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RESEARCH IN ECONOMICS AND RURAL SOCIOLOGY

Infant breast- or bottle-feeding and social position: four ways to be a mother

Promoting infant health through the implementation of a diet adapted to each of the child's development stages is one of the Public Health objectives expressed in the French National Program of Health Nutrition (NPHN). This objective is part of a long-term perspective. It follows the policies to combat infant mortality that were implemented during the 19th century and continued during the 20th century with the creation of Mother and Child Care Centres (MCCC) in 1945. Promoting breast-feeding is one of the specific actions of the second French NPHN (2006-2010). France has lower incidences and durations of breast-feeding than other countries in spite of a decline in bottle-feeding immediately after birth since the beginning of the 1990s. A sociological approach to new-born baby feeding, combining the social determinants of the mothers' choices, evidences four types of maternal behaviours, the respective place of recommendations of infancy specialists and other sources (in particular the family), the place of practical or symbolical advice and obstacles to the application of these prescriptions. More frequent in the lower classes, the first two types of maternal behaviours show a more systematic use of bottle-feeding, although these women are distinguished by their claim to a "traditional" upbringing on the one hand and a reluctance to justify their choices beyond the constraints of life style on the other. The practice of breast-feeding is at the heart of the other two model types which mainly concern the upper or middle classes. Particularly in the case of

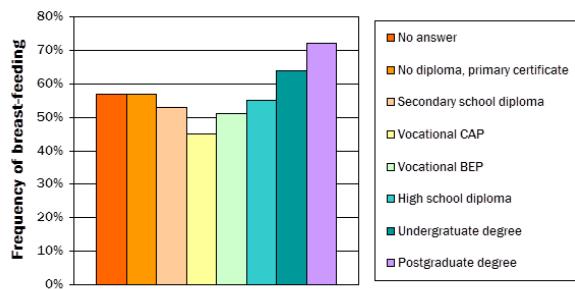
upward social mobility, the scrupulous application of professional recommendations may be at odds with family advice, while knowledge of infant care, linked to prior experiences, enables them to keep some distance with nursing rules and gives them more flexibility in the way they are applied.

Breast-feeding factors in France

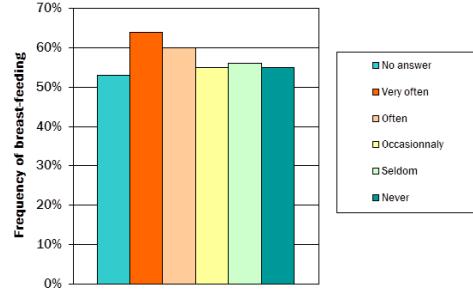
The incidence of breast-feeding after birth depends on the mother's social position, whether her educational level, her profession or that of her spouse. This is a recurring result of perinatal surveys in France. The recent increase in breast-feeding rates is not accompanied by a levelling of social differences.

In 2003, according to the perinatal survey conducted by INSERM (French Medical Research Institute), the breast-feeding rate among senior-executive women is close to 80% whereas that of skilled workers is around 45% for a national rate of slightly over 60%. More surprisingly, breast-feeding rates go up slightly among non-skilled female workers (around 50%) and unemployed women who breastfeed at the same average (Bonet *et al.* 2007). In the data of the survey conducted in the Val-de-Marne department in 1997 (see frame), a U-curve is also observed in the link between education level and breast-feeding; less-educated mothers breast-feed more often than women with a short technical/professional education, (see graph 1).

Graph 1: Breast-feeding and mother's education level



Graph 2: Breast-feeding and infant-care knowledge before first maternity



Source: Val-de-Marne Survey 1997

Breast-feeding rates also vary depending on the mothers' geographical origin: mothers who spent their childhood in Africa breast-feed distinctly more often than those having spent their childhood in France. It should be recalled that in the previous generation, breast-feeding at birth concerned approximately a third of the babies in France. In the 1990s, women who became mothers had not often been breast-fed themselves. It could be supposed that the majority practice of bottle-feeding in France in the 70s has contributed to making bottle-feeding the standard way of feeding infants, and made breast-feeding a non-spontaneous and difficult practice. An experience of infant-care before the first birth of a child is also a factor that favours breast-feeding (see graph 2). Women who have never had this experience more frequently tend to choose bottle-feeding. Women who have the greatest experience of infant-care are more numerous among women with the lowest qualifications; this positive relationship between know-how in infant-caring and breast-feeding could explain the higher incidence of breast-feeding in women without qualifications (graph 3).

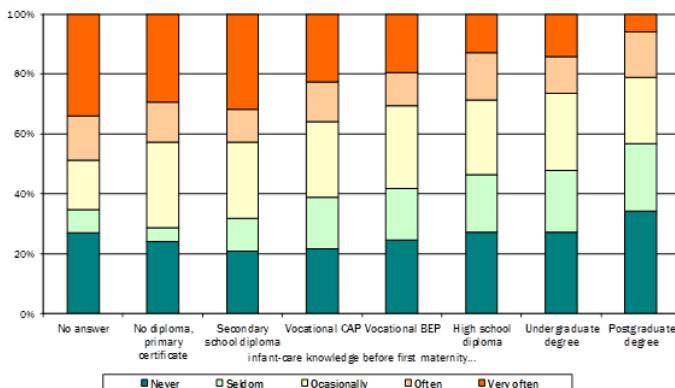
A logistic regression refines this result, showing that if we neutralize the effect of prior experience of infant-caring we obtain a stronger connection between education level and probability of breast-feeding (Gojard, 2000).

All these elements would tend to suggest that there are two factors in France which encourage the practice of breast-feeding after birth: firstly, awareness of positive effects of breast-feeding, more characteristic of women from the upper

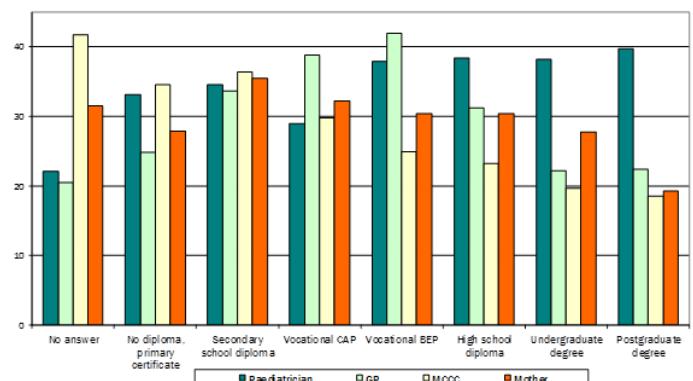
classes or from fractions of the middle classes with a higher education level, and secondly the transmission of family know-how, more widespread in the working classes, with a proportion of breast-feeding practices for some migrant women. In addition to this distinction between two breast-feeding models, it can be noted that the sources of the advice mentioned by women about infant-caring is closely linked to social position (see graph 4). Visiting a paediatrician increases regularly with the education level while consulting the MCCC decreases and visiting a GP is more frequent among women with an average education level. The results are consistent with those found in health surveys regarding the higher predisposition in the upper classes to consult a specialist practitioner and in the connection between the MCCC target community and the women who state that they consult.

Getting advice from the maternal grandmother - the mother of the woman interviewed - is barely mentioned by the mothers who graduated from university. Moreover, the interviews show that the type of advice, and the complementarity or opposition between the advice given by the grandmother and that provided by the medical profession, varies greatly according to social status. In the upper classes, the model that adheres to recommendations made by the medical profession tends to prevail over a model reproducing the practices from one generation to the next. However, in the working classes, the family transmission of infant-caring skills frequently justifies the gaps in prescriptions regarding infant diet.

Graph 3: Infant-care knowledge and mother's education level



Graph 4: Mother's education level and main source of advice



Source: Val-de-Marne Survey 1997

To be or not to be a “good” mother

Beyond breast-feeding practice, the analysis of interviews with young children's mothers and the observations from the MCCC show that in most infant-care decisions (including diet) the underlying concern is their presentation of themselves as a “good” mother. Talking with an interviewer about infant-feeding is never neutral, and even less so when the interviewer seems to know the MCCC team and is more or less part of it. Even in the case of feeding practices, which are very far removed from nursery nursing standards, which prove to be less rare than expected (for instance, at three months, babies were given semi-skimmed milk by several mothers), the points put forward to explain these practices are sound and most often emphasise the child's good health as a criterion of mothering success.

For women who breast-feed or breast-fed, this feeding technique is mostly emphasized as proof

of their mothering quality since the medical recommendations given at the beginning of the pregnancy were respected. A few exceptions to this general framework can be noted, in particular when, due to several constraints, most of them time-related, breast-feeding lasted for a shorter time than initially expected.

Hesitating between discourse in favour of breast-feeding – that is to say to long-term breast-feeding – to which they adhere and a practice they cannot apply for long because of the presence of older children or the resumption of professional activity, these women have difficulty reconciling their experience and compliance with recommendations. In other words, the argument put forward to clarify the connection between breast-feeding and quality mothering does not include compliance with these recommendations but the resumption of a family tradition (in particular for women coming from immigration).

Frame: Methods

The results of the sociological approach are based on the combination of several sources:

- In 1997, a statistical survey on just over 1800 mothers of children aged less than 3 years old, benefiting from CAF (French Child Benefit Office) in the Val-de-Marne department. The survey was conducted by post, with a 45% response rate from a sample of 4000 households with at least one child aged under 3 years, that is to say approximately one family out of 10. All the graphs presented here come from that survey.
- Direct surveys conducted in 1994-1996 and 2000-2002 in Mother and Child Care Centres located in Paris or in the inner Parisian suburbs, by observation in the waiting room and during consultation.
- Interviews conducted with young children's mothers in varying social situations, in Paris and the Parisian suburbs between 1996 and 2002.

The statistical data serve to outline trends and test correlations, and interviews and observations serve to improve analysis, in particular through mothers' feedback. The survey tracks food learning in infancy: feeding methods, feeding age with food other than milk (vegetables, meat...), use of specific infant food (baby-food jars), while giving information about various sources of advice, mother's experiences with young children, child-care systems and so on. The questionnaire also includes a precise description of the household's socio-demographic characteristics.

It can be seen that practising in compliance with a standard (here a preventive standard extensively disseminated in the circles which supervise pregnancy and motherhood) does not always respect those prescriptions but may pertain to another logic. In a field where standards change relatively fast, this form of inertia can cause women to conform to standards for one child but not for the next. While the advice to breast-feed seems to have been firmly established for a few years, the details of this recommendation, (appropriateness or not of leaving a bottle at the mother's disposal, feeding with artificial milk at night) are subject to variations according to maternity hospitals, or even hospital teams. Similarly, advice regarding sucking duration and frequency or breastfeeding proves to vary greatly. In other words, while all the specialists seem to agree on the fact that breast-feeding is a necessity, the how-to-do-it is a major question that comes up against much less homogenous answers. Therefore, women who breast-feed because of transmitted experience often prove to be less deprived than those who lack experience and breast-feed out of respect for medical standards.

On the other hand, for women who did not breastfeed, the arguments are divided in two. They come in the form of a more or less open questioning of the standard of breastfeeding promoted or show a form of indifference to this question. Most often, the open question is based on a family model of bottle-feeding, and the good health of children fed that way (most often starting by the interviewed woman herself) shows the relative nature of the arguments promoting breastfeeding. But this position from the interviewed woman supposes a resourcefulness that not all women have when faced with the interviewer (who is always suspected to be favourable to breast-feeding since he/she has an interest in it). Avoiding the question and insisting on other caring aspects helps these women paint a respectable image of themselves as mothers: in cases of very strong time constraints, the availability required by breast-feeding is not guaranteed. The precision with which these mothers describe their daily organization and the constraints they have to face show how much they value their ability to manage their home. Following recommendations does not guarantee mothering quality, whereas

ensuring family continuity or emphasising skills in everyday management does.

Four ways to be a mother

By disclosing resistance factors, the analysis of the perception and the application of infant-feeding recommendations provides a better understanding of the obstacles to dissemination of public health orders. For example, comparing these prescriptions to family know-how may contribute to enlightening social classes who are unfamiliar with medical prevention rationales. Women with a low educational level tend to favour practical efficiency criteria rather than conform to medical or paramedical recommendations from practitioners. Conversely, women with high educational level, with less practical experience in the field of infant-care, are more often inclined to follow advice from the academic sphere.

This general pattern comes out in four maternal models; the first two more frequent in the working classes and the next two in the higher and middle classes. These models, which describe the skills emphasised by mothers to justify their maternal quality during the survey, draw social definitions of motherhood.

In cases where a mother prefers "traditional" infant-care, the return to family advice is justified by a gap in professional recommendations which are discredited because of their instability over time (Gojard 2012).

A second model that could be qualified as "personal" is based on the reticence to answer questions regarding standard application, and on the importance given to domestic management skills in constrained life styles (in particular regarding budget and time availabilities). In the "to the letter" education model prescriptions from the skilled sphere are scrupulously applied even if this means breaking with family advice in cases of upward social mobility.

Lastly, in the "intuitive" model, infant-care knowledge reinforced by proper care experience keeps caring rules, which are applied in a more flexible way than in the "to the letter" model, at distance.

These models show profiles which are not rigid, and in some cases young children's mothers can oscillate between these models over time. The detail of constraints linked to daily organization (women's career, domestic workload, etc.) may also lead to a better understanding of mothers' choices, for example, in favour of bottle-feeding.

This analysis leads us to consider various ways to be a mother, organized according to women's social properties: it is therefore easy to understand that some of them emphasise their practical skills in defining their mother's role, while others refer to compliance with the recommendations they received. These various enumerations of motherly skills comprise definitions of the mother's job which is not necessarily confined to submitting to medical standards.

More generally, this analysis provides food for thought about how to apply nutritional standards by emphasising their congruence with habits. Calling daily practices into question is not equally acceptable in all social circles: with the

case of dietary standards varying from a child to the other, we note that women with more practical experience are those who are the least inclined to reconsider their habits (except for women with a higher education level who by going to graduate schools became familiarized with preventive standards and with progressive notions of expertise and development). However, women with the lowest qualifications tend to consider changes to recommendations as a fashion index rather than the result of scientific progress (discrediting it).

We also measure all the significance of lifestyles which make recommendations more or less easy to apply: domestic organization, time or economical restrictions, and management of food stocks are all elements which must be considered and which are not equally distributed in the social space.

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For more information

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