Opinion

Catholic social teaching and America's suboptimal breastfeeding rate: Where faith and policy should meet to combat injustice

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Despite the numerous health benefits of breastfeeding, few American women breastfeed for the optimal duration of time. Reasons given for not following national and global institutional breastfeeding recommendations are various and multi-faceted. However, for many American women who would like to breastfeed, unjust historical, social, economic, cultural, and environmental factors negatively impact their ability to breastfeed. Catholic social teaching seeks to protect the poor and the vulnerable by working for social and economic justice, encourages stewardship of the environment, and uplifts the family as the most important unit in society. As such, Catholic social teaching has clear implications for individuals and institutions seeking to make breastfeeding a more widespread, accepted practice. In response to the crisis in American rates of breastfeeding, American Catholic healthcare institutions should work to promote the just economic and social conditions necessary for American women to breastfeed their children, starting by implementing breastfeeding-friendly policies for patients and employees in their own institutions.

Summary: For many American women who would like to breastfeed, unjust historical, social, economic, cultural, and environmental factors negatively impact their ability to breastfeed. Catholic social teaching has clear implications for individuals and institutions seeking to make breastfeeding a more widespread, accepted practice. Therefore, American Catholic healthcare institutions should work particularly hard to promote the just economic and social conditions necessary for American women to breastfeed their children, starting by implementing breastfeeding-friendly policies for patients and employees in their own institutions.

Keywords: Breastfeeding, Infant feeding, Formula, WIC, Catholic social teaching, Social justice, Maternity leave, Economic policy

INTRODUCTION

For the past four decades, the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and World Health Organization have recommended that mothers exclusively breastfeed their infants for the first six months of life, with extended breastfeeding from

six months to one year or longer (which includes the introduction of other foods) (Eidelman and Schanler 2012; ACOG 2016; WHO 2011). These recommendations are considered to be the “optimal” breastfeeding conditions (Bartick et al. 2016; WHO 2011). The well-established nutritional superiority of breastmilk over synthetic infant formula validates these

institutional recommendations; however, most American women do not exclusively breastfeed their children for the optimal duration of time. Instead, most American women feed their infants partially or exclusively with formula (CDC 2016a). Some women are physically or medically unable to breastfeed, and it is not the intention of this paper to shame women facing breastfeeding difficulties (CDC 2016b; Schoenberg 2013). However, for hundreds of thousands—perhaps millions—of American women who would like to breastfeed, unjust historical, social, economic, cultural, and environmental factors heavily influence their ability to breastfeed, and often prevent them from doing so.

Catholic social teaching seeks to protect the poor and the vulnerable by working for social and economic justice, encourages stewardship of the environment, and uplifts the family as the most important unit in society (USCCB 2005). Therefore, the unjust causes of America’s suboptimal breastfeeding rate and its deleterious effects on maternal and child health, the environment, and healthcare and welfare costs, present a clear Catholic social justice issue. In response to the suboptimal American breastfeeding rate, Catholic healthcare institutions should heed Catholic social teaching’s call to work for the just economic and social conditions necessary for American women to breastfeed their children, starting by implementing breastfeeding-friendly policies for patients and employees in their own institutions.

SOME REASONS FOR THE SUBOPTIMAL BREASTFEEDING RATE IN THE UNITED STATES

The CDC’s 2016 *Breastfeeding Report Card* indicates that among babies born in 2013, only 22.3 percent of American women exclusively breastfed their infants

for the first six months of their lives (CDC 2016c). While this number represents progress toward the U.S. Department of Health and Human Services’ “Healthy People 2020” goal of 25.5 percent of infants exclusively breastfed at six months of age, the CDC (CDC 2016c) still cautions that “many mothers are not meeting the recommendations for continued and exclusive breastfeeding” (HHS 2012).

Reasons given for not breastfeeding for the recommended amount of time—or for not breastfeeding at all—are various and multi-faceted. A 2014 *Wall Street Journal* article on American breastfeeding trends summarized five of the reasons why some American women do not follow the recommendations for optimal breastfeeding duration (Molla 2014): “100 years of precedent,” set by synthetic infant formula manufacturers and their (sometimes false) advertising (Stevens, Patrick, and Pickler 2009); high participation of American women in the workforce (HHS 2011a); socioeconomic inequality (Jones et al. 2015; Dagher et al. 2016); the fact that formula is often “pushed” in hospitals (CDC 2011); and the decades-long practice of direct-to-consumer advertising by formula manufacturers (Greer and Apple 1991).

In particular, manipulative formula advertisements in the 1930s boasting “healthier” and bigger babies helped fuel early consumer demand for formula, especially given the growing practice of measuring infants (and making comparisons to the average) in doctors’ offices, and the significant infant weight-gain caused by early carbohydrate-laden formulas (Hall 2008). In an article in *Perinatal Education*, Stevens, Patrick, and Pickler (2009) described how by the 1940s, American physicians consistently recommended formula as a safe, effective, and convenient breastmilk substitute, to the severe detriment of the national breastfeeding rate. The authors also discuss how the American breastfeeding rate

continued to plummet until the 1970s, when a religious group-led backlash against aggressive formula advertising in developing countries slowly reversed the downward trend. However, Stevens, Patrick, and Pickler (2009) note that formula companies began direct-to-consumer advertising in the United States in 1988, which led to further confusion among consumers about the superiority of breastmilk versus formula. The American Academy of Pediatrics (AAP) publicly criticized direct-to-consumer advertising by formula manufacturers in a 1990 statement, both for the confusion it created and for its negative impact on the American breastfeeding rate (Stevens, Patrick, and Pickler 2009).

HEALTH BENEFITS OF BREASTFEEDING

Healthcare organizations like the AAP are right to be concerned with any factors that contribute to the suboptimal breastfeeding rate in the United States, and Catholic healthcare institutions should share this concern. Research has long confirmed the positive health effects of breastfeeding for babies, and more recent evidence supports the health benefits of breastfeeding for the mother as well (Bartick et al. 2016).

As Eidelman and Schanler (2012) discuss, breastfeeding protects infants from many health risks affecting multiple organ systems. They note that breastfed infants see significant risk reduction in respiratory conditions, including lower respiratory tract infections, middle ear infections, allergies, and asthma. Furthermore, Eidelman and Schanler (2012) state that exclusive breastfeeding may reduce the risk of neonatal and infant gastrointestinal tract infections, as well as celiac disease, inflammatory bowel disease, and some food allergies. Breastfed infants

may also see a reduced risk for developing obesity and diabetes, two diseases that carry an increasingly large societal burden in the United States. A reduction in the risk of certain cancers (namely, childhood leukemia and lymphoma), and improved neurodevelopmental outcomes are also associated with breastfeeding (Eidelman and Schanler 2012).

While the benefits of breastfeeding for infants have long been known, recently the health benefits for mothers have received increased attention and appreciation. A study by Bartick et al. (2016) found “a substantially larger impact on women’s health compared with infant health, as the majority of excess deaths and direct health costs from suboptimal breastfeeding are related to women’s health outcomes” (9). Both Bartick et al. and Eidelman and Schanler (2012, e831) note that long term, “cumulative lifetime duration of breastfeeding” is associated with a reduced maternal risk for many conditions, including: rheumatoid arthritis, hypertension, hyperlipidemia, cardiovascular disease (including risk of myocardial infarction), diabetes, and some breast and ovarian cancers. There is also evidence to suggest that exclusive breastfeeding may reduce symptoms of postpartum depression for mothers (Figueiredo, Canario, and Field 2014). Furthermore, studies show that mothers who exclusively breastfeed lose more weight postpartum (Samano et al. 2013), and may therefore retain less pregnancy weight long-term, than those mothers who do not exclusively breastfeed their children according to professional recommendations (Sharma, Dee, and Harden 2014). Finally, continued and exclusive breastfeeding is an important component of the lactational amenorrhea method of family planning, an effective fertility-awareness based method that

may help women to naturally and safely space subsequent pregnancies (Ramos, Kennedy, and Visness 1996).

SOCIOECONOMICS, STIGMA, AND THE SUBOPTIMAL BREASTFEEDING RATE IN THE UNITED STATES

What are the issues?

As Jensen (2012) notes, socioeconomic status, race, and associated factors such as daycare attendance and participation in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) are strong predictors of breastfeeding initiation, continuation, and exclusivity among American women. Formula inclusion in supplemental food packages from WIC, the largest governmental nutritional support program in the United States, likely contributes to formula’s increased usage among citizens who rely on the program to feed their families (Jensen 2012). Because half of the infants born in a single year are enrolled in WIC, the program accounts for nearly 54 percent of all formula consumption in the United States (Jensen 2012). Although the exact causes of the inverse relationship between WIC usage and breastfeeding rates remain unclear, WIC participants are less likely than program-ineligible nonparticipants to initiate breastfeeding, let alone continue breastfeeding for the optimal duration of time (Jensen 2012).

Comparatively higher usage of formula by women of lower socioeconomic status is likely related to their inability to take leave to stay home and breastfeed their infants. Both Human Rights Watch (2011) and the U.S. Surgeon General (HHS 2011a) have noted that high female labor-force participation, coupled with a lack of paid maternity leave

policies in the American workplace prevent many working women—from a variety of backgrounds—from breastfeeding. However, this problem is likely more prevalent among those of lower socioeconomic status, given their usual types and places of employment (such as in retail and food service), where paid maternity leave is nonexistent, and clean and private pumping facilities are not always available (Jamieson 2014).

Because of these various socioeconomic factors, poorer, younger, less-educated, and black/Hispanic women are the least likely to initiate and continue breastfeeding in the United States, especially when compared with wealthier, older, more highly educated, non-Hispanic white women. Among all other demographic groups, non-Hispanic black women have the lowest rates of breastfeeding initiation and continuation (Jones et al. 2015; Dagher et al. 2016).

In addition to the aforementioned economic and workplace obstacles, social stigma is also associated with breastfeeding and pumping milk. Some posit that our society’s “sexualization” of the breast is to blame for this phenomenon; and, with countless anecdotes of breastfeeding women being asked to leave public places, it is often an uncomfortable experience for American women to breastfeed their children or pump milk whenever (and wherever) they may need to do so, complicating women’s ability to breastfeed at all (Shaw 2016; Cook 2016; Mazziotta 2016). As the U.S. Surgeon General (HHS 2011b) notes, this can make formula feeding an attractive alternative.

Why should Catholic healthcare institutions care about these issues?

When an overwhelmingly beneficial practice such as breastfeeding is a financial or

social impossibility for so many, and especially when that impossibility is tied to stigma, race, and socioeconomic status, it is a “structural injustice.” In his papal encyclical *Sollicitudo rei socialis*, Pope St. John Paul II spoke of these and other “structures of sin,” so pervasive in modern society, which fail to recognize our interdependence on one another, and which may only be corrected by promoting and practicing true solidarity (John Paul II 1987, nos. 36–8). Not only are the factors that contribute to the suboptimal breastfeeding rate unjust, but its effects lead to continued injustice in the form of health and wealth disparities among citizens. Therefore, authentically Catholic institutions should be concerned with breastfeeding-related disparities and structural inequalities, and should answer Catholic social teaching’s call to work tirelessly to eradicate them.

The high rate of breastfeeding initiation for all American women coupled with the low rate of breastfeeding continuation for those of lower socioeconomic status indicates that many women may desire to breastfeed their children, but lack the means or support to continue breastfeeding beyond the immediate post-natal period (CDC 2016c). In his encyclical letter *Laborem exercens*, Pope St. John Paul II recognized how the structure of modern society negatively impacts women and children: “true advancement [of women] ... requires that labor should be structured in such a way that women do not have to pay for their advancement by abandoning what is specific to them” (John Paul II 1981, no. 19). Unfortunately, the current structure of many American workplaces forces the gift of breastmilk to go to waste, which is a terrible injustice to women, children, and families. This is a

call to Catholic institutions to work for a society in which women should not have to “pay for their advancement by abandoning what is specific to them” (John Paul II 1981, no. 19).

ECONOMIC IMPACT OF THE SUBOPTIMAL BREASTFEEDING RATE IN THE UNITED STATES

What are the issues?

In addition to affecting the health of mother and child, the suboptimal American breastfeeding rate disproportionately affects the economically disadvantaged, placing a significant financial burden at personal, institutional, and state levels. A recent study by Bartick et al. (2016) estimated that annual medical costs attributable to suboptimal breastfeeding total \$3 billion dollars, 79 percent of which is due to maternal healthcare costs. The same study concluded that estimated annual premature deaths (both maternal and infant) associated with suboptimal breastfeeding number more than 3,300, the cost of which is estimated at greater than \$14 billion. By the study authors’ own estimation, these numbers are conservative and may in reality be considerably higher.

Lost work days and productivity due to health issues, and loss of lifetime earnings and other societal contributions due to premature deaths directly impact the economy on both a micro and macro level. Furthermore, the cost of formula strains both personal and welfare budgets; while Oliveira and Frazao (2014) state that WIC’s formula costs have dropped in recent years, the program’s formula provision represents a publicly funded cost that could be substantially decreased if

socioeconomic conditions allowed for more women to breastfeed. Furthermore, when one considers that children enrolled in WIC also utilize state-run health insurance such as Medicaid, the issue of strain on state budgets associated with healthcare costs becomes apparent (Buescher et al. 2003).

Why should Catholic healthcare institutions care about these issues?

While economic efficiency may not immediately spring to mind when one thinks of Catholic social teaching, it falls under the umbrella of distributive justice and the preferential option for the poor. As number 182 in the *Compendium of the Social Doctrine of the Church* states, in describing the preferential option for the poor: “the principle of the universal destination of goods requires that the poor, the marginalized, and in all cases those whose living conditions interfere with their proper growth should be the focus of particular concern” (Pontifical Council for Justice and Peace 2004). The inability of any mother—disadvantaged or not—to breastfeed her child is such a condition, which Pope Francis highlighted when he compared the act of breastfeeding a crying, hungry child to the merciful act of feeding the hungry poor of the world who cry out for food (Linshi 2015). The disparities in breastfeeding caused by financial and societal inequalities therefore should be of “particular concern” to Catholic healthcare institutions concerned with distributive justice and a preferential option for the poor. Furthermore, in considering the duty that states have to their citizens to use collective resources (e.g., tax dollars) responsibly and efficiently, Catholic institutions should recognize that it is both economically inefficient and a poor use of resources to structure society such that women are unable to breastfeed their

children and should work to correct these unjust conditions.

ENVIRONMENTAL IMPACT OF THE SUBOPTIMAL BREASTFEEDING RATE IN THE UNITED STATES

What are the issues?

Breastfeeding is more beneficial than formula in terms of resource conservation. As a natural, renewable substance produced by the body, breastmilk is far more “green” to produce than synthetic formula. While breastmilk production and delivery takes place in and from a single body, mass-produced formula requires factories, and therefore substantial energy and resource utilization, before it arrives to the consumer. The packaging alone poses an environmental issue; it is estimated that for every one million babies fed by formula, 150 million containers—many of which end up in landfills—are used (Wiesinger et al. 2010). Finally, one must account for the use of fossil fuels and carbon emissions that occur as formula is delivered from factory to grocery store, hospital, or clinic. Given the extensive resources required to produce and deliver formula, breastfeeding’s carbon footprint is far smaller, making it the more environmentally friendly choice (HHS 2011a).

Why should Catholic healthcare institutions care about these issues?

In discussing the merits of breastfeeding over formula feeding, Catholic healthcare institutions must consider their calling to be stewards of creation. Care for the environment is integral to Catholic social teaching, as it goes hand-in-hand with care for all persons, especially for the most vulnerable and for future generations. As the healthiest and “greenest” option for child-feeding, breastfeeding

embodies the spirit of care for the environment illuminated by Catholic social teaching, which “emphasizes the person both as responsible for creation and at the same time the center of creation” (Brady 2008, 202). In this way, the recent movement to include “food justice”—to which the promotion of breastfeeding is key—in the sphere of environmental justice scholarship helps keep concern for the environment properly oriented toward the care for mankind (Perdue, Sbicca, and Holcomb 2012).

The Canticle of the Sun (often credited to St. Francis of Assisi) expresses the foundations of Catholic environmental teaching, and has particular relevance to the gift of breastfeeding. The Canticle praises the earth as our “mother” that “sustains us and keeps us,” paralleling the life-sustaining qualities of breastmilk provided by mothers to their children (Brady 2008, 200). For Christians, the earth’s ability to yield “diverse fruits, and flowers of many colors, and grass” is a gift from the Creator that must be cultivated and protected by mankind (Brady 2008, 200); Catholic health-care institutions must recognize and promote the breastfeeding of children as such a gift to be safeguarded and cherished.

RECOMMENDATIONS FOR PROMOTING BREASTFEEDING IN THE UNITED STATES

Many studies, including one by Brand, Kothari, and Stark (2011), have found that one of the strongest predictors of whether a woman will choose to initiate and continue breastfeeding is her perceived sense of support for her decision to breastfeed. Whether a woman’s breastfeeding support system is personal or professional, she is more likely to breastfeed (and continue breastfeeding) so long as that feeling of support remains; even in spite of factors that predict otherwise, such as low socioeconomic status. Catholic health-care institutions should

therefore take special care to resist undue influence from formula manufacturers and should implement “Baby Friendly Hospital Initiative” policies that encourage, support, and educate women about breastfeeding, and discourage routine formula use for non-medical indications (Baby-Friendly USA n. d.). Pope Francis intuited the need for lending greater support to breastfeeding women, when in unscripted remarks from 2013, 2015, and 2017, he exhorted women to feel free to breastfeed their children “without fear” whenever and wherever they can, even (and especially) during Mass (Agence France-Presse in Vatican City 2017). By heeding the pope’s call and issuing strong support for breastfeeding, Catholic health-care institutions can combat the unjust socioeconomic conditions and stigmatization that have contributed to America’s sub-optimal breastfeeding rate.

Adequate paid maternity-leave policies would help ensure financial security for mothers who wish to stay home and breastfeed their children. Likewise, paid paternity leave would more easily allow fathers to provide the vital emotional and social support necessary for mothers to confidently initiate and continue breastfeeding and/or pumping milk for their children. Unsurprisingly, countless studies have affirmed that support from a married partner plays a vital role in a woman’s decision to initiate and continue breastfeeding (Brand, Kothari, and Stark 2011). Catholic health-care institutions should therefore implement their own paid maternity and paternity leave policies and provide clean, comfortable pumping areas for their employees. They should also lobby for the promotion of these (and other) family-friendly policies and practices on state- and nationwide levels.

Pope St. John Paul II had much to say about the promotion and protection of families, famously stating, “As the family goes, so goes the nation, and so goes the

whole world in which we live" (1986, no. 4). In *Evangelium vitae*, he also wrote that "a family policy must be the basis and driving force of all social policies" (1995b, no. 90). In today's society where families face many economic and social challenges, policies and programs that support, and build up the family are an excellent way to promote and protect the bonds which begin at the breast. Paralleling the life-giving love poured forth from each member of the Holy Trinity to another, breastmilk has a beautiful and mysterious significance as the life-giving substance poured forth from the bond of the mother to her child. Unsurprisingly, studies show that breastfeeding has an evidenced-based role in facilitating the bond between mothers and babies. In a review of the literature surrounding maternal-infant bonding, Johnson (2013, 17) found that "Mothers who ... initiated breastfeeding within two hours following childbirth were more sensitive to the infant's needs and the child seemed more content at one year." Pope St. John Paul II remarked upon breastmilk's natural, mystical significance in initiating the maternal/child bond, when during a Vatican conference on breastfeeding he stated, "So human and natural is this bond that the Psalms use the image of the infant at its mother's breast as a picture of God's care for man (cf. Ps. 22:9)" (John Paul II 1995a, no. 2). Likewise, in his *Letter to Families* (John Paul II 1994), he wrote: "Human fatherhood and motherhood, while remaining biologically similar to that of other living beings in nature, contain in an essential and unique way a likeness to God which is the basis of the family as a community of human life, as a community of persons united in love (*communio personarum*)" (John Paul II, 1994, no. 6). In protecting the sacred bonds of the family, we better enable mothers to breastfeed their children, and so promote the care and keeping of all of

our brothers and sisters in Christ. Catholic healthcare institutions should therefore implement institutional practices and promote state-level policies that work to protect and uphold families as the most important unit in society.

Finally, out of concern for resource conservation, the preferential option for the poor, and the principle of distributive justice, Catholic healthcare institutions should also question whether the formula expenditures made by WIC and other government nutrition-assistance programs could be more justly spent elsewhere, especially considering the historically manipulative advertising practices of the for-profit formula industry. Such funds could be better spent by providing financial support to low-income mothers for maternity leave, so that they may stay home to breastfeed their children, and/or by subsidizing the cost of breast pumps to make them more affordable. By decreasing barriers to breastfeeding ability and increasing personal choice for women and families, these options could prove to be more just and more economically efficient for states than paying for the entire financial burden (including the associated healthcare costs, as previously discussed) of the suboptimal breastfeeding rate (Perez-Escamilla and Sellen 2015).

Whether it is done out of Catholic social teaching's call to be stewards of the environment, to reduce unjust disparities and uphold the family, or to promote fair and efficacious distribution of resources (and ideally out of a concern for all of these reasons), the promotion of breastfeeding has the potential to create a more just society for us all. It is therefore imperative that Catholic healthcare institutions concerned with working towards greater social justice be at the forefront of the movement promoting greater justice in breastfeeding. However, justice will prevail only if

leaders in Catholic health care take a strong approach to advocating for laws and implementing institutional policies that remedy the causes of the suboptimal breastfeeding rate: the unjust social and economic conditions that currently make formula feeding necessary and breastfeeding impossible for so many women and their families living in America today. It is an ambitious, albeit necessary task for any healthcare institution concerned with the promotion of an authentically Catholic vision of social justice.

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