At What Cost?

women's multiple roles and the management of breastfeeding

At What Cost?

Women's Multiple Roles and the Management of Breastfeeding

by

Rama Narayanan

A study carried out with the co-operation of

1. Department of Food Science and Nutrition	Avinashilingam Institute of Home Science and Higher Learning for Women, Coimbatore
2. Rural Unit for Health and Social Action (RUHSA Department)	Christian Medical College and Hospital, Vellore
3. College of Nursing	Christian Medical College and Hospital, Vellore
4. Department of Home Science	Gandhigram Rural Institute, Gandhigram
5. Department of Statistics	Madras Christian College, Tambaram
6. Department of Home Science	Women's Christian College, Madras

Research Report No. 2
M.S. Swaminathan Research Foundation

January 1997

M. S. SWAMINATHAN RESEARCH FOUNDATION
Centre for Research on Sustainable Agricultural and Rural Development
Third Cross Road
Taramani Institutional Area
Chennai - 6000 113 India

Telephone : 91-44-2351229, 2351698
Fax : 91-44-2351319
e-mail : MDSAA51@giasmd 01.vsnl.net.in

Design and layout : Design Space, Chennai 600 020.

Printed in India at Reliance Printers, Chennai 600 020.

Foreword

The recognition of the triple burden of women namely, that of housekeeping, childcare and economic work has helped women who were hitherto "invisible" in the work force to be recognised as workers with multiple roles. The reproductive and productive periods coincide in a woman's life cycle, making it significant from the standpoint of health and nutrition for the mother - child dyad and the economy of the family.

The research study on Women's Multiple Roles and the Management of Breastfeeding was mainly taken up to answer certain specific questions regarding the relationship between women's work and breastfeeding and the influence of one over the other. The focus of the study was to net the constraints that women faced in combining work with breastfeeding, to identify the strategies that they adopted and the support that they received in the process.

The study has provided some useful pointers in terms of the issues that need to be addressed and areas of action that would be of value for advocacy and policy making. Such a large study would not have been possible by a single institution. The involvement of several academic institutions has helped in creating a broader support base and has enabled their participation in policy making.

I thank all the Principal Investigators of the six institutions which participated in the study for their meticulous data collection and the heads of all institutions for their interest and involvement in this exercise. I thank Mrs. Rama Narayanan for writing the report and the Bernard van Leer Foundation for funding the study and the publication of its results.

M. S Swaminathan

M.S. Swaminathan

Acknowledgements

I wish to express my deep sense of gratitude to the M. S. Swaminathan Research Foundation for providing me with an opportunity to undertake this research study and to all those whose co-operation and support made this study possible. First, the Principal Investigators mentioned below who were involved right from the planning stage through the collection of data by their students and colleagues upto their valuable comments on the draft report.

1.	Ms. C. Yegammai	-	Lecturer S. G, Department of Foods and Nutrition, Avinashilingam Institute of Home Science and Higher Learning for Women, Coimbatore.
2.	Dr. Chellarani Vijayakumar	-	Dean, College of Nursing, Christian Medical College and Hospital, Vellore.
3.	Ms. Helen Rajamanickam	-	Professor in Community Health and Nursing Christian Medical College and Hospital, Vellore
4.	Dr. K. P. Vasantha Devi	-	Reader, Department of Home Science, Gandhigram Rural Institute, Gandhigram
5.	Dr. Bala Srinivasan	-	Lecturer S. F., Department of Statistics, Madras Christian College, Madras
6.	Dr. M. Bhagavan Das	-	Lecturer S. G., Department of Statics, Madras Christian College, Madras
7.	Dr. Rajaratnam Abel	-	Director, Rural Unit for Health and Social Action (RUHSA Department) Christian Medical College and Hospital, Vellore
8.	Dr. Sampath Kumar	-	Programme Officer, Rural Unit for Health and Social Action (RUHSA Department) Christian Medical College and Hospital, Vellore
9.	Dr. Janaki Kameswaran	-	Department of Home Science, Women's Christian College, Madras
10.	Dr. Sunderabai Pratap Kumar	-	Department of Home Science, Women's Christian College, Madras

I also thank the student investigators for their meticulous data collection and the students of Loyola College and Madras Christian College for coding and data entry. Special mention must be made of Mr. I. Joshua

Lecturer, Department of Statistics, Madras Christian College for his help in the tabulation of data.

I am also deeply indebted to Dr. S. Rajagopalan for his guidance in the analysis of data and Drs. S. Anandalakshmy, Barbara Isely, L. S. Saraswati and V. B. Athreya for their constructive comments on the report. I also thank Ms. Mina Swaminathan for her encouragement, guidance and support throughout the study.

I wish to express my gratitude to the advisory committee members namely, Dr. S. Gopal, Head, Department of Paediatrics, Institute of Obstetrics and Gynaecology, Egmore; Dr. V. L. Srilatha, Project Officer, Health, UNICEF; and Ms. Saulina Arnold, Executive Secretary of Tamil Nadu Voluntary Health Association for their help in carrying out the study.

I am deeply obliged to my colleagues at the M. S. Swaminathan Research Foundation, specially Ms. D. Radhika for her help in the scrutiny of schedules and processing of data, Mr. S. Raja Samuel for data retrieval and assistance with graphics, Mr. A. Sarvesan and Ms. Jayshree Vencatesan for their help in training the investigators prior to data collection and Ms. E. Rajeshwari and Ms. S. Jazeela Banu for typing the report.

Rama Narayanan

Table of Contents

1 INTRODUCTION

It has been widely accepted that infancy (0-12 months) is the most critical period for growth and development. While survival is of prime concern, growth is at its maximum, and any retardation during this period may cause irreversible damage to the young child. Infancy itself may be distinguished into two periods namely, that of 0-4 months and 5-12 months, the former requiring exclusive breastfeeding of the infant by the mother and the latter the introduction of supplementary foods along with breast milk.

In India, breastfeeding has been an universal practice, cutting across socio-economic strata and with strong cultural sanction. However, of late, increasing concern has been widely expressed over the supposed decline in the rate of breastfeeding. While several factors such as religion, education, socio-economic status, mother's work roles and her perception about lactation failure have been identified as influencing breastfeeding, the aggressive marketing strategies adopted by baby food manufacturers have usually been quoted as reasons for the decline, with less focused attention on other issues.

Constraints to Choice

The issue of breastfeeding or not breastfeeding is often looked at from a rather simplistic point of view, assuming that mothers have clear - cut choices whether to breastfeed or not. It is presumed that the "choice" to breastfeed rests completely with the mother and there has been little appreciation of forces beyond her control which may influence breastfeeding behaviour and thus render the "choice" inoperative. It has also often been presumed that the advent of the baby food manufacturers is the only change in the social scenario responsible for influencing the breastfeeding practices of women. Little attention has been paid to the other social changes that have characterised the social milieu in recent years, such as increased participation of women in the work force, nuclearisation of families, increase in female-headed households increased migration etc.

These attitudes and assumptions may be related to the reality that the issue of breastfeeding, has largely been the preoccupation of the health (both medical and paramedical) professionals due to its implications for child health and has not been considered as a serious women's issue influenced by social factors. That is the reason why much of the campaign initiated in support of breastfeeding has been either towards educating mothers to breastfeed, or making hospitals baby-friendly, or significantly, undertaking control measures such as passing of the Infant Milk Substitutes, Feeding Bottles and Infant Foods (Regulation of Production, Supply and Distribution) Act of 1992. Very little effort has been initiated to address the supporting measures that a mother needs in order to accomplish successful breastfeeding. For example, the possibility of

domestic tensions and discords and other emotional and psychological stress factors being linked to lactation failure has been little noted. The social factors underlining breastfeeding practices have been undervalued, while the issue of knowledge and awareness among women has been singled out for attention.

Rationale

While there is a body of literature relating to women's work status, roles and burden, the relationship of these factors to breastfeeding have not been very clearly established. Since an infant is completely dependent on its mother for nourishment, the arrival of the infant leads to considerable reorganisation in the mother's life style and work schedule. The extent to which a mother rearranges her work in order to combine work with breastfeeding could be influenced by several factors such as the trade-off between work and breastfeeding, strategies and options available to and adopted by the mother to combine work with breastfeeding and the support services that enable her to do so. There is little information available to indicate whether and how breastfeeding affects work or vice versa. A need has been perceived to disentangle and study these issues more clearly, in order to understand the ways in which women's work and breastfeeding are related, so as to create a climate and environment that would empower women to breastfeed.

These were the main considerations that prompted the M.S. Swaminathan Research Foundation to undertake a multicentric research study on the management of breastfeeding by women in relation to their multiple roles, with the collaboration of several members of the research network on childcare, representing different disciplines.

Objectives

1. To identify the constraints that women face in combining work with breastfeeding,

2. To understand the strategies that they adopt to overcome the constraints,

3. To determine the support services from the home, community and the State that encourage breastfeeding, and

4. To analyse the practice of introduction of supplementary foods in children below one year of age and its relationship, if any, to mothers' work roles.

2 THE ISSUES

Of all the factors that have been identified as influencing the breastfeeding practices of mothers, the least understood perhaps is that of the mother's work, her time availability and life style. This is hardly surprising since the term 'women's work' itself has had a very narrow definition for a long period, rendering a large majority of women invisible as workers. Shatrugna et al (1993) observe that according to the 1971 and 1981 Censuses, only 25% of Indian women were said to have participated in the labour force, since the definition of work at that time was based on ideas derived only from "men's" work (i.e.) it meant working outside the home at one single task for 8 hours.

This is in direct contrast to the reality that most women are at work every minute of their waking hours. Further, it is difficult to define a working day, the hours of work and nature of activities, since women perform multiple tasks, at times simultaneously, both within and outside the home. A typical day for a woman would begin with domestic chores, childcare, economic work at home or outside and wind up with domestic chores (ibid).

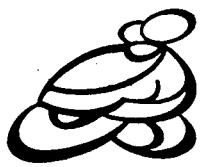
Women's multiple roles

The triple burden of women, namely that of housekeeping, child-bearing and rearing and economic activity has been very clearly set out (Shram Shakti, 1986). The recognition of the complexity of women's work and the need to capture it gave a broader definition of the term "women's work" in the 1991 Census, which defines work as `participation in any economically productive activity including unpaid work on farm or in family enterprise'.

In the context of breastfeeding the work that women do has an added significance, since breastfeeding cannot be delegated or postponed and requires close proximity between mother and child. Much of the preoccupation of researches on work and breastfeeding has been in the context of paid work outside the home and its relationship to breastfeeding practices, probably because there has been an underlying assumption that work done outside the home which involves physical separation of the mother and child would be an obstacle to satisfactory breastfeeding, while work done at home could be easily combined with breastfeeding (Swaminathan, 1994).

Potential conflicts

While this may be true, all paid work need not necessarily be done outside the home and domestic work/child care and unpaid economic activity need not be done only inside the home. This lack of perception of the possibility that it is work environment rather than work as such which influences bre-astfeeding, has been the major reason for inconclusive results regarding work and breastfeeding, in several studies. Leslie (1989) reviewing 28 studies from 20



countries examines the relationship between women's work and infant feeding practices and concludes that 'the simple fact of whether or not women are in the labour force is not a key determinant of infant feeding practices. In fact most studies showed remarkably similar patterns of infant feeding between employed and non-employed women'.

These studies (Leslie, 1989) focused narrowly on the question of time available for feeding children, particularly for breastfeeding. Work outside the home was seen as the main factor reducing such time, so much so that several studies had grouped together women working within the home and 'non-working' women. In another set of studies which examined the relationship between women's work and child nutritional status, no consistent pattern emerged of either a negative or a positive relationship between women's work and the child's nutritional status.

Cause or effect

The major drawback of these studies (Leslie, opcit) are that they did not take into consideration the possibility that causality for the above phenomenon may run in both directions. A child's nutritional status, seasonality of employment opportunities, availability of support services, possibility of breastfeeding/child care while at work etc. may affect a mother's employment decisions just as much as a mother's work may affect the nutritional status of her child.

Van Esterick and Greiner (1981) observe that understanding the impact of women's work on breastfeeding has been obscured by over-generalisation and by poorly interpreted data. According to them work as a cause of decline in breastfeeding has been exaggerated, while insufficient attention has been given to enhancing the compatibility of breastfeeding and work. It is formal employment in urban and urbanising areas that has been seen as incompatible with breastfeeding.

Women's work in India

In India, one in three of all adult women aged 15-49 are in the work force and women are engaged in almost every economic activity listed in the Census. Of the 91 million women in the work force, only 10% are in the organised sector (SHRAM SHAKTI). Nearly 80% of the rest are engaged in agriculture (45% as labourers and 34% as cultivators). Most women are in low-paid unskilled and low-status jobs. It is estimated that 24-26 million such women have children below two years.

Women are found to work 14-16 hours a day on average including domestic chores, as against men's 8-9hrs, (CWDS, 1993) and to do 53% of the total work, as against men's 43% (UNDP 1995) though there are four male workers for every female worker. 35% of all families below the poverty line are reputed to be female-headed (World Bank 1993) and 86% of all families with children below 5 years depend to some extent on the woman's economic contribution (MSSRF-1996).

In spite of these awesome statistics, women's work is still largely "invisible" and the interrelationships between her triple roles as producer, home-maker and child caretaker little understood.

Types of paid work

In the Indian context, two distinct work categories in remunerative employment can be identified-namely the organised and unorganised sectors, also referred to as the formal and informal sectors. The organised sector which necessitates that women work outside the home and with its rigid work timing and schedule is expected to interfere more with breastfeeding. On the other hand, working women in this sector enjoy certain legal privileges, such as entitlement to paid maternity leave.

While Government servants enjoy the full benefit of the privileges accorded to them under the law, those employed in the private sector may have to depend on the vagaries of their employers. Further, laws that place the financial burden for maternity benefits on employers discourage them from hiring married women (Chatterjee, 1990). For women in the unorganised sector, whose work may be home-based or outside the home, contractual or self-employed, there is no monetary compensation during the period they stay off from paid work. The decision to return to paid work is dependent on the trade off between the need to earn and the options available for breastfeeding. However, available evidence suggests that women in the unorganised sector may be able to combine work and breastfeeding more satisfactorily than women in the organised sector.

The work environment

Pandey (1990) has reported that frequency of suckling by children of women working in the unorganised sector tended to be greater than that for women working in the organised sector. Further, children of the former had greater access to their mothers than children of the latter. This study clearly indicates the advantages to the mother of combining work with breastfeeding by staying in the unorganised sector, but little is known about the price the mother has to pay for these advantages.

However Dixit (1988) observed that although most women breastfeed on demand, amongst working mothers scheduled feedings at fixed timings was done. According to Vachani (1994) working mothers could feed their infants only before going to work and after returning home, although the number of feeds given to a child depended on the child's age and mother's occupation. It is quite possible that these women worked in the organised sector where rigid timings and lack of access to children may be the major reasons for the practices observed.

In the Philippines, Popkin and Solon (1976) found that mothers breastfeed if they work close to their homes, but they practise more mixed feeding with the bottle if they work in a far-off place. In Cebu city most women work in home industries or marketing near their homes and are able to work out schedules permitting them to nurse their babies often enough to maintain lactation. Even the formal workplace can encourage breastfeeding if it does not separate the mother and child and has provisions for nursing breaks. Thus employment may not be as important a factor as the conditions in the work environment.

Breastfeeding practices

When breastfeeding practices are examined, the following four aspects need to be taken into consideration.

1. Time of initiation
2. Use of prelacteal feeds
3. Exclusivity of breastfeeding
4. Duration and frequency of breastfeeding

While the first two aspects are more related to traditional/hospital practices and beliefs, the duration, exclusivity and frequency of breastfeeding may be more affected by the mother's work roles. Whatever be the nature of work, domestic, economic or child care, the balancing act between working and breastfeeding starts the moment the mother resumes her multiple roles after a period of stay off due to delivery.

Studies which have examined the management strategies adopted by women to combine work with breastfeeding are few and even those available, have taken a limited perspective of the term 'work', referring only to paid work done outside the home. Further the strategies studied have been restricted to personal adjustments made by the women such as carrying the child to the work place, feeding more at night and altering the pattern of work. There has been little recognition of the fact that women play several roles and therefore need support from several other sources such as the family, the employer and the professionals. Consequently these issues have not been researched in depth and there is not much information on the type of support the women receive from the family, the state, the employer and professionals.

Common strategies

Some of the strategies adopted by employed lactating women who are separated from their infants are hand expression of milk or taking the help of a wet nurse. Other strategies are-working at home for the first few months, working flexible hours, part-time or shorter shifts and breastfeeding at night.

Shatrugna et al.(opcit) observed that women shifted occupations many times in the year and constantly between economic work and unemployment. The main reasons were economic, pregnancy and crisis situations. In the case of shifts due to pregnancy and stressful situations, women were either self-employed or in wage labour before they shifted out of the labour market to the 'housewife' category.

Differences and similarities

Arulraj and Samuel (1995) in a study on childcare strategies of working women in the unorganised sector have reported that all quarry workers, and 98% of construction workers feel that the workplace is not conducive for breastfeeding in terms of noise and dust and the lack of a secluded spot. With regard to frequency of feeding, more than 50% of workers in agriculture, plantation and domestic sectors who took their children to the work spot could not breastfeed more than twice during work, while those in home-based occupations such as weaving and beedi-rolling were able to breastfeed more than 6 times during working hours.

Further, all workers in home/neighbourhood - based occupations never stopped working for breastfeeding, and were able to combine work with breastfeeding more successfully than those in other occupations. Differences between occupations were also observed with regard to the age at which the children were given supplementary feeding.

Those who were taking children to the work spot started introducing supplementary feeding only after six months. Women who left their children at home in the care of others were obliged to introduce supplementary feeds earlier because of their absence from the home , and at the same time, they could draw upon the services of others to prepare the feeds.

It is thus clear that there is a need to better understand how breastfeeding and work are related and probe more deeply into the strategies that women adopt to successfully combine work with breastfeeding, the support systems that they have for so doing and possible measures that can be taken to help them continue breastfeeding along with work.

THE METHODOLOGY 3

The research study was undertaken with the collaboration of six members of the research network on child care, which is a loose body of academic institutions, representing various disciplines, with a common agenda of child care issues. At a preliminary meeting held in March '95 the objectives of the study, tentative design and clarification of terminologies and definitions to be used in the study were discussed and accepted.

Definitions

From the stand point of energy output, all women could be considered as working women, irrespective of the nature of their work. However only some types of work done by women are assigned monetary value. The following four categories of women's work were arrived at for the purposes of this study.

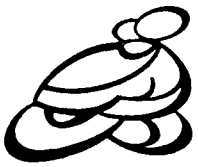
1. Domestic work

refers to all activities done by women both within and outside the home which are purely for the consumption of the family.

2. Child care

refers to all tasks which constitute the care of children other than the new born, since the latter were studied separately.

3. Unpaid family labour



refers to all economic/ production activities carried out by women for which there is no monetary compensation.

CATEGORIES OF WOMEN'S WORK

Domestic Work
Child Care
Unpaid Family Labour
Paid Work
Unorganised Sector ***Organised Sector***

4. Paid work

refers to all economic activities carried out by women for which there is a monetary compensation, further categorised as work in organised and unorganised sectors of the economy.

4a Organised sector

Employment in establishments to which the rules and regulations governing entitlement of benefits apply, that is,

- All Government services at the Central, State and local Government levels
- All public sector undertakings in the field of agriculture, industry, credit, financing, public utilities, services etc. and
- All non- agricultural private establishments employing 10 or more persons.

4b. Unorganised sector

Employment outside the defined organised sector, or the unorganised/informal sector includes self-employment, casual labour on daily or temporary basis, contractual work, employment in small establishments or those where the relationship between the employer and the employee is informal or unclear, where labour legislation is not applicable.

Other terms used in the study are defined as follows.

1. Exclusive breastfeeding

is defined as feeding the baby with only mother's milk and no other food-based fluids or drinks. Water, vitamins and minerals are excluded from this definition.

2. Prelacteal feed

Any fluid or liquid given to the new-born baby prior to breastfeeding

Universe and location of the study

Since the objective of the study was to find out how women managed breastfeeding along with their other work, it was decided that only mothers with children under one year of age (12 months) would be included in the study. Since data collection was undertaken by the staff and students of the participating institutions, it was restricted to those areas of Tamil Nadu where they resided. The cut off period for including the mother in the study was broadly defined as April-May, 1994, depending on when exactly the investigators started their work.

Selection of respondents

Sampling

No estimates were available for the numbers of mothers of young children doing paid work. Since the population was unlisted and estimates of the proportion of women with young children were not intended to be calculated in the study, it was decided to do a non-probability convenience sampling, since getting a sampling frame for probability sampling would have been very time-consuming in the circumstances. Further, the study was to be carried out by students and staff of the participating institutions who could take up the work only in their own areas and there were also constraints of time and money, which prevented inclusion of respondents from other areas as well.

Sample size

Each institution agreed to cover a minimum of 100 respondents and the urban/rural proportion was decided to be maintained at 60 and 40 percent respectively. It was decided that at least fifty percent of the respondents would be women doing paid work.

Sources

Two of the participating agencies had a complete listing of all mothers of children under five years of age in their areas. Sources of information regarding selection of respondents for the other agencies were TINP workers, health workers, Government and private hospitals. An enumeration of all the children born during the stipulated period was built up from these sources, from which the respondents were randomly selected.

Tool for data collection

Interview method with a questionnaire as the tool was the choice for data collection. A draft questionnaire was field-tested by all the participating agencies, in their own areas, on a minimum of ten respondents each and the questionnaire was then further modified. Since the investigators had varying degrees of experience and skill, a two-day orientation was conducted in April, 1995 at RUHSA, in which the conceptual framework and objectives of the study were discussed. This was followed by field experience where the investigators themselves conducted trial interviews with at least two women each. The filled in questionnaires were then scrutinised and discussed and the necessary corrections made. A checklist for consistency in the schedule was also prepared and shared with the participating agencies. Random checks were made for consistency in data collection.

Data collection was completed by the end of August 1995. About 1200 schedules were received, out of which 969 were finally included for analysis. The Statistics Department of the Madras Christian College offered to help in the data entry in the computer. The Statistical Package for Social Sciences (SPSS) was used for data analysis. The draft report was circulated to the research partners and later presented at a meeting of the research network. The final report includes the feedback and suggestions received in the critiquing process.

4 THE WOMEN

The six institutions which participated in the study covered 4 areas in Tamil Nadu, namely urban and suburban areas of Chengai M.G.R. Dist. and urban and rural areas of Anna, North Arcot Ambedkar and Coimbatore districts respectively. In Chengai M.G.R. District the urban areas chosen were Chennai city and Tambaram which is a suburb of Chennai. In Coimbatore district the urban areas chosen were in Coimbatore city, and four rural villages at a distance of about 40 km. from Coimbatore city. In North Arcot Ambedkar district the urban area chosen was Vellore. Four villages in which the RUHSA Department of Christian Medical College had been carrying out health and developmental activities since 1977 were chosen. In Anna District two villages near Gandhigram and two areas near Dindigul were chosen as the rural and urban centres respectively.

Profile of the respondents

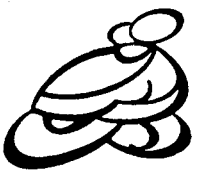
The total number of respondents were 969, of whom 34% were rural and 66% urban. Of the 6 institutions which participated in data collection one had only rural respondents while two had only urban respondents. The rest had a combination of both. It had been originally agreed to have the rural/urban proportion as 40% and 60% respectively. However since the institutions in the urban area had gathered data from a larger number of respondents and except for one institution all others had a rural-urban combination, the proportion of urban respondents in the study has gone up slightly more than anticipated.

Thirty five percent of the respondents had (later referred to as M_1 group) infants who were 0-4 months old while 65% had infants 5-12 months old (later referred to as M_2 group). Amongst the 5-12 month old infants more than 50% were above 9 months. One institution reported that locating samples of infants between 0-4 months was difficult since many of the women were not available, having shifted to their natal homes for the delivery. Forty nine percent of the infants were males while 51% were females.

Their families

The majority of the respondents (nearly 81%) had 2 children or less. In 46% of the cases the breastfed child was the eldest and had no other sibling. Amongst the rest 62% had children older to the breastfed child by 3 years or even less.

Fifty eight percent of the deliveries took place while women were residing in their natal homes, 42% at their marital and/or nuclear families. Twenty percent of the women (46% M_1 and 12% M_2) were residing in their natal homes at the time of the study and the remaining in their marital or nuclear homes.



Fifty six percent of the households were

nuclear while 44% were extended. Fifty two percent of the households had upto 4 members or less, while about 20% had 5 members and 27% had more than 6 members. The mean household size was 4.7.

Seventy eight percent of the mothers were between 21-30 years while 11% were below 21, the recommended age of child bearing. The educational levels of the women and their spouses was comparable, but illiteracy was slightly higher among women. Ninety five percent of the women were living with their spouses, but 5% were not-being either widowed or separated or with polygamous husbands.

Economic activity

About 29% of the women were doing only household work. Sixty six percent were engaged in some paid activity, being both home-based and outside-based, self-employed and wage-employed and working in organised and unorganised sectors. Of these 20% were in the primary sector, 36% in the secondary sector and the rest (44%) in the tertiary sector. The largest proportion (nearly 40%) were in "other services" which includes nearly 40 occupations (Annexure-1). 25% were working in the organised sector, and 75% in the unorganised sector.

Only 5% of the women were engaged in unpaid family labour and a majority of them (52%) were beedi workers assisting their spouses in rolling of beedis, while twenty two percent were involved in the family business and another 18% were tending cattle.

Breastfeeding practices

Fifty eight of all the women had started to feed within two hours of birth and 89% within the first 24 hours (Annexure 2). All the M_1 mothers were breastfeeding and 92% were doing so exclusively. Nearly 80% of the M_2 mothers continued to breastfeed, 16% exclusively.

5 RESUMING ROLES

In analysing the relationship between women's multiple roles and breastfeeding, all the four areas of work were taken into consideration, namely - household/domestic, childcare, unpaid family labour and paid economic work. As far as childcare is concerned, this refers only to care of children, if any, older than the new born, since breastfeeding and care of the new born infant were common to all the women in the study. Except for domestic work which was universally carried out by all the women, it was found that the other work roles such as economic and childcare were either not being performed at all or were being carried out in varying combinations.

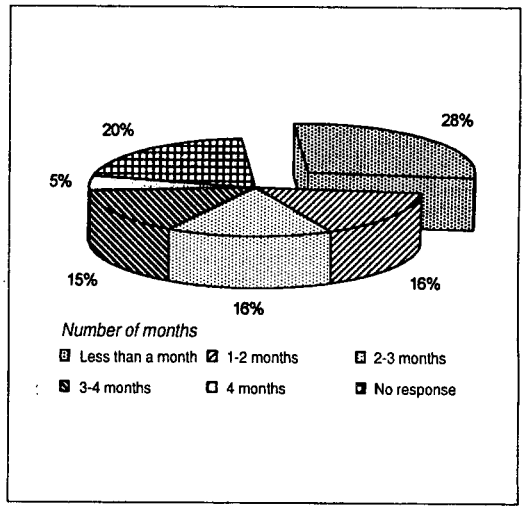
Though women are performing multiple roles, from the point of view of breastfeeding, the resumption or return to work is what is significant; whether a woman is doing paid work, or only domestic work, whether and when she resumes the work is what will influence breastfeeding rather than whether she is employed or not.

Keeping this in mind the breastfeeding practices of the respondents were analysed in relation to the time and manner in which each of her roles was resumed. Resumption of each role was first considered separately, and then in combination. Domestic work is considered first, as it is usually the first to be resumed.

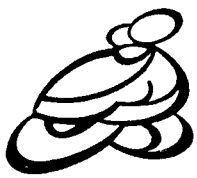
Resumption of domestic work

Domestic work was classified under nine broad categories namely, cooking, washing clothes, cleaning vessels, sweeping and mopping, collecting firewood, fetching water, shopping, grinding and milking the cow.

Fig.1
Resumption of domestic work by M_1 mothers (N=334)



For the M_1 women, (Fig.1) respite from domestic work does not appear to be for a long period, since more than a quarter resumed their duties within the first month itself. The increase in the proportion of women resuming domestic work is practically equal in the following months (16% each during the second, third and fourth months respectively). Only about 5% of women were completely free of domestic work even four months



after the birth of the baby. As far as mothers of 5-12 months old infants were concerned, all had resumed their normal domestic duties fully.

Since the place of stay of the mother is related to the extent and nature of her duties, this aspect was studied. It was found that of the 28% of M_1 mothers who had resumed work within one month, only 1/3 were residing in their natal homes whereas the rest were either in their marital homes or living with their spouses in nuclear families. On the other hand, amongst the 16 mothers who had not yet resumed domestic work at the time of the study, ten were residing in their natal homes and six in their marital homes. This finding reinforces the basis for the traditional practice of women staying with their parents during and after the birth of the child which is believed to give women greater opportunity for rest and freedom from anxiety about chores.

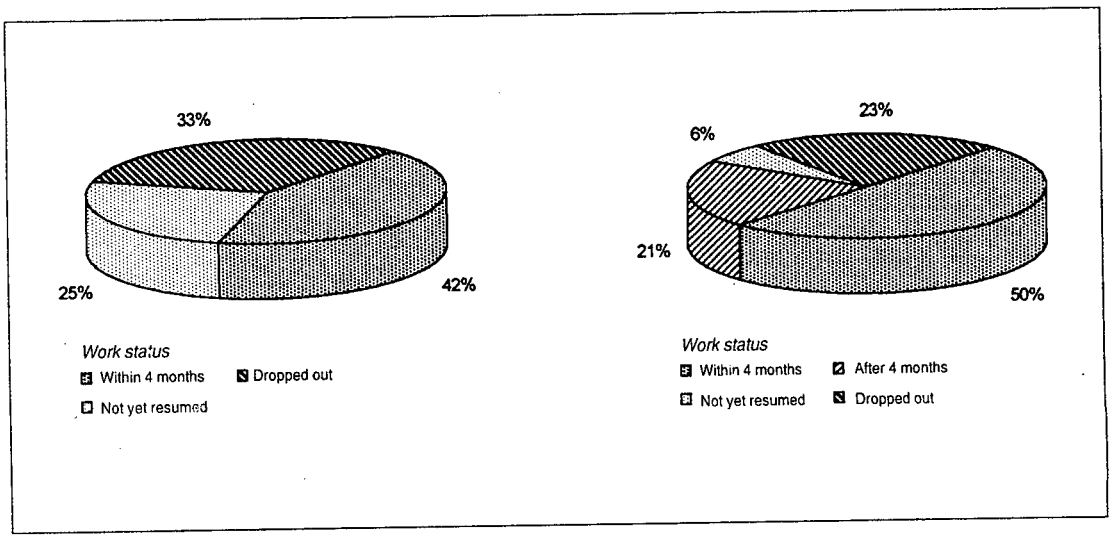
In addition to domestic work those women who had older children had to care for the older child. Care included feeding the child, attending to toilet needs, putting it to sleep, entertaining, teaching, taking to school and fetching back. However details about the period of rest from childcare and subsequent resumption could not be satisfactorily obtained in the absence of direct observation.

Resumption of economic activity

As far as economic activities were concerned, women were found to be either wholly in unpaid family labour or in paid work. There was not a single instance where both types of economic tasks were done by the same person.

Out of the 18 women in the M_1 group who were in unpaid family labour only 2 had resumed work at the time of the study. With regard to women in the M_2

Fig.2
Resumption of paid work by mothers



group, out of 32 only 4 had resumed their tasks. It is clear that though unpaid family labour is an economic activity it provides greater flexibility, having neither the same attraction as paid work, nor the compulsion of necessity as in the case of domestic work.

It was observed that 42% of the M_1 women had already resumed paid work at the time of the study, while about 25% had not yet done so but intended to do so at a later date. About 33% had dropped out of the work force, that is, they had no clear intention of going back to work in the near future. (Fig. 2)

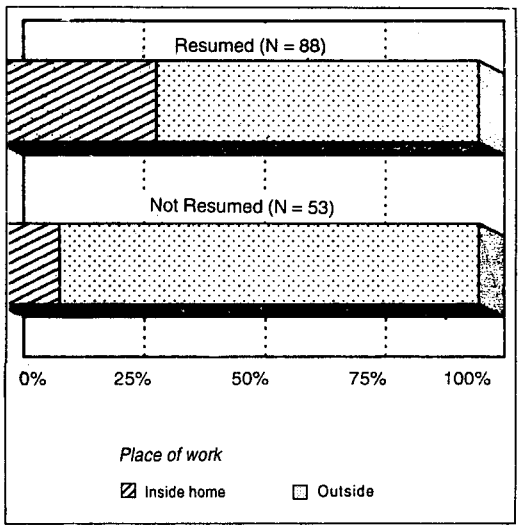
In the M_2 group, it was found that 50% of the mothers doing paid work had gone back to work within 4 months of delivery. When compared with the M_1 mothers, it is found that this percentage is a little higher, probably due to some slight but inevitable underestimation and some memory lapse. About 30% had not yet resumed work or had dropped out, which may be due to the demands of infant care, including breastfeeding.

Management strategies

Of the 88 M_1 women who had already resumed work, 31 (33%) were working within the home and thus had access to their children while at work. This may have been an incentive for them to resume work early, as it was easier for them to combine work with breastfeeding. (Fig.3)

Amongst the 57 women (67%) who were working outside only eleven carried their children to the work place. Of these 4 women said that they had crèche facilities at the work site and the rest said that they had no other alternative except to carry the child with them. Five women had taken jobs which could now be done

Fig.3
Place of work and resumption of paid work (N=141)



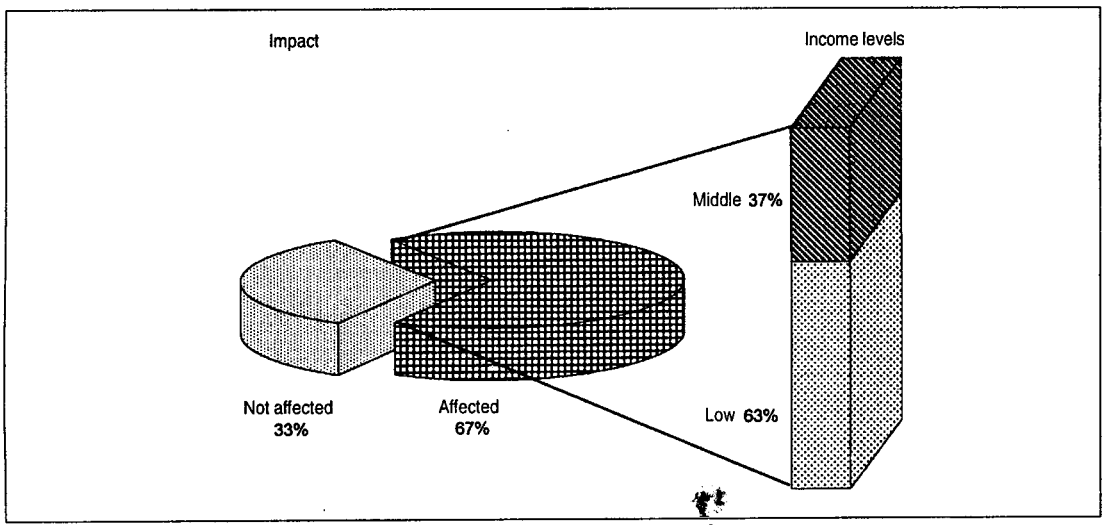
within their homes, ten had changed jobs to have greater flexibility in working conditions, three women had shifted from the organised to the unorganised sector, which could however have affected their income adversely, and fifteen had homes fairly near to their workplace. Thirteen respondents could not clearly articulate the pattern of management.

In contrast, amongst the 53 M_1 women who had not yet resumed work a majority i.e. (87%) were working outside the home and only 13% were working within. It is quite possible that their decision to postpone resumption of work was linked to the nature of the work environment, not favourable to combine work with breastfeeding.

Dropping out of the work force

Of the one hundred and sixty eight women (71 in the M_1 and 97 in the M_2 group) who had dropped out of the work

Fig. 4
Impact of withdrawal from paid work (N=168)



force because of infant care, including breastfeeding, the negative impact of having done so was experienced by 67%, all of whom belonged to either the low or the lower middle income groups (Fig.4)*.

While all of them said that they had faced serious financial constraints, 30 respondents went to the extent of saying that they had been forced to cut one meal. The most common strategy of managing the financial crunch was borrowing.

Such loss of revenue has both implications for health of the mother and the welfare of the family, which in turn may prompt the mother to take up paid work early, even if conditions are unfavourable for breastfeeding and child care.

* Socio-economic stratification of the respondents was done through ascribing values to a set of variables which included educational qualification, ownership of assets, nature of residence, fuel available for cooking and access to drinking water etc. The sum of all the values for each respondent was then computed and these were ranked in ascending order. The respondents were divided into four categories representing the poor socio-economic group, the lower middle, upper middle and the high income groups. The range of values was from 13 to 102.

6 COMBINING ROLES

The manner in which women combine their multiple roles is equally important in analysing breastfeeding practices. While all mothers had the care of the newborn as a responsibility, there was considerable difference among them with respect to the other work that they did. Based on their work, the respondents could be divided into three distinct categories. The percentage of mothers in each group in presented is Fig. 5.

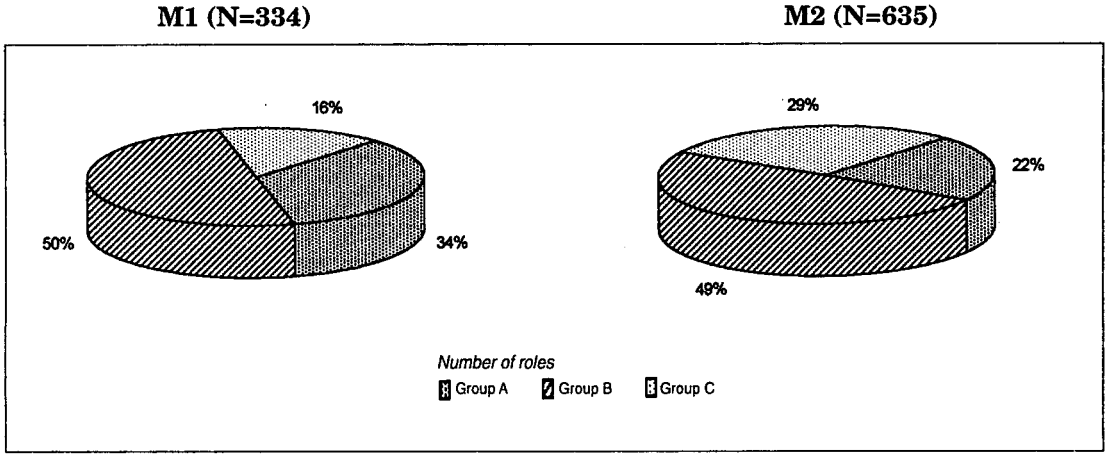
Group A (one role)
- Only domestic work

Group B (two roles)
- Domestic work as well as care of older children, or
  Domestic work as well as economic work

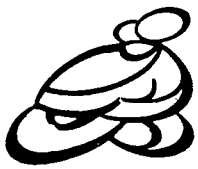
Group C (three roles)
- Domestic work, economic work and care of older children

Fig.5

Multiple work roles of mothers



It can be seen that the percentage of women with only one role decreases sharply from M1 to M2, and that of women carrying the full burden of triple roles in M_2 is nearly double that in M_1, suggesting a gradual resumption of roles with increasing age of the child. But this is not all. Within each group, some striking differences can be seen, especially if analysed in relation to the place of residence, and to the number of children.



Group A : In this group a majority of M_1 mothers (65%) (all

mothers (65%) (all primiparas) were residing in their natal homes, following the cultural practice of women going to their mothers' home for the birth of the new-born, especially the eldest. On the other hand, only 25% of M_2 mothers (also primiparas) were still residing in their natal homes while the other 75% had gone back to their marital homes, following the cultural practice by which women return to their marital homes after the fourth or fifth month of the birth of the baby.

Group B : In this group, all the M_1 mothers were multipara and only about 50% of them were residing in their natal homes. When compared to the M_1 mothers of Group A, who were living in their natal homes, this percentage is less, probably because the mothers decided to continue to stay at their marital residence for the later born children. A majority of the M_2 mothers (96%) were multiparas, while 4% were primiparas who had resumed economic activity. All the M_2 mothers were found to be residing in their marital homes.

Group C : In this group, both M_1 and M_2 mothers, (all multiparas) were found to be residing in their marital homes and they had all resumed their economic activities.

Overall, the increase in number of roles is related to both the nature of residence and the age of the child. (Tables 1a and 1b)

Frequency of breastfeeding

Demand feeding by the mother, which is recommended as the ideal method of feeding, necessitates that the mother be constantly accessible to the child. Frequency of feeding is often considered as an important factor in understanding breastfeeding practices since a higher frequency indicates that the mother is constantly accessible to the child and is thus able to establish a mutually satisfactory and satisfying feeding relationship. However, the frequency of feeds does not indicate the total intake of milk nor are there any prescribed number of feeds.

The frequency of breastfeeding amongst the three groups namely A, B and C is presented in Table 2.

Table-1a
Work roles and present stay of the mother
M_1 group (N=334)

Work Roles	Place of Residence			Total
	Natal	*Marital*	*Nuclear*	
Single Role*	70(62.5%)	28 (25.0%)	14 (12.5%)	112
Double Roles	80 (47.9%)	47 (28.1%)	40 (24.0%)	167
Triple Roles	3 (5.5%)	25 (45.5%)	27(49.0%)	55
Total	153 (45.8%)	100 (29.9%)	81 (24.9%)	334

* *All were primis*

Table-1b
Work roles and present stay of the mother
M_2 group (N=635)

Work Roles	Place of Residence			Total
	Natal	*Marital*	*Nuclear*	
Single Role*	35(25.0%)	68(48.5%)	37 (26.5%)	140
Double Roles	33 (10.5%)	161 (51.6%)	118 (37.9%)	312
Triple Roles	10 (5.4%)	103 (56.3%)	70 (38.3%)	183
Total	78 (12.2%)	332 (52.3%)	225 (35.5%)	635

* *All were primis*

It is striking that as the number of work roles increases, from Group A to Group C, the percentage of women giving the least number of feeds (<6) also increases from 29% to 44%. The opposite is also evident in that, a greater percentage of women (24%) in Group A are in the most frequently feeding group (>10) than among those with a higher work load (Groups B & C) only 13% and 16% respectively. However there were two deviations to this observed phenomenon, (shaded cells in Table 2)

Group A : Though a majority of mothers (33%) were feeding for 7-9 times a day, about 29% were feeding less than 6 times. It is not very clear as to why they could not feed more number of times, since this group is the most privileged in terms of both work load and family support compared to the other two groups. Further, out of this 29%, a majority (i.e. 67%) belonged to the upper socio-economic group and were staying in their natal homes, thus being in an advantageous position conducive for the mother's welfare. However since only 6% of them had started on supplementary foods it is presumed that either these mothers could satisfactorily nurse their babies with fewer feeds or there were other factors besides work which prevented them from feeding more frequently.

Table 2
Frequency of feeding and work roles amongst M_1 mothers (N=334)

Category	Frequency of Feeds/Day				Total
	<6 times	*7-9 times*	*10-12 times*	*No response*	
A	32 (29%)	37 (33%)	27 (24%)	16 (14%)	112 (100%)
B	61 (36%)	54 (32%)	21 (13%)	31 (19%)	167 (100%)
C	24 (44%)	11 (20%)	91(16%)	11 (20%)	55 (100%)
Total	117	102	57	58	334

Table 3
Work roles and time of maximum feeding (N=334)

Category	Time of Maximum Feeding						Total
	M	*A*	*E*	*N*	*Eq. All times*	*No. response*	
A	18 (16%)	11 (10%)	11(10%)	44(39%)	3(3%)	25(22%)	112 (100%)
B	36 (22%)	24(14%)	1 (0.5%)	64(38%)	1(0.5%)	41(25%)	167 (100%)
C	7(13%)	10(18%)	4 (7%)	25(46%)	-(0%)	9(16%)	55 (100%)
Total	61 (19%)	45(13%)	16(5%)	133(40%)	4 (1%)	75(22%)	334 (100%)

Group C : Though this group is presumably the most burdened in terms of work, having the full complement of domestic, economic and childcare roles to perform, about 16% were feeding about 10-12 times. About 75% of these mothers who were found to be staying in their marital homes said that they received the co-operation and support of their spouses and in-laws. This was probably the reason for this group to successfully breastfeed in spite of performing many roles.

Thus the support of the family and its crucial role in helping mothers to have a successful breastfeeding experience is clearly seen.

Time of maximum feeding

Irrespective of the work roles and the frequency of feeding, a majority of mothers (39%, 38% and 46%) in all the three groups fed maximum at night (Table 3). While night feeding has often been suggested as a strategy adopted by women doing paid work to breastfeed their children, such a pattern of behaviour was not observed in this study. The phenomenon, which cuts across all groups, is perhaps related to other reasons such as greater privacy, the infant having uninterrupted access to the mother and perhaps even the continued close proximity which makes it a natural response. It should however be noted that this may create fatigue which Group C mothers may less be able to make up by sleeping during the day, and is one of the issues affecting women about which little is known.

Supplementary feeding

Out of the 334 M_1 women, only 28 (about 8%) had initiated supplementary feeding, indicating that a majority of infants (92%) under 4 months were breastfed exclusively. Amongst those who had initiated, it was found that the highest percentage (16%) was among those giving less than 6 breastfeeds per day. (Table 4)

With regard to the 19 mothers in the least frequent group who had initiated supplementary feeding, 17 were in groups B and C i.e. carrying multiple roles, while only two were in group A and doing only domestic work. Thus a clear association could be seen between the increase in work roles and the introduction of supplementary foods.

Table 4
Supplementary feeding in relation to number of breastfeeds per day (N=276) *

No. of breastfeeds	Supplementary Feeding		Total
	Initiated	*Not initiated*	
<6 times	19 (16%)	98 (84%)	117 (100%)
7-9 times	7(7%)	95(93%)	102%(100%)
10-12 times	2(4%)	55 (96%)	57 (100%)
Total	28 (10%)	248 (90%)	276 (100%)

** excludes all the 'no response' category.*

Within Group A, the two mothers who had initiated supplementary feeding formed only 6% of the total number of group A mothers giving less than 6 feeds. In contrast the 17 months of Groups B and C who had initiated supplementary feeding, formed 20% of those in groups B and C giving less than 6 feeds. (refer Table 2) reinforcing the association between increased work roles and supplementary feeding.

With regard to those who gave greater frequency of feeds (i.e.) 7 to 9 times or 10 to 12 times, a very small number were found to have initiated supplementary feeding (i.e.) 7% and 4% respectively. It is possible that in these few cases supplementary feeding may be attributed to lactation failure, perceived or real, or to other reasons, rather than to pressure of work roles.

The M_1 mothers

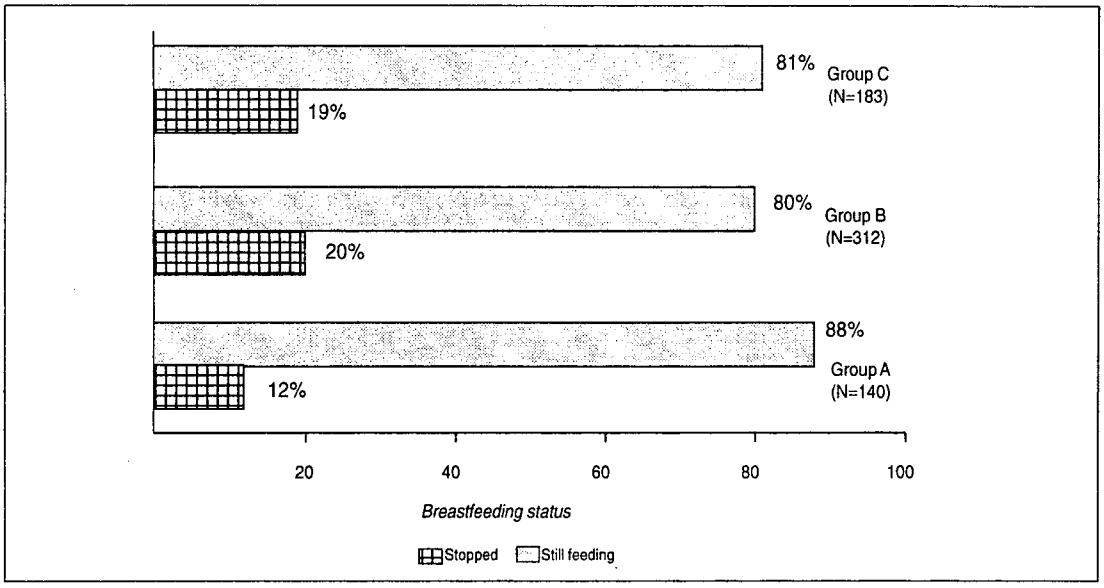
In conclusion, the following can be seen about the M_1 mothers.

1. All mothers were found to be breastfeeding. A majority of the infants (92%) were exclusively breastfed.
2. Breastfeeding had not been given up for work. Rather mothers used different strategies such as dropping out of the work force, changing jobs and place of work to combine work with breastfeeding.
3. Major financial loss is incurred by mothers staying away from work, which is likely to have a strong negative impact both on the mother's health and the general well-being of the family.

Breastfeeding practices of M_2 mothers

In this period, the mother has resumed or resumes all the tasks that she was executing prior to the delivery. Since food other than breast milk can now be given to the infant the total dependency of the child on the mother for nourishment also decreases. Thus the condition that the mother has to be constantly near the child, imposed by breastfeeding, no longer exists and there is comparatively greater

Fig.6
Breastfeeding status (5-12 months)



freedom for the mother to stay away from the child if needed. Further, supplementary feeding of the infant and general care can be delegated to someone else. But infant care is still an important role for the woman and support for infant care becomes a critical factor in influencing the mother's decision to stay away from the child for employment purposes.

Nearly 80% of the mothers continued to breastfeed and there was little difference in the proportion of women who had given up breastfeeding amongst all the three categories. (Fig. 6)

As in the previous group of mothers with children less than 4 months, these mothers were also found to be feeding more at night irrespective of their work roles. (Table 5) For these women night time may be the most convenient since all of them had resumed all the activities that they had been doing prior to delivery. As noted earlier, group C mothers may be suffering from fatigue if they are unable to take some rest during the day.

Time of introducing supplements

With regard to supplementary feeding 73% of mothers in all the three categories were found to have introduced supplementary foods while 16% stated that they were still breastfeeding exclusively. (Table 6)

However a greater percentage of mothers (i.e. 30%) who were performing the maximum number of roles had introduced the supplements within the first four months as compared to mothers who had fewer roles to perform; the percentages being only 12% for Group A and 15% for Group B, as against 30% for Group C. This more or less corresponds to a similar pattern of behaviour observed earlier with

Table 5
Work roles and time of maximum feeding (N=522*)

Groups	Time of Maximum Feeding					Total
	Mor	*Aft.*	*Eve*	*Night*	*No response*	
A	8(7%)	9(7%)	4(3%)	64(52%)	38(31%)	123 (100%)
B	13(5%)	25(10%)	14(6%)	131(52%)	67(27%)	250(100%)
C	9(6%)	10(7%)	4(3%)	93(62%)	33(22%)	149(100%)
Total	30(6%)	44(8%)	22(4%)	288(55%)	138(27%)	522(100%)

** excludes all those who had ceased to breastfeed.*

mothers of children less than four months of age, and suggests that with an increase in work load, mothers may have to resort to feeding children supplementary food as a means of combining work and breastfeeding.

Infant care strategies of M_2 mothers doing paid work

Out of the 429 M_2 mothers who were doing paid work, 303 (71%) had resumed their economic activities at the time of the study. Out of the latter group, 51 mothers were working within the home and thus had access to their infants all the time, while 252 mothers were working outside the home.

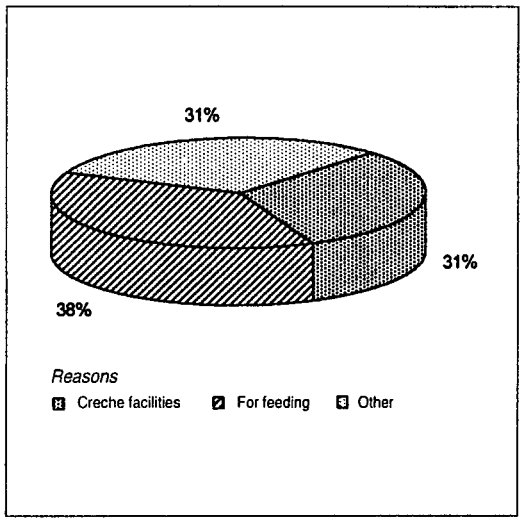
Only 42 mothers (17%) who worked outside the home were found to be carrying the children to the workplace, while the rest of the 210 (83%) left the infants at home in someone else's care.

Table 6
Time of introduction of supplementary feeding by work roles (N=522) *

Groups	Time of Introduction of Suppplementary Feeding				Total
	< 4 months	*> 4 months*	*Not yet started*	*No response*	
A	15 (12%)	58 (47%)	24 (20%)	26(21%)	123(100%)
B	38 (15%)	146 (58%)	36 (14%)	30 (13%)	250 (100%)
C	44 (30%)	78 (52%)	23 (15%)	4 (3%)	149 (100%)
Total	97 (19%)	282 (54%)	83 (16%)	60 (11%)	522 (100%)

** excludes all those who had ceased to breastfeed.*

Fig. 7
Reasons for carrying children to the work place (N=42)



Thirty one percent of the mothers said that they carried the infants with them since there were creche facilities at the work site, while 38% said that they did so in order to feed. Several other reasons were given by the rest. (Fig. 7)

With regard to the infants who were not carried to the workplace and were looked after by someone else during the mother's absence, seven categories of caregivers could be identified (Fig.8). Here again the family has emerged as the major source of support to the mother for infant care, with nearly 74% of the children being looked after by one family member or the other. This suggests that perhaps other forms of childcare support are preferred by mothers only when there is lack of family support.

The M_2 mothers

In conclusion, the following can be stated about M_2 mothers :

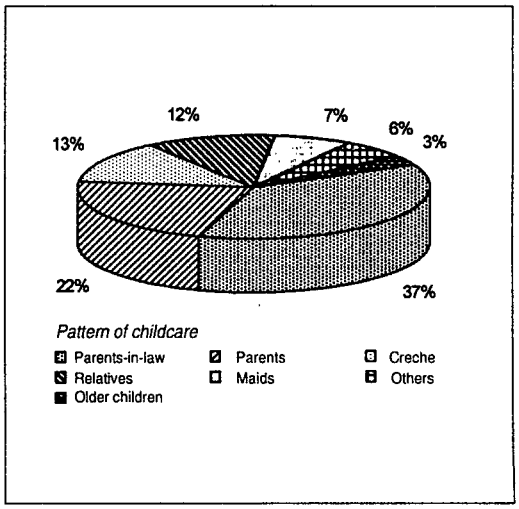
1. About 80% of the mothers continued to breastfeed (16% exclusively). About 73% had introduced supplementary feeding.
2. Only 17% of mothers who worked outside the home carried their babies to the workplace, while 83% were cared for by someone at home.
3. The family has emerged as the major support to the mother working outside the home since nearly 74% of the infants are taken care of by family members.

Single mothers

While data about emotional and psychological factors affecting breastfeeding were not sought, the findings about single mothers illustrate some of the difficulties that may be experienced by women.

It is worth noting that out of the 969 respondents, 44 were found to be single

Fig.8
Childcare patterns of employed mothers (N=210)



mothers (17-M_1, and 27-M_2). While 21 women were divorced from their husbands, 16 were separated due to migration by the spouses to other places for work. Three women had separated since their husbands were practising polygamy, while 4 were widowed.

With regard to work roles, 15 women each were in groups A and B while 14 were in group C. Out of the 23 women who were in paid work, 21 had resumed at the time of the study, thus indicating their need for financial resources. Twenty seven women were staying in their natal homes while 9 were in their marital homes and another 8 were on their own. No information is available on the emotional stress that these women would have experienced and how it affected breastfeeding. It can only be inferred that the 36 women (81%) who were staying either in their natal or marital homes would have had some degree of support (economic and psychological) from their families.

SUPPORT SERVICES 7

The handling of multiple roles along with breastfeeding is clearly an area where women need support. Support to a breastfeeding mother can therefore be considered at four levels :

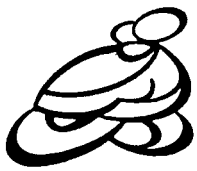
a. Professional level
b. Family level
c. Employer level
d. State / Government level

Kinds of support

At the *professional* level, support can be extended to a mother in the form of advice regarding breastfeeding during the ante-natal and post-natal periods and by following the right institutional procedures soon after birth that encourage bonding of the mother and child, thereby stimulating breastfeeding.

At the level of the *family*, support can start from the time the child is born and continue throughout infancy. The nature of support could be in the form of advice, relieving the mother of household chores, taking care of the child and even carrying the child to the workplace if needed, as well as psychological and emotional support.

Support from the *employer* is usually envisaged in the form of paid maternity leave, creche at workplace, nursing breaks and sometimes other benefits such as medical reimbursement, salary advance etc.



At the *government* level two kinds of support services are possible.

i legal measures that entitle a mother engaged in paid work to get paid maternity leave for a stipulated period

ii schemes for women in the unorganised sector that offer nutritional or cash support for breastfeeding.

Professional support

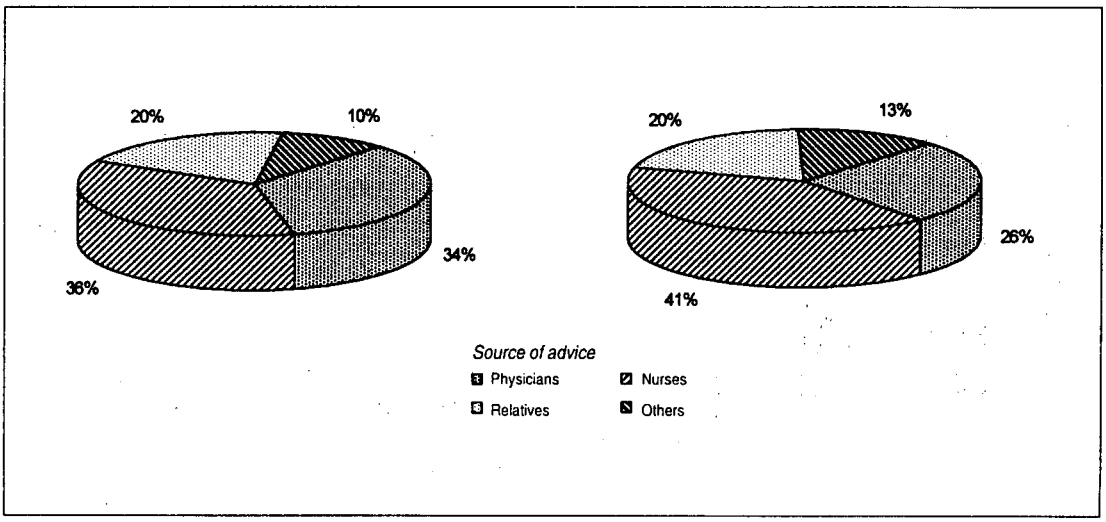
Nearly 94% of the babies were born full term and 80% of all the deliveries had been normal. A majority of the mother-baby dyads (84%) had not been separated, which augurs well from the point of view of breastfeeding, since close contact between the mother and child is important for early secretion of breast milk.

Rooming-in was practised in 84% of the cases. With regard to advice on breastfeeding, nearly 50% of the mothers had received advice during the ante-natal period, while about 74% had received it immediately after the birth, indicating that relatively greater attention is shown only after the birth of the baby.

Fig.9 indicates the extent of support from various sources. With regard to initiation of breastfeeding soon after delivery, maximum support came from relatives (44%) followed by nurses (24%) and doctors (14%) respectively.

There is no evidence of any support from the health professionals after

Fig.9
Advice to mothers (N=969)



the delivery for sustaining breastfeeding. Besides, advice is usually restricted only to the mother and there is no effort to sensitize the family members, especially the in-laws and spouses, on the importance of breastfeeding and the need for giving support to the mother to enable her to breastfeed.

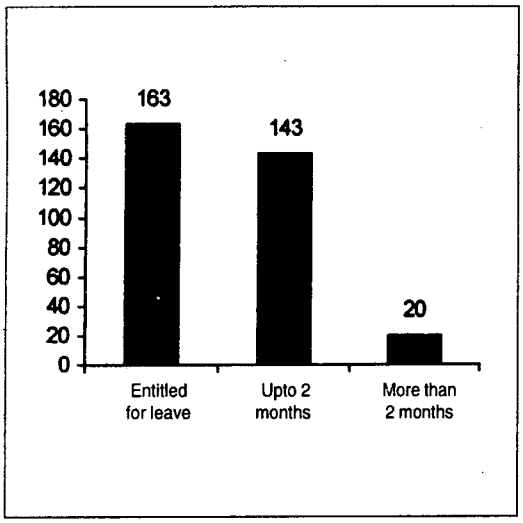
Employer support*

This support relates only to women working in the organised sector where labour legislation is applicable. Mandatory support consists of paid maternity leave for three months as provided in the Maternity Benefit Act (1961) and the Employees State Insurance Act (1948). Some private organisations offer benefits like free hospitalisation, reimbursement of medical expenses, salary advance etc. The unorganised sector has no such privileges since the employer-employee relationship is not clearly defined. Also, some may be self-employed or doing contractual work. There may be several employers, as in the case of construction workers, in which case responsibility cannot be pinned down to any one person.

Under the Maternity Benefit Act of 1961, and the Employees State Insurance Act (1948) a mother is entitled to three months of paid maternity leave, which, since 1986, can be taken according to the mother's convenience prior to and after delivery. Since most women would prefer to take some amount of leave during the last trimester of pregnancy just prior to delivery, it is obvious that the leave available to these women after delivery would be much less than 3 months. Thus exclusive breastfeeding for 4 months is out of the question for these women, unless other strategies such as leave with loss of pay are adopted.

* Family support has been discussed in earlier chapters

Fig. 10
Paid maternity leave for women in the organised sector (N=163)



Out of the 641 women doing paid work, 163 were found to be in the organised sector. All these 163 women had taken some amount of leave prior to delivery. As a result, none of them could enjoy the full three months leave after the delivery (Fig. 10).

After completion of the entitled period of leave, it was found that about 38% had gone on leave with loss of pay for another 3 months, while another 42% had done so for more than 3 months. Only 68% of the women had received their full salaries during the leave period. It is not clear whether the non-receipt of salary for the rest (32%) is because they were not technically entitled to receive it or whether they were simply cheated out of it or were not aware of their rights.

Besides salary, 11 women got free hospitalisation and 4 women got a salary advance.

State support for breastfeeding

The endeavours of the State government in Tamil Nadu to provide support to lactating mothers have two important dimensions - namely monetary and nutritional.

The former, named as Dr. Muthulakshmi Reddy Childbirth Scheme, provides cash support in two instalments* just prior to and after delivery, to women below poverty line and having only two children or less, to enable them to tide over the income loss resulting from temporary withdrawal from paid work. The latter is a nutritional supplement in the form of a *'laddu'* and is given every day during the last trimester of pregnancy and for 3 months after delivery. Since April 1995, women are also entitled to a free noon meal during pregnancy and for six months after child birth.

Comparative strengths

It has been argued that only through nutritional supplements would greater benefit accrue to the mother since it would go to her directly while other forms of support such as cash would get diverted to the family, for other purposes. However it may be argued that if a woman has a share in bearing the economic burden of the family then such cash support would indirectly help her by perhaps prolonging the period of stay off from paid work. Whatever be the nature of support, it is impera-

Recently it has been made into a single instalment of Rs. 500/- prior to delivery for administrative convenience.

Fig. 11
Utilization of cash support scheme (N=370)

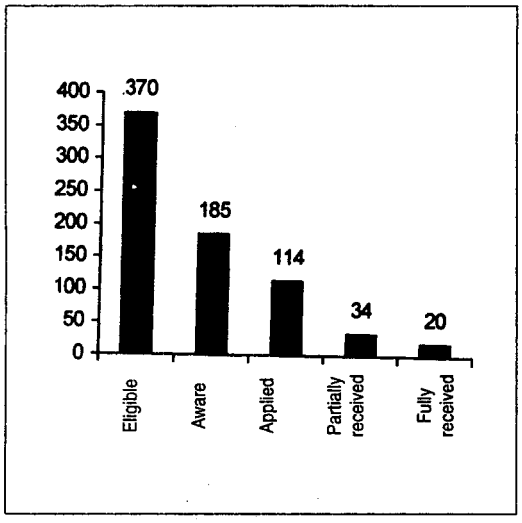
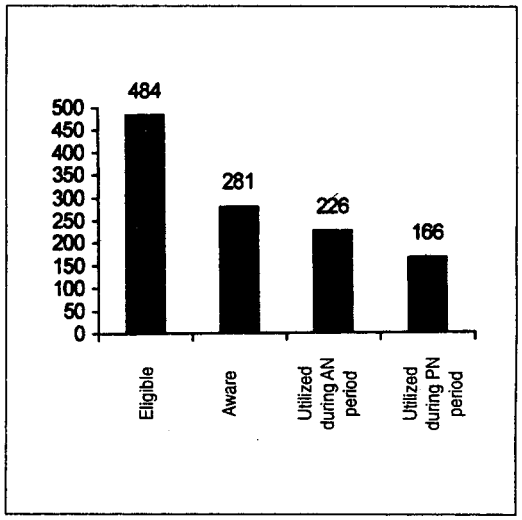


Fig. 12
Utilization of nutritional supplement (N=484)



tive that it is timely, so that it is beneficial to both the mother and the baby.

Fig.11 indicates the extent to which eligible women availed of cash support. The low utilisation can be attributed to a combination of lack of awareness, lack of assistance in dealing with procedures, bureaueratic delay and corruption, and other factors which need in-depth study.

With regard to the nutritious supplement in the form of a laddu, out of the 484 women who were eligible for it, 281 (about 58%) knew about it, a slightly higher percentage than those who knew about the cash support scheme. Fig 12 indicates the pattern of utilisation. The percentage of women availing of the supplement during post-natal period is much less, probably because women found it difficult to go to the centre and collect the "laddu" once the baby was born.

Opinions of mothers

Mothers' views and ideas on various aspects of breastfeeding were investigated. When asked whether the baby of one sex required more milk, 57% of the mothers said that both the sexes required the same amount. Thirty two percent said that they did not know. Only about 6% of the respondents said that male babies required more milk.

When asked whether they got adequate support for combining work and child care 76% of the mothers said yes and only 22% said no. However in the absence of observation and more probing study, it is possible that the true circumstances may not be adequately represented.

Similarly changes in personal life due to the arrival of the baby were articulated by only about 50% of the mothers.

Table 7
Mothers' opinions on support needed

Family support (N=363)	Percent
Advice	10
Support in child care	25
Sharing domestic work	37
Others	28
Support from Govt. (N=65)	Percent
Paid leave	35
Creche	49
Others	23
Support from employers (N=48)	Percent
Paid leave	39
Creche facilities at work place	71

* *multiple response*

Forty nine percent said that their lives were going on as usual; about 11% said they had given up all entertainment activities, while about 38% said that they did not go out at all after the birth.

Only three hundred and sixty three respondents answered the question on support to a working mother at the home front and at the workplace. This may partly be due to the fact that women could not easily visualise what kind of support they could expect, as most of them might not have thought about this before and this question was the last in a lengthy interview. Table 7 shows the type of support expected by mothers.

It is significant that the main demand of a majority (37%) of mothers was from the family in sharing of domestic duties. Paid leave and creches were suggested as support for women doing paid work. However those who had paid leave said that they preferred creches while those using creches said that they preferred paid leave. These topics needed further intensive study.

8 THE CONCLUSIONS

At first sight, the broad general conclusion seems to be that breastfeeding is widely and successfully practised. Women, it seems, are coping very well with the challenge of multiple roles, and by a combination of strategies are succeeding in breastfeeding their children adequately, thus ensuring the health and welfare of the next generation. Indeed women are coping - but against all odds. The optimistic conclusion may be a superficial one since there is a hidden social cost to both women and their families, a cost which should not be neglected and deserves to be more deeply and carefully studied.

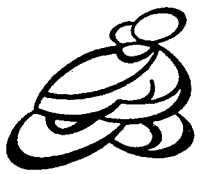
The relationship between women's multiple roles and breastfeeding has emerged as complex and non-linear, including several dimensions such as the family, the culture and the economy. No longer can breastfeeding and infant care be thought of as simply concerning mother and child; it has to be seen as a multi-faceted social issue which needs to be addressed by the family, society, employers and government, in order to create appropriate support structures for the mother-child dyad.

Domestic work

The heavy demands on a woman's time made by the still largely "invisible" burden of domestic work powerfully affect breastfeeding. The fact that two-thirds of the women who had resumed their household chores within a month of the birth of the baby, lived in marital homes, highlights the advantage of the traditional cultural practice in which women go to their natal homes for delivery and a subsequent period of rest. On the other hand, the successful breastfeeding experience of a few women living in their marital homes and enjoying the support of their in-laws, and the articulation by a majority of the rest that they needed help in doing household tasks, indicate the crucial role that the family plays in enabling the mother to breastfeed. With the growing trend towards nuclear families, the need for men to offer support by sharing this "invisible" burden will become more and more obvious, conflicting with the widespread social perception of gender roles.

Financial loss

With regard to economic activities, it is striking that breastfeeding is given priority by women and work is sacrificed when there is a situation of conflict. It was seen that women in the unorganised sector postponed resumption of paid work for the sake of breastfeeding. The negative impact of staying off from work among those in the lower socio-economic groups is reflected in the reports of reduced intake of food or resort to borrowing documented. These outcomes do not augur well for the welfare of either mother or child in the long run. Even those who resume work do so only by adopting various methods such as changing jobs or working within the home, which permit them to



combine work with breastfeeding, but with a cost to the mother's health, income and welfare, yet to be explored. With regard to women in the organised sector, insufficient leave often forces them to go on leave with loss of pay, again leading to financial loss for the family. The cost to the mother and the whole family has yet to be studiesd in quantitative terms.

Exclusive breastfeeding

The constraints on the exclusivity of breastfeeding, which is expected to be maintained during the first four months of infancy, originate in the lack of adequate support to the mother in performing her multiple roles, especially highlighted in the organised sector. Either she has to manage at economic or health cost to herself or resort to bottle feeding. The later however does not appear to be the favoured option, at least among the respondents in this study. There are also legal constraints which can probably be dealt with by appropriate amendments to the laws, but that is a far cry from implementation; and besides, such measures can affect only a small minority. The wider issue still remains unaddressed.

Emotional stress

The case of the single mothers, constituting 5% of the sample, poignantly illustrated the importance of psychological factors. There is a well-established link between lactation and the emotional state of the mother. Yet the financial, social, emotional and psychological trauma likely to be experienced by these women, bereft of their spouses within a few weeks or months of childbirth, can well be imagined. Though these could not be documented in depth in the study, it is sufficient to highlight the need for additional support from other members of the family.

9 THE IMPLICATIONS

The description of the various external constraints to sustained breastfeeding — social, economic, domestic, legal and psychological, draws attention to the need for supportive policies, actions and strategies which can remove these constraints and empower women to breastfeed.

Five distinct levels of support have been identified, namely - familial, professional, employer, state and the media. These are not, however, independent of one another but are interactive in nature since each influences the others in various ways e.g. doctors should not only advise the mother on breastfeeding but also address the family members in extending support to the mother by sharing domestic chores and thus releasing her for breastfeeding.

Family support

The family has emerged as the primary support system for the mother. Though information on the role of the family during the ante-natal period was not sought, the major role played by family members in the initiation of breastfeeding has been clearly documented. More importantly, family support has to be a long-term one, both with regard to breastfeeding during the first four months and child care (including breast-feeding) in the later period, while the mother is engaged in other remunerative work.

Since women staying in the natal residence seem to have a greater advantage in terms of rest over those staying in marital homes, and since a need was articulated by the others for support from family members in the sharing of domestic chores, these are crucial areas on which families as a whole and men in particular, need to be sensitised. With the increasing number of nuclear families, it is becoming imperative for the husband to share the domestic chores and take some responsibility for infant care. Taking leave from the workplace to help the mother should be seen as a positive form of support, and helping with chores promoted as an expression of a man's concern for his wife and children.

Professional support

It is also clear that doctors, nurses and other health functionaries have to start counselling, not only the mother, but also the other family members right from the ante-natal period; and such counselling should continue during the period of lactation to support the mother to sustain breastfeeding. Such counselling should routinely include husbands, as well as other family members, and become an active instrument to sensitise and inform men on the issues.

The Indian Association for Paediatrics has recommended six months of 'lactation leave' for working women. Active lobbying for the demand should also be taken up by other professional bod-

ies in their respective areas. Doctors should also address employers to consider breastfeeding as an important social issue, and persuade them to be generous in extending paid maternity leave for four months starting from the day of childbirth, even if not statutorily required.

Health professionals can also provide information to women about available support services, and assist them to secure it.

Employer support

For employers in the organized sector, offering four months of paid maternity leave to women employees would go a long way in helping both the mother and the child, even if only three months is stipulated under the law. Such measures would not only improve labour relations and lead to job satisfaction but enhance worker productivity in the long run.

Once the mother comes back to work, other alternative forms of support such as flexible working hours, part-time work, take-home work, etc. can be thought of, until the mother is able to resume full-time work.

Paternity leave is also a progressive step in involving men in caring for the mother and child. The Voluntary Health Association of India has already implemented the idea and set an example as an ideal employer.

State support

State support is important both in itself and as setting a social norm. State support to the mother already exists in the form of legislation for women in the organized sector and schemes for those belonging to the unorganized sector. However, at present these have certain lacunae which have to be removed if they are genuinely to empower mothers to breastfeed.

If exclusive breastfeeding for four months is to become a reality, the Maternity Benefit Act of 1961 and Employees' State Insurance Act of 1948 have to be amended to provide maternity benefit for four months starting from the date of childbirth and not three months regardless of when the leave is taken, as is the case now. Leave taken prior to delivery should be treated as medical leave.

For women in the unorganized sector, the Muthulakshmi Reddy Scheme in Tamil Nadu (and similar schemes else where) offers economic support. However the amount of Rs.500/- which is currently being offered is inadequate to enable women to survive for four months. If it is really intended to help women stay off the labour market for several months, it should be enhanced to at least Rs.1600/- to compensate for the wage loss (calculated at the rate of current Minimum Wages of Rs.20/- per day for 20 days employment per month for four months) and these rates should be regularly revised. Besides, the procedures will have to be streamlined if the really poor and often illiterate mothers have to gain. In the same way, schemes for nutritional support need to be enlarged, strengthened and made more efficient and effective.

It is unrealistic to expect employers to provide creches at every workplace since there may be only very few women employees needing the service, in any given workplace, in which case it would not be economical. Further, all employers may not have the expertise to run a creche adequately. However, "baby-friendly work places" with basic facilities to keep children should also be encouraged as one among

several support measures, such as informal family day-care centres, common creches run by groups of employers in a locality etc.

Even here, the Government should set up a Maternity and Childcare Fund to which all employers may contribute an amount as cess, which could then be utilized to fund day-care centres, as well as other flexible arrangements to suit different situations and run by different agencies.

Role of mass media

The media have a major role to play in influencing public opinion. Messages on support services to empower the mother to breastfeed should come out regularly in all the electronic media, especially AIR and Doordarshan which still have the widest reach. Messages on the role of men in helping women in household chores, the role of the professional, and of the employer in offering support etc could be carried regularly. Television should move away from programmes that currently tend to only emphasize the traditionally perceived male and female roles and strengthen programmes that highlight changing gender roles in the family, showing men and women in new ways that respond to the social challenges of the times.

Much more could be said on each of these points. But a study such as this would have served its purpose if it casts light on some of these complex issues, raises queries and suggests new directions for actions which empower women. Only then can women fulfil their multiple roles effectively and satisfactorily while ensuring the health and welfare of their children and themselves.

References

1. Arulraj, M.R. and Raja Samuel, S. : *Balancing Multiple Roles* Research Report No. 1, M.S. Swaminathan Research Foundation, Madras 1995.
2. Chatterjee, Maitreyee : *Breastfeeding and the Rights of Working Mothers* Procedings of the seminar on promotion of breastfeeding, Bengal Rural Welfare Society 1990.
3. Dixit, S. : *Effect of Feeding Pattern, Water and Hygiene on Morbidity in Children.* M.Sc. dissertation submitted to S.N.D.T. Women's University, Bombay 1988.
4. Gopalan, Sarala : *Women and Employment in India* Har-Anand Pub, New Delhi 1995.
5. Government of India : *Census of India* 1991. Registrar General of India
6. Greiner, Ted : *Sustained Breastfeeding, Complementation and Care* Food and Nutrition Bull., Vol. 16, No. 4, 1995.
7. *Human Development Report :* United Nations Development Programme. 1995.
8. Leslie, J. : *Women's Work and Child Nutrition in the Third World.* World Development, Volume 16, No.11, 1988.
9. Pandey, R. : *Breastfeeding and the Working Woman in India (Constraints and Opportunities)* Chugh Publications, Allahabad 1990.
10. Popkin, B.M. and Solon, F.S. : *Income, Time, the Working Mother and Child Nutrition.* J. Trop Paed, Volume 22, 1976.
11. Rahmatullah, Lakshmi : *Breastfeeding in the Low Socio-economic Group - a Matter for Concern.* In J. Paed, Volume 62, No.l, 1995.
12. Rao, Nitya : *Towards Empowerment - a Quest for Justice.* A case study of women quarry workers & gem cutters in Pudukottai dist (TN). National Institute of Adult Education, New Delhi 1993.
13. Shatrugna, Veena, Vidya Sagar, P. Vasanthi, G. and Sujatha, T. : *Women's Work and Time - Critical Issues for Women's Development Programmes.* Proc. Nutr. Soc. India, Volume 40, 1993.
14. *Shramshakti : Self Employed Women and Women in the Informal Sector.* Report of the National Commission on Self-Employed Women, *Government of India*, New Delhi, 1988.
15. Swaminathan, Mina : *Women, Work and Breastfeeding.* Occasional Paper 2, M.S. Swaminathan Research Foundation, Madras 1994.
16. Udipi, Shobha, A. and Merchant, Shameera S. : *Child Care and Nutrition in India : A Review.* S.N.D.T. Women's University, Bombay 1995.
17. Vachani, I. : *Time spent by Mother on Feeding and Child Care : A Factor affecting the Nutritional Status of Children?* M.Sc. Dissertation submitted to S.N.D.T. Women's University, Bombay 1994.
18. Van Esterick, Penny and Greiner, Ted : *Breastfeeding and Women's Work : Constraints and Opportunities.* Studies in Family Planning, Volume 12, No.4, 1981.
19. Vencatesan, Jayshree : *A Study of Food Security along the Continuum of Female Dependency,* M.S. Swaminathan Research Foundation, Madras 1995 (unpublished)
20. Walia, B.N.S., Gambhir, S.K. Sewa, S.R. and Choudhary, S. : *Decline in Breastfeeding in Urban Population of Chandigarh during a Decade.* Indian Pediatrician, Volume 24, 1987.
21. Williams, Suzanne : *The Oxfam Gender Training Manual.* Oxfam (U.K. & Ireland) 1994
22. World Bank : *Gender and Poverty in India.* A World Bank country study 1991.
23. *World Resources : A Guide to the Global Environment, People and the Environment.* A report by the WRI in colloboration with UNEP & UNDP. World Resources Institute, New York 1994-95.

Women's economic activity

Annexure - 1

Women in paid work (N=641)

Category	Number	Percentage
Agriculture	128	20
Manufacturing and processing within the household	134	21
Manufacturing and processing outside the household	97	15
Construction	13	2
Trade and Commerce	15	2
Other services	254	40
Total	641	100

Other services in which women were engaged

1. Accountant
2. Analyst
3. Anganwadi worker
4. Attender
5. Aayaa
6. Booking agent
7. Cashier
8. Clerk
9. Cook in hotel
10. Dietician
11. Doctor
12. Domestic servant
13. Engineer
14. Executive in companies/banks
15. Flour mill labourers
16. Gem cutting labourers
17. Helper
18. Lab assistant
19. Lecturer
20. Noon meal worker
21. Nurse
22. Office assistant
23. Packer in supermarket
24. Police constable
25. Receptionist
26. Sales executive
27. Sales girl
28. Secretary
29. Social worker
30. Stenographer
31. Superintendent
32. Sweeper
33. Tailors
34. Teacher
35. Telephone operator
36. Tuition teacher
37. Typist
38. Washerwomen
39. Weavers

Breastfeeding practices at birth

Annexure- 2

It is recommended by paediatricians that breastfeeding should be initiated within 2 hours of the birth of the baby, since colostreum or early breast milk has very high immunological value for the new - born. Out of the total respondents 58% had started to breastfeed within two hours of the birth of the baby and nearly 89% had given the first feed within 24 hours of birth. The time at which mothers initiated breastfeeding is presented in Table.1

Table-1
Time of initiation of breastfeeding
(N=969)

Time of initiation	Percent
Within 2 hours	58
3-6 hours	22
7-12 hours	5.1
12-24 hours	3.8
> 24 hors	9.6
No response	1.4

Table-2
Pattern of feeding
(N=969)

Type of feeding	Frequency	Percent
Demand	7115	74
By clock	92	9
Both	145	15
No response	17	2
Total	969	100

With regard to prelacteal feeds, 47% of the mothers had not given anything, while 38% had given sugar water, which is found to be the commonest prelacteal. Out of this 43% had given it thrice, while another 28% had given it twice.

The pattern adopted by mothers in feeding their infants is presented in Table.2 A majority of the mothers (74%) were breastfeeding on demand while only about 10% were doing it according to a schedule. The remaining fifteen percent said that though they predominantly fed their babies on demand there were periods when the baby did not cry for a long while. At these times by checking on the time of the last feed the mother decided to feed the baby so that it would not go hungry.

M. S. Swaminathan Research Foundation
Chennai