Policy Instruments and Infant Feeding for Mothers on Social Assistance: A Comparative Study of Canadian Provinces

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Abstract

Using a modified framework of the social constructions of target populations (SCTP) and Vedung's typology of policy instruments, this contribution presents a comparative analysis of policy instruments targeting mothers on social assistance to impose "successful" breastfeeding norms in the Canadian provinces. This framework distinguishes between the traditional policy tools of welfare offices and the inclusion of additional oversight by health professionals. The findings expose a variety of policy mixes despite similar commitments to encourage breastfeeding and dissuade the use of infant formula. Most provinces utilize *burdened policy instruments* for mothers who choose infant formula, such as requiring a medical note. For mothers who breastfeed, most provinces typically deploy *beneficial policy instruments* such as raising their monthly allowance with little [government] oversight. However, some provinces utilize very different tools which illustrate the diverse health care and social assistance landscape. Québec, for instance, is the only province to provide additional support for women who choose to use formula without medical authorization. In Prince Edward Island, social workers may require a medical note for breastfeeding while in Manitoba there is no additional support for the nutritional needs of breastfeeding mothers.

Keywords: social assistance, target populations, infant feeding policy, provinces, policy instruments

Résumé

En utilisant un cadre modifié des social construction of target population — SCTP — (constructions sociales des groupes cibles) et la typologie des instruments de politique de Vedung, cet article présente une analyse comparative des instruments de politique ciblant les mères bénéficiant d'aide sociale pour imposer des normes d'allaitement « efficaces » dans les provinces canadiennes. Ce cadre permet une distinction entre les mécanismes d'interventions traditionnels des bureaux d'aide sociale et l'ajout d'une supervision supplémentaire par les professionnels de la santé. Les résultats révèlent de différentes combinaisons de mesures, malgré un but commun, pour encourager l'allaitement et dissuader l'utilisation de préparations pour nourrissons. La plupart des provinces utilisent des instruments de politique contraignants pour les mères qui choisissent des préparations pour nourrissons, comme l'exigence d'un certificat médical. Pour les mères qui allaitent, la plupart des provinces déploient généralement des instruments de politique bénéfiques tels que l'augmentation de leur allocation mensuelle avec peu de contrôle [du gouvernement]. Cependant, certaines provinces utilisent des outils très différents qui illustrent la diversité dans le contexte des soins de santé et de l'aide sociale. Le Québec, par exemple, est la seule province à fournir un soutien supplémentaire aux femmes qui choisissent d'utiliser la préparation pour nourrissons sans autorisation médicale. À l'Île-du-Prince-Édouard, les travailleurs sociaux peuvent exiger une note médicale pour l'allaitement maternel, tandis qu'au Manitoba, il n'y a pas de soutien supplémentaire pour les besoins nutritionnels des mères qui allaitent.

Mots-clés : aide sociale, populations cibles, politique d'alimentation du nourrisson, provinces, instruments de politique

Introduction

Faced with increasing political obstacles to advocate for classical social policy issues, such as income redistribution, politicians in industrialized countries have increasingly turned to the promotion of public health as a way to tackle complex social problems (Lynch, 2020). Embedded within the well-established literature on public policies targeting the poor, this article examines the limits of public health initiatives, as social policy tools, by focusing specifically on infant feeding policy for mothers on social assistance. While Canada is regularly discussed as a case study in comparative welfare state literature (Daigneault et al., 2021), most social policies and innovations occur at the provincial level (McArthur, 2007). Consequently, this article features a comparative public policy analysis of the ten Canadian provinces. To clearly focus this analysis, this contribution explores the characteristics of policy instruments targeting mothers on social assistance, but not the process leading to their selection or the policy outcomes deriving from these instruments.

Since the 1990s, the provinces have adopted the World Health Organization (WHO) recommendation to exclusively breastfeed for six months. As low-income mothers are less likely to breastfeed, they represent an important target population (Gionet, 2015; Frank, 2020). Significantly, this policy initiative is connected to the long history of moral regulation of low-income mothers who face multiple and contradictory demands to find employment, often without corresponding childcare support, while simultaneously demonstrating white middle-class standards of "good mothering" (Chunn & Gavigan, 2004; McMullin, Davies, & Cassidy, 2002; Morgen, Acker, & Weigt, 2010; Frank 2020; Rippey 2021). What continues to be underexplored are broader considerations that connect breastfeeding promotion to larger debates concerning the use of policy tools for the moral regulation of low-income mothers.

Combining two complementary approaches, Schneider and Ingram's (1993) framework on the social constructions of target populations (SCTP) and a modified version of Vedung's (1998) typology of policy instruments, this paper examines two interrelated questions regarding infant feeding policy in Canadian provincial social welfare policy. First, why does the social construction of low-income mothers as "deviants" allow governments to target them for social control? Second, beyond the intent to punish or reward specific populations based on their social construction, what kind of policy tools do provincial governments employ to promote breastfeeding or restrict alternative infant feeding options? Focusing on a modified typology of *carrots*, *sticks* and *sermons* to classify policy instruments (Bemelmans-Videc, Rist, & Vedung, 1998; Vedung, 1998), our findings suggest that governments use tools such as educational campaigns (*sermons)* as well as economic measures (*carrots*) to target low-income mothers who cannot, or decide not to, breastfeed. These economic measures include stigmatizing declarations and medical authorizations that add to the existing obstacles and social regulation faced by women living on social assistance.

This article consists of three sections. It begins with a review of the policy instruments targeting mothers on social assistance, featuring a description of the social construction of breastfeeding policy and the tools deployed by governments to influence infant feeding choices. The second section presents a classification of breastfeeding and formula instruments in the context of social assistance programs, followed by the application of these instruments across the ten Canadian provinces. The conclusion summarizes the findings, revisits the place of medicalized burdens in social assistance programs, and proposes avenues for further research.

Social Assistance and the Social Construction of Target Populations (SCTP)

The policy instrument literature emphasizes that governments possess multiple tools or instruments to address policy problems and that tool selection matters since it depends on political beliefs, attitudes, and perceptions (Linder & Peters, 1989). In Schneider and Ingram's framework (1993), policy tools play a determinant role in the social construction of target populations (SCTP). This framework classifies groups on two dimensions. First, the social construction of groups, as either positive or negative, determines whether members of the group are considered deserving or undeserving of public benefits (Schneider & Ingram, 1997). Second, the degree of political power and resources, such as wealth, access to public officials, and the capacity to mobilise, also determines how a group is socially constructed (Ingram, Schneider, & deLeon, 2007, p. 101). The banking community, for example, may be constructed negatively, but because bankers benefit from wealth and political power, public policy regulating this group tends to be favorable. In short, the social construction of target populations and their respective political power defines both policy objectives and accompanying instruments.

The social construction of target populations (SCTP) typology results in four distinct mixes (Schneider & Ingram, 1993). First, the "advantaged" benefit from both positive social construction and strong political power resulting in more favourable policy design that accentuates their advantage (Schneider & Ingram, 1993, p. 337). "Advantaged" policies include self-regulation (as is the case for medical and legal associations) or monetary rewards to encourage certain behaviours without constraining criteria (such as tax credits). Second, the "contenders" benefit from strong political power, but negative social construction, such as in the case of the bankers mentioned above. Third, the "dependents" are societal groups with positive social construction but with limited resources and political power, such as mothers, children, and individuals with disabilities. Finally, the "deviants" experience both negative social construction and lack resources and political power which results in overcontrolling policies aimed at constraining their behaviour. Typical examples of "deviants" include drug users, convicted felons, and the subject of this analysis: welfare mothers (Schneider & Ingram, 1997, p. 124). This targeting of welfare mothers as "deviant" extends beyond the United States, as illustrated in Canadian (March, 2019) and Danish (Jørgensen, 2018) articles. Thus, the SCTP framework challenges the assumption that policy-makers primarily choose the least coercive policy instruments to achieve policy goals (Linder & Peters, 1989). In the case of "deviant" target

groups, instruments are intentionally coercive and can result in dire consequences, including incarceration.

The SCTP framework has been established as highly relevant in social assistance analyses. Recipients often are constructed as "deviants" and, as a result, face coercive policies that maintain and reinforce stigmas. Since those benefiting from social assistance tend to associate their treatment at the welfare office with government in general, when they are treated as "deviants" this affects their willingness to engage in democratic activities, such as voting (Soss, 1999). Women on social assistance are constructed even less positively than their male counterparts, because social benefits predominantly affecting men are assumed to be "earned" (such as employment insurance) while women receiving benefits are associated with "non-economic" roles, such as mothers or wives (Orloff, 1993). Lone mothers are particularly targeted as more than 60% may require social assistance for a portion of the year (National Council on Welfare, 2001).[1] This results in a "Catch-22" since welfare reforms not only accentuate the risk that lone mothers will require social assistance, but also feed into their social construction as "deviants" (Gazso, 2015).

The Social Construction of Breastfeeding Policy

Despite Canada's adoption of the standardized recommendation of six months of exclusive breastfeeding, the reality is that breastfeeding is a complex, learned, and biocultural practice influenced by diverse cultural norms and individual experiences (Wall, 2001; Hausman, 2003; Frank, 2020; Rippey, 2021). Government policies encouraging or influencing breastfeeding practices are not new and have existed since at least ancient Babylon. In the late eighteenth century, for example, Prussia legally required all healthy women to breastfeed, and around the same time in France, the government only provided financial support to poor mothers on the condition they breastfed (Yalom, 1997; Jung 2015). Such policy interventions were deliberate political attempts to influence norms by extolling the virtue of women who nursed their children as "true mothers" (Yalom, 1997, p. 93) and condemning those who used wet nurses as "abominations" or, as the SCTP framework would say: "deviants."

The history of Canadian breastfeeding policy reflects these early models. Starting in 1924, the Canadian government connected breastfeeding with issues of morality, citizenship, and nation-building. The Division of Child Welfare's series *The Canadian Mother's Book* promoted breastfeeding as a "patriotic duty" and the "dearest wish of a true woman" (as quoted in Nathoo & Ostry, 2009, p. 72). Even though the federal government's official policy promoted breastfeeding, with the introduction and aggressive advertising of infant formula in the 1930s, breastfeeding initiation rates fell to about 25% during that period. This trend of low rates of breastfeeding continued until the 1960s when the influence of maternalistic advocacy movements, such as the La Leche League, lobbied extensively and reversed this trend by increasing the initiation rates of breastfeeding.

[1] With the National Council on Welfare no longer in operation, we have not been able to find more recent figures.

Current federal policy continues to extol breastfeeding practices by emphasizing breastfeeding as "natural" and promoting it as "the cultural norm for infant feeding in Canada" (Breastfeeding Committee for Canada, 2015). In 2011-12, Canadian women breastfed at relatively high rates with approximately 89% initiating breastfeeding and 26% exclusively breastfeeding for six months (Gionet, 2015). These rates vary across provinces (British Columbia with the highest initiation rates at 96% and Newfoundland/Labrador with the lowest at 57%) and along socio-economic indicators such as age, race, income, education, and marital status. Overwhelmingly, the most "successful" breastfeeding mother tends to be a well-educated, middle- to upper-class older woman who is in a long-term stable relationship.

As initiation rates remain relatively high in Canada, the goals of current policy initiatives—supported by a strong coalition of breastfeeding advocates, medical associations, and government—are twofold: to increase the exclusive six-month breastfeeding duration to one year; and to increase rates of breastfeeding among "unsuccessful" mothers in lower quintiles of income, education, race, and age (Wall, 2001; Moran et al., 2015; Nathoo & Ostry, 2009). Although other issues surround this current policy, such as the low rate of Canadian hospitals achieving Baby-Friendly Initiative guidelines (see Hausman, 2003; Law, 2000; Rippey, 2021), the promotion of this idealized norm is especially problematic for poorer Canadian women for two significant reasons.

First, government policy adopts a highly medicalized model that reduces breastfeeding's complex biocultural practice solely to its biomedical indicators, such as infant and maternal health (Arneil, 2000; Wall, 2001). The only acceptable reason to use infant formula is medical necessity, such as babies with classic galactosemia or mothers with HIV or addiction issues. In other words, breastfeeding is considered solely a medical issue. Although there are established medical benefits associated with breastfeeding, statistically significant findings or replicated studies on all the proposed effects of different infant feeding methods are "notoriously difficult to come by" (Law, 2000, p. 414). Large data samples exist for certain relative benefits of breastfeeding, especially for reduced respiratory and gastrointestinal incidents (Dubois & Girard, 2003), but oft-cited benefits of breastfeeding—from higher IQs and less sensitivity to allergens, to maternal weight loss—are often based on statistically small, non-replicated studies with inconclusive or relatively marginal findings (for an overview see Knaak, 2006; Jung, 2015).

Second, the medical model sets up expectations that do not consider the variable personal, family, food security, and workplace demands involved in infant feeding decisions (Arneil, 2000; Law, 2000; Frank, 2020; Rippey, 2021). For many women, breastfeeding is not a positive bonding experience but physically painful and associated with feelings of detachment from one's child (Hausman, 2003; Knaak, 2006; Frank, 2020; Rippey 2021). In addition, although the Baby-Friendly Hospital Initiative provides some mother-to-mother assistance, many women do not have access to these hospital programs or other kinds of support systems, such as involved family members or partners. It may be no coincidence that 91% of women who exclusively breastfed for six months had a stable partner (Gionet, 2015; for further discussion see

Rippey, 2021). Such "successful" mothers also tended to have higher economic resources and access to white collar labour policies, including generous maternity leaves or in-home paid help (or both). Lone mothers on social assistance are doubly disadvantaged as they possess neither the generous labour policy benefits nor in-home supports (either from partners or paid help) which are correlated with "successful" mothering norms.

Although mothers on social assistance struggle to achieve breastfeeding standards that disregard their personal, sociocultural, and economic realities (Temple-Newhook et al., 2013; Rippey, 2021), the SCTP framework predicts that low-income mothers are the target of specific policy instruments intended to control their behaviour. In keeping with the literature on medicalization as a tool of social control within the policy-making process (Conrad, 1992), we expect that mothers on social assistance will encounter two distinct strategies intended to shape their behavior. Namely, women opting to breastfeed will likely obtain benefits with minimal constraints, as this aligns with the dominant medicalized approach to breastfeeding promotion, while women opting to use infant formula will encounter multiple hurdles, since this choice aligns with the construction of women on social assistance as both "unsuccessful" mothers and "deviants."

Breastfeeding Policy and Social Assistance Converge

There are several policy instruments utilized to "regulate" (Piven & Cloward, 1971) or "discipline" the poor (Soss, Fording, & Schram, 2011). To assess the nuance of the policy instruments used in breastfeeding policy, we employ a mixture of two approaches. We first use Vedung's (1998, p. 51) typology of policy instruments classified by "the degree of constraint intended by policy-makers": information instruments (*sermons*), regulation instruments (*sticks*), and economic instruments (*carrots*); and then, following Schneider and Ingram's (1997) original SCTP approach, we differentiate between "beneficial" and "burdened" instruments. In this approach, a policy instrument is "beneficial" if benefits are unconditional, and "burdened" if specific conditions, especially negative or stigmatizing obstacles, are required to obtain benefits. Previous literature on administrative burdens has explored the distinction between beneficial and burdened instruments, such as tools that increase the amount of information required to access benefits (learning costs), increase stigma (psychological costs), or add rules and requirements (compliance costs) (Herd & Moynihan, 2019). Removing administrative burdens moves towards a "beneficial" benefit while adding burdens generates a "burdened" benefit. One of the key distinctions between these two approaches is the extent to which burdens are in flux. In Schneider and Ingram (1997), burdens are fairly static, but they can fluctuate widely in Herd and Moynihan (2019) since they are subject to continuous political interventions. While the former implies that partisanship plays a limited role, it is the opposite for the latter.

This distinction between "beneficial" and "burdened" instruments is comparable to Vedung's (1998, p. 41) classification of instruments as positive or negative depending on the degree of constraints. Higher levels of state intervention can involve oversight which is indicative of burdens placed on target populations. The opposite is true for benefits which

require less coercive intervention by the state. Hence, rather than a dichotomous burden/benefits classification, we analyse *sticks*, *carrots*, and *sermons* in conjunction with a burdens/benefits approach resulting in different mixes or types of policy tools or instruments (see Table 1).

Table 1

Potential Packages of Instruments for Breastfeeding and Infant Formula

Infant Formula Instruments (burdened sermon discouraging formula always present)		Breastfeeding Instruments (beneficial sermons encouraging breastfeeding always present)		
		No Instrument	*Traditional Burdened Carrots*	*Beneficial Carrots*
No Instrument		(1) No allowance to support formula and/or breastfeeding beyond sermons.	(2) No allowance to support formula. Traditional burdens to receive allowance for breastfeeding.	(3) No allowance to support formula. Additional allowance with no burdens for breastfeeding.
Burdened Carrots	*Traditional*	(4) Traditional burdens to receive allowance for formula. No allowance for breastfeeding.	(5) Traditional burdens to receive allowance for formula and/or breastfeeding.	(6) Traditional burdens to receive allowance for formula. Additional allowance with no burdens for breastfeeding.
	Medicalized	(7) Medicalized burdens to receive allowance for formula. No allowance for breastfeeding.	(8) Medicalized burdens to receive an allowance for formula. Traditional burdens to receive allowance for breastfeeding.	(9) Medicalized burdens to receive an allowance for formula. Additional allowance with no burdens for breastfeeding.

Theoretically, regulations (*sticks*) are the most constraining instruments because government utilizes various coercive prohibitions involving regulatory controls and oversight (Vedung, 1998, pp. 41-43). An example of a *beneficial stick* would be a regulation on activities

with few limitations, such as requiring a park entrance pass. A *burdened stick* would be a regulation prohibiting activities or imposing harsh punishment for noncompliance. *Burdened sticks* are often used on "deviant" populations such as low-income mothers who, for instance, could be prosecuted for non-declaration of income even when administrative procedures are problematic (Chunn & Gavigan, 2004). Historically, the clearest example of a *burdened stick* in breastfeeding policy would be the eighteen-century Prussian law requiring all women to breastfeed. However, since governmental authorities in Canada do not employ either *beneficial* or *burdened sticks* with breastfeeding policy, this instrument does not feature in Table 1.

Public authorities devote resources in the form of educational campaigns (*sermons*) intended to influence or coerce citizens' behaviour (Weiss & Tschirhart, 1994). *Sermons* can be classified as *beneficial* if they encourage positive behaviour (such as the promotion of exercise), or *burdened* if they discourage negative behaviour (such as anti-smoking campaigns). Schneider and Ingram (1997, pp. 95, 131) refer to *sermons* as *hortatory tools* which further stigmatize disadvantaged groups who lack political power. Since the publication of *The Canadian Mother's Book*, both federal and provincial governments have consistently used such *hortatory tools* to promote breastfeeding and to discourage formula usage for all women (i.e., both "dependents" and "deviants") without providing other types of support (maternity leave, breastfeeding rooms, etc.) necessary to meet the goals of the s*ermons.* Provincial and federal governments continue to publish material promoting breastfeeding (for example, see Health Canada, 2015). Theoretically, *sermons* are the least constraining policy instruments. However, unlike "dependents" in better socio-economic circumstances, mothers on social assistance are less able to reject the moralization of breastfeeding as an obligation and may fear the potential consequences of opposing the *sermons* (Wall, 2001; Balint et al., 2017). Studies demonstrate that welfare recipients learn quickly that any appearance of opposition could result in the loss of benefits (Soss, 1999). Thus, we expect welfare agencies to convey the necessity of breastfeeding and discourage infant formula among the "deviant" population of mothers on social assistance, regardless of their circumstances (see Table 1).

The core emphasis of this argument is that governments provide not only *carrots* but *economic carrots* in the form of benefits or burdens intended to encourage or coerce behaviour in "deviant" populations. The *carrot* is a *beneficial carrot* if it includes cash or in-kind incentives with few conditions attached, such as grants or loans. In contrast, governments create economic *burdened carrots* by increasing the cost associated with negative behaviour (such as taxes) or adding compulsory conditions to obtain monetary benefits (such as signed declarations). To uncover the nuances of a medicalized policy model, we further distinguish between two types of *burdened carrots*: *traditional burden* and *medicalized burden*. A *traditional burdened carrot* refers to any type of long-established condition imposed by welfare offices but administered internally by case workers (i.e. signed statements); in contrast, a *medicalized burden* requires an external third party (i.e. a doctor) to obtain permission for the benefit. The expectation of a *medicalized burden* has precedence, since breastfeeding is a medicalized policy and medical reasons are historically the only exemption from cuts to social assistance benefits (Lindqvist &

Marklund, 1995). Importantly, the key distinction between *carrots* and *sticks* is the absence of prohibitions. Unlike *sticks*, with *carrots* citizens are not prohibited from engaging in the activity, even if governments make it more difficult. *Carrots*, however, can be highly coercive as benefits tied to certain behaviors can become moral obligations (Wall, 2001; Balint, et al., 2017). The historical example of eighteenth-century France which required indigent women to breastfeed in order to obtain financial benefits is a clear example of a *burdened carrot*.

At first glance, provincial income assistance programs appear to be a *beneficial carrot* since it is predominately a cash transfer to recipients (Vedung, 1998, p. 43). However, while citizens who are socially constructed positively, such as the "dependents" (Schneider & Ingram, 1993), receive such benefits with very little oversight, many of the subsidies given to poorer individuals are *burdened carrots*, since they impose multiple conditions to receive benefits. For example, to discourage applying for social assistance, individuals must continually demonstrate their efforts to reintegrate the labour market (McMullin et al., 2002; Morgen et al., 2010). In addition, industrialised countries have been increasing the number of conditions, or burdens, necessary to obtain social assistance (Brodkin & Majmundar, 2010; Dufour et al., 2003). These added conditions often focus on enforcing norms of good citizenship or "successful mothering" rather than favoring a return to the active labour market (Wall, 2011; Soss et al., 2011).

Since the federal and provincial governments actively promote the medicalized model of breastfeeding, we expect the use of different *carrots* for the "deviant" population of women on social assistance which reflects the two different social constructions of mothering ("dependents" and "deviants"). On the one hand, since *sermons* promote breastfeeding, one would expect public authorities to offer cash transfers with very little oversight to promote "successful" mothering—in other words, a *beneficial carrot*. This could take the form of a specific program targeting poorer households or include additional benefits within provincial assistance income programs. The policy design of this type of instrument reflects benefits granted to more privileged target populations ("dependents," "contenders," and "advantaged"). Thus, the medical policy encouraging breastfeeding would overrule the need to punish this population for other "deviant" behaviours, such as not being active in the labour market. However, since women on social assistance are construed as "deviants," it is equally possible that governments might not provide any policy instruments (i.e., no additional financial support to meet breastfeeding *sermons*); or they might require some form of a *traditional burden carrot*. As the medical model relies on sermons to encourage breastfeeding, we expect women should not face a *medicalized burdened carrot* to obtain funding to breastfeed. Thus, to simplify the table, this possibility of *medicalized burdens* for breastfeeding has been removed (see Table 1).

On the other hand, since mothers on social assistance are construed as "deviants" and the medical model considers the choice of infant formula a "deviant" behaviour, we anticipate social assistant recipients will face multiple obstacles or conditions if they choose infant formula. For example, if medical approval is a condition to obtain infant formula, it is a *medicalized burden*; and if conditions are imposed by a case worker, it is a *traditional burden.* Since the medicalized

breastfeeding model only accepts the use of the infant formula in strict medical circumstances, we expect most provinces will opt for a *medicalized burden*. Furthermore, since provincial governments in Canada employ *burdened sermons* to discourage the use of formula, there may be no policy instruments to support the use of formula. Finally, based on the medicalized model of breastfeeding, we assume that no province employs *beneficial carrots,* or unconditional financial incentives, to encourage women to use infant formula. Again, to simplify the table for clarity, the theoretical possibility of *beneficial carrots* for infant formula has been removed (see Table 1). Thus, we expect most provinces to be classified in box 9 (*beneficial carrots* for breastfeeding; *medicalized burden* for formula) with boxes 3 (*no instrument* for formula; *beneficial carrots* for breastfeeding) and 6 (*traditional burden* for formula; *beneficial carrots* for breastfeeding) also possible.

Classifying Breastfeeding and Formula Instruments for Mothers on Social Assistance

The ten Canadian provinces provide a unique laboratory to explore breastfeeding policy instruments targeting mothers on social assistance. Since breastfeeding policy across the country is medicalized, it includes both the social and health policy sectors which are under the primary jurisdiction of provincial governments. The federal government only has jurisdiction to promote public health which limits its policy instrument to its use of hortatory *sermons* promoting six months of exclusive breastfeeding. Canadian provinces also possess considerable flexibility in their choice of policy design, as well as the necessary financial resources to select different policy instruments. Canadian provinces exhibit very different social assistance regimes (Boychuk, 1998), disparities in poverty reduction outcomes (Bernard & Saint-Arnaud, 2004), and differences in health priorities (Barua, 2013). Thus, there are good reasons to expect provincial variations in policy instruments. In addition, welfare benefits are likely still insufficient to address the real financial needs of mothers on social assistance. Many low-income mothers compromise their own health to ensure that their children receive proper nutrition, and approximately 70% of families dependent on social assistance experience food insecurity (McIntyre et al., 2003; Tarasuk, et al., 2014; for further discussion see Frank, 2020). Hence, the type of intervention affecting mothers on social assistance is crucial to the well-being of both mothers and their children.

We used two types of data to examine provincial differences in policy instruments. To assess the stability of policies across time, we collected public information concerning social assistance and infant nutrition programs on governmental websites and public documents concerning provincial policies (reports, strategic plans, etc.) in three time periods: 2011, 2013, and 2017. We selected this kind of documentation as it is the most readily available to mothers. These documents were used to identify provincial policy instruments, such as *beneficial carrots* (instruments with little oversight) or the two types of *burdened carrots* (*traditional burdened carrots*, such as mandatory declarations of breastfeeding practices and *medicalized burdened carrots*, such as mandatory medical notes) to secure additional public benefits. While acknowledging that other social programs, such as child allowance, can impact social assistance

income, the focus of this study was limited to provincial instruments specifically targeting breastfeeding practices.

We then conducted follow-up phone consultations with social service offices in the same three time periods (2011, 2013, and 2017) and across all Canadian provinces. The purpose of these interviews was to clarify how caseworkers interpret the guiding principles and to confirm the information found on public documents/websites. We did not conduct formal interviews with caseworkers or individuals living on social assistance since our focus was a comparison of the policy tools used and not the implementation of these instruments or the differences in the lived experience of those affected by the policies. Finally, it is important to note that although mothers on social assistance face the conflicting demand to remain at home breastfeeding and to find employment, it is beyond the scope of this analysis to explore the policy tools focused on reintegrating welfare mothers into the labor market.

Criteria Employed for the Categorization of Provinces

This section classifies the provincial policy instruments used to promote exclusive breastfeeding for women on social assistance. As all governments promote medicalized breastfeeding norms, the analysis assumed that provincial policies would discourage the use of infant formula in its welfare policies. Although it is possible for governments to have no policy instruments to encourage breastfeeding or to discourage formula use, it is expected that provincial governments go beyond *sermons* and employ *carrots*. As discussed in the previous section, we theorize that *beneficial carrots* (i.e. the granting of cash benefits without stringent conditions) would be the predominant tool to promote the Canadian breastfeeding "norm" while *medicalized* and/or *traditional burdened carrots* would be in place as an obstacle for the choice of formula. It is important to emphasize that the assessment of cases within each box (in Tables 1 and 2) is based on the relative predominance of policy instruments over others; it is extremely rare to have a package of instruments for a policy objective that is fully coherent (Vedung, 1998).

What types of *beneficial* and *burdened carrots* policy tools were found in provincial breastfeeding policy for women on social assistance? *Beneficial carrots* for breastfeeding were primarily monetary incentives with little oversight, such as additional allowance or other subsidies to purchase equipment (e.g., breast pumps). These benefits are consistent with the modified SCTP framework since governmental authorities reward best practices with instruments that facilitate desired behaviours, including those promoting "successful" mothering.

Multiple instruments were used as *burdened carrots* that placed obstacles on mothers to augment, or even sustain, current benefits. Welfare agencies were found to use *traditional burdened carrots*, such as signing breastfeeding declarations, to obtain benefits for breastfeeding. To discourage alternative infant feeding choices, *traditional burdened carrots* included mandating the purchase of a specific brand of infant formula, providing formula only at specific locations, or not providing adequate funds to meet an infant's nutritional needs. Governments also employed *medicalized burdened carrots*, such as requiring medical documentation attesting

to a medical necessity for infant formula. Overall, the medicalized model was reinforced by assuming that health factors were the only possible reason not to breastfeed and that all other economic, family, and personal considerations were not relevant in infant feeding decisions.

Policy Instrument Mix in Canadian Provinces

The social assistance breastfeeding policy instruments in Canadian provinces can be categorized into five out of nine theoretically possible policy options (see Table 2). As expected, no government offered *beneficial carrots* (i.e. benefits without obstacles) for the use of formula. Also, as predicted, most of the provinces (five of ten) were in box 9 as they offered *beneficial carrots* for breastfeeding and a *medicalized burdened carrot* to obtain formula. The other five provinces showed variation and are classified in four other boxes as described below. Contrary to expectations, no province was in box 3 (*beneficial carrot* for breastfeeding; no instrument for formula) or box 6 (*beneficial carrot* for breastfeeding; *traditional burdened* for formula). Although theoretically possible, no provinces met the criteria of box 1 (no instrument for breastfeeding or formula) or box 4 (no instrument for breastfeeding; *traditional burdened* for formula).

Most provinces–British Columbia, Saskatchewan, New Brunswick, Nova Scotia, and Newfoundland and Labrador–are classified in box 9 (*beneficial carrots* for breastfeeding; *medicalized burden* for formula). The provinces in this category offer some financial assistance with little oversight to support their *sermon's* objective of six months of exclusive breastfeeding. The amount of the assistance varied between $45 and $60 per month in 2017 but was not specifically tied to breastfeeding (i.e. postnatal women receive this money whether or not they followed the advice of the *sermons*). These provinces, however, create barriers to use infant formula by requiring a *medicalized burdened carrot* in the form of a doctor's certification. Variations exist across the policy instruments used in these five provinces: for example, New Brunswick only offers postnatal support for four months after birth (two months less than the six-month guideline) but within a distinct program (Postnatal Benefit Program) targeting poorer households beyond the social assistance threshold (and without asset restrictions); in contrast, British Columbia "highly encourages" the use of the postnatal funds for breastfeeding and offers additional support, such as funding for breast pumps.

With a *beneficial carrot* for breastfeeding and *medicalized burden* for infant formula, accompanied by the *sermons*, the policy instruments in these provinces send a strong message that women on social assistance should breastfeed, regardless of their individual circumstances. Consequently, these provinces create two classes of mothers and target them accordingly.

Breastfeeding mothers are considered "successful" and thus receive a *beneficial carrot* that is easily accessible without significant administrative hurdles or oversight. This is the type of instrument associated with target populations that have positive social construction (Schneider and Ingram, 1993). Hence, breastfeeding mothers are treated more like "dependents" rather than "deviants." This is particularly the case for provinces with distinct programs offering financial

support for breastfeeding mothers, for example New Brunswick and Newfoundland and Labrador, which captures a larger segment of the population than mothers on social assistance.

Table 2

Packages of Instruments in Canadian Province

Infant Formula Instruments (burdened sermons always present)	Breastfeeding Instruments (beneficial sermons always present)		
	No Instrument	*Traditional Burdened Carrots*	*Beneficial Carrots*
No Instrument	(1)	(2) PEI	(3)
Burdened Carrots — *Traditional*	(4)	(5) QC	(6)
Burdened Carrots — *Medicalized*	(7) MB	(8) AB, ON	(9) BC, SK, NB, NS, NL

Note. Contrary to expectations, PEI's *burdened carrot* can be *traditional* or *medicalized*.

This is not the case, however, with mothers opting to use the formula who face a *medicalized burden* consistent with a construction as "deviants." These mothers face additional constraints added to those already in place for individuals on social assistance. These tools are consistent with the use of administrative burdens to discourage the use of social benefits (Herd and Moynihan, 2019). In addition, these policy instruments also involve the intrusion of a medical doctor, a professional with more independence and a higher status than caseworkers.

The provinces in box 8—Alberta and Ontario—represent the most forceful case promoting breastfeeding (*traditional burdened carrots* for breastfeeding; *medicalized burden* for formula). These two provincial authorities impose a *traditional burdened carrot* in the form of a verbal or written confirmation to the caseworker for breastfeeding women to receive financial

benefits for up to one year. There is a slight variation in generosity ($30 and $40 per month, respectively, in 2017). Also, in tandem with the other provinces mentioned above, these two provincial governments also employ a *medicalized burdened carrot* by requiring medical certification to obtain support for infant formula. The policy instruments of these two provinces are most consistent with the social construction of women on social assistance as "deviant." They also reinforce the medical model (*sermons*) by requiring women to declare that they breastfeed as well as demanding medical reasons if they choose infant formula.

The final three provinces stand out by creating instruments that deviate from the medical model *sermons*. Manitoba is classified in box 7 (*no instrument* for breastfeeding; *medicalized burden* for formula) because, like most other provinces, it employs the *medicalized burdened carrot* (medical authorization) to acquire support for infant formula; yet, contrary to all other provinces, this province has no instrument to support the increased nutritional demands of breastfeeding. This means that Manitoban women on social assistance receive all the *sermons* associated with breastfeeding but no additional support beyond regular social assistance. Hence, it is assumed that lone mothers should assume all the costs of meeting the Canadian "norm" of breastfeeding. This message represents a paternalistic approach by the state that moralizes breastfeeding without providing the resources and structural assistance to support "successful" mothering expectations (Wall, 2001).

Prince Edward Island (PEI), in box 2 (*traditional burdened carrots* for breastfeeding; *no instrument* for formula), conveys a very different mixed message concerning the medical model *sermon*. PEI is the only province that can employ two types of *burdened carrots* to receive postnatal funding for breastfeeding and no policy instrument for the use of infant formula. The postnatal funding for breastfeeding is considered a "therapeutic diet" allowance ($25 per month in 2017). Thus, similar to Alberta and Ontario, a new mother can obtain this benefit with a verbal confirmation of her breastfeeding choice (a *traditional burdened carrot*); however, if the social worker suspects that a mother is not breastfeeding, a written verification by a health care professional can be required to obtain the diet allowance. Thus, PEI can require, contrary to theoretical expectations, a *medicalized burdened carrot* for breastfeeding. By granting a great deal of discretion to social workers, this surveillance tool potentially reinforces stigma and introduces coercive restrictions akin to other benefits covered in the social assistance program (Soss, 1999). In addition, in the case of infant formula, PEI is also the only province that has no specific instrument, even in the cases of medical need, to obtain infant formula. Provincial authorities expect mothers to purchase infant formula with their general Food, Clothing, Household and Personal Allowance (FCHP). Thus, although the government in PEI promotes the *sermons* associated with breastfeeding, it has *traditional burdened carrots* for breastfeeding and can deploy a *medicalized burdened carrot* for "successful" breastfeeding practices. It also has no instrument to support the medical model's minimal recognition for medical justifications in the use of infant formula. Hence, PEI goes further than Manitoba in moralizing breastfeeding practices without financial and institutional support for their *sermons*.

Finally, Québec is classified in box 5 because it employs *traditional burdened carrots* for both breastfeeding and the use of infant formula. The provincial government strongly promotes breastfeeding *sermons* and has the highest number of health care facilities following WHO's Baby-Friendly Initiative guidelines (Breastfeeding Committee for Canada, 2015); however, it is the only province that recognizes that women should be able to choose the best infant feeding method for their families. The province introduced a "special nursing allowance" in 1994 for women on social assistance. This allowance is currently $55 per month. To obtain this benefit, women must provide attestation of birth and sign a written statement confirming their decision to breastfeed for up to one year. This is a *traditional burdened carrot* instrument similar to Ontario and Alberta.

Québec is unique, however, as it is the only province that provides financial assistance for infant formula (for up to one year) without medical authorization. To obtain formula, a woman contacts a local employment center with evidence of birth and is given an authorization number which can be used at the pharmacy of her choice. This special benefit varies with nutritional needs (i.e., in 2017, for infants up to seven months, the benefit was valued at about $64 for 48 cans per month and, from seven months to one year, it covers about $48 for 36 cans per month). Since no medical authorization is required, this is a *traditional*, as opposed to a *medicalized burdened carrot.* Both choices (breastfeeding and formula) utilize a *traditional burdened carrot*: women must sign a written declaration for breastfeeding while the mechanism to obtain infant formula is via vouchers which reinforces social stigmas. Importantly, Québec's policy acknowledges the bodily integrity of women on social assistance and respects, to some degree, the autonomy of women to choose the best infant feeding option for themselves and their children.

Conclusion

This study develops a policy instrument typology combining Schneider and Ingram's (1993) categorization of benefits and burdens with Vedung's (1998) *carrots*, *sticks*, and *sermons* to analyze the policy mix surrounding infant feeding support for mother on social assistance in Canada. As breastfeeding policy follows a medical model, the typology also distinguishes between the use of *medicalized* instruments (such as the requirement of a medical note) and *traditional* instruments (such as monthly follow up with a welfare office). This distinction highlights the additional burden of accommodating medical requirements, beyond those typically associated with welfare offices, which further restrict infant feeding decisions. Infant feeding has become increasingly medicalized to the point where medical discourses and health professionals play an authoritative role in public policy and in enforcing the cultural norm of "successful" breastfeeding practices (Andrews and Knaak, 2013).

Indicative of this policy enforcement of breastfeeding, Canadian provinces deploy instruments mainly to encourage mothers on social assistance to breastfeed rather than use infant formula. These instruments included *sermons* that categorically emphasize the medical benefits of breastfeeding without equal consideration to social, family, personal, and economic

circumstances that are relevant in infant feeding decisions. Beyond *sermons*, instruments mainly lean towards providing benefits for breastfeeding and creating burdens when adopting infant formula. For instance, in five provinces women who are assumed to follow norms of "successful" mothering by breastfeeding receive additional cash benefits with little oversight. However, in 80% of provinces women on social assistance face *medicalized burdens* to obtain formula.

Still, there are noticeable and consequential differences across the Canadian provinces. The major findings relate to the variation of *beneficial* and *burdened carrots* used by provincial authorities to target the behaviour of women on social assistance. Most provinces (except for PEI which offers no support and Québec which employs a *traditional burden*) utilize a *medicalized burdened carrot* to obtain infant formula as they require third party medical approval. This tool further reinforces a medicalized view of breastfeeding practices in Canada. The use of *beneficial carrots* for breastfeeding is more varied across the provinces. Five provinces (BC, SK, NS, NB, and NL) offer variable postnatal funding with the expectation women use this money to support breastfeeding, but no oversight or penalty if women choose to spend it on formula. Two provinces (Alberta and Ontario) offer *traditional burdened carrots* for postnatal funding contingent on declarations of breastfeeding and reinforce *medicalized burdened carrots* for infant formula. The instruments in PEI and Manitoba offer even less support to meet the breastfeeding *sermons* – PEI requires a *traditional burden* and can require a *medicalized burden* to access funds for breastfeeding while Manitoba fails to offer any type of *carrot* to support breastfeeding needs.

Currently, Québec is the only province that uses *traditional burdened carrots* for both breastfeeding and infant formula. Significantly, Québec's policy instruments represent the strongest break from the medical model by respecting the autonomy of women's agency over their body and the right to choose what is best for their family without medical or traditional oversight. This idea of autonomy stresses not only the liberal principle reflected in a right to bodily integrity in reproductive choice (which logically should extend to breastfeeding), but also the reality that poorer mothers face additional barriers which often make breastfeeding an impossible choice (Balint et al., 2017; Jung, 2015; Frank, 2020).

The implications of this research extend far beyond the *sermons* and *carrots* used by governments to enforce a medicalized model of breastfeeding since *medicalized burdens* intersect with other socio-economic conditions that accentuate the difficulties and obstacles faced by mothers on social assistance. In Canada, poorer women have already been the subject of enhanced scrutiny over the past twenty years. The findings in this paper suggest that this kind of targeting extends beyond traditional labour market policies and reinforces long-standing practices of targeting low-income mothers who fail to live up to middle-class standards of mothering (Chunn & Gavigan, 2004; McMullin et al., 2002). Ironically, policies to encourage women to return to the labour market, coupled with *sermons* and *carrots* to breastfeed, generate a contradictory and nearly impossible outcome since the types of employment often available to

mothers on social assistance (Morgen et al., 2010) are unlikely to provide the support for breastfeeding practices. Despite the consistent *sermons* to breastfeed and various *beneficial* or *burdened carrots* to promote breastfeeding, most provincial governments still do not provide enough financial support to meet the *sermonized* breastfeeding expectations (for further discussion, see Frank, 2020). In addition, the *medicalized burdened carrot* required by most provinces to obtain formula ignores the biocultural reality of breastfeeding choices and further disadvantages and stigmatizes poorer mothers. Thus, the government's use of policy instruments to encourage breastfeeding further constructs and reinforces poorer women as "deviants" who are set up to fail at achieving societal expectations, which can accentuate the anxieties and burdens already placed on poor women and their families.

In closing, potential avenues for further research reflect the limitations of this study. First, the focus is on the characteristics of policy instruments but not on how these instruments are implemented. Since case workers and other professionals, such as social workers and medical doctors, have a great degree of discretionary authority, follow-up studies could explore how *medicalized* or *burdened benefits* are used in practice. For instance, how frequently are social workers in PEI requesting a medical note as proof of breastfeeding? How stringent are breastfeeding declarations? Do caseworkers seek alternative avenues to support low-income mothers opting for formula despite strong policy signals to do otherwise?

Second, this study did not analyze the impact of instrument selection. Based on the diversity of policy mixes, one would expect different policy tools to affect infant feeding choices. Are there, for example, important intra-provincial variations based on regional differences with regards to socio-economic status and ethnic diversity? Third, this paper did not analyze the policy process behind the selection of instruments. It would be worthwhile, for instance, to investigate further why Québec is the only province to offer choice in infant feeding decisions. Could this policy decision be influenced by different actors than the usual coalition of breastfeeding activists, medical professionals, and government authorities? Finally, there are many individuals in need of financial assistance whose support depends heavily on medicalized instruments. Individuals with disabilities, for instance, face multiple constraints and must follow-up with medical professionals to access and to sustain benefits, despite benefitting from a positive social construction. An interesting avenue for inquiry might be to study whether medicalized instruments utilized in this policy area are more of a *beneficial* or *burdened carrot*.

References

Andrews, T., & Knaak, S. (2013). Medicalized Mothering: Experiences with Breastfeeding in Canada and Norway. *The Sociological Review*, *61*(1), 88–110.

Arneil, B. (2000). The politics of the breast. *Canadian Journal of Women and the Law, 12*, 346–370.

Balint, B., Eriksson, L., & Torresi, T. (2017). State power and breastfeeding promotion: A critique. *Contemporary Political Theory*, 17(3), 306–330.

Barua, B. (2013). *Provincial Healthcare Index 2013*. Fraser Institute.

Bemelmans-Videc, M.-L., Rist, R. C., & Vedung, E. (Eds.). (1998). *Carrots, Sticks & Sermons: Policy Instruments and Their Evaluation*. Transaction Publishers.

Bernard, P., & Saint-Arnaud, S. (2004). Du Pareil Au Même? la Position Des Quatre Principales Provinces Canadiennes Dans L'univers Des Régimes Providentiels. *Canadian Journal of Sociology, 29*(2), 209–240.

Boychuk, G. W. (1998). *Patchworks of purpose: the development of provincial social assistance regimes in Canada*. McGill-Queen's University Press.

Breastfeeding Committee for Canada. (2015). *Annual Report*.

Brodkin, E. Z., & Majmundar, M. (2010). Administrative Exclusion: Organizations and the Hidden Costs of Welfare Claiming. *Journal of Public Administration Research and Theory, 20*(4), 827–848.

Chunn, D. E., & Gavigan, S. A. M. (2004). Welfare Law, Welfare Fraud, and the Moral Regulation of the 'Never Deserving' Poor. *Social & Legal Studies, 13*(2), 219–243.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology, 18*(1), 209–232.

Daigneault, P.-M., Birch, L., Béland, D., & Bélanger, S.-D. (2021). Taking subnational and regional welfare states seriously: Insights from the Quebec case. *Journal of European Social Policy*, *31*(2), 239–249.

Dubois, L., & Girard, M. (2003). Social Inequalities in Infant Feeding during the First Year of Life. *Public Health Nutrition, 6*, 773–783.

Dufour, P., Boismenu, G., & Noel, A. (2003). *L'aide au conditionnel*. La Presse de l'Université de Montréal.

Frank, L. (2020). *Out of Milk: Infant Food Insecurity in a Rich Nation*. UBC Press.

Gazso, A. (2015). Gendering Social Assistance Reform. In D. Béland & P.-M. Daigneault (Eds.), *Welfare in Canada: Provincial Social Assistance in Comparative Perspective* (pp. 273–287). University of Toronto Press.

Gionet, Linda. (2015). *Health at a Glance: Breastfeeding Trends in Canada*. Statistics Catalogue #82-624 X. Statistics Canada.

Hausman, B. L. (2003). *Morther's Milk: Breastfeeding Controversies in American Culture*. Routledge.

Health Canada. (2015). "Nutrition for Healthy Infants." Government of Canada.

Herd, P., & Moynihan, D. P. (2019). *Administrative burden: Policymaking by other means*. Russell Sage Foundation.

Ingram, H., Schneider, A. L., & deLeon, P. (2007). Social Construction and Policy Design. In P. A. Sabatier (Ed.), *Theories of the Policy Process* (pp. 93–126). Westview Press.

Jørgensen, M. B. (2018). Dependent, Deprived or Deviant? The Case of Single Mothers in Denmark. *Politics and Governance, 6*(3), 170–179.

Jung, C. (2015). *Lactivism*. Basic Books.

Knaak, S. J. (2006). The Problem with Breastfeeding Discourse. *Canadian Journal of Public Health, 97*(5), 412–414.

Law, J. (2000). The Politics of Breastfeeding: Assessing Risk, Dividing Labor. *Signs, 25*, 407–451.

Linder, S. H., & Peters, B. G. (1989). Instruments of government: Perceptions and contexts. *Journal of Public Policy, 9*(1), 35–58.

Lindqvist, R., & Marklund, S. (1995). Forced to work and liberated from work. *Scandinavian Journal of Social Welfare, 4*(4), 224–237.

Lynch, J. (2020). *Regimes of Inequality: The Political Economy of Health and Wealth*. Cambridge University Press.

March, K. R. (2019). Unwed Motherhood, Adoption Reunion and Stigmatized Social Identities. *J. Soc. & Soc. Welfare, 46*, 49–71.

McArthur, D. (2007). Policy analysis in provincial governments in Canada: From PPBS to network management. In *Policy analysis in Canada: The state of the art.,* eds. L. Dobuzinsky, M. Howlett and D. Laycock (pp. 132–145). University of Toronto Press.

McIntyre, Lynn, Officer, Suzanne & Robinson, Lynn M. 2003. Feeling Poor: The Felt Experience Low-Income Lone Mothers. *Affilia,* 18**,** 316–331.

McMullin, J. A., Davies, L., & Cassidy, G. (2002). Welfare Reform in Ontario: Tough Times in Mothers' Lives. *Canadian Public Policy, 28*(2), 297–314.

Moran, V. H., Morgan, H., Rothnie, K., MacLennan, G., Stewart, F., Thomson, G., Hoddinott, P. (2015). Incentives to promote breastfeeding: a systematic review. *Pediatrics, 135*(3), e687–702.

Morgen, S., Acker, J., & Weigt, J. (2010). *Stretched Thin: Poor Families, Welfare Work, and Welfare Reform*. Cornell University Press.

Nathoo, T., & Ostry, A. (2009). *The One Best Way: Breastfeeding, Politics, and Policy in Canada*. Wilfred Laurier University Press.

National Council of Welfare (2001). *Welfare Incomes 2000.* Ottawa, National Council of Welfare.

Orloff, A. S. (1993). Gender and the Social Rights of Citizenship: The Comparative Analysis of Gender Relations and Welfare State. *American Sociological Review, 58*(3), 303–328.

Piven, F., & Cloward, R. (1971). *Regulating the Poor: The Functions of Public Welfare*. Pantheon Books.

Rippey, P. L. F. (2021) *Breastfeeding and the Pursuit of Happiness*. McGill-Queens University Press.

Schneider, A. L., & Ingram, H. (1993). Social Construction of Target Populations: Implications for Politics and Policy. *American Political Science Review, 87*(2), 334–347.

Schneider, A. L., & Ingram, H. (1997). *Policy Design for Democracy*. University Press of Kansas.

Soss, J. (1999). Lessons of welfare: Policy design, political learning, and political action. *American Political Science Review, 93*(2), 363–380.

Soss, J., Fording, R. C., & Schram, S. F. (2011). *Disciplining the Poor: Neoliberal Paternalism and the Persistent Power of Race*. University of Chicago Press.

Tarasuk, V, Mitchell, A, Dachner, N. (2014). *Household food insecurity in Canada, 2012.* Toronto: Research to identify policy options to reduce food insecurity (PROOF). http://nutritionalsciences.lamp.utoronto.ca

Temple-Newhook, J., Ludlow, V., Newhook, L. A., Bonia, K., Goodridge, J. M., & Twells, L. (2013). Infant-feeding among low-income women: the social context that shapes their perspectives and experiences. *Can J Nurs Res, 45*(3), 28–49.

Vedung, E. (1998). Policy Instruments: Typologies and Theories. In M.-L. Bemelmans-Videc, R. C. Rist, & E. Vedung (Eds.), *Carrots, Sticks & Sermons: Policy Instruments & Their Evaluation* (pp. 21–58). Transaction Publishers.

Wall, B. (2001). Moral Constructions of Motherhood in Breastfeeding Discourse. *Gender & Society*, 15(4), 592–610.

Weiss, J. A., & Tschirhart, M. (1994). Public Information Campaigns as Policy Instruments. *Journal of Policy Analysis and Management, 13*(1), 82–119.

Yalom, M. (1997). *A History of the Breast*. Knopf.