

Breastfeeding and popular aetiology in the Sahel*



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Abstract

Two views about breastfeeding and the resumption of intercourse after a birth are found to prevail in Bamako and Bobo-Dioulasso, two cities of the Sahel region of Africa: that sexual relations may spoil the milk; and that a child should be weaned when the woman is pregnant again. Both beliefs provide a rationale to abstain, but the postpartum taboo has been greatly reduced in the area, and the second belief is the most important. 'Bad milk' serves as an explanation for many of the diarrhoeas and diseases of nutritional origin that affect infants and children. Traditional medical treatments of diarrhoea and protein calorie malnutrition are consistent with the popular aetiology. The acceptance of modern techniques of infant care in this area may well be predicated on the diffusion of an alternative model of disease causation.

All populations of sub-Saharan Africa share a concern for the proper spacing of births. In one way or another, the ultimate goal of parents in spacing is to ensure the health of their children. They see particular dangers in pregnancies that are following too closely upon one another. Women are fearful of becoming pregnant too soon because they feel that some harm might be caused to the prior or subsequent child, and public opinion encourages them in delaying the next child. The main alleged victims of close spacing are not the mother or the foetus, as would be the case in the 'maternal depletion syndrome' of Western demographic literature; the child already born is the one perceived to be at special risk. Several related mechanisms are invoked, which are in part responsible for the taboo on intercourse and the norm of prolonged abstinence after a birth that characterize much of Africa. These include two distinct beliefs linked with breastfeeding: 'poisoning of the milk' by intercourse, and the notion that a new pregnancy will cause the mother's milk to turn bad.

Early resumption of sexual relations may in itself be seen as dangerous. In their extensive review of abstinence in sub-Saharan Africa, Schoenmaeckers et al. (1981) mention the belief of the Shona of Zimbabwe that semen affects the milk (p. 55), and the belief of the Twi of Ghana that intercourse may affect the quality of the mother's milk (p. 57). According to Isenalumhe and Oviawe (1986:683),

...among the Binis of Bendel State, nursing mothers are forbidden to have sexual intercourse until the baby is about 2 years old or at least can walk. The belief is that if a nursing mother has sexual intercourse, her baby 'sucks the semen from her breasts' and that can cause various illnesses, including PCM [protein calorie malnutrition] in the baby.

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And among the Yoruba of Nigeria, 'it is widely believed that the man's sperm actually enters and poisons the milk which is being fed to the baby' (Caldwell & Caldwell 1977:199; see also Orubuloye 1981:225.)

Another view is perhaps even more widespread. According to Baba of Karo, an old Hausa woman whose memoirs were collected by M.F. Smith (1954:154): 'It is not sleeping with the husband that spoils [the] milk, it is the pregnancy that does that'. 'Bad milk', in this view, results from a new conception. In a survey of Yoruba women in Ibadan, for example, they 'were insistent that pregnancy arising during lactation would prove injurious to both the suckling child and the one newly conceived' (Maclean 1979:227-8). Although the etymology is contested, the word *kwashiorkor* was said by the Western doctors who identified the syndrome, to mean 'the disease of the deposed baby when the next one is born' (Conco 1979:76, citing Sir P.H. Manson-Bahr's *Manson's Tropical Diseases*). Names for a similar disease in many African cultures reflect a concern for spacing patterns and the dangers inherent in nursing after having conceived a new child. For example, in his study on popular medicine in Bamako (one of the areas investigated in this paper), D. TraorŽ (1966) describes a clinical condition called *sŽrŽ* or *dendŽ*, the disease contracted by any child suckling the milk of a pregnant nurse: the child is strongly anemic, thin, sickly, sensitive to cold [*frileux*]; it has diarrhoea and vomits after each suckling' (cited by Erny 1972:298).

We take it for granted here that the popular aetiology is mistaken: that intercourse will not spoil the milk, that diarrhoea has an infectious origin, that continuing to nurse a child while pregnant will be less damaging to the health of the nursling than premature weaning since calorie protein deficiency is likely to be made worse by the absence of maternal milk. If so, then the popular beliefs about 'bad milk' raise a number of important health issues, because they relate to a stage of life where the child is potentially very vulnerable. The belief in 'spoiling the milk' has been frequently reported in Africa; but little attention has been paid to the health consequences or the implications of this belief for the acceptance of public programs and the resort to modern forms of treatment, including oral rehydration. We consider some of those issues in the conclusion of this paper. In the body of the paper, we want to tackle the following factual issues.

What is meant by the terms 'spoiling' or 'poisoning' the milk? Through what mechanism is intercourse believed to affect the mother's milk? Is semen reputed to enter the woman's bloodstream? But the theory that sperm poisons the milk is by no means universal in Africa. Abstinence for spacing may be justified by the fear of becoming pregnant, and of the consequences for the young child already born. It is widely believed that a woman should wean the baby immediately after a new pregnancy has started, and this is similarly related to a concern to avoid the diseases of childhood, including diarrhoea and nutritional deficiency. 'Pregnant milk' is held to be poisonous.

What are the symptoms held to result from bad milk? The assumed effect might be unsatisfactory physical development of the child or the numerous episodes of diarrhoea which are among the most visible problems of the early years of life. This raises the possibility that common diarrhoea will be blamed on the improper conduct of mothers, who will be accused of having resumed intercourse prematurely because they are 'sex crazy'. One explanatory model of diarrhoea that recurs in many cultures, particularly in Africa, involves 'moral misbehaviour, including deeds of the sick person or a sick child's parents, especially promiscuous sex and sexual intercourse, or pregnancy while breastfeeding' (Weiss 1988:7).

What are the traditional forms of treatment, and how do they correspond to beliefs about aetiology? Some women hold that there are ways to avoid the consequences of bad milk, including traditional and Western remedies. In other instances, women might believe that early weaning of a child is preferable to breastfeeding after intercourse has been resumed. Breastfeeding may be

discontinued if a child becomes ill with diarrhoea 'at a time when he or she is most vulnerable to the loss of fluids and nutrients in the breast-milk' (De Zoysa et al. 1984: 731). This is what we observed in a survey in Yaoundé (van de Walle 1987), where many young mothers stopped giving the breast or even water to the baby who was sick with diarrhoea because they were convinced that more liquid would increase the symptoms.

To study these issues, we turn to the results of two qualitative surveys on postpartum behaviour conducted in Bobo-Dioulasso, a large secondary city in Burkina Faso, and in Bamako, the capital of Mali. The survey methodology was described by Francine van de Walle (1987); it involved loosely structured taped interviews of mothers whose child had survived until its second birthday. The popular aetiology of childhood diseases is quite varied among ethnic groups, and is probably different in rural and urban populations of the same country. This diversity appears in the context of the two surveys. Both cities belong to the Sahel region, and are approximately 500 kilometres apart; their inhabitants are related by culture and language. Both are predominantly Moslem, although there is a large Christian minority in Bobo-Dioulasso. There were three clearly defined groups of interviews involving respectively 80 women of diverse ethnic groups in Bamako, and 40 Bobo women and 38 Mossi women in Bobo-Dioulasso. The Mossi are the largest group in Burkina Faso, but they are migrants to Bobo-Dioulasso, and are away from their region of origin to the east; the Bobo are indigenous to the region, and maintain frequent contacts with the countryside (for a description of these two groups, see Benoit 1982). The surveyed women reflected the characteristics of the married population of the two cities: more than two thirds had no schooling, well below ten per cent worked for wages, and four out of ten lived in polygamous unions.

The issues that involve breastfeeding and child disease can be regrouped in two main categories: may a woman have relations during the nursing period? Should a woman nurse when she is pregnant? A subsidiary problem is the effect of menstruation on the quality of the milk. Some women, in our samples, thought that this might indispose the nursing child, but the problem was only considered serious by a few women in Bamako where one said explicitly:

When you are menstruating, you should not have sexual relations because if you get pregnant, the child will catch leprosy (M14, Bamako woman).

Relations during the nursing period

In an earlier paper limited to Bobo-Dioulasso, we examined women's opinions on whether intercourse spoils the milk (Trussell, van de Walle & van de Walle 1989:439). We concluded that the belief was very widely held, although there were differences between the Mossi and the Bobo. More of the latter thought that no ill consequences would result from having intercourse while nursing. At the time, however, we failed to distinguish in our tabulations between the alleged direct effect of intercourse on milk quality, and the indirect effect, i.e. that intercourse would result in pregnancy, which would make further breastfeeding undesirable. The following discussion is based on a re-examination of our data.

It was difficult to distinguish the risk linked to intercourse and that inherent to early pregnancy. The path of causation was often made explicit only after more lengthy questioning.

Int. A woman who suckles her child, may she have relations with her husband?

Resp. Eh... if you have relations with your husband, if you don't use medicine, the child will waste. If you have the medicine, you may have relations...

Int. How does the child waste?

Resp. If you become pregnant in addition to the suckling child, it will lose weight, and if God does not give you luck, it will not stay, it will die. (B24, Bobo woman).

Among the Mossi of Bobo-Dioulasso, the main problem of early resumption of sexual intercourse seemed to be the risk of becoming pregnant again, and this had to be avoided at all cost before the child had reached a certain age. Here follows a typical answer:

Int. May a woman who nurses sleep with her husband?

Resp. (Laugh) This I don't know.

Int. And you? Don't you know what you do?

Resp. With me, the child must be weaned.

Int. Why is that?

Resp. To avoid a pregnancy.

Int. Otherwise, it causes no harm to the child?

Resp. It causes no harm.

Int. Some women say that it spoils the milk. What do you think?

Resp. We don't know, because if we do not wean, we have no relations. (M8, Mossi woman)

In fact, the Bobo women seemed more concerned than the Mossi about the direct effects of intercourse on the milk. Among 40 Bobo women interviewed, more than half thought that a child could suffer from early resumption of relations, even quite independently of the risk of becoming pregnant prematurely.

Resp. If the child walks, it does not harm the child.

Int. But if the child does not walk?

Resp. It gives it *nogo* [dirt].

Int. Even if the woman does not become pregnant?

Resp. Even if she does not become pregnant, the child gets *nogo*. (B15, Bobo woman).

Resp. You may have relations with your husband but if you are not very cautious, this may provoke small diseases in your child... Apart from getting pregnant, this gives diarrhoea to the child.

Int. Can it be serious?

Resp. It can be serious if the child has light blood [i.e. is fragile], the disease tires it. (B10, Bobo woman)

Two Bobo women held that the danger would be limited to relations with another man than the father of the child.

Resp. There are certain women who do not get along with their husband any more, and go with other men. Then *nogo* catches the child, and it becomes very ill.

Int. What do you call this disease?

Resp. *Nogo*.

Int. What are the symptoms for the child?

Resp. The child becomes weak, its body becomes soft.

Int. Is that all?

Resp. You must immediately get medicine to bathe the child. (B2, Bobo woman).

There were also a number of Mossi women who believed that the milk would be dirty because of intercourse, that the child would be weak or 'soft-bodied', would not develop normally, and would constantly fall prey to various minor ailments, most of all diarrhoea.

Int. You say that it is not well to have relations with the man if the child is not yet one year old. Why?

Resp. The child becomes a '*GnEnem Bila*' [i.e. a child of arrested growth.]

Int. What is '*GnEnem Bila*'? What does it do to the child?

Resp. It wastes the child, it gives it diarrhoea.

Int. Only diarrhoea?

Resp. The child loses its shape, it cannot be recognized, it is not itself anymore.

Int. Does it thin or thicken? What are the symptoms?

Resp. It thins too much and makes diarrhoea. (M11, Mossi woman)

The main difference between Bobo and Mossi women, however, was in the extent of their faith in traditional medicine as a way to counteract the effect of sexual relations. As we shall see below, Bobo women appeared to have access to a vast pharmacopoeia of leaves and charms to keep the milk wholesome, whereas only one Mossi woman mentioned the resort to medicine in this context:

Int. What does *regdo* [dirty] milk do to the child?

Resp. It softens the child; it becomes sickly. It is a disease that makes it lie on the floor; it is soft and has no more strength. This is why the child suffers if relations take place before it has 'come out of itself'.

Int. Can one secure medicine in that case?

Resp. If you want medicine, the old women have it. You boil the leaves, you bathe and purge the child with the medicine, and it heals. (M4, Mossi woman)

In Bamako, the prohibition of intercourse after a birth is almost generally limited to a period of 40 days. It is believed that Islam allows, and perhaps imposes the resumption of sexual relations after that period if the husband wants it. A minority of women acknowledge that there are risks involved for the child. Some interpretations involve an effect on breastmilk, which becomes warm; as in other cultures, heat is part of traditional interpretations of disease mechanisms.

Resp. If you unite with your husband... now, this warms the breast water [i.e., milk] and this gives the disease to the child. (M29, Bamako woman)

In many instances, however, the mechanism invoked seems to involve 'dirty breasts', i.e. perhaps some sperm that has reached the nipple via the woman's hand and will be swallowed by the child.

Int. Why is it that, when the child is very little, the woman cannot unite herself with the husband while she is nursing?

Resp. If the child cries after you are lying next to its father, and you get up to take it, you are dirty, your breast is not washed, if you take the breast to give it, this may be a reason that can give the child diarrhoea. (M9, Bamako woman)

The reference to 'washing the breasts' was common in Bamako. In Bobo-Dioulasso too, several Mossi and Bobo women said that they avoided the problems linked to intercourse while still nursing by cleaning their breast carefully before nursing.

Resp. I give the breast to my child but I can unite myself with my husband because, when I finish, I clean the breast with water from the kettle to remove the dirt. (M3, Bamako woman)

Resp. Sometimes I do [have relations while breastfeeding], but when I wake up, I must clean myself well before suckling the child. (M28, Mossi woman)

Resp. If you happen to give the breast to your child, when you finish [with the man] you wash the breast, it will drink. *Nogo* will not get him.

Int. Is there a way to wash the breast?

Resp. You wash it with water. (B16, Bobo woman)

Neither in Bobo-Dioulasso nor in Bamako did we note any interpretation that would involve pollution of the blood and eventually the milk through the womb. One woman in Bamako mentioned that there was no similar risk when the child was bottlefed, since the bottle would have been prepared the previous evening, before sexual intercourse.

Nursing and pregnancy

To the second question (Should a woman nurse when she is pregnant?), the answer was in general an emphatic 'No!' among both the Mossi and the Bobo of Bobo-Dioulasso, and among the women of Bamako. When a woman is pregnant, the milk becomes hot and dirty, the child gets a lot of diseases, vomits and suffers from belly ache, but above all from diarrhoea. Women were almost unanimous in disapproving of nursing after a new pregnancy had started. The topic seemed to elicit a great deal of shame among Mossi respondents. Most said that some other women took traditional medicines and continued to nurse, but that they weaned immediately themselves. There appeared to be a great deal of social pressure to wean from relatives and neighbours, although it was said that some women hide their pregnancy to nurse.

Int. May a pregnant woman nurse?

Resp. Do you think this is possible ?

Int. What does it do to the child?

Resp. Ah, if you do not manage, the child will die.

Int. Does it become ill?

Resp. It will become ill.

Int. What kind of illness?

Resp. This is what the Mossi call *yanem*... The child has fever, it gets diarrhoea and becomes soft. It will never get out of itself. (M5, Mossi woman)

Traditional medicine

The few Mossi women who expressed reservations on the subject mentioned that it was possible to take medicine to continue to nurse, an option which was not available in the village, but that they had observed in town, particularly among Bobo women. The '*yanem* medicine' consists of an infusion of leaves, in which the child is bathed and which is also used to purge it.

A large proportion of Bobo women seemed indeed to rely on traditional medicine to avoid various problems linked with pregnancy and early weaning. There are medicines that allow a woman to

continue to breastfeed even after she has become pregnant. The favourite method of administration of these medicines was by bathing the child in a decoction of leaves; sometimes this was combined with drinking the very liquid that was used for bathing the child. This was done either preventively, or after the child had exhibited the symptoms of malnutrition.

Int. Should a woman who is pregnant nurse? ...

Resp. You must wean and give the child other food.

Int. And if it is too small?

Resp. Huh! You must give it the white people's milk, you cannot let it die in your arms.

Int. So you give it milk?

Resp. Yes, and you accustom it to eat. Among the *Farafing* [the black people] there are medicines to make the child eat. If you find some leaves, you boil them in water and you bathe the child in this juice and it will eat... It does not bother you any more and the disease of the tummy does not get it. Other women wash their child in the leaves and let it suckle and it is not sick, it does not get anything, it does not even have any diarrhoea. (B1, Bobo woman)

Int. Is there no medicine for the *sŽrŽ* disease?

Resp. Some people sell the *nogo* medicines for watery faeces. You buy these medicines, you boil them and wash the child.

Int. These are leaves?

Resp. Yes, leaves... Those that are sold are good... I don't buy. I collect the leaves myself and I wash my child. (B16, Bobo woman)

Not every woman knew what leaves to use, and some were suspicious of the ones that could be bought in the market. The proper use of most medicine involves some rituals, words or esoteric knowledge on how to pluck the leaves, and exactly how they should be used. Failure in treating a disease was often blamed on some trivial details that had been inadvertently left out. There was a feeling that some of the traditional lore was being lost, and that women had been better off in the village.

Resp. Ah! I don't know the medicine, since I have never *sŽrŽd* a child.

Int. The name [of the disease] is *sŽrŽ*?

Resp. Yes... Those women who know the medicines can breastfeed, and those who do not know them, if they do, this makes the child sick.

Int. ...What kind of sickness is it? How does it affect the child?

Resp. Diarrhoea... This easily kills the children of certain persons. (B30, Bobo woman.)

In Bamako too, herbal remedies are used. Many respondents referred to the *sŽrŽtoro*, or *sŽrŽ* medicine. There is brisk business for herbalists in the Bamako markets (Imperato 1979), and women seem to rely more on the leaves purchased from herbalists than on their own collecting. They rely on traditional healers to indicate to them what herbs to buy, as a Western doctor would direct his patient to a pharmacist, and to perform the magical gestures or say the words that will confer healing virtue.

Resp. The old women told me to buy medicines in the market and to bring them. They would recite verses, and told me to wash the child with that. (M17, Bamako woman)

Several women had resorted to Western treatments, alone or in combination with traditional remedies, but the majority opinion seemed to be that traditional methods had at least an even chance of being successful against *sŽrŽ*.

Int. When *sŽrŽ* took your child, with what were you treating him?

Resp. During one month and ten days, he received shots, and we were buying him liquid medicines, powdered medicines, and that is what we gave him.

Int. Did you ever give him African medicines?

Resp. I gave him lots of African medicines...

Int. Is it the African medicines that were effective, or the European medicines?

Resp. Both were helpful because everything depends on the way the disease manifests itself. Some diseases can be cured by African medicines, but others, it is the European medicines that can cure them. (M21, Bamako woman)

A mother who wants to help her child is subjected to multiple pressures, and will try everything:

Resp. You wash the child with the leaves of *sŽrŽtoro*, as well as with the fruits of *sŽrŽtoro*. That is what you boil with several other medicines, and then there are the medicines of the doctors. You are told to go, the father forces you to go to the dispensary, and when you come back, your neighbours also tell you to bring the child and to wash it with traditional medicine. (M23, Bamako woman)

SŽrŽ.

Women in Bobo-Dioulasso provided us with multiple clinical description of *sŽrŽ* (the Dioula name; other terms frequently used are *mama* or *dendŽ*, implying pollution or dirt) or *yanem*, the Mossi equivalent.

Int. Have you never seen children sick because they had brothers too soon?

Resp. I have seen many... The child is depressed. You see them often sitting down. Even when you feed them, they eat the *to* [millet porridge] and fall asleep next to their food, their belly is inflated, their feet are swollen. It tires a lot of children. (B10, Bobo woman)

The symptoms appear to characterize protein-calorie malnutrition or kwashiorkor. Two additional diseases of weanlings are frequently mentioned in Bobo-Dioulasso, but they are quite separate in the popular aetiology: the sunken fontanelle disease, and 'haemorrhoids' (*kotiguŽ* in Dioula), characterized by a bleeding anus, perhaps as a consequence of frequent diarrhoea. Teething is often mentioned as well.

Resp. For the fontanelle, a woman came to help me. My child had the fontanelle open at one time. The woman told me to use a mortar and to grind the substance. I grind, and then I add water where I have ground. It becomes wet, I collect the paste and apply it to the fontanelle of the child and let it harden. I did that to the child, and the next day, there was improvement.

Int. I see a string around the neck of the child, what is it for?

Resp. They say that it is to bring out the teeth. I saw it in the market, I bought it and hung it around his neck from the time he was a small infant... It eases teething, so he won't be tired.

Int. When the teeth of the child grow, can he become sick?

Resp. He becomes sick.

Int. Is it serious?

Resp. It is not serious... It gives diarrhoea to the child. Often it cannot suckle because its mouth is sore... I also bought [the string for] the *kotiguŹ*.

Int. Does it heal the torn anus?

Resp. Ah! if he has the *kotiguŹ*, he must have a treatment, otherwise it does not end. The string is just to soothe, it is said to attenuate the disease... (B10, Bobo woman)

In Bamako, there seems to be an obsession with *sŹrŹ* probably because the period of postpartum abstinence has been officially reduced to 40 days under the influence of Islam. The median duration of abstinence reported in the infant and child mortality surveys that provided a sampling frame for our qualitative surveys, was 12 months in Bobo-Dioulasso and a little over two months in Bamako. Many older women in the latter city continue to strive for longer abstinence, and refer to the old practices followed in the countryside. Young women, who are also less likely to be married to a polygynist and are less able to resist the demands of their husband, are the most concerned about *sŹrŹ*.

Among the Bobo of Bobo-Dioulasso, the term *sŹrŹ* was used almost exclusively to characterize a disease of nutrition, generally after weaning, but sometimes when sexual intercourse had resumed too soon. The use of the term to denote a disease was also encountered in Bamako:

Int. I say, if the mother of the child who becomes pregnant does not want to wean it and continues to breastfeed in addition to the pregnancy, what does it do to the child?

Resp. The child... this is called *sŹrŹ*, it makes the child sick... its tummy is running... it also makes it vomit and causes many other small ailments. (M3, Bamako woman)

Resp. The children of *sŹrŹ* lose weight, they are shapeless, their hair becomes red. (D25, Bamako woman)

But in Bamako, the term *sŹrŹ* not only refers to the disease of children whose mother has conceived again (and occasionally of children whose mother had intercourse while nursing); it also denotes the circumstances when such a disease is likely:

SŹrŹ is when your child is not yet walking and you are pregnant again. (D3, Bamako woman)

It is also the qualifier used for a woman who is prone to conceive again soon after a birth; the disease and the condition of the mother are confused. A *sŹrŹmusso* is a woman with a short period of amenorrhoea; we have not encountered this use of the term in Bobo-Dioulasso. For these women, indeed, as the saying goes, '*sŹrŹ* is waiting under the bed'.

Resp. In Bambara, if the mother becomes pregnant while the child is nursing, she is called *sŹrŹ*. (M2, Bamako woman)

Resp. There are *sŹrŹmusso* who become pregnant as soon as the 40 days (of ritual abstinence prescribed by Islam) are over. This is what scares nursing mothers. (M10, Bamako woman)

Resp. There are women with rapid 'washings' (menstruation). Some see their 'washings' during the 40 days before the child has had time to grow. These must be women of *sŹrŹ*. (M37, Bamako woman)

Conclusion

We have described a series of beliefs prevailing in two cities of the Sahel region of Africa, which give a central place to breastfeeding in explaining diseases of children, particularly the multiple diarrhoeas that

are likely to occur in infancy and a disease of malnutrition called *sŽrŽ* locally. On the whole, in the two cities examined, there was some concern about the effect of intercourse on the health of a nursing child, but it seemed that most women felt that there was little they could do to delay sexual relations if the husband wanted to resume them. There was no awareness that breastfeeding would delay the time when they would be fecund again; women who conceived again soon blamed it on their temperament or their bad luck. Wives seemed to bear the sole guilt in case of a new pregnancy, and the pressure of public disapproval was focused on them, rather than on their husbands. They resorted to traditional medicines or ablutions as substitute measures to the lengthy traditional abstinence of the past. Their main fear was of becoming pregnant again, a condition that would force them to wean their child. Here too, infusions of leaves, taken mostly in the form of baths, could help the child if it suffered from diarrhoea or malnutrition.

Our survey did not focus on diarrhoea particularly, but on postpartum behaviour. We made no attempt to elicit information about other types of diarrhoea or diseases of nutrition that would not be linked with 'bad milk'. Most striking in our study was the fact that, with a few exceptions, our informants believed that some forms of diarrhoea and malnutrition at least belonged to the category of diseases for which prevention and treatment were satisfactorily covered by traditional behaviour and recipes, and that little would be gained by resorting to the medical facilities of the government and to Western medicine. No reference was made to oral rehydration therapy in our interviews, perhaps because the vast international effort to promote it had barely started in 1983. Nevertheless, oral rehydration does not seem to fit in the popular aetiology of diarrhoea, because it has no obvious logical connection with two important – perhaps the most important – alleged causes of diarrhoea in early childhood, intercourse while nursing, and 'pregnant milk'.

Such beliefs which attribute a deleterious effect to breastfeeding should be addressed in public health campaigns. In many African populations, there are strong norms about weaning in case of pregnancy, which are enforced by public opinion and censure in the family or the neighbourhood; without support from health propaganda, most mothers are powerless to adopt the best regimen for their children. Do our findings, then, have application beyond the particular cities where the surveys were taken? Little attention seems to have been paid so far to the health consequences or the implications of popular beliefs on 'quality of milk' for the acceptance of public programs and the resort to modern forms of treatment, including oral rehydration. For example, although the belief that sex poisons the milk is attested among the Yoruba (Caldwell & Caldwell 1977:199), it leaves no trace in a particular ethnographic assessment of that population made by Bentley et al. (1988) for the purpose of a diarrhoea management program. 'Teething diarrhoea', mentioned by the authors, was not linked to sexual intercourse. Programs that attempt to promote prevention and treatment should probably take the popular aetiology into account to be fully effective.

And yet, there are likely to be many different popular explanations of diarrhoea or other diseases, and public health workers should be wary of generalizations on the basis of information from other areas. Models from the Sahel region may not be applicable in other parts of Africa. For example, studies in Kenya (Eisemon, Patel & Sena 1987), or Swaziland (Green 1985), pay little or no attention to the relation between sexual intercourse and diarrhoea in the popular aetiology, although Eisemon *et al.* (1987) mention 'mother's milk "bad"' among causes of diarrhoea identified by informants in Kenya. De Zoysa et al. (1984) mention 'sex during breastfeeding' and 'breastfeeding during pregnancy' among many other alleged causes of diarrhoea in Zimbabwe. In Lubumbashi, Zaire, six different types of diarrhoea are identified; one of them, *buse*, of rather ambiguous diagnostic, originates when the mother weans her child (Yoder 1991). Thus, although pollution of the milk is quoted elsewhere in Africa, we

do not perceive in published accounts the same public obsession as in Bamako and Bobo-Dioulasso with nursing and weaning behaviour as a health hazard.

Our main point is that research into popular perceptions on what affects 'the quality of mothers' milk' would be fruitful. The explanatory model that prevails in a particular society must always be taken into account by health programs, as it constitutes a coherent and powerful system of beliefs that conditions the nutrition and care of the young child, and may stand in the way of therapies that are not compatible in the popular mind.

In the particular instance of the Sahelian cities, we suggest that public information campaigns should strive to explain the infectious nature of diarrhoea, the true causes of nutritional diseases, and the excellence of maternal milk even after intercourse has resumed or a new pregnancy has started. The message might inform couples that the resumption of intercourse presents no ill-effects for the nursing, and stress the limited contraceptive effect of nursing, which makes much of the abstinence period redundant, but cannot be as effective as modern techniques for the purpose of spacing births.

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