CHAPTER 7

Re-Africanizing Breast Feeding as Africa's Gift to Global Health in This Era of Globalization

Kelebogile T. Setiloane

The protection, promotion and support of exclusive breastfeeding in the first six months of life is acknowledged within parenting as the single most critical strategy for reducing child mortality rates in Africa. African countries have some of the highest child undernutrition and mortality rates globally. According to the United Nations Inter-agency Group for Child Mortality Estimation (UNICEF 2011), seven countries that have the highest number of children die before their fifth birthday are in Africa. These countries—Angola, the Central African Republic, Chad, Mali, Nigeria, Sierra Leone, and Somalia—all have an under-five mortality rates above 100 deaths per 1000 live births. According to the World Health Organization (WHO 2004), children in South of the Sahara are more than 14 times more likely to die before the age of five than children of the same age in developed countries. Almost half of all child deaths in this region are linked to undernutrition, which weakens the immune system and makes children more vulnerable to diseases like pneumonia,

K. T. Setiloane (✉)
University of Delaware, Newark, DE, USA
e-mail: ksetil@udel.edu

K. T. Setiloane and A. K. Bangura (eds.), *Africa and Globalization*,
https://doi.org/10.1007/978-3-030-55351-7_7

diarrhea and malaria, causing their high death rates (Ladomenou et al. 2010). Although the underlying causes of undernutrition are complex and solutions varied, exclusive breastfeeding in the first six months of life is one of the best ways to reduce child deaths and improve children's development outcomes. Antibodies in breast milk help prevent some childhood diseases like pneumonia and diarrhea, the two major causes of child deaths among infants, to which children are vulnerable. Studies have also shown that breastfeeding protects against obesity and non-communicable diseases such as asthma and diabetes (Owen et al. 2005) and is closely linked to improved cognitive development in children, which translates into higher productivity levels when they reach working age (Sauls 1979). Investment in the improvement of breastfeeding is therefore a significant step for global health, especially in areas of the globe with large populations and limited resources in the area of maternal and child healthcare.

This chapter gives an overview of the historical, sociopolitical and cultural aspects of breastfeeding in African cultures. The long tradition of breastfeeding in Africa has been changed by colonization and modernization which brought about new cultural values that contributed to a decline in breastfeeding patterns. The benefits of breastfeeding, particularly the spiritual and emotional, have always been appreciated by African cultures and any interventions to improve the breastfeeding patterns must be cognizant of the cultural factors of breastfeeding in this era of globalization.

Theoretical Framework

Critical Social Theory is used to frame this chapter. This theory emerged during the 1920s and 1930s from the Institute of Social Research at the University of Frankfurt in Germany (Wells 1995) and is used to examine relationships of power and underlying structures in society that produce inequalities among groups (Grams and Christ 1992). Critical Social Theory assumes that cultural political and economic circumstances in society are not natural and fixed but are historically established and can be altered. Moreover, the societal structures developed produce ideologies like racism, sexism, and classism which are made to appear inevitable, natural and constant, all the while serving to reinforce interests of the dominant group (Allen 1987). According to Wilson-Thomas, "Critical social theory can be used to assess how socially derived power structures

filter into healthcare practices, both in terms of how deficits in health are assessed and managed, and how they affect communication between nurses and patients" (1995, p. 573).

Critical Social Theory applies to this chapter because it helps in the development of a framework to understand how political and social factors changed the cultural landscape of African countries that in turn affected breastfeeding patterns adversely. As described earlier, the decreased breastfeeding patterns have led to a public health challenge in the high rate of mortality seen in young children. One of the goals of global public health institutions such as the World Health Organization (WHO), United Nations Children's Fund (UNICEF), and others is to reduce the high mortality and morbidity rates seen in African children and to improve their quality of life. Much of the research on breastfeeding in African countries looks only at its biomedical, clinical and nutritional values without addressing it as a social and cultural behavior. By investigating how breastfeeding culture in Africa has changed due to historical and present-day relationship with dominant cultures engendered by globalization, a fuller picture of why and how breastfeeding practices have changed will occur. This will help improve intervention strategies via several avenues, one of which is encouraging health professionals to extend their scope of practice in ways that address public health challenges on a societal level. Health professionals can use Critical Social Theory to consider how they themselves participate in reproducing social structures. Power relations between health professionals and their clients can be uneven in terms of health-related knowledge. By virtue of having biomedical scientific knowledge, health professionals too often believe that they have superior knowledge compared to their clients and believe that the knowledge their clients possess about breastfeeding is inferior. Using the framework of Social Critical Theory helps dismantle this hierarchy of knowledge, by using a dialogic approach in health professionals' encounters with their clients, to nullify the notion that learning cannot be unidirectional and for them to understand that there is much to be learned from their African clients in traditional settings. Being that globalization is the story of the inter-connectedness of all the communities of the globe, traditional communities will have to learn some practices that will make them globally relevant within mega societies. Inversely, mega societies will have to learn from traditional communities as well.

Methodology

This chapter uses qualitative research methods. This type of research, in general terms, focuses on describing, explaining, understanding, and recognizing that human experiences should be interpreted in different ways in order to grasp the decline of breastfeeding among African women (Cottrell 2005). Bangura reframed qualitative ethnographic methodology as emphasizing words, as opposed to numerical values to answer existential questions of Who? What? Where? When and How? (Bangura 2011). In this respect, Denzin and Lincoln also noted that the qualitative research method emphasizes "the socially constructed nature of reality and the value-laden nature of inquiry," and it looks for answers to how the social experiences are created and their meanings to people (2005, p. 10).

Most qualitative research works are based on studies that involve participants studied in their natural surroundings. The approach of the present chapter is different as it is based on research executed by others. Writing was the method of inquiry and used as a strategy of discovery because as a tool it allows one to comparatively analyze breastfeeding behavior from different contexts. At the center of writing as a method of inquiry is the realization that, according to Adams St. Pierre, "language does not just describe reality—does not merely tell it as it is—it also creates it and is not just a mopping up activity at the end of a research project" (2007, p. 963). In this chapter, texts are the data that illuminate how outside forces and their cultural contexts have influenced breastfeeding in Africa. The concepts of postmodern and poststructuralist thinking which see knowledge as being limited by the person trying to generate it (Richardson and St. Pierre 2005) are also evident in this method of inquiry because, according to Richardson and St. Pierre (2005), writing is always connected to the writer's life and is never entirely objective.

Pre-Industrial Traditional Western Culture of Breastfeeding

Traditional pre-industrial infant feeding practices in Western countries were quite similar to those in African countries. Prolonged breastfeeding occurred for at least 18 months, together with supplements of cereals and other substances thought to be protective of the infant's health

(Sellen 2001). During the nineteenth Century, the length of breastfeeding declined due to the increased employment of women during the Industrial Revolution (Cunningham et al. 1991). Breastfeeding also declined at this time because of the loss of traditional support networks on account of the rise in urbanization. Other factors which contributed to the all-time low rates of breastfeeding during the 1960s and 1970s include the increased availability of infant formula, medicalization and the regimented, scientific approach to infant feeding favored by the medical profession, whose members were mostly men (Sellen 2001).

The long tradition of breastfeeding has been neutralized in many parts of 'modern' Africa by the influences of European colonial cultural values legitimized by Christianity, Western money economy, industrialization, migration and urbanization—all forces and outcomes of globalization. The aggressive marketing of commercial breastmilk substitutes also played a critical role in neutralizing the long tradition of breastfeeding in Africa (Cunningham et al. 1991).

Although lactation, the biological production of milk from the body, is a physiological process, the act of breastfeeding, feeding a child breast milk directly from breast to mouth, is a cultural and learned behavior. The cultural context of breastfeeding informs the scope of understanding the normalcy of breastfeeding. Any appreciation of why breastfeeding in Africa has been neutralized while bottle-feeding rates have increased needs to be understood in its historical and cultural context. This allows for policy formulation that will energize the need for healthy breastfeeding to improve, not only in Africa but in all traditional communities of the globe.

Breastfeeding Biology

While there is no right way to breastfeed, some cultural values are better matched with the biology of breastfeeding than others. Newborns have reflexes that help them learn how to breastfeed. Prolactin and Oxytocin, the hormones of breastfeeding, are created and maintained in response to the suckling baby. The more a baby suckles, the higher the level of prolactin and the more milk the mother produces. Oxytocin ensures the delivery of milk through milk ejection from the breast or the 'let down' reflex. Non-industrial societies, in Africa and other parts of the world, that breastfeed their babies throughout the day in response to the needs of the child, and carry the infant close to the body all day, ensures the promotion

of milk production and confidence in feeding from the mother. These cultures are better matched with the biology of breastfeeding.

Cultures of Western Europe where breastfeeding is regimented by the dictates of the mother rather than the child occurs during fixed intervals and the infant is separated from the mother for long periods during the day, creating a decline in milk production by the mother and difficulty in feeding. The greater the distance between breastfeeding worldview and breastfeeding biology, the more likely the difficulty or dissatisfaction with breastfeeding will be. Two key differences that relate to the breastfeeding worldview between the Western and African cultures have to do with social relationships and the respective cultures relationship to nature. The following section summarizes how these two key cultural differences influence the breastfeeding worldviews.

Eurocentric and African Breastfeeding Worldviews Matched to Breastfeeding Biology

In this section, a number of attributes pertaining to different worldviews are analyzed as they relate to breastfeeding. They are: social relationships, breasts as sexual objects, individualism and motherhood, mother-infant relationship, distance from and control of nature, introduction of Christianity, commercial availability and promotion of infant milk. They are discussed sequentially for the sake of clarity.

Social Relationships

Social relationships are approached in two fundamental ways in society. In European societies, relationships are preferred on the basis of one-to-one individual manner. In African cultures, relationship is built on members functioning in the group. Individualistic cultures emphasize the promotion of personal goals, striving towards independence and clearly defined boundaries between individuals (Battersby 2010). Collectivistic culture on the other hand emphasizes promotion of other people's goals, striving to belong or to be a part of the group. Summarizing from the classic work of Max Weber (1905), the individualistic culture of the Western worldview began with the Reformation, which brought in its wake a questioning spirit as well as the asceticism of John Calvin's puritanical ethics. To gain his or her salvation, the individual was exhorted to work hard, be frugal and reinvest. This meant making profit for the sake of making

profit: i.e. capitalism. The optimum development of the individual became the highest good of the society. This infrastructural economic base transformed European communities into congeries of individuals at war with one another for profit. The highest goal of Western culture became the optimum satisfaction of the individual in whatever role—father, mother, sister, brother, wife, husband, young adult. The individual must pursue his or her own interest alone. If anything stands in the way of that principle, it constitutes a burden and a deprivation on the person's time and energies. Although this transition began in Europe, the United States of America provided the most fertile ground for the notion of the optimum development of the individual.

However, the Reformation brought more than economic restructuring. It also brought puritanical morality based on the hypersexualization as well as the demonization of woman as the source of sin. The cover-it-all habits of the Nuns and the long colorless dresses of Amish women are historical reminders of this intense desire by Western culture to see anything relating to sex as sinful and to see the breast as an extension of the female genitalia flaunted to invite satisfaction. This individualistic cultural way of being and puritanical morality has had far reaching consequences that still informs the cultural messages about breastfeeding today and has created major challenges to breastfeeding as described in the following subsection.

Breasts as Sexual Objects

Self-objectification involves placing looks over health, function and value of the self and can lead to an excessive focus on one's appearance. Research has highlighted how women in Western cultures self-objectify their bodies and believe that breastfeeding maternal bodies are incompatible with sexual attractiveness, sexual availability and physical attractiveness (Johnston-Robledo 2007). Also, many women are reluctant to breastfeed because they fear that their breasts' appearance will suffer and that their men will find their lactating breasts undesirable (Moradi 2010).

Consequently, many women in Western cultures feel uncomfortable about breastfeeding in public, evidenced by a vast body of literature that relates this discomfort to the belief that the main role of breasts is to sexually attract the heterosexual male (Hurst 2012; Britton 2009; Kedrowski and Lipscomb 2008; Harris et al. 2003). This is reinforced, in the United States, by attitudes towards breasts being more explicitly than

ever displayed throughout media as sexual items. Field studies around the world by Katherine Dettwyler (1995) have shown that every society holds beliefs about the function(s) of breasts, as well as how private and public spheres are separated by the function of breasts. In the United States, attitudes towards breastfeeding are shaped by the beliefs that the main purpose of breasts is for sex with men; like sex, breastfeeding requires privacy; and breastfeeding is permissible only when infants are very young. Along this theme, Boyer (2011) states that the two core concepts of patriarchy—women's bodies primarily meant to attract men and women's care-work belonging in the home—render breastfeeding as not belonging in the public sphere. Because breastfeeding is a learned behavior or activity, it is very much affected by the lack of exposure and support in many communities in Western cultures where it is seen as a marginal and liminal activity rarely seen and barely discussed. This leads many women to lack the confidence in their ability to breastfeed which results in early cessation of breastfeeding, if it is ever initiated at all.

Individualism and Motherhood

The paradigmatic shift to individualism, which began during the Reformation as described earlier, facilitated the focus of women's lives to emphasize independence, self-fulfillment and control of both one's life and body. Women today are used to and expected to act, like men, as autonomous subjects within the public and private spheres. While reproduction is still central to defining womanhood, the focus on motherhood today is predominantly centered around being an independent individual working in the public sphere rather than a focus on being a housewife and mother as in earlier times (Nicolson et al. 2010). This attitude was reinforced by the first wave of feminism, one of whose major goal was for women to gain access to the public sphere, leaving breastfeeding to be viewed as something that tied mothers down (Thulier 2009). Some researchers (e.g., Schmied and Lupton 2001) connect the dislike some mothers have towards breastfeeding to the definition of the ideal body in Western culture today which is masculine, contained and in control. The female body on the other hand is represented as inferior, in part because lactation, as one of the female fluids, disrupts the ideal of a body that is contained and controllable. Studies have shown that formula feeding is therefore linked to women being in control not only of their bodies, but also their time (see, for example, Lee 2007). This autonomous

and self-controlled cultural environment that many women enter motherhood into today is in stark contrast to the interdependent intensive and body altering relationship, between mother and child, that breastfeeding demands.

Mother-Infant Relationship

In those cultures where individualism is highly preferred, mother and baby are seen as two separate individuals in need of independence from each other with the result that children are taught from early infancy to be independent. These beliefs and practices facilitate the separation of mother and child, thereby undermining the breastfeeding practice. Workplaces are not compatible with mothering or breastfeeding and it is now not unusual for mothers and babies to spend large amounts of the day away from each other through the use of daycare and babysitters. Bottles are introduced very early in infancy so that others can feed the baby. Pacifiers are introduced so that the child will not depend on the mother for all his/her suckling needs and babies and children commonly sleep in a separate bed and room from the parents and are expected to sleep through the night. There is also the common belief in Western cultures that mothers should not 'spoil' their children by picking them up when they cry or are hungry. Children should be trained and put on a schedule as to when to breastfeed rather than according to when the baby feels hungry, which is the biological timing and need (Manne 2005).

Distance from and Control of Nature

The relationship between culture and nature contributes to how well a particular culture will accommodate the biology of breastfeeding. Western cultures can generally be described as having mastery over nature while African and other more traditional cultures may be described as living in harmony with nature. The belief that humans are the masters of nature is the foundation of Western culture's reverence for science and the medicalization of infant feeding or the belief that scientists can create an infant food that is at least equivalent or superior to the milk produced by nature (Markus and Kitayama 1991).

In her dissertation on the history of infant feeding in the United States, Berney (1998) shows that the rise of technology took infant feeding out of the realm of mothers and placed it into the hands of science, in the

guise of male doctors, in order to control, civilize and modernize it. The invention of book printing in Europe helped to spread the ideas of regimenting the infant at the breast with the idea by some German doctors that overfeeding was the cause of gastrointestinal diseases, and the, warning that "Nothing is more apt to disorder the child than suckling it too often…," British physician William Cadogan advocated for moving the medical discipline of infant feeding into the hands of "men of sense rather than foolish unlearned women" and his advice book from 1749 recommended only four feedings in 24 hours and no night time nursing (Riordan and Wambach 2010, p. 57). Berney (1998) outlines that from around the turn of the century on, like the factory, breastfeeding had to be carefully managed and the experts of the time warned that a mother's milk quality could be altered by her being too thin or too fat, too young or too old, by having constipation or imperfect teeth.

Even today, breastfeeding in Western countries is still largely controlled with infant feeding, including breastfeeding approached from a scientific angle (Wallace and Chason 2007). Rather than being conceptualized as a practice that involves instinct, communal knowledge and experience as in traditional cultures, it is viewed as requiring biomedical knowledge. According to Dykes, even a return to a natural biology in mothering and infant feeding practices over the last few decades, for example, feeding on demand, mother-infant bonding and exclusive breastfeeding, the emphasis is on the nutritional and health benefits of the milk, separated from the women who produce it (Dykes 2005, p. 2285). This is in stark contrast to non-Western relational understanding of breastfeeding that encompasses intimacy, closeness and nurture rather than a "a one-way non-reciprocal transmission of health" view of breastfeeding (Dykes 2005, p. 2287). Even though in the 1970s women reclaimed breastfeeding knowledge, it is now once again perceived as something to be gained from health experts rather than from women and breastfeeding mothers themselves. In so doing, breastfeeding is further medicalized and effectively silences the redevelopment of the emotional and social aspects of breastfeeding. Dykes (2005) highlights how this medicalization of breastfeeding forms the basis to the challenges that many Western mothers experience: a lack of confidence in their ability to breastfeed; a distrust in the quality and quantity of their own milk, and an over-reliance on the rules and advice from perceived experts rather than trusting themselves to respond to their babies needs by learning to watch for cues from their child's natural course of development.

The shift of Western culture away from breastfeeding was also facilitated, from the late nineteenth Century onwards, by a move towards clear boundaries between human culture and animal nature (Berney 1998). While nature had been viewed positively in earlier times, by the late nineteenth Century, it was something that warranted control. This resulted in a change in the perceptions of women's bodies such that reproductive activities (menstruation, gestation and lactation) were placed in a negative light, and referred to in terms of disease and 'animality' in consumer products, and popular images of the time (Cox et al. 2007). Breastfeeding was viewed by many as primitive and the milk as dirty (Battersby 2007; Cox et al. 2007). Today, participants in a study by Mahon-Daly and Andrews (2002) felt that leaking was a sign to others that they are not coping with motherhood, and many felt ashamed and unclean. Researchers, Britton (2009) and Battersby (2007) noted that rooms designated for nursing are often combined with, or adjacent to diaper changing rooms and/or restrooms, which makes the connection of breastfeeding with excretion (Dowling and Pontin 2012).

White upper-class women were thought to be too refined and civilized to breastfeed as opposed to those of the uneducated and barbarian lower classes (Forbes et al. 2003). Around this same time, the middle class began expressing disgust at the sight of women nursing their babies, and photographs depicting breastfeeding showed mostly women from marginalized groups, such as migrant workers or poor immigrants.

Some of the preceding cultural values have contributed to the decline of breastfeeding in Western countries and are now seen in populations going through modernization—the process of change toward social economic and political systems that were established in Western Europe and North America—initiated through colonization. Traditional African culture was compatible with breastfeeding biology, described earlier, until colonization took over and changed the cultural landscape from traditional to at best a hybrid culture, particularly in urban settings. Today in many parts of Africa, bottle feeding may hold higher social status while breastfeeding is being relegated to being a shameful exercise that equates the breastfeeding mother as being uneducated and of low social status (Dop and Simondon 2001). These changing values affecting infant feeding behavior are an example of how the African environment has changed because of the economic, social and political changes that have occurred through modernization brought about by colonization. The

major factors facilitating these changes in values include the introduction of Christian religion, female participation in the modern labor force, the commercial availability and promotion of processed milks; urbanization and modernization. While the relative importance of these factors might differ among individual African countries, to be discussed next, the introduction of Christianity was a major avenue to the change in cultural values affecting breastfeeding.

Introduction of Christianity

When the Europeans came to Africa as missionaries, their sin-centric culture saw many activities in which Africans engaged as sinful. Religion to the Westerner was an institution that was compartmentalized and made operable only on Sundays (Manala 2013). Sex was condemned and the European historical response to it was to suppress it. Anything relating to sex was seen by the missionaries as sinful and the breast was seen as an extension of sex. African traditional religions are embedded in everyday activity and are the foundation of rites of passage as the individual moved from one phase of life to another from birth to infancy, young adulthood to marriage and adulthood, old age and finally death and transition into 'ancestorhood' (Babatunde 1992). Traditional African cultures saw sex as an aspect of life that is to be enjoyed and that brought sacred marriage responsibilities of memorializing the dead through the transfer of names from the dead ancestors to new born babies raised in the likeness of those ancestors whose name the children now bear (Babatunde 1998). Giving birth to children and nurturing them to become responsible achieving members of the society was the price that must be paid for enjoying sex. The breast for the traditional African woman is not a part of the body used to trap men for sex, but rather is seen as the seat of nurture in the body of the mother. It is for nursing children who are the most valuable gifts that mortal humans have to perpetuate themselves. This is why the African worldview identifies giving birth to and nurturing the well-brought up child as the highest good and the most valuable historical marker to the living of the life and achievements of those who have passed on (Babatunde 1998).

Traditional African women's confident and powerful management of breastfeeding and their commitment to the practice was seen, by society, as a labor and a duty of motherhood (King et al. 2010). Moreover, in

the communal nature of African culture, other members of society played a role in supporting the breastfeeding mother. Grandmothers and family members, including fathers, supported breastfeeding from support with food and rest and infant care through to particular religious, sexual and social observances. Breastfeeding women and their infants were treated carefully and with special regard (Babatunde 1992).

These positive associations of the high status and care for breastfeeding women separated them from the cultures of breastfeeding amongst White women in Europe. African cultural values and practices that supported breastfeeding were regarded by the missionaries as curiosities to succumb to the 'superior' Western ways of being rather than cultural practices that are legitimate and workable within their own African social structural circumstance and environment. There was a tendency to coopt middle class African women to adopt a denigrating attitude towards legitimate and more effective African cultural parenting styles in preference for White middle-class practices. This is also seen today and seems to be on the rise, an example of which is seen in the article by Pelesa Thinane-Epondo in the *Mail and Guardian Africa* (March 20, 2016) captioned "Why are a woman's breasts becoming objects of shame in Africa."

Commercial Availability and Promotion of Infant Milk Formula

When infant formula was introduced to African societies, it entrenched Eurocentric ideas in the guise of modernization to make European parenting the norm which should be copied first by recipients of Western Culture, education and life style, and then by others who see those who have copied this Western culture as 'role models.' The tragedy now is that the same people whose interests forced a reduction in the level of breastfeeding in Africa now want to teach African mothers why they must breastfeed.

Female Participation in the Modern Labor Force

The traditional economic roles of African women included agricultural farming, trading and home-based activities. These activities were compatible with breastfeeding biology as they allowed the young infant to be with the mother at all times and enabled mothers to, when necessary, adjust their routine to avoid separation from her baby. Entering the modern employment sector, often in the urban setting, has meant that

babies no longer accompany their mothers to work, and a decline in breastfeeding among working mothers has ensued even though maternity benefits provide for three months of paid leave. On returning to work, mothers are faced with numerous problems including the loss of both the extended family arrangements for childcare and the traditional breastfeeding support networks. This may result in partial or total breastfeeding failure necessitating the introduction of infant formula, which may also come from a desire to imitate the elite for social prestige and to be modern, coupled with negative images of breastfeeding as primitive. Today African mothers employed in the modern labor force in busy African cities find it hard to balance work and motherhood, which helps explain the drop in the duration of breastfeeding seen in Africa.

Conclusion and Recommendations

Although African traditional ways of child and maternal care may not express breastfeeding activities in stark biomedical terms, it certainly identifies breastfeeding as one of the unique practices that serve as the foundation of the wholesomeness, integrity and emotional comfort that underpin the sentiment that 'mother is gold' which is found in many African cultures. Biomedical research carried out in the 1950s in West Africa, particularly by the University of Ibadan Medical College, reinforced the research finding that between age one day and 2 years, African children who were exposed to African traditional practices of breastfeeding and other traditional child rearing practices outperformed Western children (Morley et al. 1968). African practices that enhance the closeness of mother and child like, being carried on the mother's back, and sleeping next to her at night, facilitates superior developmental outcomes of children. On the other hand, children from cultures where individualism is forced by discouraging the close bond between mother and child, limited, regimented or no breastfeeding and isolation of the child to sleep in his/her own room reduces the opportunity for laying a foundation of trust intimacy and bonding necessary for the healthy emotional and psychological development of the child.

This Chapter outlines the background against which breastfeeding changes have occurred in individual oriented Western countries and how, through the process of colonization, some of these changes were transmitted to the more communal African setting producing changing

behaviors analogous to those observed in Western countries. Factors producing these changed breastfeeding behaviors include change from African Traditional Religions to Christianity, urbanization, increased female participation in the labor force and increased availability of infant formula and its promotion by companies and the health sector. After the ordeal of Western brainwashing, mothers in African countries are still willing to breastfeed as evidenced by the high (over 90%) initiation rates of breastfeeding seen in all African countries (UNICEF 2011) even while their harsh daily routine, born out of economic necessity, precludes them from breastfeeding exclusively for more than a limited period. There is an obvious need for women to be able both to work and to breastfeed but employment in the modem labor sector appears at present to be incompatible with prolonged lactation. This will involve legislation for improved maternity benefits and the establishment of daycare centers at or near workplaces with spaces for mothers to breastfeed and access to breast pumps and refrigerators to store the breastmilk for their children (Dop and Simondon 2001). These are some of the measures that need to be widely enforced for breastfeeding duration to increase more widely.

Health educators in the health sector need to offer breastfeeding advice based on the realities of mother's daily lives which may often be quite different culturally from their own. The cultural and sociocultural value of breast milk should be respected rather than be made into a problem by objectifying and distancing the mothers of that culture. Greater progress can be made by viewing the barriers to breastfeeding as resulting not from the traditional mother's culture but from the values and beliefs inherent in the Western biomedical culture (Setiloane 2016). Clear policy directive and extensive in-service training for health professionals and administrators are needed in cultural competency that includes the socio-political and historical aspects of breastfeeding which has not been sufficiently attended to by the academic world. Advice offered to mothers should seek to enhance their confidence in their ability to initiate and maintain breastfeeding, rather than undermine it by setting impractical and unattainable goals (Dykes 2005).

In countries with rapidly expanding urban populations and disruption of traditional support networks, voluntary groups of mothers can assist in the provision of close personal support by sharing positive breastfeeding experiences. Health personnel should therefore actively encourage, assist

and foster such groups, and not view them as an intrusion into their professional domain.

On a wider scale, public awareness on the benefits of breastfeeding can be heightened through mass media promotional campaigns. This approach which includes promotional and educational programs must also be sensitive to the realities of the lifestyles of economically-disadvantaged mothers and may achieve greater relevance and, hence, greater success when the target groups for education are actively involved in problem identification, problem solving, and message development. Several campaigns have shown national celebrities who breastfeed their babies. This provides a positive and attractive image for breastfeeding. The leadership role of elite women also needs to be harnessed. For example, it is noteworthy that the resurgence of breastfeeding in Europe, Australasia and North America was led by young elite women and that their example is now being emulated by other social groups.

Particularly important is the role model of health workers themselves who must take the lead by breastfeeding their own babies. A greater recognition of the health sector's role in influencing infant feeding practices is opportune. As experience in Western countries has shown, the combined influence of well-informed elite mothers, the dissemination of knowledge on the pertinence of breastfeeding, and the progressive element in the health sector can lead to the resurgence in breastfeeding. This successful teamwork could prove equally effective in the Global South.

References

Adams St. Pierre, E. (2007). Writing as method. In G. Ritzer (Ed.), *The Blackwell Encyclopedia of Sociology* (Vol. X, ST-Z , pp. 5296–5298). Oxford, UK: Blackwell Publishing.

Allen, D. G. (1987). Critical social theory as a model for analyzing ethical issues in family and community health. *Family & Community Health, 10,* 63–72.

Babatunde, E. D. (1992). *A Critical Study of Bini and Yoruba Value Systems of Nigeria in Change: Culture, Religion, and the Self*. Lewiston, NY: Edwin Mellen Press.

Babatunde, E. D. (1998). *Women's Rights Versus Women's Rites*. Trenton, NJ: Africa World Press.

Bangura, A. K. (2011). *African-Centered Research Methodologies: From Ancient Times to the Present*. San Diego, CA: Cognella.

Battersby, S. (2007). Not in public please: Breastfeeding as dirty work in the UK. In M. Kirkham (Ed.), *Exploring the Dirty Side of Women's Health*. London, UK: Routledge.

Battersby, S. (2010). Understanding the social and cultural influences on breastfeeding today. *Journal of Family Health Care, 20,* 128–131.

Berney, A. (1998). *Reforming the maternal breast: Infant feeding and American culture, 1870–1940*. Doctoral dissertation, University of Delaware, 1999. Retrieved on March 29, 2018, from Union Institute & University Online Library Service, http://www.myunion.edu/library.

Britton, C. (2009). Breastfeeding: A natural phenomenon or a cultural construct? In C. Squire (Ed.), *The Social Context of Birth*. Abingdon, UK: Radcliffe Publishing.

Boyer, K. (2011). The way to break the taboo is to do the taboo thing: Breastfeeding in public and citizen-activism in the UK. *Health & Place, 17,* 30–437.

Cottrell, S. (2005). *Critical Thinking Skills: Developing Effective Analysis and Argument*. London: Palgrave Macmillan.

Cottrell, R., & McKenzie, J. (2005). *Health Promotion & Education Research Methods*. Sudbury, MA: Jones and Bartlett.

Cox, C., Goldenberg, R. J., Arndt, J., & Pyszczynski, T. (2007). Mother's milk: An existential perspective on negative reactions to breastfeeding. *Personality and Social Psychology Bulletin, 33,* 110–122.

Cunningham, A., Jelliffe, D., & Jelliffe, P. (1991). Breastfeeding and health in the 1980s: A global epidemiologic review. *Journal of Pediatrics, 118,* 659–666.

Denzin, N., & Lincoln, Y. (Eds.). (2005). *Qualitative Research* (3rd ed.). Thousand Oaks, CA: Sage.

Dettwyler, K. A. (1995). Beauty and the breast: The cultural context of breastfeeding in the United States. In P. Stuart-Macadam & K. A. Dettwyler (Eds.), *Breastfeeding Biocultural Perspectives*. New York, NY: Aldine de Guyter.

Dop, M. C., & Simondon, K. B. (2001). Breastfeeding in sub-Saharan Africa: Outlook for 2000. *Public Health Nutrition, 4,* 929–930.

Dowling, S., & Pontin, D. (2012). Breastfeeding in public: Women's bodies, women's milk. In P. Hall, et al. (Eds.), *Beyond Health, Beyond Choice: Breastfeeding Constraints and Realities*. New Brunswick, NJ: Rutgers University Press.

Dykes, F. (2005). 'Supply' and 'demand': Breastfeeding as labour. *Social Science and Medicine, 60,* 2283–2293.

Forbes, G., et al. (2003). Perceptions of the woman who breastfeeds: The role of erotophobia, sexism, and attitudinal variables. *Sex Roles, 49,* 379–388.

Fredrickson, B., & Tom Roberts, T.-A. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly, 21,* 173–206.

Grams, K., & Christ, M. A. (1992). Faculty work load formulas in nursing education: A critical theory perspective. *Journal of Professional Nursing, 8,* 96–104.

Harris, M., Nayda, R., & Summers, A. (2003). Breasts and breastfeeding: Perspectives of women in the early months after birthing. *Breastfeeding Review, 11,* 21–29.

Hurst, C. G. (2012). Sexual or maternal breasts? A feminist view of the contested right to breastfeed publicly. In P. Hall, et al. (Eds.), *Beyond Health, Beyond Choice: Breastfeeding Constraints and Realities*. New Brunswick, NJ: Rutgers University Press.

Johnston, M. L., & Esposito, N. (2007). Barriers and facilitators for breastfeeding among working women in the United States. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 36,* 9–20.

Johnston-Robledo, I., Wares, S., Fricker, J., & Pasek, L. (2007). Indecent exposure: Self-objectification and young women's attitudes toward breastfeeding. *Sex Roles: A Journal of Research, 56*(7–8), 429–437.

Kedrowski, K., & Lipscomb, M. (2008). *Breastfeeding Rights in the United States*. Westport, CT: Praeger Publishers.

King, E., Cyrus, S., & Snilstveit, B. (2010). Interventions to promote social cohesion in sub-Saharan Africa. *Journal of Development Effectiveness, 2,* 336–370.

Ladomenou, F., Moschandreas, J., & Kafatos, A. (2010). Protective effect of exclusive breastfeeding against infections during infancy: A prospective study. *Archives of Disease in Childhood, 95,* 1004–1008.

Lee, E. (2007). Health, morality, and infant feeding: British mothers' experiences of formula milk use in the early weeks. *Sociology of Health & Illness, 29,* 1075–1090.

Lööf-Johanson, M., Foldevi, M., & Rudebeck, C. E. (2013). Breastfeeding as a specific value in women's lives: The experiences and decisions of breastfeeding women. *Breastfeeding Medicine, 8,* 38–44.

Mahon-Daly, P., & Andrews, G. (2002). Liminality and breastfeeding: Women negotiating space and two bodies. *Health & Place, 8,* 61–76.

Manala, M. (2013). The impact of Christianity on sub-Saharan Africa. *Studia Historiae Ecclesiasticae, 39,* 285–302.

Manne, A. (2005). *Motherhood: How Should We Care for Our Children?* Crows Nest, Australia: Allen & Unwin.

Markus, H., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotions, and motivation. *Psychological Review, 98,* 224–225.

Moradi, B. (2010). Addressing gender and cultural diversity in body image: Objectification theory as a framework for integrating theories and grounding research. *Sex Roles, 63,* 138–148.

Morley, D., Bicknel, J., & Underwood, M. (1968). Factors influencing the growth and nutritional status of infants and young children in a Nigerian village. *Transactions of the Royal Society of Tropical Medicine and Hygiene, 62,* 164–195.

Nicolson, P., Fox, R., & Heffernan, K. (2010). Constructions of pregnant and postnatal embodiment across three generations: Mothers', daughters' and others' experiences of the transition to motherhood. *Journal of Health Psychology, 15,* 575–585.

Owen, C., Richard, M., & Whincot, P. (2005). Effect of infant feeding on the risk of obesity across the life course: A quantitative review of published evidence. *Pediatrics, 115,* 1367–1377.

Richardson, L., & St. Pierre, E. A. (2005). Writing: A method of inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (3rd ed.). Thousand Oaks, CA: Sage.

Riordan, J., & Wambach, K. (2010). *Breastfeeding and Human Lactation* (4th ed.). Burlington, MA: Jones and Bartlett Publishers.

Sauls, H. (1979). Potential effect of demographic and other variables in studies comparing morbidity of breastfed and bottle-fed infants. *Pediatrics, 64,* 523–527.

Schmied, V., & Lupton, D. (2001). Blurring the boundaries: Breastfeeding and maternal subjectivity. *Sociology of Health & Illness, 23,* 234–250.

Sellen, D. (2001). Comparison of infant feeding patterns reported for nonindustrial populations with current recommendations. *The Journal of Nutrition, 131,* 2707–2715.

Setiloane, K. T. (2016). Beyond the melting pot and salad bowl views of cultural diversity: Advancing cultural diversity of nutrition educators. *Journal of Nutrition Education and Behavior, 48,* 664–666.

Thulier, D. (2009). Breastfeeding in America: A history of influencing factors. *Journal of Human Lactation, 25,* 85–94.

United Nations Children's Fund (UNICEF). (2011). *Levels & Trends in Child Mortality: Report 2011, Estimates Developed by the UN Inter-Agency Group for Child Morality Estimation.* New York, NY: United Nations Children's Fund.

Wallace, L. E., & Chason, H. (2007). Infant feeding in the modern world: Medicalization and the maternal body. *Sociological Spectrum, 27,* 405–438.

Weber, M. (1905). *The Protestant Ethic and the Spirit of Capitalism.* Crows Nest, Australia: Allen & Unwin.

Wells, D. (1995). The importance of critical theory to nursing: A description using research concerning decision-making. *Canadian Journal of Nursing Research, 27,* 45–58.

Wilson-Thomas, L. (1995). Applying critical social theory in nursing education to bridge the gap between theory, research and practice. *Journal of Advanced Nursing, 21,* 568–575.

World Health Organization (WHO) Infant and Young Child Feeding. (2004). *Guide for National Implementation of the Global Strategy for Infant and Young Child Feeding*. Geneva, Switzerland: World Health Organization.