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THE DECLINE OF THE BREAST
An Examination of Its Impact on Fertility and Health, and Its Relation to Socioeconomic Status

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Three Papers:
I. The Relationship of Breastfeeding to Human Fertility, by Michael C. Latham
II. Appropriate Strategies to Improve Infant and Young Child Feeding, by a Cornell Working Group
III. Infant Feeding Options for Bangkok Professional Women, by Penny Van Esterik

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III. Infant Feeding Options for Bangkok Professional Women[1]

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1. Introduction

The process of urbanization and modernization has progressed in Thailand's capital, Bangkok, to the point that the city of angels shares with western cities the problems of pollution, over-crowding, slum housing, and incredible traffic congestion. The distinctiveness of Bangkok as an urban center is not a recent phenomenon; Robinson estimates that the city was already large by 1850 with a population estimated at 300,000 (Robinson, 1977:6). This city of over four million is rapidly being transformed into a modern city with the technology and social organization typical of the great cities of Southeast Asia. Bangkok is the capital of the only Southeast Asian country that did not become a European colony. Nevertheless, Thailand has had a broad exposure to a range of western institutions. But as Thais have borrowed items of western origin, so they have altered them and given them new and distinctively Thai meaning. As Moerman writes in his discussion of modernity in Thailand, "When Thailand adopts to its own way of life, our needles and tractors, boy scouts and nationalism, it is childish for us to mutter continually, 'No, no, that's not the way to do it'" (Moerman, 1969:146). As items are borrowed they remain embedded in a Thai system of relations and meanings. This paper examines one part of the process of modernization, the increasing use of bottle feeding with infant formula among Bangkok's professional women, and raises the question of whether these changes are an inevitable result of urbanization and modernization.

Modernization as a process is very poorly defined (cf. Poggie and Lynch, 1974:3-4). Most definitions emphasize increasing structural differentiation, specialization, and division of labor, and a value orientation towards striving for increasing change. The definition I will use does not establish absolute standards or universal criteria

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[1]This research was supported by a seed grant from the O'Brien Fund, University of Notre Dame, and is preliminary to future fieldwork on this topic. Past research in Thailand was conducted under the auspices of the National Research Council of Thailand in a village in Uthong district, Suphanburi province (July 1971 - January 1972). From September 1973 to August 1974, I worked on an unrelated research project in Bangkok, but kept notes on the subject of infant feeding. As a research associate for a project on infant feeding practices in developing countries (including Thailand), I have had an opportunity to expand and rethink an earlier draft of this paper.

for modernization, such as the growth of rationality, secularism, or industrialization. Modernization is a concept encompassing several processes. I include within the concept, the process by which local or national elites select technological objects and ideas from the so-called developed nations, and incorporate them into their world view.[1] These reinterpreted imports become a reference standard for non-elites, and define for them what is modern. These objects, ideas and values, then, are formulated in relation to the ideas and behavior non-elites attribute to the national elites. What a Thai defines as modern would clearly differ from the definition of a Japanese or a Frenchman. In this example, both urban poor and rural women define what is modern and desirable by reference to elite urban women, such as the Bangkok professional women described here.

2. Methods

This work is based on a Thai questionnaire on childbirth and infant feeding practices administered in May 1974. These forms were distributed to a network of colleagues and former students from Thammasat University, Bangkok, and civil servants in various ministries. Of the 50 Thai questionnaires delivered or mailed out, 37 were returned and used in this study. From this small sample, it is not possible to generalize about urban Bangkok practices. Rather, this project suggests what factors are important to consider in preparing more comprehensive fieldwork in this area. Since this small study deals with a socio-economic sample not previously studied, it may provide a basis for comparisons with urban poor and rural Thai populations.

In addition to the survey results, my interpretations are based on participant observation and informal interviewing of a number of professional women and their servants over several months. Neighbors and former colleagues from Thammasat University instructed me on the correct way to raise a baby. Since my infant daughter was with me and my mother was not, I would need their instruction and advice on child care. These life experiences over the year provided much of the contextual basis for this analysis, and the knowledge of what questions were appropriate and meaningful in that cultural setting.

3. The Women

The relatively high status of Southeast Asian women in general, and Thai women in particular, is noted by most observers of Southeast Asian society (cf. Burling, 1965:2). In contrast to the position of women in Indian and pre-revolutionary Chinese societies, Thai women are dominant in commercial and economic domains, as well as in the household, and apparently have been so for many centuries (cf. La Loubère,

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[1] Chodak identifies modernization as a process of emulation, the transplantation of patterns and products from the achievements of other countries to one's own (Chodak, 1973:257). My definition emphasizes the interpretative process more than the emulation process.

1693:50). The equality between the sexes in both rural and urban communities was documented by the Hanks in 1958, and has remained essentially unchallenged as women have taken on newer roles in the last two decades. In an essay explaining this phenomenon, Kirsch cites an article reporting that "Thai women own about 90% of Bangkok real estate and have heavy interests in transportation companies, construction firms, and restaurants" (Kirsch, 1975:175). Although men outnumber women substantially in high-ranking government offices, women are well represented in the civil service, particularly in fields such as education, social welfare, and banking.

The informants who answered the questionnaire on infant feeding preferences were all professional career women who were working full time. They ranged in age from 25 to 64 years, with the majority of women in their thirties. Although they were all working in Bangkok, many of them were born in provincial towns and moved to the capital later in life. One-third of the women were born in Bangkok or Dhonburi, while the remaining two-thirds came from towns in the central plains, such as Ayutthaya or Samutprakan.

This group of women civil servants were exceptionally well educated; the majority of them (73%) continued their education beyond high school. In fact, one-third of them completed M.A. degrees in Thailand or abroad. To illustrate how atypical this group of women are, note that the 1964 official literacy rate for Thailand (based upon the capacity to read and to write one's name) was 71%. Only .6% of the total population are college graduates (Phillips, 1975:334). The M.A. and Ph.D. degrees, particularly from foreign universities, have become status symbols, much like the sakdi na (titles) in the older ranking system (cf. Dhiravegin, 1975:13). These women are largely employed by the government in civil service positions, with the majority teaching high school or college. Four women have careers outside the civil service.

4. Infant Feeding Preferences

Twenty-seven women in this sample had only one or two children. These women have a total of 73 children among them. In answer to a retrospective question about how they fed their children, the mothers reported a preference for infant formula over breastfeeding, and they clearly prefer to discuss their experiences with bottle feeding. Only nine infants were breastfed from birth without supplements of infant formula. Twenty-nine infants were fed with infant formula from the time of their birth, while thirty-four infants were fed a combination of breast milk and infant formula (mixed feeding).

Table 1. Methods of Infant Feeding

	1st child	2nd child	3rd child	4th child	Totals
Infant formula only	16	7	4	2	29
Breastfeeding only	4	3	1	1	9
Infant formula and breastfeeding (mixed)	17	11	5	2	35
Totals	37	21	10	5	N=73

The term weaning can be used to refer to the cessation of breastfeeding, to the substitution of artificial milk for one or two feedings, or to the first introduction of solid foods. The Thai term referred to the end of the nursing relationship between mother and child. The 49 infants who were nursed were weaned at the following ages. Note that these figures include infants who were given formula along with breast milk.

Table 2. Age of Weaning

Age of weaning	1st child	2nd child	3rd child	4th child	Totals
Less than 1 month	6	4	1	0	11
1-2 months	7	4	3	3	17
2-3 months	7	6	1	0	14
3 months - 1 year	4	1	1	0	6
Over 1 year	1	0	0	0	1
Totals	25	15	6	3	N=49

Table 1 shows that 44 children were breastfed, while table 2 indicates when 49 children were weaned. Six mothers who breastfed their children only 2 or 3 days did not identify themselves as nursing mothers, or even as mothers who combined breastfeeding and bottle feeding. Yet these mothers answered the questions on weaning. The most usual time for weaning babies is at 45 days of age, when the maternity leave for civil servants ends. For those women who were breastfeeding their babies, weaning presented no difficulty, for most of them were already supplementing their breast milk with infant formula. Those who were still fully breastfeeding simply substituted infant formula for breast milk and reported no difficulties. Four women reported that the baby weaned itself at 45 days, just as the maternity leave ended for civil servants.

5. Factors Influencing Choice of Infant Feeding Methods

There are numerous studies demonstrating the superiority of breastfeeding over bottle feeding for a variety of reasons; medical (Jelliffe, 1978), economic (Berg, 1973), and what might be called humanitarian (Cottingham, 1976; Muller, 1974).[1] It is clear that Thai professional women are relying heavily on imported infant formula. A recent marketing study for three American infant formula companies found a 76% usage of commercial milks in the first month of life in Bangkok (Gaither, 1980). The analysis of Thai survey data from 1969 to 1979 shows that women in Bangkok breastfeed less than rural women and less than urban women in other provincial cities (Knodel and Debavalya, 1980:40). The study also documents the decline of breastfeeding over time in both rural and urban samples.

To the extent that wealthy professional women can afford to purchase the formula and the equipment for sterilization, and have access to refrigeration, their children will probably be as healthy as North American children who are not breastfed. Of greater concern is the degree to which lower income urban women, and increasingly rural women, may emulate this pattern and judge infant formula to be more scientific, modern and progressive than breastfeeding. This is the critical issue, and it is to these groups of successful breastfeeding mothers that Latham suggests "preventative education" be addressed (Latham, 1977:ix). In order to carry out such policies, it would be valuable to know more about why women adopt certain infant feeding practices in urban centers. In the following section, I will look at six factors which relate to infant feeding preferences, and suggest to what extent each of them limit the choices available to these Bangkok professional women.

5.1 Family Structure

One factor which may contribute to the popularity of bottle feeding in urban Thailand is a change in the structure of the family. If support and information from family members is as critical as research indicates (Raphael, 1976; Ladas, 1972), then the increasing incidence of nuclear family households, at the expense of the traditional Thai

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[1] There is an extensive and growing literature on the medical advantages of breastfeeding. Jelliffe's work (1978) is perhaps the best known, and easily obtainable. The American Society for Clinical Nutrition published an important symposium in 1971, The Uniqueness of Human Milk. Another symposium on breastfeeding is published in the Journal of Tropical Pediatrics and Environmental Child Health (1975), a journal that Jelliffe edits and contributes to regularly. Another excellent publication citing a wide range of medical views in support of breastfeeding is the CIBA Foundation symposium 45 (ns) (1976, Elsevier Excerpta Medica, New York) entitled Breastfeeding and the Mother. A recent issue of Studies in Family Planning (12, 4, 1981) reviews the policy implications of breastfeeding programs.

extended family household, may be a factor to consider. The most common household arrangement among the women studied is the nuclear family, with the mother, father and children residing together with one or more servants who are often distantly related. Six women reported that they reside with their own mothers, and one woman also had her maternal grandmother living with her. One family resides with the husband's mother. Generally, these Bangkok women did not have their mothers and grandmothers to assist them on a permanent basis. As a rural Thai woman remarked incredulously, "How can a woman give birth and raise a child without her mother's assistance?"

It is difficult to assess the extent to which family members may have influenced the mother's decision on choice of infant feeding method. Most women (81%) reported making their decision about how to feed their infants some time before the baby's birth (usually during their pregnancy). In making this decision, 57% stated that they decided independently without advice from anyone. However, once the decision was made, most women (70%) did not recall any pressure to change their chosen method of infant feeding.

Twenty-three women said that their mothers breastfed them without any supplementation. These professional women might receive support and information on breastfeeding from their mothers. In their own generation, their sisters and friends generally used infant formula and could provide information on this feeding choice. In general, urban professional women are more isolated from older relatives who could provide child care or advice on breastfeeding.

5.2 Breastfeeding Problems

Another factor in the popularity of bottle feeding is the association of breastfeeding with problems--problems of clothing, problems of diet, problems of modesty--with no easily obtainable solutions. The problems identified by these women reflect the lack of breastfeeding information and support from family and medical personnel. There is no evidence of "successful nursing relationships" among these women, as defined by American La Leche League standards,[1] or by rural Thai standards. Very few women even began breastfeeding without supplementing immediately with infant formula.

Eight women (24%) reported no problems with their breastfeeding, but 19 women (51%) who tried breastfeeding cited pain, cracked nipples, too much milk, or the wrong shaped nipples as problems. The most common complaint was that they had insufficient milk, or no milk at all. This is not surprising since they began supplementing their breast milk with formula from the first day of birth, long before their own milk

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[1] La Leche League is a voluntary association of breastfeeding mothers who help other mothers who want to breastfeed.

supply could become established.[1] This supplementation will have reduced the stimulation for milk production.

To solve the problem of what they claim was an insufficient supply of breast milk, most women gave their babies more infant formula. Four women suggested alternatives that inferred they had some idea of how the process of lactation worked. These women said they drank more liquids, ate a special vegetable soup (kāeng liang), a rural galactalogue, to increase the supply of milk, and let the baby nurse longer and more often. Other solutions included going to the doctor for advice, and using a breast pump. It is interesting to note that in response to this same question asked in a central Thai village, the unanimous response was to allow the baby to nurse more often and longer (cf. Van Esterik, 1976).

Most women who nursed their babies only did so at home and in private but four women said that they would nurse their babies elsewhere if it became necessary and if they were dressed appropriately. The only Bangkok women one sees nursing their babies in public are market vendors. Professional women leave their babies home with servants as much as possible, and are seldom seen in public with their infants. When they leave home, the women freely substituted infant formula for breast milk if they were still breastfeeding.

One woman allowed a relative to breast feed her baby in her absence. Most women believed that the breast milk from other women might not be clean, and feared that the baby might contract a contagious disease. One mother pointed out that the breast milk of one mother would not be the same as the breast milk of another. Although I have no direct evidence on this subject, I overheard two servants discussing their young infant charges. Both women were breastfeeding children of their own, and breastfed their employers' children also whenever they fussed. It may be, then, that wet nurses are still used, although the professional women lacked or denied knowledge of it. Certainly, in the not too distant past, wealthy families and the nobility would use wet nurses on a regular basis.

Fourteen women (38%) who began breastfeeding said that they made no advance preparation for breastfeeding their babies. Others suggested that the breasts should be massaged and washed often.

When breastfeeding, most women ate their normal meals, but supplemented their diet with extra vitamins, minerals and tonics, and increased their intake of meat, vegetables, eggs and fruit. Six women drank milk, a drink that is generally not popular in Thailand where a large part of the adult population are lactose intolerant (Keusch et al., 1969;

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[1] In a recent article, Gussler and Briesemeister (1980) argue that insufficient milk is extremely common among urban women particularly in the developing countries. As we pointed out in a response to their paper (Greiner et al., 1981), they failed to include the early introduction of bottle feeding among the reasons accounting for this phenomenon. This is clearly why these women have insufficient milk within a few days or weeks after childbirth.

Kretchmer, 1972). Note however that it is not established whether or not lactose intolerance entirely precludes milk drinking (Stephenson and Latham, 1974). Doctors have recommended that the mother drink two to three glasses of warm milk to help her production of breast milk. In the past, companies even suggested drinking formula before each nursing (Greiner, 1975:72).

Two women recommended traditional Thai foods for nursing mothers. These include a vegetable soup (kāēng līāng) made from ginger root, and banana flowers (cf. Hanks, 1963:54).

Twelve women reported that they did not abstain from eating any foods normally in their diet. Other women specified a need to avoid hot, spicy, pickled, strong tasting foods, and alcohol. In addition, one woman said that she generally avoided all foods that the "old women" forbid such as ice and fruits. Ice either over-heats or over-cools the body, and is dangerous at certain times; fruits are not considered to give strength, and many of them also have cooling properties (Hanks, 1963:22).[1]

It would not be difficult for sophisticated Bangkok professional women to combine food regulations for lactation from a western and a traditional medical system. The systems in this instance could complement each other, with the women choosing western food supplements such as vitamins and tonics while maintaining traditional food prohibitions.

The fact that breastfeeding is associated with problems, both real and imagined, is a serious constraint on the options open to Bangkok women. For, the people who can solve the problems and provide needed support are not readily available. The stress and anxiety of pursuing a career in Bangkok may also reduce a woman's confidence to the point where she may be truly unable to nurse her child. It is also a very common idea that only women who are exceptionally healthy can breastfeed. (This is a particularly strange belief when these women know that servants and low income mothers are among those who breastfeed successfully.) Women commonly volunteered the information that they were not well enough to breastfeed. The most critical information to communicate to the women choosing to breastfeed, is the relation between the amount of milk the mother produces, and the amount of supplements in the form of solid food and infant formula that the baby is given. The cycle of formula supplements and diminishing supply of breast milk often begins within a few days of the baby's birth.

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[1] Generally in Thailand, postpartum food restrictions are more in evidence than food restrictions during pregnancy. However, authors often fail to distinguish between food beliefs and actual dietary intakes. For example, while the hot/cold system is a salient cultural pattern in many parts of Thailand, it can best be thought of as a reference system rather than as a determinant of food choices.

5.3 Medical Facilities

Thai hospitals are not ideally suited for the establishment of a nursing relationship. Past surveys have shown that urban women who deliver in modern health facilities breastfeed consistently less than those who deliver at home (Knodel and Debavalya, 1980:69). The attitude of the western trained medical personnel may often be negative toward breastfeeding, and may contribute to the decline of breastfeeding because of inappropriate or inadequate training in lactation management.[1] Further, the doctors and hospitals have been most receptive to commercial formula companies. Nevertheless, Western trained doctors and hospitals are increasingly respected, even in rural areas of Thailand (Riley, 1974).

Although Thailand's granny midwives (mǫ tam yae) may deliver many babies as successfully as western trained medical specialists, they are not the preferred practitioners in urban settings, and the knowledge and experience of these indigenous practitioners is derided in urban centers. The professional women of Bangkok clearly preferred hospital deliveries, with only 3 of the 72 babies born at home. Most women remained in hospital for seven or nine days,[2] with the remainder of the women returning home after a shorter stay. This preference for a seven or nine day stay continued for subsequent children. For the birth of their first child, most women (18) said that they gave birth naturally without the use of instruments or anesthesia, or had a forceps delivery (12 women). Seven women had their first child by Caesarean section. Table 3 shows the method of delivery for all the children.

Table 3. Method of Delivery

	1st child	2nd child	3rd child	4th child	Totals
Natural	18	10	6	4	38
Forceps	12	6	1	0	19
Caesarean	7	4	3	1	15
Totals	37	20	10	5	N=72

[1] Western medical professionals are recognizing the need to become better informed on the management of lactation. Publications providing such information are in great demand in American medical schools (see for example Psiaki et al., 1977). Winikoff and Baer (1980) review evidence that changes in hospital practices can make a difference in the rate of initiation of breastfeeding.

[2] It is interesting to note that seven or nine days is the most common duration for "lying by the fire" after childbirth in rural villages. This practice completes the birth experience and is said to dry out the uterus (cf. Hanks, 1963; Attagara, 1967).

Note that 15 children (21%) were born by Caesarean section, a high percentage compared to averages in countries such as Holland (2-4%), and even the range of 10-22% in American hospitals (Pritchard and Macdonald, 1980:1082). One woman said that she chose to have her babies by Caesarean section because "she could not stand the pain of a natural delivery." This stated reason is difficult to believe, considering the painful recovery following a Caesarean section. However, in my association with these women, those having Caesarean sections commonly scheduled them for 3 p.m. on a Friday afternoon, with their government leave of absence of 45 days beginning the following Monday. Women who had their first baby by Caesarean section had all subsequent births by this method, and were convinced that this was the only alternative open to them.

Most deliveries (61) were not accompanied by drugs to prevent or reduce the amount of breast milk, although a few women recalled an injection to "dry up" their milk supply. Before the mother's breast milk came in on the second or third day after birth, most babies were fed infant formula regardless of whether or not the mother intended to breastfeed. In an interesting study on the effect of artificial feeding in a Bangkok hospital newborn nursery, it was found that more mothers were persuaded to use infant formula after their babies were formula fed in hospital. Those mothers who entered hospital undecided about how to feed their infants were more influenced than those who had already decided how to feed their infants before entering the hospital (Kietthabthew, 1980). Mothers report that their babies were given water or glucose from a bottle in the hospital nursery.

The hospital setting, then, is clearly not conducive to breastfeeding. The women reported that their doctors gave them advice on infant formula, but did not discuss breastfeeding except in the pathological sense of "curing" abscesses. The relatively long hospital stay could be responsible for training the infant to receive nourishment from the bottle, a much simpler process for the baby and the hospital staff. The high incidence of Caesarean sections might also influence these decisions.

5.4 Promotion of Infant Formula

A factor closely related to the influence of hospitals and their medical staff is the promotion of infant formula. The promotional activities and advertising campaigns of the multinational milk companies is the subject of Greiner's disturbing study, "The Promotion of Bottle Feeding by Multinational Corporations: How Advertising and the Health Professions Have Contributed" (Greiner, 1975). In Thailand in 1974, ads for formula were in movie theaters and newspapers, and on billboards, radio and T.V. Greiner looked at 258 issues of 19 different Thai publications and found 52 issues contained ads for infant foods (second only to the Middle East in prevalence, Greiner 1975:5). The support given to formula promotion by private and clinic doctors is probably more effective in influencing these Bangkok professional women than consumer advertising. Companies may provide a doctor with

formula lauding its "richness." For lower income families, Bear Brand also produces a popular brand of full cream sweetened condensed milk. This product has a picture of a mother bear feeding a baby bear with a large feeding bottle, and the warning not to give this milk to infants, written in thin letters on the side of the tin. Bear Brand states that this milk is suitable for infants over twelve months of age, and nursing mothers. Another popular sweetened condensed milk carries a similar warning written vertically up the side of a striped tin, almost invisible to the naked eye. Sweetened condensed milk, however, is of little concern to these Bangkok professional women. They can afford the best expensive imported infant formula and know that sweetened condensed milk is not suitable for infants.

Most women did not change the brand of formula they gave to their children unless the baby was constipated or had diarrhea. Others felt that as their babies grew, their needs changed and they should be given milk appropriate for an older child. In the decision to shift brands, or in any other questions concerning formula, 24 women (65%) relied on instruction booklets received from the infant formula company. They reported finding the booklets quite helpful.

Their babies are fed on schedule, according to the mothers, most commonly 5 or 6 times a day. The regularity and scheduling of bottle feeding is an integral and important part of infant feeding. These women reported that infant formula is valuable for the child. Over half reported that in their opinion, the formula they chose provided the best possible nutrition for the child.

It might be possible to view these milk companies as simply providing an important alternative to these mothers, an alternative compatible with their professional working schedules. On the other hand, unethical marketing procedures have been used in Thailand and in other developing countries, and are of continuing concern to those interested in infant nutrition.

5.5 Employment

A factor that appears to limit the options of these women is their employment patterns. Unlike rural women whose child care responsibilities can easily be adjusted to fit the mother's subsistence activities (cf. Nerlove, 1974), these career women cannot keep their infants with them as they work. They work at high status, modern, visible jobs, where there is no provision for nurseries, nor is there any demand for them at present. Even the urban poor may have more opportunity to keep their children with them if they work at home making hats, flower garlands, or desserts to sell on the streets.

These women report great pride in their careers, and in the civil service rank they have attained. They report that it would be difficult to advance in the bureaucracy or even maintain their seniority if they took off more than their normal maternity leave of 45 days. Women who have been working for more than 180 days are entitled to receive

30 days pay in addition to 60 days (including holidays) unpaid maternity leave. But women workers may be required to sign work contracts agreeing to waive their maternity rights (Pruekpongsawalee, 1980:18). These labor laws apply to women with regular salaries, and not to day laborers or self employed women. These professional women view infant formula as the only possible answer for working mothers. Under present working conditions, they may be right.

Efforts to promote government sponsored day-care centers have failed due to the "...absence of definite government policies regarding this issue" (SEADAG Reports 1975:9). During a seminar on women wage earners in Thailand, a suggestion was made that day-care centers should be established by employers hiring a certain number of women with children. Participants quickly pointed out that this would probably result in employers discriminating against women with children in their hiring (SEADAG Reports 1975:9).[1]

Of interest here is the rapidity with which Thai professional women returned to full time employment after the birth of their babies. After the birth of their first child, most of the women (86%) returned to full time work at the end of their 45 day leave or sooner. The remaining women were back at work two weeks later. This pattern continues for later children, with all women reporting back to work by two months after the birth of their babies. Nevertheless, very few women used those first two months to breastfeed their infants.

I have already noted the relatively high status of Thai women, and their employment in important sectors of the economy. Is the economic liberation of women tied to bottle feeding?[2] The Hanks reported in 1958 the exhilaration that Thai urban women find when engaged in stimulating occupations beyond household duties. In this sense, bottle feeding and early weaning can be viewed as a means of escape from domestic burdens (Hanks and Hanks, 1958:448-9). A shift to breastfeeding under present conditions would be viewed as a return to undesirable domestic labor.

5.6 Bottles as Status Symbols

One factor influencing the popularity of bottle feeding is the most difficult to document, that is, bottle and breastfeeding as status

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[1]Their fears are probably accurate. Lim's work on the electronics multinationals in Southeast Asia showed that the corporations are reluctant to pay the maternity benefits required by law and also more likely to lay off women workers than men (Lim, 1978:12,20). After the maternity benefits were decreased for women in the Philippines, a personnel director at a textile factory is reported to have said that "this made it profitable to hire women again."

[2]Gussler and Briesemeister's article (see footnote, p. 62) infers that the decline in breastfeeding is inevitable. Movies by Nestle and Ross Labs link the use of infant formula to the need for women to work outside the home. The problems of breastfeeding and working women are complex and are explored in more detail in Van Esterik and Greiner, 1981.

symbols. There was an assumption behind most discussions on this subject, that bottle feeding was perceived as more modern, progressive, western and scientific than breastfeeding, which was often referred to as animal-like behavior. This generalization is consistent with these research results, although more clarification is needed on the concept of status symbol and the use of symbolic analysis in explaining food habits before we can probe deeper beneath these cliché statements.

In the views of these women, bottle feeding with infant formula is part of a "package" of modernized technology unavailable to peasants and urban poor who breastfeed because they cannot afford more appropriate foods. In a Thai question which combines the notion of appropriateness and popularity of infant feeding patterns for upper, middle, and lower class women, more than three-quarters of these women defined the appropriate and therefore most popular infant feeding methods for upper and middle class families as infant formula, with only two women choosing breastfeeding as a suitable method for middle and upper class women. Most women (68%) thought that the "lower income group" should breastfeed. Further, 18 women (49%) felt that sweetened condensed milk is appropriate for the lower classes to use for their infants. This suggests that breastfeeding is perceived as a "lower class" method of infant feeding, a common sense observation confirmed in many personal encounters. What is disturbing is the perception of sweetened condensed milk, a product advertised as unsuitable for babies, as a lower class substitute for infant formula.

6. Concluding Questions

A study of this size and design raises more questions than it answers. Rather than state conclusions, I will raise additional questions which may have policy implications for programs designed to improve infant nutrition in Thailand.

1. How does knowledge of the benefits of breastfeeding affect the decision to breastfeed?

I asked a class of university students (Thammasat University, Bangkok) in a course on child welfare, how they intended to feed their infants. After an informal discussion on the subject in Thai, twelve girls submitted brief statements (in Thai) regarding their intention. None of these girls have had babies, but they indicate that they are aware of the benefits of breastfeeding. Five girls stated that they intended to breastfeed for the following reasons:

> "The baby should be fed with breast milk. It provides close contact between the mother and the baby; and this does not happen when the baby is fed with canned milk. In breast feeding, the baby will be held and this will bring love and affection between mother and child. If the child is fed with canned milk, it might not have the same affectionate feeling from the mother because there is less close contact..."

And another student writes:

> "Breast feeding is very beneficial for the baby. The quality of the mother's milk is such that it does not give the baby indigestion. It gives the baby more nutrients. It is also mentally beneficial, since it binds the mother and the child together with affection..."

They generally recognize the economic advantages of breastfeeding over formula, citing this as one reason for combining breastfeeding with formula. In this regard, a student argues:

> "When the mother is working during the daytime, the baby should be given powdered milk (formula). During the period that the mother is not working, the baby should be fed breast milk. The milk comes naturally, so it is a waste not to use it. Also the mother's milk has more nutrients than the canned milk. Breast feeding also helps in putting off menstruation which is helpful for birth control, even though it only helps at this stage. Breast feeding also helps the mother take care of herself and keep herself healthy."

In the same vein, a student notes that a woman needs to work at a job to "enable her to afford the powdered milk." Even before these girls have experienced motherhood, they are aware of the cost involved in providing imported formula for babies. Yet, their comments stress the emotional benefits of breastfeeding over the economic. As one student puts it:

> "One's child is one's descendant, and therefore the mother must 'give' to him. Breast milk is one thing that will keep the child alive, and healthy, and make him feel motherly affection and close contact..."

Although they have not faced the prospect of full time employment along with motherhood, these girls assume that a schedule can be worked out combining breastfeeding with formula. Two girls who said that they would not breastfeed their babies, feared that their health would not be good enough, and that their milk would lack nutrients which would be available in formula. These impressions suggest that the benefits of breastfeeding are fairly widely known among young women in Bangkok. In a recent study of the relationship between mothers' attitudes toward breastfeeding and infant feeding practices, Temchareon et al. found that both mothers who breastfed and mothers who bottle fed had favorable attitudes toward breastfeeding (1980:548). Clearly, attitudes toward breastfeeding do not predict breastfeeding behavior. Similarly, these statements cannot show how knowledge about breastfeeding will affect the decisions made by these girls when they become mothers. However, many of these women will probably not breastfeed regardless of what they know about the superiority of breast milk.

2. What suggestions would working mothers in civil service positions make to improve infant feeding practices?

Since many of the women in this survey have jobs involving planning and administering public policy, it is possible that their views on infant feeding could influence policy decisions. Their views summarized here reflect biases that should be taken into account in planning programs to improve infant nutrition.

The women suggested that for the Bangkok area, breastfeeding should be advertised in posters and pictures, but at the same time many of them qualified this with the comment that those who are able to breastfeed, should. They also advised that poor people should not use milk without high nutritional value. They had no suggestions as to how this could be accomplished, since they were aware that the cost of imported infant formula is beyond the reach of most of the urban poor. Instead, they characterize the urban poor as having "too many children that they are unable to care for. To help them, one has to reach them individually like visiting at their homes and demonstrating what should be done." They also pointed out that lower class people do not pay attention to such things as cleaning utensils, and sterilizing bottles, ignoring the fact that many of the Bangkok slum dwellers have only communal, contaminated water supplies available to them, and constraints on the amount of fuel they can afford.

For rural mothers, the Bangkok women suggest that they be taught the advantages of breastfeeding. From studies of rural Thai communities, it is clear that rural women know much more about the maintenance of a copious supply of milk than the Bangkok professional women. Further, they have the support of close relatives and friends who assume they will be good nursing mothers and know how to insure that they will be. The Bangkok women suggested teaching rural mothers the methods of good child care, the importance of proper nutrition before and after the birth of their babies, and the proper respect for public health officials. I have noted elsewhere (Van Esterik, 1976) that these public health nurses, trained in Bangkok, often carry with them the Bangkok disdain of "peasants," and in some cases, the concession to sell the more expensive brands of sweetened condensed milk. These Bangkok women do state that it is important for villagers to breastfeed, pointing out that it is easier for them to combine their work with nursing their babies. Several Bangkok women suggested that the peasants should schedule their nursing on a more regular basis. They suggested that these changes might be accomplished through an advertising campaign using T.V., radio, posters and movies.

3. Do working women really have any choices of infant feeding methods?

Certainly there is a choice in the first six weeks of an infant's life before the mother returns to work. Even after returning to work, there are solutions which could be found short of total reliance on formula. What, then, are the options that working women might consider?

The simplest solution, and the most popular choice, is the exclusive use of infant formula from birth. This option clearly requires a large cash outlay and is only available to working women with substantial income. But this behavior reinforces the idea of bottle feeding as a modern progressive alternative, and may influence the choices made by rural women or urban slum dwellers in the future.

A second option would be exclusive breastfeeding for the first six weeks, and then substituting expressed breast milk or other breast milk substitutes during the day when the mother returns to work. The mother could nurse her child in the morning and evening, and on weekends. This more complicated mixed feeding solution is less practical and not acceptable to these women. Breastfeeding is not perceived of as important enough to go to all that trouble.

A third option might be to supplement breast milk with formula after each feeding. Then the mother could wean the child totally when she returns to regular full time work. This option is common, but it is detrimental to the maintenance of breastfeeding as an available option, because it supports the idea that breastfeeding is always associated with problems, particularly insufficient milk. This option would result in a steadily diminished milk supply.

A fourth option is really incompatible with the mothers' stated view of good child care, but it may actually occur. That is, the use of a wet nurse while the mother is at work. This option could not be publicized or actively encouraged as a valuable strategy at present. It would be interesting to know more about the use of wet nurses, but the fieldwork would be very difficult to undertake.

Underlying these popular solutions is the common idea that if a mother is going to return to work, it is better to introduce bottle feeding as soon as possible to avoid possible problems later on. Working women feel they need to establish the bottle feeding habit early. Breastfeeding only complicates the problem.

4. How could more options be made available to these women?

Additional options would require changes in government and civil service policy, and only the strongest motivation for breastfeeding on the part of working women would influence this policy. At present, there appears to be no such motivation, or rather none among my informants. One option would require a longer maternity leave with no loss in seniority. A woman, then, would be able to nurse her child exclusively until returning to work. Additionally, government supported nurseries could be set up, with provision for two or three nursing breaks in a working day. Government supported creches are most common in countries based on a socialist economic system (cf. Richardson, 1975). Considering the importance of women in the labor force in Thailand, it is surprising that such plans have not been successfully implemented. However, considering the general disinterest in breastfeeding among the elite opinion leaders, and the lack of knowledge and

support available to women who choose to breastfeed, such a solution is unlikely in the near future. In 1974 there appeared to be little motivation to push for changes in the labor laws.

5. How effective are programs to promote breastfeeding among Thai professional women likely to be?

Certain features of Thai society would suggest that there is potential for supporting breastfeeding if more women wanted this option. The flexibility of Thai family structure (S. Embree, 1969; Hanks, 1972) could easily permit a doula unrelated to the mother to live with the family and be treated as a distant relative. A doula, or a person providing support and information for the new mother (Raphael, 1976), could be important in the early weeks after birth.

If the training that Thai doctors receive, both in the west and in Thailand, emphasized the advantages of breastfeeding as well as the dangers and benefits of infant formulas, the medical facilities could be accommodated to handle nursing mothers (cf. Winikoff and Baer, 1980). Those medical personnel who do support breastfeeding could concentrate attention on information of critical importance to the women attempting to breastfeed; that is, the relation of supplements to mother's milk supply. At present, a critical question is the influence that the commercial milk companies have on the medical profession in Thailand.

The fact that the Thai Department of Health already focuses funding and personnel on maternal and child health as a priority issue, could be potential support for the maintenance of breastfeeding as an option. Further, all the women interviewed expressed a great interest in and knowledge about nutrition. By publicizing the nutritional advantages of breast milk, more women might be encouraged to reconsider breastfeeding as an option. These women who shared their thoughts with me, stressed the fact that they would make the decision on the method of feeding their infant on their own. The independence of these women and their relatively high status[1] suggests that they would consider alternate methods of feeding if breastfeeding were viewed as being "worth the trouble."

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[1] In a recent dissertation, Brack argues that breastfeeding decreases when women's social power decreases relative to that of men in their own groups. For women to succeed with breastfeeding, they also need to hold positive values about the act. Although these women have relatively high status, their values about breastfeeding are quite negative. For example, a Thai professional woman speaking against the Nestle boycott argued that the supporters of the boycott do not know "what it means to have to breastfeed your baby." She felt that Thai women needed freedom to enjoy sexual activity, and Thai men didn't like to have sex with a woman "whose breasts dripped with milk."

7. Conclusion: Studying the Elite

Most discussions of bottle feeding with infant formula focus on the urban poor in developing countries, where there is abundant evidence that the products are misused or otherwise harmful. The infant formula companies argue that they do not advertise to these segments of the population, but to upper class women who work and who use infant formula without difficulties. Because of hospital practices and consumer advertising in cities like Bangkok, knowledge of bottles and infant formula is certainly not confined to the upper income groups, nor I am sure would marketing companies ever claim it was. Nevertheless, we know very little about the practices and beliefs of the women to whom infant formula companies claim to be directing their advertising. Why study elite women if their use of infant formula is unlikely to contribute to infant malnutrition?

First, elite professional women are part of a category of economically advantaged, highly educated urban women that we know very little about. But studies have shown that the duration of breastfeeding is usually shortest among well educated professional women in developing countries (Hofvander, 1979:69). The WHO collaborative study on breastfeeding showed that wealthier urban women breastfeed less often and for a shorter duration of time than rural or urban poor women. For example, in the Philippines and Guatemala, of those women who ever breastfed, over 50% weaned their children by the second month of life (WHO, 1981:33). We would predict, then, that elite professional women in Bangkok would not be supportive of breastfeeding and might even have negative attitudes towards it. We need to know the content and context of these negative attitudes, for elite women may be a source of culturally specific negative attitudes towards breastfeeding.

For example, elite women are most likely to patronize the best known and most influential medical personnel in the country. Their attitudes and practices would further reinforce the support for artificial feeding in the medical profession. The medical profession would then be less likely to press for changes in hospital practices which would be beneficial for breastfeeding mothers.

It is the ideas and attitudes of the elite that can be most widely communicated in any social system. For they are literate, articulate, and have access to more communication channels than the poor. In Ardener's terms, elite women are the least "muted" of the muted group of women (Ardener, 1977:3). To the extent that Thai women influence national policy decisions at all, it is the elite, educated women who have the potential and opportunity for influencing health and labor policy. To understand the rationale behind policy decisions, we need to study those in power, not those who are powerless and cannot influence the decision-making process.

Finally, the beliefs and practices of the elite in developing countries set the reference standards defining what is modern and therefore desirable. Changes in infant feeding practices first involved

elite wealthy families in positions of political and economic power (Jelliffe and Jelliffe, 1978:213). They are the first bottle users, the innovators, and the opinion leaders.

Elite professional women are more likely to have contact with western countries and have opportunities to travel there for education or professional responsibilities. Their greater familiarity with western products and their experience using them contributes to the creation of expanded markets for consumer goods. Mulder defines Thailand's expanding upwardly mobile middle class as admiring everything that comes from abroad, and following the trends of fashion and consumerism, regardless of the future consequences for the society as a whole (1979: 17).[1] Although this work does not present evidence for the process of creating status symbols, it is clearly the elite women who must be understood if we are to explain the adaptation of modern western traits as markers of status in Bangkok today.

The elite act as a symbolic model for middle and lower class urbanites. This is not simply a process of emulation following one to one contact between higher and lower income women, although that contact is certainly a factor (for example, domestic servants, lower echelon civil servants, service people, etc.). Nor is it strictly a case of the "trickle down theory" in action, whereby innovations "trickle down" from the upper to the lower classes (cf. King, 1964). Clearly, innovations, including new infant feeding practices, have different meanings to different classes and groups. As trend setters and definers of modernity, their beliefs and practices are influential. And they will be equally influential if, as in Sweden, they become the vanguard of a trend back to breastfeeding (Hofvander, 1979:69). For, the elite professional mother and the poorest urban slum dweller are linked in the same system of social, economic, and political influences which contribute to infant malnutrition in developing countries.

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[1] Thais refer to artificial feeding as modern (jalern or than samaj). The first term connotes a steady improvement in character and prosperity, while the second means to follow the fashion, or fit oneself to the times. Mulder refers to the acquisition of specific technological items which demonstrate one's ability to "follow the fashion" as symbolic modernization (1979:167).

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