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Breast is Best: A Case Study of Bottom-Up Implementation

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Public Policy

by

Britni Ayers
University of Arkansas
Masters of Philosophy in Sociology, 2012

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University of Arkansas

This dissertation is approved for recommendation to the Graduate Council

Dr. Lori Holyfield
Dissertation Director

Dr. Anna Zajicek
Committee Member

Dr. Brink Kerr
Committee Member

ABSTRACT

The institutional narrative surrounding breastfeeding is that *breast is best*. Research on infant feeding practices in the United States are abundant, especially among WIC recipients. Although WIC is championed as being a breastfeeding promotional venue, WIC recipients demonstrate lower breastfeeding rates than non-WIC recipients of similar economic standing suggesting the need for further research into the policies and breastfeeding promotional tools being implemented within WIC. Concurrently, research demonstrates that breastfeeding duration rates among WIC recipients can be prolonged with women's interaction with a Breastfeeding Peer Counselor (BFPC). However, there has been little exploration into the experiences of BFPCs or the barriers they may encounter in trying to aid their clientele. This research fills the gap by examining the social construction of WIC recipients and the policy implementation process from a bottom-up perspective.

The theoretical perspectives guiding this study are narrative analysis, social construction of target populations, and bottom-up implementation. I utilize a qualitative research design with four points of entry. First, I employ content analysis of the Center for Disease and Controls Breastfeeding Report Card and Policy Suggestions to explore the institutional narrative. Secondly, I conduct three in-depth interviews with the state bureaucrats of the Arkansas Breastfeeding Pilot Project to assess the organizational narrative. Lastly, I assembled and questioned two focus groups of the Breastfeeding Peer Counselors (BFPC) within the Pilot Project and five follow up in-depth interviews with the BFPCs individually to assess the personal narrative. This research reveals that there are multiple compounding cultural, and structural barriers to breastfeeding policy implementation despite being championed as *best*.

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Chapter 1: Introduction

Hyperbole is commonplace among breastfeeding advocates. What makes the narrative of breastfeeding so powerful is its ability to resonate among a vast array of ideologies whether it is environmental progressivism, grass roots women's health, institutional medicine, or religious fundamentalism (Wolf, 2011). However, narratives come in various forms. Loseke (2007) posits that narratives can manifest as cultural, institutional, organizational, or personal that can also inform the social construction of identity and have real consequences as these narratives relate to policy decisions, implementation, and available resources. In other words, narratives, especially widely circulating narratives, can "shape the social world" thus presenting an opportunity for rich data analysis of the social construction of meaning (p. 667).

Personal, cultural, and organizational narrative identities result from public policies that constitute institutional narratives. They do so by creating categorical types of people, "target populations" (Schneider and Ingram 1993) with "expectable moral evaluations" (Loseke 2007, p. 667). The institutional narrative surrounding breastfeeding is rooted in a number of health organizations and has been campaigned as the optimal infant-feeding choice for both new mothers and their infants. The narratives articulate the immense health benefits of breastfeeding and the health risks associated with formula feeding, further solidifying the social construction of *breast is best* (American Academy of Pediatrics 2005, The World Health Organization 2003, and the United States of Health and Human Services, 2000).

Despite aggressive campaigns to increase breastfeeding rates, statistics reveal that although more women are initiating breastfeeding, duration rates are dropping greatly. The decline in duration rates varies immensely from state to state (www.cdc.gov/breastfeedingreportcard).

Although breastfeeding may be determined by policy stakeholders as best, not all women are able to meet the CDC's breastfeeding objectives for initiation and duration rates. This is in large part due to the lack of informal and formal support for women in this endeavor (Wolf, 2011; Rippeyoung and Noonan, 2012). For example, The Center for Disease and Control (CDC) reports that, on average, 79.2% of women initiate breastfeeding (which is attempting to breastfeed while still in the hospital) while only 40.7% of women maintain this practice up to three months (www.cdc.gov/breastfeedingreportcard). Certain states such as Alabama, Mississippi, Tennessee, and Arkansas currently have the lowest breastfeeding initiation and duration rates. According to the 2013 CDC breastfeeding report card, Arkansas ranks second to last in breastfeeding initiation with a 67.1% initiating rate but duration rates at 29.1% at three months (www.cdc.gov/breastfeedingreportcard). These findings suggest that Arkansas has one of the steepest declines in the nation.

In addition to understanding the variance among states with regard to breastfeeding duration, it is crucial to understand that breastfeeding rates vary greatly based on socio-demographic components

(<http://www.webmd.com/parenting/baby/news/20100325/racial-gap-in-us-breastfeeding-rates>).

Research shows that breastfeeding is not even an option for the majority of poor, less educated, and non-professional working women (Blum, 1993; Rippeyoung and Noonan, 2012).

Furthermore, Blum (1993) argues that poor women must contend with innumerable structural barriers such as inadequate health care, maternity leave, and nutrition. In addition, women of color are encumbered by racialized images further compounding their breastfeeding decision and/or experiences. Additionally, Bobel (2001) finds that while class privileged women benefit from support groups like La Leche League, there has been considerably less effort to encourage

support for low-income women. Dettwyler (1995) argues that one of the key reasons fewer low-income women are breastfeeding is the lack of socio-cultural support from structured breastfeeding peer counselor programs.

Thus, it appears that the institutional narrative of *Breast is Best* has challenges and these challenges can manifest when target breastfeeding objectives are implemented suggesting the institutional narratives may not take into account the unique differences in target populations. Yet they remain powerful because they categorize people into two groups – those who are included in policy and have access to resources and those who do not (Alexander 1992; Loseke 2007). Moreover, effective narratives in policymaking must have broad “cultural resonance” (Gamson and Modigliani 1989 quoted in Loseke 2007, p. 668). Socially constructed as the optimal infant feeding choice, the lack of more inclusive breastfeeding policies and support programs for low-income women may potentially be contributing to the steep decline in breastfeeding initiation and duration rates. In other words, for some women the narrative may not resonate with or match the real life experiences of low-income mothers who lack resources. Identifying the effect of the social construction of target populations within the institutional, organizational, cultural, and personal narratives that may affect women’s breastfeeding experiences, especially for low-income women, could potentially aid policy makers in understanding the more expansive needs of women in this endeavor.

Problem Statement:

In 2011, the United States Surgeon General released a new and expanded *Surgeon General’s Call to Action to Support Breastfeeding*. This document clearly outlined national objectives for communities, public health professionals, health care providers, and employers to better support mothers in this endeavor. These objectives are in addition to the CDC’s 2020

health objective goals (<http://www.cdc.gov/breastfeeding/>) in an attempt to foster better collaborative efforts between federal, state, and community levels.

The Arkansas Health Department responded to the call by implementing a portion of these objectives and has created a Breastfeeding Pilot Project to attend to the lack of breastfeeding supportive policies and sharp decline in breastfeeding duration rates within the state (<http://www.cdc.gov/breastfeeding/data/reportcard.htm>). The mission of this pilot project is to develop a breastfeeding program utilizing the *2011 Surgeon General's Call to Action to Support Breastfeeding Report* as a framework (<http://www.surgeongeneral.gov/library/calls/breastfeeding/index.html>).

This pilot project has set strategic objectives to educate and better facilitate breastfeeding support by addressing multiple subgroups in Arkansas: 1) healthcare professionals, 2) places of employment, 3) mothers and their families, 4) and the communities at large. Specifically, the pilot project focuses on incorporating breastfeeding into healthcare professionals' education by providing obstetricians and gynecologists with proper training on positive messages for breastfeeding. It also focuses on creating a Women Infants and Children (WIC) liaison in hospital settings, providing education to businesses on the positive aspects of breastfeeding for employers and employees, and increasing the number of childcare centers that have materials for breastfeeding employees. Additionally, it includes extended family members in breastfeeding education, and the creation of advertisements for breastfeeding with a logo for the Arkansas Department of Health (ADH) titled "The Natural Choice" in the shape of Arkansas. The objectives included in this pilot project represent an attempt of the organizational narrative to adapt and implement the suggested institutional narrative of the CDC to increase breastfeeding awareness and support statewide.

Additionally, to address the issue of the lack of socio-cultural support for low-income first time mothers one key component to the pilot project is the implementation of Breastfeeding Peer Counselors (BFPC). BFPC are counselors who provide low-income women with support, teaching, and counseling during prenatal and postpartum periods to help them with breastfeeding (Long, 1995). A BFPC is someone with breastfeeding experience and perceived this experience as a success while also living in poverty and receiving benefits from Women, Infants, and Children (WIC). This experience may foster a commonality among low-income women and create a conducive and supportive environment for increasing breastfeeding duration rates. However, there has been very little research on the experiences of BFPC or low-income mothers' responses to BFPC (Rossman, 2007).

Study Purpose

Research on infant feeding practices in the United States are abundant, especially among WIC recipients (Jensen and Lobbok, 2011; Kisten, Abramson, and Dublin, 1994; Long, Funk-Archuleta, Geiger, Moran, and Heis, 1995; Saunders and Kajosaari, 1995; Wright, Parkinson, and Drewett, 2004). Although WIC is championed as being a breastfeeding promotional venue, WIC recipients demonstrate lower breastfeeding rates than non-WIC recipients of similar economic standing (Jensen and Lobbok, 2011) suggesting the need for further research into the policies and breastfeeding promotional tools being implemented within WIC. Concurrently, recent research demonstrates that breastfeeding duration rates among WIC recipients can be prolonged with women's interaction with a BFPC (Kisten et al, 1994). The concept of social support is an important influence on a mother's infant feeding decision and predicted breastfeeding duration (Mitra, Khoury, Hinton, & Carothers, 2004; Shields, 2004; Wright, Parkinson, & Drewett, 2004). However, there has been little exploration into the experiences of BFPC or the barriers they may

encounter in trying to aid their clientele. This research fills the gap by examining the social construction of WIC recipients and the policy implementation process from a bottom-up perspective by evaluating both state bureaucrats and street-level bureaucrats (Breastfeeding Peer Counselors in the Breastfeeding Pilot Project) in relation to the implementation process.

More specifically, the purpose of this study is to examine Arkansas's response to the federal CDC's Breastfeeding Goals of 2020 from a bottom-up implementation viewpoint (Lipsky, 1980). I explore how the Arkansas Breastfeeding Pilot Project incorporates and responds to the institutional narrative of these new Breastfeeding Goals to better understand the consequences of this adaptation and implementation. For this work, I identify the CDC's policy statement as a representation of what Loseke defines as the institutional narrative. Institutional narratives construct categorical representations of identity that are inherently accepted as legitimate and thus consequential (Loseke, 2007).

I identify those working to implement the Arkansas Pilot Project as the representatives of the organizational narrative. As Loseke explains, organizational narratives provide an opportunity to evaluate how organizers and workers construct meaning around previously defined narratives, such as drawing from the institutional narratives of breastfeeding, and implement these ideals pragmatically. Additionally, I investigate how the personal narratives of the street-level bureaucrats (the BFPC's) support, respond, and challenge the organizational and institutional narratives of these policy objectives. This research attempts to fill the gap by establishing the necessity of further research into the analysis of the Breastfeeding Pilot Projects' State Bureaucrats' perceptions, target population formation, and the amount of discretion allotted street-level bureaucrats in policy implementation. More specifically, the research questions guiding this study are:

Research Questions

Research Question One: How does the organizational narrative of state bureaucrats shape the construction of the WIC breast-feeding recipients (target population) in Arkansas?

In order to address this question, I began by reviewing the documents directing the current initiative i.e. CDC's Breastfeeding Goals for 2020 and the Arkansas policy initiative and goals. Combined, these provide the institutional backdrop for the Arkansas initiative. In order to answer how this target population is socially constructed at the state level I interviewed three state bureaucrats who are responsible for implementation of the program. These included the 1) Director of Breastfeeding Peer Counselors, 2) Coordinator of Breastfeeding Peer Counselors, 3) and the State Breastfeeding Coordinator. As organizational representatives of the institutional policies their perceptions of WIC recipient's influences both their implementation practices and understanding of barriers to implementation. Drawing upon policy literature of bottom up implementation (Hill and Hupe, 2009) and social construction of policy target populations (Schnieder and Ingram 1993), I examine how their responses shape both the identities of the recipients and their perceptions of recruited recipients from the WIC pool who work directly with WIC recipients to assist in implementation. These former recipients assume the role of "street level bureaucrats" (Lipsky 1980) and interact with recipients on behalf of the organization. It is important to examine the identity construction that accompanies the policy, as research has shown that vulnerable groups who are targeted may be constructed as a type of person resulting in a tendency to over generalize a given target population or as Loseke (2007) suggests, create "disembodied

types” of people. I also examine what aspects are and are not being implemented at the state level as these may have consequences for low-income mothers involved in the program.

Research Question Two: How do the personal narratives of former WIC recipients inform the communication of the organizational narrative? And how do these personal narratives inform the actual implementation?

In order to address this question, I conducted both in-depth interviews and focus group discussions with Breastfeeding Peer Counselors to assess how they viewed the policy, its implementation, and to discover what tools they use to implement the policy. Drawing from both a framework of narrative identity construction and “bottom up” policy implementation, their personal narratives reveal how these women communicate and implement policy from both an insider status and organizational perspective. Because of their unique position within the organization, these workers constitute “front line staff” or as Lipsky (1980) suggests “street level bureaucrats.” Consequently, they may adhere to, alter, and modify implementation based upon their understanding of the socially constructed population they now serve. These encounters may inform not just social constructionist theories of target populations but it may compliment and inform policy literature on grassroots implementation.

In sum, I employ theoretical frameworks from both policy theory and sociology to address the research questions presented here drawing from the *narrative identity* and *social construction of target populations* as well as *bottom-up implementation theory* to examine the relationship of identity construction and policy implementation. Together, these theories enable

a better understanding of the relationships between institutional, organizational, cultural, and personal narratives of breastfeeding policy, the discretion allotted at the state level with regard to policy implementation, and the role BFPC assume in this adaptation process.

Organization of Dissertation:

The study is organized into six chapters. Chapter one presents an introduction, and overview of study purpose and research objectives. Chapter two examines the relevant empirical literature. Chapter three presents the theoretical frameworks employed in this study. Chapter four provides a discussion of the research design methodology and data collection techniques as well as a description of the coding process. Chapter five includes findings and a presentation of the results of the qualitative analysis. It is in this chapter I present the results of how the institutional narrative is being employed and implemented at the state level in Arkansas. Additionally, I include the findings on how the organizational narratives of state bureaucrats are shaping the social construction of target populations within the Arkansas Department of Health in response to the CDC's Healthy Policy 2020 goals. Lastly, I present the results of how BFPC understand and incorporate the personal narratives of low-income mothers within the organizational and institutional narrative of breastfeeding to reveal the challenges of street-level bureaucrats within the policy implementation process.

Finally, chapter six discusses and synthesizes the main conclusions of the findings and provides an examination of the policy implications of this study, and suggestions for future research. These multiple levels of inquiry provide the potential to foster a more holistic evaluation of breastfeeding policy implementation, the social construction of target populations in the state of Arkansas, and better inform policy makers of the key factors and barriers in low-

income mothers' breastfeeding experiences thus potentially increasing the access to breastfeeding.

Chapter Two: Literature Review

The literature in this review includes both empirical and theoretical frameworks. Part one is organized in three areas of interest: recent research on breastfeeding, research on target populations who are marginalized, and research on bottom-up policy implementation and street-level bureaucrats. I first explain the recent literature on breastfeeding. This section necessarily includes some of the theoretical perspectives that have driven empirical research on breastfeeding. Second, I discuss current studies on the social construction of target populations and the marginalization of welfare recipients. Third, I present an overview of narrative analysis and literature on street-level bureaucracy. Fourth, I provide a critique of this literature and explain how this study attempts to fill the gap.

Literature on Breastfeeding

Breastfeeding has been a contentious debate among feminists. There are two contemporary dominant discursive positions, or cultural narratives, with regard to breastfeeding. First, the women's health movement has argued *breast is best* and that formula undermines women's capabilities (Wall, 2001). Second, is the argument that breastfeeding is an archaic regression to biological determinism and neglects to take into account the structural constraints women face (Blum, 1999). Furthermore, Wolf (2007) argues that the benefits of breastfeeding are overly inflated and place societal pressure on women to breastfeed without providing social support. Some scholars are stepping over this contentious debate as to whether a mother should or should not breastfeed, and are taking a structural stance by analyzing the economic challenges (Christopher 2012; Rippeyoung and Noonan, 2012). Others examine cultural challenges with the hyper-sexualization of the breast and public breastfeeding (Johnston-Robledo et al 2007) and the

effects of formula marketing in WIC health units (Jensen and Labook, 2007). In this section of the review I present a synthesis of these new areas of study.

A. An Economic Approach to Breastfeeding

Much of the literature, with regard to women's work characteristics and breastfeeding, has been examined such as work status, hours, and occupation on the likelihood of breastfeeding. However, according to Smith and Ingham (2005) despite its substantial economic value and policy relevance, the value of women's reproductive work remains unaddressed. Feminist economists have argued that due to the interdependent nature of the paid and unpaid care economies, "policies that disregard parental labor risk unintended and potentially economically inefficient consequences," (Smith et al, 2005, p.43). Importantly, a significant aspect of the unpaid economy is breastfeeding.

Within this literature, Smith et al (2005) found that the current national accounting practices, which includes all goods within the core production boundary for the national accounts, excludes breast milk production. Galtry's (2002) comparisons of labor market policies in the United States, Sweden, and Ireland echo these findings and reveal the invisibility of mother's milk in both labor market and childcare policies. Similarly, Rippeyoung and Noonan (2012) found that although there is much literature with regard to the benefits of breastfeeding there is little empirical evidence that reveal the economic and social cost of breastfeeding. For example, Rippeyoung and Noonan's (2012) study reveal that women who breastfed more than six months experienced a steep decline in earned income in the first five years of the child's life. This is in large part due to the reduced working hours that are necessary for a long breastfeeding relationship due to the lack of societal support in the working environment. Additionally, Wolf (2007) posits that many women are leaving work entirely to have an extended breastfeeding

relationship and might lose out on earnings, promotions, and risk becoming deskilled in the process. In sum, it appears that although there is ubiquitous knowledge about the health and developmental benefits of breastfeeding there is very little focus on the economic value of breastfeeding. Furthermore, due to the lack of understanding of the economic value of breastfeeding and the structural constraints that women face very few gains have been made towards a more breastfeeding friendly work environment (Wolf, 2007).

B. Hypersexualization of the Breast and Public Breastfeeding

Another burgeoning topic in breastfeeding literature is the issue of the hypersexualization of the breast and how this affects public breastfeeding. Objectification theory argues that women are socialized to view and socially construct their bodies from the perspective of an outside observer. These perspectives are then internalized as self-objectifications and create an objectified body consciousness; which is the habitual monitoring of one's body that can result in body shame (McKinley and Hide, 1996).

Johnston-Robledo et al (2007) applied objectification theory to the domain of breastfeeding by surveying 275 female undergraduates from a small state university in the Northeastern United States. Participants were asked about their beliefs and desires about breastfeeding in the future. Students that indicated they wanted to breastfeed were also asked eight questions, on a Likert scale, regarding breastfeeding in public which ranged from 1 (strongly agree) to 7 (strongly disagree). Additionally, these participants were asked to complete an Objectification Body Shame Subscale (OBSS). As expected, majority of the women in the study (80%) intended to breastfeed during the first few months of infancy, potentially embodying *breast is best*. However, these authors found that women who ranked higher on the OBSS were more concerned about breastfeeding being embarrassing, having a negative impact on their body

shape, and having a negative impact on their sexual functioning. Thus suggesting the strong influence of the hyper-sexualization of the breast in our current culture on women's infant feeding choices.

Additionally, Li et al (2004) examined the public beliefs about breastfeeding policies in various settings by analyzing data from the 2001 Health styles survey, which is an annual national mail survey to United States adults. They found that only 43% believed that women should have legal/institutional support for breastfeeding in public. Moreover, only 27% thought that breastfeeding on television was appropriate (Li et al, 2004). Similarly, Stearns (1999) conducted a qualitative analysis of fifty-one women with regard to what comprises *good* maternal bodies, and found that women viewed the public arena as hostile for breastfeeding. Stearns (1999) argues that the notion of the *good* maternal body requires women to monitor their lactating bodies within the perceived boundaries of the breast as sexualized rather than for breastfeeding.

The literature in this area reveals two dominant paradoxes: 1) the first is a success-disgust role conflict and the 2) second is the sexual versus maternal use of breasts. The first paradox is rooted in the conceptualization of bodily fluids with regard to females. Body functions, such as menstruation and lactation, are reminders of women's inferior status which lead women to monitor or conceal evidence of bodily functions that might be viewed as disgusting (Johnston-Robledo et al, 2007). However, interestingly, a woman's ability to lactate is also viewed as a manifestation of a *successful* mother, insofar as breastfeeding embodies the discursive position championed by health officials that *Breast is Best* (Stearns, 1999).

The second paradox that women experience with regard to breastfeeding in the public sphere is the hyper-sexualization of breasts in opposition of their view as maternal, or incompatible with

sexual desirability. It is widely known that the sexualization of breast in the United States rivals, if not overshadows their maternal functions. This dichotomy provides additional challenges for mothers with regard to navigating breastfeeding in the public sphere.

Stearns (1999) reminds us that “breastfeeding *is* work” but this work is not shared and is “rendered invisible by the way it is required to be hidden” (p.323). Moreover, according to Blum (1997), contemporary advice surrounding breastfeeding in public conveys that all mothers can nurse “discreetly in nearly any location” however this type of advice renders the mother “accountable and makes managing the maternal body each woman’s individual responsibility” (p.127). These cultural conceptions exonerate society from aiding the lactating mother at all. Furthermore, these paradoxical pulls are symptomatic of the larger societal view of motherhood, as a society we think mothers are wonderful but they must fend for themselves (Bobel 2001). Implicitly, these works reveal the social construction of mothers who breastfeed as marginalized in the public sphere.

C. Women, Infant, and Children and Formula Marketing

Another area of literature with regard to breastfeeding is the aggressive formula marketing both within medical institutions and WIC. Approximately fifty-three percent of babies born in the United States are participants of the USDA’s Supplemental Nutrition Program for Women, Infants, and Children or WIC (“WIC at a glance,” 2012). The program is well primed to promote breastfeeding education and outreach to a significant portion of WIC recipients. There are program strategies built into the organization through *Loving Support Makes Breastfeeding Work* that convey the organizations breastfeeding support (Mitra, Khoury, Carothers & Foretich, 2003, p.168). Despite these efforts, WIC recipients demonstrate low breastfeeding rates

compared to the general population of postpartum women (McCann, Baydar & Williams, 2007, p.314), thus presenting an arena for exploration.

Although WIC is described as a breastfeeding supportive organization WIC also distributes infant formula as substitute and/or supplement for breast milk. By 1987, formula accounted for nearly 40 percent of WIC food costs (USDA, 2012, p.8). WIC is currently the largest buyer of formula in the United States, purchasing over half of all formula consumed, which is then distributed for free to WIC recipients (Kaplan & Graff, 2008, p.497). The pervasiveness of formula marketing within the medical arena and WIC health units adversely affects breastfeeding rates (p.497). Economic incentives play a large role in the formula marketing. For example, Oliveria and Smallwood (2011) report that by 2008, three manufacturers accounted for almost 98 percent of all U.S (Abbott, Mead Johnson and Nestle/Gerber) and all WIC contracts. In exchange for the contracts, WIC agencies receive large rebates. As an illustration, WIC received in 2009 alone, \$1.9 billion in rebates from the three manufacturers, (Oliveria and Waves, 2011).

In sum, research on infant feeding has examined barriers to breastfeeding that include both public and private perceptions of women and their breasts, economic disadvantages, and the power of formula marketing. However, an understudied variable that may factor into the low breastfeeding rates of WIC recipients, beyond these conditions, is whether the social construction of WIC recipients by those who serve them, affect both communication and implementation in these health units.

Research on Target Populations who are Marginalized

The social construction of target populations includes the analysis of the cultural depiction, or narratives, and the popularized imagery of individuals or groups whose behavior and overall well-being are impacted by public policy.

Research on socially constructed target populations can include both how organizational workers describe those they serve as well as the institutional context in which they work that results in narratives of identities at various levels. For example, Loseke (1993) examined how workers at a battered women's shelter constructed the category of "battered woman" in their daily activities and conversations with recipients at the shelter. Drawing from both interviews and participant observation, Loseke found that front line social workers uniquely defined the social problem of "wife abuse." Their narrative construction of the "battered women" created types of women, sometimes disregarding their personal understanding of their situations. The collective representations of "battered women" constituted who was sympathy-worthy and deserving of assistance, and who was not, but it also narrowed the target population into "types" of women. Loseke concluded that the constructions by social workers were then imposed upon women seeking shelter, and functioned to bring those who needed shelter into line with the organizational structure.

Another example of this organizational and cultural social construction of target populations is with welfare recipients. Political elites and state bureaucrats draw on common public identities of poor mothers, the "welfare queen" or "welfare mother" as a representation for welfare recipients in general. The introduction of the term "welfare mother" into political discourse serves a purpose similar to the term "inner city;" it becomes a code word for the social construction of an individual with certain individual behaviors preventing them from

accomplishing social ideals (Hancock, 2003). This public identity is both a product of social construction and the tendency towards individual-level explanations found more broadly in political rhetoric. The public identity of the “welfare mother” is a socially constructed identity designed for the explicit purpose of justifying specific forms of public policy implementation, or lack thereof. Hancock (2003) states that the process of public identity creation and dissemination, while subject to challenge and intervention, is largely out of the hands of those being socially constructed thus further alienating them from political participation.

For example, West (2003) used the Lexis-Nexis electronic base and sampled 2,590 child care newspaper stories and television transcripts from sixteen different states to evaluate how mothers were being socially constructed by public elites. She employs Shneider and Ingram’s (1993) social construction model and identifies four subgroups of mothers who are potential child care policy targets: “soccer moms” (advantaged), “super moms” (middle to upper class-contenders), “waitress” (working poor-dependents), and “welfare queen” (deviants). She found that in the media coverage of child care, 2,163 stories included mention of one or more types of mothers. Of these, about two thirds were working mothers or “super moms” (60.6%). Less than a third were welfare mothers (28.9%), and about a tenth of all mothers mentioned were stay-at-home mothers or “advantaged” (p.143). She states that these findings reflect the perceived demand for child care, as mothers who work or who are moving from welfare to work must find reliable child care arrangements to meet their professional obligations.

Interestingly, West (2003) found that the discussion of working mothers were overwhelmingly positive. The vast majority of working mothers (73%) were constructed as a positive target population worthy of government support with their child care needs (p.144). The same cannot be said for welfare mothers. The proportion of positive (32.8%), negative (27.5%),

and neutral (39.7%) images was distributed more evenly for mothers receiving welfare, which suggests the media's continued unease with this group of mothers. In addition to being negatively stereotyped more frequently than the other subgroups of mothers in this analysis, West (2003) found that welfare mothers were also more likely to be labeled with other derogatory descriptions. She found that welfare mothers were more likely than working mothers to be identified as single, as teenagers, and as "unwed" mothers. While statistics show that welfare recipients are much more likely to be an adolescent or unmarried, the disproportionately frequent use of the term "unwed" to describe welfare mothers show that the media are not merely reporting statistical fact here. While "unwed" is certainly a more derogatory adjective than "single" or "teen," all three of these depictions have clear negative implications. Thus these findings provide additional evidence that state media elites continue to view mothers receiving welfare as "deviant."

Amundson, Zajicek & Kerr (2015) echo this sentiment and state that when a population is determined to be deviants their problems become their own responsibility and therefore the lack of benefits to this population appears warranted. Their study analyzed state legislators' narratives on welfare recipients with regard to drug testing and unveiled a strong negative social construction of the welfare target population as being drug abusers, thus projecting the need for individual modification rather than structural social support. Concurrently, as the public identity of the welfare mother has gone largely unchallenged, policy options remain unilaterally focused on individual behavior modification rather than structural changes.

In sum, the social construction literature reveals the power of imagery and language in wielding the allocation of social and political support for certain target populations. The longstanding belief of welfare recipients as being undeserving may potentially play into the lack

of support low-income mothers are receiving in their breastfeeding endeavors, and may further reflect the low-breastfeeding rates among WIC recipients. However, the literature on the social construction of WIC recipients lacks a focus on how these depictions of welfare recipients may affect the policy implementation process.

Research on Street-Level Bureaucracy

State bureaucrats are not only influenced by institutional narratives and the social construction of target populations, in this case WIC recipients but also participate in this social construction process in how they adapt and implement policy objectives within their organizations. Shneider and Ingram's (1993) work suggests that how different target populations are socially constructed determines if the population is deserving or not.

The application of the concept of street-level bureaucracies, the issues of people-processing and the dilemmas and conflicts highlighted by Lipsky (1980) are the subject of a growing body of literature within healthcare arenas (Allen, Griffiths, & Lyne, 2004; Griffiths, 1998; Meershoek, Krumeich & Vos, 2007). These studies have focused on the routines and simplifications used by health workers to *process* people, the coping strategies developed to negotiate limitations within their organizations, and the implications for policy implementation on the frontline.

For example, Allen, Griffiths, and Lyne (2004) explored how health service professionals accommodate the social care needs of adults undergoing stroke rehabilitation to expand on how discretion among front-line workers is being exercised within health care units. They conducted eight case studies within two Welsh Health Authorities and found that although there were numerous bureaucratic barriers the health care workers (frontline workers) did exercise

discretionary leeway which bettered their patients overall experience and recovery. Accordingly, the front line workers make policy within contextual “constraints accomplished through their sense-making activities and structures of practical action,” (Allen et al, 2004, p.429). Similar to Lipsky (1980), these scholars argue that despite the barriers embedded in the bureaucratic health service profession front-line workers are *making* and *remaking policy* on the front lines and this is predicated on their discretionary leeway.

Additionally, Meershoek, Krumeich, and Vos (2007) analyzed how physicians act as *gate keepers* in determining eligibility for those needing sick or disability leave. Meershoek et al. (2007) conducted a study of over five hundred consultations between clients and twenty different doctors in varying stages of sick leave requests. These scholars found that while the practical rational of determining eligibility is assumed in policy proposals there is a reliance on normative frameworks among physicians that suggests *gate keeping*. They further argue that the implicit norms that doctors use in practice appear necessary due to the ambiguity and lack of policy cohesion in defining eligibility. Although doctors do not constitute what Lipsky (1980) would define as *front-line workers*, they do represent a sense of *gatekeeping*, wherein policy is being made and remade within the organization and this can originate from a combination of vague guidelines and discretion within the organization.

Finlay & Sandal (2009) expand on these studies and examine the effects of different models of maternity care by midwives on both the street-level bureaucrats’ themselves and their women clients to better understand the exercising of discretion. More specifically, they evaluated the need for advocacy and continuity in maternal health care as it is well documented that women’s birthing and postpartum experiences show improved psych-social outcomes through receiving continuity of midwife care. These scholars compared and contrasted the “standard

model” of care, wherein a mother will get whatever midwife is on call, to the “caseload model” of care health, where women are assigned a personal midwife from pregnancy to postpartum. They evaluated the practices of six midwives with three caseload groups and found that under the “standard model” of care midwives’ interactions with clientele were influenced by the bureaucratic tendency of hospitals to maintain a standard protocol. In contrast, the midwives that provided the “caseload model” of care were described as being able to avoid the constraints of the healthcare bureaucratic protocol and exercise discretion thus bettering the overall experience and outcome for their clients. However, the midwives that did use the “caseload model” discussed a tension in trying to meet their client’s needs while also appeasing the organizational push for efficiency. Thus it appears that the needs of the client and the needs of the organization do not always align. This struggle, as Lipsky (1980) writes, is fundamental for “street-level bureaucrats must find a way to resolve the incompatible orientations towards client-centered practice on the one hand and expedient and efficient practice on the other,” (p.45). In sum, these scholars argue that the different models of care that were implemented among the midwives did allow a favorable outcome and better exercising of discretion. However, this literature on street-level bureaucracy and bottom up policy implementation has yet to pay attention to the frontline workers that do not have the same discretionary leeway.

Synthesis of Empirical Literature

Recent literature on breastfeeding reveals both structural and cultural barriers. Structural barriers include the lack of policy support in the workplace and the hyper-capitalism of aggressive formula marketing companies whereas cultural barriers includes the challenges of public or self-perceptions in addition to breastfeeding in public (Christopher, 2012; Johnston-Robledo et al, 2007; Jensen and Labook, 2005) These studies suggest that infant feeding decision

are fraught with numerous barriers and very little socio-political support. Furthermore, it is widely demonstrated that these structural issues are compounding for low-income mothers who are WIC recipients and this may be predicated on the negative social construction of the “welfare mother” (Hancock, 2003). Lastly, while there is some research on how the social construction of WIC recipients may be affecting their low breastfeeding rates, the literature lacks a focus on how these negative depictions of “welfare mothers” may affect the allocation of support in the policy implementation process. This study seeks to fill the gap by evaluating how the organizational narrative embedded in breastfeeding promotional strategies, intended to aid the target population, are shaping the social construction of WIC recipients and how the personal narrative of former WIC recipients informs the implementation process.

Theoretical Frameworks of Social Construction of Target Populations and Narrative Analysis

A social constructionist view of social and political life assumes interaction of thought, language and action and a realization that any analysis stems from a standpoint or perspective that informs the research. More specifically, it begins with the assumption that our “social world is neither objective nor subjective, but intersubjective –based on the shared meanings of the people being studied” (Warren and Karner 2010, p. 6). In addition, it concerns itself with social inequality wherein socially constructed types become “institutional facts” (Searle 1969) that are derived from the “elaborate enactment of cultural conventions” (Mehan 1993, p. 262). It is important to evaluate the specific impact institutional narratives, or policy design, have on certain social actors, or target populations as this can potentially better explain the inequalities embedded in policy implementation.

The social construction of target populations includes the analysis of the cultural depiction, or narratives, and the popularized imagery of individuals or groups whose behavior and overall well-being are impacted by public policy, as the characterizations can be depicted negatively or positively through symbolic imagery, language, stories, or metaphors (Shneider and Ingram, 1993). This process plays a crucial role in determining agenda setting, implementation, evaluation, policy formulation, legislative behavior, and the research surrounding these individuals. Within this paradigmatic lens if a certain population is socially constructed as positive this helps justify the allocation of benefits to that specific group whereas if a population is constructed negatively their lack of benefits appear warranted. Although this concept is somewhat reductionistic, and does not provide a depiction of the complexities of social actors, it does provide an initial platform for analysis.

Importantly, these social constructions can potentially become normative frameworks and thus reference points that aid in organizing individuals for either benefits or burdens. Similar to Loseke's (2007) discussion of the informative nature of cultural narratives on institutional, organizational, and personal narratives, these scholars argue that social constructions can become integrated into public policies as "messages that are absorbed by citizens and affect their orientation and participation patterns," (p.334).

Within this framework there are two dimensions of target population construction: their political power (high or low) and how they are socially constructed (positive or negative) (Sabatier, 2007). These dimensions comprise a matrix with four distinct categories: positive construction and high political power is the advantaged, negative construction and high political power is the contender, positive construction and low political power is the dependents (this is

where mothers and children are placed), and both negative construction and low political power are coined deviants (Shneider et al, 1993; Sabatier, 2007).

However, this matrix is not comprised of obdurate categories but rather presents a fluid classification system that provides the conceptual tools with which to analyze how certain social constructions of groups within the media and political arena can determine the allocation of burdens or benefits. For example, although Schneider et al. (1993) place mothers and children in the dependent category, thus socially constructed positively yet garnering low political power, not all mothers fit in this category. Importantly, Collins (2000) reminds us that through an intersectionality lens the dimensions of identity such as race, class, age, and sexuality are not additive but rather multiplicative. For example, with regard to breastfeeding, women who are welfare recipients may not be socially constructed as positive and may experience interlocking axis of oppression making breastfeeding highly unattainable or undesirable (Collins, 2000). More specifically, these women may have low political power and negative social construction; thus typified as deviant.

Additionally, although Schneider and Ingram (1993) argue that individuals can transition from one cell to another, this can prove to be rather difficult in large part due to the power of language, imagery, culture, and the previously mentioned interlocking axis of oppression to maintain normative beliefs about individuals. It is only through the power of issue or group re-definition, moral entrepreneurs, and social movements that certain groups are able to move toward more political power or more positive social construction (Sabatier, 2007).

Narrative Analysis

Loseke (2007) posits that humans make sense of their lives and the lives around them through storytelling, or what she calls narratives of various types. These influence identities.

These narrative identities are influenced by cultural, institutional, organizational, or personal narratives that not only inform an individual's sense of identity but are also inextricably interwoven. To examine narrative identity construction of WIC recipients it's important to have an understanding of the layers of narratives, i.e., the cultural, institutions, organizational and personal. Before I elaborate on the theoretical frameworks key components I first provide an overview of each type of narrative.

Cultural Narratives

Loseke (2007) states that cultural narratives are the social organization and representation of “disembodied types of actors” (p.663). Moreover, these categorical representations manifest via components of identity like age, gender, or religion and provide a reference point of identification. Despite the immense diversity among cultural narratives there are consistent narratives that produce, and reproduce, typical actors, plots, and morals for actors to choose from that are either socially acceptable or not.

However, applying Loseke's (2007) story inquiry of who, what, why, and for whom can be challenging as cultural narratives may transform when they transfer through varying channels of communication. For example, although cultural narratives around breastfeeding may find their way into institutional practice via public health officials as something women *should* strive for, there are other influences that will make their way into the narratives at the organizational level when processed through breastfeeding advocates, state and street level workers. These narratives are influenced by structural and cultural conditions that impact not only how WIC mothers are served but how they are constructed.

Additionally, Loseke (2007) posits that symbolic codes are highly influential in cultural narratives of identity and are laden with images of the normative frameworks for how individuals *should* lead their lives. Concurrently these normative frameworks are typically dichotomized such as good/bad mother or disadvantaged/advantaged leaving little room for flexibility and choice. Furthermore, Loseke recognizes these narrative identities may or may not match lived experiences but they have powerful social functions nonetheless (p. 669). They may come to us as what Loseke (2007) describes as *formula stories* located in the public realm. Certain formula story plots and characters can have cultural resonance with audiences and thus emerge as the dominant/normative scripts which individuals incorporate into their understanding of social phenomena. Formula stories carry emotional (how to feel about) and symbolic (how to think about) codes about types of people, defining who is and is not worthy of assistance and why.

Collins (2000) reminds us that cultural formula stories that are told by disadvantaged populations are often ignored whereas formula stories told by more advantaged populations, such as scientists and doctors whose narratives carry more legitimation and are therefore more palatable with larger audiences.

Institutional Narratives

Institutional narratives, like cultural narratives, construct categorical representations of identity but because they are sanctioned, they are inherently more accepted as legitimate as they are written into law, and thus consequential (Loseke, 2007). In evaluating institutional narratives, it is important to investigate how the narrative emerged, the overall effectiveness, and its purpose. To attend to these analytic issues institutional narrative analysis requires evaluating the text within policies to deconstruct its effectiveness and purpose. Additionally, institutional narratives are reliant on symbolic codes with guidelines of who is worthy and not worthy of

services. Importantly, how these cultural and institutional narratives are scripted can feed into organizational narratives.

Organizational Narratives

Organizational narratives offer a unique lens of inquiry and provide an opportunity to evaluate how organizers and workers understand, communicate, and implement the institutional goals and ideals at the pragmatic level of service. As mentioned previously, cultural narratives have the capacity to organize categorical representation of identity and thus create symbolic representations of individuals and social problems. The institutional narratives become championed by advantaged populations, like public health advocates who author narratives that all women *can* and *should* breastfeed. The organizational narratives found in programs such as WIC, are employed to explain and identify the “troubled identities” (Gubrium and Holstein 2001) they hope to repair, or in this case, educate mothers on why they *should* breastfeed. State and street level bureaucrats become unintentional gatekeepers (Loseke 2007).

Although institutional narratives present an additional layer of power in that they are typically viewed as solidified and are embedded in social policies, organizational narratives are informed by personal narratives of the target population as well, often resulting in variation from the institutional narrative. While the Surgeon General’s recent *Call to Action to Breastfeed* provides a more consequential tone and presents a resource for organizations to draw from, structural and cultural considerations may alter the actual implementation.

Personal Narratives

Loseke (2007) posits that although social actors are consistently attempting to create a sense of self that is separate from cultural, institutional, or organizational narratives this can be difficult as personal narratives that appear too different may lack credibility or morally

acceptability. Among street level bureaucrats, who are former WIC recipients themselves yet strong advocates of breastfeeding, personal narratives become especially important in examining how they both communicate and implement services.

For example, despite the fact that cultural narratives may organize breastfeeding mothers as morally acceptable, and institutional and organizational narratives may incorporate these ideals systematically, WIC mothers may reject these narratives as inappropriate on a personal level based on their own life experiences. As passionate advocates and former recipients, personal narratives of street level workers play a significant role in so far as they must negotiate the organizational goals with their own understanding of the barriers mothers face in breastfeeding. Moreover, they are keenly aware of the organizational narratives that construct the target population they now serve.

Finally, Loseke (2012) argues that although formula stories that flow from cultural and institutional sanctions may champion others they are highly heterogeneous and fragmented in nature which can encourage the production of multiple and potentially contradictory narratives that some organizational workers and clientele draw from. As Smith (1999) and Loseke (2007) suggest, when analyzing text, the social and political context become crucial. More important, by examining the broader narrative of *Breast is Best* that results in a policy to target a specific population, there is opportunity to challenge distributions of power within social, economic, and political arenas (Sandlin, 2002). Thus this theoretical framework presents an ideal forum for the investigation of how the organizational narrative of Arkansas's pilot project is navigating, incorporating, and implementing the institutional narrative embedded in the CDC's healthy policy goals of 2020. Those working with mothers throughout the state share a specific organizational narrative that must navigate the normative stance of *Breast is Best* with the

challenges and needs of the population they serve. It is here that “categorical narratives of identity directly confront the personal narratives of embodied people” (Loseke 2007, p. 670).

Street-level bureaucracy and Breastfeeding Peer Counselors

In addition to narrative analysis and the social construction of target populations, this study also incorporates an inclusion of an understanding of bureaucracy via a policy implementation lens. Before I describe the policy implementation lens I first provide an overview of bureaucracy.

Merton (1957) describes bureaucracy as formal, rationally organized social structure with clearly defined patterns of activity that predominately relate to the functionality of the organization. However, Merton adds that there is a division within the bureaucratic organization with primary versus secondary relations. The primary relation refers to the impersonalization when working with clients, whereas the secondary refers to a more individualized and personal interaction, which may be preferred by the client. The issue is that while clients may prefer, and benefit from, more personalized care this goes against the very structure of bureaucracy. This tension may lead to the necessity to explore policy implementation from a bottom-up perspective.

Policy implementation approaches can be presented in two broad groups: top-down policy theories, meaning policy is a blueprint employed by an organizational bureaucracy. Conversely, bottom-up theorists examine how policy is created in a complex arena of tensions and demands by front line workers (Hill and Hupe, 2008). Importantly, policy implementation research is a divergence from the study of public administration through the analysis of formal structures. Lipsky (1980) encourages examining policy implementation through the day-to-day

interactions between frontline bureaucrats and clients, thus a bottom-up approach. Defining “street-level bureaucrats” as the central actors that deliver social services, interact directly with the public and exercise a significant amount of influence on their clients, Lipsky (1980) argues that public policy is not completely made by the upper levels of government. Rather, street-level bureaucrats modify policy at the implementation stage through interactions with the public (p.xii). Lipsky (1980) suggests that while many street-level bureaucrats are driven to public service for philanthropic reasons, their challenging job conditions such as unattainable goals, and lack of resources can lead them to seek coping mechanisms with their responsibilities. Although street-level bureaucrats believe they are doing the best job possible given the constraints of the working environment, their interactions with clients could run counter to organizational goals. In other words, in the case of Breast feeding Peer Counselors, their own personal narratives may lead them to challenge the organizational and institutional narratives (Loseke, 2007) that come from top-down policies. According to Lipsky (1991), use of discretion is necessary to implement policy work due to the difficult conditions within the public organization of limited resources and policy confusion (p.215). This conflict emerges out of policy goals that may be ambitious or vague, and are not backed by adequate resources needed to achieve those goals. Due to this environment, street-level bureaucrats must choose between conflicting policies or ignore those they deem unrealistic (Lipsky 1980, p.32) and may band together to solve the problems of the organizational boundaries together.

In other words, street-level bureaucrats may feel a comradeship in both their opposition to the primary and impersonal nature of the organizations bureaucratic structure, and in addition to their moral sense of duty to help others. Furthermore, as these frontline workers may be considered lower on the hierarchy, in conjunction with their passionate desire for philanthropy,

this may lead to esprit de corps. Esprit de Corps pertains to both the internal organization and leadership perspectives (Winsor, 1996). The term has been used in depictions in military or police organizations where its members have a shared sense of communal purpose. More specifically, esprit de corps is defined as “a spirit of jealous regard for the corporate honor and interest, and for those of each member of the Body as belonging to it,” (Little, Fowler & Coulson, 1973, p.633). In breaking down the terms separately, Esprit is defined as the “spirit” (Little et al, 1973, p.p.633). Whereas the term corps, a derivative of military discourse, means a “division of an army, forming a tactical unit; a body of troops regularly organized; a body of men assigned to a special service,” (Little et al, 1973, p.398). This suggests that the body or group that may be experiencing this is greater than the individuals that make it up, and that there are both shared bonds between the individual and the organization as well as between the individuals themselves. Thus, there is a sense of loyalty and devotion to the cause, beyond the confines (or in spite of) of the bureaucratic structure.

Similar to social construction and narrative analysis frameworks that suggest a redefining of objectives, the theory of policy implementation and street-level bureaucrats suggests that the front-line workers (Breastfeeding Peer Counselors, lactation consultants and related professionals) can make and remake public policy—and therefore affect the program goal of encouraging breastfeeding practice—through their behavior and advice towards clients. Importantly, this theoretical inclusion provides the additional tools needed to evaluate how the personal narratives of street-level bureaucrats may challenge the organizational and institutional narrative of breastfeeding policy at the implementation level.

Synthesis of Frameworks

Combined, these frameworks inform our understanding of policy and identity construction and implementation. These approaches argue that social change occurs through the transformation and interaction that occurs within institutional and organizational hierarchies. For example, Loseke (2007) describes this process as *altering the cultural coding* whereas Shneider and Ingram (1993) suggest *group re-definition*, and Lipsky (1980) argues that street-level bureaucrats can *make and re-make policy*. In sum, narrative inquiry can be a tool for examining individual experiences alongside social structures that may be oppressive (Ouellette, 2008), highlight the social construction of target populations (Shneider and Ingram, 1993) and examine how bottom-up policy implementation works (Lipsky, 1980). By interviewing state and street-level bureaucrats, I reveal how the organizational narrative shapes the construction of WIC recipients and how the personal narratives of WIC recipients, in turn, inform the communication and implementation of policy.

Chapter 3: Methods and Data Collection

According to Frost and Ouellette (2011), there is mounting evidence of the potential of narrative research in policy arenas by understanding the experiences of those affected by the policies. They argue “narrative research has the potential to illustrate the negative consequences of limiting and discriminatory policy or demonstrate the need for new policies that support the rights of those left out of existing policies” (p.153). As a type of qualitative data, I familiarized myself with established guidelines for design, collection, and analysis (see for example Andrews and Tamboukou 2009; Braun and Clarke 2006; Charmaz 2014; Fine 2006; Madill and Gough 2008; and Murphy and Dingwall 2003). From this, I used a grounded theory approach described later in this chapter.

The sampling design this study employs is purposive criterion sampling (Patton 2002). Participants were chosen based on the criteria of role within the organization. In this case, state workers within the Arkansas Breastfeeding Pilot Project who are responsible for adapting the CDC’s Breastfeeding Policy Goals at the state level were chosen. These workers reveal the interplay between the institutional and organizational narratives and shed light on the overarching social construction of breastfeeding mothers, revealing the cultural and structural barriers that mothers must contend with in their breastfeeding experiences.

It is noteworthy that Loseke (2007) states that while interviews are an ideal way to gather personal narratives, formula stories are embedded in “court transcripts, public policy texts, social advocacy documents, organizational manuals, transcripts of speech, and mass media,” (p.254). The institutional narrative of *breast is best* constituting the formula story that informs the organizational narrative used by state level bureaucrats.

To understand the institutional narrative that informs the organizational narrative and identities of recipients, I examined public policy texts that led to Arkansas's implementation. More specifically, to examine the institutional narrative I first reviewed the language and policy objectives of the CDC's 2010 and 2020 policy documents to determine what Loseke (2007) calls the context of the narrative. I examined this to provide a backdrop for the organizational and personal narratives presented in this study as it informs the policy implementation used by those working with WIC mothers.

To address my first research question: *How does the organizational narrative of state level workers shape the construction of the WIC breast-feeding recipients (target population) in Arkansas?* I conducted qualitative in-depth interviews of state level workers (state bureaucrats) in the Breastfeeding Pilot Project. To contact these participants, I first sent out multiple emails to individuals within the Arkansas Department of Health. The email specifically stated that I am seeking state workers within this program who have an understanding about the adaptation and implementation of the CDC's policy goals at the state level. Three individuals (N=3) responded and were interviewed. Within these interviews I was able to assess how the organizational narrative makes sense of and adapts the institutional goals/narrative of the CDC's breastfeeding policy at the state level and how this shapes the construction of WIC recipients.

To address my second research questions: *How do the personal narratives of former WIC recipients inform the communication of the organizational narrative? And how do these personal narratives inform the actual implementation?* I used both focus groups and in-depth interviews with the Breast-feeding Peer Counselors (BFPC) or street-level bureaucrats who are former WIC recipients. More specifically, to gain entry to the BFPC I was informed of two regional meetings that the BFPC were attending to conduct my focus groups. The first focus

groups consisted of ten (N=10) BFPC and the second focus groups consisted of seven (N=7) BFPC.

Lastly, I conducted five (N=5) additional in-depth interviews with the BFPC to assess the experiences of these women as peer counselors and to explore their experiences within the BFPC component of the pilot project. Importantly, these follow-up interviews fostered more candor among the respondents and provided a safe place to express any challenges they saw within the program. Through focus groups of the BFPCs and in-depth individual interviews, I assess how the personal narratives of street-level bureaucrats, i.e., BFPCs, inform how they communicate the organizational narrative to WIC breast-feeding mothers. Interviews and focus groups also reflect their personal understanding of how the target population is constructed and help to explain how they implement the policy given their former status as WIC clients, insider status, and placement in the organizational hierarchy.

Interview questions were open-ended to allow the organizational workers to share their experiences with minimal direction. The open-ended questions for this study began with a set of general questions to build rapport and help foster candor from the participant (Hennink, Inge, and Ajay, 2011). By using open ended questions in these in-depth interviews I was able to create a guided conversation (Charmaz, 2006) that then allowed for a grounded theory approach, applying both thematic and inductive coding.

Each of the interviews took between thirty minutes to two hours. Although specific questions were asked to create a guided conversation, this process was very flexible and allowed the participants to reveal their own expertise. The state bureaucrat interviews took place at the Arkansas Department of Health in Little Rock and at the Women, Infants, and Children clinic (WIC) in Harrison Arkansas. Both focus groups took place at the Arkansas Department of Health

in Little Rock. Lastly, two of the qualitative interviews of the BFPC's took place in a coffee shop while the remaining three took place in their offices within their specific WIC clinics. The data collection process for this project was approved by the University of Arkansas Institutional Review Board (IRB): 14-01-435.

Confidentiality

All interviewees were provided both confidentiality and anonymity as allowed by the parameters of the University of Arkansas. Each participant was assigned a pseudonym for later descriptions and all identifying information was deleted from transcriptions.

Grounded Theory and Analysis of Data

I used a digital recorder and transcribed the interviews and focus groups verbatim for coding purposes. Conducting qualitative data analysis incorporates the use of circular analytic frameworks that are created via the development of codes, descriptive notes, categorization, comparisons, and theory and conceptual development (Hennink, Inge, and Ajay, 2011). To employ this circular analytic framework, I used a grounded theory approach to the data. Charmaz (2006) posits that grounded theory is a systematic methodology that allows the discovery of theory to emerge through the data itself. I began the analytic process by first forming ideas throughout the analysis, rather than beginning with a direct hypothesis. This is not to say that there are not conceptual frameworks involved while approaching the research project but more that I allowed an inductive process to unfold organically and add appropriate theories and hypotheses as the project developed.

Within this inductive analytic process Charmaz (2006) states that coding is the pivotal conduit between data collection and developing emergent theories to understand the data. It is

through this coding process that the researcher can find meaning in the transcriptions. More specifically, the coding process is broken down into three distinct stages.

The first stage includes initial coding. Initial coding includes using short summations of the words or segments of the transcription in an attempt to distill patterns within the narrative (Charmaz, 2006). The initial coding process aids in organizing the data into more relevant focused codes. Focused codes are an important part of the analytic process as they aid in identifying the most salient themes within the data (Charmaz, 2006). For example, themes such as hyper-sexualization (both deductive and inductive), and professional versus paraprofessional (inductive) emerged from the data as components of barriers to implementation and the social construction of clients. Lastly, in-vivo codes were enacted in this research project to serve as a symbolic marker of speech and meaning. Importantly, in-vivo codes, like focused codes, serve to further tease out the dominant discourses and belief systems the participants weave into their narratives. An illustration of this came when BFPCs described a process of “white coat worship” wherein doctors are seen as more legitimate than organization workers.

In sum, the utilization of grounded theory aids in the discovery of the dominant themes, or discursive positions, and strategies of the participants within the institutional and organizational narrative. Due to the dynamic and complex nature of narrative analysis this inductive developing design is essential. Within this context, the most salient themes from the grounded theory analytic approach complimented this process allowing dominant themes to be revealed adding to the narrative between the data and the researcher (Charmaz, 2006).

Chapter 4: Findings

Recall that the purpose of this research is to examine Arkansas's response to the federal CDC Breastfeeding Goals of 2020 from a bottom-up implementation viewpoint and the social construction of WIC mothers who breastfeed by both state-level and street-level workers. As a reminder, the questions that guide this section are: 1) How does the organizational narrative of state level workers shape the construction of the WIC breast-feeding recipients (target population) in Arkansas? and 2) How do the personal narratives of former WIC recipients inform the communication of the organizational narrative and how do these personal narratives inform the actual implementation?

As Loseke (2007) suggests, it is important to first provide the institutional context and narrative that informs these questions. Therefore, I first present the shift in the CDC's policy goals for both 2010 and 2020. Next, I explain the adaptation process within the Arkansas Pilot policy initiative, or the organizational narrative, to establish both implementation and the shaping the social construction of the target population in Arkansas by state-level workers. Finally, I provide an overview of how the personal narratives of the Breastfeeding Peer Counselors inform the communication of the organizational narrative and inform the actual implementation.

Institutional Narrative and Context

In analyzing the CDC's policy goals from 2000-2010 and from 2010-2020 there are some notable similarities and differences. Similarities include identical introductory statements that state "There are many ways that communities support mothers and babies to breastfeed and everyone plays a role," (Breastfeeding Report Card: United States 2010, p.1; Breastfeeding Report Card: United States 2020, p.1). Additionally, both documents provide a breastfeeding

report card showing both national and state level data with numerous similar categories such as breastfeeding rates at three, six, and twelve months.

The breastfeeding report cards reveal that breastfeeding initiation is on the rise nationally with 75% of mothers initiating breastfeeding in the 2000-2010 policy document compared to 79% in 2010-2020 document, showing a 4% increase. Arkansas shows a 4.8 % increase of breastfeeding at 6 months, a 0.9% increase at 12 months, but a decrease in exclusive breastfeeding at 6 months of 1.5%. Thus, it appears that there is an increase in breastfeeding at 6 months but not exclusively, meaning women in Arkansas who breastfeed appear to supplementing with formula in the first 6 months more than other states.

Some categories within the breastfeeding report card have changed. In the 2000-2010 policy documents, the additional categories include data on state legislation about breastfeeding in public and legislation that mandates employer lactation support. The 2010-2020 document does not include data on these categories and instead interjects data on the number of both La Leche League leaders (LLL) and Certified Lactation Counselors (CLC) per 1000 live births. Additionally, the 2010-2020 document is longer and includes images of an African American mother breastfeeding on the front and an entire section on what states are doing unilaterally outside of the federal policy guidelines potentially conveying less support on a federal level and placing much of the support onto to state and local government.

Additionally, the policy goals have changed from the 2000-2010 to the 2010-2020 document. While both documents include quantifiable breastfeeding goals at 3, 6, and 12 months the 2010-2020 document provides qualitative policy goals. These goals include: 1) increase the proportion of employers that have worksite lactation support programs, 2) reduce the proportion of breastfed newborns who receive formula supplementation within the first 2 days of life, and 3)

increase the number of births that occur in facilities that provide recommended care for lactating mothers and their babies. Additionally, the document includes identical subcategories as the 2000-2010 document that target breastfeeding facility support, encourage professional support, and a focus on childcare centers. However, an additional category has been interjected, titled: mother to mother support.

In sum, the breastfeeding report cards reveal that, nationally, mothers are initiating breastfeeding at higher rates but duration rates are still problematic. Additionally, states like Arkansas still demonstrate low, and in some places, decreasing breastfeeding rates. Arkansas also saw a decrease in the number of International Board Certified Lactation Consultants (IBCLC) in the state and went from 5th lowest in the nation to 4th. Beyond quantifiable targets there appears to be a shift on the focus of support from federal (legislation targets) to state and local organizations with categories such as assessing the amount of LLL's and CLC's in the community along with encouraging mother-to-mother support. This shift may convey the shift in support from a federal lens to a state, local, and even individually focused lens.

Organizational Narrative

The state bureaucrats within the Arkansas Health Department are representative of the organizational narrative. Recall, that the organizational narrative provides an opportunity to evaluate how organizational workers and advocates construct meaning around narratives that have already been legitimized, like institutional narratives, and then execute them pragmatically. In this section, I discuss the implementation process at the state level to explore the relationship between Arkansas's adaptation of the CDC's policy goals and the social construction of the target population (low-income WIC participants) by evaluating the data from three (N=3) in-depth interviews with the state bureaucrats of the Arkansas Breastfeeding Pilot Project.

Implementation

The adaptation of the Surgeon General's Call to Action to Breastfeed at the state level appears to be modeled from Arkansas Department of Health's experiences "of developing hometown health coalitions across the state" (Sara, p.12), in addition to using the Surgeon General's objective guideline as a template. Implementing objectives was determined by which strategies the Arkansas Department of Health had "a little bit of knowledge or capacity to promote," (Sara, p.12). In implementing the pilot project, it appears that the Arkansas Department of Health is experiencing numerous salient explicit barriers such as the social construction of current and former WIC recipients. Additionally, I identify implicit barriers in the implementation process such as the challenges with generating breastfeeding support within hospital settings and WIC health units, the pervasive marketing of formula companies, and a minimal to non-existent budget. Explicit is defined in this paper as being clearly stated whereas implicit barriers refer to existing outside of one's consciousness awareness. I have titled these dominant themes into two categories: Explicit and Implicit Barriers. Within the category of Explicit Barriers, I have two subthemes titled: 1) The Social Construction of WIC recipients, and 2) BFPC: Paraprofessionals in a Professional Environment. Within the theme of Implicit Barriers there are numerous subthemes titled: 1) Hospital and WIC challenges, 2) Formula Marketing, and 3) Money.

Explicit Barriers

A salient theme within the data was the perception of both WIC participants and the BFPC, which are pulled, and employed, from the WIC population. When I inquired into what the state bureaucrats thought were the largest challenges to WIC recipients with regard to breastfeeding their responses revealed both an understanding of the structural challenges this population may

experience, but also a cultural view of WIC recipients and BFPC that may speak to the social construction of target populations.

A. The Social Construction of WIC Recipients

The state bureaucrats appeared to have a basic understanding that WIC clientele are experiencing numerous structural barriers to breastfeeding such as economic, social, and familial support but much of the discourse placed majority of the responsibility on the mother. For example, one respondent said

I would say for our WIC participants we still have a lot of moms that just aren't receptive to the concept. They don't see it as the norm and they are still embarrassed by it and they lack support from family members and spouses to encourage them. (Sara, p.14)

With regard to familial support this state bureaucrat additionally noted that “a lot of our patients, I mean, they don't have a lot of support within the family structure,” (Sara, p.3). These excerpts may suggest that state bureaucrats may see that there are structural barriers that the WIC population may accrue but the social construction of this target population also places unilateral responsibility on the mother. Furthermore, the word *patient* was used consistently to describe WIC recipients from all the state bureaucrats. The word *patient* implies that these mothers are in need of medical treatment or are *sick* in some way. This vernacular may speak to the social construction of target populations insofar as WIC recipients require medical help and this trumps the need for structural support revealing a contradiction in the discourse that although this population has structural challenges, the responsibility is primarily with the mother and that this mother is *sick* and in need of being “cured,” (Sara, p.3).

Additionally, this contradictory language was used in describing the challenges the WIC population may experience in the working environment with regard to breastfeeding. For example, one respondent was discussing pumping breast milk at work and said that

Generally, there is not a great deal of self-confidence in sticking up for those rights. Especially if you start getting into immigrant populations and they don't want to create any waves at all. So if they are working in a plant in NWA and you are telling them they need to talk to their supervisor about the need to pump you're wasting your breath. They are not going to want to single themselves out and put themselves under more scrutiny. (Teri, p.17)

Again, there is a contradictory tone here that mothers on WIC are experiencing structural challenges at work with regard to pumping breast milk but that this could be remedied, or *cured*, with self-confidence and more over that trying to encourage this population to make these needs known to their supervisor is a *waste* of time.

It appears that the state bureaucrats are aware that this population is experiencing multiple barriers to breastfeeding but their ability to relate to this population may be challenged by their distancing themselves from WIC clientele and viewing these mothers from a place of higher cultural capital. For example, one respondent stated that

You know, there is a difference, like in my situation who as a nurse, as a woman, highly educated, to think through 'this is how I am going to make this happen and this is a commitment I am going to make.' And you know and packing my little lunch bag and stuff every day to someone who has additional stressors where they work among a male workforce. (Sara, p.14)

Although this participant is aware that her cultural capital may aid her structurally in attaining a successful breastfeeding relationship there is a consistent undercurrent of stratification when making comparisons to the WIC population. Furthermore, Sara states that

I do think having pop stars or celebrities you know Beyoncé (laughs) breastfeed and talk about their experiences that does help. So you know, if we could have Tom Brady and Jay-Z do an ad campaign where they say 'real men support their wives and encourage them to breastfeed,' you know that might help (Sara, p.14)

Importantly, suggesting that the visual of pop stars supporting breastfeeding as a mode to encourage breastfeeding among this population speaks to the lack of understanding of the complexity of cultural, emotional, and structural challenges these women must navigate in order to obtain a breastfeeding relationship. Importantly, although the excerpts of three state bureaucrats cannot constitute the overarching organizational narrative, it does suggest an embedded view of WIC recipients among state workers in a place of power within the organization. Recall Hancock (2003) and Amundson et al (2015) found that the social construction of the welfare target population by state bureaucrats and legislators depicted welfare recipients as negative and needing individual behavior modification rather than structural policy support.

BFPC: Paraprofessionals in a Professional Environment

The most unexpected finding within the data was the description of the BFPC's. The state bureaucrats both championed these peer-counselors as a huge asset to encourage WIC participants to breastfeed while simultaneously describing the BFPC's as being challenging to manage because they are from the WIC population themselves.

The state bureaucrats glorified the BFPC as being able to reach a potentially unreachable population by providing that peer-support. One respondent stated that

I realized that most people aren't comfortable calling a health care professional, a nurse or a physician, with questions that they think are going to be considered silly. But, they will turn to another mother and that's what a Peer Counselor program is, mom to mom support. (Teri, p.4)

There was unanimous support for the BFPC program and the ability for these counselors to relate to the WIC population. The BFPC were all described as being highly *passionate* about breastfeeding. One respondent stated that they specifically "pick out people who are really

enthusiastic about breastfeeding and when their enthusiastic about something they can talk about it. That really gets them through,” (Teri, p.3). Recall that Lipsky (1980) informs us that the frontline workers within an organization are typically drawn to public service for philanthropic reasons and hold a sense of passion which aids them in negotiating limiting or non-existent supportive policies.

However, despite the enthusiasm about the BFPC’s there are also numerous challenges that emerged among the state bureaucrats, both with working with the peer-counselors and integrating them into the WIC health units. For example, one respondent stated that

You know supervising a paraprofessional is an entirely different thing than supervising a professional. When I was an MSH specialist I supervised nurses. This is a whole different ball game because they come from the WIC population and they come with their own problems. (Teri, p.18)

Additionally, this respondent described one of the BFPC as “I mean Mel has five kids and other one is having her sixth child. So they bring all of these problems that we see in the WIC clinic,” (Teri, p.18). This same respondent described another BFPC as “Laura worked in Taco Bell before she started here. She has been here for six or seven years and she does a great job but it was a struggle at first,” (Teri, p.18).

In sum, it appears that although the BFPC are being championed as an asset in being able to provide mother-to-mother support to a hard to reach population they are still considered part of the WIC population and are not considered professionals within the working environment. For example, one respondent stated that “so you’re putting a paraprofessional into a professional environment,” (Teri, p.1). Interestingly, the term paraprofessional refers to a person trained to assist a professional, but not licensed to practice in the profession

(<http://dictionary.reference.com/browse/paraprofessional>). However, all of the BFPC in the state

of Arkansas have received their Arkansas state CLC licensing and are therefore professionals. This specific view speaks to the larger narrative of the social construction of target populations and the altering of cultural coding. Thus, even though increasing the number of BFPC are a quantitative policy objective at the federal level, a demonstrated asset in supporting low-income women in their breastfeeding experiences, and are licensed in their professions there is still a stratification of these mothers as being *paraprofessionals* who come *with challenges* because they come from the WIC population.

Furthermore, although increasing BFPC within the state of Arkansas is a federal objective the WIC health units appear to not be conducive to incorporating these counselors into their everyday work flow with much ease. For example, one respondent states that

Another thing is that the peer counselor program is not a requirement through WIC. So sometimes the Health Unit doesn't want to make the space or accommodate a BFPC and we can't do anything about that. So if they don't want them then we can't force them to utilize peer counseling. (Taneisha, p.1)

It appears that, like the state bureaucrats, the view of BFPC as an asset to the health unit is not universally held. In fact, the position itself is only temporary with no room for advancement. One respondent described this process and stated that

So one reason is that we are hiring new moms and most of our positions are part-time anyways. So when moms get their kids a little older they move on. Another part of it is that we only have one tier of peer counselors. So there is nowhere to move up. So you can start as a peer counselor but after you have done that for a few years like in another health unit you would typically have the opportunity to advance but we don't have any way for peer counselors to advance. We understand that. And when we provide training we do it with the understanding that there will not be here long. (Taneisha, p.2)

Thus the social construction of this target population as *coming with challenges* may affect how the organizational workers approach the BFPC and may reveal the difficulty of incorporating them into the clinic work flow and provide them with better job security.

Importantly, although 3 state bureaucrats cannot be entirely indicative of the overarching organizational narrative, the narrative undercurrent does suggest a stratification between the organizational workers and those coming from the WIC population. Recall, previous literature has found that state bureaucrats, legislators and the political elite typically view welfare recipients as deviant and undeserving of policy support (Admudson et al 2015; Hancock, 2003; West 2003). The findings of this study echo this sentiment and may better explain the stratification between the organizational and frontline workers. Now that I have described the explicit barriers to the breastfeeding pilot project I now explain the implicit barriers.

Implicit Barriers

A. Hospital and WIC challenges

A dominant challenge that emerged from the data was the lack of support from hospital personnel with regard to providing a more breastfeeding friendly environment. It is widely documented (<http://www.cdc.gov/breastfeeding/pdf/BF-Guide-508.PDF>) that women are “four times as likely to breastfeed,” if they have a supportive health care provider during their pregnancy (Sara, p.16). However, it appears that not only is there a lack of breastfeeding support within the hospital setting and among health care providers there is also a lack of breastfeeding education within the medical world institutionally. One respondent stated that in trying to foster breastfeeding support among pediatricians within the state as a promotional tool within the pilot project she discovered that numerous pediatricians had little to no breastfeeding education. She said that Arkansas’s state epidemiologist, who is a recent graduate, said that he “got no training on breastfeeding,” and furthermore he stated that despite his intrigue in breastfeeding support during his training that he was “basically discouraged” to become educated on breastfeeding (Sara, p.16). Importantly, this respondent stated that if recent graduates are receiving minimal

breastfeeding education then “doctors that have been practicing for twenty to thirty years probably have zero,” (Sara, p.18).

In addition to the non-supportive environments of hospital settings it appears that WIC health units may be averse to breastfeeding support as well and this is potentially predicated on the lack of supportive staff. One respondent stated that “we have a lot of staff that do not have any background in breastfeeding and no interest in learning more about breastfeeding,” (Taneisha, p.3). This respondent described this as “one of her biggest challenges” because lack of funding and adequate staff results in more often than not having moms come “in with issues and the mom leaves with formula and not the right type of assistance that she should have received,” (Taneisha, p.3).

Beyond unsupportive staff it appears that there are basic organizational barriers to breastfeeding promotion. One respondent stated that:

Well it’s not WIC itself it’s the way it is set up. You know we are a federal program and we have money that we have sent down to the regional health department and then the health department is in charge of hiring people to carry it out. So we have lots of training and educational opportunities and we have great food packages and support for mothers it’s just not being utilized the way it should be. (Taneisha, p.3)

Adding to the organizational challenges, it appears that there is a cultural sense of fear among WIC participants with regard to choosing breastfeeding and not having formula as an option. For example, WIC food packages were updated in 2010 wherein if the mother breastfed she would be given an enhanced food package but this is only if the mother exclusively breastfeeds.

However, one participant stated that:

So what they tell me is that our numbers for exclusive breastfeeding went down because there were so many women that were worried that if I make a commitment I am not going to be able to go back and I will not get that formula and I have to have that safety net there to feel comfortable trying this incase it does not work. (Sara, p.4)

Thus it appears that although health care providers and WIC health units have the potential to strongly influence a mother's breastfeeding decision there is a lack of built in breastfeeding awareness and education suggesting a systemic narrative that although breastfeeding is championed as *best* much of this endeavor is relegated solely to the mother. This is particularly significant because it has been found that the perceptions mothers have of the attitudes of healthcare professionals towards breastfeeding significantly influences breastfeeding rates (DiGirolamo et al, 2003). Furthermore, certain policies enacted to encourage breastfeeding, like the enhanced food package, may actually be a deterrent for exclusive breastfeeding in Arkansas; potentially explaining Arkansas's decline in exclusive breastfeeding rates in the CDC's new breastfeeding report card. Moreover, these barriers to breastfeeding promotion may speak to the social construction of WIC recipients as underserving of support in their breastfeeding endeavors rendering them not "sympathy-worthy" (Loseke 2007).

B. Formula Marketing

Another salient theme within the data with regard to challenges within hospital settings and WIC health units is the pervasiveness of formula marketing. This issue of formula marketing is a well-documented theme and presents a ubiquitous challenge to breastfeeding promotion (Jensen and Lobbok, 2011). For example, Jensen and Lobbok (2011) state that WIC currently serves over half of all mothers with infants in the United States and is championed as being the ultimate pro-breastfeeding venue. However, these scholars found that WIC participants are less likely to continue breastfeeding than non-WIC participants of a similar economic standing, suggesting an underlying challenge within the WIC establishment with regard to breastfeeding promotion (2011). Furthermore, these scholars argue that much of this disconnect originates from WIC's dependency on rebates from formula companies to fund large portions of the

program. Importantly, these rebates provide the potential to meet the needs of more WIC clientele but may negatively affect breastfeeding promotion. Like these scholars, the state bureaucrats discuss a similar sentiment. For example, one respondent describes a mother's first visit to WIC and said that:

When you go in as a pregnant mom for your first visit they hand you a big bag of information that has been provided for them from formula companies and it may be the *so called* breastfeeding pack, but it is always going to be from a formula company. (Teri, p.5)

In addition to describing the challenge of formula marketing within WIC health units the respondents discuss how this extended to both hospital settings and physicians' offices. One respondent states that in order to foster better breastfeeding support "it needs to start with the obstetricians during the pregnancy and talking about getting everything formula related out of their offices," (Teri, p.5). Additionally, she said that although the discourse within the medical world is that *breast is best* it is more of "breast is best, but if it does not work try this," (Teri, p.5). The pervasiveness of formula marketing appears to be a complicated challenge that one respondent described as "a hard battle to fight," because "formula companies do not take these things lying down," (Teri, p.19). Thus it appears, that like previous research, these state bureaucrats are aware of the systemic challenges of formula marketing to breastfeeding promotion and even spoke to the implicit shift in language surrounding formula.

For example, one key stakeholder describes a new shift in the breastfeeding environment wherein formula is now being called "milk substitute" which she appeared to feel was premeditated when she said "they are calling it milk substitute probably very intentionally," (Sara, p.11). Recall, that Loseke (2007) describes this process as *altering* the cultural coding and that this is wherein social change occurs through the transformation of language. Another area of language shift appears to be around the word *risk*. One respondent stated that in the breastfeeding

community when discussing the difference between breastfeeding and formula we say “it is not the benefits of breastfeeding it is the *risk* of not breastfeeding,” (Teri, p.20). The term *risk* has been used consistently in public policy campaigns, particularly with breastfeeding (Wolf, 2007).

Wolf (2011) conducted a study of public health campaigns and laments that there has been a level of exploitation of the widespread misunderstanding of “*risk* and deep seated normative assumptions about the responsibility that mothers have to protect babies and children from harm,” (p.600), thus potentially returning to the unilateral responsibility placed on mothers with regard to breastfeeding. However, it appears that there has been a shift in the ability for public health officials to utilize this word. For example, one key stakeholder who has worked within the Arkansas breastfeeding unit for over twenty years said that “five years ago I got my hand slapped by WIC all the way from D.C. because WIC distributes formula,” so she was told to not use the term “*risk*” if you work for WIC (Teri, p. 20).

Thus it appears that there has been an altering of the cultural coding, not necessarily to relinquish mothers of the unilateral responsibility to protect their infants and successfully breastfeed without policy support, but rather revealing the exponentially growing power of formula marketing within breastfeeding promotional facilities. This may reflect the findings of Oliviera and Smallwood (2011) who highlight the exponential economic incentive for formula distribution received by WIC at the federal and state levels. Furthermore, the previous fear tactics of public health campaigns using the word *risk* coupled with the growing aggressive marketing from formula companies within WIC units may speak to the social construction of WIC recipients as lacking political power (Shneider and Ingram, 1993) in their infant feeding decisions.

C. Money

Another challenge that speaks to the narrative of breastfeeding culture is the lack of funding allocated to the Health Department to execute breastfeeding policy objectives. In implementing the pilot project all of the key stakeholders discuss issues with budgeting. One respondent states that “one of the challenges is we do not have money to support dedicated staff” within the WIC offices (Sara, p.13). Additionally, with regard to the Arkansas pilot project this respondent said “we basically did a pilot and developed it statewide with no money,” (Sara, p.12). Much of the budgetary issues appear to originate from the fact that in Arkansas’s “WIC is 100% grant funded,” whereas “other states have state funding that goes into the program,” (Taneisha, p.1). Due to these issues one respondent said that their local health unit was already “pretty lean,” and therefore the pilot project “is going to move much slower than we had originally envisioned,” (Sara, p.13).

Additionally, the lack of funding appears to affect multiple areas of implementation. For example, the budget allotted to breastfeeding units must be utilized for educational purposes rather than advertisement, more staff, or breastfeeding supplies. One respondent stated that “the number of people we are allowed to serve depends on how well we manage that grant and the resources,” suggesting that there is a constant evaluating of what to spend the minimal to non-existent breastfeeding budget on (Sara, p.3). One area that appears to be very limited was breast pumps. This respondent additionally stated that the WIC program staff “is real sensitive to the cost of breast pumps and different things so they really do not promote necessarily,” (Sara, p.3). In fact, if a WIC participant does request a breast pump this respondent stated that “they don’t give them an electric pump they have manual pumps. Which a manual pump, um, it kind of freaks me out,” (Sara, p.4).

Thus it appears that even though there is a response to the Surgeon General's *Call to Action to Breastfeed* within Arkansas there is a lack of financial support which may speak to the larger narrative of the lack of breastfeeding support for specific target populations, in this case low-income mothers on WIC in Arkansas. Recall that Shneider and Ingram (1993) argue that the lack of monetary support for target populations may be indicative of their social construction thus suggesting a possible implicit view of WIC recipients as underserving of financial support.

D. Summary of Organizational Narratives

Arkansas has responded to the Surgeon General's Call to Action to Breastfeed with a breastfeeding pilot project, however, there appears to be numerous challenges in the implementation process, both explicitly and implicitly, and this may be predicated on the cultural view of WIC recipients as undeserving (Shneider and Ingram, 1993). Recall that previous scholars, that evaluate the social construction of the welfare mother, argue that since this public identity has gone largely unchallenged the policy options remain unilaterally focused on individual behavior modifications rather than focusing on structural constraints (Hancock, 2003; West, 2003). The findings in this section echo this sentiment and this may explain the lack of more inclusive policies for WIC recipients.

With regard to the explicit challenges in the implementation process, the state bureaucrats do appear to understand that this population is experiencing multiple structural barriers. However, there was a consistent tone of relegating the responsibility of infant feeding choice on the mother with terms like they are just *not receptive*, *not a great deal of self-confidence*, and *they are not going to want to single themselves out*. Furthermore, using words like *patient* and viewing mothers' concerns of low milk-supply as something that needs to be *cured* suggests that organizational workers use the normative frameworks built into the institutional and

organizational narrative when approaching clientele (Loseke, 2007). Recall, if a population is socially constructed as negative the lack of benefits and/or support may appear warranted and altering that cultural coding can demonstrate to be very challenging.

Additionally, although the state bureaucrats championed the BFPC as having the rare capacity to reach an almost unreachable population they were still viewed through the lens of being of the WIC population. This was conveyed with language like: *paraprofessionals, come with their own problems, it was a struggle, and so they bring all these problems what we see in the WIC clinic*. These deep seated normative frameworks about individuals that are pulled from the WIC population may potentially play into the resistance to incorporate BFPC into the clinic flow and create more opportunity for advancement within the health unit for these types of positions. Furthermore, the organizational narrative of viewing the BFPC as *paraprofessionals* may present challenges for the BFPC in trying to navigate both the institutional and organizational narrative.

With regard to implicit challenges, the state bureaucrats reveal that while health care providers and WIC health units have a strong potential to influence a mothers breastfeeding decision, there is an overarching lack of: breastfeeding education, awareness, and supportive breastfeeding policies which makes the implementation process of the pilot project very difficult. Additionally, the pervasiveness of formula marketing within WIC and hospital venues appears to thwart both breastfeeding rates and potentially the desire to incorporate better breastfeeding promotion. Importantly, the shift in the language for formula to *milk substitute* and the change in fear tactic public health campaigns use of the word *risk* speaks to the power and influence formula has on these establishments. Although provoking fear in mothers with ad campaigns that

use the word *risk* in connection to breastfeeding does not provide autonomy in WIC recipients infant feeding choices, neither does omnipresent aggressive formula marketing.

In addition to the lack of breastfeeding education, awareness, and potential desire to incorporate more breastfeeding policies, amidst the undercurrent of formula, the pilot project has a minimal to non-existent budget. Furthermore, majority of the efforts executed within the pilot project and within WIC health units must be under the categorization of education. The minimal budget coupled with a unilateral focus speaks to social construction of WIC clientele as having singular needs rather than multiplicative structural barriers to infant feeding choices. Moreover, the allocation of funds towards education does not address the cultural or emotional barriers this population may be experiencing in attempting to breastfeed. Like previous research shows, the view of welfare mothers as needing to change individual behaviors in order to obtain socially accepted goals rather than provide structural support speaks to the social construction of WIC recipients as having low political power (Shneider and Ingram, 1993).

Now that I have described both the institutional and organizational narrative I now turn to the findings from the BFPC who are representative as what Lipsky (1980) calls the street-level bureaucrats. Analyzing these street-level bureaucrats provides the potential to better understand how these individuals manage and negotiate the challenges of: the social construction of WIC recipients, non-receptive hospital and WIC environments, aggressive formula marketing, and a minimal to non-existent budget.

Bottom-Up: Personal and Cultural Narratives

In this section I present the findings from two focus groups: one consisting of ten (N=10) BFPC and the other 7 (N=7) BFPC in addition to the findings from five (N=5) follow up in-depth interviews with the BFPC. Importantly, analyzing the perspective of these street-level bureaucrats provides the potential to evaluate how the personal narratives of these counselors inform the communication of the organizational narrative and the actual implementation. I have organized this portion of the project into two broad categories: 1) Understanding Multiplicative Barriers of WIC Population, and 2) Frontline worker's experiences.

Understanding Multiplicative Barriers of WIC Population

The BFPC's, like the state bureaucrats, discuss the structural barriers of the WIC population with regard to breastfeeding but with a much deeper understanding of the multiple barriers the WIC population experience in this endeavor. Within this category there are multiple subcategories to which I have labeled: 1) Partner and Family Influence, 2) Sexualization of the Breast and Age, 3) Work and Breastfeeding, and 4) Medical Systemic Challenges: White Coat Worship.

A. Partner and Family Influence

It is well documented that partner support, typically referring to the co-parent of the infant, is a highly influential component to a mother's infant feeding choice, and the WIC population does not appear to be an exception to this influence. Interestingly, the responses from the BFPC reveal that this population may potentially be subject to more malleability from their partners and/or family than mothers who have more structural stability and autonomy. For example, one respondent states that "well sometimes the dads can be critical or they can be very supportive. Or

sometimes you get the dad that says ‘I don’t want a titty baby,” (FG1, Kate, p.9). Additionally, another respondent discusses her own experience with this with her partner and states that “my husband jokingly said ‘you’re going to breastfeed my baby’,” (FG1, Mindy, p.1).

Furthermore, it appears that partners may have a strong influence not only whether the mother breastfeeds but how she breastfeeds. For example, one respondent said that

I have a client whose husband is very much pro-breastfeeding but doesn’t want her to breastfeed at church. He wouldn’t let her take the baby to church at one point because he knew that she was going to need to feed the baby so he kept the baby at home and made her pump and that type of situation (FG1, Rebekah, p.6).

Additionally, another respondent discusses a similar response from her breastfeeding supportive husband when she needed to breastfeed her infant in Sears. She said

He said ‘well don’t you have to get your boob out and feed her?’ I was like ‘I’m feeding her now!’ He was like ‘God we’re in Sears!’ I mean husbands, even the ones who are supposed to know better sometimes they freak out because ‘oh my God a booby!’” (FG1, Laura, p.7).

Thus it appears that partner influence can not only affect if a mother breastfeeds her infant, but when and how. This influence from partners appears to extend to familial influence as well. For example, one respondent states that

Well with these populations there aren’t a lot of daddies sticking around. So maybe the partner isn’t a father. Maybe the partner is their mother who had her at fifteen and didn’t breastfeed her. So now, sometimes you run into a thirty-year-old mom with fifteen-year-old pregnant daughter and she has a chance to be a good mommy and so she wants to take over that grandbaby and this kind of cuts mom out. And mom is fifteen and she is thinking ‘my mom can do so much better.’ And if that is her supportive partner then that’s not working out so great because grandmothers are like ‘I know what I’m doing come here.’ And then there goes the bottle. I’ve seen grandma make mom be milk cows basically. You go play. You go to your friends’ house and bring me back the milks you’re pumping. And this is a cycle where mom is never going to be able to keep up (FG1, Laura, p.8-9).

Another respondent added to this narrative, stating “I see a lot of support issues. Grandparents of the child or great aunts that want to keep the baby afterwards. Well how are they going to keep the baby if the baby is breastfeeding?” (FG1, Rebekah, p.5). Thus it appears that both partners and family are highly influential among this population and potentially more so as women from the WIC population may not have the structural and personal autonomy to reject such intimate influences. Importantly, vernacular like: *I don’t want a titty baby*, husbands that *freak out, wouldn’t let her take the baby to church*, or the description of family making *moms be milk cows* all speak to the moral authority given to partners and family members to scrutinize if, and how, a mother is going to breastfeed.

B. Sexualization of the Breast and Age

Another theme that emerged among the BFPC with regard to challenges that they see within the WIC population was the issue of public breastfeeding and the hyper-sexualization of the breast. Similar to the issues of partner and familial influence being more aggressive for this population the hyper-sexualization of the breast may affect these women on a deeper level and this may be predicated on their lack of autonomy and/or young age. For example, one respondent said

I think another thing is that those women just discovered that their breasts were sexual. You know these fifteen and sixteen-year-old moms have only had these boobs for two years. You know and for those whole two years they have been sexual objects. We are told to hold them up and push them up. Then to take a baby, when you have just discovered your sexuality, and then it’s like how can it be anything but sexual with your breast?” (FG1, Laura, p.6)

Additionally, another respondent states that “these moms are like ‘everyone thinks I am such a slut anyways because I had a baby at sixteen do I really want to put my boobs out every time my

baby gets hungry?” (FG1, Laura, p.6). These excerpts may suggest that age is a developmental barrier. Another respondent agrees and adds that

Like with the younger demographic they are usually both in their parents’ homes and even twenty or twenty-five year olds are still at home still. And then you run into ‘oh she doesn’t want to breastfeed in front of dad or her brother or her boyfriend’s dad. (FG1, Andi, p.6)

The above excerpts suggest that in today’s society women are encouraged to be modest once they become mothers and conceal their breasts to avoid the lurking gaze of strangers. Thus the actual labor of breastfeeding is increased because this social act must now be managed more discreetly in the public sphere (Stearns, 1999). Importantly, Blum (1997) posits that

Public breastfeeding disturbs because it violates what I termed compulsory heterosexuality. In other words, while women’s bodies are expected to be sexual and to be displayed, they are expected to signal only sexual availability to men. Breastfeeding threatens the lateral, erotic male-female coded for men (p.128).

More importantly, these excerpts suggest that women from the WIC population, which are typically younger mothers, may be experiencing exponential scrutiny for public breastfeeding because they do not fit the normative framework of what society deems a good mother because they are younger and lack autonomy, and thus may embody the sexualization of the breast on a deeper level. For example, another respondent agreed and added that “yes, and then they feel like it’s almost a dirty relationship,” (FG1, Andi, p.6). This cultural influence appears to originate from both their partners and family. One respondent states that

So sometimes it’s the family’s lack of support or having that family member thinking that they are a sexual object even if the mom doesn’t feel like that. So there is that pressure from the husband or the mothers’ mother giving them a hard time. The pressure of it all and then that mom is like ‘well I’m just going to stop because I can’t do anything,” (FG1, Rebekah, p.6).

The depictions of the *pressure* and *hard time* these mothers are experiencing have the potential to dissuade mothers from breastfeeding even if both the partner and the mother see this as what is best for the infant. For example, one respondent describes this issue when she says

You will get that a lot. ‘Oh ya, I want what’s best for the baby but those are my boobies and no other man shall see them!’ To him they are wholly sexual and sometimes seeing a baby on them they are like (makes gross face). I mean when we had sex when I was breastfeeding my husband did not go there. He was like ‘they squirt they leak they touch me and they are no longer sexual for this period.’ (FG1, Laura, p.7)

The hyper-sexualization of the breast is a well-documented challenge for women in today’s society (Johnston-Robledo, Wares, Fricker, & Pasek, 2007). Young (2003) argues that that the border between motherhood and sexuality is unveiled in the way women experience their breast as sexual rather than as a function of breastfeeding and thus when the breasts are used for nursing they are desexualized and become an open forum for examination and public critique. For example, Wall (2001) states that “mothers and mothers’ needs disappear from view here and mothers’ behaviors become legitimately subject to public scrutiny and moral authority” (p.604). Moreover, Johnston-Robledo et al’ (2007) posit that women who live in a culture that objectifies a sexually mature female body encourage women to evaluate their body from an outside observer’s point of view rather than relying on their own view of their bodies. These excerpts may suggest that mothers of the WIC population may be experiencing this cultural issue of the hyper-sexualization of the breast at a larger magnitude and this may be predicated on their younger age.

C. Work and Breastfeeding

Similar to the exponential pressures from partners, family, and the cultural hyper-sexualization of the breast on the WIC population, it appears that the BFPC’s are highly attuned to the compounding challenges of trying to juggle work and breastfeeding for this population as

well. All of the BFPC's describe having personal experience in trying to negotiate this balance. The personal narrative of this struggle is unveiled with statements like "I said 'no I can't work and breastfeed,'" (FG1, Andi, p.3), and "so I was really in a predicament because I knew that it would be very difficult for me to be a full time working mom and breastfeed," (FG1, Andi, p.3). Another respondent interjects her personal narrative of this challenge and describes her experience of working in a Doctor's office and how this is difficult even in the best of working environments when she states that

Oh yeah, if you work a job and have a baby that makes life way harder, even if you have a completely supportive work environment. You know I went back to work with my second one in a completely supportive working environment. But then I would be pumping and I would hear 'what is she doing in there?' They are like 'we need her to come do this.' I mean I worked in a really supportive environment but you know when you are infringing on someone else's comfort, time, you know, clinic flow or their schedule is to see eighteen people in a day and I am holding up a waiting room of people. You know they don't care. They want me to hurry up. (FG1, Laura, p.14-15)

Additionally, unlike the key stakeholders, the BFPC's describe a much more complex challenge the WIC population may be experiencing with regard to balancing work and breastfeeding when the working environment is not conducive to breastfeeding that did not place a unilateral responsibility on the mother. For example, one respondent states that

It's a cycle of things going on. I mean if you're on WIC you probably have a low-wage job and it is probably a physical job in a cramped space. If you are in that kind of job without a whole lot of room for pumping or money for a pump you're probably not going to. I mean and some moms don't have a car to go to the WIC office or don't have the gas money to go the WIC office. Or some moms can't take off of work to go. I mean I work eight to five every day and WIC is open eight to four every day. You know how am I supposed to get up there? These moms are going to back to work two three works postpartum. They have no maternity leave and their kids are still hungry. (FG1, Laura, p.14)

Additionally, another respondent speaks to the multiplicative structural challenges this population is experiencing when she describes the difficulty of trying to pump breast milk while working in a factory. This excerpt is below:

And they work at Tyson Chicken and their job is to rip the chicken's guts out. Do you think that same woman, on her ten-minute break, is going to go breastfeed or pump? (FG1, Thalia, p.14)

Another respondent agrees and adds that

Or the mom works in a chemical factory, and I mean come on. They work with chemicals all day. They have to de-louse when they leave the building. They can't bring a breast pump and milk in there. (FG1, Laura, p.14).

It appears that the BFPC's have a deeper insight into the multiplicative structural challenges that this population is accruing in trying to negotiate breastfeeding in the public sphere. One respondent discusses the challenges of current policy structures that are in place to aid women to breastfeed in the working environment and how limiting they are. This excerpt is below:

And I think one size doesn't fit all. I think with breastfeeding we seem to forget that every mom's situation is different. I get that a lactation room is needed. I get it. A lactation room is needed. But what about that mom that has to work twelve hour shifts and she has been standing up all day. There may be a lactation room but she never can breastfeed because she can't get off the line because if she do, she will lose her job. So there isn't a one size fit all. Give these people options. You know like this employer has to have A, B, and C and she needs to figure out which will work for her. Give these women options. We understand. We support that you are supporting us but give them more options to choose from that will make it better for them. (FG1, Mel, p.17).

In sum, it appears that, unlike the state bureaucrats, the BFPC's have a more compulsory understanding of the inadequacy of the current structural support in place for this specific population that did not include a unilateral responsibility on the mother but rather identified these as complex structural issues. This additional insight may be derivative of both experiencing these issues first hand and from being street-level bureaucrats who have frontline views of the challenges of the WIC population. Importantly, this experience and insight may better prime the

peer counselors to provide authentic peer-support to these mothers thus making them both a stronger asset to breastfeeding promotion and more equipped to challenge the current lacking policy implementation enacted for this population.

D. Medical Systemic Challenges: White Coat Worship

Similar to the key stakeholders, the BFPC's appear to have a good understanding of the unfriendly breastfeeding environments of the medical world. This was determined with statements that spoke to the lack of education the medical community has on breastfeeding. For example, one respondent said "there is a lack of education in the hospitals" with regard to breastfeeding (FG2, Jenn, p.2). Another respondent said

Because it starts at the doctor's office. It starts at the hospitals where they are getting horrible horrible information or no information at all. I mean they are the ones that are delivering their babies. They are the ones that are taking care of their babies after delivery but they don't know what they are doing. (FG1, Andi, p.15-16)

Moreover, the BFPC appear to view the lack of education within the medical community, as not only a challenge to a mother's breastfeeding relationship, but they more of viewed this issue as systemic and *sabotaging* a potential breastfeeding experience. For example, one respondent states that

You know sometimes we will see them prenatally and they can get that message from us but then they go to the hospital and it's sabotaged because they have nursing staff that is telling them this is how it needs to be. And the nurses believe what they are telling them because they aren't necessarily educated in lactation nor are the physicians. I don't think that they are purposefully unsupportive but they are systemically. (FG1, Rebekah, p.8)

Additionally, one respondent added to this when she states "it can make or break a breastfeeding experience if the hospital helps them and knows what they are talking about or not," (FG2, Jenn, p.2).

The BFPC's view of these systemic challenges within the medical community with regard to breastfeeding appear to extend beyond their interactions with WIC clientele and originate from their own experiences within hospital settings. One respondents excerpt is below

You know with my first child I had a vaginal delivery and it was just awesome. The second one I went in for a vaginal delivery and after fifteen hours she was delivered by caesarian. I was just devastated because I didn't want to do that. That was not in my plan. The medications didn't work and they knocked me out and I wake up, I don't know when, later without my baby. So I was overwhelmed. I was like 'where is he?' The nurse said 'well he has to feed.' So those nurses gave him a bottle. I had no control over it. (FG1, Kate, p.12)

The discourse surrounding the inhospitable environment of the medical community was described with a stronger sentiment among the BFPC versus the key stakeholders with language like *sabotage*, *systemic*, *knocked me out*, *make or break*, and *I had not control over it*. This vernacular may potentially speak to the personal narrative of the BFPC, not just adding to the sentiment of the key stakeholders with regard to these challenges, but elaborating on how debilitating these environments can be in providing autonomy for mothers in their birthing and infant feeding choices.

More importantly, similar to the other salient themes it appears that women of the WIC population may be subject to more scrutiny in these experiences because they place an immense amount of authority in their physicians. For example, one respondent states that "they value what their physicians say," in response to infant feeding choices (FG1, Rebekah, p.7). Additionally, another respondent added that

We look at medical professionals as the authority on what we should do with our babies, what we should do with our bodies. Some of those people you encounter don't have kids or have the experience of breastfeeding a baby and a lot of them are male. So you have this doctor that has been following you throughout your entire pregnancy and when the baby gets here he is telling you 'breastfeed the baby every 4 hours, the baby needs to

sleep on a schedule.’ And you’re wondering why breastfeeding isn’t working. (FG2, Mindy, p.3)

This reliance on medical professionals to be the authority was agreed upon by all the BFPC’s. In fact, one respondent went to so far as to say “I have never met a mom that didn’t have white coat worship. You see a doctor in a white coat and they think ‘oh thank God the doctor is here” (FG1, Laura, p.16). Thus, similar to the other salient themes of this study, the amount of faith put into medical professionals to have the authority on women’s bodies among the WIC population may supersede mothers who have more education on breastfeeding and more autonomy to articulate their needs suggesting that this population are not experiencing unilateral structural challenges but rather multiplicative.

In sum, the BFPC’s appear to have a more comprehensive understanding of the compounding structural and cultural challenges women within the WIC population are experiencing whether it is: overarching scrutiny from partners and family with regard to if, when, and how they breastfeed, the increased effects of the hyper-sexualization of the breast among WIC clientele, the complex and dynamic challenges of trying to juggle breastfeeding and work in low-income occupations, or the systemic challenges of undereducated medical institutions that are allotted immense authority over women and women’s bodies. Thus it appears that the mothers of the WIC population may not have, what Hochschild (2003) calls, a status shield. A status shield serves to protect individuals from the displaced feelings of others and persons of a lower status will in turn lack this shield against poorer treatment.

Now that I have described this deeper understanding among these BFPC’s I now discuss how the personal narratives both inform the communication of the organizational narrative and the actual implementation process.

Street-Level Bureaucrats

Street-level bureaucrats make decisions, establish routines, and utilize devices they invent to cope with the uncertainties of their job position and work pressures and thus effectively “become the public policies they carry out,” (Lipsky, 1980, p.xii). In this section I describe how the BFPC’s are using their passion for breastfeeding advocacy to circumvent their highly limited role within the WIC health units. Within this second category there are numerous sub-categories I have titled: 1) Passion, 2) Class Ceiling, 3) Changing Policy from the Inside: Discretion, and 4) Changing Policy from the Outside: Lack of Discretion.

A. Passion

All of the BFPC’s consistently used the word *passion* when describing both their desire to breastfeed and their role as peer-counselors. BFPC are “passionate about breastfeeding,” (FG1, Hallie, p.1). Another adds “I was gung-ho and completely anti-formula at the time and breastfed my daughter successfully,” (FG1, Mindy, p.2). This passion was almost a buoy for the hardships these mothers knew they may encounter in trying to sustain a breastfeeding relationship despite the obstacles that are so glaringly obvious to this demographic. For example, one respondent states that “God is going to provide for me and I don’t care if I eat beans and tators my whole life I am going to breastfeed this child. That was a passion that I have,” (FG1, Andi, p, 3).

This passion was a dominant undercurrent among all of the BFPC’s and extended into their roles as peer-counselors for other mothers who may be experiencing similar challenges. For example, one respondent describes finding such enjoyment from what she does that she does not see it as work when she states that “I don’t have a job I have a passion and I get paid for it,”

(FG2, Jenn, p.4). Additionally, one respondent adds that “I just wanted to change the world (laughs) and I didn’t think that being a mom was changing the world, even though it is,” (FG1, Rebekah, p.2). This same respondent went on to say “I’m saving lives! (laughs) Helping moms to save lives! (laughs),” (FG1, Rebekah, p.3). Concurrently one respondent added that

I think it’s just the opportunity for us to be, to a mom, that support that we wanted to have or that we did have to help someone commence breastfeeding or continue breastfeeding then that is great, because overall you are saving a life, (FG2, Laura, p.4).

In sum, this theme of passion was not unexpected as Lipsky (1980) states that street-level bureaucrats are expected to be “more than benign and passive gatekeepers,” they are supposed to be “passionate advocates,” for their position (p.72). However, the ubiquity of this passion may speak to the need for reliance on such an emotional push despite the odds these BFPC’s may experience both personally and within their role as peer counselors.

Class Ceiling

Despite the immense dedication the BFPC have for their role as advocates for breastfeeding among the WIC population there appears to be a class ceiling built into the institution with regard to how these individuals are valued as *paraprofessionals* rather than *professionals*.

The BFPC’s all appear to be aware of the limitations of their role as a peer-counselor despite the fact that all of the BFPC within the state of Arkansas have received advanced training and have a CLC and some hold a IBCLC. Interestingly, recall that it is a national objective of the CDC’s policy guidelines to increase both the number of CLC’s and IBCLC’s within each state. However, one BFPC states that she was not encouraged to obtain either of these certifications in

fact she said “I was strongly discouraged strongly discouraged to get my IBCLC or even my CLC,” (Laura, p.6).

Additionally, one respondent laments that this could be potentially because it makes them equal counterparts to other positions within the health units. Her excerpt is below

All of the breastfeeding peer counselors have CLC's and all but one is sitting to test for the IBCLC this year. So what happens if we all have IBCLC's? What does that do to our supervisor's position? I mean what does that do? I mean now we are equal. (Laura, p.7)

When I inquired into how the BFPC were able to utilize their new advanced licensing it appears that they are very limited in implementing this advanced knowledge within the confines of their role as peer-counselors.

But the limitations of the grant and how it was written doesn't enable us to use our certifications for the knowledge that we just have in general. I mean it is written specifically to promote and educate women about breastfeeding during pregnancy and within the first year after delivery and that is it, (Laura, p.2).

Another respondent addresses this issue as well in the excerpt below

Because, like many of the other peer counselors I am a board certified lactation consultant, so with that there is another layer of what I can do that is beyond the scope of the peer counselor. However, in the peer counselor role I have to operate as a peer counselor. It's kind of like if you were a doctor but had to go and act as a CN (Certified Nurse), (Hallie, p.2).

These excerpts suggest that even though these BFPC have higher level training they are discouraged from speaking with WIC clientele beyond basic peer-support. One respondent states that

However, you have the peer counselor who is supposed to just be for peer support. Which is like ‘Hi, how's it going? We want you to breastfeed,’ that type of thing-the promotion part. But, you may not see a participant unless there is an issue...that you are not supposed to handle because you are a peer counselor (laughs). It's bizarre I don't know,” (Hallie, p.5).

Another respondent speaks to the frustration she experiences in not being able to use the knowledge base that she has been trained to use to aid mothers who come to her due to the limitations of the grant. She discusses this issue below

Just for example, little things like, moms who have flat or inverted nipples may or may not benefit from a nipple shield. Well I know that. I have been trained to deal with it, observe the nipple and the feeding and all of that and size a mom (for a nipple shield). But because of the limitations of the grant I cannot issue a nipple shield. So I have to take the nipple shield to a nutritionist who has a certification as a registered dietician or one of our CPA's who has been deemed the breastfeeding go-to person. But most of them don't have any knowledge of breastfeeding and they have a very limited knowledge. The first time I brought a nipple shield to them they said "what am I supposed to do with this?" But, I cannot give it to the mom. (laughs). So, I have to hand it to this other person and then they have to hand it to the mother and explain to them how to use it. So I have to tell them what to tell the mother to let them know how to use it. I mean it's just ridiculous. (Laura, p.2)

Interestingly, the term CPA refers to Competent Professional Authority which is a far cry from *paraprofessional*. Furthermore, when I inquired into whether these additional certifications provided an increase in pay the answer was unanimously no. One respondent describes this issue below

So, yes, that is how the program looks at it. I have been running into some trouble with the IBCLC which I am sitting for in April. They are like 'no, we won't help you pay for the test or your studying materials or nothing. And you're not going to get a raise.' And you can't even use it in clinic. I can't use my CLC in clinic either. (Laura, p.5)

Another respondent commented on this and says

No. (Laughs) No pay increases. In fact, people at Wal-Mart make more than we do. And a couple of us don't even have benefits. Some have benefits if they are legit full time employees and they get healthcare and all that. Whereas some of us are called 'extra help positions,' so no benefits. But we all have the same 11\$ an hour. (Jenn, p.5)

In fact, many of the BFPC positions are part-time and therefor they do not receive benefits and subsequently numerous respondents discussed their frustration with being removed from eligibility from being able to access WIC. But this issue appears to be a double edged

sword due to the low-wages they are provided. One respondent was asked to work full-time but could not afford this transition. Her excerpt is below

I mean my paychecks are like \$330 every two weeks. So two weeks ago they did offer me a full-time position but I had to turn it down because I could get up to 40 hours a week and I also have another job cleaning houses one day a week and I make more money doing that then if I were to take a full-time position here. (Tiffany, p.4)

Beyond having an understanding that there is minimal pay for the position, no opportunity to utilize their advanced licensing, and no room for advancement the BFPC all discuss feeling isolated within their specific health units and are frustrated that they are not being placed into the basic work flow of the organization. One respondent describes this challenge below

There is no reinforcement or support as a BFPC. You are kind of like on this island within your clinic. Again, on paper you are supposed to be part of the clinic flow however that can still be an option. If the CPA or other staff want to make you an option to the participant to see you or not see you even though you are a legitimate part of the certification process. So that is a big and ongoing problem. But it's never been addressed or remedied. You may bring it up but the response is 'well it is part of the policy that you are part of the clinic flow and they should be sending them to you.' Well we know what they should be doing but if it's not happening then what? (Hallie, p. 4)

This concept of feeling isolated was unanimous among the respondents. In fact, when I went to each health unit to conduct these interviews all of the BFPC were located in the very back of the unit. One respondent states that "in my clinic I'm the last person they see," (Jenn, p.4). Another respondent addresses this issue and says

CPA's are crazy busy so this is a nice location where I can be like 'OK I'm still here so don't forget about me!' I would like to see it be a requirement that they have to see us. But not necessarily if they are really set on not breastfeeding because for me that is totally fine. But with the scheduling of my hours it would be nice if they would bump them up and let them know I am here so I don't miss certain people that would benefit from seeing me. (Mindy, p.3)

It appears that these challenges make the BFPC feel that they are not respected in their field. One respondent addresses this issue below

I get more respect from UAMS lactation consultants. I sometimes go to their classes and help which brings in referrals. I work closely with all seven of them (lactation consultants) and I get more respect and recognition than I do from WIC. It's like you are kind of seen as the extra and not that important. (Laura, p.8)

Furthermore, the BFPC feel that they are being taken advantage of. One respondent discusses this issue below

I mean there are some people who are now with WIC who have taken advantage of the passion that we have for breastfeeding and the education that we can get. A lot of us have gone on to get certification and a lot of us are in school but we can't utilize any of that information and be within policy and protocol of the grant. (Laura, p.2)

In sum, it appears that the BFPC are aware of the limitations built into their role and view this as a problematic glass ceiling. One respondent even states that “there is a glass ceiling within the program and within the profession itself,” (Hallie, p.5). While there is not a glass ceiling of a gendered barrier for advancement there does appear to be a class ceiling for these former WIC recipients.

Changing Policy from the Inside: Discretion

Despite being aware of the class ceiling, (1) the lack in substantial pay, (2) not being placed in the work-flow of the health unit, (3) not having any room for advancement, and (4) not being able to utilize their advanced training the BFPC all discuss finding ways to circumvent this by utilizing discretionary tactics. However, like the role of BFPC, their discretionary leeway appears to be highly limited as well. One respondent describes having discretion in her ability to discuss personal issues with clientele more so than her ability to use her education in breastfeeding knowledge below

Yes, I have more leeway to communicate with them about that (personal issues) than a nipple shield. So if I have a participant who is telling me about how she doesn't want to nurse directly she just wants to pump (referring to sexual abuse). So our policy is that that wouldn't qualify you for a pump. But, if we need to go around that we would contact our state office and make exceptions. (Hallie, p.7)

Additionally, another respondent describes this issue and saw her discretionary ability to discuss personal issues rather than breastfeeding issues as an asset to the program. Her excerpt is below

And they ask me all kinds of questions. I mean you become like a confidant to them. I get questions about birth control, drinking, and smoking. I mean they are more likely to open up to us then they are to anyone else in the clinic. That is one of the great things about the peer counselor program, I mean really. (Laura, p.6)

Concurrently, the BFPC appear to have discretion with regard to how they approach their clientele. One respondent describes this discretionary tactic below

I mean if someone comes in my office and they are very country I am going to be right there with you (laughs) but still professional. I mean that is part of my job, the counseling, since I am supposed to be relatable. They are supposed to feel comfortable with me and I want them to feel comfortable. So I try to meet them wherever they are. But I think a lot of the time WIC forgets about the outside of the norms, the outliers that do exist. (Laura, p.3)

Another respondent describes this same discretion and discusses that it is beyond her role to talk about whatever she wants with the client but that she does it anyways. She says

I mean it's a fine line. I think technically we are not supposed to but I let them talk about whatever they want to talk about with me because it is obviously something that they need to talk about and work through the feelings. (Laura, p.6)

Moreover, one respondent was more direct and said that she actually goes around policy if need be to meet the needs of her clientele. Her excerpt is below

So, if I have an issue and I am unsure how to answer it...well I rarely have an issue that I am unsure about. It's more of trying to go around policy to get the mom what she needs. (Laura, p.1-2)

Lastly, one respondent describes the discretion that she exhibits based on not being placed in the basic work flow within her health unit. She states that

So a lot of your time you have to just be proactive to get your clinic to realize you are here. There are some things that go beyond your role. You have to be like ‘I’m here today so send people to me.’ Or you have to go out to the lobby or maybe see them walking down the hall and stop them or do phone calls and stuff like that. (Hallie, p.4)

In sum, it appears that the BFPC’s discretion is very limited. Their discretionary tactics include: *leeway to discuss personal issues outside of breastfeeding, going around policy to get the mom what she needs, and being proactive to talk with moms despite the lack of integration into the clinic workflow.* However, this discretion is very limiting with regard to providing adequate breastfeeding support and advice. Importantly, Lipsky (1980) states that street-level bureaucrats are professionals that “are expected to exercise discretionary judgement in their field” and even “public employees who do not have claims to professional status exercise considerable discretion,” (p.14). However, the discretion allotted to BFPC may potentially be limited because the BFPC’s are viewed as being *of the WIC population* and are considered *paraprofessionals*. More importantly, it appears that the social construction of BFPC’s as lower-level workers may be a deterrent to their ability to exercise such discretionary tactics. Now that I have explained this limitation I now discuss how the BFPC’s are exercising discretion outside of the parameters of WIC.

Changing Policy from the Outside: Lack of Discretion

All of the BFPC’s appear to be aware of the limitations of their profession with issues like: lack of being put into the clinic workflow, inability to utilize their CLC licensing, and the lack of discretion allotted in spite of their unique capacity to aid WIC participants coupled with their extensive training. Due to this awareness the BFPC’s have begun working outside of the confines of WIC to aid WIC participants by creating their own non-profit organization they have called Mother’s United. One respondent speaks to the lack of ability to change policies from

within WIC and discusses her desire to aid the community from a different angle. Her excerpt is below

I don't plan to be with WIC forever because I have these bigger visions that I want to have happen. The peer counselors and I have co-founded Mothers United together and I have big ideas with that too. I mean there have been so many ideas that I have brought to the program (WIC) and they are like 'oh that's great, but I don't think we can do that right now.' So we just carry it over to Mothers United. Mothers United (laughs) was created because of the 'no's' that we got from WIC. (Laura, p.8)

Mothers United is a non-profit organization that the BFPC have created together. Within this venue they are able to organize funds via sponsored races they call the *Milk Run*, similar to the efforts for breast cancer awareness, for breastfeeding advocacy since there is a minimal to non-existent budget within WIC. One respondent states that

It's a non-profit that we can funnel milk run money through so that we can give extra money to peer counselors to pay for food for support groups, or if you need a rocking chair, or extra slings for the sling program. Oh, and we are going to help out the Ronald McDonald house for moms who are staying there while their babies are in the NICU. So we have had to step out of the WIC arena a lot of times because it's really binding inside there. And we have to be careful how we represent ourselves. Like when I am doing milk run stuff I can't say that it has anything to do with the health department or WIC or peer counseling. We do have to file every year and if they say anything we would have to do fill out a report. But, we only make like 2,500 a year. It's just enough money for a peer counselor to buy food for her support group. I mean that would be an hour and half for her to pay for that since she makes 11 bucks an hour. We just wanted to give the peer counselors a little wiggle room to buy things that we need because our funding for promotional items is nothing. Nothing. (Jenn, p.5)

Interestingly, it appears that the BFPC are executing discretionary tactics outside of WIC because they see the limitations of their positions. These unique discretionary tactics may be indicative of what Windsor (1996) called the "esprit de corps" as these BFPC are banding together with their devotion to the cause outside the confines of WIC. However, the non-profit has been met with opposition from WIC and has been highly discouraged. One respondent states that

They saw a need that wasn't being met in our role here, just kind of a gap in things that you can't address as peer counselors, and they wanted to meet those needs. The non-profit was highly encouraged by Teri and highly discouraged currently (laughs). (Hallie, p.7)

Beyond being an opportunity to fill a gap or generate funds for low-income women outside of the confines of the WIC department it appears that much of this is being driven by their passion and philanthropic desire to meet the needs of their clientele in spite of the lack of discretion within WIC. One respondents state that "We are all passionate and we can see opportunities that we could be extending to low-income women that we can't because of the limitations at WIC," (Laura, p.8).

In sum, it appears that despite the lack of discretion allotted to the peer-counselors and the lack of adequate budget the BFPC are utilizing discretionary tactics in a different capacity and this is based on their immense passion, or esprit de corps, to aid women in the community beyond the limitations of WIC. Lipsky (1980) states that

Street-level bureaucrats often spend their work lives in a corrupted world of service. They believe themselves to be doing the best they can under adverse circumstances, and they develop techniques to salvage service and decision-making values within the limits imposed upon them by the structure of the work. (p.xiii)

Thus, although the BFPC's may not be viewed as professionals due to being pulled from the WIC population, which appears to be socially constructed as having low political power, they appear to be exercising discretion and becoming street-level bureaucrats regardless through other venues. Recall that Lipsky (1980) argues that organizational workers who share insider status with the target population may alter, challenge, or resist the socially constructed institutional identities they encounter. Recall, the research question for this subset of findings asks how do the personal narratives of former WIC recipients inform the communication of the organizational narrative and the actual implementation process? It appears that the personal narratives of these

BFPC are resisting the organizational narrative and depiction of WIC recipients as having unilateral needs and are exercising discretion outside of WIC in their non-profit organization thus altering the implementation process through grassroots implementation.

Chapter Five: Discussion and Conclusion

In this chapter I first provide a discussion of the findings and describe how I answered my research questions. Second I present a conclusion synthesizing the paper. Third I make a few policy suggestions. Fourth I discuss the study limitations. Fifth I make suggestions for future research.

By examining the shift reported in the CDC's breastfeeding data and policy goals from 2010 to 2020 it becomes evident that although breastfeeding initiation rates are rising, breastfeeding duration rates and exclusive breastfeeding are still stagnant, and in some places declining, like in Arkansas. Additionally, there appears to be a shift in the policy goals from the federal level to the more state and local level.

In response to these federal guidelines to support breastfeeding, the Arkansas Department of Health has implemented a Breastfeeding Pilot Project, albeit it appears to be laden with numerous obstacles. The findings of this study reveal that the adaptation of these policy goals is difficult to implement and this may be predicated on the explicit and implicit social construction of WIC recipients. The findings among the state bureaucrats conveyed a consistent relegating of responsibility of infant feeding choice on the WIC recipients, with terms like *they are just not receptive, not a great deal of self-confidence*, and *they are not going to want to single themselves out*. Concurrently, describing the WIC recipients as *patients* and with issues that need to be *cured* may suggest a social construction of WIC recipients as needing individual behavior modifications rather than needing structural support.

Additionally, although the BFPC were deemed an asset, they were still thought of as being of the WIC population, despite their advanced training in breastfeeding education. This was

conveyed with language like *paraprofessionals, come with their own problems, it was a struggle, and so they bring all these problems that we see in the WIC clinic*. Furthermore, the consistent depiction of BFPC as being from the WIC population, may potentially play into the resistance to incorporate BFPC into the work flow, allow discretionary leeway, or provide better job security for these street-level bureaucrats.

These perceptions combine with the implicit challenges of the lack of breastfeeding education, awareness, and the desire to incorporate more breastfeeding policies in hospitals and WIC health units. In addition, the profitable formula marketing within these venues, the non-existent budget, and the unilateral focus on breastfeeding education all speak to the politicization of low-income mothers, and conveys a continuing lack of structural support for these women in their infant feeding choices.

The first research question this study asks is *How does the organizational narrative of state level workers shape the construction of the WIC breast-feeding recipients (target population) in Arkansas?* It appears that the explicit and implicit social constructions of WIC recipients suggest that despite the *call to support breastfeeding* there is a systemic aversion to providing more structural support for these women. These findings echo previous literature and suggest that this aversion may be predicated on (1) the social construction of WIC recipients as having singular needs rather than requiring structural support and (2) the immense power of aggressive formula marketing within these venues (Hancock, 2003).

The findings from the BFPC reveal that, unlike the state bureaucrats, the BFPC have a much more holistic understanding of the inadequacy of structural support for low-income women. The BFPC were able to discuss the multiple barriers this population is experiencing such as the moral authority given to partners and family with regards to if, when and how, a mother

breastfeeds. They also addressed and understood the hyper-sexualization of the breast and how this impacts younger mothers. They shared a keen understanding of the inadequate current working environment for breastfeeding support among low-income mothers, and the complete lack of autonomy within hospital settings. The understanding of these compounding challenges to a mothers' infant feeding choice suggests that these BFPC have a front-line view and are able to see the complexities these low-income mothers are experiencing.

In addition to understanding these dynamic systemic barriers for low-income mothers, they were also able to articulate how these barriers affected them as BFPC. Despite their passionate desire to aid their clientele, they were all aware of a *class ceiling* built into their position. This was described in their feelings of lack of respect, the temporary nature of their positions, the lack of incorporation into the workflow, being placed in the back of health units, and their inability to both utilize and display their advanced licensing in breastfeeding education. Moreover, these street-level bureaucrats had very little discretion within the organization. This study suggests that this lack of discretion may be predicated on the social construction of BFPC as being of the WIC population, and thus potentially, undeserving.

Recall that within Shneider and Ingram's (1993) social construction matrix there are four distinct categories with the potential to transition from one cell to the other, however, this can demonstrate to be rather difficult due to the power of language, imagery, culture, and any previously interlocking axis of oppression to maintain normative beliefs about individuals, in this case WIC recipients. Previous research does show that certain categories of mothers, like the working mother, have moved from less negative social construction to positive social construction but this is not without residual challenges (West, 1981). Shneider and Ingram (1993) argue that as a socially constructed target population transitions, there will either be a

removal of political power or that target group will be depicted negatively. The current retaliation and negative depiction of the LGBT community in response to their new political power is a good example. Thus this model provides an explanation for how the power of language and imagery can garner or dissuade political support for certain groups of people and potentially perpetuate injustices. The BFPC may be experiencing this residual challenge as they are transitioning from being *WIC recipients* to *paraprofessionals* as they appear to have a more positive social construction than current WIC recipients, but very little political power despite their certifications and knowledge base.

The second research question of this study is *How do the personal narratives of former WIC recipients inform the communication of the organizational narrative? And how do these personal narratives inform the actual implementation?* It appears that the personal narratives of these former WIC recipients are challenging the organizational narrative that WIC recipients have unilateral and singular needs, and are very aware of the systemic and compounding barriers to low-income mothers. Moreover, the BFPC are aware of how this affects their role as peer-counselors and described a class ceiling built into their position. In response, the BFPC appear to be able to reorient their passion, unique understanding of the complexity of structural barriers low-income mothers experience, and their advanced breastfeeding education by circumventing organizational constraints. They achieved this by creating their own non-profit organization to attend to these needs.

The findings of this study suggest that this awareness becomes the platform for actual implementation outside of the confines of the organization itself. The banding together of the BFPC because of, and in spite of, their inability to aid low-income women more effectively has inspired them to create their own non-profit organization to better meet the needs of low-income

mothers. Recall that Winsor (1996) described this as *esprit de corps* and Lipsky (1980) argues that street-level bureaucrats will exercise discretion in unique capacities, and that these alternative discretionary tactics originate from the frontline worker's deep passion to aid their community.

Conclusion

Previous research on breastfeeding research focuses on the structural and cultural barriers women are experiencing in their infant feeding decisions, whether it is public or self-perceptions, inadequate workplace support, the challenges of breastfeeding in public, or aggressive formula marketing (Christopher, 2012; Johnston-Robledo et al, 2007; Jensen and Labook, 2005). Furthermore, it appears that these structural and cultural barriers are multiple for low-income mothers who are WIC recipients and much of this is predicated on the negative depiction of the welfare mother as undeserving of policy support (Hancock, 2003; West, 2003). Previous literature lacks a focus on how these multiple barriers and negative depictions of welfare recipients may affect the policy implementation process from a bottom-up perspective. More important, the frontline workers or street-level bureaucrats in this study demonstrate a unique understanding given their insider status of both the target population and the organizational goals.

Similar to previous literature, the findings from this study suggest that WIC recipients are described with negative language and are viewed as requiring individual behavior modification rather than more inclusive policy support. This was revealed by the street-level bureaucrat's depiction of the compounding challenges they see both with their clientele and within their own limited role within the WIC health units because they come from this WIC population. Previous literature on street-level bureaucrats demonstrates that frontline workers have the capacity to

wield the policy process when they are allotted discretion (Allen, Griffiths, and Lyne, 2004; Finlay and Sandal, 2009; Meershoek, Krumeich, and Vos, 2007). The findings from this study suggest that as the frontline workers are socially constructed as paraprofessionals from the WIC population the discretionary leeway was very limited to meet the needs of the WIC recipients. However, the street-level bureaucrats challenge the organizational narrative that WIC recipients need unilateral educational support and use their personal narrative of the complexities of breastfeeding for this target population and have formed a venue to meet these needs more extensively.

In sum, my intent is not to encourage or discourage breastfeeding, but rather to reveal the immense and systemic challenges low-income mothers experience in this endeavor. As a society we champion *breast as best* and encourage all women to breastfeed but the lack of more supportive and dynamic policies makes breastfeeding a privilege rather than a right. Wolf (2011) posits that

Preventing risk, promoting health behavior, and providing for babies are, in theory, not terribly contentious agendas. They become problematic when proponents do not adequately consider the complex environment in which they are pursued, as if their desirability could be challenged only by the ignorant or nefarious. (P.139)

Without a more extensive understanding of the complex environment in which women must negotiate their infant feeding decisions there cannot be the appropriate supportive scaffolding implemented. Importantly, this research reveals that there are numerous challenges and tensions within breastfeeding policy promotion and that much of this tension may be predicated on the social construction of WIC recipients as needing individual behavior modification rather than structural support. This study adds to the previous literature by evaluating how the social construction of WIC recipients affects the policy implementation

process and how front line workers can challenge the organizational narrative by utilizing discretionary tactics in unique capacities from their passionate platforms.

Policy Implications

The implications of this study are that by exploring policy implementation through the lens of narrative analysis the complex ways in which bottom-up implementation occurs can be better understood. This exploratory research informs us of the potential that narrative analysis of policy implementation from both a bottom-up approach has to understand the complexities of the politicization of women, the social construction of the WIC population, and the more dynamic barriers of providing breastfeeding support to women. Consequently, by exploring breastfeeding policy and promotion through this multi-tiered lens we are better equipped to address the complex challenges to women's infant feeding choices at both an institutional and organizational level.

This study highlights the explicit and implicit social construction of WIC recipients and how this affects breastfeeding policy implementation. Recall that explicit refers to more self-explanatory whereas implicit refers to the social constructions that may be beyond conscious awareness. The policies that are currently being enacted appear to not be serving the population fully. Importantly, recall that a key objective of the CDC's policy goals is to increase the number of women who exclusively breastfeed for the first six months of an infant's life. However, this study reveals that the WIC breastfeeding incentive package is actually a deterrent to exclusive breastfeeding because the WIC recipients are opting out of the package for fear of not being able to access formula at a later time. Additionally, it appears that although the role of BFPC is highly effective at providing peer support for encouragement it is a very limiting role for them. These

counselors were able to explain the limitations in their discretion, the lack of funding, their inability to utilize their licensing, and the lack of opportunity for advancement.

If the overall goal of both the CDC and the Arkansas pilot project is to increase breastfeeding initiation and duration rates, it appears that some policy changes need to occur. The findings from this study suggest two initial changes to aid in this endeavor. First, a simple change would be to transform the breastfeeding incentive package to allow for formula use at a later date if the mother cannot breastfeed exclusively. Secondly, there needs to be a policy shift in how the BFPCs are incorporated into the WIC health units. All of the BFPC are now CLC's or IBCLC's and have a unique capacity to not only relate to their clientele but provide them with expertise on how to negotiate a breastfeeding relationship. Additionally, in order to aid the BFPC in their ability to help WIC clientele there needs to be a policy written into the grant that encourages incorporating BFPC into the clinic work flow. If BFPC are both a national objective, and a demonstrated asset to encouraging low-income mothers on WIC to breastfeed in a way that other individuals cannot, then they need to be viewed as asset to the WIC health units. Lastly, in the state of Arkansas, the role of BFPC has no potential for advancement. The findings of this study suggest that this is a deterrent to providing job security and increases turnover within the health units. If BFPC are able to reach a hard-to-reach population, and they have the advanced training to aid this population, there needs to be a transformation where there is the potential for advancement.

Overall, this study highlights that employing a holistic view of narrative analysis and evaluating policy implementation from a bottom-up perspective can help better define the problems of breastfeeding initiation and duration rates of the WIC population. Additionally, while this dissertation is a case study about breastfeeding policy implementation, it implications

are much wider and suggests that the deeply seated normative frameworks of WIC participants may be a larger challenge to policy change.

Study Limitations

The study is an exploration of the social construction of target populations within breastfeeding policy implementation in the state of Arkansas. A limitation of this study is that, although I was able to explore multiple points of entry, I was unable to gain access to mothers who utilize WIC, beyond the BFPC, to assess their experiences of both using WIC and a BFPC. A larger study might have included in-depth interviews with WIC recipients which could strengthen the validity of these findings.

In addition, I am specifically looking at Arkansas breastfeeding policy implementation. Both the state bureaucrats and the BFPC's discussed issues with budget and the limitation of the role of the BFPC in comparison to other states that have both better budgetary and BFPC discretion. Therefore, an extensive systematic comparison across different states to assess how the variation within these policy issues may provide additional insight into their effectiveness or ineffectiveness.

Recommendations for Future Research

This study explored the social construction of target populations, specifically low-income women who access WIC, within the breastfeeding policy implementation in the state of Arkansas. I recommend two ways in which future research could build on this study. First, narrative analysis could be employed to study additional social actors such as: medical professionals, hospital IBCLC's, partners and family of women who access WIC, and the WIC participants themselves. This could help in developing a more comprehensive understanding of

the challenges and barriers to this population in their infant feeding decisions. Studies of other front-line workers who have insider status could be compared to those found here to assess the ways in which they communicate other services to target populations.

Second, future research should explore the comparative nature and policies within WIC health units in different states. Studies could explore the effect of breastfeeding incentive packages on exclusive breastfeeding, incorporating BFPC within the clinic work flow, and creating room for advancement for BFPC. Expanding the research to evaluate policy differences across states in conjunction with evaluating the CDC's breastfeeding report card data on variance across states in breastfeeding initiation and duration rates has the potential to reveal, and potentially support, making policy changes.

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Appendix A



Office of Research Compliance
Institutional Review Board

February 14, 2014

MEMORANDUM

TO: Britni Ayers
Lori Holyfield

FROM: Ro Windwalker
IRB Coordinator

RE: New Protocol Approval

IRB Protocol #: 14-01-435

Protocol Title: *Democratizing Breastfeeding: An Analysis*

Review Type: ☒ EXEMPT ☐ EXPEDITED ☐ FULL IRB

Approved Project Period: Start Date: 02/13/2014, ~~Expiration Date: 02/12/2015~~

Your protocol has been approved by the IRB. Protocols are approved for a maximum period of one year. If you wish to continue the project past the approved project period (see above), you must submit a request, using the form *Continuing Review for IRB Approved Projects*, prior to the expiration date. This form is available from the IRB Coordinator or on the Research Compliance website (<http://vpred.uark.edu/210.php>). As a courtesy, you will be sent a reminder two months in advance of that date. However, failure to receive a reminder does not negate your obligation to make the request in sufficient time for review and approval. Federal regulations prohibit retroactive approval of continuation. Failure to receive approval to continue the project prior to the expiration date will result in Termination of the protocol approval. The IRB Coordinator can give you guidance on submission times.

This protocol has been approved for 30 participants. If you wish to make any modifications in the approved protocol, including enrolling more than this number, you must seek approval prior to implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 210 Administration Building, 5-2208, or irb@uark.edu.

210 Administration Building • 1 University of Arkansas • Fayetteville, AR 72701
Voice (479) 575-2208 • Fax (479) 575-3846 • Email irb@uark.edu

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Breast is Best: A Study of Bottom-Up Implementation
Consent to Participate in a Research Study
 Principal Researchers Name: Britni Ayers
 Faculty Advisor: Dr. Lori Holyfield

INVITATION TO PARTICIPATE

You are invited to participate in a research study about breastfeeding. You are being asked to participate in this study because you reside within the Northwest Arkansas community and are affiliated with breastfeeding advocacy and/or are in a position to make decisions about infant feeding choices either for yourself or others.

WHAT YOU SHOULD KNOW ABOUT THE RESEARCH STUDY

Who is the Principal Researcher?

Britni Ayers

Who is the Faculty Advisor?

Dr. Lori Holyfield

What is the purpose of this research study?

The purpose of this research is to explore the barriers with regard to women's choice in their breastfeeding experiences. More specifically, this project seeks to evaluate what the current key stakeholders in breastfeeding decisions in Arkansas are doing, experiencing, and implementing with regard to breastfeeding and women's choice.

Who will participate in this study?

This study proposes to interview up to 30 adults who are reside within the Northwest Arkansas community who are affiliated with breastfeeding advocacy and/or are in a position to make decisions about infant feeding choices either for themselves or others.

What am I being asked to do?

Your participation will require the following:

Participating in a 30 minute to one-hour in-depth interview that will be digitally recorded.

What are the possible risks or discomforts?

While there are no physical risks involved in this research, this interview will cover topics that may cause some emotional discomfort. I want to confirm that you realize that you can stop at any time and choose not to participate and there will be no penalty for choosing to do so.

Furthermore, since there is no more than minimal risk of harm within this research project an informal verbal consent will be obtained during this interview. Finally, if you have questions or concerns regarding this study please contact my project supervisor, Dr. Lori Holyfield 479-283-2277. If your concerns are not addressed via Dr. Holyfield, or if you have any questions

regarding your rights as a research subject, please contact the U of A Institutional Review Board at (479) 575-3845.

What are the possible benefits of this study?

This research has the potential to inform policy makers with regard to how to better aid women in their breastfeeding decision making process.

How long will the study last?

The in-depth interviews will take an estimated 30 minutes to one hour to complete. There is the potential for member checks to occur wherein the researcher would need to contact the participant for clarification an estimate of up to one year after the start of the research project.

Will I receive compensation for my time and inconvenience if I choose to participate in this study?

There is no compensation for participating in my study.

Will I have to pay for anything?

There will be no costs for participating in my study.

What are the options if I do not want to be in the study?

If you do not want to be in this study, you may refuse to participate. Also, you may refuse to participate at any time during the study. You will not be affected in any way if you refuse to participate.

How will my confidentiality be protected?

All information will be kept confidential to the extent allowed by applicable State and Federal law.

This interview will be audio recorded and I want to confirm that you can receive a copy of this interview in digital format for your own use if you would like to have a personal copy. Additionally, I want to inform you that all digital recordings will be kept in a locked cabinet in my office to which only I have the key. After the research project is complete these audio files will be destroyed. I would also like to inform you that all information you give me will be kept confidential to the extent allowed by law and University policies. Your name, address, and other identifying information will not be used in any form. Your age and pseudonym will be the only identifiable information recorded. Any names mentioned during the interview will be omitted from transcription as part of my attempt to provide confidentiality (e.g., names of children, co-workers, family members).

Will I know the results of the study?

At the conclusion of the study you will have the right to request feedback about the results. You may contact the faculty advisor, Dr. Holyfield 479-283-2277 or Principal Researcher, Britni Ayers 479-644-1096. You will receive a copy of this form for your files.

What do I do if I have questions about the research study?

You have the right to contact the Principal Researcher or Faculty Advisor as listed below for any concerns that you may have: Britni Ayers & Dr. Holyfield

You may also contact the University of Arkansas Research Compliance office listed below if you have questions about your rights as a participant, or to discuss any concerns about, or problems with the research.

Ro Windwalker, CIP
Institutional Review Board Coordinator
Research Compliance
University of Arkansas
210 Administration
Fayetteville, AR 72701-1201
479-575-2208
irb@uark.edu

Appendix B



Office of Research Compliance
Institutional Review Board

January 27, 2015

MEMORANDUM

TO: Britni Ayers
Lori Holyfield

FROM: Ro Windwalker
IRB Coordinator

RE: PROJECT CONTINUATION

IRB Protocol #: 14-01-435

Protocol Title: *Democratizing Breastfeeding: An Analysis*

Review Type: ☒ EXEMPT ☐ EXPEDITED ☐ FULL IRB

Previous Approval Period: Start Date: 02/13/2014 Expiration Date: 02/12/2015

New Expiration Date: 02/12/2016

Your request to extend the referenced protocol has been approved by the IRB. If at the end of this period you wish to continue the project, you must submit a request using the form [Continuing Review for IRB Approved Projects](#), prior to the expiration date. Failure to obtain approval for a continuation on or prior to this new expiration date will result in termination of the protocol and you will be required to submit a new protocol to the IRB before continuing the project. Data collected past the protocol expiration date may need to be eliminated from the dataset should you wish to publish. Only data collected under a currently approved protocol can be certified by the IRB for any purpose.

This protocol has been approved for 43 total participants. If you wish to make any modifications in the approved protocol, including enrolling more than this number, you must seek approval *prior to* implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 109 MLKG Building, 5-2208, or irb@uark.edu.

109 MLKG Building • 1 University of Arkansas • Fayetteville, AR 72701
Voice (479) 575-2208 • Fax (479) 575-6527 • Email irb@uark.edu

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Appendix C

Interview Guide for Respondents

Interview Guide: Key Stakeholders

- 1) Can you tell me a little about your job within the health department and how long you have worked here?
- 2) What brought you to this job?
- 3) Can you tell me about the Breastfeeding Pilot Project and how it got started?
- 4) Can you tell me a little about the Breastfeeding Peer Counselors?
- 5) How does someone become a Peer Counselor?
- 6) What do you think the biggest challenges are to for women who want to breastfeed?
- 7) What do you think the biggest challenges are for women who want to breastfeed who use WIC?
- 8) Do you think women who have Peer Counselors have a more successful breastfeeding experience? Why or why not?
- 9) Is there anything additional you would like to add?

Interview Guide: Focus Group

- 1) Can you each tell me your name, how long you have been a Peer Counselor, and how you got involved in the program?
- 2) What do you all think are the main challenges when you are trying to give a woman support with breastfeeding?
- 3) Can you describe what type of support the women you work with are receiving?
- 4) What do you think is the most helpful component for the women you work with regard to breastfeeding?
- 5) What do you think are the biggest challenges within the program?
- 6) What are the biggest challenges of being a Peer Counselor?
- 7) If you could change something in the program what would you change?
- 8) If you could have a one on one moment with the Governor of Arkansas to discuss what we need to do with regard to breastfeeding in the state of Arkansas what would you say?

Interview Guide: Breastfeeding Peer Counselor Interviews

- 1) How did you learn about the Peer Counselor program?
- 2) Did having a Peer Counselor help you? If so, how?
- 3) What made you decide to become a Peer Counselor?
- 4) How has being a Peer Counselor affected you?
- 5) What challenges did you have in breastfeeding?
- 6) How did the Peer Counselor program attend to these challenges?
- 7) After becoming a Peer Counselor what challenges have you experienced while being in the program?
- 8) What would you change within the program?

BFPC one-on-one questions:

Prior to BFPC

- 1) Did you have access to a BFPC before you became a BFPC?
- 2) What was that experience like?
- 3) How was it helpful and how could it have been more helpful?

After BFPC

- 4) I want to get an understanding of the organizational components of being a peer counselor. What is your relationship with your supervisor like?
- 5) Does your job involve paperwork? If so, how much and what is needed?
- 6) Do you consult other BFPC in making decisions with helping mothers?
- 7) Do you have certain goals you have to meet in being a BFPC?
- 8) Is there certain language or protocol you are supposed to use when talking with mothers?
- 9) Would you say that you have a lot of lee-way as a BFPC or would you say your position is highly regulated?
- 10) What would you say are the shortcomings of the program? And how would you remedy these?