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9

LACTATION, NUTRITION, AND CHANGING CULTURAL VALUES: INFANT FEEDING PRACTICES IN RURAL AND URBAN THAILAND

Penny Van Esterik

Introduction

In 1972, Alice Ladas published an article entitled, "Breastfeeding: the less available option," a study of breastfeeding in North America. In this study, questionnaires were sent to over 1000 mothers who intended to breastfeed, in order to test her hypothesis concerning this "less available option". She found that mothers who breastfed their children as long as they wanted to had two simple advantages over women who felt they were not successful. First, they had accurate information about breastfeeding, including the process of lactation, what to expect of both mother and baby, and practical advice on problem solving. Second, they had support and assistance of one or more individuals who approved of the woman's desire to breastfeed and had confidence in her ability to do so. Raphael (1976) refers to this individual as a doula.

It is, of course, interesting to document the increasing interest in breastfeeding among young women in North America, accompanied often by an interest in natural childbirth, and natural foods. While this increasing interest might be dismissed as a fad in North America, the question of breastfeeding is critical in other parts of the world. In Chile, for example, 95 percent of one year olds were being breastfed 20 years ago. Now, only 20 percent of infants are being breastfed at two months (Muller 1974:4). In Singapore, there was a decrease from 71 percent to 42 percent of children in low-income families breastfed for three months. Berg (1973) has calculated that this loss of a critical human resource is equivalent to $1.8 million. A similar shift from breast to bottle milk in Kenya has resulted in losses equalling two-

hirds of Kenya's national health budget ($11.5 million) (Berg 973). Accompanying this shift is an increase in infant ortality, an increase in marasmus, and general malnutrition, nd a commitment of more and more funds to purchase costly oreign milk substitutes. (I will not elaborate here the eriousness of this trend for infant welfare in developing ountries, but refer the reader to the sources listed at the nd of this paper. These, and other sources confirm the super- ority of breast milk over cow's milk and stress the complex elation between the physiological process of lactation, and he psychological state of the mother. See particularly D.B. elliffee 1971, J. Cottingham 1976, J.W. Gerrard 1974).

It is my intention here to 1) document the shift from breastfeeding to bottle feeding in Thailand, 2) apply Ladas' hypothesis concerning the importance of information and support to the Thai evidence, and 3) to define what is meant by information and support in the Thai context. To do this, I will characterize the infant feeding practices in three Thai population samples; rural, urban professional, and urban slum.

Three Thai Populations

The rural population with which I am most familiar is a central Thai agricultural village in Suphanburi province.[1] This large, prosperous village, is easily accessible by bus to provincial capital towns and to Bangkok. Fieldwork in this village (July 1971 to January 1972) focused on village religion, but my association with village women on an informal basis consistently centred around "female culture", that is, things that we had in common as women. In 1973, I returned to Thailand with an infant and found myself more deeply submerged into "female culture" both in Bangkok where I was involved with other research interests, and on short visits to the village. The contrast between the content of the "female culture" in Bangkok and the village motivated this present preliminary study. Fieldwork in this village, then, provided in depth participation in a rural Thai community. In addition, I obtained specific demographic information from 179 households, including ages of mother and children, method of feeding, and age of weaning. To summarize briefly the

infant feeding preferences of the villagers, at least 99 percent of the women breastfed their children, weaning them very late (from 2 - 10 years) on to rice, milk and solid foods. Four per cent of the younger wealthier women supplemented this with sweetened condensed milk, or a tonic such as Ovaltine. As expected, this is a community of successful breastfeeders recognizing no option to the traditional "mammalian norm".

While in Bangkok (1967-1969) I taught at Thammasat University and associated with highly educated, relatively wealthy professional civil servants with B.A. or M.A. degrees. Renewing contacts with these women in 1973 underscored their very different attitudes towards infant feeding. In addition to interviews with many of these women, I constructed a questionnaire in Thai and gave it to a small sample of elite civil service women with children. Of these, 37 questionnaires were completed.[2] Like their rural sisters, these women perceive no real alternative to their infant feeding choice. They universally provide only the most expensive imported formula for their children, regardless of when or if they returned to work. Those few (less than 5 percent) who do begin breastfeeding in the hospital pride themselves on immediately supplementing their dwindling milk supply with bottles of sweetened infant formula. The most common brands were S26, Lactogen, Similac, and Enfamil. Their reasons for not breastfeeding focus on the fact that they "have no milk", and they emphasize the pain of breastfeeding problems such as cracked sore nipples, and babies that do not "want" to breastfeed.

The third population, that of the urban slums scattered around Bangkok, is known to me only through surveys from Thammasat University, and secondary sources such as Pensri and Wray (n.d.) and Yamlinfung (1973). However, this information is a critical link between the two previous populations. The slum households have been described in a Thai magazine as "twenty dollars a month for a family consisting of one father, one mother, 8 children, 4 dogs, 10 cats, 6 ducks, and 10,000,000 mosquitoes". The housing conditions in the slums are very difficult with crowding, an

uncertain, communal and usually dirty water supply, and sewage disposal problems. Clearly, conditions for sterilizing baby bottles, filling them with sterilized water, and refrigerating them are absent, or met with extreme difficulty. Infants in this setting are commonly fed diluted sweetened condensed milk. Although the women may contribute to the family income, most of them work in cottage industries in, or near their homes making flower garlands, paper bags, or candies. Yet Drs. Pensri and Wray report that ". . . 22 percent of the children in the four districts were never breastfed at all; another 11 percent were breastfed less than 1 month; almost 12 percent more were weaned within the first six months of life" (Pensri and Wray n.d.: 9).

Relations between Populations

These three distinct patterns of infant feeding preferences, the rural, the urban professional, and the urban slums, are interrelated in several important respects. Over 50 percent of the urban slum population is composed of adults who were born in rural communities. Rural communities consider that migration into the city for seasonal or short term employment is an option that can be taken if need arises. The wealthy and well educated urban professionals are largely employed in civil service positions which create and administer public policy in such fields as public health, education, and community development. These policies directly affect both rural and urban slum populations. Thus, although not all these professional civil servants make policy decisions, this group of civil servants have occasion to characterize the urban slum and the rural populations. These stereotypes, which are not at all flattering, may well influence policy decisions. For example a large proportion of the urban elite women felt that lower class women "should" use sweetened condensed milk to feed their infants. All three populations are subject to the same high powered advertising campaigns by commercial milk companies, with varying intensity, particularly through the public health clinics where the campaigns have been most successful. Advertisements for imported milk formulas appear frequently on billboards, in movie advertisements, as well as on radio and television. Even in the village, virtually every family owned a radio, and 8 percent of the households surveyed had television sets. The morality and even the legality of some of the milk companies' advertising techniques has recently come under fire (c.f. Greiner 1975 Cottingham 1976, and Muller 1974). Such practices as salesgirls dressed as nurses, offering free samples, bottles, and other enticements at the Public Health Clinics, and the horrendous suggestion that mothers who breastfed their children should drink two glasses of warm infant formula before each nursing, are all strategies which have successfully encouraged many Thai women to accept artificial formula as the modern healthy way to feed infants. It is the infant feeding preferences of the urban professionals that has become the ideal model after which urban slum dwellers pattern themselves Recent rural migrants into the urban slums of Bangkok are not idealizing their rural past and their traditional world view, but the practices and beliefs of the Westernized modern sophisticated elite. It is this pattern that has resulted in the devaluation of breastfeeding and the desire to shift to modern, artificial, and expensive milk products. Thus, these three Thai populations are not ideologically isolated from each other, but are interrelated in such a way that a significant change in the practice and beliefs of the urban elite is highly likely to affect the other two populations.

The Consequences

Having characterized the infant feeding preferences of these three groups, let me briefly document the consequences of these choices in terms of infant welfare and growth citing the research results of a team of doctors from a Bangkok hospital (Pensri and Wray n.d.). The rural children and the children of urban professionals show the expected growth pattern during the first 6 months of life and remain well above minimum standards the second six months of life. In the second year, the growth curves "flatten out". The mean head circumference for both groups is fully equal to expected values.

The slum children measured were already well below expected growth patterns in the first six months of life and they dropped even further in the second six months. Even more

critical is the fact that the head circumference falls below average, and remains there until age six, suggesting that ". . . severe retardation in brain growth early in life is more lasting in its effects than is retardation in height" (Pensri and Wray n.d.:6). But over 30 percent of the slum children suffered from protein calorie malnutrition with 15 percent of these critical enough to be equivalent to marasmus. This nutritional deficiency is not seen in the rural population sampled.

In Bangkok, then, neither these professional women nor the slum mothers have maintained the knowledge necessary for successful breastfeeding. When rural women comment on this fact, they emphasize the fact that these women in the cities have no one to teach them about breastfeeding. If, as Ladas argues, knowledge and support are critically important, then we can only define this knowledge in the rural context. Let me summarize the nature of this knowledge and support in a rural Thai village to demonstrate how it maintains a community of successful nursing mothers.

The Rural Context

My work, and that of Hanks (1963) demonstrates that successful prolonged breastfeeding validates the merit store or karmic status of a woman. The death of an infant demonstrates the fact that the mother, or the baby have an insufficient amount of merit. Thus the timing of the birth, and the success of delivery and lactation are both natural and supernatural processes. Only a midwife is trained in the techniques necessary for interpreting and guiding these two processes in accordance with both natural and supernatural laws. A midwife must be chosen with great care. She should ideally be related to the family, be skillful and successful in past deliveries, and be a successful "nourisher" (Thai: liang dī) herself.

Hanks has emphasized the importance of initial experiences in determining an inevitable pattern of subsequent events. Success in one delivery insures success in later deliveries. Similarly, the establishment of nursing in a new infant, and even in subsequent infants is determined by the first nursing experience of mother and child (Hanks 1963:63).

Rural women are well aware of the fact that both new babies and mothers must be "taught" to manage nursing in the first few days after birth. Thus, the most experienced female relatives, those who "liang dī" are supporting the mother and instructing her on what to eat and how to behave in this critical time immediately after the birth. A close relative with a well established milk supply will often nurse the child for the first time. The advantages, according to village mothers, are great. The mother does not feed her own child until she has a copious milk supply (usually about the third day). (Parenthetically, this is why public health officials probably cannot convince women of the importance of colostrum for the baby since it is a "bad" colour, and insufficient in amount - it would set a bad habit for nursing). In addition, the baby learns to suck efficiently with someone who has a good established milk supply. When the mother's milk comes in, the baby is an experienced nurser and can immediately relieve the mother's fullness. Thus a good nursing pattern is established because every possible step has been taken by supporting females to guarantee success. A woman may nurse another's child out of metta-karunā (Pali: loving-kindness) thereby making merit for herself and confirming her status for the survival of the infant in the case of the mother's illness or death. The woman who first nurses the baby may replace the mother in the case of her death. Yet it is important not to misinterpret the function of this "wet-nurse" She acts out of kindness to guarantee the success of the mother-child bond, in no way usurping the mother's position.

The child will love, respect, and be sympathetic to the person that feeds it. Mother's milk is composed from the mother's blood. Thus, breastfeeding in rural communities is critical for creating a reciprocal relation between mother and child. For example, a son will become a monk later in his life in order to repay his mother for her milk. In the first few lines of the preordination rites, a young man will transfe the merit he makes to his mother to repay her for her milk. One close friend told me that the longer she nursed her son, the greater the chance that her son would enter the temple as a monk. A daughter, too, will repay her mother's milk by

attending sermons and making merit for her mother in later years. This reciprocity is quite explicit and calculated. If the last child is female she is often breastfed for as long as 10 years in order to tie the child to the mother, and make the child sympathetic to, and of one mind with the mother. As a result, the child repays this debt by looking after the parents in their old age. She does not leave them, but brings a husband in to work the parent's land. They in turn inherit the house and land after the death of her parents. Although this strategy was made explicit in only a few conversations, the pattern of inheritance in this village confirms this residence pattern.

The village women assume that they will have long term success as breastfeeders if they follow certain positive steps. They have complete confidence in this natural process and know that if one day their milk supply is down, they must eat a certain vegetable curry, drink boiled water, and nurse the baby more often. (In answer to my question about what to do if milk supply was low, 65 percent of the Bangkok professional women said to give the baby powdered formula - a surefire way to insure a loss of milk supply).

One commonly reiterated argument emphasizes the difference in rural and urban women's view toward the nursing relation. Most common in the village was the comment that if you feed the baby with a bottle, the baby will love the bottle; if a mother nurses the baby, the baby will love the mother, will think like the mother, and will be of one mind with the mother. Village women claimed that feeding babies artificial milk results in the child having a mind like a cow, not a desirable state of affairs. A cow (Thai: wua) is a common epithet for a stupid, clumsy, dull person. In Bangkok, those women that did explain their repugnance to breastfeeding rejected it because it was "animal like".

Prospects for Change

Both the knowledge and the social support necessary for successful nursing relations are present in rural communities. Further, this knowledge is distributed universally among rural women and is not limited to midwives or elderly women. Should we then be optimistic about the retention of this supportive

complex in rural Thai communities, and emphasize the advantages that rural children have over urban slum children nutritionally? Should research and funds, then be concentrated on the urban slum populations rather than the rural populations?

There are several important reasons to suggest that a shift is likely in the rural context - the only context where the values supporting breastfeeding still exist. Clearly a rapid change in infant feeding practices in rural communities such as occurred in Chile would be disasterous. But the preconditions for such changes in rural communities are already present. First, in central Thailand generally, and in villages in Suphanburi province, there is a shortage of land available for cultivation. As a result, more and more men and women are migrating from villages to Bangkok for seasonal or part time labour, returning to the village when they have accumulated some cash. They bring back with them aspects of the culture of urban slum dwellers, and, if they migrate as a young family, this knowledge may include reevaluation of infant feeding practices. I recall one family where the mother worked in Bangkok until her baby was born. She then returned with the baby to the village bringing a supply of baby bottles and sweetened condensed milk.

Second, although land may be in short supply for some villagers, a few individuals have been able to accumulate large landholdings (approximately 10 acres) at the expense of their less fortunate neighbours. These entrepreneurs may own and rent out tractors, which provide them with a steady source of cash. With this cash, they are speculating on risky but profitable crops such as sugar cane. The village, then, has a few wealthy individuals who are bringing signs of their wealth into the village. Their claims to high status and modern progressive identities include the purchase of televisio sets, electric rice cookers, and in two cases, imported infant formula. The appearance of formula and baby bottles, are associated with the most successful and wealthy villagers, an association that may soon be recognized by villagers who formerly recognized no alternative to breastfeeding.

Third, although Thailand has been creating new five year plans at an alarming rate in the last few years, one consistent

target of the public health programme has been to increase the number of public health nurses in the rural area, charged with the responsibility of improving maternal and child care. In an effort to "upgrade" the health care facilities in one village, the government constructed a very small building on the school ground for childbirth. Here, the public health nurse would assist at deliveries. At the top of a flight of steep stairs, a pregnant village woman can see a colourful poster advertising infant formula, much too expensive for most villagers. These facilities were under-utilized because the nurse was not evaluated as a successful mother herself. In her own store front clinic across the street, this same public health nurse is the sole retailer of three special brands of sweetened condensed milk. These companies often offer free baby bottles in return for several labels. These nurses, and most other public health officials are trained in Bangkok and carry with them the prevalent attitudes of the Western trained medical doctors in the capital who place a high value on vitamin enriched sterile imported formula.

Finally, among Thais, the typical Thai, or "ideal" Thai model no longer refers to a villager. In the media, villagers are depicted as stupid hillbillies, superstition-ridden, backward, and non-progressive. This stereotype is reinforced by the Buddhist notion that wealth and success demonstrates the merit worth of an individual. Thus, poor and traditional villagers are not worthy of admiration. Whatever special knowledge the villager possesses, whatever adaptive strategies that may be limited to rural populations, are devalued. This traditional knowledge, such as the knowledge concerning childbirth and lactation is something to be ashamed of and replaced by modern Western knowledge.

Conclusions

In conclusion, alternatives to breastfeeding are becoming widely known in Thailand. Among the urban professionals, we might recognize this process as conspicuous consumption. Among the urban slum populations, it could be understood as compensatory consumption; they can behave like the elite in this one aspect of behaviour and distinguish themselves from unprogressive upcountry cousins. It might be appropriate to

pause here and consider why. What exactly are the industrial nations exporting to Thailand and to other developing nations? First of all, European and North American countries are exporting millions of dollars worth of expensive infant formula. A poor family would find the cost of formula prohibitive (approximately 1/3 his income), but could afford cheap substitutes such as sweetened condensed milk, particularly if such products were substantially diluted. These multinational companies such as Nestles spend part of their profits on very effective advertising campaigns. The business is extremely profitable (see Greiner 1975). The resulting damage to the health of infants has been documented, but note that we also export the drugs and the vitamin supplements and tonics necessary to repair the damage.

Second, we have exported a system of Western medical training that places little emphasis on the physiology of lactation, or the benefits of breastfeeding. In North America it is not uncommon to find male doctors that have little knowledge of breastfeeding, beyond the pathological aspects of certain breastfeeding problems, such as abcesses. It is these Western trained Thai doctors that the formula companies have "converted" to their products, often offering free samples, posters and stationery advertising their brand of formula.

Third, the image of infant feeding has been successfully exported. A good mother who cares for the welfare of her child will choose a formula with vitamins. Her child will be healthy and the woman can be satisfied that she is using the most progressive possible method of infant feeding. When I described the increase of breastfeeding mothers in this country, and the formation of La Leche League Clubs, my credibility dropped drastically, for this contradicted the assumption that all Western women use expensive "scientific" infant formulas.

Lastly, through the advertising campaigns of the multinational corporations, and through other channels, we have exported to Thailand, and probably to other countries, an image of women. An image of breasts as sex symbols; an image of a nursing relation between mother and child as being some-

how animal like; an image that nice people just do not do it. What we have most successfully exported is our Western experience of lactation failure - the idea that it is difficult and painful to breastfeed, and that there are a multitude of problems that have to be overcome, the most common one being that a woman really does not have enough milk. Booklets on breastfeeding in North America often list the most common difficulties in establishing a milk supply, and I found that Bangkok women knew them all, expected, and feared failure. That fear alone is enough to inhibit the production of one of the world's most valuable and under-utilized food resource.

FOOTNOTES

1. Fieldwork in Thailand has been conducted under the auspices of the National Research Council of Thailand. In 1967 to 1969 I taught Anthropology and English at Thammasat University, Bangkok, as a member of C.U.S.O. Research in Suphanburi province was sponsored by a training grant from the Department of Anthropology, University of Illinois, and a Fellowship from the Center for Asian Studies, University of Illinois. In 1973, my husband received a dissertation research grant from the International Development Research Centre, and this grant also covered my expenses. I am grateful to the Graduate College, University of Illinois for providing me with a grant to cover my research expenses from Sept. 1973 to Aug. 1974. It is my intention to return to Thailand within the next two years to follow up on this preliminary work.
2. The analysis of this material on Thai urban women will be presented in a separate paper later this year.

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