

THE CULTURAL CONTEXT OF BREASTFEEDING IN RURAL
THAILAND

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INTRODUCTION

This paper offers a cultural interpretation of breastfeeding in rural Thai society, and demonstrates how breastfeeding behaviour is embedded in a complex system of relations, institutions, and beliefs which are themselves undergoing change. It argues that in rural Thailand, it is not breastfeeding rates that are changing dramatically; rather, the interpretation and context of breastfeeding is being transformed. Does this mean that Thailand is on the brink of a precipitous decline in breastfeeding?

Available research on infant feeding in Thailand suggests that Thailand would fit into the middle stages in the WHO typology of breastfeeding. In this model, prevalence and duration of breastfeeding are declining first among the more prosperous and better educated women, followed by the urban poor, and lastly by the rural group (WHO 1983:7). "As each population group emerges from its traditional lifestyle, forces begin to impinge on women and the prevalence and duration of breastfeeding begin to fall" (WHO 1983: 8).

Anthropologists can make a significant contribution to interdisciplinary research on breastfeeding by examining the historical, economic, political, cultural and social factors differentiating societies. In addition to available statistics on national breastfeeding trends, we can examine other clues about infant feeding style in order to explain the meaning of breastfeeding in different cultural contexts. This paper will develop these themes through an introductory section presenting national and community perspectives; a discussion of four individual case studies; and finally an investigation of how and why the meaning of breastfeeding is changing in rural Thai society.

THE NATIONAL PERSPECTIVE

It is possible to identify trends in the frequency and duration of breastfeeding in Thailand with some degree of accuracy since questions on breastfeeding have been included in national surveys from 1969 to the present. Many of these surveys and their analyses were undertaken by the Institute of Population Studies, Chulalongkorn University (Knodel and Debavalya 1980, Knodel et al. 1982).

1. There has been a slight decrease since 1969 in the number of women initiating breastfeeding. Surveys demonstrated that lower proportions breastfeed among urban, better educated, higher status and wealthier women compared to rural, less educated, lower status and poor women (Knodel and Debavalya 1980: 355-377).

2. The surveys show a moderate but steady decline in the duration of breastfeeding between 1969 and 1979, among both rural and urban women. The estimated mean age at weaning declined from 22 to 18 months for rural children and from about 13 to 8 months for urban children. Further, Knodel's analysis of the 1981 Thai Contraceptive Prevalence Survey found that the median duration of breastfeeding is only four months for urban Thai women but exceeds a year and half for rural women (Knodel et al. 1982: 9).

3. Supplementary milks or solids are introduced early, often within the first week of an infant's life. A recent marketing study for three American infant formula manufacturers found that 76% of their Bangkok sample mothers and 62% of their rural sample were using commercial milks in the first month of life (Gaither 1980:18). The same study found differences in breastfeeding patterns between rural and urban women. In the urban sample, overall 78% of children were at least partially breastfed, and 44% were still receiving breast milk at four months. In the rural sample, 89% of children were at least partially breastfed, and 76% were still receiving breast milk at four months (Gaither 1980: 32-33). In sum, very few rural women fail to initiate breastfeeding although exclusive breastfeeding is rare.

4. Evidence from these national surveys suggest that both rural and urban Thai women experience relatively short periods of postpartum amenorrhea. Over half experienced return of menstruation within 5 months of birth (Knodel et al. 1982: 313). This confirms the impression from other studies that many

Thai women who are breastfeeding are doing so only partially.

The data do not demonstrate the health consequences for Thai infants of the various patterns of infant feeding. However, in both rural and urban areas, there are few reports of protein calorie malnutrition until after six months of age (Khanjanasthiti et al. 1973). In urban areas, problems of protein calorie malnutrition are mainly seen in infants fed with sweetened condensed milk (Viseshakul 1976). The higher infant mortality (70/1000 live births) in rural areas is mainly attributable to the overall poverty, sanitation problems and lack of basic health care in many rural areas. In addition, the practice of feeding infants glutinous rice within the first week of life may be correlated with the distribution of bladder stone disease in Thailand (Valyasevi et al. 1967).

THE COMMUNITY PERSPECTIVE

Crocodile Village is a large rice growing village located at a major crossroads in Suphanburi Province, Uthong district, west central Thailand. The district is relatively prosperous compared with other districts in central Thailand. Both large and small farmers have diversified their crops, put their profits into sugar cane or cattle, and taken advantage of the convenient transportation to Bangkok to sell their products. Poor and landless families work for daily wages or seek seasonal employment in Bangkok.

Crocodile Village has a population of over 5000 individuals. The village has a school, a rice mill, shops, a midwife station, and a beautiful temple complex. Recently the largest village market closed since improved transportation made it more profitable for buyer and seller to use the large permanent market in nearby Uthong. Most homes now use electricity to power lights, refrigerators, televisions, and electric rice cookers. The community has improved measurably in the last decade, and inhabitants talk of the progress (kswam csalern) which has finally reached them.

Some basic health problems of the community are solved ritually by a number of traditional practitioners, including several midwives. Stubborn health problems are referred to the village barber whose shop carries a wide range of western drugs including intravenous solutions which are mixed with

traditional Thai medicines and consumed as tonics. A public health nurse serves the midwife station and provides a limited supply of government medicines free or at nominal cost. She assists at many home deliveries and occasionally refers complicated cases to the provincial centre.

In the mid-seventies, almost all village women breastfed their children, adding supplementary solids such as mashed bananas and rice within the first few weeks of life. In the course of a detailed household survey of social and economic characteristics, 177 village mothers were asked to recall how they had fed their children. These mothers ranged in age from 19 to 89 years. Only three mothers reported not breastfeeding their children, using instead a commercial milk product. Sixty-one (8.5%) of the 714 infants born to these women were given milk supplements while receiving breast milk. This is substantially less supplemental feeding than current studies indicate, but note that these retrospective reports span three generations of mothers - from the time before breast milk substitutes were widely available in the village, to the situation in 1974. After weaning, sweetened condensed milk was the most popular supplement, often mixed with tonics such as Ovaltine, for older children. Occasionally, mothers would deliberately delay weaning their last child in an effort to create a reciprocal obligation in the child or as an emergency food source for a sickly child. Mothers reported breastfeeding their infants until confirming their subsequent pregnancies. Only 3% of mothers reported breastfeeding their infants less than 12 months. Most breastfed until the infant was 1½-2 years of age.

In central Thailand (excluding Bangkok) there is less breastfeeding than in other regions of the country. Since urban contact is negatively associated with extent of breastfeeding (Knodel and Debavalya 1980: 45), it is likely that communities such as Crocodile Village in central Thailand are directly or indirectly affected by Bangkok. Central Thailand is generally more prosperous than other regions of Thailand, and it is not surprising that the Ministry of Public Health in their 1980 reports found that protein calorie malnutrition is less prevalent, though still not insignificant, in that region (45% of infants and preschool children).

NEIGHBOURS IN CROCODILE VILLAGE

Participant observation of four cases in Crocodile Village provided important clues to the meanings of breastfeeding in Thai culture. From the experiences of Chat, Daeng, Lek and Nong, below, we learn that some women are simply accepted as good nurturers; that infants can be born in the "wrong" family; that breastfeeding creates reciprocal obligations between mothers and their children; and that great fear of spirits surrounds infant death.

Chat

Chat sat breastfeeding her two year old son, absently tweaking his genitals, and reflecting on the fact that she might be breastfeeding for the last time. Now in her forties, Chat richly deserved her reputation as a woman who nurtures well (*liang dī*). Each of her eleven living children which she delivered herself was breastfed until she confirmed her subsequent pregnancy. By giving of herself in this manner, she creates a reciprocal obligation in her children which she expects her sons to repay by ordaining as Buddhist monks, and her daughters by attendance at sermons and merit making activities. Both activities would increase her merit store, guaranteeing her a better rebirth. She was particularly anxious to draw her youngest daughter to her in this manner so that she would feel obligated to care for her parents in their old age.

For the first few children, she followed generally accepted food regulations, avoiding ice, spicy foods, and foods which upset her during pregnancy, and her baby during the postpartum recovery period. The period of recovery following childbirth when Chat rested on a mat beside a low fire ("lying by the fire," *juu fai*) was faithfully observed for the first few children, and simplified for subsequent children as her competence as a mother was confirmed. Now, her six year old daughter took most of the responsibility for feeding her son soft rice, bananas, and occasional tidbits of adult food. Chat's services, however, were still in demand by village women who needed advice and support from a woman who had proved herself capable of nurturing well.

Daeng

Daeng's six day old baby died last night after a fever. All the older women in the neighbourhood were over examining the baby and exclaiming over its beauty before it was covered with the cloths and basket prepared for it. Chat said it died because it had not received any mother's milk but only mashed bananas. Daeng said her baby puffed up and died. Chat was particularly incensed at Daeng since the infant could have been given to someone else to breastfeed or fed with sweetened condensed milk until it was confirmed whether or not Daeng was a good milk producer.

When the ritual specialist came to arrange the funeral, there was no emotion expressed - only a resignation and a willingness to put the ritual burden on the specialist, who for 6 baht (30¢) handled the baby with practised hands steadied by a bottle of liquor and protected by amulets. The baby was buried and had to be cremated later since the cremation could not take place on a Friday. Daeng stayed in her room for three days, protected from the baby's ghost by a sacred string (*saisin*) and a path of rice and salt to lead the baby's spirit away from its distraught mother. It clearly had not been born into the right family and was called back to be reborn later into the right family.

A young prostitute who danced at temple fairs between agricultural duties, Daeng did not appear to want the baby boy, but was clearly terrified that the spirit of her dead child would harm her and prevent subsequent births. Instead of "lying by the fire" following the birth, she had purchased six bottles of Chinese liquor to warm her body. She had no prenatal care, but called a traditional midwife to assist with the delivery.

Nong

Nine year old Nong sat under the teak house with a scrawny infant straddled on her hip. She walked back and forth trying to quiet the six month old baby. Exasperated, she added more rain water to the thick residue in the bottom of the plastic bottle, shook up the mixture until it looked milky white, and fed it to the baby who drank eagerly. Although there were many breast milk substitutes available in the market, they were too expensive for the family to purchase. Sweetened condensed milk was already available in an open tin in the kitchen, since the adults had used it in their morning tea. Her

grandmother taught her how to feed and care for the baby.

Nong's brother had gone to Bangkok seeking work. There he met a young woman who had no interest in marriage or child rearing. When their child was born, no one would take responsibility for its care. He therefore brought the infant back to his rural home and left it in the care of his parents. His occasional visits and even more occasional financial contributions dwindled and ceased, leaving his youngest sister with a new responsibility, a new toy. When she was older, perhaps she would go to Bangkok, too, and escape the boredom and hard work of rice farming.

Lek

Lek's first baby was born on the same day as Daeng's baby. Her family took her into the provincial hospital for the birth and brought her back the following day. A large metal crib equipped with a mosquito net had been prepared for the baby. Lek's mother's sister breastfed the baby for the first two days before Lek's milk came in to give the baby a good start in life and set a correct breastfeeding habit.

The third day after the birth, the family prepared a ritual to welcome the child into the human world. For the first three days after birth, the newborn belongs to the spirit world; the fourth day, it becomes a human child. The ritual also protects the health and well being of the infant and ensures that the infant will be easy to raise. The ritual, as all Thai life crisis rituals, must be conducted with great care to ensure that the ritual objects and incantations are appropriate. The ritual could be dispensed with, but if the family chose to perform it, it must be done correctly. But unlike other family rituals, this one was performed quietly with only the ritual specialist and family members in attendance. A woman who was a particularly good nurturer accepted the child into the world of humans, and a protective string was tied around the infant's wrist to tie in its spirit and prevent it from wandering. Rings, necklaces and belts of three metals (gold, silver, copper), a small bag of Thai coins, a knife sharpener, and a needle were left in the cradle to symbolize the wealth, prosperity and skills the family wished to bestow on the child. Secured by the best medical

and ritual protection the family could afford, Lek's baby slept peacefully.

THE ORGANIZATION OF CULTURAL KNOWLEDGE

Rural Thai theories for interpreting infant feeding behaviour are constructed from cultural knowledge acquired on the basis of personal experience and the experience of others. New experiences are interpreted and reinterpreted by individuals on the basis of their previously acquired cultural knowledge, and may be based on more than one model. In this essay, two models will be described: one based on assumed past behaviour and one based on women's perceptions of the modern way to care for an infant. It is important to note that even if we could relate all relevant cultural categories and cultural rules for the application of these models, we would still fall short of accounting for all observed infant feeding behaviour. In fact, we might find it difficult to understand and explain the circumstances of even these four households from one central Thai village. Life experiences and unforeseen circumstances provide a potentially infinite number of individual contexts within which infant feeding decisions must be made.

Yet in everyday life, women with different theories about infant feeding can and do communicate their personal understandings about that subject, for they share basic cultural categories. Two important categories Thai women use to organize knowledge about infant feeding are samai gorn (past time) and samai mai (modern times) (cf. Mulder 1978).

Samai Gorn. The term samai gorn refers to an unspecified time in the past. Thai use samai gorn (time period before the present) and samai boran (ancient time, the mythical past) to refer to the way things used to be.

Samai gorn, the old women report, everyone breastfed their infants, for there was no alternative available. If a woman could not breastfeed her infant, the infant would be fed by another woman, or it would die. Lactation failure was rare and accounted for by unusual characteristics of mother or infant. The rare occurrence of insufficient milk was easily handled by putting the baby to the breast more often, and drinking traditional galactogogues such as gaeng

liang (nurturers soup), a watery soup made of vegetables and banana flowers.

The first few days after birth an infant belonged to the spirit world, not the human world. On the fourth day, it was coaxed into the human world, breastfed, and given honey, rice or banana to set the pattern for future food habits.

Whether or not a mother had the ability to produce sufficient supplies of milk was a fixed characteristic of each woman. Perhaps samai gorn there were more mothers who were good nurturers (liang di) and thus able to feed their infants. Certainly, infants were easier to raise as long as they were born into the right family. Babies were breastfed on demand, and carried everywhere with the mother. A crying baby meant that a spirit was disturbing the child, but the spirits could be easily appeased through ritual words and actions; meanwhile the infant was comforted by breastfeeding.

Samai gorn pregnancy was a dangerous and vulnerable time, "like setting out in a little boat to cross the sea, one foot in the water and the other on the gunwale of the boat" (Rajadon 1965: 122). Women protected themselves by avoiding foods that caused them discomfort, adhering more or less strictly to a number of food restrictions which were neither onerous nor compulsory. These varied depending on the woman, her past experiences, and whether or not she believed that altering her diet would affect her health. In the past, more women believed that food prohibitions were necessary and so more followed the rules. Samai gorn women regulated their own behaviour and that of their families to maintain moral balance in the household (cf. Muecke 1976b). To minimize childbirth complications, pregnant women avoided overeating and worked during their pregnancies to keep their muscles in shape and their weight low.

Childbirth was a time of great apprehension. Mothers and newborns often died and afterwards returned as spirits to threaten other women. Death in childbirth and death of a newborn are considered the most unfortunate kinds of death. Some of the most powerful and cruel ghosts which inhabit the minds of rural (and many urban) Thai originate from maternal and infant death.

The pervasive fear of childbirth is related to the power of the ghosts generated through maternal or infant death. Samai gorn women feared that when a newborn died, its spirit could destroy the mother, through possession, biting the mother's entrails

while still in the womb, or coming back to take the mother with it. Mothers need protection from this possibility. Samai gorn these spirits were feared and controlled ritually to protect a new mother from danger. The suffering of the mother in childbirth was a measure of her great sacrifice for her children, and a constant reminder of their obligation to her. Breastfeeding further increases the debt of a child to its mother and creates a reciprocal obligation which should be paid back later in life. Women worked hard to deliver their babies, and chose a local midwife with desirable characteristics to help them.

Samai gorn girls became women through the experience of "lying by the fire" (juu fai), the fire of maturity where a female became a full woman (cf. Hanks 1963). Since childbirth leaves the mother cold and wet, mothers lay by a hot fire to warm their bodies and dry out their insides. Resting by the fire from five to eleven days, the new mother cared for her infant, and was relieved of all household responsibilities. This period of intense interaction between the mother and her newborn ensured that the baby and mother were compatible. But women who had confidence in their capacity to raise children successfully might forego or shorten the experience. The same effect could be achieved by drinking Chinese alcohol. If a woman decided to "lie by the fire" it must be done with care to observe all ritual precautions concerning equipment and timing. It must be done right, or dispensed with altogether.

Samai Mai. Thai refer to modern times as samai mai (new times) and place value on following the times (taan samai). Following the times requires giving the appearance of progress. The acquisition of new items of material culture indicates this progress to others.

In modern times, women no longer need to follow food prohibitions during pregnancy, since they can obtain powerful medicines to relieve symptoms of discomfort. In fact, mothers are encouraged to eat more nutritious food and produce a healthy baby. When pregnant, they may obtain prenatal care at local health centres to ensure later admittance for delivery. There, a doctor or nurse will deliver the baby for them, and sometimes give them drugs to stop the pain.

In modern times few women die or even suffer greatly in childbirth. If complications do develop, women are removed to the health centres where family

and neighbours are unaware of their suffering. But the decisions to have clinic births are also conscious choices of women who opt to follow the times. (Lek, for example, made plans early in her pregnancy to have a hospital birth).

On their return from the clinic after childbirth, women have no need to alter their behaviour significantly, since the clinic has afforded them extra protection, and there are no dangerous spirits to threaten the well being of mothers and newborns. In modern times, fewer people believe in spirits or try to manipulate them. Similarly, "lying by the fire" to dry the uterus and ensure a good milk supply, and special food prohibitions are optional restrictions which inconvenience the mother.

In modern times, women have choices available to them for feeding their infants; they may breastfeed or use one of the easily available breast milk substitutes and bottle feed if necessary. In the first few days after birth, before the milk supply is established, infants can be given suitable nourishment from a bottle rather than exposed to the germs of a "wet-nurse."

In modern times, there are fewer women who are "good nurturers." Women increasingly perceive a number of other ways to evaluate their personal worth, including their value in the labour market. Women who are not "good nurturers" may suffer from insufficient milk. The fact that babies cry is a sure indication that mother's milk is not sufficient. Nevertheless, infants must be taught to accept the disciplines of scheduled feeds, survival training for modern times.

Modern times arrive sooner through development efforts. Through nutrition education programs, for example, women learn that vitamins and protein (not cold and hot) are the properties which determine the worth of a food. They can use this knowledge to evaluate the vitamin and protein content of breast milk substitutes and to ensure that their own diets are adequate in vitamins and proteins to produce breast milk of sufficient quality.

In modern times, infants are harder to raise, and children a greater burden. But family planning messages remind women to plan their families using pills, injections or sterilization. Parents have increasing responsibilities to their children to provide them with a good education and opportunities to acquire the benefits of the civilized world. Those benefits may well draw their children away

from their rural homes in search of their individual destinies.

THE DISTRIBUTION OF CULTURAL KNOWLEDGE

The two models developed here are not descriptions of a specific sector of rural Thai society, nor are they ideal types. Rather, they are culturally constructed models which people use as reference points for interpreting their infant feeding behaviour and the behaviour of those around them. These models frame activities and help women make sense out of the complexities underlying their decisions. Of necessity, they simplify, exaggerate, and stereotype behaviour, presenting to themselves and others (including anthropologists) cliché models which we might refer to as traditional and modern patterns of infant feeding.

Although older women are more likely to interpret their past behaviour and that of their daughters by reference to the samai gorn model, both models may influence any one woman's decisions. Recall Lek, for example, who chose to bypass the local midwife and have her baby delivered in the provincial hospital. On her return from the hospital, she performed a protective ritual which Chat (who uses herself as an example of the right way to give birth) considers old-fashioned. Daeng was unable to "lie by the fire." However she substituted Chinese rice wine and said that she wished she had a heating pad to relieve the coldness following childbirth.

As in stereotyping behaviour generally, urban women attribute the samai gorn model to all rural women, while village women assume urban women all follow the times, and the samai mai model sketched here. In reality, the situation is much more complex.

Women who interpret their infant feeding behaviour by reference to the samai gorn model obtain information from female family members. Expert knowledge and wider experience could be obtained from traditional midwives who know how to manage lactation, increase milk production, and solve minor problems such as engorgement. Samai mai, knowledge of childbirth, infant feeding, and health care is available from professionals located at health centres, from the media, and stores selling products for feeding infants.

ACQUIRING NEW KNOWLEDGE

Through the process of rural development in Thailand women have increasing opportunities to acquire cultural knowledge which can affect the way they interpret breastfeeding.

These new learning contexts include:

- midwife stations and health centres offering delivery services
- markets offering a variety of breast milk substitutes
- nutrition and family planning messages.

Each opportunity, taken alone, may affect the behaviour of only a few rural women. Taken together and interacting with the particulars of Thai culture, they have potential secondary effects which are hard to predict but which may discourage breastfeeding.

Clinic Deliveries

The experience of childbirth away from home in a health centre or midwife station is becoming more common in rural Thailand. In Bangkok, most deliveries are in hospitals or clinics (Durongdej 1983). In smaller cities and towns, these facilities are becoming more popular for deliveries (Muecke 1976a). The increase in the number of midwife stations and health centres in rural Thailand attests the growing popularity of modern health facilities for deliveries. This is all the more striking since health centres in rural Thailand are generally underutilized, and clients often bypass local health services to utilize the more sophisticated government facilities (Day and Leoprapai 1977).

In urban areas, health care services may affect infant feeding practices directly through the distribution of samples of infant formula and the routine use of infant formula the first few days after birth (Van Esterik 1982). Assuming that rural health facilities are not engaging in these practices, they may still affect infant feeding indirectly. Consider, for example, how clinic or hospital deliveries encourage the reinterpretation of the reproductive process. As the birth experience becomes more dissociated from the experience of pregnancy, the continuity of the process from conception to sevrage, or complete weaning, is ruptured. This dissociation is accomplished in a number of ways. First, the birth

takes place away from the mother's home and family, and from the traditional midwife who would have provided continuous care from pregnancy through breastfeeding. Second, the emphasis shifts to one segment of the reproductive process, the delivery. Finally, mothers may be physically separated from their infants after birth for examinations, special care, or operations for sterilization.

Breast milk Substitutes

The marketing of a variety of tinned milk products in colonial Malaya in the late 1800s has been well documented (Manderson 1982). Although the market for tinned milks may have been smaller in Thailand it is likely that the brands marketed in Malaya and Burma in the early 1900s were also available in Thailand. By the mid century, sweetened condensed milk was imported from at least five European countries and by 1963 the imports of sweetened condensed milk to Thailand (58.5 metric tons) exceeded the amount imported into Burma, Malaya and Indonesia (Van Esterik 1980). Statistics on Thai export-imports from the Department of Customs reveal that over twenty-six million dollars worth of infant formula was imported into Thailand from eleven countries in 1981. In addition, infant formula is being produced in the country. It is clear that a wide range of infant formula products are available in both urban and rural markets. In Crocodile Village in the mid-seventies, there were several brands available in the town market, and a wide range of sweetened condensed milk available in the village market. One brand in particular was considered richer than others, and was only available from the local public health nurse at the midwife station. Most women were becoming aware that breast milk was only one among several possible products available for feeding an infant.

Nutrition and Family Planning Messages

Another source of new information for rural women comes from the village health volunteer programs initiated in the mid-seventies. The responsibilities of the village health communicator and village health volunteer include nutrition education, with particular emphasis on diet during pregnancy and lactation. Mothers are encouraged to attend classes at the health centre and participate in meal preparation in order to learn more about

nutritious foods. The volunteers are instructed to encourage breastfeeding, particularly in low income families (Vachananda 1982).

Volunteers were also utilized to distribute oral contraceptives and condoms and other services relating to family planning. In addition to government initiatives, the Community-Based Family Planning Services (CBFPS) developed an efficient distribution network throughout rural Thailand and popularized family planning through messages such as "too many children make you poor." These messages encourage women to consider the costs of children and their parental responsibilities to their children. The appeal of family planning programs in Thailand is well known. Village women talk freely about family planning, including concerns that oral contraceptives will affect their breast milk by changing the taste or reducing the supply.

In these and other contexts, rural women have opportunities to interpret infant feeding in new ways.

EXPLAINING CHANGE

The conditions described above are likely to be increasingly common in rural Thailand in the future as primary health care programs integrated with family planning services are developed and expanded. Unless Thailand's commercial policies change radically, the supply of local and imported breast milk substitutes is unlikely to decrease. Better health care, reduced family size, and the availability of nutritious breast milk substitutes for use under certain circumstances are certainly desirable objectives. But taken together, these developments may have unanticipated effects on infant health by altering the interpretation and emphasis women place on breastfeeding.

There are reasons to be concerned about the decline in breastfeeding in rural Thailand, and reasons to suspect further decline is almost inevitable unless supportive and protective measures are taken. Why should Thailand be considered vulnerable? First, there are predispositions in the cultural logic underlying both traditional (samai gorn) and modern (samai mai) infant feeding models which are not supportive of breastfeeding. Second, there are certain synergistic relations supporting breastfeeding which are easily affected by other changes in rural Thai communities.

It is often assumed that the cultural knowledge underlying breastfeeding behaviour in rural peasant societies is supportive of breastfeeding. An examination of the range of beliefs and practices in diverse societies demonstrates that women in many societies may breastfeed successfully in spite of some detrimental beliefs and practices such as expressing colostrum, or adding supplementary solids at an early age.

The following cultural assumptions about breastfeeding can be interpreted by reference to either the samai gorn model or the samai mai model.

Assumption 1: breast milk is easily affected by what the mother eats.

In a traditional model, this may be interpreted as calling for special food proscriptions such as those restricting ice and spicy foods for lactating mothers. Breast milk spoils easily to produce nom sia (bad milk) as a result of eating foods which disagree with the mother. A modern interpretation stresses the need to eat foods with lots of vitamins and proteins to improve the quality of the mother's breast milk. Taking birth control pills can also produce bad milk.

Assumption 2: breast milk is affected by mother's health.

Samai gorn mothers protected themselves from problems by gaining strength during the period of "lying by the fire" when others cared for them. A mother could build up her strength and health with tonics.

Using a modern interpretation, rural mothers who are ill may fear contaminating their infants with their germs and stop breastfeeding. Following the times, women emphasize the need to be "superhealthy" in order to breastfeed. A perception that she is not healthy enough to breastfeed would discourage a woman from breastfeeding.

Assumption 3: the capacity to breastfeed is an inborn characteristic: some women are good milk producers and other women are not.

Women learn this through experience. Samai gorn, if a woman had problems breastfeeding a child, she might give her child away for a relative to raise, since the child was obviously born into the

wrong family. Samai mai, problems with the initiation and establishment of breastfeeding confirm that a woman is not a good milk producer. Since this is a characteristic of the woman, she is unlikely to seek medical advice.

Assumption 4: infants do not cry without cause.

Samai gorn, spirits often disturbed infants and made them cry. Spirits could be appeased by being fed or kept away by recitation of protective verses.

In modern times, spirits seldom interfere with human activities. It is more often felt that babies cry because they are hungry, a sure indication of insufficient milk.

Assumption 5: delaying initiating breastfeeding for one to three days is sensible and acceptable.

In a traditional interpretation, there is no point in breastfeeding an infant for the first three days, since it is a spirit child and does not become a human child until the fourth day of life. Breastfeeding a new born with colostrum (bad milk) would set a bad habit for future breastfeeding. A newly delivered woman in a cold state would produce cold harmful breast milk anyway.

In modern times, when a health professional delivers the baby for a mother, he or she will take the responsibility to feed the infant until the mother is strong enough to breastfeed the infant herself. Meanwhile, if the infant is hungry, it can be fed with a bottle.

Assumption 6: breastfeeding must be done right or not at all.

As in many domains of Thai life, breastfeeding must be done right, or women may feel they give their infants better protection by not breastfeeding at all. Samai gorn, women could protect themselves by following certain rules as guidelines for diet and activity.

Doing it right in modern times requires following a new set of rules for breastfeeding -- at a minimum, eating properly and keeping clean.

For rural Thai women to breastfeed successfully despite these cultural assumptions which do not encourage good lactation management, there must be strong motivation and ideological support for

breastfeeding. However, there are changes in rural Thai society which act subtly to undercut some of the motivation and ideological support for breastfeeding. Many of these changes are better understood as shifts in emphasis rather than structural innovations.

The following linkages are synergistic: that is, a cumulative set of factors taken together may have an effect on breastfeeding greater than the effect of each factor separately. Further, these suggestions should be considered the basis of further research hypotheses rather than conclusions from work completed.

Breastfeeding as a social act is linked with the value of children and a woman's identity and is considered a natural continuation of pregnancy and childbirth. Breastfeeding, then, is not part of the domain of food and eating, but part of the domain of pregnancy and childbirth. It is part of a continuity which starts with the recognition of pregnancy and ends with the last breastfeeding (sevrage).

Before the advent of adequate medical care, the entire period from conception to sevrage was one of vulnerability for a woman and her infant. If a mother experiences discomfort in her pregnancy or has a history of past problems, she may make changes in her diet based on her own experience and the advice of older women. The food prescriptions and proscriptions vary from person to person, and appear to be more important cognitively than nutritionally. Further, they have an important symbolic function which becomes more apparent as modern health care services redefine women's reproductive experiences. Food restrictions ritually define the period of pregnancy and lactation as a special period for the mother - a transitional period for both her and the newborn. Food regulations before and after birth are an effective means of encouraging mothers to view the reproductive process as a continuity. The same maternal food restrictions or avoidances may be continued after the birth of the baby to provide maximum protection for the infant or to relieve specific problems such as diarrhea. Once an infant begins solid foods, the mother chooses foods using the same principles in addition to her own experience to prevent problems in the infant, to accustom the infant to culturally appropriate foods, and to reduce the infant's hunger for breast milk (Muecke 1976a). The early introduction of mashed rice and bananas, or prechewed glutinous rice,

begins the process through which the infant is socialized as a member of Thai society. The earlier these foods are introduced, the faster the process will be completed.

When breastfeeding is seen as part of the continuity of pregnancy, birth, and postpartum recovery, women emphasize breastfeeding as a process rather than as part of the domain of food and eating. However, an examination of the way Thai mothers talk about breastfeeding reveals that they can discuss not only the process but also the product, breast milk (literally, mother's milk). As a product, breast milk invites the analogy with other milks, and its properties can be compared with other milks and other foods. Cow's milk, for example, was devalued in the past since milk does not form part of adults' regular diet. Mothers feared that if infants drank cow's milk they would have minds like cows. But as people learn of vitamins, proteins, and minerals present in breast milk substitutes, questions arise as to what breast milk is made of. Why is it watery? Bluish? How similar is it to infant formula? As breastfeeding becomes dissociated from the entire reproductive process, and as breast milk substitutes become increasingly available in rural Thailand, emphasis shifts from the process of breastfeeding to the product, breast milk, and the domain changes from the pregnancy-birth-breastfeeding nexus to one of food and nutrition.

Much of the motivation for breastfeeding came from the desire to create a strong reciprocal obligation in children. Any circumstances which discouraged the idea that children are obligated to their parents would also tend to discourage breastfeeding. As more and more young people leave their rural homes for Bangkok, parents are reminded that neither breastfeeding nor ritual precautions effectively guarantee that children will reciprocate and care for their parents in their later years.

An increase in clinic deliveries in rural Thailand might well provide a further opportunity for mothers to dissociate themselves from their newborns. By relinquishing control over the birth process, mothers gain more opportunities to break the connections between themselves and their newborns. This early dissociation helps remove the blame for an infant's sickness or even death from the mother to health professionals. Use of infant formula or bottle feeding, particularly for

newborns, further encourages the dissociation of mother and infant.

Finally, the role of belief in spirits and ghosts in encouraging mothers to seek clinic delivery should be examined in more detail. In rural Thailand, the fear of maternal and infant death is a powerful motivating impetus towards clinic births. Buddhist logic requires that a dead infant be dissociated from living survivors since it was clearly an incomplete human, born too soon and possessing significant demerit from former lives. (This is why Daeng required so much protection after her baby died). Belief in these dangerous spirits may underlie mothers' desires to dissociate themselves from their newborns.

CONCLUSION

In the context of changes which encourage rural Thai women to distance themselves from their newborns, and decreasing reciprocal obligations between parents and children, breastfeeding is losing much of its currency in rural Thai society. The existence of alternatives to breast milk may reduce the incentive to persevere through breastfeeding problems.

Devaluing breastfeeding as a social act has come about through a combination of cultural assumptions underlying both traditional and modern interpretations of infant feeding which are not strongly supportive of breastfeeding, and shifts in values and emphasis which reduce motivation to breastfeed.

These conditions, in the context of the increasing availability of breast milk substitutes in even the most isolated communities, create the potential for significant declines in the prevalence and duration of breastfeeding in the future.

However, the Thai Ministry of Health recognizes the importance of breastfeeding and has launched a number of programs to strengthen and promote breastfeeding in Thailand. In addition, the Fifth Five-Year Plan for Thailand (1982-1986) has included as one of its objectives to maintain full breastfeeding among 90% of rural mothers with infants from 0 to 6 months.

Knowledge of the sociocultural context of breastfeeding can help to predict how changes, both planned and unplanned, in the ecological and cognitive contours of rural Thai society might

affect breastfeeding. Building from the interpretation presented here, the following suggestions might strengthen efforts to protect breastfeeding in rural Thailand so that change and development do not unwittingly undermine what they seek to promote - the health of Thai infants.

1. The government of Thailand could implement regulations limiting the marketing and promotion of breast milk substitutes. Presently, the Thai government includes among its implementation plans for nutrition activities, the production of low cost infant formula for low income families (Vachananda 1982: 18).

2. Support for breastfeeding women could be provided by village health volunteers (VHV) and village health communicators (VHC) only if they were perceived by local women to be women who "nurture well" (*liang di*). Women who have successfully breastfed their own children could have an important role in supporting women through pregnancy, childbirth, and lactation.

3. Nutrition education programs might stress that extra food in pregnancy produces stronger infants, not larger infants.

4. These programs could develop messages focusing on specific problems such as the assumption that colostrum is bad milk. For example, a message such as "The sooner you breastfeed, the better the milk," leaves open the possible interpretation that breastfeeding an infant early will help get rid of the "bad milk".

5. Finally, many promotional campaigns make it hard to "breastfeed right". Using Thai cultural assumptions, if it is made hard to do correctly, then it may discourage women from breastfeeding at all. For Thai women, it is better not to try it at all, than not do it right. The main message for anyone involved in breastfeeding promotion in rural Thailand should be "make it easy for women to do it right".

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