LIQUID GOLD: COMPARATIVE AUTONOMY COSTS IN BREASTFEEDING NATIONS

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I. INTRODUCTION

Breastfeeding law and policy in the United States is often summarized as "breast is best."[1] General American consensus suggests that women should aim to breastfeed for the first six months of a baby's life for the benefit of both the baby and the mother.[2] After that first six months, a mother should continue breastfeeding for at least two years with supplemental foods added.[3] Breastfeeding rates have been on an incline,[4] which is happily received by many, but are still are criticized as insufficient. In response, the United States is pursuing "Healthy People 2020," a ten-year initiative that aims to improve general American health and specifically addresses breastfeeding goals. Although the current percentage of babies who are breastfed in the United States is only 74%, the goal is to increase these rates to 81.9% by 2020.[5] Similarly, the initiative seeks to increase the number of children who are breastfed exclusively through the first six months from a bleak 14.1% to 25.5%.[6] Compared to "model" nations for successful breastfeeding policy, such as Norway, these statistics are striking. While the United States is

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1. *See* Clare Wilson, *Are There Downsides to 'Breast is Best'?*, BBC (May 3, 2017), http://www.bbc.com/future/story/20170503-are-there-downsides-to-breast-is-best ("'Breast is best' is the advice from the World Health Organization, Unicef and countless other respected health bodies, who say babies should be fed exclusively with breastmilk for the first six months of their life . . . .").

2. *See* Andrea Freeman, *"First Food" Justice: Racial Disparities in Infant Feeding as Food Oppression*, 83 FORDHAM L. REV. 3053, 3062 (2015).

3. *Id.*

4. *U.S. Breastfeeding Rates Are Up! More Work Is Needed*, CENTERS FOR DISEASE CONTROL AND PREVENTION (Oct. 26, 2017), https://www.cdc.gov/breastfeeding/resources/us-breastfeeding-rates.html.

5. *Healthy People 2020: Breastfeeding Objectives*, U.S. BREASTFEEDING COMMITTEE, http://www.usbreastfeeding.org/p/cm/ld/fid=221 (Last visited Mar. 22, 2018).

6. *Id.*

actively making strides to decrease the number of children *never* breastfeed to around 18%, only 1% of babies in Norway have never been breastfed.[7]

This all begs the question of why Norway and the United States, despite having similar goals and attitudes towards breastmilk, have such strikingly different rates of successful breastfeeding. Both recognize the slew of benefits that come from breastfeeding children: immune and neurologic system improvements; decreased juvenile diseases such as diabetes, allergies, and cancers; improved uterine contraction for mothers post-partum; and reduced disease rates for mothers including breast cancer, osteoporosis, and diabetes.[8] Breastfeeding is clearly understood to benefit mother and child during the period immediately after birth and long-term,[9] and governments around the world have responded accordingly, by ramping up efforts to improve breastfeeding rates on a global scale.

Despite the apparent success of breastfeeding initiatives in Norway comparative to the United States, that success comes with strings attached. This Article will argue that, if the United States truly wants to increase breastfeeding rates to levels similar to those of Norway, it would require that women lose their sense of autonomy in raising their children to a degree that those breastfeeding rates would not be worth the sacrifice. Part II of this Article will discuss the World Health Organization's ("WHO") International Code of Marketing on Breastmilk Substitutes ("The Code"), which has been adopted by Norway, but not by the United States. Part III will compare cultural treatment of breastfeeding mothers in Norway and the United States.

II. IMPLEMENTATION OF THE WHO INTERNATIONAL CODE OF MARKETING ON BREAST-MILK SUBSTITUTES

A primary criticism of breastfeeding policy in the United States is its failure to adopt The Code.[10] The Code was instituted in 1981 and was voted on and adopted by 118 countries as a means of addressing high infant mortality rates that were linked to formula feeding. The United States was the sole country to vote against it.[11] Generally, The Code prohibits the promotion of breastmilk substitutes to the general public or any direct or indirect contact

7. *Norway – The WHO Code and Breastfeeding: An International Comparative Overview*, AUSTL. GOV'T DEP'T HEALTH (May 3, 2012), http://www.health.gov.au/internet/publications/publishing.nsf/Content/int-comp-whocode-bf-init~int-comp-whocode-bf-init-ico~int-comp-whocode-bf-init-ico-norway.

8. Corey Silberstein Shdaimah, *Why Breastfeeding is (Also) a Legal Issue*, 10 HASTINGS WOMEN'S L.J. 409, 410–11 (1999).

9. Jennifer Bernstein & Lainie Rutkow, *Hospital Breastfeeding Laws in the U.S.: Paternalism or Empowerment?*, 44 UNIV. BALT. L. REV. 163, 165 (2015).

10. Freeman, *supra* note 2, at 3068–69.

11. *Id.*

between marketing agents and the potential breastfeeding market.[12] The Code also sets standards for the contents of formula labels including what pictures can be used on them, the distribution of educational materials regarding breastmilk versus formula, providing free formula to women, and the interplay between the healthcare system and formula companies.[13]

Norway implements parts of The Code, but not all of it.[14] Most of Norway's use of The Code surrounds regulation about labeling, marketing, and advertising of formula in such a way that it promotes breastfeeding by limiting acceptable advertising schemes and restricting formula sample distribution.[15] Those regulations address formula ingredients, label contents, marketing, and advertising without creating outright bans on promoting formula.[16] Instead, these regulations seek to assure mothers that formula is safe, while also promoting breastfeeding.[17] Under these regulations, formula labels must include information classified as "information about breastfeeding's unsurpassed value; a request that formula be used only on the recommendation of an independent health professional; and that no pictures of babies or other images which idealize formula-feeding are permitted."[18] All formula advertising is limited to scientific publications that are based solely on "scientific fact and character."[19] Critically different from the United States is the fact that samples of formula are strictly forbidden.[20] In fact, formula cannot even be discounted or donated to institutions that provide to the poor in Norway.[21]

In stark contrast to Norway is the United States, which is the only country that voted not to adopt The Code.[22] As a result, there is no ban on formula marketing in the United States.[23] Similarly, programs like The Special Supplemental Nutrition Program for Women, Infants, and Children ("WIC") that give out free formula are also able to provide product to lower-income women.[24] This scheme proves problematic in that the United States government, much like

12. *Id.* at 3069.
13. *Id.*
14. *Norway – The WHO Code and Breastfeeding: An International Comparative Overview*, *supra* note 7.
15. *Id.*
16. *Id.*
17. *Id.*
18. *Id.*
19. *Id.*
20. *Id.*; *USA - The WHO Code and Breastfeeding: An International Comparative Overview*, AUSTL. GOV'T DEP'T HEALTH (May 3, 2012), http://www.health.gov.au/internet/publications/publishing.nsf/Content/int-comp-whocode-bf-init~int-comp-whocode-bf-init-ico~int-comp-whocode-bf-init-ico-usa.
21. *Norway – The WHO Code and Breastfeeding: An International Comparative Overview*, *supra* note 7.
22. Freeman, *supra* note 2, at 3068–69.
23. *Id.* at 3069.
24. *Id.* at 3067.

that of Norway, insists that "breast is best," but the United States government suggests otherwise by purchasing and providing so much of the formula used in the United States.[25] WIC programs have contributed to the overall use of formula in the United States in a major way, but have responded to criticisms that it fails the "breast is best" motto by rewarding mothers who choose to breastfeed with more and better food vouchers.[26]

Adopting The Code in the United States is problematic because it ignores some of the universal truths of raising children that have been recognized and supported by women in the United States. For example, The Code insists that all advertising related to formula must be limited to scientific publications, but women in the United States continue to acknowledge that there is more to childbirth and raising children than science.[27] Raising children has a slew of social and cultural aspects that may rightfully influence a woman's choice to breastfeed her children, and women deserve to be made aware of how formula feeding might impact those social and cultural aspects. A woman may choose to use formula because her employment requires it to a certain degree.[28] Many women cannot afford to take time off from work to breastfeed or to extend their maternity leave to encapsulate the entire time that they would like to breastfeed. Instead, many of these women will choose to use formula and are entitled to know how formula works on a practical level, not just a scientific one. In order for women to make a decision about whether and how long they would like to breastfeed, they need access to information that extends beyond the strictly scientific and takes into account the factors that make breastfeeding particularly difficult, if not impossible, for some mothers. The Code is a mechanism in which women can be convinced to breastfeed without having the information required in order to make a truly informed decision regarding what is best for the mother and for her baby.

Although implementation of The Code in the United States does not seem to be an adequate solution to low breastfeeding rates, the United States does stand to learn from its success in other countries and can implement some of its tenets without stripping a woman's ability to make an informed decision about raising her baby. In particular, the distribution of formula through WIC programs, which would be outright banned in a country that has adopted The Code, is problematic because it undermines United States policy that is meant to promote breastfeeding.

Despite the supposed allegiance to "breast is best" in the United States, the government purchases over half of the formula that is sold

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25. *Id.*; Dara E. Purvis, *The Rules of Maternity*, 84 TENN. L. REV. 367, 411 (2017).

26. *See* Freeman, *supra* note 2, at 3067; Purvis, *supra* note 25, at 411.

27. *See* Purvis, *supra* note 25, at 410–11 (discussing the cultural stigma and ramifications that may result from breastfeeding in public).

28. Freeman, *supra* note 2, at 3073.

in the United States at a large discount before giving it to WIC participants.[29] Formula manufacturers are willing to take the loss on government sales because they see the potential for increased sales to mothers who trust in the government's selection and distribution of a formula brand.[30] The result is a disproportionately high use of formula among lower-income families.[31]

Distributing formula through WIC programs is misleading to women because it suggests that government statements that "breast is best" are hollow, meaningless suggestions. The lower-income women who generally benefit from WIC programs are put in the precarious position of being told not to do something, while constantly being given the supplies to do it by the government. The result is a population who distrusts the government and has little faith in its policy statements regarding important health issues because of its clear contradiction on those issues. Under The Code, formula would not be distributed through a WIC program at all, which prevents problematic disparities in formula use and a general hesitation to trust in the suggestions made by the government regarding health recommendations.

Similarly, the government has chosen to reward WIC mothers who breastfeed by giving them more and better food stamp access. Although this initiative is one that would likely influence a mother's choice to use formula over breastmilk, it borders on coercion and only deepens the divide between women who are dependent on WIC programs when raising their children and those who are not. Lower-income women, who are just as interested in exercising their autonomy as wealthier women, are essentially told they are bad mothers if they do not choose breastmilk under this policy. Thus, a woman who chooses to formula feed seems to be making a statement that she does not care enough about her family to choose to breastfeed, despite its health benefits.

The unfortunate reality of this scheme is that lower-income women have very little room to make an informed decision because of the financial, social, and government pressures to choose breastmilk over formula. Although The Code would ultimately address all of these concerns by ending formula distribution through WIC, the benefits of The Code must be taken with a grain of salt. Under both the WIC distribution scheme in the United States and The Code in Norway, women have either no choice regarding formula or, perhaps more tragic, simply the illusion of choice.

To a certain extent, parts of The Code can and should be adopted in the U.S., particularly as it pertains to advertisement regulations. Advertisement regulations in the United States can be used as in Norway to ensure that formula distributed in the United States is safe for consumption but should not limit advertising to the strictly

29. *Id.* at 3067.
30. *Id.*
31. *Id.* at 3075.

scientific aspects of formula as discussed above. Instead, the United States should use regulations to control advertising in a way that stops formula companies from disseminating false information but allows women to get an idea of how formula-use may impact their lives. To require otherwise would suggest that the state would rather have a baby go hungry for a few hours so that a mother could return home to breastfeed, or that a man cannot adequately raise his baby because he cannot provide the "scientifically" preferable option to his baby. Advertising for formula-based products should be done with a focus on the fact that breastfeeding is preferable, but that formula is an option that is safe for babies.

III. CULTURAL TREATMENT OF BREASTFEEDING WOMEN

Cultural attitudes towards breastfeeding mothers in the United States and Norway are particularly different and may play a role in differing breastfeeding rates between the two. In Norway, women are expected to breastfeed whenever needed and wherever needed, whether it be in a restaurant, store, park, or bus.[32] In fact, "none leave the hospital without breastfeeding or dare ask for infant formula as a substitute. For trouble at home, the phone book obligingly lists a company called "Breastfeeding Help."[33] Societal pressures to breastfeed leave many Norwegian women feeling like "failures" in instances where they cannot successfully breastfeed.[34] The obvious benefit of this cultural outlook is simply that it makes breastfeeding easier for women. American women who struggle with the stigma of public breastfeeding and have limited access to private areas, would be able to breastfeed more openly and without criticism that many women face with a similar breastfeeding culture.

However, the American breastfeeding culture is one where women are encouraged by government entities to breastfeed and are even told that they have the freedom to do so whenever and wherever is most convenient for them, but then face stigma and potentially legal action when they do.[35] Although states have passed laws to protect breastfeeding women, those women are still subject to public criticism where they exercise that right.[36] In one instance, a woman who breastfed her baby on a plane was removed from the flight.[37] Another who breastfed in a restaurant later discovered that a man nearby had taken a picture and posted it to his social media pages with the caption, "I understand feeding in public but could you at

32. Lizette Alvarez, *Norway Leads Industrial Nations Back to Breast-Feeding*, N.Y. TIMES (Oct. 21, 2003), http://www.nytimes.com/2003/10/21/world/norway-leads-industrial-nations-back-to-breast-feeding.html.

33. *Id.*

34. *Id.*

35. Purvis, *supra* note 25, at 411.

36. *Id.* at 411–12.

37. *Id.* at 412.

least cover your boob up?!"[38] In that same vein, women who choose to breastfeed their children for periods that have been deemed "too long" by society are chastised as being abusive and even face criminal charges to that effect.[39] One mother had her son taken away and put into foster care for five months because a babysitter reported to a child abuse hotline that the mother breastfed her six-year-old.[40]

The result of this American breastfeeding culture is high consumption of baby formula, which is cited as a primary explanation for low breastfeeding rates.[41] Formula is criticized for not providing the benefits of breastfeeding[42] and has been linked to increased rates of infant death despite wide usage.[43] Granted, those downsides are hardly without benefit. Formula allows mothers to maintain roles in their communities and workplaces even after giving birth.[44] It has provided the opportunity for women to have children but continue to meet other demands of life that oftentimes keep women from successfully being able to breastfeed, such as poverty, conditions in the workplace, and a lack of resources.[45]

Typically, African American women breastfeed at alarmingly low rates compared to their counterparts of other races throughout the United States.[46] Many women in lower-income areas have insufficient access to healthcare resources that might help resolve breastfeeding issues or provide lactation consultation.[47] Similarly, low-income women that utilize WIC resources are disproportionately targeted by the relationship between the government and the formula industry and are ultimately left feeling discouraged from breastfeeding.[48] Lower-income women face workplace barriers that may prevent them from breastfeeding when they are not allowed paid breaks to pump breastmilk, insufficient facilities to privately do so, and generous maternity leave.[49] For many lower-income women, the ability to choose breastfeeding over formula simply is not feasible when they do not have the financial comfort to sacrifice some of their wages.

The United States has much to learn from the breastfeeding culture in Norway, particularly in terms of accepting public breastfeeding. However, Norwegian breastfeeding culture comes at a

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38. *Id.*
39. *Id.* at 417.
40. *Id.*
41. *See USA – The WHO Code and Breastfeeding: An International Comparative Overview*, *supra* note 20.
42. *See* Bernstein & Rutkow, *supra* note 9, at 166.
43. *See* Freeman, *supra* note 2, at 3061.
44. *Id.*
45. *Id.*
46. *Id.* at 3057.
47. *Id.* at 3055.
48. *Id.* at 3066.
49. OFF. OF THE SURGEON GEN., U.S. DEPT. OF HEALTH & HUM. SERVS., THE SURGEON GENERAL'S CALL TO ACTION TO SUPPORT BREASTFEEDING 8 (2011) https://www.ncbi.nlm.nih.gov/books/NBK52682/pdf/Bookshelf_NBK52682.pdf.

price: women who formula feed in public are subject to public criticism simply based on their decision to choose an unpopular feeding option. Breastfeeding culture in Norway is ultimately only the inverse of the culture in the United States. In Norway, a woman may be publically shamed for formula feeding in public, while in the United States, she may be publically shamed for breastfeeding in public. As beneficial as the Norwegian breastfeeding culture is for breastfeeding rates, it reinforces the idea that women who choose the minority option are inadequate mothers. Surely, the United States does not need more mom-shaming, even if it brings with it greater rates of breastfeeding.

An ideal breastfeeding culture is one that promotes breastfeeding but is supportive of all women's decisions on how they feed their children. The United States must make an active effort to move away from the stigmatization of breastfeeding in public and towards the Norwegian expectation that all mothers will breastfeed publically. However, the Norwegian expectation that *all* women will breastfeed publically is unrealistic and only serves to damage those women who choose not to breastfeed at all. Instead, the United States must carry out its promises to protect breastfeeding mothers by ending its double-standard of formula support. At the end of the day, women who feed babies should all be encouraged, supported, and promoted equally.

IV. CONCLUSION

Norway is a testament to the fact that widespread breastfeeding success is possible with the implementation of The Code and a cultural acceptance of breastfeeding at all costs. However, the United States has struggled with the proper role of healthcare in women's decision-making processes for decades. Although the U.S. has continuously suggested that a woman's autonomy is of particular importance, it does not always live out that belief. Now, more than ever, the United States needs to make a definitive stance regarding its outlook on breastfeeding in order to raise breastfeeding rates in a way that is successful, but still puts a woman's decision-making ability first. This requires that the United States no longer orally advocate for breastfeeding and then provide free formula to low-income women. It also requires that the U.S. begin to do more than simply say that "breast is best." The U.S. must begin to counsel, advise, and assist women through healthcare providers to come to a decision that is best for everyone involved. A decision that, hopefully, will be breastfeeding.