

## **AMCHP 2008 ANNUAL CONFERENCE**

### **WE ARE MAKING A DIFFERENCE:**

#### **A Breastfeeding Outreach Campaign to Young African American Women**

March 1st to 5th, 2008

BRIAN CASTRUCCI: --the house and my wife walked by and, I guess, (inaudible) at the time. She zoomed in my den and was like, "What was that?" And I said, "Well, you got to remember, that was—this was targeted to men not to women, and that is a concern." If that came out in the focus groups that I'm concerned, as a guy, you know, you hear that kind of, you know, this is something that was an object of, you know, sexualness and now it's not. It has that—so, it's addressing the men.

UNKNOWN SPEAKER: I'm totally with you but (inaudible) for a second. We also hear a lot of men saying, you know, they're concerned about the attention going to the baby and not towards them and, boy, that bond between mom and baby with breastfeeding is wonderful. So, how do you overcome that so they can feel secure that it's going to get in the way of their relationship with their partner who is having this wonderful, intimate bond with the baby?

BRIAN CASTRUCCI: And I think, you know, this kind of tries to bring out some of the positives so that we're not necessarily addressing the negative idea of how to, you know, I want to feel bonded too or I'm not feeling, you know, involved in this relationship. I think the ad really pulls out what's positive for the baby, what's positive—and then gives, you know, and she's going to be back in better shape and this great and it helps you. So, just try to plug those positive themes. And some of the brochures that I'll talk about later show some more of that father-child bonding. I'm going to play the grandmother's radio ad.

UNKNOWN SPEAKER: In (inaudible) but one thing (inaudible) importance of family. One thing that's always (inaudible) our awareness of we best care for our children. For example, it turns out that breastfeeding is really good for our babies. It makes kids healthy and strong. It saves time and (inaudible) since you don't have to prepare bottles or (inaudible). And best of all, it helps create that special bond between a mother and her baby, and that's a bond that lasts forever. So, I'm going to talk (inaudible) to make sure they breastfeed their little ones. They may think I'm (inaudible) but I know I'm right as always.

UNKNOWN SPEAKER: Breast milk, 100 percent natural ingredient (inaudible) call 1-800-942-3678. (Inaudible) to any participant.

UNKNOWN SPEAKER: (Inaudible) the Department of State Health Services.

BRIAN CASTRUCCI: Now, some of the questions on the questionnaire that I'm really interested in are some of the modeling and the role modeling. We ask—some of the questions we asked on survey addressed, do you know anyone who was breastfed? Did your mother breastfeed you? Did your grandmother breastfeed? Do you have any friends who breastfed? So, it'd be interesting to see how some of that role modeling plays out when you're stratified by race ethnicity. But to make sure we had these multigenerational messages, that was important in the focus groups. I could, you know, flip back briefly to see just as this came up my own head where grandma was—as an influencer and an encourager.

UNKNOWN SPEAKER: Not so high.

BRIAN CASTRUCCI: Not so high. And again, that's where focus group and—when I look back. Okay. So, about 20 percent in the Hispanic group noted that grandmother was an influencer, 13 percent among African Americans and 17 percent among Caucasians. Mom and partner were higher. And that's again, we hit the dads. And again, if dads can be, you know, an encourager. When they're influential, that's going to be important. So, those are just two. There were—you have a bunch of ads on the CD with peer councilors (inaudible) ads, other mothers (inaudible) ads, all those are on the CD. And recalling from our Web site, all of those are public use. You just need to, you know, send an e-mail to WIC and let them know but the Web site address is also in the packet

somewhere so that, again, if this is stuff you guys want to use, it's doable. This was the television ad.

UNKNOWN SPEAKER: (Inaudible) love, family, support, joy, health. It all starts with (inaudible) breast milk, 100 percent natural ingredients for a beautiful life.

BRIAN CASTRUCCI: And again, that was the television ad for the outreach campaign. The outreach campaign also included community outreach, a breastfeeding education bag, distributions that included brochures and magnets and baby bibs, it included posters and physician protocols so that they could understand how to bring breastfeeding in as a topic as a part of prenatal care visit or even as a pediatric visit. So, here with the posters and the brochures, you know, we have the dad's brochure.

We have the other two—the middle one was a poster and a billboard. And note the one to the far left it says, "As a doctor, I feel breastfeeding is the healthiest thing you can do for your baby. As a mother, I feel it's the most beautiful." And you can see from what she's wearing, she's a provider. So, it's again, in a targeted campaign to African American women, having African American providers is useful and you get some, you know, connection—hopefully, a greater connection with that poster, but these were the print materials. These, and I encourage you to look at these because I think these are really cool, these are the job aides, really, for the providers. And these are protocols that "doctors

make the difference incorporating breastfeeding into prenatal care, steps to a breastfeeding-friendly practice, educate, encourage, welcome.” So, these are things that you could take, you know, right to your providers and reproduce, and educate them on, you know, this is how, I mean, the one on the left, really, walks you through—you say this and then they say that and then this is that opening.

And so, you know, more of this, I mean, understanding providers are, you know, for a long time in public health who made the kind of the partner care provider, a deliverer of all messages. We’re supposed to do the domestic violence screening, the tobacco screening, the breastfeeding screening, all these 10,000 screenings. I think if you can give them something that’s very, kind of, tangible and—even if they make a breastfeeding-friendly practice and follow some of these steps, we’re making the dent into the general kind of population that we’re trying to impact. Okay. So, after the campaign, the effectiveness of the campaign is captured in the post-interview data. And what we were able to do is go back to the same women who we had the focus groups with before the campaign and kind of go through them, do focus group interviews with them. And, you know, I got the brochure at my hospital and my husband was like, “All right. Something for me.” He didn’t feel so left out. I’m trying to breastfeed now. And from the healthcare providers, they felt that they’re more informed, I’m (inaudible) more questions than I used to, people are trying to confirm what they’ve heard on the radio and I’ve noticed more African American mothers in my prenatal class. And when you kind of drill those down, we saw these, you know, broad codes of

incorporating the father's increased interest, more breastfeeding and then some attitudinal change which the main theme there is positive response.

So from the focus group perspective, there was positive response to this breastfeeding outreach campaign. However, focus group data is not as strong from an evidence standpoint as quantitative data. So, we constructed a way to kind of look at this using surveillance data to show change among members of the population. We took six counties, we had three intervention counties, we found three control counties, and we took 11 time points, which was the 10-month baseline month and then the 10 months of the actual campaign, to see what was happening to breastfeeding in this follow up period.

From baseline, which is month zero to month 10, rates of breastfeeding among African American women increased by 10 percent or an average of about one percent per month. In doing this presentation, we went back-and-forth with how technical we wanted to get this piece of this presentation. I want to break it down as simply as I can. The analysis that we used allows you to look at time and intervention separately because the first question that you'd want to ask when you see these data is how do you know that just didn't happen over time like it's just a natural component of just the evolution of time? Well, when we put just time in the model alone, nothing was significant. When you put time and intervention kind of treatment effect, we were able to see this increase and it was significant. Also, it was interesting was that the campaign only impacted African

American women. It didn't have an impact in Hispanic women, it didn't have an impact in Caucasian women which kind of demonstrates the power of tailoring, you know, the good and the bad side of tailoring but, you know, it was effective in the target population, it increased breastfeeding rate. So, when you think of, you know, from a quantitative standpoint, it actually gave us—and it was hierarchical-linear modeling for those of you who likes fancy terms. It allowed us to really show that at a community level, there were changes from the intervention communities in comparing the control communities.

So, we had a really positive qualitative data that was then supported by some real and interesting quantitative data. So, in research you'll call that triangulating methods. And if you can triangulate methods, you have a stronger overall picture. It's like if—there was a study we did back a couple of years ago that looked at condom use among adolescent girls. And what we saw in the focus groups was trust. Trust always preceded choosing not to use condoms. And then in the quantitative data, we were able to look at the number of months that you were with somebody before you chose not to use condoms. So, we kind of were able to say, "Okay, what's happening here is trust " and were able to kind of say, "After 4.2 months, you develop trust and you're therefore not going to use condoms." And so, we were able to triangulate data, the same thing we did here, a focus group data with a quantitative data. It helps us understand from both perspectives that, you know, that we've had the same result using both kinds of data. So, I think it's a really strong evaluation and shows that this was effective.

Let's just talk about the costs because the first bullet you're going to go, "Whoa, that's really expensive." Yeah, 850,000 over three years, that's (inaudible) media, developing the materials, developing the radio ads, developing the TV ads, but let's just think about that for a second. There are studies—if you just take the base kind of cost that you can save with breastfeeding. I'm not going to bring in all the long-term effects. There are some studies that'll tell you breastfeeding save \$16,000 per breastfed child over the five-year period of early childhood. Let's just take this real simple and look at savings to medicated clients.

Medicated clients who breastfed have about \$400 less in annual expenditures than medicated clients who don't breastfeed. That's in the literature. So, at about 2,000 clients who—that you would actually give this to, you'd kind of start to breakeven. So, in a size of 20,000—in a 20,000-person population size—if this was applied to 20,000 people, you'd get, based on these results, 2,000 women who would then breastfeed, an increase of 2,000 women, and you'd breakeven. In smaller populations, maybe this isn't the most effective. But in large populations, a population of like at least a minimum threshold of 20,000 women, this is going to be at least breakeven. You'll at least going to hit the breakeven point. So, looking at that big number, looking at that 850,000 is going to be off putting it first. But if you really just think about it for a second, okay, it's possible for a breakeven point and this is a way to kind of market this kind of campaign to Medicaid, other possible funders because there is going to be a cost savings that

we can prove and we know where our breakeven points are and we know where our cost saving points would be.

So, really, what we're able to see is that the data demonstrated that the target media campaign was effective in promoting breastfeeding among rural populations of African American women. As the campaign rolled out, increased breastfeeding visibility in public discussion, there was an increase in the breastfeeding rates among the African American women. So, I think this is where we talk about the social norms. From the earlier question, again, we're hitting providers, we're hitting parents, we're hitting a lot of different kind of folks within the network to help encourage breastfeeding. Both time and campaign influenced the rate of the increase and that demonstrates that this program was effective and not just a factor of time alone. In the past several years, you've had intervention and prevention. Researches found that target efforts are effective in health promotion. In particular, targeted media campaigns have proven useful in public health efforts that focus on behavioral change. Ample evidence exist of the relationship between media campaign and change in attitudes, knowledge and belief does exist. And performance indicators such as health (inaudible) behaviors are using the kind of population data that we did here can be implemented. So, you can actually show movement towards a performance measure, a before-after. You don't have to get so fancy with the methods. You really can say, "Okay, we did it. Here is our WIC data before. Here is our WIC data after." Any questions on this part? Yes, ma'am?

UNKNOWN SPEAKER: Can you talk a little bit about who did your community outreach? I know you had the (inaudible) and you had the (inaudible) and things in it but was this just WIC staff (inaudible) outreach or did you work with community organizations?

BRIAN CASTRUCCI: The WIC staff did a lot of the outreach. The outreach was also done at the provider level. And, while I'm not going to—I don't have an answer right on the top of my head, but you have on your CD. I love the CD because I hate when I go to presentations and they give me nothing. So, I really want to give you guys something that could get—because I'm only going to give you top level. This align—on the CD is the executive summary and the full report from the focus group and the project development. So, if you really want to drill into something of the specifics that I'm just not pulling off the top of my head at the moment, they're going to be right there on the CD for you. So, it gives you an opportunity to kind of go step-by-step into things that I couldn't address in the limited time I have. So, hopefully, that's something you can look at post presentation. Yes, ma'am?

UNKNOWN SPEAKER: You mentioned for minors. How about hospital, birthing hospitals (inaudible) to—

BRIAN CASTRUCCI: I think this was—it was provider, prenatal care provider and not the birthing hospitals, specifically, I do not recall were involved. What we wanted to do in some of our future activities, there was a researcher in Philadelphia who looked at the impact of IBCLC on breastfeeding rates. And he's brilliant and he's handsome and he's a really great guy, to me. Two papers, (inaudible) in American Journal of Health Promotion and in Journal of Public Health Management and Practice, both looking—Philadelphia you got three hospitals that didn't have IBCLCs, before they did and compared breastfeeding rates in those two hospitals—Pennsylvania implemented in 2003 (inaudible) actually in 2003. So, we have the breastfeeding rate. So, that's (inaudible) intervention than this because this was really trying to get at the prenatal care and those kind of (inaudible) so that people felt good about breastfeeding in general. I think the point of the delivery hospital, I think, it's hard because you had so much stuff coming at you, you know, generally.

UNKNOWN SPEAKER: Including formula.

BRIAN CASTRUCCI: Including formula, (inaudible) for this and all those kinds of things. A lot of times—we, my wife and I, (inaudible) children. I do this for a living. I've done maternal and child health for a long time and I don't really—I'm going to know what to do with it when it comes. So, and that's me. I'm educated and I should know these stuff. So, I think just the (inaudible) I think the (inaudible) intervention at the birthing hospitals is better than an individual intervention

(inaudible) intervention making sure that, you know, the nursing staff, the physician staff aren't allowing you to have an easy out. I'm part of breastfeeding research, oh, since—I started in Philadelphia and I was the first person to say is it really that hard because we wouldn't be here if it's really that hard. We wouldn't survive as a species. And I (inaudible) I think Kay Hoover, I mean did you know Kay Hoover? She's a big breastfeeding advocate, walked me in the room and just, you know, (inaudible) me with all these stuff. It really made an impact and the need for having these, you know, these kind of intervention (inaudible) because the people tend kind of get out when it's hard. You know, it's like, "Oh, it hurts." Well, you really need those (inaudible) peer councilors, those IBCLCs. It's not as easy as people think. I think there are some cultural change and some (inaudible) change that needs to happen, and that sort (inaudible). Yeah?

UNKNOWN SPEAKER: I'm curious about the 800 number. Did you get a lot of action out of the 800 number for the ads or is that the way people (inaudible) the information?

BRIAN CASTRUCCI: I do not have that on the top of my head but look at that report on the CD. Yes, ma'am?

UNKNOWN SPEAKER: I'm from Philadelphia too, well, were from Philadelphia. And we were part of the National Breastfeeding Awareness Campaign. And as part of that, we were required to have (inaudible) very, very, very (inaudible).

UNKNOWN SPEAKER: Yeah, I don't think (inaudible).

UNKNOWN SPEAKER: I'm wondering if this—what were the years of this?

BRIAN CASTRUCCI: 2004. It was a 10-month campaign in the year 2004.

UNKNOWN SPEAKER: So, it actually overlapped the National Breastfeeding Awareness Campaign?

BRIAN CASTRUCCI: But that's all right. We have control communities. Because if it was a time effect alone, which (inaudible) time effect would measure the effect (inaudible) campaign, then you would've seen increases in both control and interventions. So, the fact—and that's why those data are important on the quantitative side. And over the qualitative side, (inaudible) hearing that that was brought up but the comments of the group, the focus group are very much targeted towards this campaign.

UNKNOWN SPEAKER: With the focus groups, did you have groups in different areas of Texas or was it (inaudible) or all on one area?

BRIAN CASTRUCCI: This was a target (inaudible) rural communities in Texas.

UNKNOWN SPEAKER: Rural?

BRIAN CASTRUCCI: Yeah. And someone said, “Well, you should show the map and—“ Well, (inaudible) Texas (inaudible) actually know the landscape of Texas and it’s big, 254 counties in Texas which is just (inaudible) health service regions in Texas. Each of those health service regions has the population of at least one other state. So, it was rural and those three counties, that’s where the focus groups were conducted and those three counties, that’s where the intervention was to the post intervention focus groups happened.

UNKNOWN SPEAKER: So my second question is how generalizable do you think (inaudible) in Texas it’s for us and different places, would you say it will— we’re going to have a campaign in Chicago and we need to do all these test (inaudible) that might be different for—

BRIAN CASTRUCCI: I think reviewing the material and looking at the kind of (inaudible) results from the previous survey (inaudible), I don’t see anything in these materials that scream out rural Texas. No one was driving horses. No one was, you know, doing things that we might associate with rural Texas. So, I think it is pretty, I mean, if generalizable is a research word that means different things to me because I’m a researcher by trade but I think they’re useable materials and I think they can easily translate. And I think before I would use this in a community, I would pilot test it in a focus group and say, “Guys, (inaudible)”

because again, there are going to be nuisances within every community (inaudible).

You know, I think in one of the things we worked on Hispanic pregnancy prevention in Texas is understanding that, you know, Hispanic as a word is a group. It's not a (inaudible). You can't say Hispanic. (inaudible) you know, four, five or six variations of Hispanic within Texas. The same thing with African American and the same with Caucasian when you put in education and income and all those things, so we need to be, especially this kind of campaign that is trying to target . You just want to make sure that you're not missing something that's a nuisance in a specific group or, you know, a subgroup of a group that would, you know, turn them off. But I think the posters are good to go. I think, you know, these are materials that people can use. And that's really ultimately what (inaudible) something like (inaudible) learn from each other and hopefully take something away that could reduce our cost because remember, (inaudible) towns was the cost to develop those materials.

So, if you can use those, again, the WIC Web site is in—on the CD somewhere. All of these things can be ordered from Texas WIC. It's free for Texas residents. There's a slight charge for people outside of Texas who wants the material. Texas WIC has been a huge leader in producing these kind of materials. And I think just as a public health community, we sometimes do very good job in informing each other of what we're doing, "Hey, you use this and I'll take that

from you.” And, I mean, I, you know, I talk about (inaudible) for kids which was a big Pittsburgh, Philadelphia thing but we don’t hear a lot of (inaudible) kids in Texas and, you know, why is that? There are all these unique regional variations but this is an opportunity for us to share this with you guys and you’re hopefully going to use it in some way or at least making it a jumping off point for maybe your own kind of initiative because, again, we’re talking about saving money, healthier women and (inaudible) can closing thinking that we (inaudible) those who say that if you breastfeed, you have lower rates of breast cancer, you have lower rates of obesity, you have all these things that are disparities later in (inaudible). So, this idea to tie these—they’re preventing these disparities all the way back here when we first start out is a good deal and it’s relatively cheap and we’re going to see a cost savings. So, yeah?

UNKNOWN SPEAKER: Was there any particular reason why (inaudible) rural as to oppose to urban? (Inaudible).

BRIAN CASTRUCCI: One of the—somewhere in the talk that I didn’t read because that young, rural women make up about 12 percent of our WIC population. So, that was just where the target of the campaign was. That’s where they felt they really needed that—a place where you’re not going to have as many resources. Because remember, if you’re in an urban area, you know, your hospital might have IBCLCs. The hospital might have peer councilors. There are going to be many more resources in that—you probably have a little health

department. You know, I want to say most of our large urban areas have little health departments but our vast rural expanses (inaudible) where there is no little health departments. So, it needs some time the resource issue and then who (inaudible) might not have a hospital in your community. I always find that amusing. When I was in Philly and we talked about the shortage of birth hospitals and shortage of, you know? When you map it out, there wasn't a birth that was more than three miles away from a birth hospital. In Texas, that's down the street. I mean, you could be a significant distance from a hospital. So, some of the typical readers for this kind of action and we've seen it on, you know, urban area, aren't there in the rural area.

UNKNOWN SPEAKER: One other question is, (inaudible) racial groups represent in the (inaudible)?

BRIAN CASTRUCCI: Yes. I mean, you know, we tried to do a good job in including everyone—this actually, we did the evaluation, the creation of this happened before (inaudible) in Texas. And I think, you know, again, every time I'm at a meeting I hear these groups brought up. There are times, you know, (inaudible). So, again, this is (inaudible) of doing this as our learning (inaudible). Yeah?

UNKNOWN SPEAKER: Are you continuing to follow up with those controlled counties and the observing counties (inaudible) success through 18 months or—

BRIAN CASTRUCCI: Someone asked that. Last week, we were (inaudible). That's a whole another analysis that we didn't do because this is based on (inaudible). So, there's a separate paper there, the 48-month follow up on the post. So, we could look at that but it would be a whole separate analysis, a whole separate presentation.

UNKNOWN SPEAKER: It just would be interesting to see (inaudible).

BRIAN CASTRUCCI: We're going to continue (inaudible) used to be.

UNKNOWN SPEAKER: I have a question on the cost—under cost (inaudible). So, (inaudible).

BRIAN CASTRUCCI: It was initiation.

UNKNOWN SPEAKER: So, the \$400 figure, is that just from (inaudible) those, you know, those (inaudible) big assumptions but—so, do you feel comfortable with saying that a 10 percent increase in initiation would really lead to \$400 (inaudible)?

BRIAN CASTRUCCI: Well, again—but the \$400 is the minimum savings to plug in to that assumption and that's just looking at expenditures. If you include, you

know, mom not missing work, if you include less (inaudible) among the child, you include all these other things, that number inflates. And, yes, they're all magical numbers so don't, you know, they're not founded in—they're founded in reality but they don't reflect reality. I think any, and this is where, you know, the breastfeeding—we need to do a better job of packaging our breastfeeding discussion so that we are talking about cost savings and, you know, the money that one can save with breastfeeding. I do feel that you can make that argument with this media campaign.

Okay, I do not wear my watch this morning. Ooh, okay. I have 10 minutes and we started a little late. So, let me run through because there are just cool stuff in this last leg of the talk. And we're looking at—the title is yet another benefit of breastfeeding emergency preparedness. We're going to describe the need to consider breastfeeding during disasters and identify the best practices available to support breastfeeding during disasters. What was found during, you know, some of the hurricanes that affected Texas, Rita and Katrina specifically. With an absence of electricity and an absence of clean water, it was difficult—a lot of women who weren't breastfeeding or who were having difficulty breastfeeding during the disaster were kind of provided formula without recognition to have that person was feeding beforehand. And when you quickly switch from breastfeeding to formula, you heighten the risk of malnutrition, illness and death. And WHO has said that breastfeeding is really the safest way to feed an infant during a natural disaster. The uncontrolled distribution of breast milk substitutes really revealed

the need for education for the first responders about breastfeeding support in emergency situations and the need for state-wide systems to locate breastfeeding councilors in times of disasters.

So, here is the DSHS Web site. In case of future disaster, an infant feeding in disasters Web page was actually added to the DSHS homepage and it included recommended protocols for helping families who are breastfeeding during crisis. The WIC program also—yeah, down here in the highlighted—here. The WIC program also established a protocol for locating trained breastfeeding councilors and lactation consultants willing to offer their services in shelters during crisis. We talk a lot about medical reserve corps when we talk about disaster—well, how are we going to get enough physicians, how are we going to get enough nurses? Well, let's have this medical reserve corps that includes, you know, retired nurses, retired physicians that we can call them up at times of great need. This kind of extends that idea to a lactation consultant. And I guess, you know, in some ways, you can understand the need to get prophylaxis to people to actually deal with the most immediate needs that present themselves in a disaster but to really—to neglect this very important need is dangerous to mother and the child, and something we need to think about prior to disaster because during the day of a disaster, this is probably not going to get the most attention. So, we need to think this through.

And WIC has also created this lactation support directory which includes names of people who are willing to come in disaster, times of disaster. So, first responders can look at this and be there and call lactation consultants and get them to the site. This is our state-wide lactation support hotline. For the person who asked for a hotline support, this is was, again, is a good tool for first responders to call and say, “Hey, I need lactation support. I need help. We have women who are trying to breastfeed and I need some support there.”

Texas was able to develop this campaign, this poster campaign, to encourage first responders to follow, you know, verbal support and positive reinforcement, physical comfort, skilled breastfeeding assistants and privacy, all the things that women need during disasters to continue breastfeeding. And again, this poster is on your CD and it's something that, again, is available through our WIC program.

Now, when you look at feeding during disasters, and this is from the American Academy of Pediatrics, you notice that the ready-to-feed formula is here and it's the only box that gets there. But you have to go—there are a lot of paths that get you into continued breastfeeding or even re-lactation during a disaster. So, the option to go immediately to here may be easier at—if there's not appropriate planning done beforehand. But with appropriate planning, we can hopefully get women to these other boxes and prevent just the immediate mass distribution of formula. So, what we've done in Texas and the Texas WIC program has done is establish Web resources and a network of lactation consultants and we've

development campaign materials. And I'm going to actually share a video that—the first thing when I showed this to the WIC folks they said, “You got to play this video.” This video is a follow up to a woman who had difficulty breastfeeding in one of the hurricanes. So, it's short but I think it's interesting. Let me get it to play.

UNKNOWN SPEAKER: (Inaudible).

UNKNOWN SPEAKER: (Inaudible)

UNKNOWN SPEAKER: Thank you.

UNKNOWN SPEAKER: (Inaudible) awesome. Do you want me to (inaudible).

UNKNOWN SPEAKER: Yes it is. (Inaudible).

UNKNOWN SPEAKER: (Inaudible).

UNKNOWN SPEAKER: Sure. (Inaudible).

UNKNOWN SPEAKER: (Inaudible) formula feeding in the hospital and (inaudible) breastfeeding in the hurricane so many years. And you (inaudible) without anything and running out of (inaudible).

UNKNOWN SPEAKER: Yeah. I called them because (inaudible) of TV and they told me (inaudible) told everyone on TV said you would call if you have any emergency (inaudible) idea about breastfeeding. (Inaudible). It hurts so much. But then once he starts sucking and sucking, it felt much better. (Inaudible).

UNKNOWN SPEAKER: Right. Babies know what to do. We just have to give them (inaudible).

UNKNOWN SPEAKER: Yeah, that's right. Exactly. (Inaudible).

UNKNOWN SPEAKER: (Inaudible). That made me feel so good. I felt so (inaudible) was like an angel coming to help us because (inaudible) what to do. (Inaudible). I thank you so much. (Inaudible).

UNKNOWN SPEAKER: (Inaudible).

UNKNOWN SPEAKER: (Inaudible).

BRIAN CASTRUCCI: So, just to wrap up, this is, you know, some of what we can be doing. And what we are doing is what I presented but what we can do is to make sure that, you know, the disaster preparedness folks are going to be there and are going to hear this message before we get to the point of the disaster. So,

make sure that breastfeeding is discussed amongst, you know, the—how do we distribute pills, how do we do this and how, you know, how do we make sure that people get their medications? And this is just as important—this is kind of the back flip of it. You have a young lady here who was running out of formula. And again, how do we help her in that situation? How would she have fed her baby? We have a lot of Web resources that we talked about but remember that in disaster, Web might not be available. So, to have some hard copies of these kind of materials available for distribution, you know, some (inaudible) education for first responders would be useful. You know, I think first responders are willing to hear this message and learn about it. I don't know that it's the first thing that comes to their mind when you think disaster. You know, having lived in New York City, you know, 9/11, remember that, you know, breastfeeding was not on anyone's mind. You know, what are we doing for the baby whose moms were killed in the towers? What happens there? Just, it's important but not something worth thinking about. So, we need to make sure we're keeping this on that agenda to make sure the maternal and child health is strongly represented in all disaster preparedness. And we really—and that's talking about the seamless integration into planning.

Before I wrap up, I need to really thank Tracy Erickson from WIC, Mary Van Eck from WIC, Linda Bramble from WIC, Mike Montgomery who's our WIC director in Texas, (inaudible) Sam Cooper. Sam is our block (inaudible) administrator (inaudible) director, my staff who helped with this tremendous (inaudible) and a

special thanks to our assistant commissioner with whom all this work is done and that's Evelyn Delgado who's here in the corner. Thank you everyone for your attention. This was a quick hour-and-a-half for me. Hopefully, it was a quick hour-and-a-half for you. You have some good materials to take home with you. And I hope you all enjoy the rest of the conference. Thank you.