

Triggering Institutional Change: Examining the Development of the 2001 Quebec Breastfeeding Policy

Déclencher le changement institutionnel : examen de l'élaboration de la politique de 2001 sur l'allaitement maternel au Québec



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Abstract

Background: The Quebec Government published Canada's first breastfeeding policy in 2001 with the goal to increase breastfeeding rates in the province.

Objective: To ultimately contribute to more informed policy decision-making, this investigation aimed to identify key stakeholders and understand events and processes that contributed to the establishment of this policy.

Methods: Building from the neo-institutional theory, this was a retrospective case study. Interviews with key informants were conducted, and several texts were compiled. Hybrid thematic analysis was used to analyze text transcribed verbatim from interviews. Resulting

themes, summary of archival material and temporal bracketing were adopted to elaborate a historical narrative of the development of the policy.

Results: The emergence, development and initial implementation of the Quebec breastfeeding policy phases were traced from 1977 to 2009. The policy was triggered by a grassroots health professional movement that advocated for years for a cultural change toward breastfeeding in Quebec. Once Quebec's Ministry of Health finally accepted dialogue, institutional actors cooperated to formulate the policy. However, conflicts arose because of the Ministry's increasingly centralized mechanisms of governance. By 2009, discontent was so pervasive that several health professionals and other breastfeeding actors created an independent organization to further support breastfeeding, out of the Ministry's scope of control.

Conclusion: Collaboration in this domain was possible when shared decision-making was accepted, but conflict emerged when the institutional actor with formal authority re-adopted traditional top-down modes of action.

Résumé

Contexte : Le gouvernement du Québec publiait en 2001 la première politique au Canada d'allaitement maternel dans l'optique d'accroître les taux d'allaitement naturel dans la province.

Objectif : En vue de fournir un apport à la prise de décisions politiques informées, cette enquête vise à identifier les principaux intervenants et à comprendre les événements et processus qui ont contribué à l'élaboration de cette politique.

Méthode : Il s'agit d'une étude de cas rétrospective qui s'appuie sur la théorie néo-institutionnelle. Des entrevues auprès d'intervenants clés ont été menées et plusieurs textes ont été compilés. Les transcriptions des entrevues ont été analysées au moyen d'une analyse thématique hybride. Les thèmes qui en ont découlé, un sommaire des documents d'archives et la décomposition temporelle ont servi à l'élaboration d'un discours narratif sur l'élaboration de la politique.

Résultats : L'émergence, l'élaboration et la mise en œuvre initiale des phases de la politique québécoise d'allaitement maternel ont été retracées de 1977 à 2009. La politique tire son origine d'un mouvement de professionnels de la santé qui, pendant des années, ont plaidé pour un changement de culture en faveur de l'allaitement maternel au Québec. Une fois que le ministère québécois de la Santé a accepté d'entamer le dialogue, les acteurs institutionnels ont collaboré à l'élaboration de la politique. Toutefois, des conflits ont survenu en raison des mécanismes de gouvernance de plus en plus centralisés mis en place par le Ministère. Dès 2009, le mécontentement était si répandu que plusieurs professionnels de la santé ont créé, avec d'autres intervenants en faveur de l'allaitement, un organisme indépendant pour encourager l'allaitement, organisme dont la portée restait en dehors des contrôles du Ministère.

Conclusion : La collaboration dans ce domaine a été possible quand on a accepté de partager la prise de décisions, mais les conflits ont survenus dès que l'acteur institutionnel détenant l'autorité officielle a adopté de nouveau les modes d'action hiérarchiques habituels.

Introduction

The scientific community and international health organizations alike view breastfeeding as the optimal way to feed newborns and infants (Victora et al. 2016). It has been about 30 years since the World Health Organization (WHO) and the United Nations International Children's Emergency Fund (UNICEF) launched the Baby-Friendly Hospital Initiative (BFHI) to promote breastfeeding around the world (WHO and UNICEF 1989; UNICEF 1990). Most WHO members have endorsed the BFHI and progressively translated the WHO/UNICEF strategies into regional and national breastfeeding policies (Aryeetey and Dykes 2018; Dyson et al. 2010).

Within this international context, Quebec (Canada's largest province) had the lowest breastfeeding rates in the country in 1996–1997, with an initiation rate of 58% at birth and 35% at three months, compared to the Canadian national rates of 77% and 54%, respectively (Health Care Canada 2000). In response, Quebec's Ministry of Health (MoH) recognized breastfeeding as a provincial public health priority in 1997 and aimed to increase Quebec's breastfeeding rates to 80% at birth, 60% at three months and 30% at 6 months by 2002 (Department of Health and Social Services publications 1997). In 2001, Quebec became the first Canadian province to publish a breastfeeding policy entitled *L'allaitement maternel au Québec : Lignes directrices* ([LD]; Ministère de la Santé et des Services sociaux du Québec 2001). In addition, the BFHI was integrated into Quebec's 2003–2012 provincial public health program (Publications du ministère de la Santé et des Services sociaux 2003). Overall breastfeeding rates in Quebec increased significantly following the adoption of the LD: in 2005–2006, the rates reached 85% at birth and 67%, 56% and 47% at two, four and six months, respectively (Neill et al. 2006). However, exclusive breastfeeding rates were only 52% at birth and 3% at six months (Neill et al. 2006) despite global recommendations to exclusively breastfeed for the first six months of life (WHO 2003), indicating that public health efforts were still needed in the province.

This inquiry was part of a larger evaluative study conducted from 2009 to 2012, whose overarching goal was to contribute to evidence-based policies and strategic decision-making related to breastfeeding in Quebec (Semenic et al. 2012). The purpose of the present investigation was to examine in depth the processes whereby the LD policy came into existence. Three interrelated research questions guided the investigation: (1) How did the LD unfold over time? (2) Who were the key actors and critical decisions and events that influenced the elaboration and implementation of this breastfeeding policy? (3) How did the newly created provincial breastfeeding mechanisms of negotiation contribute to the LD elaboration and adoption?

Theoretical Framework

We adopted the neo-institutional theory as a theoretical perspective for this empirical investigation. Widespread in organizational studies (Greenwood et al. 2008), the neo-institutional theory (Scott 2004):

... attends to the deeper and more resilient aspects of social structure. It considers the processes by which structures, including schemas, rules, norms, and routines become established as authoritative guidelines for social behavior. It inquires into how these elements are created, diffused, adopted, and adapted over space and time, and how they fall into decline and disuse (p. 2).

Institutionalists were initially interested in studying the influence of environmental conditions on organizations, and how organizations should conform to institutional templates to gain *legitimacy* in the *institutional field* (i.e., the aggregate of organizations and other actors that operate in the same sphere of institutional life; DiMaggio and Powell 1983). They have more recently focused on understanding the roles played, and actions undertaken, by individuals and organizations in *institutional change* (Battilana 2006). In this context, the phenomenon labelled *institutional entrepreneurship* is defined as “the activities of actors who have an interest in particular institutional arrangements and who leverage resources to create new institutions or to transform existing ones” (Maguire et al. 2004: 657). *Institutional entrepreneurs* are therefore those social actors (individual and collective) that make institutional change possible (Hardy and Phillips 1998). More or less powerful *social positions* occupied by actors in the institutional field will facilitate or prevent their abilities to act as institutional entrepreneurs (Battilana 2006).

Institutional change is not only a *political* but also a *collective* endeavour. Institutional change is “a dialectical process in which partisan actors espousing conflicting views confront each other and engage in political behaviors to create institutions” (Hargrave and Van de Ven 2006, p. 864). Unfolding in several consecutive *phases* (Hargrave and Van de Ven 2006), the collective action characteristic of institutional change requires that actors adopt different *strategies of engagement* to support, or eventually resist, institutional change (Hardy and Phillips 1998). Actors’ strategies of engagement in institutional change can be cooperative (*collaboration* and *compliance*) or conflictual (*contention* or *contestation*; Hardy and Phillips 1998; Table 1). To adopt any of these strategies, actors must mobilize the *power attributes* (i.e., formal authority, control over critical resources such as expertise and money and discursive legitimacy; Hardy and Phillips 1998; Table 2) associated with their social position in the institutional field (Battilana 2006). Figure 1 represents the adaptation of these theoretical insights into the present investigation.

Material and methods

RESEARCH DESIGN

This was an intrinsic qualitative case study (Stake 1995). As the case was related to the LD policy, the study was located at the institutional macro level of analysis. The case study was retrospective, beginning with the initial actions undertaken by the actors involved in the LD’s formulation. The Research Institute of the McGill University Health Center at Montreal, Quebec, granted ethics approval for the study (# GEN-09-095).

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FIGURE 1. The problem definition process – transforming political issues into policy problems

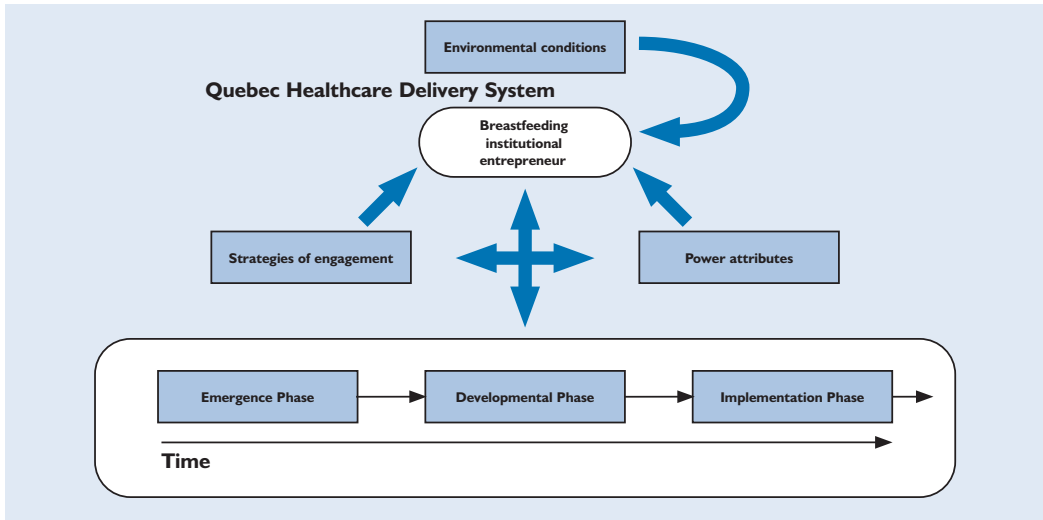


TABLE 1. Strategies of engagement in an interorganizational domain

Strategy	Modality	Definition
Cooperation	Collaboration	Interaction mutually and highly cooperative
	Compliance	Cooperative interaction but only on the surface
Conflict	Contention	Adversarial relationships
	Contestation	Challenging attitudes and behaviours vis-à-vis existing powerholders

Source: Adapted from Hardy and Phillips 1998

TABLE 2. Power in an interorganizational domain

Source of power	Definition
Formal authority	Recognized, legitimated right to make a decision
Scarce or critical resources	Control over critical resources such as expertise, money and information
Discursive legitimacy	Legitimated to speak for issues and other actors of the domain

Source: Adapted from Hardy and Phillips 1998

PARTICIPANTS AND SAMPLING STRATEGY

We adopted purposeful sampling (Patton 2002) to solicit the participation of key individuals who were knowledgeable about the historical development of the LD: (1) health professionals and managers who participated in the writing of the LD, (2) health professionals and managers who were involved in one or more mechanisms of negotiation put in place to implement the policy and (3) civil servants directly responsible for the breastfeeding policy at the Quebec MoH over time. To maximize diversity in points of view and opinions, we selected participants following a maximum variation sampling strategy (Patton 2002) using

two major criteria: position occupied in the institutional domain (i.e., local, regional or provincial) and role (e.g., health professional, manager or representative of breastfeeding community organization). Owing to the large period covered (more than three decades), we first elaborated an initial list of potential participants and progressively completed it via snowball sampling (Patton 2002), for a final sample of 25 participants.

DATA COLLECTION

The first author conducted individual face-to-face semi-structured qualitative interviews (Rubin and Rubin 2012) with 17 key players in the elaboration of the LD between October 2009 and February 2010. Seven had actively participated in the process over time, and the remaining 10 were members of one or more of the following provincial committees (Table 3, available online at www.longwoods.com/content/26221): the Baby Friendly Certification Committee ($n = 5$), the Quebec Breastfeeding Committee (Comité québécois en allaitement [CQA]) and the Breastfeeding Consultation Committee (Table de consultation en allaitement [TCA]; $n = 5$). In February 2010, with the support of three research assistants, the lead author also conducted a focus group (Krueger and Casey 2000) with eight members of the Provincial Committee of Breastfeeding Representatives (Table nationale des répondantes en allaitement maternel – see Table 3).

We also retrieved a significant amount of archival material pertinent to the LD, such as minutes of committee meetings, successive drafts of the LD and e-mails. We organized this material by event and date to facilitate data triangulation, as well as the detailed description of the case (Berg 2001; Green and Thorogood 2014). We gathered data until saturation was reached (Boutin 2000).

DATA ANALYSIS

The first and second authors established a preliminary list of initial codes from the above-mentioned theoretical framework. Then, with the support of the ATLAS.ti – a well-known software for qualitative data analysis – the lead author transcribed content verbatim from interviews and coded the material following a deductive–inductive approach (Table 4, available online at www.longwoods.com/content/26221). Both authors progressively validated codes as data were collected. Successive iterations allowed the emergence of recurrent patterns (Braun and Clarke 2006), and the three co-authors further discussed and validated the resulting themes. This thematic analysis and the careful reading and triangulation of the material allowed us to adopt a narrative strategy (Langley 1999) through which we constructed the history of the LD. The narrative was broken down into several phases through temporal bracketing (Langley 1999).

Results

We identified three important *phases* in the elaboration of the LD in Quebec. For each of those, we detailed the *context*, the most important *decisions and actions* undertaken by

breastfeeding *institutional entrepreneurs* (Table 3) and the *key events* that had an influence on how the LD unfolded over time. Respecting the confidentiality and anonymity of the participants prevents the identification of the source of the quotations selected to illustrate the study findings.

From 1977 to 1997 – emergence phase

The emergence phase in the history of the LD precedes the Quebec MoH's formalization in 1997 of a breastfeeding working group to elaborate the LD. This 20-year period witnessed the advent of different provincial initiatives to improve women's and perinatal health in Quebec, including the legalization of midwifery. Throughout these years, breastfeeding practices were primarily promoted by community organizations:

There was a void! There were not many things that were done apart from that [self-help groups]. We must never forget ... I think that breastfeeding has survived in Quebec ... it was a lot thanks to self-help groups ... And I think that all women who were breastfeeding and giving support to others were much more important in those years than the health care system.

Over this period, we identified two major institutional entrepreneurs: Dr. Milk (fictitious name) and the MoH. Dr. Milk was a family physician who, in her own words, “decided to play the role of human milk representative.” Her professional engagement regarding breastfeeding began in 1977, when she participated in a conference about the humanization of births. She then progressively modified her clinical practice, and a few years later, opened a breastfeeding clinic: “I created the breastfeeding clinic to support the mothers who had difficulties to breastfeed, and did not find the support they needed from their families or the health professionals they had consulted.”

Deeply convinced of the necessity to sensitize the MoH about the low breastfeeding rates in Quebec, Dr. Milk decided to send letters to different health policy decision-makers in 1991, an initiative that lasted for years. By that time, she also contributed to the creation of a first local breastfeeding working group, whose principal purpose was to lobby the MoH for greater breastfeeding support. Dr. Milk was the undisputable leader of this health professional movement, and her collaborative approach was undeniable: “[Dr. Milk] was the element needed to trigger all this, but she also consulted a lot of people.”

The LD's emergence phase ended when the MoH Public Health Division finally responded to Dr. Milk's long pending requests: In a letter dated January 31, 1997, they informed Dr. Milk that they would like to hire her services as a medical consultant to put in place a ministerial plan to sustain, promote and protect breastfeeding.

From 1997 to 2001 – developmental phase

This phase extended from the recruitment of the members of the LD's ministerial working

group to the LD's publication in 2001. During this period, the breastfeeding landscape was fertile in activities and events related to breastfeeding. For instance, in 1999, the Brome-Missisquoi-Perkins Hospital, in Cowansville, Quebec, was the first Canadian hospital to receive the BFHI certification. The same year, several nurses and physicians working in the Quebec City region united to better advocate for breastfeeding. This group constituted the core of what would later become one of the regional breastfeeding committees. Nevertheless, at this phase, as noted by one of the study participants:

There was not much dialogue, and when I arrived in '99, we were still in the early stages of dialogue. [...] It was a dialogue that was still fragile, where people did not trust each other ... There were not many projects started and it was the beginning, you know? The beginning of knowing ... each other, to trust each other.

Three specific actors could, however, be considered institutional entrepreneurs during this phase: (1) Dr. Milk as President of the ministerial Working Group on Breastfeeding; (2) the Working Group itself, composed of about a dozen members and operating at the Social Services Divisions of the MoH; and (3) the Breastfeeding Coalition, created in 1998, which involved a variety of breastfeeding key actors in the province, highly regarded by their peers for their expertise and discursive legitimacy regarding breastfeeding.

Dr. Milk's authority in the process was so strong that, having been co-opted by the MoH, she was given responsibility for selecting the members of the ministerial working group. As illustrated below, Dr. Milk looked for a high degree of expertise around the table to make the task as efficient as possible:

We decided to create a working group with people who knew breastfeeding, who were interested in breastfeeding. We could have done a task force ... just get a medical representative, a nurse representative, a dietitian representative, a self-help group representative, but we thought there was so much work to be done that, if we went to include people who did not know breastfeeding, it would take longer to reach a consensus. We made the choice. I would say that really it was because we wanted to have people who knew breastfeeding to be able to get a result maybe faster.

Heterogeneity among group members was also sought to develop a policy document based on the perceived needs of different people working in the field. In the group, "all were invited to participate and bring their point of view," and each one of the members had the "feeling of being welcome, and that our opinions, our participation were important for the elaboration [of the LD]." What is more, the group established fruitful relationships with external actors such as different community groups, as well as the provincial Breastfeeding Coalition. The collaborative strategies adopted led to the development of a very inclusive policy document that centred on the implementation of four key strategies, namely, the Baby Friendly

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Initiative, breastfeeding community-based support, an effective system for monitoring breastfeeding rates and the exercise of MoH's and healthcare system's influence to involve other sectors in the protection of breastfeeding. The document also carefully defined the specific responsibilities of the various stakeholders involved in breastfeeding in Quebec.

However, the developmental phase did not evolve without difficulties. Notably, the financial resources provided by the MoH to the Working Group were insufficient, resulting in a delayed timeline (4 years) for the writing of the LD. Also, owing to lack of resources for this initiative, the MoH waited another full year before finally releasing the LD. This decision upset members of the Breastfeeding Coalition, who threatened to publicize the delay. A conflictual dynamic therefore disrupted the Breastfeeding Coalition. The *tour de force* ended with the disbanding of the Breastfeeding Coalition, and the constitution of a new board under the MoH's control – the TCA – which integrated some former members of the Breastfeeding Coalition.

From 2001 to 2009 – implementation phase

This phase began when, immediately after the LD was released, the MoH appointed its first ministerial breastfeeding authority (MBA1) to ensure the policy implementation. The phase finished in 2009, when the Quebec Breastfeeding Movement (Mouvement allaitement du Québec [MAQ]; Table 3) came into existence. Four major events punctuated this eight-year period: (1) the publication of the Quebec Public Health Program in 2003; (2) within the MoH, the transfer of the breastfeeding dossier from the Social Services Division to the Public Health Division in 2006; (3) the resulting change of ministerial breastfeeding authority in 2006; and (4) the emergence of the MAQ.

Among the numerous breastfeeding actors that we could identify during this phase, four may be considered institutional entrepreneurs: MBA1, the CQA, the MoH and the MAQ. One of the study participants described MBA1 as follows:

It is a person [...] who represented everyone. That is, a very, very human woman who was sensitive to our passions, who was as passionate as we were. So ... she was a very credible person. In addition to knowing all the policy decision-makers, we felt she was concerned about our concerns.

Moreover, MBA1 recognized the great scope of action that breastfeeding experts outside the governmental structure possessed:

At the meetings with the Quebec Breastfeeding Committee [CQA], for example, [...], she told people: "Give me a hand, send letters to the Ministry." She [MBA1] encouraged people to mobilize for the dossier to move forward, but ... She asked to exert pressure. She often used this tactic.

MBA1 also pushed enormously for the National Treasure to approve the financial resources needed to implement the LD across the province. This budget boosted the motivation of people on the ground and was perceived as the MoH's political will to enhance breastfeeding in the regions. However, several participants thought that the amount allocated (CA\$900,000 per year) was not at all enough to put in place all the elements proposed in the LD:

It is impossible to do it with this budget. That is why people had to believe that the project was interesting, motivating and mobilizing enough for people to say: "OK! Well, there is not a lot of money. We will see how we can use it at best." Every region used a lot of imagination to decide what they would do with that amount, and despite everything, we moved forward. Sure! Money was not a factor that hurt, but it was not a factor that facilitated the process either because we did not have enough money on the table. This is very, very clear! There is no other project in Quebec of this size that can be compared to breastfeeding for which there has been so little money put in by the Ministry.

Nevertheless, a great deal of enthusiasm prevailed at the earlier stages of the LD implementation, mainly thanks to the CQA. The actors involved in the process, those at the MoH level as well as those at the regional and local levels, worked in close collaboration through the different mechanisms of governance created for the LD (i.e., CQA and TCA) to be properly adopted in the province.

The breastfeeding dossier was further advanced when the Baby Friendly Initiative was included in the 2003 Quebec Public Health Program. Although this initiative was part of the LD, the LD policy was much more ambitious because it also included other interventions:

The Baby Friendly Initiative is something extraordinary, I think, that provides quality of care to all families and young children. On the other hand, it [the BFI] is very, very focused on the healthcare network. So, we want the network to change its practices to improve the quality of services that we give to families, that's good, there, but all that it is not ... it is not enough to change a culture. And to achieve results that will be permanent, where we will really have a change in the health of the population, we must not work solely on the network, we must not work only on a strategy. And it is not for nothing that there were four strategies in the LD, it is that we really wanted to make that cultural change.

In 2006, MBA1 had to step down from her position because of personal issues, and MBA2 was appointed in her place. At the same time, the MoH decided to transfer the breastfeeding dossier to the Public Health Division, which had a much more centralized

functioning. This decision downplayed the role of the CQA and TCA, whose meetings eventually ceased. Breastfeeding provincial actors outside the MoH increasingly felt they had lost the shared decision-making power they enjoyed when the dossier was under the responsibility of the Social Services Division:

So, there, in Public Health, we have entered in a much more rigid framework where the Ministry takes much more room in the decisions and we are executors. We can suggest, advise ... but that is all. Before, we had decision-making power.

Discontent and disappointment became increasingly prevalent among actors outside the MoH, which had progressively transformed their initial strategy of collaborative engagement into one of compliance first and then of contention. The corollary of the latest conflictual exchanges was the creation of the MAQ on April 7, 2009. The MAQ integrated health professionals and other individuals from the regional and local institutional levels deeply committed to the breastfeeding project and dissatisfied with the way the MoH was centralizing power decision-making regarding the LD:

The people at ..., other people I have spoken to, are as disappointed as I am. Then, we would like to restart again, and we will need to restart something. Because we will not let that [the LD] die at the Ministry. That is the idea right now. We say that since the Ministry has abandoned us somewhere, well, we are going to water the plant like this.

In sum, the MAQ, as a collective institutional entrepreneur in the latest stages of the LD implementation phase, held expertise in breastfeeding and strong legitimacy among people at the local and regional levels. The MoH maintained formal authority and control over the financial resources that could advance the breastfeeding dossier. Although these two actors had attributes of power that could be considered complementary, there was no discussion or formal meeting scheduled between them at the time we finished data collection for this study.

Discussion and Conclusion

This research first highlights the crucial role played by a very motivated group of health professionals who, working in an international political context favourable to breastfeeding, behaved as institutional entrepreneurs in triggering the process of formal development of the LD. Their deep shared belief that breastfeeding is the optimal way to feed infants and young children, and their perseverance over years, promoted collective engagement led by the individual who possessed the necessary power attributes (i.e., expertise and discursive legitimacy; Hardy and Phillips 1998) to pave the way for the LD. By finally accepting their request, and formally supporting this group of highly committed professionals, the MoH mobilized its

authority and the financial resources for the materialization of this policy. Consistent with prior work, which highlights perseverance and self-efficacy as personal traits of entrepreneurs (Markman et al. 2005), this finding corroborates the attributes and ways in which to behave for institutional entrepreneurs to trigger institutional change.

Second, the study highlights the capacity of different institutional actors to overcome challenges and begin working together (i.e., collaborate) in the achievement of a common goal. Once the LD was elaborated and released, the relationships between professionals at the local and regional levels and the policy makers involved in the implementation of the LD were characterized by dialogue and cooperation. Several governance structures for the implementation of the LD were set up to support this institutional enterprise, which effectively allowed negotiation and power sharing. Actors who occupied different social positions in the institutional field and possessed different power attributes, but who collectively shared the common interest of facilitating breastfeeding practices, were all engaged in a strategy of collaboration (Hardy and Phillips 1998) in the initial phases of LD implementation.

Third, whereas this investigation confirms the political nature of collective institutional action, it stresses the enduring character of different actors' institutional logics, that is, "the socially constructed, historical patterns of material practices, assumptions, values, beliefs and rules by which individuals produced and reproduce their material subsistence, organize time and space, and provide meaning to their social reality" (Thornton and Ocasio 1999: 804). In our case, the relations among breastfeeding actors, cooperative during the phases of development and early implementation, progressively shifted to conflict when the LD dossier was transferred to the Ministry's Public Health division, whose much more centralized ways of behaving appeared difficult to harmonize with those of professional actors strongly committed to foster a provincial cultural shift toward breastfeeding. The MoH thereby perpetuated a traditional top-down approach, which generated conflictual responses from local and regional professionals. It then followed that the governance structures put in place to elaborate and implement the LD became progressively obsolete. It is important to remember that, according to Hardy and Phillips (1998), conflict cannot occur without the opposite party also having power to confront the one with formal authority. Said differently, in this case, local and regional actors' discursive legitimacy and expertise were powerful attributes that allowed them to react against the top-down decision-making advanced by the actor with formal authority. This finding highlights that the "bridges" that might harmonize the respective institutional actors' logics of action may remain fragile, requiring a continuous process of reconstruction through collective action to reach common goals, which is in line with the dialectical nature of change processes described by Hargrave and Van de Ven (2006).

Fourth, the study points out the inescapable key role that the actor with authority and financial resources plays in institutional change, even if, as in our case study, this actor (i.e., the MoH) rather (re)acted to tenacious pressures from other more proactive players in the provincial breastfeeding landscape during the phase of LD emergence. Without the mobilization of the MoH's power attributes within a logic of collective action, the LD elaboration

and implementation would not have taken place. This reinforces the idea that “[t]he dominant members of a collaboration will be those with greater formal authority, resources and discursive legitimacy” (Phillips et al. 2000: 3).

The study finished at a moment of high tension among breastfeeding actors. The reported progressive deterioration of the relations between these actors responded to their difficulties, particularly those of MoH, to depart from their traditional ways of behaving and keep investing in collaborative strategies of engagement for the sake of breastfeeding in the province. As a way to move forward, we refer to Wijen and Ansari (2006) who suggest that “[i]n situations where groups of stakeholders are concerned about a common issue or problem [...], the only road to achieving change is by developing collaborative solutions [...] and a collective logic of action ...” (p. 1081). That said, the political nature of these processes is pervasive. After this study was completed, the MoH decided to not only integrate the LD in a more general provincial public health policy but also financially support the MAQ shortly after it was created, as well as promote BFHI certification and breastfeeding education programs for healthcare providers.

A final observation arising from this study is the relative absence of mothers in the Quebec’s breastfeeding policy journey so far. There are several reasons sustaining mothers’ decision-making about feeding their babies with breastmilk or formula (Radzyski and Callister 2016) and, likewise, stopping breastfeeding once this practice was initiated (Brown et al. 2014; Morrison et al. 2019). In an era of person-centred care (Bhattacharyya et al. 2019; Santana et al. 2018) and partnerships with health users (Ministère de la Santé et des Services sociaux du Québec 2018), and when the most recent available rates of exclusive breastfeeding for six months or more in Quebec still remain the lowest in Canada (Statistics Canada 2013), mothers should be considered *leading* actors in the development and implementation of breastfeeding-related policies. Therefore, for collaboration around such policies to be reconstructed in this institutional field, health professionals and political actors should take a step forward and fully involve mothers in this institutional endeavour (Semenic et al. 2012). This would ensure more success for institutional work in fostering and maintaining breastfeeding practices (Lawrence and Suddaby 2006).

Despite its considerable scope and rigour, this work has some limitations. Whereas all the study participants were individual or collective key actors in the development of the LD, and given the long period considered, not *all* the study participants were involved in all phases of the history of this policy. In addition, because of its retrospective longitudinal design and the political nature of the phenomenon under scrutiny, our research was based on what participants recalled or decided to share with us. The validity of these data was, however, strengthened with the use of extensive archival material that helped us ensure the congruence of what was said.

This investigation makes two major contributions. For research, it demonstrates the usefulness of empirically applying the concept of institutional entrepreneurship to understand the extremely complex processes of public health policy development and adoption.

Institutional theories constitute a dominant approach in the macrosociological understanding of how organizations operate (Lawrence et al. 2011). However, its uptake by healthcare policy scholars has been rather limited so far. The present work contributes to fulfill this research gap. We do so by addressing one of the major streams of current institutional scholarly work, that is, institutional entrepreneurship. Moreover, this was done in a comprehensive way because the focus was on not only actors (actor-centric accounts) but also their actions (process-centric accounts) over time (Hardy and Maguire 2017). For policy decision-making, the study specifically pointed out that, to achieve their shared goal of protecting, promoting and effectively supporting a public health practice (in this case breastfeeding), all stakeholders have to recognize the need to (re)construct a logic of collective action, which requires mutual recognition and collaborative strategies of engagement in the institutional field.

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Conflict of Interest

Maria Carolina Agnolon and Charo Rodríguez report no conflict of interest. Julie Lauzière was a member of the CQA from mid-2004 to its dissolution in 2006 and has been a member of the MAQ since its inception.

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