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Examining the Washington State Breastfeeding-Friendly Policy Development Process Using the Advocacy Coalition Framework

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Abstract *Objectives* Breastfeeding promotion is increasingly recognized as a key public health strategy. Policies can promote breastfeeding by creating supportive environments and addressing challenges. In 2014, the Washington State legislature considered bills to create a voluntary recognition system for breastfeeding-friendly hospitals, clinics, worksites and childcare settings. These Breastfeeding-Friendly Washington (BFW) bills (SB 6298 and HB 2329) did not pass. *Methods* The purpose of this case study was to analyze the policy development process for the BFW bills using the Advocacy Coalition Framework. Data were collected through semi-structured interviews with key stakeholders in the state policy process, and document review. We used thematic analysis to identify deductive and inductive themes. *Results* Though all policy actors indicated general support for breastfeeding, two main coalitions (proponents and opponents) diverged in their support of the BFW bills as policy solutions to address barriers to breastfeeding. We conducted 29 interviews with mainly bill proponents, and 54 documents confirmed data about bill opponents. Proponents supported the bills given increasingly strong evidence of breastfeeding's benefits and that public policy could address environmental challenges to breastfeeding. Opponents saw the bills as government overreach into the private matter of choosing to breastfeed. Opposition to the bills came late in the session, and proponents felt opponents' messaging misconstrued the intent of the legislation. *Conclusions for Practice* Key learnings for developing breastfeeding-friendly state policies include analyzing differences between proponents' and opponents' beliefs, framing advocacy messages beyond individuals and health, expanding the coalition outside of traditional health entities, and anticipating the opposition.

Keywords Policy and practice · Breastfeeding support · U.S. · Legislation

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Significance

What is already known about the topic? Breastfeeding-friendly policies can improve breastfeeding outcomes such as reducing disparities in initiation rates. There has been opposition to US policies that support breastfeeding, and little is known about the process for developing these policies.

What this study adds? This study suggests that those working to develop supportive breastfeeding policies may benefit from the following policy learnings—analyzing differences between proponents' and opponents' beliefs, framing advocacy messages beyond individuals and health, expanding the coalition outside of traditional health entities, and anticipating the opposition. This study also utilizes an established policy process framework.

Introduction

Breastfeeding benefits infants, mothers, families, communities, and society, and is an important foundation of population health (US Department of Health and Human Services 2011; American Public Health Association 2007; World Health Organization, UNICEF 2003). Unfortunately, some barriers may prevent even the most dedicated mother from breastfeeding. Policies that support breastfeeding can be part of the solution. For example, supportive maternity care policies and practices have a dramatic effect on breastfeeding success and can reduce disparities in breastfeeding initiation (Murray et al, 2007; DiGirolamo et al. 2008; California WIC Association and U.C. Davis Center for Human Lactation 2013), and worksite policies are associated with greater breastfeeding duration (Bai and Wunderlich 2013; Tsai 2013).

In the US, state laws that support breastfeeding across hospitals, worksites, and communities are associated with increased breastfeeding rates (Hawkins et al. 2013; Kogan et al. 2008). For instance, breastfeeding rates are higher when US states enforce worksite requirements for private areas to express breast milk and break time to breastfeed or pump (Smith-Gagen et al. 2014a, b). Less than half of US states have laws to support breastfeeding at work, and very few state laws address hospital maternity care practices that support breastfeeding or enforce mandates for breastfeeding policies (Murtagh and Moulton 2011).

Many US state health departments are committed to improving breastfeeding policies and practices as part of comprehensive approaches to improve maternal and infant health and reduce disparities in infant mortality (Jarris and Pliska 2012). However, there is opposition to US state breastfeeding legislation from hospitals, businesses, and groups that seek to minimize government regulation (Saadeh 2012). Public health practitioners need a better understanding of the policy development process so they can help design effective breastfeeding policy initiatives that incorporate factors associated with policy success (Pérez-Escamilla 2012).

In 2014, the Washington State legislature considered Breastfeeding-Friendly Washington (BFW) bills to create a voluntary recognition system for breastfeeding-friendly hospitals, clinics, worksites and child care settings. Senate Bill (SB) 6298 and House Bill (HB) 2329 were discussed in committees but were not passed. The purpose of this study was to understand the BFW policy process to inform future breastfeeding policy development.

Methods

We conducted a policy case study using semi-structured interviews and document analysis. We were guided by local advisors from state agencies and coalitions (e.g., state and local public health departments, state legislative staff, breastfeeding coalitions, hospital associations) and by the consolidated criteria for reporting qualitative research (COREQ) (Tong et al. 2007). This study was exempt by the University of Washington IRB (May 2014).

Framework

Policy process frameworks, such as the Advocacy Coalition Framework (ACF) (Sabatier 2007), provide a structure for understanding multiple influences on policy outcomes. We used the ACF to examine how groups of stakeholders were brought together by common values and beliefs to advocate for or oppose the BFW bills. The framework also identifies factors outside the immediate policy proposal and legislative process and highlights the importance of policy learning over time (Sabatier 1988). Further details about key ACF constructs of interest are provided in Table 1.

Participants

We recruited interviewees through purposive sampling (Miles et al. 2014). The criteria for participating in the study was for the participant to have knowledge of the process to develop and/or try to enact the breastfeeding-friendly Washington legislation; including people who proposed or opposed the legislation. We did not sample specifically for proponents and opponents as people do not always fall cleanly into these categories; e.g., may be supportive of the legislation when it is being written and then against it after discussing in committee. Advisors identified key players in the BFW policy process and sent them an introductory email to invite them to participate in the study. Interested parties completed a brief online survey with their contact information and best time to contact them, and research staff then contacted them via email and phone to review study protocol and schedule interviews. Participant recruitment continued until we reached our target goal of 40 interviewees.

Table 1 Key components of the advocacy coalition framework (ACF) Adapted from Sabatier (1988) and Johnson et al. (2012)

Key component	Definition
Relatively stable parameters	Factors external to the policy subsystem that are stable over long periods of time (e.g. social values)
External events	Dynamic external factors that perturb the policy subsystem (e.g. socioeconomic change, a change in government). These events influence advocacy coalitions efforts to affect policy change
Policy subsystem	Composed of networks of advocacy coalitions that focus on a specific policy arena (i.e. breastfeeding, tobacco)
Advocacy coalitions	Where members are brought together to advocate for a common policy outcome based on their common values and beliefs. Policies are developed through the interaction between different coalitions
Constraints and resources of the subsystem	Factors that hinder or help the subsystem
The BFW bill subsystem	
Beliefs	The overarching driver for coalition members divided into three levels:
	1. Deep core beliefs: essentially unchangeable deeply held personal beliefs about human nature, freedom, the role of distributive justice and similar ideas
	2. Near core beliefs: fundamental policy positions concerning the articulated policy goals of an advocacy coalition
	3. Secondary policy beliefs: concerned with issues related to the administration and implementation of policy
Strategies	Tactics, messages, and actions taken by advocacy coalitions to further its policy objectives
Constraints and resources of the coalition	Factors that hinder or help each advocacy coalition
Policy outputs and impacts	The end result of the policy process, usually passed legislation, that in turn impact the identified problem
Policy-oriented learning	Mutual learning about and between advocacy coalitions within a subsystem that occurs as a result of direct challenge to a coalition, accumulated experience, confrontation, and compromise

Data Collection

The semi-structured interview guide asked about beliefs about breastfeeding practices and policies, roles in the BFW policy development and legislative session, past and current state policy efforts to support breastfeeding, and contextual factors. Trained interviewers (KF, LS, VB) conducted phone interviews from August 2014 to January 2015, obtaining verbal consent prior to each interview. Interviews lasted approximately 45 min, and participants were offered a $35 gift card for participation. Additional data were provided by documents such as emails, reports, legislative minutes, and the actual bills and amendments. These documents were obtained from interviewees at the end of the phone interview, when we asked them for documents that would help us to better understand how the BFW legislation was developed or put into place.

Data Analysis

Interviews were recorded and transcribed verbatim. Using a thematic analysis approach (Daly et al. 1997), members of the research team read and re-read (Rice and Ezzy 1999) interview transcripts to develop a list of deductive codes based on the ACF and inductive codes that emerged from the data. Team members (LS, EQ, VB, EP) coded transcripts independently, then met to review and compare codes, discussing discrepancies until consensus was reached. After coding, we (LS, EQ, VB, DJ) summarized coded text by each ACF construct. This process highlighted key themes and subthemes while also providing a framework for interpreting the findings (Miles et al. 2014). Atlas.ti (Atlas.ti 7.5.7, GmbH, Berlin) was used to support analysis.

We (VB, DJ) reviewed, coded and summarized documents. Documents provided supplementary information unavailable from the interviews and were used for triangulation (Bowen 2009). We also presented findings to advisory group members whose feedback was incorporated in this report.

Results

Twenty of 45 identified state-level policy actors and 21 of 65 identified breastfeeding coalition members participated in the interviews (N = 29). We excluded twelve coalition interviews that did not describe state policy processes. Interviewees were from the State House and Senate; the state health and early learning departments, hospital association, and employees union; and health advocacy and breastfeeding coalitions. The majority were proponents of

the Breastfeeding-Friendly Washington (BFW) bills despite several attempts to recruit bill opponents. Interviewee characteristics are summarized in Table 2.

We analyzed 54 documents to supplement interview findings. Documents provided further information on bill opponents' perspectives and strategies, and on specific legislative session activities that were not recalled by interviewees. Unless otherwise noted, results of the document analysis did not contrast with interview findings.

We used the ACF to describe the policy development process of the BFW bills (Fig. 1). Illustrative quotes are provided in Table 3.

BFW Policy Subsystem

Coalitions are made up of various policy actors who share beliefs and coordinate activities over time. For the BFW bills, two coalitions comprised the policy subsystem—proponents and opponents. Proponents included several state legislators, the state health department and hospital association, breastfeeding advocacy coalitions, and the governor's office. The main opponents were corporations that manufacture infant formula. Document analysis confirmed these corporations were represented by an advocacy organization that was sponsored by an international association of formula manufacturers and marketers. Historically, both proponents and opponents have publically shown support for breastfeeding. Despite this general support, proponents and opponents diverge on how to overcome the continued environmental challenges to breastfeeding (e.g., lack of adequate time and space to pump at work; free formula provided universally at many hospital settings).

Table 2 Participant characteristics (N = 29), Breastfeeding-friendly Washington (BFW) bills case study, 2014–2015

Respondents	Category	# (%)
Sector	State policy	20 (69)
	Breastfeeding coalitions	9 (31)
Position years	<1	3 (10)
	1–5	11 (38)
	6–10	5 (17)
	11–20	7 (24)
	21+	3 (10)
Age	36–45	8 (28)
	46–55	9 (31)
	56+	12 (41)
Gender	Male	9 (31)
	Female	20 (69)
Race/ethnicity	White, Non-Hispanic	28 (97)
	Non-white, Hispanic	1 (3)

The Origins of the BFW Bills

The behavior of coalition members is influenced by contextual factors that are relatively stable parameters and often resistant to change (i.e., societal values or finite resources) and by more dynamic external events that can radically alter a policy subsystem (e.g., a change in government or socioeconomic conditions).

Relatively stable parameters: Interviewees described a number of US-specific factors that pose environmental challenges to breastfeeding: "Mixed messages" about breasts as sexual objects and as a source of nourishment for babies; a history of limited policy support for women and families; and, a capitalist economy that may not prioritize public health. Interviewees saw improved breastfeeding policies as a way to promote population health, economic benefits for workplaces, and safe and fair labor conditions for mothers.

External events: Participants mentioned many external events that set the stage for developing the BFW bills. In particular, social and behavioral norms have changed considerably: more women with children under one are working, more women are articulating a desire to breastfeed and the need for supportive environments, and "more elected officials who are women and/or have young children." Younger generations also seem more comfortable breastfeeding. There has been increasing evidence about breastfeeding benefits for not only babies and mothers but also for families, workplaces, and the public's health. Table 4 provides recent breastfeeding recommendations, policies and grants that buoyed the BFW policy development.

Coalition Beliefs

The ACF suggests people engage in policymaking to translate their beliefs into action. The framework describes three types of beliefs that guide coalitions– *deep core* (fundamental and unlikely to change), *policy core* (more specific but still unlikely to change), and *secondary aspects* (related to policy implementation and most amenable to change). Exemplar quotes for each of these types of beliefs is provided in Table 3.

Proponents of the BFW bills believed it is in society's best interest to promote health (*deep core*). As one participant shared, "we're trying to make the next generation healthier for kids, and we should make sure we give kids the best start." Proponents' *policy core* beliefs included: viewing breastfeeding as the healthiest option, that every woman has a right to choose to breastfeed, and that breastfeeding is a private decision that takes place in a public context (given the environmental constraints to exclusive breastfeeding and pumping). Many proponents

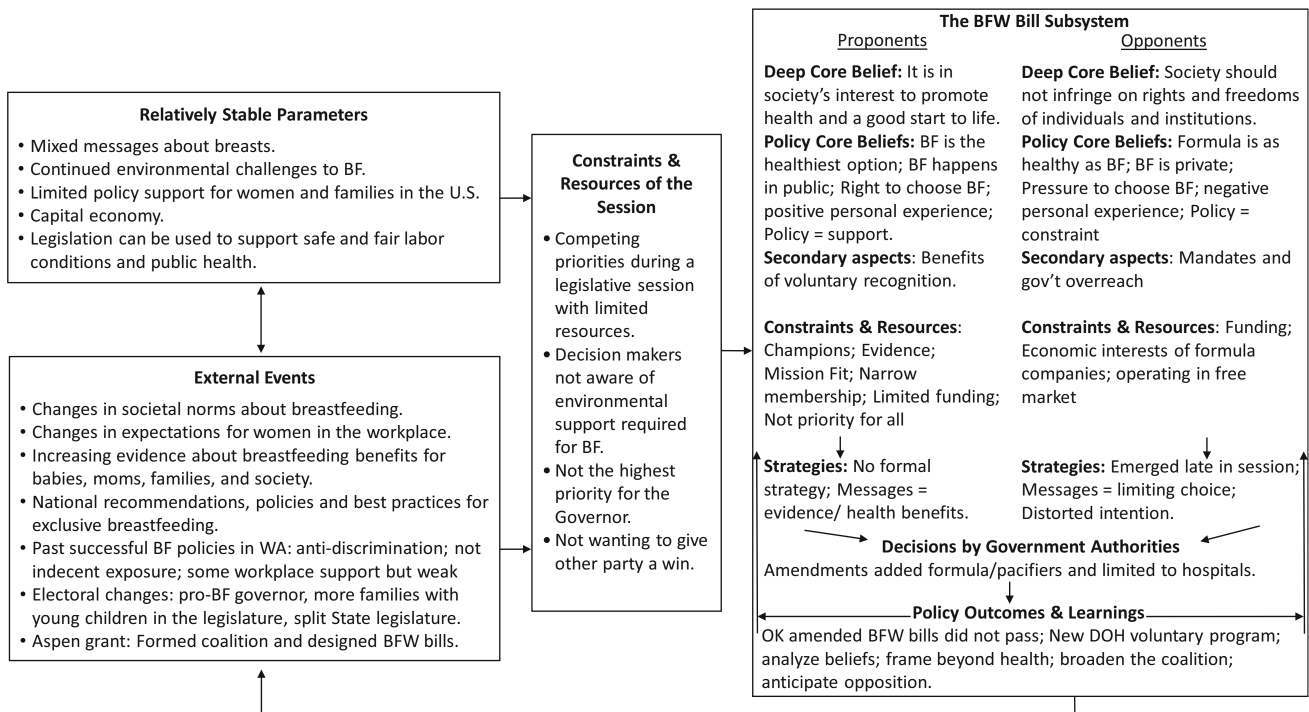

Fig. 1 A modified advocacy coalition framework for statewide breastfeeding legislation Adapted from Breton et al. (2006)

had a positive personal experience with breastfeeding and had overcome challenges to breastfeed. They believed a voluntary recognition program was an appropriate approach (*secondary aspect*) for the state given limited state resources and the expected pushback from a mandatory program.

Interviewees provided their perspectives on opponents' beliefs. They thought that opponents held the *deep core* belief that society should not infringe on the rights and freedoms of individuals and institutions; as such, opponents' *policy core* beliefs were that the BFW bills would constrain women and environments, that breastfeeding is a private matter, and that the state policy would be "essentially promoting a kind of pressure" on women to choose to breastfeed. Interviewees felt that many opponents had experienced negative personal experiences with breastfeeding in which they or someone they knew felt guilty for not breastfeeding. Interviewees believed that opponents saw the BFW bills as government overreach and as mandates (*secondary aspects*) to breastfeed even though the bills supported only a voluntary recognition program.

Coalition Resources and Constraints

Proponents of the BFW bills had several resources to support policy development. They had champions in state agencies, in both parties and branches of the legislature, and in advocacy and other community-based organizations. They could cite increasing evidence about breastfeeding's benefits, and the BFW bills aligned well with their organizational missions. Proponents were hindered by limited funding to promote the bills, the narrow membership of their coalition (which included primarily health-related entities), and some members' viewing breastfeeding as important but not "critical."

Interviewees thought opponents benefited from having ample funding (as formula companies and other lobbyists) to challenge the bills. Not passing the bills also aligned with economic interests to maintain or expand formula's reach to new families. Opponents may have been constrained by having to operate in the free market and the need to appear to support breastfeeding as a public health issue, even if it interferes with their bottom line. Sample quotes about this and other ACF constructs are offered in Table 3.

Coalition Strategies

Proponents' key messages to legislators centered on increasing evidence to support why breastfeeding is good for mothers, babies, worksites, and society. Sharing information about these health and other benefits was how proponents aimed to gain support for the bills; no formal strategy was in place to combat the opposition that emerged later in the legislative session.

Table 3 Themes, subthemes and sample quotes from the Breastfeeding-Friendly Washington (BFW) bills case study, 2014–2015

Theme/subtheme	Sample quote
Stable parameters	
Parents want what's best for their kids	I think that we find most women want to feed the best to their children, and dads certainly want the best as well for their kids. (SP18)
General support for breastfeeding	I think that there was no real opposition to having breastfeeding and promoting breastfeeding. The question is how much do you promote it. (SP1)
Mixed messages about breasts	I think it's very difficult to breastfeed in this particular society because we get so many mixed messages about breasts. Even women sometimes feel bothered by women who breastfeed in public. (BFC12)
Environmental challenges	We have a lot of workplaces who are not very supportive of breastfeeding moms. That it makes it almost impossible for many of them to continue to breastfeed, if they don't have places they can safely pump, and they don't have supportive work environments. (SP20)
Limited policy support for US women and families	You can look at this from a nationwide perspective and understand that women's health issues don't really get the kind of airplay that we really think they should. We're not family supportive as a nation, you know? (BFC15)
Free market economy	The formula companies are not opposed to the breastfeeding policy; they just are opposed to anything in this statute limiting the access they have historically had. (SP6)
Legislation can support safe and fair labor conditions and public health	I think that it's really important for the community as a whole. We can save like $19 billion I think in healthcare dollars, if every baby was breastfed in the US, and so it's a really important public health concern. (BFC13)
External events	
Increasing evidence about BF benefits	I'd say that the overwhelming research out there about the short-term and long-term benefits to it. I would say that that has been the strongest influence. (SP2)
Recommendations and best practices for exclusive BF	What CDC has put out, especially that the US Surgeon General, has put out about breastfeeding; looking at more policy and environmental issues that affect breastfeeding vs. just educating moms. (SP12)
Past successful BF policies in WA	Some of the external factors that have influenced, of course, are state and federal laws that have kind of broadened the scope. It is now okay to breastfeed in public environments where before there were some inhibitions for that activity. (SP5)
National policies set stage for BFW bills	The ACA has definitely opened the door to help with guidance in regards to hey, you need to provide a place for moms to pump. I think that it helps create a dialogue. (BFC1)
Electoral changes	I don't know if there has been a time where there have been so many members that have young families. I think that was important. (SP4)
Aspen grant	Through that opportunity Aspen and RWJF dictated $10,000. It was seed money to get us together to look at opportunities in our state to improve breastfeeding policy. (SP13)
Changes in societal norms	I would think there have been changes in the environment in terms of normative behavior around breastfeeding. There is probably more public breastfeeding that they see. (SP14)
Changes in expectations for women at work	I do think the discussions then vs. what it was even years ago was much more acceptance in that breastfeeding happens; that breastfeeding happens for working women. (SP6)
Constrains and resources	
Legislature membership/majority in power in the House	We have a very strong chair who I think works fairly and for the most part, folks are bringing legislation that saw the light of day and got a fair hearing. And then the people with the votes get to push stuff out of committee, and so I think it's run very well. (SP4)
Competing priorities during a session with limited resources	You're thinking about health-related vs. education vs. corrections…when you start to lay out all those different aspects of what these legislators have to think about and balance in an environment where this no new revenue, it's just incredibly challenging. (SP16)
Not the highest priority for the Governor	It's something we care about, but I would say that it isn't the primary issue right now…The department was active in it, but it didn't make the cut for the governor's bills. We only do about 6 or 8 bills every year….It is a priority without the highest priority. (SP1)
Time/tries needed to successfully pass bills	This place is so deadline-oriented and there are so many steps that you have to hit in order for a bill to pass. Usually, it takes about two or three years for a bill—it usually takes a new idea really–about 2 or 3 years to pass. (SP7)
Lack of awareness about need for environmental support for breastfeeding	I think that the legislators that are advocates for it need more information. Some have that and they really get it…But then there are some others that don't necessarily understand enough about it. They're supportive about it, but it's a little more complicated–how important it is to not change the baby-friendly steps. (SP8)

Table 3 continued

Theme/subtheme	Sample quote
Not wanting to give other party a win	They were against basically everything we did, no matter whether they agreed with it or not. They had agreed with it in previous years, but were against it this year. (SP1)
The policy bill subsystem	
Proponents	
Deep core beliefs	I feel it's a public health issue. I think that the health of our community is very important, and by promoting breastfeeding we are improving the health of our community. (BFC14)
Policy core beliefs	Breastfeeding is both an evidence-based healthy start, very important part of a child's development, and an important part of maternal bonding. (SP9)
Secondary aspects	We also know that there can be a lot of barriers to breastfeeding, in that we don't think people should have to go this alone. Helping to figure out the policy systems and other supports that are needed to address those barriers is important. (SP18)
Constraints/resources	Legislators have to use chips to move bills forward… it's just a question of how you play the game, you know? You need a champion that's willing to go to bat and say that this needs to get to X committee. (SP14)
Strategies	If moms and babies are healthier, then insurance costs to businesses are going to be less as well, because there is going to be less sickness among both baby and mom. (BFC12)
Opponents	
Deep core beliefs	I don't know if they're organized as a group, but sort of as a philosophy of 'don't let government tell me what to do', kind of people. (SP10)
Policy core beliefs	It's my business as to whether or not I breastfeed. Government shouldn't tell me. (SP2)
Secondary aspects	Whenever you come in and you say that we're going to have this new program where we're going to designate people but It's not mandatory, there is always a bit of suspicion as to how much government overreaching is going on. (SP7)
Constraints/resources	I think that they're never going to be happy with something in statute that would get in the way of them marketing their product as they see it. (BFC13)
Strategies	They characterized these bills as an assault on a woman's right to choose. (SP13)
Decisions and policy outputs and impacts	
Amendments	And in the end she [the Senator] passed my bill out of committee, but stripped it down to just be the hospitals because she had some concerns. (SP4)
Outputs	Some of the elected, they're actually supportive of breastfeeding overall. But then some of their perspectives or some of their real-life experiences potentially got involved in their interest in amending the bill language, which in some ways dramatically changed the steps enough to the point where there wasn't support from the advocates that that should actually be the framework for the bill. (SP8)

ACA Affordable Care Act, *BFC* Breastfeeding coalition interviewee, *CDC* Centers for disease control and prevention, *RWJF* Robert wood johnson foundation, *SP* State policy interviewee, *US* United States

Meanwhile, proponents felt that the opposition waited until the end of the session to spread messages about how the BFW bills would limit choices for women and families. Women testified that the BFW bills would make them feel guilty or coerced to breastfeed; opponents generally framed the bill as "the government telling people what to do." Proponents believed the opposition distorted the intention of the bills, saying that families would be forced to breastfeed and could not choose formula if they wanted or needed it. Document review showed that opponents described the BFW bills as limiting formula to everyone, while the bill language only limited health care providers from marketing formula through gift bags, coupons, and free samples.

Constraints and Resources of the Legislative Session

The ACF suggests that policymaking takes place in a broader system that sets the boundaries for action and provides each coalition with different constraints and opportunities.

The legislative session was constrained by several factors, particularly a short session (2 months) and a climate of limited resources and competing state priorities (even

Table 4 International, national and local recommendations, policies, and grants identified by interviewees as setting the stage for the Breastfeeding-Friendly Washington bills, 2001–2014

Recommendations/policies/grants	Summary	Year
Recommendations		
Centers for Disease Control and Prevention (CDC 2013)	Summarized the latest evidence on policy and environmental strategies to promote breastfeeding	2013
American Academy of Pediatrics (AAP)	Recognized breastfeeding as a public health issue (not a lifestyle choice); Endorsed BFHI	2012
US Surgeon General's Call to Action	Identified 20 key actions (including for communities, health care, employment, and public health) to support breastfeeding	2011
World Health Organization (WHO)/Baby-Friendly Hospital Initiative (BFHI) (WHO and UNICEF 2009)	Revised, updated, and expanded 10 evidence-based steps for promoting breastfeeding in hospitals	2009
National policies		
Affordable Care Act	Required support for breastfeeding at worksites (adequate break time and space), and health care coverage for breastfeeding support, supplies and lactation support	2010
Women, Infants and Children (WIC)	Funding for community breastfeeding promotion (with WIC families and providers)	2009
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	Established new breastfeeding quality measures for hospitals (including exclusive breastfeeding)	2014
State policies		
RCW 49.60.030	Added breastfeeding to anti-discrimination laws	2009
RCW 9A.88.010	Removed breastfeeding from indecent exposure laws	2003
RCW 43.70.640	Provided some policy support (albeit weakly) to workplaces	2001
Grants		
RWJF-funded Excellence in State Public Health Law ("Aspen")	Funded teams of state public health, legislators, and governor's office to advance breastfeeding	2014

RCW Revised Code of Washington, *RWJF* Robert Wood Johnson Foundation

among proponents), such as education and corrections. Even though breastfeeding support was seen as an important issue, it was not a top priority amidst other issues the legislature had to address. Furthermore, there was limited awareness about what specific, evidence-based policies were needed to optimally facilitate breastfeeding. The bill was also perceived as Democrat-led and sanctioned by the Governor, which meant some legislators who were supportive of breastfeeding did not support bills that would give the other party a win. No specific resources of the legislative session were identified by either coalition.

Policy Decisions and Outcomes

In order to address the opposition, amendments were passed to remove bill restrictions on pacifiers and formula marketing and to limit the House Bill to hospitals only. The BFW bills had some traction in both committees, but never received formal votes on the floor. Many proponents were comfortable with this outcome since the original bills had been "watered down until they lost most of their meaning." Proponents also understood that bills are not often passed on their first try. Recognizing that a bill was not the only way to enact policy, the state department of health has since launched a voluntary recognition program for hospitals that includes many elements from the BFW bills (Washington Department of Health 2015).

Conclusions for Practice

The 2014 Breastfeeding-Friendly Washington (BFW) bills provided an opportunity to test coalitions, develop legislation based on evidence-based policies and practices, design messages to support policy adoption, and hear concerns from various stakeholders. This policy case study helped identify key factors in policymaking, including stable and dynamic contextual factors; beliefs, resources, and strategies of each coalition; constraints of the legislative session; and subsequent policy decisions and outcomes. Other public health policymaking efforts may benefit from these important policy learnings.

Analyze beliefs: There were several dichotomies between proponents' and opponents' attitudes, from deep core beliefs about public health versus free markets; to policy core beliefs that viewed breastfeeding as a public vs. private matter, breastmilk as the healthiest option versus one option for feeding babies, and breastfeeding policies as

supporting women's right to choose versus constraining women's right to choose not to breastfeed. These contrasting beliefs inspired very different policy approaches (secondary aspects): proponents supported a voluntary recognition program that would change environments to make it easier to choose breastfeeding, while opponents viewed the BFW bills as government overreach and mandates that infringed on individuals' right to choose formula and on organizations' right to run their businesses. The personal also proved to be political: personal experience influenced support or opposition to the bills depending on positive or negative experiences with breastfeeding.

Frame beyond individuals and health: Proponents' policy core beliefs and messaging centered on the health of mothers and babies. The Berkeley Media Studies Group (BMSG 2010) has found that a health argument for breastfeeding is insufficient since it oversimplifies breastfeeding as a function of an individual mothers' intent; not as an outcome of a society that does not support women, children and families. Focusing on health benefits absent of environmental barriers is akin to encouraging children to play outside without regard to neighborhood safety. Using a fact-based argument (e.g., research evidence about breastfeeding benefits for moms and babies) to support breastfeeding is also futile when up against deep core and policy core beliefs surrounding privacy and capitalism. Expanding the frame beyond individuals and health is needed so that non-health policy actors have a stake in passing bills to support breastfeeding.

Broaden the coalition: Likewise, while there was general support for breastfeeding within and across coalitions, a broader coalition of proponents is needed beyond traditional health entities. The BFW bills were perceived as an extension of the state public health agency instead of a comprehensive movement. Broadening the coalition to strategically and specifically engage women, families, providers, and organizations across sectors may better support policy change and anticipate and address opponents' concerns. It is particularly important to engage labor and other business groups, professional associations for nurses and pediatricians, and nursing mothers.

Anticipate the opposition: The general support for breastfeeding across policy actors, along with the late-breaking opposition, led to the misperception that the BFW bills would pass easily. Previous breastfeeding policy opponents (businesses) were largely absent from the debate, and formula companies had not opposed earlier breastfeeding policy efforts since they did not infringe on their bottom line. The ACF suggests that brokering between coalitions is needed early in the policy process so that proponents can proactively address opponents' concerns instead of being caught on the defensive. The recently approved Hospital Infant Feeding Bills in California (SB 402 and SB 502) (California WIC Association 2014) suggest that legislation to promote evidence-based policies can pass when explicit language against formula feeding is removed from the bills.

This study was limited by several factors. First, we were unable to obtain interview data from opponents of the BFW bills despite several attempts to both find and invite them to participate. Their lack of interest in participating in the study is not surprising given that they were not supportive of this state legislation. As such, all interviewees were proponents or were more neutral about the bill either during its development or process of trying to get passed. To address this limitation, we reviewed documents to locate accurate bill details and confirm interview findings, especially in reference to the opposition. Our sample also lacked racial/ethnic diversity. We recognize that this is a limitation of the breastfeeding promotion field that has traditionally been led by White women.

Reflexivity is the 'active acknowledgement by the researcher that her/his own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation' (Horsburgh 2003: 309); the positioning of research team members in relation to the group of study is one way to understand reflexivity in context. Our study team members included people with different positions from insider to outsider of the BFW legislation—people who were unfamiliar with the BFW legislation, people who knew about the legislation but were not involved in its development or attempt to enact or oppose the bills, and people who were familiar with the BFW legislation through previous research on evidence-based breastfeeding policies. Our advisors further provided context for the BFW legislation development and attempt to pass the bills. Including these different positions helped strengthen our research by sensitizing the researchers to threats to trustworthiness, and to raising awareness of potential biases and increasing diligence during the data analysis process (Berger 2013). We also used triangulation by comparing analysis of the same content by two members of our research team to help ensure that the data analysis was an accurate representation of the themes.

Public health practitioners are charged with developing policies as one of their ten core competencies as policies that create healthier environmental contexts have an enormous potential to promote population health across communities (Frieden 2010). Theories such as the ACF can help distill key factors that drive policy change in a complex policymaking environment (Breton and De Leeuw 2011). Other public health studies utilizing the ACF report similar findings as in this case study; such as the importance of having a broad coalition and identifying the beliefs and external factors that shape the policy-making environment (Breton et al. 2006; Johnson et al. 2012; Ulmer

et al. 2012). While this study was conducted on a US state policy legislation to support breastfeeding, we see broader implications for other countries who have a social responsibility to create enabling environments for women who want to breastfeed (Rollins 2016). This study can inform the efforts of practitioners and policymakers who are working to improve breastfeeding outcomes through policy change.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

References

American Public Health Association. (2007). A call to action on breastfeeding: A fundamental public health issue. http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1360. Accessed 27 Oct 2015.

Bai, Y., & Wunderlich, S. M. (2013). Lactation accommodation in the workplace and duration of exclusive breastfeeding. *Journal of Midwifery and Women's Health, 58*(6), 690–696.

Berger, R. (2013). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219–234.

Berkeley Media Studies Group. (2010). Talking about breastfeeding: Why the health argument isn't enough. Issue 18. Prepared by Lori Dorfman and Heather Gehlert. www.bmsg.org/sites/default/files/bmsg_issue18_talking_about_breastfeeding.pdf. Accessed 27 Oct 2015.

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal, 9*(2), 27–40.

Breton, E., & De Leeuw, E. (2011). Theories of the policy process in health promotion research: A review. *Health Promotion International, 26*(1), 82–90.

Breton, E., Richard, L., Gagnon, F., Jacques, M., & Bergeron, P. J. (2006). Fighting a tobacco-tax rollback: A political analysis of the 1994 cigarette contraband crisis in Canada. *Public Health Policy, 27*(1), 77–99.

California WIC Association. (2014). Hospital breastfeeding support legislation. www.calwic.org/policy-center/state/291. Accessed 27 Oct 2015.

California WIC Association & U.C. Davis Center for Human Lactation Center. (2013). Policies, promises, and practice: Supporting breastfeeding across the continuum of care: A policy update on California breastfeeding and hospital performance. http://www.calwic.org/storage/documents/factsheets2013/statefactsheet2013FINALrevised.pdf. Accessed 31 Mar 2016.

Centers for Disease Control and Prevention (CDC). (2013). Strategies to prevent obesity and other chronic diseases: The CDC guide to strategies to support breastfeeding mothers and babies. Atlanta (GA): US Department of Health and Human Services. http://www.cdc.gov/breastfeeding/pdf/BF-Guide-508.PDF. Accessed 17 Nov 2015.

Daly, J., Kellehear, A., & Gliksman, M. (Eds.). (1997). *The public health researcher: A methodological guide*. Melbourne: Oxford University Press.

DiGirolamo, A. M., Grummer-Strawn, L. M., & Fein, S. B. (2008). Effect of maternity-care practices on breastfeeding. *Pediatrics, 122*(Suppl 2), S43–S49.

Frieden, T. R. (2010). A framework for public health action: The health impact pyramid. *American Journal of Public Health, 100*(4), 590–595.

Hawkins, S. S., Stern, A. D., & Gillman, M. W. (2013). Do state breastfeeding laws in the US promote breastfeeding? *Journal of Epidemiology and Community Health, 67*(3), 250–256.

Horsburgh, D. (2003). Evaluation of qualitative research. *Journal of Clinical Nursing, 12*, 307–312.

Jarris, P. E., & Pliska, E. S. (2012). State public health agencies' commitment to healthy babies: Addressing the goodness and fairness in breastfeeding rates. *Breastfeeding Medicine, 7*(5), 350–353.

Johnson, D. B., Payne, E. C., McNeese, M. A., & Allen, D. (2012). Menu-labeling policy in King County, Washington. *American Journal of Preventive Medicine, 43*(3 Suppl 2), S130–S135.

Kogan, M. D., Singh, G. K., Dee, D. L., Belanoff, C., & Grummer-Strawn, L. M. (2008). Multivariate analysis of state variation in breastfeeding rates in the United States. *American Journal of Public Health, 98*(10), 1872–1880.

Miles, M. B., Huberman, A. M., & Saldana, J. (Eds.). (2014). *Qualitative data analysis: An expanded sourcebook* (3rd ed.). Thousand Oaks: Sage.

Murray, E. K., Ricketts, S., & Dellaport, J. (2007). Hospital practices that increase breastfeeding duration: Results from a population-based study. *Birth, 34*(3), 202–211.

Murtagh, L., & Moulton, A. D. (2011). Working mothers, breastfeeding, and the law. *American Journal of Public Health, 101*, 217–223.

Pérez-Escamilla, R. (2012). Breastfeeding social marketing: Lessons learned from USDA's "Loving Support" campaign. *Breastfeeding Medicine, 7*(5), 358–363.

Rice, P. L., & Ezzy, D. (1999). *Qualitative research methods: A health focus* (p. 291). Melbourne: Oxford University Press.

Rollins, N.C., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C.K., Martines, J.C., Piwoz E.G., Richter L.M., Victora C.G.; Lancet Breastfeeding Series Group. (2016). Why invest, and what it will take to improve breastfeeding practices? *Lancet, 387*(10017), 491–504.

Saadeh, R. J. (2012). The baby-friendly hospital initiative 20 years on: Facts, progress, and the way forward. *Journal of Human Lactation, 28*(3), 272–275.

Sabatier, P. (1988). An advocacy coalition framework of policy change and the role of policy-oriented learning therein. *Policy Sciences, 2*(213), 129–168.

Sabatier, P. (Ed.). (2007). *Theories of the policy process* (2nd ed.). Boulder: Westview Press.

Smith-Gagen, J., Hollen, R., Tashiro, S., Cook, D. M., & Yang, W. (2014a). The association of state law to breastfeeding practices in the US. *Maternal and Child Health Journal, 18*(9), 2034–2043.

Smith-Gagen, J., Hollen, R., Walker, M., Cook, D. M., & Yang, W. (2014b). Breastfeeding laws and breastfeeding practices by race and ethnicity. Centers for disease control and prevention. National immunization survey. *Women's Health Issues, 24*(1), e11–e19.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-tem checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349–357.

Tsai, S. Y. (2013). Impact of a breastfeeding-friendly workplace on an employed mother's intention to continue breastfeeding after returning to work. *Breastfeeding Medicine, 8*, 210–216.

Ulmer, V. M., Rathert, A. R., & Rose, D. (2012). Understanding policy enactment: The New Orleans fresh food retailer initiative. *American Journal of Preventive Medicine, 43*(3 Supp 2), S116–S122.

US Department of Health and Human Services. (2011). *The surgeon General's call to action to support breastfeeding*. Washington: US Department of Health and Human Services, Office of the Surgeon General.

Washington State Department of Health. (2015). Breastfeeding friendly Washington hospitals. www.doh.wa.gov/ForPublicHealthandHealthcareProviders/BreastfeedingFriendlyWashington/Hospitals. Accessed 27 Oct 2015.

WHO and UNICEF. (2009). Baby-friendly hospital initiative: Revised, updated and expanded for integrated care. World Health Organization, UNICEF, and Wellstart International. http://www.who.int/nutrition/publications/infantfeeding/bfhi_trainingcourse/en/. Accessed 27 Oct 2015.

World Health Organization, UNICEF. (2003). *Global strategy for infant and young child feeding*. Geneva: World Health Organization.