Editorial

The ideational dimension of maternal and infant nutrition: the importance of conflicting values

In their study ('Exploring Middle Eastern Mothers' Perceptions and Experiences of Breastfeeding in Canada: an Ethnographic Study'), Jessri, Farmer and Olson present research conducted with immigrant women, using qualitative data collection and analysis techniques (Jessri *et al.* 2012). The authors identify the ways in which religion and cultural beliefs affect breastfeeding behaviours, as well as the nature of the women's interactions with the health system in Edmonton, Canada. The paper also contains data on the beliefs and attitudes of frontline health providers, which were obtained in connection with the focus on the experiences of the women. This paper, which contributes to contemporary knowledge and understanding about behavioural aspects of breastfeeding, is important for several reasons.

The study highlights an ethnic, migrant minority that has been largely invisible to the nutrition and public health community, at least in North America, even to those who are generally concerned with minority issues. As useful as it is to correct this gap in attention to a minority whose needs and concerns should be more widely recognised, the contributions of this paper go beyond that purpose, and my motivation in writing this editorial is to call attention to these latter.

Firstly, the authors have contributed to the development of social theory in maternal and infant nutrition by drawing attention to and illustrating a ubiquitous feature of the role of ideational elements as determinants of nutrition behaviour – specifically the dynamic and often conflicting nature of these determinants. The concept of 'value conflicts' and the analysis of conflicting values have a long history in anthropological and sociological thinking (c.f. Parsons 1954; Harris 1968; Bardi & Schwartz 2003). In addition to theoretical scholarship aimed at explicating the nature and effects of conflicting values on behaviour, value conflicts have been examined in relation to a number of areas of public policy and social action. In public health contexts, explicit attention to value conflicts has been given in studies of preventive

health behaviours, patient responses to treatment and health care provider behaviour. In nutrition, interest in the dynamics of value conflict is being incorporated into research on obesity and weight management, as well as in relation to the psychology of food marketing (cf. Hauser *et al.* 2011).

The paper by Jessri, Farmer and Olson provides an insightful contribution to understanding the importance of value conflicts in nutrition behaviour. Specifically they articulate the behavioural dilemmas that women face as a consequence of conflicts that arise from the interactions of Islamic religious determinants, Arabic cultural determinants and the Canadian bio-medical culture within which infant feeding occurs. For example, the religious value of breastfeeding for 24 months is concordant with best practice recommendations but discordant with frontline health worker values and Canadian cultural values. The cultural emphasis on prelacteal feeds and continued feeding of sweet foods from birth is discordant with exclusive breastfeeding recommendations. All of these determinants fall within the general category of the 'ideational' domain in an ecological or biocultural framework for nutrition (Pelto *et al.* 2012). For women of Middle Eastern origin, who are adapting to life in Canada, all of these elements – religious, cultural and biomedical – exert powerful influences on their behaviour. Recognising that they are often discordant, that they encompass significant internal and external value conflicts, is not only helpful for understanding the women's infant feeding behaviours, it also draws attention to the importance of examining value conflict more broadly in our studies in maternal and child nutrition.

Secondly, a feature of the report that should trigger concern among the wider MCN community is readily apparent in the quotes from the interviews with the health professionals. In addition to revealing lack of knowledge about breastfeeding, they also reflect attitudes that undermine good breastfeeding practices and breastfeeding in general. The quotations are particularly disturbing when they are viewed together

with the authors' description of health worker–mother interactions, as seen through the eyes of the mothers. In earlier years, the problem of disinterested or even openly hostile attitudes towards breastfeeding on the part of frontline health workers had high salience in the maternal and child nutrition community, and considerable efforts were invested in attempting to change attitudes and behaviours that were counter to the promotion of breastfeeding. Have these efforts been reduced in the face of budget cuts? Perhaps we have become complacent and often make the assumption that the problems have been essentially overcome? Many of us had hoped that, by now, a pro-breastfeeding cultural milieu has become normative in the health community. The findings in this paper give one pause. It is unlikely that the negative attitudes of some of the health workers in Edmonton are unique to that place. Thus, another contribution of the paper by Jessri and her colleagues is that it is a wake-up call – we have to do a lot more to educate and persuade the medical community about the importance of breastfeeding for infant and maternal health and well-being.

Thirdly, although this paper is focused explicitly on breastfeeding, it also contributes information on motivations for early introduction of complementary foods. Breastfeeding and complementary feeding are so intimately linked behaviourally that it is, in fact, difficult to discuss one without at least passing attention to the other. In this case, the authors' revelations concerning the women's reasons for early introduction of foods, and specifically their concern about inadequate milk should remind us that the whole issue of 'milk insufficiency' is still very current. It is not receiving the kind of research attention or clinical management attention that it deserves.

A fourth contribution of the paper is the excellent description of the qualitative methodology the authors used to collect and analyse their data. Most important is the effective way in which they use direct quotations from their respondents throughout the

paper. Typically, authors provide fewer examples to illustrate their points than we find in this paper. Although it adds to the length of the paper, each of the quotations contributes to supporting the arguments. In addition to providing empirical data to support the authors' conclusions, the effective and extensive use of quotations provides an excellent model for others on how to write qualitative papers that rely heavily on data in respondent statements for evidence-based conclusions. Moreover, it provides a means of giving women a voice, and by listening to their voices we not only gain insights and understanding, but we also build empathy.

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