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Qualitative analysis of institutional advertising in the promotion of breastfeeding: gender biases and co-responsible breastfeeding environments. For a Comprehensive Human Lactation Model

Análisis cualitativo de la publicidad institucional en la promoción de lactancia materna: sesgos de género y entornos lactantes corresponsables. Por un Modelo de Lactancia Humana Integral

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ABSTRACT

BACKGROUND // Current international institutional promotion of breastfeeding (WHO-UNICEF) incorporates cultural and social elements that shape experiences related to caregiving and parenting practices for infants in their first months of life. The aim of this paper was the analysis of the theoretical framework underpinning current breastfeeding promotion efforts, and given that global breastfeeding rates do not reach 50 percent of infants breastfed up to six months, as well as to identify new theoretical premises from a gender perspective. This analysis will focus on uncovering gender biases and the role assigned to male partners in current institutional advertising aimed at promoting breastfeeding.

METHODS // The research was conducted in Granada (Spain) in 2023, using a qualitative analysis approach (Strauss-Corbin Grounded Theory). Seventy promotional materials related to breastfeeding, located in healthcare settings, were analyzed.

RESULTS // Gender biases were confirmed through a gender-focused qualitative analysis of institutional materials intended to promote breastfeeding. These biases were grouped into six conceptual categories.

CONCLUSIONS // Current institutional health promotion of breastfeeding contains numerous explicit and implicit gender biases. The fundamental theoretical finding (substantial category) is developed through six key propositions that give rise to novel theoretical categories (such as the co-responsibility of breastfeeding environments), which become determining factors in future promotional theoretical frameworks. As an alternative, a Comprehensive Human Latation Model is proposed.

KEYWORDS // Health promotion; Breast feeding; Feminism; Gender [Identity]; (Co)Parenting.

RESUMEN

FUNDAMENTOS // La actual promoción institucional internacional de la lactancia materna (OMS-UNICEF) contiene elementos culturales y sociales que condicionan las experiencias relacionadas con el cuidado y la práctica de la crianza de criaturas humanas en los primeros meses de vida. El objetivo de este trabajo fue el análisis y cuestionamiento del marco teórico sobre el que se sustenta la actual promoción de la lactancia, y ya que las cifras de la misma a nivel mundial no alcanzan ni el 50% de bebés amamantados hasta los seis meses, así como determinar nuevas premisas teóricas con perspectiva de género para la promoción de la lactancia a partir del análisis de los sesgos de género y el papel asignado a las parejas masculinas en la actual publicidad destinada a promocionar institucionalmente la lactancia materna.

MÉTODOS // La investigación se realizó en la ciudad de Granada (España) en 2023, en forma de análisis cualitativo (Teoría Fundamentada de Strauss-Corbin), analizándose setenta materiales promocionales de la lactancia materna sitos en áreas sanitarias.

RESULTADOS // Se confirmaron los sesgos de género a través del análisis cualitativo con perspectiva de género de los materiales institucionales que pretendían promocionar la lactancia materna, sesgos que fueron agrupados en seis categorías conceptuales.

CONCLUSIONES // La promoción sanitaria institucional actual de la lactancia materna contiene, explícita e implícitamente, numerosos sesgos de género. El hallazgo teórico fundamental (categoría sustancial) se desarrolla en seis planteamientos fundamentales que dan lugar a categorías teóricas novedosas (como la corresponsabilidad de los entornos lactantes), que devienen claves determinantes en futuros marcos teóricos promocionales. Se propone como alternativa un Modelo de Lactancia Humana Integral.

PALABRAS CLAVE // Promoción de la salud; Lactancia materna; Feminismo; Género; (Co)Responsabilidad Parental.

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RE SP

INTRODUCTION

According to available data, global breastfeeding rates for infants under six months do not even reach 50% **(1)**. While breastfeeding is promoted at the institutional level, the question remains: is it being promoted in a truly effective, rights-respecting, inclusive, and feminist way?

The multidisciplinary approach to the phenomenon of *breastfeeding* is well-established in the current scientific literature **(2)**. The classic promotional model —focused primarily on the numerous physiological health benefits for mothers and newborns— **(3)** has been expanded by theoretical arguments and evidence that go beyond the health dimension **(4)** in support of breastfeeding. This new and powerful pro-breastfeeding discourse has emerged from disciplines such as social and cultural anthropology **(5)**, moral philosophy (ethics of care) and social justice **(6)**, economics **(7)**, ecology **(8)**, and gender studies **(9)**.

However, it is precisely within this latter field —gender studies— where the greatest controversy has arisen, often framed as a clash between opposing views on breastfeeding promotion. On one side, there are feminist voices that affirm breastfeeding as a healthy and empowering practice for women who choose to nurse **(2,12)**. On the other hand, critiques have emerged from certain feminist sectors that view breastfeeding as a potential threat to the achievements already gained —or still being pursued —in the struggle for gender equality **(10,24)**.

Setting aside the dispute between opposing views on what breastfeeding entails (a topic we address in more detail elsewhere) **(10)**, one shared concern within this feminist debate is the limited involvement of the various surrounding environments **(11)** in supporting the mother-infant dyad, particularly through different shared responsibilities related to breastfeeding. It is precisely this lack of involvement —and not the act of breastfeeding itself— that, as the *lactivist* movement rightly argues **(12)**, lies at the root of many of the issues raised by classical feminist theory **(13)** regarding the promotion of this practice, which is extremely beneficial in every respect.

Lactivism **(2,12)** is understood as the movement, led primarily by mothers, that advocates for breastfeeding and seeks to challenge the classical feminist stance that views the practice as a threat to women's public and professional integration.

Shared responsibility in breastfeeding environments —whether involving partners (when present), family, social networks, workplaces, healthcare providers, legal systems, or political institutions— requires a shift from merely recommending supportive behaviors to recognizing breastfeeding as a matter of rights and responsibilities **(14,25,26,27)**. This fair assump-

tion of shared responsibility would go a long way toward properly addressing certain feminist critiques, rather than attempting to *cut off* the promotion of breastfeeding as a quick, easy, and profoundly unfair and harmful solution for mothers themselves.

It is therefore appropriate to examine whether institutional or associative breastfeeding campaigns are indeed proposing this paradigm shift, one in which the focus is also placed on these surrounding environments, rather than solely on breastfeeding mothers **(15)**. This is the context in which the present study is situated, which involved a qualitative analysis of such campaigns, specifically focusing on printed materials. Qualitative analyses of institutional advertising are extremely scarce, and virtually nonexistent when it comes to issues related to motherhood and/or breastfeeding in connection with gender bias **(16,28)**. No references were found regarding the gender analysis of institutional breastfeeding advertising through printed materials. The only document found with some degree of relevance is a book chapter published by the World Health Organization (WHO) **(17)** in 2016, which selects breastfeeding as one of the main areas of institutional advertising through posters, but it lacks any form of gender analysis on the matter.

The primary objective of this study was to establish new theoretical premises for promoting breastfeeding from a gender-sensitive perspective, based on an analysis of gender biases and the role assigned to male partners in current institutional breastfeeding advertisements.

To this end, the following specific objectives were pursued:

1. To explore printed institutional advertising materials (posters, brochures, guides, etc.) for breastfeeding promotion displayed in public spaces within seventeen health centers and three maternity-pediatric hospital wards in Granada (Andalusia, Spain).

2. To analyze gender biases concerning the roles assigned in the actual theoretical discourse —both explicit and implicit— present in institutional breastfeeding advertising.

3. To analyze the qualitative descriptive data obtained, extracting conceptual categories and establishing internal relationships among them to reveal gender biases regarding the roles assigned in the actual theoretical discourse (explicit and implicit) present in institutional breastfeeding advertising.

4. To extract qualitative data from the printed materials according to their gender content, focusing on the roles assigned to the various individuals and groups responsible for supporting breastfeeding, with particular attention to the auxiliary paternal role and the breastfeeding environment it helps shape.

5. To identify the underlying substantive category within the current theoretical model of institutional breastfeeding promotion that may sustain the observed gender biases and help explain the limited involvement of key support agents —particularly paternal involvement— in this practice.

MATERIALS & METHODS

Design and Methodological Approach: A qualitative analysis was conducted using Grounded Theory as outlined by Strauss and Corbin **(18)**, following an observational strategy to theoretically identify the *basic social process* underlying institutional messages related to breastfeeding, specifically gender bias and paternal involvement.

- Study Setting: Pediatric and maternity areas within public healthcare facilities, including seventeen primary care centers and three hospital maternity wards in Granada.

- Study Population: Seventy printed materials (posters, brochures, informational leaflets) promoting breastfeeding, located in the aforementioned healthcare settings.

  - Unit of Analysis: The institutional discourse contained within the printed materials promoting breastfeeding.

  - Inclusion Criteria: Printed materials that directly or indirectly promote breastfeeding, displayed in publicly accessible areas of public healthcare centers in Granada, and placed by healthcare staff within those settings.

  - Exclusion Criteria: Materials in poor condition that rendered their promotional message unreadable; materials for which it was unclear whether they had been displayed by healthcare personnel rather than individuals, companies, or support groups.

  - Further details: In the Primary Care centers, the main format chosen was information sheets about workshops and activities related to breastfeeding. In contrast, posters and brochures were more commonly used within hospital settings, specifically in maternal and child areas. In the Primary Care centers, materials were primarily located in the Women's and Midwives' Consultation areas, on walls adjacent to these rooms. In the hospital's maternal-child wards, the preferred location was the central corridors of each of the three observed floors.

    Priority was given to materials with the highest visibility due to their size, central placement in maternal-child areas, and high recurrence. These included the three breastfeeding decalogue posters developed by the Spanish Association of Primary Care Pediatrics (AEPAP in its Spanish acronym), the United Nations Children's Fund-World Health Organization (UNICEF-WHO), and the United Nations Children's Fund-Baby-Friendly Hospital Initiative (UNICEF-BFHI), as well as a poster titled *The Importance of Breastfeeding*, sponsored by the Ministry of Health and Consumer Affairs, BFHI, and the University of Lleida. This high visibility, combined with the amount of information they contained from institutions widely recognized for their healthcare authority, led to their selection as key *informant materials*. The data extracted from these materials were therefore considered espe-

cially relevant in the subsequent analysis.

Regarding the printed materials, both the type of material used and the degree of relevance to breastfeeding promotion were considered:

a) According to the type of printed material:

a1) Posters: Printed materials ranging from small size (A4 sheet) to large format (approximately 70x100 cm), combining image and text. They provided a wealth of information drawn from both visual and textual content, with high visibility and a strong presence in their context.

a2) Brochures: Printed materials primarily focused on text, sometimes accompanied by illustrations or photographs. These offered dense theoretical content, mostly extracted from the text, but had lower visibility and user reach (the more text-heavy, the less likely to be noticed).

a3) Informational leaflets: Informative announcements (date, time, location) of events, workshops, meetings, etc., related to the promotion of breastfeeding, with or without images. This type of material provided exclusively factual information about events, with limited theoretical content, except for details concerning the intended audience.

b) According to the degree of relevance to breastfeeding promotion:

b1) Materials with direct reference to breastfeeding promotion (Direct BFP): Materials explicitly aimed at promoting breastfeeding.

b2) Materials promoting healthy parenting behaviors, with breastfeeding included as one component among others (Indirect BFP).

b3) Materials displaying images of breastfeeding, even if the topic was not explicitly mentioned or the material was intended for other purposes (Latent BFP).

– Access to the Study Site: The *mystery shoppin*g technique was adapted for use in Health Sciences **(19)**.

Access to public healthcare centers was carried out as if by any other user, over several days and across different geographic areas of the city. A thorough exploration was conducted of all physical display surfaces (walls, doors, columns, noticeboards, and panels) in each center, seeking printed materials containing information relevant to the study objectives.

– Sampling Method: Theoretical and purposive qualitative sampling.

– Sample Size: Determined by the principle of saturation (for gender bias) and total sample (for paternal involvement).

- Data Collection Technique: Observations (fieldwork) were conducted between April and October 2023, in two phases:

- Direct observation of the materials (both *in situ* and post-visit).
- Analytical-reflective *memos*, written during the observation process[1].

- Data Analysis Strategy:
  - Primary classification of materials: data preparation.
  - Data Coding and Analysis:
    - Open Coding[2]: target population, message framing, and advertising format.
    - Axial Coding[3]: focused on establishing categorical relationships.
    - Selective Coding: Aimed at deriving theoretical conclusions.

All issues related to the promotion of breastfeeding were analyzed with a focus on the roles assigned to mothers and the aforementioned co-responsible environments **(20)**. Coding was carried out based on data extracted from the seventy printed materials over a six-month period. These data underwent open, axial, and selective coding, with preliminary coding into six conceptual subcodes within the five previously established categories **[Figure 1]**. In the process of generating conceptual categories (biases in institutional breastfeeding promotion), the data recorded within each category–subcategory –developed during the adjustment process (open coding)– were interpreted according to their explanatory power in line with the objectives of this study, and based on their degree of similarity or difference, association, contradiction, subordination, or causality among the predefined categories **[Figures 2 & 3]**.

A computer-assisted analysis was also conducted using *Atlas.ti* software, by creating *word clouds* **[Figure 4]** based on the written messages found in the four previously identified key informant materials. The aim was to compare the information gathered through direct observation with data generated via textual frequency analysis. Word clouds were produced for each material individually and in a combined final analysis.

The content revealed through the word clouds closely aligned with the findings of the prior category-based analysis derived from direct observation of the printed materials. In particular, the appeals, message content, persuasive elements, and advertising codes predominantly employed language that centered breastfeeding as an almost exclusively maternal responsibility (with some degree of institutional or hospital support). This dominant use of mother-focused language was further reinforced when counting the

1 These elements, generated during the in situ observation and subsequently throughout the various coding phases, were of utmost importance throughout the entire process. The critical reflections that emerged from them –constantly compared with the findings derived from the observation of the printed materials– necessitated a revision of the theoretical assumptions (through continuous reassessment of the different theoretical frameworks employed) as well as a reconsideration of the very objectives and hypotheses of the present study.

2 The indicated terms refer to the different aspects (categories or families) under study, within which the analysis of texts, images, etc., will give rise to codes and subcodes.

3 This emerges from the relationships identified between codes and subcodes; the interpretation of these relationships –whether based on similarity or difference, association, contradiction, subordination, or causality among the previously established categories– together with the analysis of the density of these connections, will support, as will be shown, the theoretical conclusions.

Figure 1
Open Coding Framework.

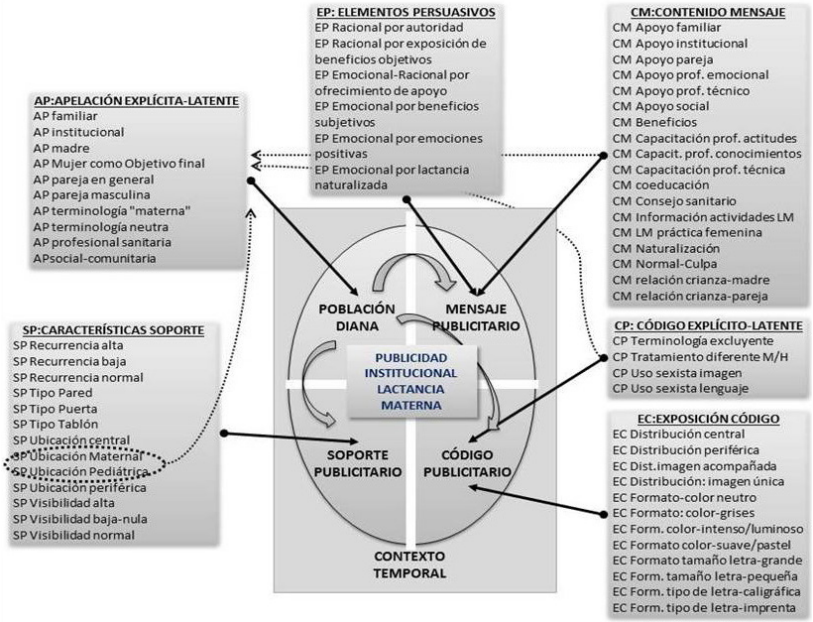


Figure 2
Relational Category Network.

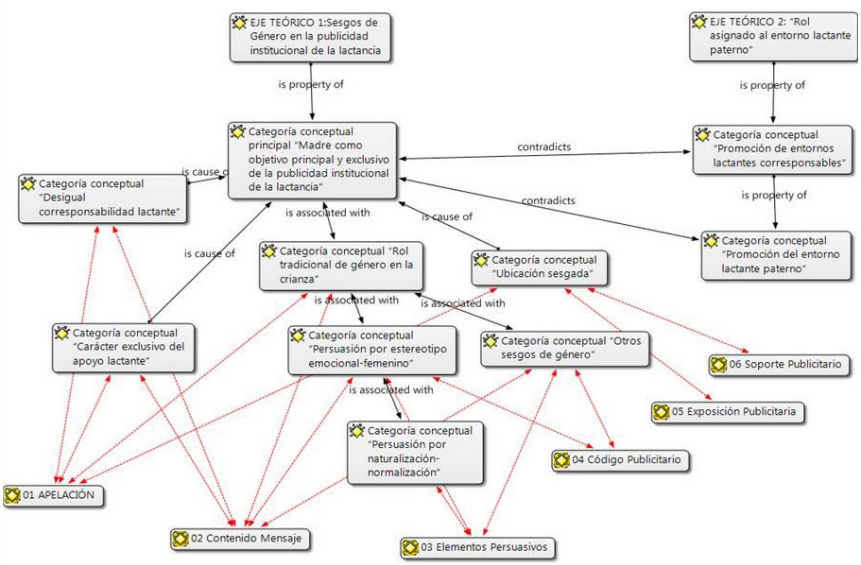
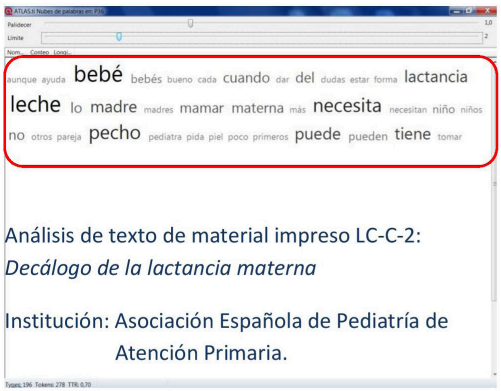
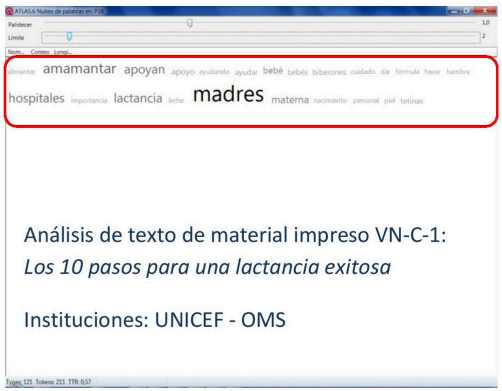


Figure 3
Word Cloud Content Analysis (Key Informant Materials).



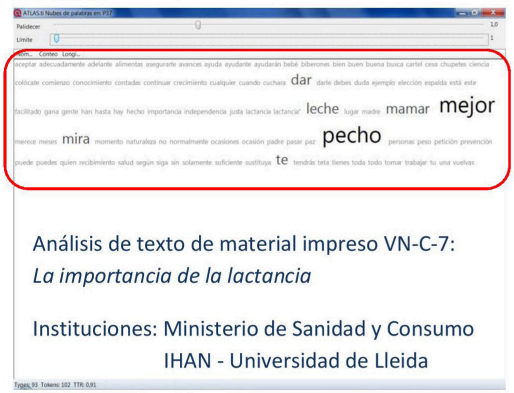
Análisis de texto de material impreso LC-C-2:
Decálogo de la lactancia materna

Institución: Asociación Española de Pediatría de Atención Primaria.



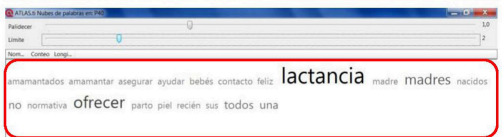
Análisis de texto de material impreso VN-C-1:
Los 10 pasos para una lactancia exitosa

Instituciones: UNICEF - OMS



Análisis de texto de material impreso VN-C-7:
La importancia de la lactancia

Instituciones: Ministerio de Sanidad y Consumo
IHAN - Universidad de Lleida



Análisis de texto de material impreso VN-F-1:
10 pasos para una lactancia natural feliz

Instituciones: IHAN - UNICEF

Análisis conjunto de textos de materiales impresos anteriores:

Nota: no se ha limitado el conteo en el último análisis para resaltar más visualmente como destacan las palabras más importantes sobre una gran multitud de conceptos.

Figure 4
Axial Coding Example – *Explicit Appeal to Women in Breastfeeding Practice.*

number of female versus male figures depicted in the four key materials. This image count complemented the textual analysis and proved essential for contextualizing the results presented in the word clouds.

- Ethical Considerations: Informed consent was not required, as the units of analysis in the *population* were not individuals but *documents* —specifically, publicly available printed materials displayed in accessible areas visible to all users during a routine visit to their healthcare center—. While institutional permission was considered as a courtesy, it was ultimately not requested following consultation on ethical and methodological suitability. The decision was based on strict adherence to ethical standards consistent with similar techniques used in *marketing* evaluations, which are also applied in healthcare service assessments. In this regard, the ethical guidelines of the *Scottish Health Council* **(21)** were considered particularly relevant when employing such strategies. These guidelines would

apply to the type of observational technique used in this study (exclusively concerning the displayed materials). The absence of individuals in the study, along with the exclusion of any direct or indirect mention of healthcare professionals and/or the centers observed, justified the decision not to issue prior notice. Furthermore, this approach helped to avoid potential response bias, particularly that linked to social desirability regarding the subject of study: prior notice could have led to an increased presence (in both quantity and visibility) of materials related to the study's objective, thereby definitively contaminating the results.

No personal data was collected or stored in any digital archive. Likewise, the photographic records contained no images of individuals (such as professionals or users of the healthcare centers explored); the recordings were strictly limited to the physical boundaries of the printed materials themselves, which did not contain any visual elements that could directly link them to a specific center. All these conditions facilitated both access to and the safeguarding of the collected information, as it could be shared without the ethical constraints associated with personal testimony. Such constraints typically require significantly stricter ethical and legal measures for data protection.

- Regarding the main limitations of the study or potential sources of interference, several factors can be noted: the limited geographical scope, the sample size and type of data, potential selection bias in the materials included, and the absence of methodological triangulation. All of these aspects could be addressed within the framework of a broader research project, which, for obvious reasons, was not the aim of the present study.

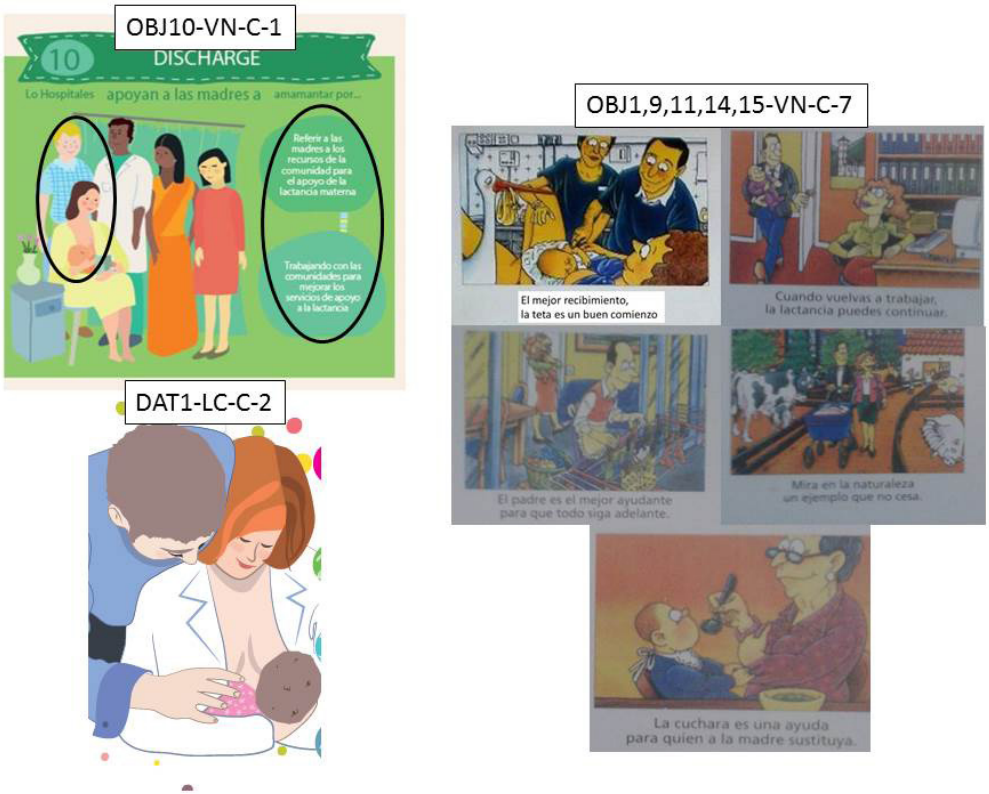
RESULTS

The gender-sensitive qualitative analysis of institutional materials intended to promote breastfeeding revealed clear patterns of gender bias. These biases were grouped into six conceptual categories. Additionally, a cross-sectional analysis of both explicit and implicit content and formats was conducted **[Figures 5, 6 & 7]**.

1. Bias due to unequal breastfeeding responsibility: The materials appealed almost exclusively to breastfeeding mothers. There was little mention, therefore, of the shared responsibility of other environments and, when such references did appear, they were framed in terms of *voluntary convenience* rather than as *duties or rights* to contribute to the establishment and maintenance of breastfeeding. In these cases —as well as in references to healthcare involvement— an implicit appeal was also conveyed through the content of the messages, the format of the materials, and their placement, as will be discussed later.

2. Bias due to the exclusive nature of breastfeeding support: An overwhelming presence of explicit and implicit messages in informational materials about workshops, meetings, and gatherings aimed primarily at mothers, while other individuals (partners, family members, friends,

Figure 5
Axial Coding Examples – *Imagery Appealing to Non-Maternal Environments*.



etc.) were only invited to attend on a voluntary basis.

3. Traditional gender roles in parenting: Numerous data points revealed the use of specific messages, the implicit appeals already noted, and the selection of certain images that promoted, beyond breastfeeding itself, traditional gender roles[4] in parenting, such as domestic tasks and the public-private space divide.

4. Persuasion through emotional-feminine stereotypes: Persuasive strategies heavily relied on emotional imagery and narratives linked to classical notions of *femininity*. While this approach may be understandable in materials intended to offer

4 Since this was not the specific focus of this research, the possible types of families represented were not formally addressed, for example, in terms of heteronormativity or two-parent family composition; it is suggested that this be considered for future research.

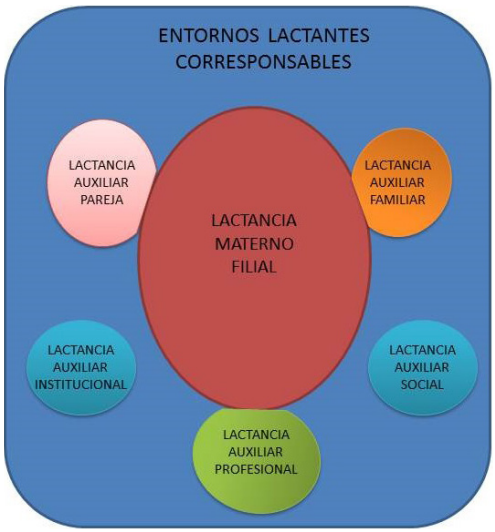
emotional support to breastfeeding mothers, it does not justify an explicit disregard for persuasion through rational argument and/or the use of explanatory formats in place of those traditionally associated with emotional and feminine communication. Persuasion also relied on appeals to authority (e.g., *your doctor says so*) without additional substantive reasoning.

5. Persuasion through naturalization-normalization: The use of pseudo-rational arguments appealing to the normalization and/or natural character of breastfeeding —although justifiable within the internal frameworks of pro-breastfeeding support groups and healthcare professionals— promoted a deterministic image of women as mothers, particularly given the near-exclusive use of this argument in the absence of alternative perspectives. Efforts to adjust terminology were already visible in some materials, for example, replacing *natural* with *physiological* or *healthy*, and substituting *normal* with terms such as *more appropriate* or similar alternatives.

6. Placement Bias: The materials were almost exclusively placed in spaces associated with women —such as maternity education rooms, women's health consultation doors, or midwife offices— rather than in more gender-neutral locations like pediatric or general family medicine areas (despite mothers being the primary attendees in those settings as well). This reinforced the first bias: the near-exclusive appeal to mothers as the primary agents of breastfeeding.

Figure 6
Pre-Code Example - *Target Population*.

Figure 7
Summary diagram of the *Human Breastfeeding Environments Model*.



DISCUSSION

The following theoretical findings are discussed within the framework of substantive categories:

1. Fusion of promotional concepts as a source of gender bias. The qualitative analysis reveals a clear alignment between the campaign's main objective (in theory, to establish and maintain breastfeeding) and the target population (as observed, almost exclusively breastfeeding mothers). This fusion of *promotional aims and target audiences* has become so normalized within healthcare institutions and support groups that questioning it now seems unusual. However, this conflation inevitably merges the *promotional goal* (to promote breastfeeding) with its *presumed outcome* (that mothers breastfeed). As a result, breastfeeding mothers are inadvertently treated as passive objects of attention and support, effectively becoming *promotional products* rather than target recipients. They may be the principal audience, but not the only one in breastfeeding promotion. This aligns with recommendations that health promotion campaigns **(28)** should avoid objectifying or reducing individuals to mere instruments of campaign goals, especially when doing so places the burden on mothers, potentially leading to guilt rather than recognition of systemic failures. Therefore, it is proposed that the focus be shifted toward those responsible for public policy.

2. Shared Responsibility in Breastfeeding Environments. As a consequence of the above, expanding the campaign's reach to include other target populations requires the development of new promotional strategies aimed at co-responsible breastfeeding environments. This broadening helps avoid placing sole responsibility for the success or failure of breastfeeding on mothers, while simultaneously promoting the inclusion of new actors (partners, family, society, institutions, etc.) whose involvement has been shown to be critical in numerous recent studies **(22,25,26,27)**. Among all these environments, the most significant —both statistically and culturally— continues to be that constituted by fathers**5**.

3. Promoting Paternal Responsibility: Auxiliary and Subordinate Support in Breastfeeding: Numerous studies have demonstrated that appropriate paternal involvement significantly supports breastfeeding initiation and long-term maintenance **(23,25,26,27)**. These studies consistently conclude ▶

that breastfeeding support policies should actively include both parents to improve family dynamics and child well-being. Yet, research specifically addressing the impact of paternal support remains limited [25]. Zhou *et al.*'s comprehensive study [25] showed that paternal involvement increased exclusive breastfeeding rates at various postpartum stages and positively influenced maternal motivation [27]. This evidence supports the existence of a positive and significant correlation between paternal support and mothers' autonomous motivation to breastfeed [27,29].

However, this fact (paternal involvement in breastfeeding) should not be confused with how such involvement ought to occur: it is not about equal responsibility in actions, decisions, or the type of support and/or resources used. Rather, it concerns *equitable* co-responsibility, where each person's role within the breastfeeding process is acknowledged, with breastfeeding mothers and their infants holding a central place in decision-making and the support they receive. Breastfeeding environments (with the paternal one being among the most influential) should never occupy that central space but instead provide *auxiliary* support, *subordinate* to the interests of the mother-infant dyad. A different kind of paternal involvement —where fathers end up encroaching on maternal roles and responsibilities within breastfeeding— not only fails to support the practice but can hinder both breastfeeding itself and the father's later involvement in parenting[6].

Finally, the *strengths* and *limitations* of this study warrant reflection. One of its strengths lies in its ability to identify and analyze a crucial aspect of breastfeeding promotion —namely, the traditional gender bias —offering a critical perspective on how the lack of co-responsibility in surrounding environments can undermine the effectiveness of public policy. In addition, the study stands out for proposing clear solutions, such as the need to involve all co-responsible agents and to present more inclusive and comprehensive promotional materials. However, a limitation of the study is its lack of in-depth exploration of potential sociocultural or economic barriers that might hinder the implementation of these recommendations, leaving certain questions unanswered regarding the feasibility of the proposed changes. Moreover, the analysis focuses primarily on healthcare centers in Granada, which may limit the generalizability of the findings to broader contexts. As noted in the *Materials & Methods* section, both the strengths and limitations are closely tied to the design and scope of the research itself, as is typical of any scientific study.

CONCLUSIONS

The main conclusion of this study is that current institutional health promotion of breastfeeding contains both explicit and implicit gender

5 For this reason, the focus was placed on fathers/male partners, both due to their statistical prevalence and to the understanding that, in the case of female couples, the dynamics are markedly different and gender stereotypes and cultural influences operate in distinct ways.

6 This has been widely observed and documented in the work of breastfeeding support groups and is something frequently noted by volunteers[12].

biases, as outlined throughout the text. The core theoretical finding —the substantive category— can be summarized through *three key pillars*:

1. A clear distinction must be made between promotional objectives (with the primary goal being the practice of breastfeeding itself) and the various target populations to be engaged, namely, all the agents who should share responsibility for breastfeeding, not just mothers.

2. Every breastfeeding promotion effort must assume an equitable distribution of responsibility across the socio-familial environment, ensuring breastfeeding mothers can exercise their right to health through nursing.

3. Any breastfeeding promotion effort aimed at engaging co-responsible breastfeeding environments (particularly the paternal one, due to gender-related factors), whether institutional or led by support groups, must adhere to this model of subordinate and auxiliary involvement in the support requested by mothers. This is what we refer to as the *Human Breastfeeding Model*[7] (see **Figure 7** for a graphical representation) **(10)**, a model that reflects a genuine recognition of co-responsible breastfeeding environments. We understand this model to be broader and more illustrative of what constitutes a true breastfeeding socialization process in a global sense **(30)**, aligned with the Breastfeeding-Friendly Planet approach and with UNICEF's goals[8] regarding the universal expansion of the *breastfeeding-friendly* strategy, toward a concept that might be described as a *Breastfeeding-Friendly Planet*.

Building on these three pillars and in pursuit of the *Human Breastfeeding Model* as an expanded framework for breastfeeding promotion, we propose the following *specific recommendations*, linked to future research and public policy:

- Broaden the promotional focus: A clear distinction must be made between the goal of promoting breastfeeding and the target populations involved, including not only mothers but also other co-responsible agents.

- Promote equitable shared responsibility: Promotion strategies should actively involve the socio-familial environment, ensuring that breastfeeding mothers receive the necessary support without bearing sole responsibility for the success of breastfeeding.

- Revise promotional materials: It is essential to avoid gender bias in institutional advertising, ensuring a more balanced representation of the various environments that can support breastfeeding, rather than focusing exclusively on mothers.

- Include fathers without encroaching on maternal roles: Paternal involvement should be understood as auxiliary and subordinate support to the

7 See references **10** and **30** for clarity on the terminology and use of human breastfeeding, which in no way seeks to obscure or diminish the leading, prominent, and central role of the term maternal or maternal-infant, intrinsically linked to the breastfeeding reality.

8 *https://www.unicef.org.uk/babyfriendly/breastfeeding-and-climate-change/*

mother and baby, avoiding narratives that position fathers in a central role that could interfere with breastfeeding.

– Strategically place informational materials: Breastfeeding information should be made available in more inclusive spaces, such as Pediatrics or Family Medicine, and not only in areas traditionally associated with mothers.

Naturally, these proposals should be embedded within a far-reaching and comprehensive strategy that reflects a collective commitment to a breastfeeding-supportive society. This requires systemic, economic, and political backing to ensure that breastfeeding becomes a full expression of rights and personal sovereignty **(30)**.

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