



OMB Control No. 0920-0743

Assessment & Monitoring of Breastfeeding-Related Maternity Care Practices in Intrapartum Care Facilities in the United States and Territories

Key Points

1. We strongly support the continuation of the Breastfeeding-Related Maternity Care Practices in Intrapartum Care Facilities (“mPINC”) survey administration across the U.S. and Territories, without redaction of any data collection points.
2. The data collected by the mPINC survey helps to identify and improve the implementation of best practices and policies in maternity care to improve breastfeeding outcomes.

Introduction

The mission of the Infant Feeding Action Coalition USA, Inc. (INFACT USA) is to protect, promote and support breastfeeding in the United States by providing information and education on the World Health Organization's (WHO) International Code of Marketing of Breastmilk Substitutes (the Code) and subsequent World Health Assembly (WHA) resolutions and the U.S. Surgeon General's Call to Action to Support Breastfeeding, Action 6. INFACT USA is a representative of the International Baby Food Action Network (IBFAN) – a 45-year old global network aiming to improve maternal, infant and young child health through protection, support and promotion of breastfeeding and optimal complementary feeding.

Breastfeeding plays a pivotal role in ensuring the health and well-being of mothers and children. Beyond its extensively documented nutritional advantages, breastfeeding is central to establishing the foundation of optimal maternal and child health. Breastmilk is the best, and most optimal, food for babies in the first year of life. It provides the safest nutrition to help babies grow, supplies antibodies to

protect from illness, reduces the risk of sudden infant death syndrome, and is always adapting - breastmilk changes as babies grow, giving them exactly the right nutrition needed at any given time.

The importance of protecting, promoting and supporting breastfeeding

The U.S. ranks 26th of 29 countries in infant mortality rates in countries in the Organization for Economic Co-operation and Development Database, with a higher rate for Black or African-American infants than White.¹⁻² But optimal breastfeeding, meaning women exclusively breastfeeding for six months and continuing to breastfeed for at least one year could prevent 721 child deaths in the country annually from Sudden Infant Death Syndrome (SIDS), necrotizing enterocolitis (NEC), and lower respiratory infections.³

In addition, babies who are breastfed have lower risks of other potentially fatal conditions, including asthma, childhood leukemia, and Type 2 diabetes.⁴ Optimal breastfeeding also reduces mortality in women, preventing 2,619 maternal deaths annually in the U.S.⁵ And for breast cancer, the second leading cause of cancer deaths among women, even any prior breastfeeding is associated with decreased risks of breast cancer-specific death.⁶⁻⁷

There is a consensus that breastfeeding provides significant benefits to mothers and babies. There is a further consensus that breastfeeding rates are lower than optimal. Currently, 84.1% of women initiate breastfeeding, but many don't continue for as long or as exclusively as they'd hoped. In fact, by 6 months postpartum, only 58.3% were breastfeeding, and at 1 year postpartum, only 35.3% were breastfeeding.⁸

In addition to the numerous health benefits, increasing breastfeeding rates in the U.S. and Territories is estimated to produce significant cost savings. For example, optimal breastfeeding could prevent:

- 45,298 cases of childhood obesity, which costs \$19,000 in lifetime medical costs per child compared to a normal weight child.⁹

¹ MacDorman, M.F., Matthews, T.J., Hindori-Mohangoo, A.D., & Zeitlin, J. (2014). International Comparisons of Infant Mortality and Related Factors: United States and Europe, 2010. *National Vital Statistics Report*, 63(5): 1-7.

² Riddell, C.A., Harper, S., & Kaufman, J.S. (2017). Trends in Differences in US Mortality Rates Between Black and White Infants. *JAMA Pediatrics*, 171(9): 911-913.

³ Bartick, M., Jegier, B., Green, B., Schwarz, E. B., Reinhold, A., & Stuebe, A. (2016). Disparities in Breastfeeding: Impact on Maternal and Child Health Outcomes and Costs. *The Journal of Pediatrics*, 6(5): 51-55.

⁴ American Academy of Pediatrics. (2012). Breastfeeding and the use of human milk. *Pediatrics*, 129(3): e827-e841.

⁵ *Ibid*

⁶ Siegel, R. L., Miller, K. D. & Jemal, A. (2017). Cancer statistics, 2017. *CA: A Cancer Journal for Clinicians*, 67: 7–30.

⁷ Kwan, M.L., Bernard, P.S., Kroenke, C.H., Factor, R.E., Habel, L.A., Weltzien, E.K., ... Caan, B.J. (2015). Breastfeeding, PAM50 Tumor Subtype, and Breast Cancer Prognosis and Survival. *JNCI: Journal of the National Cancer Institute*, 107(7).

⁸ Centers for Disease Control & Prevention, Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion. National Immunization Surveys 2018-2019, among children born in 2017. (2019). Available at: <https://www.cdc.gov/breastfeeding/data/facts.html>.

⁹ Finkelstein, E.A., Graham, W.C., & Malhotra, R. (2014). Lifetime direct medical costs of childhood obesity. *Pediatrics*, 133(5): 854-62.

- 601,825 ear infections in children, the annual cost for which is \$2.88 billion in the U.S.¹⁰
- 1,355 cases of necrotizing enterocolitis, which costs an estimated \$500 million to \$1 billion annually to care for affected infants.¹¹

Optimal breastfeeding could also reduce expenditures associated with these diseases among women by preventing:

- \$16.5 billion in direct medical spending related to breast cancer cases in 2010.¹²
- 12,320 cases of Type 2 diabetes, which carries lifetime direct medical costs of \$130,800 in women diagnosed between the ages of 25 and 44 years.¹³
- 5,982 cases of hypertension, for which \$751 is the mean expenditure per woman for treatment.¹⁴

The importance of the mPINC Survey

The mPINC survey was first administered by the Centers for Disease Control and Prevention (CDC) in 2007, establishing baseline data on maternity care practices that support breastfeeding across U.S. hospitals and birth centers. The mPINC questionnaire includes 21 measures of maternity care practices and policies that are consistent with national and international recommendations and supported by scientific evidence.¹⁵

The data collected by the survey is multi-purposeful, including for national and state surveillance of infant feeding-related practices, for hospital quality improvement and for public health research. National mPINC data have been used to analyze the use of human milk in neonatal intensive care units,¹⁶ to monitor the progress of implementation of the Baby-Friendly Hospital Initiative's 10 Steps,¹⁷ and to monitor compliance with the International Code of Marketing of Breastmilk Substitutes.¹⁸

¹⁰ Ahmed, S., Shapiro, N., & Bhattacharyya, N. (2014). Incremental health care utilization and costs for acute otitis media in children. *The Laryngoscope*, 124(1): 301-305.

¹¹ Neu, J. & Walker, A. (2011, January 20). Necrotizing Enterocolitis. *The New England Journal of Medicine*, 364: 255-264.

¹² Farina, K. (2012, March 16). The Economics of Cancer Care in the United States. *American Journal of Managed Care*. Retrieved from www.ajmc.com/journals/evidence-based-oncology/2012/2012-2-vol18-n1/the-economics-of-cancer-care-in-the-united-states-how-much-do-we-spend-and-how-can-we-spend-it-better

¹³ Zhuo, X., Zhang, P., & Hoerger, T.J. (2013, September). Lifetime direct medical costs of treating type 2 diabetes and diabetic complications. *American Journal of Preventive Medicine*, 45(3): 253-61.

¹⁴ Davis, K. (2013, April). Expenditures for Hypertension among Adults age 18 and Older, 2010: Estimates for the U.S. Civilian Noninstitutionalized Population. Statistical Brief #404, Agency for Healthcare Research and Quality. Retrieved from meps.ahrq.gov/data_files/publications/st404/stat404.shtml

¹⁵ Centers for Disease Control and Prevention. Supporting Evidence: Maternity Care Practices. Available online.

¹⁶ Perrin, M. T. (2018). Donor human milk and fortifier use in United States level 2, 3, and 4 neonatal care hospitals. *Journal of Pediatric Gastroenterology and Nutrition*, 66(4), 664–669.

¹⁷ Barrera, C. M. , Nelson, J. M. , Boundy, E. O. , & Perrine, C. G. (2018). Trends in rooming-in practices among hospitals in the United States, 2007-2015. *Birth*, 45, 432–439. 10.1111/birt.12359

¹⁸ Nelson, J. M. , Li, R. , & Perrine, C. G. (2015). Trends of US hospitals distributing infant formula packs to breastfeeding mothers, 2007 to 2013. *Pediatrics*, 135(6), 1051–1056. 10.1542/peds.2015-0093

According to the Global Breastfeeding Collective’s Breastfeeding Scorecard, published annually, just 40% of countries in the world collect have data on exclusive breastfeeding rates in their country over the past five years.¹⁹ Data systems that collect information and statistics on exclusive breastfeeding are needed and necessary for accountability, both at the country, state and local county levels.

At the national surveillance level, according to a longitudinal cohort study published in 2025, “over a 4-year period, U.S. hospitals with better maternity care practices and policies supportive of breastfeeding had higher rates of in-hospital exclusive breastfeeding.”²⁰

At the state surveillance level, and for the purposes of individual hospital improvement, the case study of Boston Medical Center in 2010 is relevant. Aiming to decrease maternal-infant separation and to increase rates of exclusive breastfeeding, delaying newborn baths was identified as an intervention to achieve both goals. Compared with infants born before the intervention, infants born after the intervention had 166% greater odds of initiating breastfeeding and 39% greater odds of breastfeeding exclusively.²¹

Hospitals that participate in the mPINC survey get a report afterwards that provides benchmarks for their own maternity care practices against other hospitals that share similar characteristics. These benchmarks allow hospitals to identify which areas can be improved to set strategic goals and optimize the overall maternity care performance. Benchmark reports are also provided to participating hospitals that compare hospital performances and practices across state lines. Benchmarking techniques and the use of achievable, realistic reference points for quality improvement efforts can advance maternity quality of care for breastfeeding mothers and catalyze change at the state level based on state peer groups.²²

Public health research based on the mPINC survey is important because it measures how well maternity care practices support breastfeeding in hospitals and birth centers across the United States. Since early hospital practices strongly influence whether breastfeeding is initiated and continued, mPINC data help identify practices that promote or hinder optimal infant feeding. Using mPINC data allows public health professionals to track trends over time, compare facilities and regions, and pinpoint gaps in care, such as unnecessary formula supplementation or lack of lactation support. This research informs quality

¹⁹ Global Breastfeeding Collective, World Health Organization/UNICEF. (2025). Global Breastfeeding Collective Scorecard, 2025. Available from: <https://www.globalbreastfeedingcollective.org/media/3246/file>

²⁰ Gosdin, L., Marks, K. J., Addo, O. Y., O’Connor, L., Awan, S., Grossniklaus, D. A., & Hamner, H. C. (2025). Longitudinal Association of Maternity Care Practices with Exclusive Breastfeeding in U.S. Hospitals, 2018–2022. *Children*, 12(11), 1454. <https://doi.org/10.3390/children12111454>

²¹ Preer, G. , Pisegna, J. M. , Cook, J. T. , Henri, A. M. , & Philipp, B. L. (2013). Delaying the bath and in-hospital breastfeeding rates. *Breastfeeding Medicine*, 8(6), 485–490. 10.1089/bfm.2012.0158

²² Edwards RA, Dee D, Umer A, Perrine CG, Shealy KR, Grummer-Strawn LM. Using benchmarking techniques and the 2011 maternity practices infant nutrition and care (mPINC) survey to improve performance among peer groups across the United States. *J Hum Lact*. 2014 Feb;30(1):31-40. doi: 10.1177/0890334413515948. PMID: 24394963; PMCID: PMC4546102.

improvement efforts, guides policy and accreditation standards, and helps health systems implement evidence-based practices that improve maternal and infant health outcomes at a population level.

Conclusion

In response to the information collection request for the Office of Management and Budget (OMB) final review and approval, INFACT USA urges the continuation of the mPINC survey across the U.S. and Territories. Most significantly, our comment highlights the practical utility of the data collected by the mPINC survey – the impact of which cannot be understated.

From its inception in 2007, results of the mPINC survey at the national level demonstrate improvements in maternity care policies and practices that are supportive of breastfeeding are improving.²³ The ability to track and monitor national progress of this kind has a direct impact on the health and wellbeing of infants and mothers. Action 7 of the Surgeon General's *Call to Action to Support Breastfeeding* is to ensure US maternity care practices are fully supportive of breastfeeding.²⁴ The mPINC survey, used as a surveillance tool, monitors this action. It is often said that we measure what we value. In the case of the mPINC data and the practicality of its use, it is critical to continue measuring maternity care practices that directly affect the health of our population.

The CDC collaborates to create the expertise, information, and tools that people and communities need to protect their health through health promotion, prevention of disease, injury and disability, and preparedness for new health threats. Similarly, the mission of the U.S. Department of Health and Human Services (HHS) is to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services.

When considering the question of if the mPINC survey and the process of collecting that information is necessary for the proper performance and functions of these agencies, the public health benefits of breastfeeding should be the answer. Breastfeeding directly promotes health of all individuals, protects the health of our mothers and babies, and serves as a preventative tool against future disease, illness and fatalities of human beings.

²³ Perrine CG, Galuska DA, Dohack JL, Shealy KR, Murphy PE; MLIS; Grummer-Strawn LM, Scanlon KS. Vital Signs: Improvements in Maternity Care Policies and Practices That Support Breastfeeding - United States, 2007-2013. *MMWR Morb Mortal Wkly Rep*. 2015 Oct 9;64(39):1112-7. doi: 10.15585/mmwr.mm6439a5. PMID: 26447527.

²⁴ US Department of Health and Human Services . (2011). Executive summary: The surgeon general's call to action to support breastfeeding. *Breastfeeding Medicine*, 6(1), 3–5. 10.1089/bfm.2011.9996