

Efforts to Promote Breastfeeding in the United States: Development of a National Breastfeeding Awareness Campaign

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According to *Healthy People 2010*, which outlines public health aims for the United States, national breastfeeding goals are for 75% of all birthing women to initiate breastfeeding, for 50% to breastfeed for 6 months, and for 25% to continue breastfeeding for 12 months.¹ In 2002, 70% of US women initiated breastfeeding, although only 46% breastfed exclusively during their hospital stay. By 6 months, just 33% of US women were breastfeeding. Rates are lower among low-income and African American women—just 59% of new mothers on the Special Supplementary Nutrition Program for Women, Infants and Children and 54% of African American women initiate breastfeeding.² Concerns about low breastfeeding rates and short breastfeeding duration seen in the United States have prompted efforts to support breastfeeding on a national level. These efforts include reports from the Office of the Surgeon General,^{3,5} adoption of breastfeeding objectives in the *Healthy People 2010* goals,¹ and the development and publication of the US Department of Health and Human Services' (USDHHS) *Blueprint for Action on Breastfeeding*.⁶

More recently, the Office of Women's Health (OWH) in the USDHHS, which published the *Blueprint*, was given the task of creating the first national public health campaign for breastfeeding since 1911. The National Breastfeeding Awareness Campaign's (NBAC's) goals are to increase breastfeeding rates to 75%, to target

African American women and first-time mothers, and to encourage exclusive breastfeeding for 6 months.

The task of communicating the campaign messages to the public was assumed by the Ad Council, a private, nonprofit organization that has relied on pro bono work from advertising companies to produce public service announcements (PSAs) on various issues since 1942. The Ad Council's best known creations include "Smokey Bear" (a character used in an effort to affect behavior associated with fire risk) and "Crash Test Dummies" (characters used to encourage the use of seatbelts). PSAs appear, like other forms of advertising, in print, on billboards, and on TV and radio; however, airtime and print space for the PSAs are donated by the media outlets.

In 2003, the OWH contracted with breastfeeding organizations in 18 US locations to become community demonstration projects (CDPs) to facilitate contact with the local media and dissemination of the NBAC materials. Specifically, funding and training were provided for the CDPs to (1) place the PSAs in local media outlets, (2) create local telephone support systems for breastfeeding women, (3) create local contacts for regional media representatives with questions about the campaign, and (4) coordinate efforts with other regional breastfeeding organizations interested in providing volunteers to help with the campaign.

Originally, the campaign was scheduled to launch during World Breastfeeding Week of 2003. Delays during the creation of the original PSAs pushed the projected launch into November of 2003; however, the release date was delayed again after representatives of the infant formula industry and executive board members of the American Academy of Pediatrics (AAP) raised concerns about the content and approach. When news spread that the infant formula industry was in part responsible for delaying the campaign, lactation supporters and public health advocates began a letter-

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writing campaign calling for the immediate launch of the NBAC in its existing form. Controversy ensued within the AAP after the AAP Section on Breastfeeding and other AAP members questioned the leadership's decision to write a letter opposing the NBAC without notifying or consulting them.

Why the controversy? The NBAC approach was novel for US breastfeeding promotion because the decision was made to describe the risks of not breastfeeding rather than to emphasize the benefits of breastfeeding. Used effectively, this strategy has the potential to change radically the public's perception of breast milk substitutes from "the norm" to a potentially dangerous feeding option. For a new mother, the perception that formula may harm her child would be expected to deepen her commitment to breastfeeding even when she is faced with obstacles. It is not surprising that formula representatives and even some health professionals would find the approach alarming. Given the pervasive use of infant formula in the United States, questions were certain to arise around how campaign messages would be received by the public, particularly by mothers who feel unable to breastfeed due to physical, emotional, or social constraints; those who have unsupportive work environments; or those who have difficult breastfeeding experiences. Currently, there is no specific launch date for the campaign, and several of the PSAs that were originally to have been used have been eliminated. Meanwhile, the language and content of the remaining messages are being reviewed by USDHHS.

While it is easy to dismiss opposition to the risk-based approach, understanding the rationale behind the approach may better serve breastfeeding advocates in the future. It is equally important to be familiar with the process required for a critical evaluation of the relevant scientific literature when discussing the campaign messages with the public, the media, and new mothers.

The risk-based strategy was based on findings from a large focus group research project funded by the OWH. Thirty-six focus groups were convened in New Orleans, Chicago, and San Francisco to supplement existing data. The objectives of the research were to identify (1) perceptions and understanding of breastfeeding and formula-feeding behaviors; (2) key societal, emotional, and rational factors that promote or serve as barriers to breastfeeding; (3) the most compelling triggers to changes in practices; and (4) important target groups and ideal timing for intervention. The focus groups included a high percentage of African Americans and

were composed of expectant mothers, formula-feeding mothers with children younger than 1 year, breastfeeding mothers with children younger than 1 year, expectant fathers, and expectant grandmothers.

Many insights emerged from the research, most of which support results from other studies. Some of these insights were as follows:

- Almost all respondents perceived that breastfeeding was healthier and better than formula, but many thought that formula was "good enough" and not "bad" for the baby.
- Formula was seen as more convenient but expensive.
- Many more mothers intended or wanted to breastfeed than actually breastfed their infants.
- Breastfeeding was seen as "ideal" while formula was "standard" (not inferior).
- Practical and psychological barriers, such as time requirements, employment, fear of pain, fear of insufficient milk, and fear of embarrassment, interfered with breastfeeding.
- Maternal confidence was a factor in commitment to breastfeeding.
- Mothers stated that infant feeding was their decision.
- Fathers and grandmothers influenced duration of breastfeeding in their role as supporters.
- Mothers were guided by and learned from other successful mothers.

Based on the focus groups results, the OWH determined that a risk-based approach was needed to change current attitudes and behavior. This approach has been used effectively to promote car booster seat use⁷ and to decrease smoking among teens.⁸ This approach may be particularly useful when the message is counter to existing product advertising (eg, cigarettes, breast milk substitutes) and when the messages serve to raise awareness of community members as well as members of the target population. For example, the NBAC message (reflecting the importance of breastfeeding) will reach the *general public*, not just new mothers. Research has shown that employers, day care providers, hospital policy makers and staff, and even health care providers can and do present barriers to breastfeeding mothers.⁶ It is likely that many of these individuals believe formula-feeding is essentially a benign decision and other priori-

ties are paramount. Without a clear message that breastfeeding is critical for maternal and child health, it is unlikely that the community and employment barriers faced by breastfeeding women will change. Without significant changes in health care and employment practices, mothers may perceive that the psychological and social "costs" of breastfeeding exceed the financial costs of formula.

When discussing risk related to a common behavior (such as smoking in the 1950s and 1960s), it can be an enormous challenge to change the prevailing attitudes and beliefs about the behavior. The benefits-based message of breastfeeding has been interpreted to mean that breastfed infants are "healthier" than "normal" infants, akin to an athlete being more fit than an average healthy person. By this reasoning, formula-feeding is accepted by the public as "normal," and breastfeeding is an "ideal" that may be achieved only by a select few. With a risk-based message, we are insisting that the public accept that something that well-intentioned mothers do everyday is causing harm to their children. This kind of message will be highly controversial, and those who advocate it must be prepared for heavy opposition.

Any researcher knows that science often gives us more questions than answers. Few disciplines have consistency in outcomes over time. Given a list of reports related to illness rates among breastfed versus formula-fed infants, there will be studies that do and others that do not indicate significant differences between groups. It is important, then, that each study be reviewed with an objective and critical eye. Conclusions must be based on a *preponderance of evidence* from studies that have been *effectively designed* to address the question of interest. In an effort to identify the best evidence of the risks of not breastfeeding, the original campaign messages were based on a systematic selection of studies meeting specific criteria based on date of publication, study design, and the number of participants.

The public and the media are more accustomed, however, to the sound bites and excerpts that they see and hear every day. To present an effective message to the public through advertising media, the science must be distilled into factual, understandable messages that reflect the best and most current evidence we have. Any risk-based message is subject to intense scrutiny by policy makers, clinicians, and scientists. It will be important that the methods used by the OWH to evaluate the literature and create the final PSAs be made available to all members of the breastfeeding community positioned

to address the questions of the public and the media. Supporting evidence will be a powerful tool in this process and can be used on many levels.

One of the NBAC's goals is to increase the numbers of women who exclusively breastfeed their infants for 6 months. Breastfeeding advocates all over the world share this goal.

In practical terms, lactation professionals wishing to help in the effort should contact the nearest CDP once the NBAC launches and offer to share extended support services. Each CDP serves a large region and would be delighted to refer women to breastfeeding classes, for example, or to telephone support closer to home. In addition, regional coalitions or lay support groups can help to place PSAs in their local media, such as a community newspaper, under the guidance of the CDP.

When the NBAC does launch, lactation professionals may be dealing with a double-edged sword: an increase in the number of women wishing to breastfeed means an increased need for support from a system that is already overburdened and, many would claim, far from effective. It would be wonderful if the NBAC would bring with it additional breastfeeding-related resources for hospitals, education, and employers. Given that many more women in the focus groups wanted to breastfeed than those who did, increasing support sounds like a logical next step. However, apart from the basic resources offered by the CDPs, which consist primarily of a telephone support line, classes, and, in some regions, peer counselors, providing additional support will fall to maternal child health professionals already working in resource-constrained environments.

In a profession in which many already feel overextended and frustrated, the inclination may be to declare that while the NBAC may encourage more women to breastfeed, the lack of support services will only mean more women will be disappointed. However, as more and more women breastfeed, more women will be available to support and encourage each other through the sometimes difficult early days, more women will demand increased knowledge and support from health care providers, and more women will pass on the rediscovered tradition to their daughters. Eventually, greater need will lead to improved support from personnel and systems, challenging the legacy that has resulted from a half century dominated by a formula-feeding culture.

Although the current controversy has delayed the NBAC, it has brought breastfeeding into the media, raised public awareness, and galvanized the breastfeed-

ing community. The NBAC launch will represent a major step forward for breastfeeding advocacy in the United States. While the debate about the content and tone of the message will doubtless continue beyond the launch, the discussion will serve to strengthen the position of breastfeeding as the “normal” method of infant feeding. As the interest in breastfeeding increases, researchers, clinicians, and policy makers will need to determine what policies and practices must be in place to effectively support women who choose to breastfeed their infants. However, given the competing financial interests that exist for members of the formula industry, their voices should not be part of this process.

Appendix

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