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CASE AND COMMENTARY

Do Infant Formula Giveaways Undermine or Support Women's Choices?

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Abstract

Eliminating formula giveaways ("banning the bag") has been embraced as a way to reduce the influence of formula marketing in hospitals and to increase breastfeeding rates among new mothers, but the policy raises ethical concerns in the mind of some, notably because it denies a useful benefit to mothers who have trouble affording formula. Hospital policies to promote breastfeeding, including banning the bag, should be sensitive to the economic and other costs associated with breastfeeding and should be consciously designed to make breastfeeding easier and not just to make formula feeding more difficult. We recommend that hospitals evaluate the negative impacts of banning the bag on their patient population in order to ensure that families are not being negatively affected.

Case

B General Hospital has been serving its community for more than 100 years. While its patient population has changed substantially over the years to one that is more demographically diverse, the hospital is still relied upon to provide a full range of health care services despite the fact that it serves mostly patients who are poor, underinsured, or undocumented. To patients who are new mothers, B General Hospital has been distributing infant formula discharge bags for many years, and, from all accounts, this service is highly valued among community members and widely regarded as not only successful but essential.

Dr X is a family physician who just started at B General Hospital 9 months ago. She saw it as a place where she could deliver good prenatal and postnatal care to a vulnerable and underserved patient population. With that in mind, she raises a concern at the next department meeting: "Given the widely documented benefits of breastfeeding, I don't think we should continue to distribute infant formula discharge bags. Continuing to distribute the formulas primarily serves the needs of the breastmilk substitute companies rather than our patients."

Another physician disagrees, emphasizing, "The patients in this community appreciate and rely upon getting the infant formula. We still encourage breastfeeding, but our

patients—these new mothers—see the formula as an easy-to-use supplement to their baby's overall nutritional intake."

Dr S, the department chair, wonders how best to address this difference in professional opinion and the needs of the community members she and her colleagues serve.

Commentary

Leading clinical and public health organizations, including the American Academy of Pediatrics[1] and the World Health Organization,[2] recommend exclusive breastfeeding for about 6 months, citing health benefits to both the infant and the mother, including decreased rates of infant gastrointestinal disease and ear infections as well as earlier return to maternal prepregnancy weight.[1] However, rates of women in the United States who initiate breastfeeding and who breastfeed exclusively to 6 months consistently fall short of public health goals. While roughly 81% of women in the United States initiate breastfeeding, less than 23% breastfeed exclusively to 6 months.[1,3] Various strategies have been proposed to increase rates of exclusive breastfeeding and reduce the use of infant formula.[4] However, efforts to reduce formula feeding have provoked public controversy over questions ranging from the strength of the evidence of the health benefits associated with breastfeeding, to whether breastfeeding should be viewed as a matter of personal choice or public health, to the broader social and economic features that shape infant feeding practices.[5]

In this commentary, we examine the arguments for and against eliminating formula giveaways and suggest ethical questions to guide decisions about whether to continue their use. Ultimately, we argue that efforts to promote the health of women and infants in an ethically appropriate way will require health systems—and society—to do more than merely "ban the bag."

The Case for Eliminating Formula Giveaways

Eliminating formula giveaways to new mothers when they are discharged from the hospital (banning the bag) has been embraced as part of comprehensive breastfeeding promotion—a way to increase rates of exclusive breastfeeding, increase breastfeeding duration, and protect women from the influence of formula marketing.[6,7] The evidence supporting these claims, however, is mixed.

Advocates of eliminating formula giveaways argue that they are associated with lower rates of exclusive and long-duration breastfeeding.[8] Some studies show that receiving free formula in a hospital gift pack is associated with lower rates of exclusive breastfeeding at 3 weeks, 10 weeks or 4 months.[7,9-11] On the other hand, Neifert et al. found no significant effect of formula giveaways on breastfeeding duration among adolescent mothers,[12] and Evans et al. found no significant difference in breastfeeding duration between women who received a formula giveaway and those who did not.[13]

According to a 2000 review by the Cochrane Collaboration, formula giveaways are associated with a small overall reduction in rates of exclusive breastfeeding at 6 weeks, 3 months and 6 months postpartum.[14] However, this review did not find evidence that formula giveaways led to earlier termination of nonexclusive breastfeeding. Furthermore, the Cochrane authors noted that the study populations consisted primarily of well-educated, English-speaking women and that the results might not generalize to women with low income or Hispanic women.[14]

Eliminating formula giveaways is sometimes framed as a way to protect women from formula marketing. For example, in 2012, New York City launched a voluntary initiative asking hospitals to ban the bag and to refrain from giving supplementary formula to breast-fed infants unless medically indicated. In announcing the initiative, the city claimed that formula giveaways "interfere" with breastfeeding.[15] Dr X also gives voice to the perspective that formula marketing is a potentially harmful influence when she says that continuing the formula giveaways "primarily serves the needs of the breastmilk substitute companies rather than our patients." It is reasonable that Dr X would assume that formula companies' marketing efforts—including formula giveaways in hospitals—aim to maximize companies' profits and not to maximize benefits to infants and families. Nevertheless, as the other physician in this case scenario emphasized, formula giveaways might benefit some patients, particularly patients with lower incomes.

The Case for Maintaining Formula Giveaways

The case for maintaining formula giveaways is that formula feeding and supplementing with formula can be the right choice for some women and families. Ending giveaways does not support these women's choices and in fact denies them economic benefit. Banning the bag could also reinforce a broader dynamic—of concern to critics of breastfeeding promotion—in which formula-feeding women feel shamed for their choices.

Costs of breastfeeding for women and families. Concerns have also been raised by scholars, clinicians, and mothers themselves that breastfeeding can have significant costs for women and their families, which often go unrecognized and unmeasured.[5,16] Breastfeeding imposes substantial time constraints, disrupts sleep, and could cause physical discomfort or even pain.[17] Breastfeeding can also have economic costs. Motherhood is associated with earnings losses for women, and mothers who breastfeed for 6 months or more experience larger and more prolonged earnings losses than mothers who breastfeed for a shorter duration or who do not breastfeed at all.[18] Breastfeeding is time consuming, and breastfeeding—especially exclusive breastfeeding—can make returning to work more difficult, given the need to pump multiple times per day.

Additional challenges have been raised related to breastfeeding and employment. Employment outside the home, particularly full-time employment, is negatively associated with breastfeeding duration. One study of new mothers found little difference in breastfeeding initiation in the hospital between women who were and who were not employed full time outside the home (65.5% vs 64.8%, respectively).[19] However, a clear gap emerged upon return to full-time employment: 35% of nonworking mothers breastfed 6 months after delivery and only 26.1% of those working full time did so.[19]Another study of mostly single mothers with low income found that mothers returning to work have 2.18 times the odds of terminating breastfeeding as their nonworking counterparts.[20] The burdens of combining work and breastfeeding are particularly high for women with low incomes due to a variety of factors including lack of flexibility in scheduling, lack of privacy, and insufficient protections from employment discrimination.[21]

Supporting women's choice to breastfeed or formula feed. In light of the costs of breastfeeding, formula feeding or formula supplementation can be the right decision for some women and families. Therefore, health care systems should not denigrate or dismiss women's choices to use formula as merely the result of clever formula marketing. Instead, they should recognize that formula might be an informed choice, one made for good reasons. This position is consistent with that of the American College of Obstetricians and Gynecologists, which explicitly affirms the importance of supporting women in their infant feeding choices: "Obstetrician-gynecologists and other obstetric care providers should support each woman's informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant."[22]

Despite the recognized importance of helping women make informed infant feeding choices and of supporting these choices, there is both anecdotal and empirical evidence that some mothers do not feel supported but instead feel judged or shamed. As reported in blogs and personal accounts, some mothers express dissatisfaction with hospital practices meant to promote breastfeeding, reporting that they were pressured to breastfeed and not supported in formula feeding or formula supplementation.[23-26] Additionally, one survey of mothers in a Baby-Friendly hospital (a hospital conforming with practices recommended by the Baby Friendly Hospital Initiative, a global program to encourage breastfeeding and refrain from promoting formula[27]) found that 26% of formula-feeding mothers felt shamed for the decision to formula feed and 35.7% felt not adequately informed about formula feeding.[28] In a qualitative study, nonbreastfeeding women reported that probreastfeeding messages from health professionals could lead them to feel that not breastfeeding makes them a "bad mother," one who was "denying" or "depriving" her child. As one explained, "breastfeeding […] is pushed down your throat and out of guilt you are made to feel if you don't do it, you are doing your child a mis-

justice."[29] Women report feeling both guilt and shame for using formula—guilt for the potential harm associated with the "risks" of not breastfeeding and shame for failing to live up to the standard of "good motherhood."[30]

Do Formula Giveaways Support or Undermine Women's Choices?

What counts as supporting women's choices in the context of formula giveaways, given that women make different choices about how to feed their infants and that women may change their minds? For women who have already decided to formula feed or to supplement with formula, not getting the free formula in no respect supports their choice and denies them an economic benefit—one that could be particularly important if they have low incomes, like those served by B General Hospital, and thus generally face higher obstacles to breastfeeding. For women who plan to breastfeed exclusively, it is a complex question whether the offer of free formula undermines their choices or not. Perrine et al. found that most mothers do not meet their prepartum breastfeeding goals, including the goals of breastfeeding exclusively and breastfeeding for at least 3 months.[31] When a woman who intended to breastfeed exclusively feeds her infant the free formula she got in the hospital, how should we describe what has happened? Has she had her intentions to breastfeed exclusively undermined by formula giveaways? Or has she changed her mind about the best way for her to feed her infant, now that she has more information about the implications of breastfeeding for her and her family? Both scenarios seem plausible. Some women who supplement with formula might have had their breastfeeding intentions undermined by hospital formula giveaways. Yet other women might have simply changed their minds—and have done so for legitimate reasons.

In light of these ethical considerations, we recommend that Dr S explore what B General Hospital's patient population is likely to experience were formula giveaways to cease. For example, if new mothers intend to use formula, can they readily access it through other programs than hospital giveaways, and can they do so without experiencing substantial delays or significant financial hardships? For women who intend to breastfeed, does ending giveaways better enable them to fulfill their intentions? Do women who consider switching or supplementing to formula feel supported or shamed when doing so? Before making a policy change, Dr S should consider engaging with B General Hospital patients to better understand how they experience formula giveaways. Additionally, Dr S should consider other ways that the institution could support breastfeeding. Prior research has identified several strategies that can support breastfeeding among women similar to those served by B Hospital, including breast-pump programs to reduce known financial barriers associated with breastfeeding, peer counseling, and enhanced lactation education and supportive services.[4]

Ultimately, making formula feeding harder is not the same as making breastfeeding easier. Infant feeding decisions reflect a complex set of factors, reflecting influences at

the individual, family, health institution, and societal levels—some of which could be more or less readily modifiable. Health systems should strive to be pro-mother and pro-baby, and not just antiformula.

References

1. American Academy of Pediatrics. Breastfeeding and the use of human milk. *Pediatrics*. 2012;129(3):e827-e841. doi:10.1542/peds.2011-3552.
2. World Health Organization. The optimal duration of exclusive breastfeeding: report of an expert consultation, Geneva, Switzerland, 28-30 March 2001. http://apps.who.int/iris/bitstream/handle/10665/67219/WHO_NHD_01.09.pdf?ua=1. Published 2002. Accessed August 15, 2018.
3. Centers for Disease Control and Prevention. Breastfeeding report Card: progressing toward national breastfeeding goals: United States, 2016. https://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf. Accessed August 15, 2018.
4. Hedberg IC. Barriers to breastfeeding in the WIC population. *MCN Am J Matern Child Nurs*. 2013;38(4):244-249.
5. Barnhill A, Morain SR. Latch on or back off? Public health, choice, and the ethics of breast-feeding promotion campaigns. *Int J Fem Approaches Bioeth*. 2015;8(2):139-171.
6. Kaplan DL, Graff KM. Marketing breastfeeding—reversing corporate influence on infant feeding practices. *J Urban Health Bull N Y Acad Med*. 2008;85(4):486-504.
7. Rosenberg KD, Eastham CA, Kasehagen LJ, Sandoval AP. Marketing infant formula through hospitals: the impact of commercial hospital discharge packs on breastfeeding. *Am J Public Health*. 2008;98(2):290-295.
8. Walker M. Why infant formula samples pose a risk to health care providers, hospitals, and patients. *J Obstet Gynecol Neonatal Nurs*. 2015;44(5):618-623.
9. Frank DA, Wirtz SJ, Sorenson JR, Heeren T. Commercial discharge packs and breast-feeding counseling: effects on infant-feeding practices in a randomized trial. *Pediatrics*. 1987;80(6):845-854.
10. Snell BJ, Krantz M, Keeton R, Delgado K, Peckham C. The association of formula samples given at hospital discharge with the early duration of breastfeeding. *J Hum Lact*. 1992;8(2):67-72.
11. Sadacharan R, Grossman X, Matlak S, Merewood A. Hospital discharge bags and breastfeeding at 6 months: data from the Infant Feeding Practices Study II. *J Hum Lact*. 2014;30(1):73-79.
12. Neifert M, Gray J, Gary N, Camp B. Effect of two types of hospital feeding gift packs on duration of breast-feeding among adolescent mothers. *J Adolesc Health Care Off Publ Soc Adolesc Med*. 1988;9(5):411-413.
13. Evans CJ, Lyons NB, Killien Marcia G. The effect of infant formula samples on breastfeeding practice. *J Obstet Gynecol Neonatal Nurs*. 1986;15(5):401-405.
14. Donnelly A, Snowden HM, Renfrew MJ, Woolridge MW. Commercial hospital discharge packs for breastfeeding women. *Cochrane Database Syst Rev*. 2000;(2):CD002075.

15. New York City Department of Health and Mental Hygiene. Latch On NYC: a hospital-based initiative to support a mother's decision to breastfeed. https://www1.nyc.gov/assets/doh/downloads/pdf/ms/initiative-description.pdf. Accessed April 16, 2018.
16. Wolf JB. *Is Breast Best?: Taking on the Breastfeeding Experts and the New High Stakes of Motherhood*. New York, NY: New York University Press; 2010.
17. Li R, Fein SB, Chen J, Grummer-Strawn LM. Why mothers stop breastfeeding: mothers' self-reported reasons for stopping during the first year. *Pediatrics*. 2008;122(suppl 2):S69-S76.
18. Rippeyoung PLF, Noonan MC. Is breastfeeding truly cost free? Income consequences of breastfeeding for women. *Am Sociol Rev*. 2012;77(2):244-267.
19. Kimbro RT. On-the-job moms: work and breastfeeding initiation and duration for a sample of low-income women. *Matern Child Health J*. 2006;10(1):19-26.
20. Ryan AS, Zhou W, Arensberg MB. The effect of employment status on breastfeeding in the United States. *Womens Health Issues*. 2006;16(5):243-251.
21. Murtagh L, Moulton AD. Working mothers, breastfeeding, and the law. *Am J Public Health*. 2011;101(2):217-223.
22. American College of Obstetricians and Gynecologists. Optimizing support for breastfeeding as part of obstetric practice. https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Support-for-Breastfeeding-as-Part-of-Obstetric-Practice. Published February 2016. Accessed April 11, 2018.
23. Marcus W. What's wrong with the baby friendly hospital initiative? I'm glad you asked. Mediocre Mom. http://www.mediocre-mom.com/whats-wrong-with-the-baby-friendly-health-initiative-im-glad-you-asked/. Published September 3, 2016. Updated September 6, 2016. Accessed April 11, 2018.
24. Schwartz J. How mommy-friendly is the baby-friendly hospital initiative? *HuffPost*. April 20, 2017. https://www.huffingtonpost.com/entry/how-mommy-friendly-is-the-baby-friendly-hospital-initiative_us_58a1d2d0e4b0cd37efcfeaf7. Updated April 21, 2017. Accessed April 11, 2018.
25. Austrew A. My baby-friendly hospital made my birth miserable. SheKnows. http://www.sheknows.com/parenting/articles/1127880/giving-birth-baby-friendly-hospital. Published August 9, 2016. Accessed April 11, 2018.
26. Pearson C. Behind the baby-friendly hospital practice that not all moms love. *HuffPost*. July 13, 2016. https://www.huffingtonpost.com/entry/behind-the-baby-friendly-hospital-practice-that-not-all-moms-love_us_57854bd0e4b08608d332048e. Updated July 14, 2016. Accessed April 11, 2018.
27. UNICEF; World Health Organization. Implementation guidance: protecting, promoting and supporting breastfeeding in facilities providing maternity and newborn services: the revised Baby-Friendly Hospital Initiative. http://apps.who.int/iris/bitstream/handle/10665/272943/9789241513807-eng.pdf?ua=1. Published 2018. Accessed August 15, 2018.

28. Ebinger J, Castleberry L, Cai B. Is "baby-friendly" actually "mommy-friendly?" The Baby-Friendly Initiative and effect on patient satisfaction. *Obstet Gynecol*. 2017;129 (suppl 1):S156. doi:10.1097/01.AOG.0000514760.55963.a5
29. Thomson G, Ebisch-Burton K, Flacking R. Shame if you do—shame if you don't: women's experiences of infant feeding. *Matern Child Nutr*. 2015;11(1):33-46.
30. Taylor EN, Wallace LE. For shame: feminism, breastfeeding advocacy, and maternal guilt. *Hypatia*. 2012;27(1):76-98.
31. Perrine CG, Scanlon KS, Li R, Odom E, Grummer-Strawn LM. Baby-Friendly hospital practices and meeting exclusive breastfeeding intention. *Pediatrics*. 2012;130(1):54-60.

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