) reported in 2018 demonstrated reductions in the early introduction of complementary food.
3. Beginning in 1990 breastfeeding data led to the segregation of breastfeeding funds from other WIC funds to be sure that breastfeeding programs were adequately funded at the state and local levels. This led to a rise in WIC breastfeeding rates in the 1990s such that the major increase in BF in the US was among low income women due to this programmatic funding change. More recent examples of how these data are used include: changes in the nutrition package, funding for BF peer counselors, training and materials and the every five year federal reauthorization of the program. (10.2)
4. As noted individual data on WIC mothers are routinely and systematically collected at the local/agency level, aggregated at the state (sub-national) level and national level <https://fns-prod.azureedge.net/sites/default/files/wic/FY%202017%20BFDLA%20Report.pdf>. Data from the WIC-IFPS are publically available. (10.3)
5. Key decision makers are defined as local WIC coordinators/managers, state programs directors, federal bureaucrats and elected officials for both the purpose of evaluating the program and funding reauthorization. (10.4)
6. Data from the WIC program is limited to its participants. Other national surveys include breastfeeding data, most notably the National Immunization Survey that started including these data over a decade ago. The NIS uses a population, sampling strategy that includes all mothers (of infants ages 19-35) including those who would be WIC eligible. Donor milk distribution is being reported by Human Milk Banking Association of North America (10.5)
7. The Infant Feeding Practices Survey, while not nationally representative, collected longitudinal data on approximately 2000 mother-infant/child dyads participated (enrollment occurred in 2005) and participated through the child's first year; a six-year follow-up was subsequently conducted in 2012 (with nearly 3000 eligible dyads). This federally funded work has resulted in significant publications. Both databases are available for additional studies/analysis. <https://www.cdc.gov/breastfeeding/data/ifps/results.htm>
8. The national birth certificate, while not a surveillance system or health survey, includes feeding status at hospital discharge. As of 2017 most states are using the 2003 revised birth certificate items. Specific to BF the question is "Is the infant being breastfed at discharge".

<https://www.cdc.gov/nchs/data/dvs/birth11-03final-ACC.pdf>

9. NHANES (a nationally representative sample of US families) began including early infant feeding items in their 2003 survey. Survey data can be used to assess duration and exclusivity of breastfeeding. There are no routinely published reports summarizing the NHANES data.  
<https://www.cdc.gov/nchs/nhanes/index.htm>
10. The Pregnancy Risk Assessment Monitoring System (PRAMS) is a national system implemented by states (voluntarily) that includes questions about mothers experiences with hospital breastfeeding practices and postpartum breastfeeding outcomes. Forty-seven states, New York City, Puerto Rico, the District of Columbia and the Great Plains Tribal Chairmen's Health Board (GPTCHB) currently participate in PRAMS, representing approximately 83% of all U.S. live births. Two other states (California and Ohio) previously participated.
11. Legislative progress at the state level is tracked for several breastfeeding related initiatives: protections for breastfeeding in public (all 50 state), paid leave, breastfeeding awareness education and workplace lactation.
12. Disparities remain a significant concern when interpreting BF outcome data. While progress is being made it is uneven across key demographic subgroups (income, geographic, race/ethnicity).
13. mPINC is a national monitoring platform of hospital practices related to maternal and infant nutrition and care.
14. Economic costs: Bartick M. Breastfeeding and the U.S. economy. Breastfeed Med. 2011 Oct;6:313-8. doi: 10.1089/bfm.2011.0057. PubMed PMID: 22007819
15. Rates of perinatal transmission of HIV are monitored but not specific to BF as BF is not recommended for HIV+ mothers in the US.  
<https://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html>
16. The following tables crosswalks Indicator 10 with the other indicators and the portions of those indicators that relate to Indicator 10:

Indicator 1	
There is no national IYCF policy to monitor or evaluate	
US Dietary Guidelines do not include under two's and are not monitored however guidelines for under 2's are being developed	
SG call to action has formed the basis of the USBC strategic plan and is monitored by the USBC and reported by that organization	<a href="http://www.usbreastfeeding.org/p/cm/ld/fid=168">http://www.usbreastfeeding.org/p/cm/ld/fid=168</a>
The USBC reports on its links with health, nutrition and other sectors.	<a href="http://www.usbreastfeeding.org/p/cm/ld/fid=17">http://www.usbreastfeeding.org/p/cm/ld/fid=17</a>
Indicator 2	

The BFHI program data is collected by Baby-Friendly USA and reported as part of the Healthy People Goals and the CDC's Breastfeeding Report Card	<a href="https://www.babyfriendlyusa.org/about/">https://www.babyfriendlyusa.org/about/</a>  <a href="https://www.cdc.gov/breastfeeding/data/reportcard.htm">https://www.cdc.gov/breastfeeding/data/reportcard.htm</a>
Indicator 3	
The USBC has indicated interest in working toward implementing the International Code of Marketing of Breastmilk Substitutes and subsequent resolutions. No monitoring in place.	<a href="http://www.usbreastfeeding.org/p/cm/ld/fid=398">http://www.usbreastfeeding.org/p/cm/ld/fid=398</a>
Indicator 4	
<p>The Healthy People Goal on maternity protection by workplaces is monitored by SHERM and reported by the CDC on the Breastfeeding Report Card</p> <p>Legislation related to state laws and maternity protection is monitored and reported by NCSL</p>	<a href="https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/pages/2018-employee-benefits.aspx">https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/pages/2018-employee-benefits.aspx</a>  <a href="https://www.cdc.gov/breastfeeding/data/reportcard.htm">https://www.cdc.gov/breastfeeding/data/reportcard.htm</a>  <a href="http://www.ncsl.org/research/health/maternal-and-child-health-database.aspx">http://www.ncsl.org/research/health/maternal-and-child-health-database.aspx</a>
Indicator 5	
Baby-Friendly USA reports the number of hospitals that are designated with the assumption that staff have been trained.	<a href="https://www.babyfriendlyusa.org/about/">https://www.babyfriendlyusa.org/about/</a>
Indicator 6	
<p>PRAMS Core and Standard Questionnaire collect breastfeeding data</p> <p>WIC-IFPS, mPINC and NIS report on whether women receive support for IYCF at birth to initiate breastfeeding</p> <p>There is no national monitoring of M2M support although the number of La Leche Leaders has been reported on the CDC's Breastfeeding Report Card.</p>	<a href="https://www.cdc.gov/prams/questionnaire.htm">https://www.cdc.gov/prams/questionnaire.htm</a>   <a href="https://www.fns.usda.gov/wic/wic-infant-feeding-practices-study">https://www.fns.usda.gov/wic/wic-infant-feeding-practices-study</a>  <a href="https://www.cdc.gov/breastfeeding/data/mpinc/index.htm">https://www.cdc.gov/breastfeeding/data/mpinc/index.htm</a>  <a href="https://www.cdc.gov/breastfeeding/data/nis_data/">https://www.cdc.gov/breastfeeding/data/nis_data/</a>

Indicator 7	
Nothing Specific to monitoring	
Indicator 8	
Breastfeeding is not recommended for HIV+ women in the united States, however perinatally acquired HIV is monitored and reported on the CDC HIV among pregnant women infants and children website.	<a href="https://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html">https://www.cdc.gov/hiv/group/gender/pregnantwomen/index.html</a>
Indicator 10	
Resources could be monitored as well as orientation and training for relevant personnel however no action has been taken	

**Gaps** (*List gaps identified in the implementation of this indicator*):

1. IYCF program only covers women at lower socioeconomic status
2. PRAMS response rates are falling although we are approaching universal survey implementation
3. How breastfeeding is defined varies widely and limits comparisons across data sources
4. Difficult to make comparisons between WIC and non-WIC mothers to separate secular trends from WIC program impacts
5. Data are not sufficiently granular at the state or local or program level to develop or evaluate programs that are specific to the local or state or program context including breakdowns by subgroup across key breastfeeding time periods or outcomes
6. Racial and demographic data are not consistently collected or collected in a usable fashion to address disparities and access to care

**Recommendations** (*List actions recommended to bridge the gaps*):

1. Establish more consistent definitions of breastfeeding to be used across the various data collection platforms.
2. Expand the dissemination of PRAMS to key decision makers in a digestible format; key decision makers to include those who influence policy and funding either directly (as elected or appointed officials or leaders of health care organizations (including insurers) or funders (e.g. WKCF; Gates Foundation) or indirectly as advocacy organizations (American Public Health Association), associations representing public health officials (e.g. NACCHO, APHN or professional organizations (e.g. ANA, AAP).
3. 2016 recommendation that continues: Explore opportunities to link across datasets
4. Link BF peer counselor programs and community outreach programs to outcome measurement.
5. Preserve monitoring even as breastfeeding rates improve in that improvements are uneven across subgroups (e.g. geographic, racial/ethnic, income status).
6. Donor milk should be included as a key IYC feeding practice.

## Indicator 11: Early Initiation of Breastfeeding

**Key question:** What is the percentage of babies breastfed within one hour of birth? **69.4%**

### Guideline:

Indicator 11	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
Initiation of Breastfeeding (within 1 hour)		<i>Scores</i>	<i>Colour-rating</i>
	0.1-29%	3	Red
	29.1-49%	6	Yellow
	49.1-89%	9	Blue
	89.1-100%	10	Green

### Data Source (including year):

- Centers for Disease Control and Prevention (2015) Maternity practices in infant care and nutrition (mPINC) survey. Data table Survey results, 2007-2015; 2015; Maternity Care Practices; Results; Labor & Delivery; Tables 1.3a and 1.4a.
- [https://www.cdc.gov/breastfeeding/data/mpinc/data/2015/tables1\\_1a-1\\_5a.htm](https://www.cdc.gov/breastfeeding/data/mpinc/data/2015/tables1_1a-1_5a.htm)

### Comments:

The percentage reported in this table is actually the percentage of hospitals reporting in mPINC survey that 90% of infants born via uncomplicated vaginal delivery who are put to the breast within one hour of birth (69.4%).

In the case of uncomplicated Cesarean delivery, the percentage is those hospitals reporting infants go to the breast within 2 hours of birth. In this case, 67.6% of hospitals reported that in 90% or more births, this was the case.

There does exist a disparity in the placement of Baby-Friendly hospitals in the US with fewer Baby-Friendly designated hospitals being located in neighborhoods where black women live.

## Indicator 12: Exclusive Breastfeeding for the First Six Months

**Key question:** What is the percentage of babies 0<6 months of age exclusively breastfed<sup>10</sup> in the last 24 hours? **24.9%**

### Guideline:

Indicator 12	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
Exclusive Breastfeeding (for first 6 months)		<i>Scores</i>	<i>Colour-rating</i>
	0.1-11%	3	Red
	11.1-49%	6	Yellow
	49.1-89%	9	Blue
	89.1-100%	10	Green

### Data Source (including year):

Center for Disease Control and Prevention Breastfeeding Report Card 2018

<https://www.cdc.gov/breastfeeding/data/reportcard.htm>

**Conclusions:** US National Immunization Survey (NIS) is conducted yearly and includes breastfeeding questions to determine population rates. There is a 2 year time span between collecting and publishing the data. Five breastfeeding indicators are collected, including exclusive breastfeeding at 6 months. Other indicators collected include ever breastfed, breastfeeding at 6 months, breastfeeding at 12 months and exclusive breastfeeding at 3 months. Healthy People 2020, the nation's health indicators, establish targets for each indicator. Efforts are under way for the development of the 2030 agenda.

<sup>10</sup> Exclusive breastfeeding means the infant has received only breastmilk (from his/her mother or a wet nurse, or expressed breastmilk) and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines (2)

## Indicator 13: Median Duration of Breastfeeding

**Key question:** *Babies are breastfed for a median duration of how many months?* **Est. 6 months**

### Guideline:

Indicator 13	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
Median Duration of Breastfeeding		Scores	Colour-rating
	0.1-18 Months	3	Red
	18.1-20   ''	6	Yellow
	20.1-22   ''	9	Blue
	22.1- 24   or beyond   ''	10	Green

Median US eBF duration in 2016 was 4 months (IQR (interquartile range): 1.35–5.97), increased from 2 months (IQR: 0.03–4.97) in 2011. Median duration of BF was 6 months (IQR: 3.00 – 12.00) in 2011 and increased to 8 months (IQR: 3.00 – 12.00) in 2016.

### Data Source (including year):

<https://www.liebertpub.com/doi/full/10.1089/bfm.2018.29100.abstracts>

<https://www.cdc.gov/vaccines/imz-managers/nis/index.html>

### Comments:

The National Immunization Surveys (NIS) are a group of telephone surveys sponsored and conducted by CDC's National Center for Immunization and Respiratory Diseases (NCIRD). Since 2011, the National Immunization Surveys have used a dual frame survey design, including landline and cell phone numbers for household interviews with parents or guardians. Infant feeding questions were added in 2001. The questions as of 2006 are:

1. Was [child] ever breastfed or fed breast milk?
2. How old was [child's name] when [child's name] completely stopped breastfeeding or being fed breast milk?
3. How old was [child's name] when (he/she) was first fed formula?
4. This next question is about the first thing that [child] was given other than breast milk or formula. Please include juice, cow's milk, sugar water, baby food, or anything else that [child] may have been given, even water. How old was [child's name] when (he/she) was first fed anything other than breast milk or formula?

The limitation of using the NIS data is that they are collected for children between the ages of 18 and 36 months and some mothers will still be breastfeeding. As a result our calculated median likely *slightly* understates the US median but not significantly enough for it to change our score on this indicator.

## Indicator 14: Bottle feeding

**Key question:** *What percentage of breastfed babies 0-12 months of age, who are fed with any foods or drinks (even breastmilk) from bottles? Est. 30%*

### Guideline:

Indicator 14	Key to rating adapted from WHO tool (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
Bottle Feeding (0-12 months)		Scores	Colour-rating
	29.1-100%	3	Red
	4.1-29%	6	Yellow
	2.1-4%	9	Blue
	0.1-2%	10	Green

### Data Source (including year):

Centers for Disease Control and Prevention. (2012). Infant feeding practices study II and its year 6 follow-up results. Retrieved from table 3.9

<http://www.cdc.gov/breastfeeding/data/ifps/results/ch3/table3-22.htm>

### Comments:

This data is not reported on specifically. We have estimated that 30% of babies are fed from bottles by one year based on latest CDC/FDA Infant Feeding Practices Study (IFPSII)

## Indicator 15: Complementary feeding --- Introduction of solid, semi-solid or soft foods

**Key question:** *Percentage of breastfed babies receiving complementary foods at 6-8 months of age?*  
**91.8%**

### Guideline

Indicator 15	WHO's	IBFAN Asia Guideline for WBTi	
Complementary Feeding (6-8 months)	<i>Key to rating</i>	<i>Scores</i>	<i>Colour-rating</i>
	0.1-59%	3	Red
	59.1-79%	6	Yellow
	<b>79.1-94%</b>	<b>9</b>	<b>Blue</b>
	94.1-100%	10	Green

### Data Source (including year):

Barrera, Hamner, Perrine, & Scanlon, 2018 (data collected between 2009-2014)

### Comments:

In the United States, it is more common that complementary feeding (CF) starts *too early*, rather than too late. Current U.S. recommendations call for the addition of complementary foods at “around 6 months of age as developmentally appropriate” (American Academy of Pediatrics, 2019).

Data from the National Health and Nutrition Examination Survey (NHANES) collected between 2009 and 2014 indicates that 54.6% of infants receive CF prior to 6 months; 37.2% between 6 and <8 months, and 8.2% between 8 and 12 months (Barrera, Hamner, Perrine, & Scanlon, 2018). Thus, 91.8% of US infants have received CF by 6-8 months.

Data from the WIC Infant Toddler Feeding Practices Survey-2 collected data on infants born in 2013 and 2014, finding that 20% received CF before 4 months and that the median age of introduction of first foods (infant cereal) was 4.5 months (May et al., 2017). The manner of presentation of this data does not enable comparison with the formulation of this indicator.

While early CF is more of a challenge in the US than late CF, it is of concern that the 8.2% of US infants receive complementary foods after the recommended time frame (>8 and before 12 months). This parallels the concern raised by Woo et al. (2015), that those infants who receive the greatest proportion of their daily caloric intake as human milk at and after 6 months of age are also the least likely to achieve dietary diversity in the first 12 months, underscoring the need for education and support regarding the importance of appropriate, timely CF along with ongoing breastfeeding.

## References:

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## Summary Part I: IYCF Policies and Programmes

Targets:	Score (Out of 10)
1. National Policy, Programme and Coordination	4
2. Baby Friendly Hospital Initiative	6
3. Implementation of the International Code	0.5
4. Maternity Protection	2.5
5. Health and Nutrition Care Systems	8
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
<b>Score Part I (Total):</b>	<b>40.5</b>

### IBFAN Asia Guidelines for WBTi

Total score of infant and young child feeding policies and programmes (indicators 1-10) are calculated out of 100.

Scores	Colour- rating
0 – 30.9	Red
<b>31 – 60.9</b>	<b>Yellow</b>
61 – 90.9	Blue
91 – 100	Green

The United States does not have a national infant and young child feeding policy that has been officially adopted or approved by the government, although published position statements of national organizations support exclusive breastfeeding for six months and continued breastfeeding to at least one year. Although the current US Dietary Guidelines only include people aged 2 and above, it is anticipated that the 2020 revision is expected to include birth to 24 months.

The United States Breastfeeding Committee (USBC) links effectively with professional organizations, mother-to-mother support and advocacy organizations, state and local breastfeeding coalitions and federal and state governmental bodies. The structure of the USBC includes both elected and permanent staff including an Executive Director who regularly communicates to members and other interested parties throughout the country.

The United States has a robust Baby-Friendly Hospital Initiative (BFHI) with about 25% of hospitals designated and more than 25% of babies born in designated hospitals. An NGO, Baby-

Friendly USA is responsible for the designation process in the United States. Global criteria have been incorporated except in a few areas: HIV is contraindicated for breastfeeding mothers and babies in the US, so counseling is not included and the global expectation for exclusive breastfeeding is not mandated prior to assessment. Implementation of the International Code of Marketing of Breastmilk Substitutes and Subsequent Resolutions as they apply to hospitals is required for designated hospitals. Outside of the BFHI there has been no comprehensive action taken to implement the Code. The USBC is considering the best approach to fully implement the Code.

Recently, the United States has demonstrated interest in Family Leave and Maternity Protection. Currently there is no federal maternity leave law and no paid family leave law. Family and Medical Leave Act (FLMA) is unpaid leave for up to 12 work weeks, and only applicable to certain employees. The Pregnancy Discrimination Act makes discrimination illegal for “pregnancy or related conditions” and includes lactating people. The Affordable care Act (ACA) allows hourly workers unpaid milk expression related breaks at work.

Although training occurs as part of the journey to designation in Baby-Friendly Hospitals, only a quarter of US hospitals have been designated. Outside of the Baby-Friendly process there is an inconsistency across programs in meeting core breastfeeding competencies. Although the USBC includes delegates from mother-to-mother support organizations (and there are doubtlessly many others who are not represented), there is no national tracking or referral method in place.

The United States has no national, comprehensive information, education and communication strategy nor a national policy or program for improving infant and young child feeding across the population. The Woman Infants and Children (WIC) program (a supplementary nutrition and education program, funded with both state and national monies) serves more than 50% of all infants and, along with programs such as Head Start, Early Head Start reach at risk populations with commercial free materials and individual counseling.

The US has not developed a comprehensive, updated, evidence-based national infant and young child feeding policy which includes HIV and infant feeding. The national strategy, promulgated by the CDC, is that breastfeeding is contraindicated if the mother is HIV positive. Hurricanes and fires have demonstrated the cracks and weakness in the US system of emergency response system especially in regard to infants and young child feeding; however, no substantive policy changes have been put forth or implemented.

The United States has a robust monitoring and evaluation system that routinely collects, analyses and uses data to improve infant and young child feeding and reports the results to the public.

## ***Summary Part II: Infant and young child feeding (IYCF) practices***

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<b>IYCF Practice</b>	<b>Result</b>	<b>Score</b>
Indicator 11 Starting Breastfeeding (Initiation)	69.4%	9
Indicator 12 Exclusive Breastfeeding for first 6 months	24.9%	6
Indicator 13 Median duration of Breastfeeding	Est. 6 months	3
Indicator 14 Bottle-feeding	Est. 30%	3
Indicator 15 Complementary Feeding	91.8%	9
<b>Score Part II (Total)</b>		<b>30</b>

### **IBFAN Asia Guidelines for WBTi**

Total score of infant and young child feeding Practice (indicators 11-15) are calculated out of 50.

<b>Scores</b>	<b>Colour-rating</b>
0 – 15	<b>Red</b>
<b>16 - 30</b>	<b>Yellow</b>
31 - 45	<b>Blue</b>
46 – 50	<b>Green</b>

## Total of Part I and Part II (indicator 1-15): IYCF Practices and Policies and Programmes

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Total score of infant and young child feeding **practices, policies and programmes** (indicators 1-15) are calculated out of 150. Countries are then rated as:

Scores	Colour- rating
0 – 45.5	Red
46 – 90.5	Yellow
91 – 135.5	Blue
136 – 150	Green