Alberta Health Services

ALBERTA HEALTH SERVICES BREASTFEEDING STRATEGY

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Background

Breastfeeding provides nutritional, immunological and emotional benefits for the growth and development of infants, improves maternal health, provides economic benefits to the family and the, health care system and, as a result, is strongly supported nationally and internationally (Canada, 2013; Critch et al., 2014; Health Canada, 2004; Infant Feeding Joint Working Group, 2015; Public Health Agency of Canada, 2014, 2019; World Health Organization, 2002). Despite this strong support, breastfeeding rates in Canada and other industrialized countries remain below the World Health Organization's (WHO) recommendations of breastfeeding exclusively for six months and, with appropriate introduction of complementary foods, up to two years and beyond (Critch et al., 2014; Infant Feeding Joint Working Group, 2015). To address this issue, improving breastfeeding rates has become a key public health priority for governments and healthcare organizations at the provincial, national, and international levels (World Health Organization, 2002). Improving breastfeeding rates was identified as a priority in the Government of Alberta's Maternal and Infant Health Action Plan, as well as the Health Children and Families (HCF) Strategic Action Plan (Alberta Health, 2013; Alberta Health Services, 2015).

Canadian Community Health Survey (CCHS) data from 2012 indicates that breastfeeding initiation rates are relatively high in Alberta (91%) and are similar to that of the rest of the country (90%). Initiation rates ranged from 87% in the North Zone to 97% in the South Zone. Among Alberta mothers who initiated breastfeeding, 42% reported total breastfeeding duration of up to 12 months, and 16% reported a total breastfeeding duration of greater than one year (slightly below national rates of 44% and 18%, respectively). Among Alberta mothers who reported breastfeeding initiation, 26% reported exclusive breastfeeding for six months, slightly higher than the national rate of 23%. There was substantial variation in the six month exclusive breastfeeding rates across the province, ranging from 20% in the Edmonton Zone to 44% in the South Zone (Alberta Health Services, 2014b).Where zone specific data were available, the South Zone consistently reported the most favorable breastfeeding outcomes (Alberta Health Services, 2014b). Appendix A contains breastfeeding initiation, duration and exclusivity rates for each zone. To gain insight on this drop-off, a literature review completed by Mackean & Spragins (2012) cited a number of reasons mothers discontinue breastfeeding that include:

- Lack of confidence in breastfeeding
- Lack of support from their family, especially partner
- A culture within the healthcare system that undermines rather than builds on mother's confidence in breastfeeding
- Feeling isolated and excluded; primarily because they feel that people disapprove of breastfeeding in public

To begin to understand how AHS can make an impact on parent experiences and breastfeeding rates, an environmental scan on current breastfeeding services within AHS acute care and community facilities was conducted. The results from this scan demonstrated varied support and clinical and public health practices for breastfeeding within each zone (Alberta Health Services, 2014a). Some of the variations across the zones included:

- Availability and use of breastfeeding documents such as guidelines, evaluations, curricula
- Education, training and support for staff and volunteers
- Clinical practices
- Client/patient teaching and support
- Availability and accessibility of breastfeeding services and resources, e.g., prenatal classes

Overall, these data indicated that there is a need for standardized province-wide policies and guidelines, education and training of healthcare staff, as well as consistent support for Albertan parents and their families.

Breastfeeding Strategy

The breastfeeding strategy is intended to guide decision-making and implementation of evidence-informed approaches related to breastfeeding promotion, protection and support across AHS. The Population Health Promotion Model (Public Health Agency of Canada, 2012; Public Health Agency of Canada & Breastfeeding Committee for Canada, 2014) provided a helpful framework to design this strategy, acknowledging the complexity of the interrelated factors that influence breastfeeding decisions and practices, including the role of the healthcare system, and addressing them through evidence-informed approaches. Successful population health interventions to improve breastfeeding address multiple determinants of health across multiple levels and sectors in relation to the circumstances of a mother's life, her immediate sociocultural context and her individual experience (MacKean & Spragins, 2012; Public Health Agency of Canada, 2012).

The breastfeeding strategy was developed after reviewing numerous background documents related to breastfeeding best practices, literature reviews, and model strategies within AHS as well as provincially, nationally and internationally (see Appendix B), including alignment with the WHO/UNICEF BFI components. It includes a set of guiding principles, goal, objectives, and strategic action areas supported by monitoring and evaluation activities.

Goal

Breastfeeding is promoted, protected and supported in Alberta within a patient and family centered care approach

Objectives

- To provide families with support to meet their breastfeeding goals
- To improve system level support for breastfeeding
- To improve health care provider knowledge, attitudes and practices
- To improve breastfeeding rates

Strategic Action Areas

Three broad strategic action areas include:

- Policy and Leadership
- Capacity Building
- Health Marketing

Each strategic action areas and its respective actions are described in Table 1. The evidence used for the development of the strategy and its components can be found in Appendix C. Once finalized and approved, project charters and work plans will be developed to accompany the actions described below.

Table 1: Provincial breastfeeding strategic actions.

Strategic Action Area	Action
Policy and Leadership	Strategic Leadership • Ensure alignment with strategic actions identified by the Government of Alberta and AHS at multiple levels (provincial and zone) • Influence future strategic directions related to breastfeeding • Ongoing communication and collaboration across AHS Leadership for the breastfeeding priority identified in the HCF Strategic Action Plan
	Provincial Breastfeeding Policy • Create a corporate-level policy to establish an environment that protects, promotes and supports breastfeeding across AHS within a patient and family centered care approach • Create clinical policies and/or guidelines to standardize breastfeeding practices and services across the continuum of care from preconception to postpartum • Align and/or integrate with other related policies and guidelines within AHS (e.g., Donor Human Milk, Expressed Breastmilk, Nutrition Services Infant Feeding Guidelines, Pregnancy Pathways for Alberta)

Capacity Building	**Staff Education** • Standardize breastfeeding education and training for staff and volunteers across AHS (e.g., Breastfeeding Foundations Module, Breastfeeding Challenges and Supplementation Module, 20-hour Breastfeeding Course (TBD)) • Consider strategies to engage and educate other health care providers • Promote consistent and appropriate informed feeding and breastfeeding messages
	Parent Education • Enhance and maintain consistent approaches to informed feeding decisions and breastfeeding education for parents and their families, including populations vulnerable to poor health outcomes (e.g., HPHC resources, Ready or Not Alberta website, key messages for the informed feeding conversation)
	Peer Support • Create a provincial breastfeeding peer support model/tool kit for parents and their families that meets local zone needs
Health Marketing	**Social Marketing** • Establish a provincial social marketing campaign to create supportive social environments to promote breastfeeding • Explore the development of targeted campaigns and/or activities for populations vulnerable to poor health outcomes (e.g., Indigenous populations, low SES groups, young parents, minority groups, rural settings) and supporters (e.g., fathers, grandparents)
	Health Communications • Develop and implement a communication plan/strategy to protect, promote and support breastfeeding • Communicate the availability of existing resources for staff and public more widely, through a variety of means (e.g., print, social media, digital marketing) • Promote consistent and appropriate informed feeding and breastfeeding messages for parents and health care providers

Monitoring and Evaluation

Evaluation will be essential to assessing the implementation and the impact of the strategy. Once the goals, objectives, and activities of each specific strategic action area have been identified, evaluation plans will be completed. Evaluation plans for each strategic action area will include the identification of short- and long-term outputs and outcomes, data collection sources, timelines, ethical considerations, analysis, and reporting plans.

Existing data sources may help support future evaluation activities. Some of the data sources that may be used to support the evaluation work include:

- The environmental scan completed in 2014 with the purpose of understanding current breastfeeding services within AHS acute care and community facilities (Alberta Health Services, 2014a).
- Meditech data collected through public health activities during Well-Child Clinic visits.
- Surveillance data collected provincially and nationally.

Guiding Principles

The following guiding principles are intended to set the foundation for all actions undertaken as part of the strategy. These were chosen based on their relevance to the topic of breastfeeding and their alignment with other projects within HCF. A brief description of how they apply to the strategy is included and, where applicable, definitions are included as footnotes.

Patient and Family-Centered Care[1]**.** Working in partnership with parents and their families by encouraging participation in all aspects of care.

Evidence-Informed Practice. Utilizing the best available evidence from research, organizational context and experience to inform and guide the development and implementation of the strategy. (National Collaborating Centre for Methods and Tools, 2016).

Informed-Feeding Decision. Working with parents and their families to facilitate informed decision making about breastfeeding; where information and supports related to infant feeding are provided in a non-judgmental and supportive way.

Health Equity[2]. The strategy will consider and address the provision of supports as needed to provide optimum care to all breastfeeding parents and their families.

Continuity of Care. The strategy will address and support provision of care that is coordinated between acute care, public health, primary care and community services, where feasible.

Cost/Resource Neutrality. There is no additional financial or human resources available to support the implementation of this strategy.

Population Health Approach[3]. This approach is used to design the strategy and its actions. Essential to the Approach is its focus in addressing inequities in health status between population groups and the determinants of health that influence a parent's decision to initiate and continue breastfeeding.

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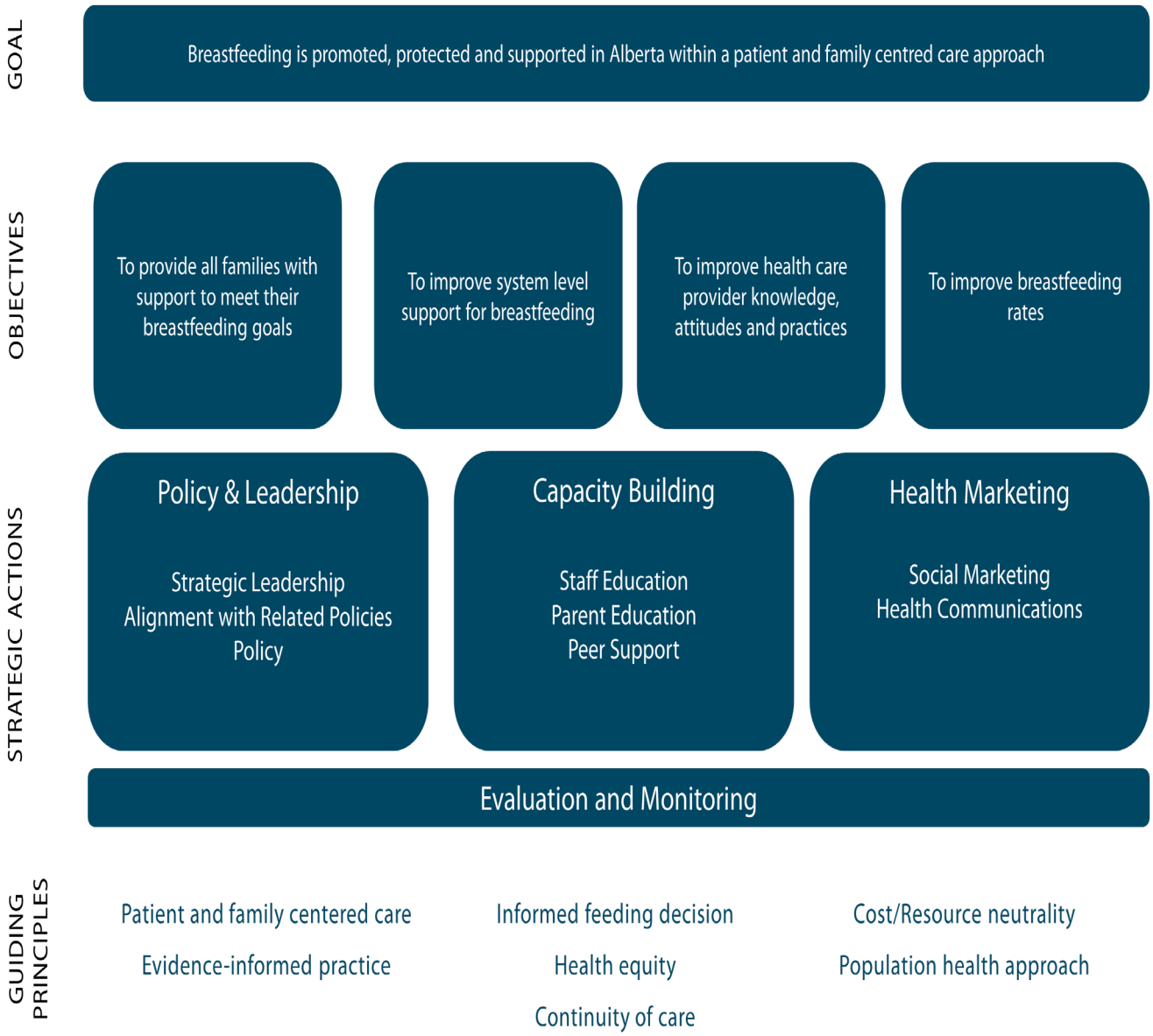
[1] **Patient and family centred care** means care provided working in partnership with patients and families by encouraging active participation of patients and families in all aspects of care as integral members of the patient's care and support team, and as partners in planning and improving facilities and services. Patient- and family-centred care applies to patients of all ages and to all areas of health care. (AHS Policy and Forms Department)

[2] **Health equity** means that all people (individuals, groups and communities) have a fair chance to reach their full health potential and are not disadvantaged by social, economic and environmental conditions. (AHS Health Equity Department)

[3] **Population health** refers to the health of a population as measured by heath status indicators and as influenced by social, economic and physical environments; personal health practices; individual capacity and coping skills; human biology; early childhood development; and health services. It focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their pattern of occurrence and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations. (Public Health Agency of Canada)

Breastfeeding Strategy Visual



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Appendix A: Breastfeeding Outcomes

Breastfeeding Indicator	Geographic Region							Provincial Data Sources		National Data Sources	
	Canada	Alberta	North Zone	Edmonton Zone	Central Zone	Calgary Zone	South Zone	Data Source	Reference	Data Source	Reference
BREASTFEEDING INITIATION											
Tried breastfeeding at least once with most recent infant	89.6%	91.1%	86.7%	87.9%	91.9%	93.4%	96.8%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
TOTAL BREASTFEEDING DURATION											
Total duration of breastfeeding (categorical)											
Up to 2 months	25.0%	31.6%	39.1%	39.4%	29.2%	25.9%	19.4%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
2-4 months	15.1%	14.3%	9.7%	15.9%	14.1%	12.8%	20.0%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
4-6 months	15.2%	11.1%	7.6%	9.4%	23.9%	10.0%	3.7%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
6-12 months	25.2%	26.3%	34.6%	22.5%	23.8%	27.3%	29.9%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
>1 year	18.3%	16.0%	9.1%	11.2%	7.8%	24.0%	27.0%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
Total duration of breastfeeding (cumulative)											
Up to 2 months	98.8%	99.3%	100.0%	98.4%	98.8%	100.0%	100.0%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
Up to 4 months	73.8%	67.7%	61.0%	59.0%	69.6%	74.1%	80.6%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
Up to 6 months	58.7%	53.4%	51.3%	43.1%	55.5%	61.3%	60.6%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
Up to 12 months	43.5%	42.3%	43.7%	33.7%	31.6%	51.3%	56.9%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
>1 year	18.3%	16.0%	9.1%	11.2%	7.8%	24.0%	27.0%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)

EXCLUSIVE BREASTFEEDING DURATION											
Exclusive breastfeeding for 6 months	23.3%	26.0%	25.0%	19.5%	21.5%	29.5%	44.2%	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
Exclusive breastfeeding by week (categorical)											
Less than 1 week	13.2%	9.2%	..	..	..	..	..	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
1-12 weeks	23.0%	23.8%	..	..	..	..	..	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
12-20 weeks	16.7%	12.3%	..	..	..	..	..	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
20-28 weeks	27.7%	29.3%	..	..	..	..	..	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
>28 weeks	5.3%	7.9%	..	..	..	..	..	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
Exclusive breastfeeding by week (cumulative)											
Less than 1 week	13.2%	9.2%	..	..	..	..	..	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
Up to 12 weeks	72.7%	73.3%	..	..	..	..	..	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
Up to 20 weeks	49.7%	49.5%	..	..	..	..	..	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
Up to 28 weeks	27.7%	29.3%	..	..	..	..	..	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)
>28 weeks	5.3%	7.9%	..	..	..	..	..	CCHS (2012)	AHS (2014d)	CCHS (2012)	AHS (2014d)

Appendix B: Background Documents

In 2012, Healthy Children and Families commissioned a review of the literature to inform the development of initiatives for improving breastfeeding rates in Alberta. The review focused on population health strategies aimed at maintaining and increasing breastfeeding rates (Nagulesapillai, 2013). A qualitative literature review was also completed exploring breastfeeding perceptions, attitudes, and experiences of mothers and their partners (MacKean & Spragins, 2012), as well as an environmental scan to understand current breastfeeding services within AHS acute care and community services (AHS, 2014). These, as well as each of the following documents, were utilized and considered in the development of the strategy and actions adapted for the Alberta context. Thus, building on the achievements of previous breastfeeding efforts, this strategy draws on:

At an International level:

1. The Ottawa Charter for Health Promotion (WHO, 1986)
2. The Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (WHO/UNICEF, 1990)
3. The WHO/UNICEF Global Strategy for Infant and Young Child Feeding (World Health Organization, 2002)
4. Protection, Promotion and Support of Breastfeeding in Europe: A Blueprint for Action (EU Project on Promotion of Breastfeeding in Europe, 2004)
5. The International Code of Marketing Breast Milk Substitutes (International Code of Marketing Breast-Milk Substitutes, 1981)
6. Interventions that promote increased breastfeeding rates and breastfeeding duration among women (Sutton et al., 2016)

At National/Canadian level:

1. BFI Integrated 10 Steps Practice Outcome Indicators for Hospitals and Community Health Services (BCC, 2012)
2. Protecting, Promoting and Supporting Breastfeeding, a practical community workbook for community-based programs (Public Health Agency of Canada & Breastfeeding Committee for Canada, 2014)
3. Implementation of the Nova Scotia Breastfeeding Policy: Evaluation Report (Kirk, Hemmens, Price, & Sim, 2011)

At Provincial level:

1. Healthy Mothers, Healthy Babies: Alberta's Maternal-Infant Health Strategy and Action Plan (Alberta Health, 2013)
2. Healthy Children and Families Strategic Action Plan 2015-2018 (Alberta Health Services, 2015)
3. Breastfeeding Guidelines, Practices and Services in AHS: An Environmental Scan (AHS, 2014)
4. Population health strategies to maintain or increase breastfeeding rates: a review of systematic reviews (Nagulesapillai, 2013)
5. The Challenges of Breastfeeding in a Complex World (MacKean & Spragins, 2012)

Model Strategy Documents:

1. Australian National Breastfeeding Strategy 2010-2015 (Australian Health Ministers' Conference, 2009)
2. Breastfeeding Ireland: 5 Year Strategic Plan (National Committee on Breastfeeding Department of Health and Children, 2005)
3. CDC Guide to Strategies to Support Breastfeeding Mothers and Babies (Centers for Disease Control and Prevention, 2013)
4. Recommendations for a Provincial Breastfeeding Strategy for Ontario (Province of Ontario & Best Start, Breastfeeding Committee of Canada, 2009)
5. Manitoba Provincial Breastfeeding Strategy (Manitoba, 2013)
6. Breastfeeding in Manitoba: Provincial Strategy and Framework (Manitoba Healthy Living Ministry, 2006)
7. Breastfeeding Strategic Plan II Nfld and Labrador 2008-2011 (The Breastfeeding Coalition of Newfoundland and Labrador, 2008)
8. A Great Start Breastfeeding Strategic Plan for Nfld and Labrador 2014-2017 (Baby Friendly Newfoundland & Perinatal Program Newfoundland Labrador, 2014)
9. Food for Life 2010-2015 Leeds Breastfeeding Strategy (Erksine et al., 2010)

Appendix C: Evidence for Strategic Priority Areas

The population health promotion approach provides a helpful model to guide efforts for promoting, protecting and supporting breastfeeding (Public Health Agency of Canada, 2012; Public Health Agency of Canada & Breastfeeding Committee for Canada, 2014). There are a number of factors that influence breastfeeding decisions and behaviours, which can be best understood and supported in relation to the circumstances of a mother's life, her immediate sociocultural context and her individual experience (MacKean & Spragins, 2012). When deciding on which actions to take, identifying these interrelated factors and conditions that increase the risk of early breastfeeding cessation was important. Factors and examples include:

- Individual factors: intention, knowledge, education
- Interpersonal: support, recommendations from others including family
- System: policies, resources, workplace
- Sociocultural: societal values and norms

Literature on breastfeeding suggests that multi-faceted interventions are more effective than single interventions and have greater positive impact on breastfeeding outcomes (Nagulesapillai, 2013; Sutton et al., 2016). Although some findings from this synthesis of evidence indicate smaller effects of interventions on breastfeeding initiation due to the ceiling effect, and already high initiation rates in developed countries (Patnode et al., 2016) findings from a recent Cochrane review (2016) suggests some improvements in the number of mothers beginning to breastfeed after education by healthcare professionals and peer support interventions (Balogun et al., 2016). Interventions to improve duration and exclusivity of breastfeeding have been shown to be more promising. The USPTF findings suggest that population-level interventions can be categorized as professional support, peer support, and formal education, although none of these categories are mutually exclusive, and interventions may be combined within and between categories (US Preventive Task Force, 2016). The evidence also indicates that facility- and community-based interventions that include marketing communications campaigns along with other health education programs, health professional training and/or changes in government and hospital policies are most promising for promoting breastfeeding initiation, duration and exclusivity (Nagulesapillai, 2013; Protheroe et al., 2003; Sutton et al., 2016).

Breastfeeding Policy

Policy is crucial to ensuring that practices and procedures in maternity care/ services in clinical and community settings support breastfeeding. Policy development is the first item BFI Integrated 10 Steps Practice Outcome Indicators for Hospitals and Community Health Services, that outline the international standards for the WHO/UNICEF Global Criteria within the Canadian context (Breastfeeding Committee for Canada, 2012). Supportive breastfeeding policies have the potential to positively impact the breastfeeding environments in which parents interact with their children, and the breastfeeding behaviours that occur in those environments (Nagulesapillai, 2013). However, a recent review by the US Preventive Services Task Force (USPTF) on system-level interventions has shown that it's the implementation of the individual steps within the BFHI that positively influence rates of breastfeeding, rather than BFHI accreditation itself (Patnode et al., 2016). Despite this, the Breastfeeding Committee for Canada (BCC) and their provincial chapters endorse BFI and provide guidance for undertaking

efforts to support breastfeeding in acute care and community settings. A provincial policy emphasizes breastfeeding in a very tangible and visible way, and in doing so, stimulates, complements and reinforces other health promotion strategies that may be implemented (Kirk, Sim, Hemmens, & Price, 2012).

Staff Education

A recent meta-analysis by the USPTF of 43 trials found that individual-level interventions including breastfeeding support and education were associated with a higher rate and duration of breastfeeding compared with usual care (US Preventive Task Force, 2016). This synthesis of evidence indicated that healthcare providers can support mothers before and after childbirth by providing interventions directly, or by referral to help them make an informed choice about how to feed their infants and to be successful in their choice. The importance of a standardized education program to ensure consistency in breastfeeding messaging amongst health care providers has been demonstrated in the literature, and articulated in many provincial and national documents. Based on several AHS and Alberta Health documents (AH, 2013; AHS, 2013; MacKean & Spragins, 2012; Nagulesapillai, 2013) and stakeholder feedback, there is a strong recommendation to standardize a 20 hour breastfeeding course for staff and volunteer education and training. In alignment with this recommendation is the second step of the BFI 10 Steps: to provide health care staff with adequate training to support breastfeeding practices (WHO/UNICEF, 1990). The gold standard for this education has been recognized as the WHO 20 hour course (Breastfeeding Committee for Canada, 2012a; WHO/UNICEF, 2009; WHO, 1998). Professionals require breastfeeding education to act as breastfeeding supporters as well as the support of their organizations in this work (Hannula et al., 2008).

Peer Support

A literature review completed by AHS in 2013 provided an analysis and summary of population health strategies aimed at maintaining and increasing breastfeeding initiation, duration, and exclusivity in Canada and countries similar to Canada (Nagulesapillai, 2013). A recommendation from this report was breastfeeding peer support, suggesting that peer support be provided frequently, in collaboration with professional support, provided from pregnancy into the postpartum period, as well as include well-planned educational materials. One review suggests that the role of continuous peer support is most important during the postnatal period, and can provide an alternative to professional support when it is not available for mothers (Hannula et al., 2008), and that combined individual and group counseling appeared to be superior to individual or group counseling alone (Haroon et al., 2013). A recent Cochrane review by McFadden et al (2017) found that providing women with any extra organized support helps them breastfeed their babies longer, but it may be more helpful if it is predictable, scheduled, and includes ongoing visits with trained health professionals including midwives, nurses and doctors, or with trained volunteers. Different kinds of support may be needed in different geographical locations to meet the needs of the people within that location (McFadden et al., 2017). Further exploration is needed with AHS zone stakeholders to understand local contexts and needs in order to develop a peer support program.

Social Marketing

Social marketing seeks to bring about behaviour change through comprehensive, multifaceted approaches that provide coordinated interventions to specific audiences (CDC, 2005). It has emerged as a popular framework in health promotion based on evidence that carefully managed social marketing programs can be very effective in creating behaviour change for complex social issues, such as

breastfeeding (Andreasen, 2006; Bryant, 2010; Centers for Disease Control and Prevention, 2013; Grier & Bryant, 2005; Lindenberger & Bryant, 2000; Nagulesapillai, 2013; Protheroe et al., 2003; Schmidt, 2013; Stead et al., 2007; Sutton et al., 2016). However, when reviewing social marketing effectiveness, it is important not to rely solely on the "label" of social marketing, as the concepts and processes of social marketing that are often associated with successful campaigns, are often misrepresented, not consistently applied, and perceived as limited to advertising or promotional activities (Dooley et al., 2009; Grier & Bryant, 2005; Stead et al., 2007). Rather than dictating the way that information is to be conveyed from the top-down, (e.g. relying on one-dimensional public service announcements), listening to the needs and desires of the target audience (mothers, families, healthcare providers, etc.), drawing from successful techniques used by commercial marketers is critical in today's world (Lindenberger & Bryant, 2000; Weinreich, 2006). To be effective, the campaigns should be collaborative and coordinated to include all sectors that are working to promote breastfeeding in the community and interventions should be developed strategically with the targeted population in mind (Centers for Disease Control and Prevention, 2013; Lindenberger & Bryant, 2000; Nagulesapillai, 2013).

Appendix D: Glossary

Health Marketing: An umbrella term that incorporates social marketing and health communications. It involves creating, communicating, and delivering health information and interventions using customer-centered and science-based strategies to protect and promote the health of diverse populations (CDC, 2011b). Health Marketing uses marketing and health promotion research to find innovative ways to educate, motivate and inform the public on health messages. It can provide guidance for designing health interventions, campaigns, communications, and research projects. Finally, it can employ a broad range of strategies and techniques to create communication messages and promote various health behaviors (CDC, 2005).

Social Marketing: Seeks to develop and integrate marketing concepts with other approaches to influence behaviours that benefit individuals and communities for the greater social good (Consensus Definition of Social Marketing, 2013). It draws on research, best practice, theory, audience and partnership insight, to inform the delivery of competition sensitive and segmented social change programs that are effective, efficient, equitable and sustainable with a focus on understanding the consumer (CDC, 2005; Grier & Bryant, 2005; Consensus Definition of Social Marketing, 2013; Lee & Kotler, 2008; Lefebvre, 2013; Scott, 2015).

Health Communications: The study and practice of communicating health information (CDC, 2011a). It is the process of making your “product” and service known to the marketplace. It is spreading the word about what your organization has to offer and how you communicate to them about the existence of that product or message.