Updating the USDA National Breastfeeding Campaign: Workshop Summary

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UPDATING THE USDA NATIONAL *Breastfeeding Campaign*

Workshop Summary

Paula Tarnapol Whitacre and Sheila Moats, *Rapporteurs*

Food and Nutrition Board

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

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"Knowing is not enough; we must apply.
Willing is not enough; we must do."
—Goethe

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*Institute of Medicine planning committees (IOM) are solely responsible for organizing the workshop, identifying topics, and choosing speakers. The responsibility for the published workshop summary rests with the workshop rapporteur and the institution.

Reviewers

This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the NRC's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this report:

Adam Burns, Strategic Planning and Research, Porter Novelli, Washington, DC
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Hope Kenefick, HWK Consulting, Barrington, NH
Carol A. MacGowan, National Center for Chronic Disease Prevention and Health Promotion, CDC, Atlanta, GA

Although the reviewers listed above have provided many constructive comments and suggestions, they were not asked to endorse the final draft of the report before its release. The review of this report was overseen by **Hugh H. Tilson, University of North Carolina**. Appointed by the Institute of Medicine, he was responsible for making certain that an independent examination of this report was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this report rests entirely with the authors and the institution.

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Overview

Every month the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides 9.2 million Americans with nutritious food, nutrition education, including breastfeeding support, and referrals to healthcare and social services. Among the services provided by WIC, breastfeeding support has been a priority of the program since it began in the 1970s.

In 1997 the Food and Nutrition Service (FNS) of the U.S Department of Agriculture (USDA) launched a national breastfeeding promotion and support campaign called *Loving Support Makes Breastfeeding Work*. Frequently referred to as *Loving Support*, the campaign emphasizes that the support of family and friends, the health-care system, and the community are essential for a breastfeeding mother to be successful. Since its inception the campaign has offered social marketing research, a media campaign, a community organizer's kit, a training conference, a breastfeeding resource guide, and continuing education and technical assistance (Best Start Social Marketing, 1996). Peer counseling was added later as an additional resource. WIC agencies across the country can use whichever pieces of the campaign fit their needs.

FNS is planning to update the campaign to reflect changes in the WIC program and the environment in which it operates. As one of the first steps, the agency asked the Institute of Medicine (IOM) to conduct a one-day workshop. The objective of the workshop was to provide critical input from experts about the actions needed to build effectively on the successes of the existing campaign, using an evidence-based social marketing strategy to make the campaign relevant and effective. This publication summarizes

the main points of the presentations and discussions at that workshop, held April 26, 2011, at the Keck Center of the National Academies. The full presentations of the speakers are available on the IOM website at http://www.iom.edu/Activities/Nutrition/USDABreastfeeding/2011-APR-26.aspx.

The IOM Food and Nutrition Board established a workshop planning committee of six people with diverse nutrition, social marketing, and public health expertise (see the front matter for committee membership and Appendix B for biographical sketches). The committee fulfilled the workshop objective by setting up panels around three broad themes: what has changed since *Loving Support* began in 1997, lessons learned from other public health campaigns, and suggestions for where to take the campaign in the future (see Appendix A for the agenda).

This summary is an accurate representation of the workshop presentations and discussions which has been prepared from the workshop transcript and slides. Chapter 1 summarizes the opening remarks from the president of the National WIC Association, which represents WIC participants and agencies, and a historical overview about *Loving Support* from Debra Whitford, director of the Special Supplemental Food Program Division of the FNS. Chapter 2 highlights presentations about what has changed since the *Loving Support* campaign was launched almost 15 years ago in terms of the characteristics of the mothers who use WIC, the WIC program environment, new and emerging research, and changes in laws and policies. The changes identified by the speakers included the appearance of interactive, democratized communication created by new technology; the growing importance of peer networks among today's mothers; and strong support by WIC state programs to promote breastfeeding, including exclusive breastfeeding. A steadily more positive policy environment for breastfeeding has emerged over the years.

Chapter 3 focuses on the second panel, in which presenters discussed lessons from other public health campaigns that may have resonance for the updated WIC effort. After an overview of social marketing was presented, panel members discussed the VERB™ campaign to promote physical activity among young people, the National Breastfeeding Awareness Campaign, four state-level programs, and, as an international example, the Brazilian Breastfeeding Promotion Program. A common theme throughout these presentations was the importance of truly understanding audience needs and perceptions before moving forward with campaign design or implementation.

The discussions of the final panel of the workshop are covered in Chapter 4. Presenters on this panel offered a range of suggestions for moving the social marketing campaign forward, including program components and messages, communication tools, implementation tools for state WIC programs, strategic community-based partnerships, the identification of

research gaps, and the evaluation of program success. The presenters built on many of the topics covered earlier in the day, such as research and evaluation, the importance of social media, and broad community-based partnerships.

The presentations from each panel were followed by a general discussion and questions from the approximately 75 participants. Two respondents and the workshop chair also reflected on messages and suggestions that emerged from the panels; their comments are grouped together in Chapter 5. Additionally, a website was open for public comments before and after the workshop. These comments are excerpted in Appendix E. Appendix C provides a list of Workshop Attendees and Appendix D lists Abbreviations and Acronyms used in the report.

The suggestions of individual presenters and participants for the future of the campaign and, more generally, for WIC's efforts to promote breastfeeding are captured here, but, in keeping with the workshop guidelines of the IOM, their suggestions do not represent a group consensus.

REFERENCE

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Opening Session

WELCOME AND WORKSHOP PURPOSE

Presenter: Rafael Pérez-Escamilla

The Food and Nutrition Service (FNS) of the U.S. Department of Agriculture (USDA) administers the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). WIC promotes breastfeeding as the optimal method of infant feeding, and funds are designated for the promotion, education, and support of breastfeeding activities.

In 1997 USDA launched *Loving Support Makes Breastfeeding Work*,[1] a national campaign to promote breastfeeding to WIC participants and their families. More than 10 years later USDA wants to build on the successes of the campaign, taking into account the changes that have occurred and the knowledge gained in this country and in the WIC Program since that time. USDA requested that the Institute of Medicine (IOM) convene a workshop to gather ideas concerning how WIC can best promote and support breastfeeding.

In his opening comments planning committee chair Rafael Pérez-Escamilla welcomed participants and explained the goal of the workshop. The committee structured the workshop to discuss what has changed in the more than 10 years since the campaign began, given changes in the socioeconomic and demographic characteristics of WIC participants, in society,

[1]USDA also refers to the campaign by the shortened title *Loving Support*. Presenters used this shortened form, which is reflected throughout this report.

in the WIC program environment, and in information technology. Three panels, each followed by group discussion, reviewed these changes, covered lessons from other public health campaigns and programs, and provided input on future directions for the WIC breastfeeding campaign.

As he turned over the podium to the next speaker, Pérez-Escamilla thanked the planning committee, speakers, and IOM staff for their contributions. He also noted that the workshop sponsors at USDA/FNS gave the committee the freedom to organize the workshop as it saw fit and provided useful guidance when necessary.

OPENING REMARKS

Presenter: Douglas Greenaway

Douglas Greenaway, president and chief executive officer of the National WIC Association (NWA), lauded USDA's decision to enlist the IOM Food and Nutrition Board to assist in sorting out the challenges and opportunities associated with offering meaningful support to WIC program administrators and staff. He also expressed his appreciation to the Centers for Disease Control and Prevention for its leadership and dedication in supporting and promoting breastfeeding and also to NWA professionals for their commitment to achieving breastfeeding success for WIC mothers and their infants.

Families who turn to WIC for nutrition assistance are vulnerable and at risk; meeting their nutritional needs is an essential priority of the WIC community and of NWA. NWA represents 12,200 service provider agencies and the more than 9 million mothers and young children participating in the WIC Program. NWA serves as an education arm and advocacy voice on Capitol Hill; before the USDA and other federal agencies; and with the White House, stakeholders, and collaborating partners.

Greenaway said that NWA supports, promotes, and encourages breastfeeding as the first and most important form of infant feeding in order to improve the overall health and nutritional health of WIC mothers and infants. The association recently released a comprehensive national breastfeeding strategic plan for the WIC Program, accompanied by a blueprint with six steps to achieve WIC breastfeeding goals (NWA, 2011). (Several panelists summarized aspects of the plan and the steps later in the workshop.) Greenaway said that it is NWA's desire for WIC to be known as the "Go-to Breastfeeding Program."

Greenaway offered feedback from NWA members on the current *Loving Support* campaign as a new campaign is being considered. He relayed their comments that "the branding has been terrific and is widely recognized" and that the materials are attractive, of professional quality, and

appealing to both participants and the general public. Members have commented that the interactive group activities are engaging and have said that they appreciate that WIC agencies are allowed to integrate the brand into their own materials. The peer counselor curriculum offers positive overall training at an appropriate depth for the new breastfeeding peer counselor.

Greenaway also relayed some recommendations from NWA. NWA members have suggested that the campaign be revised more frequently to reflect emerging evidence and to incorporate social marketing and tools, such as electronic media. They recommended avenues for peer counselors to access clients soon after giving birth so as not to lose new mothers prior to their first postpartum certification for WIC benefits. It would also be helpful to include more role-playing tools, especially those that address issues that breastfeeding mothers confront daily, such as helping them to withstand pressure to wean early, to deal with difficult employer situations, and to manage breastfeeding while working or attending school. They suggested tools for facilitating or implementing breastfeeding support groups in the WIC clinics or other WIC settings as well as expanded partnerships between WIC and community groups, particularly physician partners. Overall, they recommended that the *Loving Support* campaign be used as the nation's breastfeeding brand to reach all families, not just WIC families.

Greenaway concluded by thanking participants for their support of the WIC Program and wished the group success in the day's agenda and the work ahead.

HISTORICAL PERSPECTIVE ON THE *LOVING SUPPORT* CAMPAIGN

Presenter: Debra Whitford

Debra Whitford, director of the Supplemental Food Programs Division of FNS, has been involved with WIC for more than 30 years. She noted that breastfeeding is a core component of the services that the WIC Program provides and said that *Loving Support* has helped WIC make great strides in fulfilling its mission to safeguard the health of low-income women, infants, and children. Her presentation was designed to provide the background and context against which to consider current and future directions of the campaign.

According to Whitford, the mission of the WIC Program is to "serve as an adjunct to good health care during critical times of growth and development, in order to prevent the occurrence of health problems . . . and to improve the health status of eligible infants, mothers and children," (*Child Nutrition Act*, P.L 94-105, Sec. 17(a) [October 7, 1975]; *Child Nutrition Amendments of 1978*, P.L. 95-267, Sec. 17(a) [November 10, 1978]). Those

eligible for WIC are pregnant and postpartum women up to 6 months after giving birth, with breastfeeding women served up to 1 year, and also infants and children through 5 years of age.

On average the WIC Program served about 9.2 million women and children per month through 90 state agencies in fiscal year (FY) 2010. About 25 percent of the participants were pregnant and postpartum women, and about 25 percent were infants under 1 year of age. Overall, children 1 to 2 years of age make up the largest population served. Whitford also noted that half of all infants born in the United States every year are WIC participants.

WIC provides participants with supplemental foods, nutrition education (the only program within FNS with this mandate), and referrals to health and social services in addition to breastfeeding promotion and support. Whitford stressed that breastfeeding is a priority for everyone involved with WIC, whether at the local, the state, or the federal level. All mothers are encouraged to breastfeed unless medically contraindicated, so it is important to have all the pieces in place so that mothers have the information and support they need to make this important choice.

The WIC Program supports breastfeeding mothers by providing anticipatory guidance, counseling, and educational materials; a greater quantity and variety of foods for breastfeeding mothers than for non-breastfeeding mothers; one-on-one support from WIC Peer Counselors; longer participation in the program than for non-breastfeeding mothers; and breastfeeding aids, such as breast pumps and shells, to help women continue their commitment to breastfeeding.

Establishing *Loving Support*

Loving Support Makes Breastfeeding Work is the USDA campaign launched in 1997 to promote breastfeeding to WIC participants and their families with a social marketing strategy that includes mass media, participant education materials, and technical assistance to WIC staff. While it has been USDA's most comprehensive breastfeeding campaign, Whitford said that other efforts had been undertaken to promote breastfeeding before WIC's launch.

Whitford reviewed a chronology of legislation and other milestones leading up to the *Loving Support* campaign. At its inception in 1972 WIC was designed to reach pregnant and lactating women and, at the time, infants and children up to 4 years of age. In 1975, when WIC became a permanent program, the legislation establishing it explicitly used the term breastfeeding. With the passage of the 1989 reauthorization of WIC, greater emphasis was placed on breastfeeding support. That law also required that WIC establish a national definition of breastfeeding, which

USDA did in conjunction with NWA and the U.S. Department of Health and Human Services (HHS).

In the 1990s additional measures were put in place to support breastfeeding. Participants of the first meeting of the Breastfeeding Promotion Consortium, which consisted of USDA, HHS, the American Academy of Pediatrics, and other groups, proposed a national breastfeeding campaign for WIC's target population. FNS convened a Technical Consultant Group to discuss how to design a campaign, and in 1992, P.L. 102-342 (the *Child Nutrition Amendments of 1992*) called for a National Breastfeeding Promotion Program. During that same year FNS awarded grants (Breastfeeding Incentive Demonstration Projects) to local and state agencies specifically to foster wider acceptance for breastfeeding, and special food packages were established for fully breastfeeding women. Whitford noted that the changes, while small compared to the food package of today, were the first since the program began in 1980 and underscored the importance of women breastfeeding their infants.

In 1994, P.L. 103-448, the *Healthy Meals for Americans Act*, revised the funding formula for breastfeeding promotion and support and required agencies to report breastfeeding incidence and duration among participants.

In 1995 FNS entered into a cooperative agreement with Best Start Social Marketing to develop the campaign that became the *Loving Support* campaign. Research and pilot programs took place in Arkansas, California, the Chickasaw Nation (Oklahoma), Iowa, Mississippi, Nevada, New Jersey, New York, Ohio, and West Virginia, and the initiative that emerged was formally evaluated in Iowa and Mississippi. USDA officially launched *Loving Support* during Breastfeeding Week, August 1–7, 1997.

The campaign has five goals:

1. Increase breastfeeding initiation rates among WIC participants.
2. Increase breastfeeding duration among WIC participants.
3. Increase referrals to WIC for breastfeeding support.
4. Increase general public acceptance and support of breastfeeding.
5. Provide support and technical assistance to WIC state and local agencies in the promotion and support of breastfeeding.

The primary target audiences are those directly involved with WIC: participants, local WIC staff, and WIC state breastfeeding coordinators. Secondary audiences include those who interact with WIC mothers: significant others and grandmothers, health care providers, and the general population. The project has a number of components, including consumer research, a media campaign, a community organizer's kit, a breastfeeding support resource guide, a training conference, and continuing education and technical assistance.

Formative research in the 10 pilot states pinpointed three key barriers that discouraged WIC mothers from initiating or continuing to breastfeed:

1. Embarrassment to breastfeed in front of others
2. Time and social constraints when breastfeeding while going to work or school
3. Lack of social support, especially in the two weeks postpartum

To address these barriers, messages were developed that were designed to help women feel comfortable breastfeeding, to show how breastfeeding can work within a busy schedule, and to encourage the involvement of family and friends so that they support the mother's breastfeeding decision, and these messages were disseminated through ads, pamphlets, and staff support kits and were integrated into training and technical assistance. Throughout the workshop, presenters and participants returned to the three barriers, stating they had not changed and offering suggestions about how the WIC Program can overcome them.

Changes and Constants

The *Loving Support* campaign is now almost 15 years old and is used in varying degrees by all WIC state agencies. Whitford summarized the changes that have taken place in the WIC Program and society at large since *Loving Support* began that will have an impact on a new campaign. For example, both advances in nutrition and breastfeeding research and the country's expanded food supply and changing dietary patterns will need to be taken into account. Obesity has emerged as a major public health problem. At the same time, the WIC Program not only has grown, but also serves a more culturally diverse population. Changes in benefits offered in the WIC Program include revisions to the WIC food packages that strengthen WIC's breastfeeding promotion efforts and provide incentive to mothers to initiate and continue breastfeeding their infants. Workplace accommodations for breastfeeding mothers are another important change to consider.

Whitford noted that some obstacles related to breastfeeding have stayed the same. Drawing on findings from the 1997 WIC Infant Feeding Practices Study (USDA/FCS, 1997), Whitford said that unsupportive hospital practices and early formula supplementation were cited among the factors leading to early cessation of breastfeeding. The study found that one-fourth of the WIC mothers who had initiated breastfeeding stopped by the end of the second week and one-half stopped by the end of the second month. Furthermore, mothers who perceived that they did not have an adequate milk supply or that there was something wrong with their milk were more likely to stop breastfeeding. The study also found that Hispanic mothers

believed in the benefits of breastfeeding more strongly than mothers in other racial or ethnic groups, and African American mothers believed more strongly than mothers in other racial or ethnic groups that there were barriers to breastfeeding.

In the decade or so since the 1997 WIC Infant Feeding Practices Study, previous obstacles to breastfeeding still remain for both WIC and non-WIC mothers, according to an article cited by Whitford (Grummer-Strawn et al., 2008). As a result of continuing hospital practices that are not supportive of breastfeeding, 52 percent of babies receive supplemental formula while they are in the hospital. Supplementation begins early: By 3 months of age, 61 percent of mothers regularly give formula to their infants, and half of new mothers have started feeding their infants solid food by 4 months of age. Racial and ethnic disparities continue, with breastfeeding rates at birth 50 percent lower for African American infants than for white infants.

But a number of changes have taken place since the 1990s. Participation in WIC has increased from an average of 7.2 million in FY 1996 to 9.2 million in FY 2010 (USDA/FNS, 2011). There has been a steady decline in the percentage of women participating in WIC who are under 18 and an increase in those who are older; in 2008, 85 percent of women participating in WIC were aged 18 to 34. Breastfeeding women tend to be older, with 11.5 percent over age 34. The demographics of the WIC population are also changing. In 2008 about 60 percent of participants were white, about 20 percent were African American, and about 11 percent were American Indian or Alaskan Native. About 43 percent of participants reported their ethnicity as Hispanic/Latino (USDA/FNS, 2010). Whitford said that changes in the method of collecting these data prevent a direct comparison with the past but that the program is more diverse than in its earlier days.

According to USDA surveys, a larger percentage of WIC women are now initiating breastfeeding than in the 1990s. Based on reporting from 63 state agencies, only about 41.5 percent of WIC mothers nationwide initiated breastfeeding in 1998 (Figure 1-1), whereas about 59 percent initiated breastfeeding in 2008 (Figure 1-2). Whitford noted that breastfeeding is now initiated in most parts of the country by a sizable percentage of WIC mothers, although convincing mothers to continue breastfeeding exclusively remains a challenge.

Loving Support in Action

Since the launch of the *Loving Support* campaign in 1997, FNS has implemented several initiatives and trainings that are built on the *Loving Support* theme. In 2002 grants were awarded to state agencies to bring WIC staff together with community partners to develop strategies and conduct trainings to build breastfeeding-friendly communities. WIC staff and part-

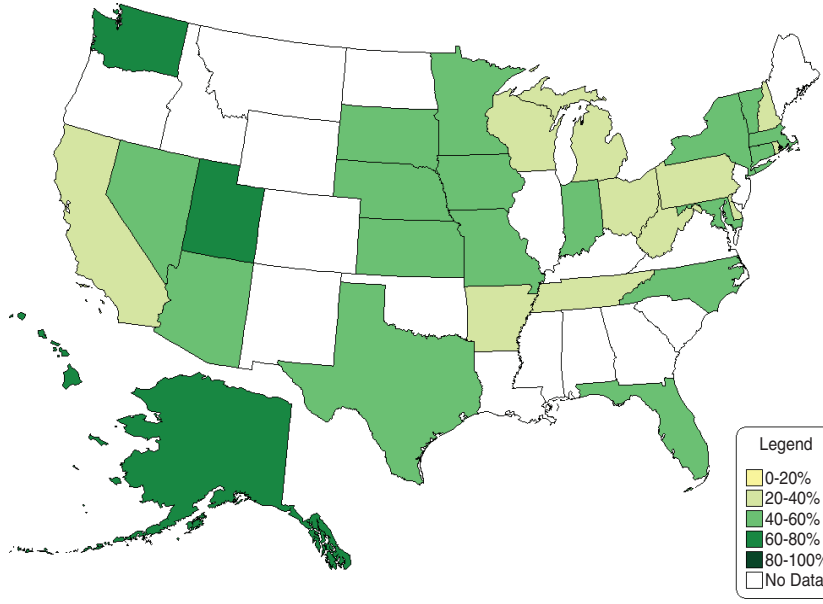

FIGURE 1-1 Breastfeeding initiation rates among WIC infants, 1998.
SOURCE: USDA/FNS, 2000.

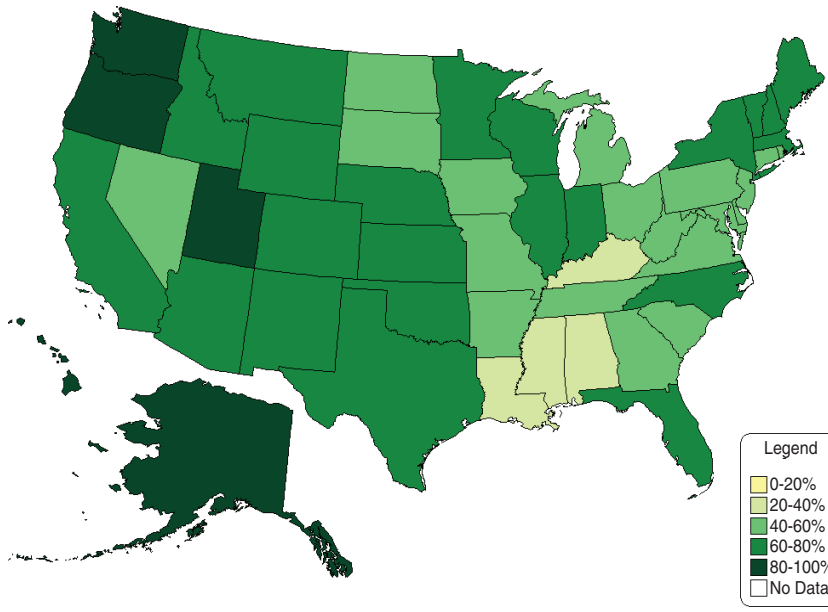

FIGURE 1-2 Breastfeeding initiation rates among WIC infants, 2008.
SOURCE: USDA/FNS, 2010.

ners created strategic plans that addressed barriers to breastfeeding. These plans are useful as technical assistance and for helping other state and local agencies to develop comprehensive community-based breastfeeding programs.

Recently, new WIC food packages were introduced with the goals of better meeting the nutritional needs of breastfeeding mothers and infants, minimizing the amount of formula provided to breastfed infants while mothers develop their milk supply, and increasing the dollar value and attractiveness of the full-breastfeeding food package.

The WIC Peer Counseling Program has also expanded. This is important, Whitford said, because peer counseling combined with other WIC services can have a positive impact on breastfeeding initiation and duration rates. Beginning in FY 2004 Congress has provided funds for breastfeeding peer counseling grants; grants in the first year totaled $14 million, and that amount has since increased substantially, to $80 million in FY 2010. State agencies that use an approved *Loving Support* model can use these grants to fund salaries, training, tools, print materials, travel expenses, and program expansion. The *Loving Support* Peer Counseling curricula have been updated, with training sessions planned for fall of 2011.

It was recently announced that $5 million in breastfeeding performance bonuses will be awarded to the 10 states with the highest rates of breastfeeding and the 10 states that have shown the greatest improvement in breastfeeding rates. States can use the funds for a wide range of projects but are encouraged to direct the funds toward projects involving breastfeeding. For example, many state agencies have used the funds to support breastfeeding-related training for staff.

Promotional and training materials for specific groups have been developed through *Loving Support*. "A Magical Bond of Love" was developed for Hispanic families based on research that identified specific barriers to breastfeeding in Hispanic communities. "Fathers Supporting Breastfeeding" was designed and targeted for African American fathers in an effort to address the disparities in breastfeeding rates for African American infants, although state agencies report that they have successfully used the materials with wider audiences. "Partnering with WIC for Breastfeeding Success" is a program in which health care providers, health care organizations, policy makers, and other stakeholders can partner with WIC to promote breastfeeding for healthy babies, mothers, and families. Finally, the new initiative "Using *Loving Support* to Grow and Glow" provides a training curriculum for all local agency staff who interact with breastfeeding mothers at the local level.

P.L. 111-296, the *Healthy, Hunger-Free Kids Act of 2010*, reauthorized the WIC Program and includes provisions supporting breastfeeding. It requires the collection and publication of breastfeeding data at the state

and local levels and requires the review of the food package not less than every 10 years. More broadly, there was acknowledgment in the law that any mention of "nutrition education" in the law includes breastfeeding support and promotion. The legislation extended breastfeeding performance bonuses and doubled the funding for them to $10 million. FNS is designing a local agency recognition program, as set out in the legislation, for agencies and clinics that demonstrate exemplary breastfeeding promotion and support activities. Public comment on the criteria developed for the program will be requested through a notice in the Federal Register.

Next Steps

Whitford closed her historical overview by asking the group for guidance on where to go from here with the *Loving Support* campaign. She posed a series of questions to consider over the course of the workshop: Where does the campaign go from here? How does the WIC Program sustain the progress in breastfeeding rates and support that have been accomplished thus far? How can the images used in the media for communication efforts with WIC participants be revitalized? How can the WIC Program address the barriers that continue to exist for WIC breastfeeding mothers? What are the staff needs that should be addressed at the local level? What technical assistance materials are needed by the staff? What are the educational materials that the staff may need in their efforts to talk with WIC moms?

Whitford closed by thanking participants for their time and input. The understanding gained today will revitalize the campaign and help with the next steps.

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What Has Changed?

Presenters in this session, which was moderated by Gail Harrison, a professor in the Department of Community Health Sciences at the University of California, Los Angeles School of Public Health, reviewed changes in the WIC program and society that have occurred since the *Loving Support* campaign was launched over a decade ago.

Georgia Galanoudis began by focusing on mothers, highlighting salient characteristics about "Millennial Moms" (women born between 1977 and 1994), such as how they use technology, interact with peers and family members, and perceive their own wants and needs. Kiran Saluja looked at changes in the WIC program environment, drawing from an informal survey of state and local WIC programs. She noted that the programs expressed strong support for breastfeeding, but she also commented on the need to involve the whole community in order to have an impact, especially in order to achieve exclusive breastfeeding. Joseph Robare summarized recent and current studies that will provide data related to changes in WIC participation, hospital practices, the WIC program, and other relevant subjects. Marsha Walker highlighted programs, policies, and laws at the federal and state levels that have created a more supportive environment for breastfeeding than when the *Loving Support* campaign was first launched. A question-and-answer period followed the panelists' presentations.

CHANGES IN COMMUNICATIONS PATTERNS: COMMUNICATING WITH TODAY'S MOM

Presenter: Georgia Galanoudis

Georgia Galanoudis, executive director of the Meredith Corporation Parents Custom Network Solutions Group, described the characteristics of "millennial moms," the 37 million women born in the United States between 1977 and 1994. Except where noted, her findings are based on the Moms & Media: Always On survey (The Meredith Parents Network MomTrak®, 2011).

Changes in Demographics and Technology

More than 14 million of the U.S. women born between 1977 and 1994 are already mothers, and by 2030 more than 30 million of them will be mothers, making them a large and powerful group. Fertility rates are the highest that they have been in the last 15 years. In 2009 the millennial moms gave birth to 63 percent of all babies born in the United States and 76 percent of first births, according to National Center for Health Statistics figures (CDC/NCHS, 2010). They are also a more diverse group than earlier generations. Two in five millennial moms belong to a racial or ethnic group other than non-Hispanic White, and one in nine, or 11 percent, were born in the United States of an immigrant parent. Hispanic mothers account for the largest percentage of the population boom (Pew Research Center, 2010).

Galanoudis noted that these women grew up with home computers and the Internet. A woman born in 1985 was in first grade when the Internet came into widespread existence, and she considers a computer to be a normal household item. These mothers are tech-savvy, Galanoudis said, and they expect to find information online, especially because many do not have their parents living nearby to help them with various issues. They turn instead to their peers, to blogs, and to Web communities. As one mother said, "It isn't technology for the sake of technology. It's about making connections and staying connected." WIC mothers' use of technology is similar to that of others in their peer group. Virtually all (99 percent) of WIC mothers use electronic resources, 89 percent of them use parenthood advice and information websites, and 72 percent visit retailer websites. When an e-newsletter was offered to expectant and new mothers, 54 percent of all WIC mothers signed up, which was only slightly behind the percentage of all mothers who signed up (63 percent) (The Meredith Parents Network MomTrak®, 2011).

Implications

The millennial moms place a high importance on feeling connected with their peers, Galanoudis said. Eighty-two percent use social networks, such as Facebook, leading Galanoudis to conclude that marketing to this group will require using those networks to participate in the conversations millennial moms are having with their peers, friends, and family members. They look to friendships with other women for perspective and nonjudgmental support, for adult interaction and socialization, and for advice and honest assessments.

Referring to findings from The Meredith Parents Network MomTrak® survey (2011) as well as from the Pew Internet & American Life Project (Horrigan, 2008), Galanoudis said that millennial mothers view mobile technology as "a functional tool that they cannot live without." Sixty-two percent say that, of all forms of communication, their cell phones would hardest to give up, more so than the Internet, television, landline telephones, or e-mail. According to Galanoudis, 90 percent of WIC mothers have a mobile device and 26 percent had a smart phone at the time of the Meredith survey, but, Galanoudis noted, that figure is steadily rising.

Galanoudis described WIC mothers as "media omnivores." Expectant and new mothers reported that they get information from 11 different sources each month—magazines, books, websites, and other resources—with Hispanic mothers reporting that they use 17 different sources monthly. They do not find this amount of information overwhelming; rather they say that they optimize and filter the information to fit their own needs. When asked about the information sources that influence their decisions to purchase foods and beverages for their children, they ranked in-store product displays first, followed by television, retailer/company websites, nonparenthood websites, healthcare professionals, catalogues, health/medical websites, and parenthood magazines.

People marketing to this group should, Galanoudis recommended, keep five characteristics about them in mind:

1. Instant gratification: They are pressed for time, and convenience is key. They grew up accustomed to the speed of the Internet, and they demand quick access and immediate action. As noted earlier, mobile technology plays an increasingly important role in their lives, providing them with multifunctional information devices.
2. Personalization: Technology also provides the ability to customize information, such as tailored Web page content. Many of these mothers have custom Web pages, iPods tailored to their musical tastes, and the ability to watch their favorite television shows on

their own schedule. They expect messages to be personalized and interactive in order to catch their attention.

3. Diversification: These women represent more cultures and ethnicities than ever before in U.S. history, and they are also quick to embrace different cultures. Messages and images must reflect this diversity.
4. Recognition as a multi-dimensional person: Millennial mothers do not want to give up their "non-mom" identity. Connecting with them means appealing to all aspects of their identities. As an example, when postpartum women were asked what they would choose to do if they had a "magic wand" that could magically fix something for them, one common response was that they wanted to lose their baby weight. Galanoudis suggested finding ways to use that information to promote breastfeeding.
5. A voice: They do not want to be talked at but rather to be involved in a two-way conversation. Start a dialogue with these women, Galanoudis suggested. Get them involved.

Recognizing these characteristics, Galanoudis concluded, will lead to a successful campaign.

CHANGES IN THE WIC PROGRAM ENVIRONMENT

Presenter: Kiran Saluja

Just as the WIC participants' demographics and use of technology have changed since 1997, so too have WIC and the environment in which it operates, said Kiran Saluja, chair-elect of the executive committee of the National WIC Association and deputy director of the Public Health Foundation WIC Program, which serves more than 300,000 participants in and around Los Angeles, California. She began her presentation with a comment received on the agency's website, in which a mother expressed her appreciation for and willingness to publicly promote WIC breastfeeding support. She noted that this comment, as well as many similar ones heard throughout the Los Angeles area, reflects Galanoudis's observations that mothers today are using technology and want to be involved.

In what Saluja termed "the new WIC world," breastfeeding is a cornerstone activity. Breastfeeding is the most discussed topic in WIC and is a part of everything that people involved with WIC do, from the food package to training. Many changes have occurred since *Loving Support* began in 1997. Some of these changes, Saluja said, are that many states have enacted breastfeeding legislation; lactation accommodation was included as part of health care reform (*Patient Protection and Affordable*

Care Act, P.L. 111-148, Sec. 4207 [2010]); exclusive breastfeeding goals were set forth in Healthy People 2020 (HHS/ODPHP, 2010), the Surgeon General's Call to Action to Support Breastfeeding (HHS, 2011); the number of Baby-Friendly Hospitals nationwide has increased (Baby-Friendly USA, 2011); and the Centers for Disease Control and Prevention (CDC) collected data on breastfeeding and maternity practices to produce the *Breastfeeding Report Card*, which provides perspectives on state and national trends in breastfeeding (CDC, 2011). In addition, the evidence base for the benefits of exclusive breastfeeding—such as its protective effect against obesity—is growing. In light of these changes, the WIC program has stepped up to become the face of breastfeeding support in the community—active in coalitions and task forces, providing peer counseling and staff training, working with the National WIC Association to develop a summit and strategic plan, and making funds available to support breastfeeding.

Informal Survey Results

To assess where different states are in the continuum of change in providing breastfeeding promotion and support, Saluja sent an informal survey to state breastfeeding coordinators via the National WIC Association. She received more than 20 responses which came from all USDA regions of the country.

All of the states that responded except for one Southeastern state reported that they provide staff training on breastfeeding and provide breast pumps to mothers. Those same states reported making mothers feel welcome to breastfeed while at WIC clinics, and none reported displaying images of formula feeding. All respondents indicated that they provide prenatal breastfeeding education, with a range and variety of programs offered. About two-thirds of the 20 respondents offer breastfeeding support groups, and 14 states either had or would soon have International Board Certified Lactation Consultants (IBCLCs) on staff. About two-thirds of the respondents said they offer home visits to support breastfeeding, and all have peer counselors. Two-thirds of the states do not routinely issue formula in the first month, but some states do provide a can of formula at that time. Saluja called the new food packages "manna from heaven" and noted that all states promote them to encourage breastfeeding.

Moving Forward

Saluja's general conclusion was that the trend of responses indicates a WIC environment that has evolved over the last 14 years. Despite varying levels of breastfeeding support reported by WIC sites, survey responses

indicate that sites are committed to providing support and improving the ways in which they approach breastfeeding.

She noted some people have suggested implementing breastfeeding service standards similar to those set for nutrition services. A dilemma arises, however, in that WIC strongly supports breastfeeding while simultaneously providing free formula, which is a fierce competitor to breastfeeding because of its perceived monetary value, direct marketing, and other incentives. The new food package, Saluja said, offers a more viable alternative to the issuance of formula than existed previously.

While not suggesting that mothers who do not breastfeed should be penalized, Saluja urged that increasing exclusive breastfeeding should be the focus of future efforts. She highlighted the regional disparities that exist in the numbers of infants being exclusively breastfed. That is, the percentage of infants exclusively breastfed in the southeast region of the United States is much lower than the percentage in the northwest region (see Figure 2-1). As one state coordinator said in the survey, "It takes the efforts of the full community of partners and agencies [for] breastfeeding promotion and support." Saluja said that increasing the number of babies exclusively breastfed

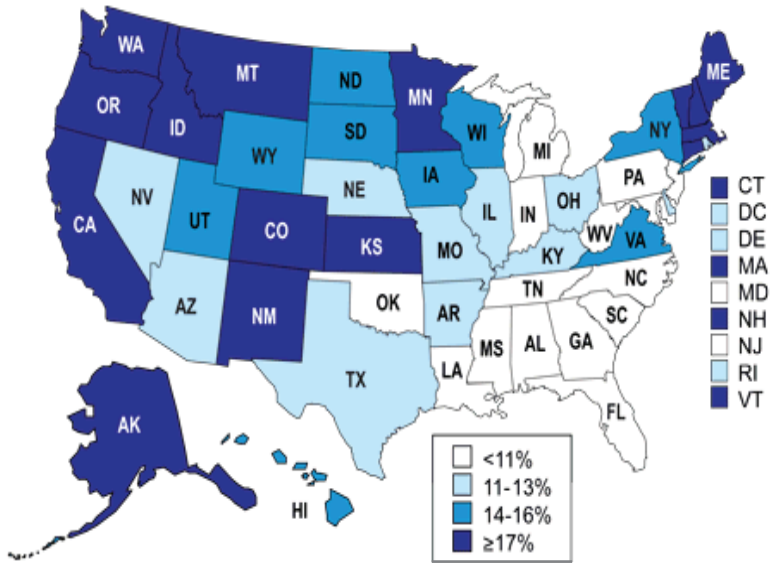

FIGURE 2-1 Percentage of all U.S. children exclusively breastfed through six months of age among children born in 2007.
SOURCE: CDC, 2010a.

to 6 months of age will involve not just making sure that the mothers know what to do but also teaching mothers how to accomplish this with the help of everyone around them. Just as immunization and the use of car seats have has become norms, so too should breastfeeding, Saluja urged.

FNS WIC BREASTFEEDING RESEARCH UPDATE

Presenter: Joseph Robare

Joseph Robare, an epidemiologist and research analyst in the FNS Special Nutrition Evaluation Branch, presented data from recent studies and described several ongoing studies that should contribute useful insights as the *Loving Support* campaign is updated. Specifically, the studies he discussed were the WIC Participant and Program Characteristic Study from 2008 (the 2010 data had not been not published at the time of the workshop), the CDC National Immunization Survey data related to breastfeeding, the WIC Birth Month Study, the WIC Breastfeeding Peer Counseling Study, and the proposed WIC Infant and Toddler Feeding Practices Study II.

WIC Participant and Program Characteristics, 2008

The WIC Participant and Program Characteristic Study, published in January 2010, is a huge dataset (9.5 million records) that offers a broad view of WIC and its participants over a 10-year period. Robare shared some of the findings and pointed participants to the final report (http://www.fns.usda/ora).

Of note, the percentage of non-Hispanic White and African American infants in the WIC program has declined since 1998, while Hispanic infants and those from other ethnic groups have increased in proportion (see Figure 2-2). Therefore, Robare noted, as it redevelops the *Loving Support* campaign, FNS should take a look at the ethnic distribution of both the infants and mothers and make the appropriate changes where necessary.

CDC National Immunization Study

The CDC National Immunization Study includes information about breastfeeding. Robare shared data from that study concerning exclusive breastfeeding of infants at 3 and 6 months of age and noted that WIC mothers lag behind national averages. At 3 months of age, about 33 percent of mothers overall breastfeed their infants, compared with about 25.5 percent of WIC mothers. Both percentages drop at 6 months of age, and, again, WIC mothers lag. At 6 months of age, 13.3 percent of mothers overall exclusively breastfeed their infants, compared to only 9.2 percent

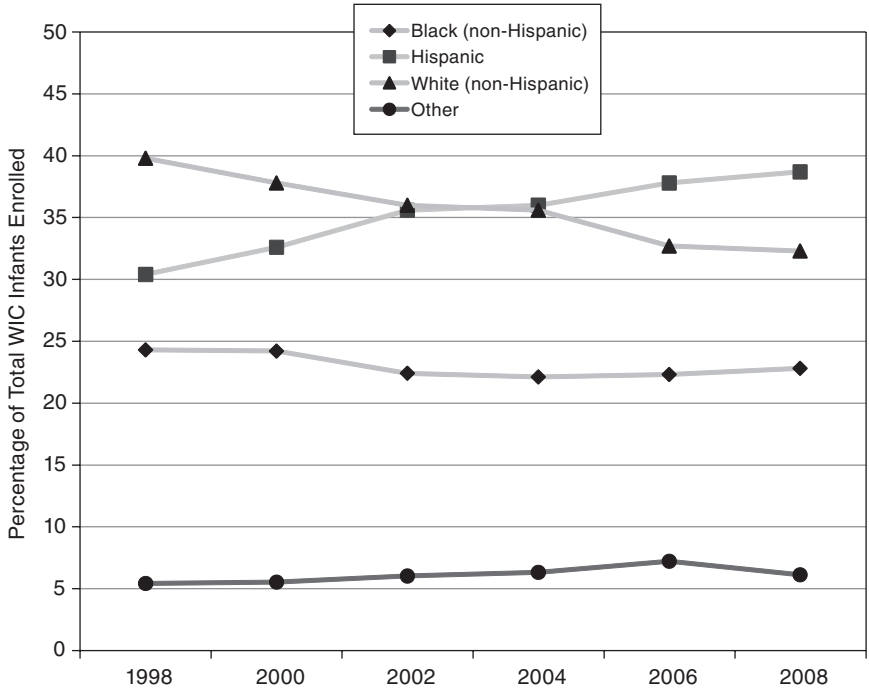

FIGURE 2-2 Racial and ethnic distribution for WIC infants, 1998–2008.
SOURCE: Adapted from USDA/FNS, 2010.

of WIC mothers (Figure 2-3). However, Robare offered two caveats about the data: The study was done without taking into account the new food package, since it only included data through 2007, and it does not represent data coming out in the WIC Birth Month Study (see below).

WIC Birth Month Study

The design of the WIC Birth Month Study was based on a recommendation in the IOM report, *WIC Food Packages: Time for a Change* (IOM, 2006). The study, which was conducted by Abt Associates, examined the impact that the interim rule on food packages had on breastfeeding initiation, duration, and intensity in the month after birth. Intensity is a dichotomous variable that measures exclusive breastfeeding and partial breastfeeding rates. The study also analyzed how site characteristics affected the food package choices before and after the interim rule. Methods included interviews with WIC staff and recipients and data collection at

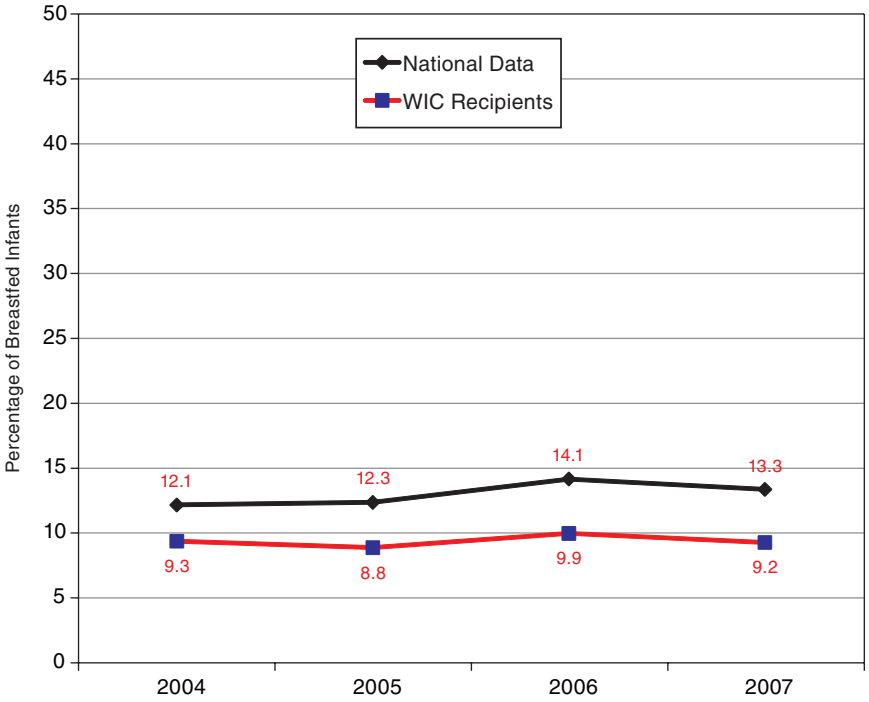

FIGURE 2-3 Percentages of infants exclusively breastfeeding at 6 months of age: National figures compared to WIC recipients.
SOURCE: Adapted from data from CDC, 2010b.

17 local WIC agencies in 10 states with about 1,600 individuals. The final report is scheduled for release in September 2011.

WIC Breastfeeding Peer Counseling Study

The WIC Breastfeeding Peer Counseling Study, Phase I, which was also conducted by Abt Associates and is scheduled to be released shortly, provides a comprehensive and systematic picture of the implementation of the *Loving Support* peer-counseling program. Phase II will examine specific variations in how implementing peer counseling affects the exclusivity and intensity of breastfeeding. Between the two phases, Congress appropriated $80 million to support peer counseling. Although the main goals of Phase II will remain the same, the study is being reexamined to determine if, given that expansion of peer counseling, changes in the study are warranted. The study will be carried out at about eight of the largest local WIC agencies involving more than 1,000 expectant mothers in total. At the time of the

workshop, FNS was close to submitting its data collection package to the Office of Management and Budget for clearance.

WIC Infant and Toddler Feeding Practices Study II

The final study that Robare highlighted, the WIC Infant and Toddler Feeding Practices Study II, is contained in the fiscal year 2010 Research and Evaluation Plan. As an update to the Infant and Childhood Feeding Practices Study, the upcoming study will be longitudinal in design in order to provide updated information on the feeding patterns of WIC infants, with expanded information on infant and toddler feeding behaviors. It will review nutrition education and breastfeeding promotion and support by WIC and other sources to determine the relative effectiveness of different approaches. One objective will be to identify aspects of WIC nutrition education that could influence feeding practices in order to address the problem of high body weight among young children in WIC.

Robare closed by thanking the WIC division and the IOM planning committee, and he invited participants to contact FNS with questions or to alert his office to other relevant studies.

CHANGES IN FEDERAL AND STATE PROGRAMS, LAWS, AND POLICIES

Presenter: Marsha Walker

Marsha Walker, executive director of the National Alliance for Breastfeeding Advocacy: Research, Education and Legal Branch, presented a timeline of significant breastfeeding actions since 1996. An unprecedented number of changes have occurred, she said, and she identified what she saw as high points.

Chronology, 1996–2011

1996

Walker began by highlighting a piece of legislation that was enacted shortly before the *Loving Support* campaign began: the 1996 *Personal Responsibility and Work Opportunity Reconciliation Act*. According to one study (Haider et al., 2003), this act coincided with a decline in breastfeeding by 22 percent in WIC mothers, so, as Walker phrased it, "We almost started from behind the eight ball when *Loving Support* began." In 1996 the *Loving Support* campaign was designed (officially launched in 1997), and the country's first Baby-Friendly Hospital was designated in Washing-

ton. (There are currently 107 Baby-Friendly Hospitals nationwide and an additional 256 in various stages of becoming designated as Baby-Friendly.) Walker said that a supportive hospital environment is critical not only to initiate but to continue breastfeeding.

1997

A key event in 1997 was the release by the American Academy of Pediatrics (AAP) of its influential policy statement "Breastfeeding and the Use of Human Milk." Walker said that this statement, since updated, is almost always cited in breastfeeding research articles. It underscores the value of not only initiation, she said, but also duration and exclusivity.

1998

In 1998 the U.S. Breastfeeding Committee (USBC) was formed with financial support from the CDC, the Department of Health and Human Services' Maternal and Child Health Bureau (HHS/MCHB), the HHS Office on Women's Health, and the USDA. The USBC assists the state breastfeeding coalitions that now exist in every state, and many WIC state breastfeeding programs belong to these coalitions. Much of the grassroots effort that is needed to change legislation and policy comes through the state breastfeeding coalitions.

1999

Walker highlighted a piece of legislation passed in 1999, the *Right to Breastfeed Act* (H.R. 1848), which was spearheaded by Rep. Carolyn Maloney (D-NY). It ensures a woman's right to breastfeed on all federal property. By the time the federal legislation passed, 16 states had already enacted their own breastfeeding laws, but, to Walker's knowledge, the *Right to Breastfeed Act* was the first piece of federal legislation specifically related to breastfeeding.

2000

In 2000 Healthy People 2010 was released. It included various breastfeeding objectives, and of particular significance, Walker said, was its 2005 midcourse review that added exclusive breastfeeding targets. In that same year HHS issued the Blueprint for Action on Breastfeeding, which positioned breastfeeding as a public health issue, not just a positive individual choice.

2003

The National Breastfeeding Awareness Campaign was launched in 2003, aimed at promoting breastfeeding among all first-time parents. (See the next chapter of this report for a summary of a presentation on this campaign.)

2007

In 2007 the CDC conducted the Maternity Practices in Infant Nutrition and Care (mPINC) study, which highlighted hospital practices related to breastfeeding. Walker said that the findings demonstrated to hospitals how poorly they were supporting breastfeeding mothers and that they have led many hospitals to improve their practices (Bartick et al., 2010; CDC, 2008; Edwards and Philipp, 2010).

2008

With the publication in 2008 of the information package, *Business Case for Breastfeeding* (HHS/Office of Women's Health, 2010), MCHB and the Health Resources and Services Administration involved employers by providing a series of materials designed to create breastfeeding-friendly work environments. Throughout the workshop Walker and others pointed out that lack of employer support often makes breastfeeding difficult for WIC mothers who return to work, and this publication laid out the economic case for workplace accommodations.

2010

Walker described four significant events that took place in 2010. First, the Joint Commission Perinatal Core Measure Set was established, which measures (among other things) the number of infants exclusively fed breast milk at hospital discharge. As with the mPINC mentioned above, this measure shines a light on hospital practices (Joint Commission, 2011).

The *Patient Protection and Affordable Care Act of 2010* (P.L. 111-148, Sec. 4207 [2010]) introduced specific worksite protections for many breastfeeding mothers. In addition, a presidential memorandum ordered the creation of appropriate workplace accommodations for nursing mothers who are federal civilian employees (White House, 2010). The Healthy People 2020 objectives, announced by HHS in 2010, set three breastfeeding-related objectives: (1) increase the proportion of employers that have worksite lactation support programs, (2) reduce the proportion of breastfed newborns who receive formula supplementation within the first two days of life, and

(3) increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies (HHS/ODPHP, 2010).

The *Healthy, Hunger-Free Kids Act*, described earlier in the morning by Debra Whitford, contains provisions to recognize exemplary breastfeeding practices at local agencies. In addition, the act provides bonuses to states to reward various breastfeeding accomplishments, and it appropriates $80 million for peer-counseling programs.

2011

In 2011 several important policy-related events have already taken place, such as the Surgeon General's issuance of a Call to Action to Support Breastfeeding. In addition, as an example of how broader policies can be used to support breastfeeding, the Internal Revenue Service began to allow breastfeeding equipment to be reimbursed by flexible health spending accounts.

Other Policy Changes

The past few years have also seen an increase in the number of states with laws protecting breastfeeding in public. Forty-four states now have laws protecting the right to breastfeed in public, and 28 specifically exempt breastfeeding from public indecency laws. Twenty-four states have laws related to worksite protection for breastfeeding mothers; only West Virginia has no breastfeeding laws on its books.

The number of International Board Certified Lactation Consultants (ICBLCs) has doubled from 5,513 in 1999 to 11,064 in 2010, although many mothers still lack convenient access to the level of care they need. Walker also pointed to an explosion of articles (some 30,000) related to breastfeeding on PubMed.

The federal government supports breastfeeding through other agencies and programs, such as the USDA Child and Adult Care Feeding Program, the CDC Communities Putting Prevention to Work grants, and the White House's Let's Move campaign.

Mothers, advocates, and health professionals are now much more vocal and politically savvy regarding breastfeeding and a woman's right to feed her child in a public place. In the past, women would not have been vocal about breastfeeding, Walker observed, and now they are holding "nurse-ins" to advocate for their rights. In addition, more than 400 hospitals have eliminated formula discharge bags. Breastfeeding coalitions provide mothers with printed cards that spell out their right to breastfeed in public if they

are challenged. Applications on mobile phones also help women manage their breastfeeding.

GROUP DISCUSSION

Moderator: Gail Harrison

In keeping with the format of the workshop, moderator Gail Harrison took written questions from the audience that she then directed to the speakers. The topics included the following:

- *Reaching women with special needs* (such as those who are homeless, in detention, or have medical conditions): Whitford said WIC provides breastfeeding education to all women participants, unless contraindicated. On the local level, Saluja said, the initial assessment with a mother is very thorough to determine what issues the mother may be experiencing that discourage breastfeeding her infant. This enables the WIC staff to provide appropriate support for the mother to continue breastfeeding. This support could involve putting pumps in schools, referrals to other agencies, or providing translators to understand the nutrition education materials.
- *Existence of data about ongoing breastfeeding mothers versus discontinuers*: Robare offered to check to see if the data exist. Harrison suggested that, if not, this might indicate the need for a new line of research for FNS going forward.
- *Broadening the campaign to reach all mothers*: In answer to a question about whether USDA is considering a program analogous to the National School Lunch Program, which targets all children, Whitford said that posters and other media will be visible to all, not just WIC participants.
- *Knowledge gaps at the local level that prevent implementation*: Saluja said that although she could not speak for the 3,200 local agencies nationwide, she could identify one gap as a more general one—how to provide effective counseling, such as asking open-ended questions and listening to participants closely, given the time constraints. Galanoudis noted that information about breastfeeding is abundant but that how the information is packaged or how accessible it is on the local level can affect its usefulness. Whitford said that WIC has various resources and training materials available; one way they are available is online through WIC Works Resources. The material has to be kept fresh for the more experienced staff members, but it also needs to contain basic information for new staff members coming in.

- *Percentage of eligible women who are WIC participants*: This information was not readily available, but Robare said he would obtain it. Saluja queried whether some eligible women who breastfeed choose not to participate in WIC because of their perception that women only participate in WIC to get formula, and she suggested this as a potential area of formative research.
- *Use of social media*: The panel agreed that using social media to promote breastfeeding is a must. However, there was not support among the panel members for WIC getting involved in nurse-ins or other actions organized through social media. Galanoudis suggested utilizing lactation consultants to get more involved in social media, since many are already very savvy about using Facebook and other social media and, with the right tools, would be great advocates. Saluja warned that, even though there is rapidly increasing usage of social media, not all mothers have access to these tools. She reported that data from her agency show that only 45 percent of English speakers and 17 percent of Spanish speakers use social media (PHFE WIC Program, 2011 Survey of Los Angeles County WIC Parents, unpublished data, March 2011). Those who have access use social media extensively, but Saluja said that they represent only a small percentage of overall WIC participants, at least in Los Angeles. She went on to say social media has a niche, but she would not advise using it in WIC.
- *Food sharing*: WIC does not employ "food police," Whitford said, but the intention of the food package is to improve the nursing mother's nutritional health to assist her and her infant. The foods in the package are designed to meet specific nutritional needs, and women are counseled about these issues.
- *Barriers to breastfeeding today*: Panelists noted that the barriers identified prior to the 1997 launch—embarrassment, time, social constraints, and social support—persist today. Galanoudis said although the barriers cannot be eliminated, coping mechanisms can help women overcome them—by, for example, empowering mothers to make sure they know their rights and are aware of support mechanisms. Saluja said that having more Baby-Friendly hospitals would provide support to more mothers in the crucial first 48 hours. Walker said that mothers need support so they continue breastfeeding successfully, beyond initiation. Peer counselors need to be able to refer more complex cases, such as diabetic mothers or a late pre-term baby, to a lactation consultant or other expert. Robare noted that Phase II of the Peer Counseling study will look at what works in peer counseling in order to inform planning for the future.

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3

Lessons Learned from Other Social Marketing and Breastfeeding Campaigns

Karen DiMartino, marketing and media manager for the Massachusetts Department of Public Health WIC Nutrition Program, served as moderator for the second panel. The goal for this panel was to learn from other social marketing campaigns what has worked and what has not worked in their campaigns. R. Craig Lefebvre began by first presenting an overview of social marketing and how it differs from health communications. As an example of social marketing, Faye Wong discussed VERB™, a multiyear campaign that promoted physical activity in youth ages 9 to 13. Suzanne Haynes explained the National Breastfeeding Awareness campaign, which the U.S. Department of Health and Human Services undertook to promote breastfeeding among first-time parents. Carole Peterson presented ideas from innovative breastfeeding promotion campaigns in state WIC programs across the country, focusing on Colorado, Missouri, Texas, and California. In the last presentation, Rafael Pérez-Escamilla highlighted the lessons learned from the Brazilian National Breastfeeding Promotion Program, which resulted in an increase in the median duration of breastfeeding from less than 3 months to more than 10.

WHAT IS SOCIAL MARKETING?

Presenter: R. Craig Lefebvre

R. Craig Lefebvre, a national expert in social marketing and professor at the University of South Florida, distinguished social marketing from a health communication approach. Social marketing is broader than health

communications and can potentially have a greater impact on changing behaviors. He said that people often confuse the two approaches. To explain health communications, he referred to the Centers for Disease Control and Prevention (CDC) "wheel" (see Figure 3-1). The approach involves analyzing and segmenting target audiences, identifying message concepts, selecting communication channels, and creating and pretesting message materials. But, Lefebvre said, "When we're thinking about breastfeeding, we need to think about a lot more than what our materials look like and what our communications look like." And that brought him to an explanation of social marketing.

Social marketing starts with an understanding of a target audience's

FIGURE 3-1 Health communication approach.
SOURCE: Roper, 1993. Reprinted with permission from the Association of Schools of Public Health. March–April 1993. 108(2):181. Copyright © Association of Schools of Public Health. All rights reserved.

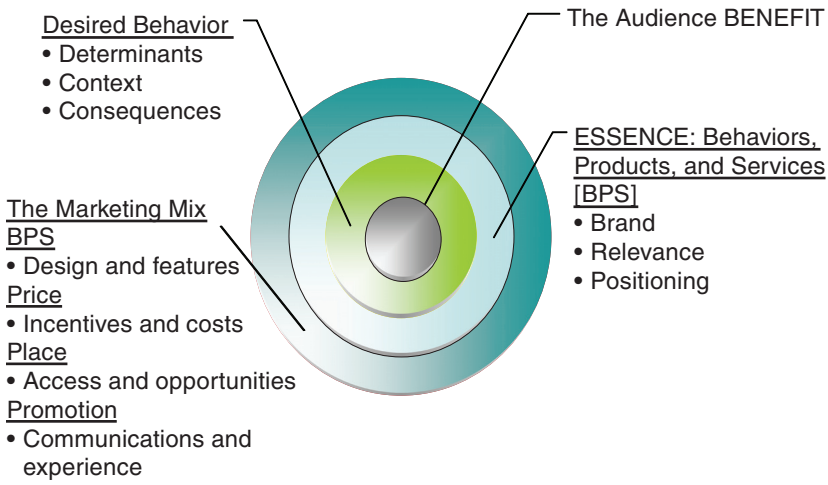

FIGURE 3-2 The social marketing idea, with audience at the core.
SOURCE: Lefebvre, 2011. Reprinted with permission from the *Journal of Social Marketing* 1(1):54–72. Copyright © Emerald Group Publishing. Limited all rights reserved.

benefit: in this case, the benefit of engaging in breastfeeding. In order to market to a specific audience, one needs to understand how people perceive the benefit. Depicted graphically (see Figure 3-2), the benefit to the audience is at the center of the social marketing construct. Then, by considering the audience, one should identify the desired behavior to work toward, including the determinants of whether the desired behavior will take place or not, the context, and the consequences of doing or not doing the behavior (the next circle out from Audience Benefit in Figure 3-2). Consideration of brand, relevance, and positioning comes after understanding the determinants, context, and consequences of the desired behavior, product, or service (the next concentric circle in Figure 3-2). Finally comes the design of the marketing mix, or the "4 Ps" (product, price, place, and promotion). Lefebvre noted that the WIC program has an enormous amount of resources and an array of factors, such as incentives, costs, and opportunities, that can be considered as stakeholders focus on how to improve breastfeeding rates and duration. Communications is just one piece of the overall social marketing idea.

A meta-analysis of more than 400 health communications campaigns (Snyder, 2007) identified characteristics that make some campaigns more effective than others. First, promoting the adoption of healthier behaviors or substitutions is more effective than trying to stop or prevent unhealthy

ones. Habitual behaviors are difficult to modify. Behavior change should be an explicit goal or objective, and formative research should be conducted and used in design and planning. Other characteristics of effective health communications campaigns indicated by the meta-analysis are direct communications with homogeneous population groups (rather than communicating through intermediaries), multiple executions of messages, frequency of exposure to the messages, media multiplexity, and sustained activity. A 5 percent change in behavior could be reasonably expected if a campaign has the elements in place to be effective, which, Lefebvre said, is why it is important to move to marketing.

One issue considered by marketing is how to design—or redesign—products and services. Lefebvre suggested a number of questions that need to be addressed in considering how best to market *Loving Support*: How should services be redesigned so that they start appealing to different segments of people to whom *Loving Support* may not be appealing right now, including those who come in and try WIC services only to leave after a few weeks or a few months, or those who stop breastfeeding for a variety of reasons? How should product and service innovations be introduced? How should new opportunities be created for women to be exposed to breastfeeding information, services, and support products?

When marketing and communications are used in concert, the impact can be greater than when one relies on communications alone, as has been demonstrated in such areas as nicotine replacement therapy, child safety seats, recreational safety helmets, and condom use. The Community Preventive Services Task Force (Community Guide Branch/CDC, 2011) recently reviewed the role of marketing in improving these and other health behaviors and found that marketing can result in an average 8.4 percent increase in people who engage in the healthy behavior. The task force found that successful campaigns applied the "marketing 4 Ps" by offering the product at a free or reduced price, distributing it in accessible and convenient locations, and promoting it through mass and multiple channel delivery to increase awareness of, demand for, and appropriate use of the product. Although the review addressed only products, Lefebvre said he felt its lessons could be extended to services.

According to Lefebvre, one of the values of the task force study is that it provides a science-based recommendation for the use of social marketing in the area of public health as compared with a communications approach alone. Another study (Sorensen et al., 2011) also provides evidence of how the 4 Ps can be used to move someone from not thinking at all about a healthy behavior (in this case, Pennsylvania farmers' use of a rollover basket to improve tractor safety) to action. In this study the biggest increase

in usage came for the group in which all aspects of a social marketing campaign were used.

Questions to Ponder

As an example of a different way of thinking, Lefebvre asked the group to consider the role of mobile phones. The "old way" of thinking about mobile phones in a campaign would be to send out messages to the target audiences. Instead, he challenged participants to consider other, more interactive applications. The beer company Stella Artois has an application for mobile phones in which people can locate the nearest locations that serve its product. "Imagine if a woman could do that for WIC clinic products and services," he suggested.

Lefebvre said that it is important for social marketing campaign planners to involve the target audience in creating program content. He concluded by posing a series of questions for participants to consider when contemplating how to move a breastfeeding promotion campaign forward:

- Could breastfeeding patterns be designed to fit people's lives?
- What if a social change movement could be successful with little or no promotion?
- How can WIC cocreate value with the people served by the program?
- How can learning and change be made into a social event?
- How can a move be made to solve puzzles and create patterns of change?

OVERVIEW AND LESSONS LEARNED FROM THE VERB™ CAMPAIGN

Presenter: Faye L. Wong

The VERB™ It's What You Do campaign, which ran from 2002 to 2006, was designed to increase and maintain physical activity among "tweens," defined for the purpose of the campaign as youths from 9 to 13 years of age. Faye Wong, chief of the Program Services Branch in the CDC Division of Cancer Prevention and Control and the former director of the VERB™ campaign, summarized the lessons from this social marketing campaign that could potentially apply to promoting breastfeeding.

The campaign vision was for youth to lead healthy lifestyles. Wong emphasized that the focus was deliberately on physical activity and not on nutrition, obesity, or other related issues and that the 9- to 13-year-old

BOX 3-1
Know Your Product!
Selling Physical Activity

It's not a physical product → It's an experience
For kids, it's not about a rational need → It's about an emotional desire
It shouldn't just inform → It creates affinity, a feeling of belonging
It shouldn't preach → It should self-motivate

SOURCE: Wong, 2011.

age group was defined as the primary audience, with parents, teachers, and youth leaders as secondary audiences.

Building on Lefebvre's discussion of marketing versus communications, Wong said that the campaign had four interlinking components—marketing (mass media, public relations, and edutainment), partnerships, research and evaluation, and community events. In terms of the "4 Ps," the product was physical activity and the price[1] was the benefits and costs of being physically active. According to Wong to sell physical activity as the product, tweens have to see the benefit (what will I get out of it? e.g., time outside with my friends) and be willing to pay the cost (what do I have to give up? e.g., time playing video games). Further, she said the cost would be too high if tweens felt the benefit was not of value to them.

Wong continued the place in the "4 Ps" was the different places where tweens could be physically active and the promotion involved messages, delivery channels, campaign strategies, and tactics that ranged from contests to kid-friendly partnerships.

VERB's main lesson was that it is important to frame messages with words and images that appeal to the target audience, based on audience research. For example, the campaign learned to sell physical activity as a fun experience to do with friends (see Box 3-1) rather than to rely on such messages as the need to exercise to avoid heart disease or other messages that might resonate with older audiences.

Audience research is critically important in planning a campaign, Wong stressed. Without it, one does not really know what the product is, what

[1] "Price refers to the cost or sacrifice exchanged for the promised benefits. This cost is always considered from the consumer's point of view. As such, price usually encompasses intangible costs, such as diminished pleasure, embarrassment, loss of time, and the psychological hassle that often accompanies change, especially when modifying ingrained habits" (Grier and Bryant (2005).

its price should be, or what the barriers and motivations are. The VERB™ campaign team, including CDC staff and contractors, conducted extensive research both before and continuously throughout the campaign, in addition to performing an ongoing evaluation. That research informed them that the messages should relate to such things as "play, discover, being positive, try and try again, explore, fun, and laugh."

The VERB™ campaign developers also recognized the importance of creating a brand—in this case, a kid's brand for having fun. They had a big brand idea based on the fact that there are 7,000 action words or verbs in the dictionary. The message the developers created was that children should try a new action. Specifically, Wong said, the message was "Find a verb that motivates you and is yours," such as run, jump, bounce, kick, toss, or dance. The VERB™ brand became visible in places that reached tweens—the child's media (TV, radio, magazines) targeted to them, shopping malls, schools, community-based organizations that offered a place to play, sports arenas, and so on. The campaign was implemented with a surround strategy, which Wong described as meaning that wherever children are—at home, at school, or somewhere in their communities—they are exposed to the VERB™ brand. To strengthen the strategy and ensure consistency, partners and communities that participated in the campaign were given guidelines that described the VERB™ brand's purpose and attributes (Asbury et al., 2008). The campaign created a multiethnic, "true to the VERB™ brand" campaign.

The campaign had four phases,[2] each with a distinct objective:

- Phase 1: Build awareness and affinity for the brand: "What is our VERB?"
- Phase 2: Motivate tweens to incorporate physical activity into their everyday lives.
- Phase 3: Motivate tweens to play anytime, anywhere, anyway.
- Phase 4: Ignite kids' desire to play.

In Phase 4, the objective was to have children so eager to play and undertake physical activity that they would think, as Wong phrased it, "I cannot *not* play." Phase 4 was carried out with the Yellowball campaign—distributing 500,000 branded, bright yellow balls, each imprinted with its own number (Figure 3-3). Tweens played with a ball, passed it on to another child, and went online at VERBnow.com to share their experi-

[2]For a more detailed explanation of the 4 phases see Huhman, M., J. M. Berkowitz, F. L. Wong, E. Prosper, M. Gray, D. Prince, and J. Yuen. 2008. The VERB™ campaign's strategy for reaching African American, Hispanic, Asian, and American Indian children and parents. *American Journal of Preventive Medicine* 34(6):S194–S209.

FIGURE 3-3 Phase 4: The VERB Yellowball™ Campaign.
SOURCE: Yellowball. Reprinted from "New media and the VERB campaign: Tools to motivate tweens to be physically active," by M. Huhman, 2008, *Cases in Public Health Communication & Marketing*, 2, p. 134. Copyright 2008 by the *Public Health Communication & Marketing* journal. Reprinted with permission. All rights reserved.

ences about how they played with their specific ball. Children were not just reading or hearing about the VERB™ brand, but literally touching it and playing with it.

Activities during the 4 years of the campaign also included a designated "National Day of Play" (June 21, the day with the most daylight), contests and promotions by media partners, summer tours around the country in "branded" vans, and other special events. Funding for the campaign ended in 2006. Several locations, including Kentucky and Iowa, continue to plan and offer a VERB™ Summer Scorecard Program in communities, even five years after the national campaign ended.

Results and Lessons Learned

Wong reviewed the results as measured throughout the VERB™ campaign. After Year 1, various effects in free-play physical activity were seen in sub-populations, notably younger tweens (age 9 and 10) and girls. In

years 2 and 3, effects were found for the entire target population for free-time physical activity. In Year 4, the level of exposure of tweens to VERB™ was significantly associated with physical activity on the day before the survey and with each of the psychosocial variables, with 72 to 74 percent awareness. The more a tween was exposed to the campaign, the more physical activity he or she was likely to perform.

Wong concluded by offering eight lessons from the VERB™ campaign that may be applied to the *Loving Support* campaign:

- Develop clear, focused campaign goals.
- Develop a logic model.[3]
- Plan using the 4 P's of social marketing to design an audience-driven intervention.
- Consider a branding approach, with instant association of the brand to the message and with interactions by the audience with the brand.
- Build in multiple and reinforcing strategies.
- Plan for sustainability.
- Take risks to make a difference.
- Continuously evaluate and refine the campaign.

LESSONS LEARNED FROM THE NATIONAL BREASTFEEDING AWARENESS CAMPAIGN, 2004–2006

Presenter: Suzanne G. Haynes

The National Breastfeeding Awareness Campaign (NBAC) was designed to promote breastfeeding among first-time parents, both mothers and fathers, who would not normally breastfeed their babies. The campaign was planned in 2003, launched in 2004, and continued until 2006. Suzanne Haynes, senior science advisor for the Department of Health and Human Services Office of Women's Health and the NBAC campaign manager, said that the lessons learned from the campaign have implications for the WIC campaign.

The first lesson that Haynes discussed related to that target audience of first-time parents. In choosing them as the target audience, NBAC decided it would not consider pediatricians, obstetrician/gynecologists, family practitioners, nurses, hospitals, and worksites as primary target audiences, but, she noted, all of these others have a huge influence on parents' decisions. These groups were NBAC research and publicity partners, and Haynes

[3]As noted by Wong, the development of the VERB™ logic model was not discussed during her presentation.

recommended they also be targeted as audiences in any new campaign because of their influence. The WIC campaign, she said, must go beyond social marketing to parents and be comprehensive, multi-modal, and multi-sectoral (or, referring to a CDC term discussed more fully in the next panel, socio-ecological) in order to be successful.

The overall goals of NBAC were to increase the proportion of mothers who breastfeed their babies in the early postpartum period to 75 percent and to increase breastfeeding at 6 months postpartum to 50 percent by 2010. The campaign also aimed to empower women to commit to breastfeeding. In retrospect, Haynes said, the goal to increase breastfeeding at 6 months was unrealistic for a two-year campaign. Reaching that goal would take 10 years, with messages reevaluated every 2 years. In her opinion, empowerment must come from other aspects of a mother's surroundings that cannot be addressed in social marketing campaigns.

Focus Group Research

Haynes said that NBAC conducted the largest qualitative study to date to explore the process that successful breastfeeding mothers, who participated in focus groups, used in deciding to breastfeed. Twenty-four focus groups were held in 2002 in Chicago, San Francisco, and New Orleans. They included women of a range of ages and socioeconomic groups, African Americans and Caucasians, and pregnant, breastfeeding, and formula-feeding mothers.

The research identified two processes associated with successful breastfeeding. The first was what Haynes termed "confident commitment." In the prenatal period, all groups voiced a lack of confidence in the process of breastfeeding. Most said they would "try" to breastfeed, although few said they "definitely would." Pregnant women's confidence in their ability to breastfeed was affected by such concerns as whether they could sufficiently nourish and satisfy their babies and whether they would be able to cope with the discomfort or inconvenience. Commitment refers to making breastfeeding work despite challenges or a lack of support. Taken together, "confident commitment" relates to self-efficacy. Breastfeeding mothers had been confident in the process and committed to making it work. Based on an analysis of the focus groups' responses, Avery et al. (2009) concluded that women who believe that their bodies can produce milk of sufficient quality and quantity to nourish their baby and that their babies are capable of latching and feeding properly and who view breastfeeding as a learned process may be more successful than those who see breastfeeding as natural. Haynes suggested that the WIC campaign focus on instilling "confident commitment" by reconceptualizing breastfeeding as a learned skill. Draw-

ing from the focus groups, she noted that women did not know that they had to learn how to breastfeed.

The second important issue related to successful breastfeeding identified by focus group participants was workplace accommodations, in that confusion about how to breastfeed at work can result in the decision to wean. When a woman returned to work often determined when she would stop breastfeeding. Haynes noted that mothers' apprehension about how to breastfeed at work suggests that dialogue with the business community is needed, which would be a possible role for WIC.

Components of the Campaign

The NBAC consisted of a media campaign, community-based demonstration projects (CDPs), and a breastfeeding help phone line and website.

The Advertising Council selected NBAC for official sponsorship and assisted with multimedia ads and public service announcements (PSAs). The Office of Women's Health worked in close coordination with the Ad Council to produce ads for television, radio, the Internet, bus stop shelters, newspapers, magazines, and billboards. It received $30 million in free advertising in two years, although, as Haynes noted, the formula industry spent $80 million in advertising during that same period. One challenge was that baby magazines that ran paid advertising from the formula industry did not run the PSAs, and NBAC did not have the funds to purchase ads to run in these magazines. On the other hand, radio, newspapers, other magazines, and billboards did run a large percentage of the PSAs.

A high number of women said they saw the NBAC PSAs, Haynes said, and African American mothers were more aware of the ads than many other groups. WIC mothers were clearly exposed to the campaign, with 34.8 percent of WIC participants reporting seeing some part of the campaign, compared to 22 percent among non-WIC participants. Among mothers with less than a high school education, 38.1 percent were aware of the ads, which was the highest percentage among the different levels of education. About 30 percent of pregnant women across the country saw the campaign. Billboards were the most popular vehicle, and "Babies were Born to be Breastfed" was the most popular message that came out of the campaign.

In the NBAC's second component, 18 CDPs throughout the country implemented the campaign at the grassroots level. Funds went to increase existing services, provide outreach, train healthcare providers in breastfeeding, implement the media aspect of the campaign locally, and track breastfeeding rates. Grantees included breastfeeding coalitions, hospitals, universities, state health departments, and other organizations, and particular attention was paid to grantees in the Southeast. An evaluation of

TABLE 3-1 Breastfeeding Rates by Ad Awareness and CDP Area

Breastfeeding Duration and Exclusivity	Not Aware (%)	Aware (%)	P Value	Not CDP Area	CDP Area	P Value
Breastfed > 1 month	70.6	66.2	0.02	68.3	78.5	< 0.001
Breastfed > 6 months	41.2	34.7	0.002	38.8	45.4	0.01
Exclusively breastfed > 3 months	41.4	16.3	< 0.001	19.6	24.1	0.04
Exclusively breastfed > 6 months	3.4	3.1	NS	3.2	4.5	NS

SOURCE: Haynes, 2011.

breastfeeding rates after the campaign showed that women who were aware of the ads actually had lower breastfeeding rates than those who were not aware of it. In light of this, Haynes said that some might conclude that the campaign failed, but she disagreed with that conclusion, noting toward its end the campaign did reach a higher proportion of women who are at higher risk of not breastfeeding, e.g., low-income African American women. However, the campaign did not last long enough (two years) to make a substantial change in breastfeeding rates. Furthermore, marketing campaigns alone cannot change behavior without the help of the community, including family members, hospitals, health professionals, and worksites. Bolstering her point, Haynes noted that the CDP areas that provided on-the-ground support had higher breastfeeding rates at various stages (Table 3-1) recommended that the WIC campaign incorporate a way to reach out to the community and bring in the resources of breastfeeding coalitions, hospitals, and other organizations. She also suggested drawing from the Infant Feeding Practices Survey and other research to conduct a detailed analysis on WIC versus non-WIC mothers.

The third component of the campaign was a breastfeeding helpline and website. The National Women's Health Information Center created and maintains these resources to help mothers with common breastfeeding questions and challenges. Trained information specialists answer calls and e-mails in both English and Spanish. They receive about 500 calls a month, while the website gets 500,000 users. Haynes attributed the difference both to the role of the Internet and to the fact that the phone system operates only during weekday office hours. She recommended 24-hour phone support in the future.

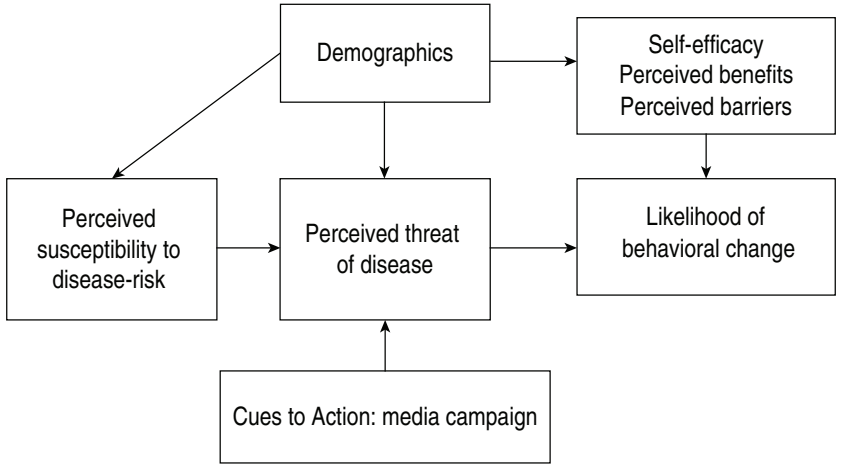

FIGURE 3-4 Health Belief Model.
SOURCE: Adapted from Champion and Skinner, 2008. Permission to reprint from John Wiley & Sons.

The campaign was based on the Health Belief Model, which is based on the theory that self-efficacy, perceived benefits, and perceived barriers all affect the likelihood of behavior change (Figure 3-4). Haynes suggested that the next campaign focus on self-efficacy in order to increase women's confidence in their commitment to breastfeeding, i.e., "confident commitment."

BREASTFEEDING BEST PRACTICES IN FOUR STATES

Presenter: Carole Peterson

Carole Peterson, chairperson of the National WIC Association (NWA) Breastfeeding Committee, said that the workshop planning committee, of which she was a member, realized that there is little evidence about what is working in WIC clinics. She was asked to speak about the efforts of WIC programs in four states: Colorado, Texas, Missouri, and California. Although her presentation did focus on these four, she noted that WIC programs in other states are also developing many innovative efforts to support breastfeeding.

Loving Support is the basis of the state programs. However, Peterson said, many states have gone beyond *Loving Support* in supporting breastfeeding. Thus the National WIC Association has developed six steps to meet breastfeeding goals in WIC clinics (see Box 3-2). The steps are intended to position WIC as a "go-to" place for breastfeeding support and to create a goal of exclusive breastfeeding for WIC mothers. Peterson said that states

BOX 3-2
The NWA Six Steps to Achieve Breastfeeding Goals in WIC Clinics

1. Present exclusive breastfeeding as the norm for all mothers and babies.
2. Provide an appropriate breastfeeding friendly environment.
3. Ensure access to competently trained breastfeeding staff at each WIC site.
4. Develop procedures to accommodate breastfeeding mothers and babies.
5. Mentor and train all staff to become competent breastfeeding advocates and/or counselors.
6. Support exclusive breastfeeding through assessment, evaluation, and assistance.

SOURCE: NWA, 2011.

that have adopted these steps have increased their breastfeeding rates and serve as examples of what WIC can do to support exclusive breastfeeding.

Colorado

Colorado focused on training and working with hospitals. A three-day training session in lactation management was developed for WIC-registered dietitians, nurses, and select educators, of which about 45 percent had attended at the time of the workshop. The training is on the effective assessment of participants and counseling of those identified as high risk based on the Colorado WIC Program's breastfeeding Nutrition Risk Factors for Breastfeeding listed in the Nutrition Risk Factor Module that is part of the state's Level I WIC certification (Colorado WIC, 2011). Colorado WIC also promotes exclusive breastfeeding in the first month through the new food package; in addition, infants not receiving formula receive a voucher imprinted with "Thank you for breastfeeding." As of June 2009, Colorado WIC's policy is to not provide formula to infants younger than one month of age except for medical reasons or the mother's intent to wean. Intense follow-up allows supervisors to see if the policy is followed by agencies throughout the state.

Through the Colorado Can Do 5! Initiative, WIC staff promote five actions at every opportunity: (1) infants are breastfed in the first hour after birth; (2) the infant stays in the same room as the mother; (3) infants are fed only breast milk and receive no supplementation; (4) no pacifiers are used; and (5) the staff gives mothers a phone number to call for help with breastfeeding. These five actions are listed on a crib card provided to preg-

nant women by WIC staff. (A crib card is a card placed in the baby's crib listing the baby's and mother's names; the baby's date of birth, weight, and length; and the doctor's name. See http://www.coloradoaap.org/Crib%20Cards%20for%20Web08.pdf.) The card used by the Colorado WIC Program is for use in the hospital to indicate that the baby is to be breastfed. This approach is based on a population-based study that found that implementing these five practices significantly increased breastfeeding duration rates regardless of maternal socioeconomic status. Overall, Colorado has seen a decrease in the issuance of formula since these measures began.

Texas

Texas is an example of a state WIC program working with a range of partners, including hospitals and worksites. Hospitals can earn the Texas Ten Step designation through a series of measures that are less rigorous than a Baby-Friendly designation but that still support breastfeeding. A website provides expectant mothers with a list of these hospitals as well as with information and resources about breastfeeding. Across racial and ethnic groups, more mothers are exclusively breastfeeding at Baby-Friendly and at Texas Ten Step hospitals than at other hospitals in the state. WIC also works with the Texas Mother-Friendly Worksite Program. In this program, the Department of State Health Services designates businesses as Mother-Friendly if they take certain steps to accommodate breastfeeding.

Missouri

Missouri has launched numerous best-practice interventions to support breastfeeding. There are more than 100 peer counselors throughout the state, and the number of International Board Certified Lactation Consultants (IBCLCs) has more than tripled, from 20 to 65, over the past few years. A 45-hour course was developed to train additional IBCLCs. Missouri also set up local breastfeeding coordinator mentors, recognizes breastfeeding-friendly WIC clinics, and partners with breastfeeding coalitions. A "Show Me 5" tool kit was created to assist hospitals in supporting breastfeeding initiation and continuation. All agencies have experienced an increase in breastfeeding rates, but the agencies with peer counselors and IBCLCs had the greatest increase. Missouri plans to assist more WIC staff to become IBCLCs.

California

Peterson discussed three efforts in California: (1) strengthening counseling, (2) improving clinic flow, and (3) convening diverse stakeholders.

California now hires peer counselors (PCs) for their passion and then educates them for the requisite knowledge. The PCs facilitate Moms2Moms groups and are available to mothers 24 hours a day. A training curriculum addresses emotional reasons why mothers stop breastfeeding. Training to increase the number of IBCLCs was stepped up. The IBCLCs train staff at the local level and support the peer counselors and other staff working with high-risk mothers.

At WIC clinics decisions about providing formula are now made with a lactation specialist, who can often resolve an issue preventing breastfeeding, rather than at check-in or at the front desk. The new food package is being promoted as an incentive to begin and continue exclusive breastfeeding, and Peterson said it has been working.

The California Breastfeeding Summit was held in January 2011. More than 300 hospital administrators, managers, health professionals, and policy makers gathered to discuss practical strategies to establish policies and strengthen community partnerships.

Common Threads in All Four States

Peterson suggested that successes in the four states have some elements in common:

- Human milk as the norm—and, indeed, Peterson said, these states made it a priority
- Increased staff professional training
- Increased numbers of peer counselors and IBCLCs
- Cooperation with hospitals
- Encouragement of Baby-Friendly initiatives

Addressing the knowledge gaps that impede further progress, as were brought up in the discussion after the first session, Peterson said that WIC programs suggested there be a mentorship component to training. WIC staff learn what to do in a training situation but often ask, "What do we do when a mother walks in to the clinic and we are not sure how to identify her problem?"

In summary, the states that are implementing the NWA six steps and working toward the NWA strategic plan are increasing their breastfeeding rates and duration. Although this observation is not based on research, Peterson suggested that the U.S. Department of Agriculture could encourage other states to adopt the six steps because states that have followed these guidelines have had increases in breastfeeding initiation and duration rates.

BRAZILIAN NATIONAL BREASTFEEDING PROMOTION PROGRAM

Presenter: Rafael Pérez-Escamilla

The panel's final presentation focused on Brazil's National Breastfeeding Promotion Program. Over a period of 25 years Brazil increased the median length of breastfeeding from 2.5 to 10 months. Rafael Pérez-Escamilla, the planning committee chair and a professor at Yale University, discussed the program, drawing on a publication that described it (Rea, 2003). According to Pérez-Escamilla, the key to the program's success was its intersectorial coordination[4] (see Figure 3-5) across programs, institutions, and strategies, which he referred to as the "social glue" which was created early on and which still exists today for breastfeeding and for many other social programs. He also stressed the length of time it took for the program to achieve results—more than two decades.

The program began in 1980, after many years in which little improvement had been made in increasing median breastfeeding duration. The goal of the launching phase was to mobilize stakeholders, such as politicians, journalists, and other decision makers and opinion leaders. Well-known pediatricians delivered the messages that "Breastfeeding saves money" (as this was during a time of economic crisis) and "We know what works to promote breastfeeding." At that point the Ministers of Health and Social Development approved the launching of the National Breastfeeding Promotion Program.

From 1981 to 1986, in a phase that Rea refers to as "social communication" in her article, improvements began to appear. The goals of the phase were to generate a social movement through key stakeholders and to develop and launch well-designed mass media campaigns. The first such campaign took place in 1981; its main message was to breastfeed for at least 6 months. Stakeholders included members of various civic, social, community, faith-based, and mother support groups. These people were reached through TV and radio as well as through printed collateral on lottery tickets, utility bills, and bank statements. Newspaper articles targeted opinion leaders, and articles in professional journals and meetings were developed for health practitioners and academics, particularly members of the Brazilian Association of Obstetrics and Gynecology and the Brazilian Association of Pediatrics.

A second phase in 1982 to 1983 built on lessons learned. It used formative research to determine what should be said now that people had been

[4]Different sectors of society working together toward a common goal in a well coordinated manner.

FIGURE 3-5 Intersectorial coordination as the "glue" in a campaign.
SOURCE: Pérez-Escamilla, 2011.

generally sensitized. This campaign had pretested messages for mothers, such as "Continue breastfeeding; every woman can"; "You can produce enough milk"; and "Your breasts will not drop if you breastfeed." The campaign also urged mothers to "Make up your own mind" in recognition of the bias of many pediatricians for formula. A popular soap opera included pro-breastfeeding messages and celebrities appeared in TV PSAs in further attempts to reach the intended audience.

Pérez-Escamilla reported that Brazil essentially followed a social marketing framework after 1983, applying the 4 P's in an integrated manner. Efforts ranged from helping to develop and then enforcing the WHO International Code for Marketing of Breast-Milk Substitutes, to promoting the Baby-Friendly Hospital Initiative (although Brazil's high rates of Caesarean sections has meant a lower number of hospitals that qualify), and to supporting community-based approaches. Changes in legislation were needed, such as those related to maternity leave and the work environment. The country now has one of the most extensive human milk bank networks in the world, which it has used to promote the social and economic value of breastfeeding.

Conclusions and Implications for *Loving Support*

Social marketing played a key role in the Brazilian Breastfeeding Promotion Program and its impact on breastfeeding. Possible reasons for its

success include its targeting of multiple stakeholders with effective messages and dissemination channels in a well thought-out program based on social marketing. Pérez-Escamilla noted that Brazil also took advantage of the global consensus on the need to reverse the decline in breastfeeding. Furthermore, the program is still ongoing, rather than ending as a discrete activity.

Pérez-Escamilla said that political support will be of key importance in moving forward with the *Loving Support* campaign. Although *Loving Support* should take advantage of strong support from the Surgeon General and First Lady Michelle Obama, political support for the program should transcend individual presidential administrations. Public opinion can shape that political support. As the Brazilian program shows, sustainability depends on a strong and well-coordinated national promotion program, with intersectorial coordination providing the glue. Messages must resonate across different stakeholders, may need to change over time, and must reach diverse audiences, including family members, different racial and socioeconomic groups and ages, and communities.

GROUP DISCUSSION

Presenter: Karan DiMartino

In keeping with the format of the workshop, moderator Karan DiMartino took written questions from the audience and directed them to the speakers. The issues included the following:

- *Definition of social marketing in the context of updating* Loving Support: Suzanne Haynes said that social marketing is important, but that other elements are also needed, and she agreed with the need for what Wong called a "surround campaign" in VERB™. For breastfeeding this might include ways to reach out not only to mothers, but also to workplaces, hospitals, and health care providers, among others. Lefebvre urged the group not to carry out just a health communications campaign.
- *Breastfeeding after C-sections:* The rate of Caesarean sections is high in Brazil—as much as 36 percent in public hospitals and more than 80 percent in private hospitals (Barros et al., 2011), according to Pérez-Escamilla. C-sections are generally considered a risk factor for a poor breastfeeding outcome. However, as shown in Brazil, breastfeeding can still succeed after a C-section if the hospital supports it. In fact, one beneficial consequence of a C-section is that women stay in the hospital longer so their milk may come in before they are discharged.

- *Budget and political considerations*: Wong said that VERB's budget averaged about $60 million per year ($125 million in the first year, with lesser amounts in subsequent years). Thus, as she noted, the VERB™ campaign staff had the resources to follow the appropriate social marketing methods from the beginning, although she stressed the importance of paying attention to the 4 P's no matter the size of budget available for a campaign. The chair of the House Appropriations Committee, the Honorable John Porter, was concerned about children's poor health behaviors and strongly believed in supporting long-term health, and he championed VERB's funding. It became difficult to sustain the high level of appropriations support when he was no longer in office. Wong also observed that the campaign's direct focus on children made it difficult for adults to understand and support what VERB™ was doing initially; this changed as VERB™ became more broadly known and evaluation results became available. This experience, she said, illustrates the need to build support early in order to weather changes in the political climate. Even though some people felt the campaign was too expensive compared to the typical low-budget public health campaign, she said that the cost paled in comparison to the advertising and marketing budgets of such companies as McDonald's and Coca-Cola. Haynes observed that political cycles often mean that leaders come in and favor their own programs—which is one of the impediments to a 10-year campaign.
- *Acknowledging difficulties in breastfeeding*: The panelists discussed presenting breastfeeding as "easy and normal" versus acknowledging difficulties. Wong suggested testing the messages in focus groups or through other research. Lefebvre said that audience segmentation should help identify the messages needed, explaining that different sets of expectations will exist concerning this issue and that these different expectations will need to be acknowledged in order for the mothers to believe the message. Haynes noted that the original title of an NBAC publication was "Easy Guide to Breastfeeding" but that when focus groups said they did not consider breastfeeding easy, the title was changed to "Your Guide to Breastfeeding." Pérez-Escamilla said that segmentation is a challenge and noted that even within the Latino community people are from many different countries and have different levels of acculturation.
- *Building on and sharing existing research*: A participant suggested that sharing findings from states' formative and outcome evaluations, which often are not published, can maximize the dollars spent on research. Haynes suggested holding a conference to bring

together research and researchers from different states. A participant suggested using research to develop a script for providers similar to the 5-2-1-0 message for obesity (5 or more fruits and vegetables; 2 hours or less recreational screen time; 1 hour or more of physical activity; 0 sugary drinks and more water and low-fat milk [http://www.letsgo.org]), which is a public education campaign designed to develop awareness of the daily guidelines for nutrition and physical activity.

- *Reaching the healthcare delivery system*: The nonprofit Wellstart International played a large role in Brazil in building capacity for lactation management. Brazil made breastfeeding education for health care providers a large part of its program.
- *Building a brand*: The VERB™ campaign staff talked to many children in order to build the brand, Wong said. Three different brand concepts developed by an advertising agency were tested with children and mothers in order to receive their input. According to Wong, a brand is more than a slogan—it is the promise made to the target audience. Go back to the target audience for its views, Wong said, rather than substituting one's own opinions. With respect to VERB™, the target audience was tweens; adults see the world differently than tweens. Lefebvre reminded participants that they should consider the important benefits to focus on are those identified by the audience, not by the campaign developers. He said that the questions addressed in developing the *Loving Support* brand should include such things as, What does this brand mean to women? and, Does it need to be refreshed, updated, or does a new brand need to be developed?
- *Ongoing use of the name* "Loving Support"*:* The panelists were asked if the title *"Loving Support"* should change. Generally, presenters were not wedded to the title but also did not feel it should change just for the sake of something new. Lefebvre said it depends on what the audience says. Peterson agreed, observing that states often do *Loving Support*–type activities without using that title. Haynes suggested that the word "support" is important and that it helps build mothers' confidence. Pérez-Escamilla said that while he thought the research supports the term, he wondered why the logo does not include a woman breastfeeding a baby. Wong said that, as someone who does not work in promoting breastfeeding, the brand struck her as aimed more at the people providing support rather than at women who may be breastfeeding or are going to breastfeed.

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4

Where Does the Breastfeeding Campaign Go from Here?

The final panel of the workshop, moderated by James Lindenberger of the University of South Florida, was designed to examine what might happen next with the *Loving Support* campaign. Panelists offered suggestions from a number of perspectives. Claudia Parvanta spoke on how social marketing principles could be applied to the new campaign. Jay Bernhardt discussed new communication tools that can play a role in engaging mothers and other stakeholders. Cathy Carothers, relying on feedback from seven state programs, suggested several implementation tools needed by local WIC staff to move forward. Katherine Shealy discussed the potential benefits of—and many possibilities for—strategic community-based partnerships. Kiran Saluja identified a number research gaps as well as some existing research, especially at the state and local level, that could be better utilized. Dawn Baxter discussed the use of evaluation as a planning tool in designing or updating the campaign. She also emphasized that evaluation makes it possible to measure impact and to implement quality improvement.

CONSIDERATIONS FOR PROGRAM COMPONENTS, MESSAGES, AND IMAGES

Presenter: Claudia Parvanta

Claudia Parvanta, a professor of anthropology and chair of the Department of Behavioral and Social Sciences at the University of the Sciences, Philadelphia, said she agreed with other speakers who called for a campaign

that encompasses an aligned set of actions designed to achieve a goal, rather than simply an advertising campaign.

The Message and the Brand

Campaign messages should support a goal. Parvanta characterized messages as memorable, explanatory words or images that convey an idea and communicate whatever the person creating the message wants people to know, feel, or do. Messages are crafted after concepts are tested; the concepts, in turn, should be derived from specific behaviors to be promoted. More than ever, Parvanta said, the messages depend on the medium that will carry them.

As an example of a campaign that targeted a behavior, Parvanta presented a campaign that was developed to encourage women capable of becoming pregnant to take folic acid. She offered two very different concepts that could be used to promote this behavior that were based on research with this population: one for women who have or want to start families soon and another for women of child-bearing age who do not plan on getting pregnant soon. The words and images used to promote folic acid differed depending on the intended audience.

The brand represents a promise made to consumers by a company or organization. A brand delivers on its promise, Parvanta said, by having every single activity linked under it to support the idea. In this case, she said, *Loving Support* is the brand, and "makes breastfeeding work" is the brand's promise. WIC tries to deliver on the promise through program service delivery (to include staff, facilities, hours, and communications) as well as through community support, such as the legislative environment, hospital and physician practice, peer network, and community attitudes.

When launched, the *Loving Support* campaign was based on formative research and then-leading theories in health communications. For example, research showed that the campaign strategy should emphasize the emotional benefits of breastfeeding for families, so this is the focus rather than the health benefits of breastfeeding. Parvanta advised building the campaign from the ground up for maximum brand integrity, with community and family attitudes, the birthing hospital policies, and staff and community physicians providing a strong base so that WIC can make breastfeeding work. The question is now, what research is needed to update the positioning and marketing mix for WIC breastfeeding promotion?

Theoretical Considerations

Parvanta suggested thinking deeply about how the audiences will be defined, what kind of change is desired from these audiences, and how to motivate them.

In the years since the campaign began, much has been learned about self-efficacy in breastfeeding, Parvanta said, although she added that she has not yet seen many of these lessons applied. For example, research has shown that women scored higher on breastfeeding self-efficacy scales at 2 days and at 4 weeks postpartum if they had observed breastfeeding role models through videotapes, if they received praise from their partners for breastfeeding, or if their own mothers had significantly higher levels of breastfeeding self-efficacy. In contrast, women who experienced physical pain or received professional assistance with breastfeeding difficulties had significantly lower levels of self-efficacy (Kingston et al., 2007). These findings and others on self-efficacy have implications for lactation counseling.

Parvanta also suggested revisiting the Stages of Change model, which posits that people go through stages (pre-contemplation, contemplation, preparation, action, and maintenance) on their way to behavior change rather than changing all at once. Pregnancy gives women several months to move through the initial stages, but the real test comes in the first days after giving birth. Parvanta recommended applying the model more specifically to the change period at that critical point in time.

Risk-communication theories can also inform the new campaign. Parvanta urged paying attention to fears about breastfeeding. The Extended Parallel Process Model posits that the mother may protect herself against the "fear of the threat" rather than against the threat itself. For example, if a mother is afraid she will not have enough milk (fear of the threat), she may start formula feeding, even though the threat itself does not occur.

Risk communication is not intuitive. One principle of risk communication, known as the Sandman seesaw (Sandman, 2007), suggests dealing with ambivalence about a behavior change like breastfeeding by "[taking] the seat opposite from what you want your participant to be doing." In other words, on a seesaw, if you want your partner to go up, you need to go down. In risk communication, this means acknowledging and exploring the concerns that women have about breastfeeding by allowing them to consider the possibility of alternatives—not simply by telling them that these alternatives are inferior. There may be conflicts between what gatekeepers believe and what mothers need to believe in order to breastfeed, such as the role of choice and their decision, availability of a breast pump and formula, or acknowledgment that they are not failures if they resort to formula once or twice.

Segmenting Audiences

Parvanta suggested segmenting audiences by the desired behavior change—that is, rather than sorting an audience by demographic group, one should think about the specific objective for a segment and what motivates change for members of that segment. Audience segments might include the participant herself, her key influencer, her family, her community, and health professionals. Important segments to understand include both fathers and grandmothers, who for various reasons may want to separate the mother from the baby and thus may discourage breastfeeding. Parvanata recommended that special attention should be directed to first-generation Americans who have come from different cultures, as some of them may see bottle-feeding as something they could not do in their country of origin but which is the norm in the United States. Healthcare providers also play a very large role, and, in particular, maternity care nurses are often not supportive of breastfeeding.

Four Suggestions for FNS

Parvanta wrapped up her presentation with final suggestions to FNS:

- If available, put funds into support for community resources and for lactation counseling personnel and hotlines.
- Focus on public opinion and healthcare providers. Without support from the public and healthcare providers, the campaign will be difficult to sustain.
- Explore risk communication and related theories.
- Match new media to the audience and behavior change objectives.

LOVING SUPPORT 2.0: LEVERAGING NEW MEDIA

Presenter: Jay M. Bernhardt

Since the launch of the *Loving Support* campaign, a variety of new communications technologies have been developed for creating and sharing, interactivity and engagement, and collaboration. Jay Bernhardt, a professor at University of Florida, noted that people are no longer only passive recipients of information, but rather they are active, creative participants. According to Bernhardt, 2.0 communication[1] harnesses the power of groups

[1]A phrase referring to the use of use of blogs, wikis, and social networking technologies for communication purposes. It is based on the term "Web 2.0" believed to be coined by Tim O'Reilly referring to information technologies that harness active participation to improve themselves over time.

of people to produce better outcomes. Women who turn to social media to share their own stories are an important, influential source of information for other women making decisions. The question is how to use this technology to make a breastfeeding campaign more effective.

Crossing the Digital Divide

Bernhardt presented data from the Pew Internet & American Life Project (2010) about communication trends and usage in the United States. Internet usage is high (95 percent among adults ages 18–29 and 87 percent among adults ages 30–49), although its growth has flattened out in recent years, in part because the price for broadband access has not dropped as much as it has in other developed countries. What people do online is changing rapidly. Reading text online has declined, while the amount of time spent playing games and watching videos has increased. The implication, Bernhardt said, is that people are much less likely to read sites full of text than to watch short entertaining or educational videos. Social networking, downloading and listening to music, and microblogging (such as with Twitter) are also increasing in popularity. According to the Pew data, in May 2010 86 percent of adults ages 18–29 and 61 percent of adults ages 30–49 used social media, up from 16 percent and 12 percent, respectively in September 2005 (Madden, 2010).

While increasing percentages of the population have Internet access, Bernhardt warned that a digital divide still exists. Only two-thirds of the population has broadband access, which he characterized as not only too low but also a "missed opportunity for public health in the U.S." Significant portions of the general population do not have traditional Internet access. In contrast, he said, cell phones are "perhaps a great equalizer in terms of digital access." According to the wireless telecommunications association CTIA, there were 303 million wireless subscribers in December 2010 (CTIA, 2010). The use of text messaging in particular has skyrocketed. African Americans and Latinos lead whites in their use of many mobile data applications (Table 4-1). To Bernhardt the take-home message is that while audiences vary in their access to the Internet, mobile technology may help health information cross the digital divide to hard-to-reach populations.

Bernhardt listed what he sees as the advantages of more interactive and participatory "2.0 communication programs": increased and sustained reach; deeper audience relevance, involvement, and engagement; scalable and affordable interventions; and the ability to perform measurement and evaluation through data mining and automated monitoring. While more traditional forms of media should not be abandoned, using these new forms of communication can potentially lead to more effective programs, with

TABLE 4-1 Use of Mobile Technology: African Americans and Latinos Lead Whites in Their Use of Mobile Data Applications

	All adults (%)	White, non-Hispanic (%)	Black, non-Hispanic (%)	Hispanic (English-speaking) (%)
Own a cell phone	82	80	87*	87*
	% of cell phone owners within each group who do the following on their phones			
Take a picture	76	75	76	83*
Send/receive text messages	72	68	79*	83*
Access the internet	38	33	46*	51*
Send/receive email	34	30	41*	47*
Play a game	34	29	51*	46*
Record a video	34	29	48*	45*
Play music	33	26	52*	49*
Send/receive instant messages	30	23	44*	49*
Use a social networking site	23	19	33*	36*
Watch a video	20	15	27*	33*
Post a photo or video online	15	13	20*	25*
Purchase a product	11	10	13	18
Use a status update service	10	8	13	15
Mean number of cell activities	4.3	3.8	5.4	5.8

NOTE: N = 2,252 adults 18 years and older, including 1,917 cell phone users.
*Statistically significant difference compared to whites.
SOURCE: Adapted from Smith, 2010. Pew Research Center's Internet & American Life Project, April 29–May 30, 2010 Tracking Survey. Reprinted with permission from the Pew Internet & American Life Project.

both the opportunity and the challenge to "get the right message to the right audience from the right source at the right time."

Bernhardt suggested four steps in determining how to use new media for *Loving Support*. First, identify, understand, and prioritize the target audience segments. This, Bernhardt said, is the single most important thing to do. Second, determine the specific objectives for each audience, in terms of knowledge, skills, norms, behaviors, support, and resources. Third, determine the media access and use of each audience, both for traditional and new media forms. Only after the first three steps are completed should the fourth step be done: Develop and pretest the media mix and messages.

Although businesses routinely do it, public health programs are not so likely to leverage the range of available Web and mobile platforms (see Box 4-1). Bernhardt encouraged *Loving Support* to take advantage of existing resources, noting that text4baby (a mobile phone application also discussed by the next panel) and other tools offer exciting possibilities for

BOX 4-1
Available Web and Mobile Platforms

Web-Based Communication
Search engine optimization
Social networking sites
User-generated content
Blogging and micro blogging
Online streaming video

Mobile-Based Communication
SMS-based (texting) tools
Free "apps"
Mobile websites
Local and tracking tools

Practitioner Tools
Apps and mobile

SOURCE: Bernhardt, 2011.

improving the communication of messages. Bernhardt finished by discussing the innovative potential of leveraging mobile technology for offering "digital coaching" about breastfeeding to women in the field during the immediate hours after delivery.

IMPLEMENTATION TOOLS NEEDED BY WIC STAFF

Presenter: Cathy Carothers

When the *Loving Support* campaign was created in 1997, it used the implementation tools available at that time to address the barriers to breastfeeding. Cathy Carothers, co-director of Every Mother, Inc., reminded participants of the various approaches—the consumer information, the media used to raise public awareness, and the staff training—that were developed to overcome barriers to breastfeeding and create breastfeeding-friendly communities.

Issues Raised

When Carothers asked WIC staff to identify the most relevant issues to them in 2011, she found that there is now an emphasis on the impor-

tance of exclusive breastfeeding. WIC staff observed that breastfeeding mothers do not come back to WIC until they have started to use formula. (A new study [Gross et al., 2011] supports this observation, Carothers said.) Mothers are often excited about breastfeeding while pregnant, but, as Carothers put it, "All bets are off once that baby is born." Hospitals' policies can be a detriment to breastfeeding. WIC staff told Carothers that they feel ill-equipped to reverse the situation in which a woman leaves the hospital supplementing with formula. Mothers express concern, real or perceived, about a lack of breast milk, which leads many of them to wean early. Despite a national movement to support breastfeeding at the workplace, WIC staff report a different situation at the local level, where most low-wage settings that employ WIC mothers are not conducive to breastfeeding or milk expression.

Carothers said that WIC staff members have embraced the Surgeon General's Call to Action and its support for making breastfeeding easier for new mothers through changing the environment of support from health care providers, family, employers, and the community. *Loving Support* can help create that support.

Recommendations from the States

To understand these issues and what WIC staff at the local level feel would be important in a new campaign, Carothers asked for feedback from seven state programs—those in New York, Texas, Iowa, Mississippi, Virginia, Michigan, and Washington. People in the state programs in turn talked with people at local agencies within their states.

Carothers reported that she received the following feedback concerning implementation tools needed in a new campaign:

- Recommended target audiences: While mothers should continue to be targeted, respondents suggested that the audience should be broadened to include hospitals, healthcare providers, employers of low-wage earners, and the general public.
- Media tools: Television and radio PSAs should continue, but they should be focused on the community support needed, rather than trying to get women to breastfeed. Respondents suggested that these ads run in cycles, not just during World Breastfeeding Week, and that they should also be available to post on YouTube or local websites.
- Social media needs: The respondents agreed, as was discussed throughout the workshop, that WIC mothers are communicating via texting and social media. Given that situation, Carothers said that it would be helpful to provide WIC staff with training on

how to use social media effectively; with templates for Facebook, texting, Twitter, mothering blogs, and other platforms; and with engaging YouTube video sound bites.

- Other tools: Several WIC staff said they found that brochures were often thrown away and not used. Thus they suggested that it would be useful instead to have such things as magazines targeted at low-literacy mothers, resources for fathers and grandmothers, a national website where mothers can get current information and links to local resources, materials in different languages (such as Spanish, Hmong, Chinese, and Vietnamese), and gifts like discharge bags. The Texas Every Ounce Counts Program, which uses more online materials than printed materials, was mentioned as a successful model.
- Resources for WIC staff: WIC staff were very positive about Grow & Glow training. They also asked for strategies on how to approach hospitals, healthcare providers, community groups (such as malls and other organizations), and employers of low-wage mothers. They requested training in how to conduct effective local campaigns and to use partners more effectively.
- Resources for the community: Respondents suggested adaptations of Grow & Glow for community organizations (for example, short lunch-and-learn training for community groups and more full-scale training for home visiting nurses). They also suggested Web-based physician tools, Business Case for Breastfeeding companion materials focusing on employers of low-wage women, and ready-made displays for the community.

Finally, respondents from the different state WIC programs suggested that it would be useful to have strategies and funding to help more WIC staff become International Board Certified Lactation Consultants (IBCLCs), information and tools to share with Medicaid offices to get buy-in from that program to support breastfeeding, and sustainable funding to expand peer counseling. Carothers said that many respondents told her that peer counseling is "one of the greatest things to happen to the WIC program."

STRATEGIC COMMUNITY-BASED PARTNERSHIPS

Presenter: Katherine Shealy

Throughout the workshop participants discussed the importance of partnerships. Katherine Shealy, public health advisor at the Centers for Disease Control and Prevention (CDC), said she wanted to explore further the role that community partners can play in the new *Loving Support* campaign

and posed the question, "What community partners provide opportunities for FNS collaboration, and what role can they play in *Loving Support*?"

Shealy said that her vision for a primary goal for *Loving Support* would be not to change mothers' decisions about infant feeding but rather to remove the barriers that impair mothers' abilities to carry out their decisions. Achieving this goal requires *Loving Support* to reach the settings, people, and groups that influence infant feeding decisions beyond mothers and their immediate circle of care, such as hospitals and employers. FNS has been a responsive partner in the community, Shealy said, but she recommended that the agency become a more proactive initiator of partnerships and an engaged contributor with "some skin in the game," contributing financial and human resources to partnership activities that go beyond the traditional WIC clinical setting. With these thoughts in mind, she then explored what these strategic partnerships might entail.

Potential Partners

A variety of stakeholders, including the Surgeon General's Call to Action to Support Breastfeeding, the National WIC Association (NWA) Strategic Plan and Six Steps to Breastfeeding, the White House Task Force on Childhood Obesity Report, the Business Case for Breastfeeding, the recently launched U.S. Department of Health and Human Services Partnership for Patients, and various other publications and activities, have said that partnerships are essential for success and list potential partners for *Loving Support*. These publications recognize that partnerships must be based on the socioecological model (a construct used by the CDC in promoting health behavior that considers the interaction between individual, relationship, community, and societal factors), and span agencies, programs, and program eligibility groups (including WIC participants, potential participants, and the wide community). Shealy noted that the Surgeon General's Call to Action is based on the idea that most mothers in the United States want to breastfeed and everyone can help make it easier for them to do so. The document offers a number of action items concerning mothers and their families, communities, the healthcare system, employers, research and surveillance, and infrastructure.

National breastfeeding activists, such as the NWA and the U.S. Breastfeeding Committee, identify some priority partners based on how they support or impede mothers' breastfeeding decision: birth hospitals and healthcare providers at the local level; breastfeeding coalitions, healthcare organizations, and health departments at the state level; and key federal agencies at the national level. The healthcare system includes everyone from the individual clinicians with whom a mother interacts, through hospitals and doctor's offices to insurers, credentialing boards, the Joint Commission, and the American Hospital Association.

Shealy urged going beyond the "choir" (WIC and public health entities) to develop novel national and federal partnerships that "empower the local choir" to carry out its work: partnering with groups that influence mothers' decisions, such as employer organizations, chambers of commerce, manufacturers, government agencies not involved with public health, universities, and medical schools. Partnerships that are "authentically strategic"—which Shealy defined as engaged in such a way that the entities accomplish more together than they could on their own—are challenging but necessary. As shown in Figure 4-1, the socio-ecological model mentioned above connects the mother and baby to these organizations and to the institutions that affect them.

Shealy identified some current partnerships already in place: the new Federal Breastfeeding Workgroup, the U.S. Breastfeeding Committee, the Breastfeeding Consortium, and text4baby, which provides free, text-based health information to pregnant women and new mothers in vulnerable populations. That initiative already reaches 500,000 women and has 138 outreach partners from businesses, government agencies, and nonprofit organizations. As an example of innovative ways that text4baby works with partners, Shealy said that wireless companies have agreed to allow subscribers to receive the texts from text4baby without those texts counting toward the mothers' monthly limits. Text4baby partners also have access to customizable materials and tools, along the lines of what some WIC programs say they would like.

Shealy gave a few examples of effective WIC partnerships on the local and state level. In Mississippi, for instance, a WIC clinic at University Medical Center in Jackson has fully collaborated with the postpartum unit for 15 years. Mothers are certified prior to discharge and are already assigned to and can meet with a peer counselor. In north Georgia local WIC staff members work with carpet factories that employ large numbers of WIC mothers to establish workplace support programs. In New York WIC participates in program planning and activities in a CDC-funded obesity program, which ensures consistent messaging and shared resources. And in North Dakota WIC provides local support to coalitions, is involved with the state Business Case of Breastfeeding initiative, and partners closely with the Communities Putting Prevention to Work team.

Shealy concluded her presentation by emphasizing the benefits to FNS of working with partners in the new *Loving Support* campaign. Partners can amplify the messages that WIC mothers receive during their WIC interactions. They can help share the load so that WIC staff are more effective and can spend less time correcting inaccurate or incomplete information that mothers hear elsewhere, and they can lend credibility by echoing WIC's messages prioritizing breastfeeding support. Some partners that Shealy identified as essential in a new campaign are federal and state

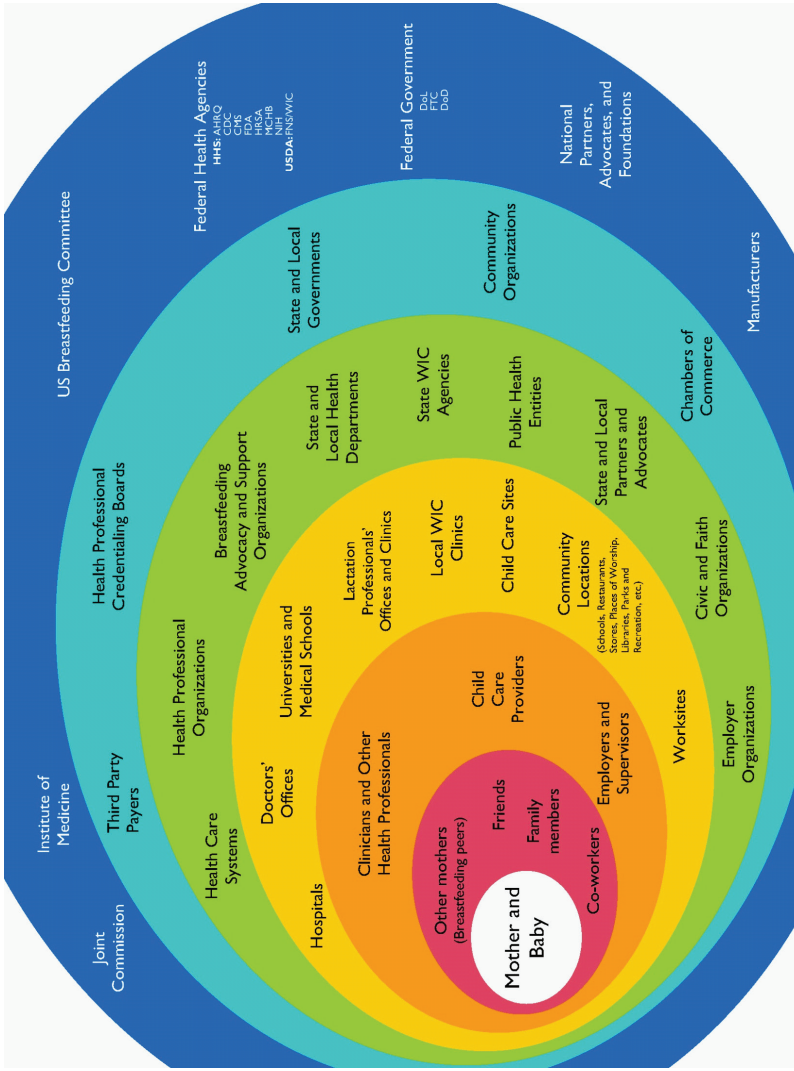

FIGURE 4-1 Organizations and institutions that affect mother and baby.
SOURCE: CDC/DNPAO, 2011. Reprinted with permission from CDC/DNPAO.

departments of labor, which can help with legislation requiring accommodations for breastfeeding mothers; local and state breastfeeding coalitions; hospitals; and organizations of healthcare professional, such as the American Academy of Pediatrics or the American Congress of Obstetricians and Gynecologists.

IDENTIFYING RESEARCH GAPS

Presenter: Kiran Saluja

Saluja returned to the podium to discuss what WIC needs to know about current perceptions of breastfeeding and the need for early support. It is important, she said, to learn not only about a mother's perceptions but also about the perceptions of those around her, including healthcare providers, WIC staff, family, and friends.

Understanding Perceptions

It is important to understand the perceptions that these different groups have concerning a variety of topics, such as the following:

- Exclusive breastfeeding for the first 6 months and the critical role of early support to make that happen: What does "exclusive breastfeeding" really mean? Does even one bottle in the first few days sabotage breastfeeding? What does "early support" really entail, and how can WIC reach out in the first 72 hours after giving birth?
- Continuation of breastfeeding: How can WIC mothers who take a fully breastfeeding package in the first month be prevented from coming in for formula in subsequent months? What is the best way to deal with the mothers and also the healthcare providers and public health clinics that may be giving them a different message about formula versus breastfeeding?
- Breastfeeding success: What are the salient predictors of resiliency and efficacy that will improve breastfeeding success? Talking with successfully breastfeeding mothers can provide insight about their common characteristics and about what distinguishes them from mothers who are not breastfeeding. Are some elements of the Breastfeeding Self-Efficacy Scale more salient than others for different settings?

Every state WIC program has data that can be mined to answer some of these questions. Saluja suggested that USDA should provide resources

to the states so they can mine the data and possibly use it to answer some of their questions. For example, Saluja's agency in southern California (the Public Health Foundation Enterprises WIC Program) evaluates everything: the new food package, breastfeeding rate variables, mothers' perceptions about their hospital stays, and much more. The agency's research demonstrated the impact of the new food package when it was reinforced with a policy of not routinely issuing formula plus staff training on that policy. Another survey looked at women's perceptions of their hospital stay and the effect of hospital policies.

Sample Ideas from WIC Staff

Saluja passed along other suggestions for research that she heard from WIC staff around the country. Several people had suggested investigating what the WIC population understands about the risks of formula feeding. Some told her that "Many of our moms do not see the foods for themselves [the food package] as important as formula. . . . The [dollar] amount of the foods that they would get just doesn't compute the same [as the value of formula]." Others pointed out that breastfeeding has to be something the mother believes in and values, beyond the incentive of the mother getting additional food or food for a longer duration. They suggested researching the role of images in WIC clinics and hospitals. Another suggestion was to look closely at the research behind "no bed sharing," since safe bed sharing can help mothers continue to breastfeed.

DEFINING GOALS AND EVALUATING SUCCESS

Presenter: Dawn Baxter

Evaluation consultant Dawn Baxter encouraged participants to think of evaluation as a planning tool and not just the final step of a campaign. That means that people should make sure from the start that the information needed to determine success will be available at the end of the campaign. Baxter said that she was asked to address four questions: (1) how to identify behavioral and process outcomes; (2) how the USDA can establish baseline data; (3) what is required to develop an evaluation and monitoring plan; and (4) how evaluation and monitoring can be designed to accommodate budget, staffing, and other resources limitations.

Identifying Outcomes

In reviewing the current goals of *Loving Support*, Baxter noted that exclusive breastfeeding is not mentioned, although it is something that

many participants discussed during the workshop. Thus, the first question in a new campaign should be to determine whether the current goals are still relevant and what changes in the goals are needed.

Baxter presented a sample logic model (Figure 4-2) based on the goal to "increase the number of infants born to WIC participants who are breastfed for the recommended period of one year." Whatever specific goal is ultimately decided upon, Baxter advocated thinking through a similar logic model that covers measurable objectives, strategies to reach those objectives, outputs, and both short- and long-term outcomes. Knowing the outputs—for example, the percentage of participants offered support for breastfeeding or the percentage of healthcare providers given information about WIC's breastfeeding services—can also help from a process perspective to catalogue what has been done and by whom, what materials were sent out, and who saw them. This would be especially helpful, she said, when different states use different components of the campaign.

The crux of an evaluation is defining the objectives. Baxter said the "gold standard" is to develop what are known as SMART objectives: specific, measurable, attainable/achievable, relevant, and time-bound objectives. For example, the objectives "increase initiation of breastfeeding" or "increase duration rates" need more definition in terms of how long it should take to implement a specific change. Similarly, the objective "increase public acceptance of breastfeeding" could be measured by determining the number of employers who receive information about the benefits of a breastfeeding-friendly workplace; gauging public attitudes through focus groups, surveys, and polling; or finding out the percentage of WIC participants who report support from their family members. In many cases, WIC programs have this information, and Baxter encouraged acting on it to make modifications as needed, rather than waiting for data to be compiled and published.

Baseline Data

Ideally, baseline data should be collected for a year before a campaign starts and for a year after its launch. WIC may already have these data in its archives, unlike many other organizations that are starting from scratch. States and local programs will probably need assistance compiling the data and ensuring sufficient consistency that the data can be compared. Moving forward, it will be important to communicate to the states what they need to measure for the campaign so that data collected by programs differently could be compared and analyzed.

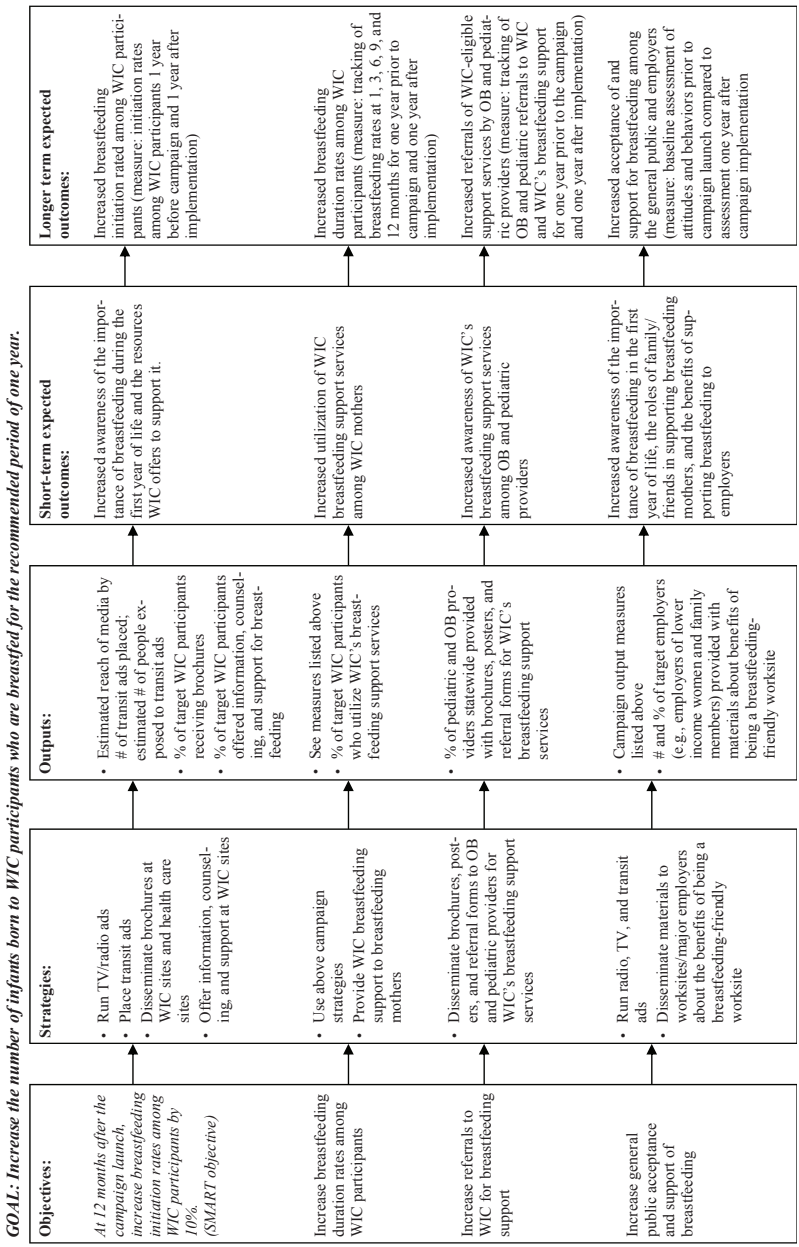

FIGURE 4-2 *Loving Support* campaign logic model sample.
SOURCE: Baxter, 2011.

Developing an Evaluation and Monitoring Plan

The USDA needs a "big picture" strategy that includes objectives, measures, data sources, roles and responsibilities, a timeline, data collection tools, and an analysis plan, Baxter said. Monitoring the campaign involves tracking program activities, such as the materials distributed or the ads placed, as well as relevant outcomes, such as monthly referrals, initiation, or duration rates. Tracking activities and outcomes can help with continuous quality improvement and can also help identify and address problems in a timely way.

Evaluating with Limited Resources

To address the final topic, evaluation with limited resources, Baxter returned to the importance of planning in advance of the campaign. Planning an evaluation at the beginning of the campaign is easier and less costly than trying to put together an evaluation after the fact. The evaluation must be practical at the local level. This means developing measurable objectives, selecting measures that will work within operational constraints, and developing a system for collecting and tracking data over time; coding data in ways that are easy for staff to understand, track, and analyze; preparing staff for their evaluation role; and aligning new data collection with existing operations (such as a new item on an existing form, rather than a new form).

It is helpful to demystify the concept of evaluation, Baxter said. Evaluation takes planning and organization, but it can be accomplished if people know what it entails. Baxter closed by urging USDA to invest in formative research to increase the likelihood that strategies and materials will be on target.

GROUP DISCUSSION

Presenter: James Lindenberger

Again, the moderator took written questions from the audience and directed them to the speakers. The topics discussed included

- *Availability of existing data for evaluation purposes*: Shealy noted that several existing CDC surveys, such as the National Immunization Survey and the National Survey of Maternity Practices in Infant Nutrition and Care, include information about breastfeeding and hospital practices. Concerning social media, Bernhardt said that data can be scraped or mined from media streams for forma-

tive research. Using Facebook groups, Twitter hashtags, or other types of key word searches can help identify relevant information to analyze. More sophisticated quantitative tools, such as Radian6 (http://www.radian6.com), can also run aggregations against streams to look for trends and themes as well as to measure the overall reach of a campaign. Saluja pointed out that WIC has data collected about the food package that cover every state and stretch over a period of time. In general, the panelists strongly supported the concept and value of using existing data.

- *Specific products or services to support*: Baxter said that she felt there is some ambiguity about what "support services" are, although Saluja said that WIC recipients or potential recipients receive an explanation from the outset of enrollment. Saluja said that increasing the number of Baby-Friendly Hospitals would make a difference. Shealy suggested coming up with a product to offer as an incentive in addition to intangible services because society often values "stuff" for babies. The product could be a sling or an outfit for each successful month of breastfeeding—something related to the baby but not necessarily directly to breastfeeding. A drop-in breastfeeding clinic might be another community service to offer. Carothers said that focusing on implementing just a few breastfeeding-friendly practices, as was done with the Colorado Can Do 5! Initiative, is useful. WIC staff also suggest using a referral network to find out where the new mothers are delivering, so peer counselors can help them from the start. Place can be a barrier, Bernhardt noted, which is what makes digital coaching an exciting option. Virtual tools have a huge potential for improving health care. For breastfeeding, having a lactation coach or consultant at the very point of need could be revolutionary.
- *Images of breastfeeding*: Participants were asked to address the way in which, in some cultures, breastfeeding has a sexual connation. We have to address it head on as part of the necessary formative research, Parvanta said, even if it is an uncomfortable topic. For example, some women will feel comfortable using a breast pump in private but not breastfeeding in front of others. Another example of society's uneasy relationship with breastfeeding is that a mother cannot post a picture of herself on Facebook breastfeeding (although a petition is circulating to change that policy). "If you want something to be normal, it's got to be on Facebook," Parvanta said.
- *Distribution of formula by prescription*: Saluja noted that recommendations for what to do about formula come up periodically in the WIC program. She said that it is her personal opinion that if a

policy is punitive to the mother, it is wrong, and she also noted the administrative burden it would create if WIC staff had to control distribution in this way. To her, the best approach relies on prenatal education and hospital and community support afterward. She tells her staff that success is when a mother says, "I don't want formula. I want to breastfeed."

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5

Responses and Concluding Remarks

At two different times during the workshop—in the morning, after the first two panels, and in the afternoon, after the third panel—the committee asked an expert to reflect on what he had heard and to identify themes. Laurence Grummer-Strawn, who responded to the first two panels, is chief of the Centers for Disease Control and Prevention (CDC) Nutrition Branch and is recognized internationally for his work on breastfeeding policy, among other topics. The second responder was William Smith, editor of Social Marketing Quarterly, who has more than 40 years of experience in behavior change, social marketing, and community building.

At the end of the day, workshop chair Rafael Pérez-Escamilla offered some common messages and challenges to conclude the workshop.

RESPONSE TO PANELS 1 AND 2: BREASTFEEDING MARKETING IN THE NEW ENVIRONMENT

Respondent: Laurence Grummer-Strawn

Grummer-Strawn thanked the panelists for pulling together a large amount of literature into the short presentations required by time constraints. He said that he had captured eight main messages from the first two panels:

1. Breastfeeding has increasingly become the norm. Rates of breastfeeding at six months have nearly doubled since 1997 when *Loving Support* began, and a majority of WIC mothers are initiating

breastfeeding. This fact, he said, changes the dynamics of the conversation a WIC staff member is likely to have with a WIC participant from one that encourages a mother to breastfeed who has reservations and questions about it to a conversation that supports the mother's choice to breastfeed. There may not be a huge change in the number of women breastfeeding, Grummer-Strawn said, but the nature of the dialogue has changed. However, he noted that WIC breastfeeding rates, while increasing, still lag behind the national average.

2. The environment to support breastfeeding has improved considerably. Looking at such factors as state legislation and policies, increases in Baby-Friendly Hospitals and International Board Certified Lactation Consultants (IBCLCs), and other trends, one can see these positive trends as evidence of a far more supportive environment than existed 14 years ago.
3. The same barriers exist that have existed for the last 25 years. In 1985 recommendations from the Surgeon General's Workshop on Breastfeeding focused on work, public education, professional education, the healthcare system, support services, and research—issues that are still relevant today. This is because while the trends are positive, as noted above, they remain insufficient. For example, there are just over 100 Baby-Friendly hospitals, and they account for only 4 percent of the births in this country.
4. Society's beliefs about breastfeeding have not changed much, at least on such issues as breastfeeding in public and the benefits of breast milk versus formula. Grummer-Strawn shared some data from Porter Novelli's HealthStyles surveys (http://www.cdc.gov/breastfeeding/data/healthstyles_survey/survey_2007.htm#) on public attitudes about breastfeeding in 1999, 2003, and 2007. In 2007 respondents actually felt a little less comfortable than those in 1999 when seeing women breastfeed in public. Similarly, Grummer-Strawn noted that the two-year National Breastfeeding Awareness Campaign did not show any significant changes in beliefs about breastfeeding.
5. How breastfeeding messages are framed is more important than the content of the message. Grummer-Strawn suggested that those designing the new campaign should read a paper by the Berkeley Media Studies Group entitled "Talking about Breastfeeding: Why the Health Argument Isn't Enough" (Dorfman and Gehlert, 2010). According to the paper, current breastfeeding frames in the media include the beliefs that good mothers breastfed their babies and that breastfeeding is a natural thing to do that has be going on for generations but also that mothers need experts to show them how

to breastfeed properly. The Berkeley group suggested alternative frames: Successful breastfeeding requires support, breastfeeding benefits women's health (not just children's), and well-supported breastfeeding improves everyone's well-being.

6. Effective marketing must appeal to emotions, experience, and motivations, not just provide information. Often, Grummer-Strawn said, WIC counseling is aimed at providing information about the benefits of breastfeeding, yet, he noted, literature on social marketing and communication indicates that decisions are not generally made on the basis of breastfeeding's benefits.
7. Communications channels have changed rapidly, and there are completely different ways to communicate with audiences than existed 14 years ago. With those changes has come a population that is technology-dependent. Grummer-Strawn said that he learned at a recent conference that the main resource people rely on to learn a new behavior is YouTube. New technology has also led to the democratization of information. Grummer-Strawn said that information leaders are no longer deciding what information the public should have, but rather the millennial population will search for the information they want, access the information that appeals to them, and ignore what does not.
8. Millennial women want to be unique. They have an expectation of personalized messages and want to be recognized as a diverse population and as multidimensional people. Grummer-Strawn said the message he heard from the panelists was that millennial women want to be addressed not only as mothers but also as people who have careers, friends, and families because it is all part of who they are. They also want to be involved in the communication process, "pulling" messages of interest rather than having the messages pushed out at them.

RESPONSE TO PANEL 3: WHERE TO GO FROM HERE

Presenter: William Smith

After the third panel, William Smith, editor of *Social Marketing Quarterly*, observed that while many good ideas were presented in the workshop, they were offered without much priority-setting. One way to move forward would be to consider what unique contributions the U.S. Department of Agriculture (USDA) can make to support breastfeeding through an evidence-based social marketing campaign and to leverage resources. For example, rather than creating a social media strategy to compete with existing and successful initiatives, the USDA could determine how to leverage or support

these existing efforts. Smith also suggested sorting through all the data accumulated from various sources because, he said, "You don't know what it all means." He suggested that the book *How Doctors Think* (Groopman, 2007) provides useful suggestions for how to look at data objectively and avoid confirmation bias seeping in.

Overall, Smith encouraged participants to recognize their successes. He reminded them that within a decade after World War II, millions of women had turned their backs on breastfeeding and were using formula. Now, breastfeeding is again promoted as a social norm, and 75 to 80 percent of women are at least initiating breastfeeding. "Stop talking about women who aren't breastfeeding and talk about the women who are," he said. "You have created a norm."

Smith proposed moving away from focus groups and using observation studies. He noted that many presenters talked about the fact that WIC is not reaching mothers during the critical 72-hour window after the mother gives birth. What can WIC do to help mothers get through that time? Smith suggested gathering real metrics about what these new mothers are experiencing. What really happens during that period that is so critical? How do they feel? What is happening with their husbands or their other children? First-hand information could provide WIC with a huge opportunity during these 72 hours.

Smith discussed imagery in several ways. First, he suggested making WIC participation exciting, almost like being a member in an organization. Concerning the public's images of breastfeeding, he noted that a search on "breastfeeding" in Google came up with pages of women breastfeeding in fields or other idealized settings, but not in public around other people. Images of breastfeeding in public, such as in the workplace, could help minimize the embarrassment that many women still feel.

The current WIC website emphasizes the WIC program, with less focus on women and little mention of or images from the *Loving Support* brand. In contrast, private companies tend to focus their sites around women, and some government agencies, such as CDC and the Health Resources and Services Administration, have also successfully developed people-centered websites. Smith singled out Weight Watchers as an example of a website that focuses on success, belonging, and being challenged to succeed.

Smith suggested developing a brand extension, perhaps "*Loving Support* Plus," to use going forward. Following a very traditional social marketing and marketing technique, new elements could be added to the current campaign.

Smith said that, based on what he heard during the workshop, priorities for the future might include celebrating WIC women; updating the market research; targeting that 72-hour critical period; and creating on a

brand extension that focuses on breastfeeding duration and workplace and public place feeding.

CONCLUDING REMARKS

Presenter: Rafael Pérez-Escamilla

Rafael Pérez-Escamilla wrapped up the workshop by repeating a number of comments and insights he said he had heard during the day. First, though, he described a project in which he had been involved in Hartford, Connecticut. He had developed messages based on his own preconceived notions. Fortunately, he said, a colleague reminded him that he had to heed what the target audience—in this case mostly Puerto Rican women—were identifying as barriers to breastfeeding, not what he assumed from his own experience in Mexico. In line with that lesson, he noted that it is important to consider market segmentation and also to remain objective and to be unbiased even when the "right" answer seems obvious. He also noted that the campaign he was involved in was more successful because of a partnership, in this case with the Hispanic Health Council and Hartford Hospital (Stopka et al., 2002).

Other points from the workshop that Pérez-Escamilla said he felt would be useful to the Food and Nutrition Service (FNS) included the following:

- Deciding the scope of the campaign: An overwhelming amount of information about potential activities and approaches was presented throughout the day. The first task for USDA is to decide the scope for the campaign: whether to focus on social marketing and the 4 P's or to mount a well-focused health communication effort. The amount of funding will help decide the scope.
- Defining the outcomes—initiation, duration, exclusivity: Exclusivity is important, but it is a challenge if there is not a very well-coordinated system with peer counselors and better connections with hospitals. Adding a focus on exclusive breastfeeding to *Loving Support* would require addressing factors that include targeting mothers within the first few days after they give birth, training for medical students, and understanding the health implications of complementary feeding.
- Market segmentation: A variety of different factors should be taken into account: ethnicity, whether a mother has already given birth or if this is the first time, the age of the mother, acculturation, and so on. Pérez-Escamilla recommended considering the Stages of Change model in planning the campaign.

- Research into specific and contextual issues: Research about social media and the image of the WIC program can help the campaign. How, for instance, do participants and potential participants perceive the program? What is the explanation for WIC-eligible women who choose not to participate? What is the impact of the new food package as an incentive? Deciding whether to frame the issue so as to motivate women to breastfeed versus warning them against formula feeding is deserving of a good amount of research. The book *Nudge* (Thaler and Sunstein, 2008) suggests changing the "default systems" so that people gradually adopt more healthful behaviors; this would be a useful way to discuss how far to go in promoting breastfeeding and discouraging formula feeding.
- Evaluation: Formative, process, and outcome evaluations are all crucial, Pérez-Escamilla said. The formative evaluation will offer information about the needs and the wants of the target communities. Concerning process evaluation, if the campaign is not user-friendly, it will be very difficult to move forward.
- Monitoring tools: Good tools are in place from the CDC, the Food and Drug Administration, and other sources. They can help document feeding practices, hospital policies, and other important information, but better coordination across information systems is needed.

CLOSING DISCUSSION

The workshop ended with a few minutes of general discussion. The topics included

- *Motivational interviewing*: A participant suggested using this technique, in which the participant is guided to reach his or her own conclusion about the target behavior. Saluja said that the technique has been part of the WIC program for some time.
- *"Hot" and "cold" states in marketing*: Smith suggested that this concept may be useful in thinking about breastfeeding. In this case the "cold" state would be the situation in which the mother is pregnant and is thinking about breastfeeding, and the "hot state" would be the period right after she gives birth. The challenge is how to prepare her for the hot state.
- *Reaching out to policy makers and other key players*: A participant said that it is very important to engage with stakeholders at the community, state, and federal levels. As the participant put it, "A very important piece of this next generation of *Loving Support* is getting "loving support" from some other people—policy makers

at the state level, at the federal level, and at the community level. They need to know the concepts and the successes of WIC." Pérez-Escamilla agreed, mentioning the role that advocacy groups play in Brazil in reaching policy makers. They could do things that the government could not do, he said.

- *Viability of counter-marketing*: Several participants asked whether a campaign to support breastfeeding should take cues from the anti-tobacco campaign. Smith suggested focusing on what is happening with breastfeeding, not on demonizing choices.

Pérez-Escamilla said he wanted to close by highlighting the very relevant issue of finding out how best to "nudge" women away from formula into breastfeeding. "It is a very complex matter," he said, "but I think there are some good signs on the horizon." He thanked the participants and panelists on behalf of the planning committee and the Institute of Medicine staff and expressed the hope that USDA/FNS benefited from the discussion.

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A

Workshop Agenda

UPDATING THE USDA NATIONAL BREASTFEEDING CAMPAIGN: LOVING SUPPORT MAKES BREASTFEEDING WORK
April 26, 2011

Keck Center
500 Fifth Street, NW
Room 100
Washington, DC 20001

INTRODUCTION AND KEYNOTE

8:30 – 8:40 a.m. **Welcome, Introductions, and Purpose**
Rafael Pérez-Escamilla
Workshop Moderator and Planning Committee Chair
Yale University

8:40 – 8:45 a.m. **Opening Remarks**
Douglas Greenaway
National WIC Association

8:45 – 9:15 a.m. **Keynote Address**
Loving Support Makes Breastfeeding Work—Historical Perspective
Debra R. Whitford
Supplemental Food Programs Division
Food and Nutrition Service, USDA

PANEL 1—WHAT HAS CHANGED?

9:15 – 10:00 a.m. **Panel Presentations**
Introduction by Moderator
Gail Harrison
University of California, Los Angeles

Panelists
Changes in Communications Patterns
Georgia Galanoudis
Parents Network Custom Solutions

Changes in the WIC Program Environment
Kiran Saluja
Public Health Foundation Enterprises WIC Program

Research Findings on Changes and Impacts: Birth Month Study, Peer Counseling Study, Participant Characteristics
Joseph Robare
Office of Research and Analysis, Food and Nutrition Service, USDA

Changes in Programs, Laws, and Policies in Relation to Breastfeeding
Marsha Walker
U.S. Breastfeeding Committee Legislative Group

10:00 – 10:15 a.m. Break

10:15 – 10:45 a.m. Discussion: Panelists to Address Select Audience Questions

PANEL 2—LESSONS LEARNED FROM OTHER CAMPAIGNS

10:45 – 11:45 a.m. Panel Presentations
Introduction by Moderator
Karan DiMartino
Massachusetts Department of Public Health

Panelists
What Is Social Marketing?
R. Craig Lefebvre
University of South Florida, RTI International

The VERB Campaign
Faye L. Wong
National Centers for Chronic Disease Prevention and Health Promotion

Lessons Learned from the National Breastfeeding Awareness Campaign: 2004–2006
Suzanne Haynes
Office of Women's Health, HHS

Loving Support and Innovative State Campaigns
Carole Peterson
National WIC Association, Breastfeeding Chairperson

Brazilian Breastfeeding Promotion Experience
Rafael Pérez-Escamilla, Yale University

11:45 a.m. – 12:00 p.m. **Break**

12:00 p.m. – 12:30 p.m. **Discussion: Panelists to Address Select Audience Questions**

12:30 – 12:45 p.m. **RESPONSE TO MORNING SESSIONS**
Laurence Grummer-Strawn
Centers for Disease Control and Prevention, HHS

12:45 – 2:00 p.m. **Lunch**

PANEL 3—WHERE DOES THE CAMPAIGN GO FROM HERE?

2:00 – 3:10 p.m. **Panel Presentations**
Introduction by Moderator
James Lindenberger
University of South Florida

Panelists
Considerations for Program Components, Messages, and Image
Claudia F. Parvanta
University of the Sciences in Philadelphia

Communication Tools
Jay Bernhardt
University of Florida

	Implementation Tools Needed by WIC Staff *Cathy Carothers* *Every Mother, Inc.*
	Strategic Community-Based Partnerships *Katherine Shealy* *Division of Nutrition, Physical Activity, and Obesity, CDC*
	Identifying Research Gaps *Kiran Saluja* *Public Health Foundation Enterprises WIC Program*
	Defining Goals and Evaluating Success *Dawn E. Baxter* *Independent Consultant, Public Health Campaigns*
3:10 – 3:30 p.m.	**Break**
3:30 – 4:15 p.m.	**Discussion: Panelists to Address Select Audience Questions**
4:15 – 4:30 p.m.	**RESPONSE TO AFTERNOON SESSION** *William A. Smith* *Editor, Social Marketing Quarterly*
4:30 p.m.	**CONCLUDING REMARKS AND ADJOURNMENT** *Rafael Pérez-Escamilla* *Workshop Moderator and Planning Committee Chair* *Yale University*

B

Planning Committee and Speaker Biographical Sketches

Dawn Baxter, M.B.A., is an independent consultant who has been based in Cambridge, Massachusetts, since 2008. Her range of projects includes planning and communications for the Centers for Disease Control and Prevention Public Health Leadership Initiative; evaluations for the Stop TB Partnership of the World Health Organization; and the breastfeeding support initiative of the Massachusetts WIC Program. Prior to working as an independent consultant she was a vice president at Policy Studies Inc. (PSI), consulting in strategic planning, communications, and evaluation for public- and nonprofit-sector clients. Ms. Baxter developed several award-winning educational campaigns on such diverse topics as hepatitis C, flu, MRSA, West Nile virus and women's health (Title V) while at PSI. She has a B.A. from Smith College and an M.B.A. focused on public/nonprofit management from the Columbia Business School.

Jay M. Bernhardt, Ph.D., M.P.H., is widely recognized as a visionary leader and innovative scholar on the application of communication, marketing, and new media to public health, health care, and medicine. He serves as department chairperson and professor of health education and behavior at the University of Florida, where he is the founding director of the Center for Digital Health and Wellness. From 2005 to 2010 Dr. Bernhardt served as the director of the National Center for Health Marketing at the Centers for Disease Control and Prevention (CDC). Before that, Dr. Bernhardt was assistant professor of behavioral sciences and health education at Emory University Rollins School of Public Health and assistant professor of health promotion and behavior at the University of Georgia. He is an associate

editor of *Health Education and Behavior*, serves on three editorial boards, is a member of five honor societies, and has received numerous prestigious awards. In 2001 Dr. Bernhardt was the youngest member ever elected to the executive board of the American Public Health Association and he was subsequently elected by his peers to serve as board vice chairperson.

Cathy Carothers, BLA, IBCLC, FILCA, is co-director of Every Mother, Inc., a nonprofit organization providing breastfeeding training and technical assistance for WIC agencies and health professionals across the United States. She is the current president of the International Lactation Consultant Association, a fellow of International Lactation Consultant Association, and media/public relations chair for the U.S. Breastfeeding Committee. An experienced trainer and speaker, she has provided more than 350 training events in the United States and overseas. She is the project director for several national breastfeeding promotion projects and project director for the national Business Case for Breastfeeding initiative through the Department of Health and Human Services.

Karan DiMartino, A.L.A., is the marketing and media manager for the Massachusetts WIC Nutrition Program. She is responsible for planning, organizing, trouble-shooting, tracking, and evaluating WIC statewide media and outreach campaigns; designing, printing and purchasing WIC educational and outreach materials and items; and managing the WIC social marketing campaign and statewide WIC website. She has run successful media campaigns collaborating with professional sports teams to promote the importance of good nutrition and physical activity for kids and their families and the WIC Program on-air, on-line, and on-site at various events throughout the state. The Massachusetts WIC program currently serves over 90 percent of all eligible families in the state, one of the higher percentages in the country, due to these innovative marketing plans. Ms. DiMartino was a presenter at the 2005 and 2010 National WIC Association sponsored WIC conferences discussing best practices on marketing. She has experience planning and managing WIC conferences, worked on the 2003 conference planning committee for the national WIC conference in New York City, and managed the Massachusetts statewide WIC conference for the past ten years.

Georgia Galanoudis joined Meredith Corporation in 2004 and serves as the executive director of the Parents Network and Hispanic Ventures Custom Solutions Group. Ms. Galanoudis is responsible for the overall strategy, development, and execution of customized marketing programs targeting young families. Her 14-plus years of expertise in developing customized marketing programs has helped clients such as Johnson & Johnson, Kim-

berly Clark, Fisher-Price, and Kellogg's successfully connect with today's young families, engaging with all cultural and socio-economic backgrounds. She combines a rich background in direct marketing and consumer insights with the power of relevant content. She has been a friend and business partner of the National WIC Association for over 10 years.

Rev. Fr. Douglas A. Greenaway has served as president and chief executive officer of the National WIC Association (NWA) since 1990. NWA is a nonprofit education arm and advocacy voice for over 9 million mothers and young children participating in WIC and the nation's more than 12,200 WIC service provider agencies and clinics. Fr. Douglas is responsible for directing the association as well as representing the WIC community's interests to the White House, Congress, the U.S. Department of Agriculture, and other federal agencies and departments. Ordained to the Holy Order of Priests in the Anglican/Episcopal Diocese of Washington in 2000, Douglas serves as associate rector at St. Paul's Rock Creek Parish and as an assistant at St. Paul's Parish, K Street. He previously served as assistant rector at St. Alban's Parish on Mount St. Albans. He holds a master of divinity from Wesley Theological Seminary, a master of architecture from the Catholic University of America in Washington, D.C., and is a graduate of Carleton University, Ottawa, Canada.

Laurence M. Grummer-Strawn, M.P.A., M.A., Ph.D., is chief of the nutrition branch at the Centers for Disease Control and Prevention (CDC). As branch chief he is responsible for national surveillance of nutrition among low-income children, national breastfeeding support efforts, fruit and vegetable promotion, and international micronutrient deficiency programs. Dr. Grummer-Strawn is recognized internationally for his work on vitamin and mineral deficiencies, breastfeeding policy, and development of both the CDC and the WHO growth charts. He is also widely known in the breastfeeding research and advocacy communities, serving as scientific editor of the Surgeon General's Call to Action on Breastfeeding, an executive committee member of the International Society for Research on Human Milk and Lactation, and a liaison to the U.S. Breastfeeding Committee. Dr. Grummer-Strawn is cochair of the National Fruit and Vegetable Alliance. He has published over 100 scientific publications. Dr. Grummer-Strawn earned his Ph.D. from Princeton University.

Gail G. Harrison, Ph.D., is a professor in the Department of Community Health Sciences at the University of California, Los Angeles (UCLA) School of Public Health and senior research scientist at the UCLA Center for Health and Policy Research. Previously she was a professor in the Department of Family and Community Medicine at the University of Arizona.

Dr. Harrison has worked extensively in the area of dietary and nutritional assessment of diverse populations. She is a former member of the Food and Nutrition Board and has served on several of its committees, including the Committee on International Nutrition Programs, the Committee to Review the Risk Criteria for the Women, Infants and Children (WIC) Program, the Committee on Implications of Dioxin in the Food Supply, the Committee to Revise the WIC Food Packages, and the Committee on Nutrition Standards for National School Lunch and Breakfast Programs. She has served in various advisory capacities for the National Institutes of Health and the U.S. Department of Agriculture, consulted with the World Health Organization and UNICEF, and has worked in Egypt, the Sudan, Iran, Indonesia, and Lesotho, besides the United States. Dr. Harrison has an M.N.S. (nutritional sciences) from Cornell University and a Ph.D. in physical anthropology from the University of Arizona. She also serves on the board of the California Food Policy Advocates organization. Dr. Harrison is a fellow of the American Society for Nutrition and an Institute of Medicine (IOM) member.

Suzanne G. Haynes, Ph.D., has held several key breastfeeding leadership roles at the request of the assistant secretary of health during her tenure as the senior science advisor for the Office on Women's Health (OWH) in the Department of Health and Human Services. She chaired the *HHS Blueprint for Action on Breastfeeding* Committee between 1998 and 2000, which produced the department's first comprehensive policy on breastfeeding. She served as campaign director for the first National Breastfeeding Awareness Campaign, a national, award-winning, social marketing campaign sponsored by OWH and the Advertising Council between 2003 and 2006. Dr. Haynes commissioned the Agency for Healthcare Research and Quality to conduct the well-cited Evidence Report No. 153 that was published in 2007 as *Breastfeeding and Maternal and Infant Outcomes in Developed Countries*. Joining forces with the Health Resources and Services Administration, during the last four years Dr. Haynes has been promoting the Business Case for Breastfeeding through partnerships with 30 state breastfeeding coalitions and with the National Business Group on Health. She was the managing editor of the newly released *Surgeon General's Call to Action to Support Breastfeeding*, published in January 2011. In recognition and appreciation of her tireless efforts to promote breastfeeding in the United States, Dr. Haynes received the Assistant Secretary for Health's Award for Superior Service in June 2010. Dr. Haynes received her Ph.D. in epidemiology at the University of North Carolina and has published over 80 books and articles in peer-reviewed journals.

M. Jane Heinig, Ph.D., IBCLC, is an international board certified lactation consultant on the faculty in the Department of Nutrition at the University of California (UC), Davis where she conducts research in the areas of public health nutrition, clinical lactation, nutrition education, program evaluation, policy development, and infant nutrition, growth, and development. She received her Ph.D. in nutrition science from UC Davis in 1992 with minors in statistics and physiological chemistry. She became an IBCLC in 1993 and was part of the study team that collected data for the World Health Organization Growth Reference which recently was recommended by the American Academy of Pediatrics and the Centers for Disease Control and Prevention for use in the United States. Dr. Heinig also serves as the editor-in-chief of the *Journal of Human Lactation* and is the executive director of the UC Davis Human Lactation Center and graduate advisor for the masters degree program in maternal and child nutrition at UC Davis. She has published widely in the scientific literature and is a member of the International Lactation Consultant Association, the American Public Health Association, and the International Society for Research in Human Milk and Lactation. She is also a coauthor of the UC Davis-based blog Secrets of Baby Behavior.

R. Craig Lefebvre, Ph.D., is an architect and designer of public health and social change programs. He is chief maven of socialShift, a social design, marketing, and media consultancy in Sarasota, Florida; the lead change designer in health communication and marketing at RTI International; and research professor in the College of Public Health at the University of South Florida. His current work focuses on the use of service design, social media, and mobile technologies in social marketing and organizational change. Dr. Lefebvre is an internationally recognized expert in social marketing and social technologies and has worked with several hundred projects that have addressed a multitude of health risks for a broad array of audiences in global, national, state, and community contexts. He is the author of over 100 articles and chapters and serves on the editorial boards of the *Journal of Management & Marketing in Healthcare*, the *Journal of Social Marketing*, and *Social Marketing Quarterly*. He is a fellow in the Society for New Communications Research and an elected member of the American Academy of Health Behavior. Dr Lefebvre received his Ph.D. in clinical psychology from North Texas State University and produces and writes the blog On Social Marketing and Social Change [http://socialmarketing.blogs.com].

James H. Lindenberger, B.A., is the director of the Center for Social Marketing at the University of South Florida College of Public Health. He has 25 years experience in not-for-profit management, instructional design, and

writing, producing, and directing for film, television, multimedia, and print. He cofounded and, for 15 years, was executive director of Best Start Social Marketing, where he worked with public health professionals throughout the nation to develop and direct numerous social marketing programs dealing with a variety of public health issues at the national and state levels. This includes, among others, the WIC National Breastfeeding Promotion Social Marketing Project and the USDA's national breastfeeding brand, Loving Support Makes Breastfeeding Work™. He is also founder and former publisher of the *Social Marketing Quarterly*, the only peer-reviewed journal dedicated to social marketing. He has served on numerous national advisory panels and boards related to social marketing and public health initiatives, including the National Advisory Committee for the Florida Prevention Research Center, the Innovations in Social Marketing Conference steering committee, the Social Marketing in Public Health Conference planning committee, the *Social Marketing Quarterly* editorial board, the National Perinatal Association, Healthy Mothers Healthy Babies, the Healthy People 2010 health communication focus area workgroup, the Society for Social Marketing, and the National Training Center for Social Marketing.

Claudia F. Parvanta, Ph.D., professor of anthropology, teaches behavioral science research and culturally competent health communications to public health and health professions students at the University of the Sciences. Together with David Nelson, Sarah Parvanta, and Richard Harner, she is the author of *Essentials of Public Health Communication* (Jones and Bartlett Learning, 2011) and has authored several important papers in risk or health communication. Before joining the University of the Sciences in 2005, Parvanta headed the Division of Health Communication at the Centers for Disease Control and Prevention (CDC) for six years. Before that, Parvanta was an assistant professor at the Rollins School of Public Health, Emory University; the assistant director of the U.S. Agency for International Development's Nutrition Communication Project (for Porter/Novelli, a global marketing and public relations agency); and the consulting anthropologist for the Public Health Foundation WIC (Women, Infants and Children) program in Los Angeles where, among other tasks, she provided individualized client counseling to Southeast Asian women.

Rafael Pérez-Escamilla, Ph.D. (*Chair*), is professor of epidemiology and public health and director of the Office of Community Health, Yale School of Public Health. He is also director and principal investigator of the Connecticut NIH EXPORT Center of Excellence for Eliminating Health Disparities among Latinos (CEHDL). His public health nutrition and food security research has led to improvements in breastfeeding promotion, iron deficiency anemia among infants (by delaying the clamping of the umbilical

cord after birth), household food security measurement and outcomes, and community nutrition education programs worldwide. His health disparities research involves assessing the impact of community health workers at improving behavioral and metabolic outcomes among Latinos with type 2 diabetes. He has published over 100 research articles and over 300 conference abstracts, book chapters, and technical reports. He is currently chair-elect of the American Society for Nutrition International Nutrition Council and has served on the editorial boards of the *Journal of Nutrition*, the *Journal of Human Lactation*, and the *Journal of Hunger and Environmental Nutrition*. He served as a member of the 2009 IOM Gestational Weight Gain Guidelines Committee and of the 2010 Dietary Guidelines Advisory Committee. Dr. Perez-Escamilla received a B.S. in chemical engineering from the Universidad Iberoamericana in Mexico City. He earned an M.S. in food science and a Ph.D. in nutrition from the University of California, Davis.

Carole Peterson, M.S., IBCLC, has been employed by the Indiana WIC program in many capacities related to breastfeeding since 1989. She was the chairperson of the Indiana WIC program breastfeeding committee from 1997 until 2007. She has been on the NWA breastfeeding committee since 2006 and is now the NWA breastfeeding committee chairperson. Ms. Peterson is also the NWA representative to the United States Breastfeeding Committee. She was awarded the Excellence in Breastfeeding Award from the USDA Midwest Region, the Making a Difference Award from Illinois for lactation education and was the first WIC inductee into the Hall of Lactation Excellence in 2009 from Medela. She established a scholarship fund for WIC staff to apply for the IBLCE exam. Since 1995 she has lectured on lactation all over the United States as a director and instructor at Lactation Education Consultants (LEC). As an instructor at LEC, she researches and develops 45-hour lactation management courses. She has implemented employer lactation programs. She was a member of the ILCA board from 1991 to 1996. Ms. Peterson was a contributing author to *Counseling the Nursing Mother* and *Blueprints: A Guide for the Public Health Professional*. She was an instructor of child development at Indiana University until she followed her first passion, lactation, and began preparing lectures and courses to bring this education to people across the nation.

Joseph F. Robare, Dr.P.H., M.S., R.D., is currently a projects officer at the U.S. Department of Agriculture Food and Nutrition Service Office of Research and Analysis. In his current position Dr. Robare directs numerous research studies focusing on the WIC program. Previously he was a researcher for the University of Pittsburgh, Graduate School of Public Health and Department of Epidemiology. Dr. Robare received his Dr.P.H. in chronic disease epidemiology from the University of Pittsburgh and his

M.S. in human nutrition from Indiana University of Pennsylvania. He is also a registered dietitian.

Kiran Saluja M.P.H., R.D., is the deputy director of the Public Health Foundation Enterprise (PHFE) WIC program. PHFE is the largest local WIC agency in the country, serving approximately 4 percent of the nation's total and 23 percent of California's WIC recipients. She has been working with WIC since 1984. She is a passionate supporter of breastfeeding and has participated in breastfeeding coalitions, task forces, and special committees at the local, state, and federal levels. She has been speaking about WIC, breastfeeding, and nutrition education at national conferences for the last 17 years. Most recently, in February 2010, Ms. Saluja represented the National WIC Association testifying on WIC and breastfeeding before the House Education and Labor Committee reauthorizing WIC and child nutrition programs. She is the incoming chair of the National WIC Association.

Katherine Shealy, M.P.H., IBCLC, RLC, is a public health advisor at the Centers for Disease Control and Prevention (CDC) in Atlanta, Georgia. Ms. Shealy coleads CDC's Breastfeeding Work Group, coordinating CDC's breastfeeding efforts to protect, promote, and support mothers' feeding decisions through policy and environmental change, synthesis and dissemination of evidence, expansion of the knowledge base through research, and partnerships. She is a federal liaison to the U.S. Breastfeeding Committee (USBC) and helped establish the National Conference of State Breastfeeding Coalitions. She is a member of the federal steering committee for the Surgeon General's Call to Action to Support Breastfeeding and provides subject matter expertise and technical assistance to the White House Domestic Policy Council's Childhood Obesity Task Force and the First Lady's Let's Move Campaign. Ms. Shealy helped to create CDC's national census of Maternity Practices in Infant Nutrition and Care and serves as CDC's project officer of this unique ongoing surveillance system. She coordinates the survey's implementation, analyses, and reporting to states, facilities, and other key stakeholders. Along with the entire Breastfeeding Work Group she also creates the Breastfeeding Report Card, monitors Healthy People 2020 objectives, provides technical assistance to state and other partners, and supports strategic initiatives focused on support for employed mothers and improving maternity care practices. She is an international board certified lactation consultant (IBCLC) and provides subject matter expertise across CDC and sister federal agencies on a vast range of public health and policy issues that affect human lactation. Prior to joining CDC, Ms. Shealy served as maternal and child health epidemiologist for the state of Kansas and provided hospital-based clinical lactation care. Her academic background is in epidemiology and maternal child nutrition, with an em-

phasis on cognitive processing, survey design and data collection, and the psychology of child language and development.

William Smith, Ed.D, Honorary Ph.D., recently retired from 40 years in international development which combined an eclectic career of behavior change, social marketing, and community building to help organizations understand and connect with the people they hope to serve. He has designed, supervised, created, and evaluated social marketing and communication campaigns on HIV/AIDS prevention, infant and maternal health, health literacy, seat belt use, biodiversity, and energy efficiency and promoted youth development and advocacy in more than 22 countries and throughout the United States. Dr. Smith is also a cofounder of the Institute for Social Marketing. He was the recipient of the 2004 Alan Andreasen Award for Excellence in Social Marketing and in 2010 was the first recipient of the Phillip Kotler Distinguished Service Award. He received his Ed.D. in adult education and gaming theory from the University of Massachusetts and his honorary Ph.D. for leadership in social change from the University of South Florida.

Marsha Walker, R.N., IBCLC, is the executive director of the National Alliance for Breastfeeding Advocacy: Research, Education, and Legal Branch (NABA REAL). As such, she advocates for breastfeeding at the state and federal levels. She served as a vice president of the International Lactation Consultant Association (ILCA) from 1990 to 1994 and in 1999 served as president of ILCA. Ms. Walker is a board member of the Massachusetts Breastfeeding Coalition, the United States Lactation Consultant Association, and Baby Friendly USA, and she serves as ILCA's representative to the U.S. Department of Agriculture's Breastfeeding Promotion Consortium and NABA REAL's representative to the U.S. Breastfeeding Committee. She is a registered nurse and international board certified lactation consultant. Ms. Walker has been assisting breastfeeding families in hospital, clinic, and home settings since 1976. She is an international speaker and an author of numerous publications including ones on the hazards of infant formula use, code issues in the US, and *Breastfeeding Management for the Clinician: Using the Evidence.*

Debra R. Whitford is director of the Supplemental Food Programs Division (SFPD). As director, she is responsible for the management and oversight of the WIC program, the WIC Farmers' Market Nutrition Program, and the Senior Farmers' Market Nutrition Program. Prior to her appointment she served for 10 years as chief of policy and program development at SFPD. In this capacity Ms. Whitford was responsible for developing legislative and regulatory proposals and policy guidance for a wide range of WIC

Program areas, including vendor management, food packaging, certification, and nutritional risk. In addition, her branch managed all aspects of the WIC and Senior Farmers' Market Nutrition Programs. Before moving to the policy side of the division, she served for four years as the head of the WIC funding section. Ms. Whitford has been with the WIC Program for over 33 years. She has a bachelor's degree in early childhood education.

Faye L. Wong, M.P.H., is chief of the program services branch in the Division of Cancer Prevention and Control (DCPC) at the Centers for Disease Control and Prevention (CDC). In this position Ms. Wong provides leadership direction and manages the National Breast and Cervical Cancer Early Detection Program which provides screening for low-income, under- and uninsured women in the United States, 12 tribes and tribal organizations, and five U.S. territories. Ms. Wong provides strategic leadership within DCPC to address national health reform and the potential changing role for public health and screening programs. She has had a long career in public health at the Federal (CDC), State (OR) and local (rural—Flagstaff, AZ; inner city—Detroit, MI) levels in particular in the creation, growth, and management of new programs and media campaigns. Prior to returning to DCPC, Ms. Wong was director of CDC's VERB™ Campaign for six years. This award-winning national paid media campaign was based on social marketing principles and aimed to increase physical activity among tweens (youths 9 to 13 years of age). The campaign was highly successful through using a branding approach that presented physical activity to tweens as fun, as being about exploration and discovery, and as about being with friends. Before the VERB Campaign, Ms. Wong was director of the National Diabetes Education Program, a jointly sponsored program of the CDC and the National Institute of Diabetes and Digestive and Kidney Diseases.

C

Workshop Attendees

Joanne Arsenault
Nutrition Policy Analyst
RTI International

Eileen Beard
American College of Nurse-Midwives

Holly Campbell
Ogilvy Washington

Sandy Clark
Chief, Policy and Program Development Branch
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Jean Drummond
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Cheryl Funanich
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Anne Gaines
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Susan Gross
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D

Abbreviations and Acronyms

AAP	American Academy of Pediatrics
CDC	Centers for Disease Control and Prevention
CDP	community-based demonstration project
FNS	Food and Nutrition Service (U.S. Department of Agriculture)
FY	fiscal year
HHS	U.S. Department of Health and Human Services
H.R.	house resolution
IBCLC	International Board Certified Lactation Consultant
IOM	Institute of Medicine (The National Academies)
MCHB	Maternal and Child Health Bureau (U.S. Department of Health and Human Services)
mPINC	Maternity Practices in Infant Nutrition and Care
NBAC	National Breastfeeding Awareness Campaign
NWA	National WIC Association
OB/GYN	obstetrician/gynecologist

PC	peer counselor
P.L.	public law
PSA	public service announcement
USBC	U.S. Breastfeeding Committee
USDA	U.S. Department of Agriculture
WHO	World Health Organization
WIC	Supplemental Nutrition Program for Women, Infants, and Children

E

Excerpts from Comments Received on the Institute of Medicine's Website for the Workshop to Update the USDA National Breastfeeding Campaign

From March to May 2011, a public website was set up (www.iom.edu/USDABreastfeeding) to provide input to the U.S. Department of Agriculture's Food and Nutrition Service about the *Loving Support* campaign. About 40 comments were received from health departments, hospitals, breastfeeding coalitions, WIC offices, and other settings.

A sampling of the comments is reprinted below. They have been edited for length, in some cases with some minor copyediting.

Question 1: How does FNS build on the success of the current Loving Support Makes Breastfeeding Work campaign to promote breastfeeding among WIC participants?

From a medical school professor:

> Breastfeeding is an incredibly difficult skill to master. Doctors, midwives, and lactation consultants all offer conflicting advice about breastfeeding. There needs to be a consistent approach across disciplines, and it needs to be offered early—in the hours and days immediately after childbirth—and continued in the early weeks, and then support and encouragement needs to happen when mothers return to work.

From a peer counselor:

> I think the current food instruments allowing for more food for breastfeeding mothers and their babies is wonderful. . . . I must add, however,

that I don't personally feel the breastfeeding package is big enough, meaning I believe even more food choices should be allowed for these mothers.

From a WIC staff member:

Expansion of early education/promotion with a focus on the use of materials that truly make a difference is one strategy for building on the success of the current campaign. Our aim was to develop an educational kit that clearly communicated that WIC moms and babies are important and that breastfeeding is important, and this kit evidences that. All of the products contained in the kit are of the highest quality, effectiveness tested, and specifically targeted. We received the nicest compliment from a nurse/IBCLC who works with middle- and upper-income breastfeeding moms: "This kit looks like something we would give our moms." And indeed the kit clearly communicates to each WIC mom, "You and your baby are important. So let's talk about breastfeeding."

From a WIC nutrition/breastfeeding coordinator:

In the Southwest region we have used the campaign with an FNS-sponsored workgroup to provide prenatal education bags for WIC participants.

From a medical school employee:

I believe the campaign needs to focus on clear, simple, concise messages about breastfeeding that are at a reading level of participants targeted. Although technology and media, such as Facebook and texting, are popular forms of communication, the message that exclusive breastfeeding is best for newborns still must be comprehended by the participants at a deeper level.

From an IBCLC:

Increase funding to hire more peer counselors in areas where there are none, and increase their availability to WIC clients (e.g., more hours, more activity) where programs are in existence. Provide support and funding for clinics to offer comprehensive prenatal breastfeeding classes and ongoing breastfeeding support groups. Fund at least one breastfeeding expert for every clinic and recommend that states hire IBCLCs.

Increase funding to allow for hospital and home visits by IBCLCs, when indicated. In order to increase access to skilled breastfeeding support, suggest clinics consider hiring non-licensed IBCLCs (meaning without a state license such as RN or RD) as well as licensed IBCLCs. The level of breastfeeding education and knowledge needed to pass the IBLCE exam is equal, so clinics would not be compromising care. Additionally, non-licensed IBCLCs may save the clinic money as they often will work for a lower salary. Promote the campaign in the community, especially to physicians and hospitals. Encourage hospitals to offer care that promotes early breastfeeding initiation and bonding. Provide ongoing breastfeeding education for peer counselors and WIC staff. Provide clients with access to comprehensive breastfeeding information, whether via print or online. Provide funding for current breastfeeding education materials, including videos and demonstration models that represent current knowledge of breast anatomy. Encourage clinics to develop relationships with community breastfeeding resources such as La Leche League, Black Breastfeeding Association, Breastfeeding USA, Mocha Moms, Attachment Parenting International, etc.

From a peer counselor coordinator:

The *Loving Support* curriculum is engaging and inspiring. It could be enhanced by more fully utilizing additional evidence-based materials, such as Breastfeeding: A Magical Bond of Love.

From a peer counselor:

By creating a net for moms who have no idea of how to find resources or do not even consider finding them. For many of them, the thought process begins when they are contacted by a peer counselor or someone asks, "What are your breastfeeding goals?" Many times it is not on their radar until they are caught by this loving and supportive net!

From a WIC state supervisor:

Fund the WIC Peer Counselor Program so that there will be a minimum of one WIC Peer Counselor in every WIC local agency to provide peer-to-peer latch and position support to all WIC breastfeeding women. Ensure that all local agencies have competent professional authorities with certification to better support WIC participants toward successful breastfeeding up to and beyond 12 months postpartum.

From a lactation consultant:

> My recommendation is to involve all the WIC participants' families, friends, and their community. Stop giving away free formula to everyone.

From a hospital staff member:

> Focus more on the hazards of formula as opposed to the benefits of breastfeeding.

From a WIC client:

> Breastfeeding needs the support of pediatricians and nurses. I have too many friends who were unable to successfully breastfeed mostly because of the advice or recommendation of a doctor or nurse! Parents need to see more information on why breast milk is simply far superior to infant formula. I would like to see breastfeeding addressed on public television. If we run ads about the risks of drunk driving and smoking, why can't we run ads about the benefits of breastfeeding?

From a nutrition education coordinator:

> Add to the messages so that they appeal to grandmothers, fathers, etc. and make those people start thinking of breastfeeding as the first choice for feeding a baby. Add messages that can be used to promote breastfeeding to doctors, clinics, nurses, and hospitals as the first choice for feeding a baby. Include materials to help market mother/baby breastfeeding-friendly care protocols to the above audiences.

From a peer counselor:

> Our peer counseling program has taken steps to network with the local lactation experts to bring better service to our clients. This includes hospitals, independent lactation consultants, schools, and home visit nurses. By collaborating with other community resources, we have been able to make more of a difference with our clients and in a speedier time frame as well. We have also utilized e-mail and text messaging with our clients who are interested. This has been especially helpful with our younger moms who are more comfortable with this method of communication.

From a WIC program:

> Have more specific examples and guidelines for referral to an IBCLC as the breastfeeding expert. The guidelines should be very specific with respect to the job functions of peer counselors.

From a lactation consultant:

> To move this campaign along, there need to be more incentives for businesses to participate willingly. Currently they are being "threatened" by new laws being passed where they have to comply with offering breastfeeding women time/space to pump. What if we offer the businesses a way to hire an IBCLC consultant to help set up and provide ongoing support to their breastfeeding moms?

From a WIC program:

> Review current requirements for breastfeeding peer counselors (BFPCs) to see if updating the qualifications would support women better by making it possible to expand the program. Our state developed online modules for BFPC training. If a national online training existed, it would provide more standardization, and accessibility to training would become more flexible.

From a lactation program coordinator:

> Utilizing International Board Certified Lactation Consultants for education and support of breastfeeding has shown to result in better breastfeeding duration rates for areas.

From a county health department:

> I would like to see more education focused on physicians and the misconceptions they have about breastfeeding as well as more emphasis on appetite and growth spurts and how to help the confidence of the mother regarding milk supply.

From a breastfeeding counselor:

> I've been a breastfeeding counselor for 6 months. I really admire the title "Loving Support." It's when I sound a little less controlling and more interested in caring for WIC participants that I'm more successful.

From a prenatal education coordinator

> Provide (1) consistent professional information/education for all breastfeeding families; (2) support using easily accessible lactation counselors; (3) physical space for lactating moms to pump at their place of work; (4) a healthy point of reference accepting breastfeeding mothers and babies in public places in our society; (5) education for the upcoming generation that breastfeeding is a healthy and normal method of feeding our babies; and (6) monetary support for various breastfeeding advocacy groups and agencies.

From a breastfeeding coordinator:

> Continue to support the Peer Breastfeeding Grant. It has proven very successful in our small county. Make available free large posters of women breastfeeding in a wide variety of settings and in a wide variety of cultures. Make the sight of breastfeeding a normal, natural phenomenon.

From a breastfeeding peer counselor manager:

> The standard would be that all pregnant participants without exception (including those mothers who indicate that they don't want to breastfeed) would have an educational contact with a breastfeeding peer counselor.

From a social marketing consultant:

> My feeling is that you have a wealth of information about possible strategies that could be part of the campaign. But the first most important step for moving the campaign forward, in my opinion, is to do formative research and include testing of the current campaign materials in the formative research. The findings from the formative research will then allow the USDA to select the most appropriate strategies for the campaign, to select appropriate targets and messages, etc. I would then recommend creating a very straightforward logic model that lays out the goal and objectives of the campaign, the strategies you will use, and how you will measure success based on the outcomes you expect. The logic model, if very simple, will be an excellent educational tool for state and local programs.

From a medical center employee:

> Work out a way to include moms willing to pump and feed. There is a small number who cannot breastfeed due to past abuse histories, etc., and they should not be excluded. It can help them mend as well.

Question 2: The original Loving Support Makes Breastfeeding Work campaign was launched in 1997. How can the campaign be improved to better meet the needs of current WIC participants? Specifically, what are key considerations for breastfeeding messages, communication tools (including social media), technical assistance for WIC staff, community partners and collaboration, and changes in laws, policies, and other initiatives?

From a medical school professor:

> So many mothers stop breastfeeding when they return to work. Support for working mothers needs to happen—support in terms of offering materials, tips, guidance, and encouragement. Asking mothers if they are breastfeeding and if it is working is not enough—they may not realize that they are or are not doing it correctly.

From a peer counselor:

> I was trained using the *Loving Support* module. While I feel it was sufficient, I must admit I thought it to be a bit "dated," from the information to the pictures. Also, more emphasis needs to be placed on new ways of communicating such as e-mail, text messaging, and social networking. That said, women still need to have real live communication and contact with other moms, PCs, and LCs in a support group type setting. Whether it be at a clinic or elsewhere, I believe this is crucial to getting the breastfeeding numbers up and keeping them up.

From a lactation consultant:

> Messages need to target today's parents in terms of language and appearance—contemporary images, edgy messages, eye-catching designs. Campaigns need to be multi-faceted, tapping into social media platforms as a means of dissemination. The Text4Baby campaign by Healthy Mothers Healthy Babies is a good example. Expand the WIC Peer Counseling Program and integrate WIC programs and hospital services so that there is seamless care throughout the perinatal period. Change needs to occur not only among mothers, but also among employers, healthcare facilities, schools, faith-based communities, and

state, local, and federal governments, so materials need to be targeted but integrated. Too much time is spent telling people something they already know. We need to focus instead on "You can do this. I can help."

From a WIC nutrition/breastfeeding coordinator:

I feel that the word "support" for many moms is taken for granted. We make the law, we train WIC staff, we collaborate and do all these things, but when it comes down to it, in this society a breastfeeding mom still has to fight for her right to breastfeed. As individuals we may support breastfeeding, but as a *society* we do not "support" breastfeeding moms.

From a medical school:

Although computer technology is popular, I hope that that will not be the focus of this campaign, for we see too many women ignoring contact and interaction with their newborns while they use their cell phones or computers. Somehow the importance of putting children before technology needs to be stressed in this new campaign.

From an IBCLC:

So many mothers have difficulty breastfeeding in the hospital and in the early days. Strengthening messages about getting breastfeeding off to a good start would be incredibly helpful to mothers. Promote ways to make breastfeeding and working easier (tips for expressing milk, bringing baby to work, etc). Inform clients of their rights as employees. Encourage clients to advocate for themselves. Additionally, offer information targeted to specific communities, especially African American, Native American, and Hispanic. Online forums and webinars could be used to provide support to clients as well as to inform the community. Offer accurate info about breast milk storage and handling, amounts that breastfed babies take in bottles, normal infant behavior, needs of the breastfeeding mother, etc. Encourage staff to join or start area breastfeeding coalitions. Promote WIC breastfeeding services through church, community, and civic groups. Provide targeted breastfeeding promotional materials for fathers, grandparents, schools, employers, community leaders, and healthcare providers. Lack of access to accurate, comprehensive breastfeeding information is a barrier to breastfeeding, at least in my community. If every clinic could provide

a breastfeeding class specifically for clients who are returning to work or school, attending the class could be made part of the requirement for receiving a full-size double electric pump, too.

From a peer counseling coordinator:

Include guidance on and tools for social media use and etiquette (e.g., following HIPAA guidelines while using Facebook, YouTube, and Twitter) as well as guidance on how to go about building rapport and collaborating with community partners.

From a nutritionist:

Breastfeeding peer counselors (with IBCLC) in hospital setting to work with moms on first-hour latch, more hands-on staff trainings, and aggressive media and ad campaigns to promote breastfeeding; also increasing community partnerships and collaborations may help.

From a peer counselor:

I am a huge advocate for using technology. Many moms will only connect on a text message agenda, and although many may argue that you just don't have the same communication via texts, sometimes it is the only way to establish communication and provide that support that otherwise they would not be interested in. Establishing communication with lactation consultants at the hospitals where my clients deliver has made all the difference and has had a huge impact.

From a WIC state supervisor:

Provide more advanced training on resolving breastfeeding problems that WIC participants have. Simple, direct breastfeeding messages for WIC participants and the public, including the link to obesity. Social media focus on breastfeeding as the norm for feeding infants. Provide more education on the importance of skin-to-skin contact through the first six weeks to six months of life to stabilize preemies and enhance preemie and full-term infant health outcomes and growth. Better training on breastfeeding problem resolution; funding/support for state breastfeeding coalitions. More laws and initiatives that support WIC breastfeeding women and infants.

From a lactation consultant:

> Prepare women to survive the hospital experience. Most hospitals are a barrier to breastfeeding, as reported by the CDC in the mPINC survey.

From a hospital staff member:

> The Health Care Act of 2010 made time and a place for pumping at work mandated in companies with 50 or more employees This should be shared with WIC participants.

From a WIC client:

> I have to say that the key to my success was accurate information about milk production and babies, but also my mother-in-law works for a WIC program certifying women and children, and she breastfed 3 boys in her day. She came to my home to support me. We cannot give full support over the phone! How can we create a way for WIC staff to support mothers in their home?

From a nutrition education coordinator:

> Key messages: Breastfeeding is the first and best choice in feeding a baby; ways to talk with their healthcare provider and delivery site about breastfeeding; go with more emotion-based messages, messages geared toward a generation of grandparents who chose not to breastfeed, etc.

From a peer counselor:

> Our agency has been given Blackberries, which has made communication with other WIC staff much more efficient. We also have the option of text messaging. This has been very helpful especially when clients deliver and are too overwhelmed for phone calls. We can send quick tips and guidance when necessary. Our teen moms have been much more receptive to this means of communication as well.

From a breastfeeding coordinator:

> USDA needs to redefine breastfeeding. Breastfeeding should not be defined as a woman that breastfeeds once a day. If we are going to impact the populations that are most at risk, we need to send clear messages on the normalcy of infant feeding.

From a WIC program:

> Information that is factual and evidence-based allows the customer to make a more informed feeding choice. Breastfeeding messages that are more risk-based would be more effective; e.g., enumerate the risks of formula feeding. Encourage the use of social media applications such as Facebook and Twitter to connect with moms. In-person contact is great, but many moms are unable or unwilling to connect in that manner any longer due to time constraints or transportation issues.

From a lactation consultant

> IBCLCs need to be reimbursed by insurance for their services. This is the key to increasing breastfeeding rates on all levels, especially among the WIC population, who can least afford the out-of-pocket cost of IBCLC assistance but need the help the most.

From a WIC program:

> A "Text4Baby" format with exclusively breastfeeding messages for moms would be ideal. Any formal policy guidance for utilizing social media formats to support breastfeeding within WIC is appreciated. Breastfeeding messages need to be aimed at supporting duration and be targeted to the areas identified in the Surgeon General's Call to Action.

From a lactation program coordinator:

> I would like to see stronger language to include the International Board Certified Lactation Consultant's role in promoting and supporting lactation.

From a WIC program:

> I think a key breastfeeding message might be not the benefits of breastfeeding but rather the hazards of formula feeding. Community partners: reaching out to middle school health classes. Changes in laws: healthcare reform and tax-deductable pumps would be a major step in the right direction. Make breastfeeding the norm.

From a county health department:

> More emphasis on hospitals limiting formula offered, and increase Baby-Friendly Hospitals.

From a breastfeeding coordinator:

> Make it a law that insurance companies have to cover a certain number of visits with an IBCLC after the baby is born so that if a mom needs help she can get it. Make it a law that formula bags are not allowed to be given out at hospitals. It is unethical, but now is the time to become Baby Friendly. Give personal-use pumps to each WIC mother the last month of her pregnancy. The cost is so much cheaper than formula and would save the government hundreds of dollars from just one doctor's visit alone. Make lactation management an entire mandatory course for pediatricians, OB/GYNs, and family practice doctors, as well as labor and delivery nurses, NICU nurses, and registered dietitians. Get a celebrity to campaign it so that it can become more popular.

From a breastfeeding counselor:

> Many issues crop up in regard to pumping and working, and many participants seem to know all about benefits, but I have trouble getting them to answer until it's too late.

From a breastfeeding coordinator:

> Put some teeth in the law. The small businesses and factories in our area all think they are exempt because pumping is a "hardship" on their business hours. Give WICs more money for IBCLCs and breastfeeding messages.

From a breastfeeding peer counselor manager:

> Use Facebook and Twitter accounts to communicate with moms. Establish a model workplace breastfeeding program in WIC.

From a breastfeeding coordinator:

> I think that prenatal education should be a focus. I think it should be mandatory that all prenatal clients receive an instructional breastfeeding class regardless of whether they plan to breastfeed or not. Performance bonuses for peer counselors would be helpful in retaining effective peer counselors.

From a WIC project director:

> It would be helpful if more representation of breastfeeding moms for the promotional and educational materials included the populations that are least likely to breastfeed (African American women, blue-collar workers, and young teen moms).

From a U.S. Public Health Service employee:

> Cell phones for breastfeeding peer counselors need to be funded.

From an IBCLC:

> WIC mothers need the support to breastfeed most critically in the 1- to 3-day hospital stay. Mothers state their first WIC appointment is in two weeks, but they are losing heart to continue breastfeeding by day 2, especially if the hospital is not providing hour-to-hour bedside support to help mom and baby be successful. How can WIC provide loving support during the critical early hours and days of breastfeeding? Can phone communication or hospital visits be incorporated into the program? Can peer assignments develop a stronger bond prenatally?

From a social marketing consultant:

> These questions are best answered through formative research. Women's circumstances haven't changed all that much (still too busy, still embarrassed to feed in public, still pressured to bottle feed by family and friends). I think the world of technology, and how we communicate with target audiences is where the big change has occurred. We should inquire about preferred communications methods with audiences (WIC-eligibles, medical staff, employers of low wage earners, etc.) in the formative research.

From a peer counselor at a county health department:

> The key is to go out into the community and make them aware. We can post as many posters as we want out there, but the better advertisement is word of mouth.

From a medical center staff person:

> Our WIC offices are different in their education, opinions, how they are run, and what they do to support moms. We need more consistency.

From a WIC program director:

> There appears to be a shifting direction in the program. The concern: Are peer counselors intended to encourage and support mothers, and only directly address (counsel) low-risk issues? Or are they expected to also address more high-risk situations with a mother? I believe future changes in the *Loving Support* Program need to address the "scope creep" that can occur as the peer counselors get more experience and feel more confident in their "scope of practice." Continuing education needs to remain limited to the "normal" breastfeeding condition. Understanding the WIC program does not enrich the peer counselor's knowledge as much as understanding the same struggles that our clients experience. The ideal peer counselor also does not need to be of a similar age as the WIC clients (usually under 30). Our experience has shown that an older woman can provide as much, or more, comfort to a young mother who is having problems. The peer counselor program needs to be more integrated with the WIC Program.