

Rebranding Breastmilk: Social Marketing in South Africa

Shannon Kenny, Professor Anna Coutsooudis and
Patrick Kenny

Introduction

After years of improvement the infant mortality rate worsened from 1995–2003 in South Africa, reversing some of the gains achieved in previous years. Much of the literature attributes this rising mortality to HIV/AIDS, but the response to that pandemic may have had other, negative effects that have had wider health repercussions on the South African community.

It is difficult to attribute causality in studies about the effect of breastmilk on babies, because of the complexity of the confounding variables. The behaviours of a mother who breastfeeds may be typically different to one who feeds a baby commercial infant formula;¹ these behaviours may affect the child in other physical and psychological ways than are direct results of the breastmilk. There are many factors contributing to the health of an infant. However, the best evidence we have so far has proven that breastmilk offers babies extra gastrointestinal protection against infection, which is a serious concern in sub-Saharan Africa. Breastmilk plays a great role in countering malnutrition, as it provides infants with the right amount of protein, fat, sugar and vitamins, in a digestible form. It also avoids the many dangers of formula feeding: poor quality water; poor formula preparation leading to nutritional deficiency; contamination of milk bottles with faecal bacteria (a small study in 2007 found 67% of clinic samples and 81% of home samples were contaminated (Andresen et al. 2007)).

In 2009, the World Health Organization revised its principles to recommend that breastfeeding is best, including for mothers who are HIV-positive (if they are on anti-retroviral medicine), and their Global Strategy for Infant and Young Child Feeding

¹ Formula: industrially produced substitute for breastmilk. Sold in powdered form, formula needs to be prepared with water for consumption by the infant, and contains dairy and/or soy protein as some of the main ingredients. Formula attempts to duplicate the properties of, but is nutritionally inferior to, breastmilk.

recommends that infants start breastfeeding within one hour of life. Unfortunately, South Africa still has one of the lowest exclusive breastfeeding rates in the world. Formula feeding is prevalent in South Africa for complex reasons: because it has been distributed at no cost, by public health bodies, through a 'prevention of the mother-to-child transmission' (PMTCT) of HIV programme; the support of formula milk through the Government's protein-energy malnutrition scheme; inherited cultural practices; and because it has been actively marketed using unfounded claims that the formula milk contains special ingredients that improve baby's health.

The team referred to in the rest of this chapter are working on a project to develop a social marketing strategy to rebrand breastmilk in South Africa, as a counterweight to the prevalence of formula feeding. The team is made up of the authors, along with researchers/lactation consultants and a marketing consultant, all of whom are volunteers. We have, in the development of the rebranding exercise, consulted with parents from various walks of life, policymakers, funding agency representatives, members of the media, private-sector representatives, researchers and health care workers. In addition we have kept a close eye on the media (print, broadcast and digital) to gauge public opinion and how it is being shaped.

Our position and the context for the challenge

Throughout this chapter, we set out our viewpoints and our agenda plainly and clearly. Our position is as follows: exclusive breastfeeding (with ARV prophylaxis for HIV-positive mothers) should be the default feeding option. Infant feeding decisions affect all members of society – regardless of culture, gender and socioeconomic status.

South Africa is among one of the top ten countries with a high infant mortality rate of 40 or more deaths per 1000 according to the *United Nations Progress Report* (UNICEF's Division of Policy and Strategy 2012). At an average rate of 47 deaths per 1000 live births, we do only slightly better than Rwanda (54) and slightly worse than Namibia (42), which are both significantly poorer countries economically. Among the other countries in the top 10 are Cambodia, Zimbabwe, and Senegal, which are significantly more resource-deprived than South Africa (a member of the G20 countries). Preventable diseases, largely pneumonia and diarrhoea, cause most of the morbidity and mortality and significant evidence (Bhutta et al. 2013) in recent years suggests that increasing rates of exclusive breastfeeding will be a major factor in reducing infant mortality rates – in South Africa and globally.

The majority of South African infants are born into impoverished conditions where access to clean running water and sanitary conditions is limited and sometimes non-existent. Under such conditions, the use of formula puts infants at great risk of contracting the diseases that are a major cause of death and illness. The single most effective intervention to save the lives of millions of young children in developing countries is the promotion of exclusive breastfeeding (Jones et al. 2003). Even for infants born into affluence, where they have access to good healthcare, where formula

can be prepared safely and the risk of infectious disease is considerably reduced, breastmilk is still shown to be the best form of infant food, aiding in the child's development and considerably reducing the prevalence of early childhood death. Compared with the use of breastmilk substitutes, breastfeeding has been consistently shown to reduce infant morbidity and mortality associated with infectious diseases in both resource-rich and resource-poor settings, particularly in the first months of life (Black et al. 2003), because of the transferral of gastrointestinal antibodies.

In August 2011, the Tshwane Declaration – by South Africa's National Minister of Health, Dr Aaron Motsoaledi (Motsoaledi 2011) – tabled a commitment by the South African government to reposition, promote, protect and support breastfeeding as a key infant survival strategy through the implementation of appropriate policy, which included full adoption of the World Health Organization's International Code of Marketing of Breastmilk Substitutes (World Health Organization 1981), which aims to protect and promote breastfeeding by ensuring appropriate marketing and distribution of breastmilk substitutes.

In light of Anna Coutsooudis' discussions with various policymakers, researchers and advocates – before and after the Tshwane National Breastfeeding Consultative Meeting – which revealed that there was no proposed mass communication strategy to accompany the government's new policy position, our team decided to seize upon the momentum created by the government support. 'The People, The Planet, The Can', became the beginning of what we hoped would be an ongoing campaign to rebrand, encourage, promote and support breastfeeding through public service announcements on various media channels.

While some policymakers have agreed that an effective communication strategy to accompany the government's commitment is necessary, there is still a battle, so to speak, for the 'hearts and minds' of policymakers, their funding partners (the South African Department of Health is heavily dependent on funding from non-South African government funders) and the public (who are often the recipients of confused messages around infant feeding).

To put the challenge in context, only 8% of mothers in 2003 fed children exclusively and extendedly (that is, breastmilk only, with no complimentary solids or liquids for the first 6 months) (Department of Health et al. 2007). In 2008, only 25.7% of children under the age of six months were reported to be exclusively breastfed; 51.3% were mixed-fed (both breastmilk and formula or other substances such as tea, water or porridge); the remaining 24% were exclusively infant formula fed. (Shisana et al. 2010).

The current challenge to rebrand breastmilk is multi-faceted. The contributing factors influencing this low rate range from inadequate maternal counseling, to misinformation, social stigma, traditional medicine practices, insufficient maternity leave and unsupportive work environments and social networks, as well as the effect of and the successful marketing of breastmilk substitutes by the commercial formula

industry. These factors have been acknowledged by government policymakers and Dr. Motsoaledi's declaration especially highlighted the marketing of breastmilk substitutes.

Presently, our challenge is not only to rebrand breastmilk and breastfeeding, but to convince policymakers and their funding partners (who have a say over how funds are spent) that the communications effort – that is, the rebranding and social marketing exercise – is crucial to the successful and continued uptake of this policy.

Despite a recent increase in the availability of infant feeding counseling at hospitals and clinics countrywide and the training of healthcare workers in this regard, there is still a general ignorance about the facts of breastmilk and breastfeeding, and social stigmas still exist in the mind of the general public across cultural and economic strata – demonstrating that communications so far have been less than effective.

There has been a general trend to communicate health issues – especially those directed at the poorest of the poor (who are most affected by disease and mortality) in a didactic, informative, and often unentertaining and unattractive, manner. Often the promotional material in the public health sector (which is utilised mostly by the poorest in the population) is viewed as cheap and of lesser quality than other lifestyle advertising they see in magazines and on television. Infant formula advertising – in print, in online magazines and catalogues, and in other visual media – has been presented as an attractive lifestyle choice while breastfeeding has been regarded as inferior. As research into decisionmaking and behavioural economics has shown, the design and frequency of advertising and promotional material play a large role in whether messages are accepted or not by an audience.

If the facts are not faulty, the presentation of those facts must change

Traditional public health campaigns have often focused on a specific category of person or economic sector and, in South Africa, this is often the poorest of the poor. This focus suggests that certain health issues and messages were meant exclusively for poor people.

Our team understand that breastfeeding needs to be addressed as a public health issue that affects all South Africans, rich and poor. It is not a practice that we only need to encourage the poor to adopt, for fear of their children dying.

Breastfeeding promotion material in South Africa has, until now, been lacking in knowledge about motivations. We know that people, regardless of whether they are in the poorest or wealthiest groups of society, are more easily convinced to make lifestyle choices based on the promise of emotional satisfaction than on dry facts about health benefits. Commercial advertisers create a need or desire for a product and then, in a process of post-purchase rationalisation, provide further education and more in-depth facts that validate that desire. This approach offers valuable and

urgent lessons for future communications for breastmilk and breastfeeding, and for social marketing strategy in general.

The initial strategy

‘The People, The Planet, The Can’ started life in early 2011 as a multimedia communication strategy for effective breastmilk marketing that would ultimately affect and effect a culture change. It recognised the need to involve all of society (not just women and expectant mothers) and sought to convince them of the facts by addressing their aspirations. It can be summarised as a 3-pronged ‘hearts and minds’ strategy to present breastfeeding and breastmilk as normative and desirable, to generate a public conversation around the issue, and to create a demand for breastmilk.

- **The People.** Most importantly, we recognised the issue as a public health issue in a non-traditional way. Traditionally (because this particular health issue affects them most clearly) poor and low socioeconomic status mothers had been the primary focus of education and information campaigns. However, we believe that the issue needs to be something owned by South Africans in general, not just certain individuals or a certain socioeconomic group. South Africans – men and women, whether parents or not, young and old – would be presented with images and messages that showed breastfeeding in a positive light, and which united an ethnically and socioeconomically diverse population around the issue.
- **The Planet.** This aspect focuses on the socioeconomic cost-benefit analysis (breastfeeding does not cost money and is therefore more cost-effective than formula), presenting breastfeeding as a part of a broader conversation, locally and globally, around food security (breastfeeding as a sustainable resource, not dependent on markets), climate change (breastfeeding is ecologically sound), and humanitarian/social responsibility (suitable breastmilk can be shared with and donated to those who lack access to it).
- **The Can.** This element focuses more directly on the nutritional and remedial superiority of breastmilk over any other infant food products, as well as tackling – and holding up for scrutiny – the myths and inaccurate information promoted by the formula industry.

As a first step to generating a public conversation around the issue, our strategy aims to address South Africans as equals in a variety of public service announcements (PSAs), in order to create a desire for breastmilk and, ultimately, to help them to make the best infant feeding choice.

We defined some common values and aspirations that transcend gender, culture and socioeconomic status, and drew out some of the myths and taboos around breastfeeding, and then used these as the guide for the development of the campaign and the PSAs. The development process was informed by evidence-based research

around breastmilk and breastfeeding in South Africa; information gleaned from focus groups we had conducted; conversations with parents who had exclusively breastfed, mix-fed or exclusively formula-fed their infants, as well as conversations with people who were not parents, to gauge their attitudes to, and knowledge of, breastfeeding.

Key questions for researcher-communicator teams

The campaign provoked some important questions:

- What are the key characteristics, if any, of a healthy researcher–communicator partnership?
- How does the relationship between policymakers and their funding partners (i.e. aid agencies/foundations; private sector/business partners) affect policy implementation, communication and uptake?
- How can the media (press, broadcast, digital and social media) be used effectively to influence uptake of an idea?

As a researcher/communicator team, we are of the belief that at the heart of a desire to effectively communicate complex research ideas to policy-makers should lie the knowledge that these ideas and findings ultimately will need to be communicated to civil society and that, where possible, a clear communication strategy for this needs to be outlined. Our researcher-communicator team shares an understanding that research communications intended for policymakers should actually have civil society (the public) at large as their ultimate, and proper audience. From our experience of researcher-communicator collaboration, we have learned that:

- Communication is *dialogue*. Constant critical evaluation and review of the communication methods chosen is necessary. This means humbling ourselves to admit what and when we got it wrong, or that we could do it better or in a different way when presented with new evidence.
- Communication is a *process*. There has to be a long-term commitment to creating and refining the communication methods and tools employed. We have to recognise that no single strategy, method or medium will be appropriate for all contexts and, sometimes, getting it right will require taking an opposite view or looking at the successes of one's detractors.
- Communication is *equitable*. Policymakers, as well as their funding partners, are as much a part of society as any other member of civil society and are therefore influenced by prevailing cultural norms, advertising, and promotional materials. Therefore, when communicating ideas that come into conflict with a prevailing cultural norm, researchers and communicators need to take into account that the facts accompanied by a strong emotional argument will be more persuasive than mere facts.

- Communication is *partnership*. An effective communication strategy may require leverage: creating partnerships with individuals or organisations that have resources (skills and/or funds) lacking in your own team.
- Communication is *subjective*. How we, as researchers and communicators, perceive people will influence how we address them: we are stakeholders in the process.
- Communication is *important*. What and how we communicate ultimately affects the lives and decisions of people – individuals, families, communities, nations – and in this specific case, is a matter of life and death.

People's stories are important. Throughout our experience we have chosen to look at the stories behind the statistics – the lives of the people who are affected by policy decisions, communication and marketing strategies, as well as the experiences of individual policymakers and funders. These stories are what have shaped and continue to shape how we address our audiences.

In order to better understand and more effectively achieve our goal, it has been important that we understand the perspectives of the various players who ultimately affect the policies and practices we wish to change; it is this context that has defined how we should proceed.

Team history and initial research

In November 2000, the first iThemba Lethu transition home, was founded in Durban by Anna Coutsooudis (a researcher) and some friends, in response to the growing number of South African children orphaned and/or abandoned as a result of the HIV/AIDS pandemic. The funding came from the United Nations Children's Fund (UNICEF). The aim of the transition home was to accommodate and nurture infants in transition – until their adoptions are finalised and they were placed with permanent families – rather than to institutionalise them for the duration of their formative years.

In addition to the Family Integration Programme (of which the transition homes are part) iThemba Lethu also conducts an HIV Prevention Programme (a youth, parent and teacher programme), piloted through local schools with at-risk children.

Significantly impacting the futures of these young lives also meant providing them with the best form of nutrition. In light of Anna Coutsooudis' extensive research and work in the area of infant and maternal health and nutrition, breastmilk was the most obvious choice.

In August 2001, under the auspices of iThemba Lethu, Anna Coutsooudis opened the iThemba Lethu Breastmilk Bank, South Africa's first community-based breastmilk

bank, with funding from UNICEF. Suitable candidates were screened, and the donated breastmilk was stored. Where possible, donor mothers were matched with infants of the same age as their own children. The impact on the health of the infants (both HIV positive and HIV negative) was remarkable and iThemba Lethu has, since then, prioritised nourishing the 0-6 month old infants in its care exclusively with breastmilk. Initially started as a repository for the iThemba Lethu transition home only, it has grown in capacity and now donates milk to infants at other institutions (where possible), and has been the seed-bed for the establishment of breastmilk banks in the region and around the country. Anna Coutsooudis and Penny Reimers, a researcher, lactation consultant, Director of the iThemba Lethu Breastmilk Bank and a Human Milk Banking Association of South Africa (HMBASA) member, have assisted in establishing milk banks at hospitals in Durban, as well as other facilities across South Africa.

The other authors' (Patrick Kenny's and Shannon Kenny's) involvement with iThemba Lethu began through their friendship with Anna and other staff and volunteers with the organisation. As trainers and facilitators, they offered communication training to the iThemba Lethu youth workers in the schools-based HIV Prevention Programme.

A researcher-communicator team needs a convincing pitch

Initially, the benefits of the approach (to eschew formula for donated breastmilk) were not clear to all. While understanding the need for the transition home as a social intervention, and the importance of ensuring that children were nurtured in families rather than institutions, Shannon Kenny in particular questioned the need for a breastmilk bank and donors – especially when breastmilk substitute (formula) was readily available and – to her knowledge – equal to the task of nourishing the infants in iThemba Lethu's care.

Anna took the opportunity to invite Shannon to see for herself. Infants had been received into iThemba Lethu's care who were malnourished, sickly and neglected. Anna introduced the Kennys to a variety of research, providing evidence for breastmilk's biological superiority over breastmilk substitutes, as well as the psychosocial advantages of breastfeeding. Some of the literature provided insights into breastmilk and breastmilk substitutes within different cultural contexts, and the traditions, taboos, myths and social attitudes associated with these practices. Further evidence for the argument in favour of breastmilk feeding came from Anna's own research within the context of the HIV/AIDS pandemic (Coutsooudis et al. 1999; 2001). Shannon and Patrick further studied the history of formula, the marketing practices of manufacturers and the socioeconomic reasons for its proliferation and ubiquity as an alternative to breastmilk (Baumslag and Michels 1995).

In addition, Anna and Penny presented their personal experiences of having breastfed their own children and described how, before the HIV/AIDS pandemic, breastfeeding and wet-nursing had been quite a normal part of the experience of many South African women. With their curiosity piqued, Patrick and Shannon started to look at various approaches to breastmilk and breastfeeding promotion worldwide.

It must be noted that, within the Kennys' largely middle- to upper-middle-class social circles, comprising working and stay-at-home mothers, mixed feeding or exclusive formula-feeding was still the accepted norm, with very few exclusively breastfeeding for 6 months and even fewer continuing for longer. At the same time, a growing number of people known to the Kennys were becoming parents and some were choosing to exclusively breastfeed their children.

Noticing these two trends (mixed and exclusive formula feeding on the one hand; exclusive breastfeeding on the other), they set about discussing with these various parents the reasons for their choice to either breastfeed or formula feed. One of the first breastmilk bank donors, Shirley, and her husband, Patrick, were friends of the Kennys'. Shirley and Patrick allowed their youngest son to breastfeed until the age of 3 (when he self-weaned). They shed light on the social attitudes their choice had generated, attitudes that would range from the mildly curious, to the supportive, to disapproval.

Shirley saw donated breastmilk as a form of humanitarian aid; and this further encouraged her to participate. Shirley had been matched with an orphaned boy who was a similar age as her youngest son, whom she was breastfeeding at the time. In her own words, the value of knowing that another child was able to benefit as equally as her own son from something unique to her – her breastmilk – was immeasurable. The increase in milk supply that she experienced as a result of expressing more milk every day also helped her to encourage other mothers, who felt that they were producing insufficient milk (a common misconception) for their own children, to continue to breastfeed exclusively. Shirley also recounted her experience as a donor to her son and he, too was able to share in his mother's experience and, Shirley believes, understand his role as part of a humanitarian aid story.

Anna's knowledge of different social contexts, for example, the National WIC Breastfeeding Promotion Programme in the USA (Lindenberger, Bryant 2000) and the LINKAGES Project in Madagascar (WHO 2003), where social marketing of breastmilk and breastfeeding had worked as an agent of change convinced her that social marketing would be a route to culture change in South Africa. The LINKAGES Project is of particular significance because the programme uses a combination of interpersonal communication strategies, group activities, and media to change individual behaviour, while at the same time educating and engaging those who influence mothers' choices. The programme saw significant behaviour change over a relatively short space of time: 45%–47% exclusive breastfeeding at start of programme to 68% within one year and 79% the following year. (WHO 2003). Shannon and Patrick had experience marketing commercial products to a public audience, and so had a good understanding of the dynamics of well-coordinated marketing strategies.

Shannon and Patrick Kenny began to look at their journey from ignorance to knowledge about breastmilk and breastfeeding and the key contributing factors. Their ignorance stemmed from, especially in Shannon's case, a society where exclusive

breastfeeding was mostly unheard of and where formula and mixed-feeding was perceived to be a scientifically sound and modern choice. An even bigger factor was that they were not parents or directly involved in any significant way with infants, so even the issue of infant feeding would not factor into their daily lives. Their interest in the subject came from their involvement with iThemba Lethu and their friendships with Anna, Shirley, Patrick and others, and their curiosity about the breastmilk bank. The body of scientific evidence in support of breastfeeding and breastmilk, weighted against opposing views, was of particular significance.

They had established relationships with, and had access to, experts and researchers in the form of Anna, Penny and their colleagues (with whom they could consult, raise concerns and seek advice) and a growing community of parents who were choosing to breastfeed their infants. Just as important as the published research was witnessing, first hand, the effect of breastmilk alimentation on infants in iThemba Lethu's care. However, it seemed that, away from the experts, researchers and niche media targeted at prospective parents, sound information on breastfeeding was not very accessible.

Social marketing for public health

Policies in isolation, which are not accompanied and supported by an implementation strategy and appropriate support mechanisms, are ineffective as an agent of any significant individual behavioural or wider societal change.

We see social marketing as one such implementation strategy. While there is some support globally for social marketing as effective health interventions (Kotler, Roberto and Lee 2002), ours is the first clear communication strategy around the social marketing of breastfeeding and breastmilk within the context of South African policy. Having a clear communication strategy, however, is no guarantee of its implementation. Obtaining funds for social-marketing communication and education approaches has been a challenge. While the team recognised that doing things differently in a resource-strapped environment could be a costly experiment and carries significant risk, we took our cue from the success story of Brazil (Rea 2003; Perez-Escamilla 2011).

In Brazil, supportive political will has led to sound policy accompanied by a sustained social marketing campaign, which has significantly driven their high rate of exclusive and continued breastfeeding as well as the high degree of knowledge about breastfeeding in society in general (Rea 2003). In turn, this has been linked to a dramatic reduction of their infant mortality rate (Perez-Escamilla 2011).

The common denominator in these instances seems to have been the close collaboration of researchers, communicators and policy-makers, working with and through individuals, communities, organisations and businesses.

Specifics of the South African situation

Breastfeeding and HIV

In the past, as a result of the HIV/AIDS pandemic and prior to government supplying access to Anti-Retroviral Therapy, breastmilk and breastfeeding acquired a stigma as a conduit for the transmission of HIV. Free formula was supplied at clinics and hospitals to feed infants whose mothers were HIV-positive. Research, however, has shown that a mother who is HIV positive and on the appropriate Anti-Retroviral Therapy can exclusively breastfeed her baby safely without transmitting the HIV Virus (Langa 2010; Coutsooudis et al. 1999).

KwaZulu-Natal was the first province, in January 2011, to stop supplying free formula at clinics and hospitals, only dispensing formula on a need basis, i.e. in cases where there is no access to suitable breastmilk as well as ramping up its training of healthcare workers in infant and young child feeding. Anna, Penny and fellow researchers' lobbying involved making appointments to see the Department of Health officials and to provide them with up to date evidence on the dangers of formula feeding. Some of the information was from their own as well as international research. Anna believes that the most important reason for success has been her and her colleagues' international credibility as scientists and that they were part of the consultative groups on infant feeding. This made it easier to ensure that government would listen to them. Anna continues to provide evidence to the DoH and write policy briefs, and writes scientific papers and appears in interviews on TV, radio and in the press. There are also efforts to establish breastmilk banks at provincial hospitals across KwaZulu-Natal, spearheaded by HMBASA in partnership with the DoH. Anecdotally, according to Dr S Dhlomo who heads the Department of Health in KwaZulu-Natal, this policy has resulted in an increase in the number of exclusively breastfed infants and a decrease in the number of children admitted to hospitals with diarrhoea and respiratory diseases.

The spectre of HIV looms large in South Africa. KwaZulu-Natal, in particular, is the province with the highest rates of HIV and tuberculosis in South Africa. The subject of breastfeeding and HIV has developed into a highly emotive debate because of the polarisation between those whose mandate is preventing the spread of HIV, and who therefore stress the importance of replacing breastfeeding, and those whose mandate is child survival, who promote breastfeeding as one of its pillars. Furthermore, infant feeding, and breastfeeding in particular, remains a contested area in the scientific community, with studies by researchers on either side of the policy debate. Some argue that the latest South African Government policy is shortsighted, unconstitutional, retrogressive, and are dismayed at what they perceive to be the lack of response from clinicians and civil society (Saloojee et al. 2011). Others argue just the opposite (Kuhn 2012).

However, policy makers at the South African Department of Health have now not only accepted this body of evidence, but are looking at how the promotion of exclusive breastfeeding could relieve the already strained health system of a considerable disease and financial burden.

Social attitudes to breastmilk and breastfeeding

According to the lactation consultants who were interviewed (who regularly meet with mothers at hospital-based support groups and in non-clinical environments), the factors that explain the low rate of breastfeeding include ignorance and little or no counseling by paediatricians and other clinical staff with regard to infant feeding; little or no encouragement for mothers to initiate breastfeeding within the first hour from birth; and infants being fed formula and/or sugar water in hospital nurseries by clinical staff without the knowledge or permission of the mother.

Economic and employment factors include inadequate (or in the case of some casually or informally employed mothers, non-existent) maternity leave; lack of childcare facilities at or close to the workplace; no storage facilities (namely, fridges and containers) at workplaces for lactating mothers' expressed milk. An unsupportive working environment was what most working mothers cited as a barrier to continued breastfeeding (Bester 2006).

Myths and taboos also play an important role. Talking to mothers, focus groups and lactation experts, we encountered the following myths:

- breastmilk is inadequate at fulfilling all an infant's nutritional needs and therefore needed to be supplemented with herbal preparations, sugar water (also in Kassier et al. 2003), or porridge;
- formula is better nourishment for a baby;
- formula is what progressive, affluent people feed their children and, conversely, breastfeeding is what poor people do because they cannot afford formula.

Breastfeeding is a largely invisible practice in public. Among parents who chose to feed their babies formula, many mentioned the convenience and how it saved them the embarrassment of breastfeeding in public. One very rarely sees mothers nursing their infants publicly; on exception, it is noticed precisely because of its relative absence.

There have been stories in the press, and in local communities, of malls discouraging the practice of breastfeeding in public, instead encouraging mothers to use unhygienic toilet facilities, which have been set aside as baby feeding areas. Public responses seem to have been sympathetic to the mothers' cases.

Parents using formula extol the inclusiveness that formula offers: the father is able

to participate in the feeding of the child, at the same time relieving the mother of the tedium of feeding and allowing her rest, whereas this is not an option if the mother breastfeeds exclusively. These parents also asserted that formula feeding allowed for the greater involvement of grandparents and other carers within the parent/s' support system, especially when mothers needed to return to work.

However, there is still information in circulation that explains to some extent why breastmilk does not enjoy the same social status as formula. In a popular South African-authored baby book, which is generally very pro-breastfeeding, a nutrient table comparing the amount of nutrients in equal portions of breastmilk and formula reveal a significantly higher proportion of nutrients in formula than breastmilk (Otte 1997). This unexplained table indicates that formula is significantly more nutritious than breastmilk. The accompanying text, professing that breastmilk is perfect for babies, does not explain that the disproportionately high mineral content in formula is potentially harmful to the baby's kidneys and gut, as the infant does not have the facility to digest the nutrients in the quantities it is ingesting them.

'Breast is best' is a well-known, and well-worn, motto of the pro-breastfeeding movement. It is a statement that formula manufacturers are required by South African law to print on formula packaging, and in advertising their products. However, the close relationship between this slogan and the formula companies that publish it renders it at best empty, at worst hypocritical, and so it has become somewhat inconsequential as a communications message.

The media's response to the Tshwane Declaration

The media plays an important role in defining the attitudes toward breastfeeding in South Africa. One of the country's most prominent weekly newspapers, the *Mail & Guardian*, featured two articles in response to the Tshwane Declaration hailing it as impractical (Malan 2011). Anna and her colleagues responded to the reports in a follow-up article in the *Mail & Guardian* (Doherty et al. 2011), which outlined the arguments to support the policy.

But the debate has continued. Almost a year after Tshwane, a daily newspaper ran another story decrying the government's efforts to implement the WHO code and restrict the marketing of formula (Naidoo 2012b). Once again, the team responded with a detailed explanation of the importance of protecting breastfeeding and the rights of the child (Coutsoudis et al. 2012).

Other media have also been involved. One of the country's largest national radio stations had their DJs and personalities discussing the declaration – mostly in negative terms. The broadcasters' point of view was that the new policy was unsupportive of working mothers and that the policy was depriving poorer women (who relied on free, government sponsored formula) of the right to choose how they could feed their babies.

Media representations of breastfeeding and formula feeding

The most pervasive image associated with infant feeding in mainstream print and other visual media is of the bottle, which is, in turn, associated with formula feeding (phdinparenting 2011). Breastfeeding images in South Africa have often been of poor women in rural settings. Attractive, aspirational images of formula feeding, on the other hand, have been, and still are featured prominently in popular media, from movies to soap operas to parenting magazines, and even children's toys and their packaging. .

Breastfeeding, however, seems to feature most prominently and almost exclusively in baby and parenting magazines, where it shares space with glossy adverts for infant formula and 'growing-up milk'.

That said, breastfeeding has become a permanent feature in these print magazines and their online versions, with articles and sound advice being dispensed by lactation consultants, sometimes accompanied by attractive, positive images. It also features on the websites of some private healthcare providers in articles and content aimed at prospective mothers and lactating women. Still, most of this content is rather dry and in our opinion, not particularly encouraging. While skirting obvious regulation-flouting by not advertising formula for infants below six months, manufacturers are now concentrating marketing efforts on their 'growing-up milk' or 'follow-on formula' products.

Since articles on breastfeeding and adverts for formula jostle for attention, the sheer volume and ease with which lifestyle-oriented formula adverts are digested do win out over articles on breastfeeding. The reader is still, therefore, served with conflicting messages, and perverse incentives.

On state-owned, free television breastfeeding has been represented in news reports and feature films. In news reports, the most prominent breastfeeding-related images are of rural or impoverished women. Among these was the ubiquitous image of the malnourished African mother and her malnourished child accompanying news items on famine and or aid. The feature films have shown the act of breastfeeding to be either comical or slightly strange (for example, *Grown Ups*). One TV series from the US (*Six Feet Under*), which had been aired on South African television, had an eccentric main character who exclusively breastfed her infant for the first six months and then continued breastfeeding past that period. *Soul City*, a South African TV drama series aimed at educating the public on various health issues, specifically HIV/AIDS, did deal with breastfeeding. However, in other non-education-related South African television shows, breastfeeding did not feature and formula feeding was represented as the norm.

South Africa's biggest-selling weekly English language magazine – with a readership of over 2.5 million – featured nine different articles and comments related to breastfeeding between September 2011 and August 2012, compared to five for the

same period the year before. Two of the articles portrayed breastfeeding in a negative light. One was a comment by a celebrity about how breastfeeding had destroyed her breasts; in another parenting-related article a reader felt that extended breastfeeding was harmful to a child's development (Naidoo 2012a). Most of the articles featured celebrities and mentioned their breastfeeding experience as beneficial to mother and child, tiring but rewarding, and helping the mother to lose weight (*You Magazine* September 2011–August 2012).

Formula manufacturers have also been very adept at pushing the boundaries of advertising regulations, by supplying paid-for editorial content (advertorial) which promotes their products. One such example was a formula brand promotion in an in-flight magazine that acknowledged that 'breast is best' and then went on to tout the convenience of their product over breastfeeding.

The private sector's position

Private healthcare providers (insurers) provide their customers with access to advice, education and counseling on infant feeding and breastfeeding through their various health-plan offerings. These services are covered by monthly premiums paid for by the customer. Whether or not the customer makes use of these services will largely depend on whether these services are included in the premium payment or not.

Some manufacturers of baby products such as Johnson & Johnson also are active in making available and sponsoring advice on breastfeeding, as are private hospitals and clinics who regularly host open days. These are free to the public and, especially since August 2011, lactation consultants are brought in to dispense advice on breastfeeding and optimal infant feeding. Some private hospitals have even partnered with government hospitals to provide advice and resources and to encourage and assist in promoting breastfeeding. Private hospitals and clinics also host antenatal classes, often presided over by a midwife and or lactation consultant, who will provide advice. While this may seem promising there was still, at time of writing, a tendency across private sector clinics and healthcare workers to advise mothers to start introducing complementary foods for infants from 4 months old.

Medela, which has a market presence in South Africa, is a manufacturer of breastpumps and a leading researcher and developer of products that support breastfeeding. The company dispenses free breast and infant feeding advice to expectant mothers via its website. Medela was accused of violating the WHO Code in the US and Canada (because it promoted its BPA-free bottles and teats). In a public statement, Michael Larsson, Chairman of Medela's Board of Directors apologised for the company exercising less than optimal judgment in the marketing of their BPA-free products and emphasised the company's commitment to developing the best products to support breastfeeding (Larsson 2009).

Formula manufacturers also have a hand in providing advice on breastfeeding. Nestlé, the largest producer of formula in South Africa and worldwide, has a

statement on its website indicating its commitment to promoting breastfeeding; however, this is contradicted by Nestlé's continued efforts at marketing its products: from carefully placed print advertisements, sponsorship of events and product placement. Nestle, while the largest, is not the only manufacturer that claims to support breastfeeding on the one hand and then actively markets its products as equal to breastmilk, on the other. Nestlé's empire was built on infant formula (Hill 2003). Promoting breastfeeding while simultaneously marketing an opposing product again renders the impact inconsequential.

The rebranding process: if at first you don't succeed, try and try again

What factors actually affect people's decision to breastfeed? We realised understanding the facts around breastmilk and breastfeeding would not be enough, especially because it was a subject so fraught with controversy. What would positively or negatively influence people's reaction to the subject, what would pique their curiosity and what would make an impression on them?

For the development of 'The People, The Planet, The Can' in 2011, we started looking at breastmilk as a sellable 'product' and breastfeeding as a sellable practice, but not in the sense that breastmilk or breastfeeding should be sold for monetary gain. How did we reconcile this 'product' approach with our opinion that breastmilk is a precious substance and breastfeeding an invaluable practice and that their actual worth should not and cannot be measured monetarily? Well, if a person makes an economic decision to breastfeed exclusively, and not resort to substitutes, there will be long-term measurable, financial gains. As well as positioning breastmilk as being of better 'value' for babies and parents, we were also experimenting with sales techniques, that is, creating a complex of meaning around a product (breastmilk), to make it seem appealing and desirable as a lifestyle choice. In effect, we adopted the most successful techniques of our competitors, by taking a similar approach to that of the formula manufacturing industry.

In 2004, newly filled with zeal, we decided to create a public service announcement (PSA) in the form of a 45 second filmed advert. This was privately coordinated between the Kennys and another couple and no other organisations were involved. This first attempt at producing a PSA film failed because of lack of resources, skills and funding. The ideas and concepts were there: there was a camera, a photographer, director and cast – but no editor. We failed to realise what a fringe topic breastfeeding was at this time, and overestimated our powers of persuasion at being able to involve an editor at no cost.

In 2005, a second effort, supported by the iThemba Lethu Breastmilk Bank team, resulted in the production of short TV commercial called *Substitute Abuse*² to highlight the potential harm that incorrect use of breastmilk substitute (formula) could pose to an infant. This time, there was a very small budget and we were

2 *Substitute Abuse* www.youtube.com/watch?v=dStJO7EoLvs

able to afford some film and courier services (albeit, at a fraction of the normal professional rate). Through various other professional projects, we had developed a good relationship with the local office of the South African Broadcasting Corporation (SABC), who allowed us to use their foyer and a studio as a set for four hours at no cost. While the Kennys produced, coordinated, scripted, directed and filmed the PSA, we ensured that we had included an editor (sympathetic to the cause and a former medical student) at no cost as well. All of us, cast and crew, were volunteers.

This PSA showed parents and their baby being taken away for questioning by airport security officials when it is discovered that they are in possession of a white powder. In the interrogation room an official informs them that they were in possession of a potentially harmful substance. The father protests that the powder is only baby formula. The official then says that she would read the baby its rights and the film concludes with the film's key message: 'You have the right to be breastfed'.

DVD copies were made and distributed and the PSA was entered into a local satellite TV channel's competition, where the prize was free broadcast of that PSA on the channel. Although it was not among the winners, it was played at conferences and as part of presentations on lactation and infant feeding. It was also uploaded to YouTube. It is difficult to gauge how many people have actually seen the PSA, but Youtube can give some indication: on YouTube alone it has had over 9000 views at time of writing.

We found by eliciting comment from various people we showed it to, that it's hard-hitting message worked mostly to shock the audience. According to a focus group made up of breastfeeding mothers, it did emphasise the importance of breastmilk and showed the potential harm of formula but the PSA also had the potential to alienate some, especially mothers who had already chosen to formula feed their children. While it caused some controversy, we have no record of anyone who changed his or her mind from being ambivalent or against breastfeeding to being in favour, after watching it.

So, what did we learn? We had overlooked a crucial step in communicating. We, as a team, had already gone through a process of fact-finding, thinking and consulting around infant feeding and had had time to revise our own thoughts on the matter over a period of weeks and months. Here, in less than 60 seconds, we were telling a largely uninformed audience that formula was wrong, breastmilk was right, and that they were bad parents for feeding their child formula.

What was badly formed about the PSA was not the factual information, but the approach. The PSA found favour mostly among people who were already convinced that breastmilk was the best infant feeding choice: researchers and policymakers and parents who had breastfed their own (now grown) children. We were preaching to the converted. Not only that, but even some of those who were in favour of breastfeeding were put off by what they perceived to be the 'finger-wagging attitude' of the PSA.

Mothers, and prospective mothers, who had already made the decision to exclusively breastfeed their children, pointed out that while they understood the intention of the message, its execution alienated the target audience. We had overlooked the fact that parents who had chosen to formula feed had made that choice believing that they were making the best nutritional choice for their children: they too, with the information that they had, made an evidence-based choice. Merely telling them that they had made a wrong choice and were placing their children in mortal danger when their children were perfectly healthy was unwise and insensitive to their situation.

What we learned from this was that good intentions don't automatically translate into well-crafted, well-received or correct messages. Also, shock-value may derive a quick response but does not necessarily translate into the acceptance of a message. After *Substitute Abuse*, another concept PSA *Sharing is Caring*,³ aimed at promoting breastmilk banking, was produced and received a much warmer reception from the focus group. We were also able, through professional relationships with suppliers, to use professional High Definition digital video equipment cost free.

While this was good and well, the team – Anna Coutsooudis and Penny Reimers, as technical/scientific advisors, and Patrick and Shannon Kenny as creative directors – concluded that a successful social marketing campaign could not rely solely on PSAs to encourage breastfeeding, since these would be limited to TV, exhibitions, web-based social media and the internet. We would have to include print media and radio, as well as the coordinated support of the public and private health sector in sharing beneficial information.

Patrick and Shannon, with the input of the lactation consultants, started the next stage of the process by identifying some of the stigmas and myths around breastmilk and feeding, and looking at the social limitations and design oversights and deficiencies in existing promotional material. They then formulated some concepts for print advertisements, using this knowledge. Some were humorous, some were traditional and some were 'soft sell' (casual and friendly). Some were more personal (The People), while others had a broader social and environmental focus (The Planet). Others showed how even the formula manufacturers agreed that breastmilk was superior (The Can).

How would we assess whether we were falling back into familiar patterns of communication? Without the budget to contract an advertising agency or market research company it would be difficult to verify whether we were on the right track with this fledgling strategy.

Enter a volunteer in the form of a marketing consultant. We were cautioned in an initial meeting with the consultant that, because we had already started the concept process, we may have to deal with the potential disappointment of our ideas being off track, having to go back to the drawing board and nursing bruised egos. A decision

3 *Sharing is Caring* www.youtube.com/watch?v=HMukYDGMjb8

was made immediately that bruised egos were not going to be fatal and so began our workshop and the start of a more focused approach to this rebranding exercise.

It must be noted that this consultant is the husband of a fellow researcher and HMBASA team member: proof that precious resources can sometimes be hiding in plain sight, overlooked and a great deal more obtainable than one would think.

Social marketing strategy in practice

Step 1: Research past and present campaigns and lessons from the formula, soft drinks and tobacco industry

The marketing consultant advised us to look at and think about pro-breastfeeding and pro-formula advertising and promotional material before our first workshop. What set them apart? What did they have in common, if at all? Additional questions he posed were:

- How has infant feeding been portrayed and by whom?
- What messages were being conveyed and to whom?
- How was the media used to promote these messages?
- How were these messages digested?

We found that crucial elements of the marketing success of formula included innovative product association and placement, a strong political lobby and manufacturers pushing the boundaries of legal codes, for example, advertorial content in baby and parenting magazines and sponsorship of infant nutrition workshops; all of which is underpinned by large PR, advertising and marketing budgets.

The consultant encouraged us to view breastmilk as a product that needed ‘selling’. The reasoning behind this was that if we approached the subject from a different angle, it would help us to see facets of its character we may previously have overlooked. Our approach, up until then, had been a concentration on breastmilk education, and the results of that approach were no different to the very campaigns of which we had been critical. It was pointed out to us that, in order to create a demand for breastmilk, the practice of breastfeeding needed to be made appealing and normative. Examples we looked at were from infant formula, soft drink (Hill 2003) and cigarette marketing campaigns (Levinson 2007).

We felt that if we could learn from the marketing strategies of these industries – which were particularly successful at marketing products that were socially relevant, but either unnecessary, useless or even harmful – it would only help us to market a product that is necessary and useful. We were further encouraged in our efforts when we discovered that other organisations had also successfully harnessed the advertising strategies of big business for public health causes (Massachusetts Breastfeeding Coalition 2006).

Cigarette advertising in particular had been successful precisely because of the very innovative approaches to selling products with no actual benefit to the consumer. The alternative to tobacco consumption (breathing relatively clean air and significantly reducing one's risk of developing a variety of diseases associated with smoking and/or breathing secondary smoke) – unlike breastmilk – does not have any immediate commercial benefit to the consumer. However both practices (breastfeeding and not smoking) do have long-term health benefits, such as increased life expectancy and reduced morbidity, which also result in significant financial savings to the individual and the state.

We recognised that the long-term savings would and had served to bolster an argument presented to policymakers but were not what could or should underpin an advertising campaign. For the general South African public (and from the Kennys' experience as former smokers) advertising showing the potential harm of tobacco consumption contributed in only a small way to decreased smoking and certainly did not stop them from taking up smoking as teenagers. What significantly reduced tobacco sales and consumption was legislation that culminated in the banning of cigarette advertising, the normalising of clean air and supportive environments: public buildings and enclosed areas, places of work and leisure were required by law to be smoke-free zones. Smoke-free environments became the accepted norm for South Africans and clean air became the standard. Some of what we learned through this process was that our experiences as individual communicators and researchers have an integral role to play, since we all have our own views, values, perceptions and even prejudices. These should be examined, but need not – and can not – always be 'left at the door'. They should be regarded as valuable in informing how we proceed or develop strategy.

Rather than reinventing the wheel and attempting to do large-scale market research, which lack of funds made impossible, we assessed current successful advertising campaigns by large South African companies such as mobile communications providers like MTN and soft drinks manufacturers such as Coca Cola. These particular campaigns, for instance, MTN's 'Ayoba' for the 2010 Football World Cup and Coca Cola's 'Open Happiness', exploited values of equality, togetherness, the pursuit of happiness and well-being, caring and sharing as being common South African values, in order to create brand awareness, position themselves in the market and ultimately sell their products. We specifically looked at these products because they are purchased by a large majority of South Africans regardless of socioeconomic status and culture. Also, the companies competing for market share in this sector were generally competing for consumer loyalty based more on brand awareness, and less on better prices, since price differences across the board were negligible. Also assessed were gender-specific campaigns for products aimed at a broad spectrum of South African women and men.

Step 2: Who is the target market and what are they to be sold?

The second step was to identify the main audience for the campaign and what would most appeal to them. Based on the South African Audience Research Foundation table of Living Standards Measures, we defined the main audience as urban men and women in the LSM (Living Standards Measure) 6-8 group, who socialised regularly, had access to a variety of media and disposable income and who were aged 18-35 years old.

Our assumption was that this particular demographic desires to be seen as progressive and successful, have an aspirational lifestyle, and looked to role models of 'success' whom they could emulate or identify with. Their aspirations could be targeted by focusing on how the choice to breastfeed would complement and maybe even enhance a progressive, upwardly mobile lifestyle. In addition to this we would need to depict other successful men and women who supported breastfeeding.

We believe that by targeting this group in particular the messages would also appeal to and influence people in the LSM 1-5 and LSM 8-10 groups. This would also allow for the kind of images and messages that had a much more general appeal, like those in popular soft drink campaigns, which present their audiences with a desirable world or lifestyle, which generates a desire for the product.

We concluded that breastfeeding needed to be more visible in public: displayed as normative, with peer support, seen as progressive and 'trendy' and recognised as the best scientific choice. The material would need to be presented in an attractive, desirable format. We were going to use classic sales techniques: the purpose of the initial material was to create a desire and need. Then, follow-up education and information material would serve, in a post-choice rationalisation process, to reinforce the desire and need, and validate the choice.

Step 3: Compiling an audience-appropriate strategy proposal

We then examined some of our original ideas. We threw out what would not work, kept what would and put some on the back burner. We realised that we could not be precious about ideas that we liked but needed to concentrate on what would work best for the audience we intended to address.

Before we could address a wider public audience, however, we had to convince the policymakers and funders whose support we needed. Our first task was to create an appropriate presentation that would sensitise them to the issue and ultimately find favour. During this period we created a new PSA, *2 Ways to Feed a Baby*. It was hoped that this PSA, which highlighted breastfeeding as a food security and environmental issue, would appeal to policymakers beyond the public health sector, as well as funding agencies and private donors.

The idea behind this film was to show the vast human and environmental cost involved in the manufacture of formula in comparison to breastfeeding (which is environmentally sound, in terms of production). The team agreed that the idea was a good one and obtained permission to use the film footage we wanted to re-edit. We arranged to use this film footage at no cost for the purpose of advocating for funding for ‘The People, The Planet, The Can.’

Once this was complete, we needed to show it to the right people. Anna contacted national and regional representatives of the Department of Health and aid agencies and informed them that we had a strategy proposal in line with the government’s latest policy announcements. We were able to secure a meeting with a regional representative of the Department of Health (DoH) and the national Head of Nutrition for a major aid agency to present ‘The People, The Planet, The Can.’

Step 4: Presenting the communication strategy to an audience

‘The People, The Planet, The Can’ was very enthusiastically received by the regional representative of the Department of Health (DoH) and the national Head of Nutrition for a major aid agency and their DoH partner who was also present.

We presented the sample PSA *2 Ways to Feed a Baby* and mock-ups of prospective adverts, called ‘What Do these Women have in Common?’ One of these showed photographs of a variety of South African women of different ages and ethnicities, while another showed different women who are identified as doctors. But it is revealed in both instances that what these women actually have in common is that they have all breastfed their children. We also shared other script ideas that depicted men who had in common their support for breastfeeding. Then we played the PSA *Substitute Abuse* which, as we had predicted, would appeal to policymakers. However, this time we used it to illustrate what we had learned, that one commercial could work for a certain audience demographic but not work for another, by recounting the reactions of members of our focus groups.

The presentation worked. Why? Because we had not presented them with statistics and facts with which they were already familiar. We presented our case by recounting some of the stories that had influenced the strategy.

Of particular significance was the story of a group of low socioeconomic status (SES) mothers who had gone on to start a breastfeeding-support group in their community after attending an event hosted by the iThemba Lethu Breastmilk Bank/HMBASA as part of the International Breastfeeding Challenge in 2011. The group in attendance was made up of lactating mothers, their female friends and/or family. All the lactating mothers at the event exclusively breastfed their infants, were ethnically diverse, but were mostly in the high SES group. All attendees had been encouraged to bring along their older, non-breastfeeding children for whom child-minders had been arranged. A lactation consultant spoke about the work of the Breastmilk Bank and other consultants were also on hand to field questions and concerns or consult with

mothers individually if they so wished. A midwife who had accompanied the group of low SES mums reported to Anna a few days later that these mums were now starting a support group because they were now even more convinced of the importance of breastfeeding after spending time with, in their words ‘well-off mothers who could afford formula but chose to breastfeed because it really was the best thing for their babies’ and made them realise that ‘breastfeeding was not just for poor black women who could not afford formula.’ This midwife had been trying for months to get this group of women to start a support group and now, after one event, these women were extolling the importance of breastmilk to others in their community.

Along with such powerful stories, we rather boldly asserted that present breastfeeding promotional material was largely either condescending or ugly. In addition, we presented a strategy for moving forward and made ourselves available for continued consultation. It was in our favour that both parties were supportive of breastfeeding to start with and they both agreed that a new strategy was in order.

Additionally, we had also been quite clear that we really believed in what we were doing and even if government could not or was not going to support this initiative immediately, we would be working independently to see it realised.

The representatives were encouraging and enthusiastic about the presentation. So much so that they even agreed to canvas support via their departments to generate funding to secure the rights to the film footage, in order to publicly exhibit the PSA for exhibition at the then upcoming COP 17 Conference in Durban. Unfortunately, they were unable to convince the other key decisionmakers in their respective circles of the value of this endeavour, but they have continued to look at ways and means of advancing ‘The People, the Planet, the Can’ as a strategy.

Step 5: Presenting the strategy to potential funders

Fuelled by the encouragement and support we had received from the policymaker and aid-agency representative, we decided to approach the private sector. We were referred by the CEO of one of South Africa’s largest private healthcare insurance providers to his company’s Head of Corporate Sustainability, Head of Public Relations and Corporate Marketing and Deputy Head of Corporate Social Investment (CSI). This particular company has considerable clout within its industry and the ear of government policymakers. In the words of the company chairman ‘When you’re our scale, you’re a policymaker...’ (*Sunday Times* 2012) We had identified the company as progressive, pioneering and somewhat daring – famed for ‘doing things differently’. The company had over the past year also adopted a more conciliatory tone with regard to working more closely with government by being more supportive of public policy, especially with regard to the proposed National Health Insurance scheme. It is also a major contributor to the public-health sector through its Corporate Social Investment. We saw this connection as an opportunity and possibly a perfect fit, partnering with a major private-sector player to help to implement and promote public policy.

The meeting with the panel would be 45 minutes long. To maximise our time with them we determined to send the concept sheet for the funding proposal three weeks in advance in order to give them enough time to scrutinise it and advance questions, ideas and concerns.

The proposal explained how the communication strategy had the backing of government and the support of a major aid agency, how their partnership in the campaign could serve their client base and the general public. Included in the document were the reasons behind – and the finer details of – the strategy. The idea we would be pitching to this company was that the promotion of breastfeeding would not only benefit their clients' overall health, but that healthier clients meant fewer claims against their insurance, which would be beneficial to the company's bottom line. We drew on the company's own example of how, a decade previously, they had embarked on a successful campaign to encourage their members with gym memberships, with the same rationale. In addition to making good business and public relations sense, the company would be supporting government policy and spearheading a sidelined public health issue that could only be beneficial for their clients, and the country as a whole. We also explained how we already had the support of government and a major aid agency for this strategy, so all we needed was their support and access to the resources, which they could provide.

We proposed to partner with the company as advisors on the communications strategy, using their existing resources – website, online magazine, benefit schemes, partnerships with other businesses and organisations and access to healthcare facilities – to pilot this communication strategy through their client base. Building on that, we would then roll out the programme further into the public arena.

In preparation, we had agreed that Anna would give a brief introduction of the team and the purpose – preventing infant deaths and morbidity through breastfeeding – of the campaign proposal. Patrick would present and give a brief summary of some of the campaign PSAs (in effect, the sales pitch). Shannon would deal largely with the specific media and messages and how this campaign would practically serve the company, its clients and ultimately serve the country. All would tackle questions presented by the panel.

Further encouraged that we had received no questions of concern from any of the parties on the panel we were to meet with, we flew to Johannesburg quite confident of a smooth meeting that would end in further discussion of a 'way forward' for the campaign and an exciting partnership with both government and the private sector.

Anna's introduction to the panel was personable, free from scientific jargon (which we assumed they would be unfamiliar with) and explained the team's relationship and the case for a social marketing strategy. We introduced the visual concept for the strategy with the '2 Ways to Feed a Baby' PSA. The dramatic footage, sweeping music and accompanying copy was an ideal way, we felt, to kick start the discussion around

our strategy proposal and show how breastfeeding was not just an issue for the poor. Patrick succinctly explained the various other concepts for PSAs and gave a brief summary of the campaign.

When we asked the panel whether they had any questions at that point, the head of the panel asked what the purpose of the meeting was and whether we had a more detailed strategy proposal. It was at that point that we realised that none of the panel had even read the strategy proposal we had sent ahead. Not only had they not read the proposal, they had no idea why were meeting with them. We were flabbergasted!

Impromptu teamwork and a quick rethink of the intended plan resulted in Shannon taking the panel on a step-by-step guide through the proposal and the team fielding questions from the panel.

After explaining our position and motivation, one representative questioned the validity and effectiveness of a social marketing campaign of this nature, based on their failure as a company to dissuade their clients from increasingly opting for elective caesarian section births. This company had also been the recent sponsors of a short (and well-meaning) film on breastfeeding. As a team, we had been critical: not of its production value or factual content, but that the film would have limited appeal and audience reach and ultimately be a less than effective resource.

The intended 45-minute meeting was extended to an hour and a half. Still, the panel was less than enthusiastic about our proposal and explained that any key business decisions (which our proposal entailed) would have to be reviewed by a board. This would require us to resubmit our proposal, which this (less than enthusiastic) panel would then submit for review.

What we took away from this meeting was that strategies, plans and projects (good and bad, in the public and private sector) often come to fruition because a key decisionmaker champions them. Also, the Government is often criticised for being slow or reluctant to act on issues and here we experienced first hand the reluctance of the private sector to advance a policy issue, even one that could directly benefit them.

Breastmilk social marketing strategy outcomes

At present, we are still persevering in efforts to bring this social marketing strategy to fruition. We have experienced on numerous occasions the disappointment of unsuccessful funding applications, due to other projects taking precedence or the slashing of budgets. At the same time, we have maintained open communications and continue to enjoy cooperation with policymakers and funding agency representatives. The aid agency representative in particular has championed the case for the social marketing of breastmilk.

The regional and national press have published our rebuttals to articles and two community publications have published supportive stories about and related to the

Breastmilk Bank. HMBASA and iThemba Lethu Breastmilk Bank continue to support and resource antenatal clinics, milk banks, expectant mothers' support groups and the training of lactation consultants.

There is infant feeding information and counseling available at private and public antenatal clinics, in addition to parenting magazines. This information is mostly championed by breastfeeding advocates, which include healthcare professionals such as midwives, doctors, lactation consultants and infant feeding specialists in private practice or connected to NGOs.

Thus far, there is still no coordinated, national strategy in place to fill the communication gap that exists between government policy and the public. A further avenue for us to explore is to approach like-minded teams and organisations with a view to pooling resources to develop a national, coordinated social marketing strategy, in order to fill this gap.

A note on campaign team working practices

As a team, we are all volunteers. Our professional work and personal lives facilitate – and sometimes constrain – our participation as a team. Mutual respect, an appreciation of each team member's role, contribution and expertise has been vitally important. A desire to see each team member excel in their role has provided us a platform for genuine encouragement and a willingness to provide – and an openness in asking for – both emotional and professional support. We understand that not all teams or organisations are comprised of groups of friends but friendships can and do develop out of these contexts. Even if they don't, respect and mutual appreciation need not be dependent on friendship.

For this campaign, it is incumbent upon us to continue to keep abreast of the latest research and press – local, national and international – on the issue of breastfeeding, and to keep one another updated. We have, and are continually learning to cope with, very limited resources and how to use what we have effectively and to be appreciative of and enjoy the support of other volunteers. A passion for the issue that goes beyond personal contributions and an empathy (or compassion or, dare we say, 'love') for the people affected by this issue is probably the glue that holds our team together and has been the major factor in our healthy team relationship.

One of the positive outcomes is that our team has shown (to ourselves, at least) that we can work well together even in unfavourable circumstances and that we were able to coordinate efforts not just as planned, but also that we were also able to change tack when the unexpected presented itself. This, we believe, is largely due to us having a good grasp of each other's work: the communicators are well-versed in the science and facts of the research that informs their communication strategy and the scientist is a part of the communications process and strategy creation.

In conclusion

Funding is always an issue, whether one is in a resource-rich or resource-poor setting. Ultimately, funders have to be convinced of the importance and worth of any project. In our case, a project proposing a different approach has been at a distinct disadvantage, since it is competing with traditional approaches. Funders may actively view traditional approaches as adequate, correct or better, and we must not forget that there is also always a bias towards the status quo. We believe that expenditure on communication in particular is still difficult to attain. It may be regarded as not important and possibly even frivolous, since the results are not immediately measurable. If communication strategies were regarded as an investment in – and an integral part of – policy uptake, significant changes in approach would be more possible.

Understanding media usage and access is a key to policy uptake and implementation. Within our context in advocacy, the press, TV and radio are important channels to attract the attention of key policymakers. In communicating policy to the public, the radio, the tabloid press, mobile devices, magazines and TV are important channels. Understanding how and where media is accessed and used is important for us in the formulation of budgets and allocation of resources, specifically for paid-for advertising. Sources such as the South African Audience Research Foundation and the Human Sciences Research Council provide valuable, accessible research which can guide the development of communications strategies, advertising and media placement. Fostering good relationships with members of the press cannot be overlooked. Also being vigilant at rebutting inaccuracies – and seeing these as opportunities for advocacy rather than an attack on one's cause – provides cost-free press.

The disappointments that we have experienced during our journey as a team have only served to cement our resolve around the issue of infant feeding and child survival and we believe that our strategies and ideas for 'The People, the Planet, the Can' could well be adapted for and applied in other contexts.

References

- Andresen E.; N.C Rollins; A.W. Sturm; N. Conana; T, Greiner (2007) 'Bacterial contamination and over-dilution of commercial infant formula prepared by HIV-infected mothers in a prevention of mother-to-child transmission (PMTCT) programme, South Africa.' *Journal of Tropical Pediatrics* 53: 409–14. doi: 10.1093/tropej/fmm059.
- Jones G; R.W. Steketee; R.E. Black; Z.A. Bhutta; S.S. Morris (2003) 'How many child deaths can we prevent this year?' *The Lancet* 362: 65–71
- Bhutta, Zulfiqar A.; Jai K. Das; Arjumand Rizvi; Michelle F Gaffey; Neff Walker;

Susan Horton; Patrick Webb; Anna Lartey; Robert E Black (2013) 'Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?' *The Lancet* 382(9890): 452–477, 3 August 2013. doi:10.1016/S0140-6736(13)60996-4.

World Health Organization (1981) *International Code of Marketing of Breastmilk Substitutes* Geneva: World Health Organization. ISBN 92 4 1541601.

Black. R.E., S.S. Morris, J. Bryce (2003) 'Where and why are 10 million children dying every year?' *The Lancet* 361: 2226–34.

Department of Health, Medical Research Council, OrcMacro (2007) *South Africa Demographic and Health Survey 2003*. Pretoria, South Africa: Department of Health.

Lawrence, R.A. (1994) *Breastfeeding. A Guide for the Medical Profession*. 4th ed. St Louis: Mosby.

WHO Collaborative Study Team on the Role of Breastfeeding on the Prevention of Infant Mortality. (2000) 'Effect of breastfeeding on infant and child mortality due to infectious diseases in less developed countries: a pooled analysis.' *The Lancet* 355: 451–455.

Coutsoudis A.; K. Pillay; E. Spooner; L. Kuhn; and H.M. Coovadia (1999) 'Influence of infant feeding patterns on early mother-to-child transmission of HIV-1 in Durban, South Africa: a prospective cohort study.' *The Lancet* 354: 471–76.

Coutsoudis A.; K. Pillay; L. Kuhn; E. Spooner; W.Y. Tsai; H.M. Coovadia; South African Vitamin A Study Group (2001) 'Method of feeding and transmission of HIV-1 from mothers to children by 15 months of age: prospective cohort study from Durban, South Africa.' *AIDS* 15(3) February 16: 379–87.

Baumslag, Naomi M.D. and Dia L. Michels (1995) *Milk, Money and Madness: The Culture and Politics of Breastfeeding*. Westport, CT: Praeger.

UNICEF's Division of Policy and Strategy (2012) *Committing to Child Survival: A Promise Renewed*. New York: UNICEF. www.apromiserenewed.org

Perez-Escamilla, R. (2011) 'Social Marketing Lessons Learned' IOM Workshop Sponsored by USDA-FNS Keck Center, Washington, DC, April 26. The Brazilian National Breastfeeding Promotion Program.

Rea, M.F. (2003) 'A review of breastfeeding in Brazil and how the country has reached ten months breastfeeding duration.' *Cadernos Saúde Pública*, Rio de Janeiro 19(Sup. 1): S37–S45.

Lindenberger, James H. and Bryant, Carol A. (2000) 'Promoting Breastfeeding in the WIC program: A Social Marketing Case Study'. *American Journal of Health Behavior* 24, 1: 53–60.

World Health Organization (2003) *Community-based strategies for breastfeeding promotion and support in developing countries*. Geneva: WHO.

Kotler, Philip; Ned Roberto; Nancy Lee (2002) *Social Marketing: Improving the Quality of Life*. 2nd ed. Thousand Oaks, CA: Sage Publications.

Goodridge, Janet Murphy (2008) *Breastfeeding Strategic Plan II, 2008–2011*. The Breastfeeding Coalition of Newfoundland and Labrador, November.

The Tshwane Declaration of support for breastfeeding in South Africa (August 2011) *South African Journal of Clinical Nutrition* 5 (24): 214. <http://www.sajcn.co.za/index.php/SAJCN/article/viewFile/586/820>

Motsoaledi, Aaron (2011) Media Statement by South African Minister of Health, Dr Aaron Motsoaledi, Department of Health, August. <http://www.gov.za/speeches/view.php?sid=20973>

Coutsoudis, A. (2004) 'Breast-feeding and HIV: An update.' *Southern African Journal of HIV Medicine* 5(4): 45–48.

Saloojee, H., G. Gray and J.A. McIntyre (2011) 'HIV and infant feeding – one step forward, two steps back.' Opinion. *Southern African Journal of HIV Medicine* 12(4), December.

Kuhn, Louise (2012) 'Maternal and Infant Health is Protected by Anti-Retroviral Drug Strategies that Preserve Breastfeeding by HIV Positive Women.' *The Southern African Journal of HIV Medicine* 13(1), March.

Kassier S., E. Maunder and M. Senekal (2003) *Infant Feeding Practices in KwaZulu-Natal: An exploratory study of current infant feeding practices of mothers with 0-6 month old infants attending PMTCT and non-PMTCT clinics in Central Durban*. Durban, South Africa: Health Systems Trust. <http://www.hst.org.za/category/opencalais/breastfeeding>

Bester, M. (2006) 'Factors influencing high socioeconomic class mothers' decision regarding formula feeding in the Cape Metropole.' Master's thesis, University of Stellenbosch (mimeo).

Otte, T. (1997) *Tina Otte's Pregnancy and Birth Book*. Cape Town: Struik publishers.

Malan, Mia (2011) 'Exclusive Breastfeeding Plan "Impractical".' *Mail & Guardian*, 26 August 2011. <http://mg.co.za/article/2011-08-26-exclusive-breastfeeding-plan-impractical>

Motsoaledi, A (2011) Media statement by Dr Motsoaledi on 23 August, 2011. <http://www.gov.za/speeches/view.php?sid=20973>

Doherty, et al. (2011) 'Stop Dithering At Death's Door.' *Mail & Guardian* 16 September 2011. <http://mg.co.za/article/2011-09-16-stop-dithering-at-deaths-door>

Naidoo, L. (2012a) 'Attachment Parenting.' *You Magazine*, 31 May 2012.

Naidoo, O. (2012b) 'It's a formula for disaster.' IOL Lifestyle blog. <http://www.iol.co.za/lifestyle/family/baby-toddler/it-s-a-formula-for-disaster-1.1342247>

Coutsoudis A, Reimers P (2012) 'Regulating Marketing of Breastmilk Substitutes: A Recipe/Formula for saving lives!' *The Mercury*, 13 September 2012.

phdinparenting (2011) 'Infant formula advertising does influence mothers.' PhD in Parenting blog, November 20, 2011. <http://www.phdinparenting.com/blog/2011/11/20/infant-formula-advertising-does-influence-mothers.html>

Larsson, M. (2009) 'Is Who Code compliance enough to effectively promote breastfeeding?' Statement from Michael Larsson, Medela's Chairman of the Board. <http://www.medelabreastfeedingus.com/assets/file/MedelaStatementIIWHOCODEFINAL%281%29.pdf>

Hill, C.W. (2003) *International Business, Competing in the Global Marketplace*. 4th International Edition. New York: McGraw-Hill/Irwin.

Levinson, J.C. (2007) *Guerilla Marketing: Easy and inexpensive strategies for making big profits from your small business*. London: Piatkus Books.

Massachusetts Breastfeeding Coalition (2006) 'Breastfeeding as normal: An urban breastfeeding advertising campaign inspired by the tobacco industry.' Recorded presentation. Boston, MA: APHA. https://apha.confex.com/apha/134am/techprogram/paper_128849.htm

Langa, Lungi (2010) 'Breast is always best, even for HIV-positive mothers.' *Bulletin of the World Health Organization* 88(1) January: 1–80.

Shisana O; L.C. Simbayi; T. Rehle; N.P. Zungu; K. Zuma; N. Ngogo; S. Jooste; V. Pillay-Van Wyk; W. Parker; S. Pezi; A. Davids; O. Nwanyanwu; T.H. Dinh and SABSSM III Implementation Team (2010) *South African National HIV Prevalence, Incidence, Behaviour and Communication Survey, 2008: The health of our children*. Cape Town: HSRC Press.