# Tanzanian Women's Experiences of Combining Exclusive Breast-feeding and Working Outside the Home: Living with the Hurdles and the Contradictions

by

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DALHOUSIE UNIVERSITY

SCHOOL OF NURSING

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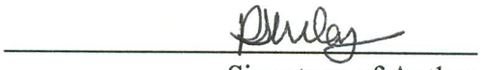
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## DEDICATION

This work is dedicated to the memory of a very special person in my life: my beloved husband, Sam, whose love, care, and inspiration shall be with me all days of my life. His death during my graduate program shocked me beyond any description. I thank God for bringing this wonderful man into my life and for permitting this permanent separation between us, for God never makes mistakes.

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## ABSTRACT

Many women realize the importance of breast milk. The literature points out that it protects children against illness (Lawrence, 1995), is cost-effective, increases mothers' confidence and self-esteem, and increases the mother-child bond. Because of this knowledge, many women try their best to breast-feed exclusively, whether they work or not. The issue of HIV/AIDS cannot be overlooked. Less than 30% of infants breast-feeding from HIV infected mothers may be infected, but more than 50% of infants in re-developing countries die of diarrhoea and malnutrition exclusive of AIDS (Lawrence, 1994). Mothers who are HIV positive must be helped to make informed decisions about whether to breast - feed their infants or not. Those who cannot breast-feed because of poor health, their infants could be breast-fed by infants' aunts or grandmothers who must be tested and proved to be HIV negative. This family network approach which is common in Tanzania is more realistic in Africa than advising on formula and bottle feeding.

Mothers who are at home with their newborns find it much easier to breast-feed exclusively than do women who work outside the home. This study was conducted in Tanzania, the participants being 6 women who combined exclusive breast-feeding with working outside the home in 1996. The purpose of the studywais to use the women experiences to educate Tanzanian society to support and protect womens' rights to breast-feed in a conducive environment. The feminist methodology and grounded theory used in the study describe this experience. From the analysis it appeared that the essence of their stories was a social process of **living with the hurdles and the contradictions** of combining exclusive breast-feeding and working outside the home. The women dealt with hurdles and contradictions experienced within themselves (such as dribbling breasts), within the workplace (such as no on-site babycare at the workplace, lack of expressing or breast-feeding rooms and short maternity leave), and within the society at large in terms of the cultural norms and gender role.

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# CHAPTER I

## Introduction

Mothers, whether they breast-feed or not, generally have unconditional love for their infants. However, studies suggest that breast-feeding increases the mother-child bond (Van Esterik, 1996). For the past one-and-a-half decades, breast-feeding promotion has become very popular. The emphasis is upon exclusive breast-feeding. That is, the infant is fed only human milk for the first 4 to 6 months of age either by suckling from the breast or from expressed human milk by means of a cup and spoon, with nothing else, including water, given to the infant within the mentioned period. Breast-feeding promotion was re-established because studies have shown that human milk is superior to all other infant foods. It is biologically specific to the human baby. Its composition changes daily to encourage a baby to use his or her own satiation control system (Lawrence, 1989). One of the goals for the World Health Organization for the health of the baby is that by the year 2000, babies should be fed only human milk from day zero to 6 months.

Breast milk contains the best balance of nutrients, enzymes, hormones, growth factors, immunoglobulin, and anti-infective substances (antibodies) for the developing infant (Freed, 1993). Antibodies cannot be manufactured by industry because they are found in living cells. In addition, human milk is rich in long-chained polyunsaturated fatty acids, which are important in brain development and myelinization (Akre, 1989). Breast-feeding minimizes potential allergic reactions when the baby is exclusively breast fed for the first 4 to 6 months. Formulas can trigger an allergic reaction in sensitive babies (Lawrence, 1993). Financially, promoting breast-feeding is also cost-effective because it

reduces hospital admissions for gastro-enteritis, which is very common in bottle-fed babies. Breast-fed infants have lower rates of hospital admissions, ear infections, diarrhoeal illness, and atopic skin disorders than their bottle-fed counterparts (Freed, 1993).

Mothers Infected with HIV and the Breast-feeding Process

There are evolving difficulties however. In a recent article in the Canadian Globe and Mail newspaper, titled "Breast-feeding wisdom in question," Meier (1997) raised an issue that has caused a great deal of debate in the past two decades among health workers about whether mothers who are infected with Human Immunodeficiency Virus (HIV) should be advised to breast-feed their newborns. The author highlighted that, "In 90 percent of the redeveloping world, the protection that is afforded by breast-feeding against the diseases of the 'Third World' is higher than the rate of HIV transmission" (p. A8). The HIV has been isolated from blood, vaginal secretions, semen, saliva, tears, cerebral-spinal fluid, urine, amniotic fluid, and breast milk. Lawrence (1994) suggested that only blood, semen, vaginal secretions, and possibly breast milk have been implicated in person-to-person HIV transmission. She reported a case study of a healthy woman who was assisted to deliver by an emergency cesarean section and transfused with blood from an HIV-infected donor. This mother breast-fed her healthy baby for 6 weeks. At 3 months of age the infant failed to thrive. When tested at 13 months, the mother and the infant were sero-positive for HIV and had generalized adenopathy. The father and other siblings were negative.

A European collaborative study, also described by Lawrence (1994), in which 271 children born to HIV-infected mothers were followed from birth for over a year, 10 developed AIDS, all by the age of 9 months, and 5 died. Twenty-two others had signs and symptoms of HIV. Three others died from other reasons. The other 234 children were immunologically normal and clinically well. There is, therefore, a risk (12.5% in this report) of HIV-infected mothers transmitting the disease to their beloved infants.

Discussions in which I participated in Tanzania, regarding how to help mothers infected with HIV to breast-feed or not, were fraught with turmoil because of the complexity and sensitivity of the issue. Infected mothers do not know whether they are sero-positive because they do not follow up for the results after tests that are done during antenatal visits. Those who know that they are positive may not know how they could infect their infants. The situation faced by Tanzanian health workers is whether to give information about HIV status to all women or to give the information only to women who appear to be able to afford formula feeding and say nothing to the women who are economically poor and have no access to clean water or electricity. The decision made was that a woman should be assessed from her economical point of view to discover whether she can afford to safely feed her baby from sources other than her breast milk. For some mothers, it is literally impossible not to breast-feed, because their infants hardly survive. Mothers, for example, who are in the lowest paying jobs will not be able to afford any baby formula. They usually cannot develop extra income-generating projects because they lack the capital. It is unrealistic, therefore, to suggest to them to buy formula, no matter how the companies make the formula affordable. These mothers will be encouraged

to breast-feed and hope for the chances of infants not contracting the disease, which could be more than 70%. Thus, the basis of this decision is that less than 30% of infants breast-feeding from HIV infected mothers may be infected, but more than 50% of infants in developing countries die of diarrhoea and malnutrition exclusive of AIDS (Lawrence, 1994).

I must state emphatically that death is death no matter what the cause is, and that, even if the risk of dying is 1%, it is 100% to the person directly affected, which is why it is so sensitive. I think it is critical that all pregnant mothers should be told if they have antibodies to the AIDS virus. This should be followed by a careful explanation of the consequences of breast-feeding and/or other substitutes such as cow's milk. Mothers must be helped to make informed decisions. Health workers must also consider the fact that pregnancy and HIV compromise the woman's immunity so that by the time the women delivers the baby she may not be able to breast-feed even if she wanted to. In such situations, the health worker should help to rally the woman's relatives, especially the baby's grandmothers or the mother's sisters, to provide the necessary support. Many infants, whose mothers die immediately after delivery, have been breast-fed by these close relatives. The family network approach is more realistic in Africa than advising on formula and bottle feeding. Additionally, I think the same approach of luring and screening blood donors for HIV could be used for women who could donate human milk so we could establish milk banks.

Although studies have identified that babies have been infected through breast-feeding from HIV-infected mothers, I believe that there are many factors to consider,

especially in developing countries where AIDS patients develop multiple open skin conditions. Mothers' blood, for example, may come in contact with infants' blood during the breast-feeding process, from cracked nipples and infants' sore mouths, or contact between mothers' sore hands and infants' umbilical raw stumps during bathing or other baby-care procedures. In fact, mother-baby skin-to-skin contact is almost continuous, especially if breast-feeding. Research must be conducted to find out the rate at which infants can contract HIV infection from feeding only on expressed milk, compared to those who breast-feed directly from mothers who have antibodies to the AIDS virus. Additional precautions such as use of gloves could be used in the experiment to reduce chances of mother-infant blood contact. None of the mothers in this study reported any concerns about HIV. I recognize that it is a serious and complex issue compounding all the other factors I will continue to address.

Breast-feeding provides a unique and intense time of mother-infant interaction in Tanzania as well as in other countries. The advantages of breast-feeding are numerous, thus, the significance of breast-feeding promotion. From a feminist perspective, however, breast-feeding promotion has not taken into consideration the experiences of women during the breast-feeding process. Women are bombarded with much information on how to breast-feed because a healthy baby is perceived to be the source of happiness of the family, and thus it is only the uncaring mother who would not breast-feed her baby. The mother's breast and the infant are of primary importance to the promoters of the practice when it comes to breast-feeding. The mother's life is often not regarded holistically. But

whatever affects the mother, be it psychological, physical, social-environmental, or economical, may influence the breast-feeding process and, consequently, the baby.

Considering the advantages of breast milk, it is likely that mothers would wish to breast-feed because it is widely known that breast milk is the best food for their babies. But, how would a working mother succeed in breast-feeding exclusively and work outside the home? And if she does, what is her lived experience in the process of breast-feeding and working? In addition, if it is actually impossible to carry out, to what extent does a mother experience guilt and/or shame?

Studies have reported a decline of breast-feeding, despite the promotion of the practice. The reasons given include mothers' employment outside the home, short maternity leave, low income and education levels, urbanization, industrialization, and "Westernization" in developing countries (Hills-Bonczyk, Avery, Savik, Potter, & Duckett, 1993). Historically, breast-feeding was not a problem in developing countries. Mothers usually breast fed their infants, although not exclusively; that is, they gave water, gruel, and tea with a cup and spoon very early in life. For example, they gave water when the infant was a few days old because they thought babies become thirsty. Babies were not afflicted with malnutrition and gastroenteritis as nowadays, because breast milk was the major food. In Tanzania the breast-feeding process would continue for 3 to 4 years.

The major problem arose when the ideology of Westernization influenced working women in the majority of countries. Multinationals were responsible for bringing in artificial baby milk as a means to dupe mothers into thinking that this was a progressive step. The introduction of bottle-feeding quickly emerged, and breast-feeding became

considered something that a primitive or an uneducated women would do. Commercial advertisement which were only in English, could not be read by an uneducated woman. Women who were uneducated or less educated thus copied the more educated women because they thought the educated women knew what was better for infants. A baby on a formula with the required constitution, who may grow bigger than its breast-fed counterpart or may develop obesity, does not portray a lack of health, such as the potential for heart diseases, but instead is considered healthy. Most of the less infra structured (poor and less organized) societies copied the use of bottle-feeding and stopped breast-feeding. What they often put in the bottle includes diluted baby formulas, water, diluted juices, tea, gruel, and soups, which lead to severe malnutrition (personal observation). Because of unsanitary environments, especially in Africa, the feeding bottles are often highly contaminated for both working and non-working mothers. Working mothers often leave their infants with uneducated maids. These practices have made diarrhoeal disease the number one infant killer in countries such as Tanzania where I come from and the country about which I am most concerned. Many of the statements made above are based upon personal experiences and observations.

Tanzanian health workers have made mothers to understand that bottle-feeding is equal to the "infant's grave." This Tanzanian expression means that if mothers use bottles to feed their infants is like murdering them. It is quite frightening for mothers, especially working mothers who feel very guilty when admitted to hospital with a bottle-fed baby with diarrhoea. This is ironic, because they are not made to understand their rights, in that they are not well informed on how to demand that working hours fit their requirements to

breast-feed. Some mothers try to breast-feed exclusively and work full time, which is usually extremely difficult. Breast-feeding and employment are often viewed as mutually exclusive (Auerbach, 1990). They are, in fact, very closely linked in that they are both full-time jobs requiring a very careful balance between the two.

There are a limited number of studies describing the experiences of mothers who have successfully combined breast-feeding and employment, suggesting that experiences of breast-feeding and working mothers should be examined in more detail (Morse & Bottorff, 1988). These few studies were conducted in developed countries. The experience of a mother in feeding an infant of less than 6 months old and working in the developed world is totally different from her counterpart in a developing country, where 125 million and more infants live in poverty and unsanitary environments (Lindernberg, Artola, & Jimenez, 1990). In addition to financial problems and environments, mothers in developing countries have to work full time if they work because there is no provision for part-time jobs. Mothers in countries such as Tanzania are given only 84 days maternity leave and cannot extend the time because of financial constraints. The babysitter, with whom the mother has to leave the infant, is often young and uneducated, with her own beliefs, such as that human milk is "dirty" and "nauseating," and therefore she may opt to throw out the expressed milk and give the infant some gruel.

The working mothers in such situations have a plethora of worries and problems; this requires research which will uncover their plight. It is interesting to note that the concerns listed by breast-feeding promoters in Canada as mothers' worries include: feeling uncomfortable breast-feeding in the presence of other people, breast cancer, feeling tied

down, feeling they will lose their figure, nipple tenderness, little social support, worry that the baby is not getting enough breast milk as it suckles, fears around breast reduction surgery, and the role of the father in the breast-feeding family (Szpakowsk, 1994). These may no doubt be issues with mothers in highly industrialized nations. These concerns were identified to be used for teaching mothers during breast-feeding promotion sessions. I could not find in Szpakowsk's document the concerns for a mother who is breast-feeding exclusively and working. It is possible that these concerns were culturally and class biased, which could have contributed to the low exclusive breast-feeding rate in Canada.

Female Health Professionals and Breast-feeding Mothers

The practice of assisting women to deliver babies in Tanzania is conducted by women of different levels of education and experiences, which include traditional birth attendants (TBAs), maternal and child health aides (MCHAs), and professionally qualified nurse-midwives. The TBAs are usually older, postmenopausal women in the community who are trusted by the child-bearing-age women with the task of assisting them in birthing. The deliveries take place either in the homes of the TBAs or in the mothers' houses. Many deliveries, especially in the rural communities, are assisted by TBAs because of personal choice and probably lack of transport and bus fares when labour begins. MCHAs are young women, the majority of whom have never had a child of their own. They undergo a 3-year midwifery training after 7 years of formal education known in Tanzania as primary education. These young women practice in dispensaries/MCH clinics which are widely distributed in almost every village as a result of the Primary Health Care policy which urged government to ensure that affordable health services reach everybody,

the ultimate goal being health for all by the year 2000. Nurse-midwives, who are professionally prepared, assist women to deliver their babies in health facilities which include health centres, district hospitals, and consultant/regional hospitals.

All these women are experts in conducting normal delivery and, most important of all, they assist their fellow women through a careful process that respects their needs and wishes. Any woman assisted by a midwife will actively participate in the delivery process with the midwife without any interference to the normal process of birthing. Worth mentioning is that the services conducted by women for women require very small fees to the health facility or a small gift as a personal appreciation to the TBAs. As a continuation, it is therefore expected that a midwife could be the best person to assist women to breast-feed successfully. Unfortunately this does not happen. Nurse-midwives do not choose to leave breast-feeding women to live with the hurdles and the contradictions of combining exclusive breast-feeding and working outside the home. These midwives, however, are part of a society that does not value exclusive breast-feeding as something significant enough to think about and to include in the system as one of the health promotion strategies. As well as being a societal attitude, it is also economic in nature.

The purpose of this study is to explore the experiences of Tanzanian mothers who combined exclusive breast-feeding for the first 4 to 6 months after delivery and working outside their homes. It is appreciated that women work hard in their homes, but this study focused on employed women.

# CHAPTER II

## Critique of the Literature

### Breast-feeding Promotion

Breast-feeding promotion is a goal of health for all by the year 2000 (Freed, 1993). To achieve the somewhat unrealistic goal, all mothers, whether employed or not, must breast-feed their infants exclusively and on demand for the first 4 to 6 months postpartum. Many authors have written about the promotion as follows: all mothers are capable of breast-feeding (Stephens & Phillips, 1992); breast-feeding can take place, anytime, anywhere (Ridgway, 1992); "healthy baby: healthy family" is the slogan of a new breast-feeding programme (Rodrigue-Gargia, Aumack & Ramos, 1990). The common reason for breast-feeding is that it is "best" for the baby's health (Macaulay, Hamusalk, & Beayas, 1989). Little has been written about the stress that might impinge upon the mother in her effort to meet this challenge.

Ellis (1991) argued that efforts to maintain breast-feeding could compromise the health of the mother. This perspective hinted that breast-feeding could be draining on the mothers' or infants' resources, rather than the way it simply involves physiological behaviours. But Szpakowski (1994), among others, pointed out that breast-feeding is the best one can give a baby. The question arises: what about the mother?

The critique of dogmatic statements. Breast-feeding promoters, according to the literature, have done good work to stimulate mothers to breast-feed exclusively. The language used is quite convincing, but the same language can also frustrate mothers who may fail to breast-feed exclusively. For example, "all mothers can breast-feed" is generally

true, but the way it is stated may make some mothers feel guilty and frustrated, especially if they prefer to breast-feed exclusively but for genuine reasons are incapable of doing so. Some mothers, however, cannot breast-feed, for example, a woman who may have had a double mastectomy, or may not be able to breast-feed exclusively, such as the undernourished mother of multiple births, like triplets.

"Breast-feeding can take place anytime and anywhere" is another example of a generalised use of language that does not consider individual values. Many women would not breast-feed anywhere because for social reasons they cannot relax and relaxation is a requirement for milk flow. A study conducted by Morse and Bottorf (1988) indicated that women who had a relaxed attitude toward breast milk expression were successful with the practice. Those who felt awkward and embarrassed had a more difficult time. Thus, mothers' personal experiences, lifestyles, economic situations, and attitudes must be acknowledged in breast-feeding promotion packages hoping for greater success.

Advantages of breast-feeding. The literature identified a long list of advantages of exclusive breast-feeding in the first 6 months of life. Critics, however, would expect a few disadvantages along with the many advantages. I could not find any disadvantages of breast-feeding reported in the literature. However, time, travel, work situation, and medication usage are among the social barriers which could possibly disadvantage the mother.

The advantages of exclusive breast-feeding for the first 6 months include:

1. Breast milk protects the exclusively breast-fed baby from infection, even when pathogenic microorganisms have been ingested. Breast milk interferes with or prevents

many of the reactions that occur once infection is established, such as microbacterial adherence, colonization, and multiplication. Breast milk contains substances that release antitoxin activity against bacteria and neutralizing activity against viruses (Vickerstaff Joneja, 1992). These actions significantly reduce the risk to the baby of gastrointestinal, respiratory, ear, skin, and other infections, and allergic reactions and other illnesses (Akre, 1989; Cunningham & Segree, 1990; Freed, 1993; Lawrence, 1993; Vickerstaff Joneja, 1992). A significantly reduced incidence of insulin-dependent diabetes mellitus and a decrease of lymphomas was reported in children who had been breast-fed compared with matched groups who were not (Vickerstaff Joneja). Breast-fed children also had less chance of developing dental problems than bottle-fed ones (McIntosh, Wu, & Buhler, 1991).

> I acknowledge with regret the following statements in Meier's (1997) article:
>
> That it is imperative to find alternatives to breast-feeding including ways to make safe affordable formula widely available. To some experts, including many who led the international boycott campaign against the Swiss Nestlé and other formula makers in the 1990s, there is little debate. Although the information is incomplete, they say, in the vast majority of the "Third World" more infants will be imperilled by renewed promotion of bottle-feeding, with its accompanying risks of diarrhoea and dehydration than the danger of HIV transmission through breast-feeding. (p. A8)

In other words, the statement made by Meier implies that it is better, here safer, to bottle feed than to breast-feed. But that is unrealistic. Subsequently more babies may die of

diarrhoea and dehydration caused by bottle feeding than die from HIV infection transmitted through breast-milk. But what is the reality? Is it not a promotion of formula and bottle feeding to the developing countries?

Of late, many more women in developed countries have decided to breast-feed their infants than ever before. I would not, therefore, be surprised that the formula and bottle companies may want to move their markets to developing countries, expecting increased acceptance because of fear mongering about AIDS. The practice of dumping what is unwanted and unhealthy in developed countries to developing countries, is INHUMANE. I realize that currently the Tanzanian government is encouraging foreign investors but these investors must advocate human rights as a priority over and above profits. The idea that "mothers' milk can be dangerous" needs to be scrutinised. Consider this statement which was quoted in Meier's (1997) article:

> Meanwhile, the UN has come under criticism from scientists who say that the group, in its zeal to promote breast-feeding, has not confronted the HIV issue. For years, they could say that "Breast is best, full stop," said Dr. Angus Nicoll, a British government epidemiologist in London, referring to the slogan of advocates for breast-feeding. "That mother's milk might also pose dangers," he said, "is a difficult thing for them to take on board." (p. A8)

For a person in Britain or other developed countries, it is difficult to comprehend that bottle-feeding is more dangerous than human milk infected with the AIDS virus. They need to visit a paediatric infectious ward in Tanzania and other African countries to see the number of infants who die because of contaminated bottles that caused diarrhoea. Let

it be understood that diarrhea kills because the infants are brought to the hospitals when it is too late, which may not be the case in developed countries where each family has its own doctor and money to pay or free care.

2. Breast milk has hormones, growth factor, and is rich in long-chained polyunsaturated fatty acids (Akre, 1989; Lawrence, 1993).

3. Breast milk does not need preparation. It is always available at the required temperature. Breast milk is free from additives, free from colouring, biodegradable, ozone friendly, energy-efficient, a renewable resource, and free at point of supply (Stephens & Phillips, 1992; Szpakowsiki, 1994). The use of breast milk substitutes, especially by impoverished women in redeveloping countries, increases the risk of over-dilution, contamination, and infection, often causing diarrhoea which is a major cause of infant morbidity and mortality (Cunningham & Segree, 1990; Sachdev, Krishna, Puri, Satyanarayana, & Kumar, 1991).

4. Breast-feeding is economical. Reduced hospital admissions for gastroenteritis alone amount to several million pounds a year (Jackson, 1995; Szpakowsiki, 1994). It has been observed that women who breast-feed are less likely to develop breast cancer, diabetes, and osteoporosis than women who never breast-feed. These conditions are long-term, debilitating, and expensive (Jackson, 1995). In addition, breast-feeding saves money because infant formula must be paid for in cash, which for financially disadvantaged families, especially in developing countries, can reduce a large portion of the family income. Countries often have to use foreign exchange to import breast milk substitutes (Cunningham & Segree, 1990).

5. Breast-feeding promotes involution of the mother's uterus by releasing oxytocin. Exclusive breast-feeding reduces the chance of the mother's developing engorgement and mastitis (Kaufman & Foxman, 1991).

6. Breast-feeding encourages the mother to relax while feeding and provides unique physical closeness between the mother and baby.

7. The act of breast-feeding exclusively has been found to contribute to birth spacing because frequent suckling from day zero postpartum maintains high levels of progesterone in the mother's body, which inhibits ovulation and therefore pregnancy (Freed, 1993; Lawrence, 1993; Rodriguez-Gargia et al., 1990).

8. It is interesting to note that women who knew that they had been breast-fed or that their mothers had breast-fed were more likely to indicate that they would breast-feed their own children than would their counterparts (Kriel, Hudson, Bamoubs, & Ross, (1989), which means that breast-feeding can run through generations.

9. Breast-feeding is a new way to create a safer, cleaner world by reducing environmental waste. Mothers who breast-feed do not use or throw away empty formula-tins or bottles.

The advantages of breast-feeding are so many and so important that advocates for exclusive breast-feeding must recognize benefits from the mothers' standpoint, the baby's and the environment's.

Experiences of Mothers Who Exclusively Breast-Feed for the First 6 Months Postpartum and Work

I could not find any study in the literature that has specifically looked into the experiences of mothers combining exclusive breast-feeding for the first 6 months

postpartum and working. According to Auerbach (1990), society often views the act of breast-feeding and working as mutually exclusive. It has been observed that breast-feeding is a part of the overall pattern of mother-child interaction and will be affected by the degree of separation that occurs at a time when a mother and baby need to be together (Auerbach, 1990; Freed, 1993; Lawrence, 1993; Lindernberg & Artola, 1990).

Morse and Harrison (1988) identified three patterns of mixed feeding, which according to the authors were to help working mothers breast-feed: (a) combining breast-feeding and bottle-feeding as a flexible feeding; (b) breast-feeding at night and on weekends as partial breast-feeding; and (c) breast-feeding once or twice per day as minimal breast-feeding. I consider these patterns as a total contradiction to exclusive breast-feeding. The outcome of this kind of feeding will be reduction of milk flow, which may frustrate the mother and the infant who likes to breast-feed. These researchers, however, failed to consider the effects of expressing breast milk as one method of helping working mothers continue to breast-feed.

Although many mothers intend to continue breast-feeding after they return to work, a remarkable lack of literature exists about the process of preparing for the transition from breast-feeding in the home to continuing breast-feeding while working (Morse & Bottorf, 1989). A quantitative study on patterns of breast-feeding and work, as experienced by Canadian mothers, revealed that 6 mothers out of 61 could continue to exclusively breast-feed on demand (the baby is fed as he/she needs without timing) for 21 weeks. These mothers were geographically close to their infants while they were working (Morse, Bottorf, & Boman, 1989). A qualitative study is required to describe the

experiences of these mothers in more detail, and I believe such a description of experiences will be helpful to mothers. Morse et al. concluded that mothers should be advised on how to introduce bottle-feeding as a preparation to start working outside the home. Such advice, however, simply causes mothers to avoid breast-feeding, which is not desirable especially in developing countries where bottle-feeding is responsible for the high infant morbility and mortality rates caused by diarrhoea.

Mothers find it hard to breast-feed and work because places conducive to breast-feeding are rare at most working places. In some states in the United States, for example, many working mothers by necessity resume employment during a time period that conflicts with the need for considerable mother-infant contact in exclusive breast-feeding. While expressing breast milk is possible, it becomes difficult in many working situations (Kurinij, Shiono, Ezrine, & Rhoads, 1989). A longitudinal study on 42 primiparous women revealed that 62% of the women combined breast-feeding and employment for 15 weeks. These women reported negative responses from relatives and co-workers, inadequate facilities to express milk at work places, and lack of access to the baby during the work day (Hedstrom, 1991). Women in these studies, however, recommend exclusive breast-feeding because it is worthwhile, despite the commitment required (Hedstrom; Hills-Bonczyk et al., 1993).

Summary of the Critique of Literature

Research on breast-feeding behaviour and promotion emphasizes maternal education about the advantages of breast-feeding. Some women, however, wish to combine breast-feeding and work because they acknowledge the advantages of human

milk, but do not know if they would fulfil the commitment. Many of the studies were quantitative and hence could not convey the personal experiences of breast-feeding women, especially those who combined exclusive breast-feeding and work. In fact, these quantitative "instruments" reflected the views of the researchers, not the mothers. In addition, most of the research cited in the literature was conducted in the developed world, whose findings cannot be applied to redeveloping nations. The uniqueness of human milk warrants intensive efforts to overcome obstacles that prevent infants, especially neonates (zero to 6 months old), from receiving an uninterrupted exclusive breast-feeding.

The goal of this study was thus to explore the experiences of mothers who combined work and exclusive breast-feeding. I hope this research will contribute a great deal to overcoming obstacles of exclusive breast-feeding, especially in redeveloping countries. It is obvious that this issue is a political and economic one. Multinational corporations profit from selling prepared formula to the majority world. Colonialism, imperialism, and capitalism could be responsible for the trend of bottle-feeding because of the value they have on profit making. Feminists have been quick to identify this exploitation of women in developing countries and around the world. For this reason a critical theory approach in which feminist methodology is based will be the force in this analysis.

# CHAPTER III

## Methodology

### Feminist Methodology

Harding (cited in Jayaratne & Stewart, 1991) defined methodology as "a theory of how research is carried out or the broad principles about how theory is applied" (p. 92). Feminist methodology must therefore be taken to refer to a broader theory that is used to do feminist research (Jayaratne & Stewart). Feminist research is designed, implemented, and disseminated with the goal of providing for women's explanations for what they want and need about phenomena that affect their lives (Hall & Stevens, 1991). Positivists may query the reliability and validity of feminist research, but on the contrary, it is evaluated by standards that reflect the adequacy of the whole process of inquiry, relative to the purpose of the study, rather than by standards that focus on the validity and reliability of measurement within the research (Hall & Stevens).

For this study I followed some of the strategies for implementing feminist research described by Jayaratne and Stewart (1991), which include: (a) the selected research topic or problem should have a potentiality to help women's lives and provide the information necessary for such an impact. My research area in this study, I believe, has a great potential to help women deal with desired and undesired experiences in combining breast-feeding and working in the first 6 months postpartum. (b) When designing the study, one should propose methods that are both appropriate for the kind of question asked and the information needed and which permit answers persuasive to a particular audience. I used a grounded theory method which enabled me and the participants to describe the breast-

feeding experiences. (c) Researchers should take the time and effort to qualify their research through learning and using research skills. My intentions in this study were to learn a great deal from the beginning of the research process to the end and to use appropriate research skills. (d) When interpreting results, researchers should look for interpretations that are always consistent with the findings and that might imply suggestions for change in women's lives. In this study the participants and I considered interpretations that we hoped will improve women's situations during exclusive breast-feeding. (e) Researchers should always attempt some political analysis of the findings. This was a necessity because a working policy change to favour women who wish to combine exclusive breast-feeding and work, we hope, will be an achievement of this study. (f) Researchers should try to actively participate in dissemination of research findings. I intended and will continue to disseminate the results by publishing in national and international journals, presenting them in relevant conferences and workshops and other significant areas, and ensuring that they have impact on policy makers and society at large. The ultimate goal was to bring about changes that will allow a breast-feeding woman to do so comfortably.

## Method

According to Harding (cited in DeMarco, Campbell, & Wuest, 1993), there is no unique feminist method: "all data are collected by asking questions and listening to informers" (p. 35). In this study, the approach was grounded theory, which has been widely recognized by nurse researchers and has resulted in its continued application as a qualitative approach. The method explores the richness and diversity of human

experiences and contributes to the development of middle range theories in nursing (Streubert & Carpenter, 1995). The theory-developing properties of this approach allow for complex analysis of complicated data questions (Keddy, Sims, & Stern, 1996).

The Research Question: Locating Myself

The origin of the research question is important in feminist research (Demarco, Campbell & Wuest, 1993). Weskott (cited in DeMarco, Campbell and Wuest) suggested:

> Patriarchal bias in research questions is reflected in the way in which questions about women are posed: the absence of concepts that tap women's experience, the viewing of women as an unchanging essence independent of time and place, and the narrowness of the concept of human beings reflected in limited ways of understanding human behaviour. (p. 33)

The research question in this study originated from me, as a mother of three sons, who combined breast-feeding and work, which was a challenge. When my first born was 3 months old I was posted to a new work place. I had read from baby books that I should introduce the baby to the bottle and formula before going back to work, which I did. There was no programme that promoted exclusive breast-feeding at that time, instead, the baby books promoted bottle-feeding. This violated my right to breast-feeding information, and makes me angry because as a new mother, had I been well informed, I could have breast-fed exclusively for 6 months. I lived very close to my place of work. Also, breast-feeding was not emphasized in my nursing curriculum. I had a babysitter to take care of the baby during my absence. I taught her how to prepare the formula using sterile technique. One day I came home during working hours and found her adding tap water to

the feed to cool it because it was hot and the baby was crying. I wondered how often she had fed my baby with contaminated food. I was very disturbed. I just asked her to throw the milk away and took my baby to breast-feed him. But I had no such opportunities to come home regularly to breast-feed. So I had to reemphasise to the sitter the importance of sterility. I had no peace during working hours because I had lost trust in this babysitter. I was so worried about the possibility of having my child admitted to the hospital with diarrhoea. I breast-fed after work and during the night and had enough milk. In fact, I used to express the breasts and throw the milk in a sink during working hours. It was a terrible experience; I wonder about the experiences of other women who breast-feed and work outside their homes.

Breast-feeding is a preventive and caring process rather than curative, meaning that the whole process of breast-feeding is grounded in a symbiotic relationship between mother and baby. It is thus relevant for a nurse to know the breast-feeding woman's experience, in order to provide opportunities to help educate new mothers.

Setting

This research was conducted in Dar es Salaam, Tanzania. Dar Es Salaam is the largest city in Tanzania with a population of about 1.5 million. Tanzania is a redeveloping country with a population of more than 31 million people and high neonatal and infant morbidity and mortality rates. In 1978 and 1988, infant mortality rates (IMR) in Tanzania were 139 and 130 per 1000 live infants respectively (Government of Tanzania, 1988). As with many redeveloping countries, Tanzania has limited resources for sanitation. The common causes of neonatal and infant deaths are diarrhoeal diseases and malnutrition,

probably due to contaminated feeding bottles and over dilution of baby formula. Most of the women in the city are employed. These women who work outside the home employ other women as babysitters for their children and to care for the homes.

The experiences which were described by these working women could be representative of other working women because people who work and live in Dar es Salaam originate from all districts in the country. Dar Es Salaam has three districts with a hospital in each. There is one consultant hospital, Muhimbili Medical Centre (MMC), which receives referred clients from the districts and from other regions outside Dar es Salaam. MMC has a maternity wing where women give birth to their babies.

Sample

Since I worked in MMC as a nurse educator, I was allowed to search for participants for my research from the wards. I was able to go into the records to find women who gave birth within the past year. I needed women with babies aged from 4 to 12 months. This approach, however, did not work because the addresses were incomplete in that the streets and number of houses were missing (many of the Dar es Salaam streets are not labelled). I decided to search for the mothers from their work places through their administrators. The letter from the Ministry of Health Tanzania which approved the study helped my acceptance by the administrators who introduced me to women who were breast-feeding babies who were less than 7 months old. I told the women the aim of the study and asked if they were willing to participate in it. The six (6) women who participated in the study ranged in age from 25 to 30 years, and they were married to husbands who worked outside their homes. Some of these women had other children. The

majority had professional jobs, such as nursing, teaching, and accounting. A few had nonprofessional, but full-time, jobs, such as cleaning. These mothers originated from different parts of the country but had lived in Dar es Salaam for periods ranging from 5 to 10 years. In addition, they all gave birth to their babies in either Muhimbili Medical Centre, private hospitals, or in one of the district hospitals within Dar es Salaam Region.

Muhimbili Medical Centre and the district hospitals are run by the government and their health services fee is smaller compared to that charged in private hospitals which is enormously high. It is, however, not necessarily true that women who seek services are better off in their financial situation than those who do not. It depends on individual choices and also their obstetricians' advice. Obstetricians, especially those who practise privately, may convince and attract the women to delivering in private hospitals so they obtain money from these women. They are made to believe that services offered in private hospitals are better than those offered in government hospitals. In actual fact, the former may offer better services than the latter because the workers in government hospitals are usually more professionally prepared than those employed by hospitals which are run by individuals.

According to my observations, the private hospitals hardly practice breast-feeding support, promotion, or protection. The nurses in these hospitals feed the newborns with formulas in the guise of helping the mothers who, according to these workers, are too weak to care for their own babies. The truth behind such "help" is (a) just a way of making the mothers pay more and (b) the nurses in private hospital may not have enough knowledge to impart to mothers regarding breast-feeding. On the contrary, government

hospitals' workers try to maintain a mother-baby-friendly environment in which the mothers are encouraged and assisted to initiate breast-feeding within the first hour of delivery (personal observation). It is expected therefore that mothers' breast-feeding practice will be influenced by whether they delivered their babies in government or private hospitals. Presumably mothers who delivered in government hospitals will be more confident in exclusive breast-feeding than their counterparts who delivered in private hospitals.

In an effort to understand the lived experiences of people in context, some researchers have turned to in-depth qualitative studies that use small homogeneous samples (DeMarco, Campbell, & Wuest, 1993). Saturation, a feature closely related to sampling (Streubert & Carpenter, 1995), was applied in this study. I interviewed the women individually until I heard the repetition of discovered information and confirmation of previous collected data. I experienced saturation after interviewing 6 mothers, after which I stopped the interview process.

Data Collection

In-depth unstructured interviews and participant observation are the methods I used to collect data. In order to clarify the general areas about which the mothers were asked (Swanson, 1986), the guideline questions were given to mothers who wanted to see them before answering the questions (Appendix B). Equality between the mothers and the researcher was observed. We both shared and learned from each other. Interviews took a minimum of 1 hour and a maximum of 2 hours. I interviewed one woman per day and did interviews 3 days per week. I had allocated myself 3 weeks for the interviews. There were

no time constraints for either the mother or myself. Swanson stated that "nothing is more frustrating than to have to terminate or reschedule time with a respondent who is just beginning to disclose an important or private information to the interviewer" (p. 72).

The interviews were conducted at the mothers' work places (not during working hours) for their convenience. Privacy was ensured. The interviews were tape recorded, and I jotted down some important points that I heard and saw because I wanted to be mindful of what the mother was telling me and observe what was happening within her and around her in relation to the study. We engaged in some conversation (the women could ask questions of their concern and get I could answers or talk about it) along with the interviews which enabled me to ask for clarification of some events that I had observed. "The use of interviewing with participant observation increases validity since it assures that the truth in the observation is checked with the active questioning of the interview situation and vice versa" (Chenitz, 1986, p. 88). The tapes were assessed after each session to make sure that the interview was recorded. The interviews were conducted in Kiswahili. Some women could use English, too. I translated the tapes into English and there was no impact on the study because Kiswahili is my first language. I transcribed the interviews from tapes and field notes on the day of the interview.

Ethical Considerations

A proposal of this study was sent to the Human Ethics Committee at Dalhousie University who provided permission for the study to be started. When I went to Tanzania, I wrote to the Ministry of Health asking them to allow my study to be conducted in the community (Appendix C), which they did after receiving clearance from Muhimbili

University College of Health Science, where I work. A consent form (see Appendix D) was prepared with necessary information regarding the study and given to the women to sign when they agreed to participate in the study. Informed consent and confidentiality were assured. The participants were told that they could withdraw from the study at any time. They were also told that the tapes would be erased and the transcripts destroyed after analysis of the report of the study.

Data Analysis and Theory Generating

Comparative analysis method (Glaser & Strauss, 1967) was used, which is a process requiring a direct interaction between the analyst and the data, taking place over time, moving through phases, and resulting in a grounded theory (Corbin, 1986). Comparative analysis, according to Glasser and Strauss, is a general method just as are statistical methods which use the logic of comparison. The aim of grounded theory investigation is discovery of theoretically complete explanations about practices, behaviours, beliefs, and attitudes of individual or groups as they normally function in real life (Streubert & Carpenter, 1995). Stern (cited in Streubert & Carpenter) isolated five basic differences that differentiate grounded theory from other qualitative methodologies, which include the following:

1. the conceptual framework is generated from the data rather than from previous studies;
2. the researcher attempts to discover dominant processes in the social scene rather than describing the unit under investigation;
3. every piece of data is compared with every other piece of data;

4. the collection of data may be modified according to the advancing theory, that is, false leads are dropped, or more penetrating questions are asked as needed;

5. the investigator examines data as they arrive and begins to code, categorize, conceptualize, and to write the first few thoughts concerning the research report almost from the beginning of the study. (p. 147)

In the study, I examined the experiences and behaviours of women who tried to combine exclusive breast-feeding and work outside the home. Stern, Allen, and Moxley (1984) stressed that carefully comparing data as they are received, the researcher makes a choice regarding the relative importance of the problem presented in the study, which is what happened. The grounded theory in my study was therefore formal rather than substantive. Glaser and Straus (1967) and Hutchinson (1986) suggested that formal theories address conceptual levels of inquiry such as negotiations, socialization status congruency, behaviour, stigma, or authority and power. Hutchison continued that substantive theories are generated for a specific, circumscribed, and empirical area of inquiry such as patient care, race relations, professional education or delinquency.

The significance of grounded theory in this study. Grounded theory was relevant in my study because there has not been a complete explanation of the experiences of mothers who try to combine breast-feeding and work outside the home. This method combined with feminist research allowed subjective experiences of the participants (experts in their situation) and their expression of emotional and psychological feelings encountered in this endeavour to be heard. Feminist researchers insist that women's voices must be heard as

they tell their lived experiences (Hall & Stevens, 1991). It would be difficult to understand the women's experiences through variables and numbers, but with the grounded theory method, experiences and feelings were explored.

During the interaction between the researcher and participants a mutual caring experience took place where the researcher learned from participants and participants had their questions answered. Such an experience is believed to be empowering. Grounded theory and feminist research demand that the researcher discover dominant processes in the society rather than describing the unit under study (Stern, cited in Streubert & Carpenter, 1995). The error of describing a unit under study in this work would unnecessarily blame the women for "failures" that are socially constructed.

In order to increase my understanding in the use of grounded theory, I acknowledged the conditions influencing data analysis described by Corbin (1986) which include: (a) the researcher must be trained to do a grounded theory study, (b) the researcher must have knowledge and experience in research, (c) the researcher must have self-confidence, and (e) the researcher must have tolerance for ambiguity. I tried to achieve all the conditions before, during, and after this study. Strategies written by Corbin (1986) guided me during the analysis of my data and the process of developing the theory of combining breast feeding and work outside the home.

Discovering categories: To discover categories, I reflected on the research question and asked myself, "what categories have I seen in the data and what are they examples of?" I broke down the data into bits and pieces and organized them under specific facts or incidents and made comparisons. Constant comparative analysis (Keddy,

Sims, & Stern, 1996) was done throughout the analysis process, and the use of the literature helped. At this stage of analysis, I discovered a number of categories which I will discuss in the subsequent chapter.

• Theoretical sampling: It was not necessary to interview another group of women to get additional data because the theory evolved well.

• Linking the categories: By using this strategy, I read through the categories and moved them from a lower to a higher level of abstraction. Several major categories emerged at this stage.

• Identifying the core category: At this stage I pulled the theory together around a central core by reading the data to find the main story line, that is, what was happening over and over again. I used diagrams to change orders of category until a core category was determined.

• Refining the theory: Having had a core category around which other categories fitted, I refined the theory by carefully examining all categories, their relationship to each other and to the core category.

• Writing memos and diagramming are strongly emphasized by Corbin (1986) and I adhered to the emphasis for the success of the study. In this study, categories, their relationships, and supporting text were recorded in detailed memos. Further comparison of data and reexamination of categories was conducted.

The end result of the work was the "grounded theory" itself that explained the major themes in the situation under study. The generated theory fitted with and explained

how social processes influenced the experiences of mothers who tried to combine exclusive breast-feeding and work outside the home in the first 6 months of infants' lives.

# CHAPTER IV

## Presentation of Data

### Typical Work Patterns of Tanzanian Women Working Outside the Home

For the purpose of placing the options and responsibilities of women who combine breast-feeding and work outside the home into context, typical work patterns within the community of employed Tanzanian women are described. In Tanzania, one is either a full-time employee or not employed. Women and men with similar qualifications and employed in same jobs are equally paid. The majority of women, however, are found in low paying jobs because they are less qualified for higher paying jobs. Salaries are usually not enough for the basic needs of the majority of families, even if a husband and wife are working. Both government and the people know the fact. Thus, people must use their ingenuity, talents, efforts, and experiences to generate extra income to sustain themselves, their children, parents, and other distant dependents. For this reason Tanzanians nicknamed their country as "Bongo Land" [a country where people must use brains to survive] (personal experience).

The task of generating extra income which is topped up by government salaries is added to the women's workload. This is because of their loving and caring nature. Women's main concern is their family's welfare. The women work full time, but must have an income-generating project which the husband and children call "mradi wa mama" [mum's project]. Dad's projects are rare. Usually the project depends on individual women's domestic skills, interest, how hard-working she is, how much stamina she has, her health status, and a capital to start a project. The time that a woman has to commit the

project is rarely considered. I remember myself having worked almost all night because after I worked 9 hours as a nurse teacher during the day, later in the night I had to pack some goods, which were required in a shop the following day. It was very exhausting, and I had to give up the project. Miradi ya mama vary from sewing, knitting, rearing cows for milk, pigs for pork, chickens for meat and/or eggs, to vegetable gardens, cake- and buns-making for commercial purposes. These projects generate income which most of the time suffices the family's financial needs, but very few men support the women in this work or in the household. The women, without complaining, ensure that the projects thrive. The households are cared for in terms of eating (breast-feeding included), children are dressed well and are disciplined, houses and home environment are clean, laundry for everybody is done, repairs in the house are done, and many more tasks are organized and carried out. In short, they are responsible for organizing and doing everything in the home as if they do not work outside the home, and this is a societal expectation. Men do their government-paid jobs, which are valued by everyone, but they count on their wives' extra income. The value in this society is that a woman, whether she is working outside the home or not, is a homemaker.

Traditionally, for example, when a young man asks his parents to suggest for him some qualities of a good wife, the major suggestion is he should marry from a family where the mother is known to be hard working because the daughter will be as hard working as the mother. Women constantly struggle to be all things for everyone with little appreciation. Much of the woman's work is invisible to men. Few care whether she is breast-feeding or not. She is to sort that out herself, as long as nothing is disruptive to her

family and/or place of employment. It is only other women who can understand the deep meaning of the struggle, yet mothers encourage sons to find women who are "hard working." The result is oppression, while women remain pitted against one another.

Living With the Hurdles and the Contradictions: The Core Variable

In this study, the women provided rich information about their lived experiences of exclusive breast feeding in the first 4 to 6 months of the infant's life. On reading the 6 women's stories several times, I realized that even though they had similar experiences, there were some unique differences between individuals. Many expressed negative experiences while a few had positive experiences. Because of the unconditional love for their infants, none of the mothers gave up on breast-feeding completely. Throughout the interviews the Swahili terms of hurdles and contradiction kept occurring but when they did not, upon interpretation, I realized that the terms were implied. Thus, all of the women were **living with the hurdles and the contradictions** of breast feeding and working outside the home within a foray of mixed emotions and physical stresses. This included shock, panic, anger, torn between work and breast-feeding, frustration, guilt, fatigue, fear of failure, uncertainty, difficulty, anxiety about infection, and actuality of ful,l dribbling breasts leading to embarrassment and shame.

Studies have identified that breast-feeding difficulties tended to cluster in the first 4 months of the infants' lives (Auerbach, 1993). It is at that time that Tanzanian women have to start working exactly, at the 84th day after delivery. These women told me they have to live with the hurdles and the contradictions within themselves, for example, what it meant to their body image to be wet from leakage of milk and how to deal with that, while at the

same time what it meant to the infant-mother-bonding to leave the infant at home for a long time. While they needed to work outside the home, they were loathe to leave their infants to the care of another, usually less skilled, worker. They discussed what it meant to leave with fear of their infants becoming infected because of an unsanitary environment, especially if they wanted to express milk in order to be relieved from full, painful breasts or leave it at home for others to administer. Auerbach (1993) and Gjerdingen, Caloner, and Vandescoff (1995) suggested that the sooner the mother returned to work, the longer she had to deal with one or more of the following hurdles:

* concern about an inadequate or fluctuating milk supply
* engorgement
* leaking
* sleep deprivation
* difficulty arranging for child care
* guilt about child care
* emotional liability
* the need to express or pump milk (its frequency, duration, and likelihood over time)
* the baby's need for frequent feedings particularly if he/she was very young when the mother returned to work
* the baby's frequency changing feeding patterns, including appetite spurts and nighttime nursing.

The hurdles listed above are similar to those experienced by the women in this study.

An ethnographic study involving lactating women in Madura (Launer, 1993) showed that the women in this particular culture had fear of leaving their young babies of less than 40 days in age for any length of time because if the baby cried she/he would be agitated. The Madura women also believed that long periods of maternal-infant separation caused illness in the body and that milk left too long in the breast spoiled and caused diarrhoea.

This is what one woman in my study said:

> My baby is now 3½ months old. When I am working my breasts become full and painful and almost dribbling. I could express so that the milk won't dry up, but my fear is I could be infected because of the poor sanitation. There is no safe place to express the milk. I just massage the breasts hoping that I will not develop mastitis and also hope that the milk continues to flow enough for the baby. It is so *frustrating. Sometimes I find myself wet from leakage of milk and some dribbling* to the floor. *I feel ashamed and embarrassed because of the mess I make. At the same time I get angry and hate the work because, here am I throwing milk while my son is crying and being fed with gruel prepared by the babysitter whom I am* not sure of her personal hygiene.

It is devastating to leave a baby with someone one does not trust. These mothers had no alternatives. They experienced pain from full breasts, and when the milk started dribbling, it became a body image issue. Working women are expected to be presentable to the public. Unfortunately, it is considered to be shameful to walk around with a wet outfit.

It is interesting to note that while women in developed countries are made to feel ashamed and embarrassed about the need to expose their breasts during breast-feeding at work places (Baumslag & Michels, 1995), the same feelings are experienced by their counterparts in developing countries. The reasons they give for their feelings include full and dribbling breasts which make a mess during the working time and their frustrations

that their babies cannot be reached until the working time is over. The women's feelings from these different societies are related to their body images but, more significantly, to the lack of appreciation within their cultures regarding the nurturing of children.

Auerbach (1993) suggested that mothers need to be informed that breast-feeding difficulties will be resolved over time and that the longer the women stay home with the babies the less likelihood there is that any of the problems will persist. The suggestions given by Auerbach may not relevant to Tanzanian women, in that the women cannot stay home without being paid, even though the majority have some income-generating projects in the homes, because of severe financial constraints. In fact, such advice could cause the women to feel guilty about going back to work so early in their infant's life. Going back to work outside the home before the infant is 3 months and trying to breast-feeding exclusively is what the women are forced to do. None of them can plan to be home longer without pay. They must go back to work as soon as possible. Advice, such as that of Auerbach, must be critiqued from a culture, class, and gender perspective as it has inherent flaws in its analysis.

The happiness that is achieved from the mothering process is related to infants gaining weight, not becoming ill, and being well attached to the mother. A few mothers expressed some satisfaction for themselves and their babies.

> My baby is now 6 months and I am quite happy with my breast-feeding. He [the baby] has started on other foods and his weight is good. This is my first born and I have not faced any problem. My baby clings to me and I really want to be with him. He has never been a bother to me. All the time we have together is wonderful. I enjoy breast-feeding more than anything I can think of. I even miss my baby when somebody else takes him. The experience of exclusive breast-feeding was good to me. I think I will do the same to other babies to come. I am not saying that breast-

> feeding is the only thing I do. As you know our country, women have to work hard to earn money otherwise one will go to eat at the police station [if you have no money, you will steal and be apprehended by the police who will then feed you]. I have my own project [chicken-rearing]. It is a lot of work but since it is in the home I make time for the baby.

Mothers who had positive experiences spoke of breast feeding exclusively for their subsequent deliveries. They are the ones who could be role models to new mothers and to their daughters.

It is worth noting that mothers who were happy with the task of exclusive breast-feeding were those who had the chance to be at home for a month after their maternity leave. It did not matter how busy they were at home so long as they could breast feed on demand. This is confirmed by one woman who said:

> Being a teacher, it is not difficult to breast-feed exclusively for the first 4 months and more. I stayed with my baby for 4 months because I was lucky, in that when the maternity leave ended, the schools had their holidays for 1 month which enabled me to be with my baby at home for that extra month.

The mother in the above situation considers herself lucky, even though it could be her right, because everyone else (teachers) had the same 1 month holiday. The anecdote just mentioned, the chance of a maternity leave coinciding with the beginning of a school holiday, is rare. This woman was very lucky and it is a chance occurrence. This shows how determined these women were to breast feed, given the opportunity. The women's voices in this study did not agree with the stereotype that women of this generation do not want to breast-feed their infants for cosmetic reasons.

Whether the women had negative or positive experiences, they all had desire and motivation to breast-feed exclusively because they knew and valued breast milk as the best

food for their babies whom they loved very much. Through the process of **living with the hurdles and the contradictions,** the women tried to work through issues within themselves (lack of knowledge, difficulties related to body image, physical and emotional stresses). They also had to deal with the issues in the workplace and with society at large. The women started the process of living with the hurdles and the contradictions of exclusive breast-feeding by focusing on themselves as individuals. This is reflected by this woman: "I just need to eat well to have enough milk for my baby, but I have to work hard to get the food." While this statement can be interpreted as focusing on the self, a further analysis showed that the focus was on the baby as well.

The women ate to remain healthy while breast-feeding, but the major purpose was to produce enough milk for the baby because they realized under-nutrition causes a low production of milk. Launer (1993) hypothesized that if opportunities to increase food intake for breast-feeding mothers or to decrease their work activities are limited, their work activities may exacerbate the negative effect of their nutritional status and their performance. That is, breast-feeding and work are together draining the mother's body reserves. If there is no opportunity to reduce her workload or improve the quality and the quantity of her nutritional intake, the mother and infant's health, will be in jeopardy. While studies conducted worldwide indicate that maternal nutrition has only a modest effect on milk production and composition in the face of malnutrition (Riordan & Auerbach, 1993), it is virtuous of the mothers to realize that their caloric intake will assist in sustaining the milk flow.

A mother's previous experience and knowledge had some influence on the process of living with the hurdles and the contradictions. She may have reflected on what she did and improved upon or avoided a breast-feeding behaviour which worked or did not work, as expressed here:

> When I knew I was pregnant I started thinking of exclusive breast-feeding because it was emphasized during the antenatal clinic visits. I really felt guilt when my first son who is now 9 years old refused to suckle from my breast when I returned to work. I even sent him to a doctor because I thought he was ill, but the doctor said the baby was fine. I do not want the same thing to happen to this baby.

When Tanzanian women are pregnant, especially for the first time, their planning focuses on caring for babies and breast-feeding without the realities of hurdles and contradictions inherent in the reality of day-to-day living. A working mother has to plan for her return to the employment which is what is voiced from the mother who has already had one child. The story given above indicates the fear the woman had on failing to breast-feed exclusively for the second time. It was noticed that she was living with guilt for 9 years.

The process of living with the hurdles and contradictions, which was the core variable in this study, consisted of three themes or "co-variables", as they are called in grounded theory. These included: (a) **women's resiliency, love, caring, values, hope, knowledge and mixed emotions;** (b) **work expectation, values and support;** (c) **society's norms, views on gender and economic reality**, as displayed in Figure 1.

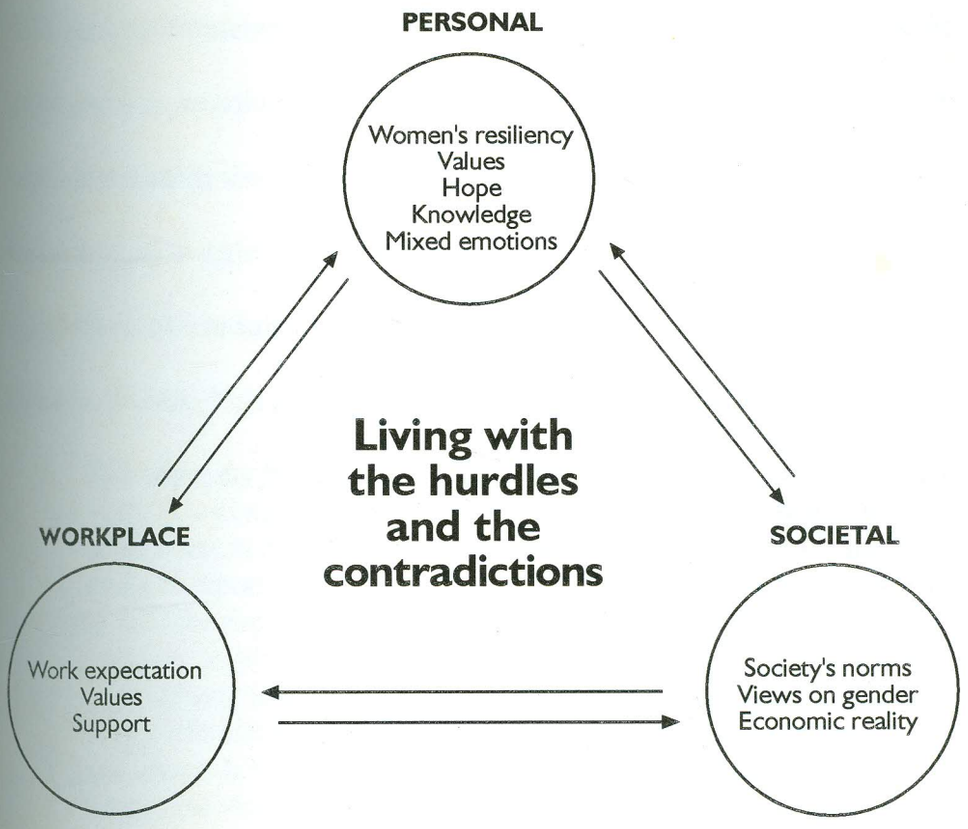



**Figure 1. Living with the Hurdles and the Contradictions of Combining Exclusive Breast Feeeding and Working Outside the Home**

Women's Resiliency, Values, Love, Caring, Hope, Knowledge and Mixed Emotions

This theme, women's resilience, values, love, caring, hope, knowledge and mixed emotions, was the personal foundation that originated from within the women themselves. This is where they obtained the energy to pursue the task of breast feeding exclusively, while forcing themselves to work outside the home and simultaneously confront economic and societal expectations, which produced all those hurdles and contradictions. Women's **resiliency** enabled them to recover from emotions and shock, in order to proceed with breast-feeding in spite of the hurdles. They were shocked because their positive expectations of managing to work and breast feed turned around to be negative on the first day of work. This is what one of the women in the study said:

> This being my first born I thought I could manage to breast-feed exclusively and work. It was not an easy practice. I breast-fed exclusively for the first 84 days when I was in maternity leave. I suddenly panicked when I learned that I was going to report on duty. It was a shock. It was, oh, my goodness, what I am going to do? The first day was so hard to me. Later on within that same day, I had to settle my mind and searched for nice words to tell my boss so she could give me 7 days off duty to sort myself out. Being a woman, she understood me and gave me 7 days off which I used to practise expressing milk and feed my baby with a cup and spoon. I, however, paid the days later by working extra hours because I needed the money.

The women's **hope** was to manage to combine breast-feeding and work outside the home. Their situation was horrendous on the day they returned to work only to find that what they had hoped for was totally impossible. Because of their personal resiliency they could rethink alternatives rather than becoming hopeless and helpless. In this particular incident, the alternatives included asking for a week out of work, which was treated as an emergency leave. This required an understanding and flexible manager. Obviously an

employee who is afraid of either her child's becoming unhealthy or losing a job can hardly be productive at the workplace.

Concerns about keeping a job and loss of income from extra days of maternity leave affect almost every woman who breast-feeds and works (Baumslag & Michels, 1995). It is especially difficult for women in a redeveloping country who have a triple jeopardy, that is home, work usually two jobs, and a desire to breast-feed a newborn.

A model that illustrates categories of contextual influences on the task of exclusive breast-feeding and work outside the home is found in Appendix F. This model shows the multitude of issues that impinge upon a new breast-feeding and working mother, resulting in mixed emotions. I have chosen not to include the model in the text as it can appear overwhelming to the reader. I will, however, discuss some of the issues as they relate to one another.

While experiencing **mixed emotions**, the women made judgements about the **value** of human milk and their **hope** for success in breast-feeding. The importance of feeding the baby with mother's milk was weighed by all women in relation to the time they had to work outside the home and the method of feeding. The value assigned to human milk by the women was reinforced by the **knowledge** they had received from nurses during antenatal visits. Almost all women became aware of the advantages of human milk as stated by one them:

> The nurses at the antenatal clinic told us, and I agree with them, that mother's milk is good for the baby because the milk has all the nutrients that the baby needs including water. Also, mother's milk is the cheapest of all other baby foods. Baby formulas are just too expensive and may cause stomach problem.

The Tanzanian climate is warm with a humid climate and people perspire a great deal. It is erroneously believed, therefore, that babies get thirsty, requiring water. Many mothers give water because they think milk cannot replace water, and they believe that babies cry after breast-feeding because they are thirsty. The anecdote above asserts that the mothers had appreciated the fact that breast-feeding babies get enough water, in addition to other nutrients, from the milk. I consider this knowledge given to them by nurses to be extremely important because waterborne diseases, such as diarrhoea in breast-feeding infants, especially the very young ones whose body resistance is relatively low, may be caused by drinking water.

The water in Tanzania may be contaminated, requiring boiling. Boiling may not be done because of the carelessness or lack of information of a baby-care-taker, lack of fuel, and time. Usually mothers become confused when their babies get sick or die of diarrhoea while breast-feeding, not realizing drinking water could be the source. It was ironic that these women had this infant-life-saving **knowledge** and wanted to put it into practice (exclusive breast-feeding) as they incorporated it into their own value system with a great deal of hope for a healthy feeding practice, but because such practice was not valued by the larger system and the work place, the women confronted the hurdles and the contradictions.

Women learned from nurses during the prenatal visits, but some women did not want to change what they saw their mothers doing in relation to baby feeding. It was a belief they inherited from their mothers. This indicated the importance of creating from the mothers in the present generation (if they are well supported), a chain of generations who

would breast-feed exclusively for the first 4 to 6 months. Usually daughters consider their mothers as the best role models. Despite the teachings that breast milk is made up of more than 75% water, one mother thought that water was still necessary because that was how her mother fed babies. Her reluctance to change what she learned from her mother is expressed:

> I heard and understood about exclusive breast feeding, that you do not give your newborn anything else except breast milk for the first 4 months. After trying this approach, I decided to go back to what I saw my mother doing. She told me if a baby cries after a feed, he is thirsty and needs water. I therefore gave my baby boiled and cooled water whenever he cried after feeding. Eventually I was giving a little amount of water as a routine after every feed.

A little knowledge can be more destructive than no knowledge at all, because with no knowledge one can seek it. The woman in the above situation confidently expressed her understanding of exclusive breast-feeding. She was not aware that a well breast-fed baby gets enough fluid from the milk. One reason babies may cry immediately after breast-feeding is probably that the mothers change breasts too soon, before the babies get the hind fatty milk which causes satiation. A baby can be full of the fore milk, which is watery, causing hunger to the baby after a short while, and the consequence of such an outcome is baby crying. Additionally, there are many causes of baby crying, and the tendency to give water, not only dangerous to the baby's health, decreases the volume of milk which is directly influenced by the frequency of baby suckling; that is, when the baby is full from drinking water, she/he will not suckle.

Personal knowledge and values which were not based strictly on teachings from nurses but developed from personal experiences that became values were also expressed. Consider this quote:

> I am completely against cow's milk or formulas. Cow's milk is not good for humans. Nowadays, I see babies with skin problems and it is said that babies react to cow's milk. I would be very happy if my baby would like to take my expressed milk easily. My babysitter tried to feed him [the baby] with my milk, but she gave up and fed him with juice. I was so angry.

When the mothers were asked whether they instructed the babysitters on what to feed the babies while mothers were away, they answered that they usually leave them with instructions, but because the babysitters usually do not appreciate the importance of breast milk, they may give anything from juice to gruel. The key issue here is that the babysitters help the women, not because they like the job, but because they need the money and do not have any alternatives. The babysitters usually do not have love connections with the baby, although in two instances in my study the sitters were grandmothers. Additionally, the babysitters are usually young women from 12 to 18 years of age, with few skills or experience to care for babies. Their pay is low, their level of education is low. They are exploited within a system that also exploits their own employers, the mothers. Since the mothers must work full time, the sitter has to do other domestic activities such as house cleaning, cooking, laundry, and caring for older children if they are present. Thus, there is little time for the baby sitter to struggle with a baby who is not willing to take mother's expressed milk. (From personal experience I know that to the babysitter it is somebody else's body fluid and could be nauseating sometimes.) Instead they choose to give anything that the baby would readily take and which is quickly fixed, such as juice or gruel.

The mothers were dismayed when they came home only to find the milk that they painfully expressed was not given to the baby at all. One woman had this to say:

> Personally, I did not want my baby to feed on formulas or any other thing during the first 4 months of his life. Up to today (6 months old) he has not tasted formula. The baby formulas are expensive for nothing. The biggest problem started the very first day I went to work. I really worked hard to express my milk into a cup and left it with my house maid to feed the baby using a spoon while I was away. I told the maid to be patient with the baby because to the baby it was another way of feeding. After a few hours, according to my maid, the baby cried nonstop. The maid tried to feed the baby on my milk, but the baby refused. The maid was not patient as I had instructed her. I think she did not want to handle my milk too much. She decided on her own to feed my baby with a diluted orange juice. The baby liked the diluted juice, but I was not planning to give, of all things, the diluted juice to my baby at this stage. On coming home from work, I found the milk I had painfully expressed, as I had left it, and upon hearing the story of what had happened, I was very frustrated. I asked myself whether I am being fair to my baby. I have to do something, I said.

While the women lived with so many difficulties related to mothering and working outside the home, their social situation magnified the hurdles and the contradictions to their values.

Another woman told her story:

> We were taught in the antenatal clinic that an infant should feed on mother's milk only for the first 4 months and that we should not give anything else, even water. I wanted to follow the teachings, but my baby cried so much when he was 2 weeks old. My mother, who is a retired nurse, told me that the baby was not getting enough of my milk. She prepared a thin gruel, sieved it, and gave one tablespoon to the baby who stopped crying. I felt like a fool because I was insisting to give my milk only which was not enough for my baby. I, however, wondered about how would one tablespoon of gruel satisfy my baby more than my milk?

The consequence of giving other foods when the baby is very young is that the baby will be full and therefore not suckle frequently. The milk volume is directly proportional to the frequency of suckling. The young woman in the above anecdote did not have enough

knowledge of the process of milk production and the advantages of breast milk over other types of infant feeds for her to stand against her mother on the issue of topping up the milk with gruel. Instead, she felt stupid and powerless in front of her mother. Knowledge is power. Lack of it renders people powerless.

World Alliance for Breastfeeding Action (WABA) (1995), in their Statement, Breastfeeding is a Feminist Issue, stressed that women cannot fully exercise their right to choose breast-feeding because of, among other things, a lack of information. The statement continued that most of the women are unaware that breast-feeding benefits their health and also benefits their babies' physical and intellectual development. The women are not told that artificial milk and other types of baby foods are inferior to breast milk. The authors pointed out that informed choice is not possible without being informed.

Inadequate knowledge involved fewer skills regarding breast-feeding which caused the women in the study to face obstacles which could have been avoided. Lack of enough skills, for example, to express milk caused a woman to give other foods other than her milk to the baby, which was contrary to what she had planned when she returned to work outside the home. The end result was feelings of guilt and frustration for not achieving a goal, as expressed in the following quotation:

> I was not advised to express my milk during the antenatal visits, but I heard a certain woman talking about expressing milk from her breast using a device. I did not follow it up to know how she did it. I therefore do not know how to express the milk. If I knew how to express my milk I would leave some with my mother to feed my baby while I am at work. As it is now if I do not get a break to go home to breast feed, my mother feeds the baby with anything which she can prepare. My mother prepared nice food for my baby and I trust her, but I had planned to give my baby nothing other than my milk until he turns 5 months. I am so disappointed

> that I have failed to achieve my plan. I do not know how much harm I have done to my little boy.

The mother in the above anecdote expressed those concerns because of her **caring and loving** nature to her infant which was common to all women who participated in the study. This woman regretted not knowing how to express her milk right from the beginning. She tried hard to give what she believed to be the best, which is exclusive breast-feeding, but failed due to lack of societal social support. Combining exclusive breast-feeding and working outside the home, being a difficult task, required that the women be taught a variety of skills in breast-feeding techniques such as hand expression and/or breast pumps. This would increase their area of choice. It is important that everyone, mothers, grandmothers, babysitters, and especially fathers, receive breast-feeding education so that they can deal with the breast-feeding process. This information should also be available in the school system.

The Tanzanian breast-feeding working mothers realistically assessed their situation and realized that balancing the roles of a mother and a good worker would be extremely hard. Two had asked their mothers to help care for the baby, but these babies' grandmothers unknowingly imposed on their daughters, which frustrated them. These grandmothers, for example, gave water and/or gruel to the infants against their daughter's wishes. One mother had her mother in-law in the house, but not as a baby sitter. The mother-in-law gave instructions, which were against those of her daughter-in-law, to the babysitter regarding what to feed the baby. It should be understood that these grandmothers thought they were being good to their daughters and their grandchildren. In

Tanzania, elderly women believe that they know better regarding pregnancy, labour and delivery, and child care than younger people, regardless of type and/or levels of education, including nursing or medicine.

The majority (4) of the participating women employed young women who were desperate for money, with absolutely no other alternative to earn the money and also not committed to baby-sitting and house care jobs. These breast-feeding working women also realized that the babysitters were not trustworthy. While I cannot help but have empathy for these young, inexperienced sitters, I am equally empathetic for the mothers. It becomes an issue of women pitted against other women. The women **hoped** for the best but the best did not happen. Some women changed baby sitters weekly hoping to get one who would suit the baby. This situation is as problematic as keeping the same sitter. The women continued searching for solutions for these problems in addition to managing their work, households, husband, and often other children. Thus, the mothers had two types of babysitters: young women, who were working for money, and grandmothers who were helping (no payment). They, in one way or another, contributed to the mother's failure in exclusive breast-feeding. It is worth mentioning that the infants received more tender and loving care from their grandmothers than from the paid babysitters.

Work Expectation, Values, and Breast-feeding Support

It has been observed that employment cannot be combined with exclusive breast-feeding unless the workplace can accommodate the various needs of the women including those needs that cannot be foreseen (Baumslag & Michels, 1995). In Tanzania the management at the workplace expects that once a woman has been on maternity leave of

84 days she has to work full time just as if she never had a new baby. This patriarchal working system is such that one cannot work part-time or apply for an unpaid leave and later return to work when the baby is older. Nobody asks a breast-feeding woman about how she is managing. What is expected of her is to be at her work at the required time.

From personal experience I know, in fact, that the majority of males, who are decision makers, do not think breast-feeding is a problem or an issue to reflect upon. When one mentions breast-feeding, the usual response and questions are, "Our mothers breast-fed without a problem, why should it be a big issue now?" It is a Tanzanian tradition, that the unpaid work that women do can be done under any circumstances and it should not give anybody else a problem. In short, it is up to her, to breast-feed exclusively and on demand for the health of a future nation; to make the home healthy and comfortable for all members, to top up the wages by proposing and establishing home projects; and to be the best worker to her employer. The pictures in Appendix E, which were taken by UNICEF, who gave me permission to use them, show how women struggle to breast-feed while performing other tasks. Juggling the demands of a family against the demands of a career requires constant balancing. Additionally combining the responsibilities of work and mothering is difficult, painful, and tiring in the best circumstances (Baumslag & Michels, 1995). It is an oppressive situation. One mother said:

> I do not have the words to express the pain I am going through. What I can say is that the whole experience of combining breast-feeding and working far away from home is a torture to me. People must work for a living but we mothers suffer. We search for jobs but it becomes a pain when we are caught in between work and breast feeding our beloved babies.

Currently the length of breast-feeding world-wide corresponds largely with the spacing between the birth and the return to work outside the home. It is ironic that this is so because it is entirely possible to combine working and breast-feeding. The perception, however, is that the two must be exclusive (Baumslag & Michels, 1995) since even in the more industrialized countries social policies in places of employment regarding breast-feeding are nonexistent.

Many women work because it gives them higher self-esteem in that their market skills are valued somewhat. This is specifically true if the women have professional status and are not doing work which is considered menial. The social rewards for professionals regarding the time they spend with colleagues on the job allows them to feel good about themselves. The women improve their skills for which they sought higher education, and as individuals they are not going to "stagnate" and become outdated from lack of use of skills and/or education (Auerbach, 1993). There can also be a sharing and caring atmosphere between workers. In short, women work for the same reason most men do. One woman said:

> We mothers who are breast-feeding work because we desperately need the money. Even if one is married, one salary is not enough. The inflation is too high. On top of buying food, we need to pay for medical care, children's school fees, rent, and many more. Personally, I also work to share my problems with other women. Sometimes you become so relieved when you realize your colleague is dealing with similar or bigger problem than yourself. That way we can survive the hassles in life nowadays. I am trying to breast-feed and work outside the home, but frankly speaking, to combine the two is extremely difficult.

In Tanzania, as in many other societies, work is conceptualized from a male perspective and valued only if it produces a large cash income. When women work, their

workplace expects them to work according to regulations that were based on male conveniences. The workplace seldom accommodates the women's unpaid reproductive work, including pregnancy, breast-feeding, and childcare (Van Esterik, 1996). Baumslag and Michels (1995) stressed:

> The issues that affect women in the workplace are the issues that we must all face if we are concerned with infant and maternal health. The battle for breast-feeding has been largely waged around limiting the grasp of formula marketers. But as we approach the year 2000, the battle will be lost unless there is a recognition of the importance of breast-feeding to everyone in the society and women are given the opportunity to breast-feed. (p. 190)

The campaign for support, protection, and promotion of breast feeding in Tanzania stresses the recommendations of the Innocenti Declaration (UNICEF, 1990), signed by heads of governments, World Health Organization (WHO), and the United Nations Children's Education Fund (UNICEF), by advocating that all women must be empowered to breast-feed exclusively for the first 4 to 6 months and continue to breast-feed for 2 years with the addition of family foods. The recommendations are relevant, but the general concern which I think was overlooked is the difficulty the working women face as they plan to follow the recommendations without appropriate facilities at the workplace to support them. If you look at the signatures of people who participated in the Innocenti Declaration on the protection, promotion, and support of breast-feeding which took place in Florence, Italy on August 1, 1990, in which Tanzania was represented, you will find that majority were males.

Hurdles and contradictions in the work place. The categories in this co-variable were interactive, in that the women had to plan and negotiate and, at the same time, speak-up and act for the hope of success in their endeavour within the work environment. Often the women's values clashed with those of their employers and more hurdles occurred. In some situations they did not feel supported, while in others they found good support. The result was more contradictions. It was not necessarily female managers who were the most understanding. One woman said:

> Two weeks before resuming my duties I planned to meet with my boss to ask for permission to report for work in the morning at 09:00 a.m. instead of at 07:30 a.m. and to leave for home after work at 2:00 p.m. instead of at 4:30 p.m.

Even though it was humiliating for a mother to ask for permission to stay with her own baby, the mothers had to become humble and submissive for the sake of their babies. The woman in the above anecdote continued:

> My boss is such a kind man. He gave me permission to stay a little longer with my baby for the purpose of breast-feeding him. It does not matter how I feel about this process of negotiation but I am glad I was allowed some time with my baby.

Some mothers succeeded in getting some time off from the work place while others did not. All breast-feeding mothers should have equal rights to get some time off their work to stay with their babies a little longer. Nurses as breast-feeding mothers themselves (two nurses participated in the study) found it extremely hard to get time off their work to nurture their babies. They negotiated with the system without a success. This is ironic because nurses, being the very people who advise and counsel mothers to combine breast-feeding and work outside the home, were not given the chance to practice this task. Raisler (cited in Van Esterik, 1996) stated:

> Providing hospital workers with nursing breaks and a comfortable place to express breast milk helps the breast-feeding health worker to prolong lactation and raises consciousness among hospital staff. After all, if hospitals cannot demonstrate a model of caring for breast-feeding workers, what can be expected from the world of business and industry? (p. 6)

The mothers who were nurses, however, knew that it was they who must do something for their babies. Speaking for self was important.

> I tried to negotiate with my administrator not to put me on night shift because he [the baby] suckles so much in the night. She [the administrator] is a woman, but she would not listen to me. I went to see a paediatrician who wrote a letter to the administrator instructing her not to put me on night shift because my baby needs me. That [the letter] did not work! My administrator would not even look at it. She clearly stated that all nurses must rotate for the night shifts, whether they are breast-feeding or not. She is so difficult. You won't believe that she has children. I am so frustrated and guilty to leave such a young baby for the whole night. Right now I really hate nursing, but I cannot quit. I am completely torn between my job and breast-feeding my baby.

"The successful integration of women's productive and reproductive lives is the goal of many women. Our lives reflect the fact that this is not easily accomplished" (Van Esterik, 1996, p. 2). The ability and possibility to plan or arrange breaks to breast-feed or express milk is one of the factors that influence whether breast-feeding can be combined with maternal employment. For the plan to work, the woman had to sacrifice her leisure time and isolate herself from colleagues who usually meet during break times to socialize. The women treasured the time they had to breast-feed so much, to the extent of thinking that to take a break for socialization was wasting time. Consider this:

> When I started working, my baby had not reached 3 months. What I did was to go to the school when I had a class to teach only. Most of the periods last for 70

> minutes and that is all. So after teaching for 70 minutes I rush home for my baby and continue with breast feeding. Our school administration is such that if a teacher is not in class, she can go out of the school and do other productive work rather than just sitting in the staff-room telling stories and waste time.

Tanzanian women's **love and caring** attitude, which is characteristic of many women world wide, is reflected in they way they see themselves as responsible for the welfare of their family and everybody around, to the detriment of themselves. They are ready to do anything, even if it is physically and/or psychologically costly, for the sake of their family, especially the children and more so for the infant. Plans for successful exclusive breast-feeding, however, may fail to overcome the hurdles and/or the contradictions created by people whose primarily objective is the profit motive rather than the individual mother/infants' health. It becomes difficult for the mother to comprehend the contradictions, which may start from the moment of birth. For example, a nurse in the antenatal clinic planned with the mother to put the baby to the breast within 30 to 60 minutes after delivery and then another nurse at the delivery room would not give the mother the chance to practice what she was told. This mother said:

> I delivered my baby in a private hospital and because I was not in good condition the nurses took my baby away. I do not know what they fed him. I had planned to breast-feed exclusively. After 3 hours I was still very weak, but I asked the nurses to bring my baby to me. I breast-fed but nothing was coming out. I could not handle the baby properly. I was weak. The nurses took him again. I did not see him for the whole night. I just do not know what they fed my baby and I was afraid to ask lest they label me a great complainer. I did not hear him cry, but I know he was not feeding the best food.

Employees of private hospitals in Tanzania are forced by the management to explore all possibilities to make extra charges from their clients. Again, it is the profit motive, the **value** of the work place, which guides this practice. Thus, nurses taking away

a newborn from the mother just after delivery means that the mother has to pay extra money for the formula and care provided for the baby. It is abhorrent that the private hospitals care only about making money even if they have to jeopardize the health of their clients. It is not a supportive atmosphere for women. The biggest issue cited above in the anecdote was when the mother had learned about the breast-feeding process and planned to breast-feed exclusively but was made to fail for not initiating early suckling. Additionally, it was unjust for the woman not to be told about what her baby was being fed, but asked to pay for it. From the anecdote above, it is obvious that the mother was afraid to ask the nurses to bring the baby to her to initiate breast-feeding, indicating an unequal power distribution between nurses and the women. The woman was upset because she knew that the chances of facing breast-feeding difficulties such as engorgement, insufficient milk, and consequently failure to breast feed exclusively were high. She was in an emotional turmoil, not knowing what the nurses were doing with her baby nor feeling supported by them. Such stresses may cause delay in the flow of milk which worsens the situation.

Quandt (1995), in her review of the behavioural interactions of breast-feeding, pointed out that success of breast-feeding of any kind depends on early initiation of suckling, which triggers the production and ejection of milk through a hormonal regulated process. She noted that once the breast-feeding is initiated, the frequency of suckling and its duration regulates the volume and probably the nutrient content of the milk through the process of production of prolactin which promotes the synthesis of milk. This natural process is contradictory to what some medical practitioners believed about the way in

which breast-feeding should be practised. Quandt reviewed how historically in United States increasing numbers of births took place in hospitals, where mothers were frequently anaesthetized for birth and for money and where infants were kept in separate nurseries. Similar practice was described by Tanzanian women, especially those who had their babies delivered in private hospitals. Infants were breast-fed or given formula on set schedules which were several hours apart, rather than in response to infants' demands. This practice was consistent with the medical advice given to mothers after hospital discharge. The physicians wrote textbooks on these issues which were sold or distributed by artificial milk companies to their counterparts in the developing world, including Tanzania.

Newborns being separated from the mother is an additional contradiction which a mother has to deal within the process of achieving her plan to breast feed exclusively. The Tanzanian culture is such that mothers stay with their babies after delivery; this was the expectation of the women and therefore part and parcel of their plan. Being in one room and/or one bed with the infant increases the proximity between mother and baby and hence the frequency of breast-feeding which in turn increases the milk volume. The more frequently the breasts are emptied through suckling the greater the volume of milk (negative feedback system).

Discussion around being assertive and voicing a stand took place during data collection as an effort to help these women to empower themselves. This is one of the purposes of feminist methodology. The women appreciated the importance of speaking up for themselves because no one else will speak for them, either at home, hospital, at the work place, or in the society at large.

The employed mothers voiced the hurdles to breast feeding at the work place (as displayed in Appendix F), under the umbrella of lack of societal social support at the work place and in society at large: maternity leave not being long enough, role overload and multiple demands on the woman's time, unsanitary environment and lack of breast-feeding/expressing rooms at the place of work, lack of time to express milk, lack of milk storing facilities, and work inflexibility. As suggested by Auerbach (1993), such barriers are quite significant and raise issues about the impact of maternal employment on breast-feeding and the legitimacy of promoting exclusive breast-feeding among working mothers.

Support through maternity leave. All the women were aware of the 84 days paid maternity leave, but expressed that it was too short. Obviously, employment plans for governmental and non-governmental organizations and ministries in Tanzania were based on the male employee and employer. Women working in men's world are therefore expected to behave like men. Pregnancy, birthing, breast-feeding, and other family issues complicate the employer/employee situation. Few have bothered to critically explore how to classify the process of maternity leave. One mother described her experience as follows:

> I am so unhappy. I feel that I am being unfair to my baby. You see, for 84 days you are with your baby and you both get used to each other so much. The 84 days are not enough. I needed at least another month to be with my baby. Sometimes when I hear babies crying in the neighbourhood here at the place of work, I feel as though it is my baby crying for breast-feeding. It was just too early. I was not ready to leave him. The policy makers need to increase our maternity leaves to exactly 4 months so that we can breast-feed exclusively and on demand. Sometimes I wonder as to how do they expect us to breast-feed exclusively and on demand for 4 months while our maternity leave is only 84 days. It is hard to understand how they think we can do it.

The Tanzanian woman is expected to have super power, in that after the 84 days maternity leave she is expected to work outside the home, breast-feed exclusively, and carry on with other family responsibilities. She, however, may not be alone. Her counterpart in the developed countries, as stated by Baumslag and Michels (1995), also face unrealistic expectations: "The 80s hero was Superwoman -- she had a successful career, a stable marriage, was a loving mother to 2.5 children, had a spotlessly clean house, was a gourmet cook, spoke three languages, and taught aerobics on weekends " (p. 191). Thus, women's role overload is worldwide, the context changes depending upon the culture. Working women feel constantly pulled in different directions. Therefore, some short- and long-term strategies are needed to support and hence alleviate this burden. Joint efforts from management and individuals at the workplace and the state must be involved in the implementation of the strategies.

In developed countries, such as Sweden where there are subsidized day care centres, women are entitled to long (78 weeks) paid maternity leave (Baumslag & Michels, 1995), while in Tanzania where there are no day care centres, the women are entitled to only 12 weeks paid maternity leave. Additionally, breast-feeding in Tanzania means life to the babies because bottle-feeding can be too expensive and risky due to poor sanitation. In fact, bottle feeding could easily be the infant's passport to death. One would, therefore, expect Tanzanian women to be entitled to longer paid maternity leave than women in Sweden if the breast-feeding work was valued by employers and the government as a whole. There is also a written policy that the working woman in Tanzania can take two ½-hour breaks from her working time to go to breast-feed her infant. The

women in this study felt cheated on this entitlement because it was not feasible to them. They lived far away, and transport to and from their homes was not reliable. In addition, the fare to and from home several times a day was not affordable. Even if they were very near to the work place, it takes more than an ½ hour to complete a feed. A woman said:

> I hate to think about the idea that we can go home to breast-feed for half an hour and come back to work. How impossible? I think the policy makers just suggested the half-hour breaks knowing that no woman can benefit from it. To me the policy makers are trying to be away with blames. Some of us spend three hours before we get home from work. We do not have daily bus-fares, so most of the time we walk miles and get home extremely tired. The only support we can get from our employers is to increase the maternity leaves to at 4 four months. This will enable us to breast-feed exclusively.

Maternity leave should accommodate the woman's goal to exclusively breast-feed for at least 4 months. That is what the women needed. Just one more month to the duration of the present maternity leave would enable them to achieve their desire and achieve what health advisers in and outside the country insist upon. Reports of the National Surveys of Family Growth and the Ross Laboratories Mothers Survey conducted in the United States of America (Ryan & Martinez, cited in Riordan & Auerbach, 1993) concluded that the employed mother is less likely to continue to breast-feed than the one who chooses to stay at home during the baby's early infancy (Auerbach, 1993). In this study the women continued to breast-feed after they returned to work, but due to the distance between them and their infants during the working hours, lack of expressing rooms, pumps, and storage facilities for milk, they could not breast-feed exclusively for the first 4 months of their infants' lives as the mothers had planned.

Unsanitary environment at the workplace and lack of breast expressing rooms.

Lack of enough resources for sanitation is one of the biggest health problems in Tanzania. Women who breast fed and worked had fear of been infected (mastitis) and contaminating breast milk if they expressed at the place of work. If there was an isolated room for expressing milk, they could keep the place clean, but there was none. Instead, they were supposed to express breast milk in the public bathrooms.

> The toilets [bathrooms] are not conducive for expressing milk at all. We have few toilets for so many workers. If you stay in the toilet expressing milk, you will block others who wish to use the facility. I also fear contracting infection to myself and to my baby because the toilets are not clean enough. I could volunteer to do the cleaning if there was a room isolated for the purpose of expressing breast milk. The system did not include breast-feeding mothers in its plan. You cannot find anything at the workplace which was placed for the intentions of assisting a breast-feeding woman.

Since the work places were planned to suit male workers and men do not breast-feed, it is not surprising that nobody thought of a breast-feeding room for mothers. In addition, while employed women in developed countries talk of pumping milk and storing it for their babies, this is not the talk of a Tanzanian woman employee because it is almost impossible to purchase the pumps. They are not readily available in the market. Scholars think that women should be encouraged to express milk by hand because working mothers are a special target for infant formula and breast pump companies because the task of managing breast-feeding and work outside the home is a real challenge (Van Esterik, 1996). The author continued that breast pumps contribute to the medicalization of breast-feeding and emphasize breast milk as a product rather than breast-feeding as a process. She further suggested that the product orientation reinforces the belief that infant formula

and breast milk are equivalent products served in the same container (bottle) but coming from different sources. In addition, Van Esterik stated that the breast pump can create dependency on a piece of technology instead of encouraging a human solution for a human problem.

Van Esterik's (1996) argument that pump companies take advantage of and/or exploit working women because of their hardship in combining breast-feeding and employment is genuine. The argument, however, may not be helpful to women who are in this era of high technology. Centuries ago, for example, information was sent from one person to another through a messenger who walked or took a bicycle. Today information is sent across the world by computers and Internet. People in paved cities or towns who cannot drive cars can go from one office to another using roller blades to beat the time. Everybody and everything is moving so fast! For a mother who takes a quick 30-minute break to express milk, obviously, a pump would ease the process rather than hand expressing. It was frustrating when the women had to suffer (hand expression of breasts is difficult when time is limited) to sustain a natural process in an unnatural and unfriendly breast-feeding environment.

Thus, anything that will take too much time is an obstacle to their lives and to these women so is the process of expressing milk by hand. In the world today in a rush to beat the time, the woman is not expected to separate herself from her usual rush for everything to slow down when she is expressing the breast. If she is forced by circumstances to slow down, then it becomes unnatural to her and may cause frustration. Probably this time consuming practice could be the reason the majority of women in

Tanzania did not express their milk for their babies. Therefore, anything which will assist her in expressing the milk faster, will be one of the less frustrating solutions. This woman said:

> I read and heard that there are devices which can help you express milk quickly when you are working and cannot go home to breast-feed. I have no idea how they work. It is so tiring and time consuming when your breasts become full and you want to express to relieve yourself of the pain. It take ages to empty one breast while I have to work. I wish I could get an access to the devices. Nothing is available to help a Tanzanian women to do whatever she does comfortably. If they sell bottles, why can't they sell pumps. They just want us to do it (express milk) in a hard way. I do not know when anything will be easy for us.

It appears that the women would like to move with the new technology in the area of breast-feeding. It is also true that while pumps are manufactured or imported, other requirements such as refrigerators to store milk and equipment to cleanse the pumps will also be needed. The fact is, buying and selling are the order of life. If other products such as workplace cars, computers, and photocopiers are bought to make working lives easier, why should it become a problem when it is something to make a woman's life easier and give her a variety of choices? Is it because breast-feeding is not valued or is it because it is a women's issue and therefore natural for them to do whatever they do in the hardest way?

Buying some pumps for the few breast-feeding women at the place of work may not be too expensive. When pumps are bought, it is always hoped that a room will be created to keep the pumps and consequently this room will be used by the women to pump and store the milk in a refrigerator to be taken home at the end of the day. It may seem expensive, but breast-fed babies are a big investment to the nation.

Governments put a great deal of effort into direct income-generating sectors. They, however, do not realize that neglecting the indirect income-generating sectors, the major one being the reproductive and childcare sector managed by women, may greatly compromise the entire government income. In developed countries where people have a higher standard of living, they can acknowledge the contribution of the reproductive and childcare sector toward their governments' wealth. The National Research Council in the United States of America (cited by Baumslag & Michels, 1995), for example, argued that parents should be allowed to take as much as a year off from work during the critical early period of their children's lives. Most employers will grant maternity leave and, as well, some paternity leave for employees, not for a full year but for a reasonable term.

Tanzanians are not asking for the two parents to be off from work for a leave (even though children's needs are the same all over the world), but just the mother, and not for 1 year, but for 4 months. I am not sure whether the American government accepted the idea given by the researchers, but for the Tanzanians the policy is a paid maternity leave for less than 3 months. The American researchers continued that parents should not be forced to put their children in second place. They further stressed that parental leave and quality childcare is an investment in the future and a way to build a reproductive force. They added that the costs of not having a long enough maternal leave are significant, including growth and developmental problems for children, stress on parents trying to combine work and families, and lost wages and increased welfare costs for some women if they quit their jobs. In fact, paternity leave is becoming the norm.

Being a mother myself, I find it impossible to put a child in second place. Although some women in developed countries can depend on social welfare to some extent (if it becomes too stressful to combine breast-feeding and work outside the home), women in Tanzania can never think of quitting a job because there is no social welfare system to help out. In other words, a mother has no alternative but to live with the hurdles and the contradictions of combining breast-feeding and work outside the home.

The mothers in the study appreciated how cost effective breast-feeding is, as one of them plainly stated:

> My milk is the cheapest of all baby foods. Baby formulas are just too expensive. I eat the food which everyone in the family eats and at the same time make enough milk for the baby. I don't have to waste time and money walking to shops to look for formulas. The baby food is with me and ready-made.

The baby food being with the mother, it is reasonable that efforts be made to enable the baby to be with the mother when s/he wants to feed, especially at the younger age. For a Tanzanian woman to successfully combine exclusive breast-feeding and work outside the home, she requires support in the workplace. A breast-feeding policy is needed to ensure that the women get adequate maternity leave and time, space, and facility to express milk. On-site daycare centres have been found to be helpful, because the women could just go to the centre to breast-feed and come back to work. Some of the women's desire was to have someone such as the husband bringing the baby to the workplace for them to breast-feed, but this practice could not be achieved because of the lack of rooms to sit to breast-feed.

When asked about the experience of breast-feeding in the work place, one mother said:

> I am not happy because I liked and had planned to breast-feed exclusively for the first 4 months. This was not possible at the end of maternity leave. I wish there was a place I could sit at my work and breast-feed. I could have asked my husband to bring the baby to me, because we have a car. But as it is now, there is no such place. I cannot allow my baby to be brought to feed in the office where all of us share. He will pick up infections. The office is not comfortable to sit and breast-feed because there are so much movements. The baby will not be feeding, but looking at people as they walk by.

To ask for a private place to sit and breast-feed is not asking too much. I believe all workplaces in Tanzania can create such rooms where breast-feeding women can either express their breast or breast-feed their babies. Women need privacy while breast-feeding. The mother and baby need to be free from external distraction when breast-feeding and this is confirmed by the woman who spoke in the above anecdote. Blaumslag and Michels (1995) stated: "Ironically, the more a woman feels inhibited, restricted, and controlled, the less likely she will be able to breast-feed as breast-feeding requires the woman to be relaxed or the milk refuses to flow" (p. 203).

One of the reasons given by women worldwide for stopping breast-feeding before the infant was 4 months was perceived as insufficient breast milk (Essex, Smale & Geddis, 1995). In other words, the milk does not flow adequately to satisfy their infants. Stopping breast-feeding before a Tanzanian infant is 4 months is not only unhealthy but can be fatal to the infant. The stress the Tanzanian breast-feeding and working women deal with is most likely to cause insufficient milk.

To sum up, early returning to work seems to be a deterrent to exclusive breast feeding, but it does not have to be if the workplace management would provide the support which the women want, that is, if, for example, there is enough support at the workplace, which included either rooms, pumps, milk storage facilities, breaks to breast-feed/express milk; longer maternity leave (at least 4 months); work schedule flexibility, on-site daycare; or some combination of the above. It can be assumed that the workplace would be more supportive if the larger society was positively behind the whole issue of breast-feeding.

Society's Norms, Views on Gender, and Economic Reality

The women who participated in this study described their experiences of living with hurdles and contradictions that were created by the social norms, views of gender, and economic reality in Tanzania. One woman described a **cultural norm** which was extremely frustrating during the process of exclusive breast-feeding:

> When I came from the hospital, I told my mother-in-law that I wanted to breast-feed exclusively. She could not understand how possible it would be to breast feed for months without giving gruel or water to the baby. She told me I was bringing new practices into their clan, and that she will be surprised if they worked. She insisted that I must give water otherwise the baby will die of thirst. I was so scared and confused because if the baby happened to be sick, they [the in-laws] would say it is because I did not give him [the baby] water. She is the one who forced my babysitter to give gruel and water to my baby when I had gone to work. The baby was a week less than 3 months old. I was so mad, but I didn't blame her because that is how she fed her son [my husband]. I just prayed that my baby would not develop diarrhoea because I did not think the water was boiled. I did not even want to know whether the water was boiled lest I die of fear. From the day I was discharged from the maternity ward my mother in-law has being driving me up the wall. I know my own mother could have done the same because they think being older is knowing everything better than the younger people.

The mother-in-law described above obviously was one of the barriers to exclusive breast-feeding, which the young women have to live with. It is, however, not the mother-in-law's fault to behave that way, but it is the norms and beliefs of this society which are hard to change within a short period of time. Often they are myths which have a long history. The problem here is the new mother had to depend on her mother-in-law and the babysitter to decide upon what to feed the baby because the mother had to work outside the home. The mother who described her situation above appeared emotionally very tense for being so intimidated by her mother-in-law.

The older woman in the above situation raised her infants decades ago and in the rural area, while the younger woman was raising hers in this era and in the city, a completely different environment and generation. It is not surprising, therefore, that the two women would not agree on one principle of childcare. Quandt (1995) pointed out that the social environment in which women mother their infants has a profound effect on their behaviour.

Raphael (cited in Quandt, 1995) proposed the term "doula" for what was regarded as a near universal -- the women culturally prescribed to assist the new mother, offering instrumental support and advice as she mothers her infant. The doula teaches the new mother techniques necessary for successful breast-feeding. With good intention she disciplines and educates older children in the new mother's family. Currently, in Tanzania the doula is mostly the young woman's mother or mother-in-law who most of the time do not agree with the young mother because of the socio-environmental differences. We, therefore, need to establish our own trained doulas or peer group support other than the

older relatives. These doulas will also assist new mothers to overcome bad advice from friends and relatives regarding infant feeding styles.

Infant feeding practices, including whether and how to breast-feed, depend a great deal on the **cultural norms of** the particular society. Historically, Tanzanian women breast-fed while attending to the family needs most of the time around their homes until the infants were more than 3 months old. The breast-feeding was combined with other foods such as gruel and water. The environment at the time was not as contaminated and polluted as today. Waterborne diseases were not present at the time. In fact, most of the rural areas today do not have to boil water because their water is not contaminated. Contamination and pollution are present mainly in towns and in the city, which is difficult for the older generation to comprehend.

While a Tanzanian woman is fighting with cultural norms that obstruct her from the success of exclusive breast feeding, her counterpart in other countries is doing the same, although in different types of situations. Consider the following Canadian commentary by Samuel (1997):

> A woman sits down in a shopping mall to breast-feed her infant. Soon she is approached by a security guard who informs her she is not allowed to breast-feed there. The woman begins to protest, her infant comes off the breast, wailing, and the commotion attracts the attention of people nearby. The woman is embarrassed, and decides to leave as quickly as possible, vowing never to breast-feed again. (p. 47)

The author continued that in North America it is possible that a child grows to adulthood without having seen a breast-feeding mother and yet will frequently see breasts displayed in a sexually provocative fashion on television and other media and at the corner stores on the magazine rack. She continued further that breasts are commonly used in advertising to sell products such as cars and watches, yet when a mother uses them as they were naturally intended, she might find herself the object of unwanted attention, violating cultural norms.

In countries such as Ireland, for example, many experienced breast-feeding mothers have formed mothers' support groups to help new mothers overcome the hurdles and the contradictions in breast-feeding within their society (Kyenkya-Isabirye & Magalheas, 1990). The report continued that these mothers were trained and updated with scientific and other knowledge related to breast-feeding and infant health. The desire for peer support groups in breast-feeding was expressed by the women in the present study as follows:

> I received the breast-feeding teachings from nurses before I delivered the baby and was very much assisted to start breast feeding in the maternity ward in Muhimbili. When I came home and was alone with my baby, he started crying, not wanting to breast-feed. No matter what you do, he wouldn't stop crying. I completely forgot about what they [nurses] had told me to do when the baby cries and refusing the breast. I was so disturbed, tired, and confused I wish I had somebody within the neighbourhood who could help me out of my confusion.

It is overwhelming to a new mother when a newborn cries nonstop and refuses anything that the mother tries to offer. This kind of baby behaviour is not uncommon. A study conducted in Israel found that duration of breast-feeding was reduced when the mother suffered from stress, tiredness, encountered breast-feeding problems, or if the baby

cried excessively (Bergman & Feinberg, 1981). Such situations require someone with experience to calm the mother and together try a problem-solving approach. It could simply be that the baby was not latching on properly, which is usually the case with new mothers. The mothers needed such helpers within the neighbourhood whom the mother could call or send for help. In Halifax, Nova Scotia, such women helpers who were established recently are called "breast-feeding buddies." The breast-feeding buddies, who have breast-fed or are currently breast-feeding, volunteer to be called by a neighbour who is having breast-feeding problems. The helper's telephone numbers are given to new mothers on discharge from the maternity ward. In about 70 developing and developed countries, Tanzania excluded, mother-to-mother support in breast-feeding is available through LaLeche (LaLeche League International, 1997). It is women helping women.

In Tanzania, mothers who might be having a problem with breast-feeding at home must go to maternal and child clinics (MCH). Such practices are unrealistic because of the distance from the mothers' homes to the clinics, the large numbers of women who come with sick babies (not enough time to discover a breast-feeding problem and work out a solution), and the clinics operate only during the morning hours. Additionally, not all MCH workers are fully conversant with breast-feeding, let alone solving problems. Thus, a woman may travel all the way to the MCH clinic and not receive any constructive solution to her breast-feeding problem. This frustrates the mothers and increases their level of anxiety, leading to poor flow of breast milk. It becomes a problem on top of a problem.

For working women, the anxiety will be higher because time is so limited for them. That is, if a breast-feeding problem occurred in the evening, a woman who is not working outside the home can go to the clinic, but the working mother must go to the workplace. One might expect a working mother to stay home and deal with a breast-feeding problem, but because Tanzanian society is male-oriented, nobody pays attention enough to listen to a breast-feeding woman and understand her female-centred problem. In Tanzania men can understand and actually become very concerned when their children get sick. So a working woman is allowed to stay home with the baby only when the baby is sick and she must get a doctor's certificate prescribing the number of days she can be off-duty to care for the sick baby. As for a breast-feeding problem, the woman has to live with it, even though breast-feeding has a lifelong mechanism to prevent children from getting sick.

The society in Tanzania views **gender roles** as clearly demarcated, in that there are roles specific for men and different from those of women and vice versa. One may wonder how children think, growing up in a society where mothers do everything for them and their fathers and that these mothers have all answers to these children's questions; it would not matter whether a woman has an extra responsibility such as working outside the home. One participant commented on the gender role, work, and breast-feeding.

> When I was growing, as a girl, I thought fathers were there for their presence and to check on the mothers that they were doing things correctly. For example my father ensured among other things that my mother feeds the cows properly so that he gets a credibility from his friends when he slaughters a fat cow. My mother used to get angry, but I could not tell why. I thought my mother was like a machine. She never stopped. I am doing the same thing. My husband is like my father. He does almost nothing, but keeps on telling me what I have done wrong for the growth of the family. For example, we work full time, I am breast-feeding, but he

> expects me to run the household smoothly and if anything went wrong, it is my mistake. Sometimes I wonder how I manage all these, but the days move on.

The women's workload is passed down from one generation to another, and it appears that nobody will do much about it except the women themselves, who cannot because they are so overwhelmed. The society is such that the mothers are forced to prepare their daughters and sons to take these gender prescribed roles. Mothers fear that if their daughters are not prepared to take that workload, they will not get married, and because sons are better educated, hence earning better salaries, the unmarried daughters will not be able to sustain themselves without husbands. The issue of not marrying is never considered. Thus, if a woman wishes not to marry she can choose to remain unmarried.

Sons are encouraged by their mothers and fathers to be tough and study hard for a bright and successful future. One can hear parents telling sons not to be seen in the kitchen or do any housework, but to study. Very few parents encourage daughters to study and/or not to bother themselves with housework. Instead, daughters are encouraged to assist their mothers with household duties so they can learn, especially how to cook for a future husband. Additionally, sons, whether educated or not, inherit from their parents while daughters do not. Thus, a man is secure right from the beginning.

Currently the **economic reality** is that inflation is very high and women feel responsible for their families' welfare to the extent of working to exhaustion in an effort to curb the overwhelming financial needs. The men take for granted that their women will manage because they do not have the slightest insight about how difficult and tiring the whole women's workload could be. There is neither an equal division of labour within the

household nor in the workplace where a breast-feeding mother tries to carry out several of her functions. This is in full accord with this woman's statement:

> I have this baby who is now 4 months and I am breast-feeding. His brother is 3 years, requiring my full attention. I feel like crying as I tell you this. You know, my babysitter went away to visit her parents so I have a new one who is so inexperienced. She is simply another burden to me. Teacher [she is addressing me], I wake up at 3:00 a.m. daily to feed my chickens. This project [poultry] is killing me, but I just cannot do without it because it assists our financial needs substantially. From there, I prepare food for the 3-year-old, breast-feed the baby, express my milk to leave for him, and rush for work at 6:00 a.m. I live very far from my workplace and have to start working at 7:30 a.m.

Tanzanian society forces women to believe that no matter how much cash they can earn from their own personal efforts, they can hardly survive financially without a male symbol (husband) in the household. They therefore struggle so much to ensure that they keep the husbands, however, it is a one-sided struggle. This attempt becomes energy draining for the woman as one expresses below:

> I have a husband who is also working and I think he does not know when I wake up to feed the chickens. At the end of my long and tiring working day I go home to continue with the housework. My babysitter being so new, she is just a symbol needing my help. When I finish washing the dishes around 12 midnight, and believing that everybody is asleep, I stagger, deadly tired, to take a shower and go to die in bed. Well, believe you me, my husband would be there in bed fully awake waiting for me with a big smile.Having no energy left, I quietly sleep wondering whether there is any advantage for a woman to get married. I, however, cannot afford to lose him to other women. I still love him, also our children need him. As a woman, I have to try hard to keep our marriage intact otherwise if the marriage disintegrates I will be the loser and everybody will blame me.

The woman was speaking about the fact that her family could not be sustained without her efforts. If she does not work hard for her poultry, there could be not enough food for the family. Society will consider her a failure. If she does not go to work for her employment as per schedule, she will be fired and society will consider her a failure. In addition,

poultry is not a reliable source of finance because the market-prices fluctuate so much. Sometimes there can be a big loss in these projects, raising concerns about family survival if a husband and wife are not employed. She has to breast-feed because if the baby becomes sick society will consider the mother a failure. The other alternatives to breast-feeding are expensive for the mother and unsafe for the baby. She has to satisfy the husband sexually, because of a fear that if she does not, she might lose him to other women and society might consider her a failure. It is a no-win, dead-end situation. It is obvious that the feminist movement has had little impact on the lives of these women.

Thus, the women are confronted daily with reminders that they have failed to live up to expectations of their society. It appears, therefore, that women in Tanzanian society, because of their loving and caring nature, do whatever they can to improve their families' economic and psychological well being to their own detriment.

# CHAPTER V

## Analysis

One may argue that the breast-feeding promotion, support, and protection programs which were conducted in Tanzania as a form of campaign in the 1980s would be enough to support a breast-feeding woman. It has been observed that social programs may or may not be accessible or beneficial to the receiver, which is what occurred for the women in the study. Some of the women, as mentioned earlier in the text, did not know how to express their breast milk, they had no milk storage at the workplace, maternity leave was not long enough, and their significant others did not relieve these women of the household responsibility.

One would have expected that the breast-feeding campaign could have considered these barriers and proposed a way to eliminate them, but this did not happen. Some of the women had their mothers/mothers-in-law come into their houses with intentions to provide emotional, informational, and tangible support to mothers, but some of these supports turned out to be great stumbling blocks to the success in exclusive breast-feeding. It was a social support that did not benefit the receiver.

According to Stewart (1995), sources of societal social support comprise lay sources of support such as partners, husbands, family members, neighbours, coworkers, volunteers, self-help groups, and professionals. The women in the study hardly received any meaningful support from the mentioned sources. On the contrary, they experienced a lack of support at the workplace and in the homes. Appendix F show how emotional experiences and barriers to breast-feeding bombarded the mothers in the study.

Barron et al. (cited in Riordan & Auerbach, 1993) found that the availability of an outside source of support in the first 6 weeks postpartum nearly doubled the mean breast-feeding duration in a group of low-income women. One of the societal social supports this particular group of low-income women received was encouragement to breast-feed.

The Tanzanian society traditionally neither encouraged nor discouraged any woman during the process of breast-feeding, until recently, when the breast-feeding campaign was conducted to inform women of the advantages of exclusive breast-feeding. The campaign did its best by ensuring that a few health workers in the country trained in the importance of exclusive breast-feeding. The aim for the campaigners in training these health workers is for them to train others and consequently impart the knowledge to their clients (mothers). But how is this to change the lives of poor women? Are these problems to be solved by social supports? This concept is an end in and of itself; it is a Western idea that assumes equality in economic, gender, race, and cultural situations. These women would fare far better if (a) their husbands would assume half of the labour in the home, (b) they were not expected to carry out projects, and (c) they were economically secure. Knowledge alone is not enough nor are social supports. Change in social structures is required.

It is obvious that the health workers, however, do not have the power or mandate to eliminate the barriers which a woman who combines exclusive breast-feeding with full-time employment and full-time housework encounters. The health workers, after imparting their breast-feeding knowledge to mothers, leave the mothers to live with the hurdles and contradictions to exclusive breast-feeding. Society gives a blind eye and a deaf ear to the

whole issue. Consider this quotation by Boulding (cited by Riordan & Auerbach, 1993): "When women have too heavy a work burden with the triple breeder-feeder-producer role, the whole society suffers. Women suffer role strain, men suffer role deprivation and children suffer from inadequate experiences of relating to the human community" (p. 410).

It cannot be overemphasized that women who combine exclusive breast-feeding require extensive support and firm social policies for them to be able to perform this challenging task. One of the women participating in the study said:

> I do not think that our society appreciates what we do, especially when it comes to breast-feeding. I hate to say that even my husband does not think that when I breast-feed it is an extra task to me. He simply does not know or care how I manage working outside the home, breast-feed exclusively, and carry out the household activities. He never asks. You will be wasting time if you try to make him understand how hard the practice is. It will take us a long time for our people to appreciate and value what women do for the benefit of the whole society. What seems to be valued is our employments. I think breast-feeding is cost-effective, but we cannot stay home and breast-feed because of job and financial insecurity. I did not succeed in breast-feeding exclusively for the first 4 months, but I could have succeeded if my baby was brought to me or if I could express milk at the place of work or if the maternity leave was at least 4 months.

The woman in the anecdote above is saying that she received support from neither her family nor from society. The lack of support was not due to facilities, but due to lack of equality between men and women and living in a financially poor country. The alternative to having the infants in closer proximity with the mother, as expressed by the women, is that of being provided with the means to express and store milk for use when they are at a distance from their infants. In this way, although they could succeed in exclusive breast-feeding, the more pressing economic and political issues of poverty, oppression, and

exploitation are not solved. This would be a panacea only while the inequalities remain unattended to.

As a summary of the types of societal social support needed by a woman who combines exclusive breast-feeding and full time employment, Auerbach (1993) stressed that the mother will require specifically:

* a person who cares about her and what she wants for her baby
* a role model
* a knowledgeable advisor
* a person who obviously values breast-feeding
* a person on whose shoulder she can lean or cry. (p. 415)

Based on the 'stories' shared by the women in this study I would add gender equality and adequate income, services, and resources. I consider these latter of primary importance. It is men who must share half the burden, and the government which must develop policies based upon equity for women and mothers.

A Person Who Cares About the Mother and What She Wants for Her Baby

This could be the baby's father, but most Tanzanian fathers referred to in this study were unlikely to provide meaningful support to their wives during the process of breast-feeding. They were practically unaware of what was going on with the women, even though they lived under one roof, within four walls. None of the mothers in the study reported having received any kind of support from her husband. This is of primary importance if a woman is to be treated fairly and equally in any society. Traditionally,

Taking the Micro Level of Analysis to the Macro: Women's Issues Worldwide

My study identified maternal employment as a major determinant of the length of exclusive breast-feeding in the first 4 months postpartum. As soon as the women returned to work at the end of the maternity leave of 84 days, the majority of the infants started to feed on mixed foods. This is consistent with results of other studies conducted in industrialized and non-industrialized countries on similar topics. Haider and Begum (1995), in their study conducted in Bangladesh, found that almost half of their respondents (mothers who combined breast-feeding with employment) had introduced complementary foods as a preparation to returning to paid employment, which was at 76 days postpartum. Likewise, in the United States, only 13% of the women who return to work full-time shortly after delivering a baby breast-feed for at least 6 weeks (Baumslag & Michels, 1995).

The theoretical adequacy of living with the hurdles and the contradictions is supported by its similarity to other inductive descriptions of women's hope and struggle in combining breast-feeding and working outside the home. Morse and Doberneck (1995) conducted a study in Pennsylvania to describe the concept of hope among patients undergoing heart transplant, spinal cord-injured patients, breast cancer survivors, and breast-feeding mothers intending to continue to breast-feed while employed. From their study, the authors discovered that mothers who combined breast-feeding and working outside the home **endured** the hassles, extra worry, and awkwardness of managing breast milk in the workplace as long as the baby wanted to breast-feed.

Morse and Dorberneck (1995) continued that the mothers' hope for **balancing roles of a good mother and satisfactory employee resulted in impossible dilemmas.** The employed and breast-feeding mothers in Morse and Dorberneck's study, as well as those who participated in my study, were determined to do what was best for the baby under difficult circumstances, hoping for a chance for a chance to succeed in exclusive breast-feeding and working outside the home, recognising that the chances were very narrow.

Likewise, Tanzanian mothers' experiences living with the hurdles and the inherent contradictions of being employed full time and using exclusive breast-feeding resembles American residents' descriptions of the difficulty and endurance they had to undertake having to breast-feed their babies and arrange for baby care during their residency (Gjerdingen, Chaloner, & Vanderscoff, 1995). The breast-feeding literature has emphasized a great deal the notion that it is possible to combine exclusive breast-feeding and working outside the home (Baumslag & Michels, 1995; Haider & Begum, 1995; Riordan & Auerbach, 1993; Van Esterik, 1996). All of this depends upon the value placed on women and children in any given cultural context and the extent to which social policies are developed to assist these mothers.

Back to the Micro Level

Some scholars, for example, Riordan and Auerbach (1993), stressed that persons helping a new mother to succeed in breast-feeding exclusively should focus on the positive aspects of breast-feeding rather than the negative ones. While I agree with the idea of being positive, I think in situations such as the breast-feeding process, the helper and the

woman together should explore all positive and negative aspects of exclusive breast-feeding and especially so when the mother has to combine it with employment and other household responsibilities. This will enable the mother to manage, for example, the negative aspects when they occur in the middle of the process when nobody is around immediately for help. Often these surprises, which are left for the mother to discover after being convinced that she can do it because every woman can, are the very ones which cause women to discontinue exclusive breast-feeding. An example is the mother who was really prepared, during the antenatal classes and in the delivery room, to breast-feed but was not cautioned of any negative experiences during the process of breast-feeding. Following is her anecdote:

> I had decided to breast-feed exclusively. The nurses in my prenatal sessions taught me everything I needed to know. On the day I delivered my son, the nurses helped me to initiate breast-feeding within the first hour of delivery. It was so simple and exciting. I knew I could do it. I was so convinced. The nurses made it look like it was so simple. Only a dummy woman could fail. I was discharged within 24 hours of delivery. At home the baby sucked well during the day and night, okay for the first 2 days. When he was 3 days old, he was so fussy. He wouldn't suckle, but cried all the time. I did all what we could to get him to suckle but he refused. I decided to give him a dummy, got some sleep. The next morning I decided to put him on the bottle which is what he likes.

Surprises are better when they are positive than when they are negative. Mothers who were told that they could easily hand express their milk, gave up frustrated on the day they tried, because their expectation was completely the opposite. They could hardly get a few millilitres of milk after spending hours. The same is true with latching on. Mothers need to know that some babies may not latch on perfectly well right from the start. Some patience is required for the baby and mother to learn about each other and about the

breast-feeding task. Maybe every woman can breast-feed her own baby, but only if there are fewer hurdles to overcome.

Conclusion and Summary

My study, which was based on feminist and grounded theory methodology, is a contribution toward the understanding of women-centred tasks and how Tanzanian society views these women's tasks. During the process of this study, where a dialogue between the researcher and mothers who participated took place, the women were empowered and there was reciprocal caring between the two sides. But awareness is not enough; there must be political and social transformation as well.

From the women's descriptions, a model was formed showing how the women lived with the hurdles and contradictions in combining exclusive breast-feeding and working outside the home. The model demonstrated the women's experiences as they were dealing with the hurdles and the contradictions within three systems which include (a) the women themselves, (b) workplace, and (c) society at large. Each of the three systems appear distinct to people, but to the women who combined exclusive breast-feeding and employment, the systems were interrelated.

**Within themselves,** the women were dealing with conflicting issues such as mixed emotions, lack of enough knowledge, body image. They survived, however, because of their personal resilience, and if they had breast-fed previously, it was an advantage.

**Within the workplace**, these women had to deal with separation from their infants with whom they had been very much attached during the 84-days maternity leave. It could be helpful if they had facilities to express milk and store or a baby brought to them

to breast-feed, but nothing was available for them. The two ½-hour breast-feeding breaks were useless to them because of the long distance between their homes and the place of work.

**Within the larger society,** the women had to deal with society's views on gender roles. Society's attitudes toward gender roles left the women to be responsible for all family issues related to health, childcare, and filling up the family's financial pit holes. The men could at most bring home the cash that was available for them, mainly from employment, which was also done by the women. The combination of exclusive breast-feeding and employment in this society was extremely difficult for the women. They had to live with the hurdles and the contradictions, some of which were related to the cultural norms in child-feeding. It appeared that the new mothers intended to violate some cultural norms in infant feeding such as, for example, not giving a young infant water to drink. This was equated by the culture as killing the infant of thirst. The women required a great deal of support for their actions for them to succeed in exclusive breast-feeding and working outside the home. None of the women said they were praised by anybody for all that they were doing.

The study also showed that an employed woman cannot separate the task of breast-feeding from her employment and other societal expectations and responsibilities. They are all interrelated and affect each other, not the tasks only, but also the people involved in these systems (See Fig 1). Thus, the dream of the mother to raise up a healthy future citizen should be the dream of the employer and the society at large, who must solicit efforts to support the woman who is the core person in seeing that the dream comes

true. However, these issues are socio-political and economic in nature. "The personal is political" to coin a commonly cited feminist phrase. For most Tanzanian women it is the story of their lives: they live in severe oppression and exploitation which cannot be alleviated by focussing solely on the mechanics of breast-feeding. What is needed is socio-political change based on feminist education of gender equity and recognition of work.

# CHAPTER VI

## Implications for Nursing/midwifery Practices and Education

### Societal Social and Economic Support: Roles of Nurse-midwives

Mothers need societal social and economic support to accomplish the task of combining breast-feeding and work outside the home. Nurse-midwives offer support to mothers mainly in the form of breast-feeding information, specifically on the advantages of breast-feeding as directed by breast-feeding promoters. Nurse-midwives do not have enough time to teach a new mother the practical issues related to breast-feeding. Besides, many nurse-midwives may not be very conversant with the process of exclusive breast-feeding. Right now breast-feeding is taught as a 2-hour topic, which is not enough for the graduates to assist mothers during the breast-feeding process. Nurse and midwifery educators therefore are urged to include a significant amount of breast-feeding content in the nursing curricula at all levels. This should be coupled with practical experiences so that a nurse-midwife can assist a new mother who, for example, has a problem with latching an infant.

Additionally, there must be nurse-midwives specifically dealing with helping mothers to breast-feed throughout the country, just as they run immunization or antenatal clinics. Van Esterik (1996) pointed out that the policy statement issued by the International Confederation of Midwives recognized a nurse-midwive's distinctive and critical role in the promotion, support, and protection of breast-feeding at governmental, institutional, and individual levels. It is important to note here that in Tanzania every nurse

is a midwife. In the delivery rooms there should be nurse-midwives specifically responsible for handling breast-feeding issues, rather than leaving this important task to those who conduct the deliveries. This is because nurse-midwives who assist mothers to deliver babies are over-worked due to the large numbers of women having babies at the same time. As I have already pointed out, this is an economic issue. Overworked nurses in understaffed hospitals cannot provide safe care in that kind of environment.

Politics and Breast-feeding

It is important to begin with politics. Tanzania being one of the countries where a number of women are actively involved in policy making, it becomes easier for women to be understood if they speak up; this is quite rare. It is not clear why women tend to live with their problems other than the fact that they have intense fatigue and grave concern for their families, but what is clear especially from this study is that the consequences are detrimental. Malnutrition and diarrhoea are among the top 10 conditions contributing to an infant mortality rate in developing countries such as Tanzania (Lawrence 1994). Breast-fed babies are usually free from these killer diseases. Most women know this and that is why they struggle, but unsupported they cannot alone prevent these preventable diseases. Nurses and the women need to encourage each other to voice our concerns to our decision makers through social activism.

The majority of nurses are women, who perhaps have breast-fed, are breast-feeding, or will breast-feed. We can be advocates to mothers who combine working outside the home and breast-feeding through talking with policy makers. Some nurses are policy makers or involved one way or another in policy making. Exclusive breast-feeding

for the first 4 to 6 months, which is a directive originating from WHO and UNICEF and agreed upon by governments, Tanzania included, cannot be achieved within the current policy on maternity entitlement and situation at a workplace.

It is understood that people, especially women, fear that if a policy is passed that maternity leave is 4 months, then employers, especially private ones, will not consider employing women. Employers, however, should be made to understand that it is more costly and more unproductive to have an employee who is frustrated. Mothers in this study were extremely frustrated when they had to leave their infants, who were less than 3 months old, to return to work, not knowing how these infants were fed by the babysitters.

Employers and society at large need to realize that it is very expensive to have employees who might be admitted to a health care clinic every month for a sick child and therefore absent from work. Money is spent for treatment and time is lost in the process. Children who are exclusively breast-fed are more likely to stay healthy than their counterparts who did not breast-feed exclusively, because breast milk is sterile and confers immunity. Many children contract diarrhoea from drinking contaminated water or from contamination that might take place during the process of preparing formulas or other foods. Thus, nurses must help policy makers understand that breast-feeding is the cheapest and most cost-effective to families, employers and society at large.

What to Do In the Current Reality

Prenatal education. Nurses should provide information to new mothers regarding combining exclusive breast-feeding and employment. There should not be any hidden agendas left to be discovered by the woman when she is alone. Some of the nurse-

midwives cannot give proper advice to a mother regarding combining exclusive breast-feeding and work outside the home because they themselves were not supported by the hospitals to carry out the task. Palmer (cited in Van Esterik, 1996) stated, "It is scandalous that all hospitals do not provide facilities for breast-feeding for their staff, and in fact, where this has been done, HPs (health professionals) have returned earlier from maternity leave thus benefitting the system" (p.4). In Tanzania, most of the government-run hospitals are mother-baby-friendly, but this has nothing to do with supporting the workers of these hospitals. This is confirmed by just going through the questions on the Mother-Friendly Workplace Assessment Form by WABA (1992). (See Appendix G.) The form assesses the knowledge which managers have regarding breast-feeding. It also assesses policies and services that managers offer to employees which might enhance the process of breast-feeding at the workplace.

Some nurse-midwives gave misleading messages to mothers regarding breast-feeding. The false messages could be due partly to lack of breast-feeding knowledge or as a projection of maltreatment the midwives received from the system as breast-feeding mothers. On the other hand, nurse-midwives might be comfortable and knowledgeable with the intimacy of exclusive breast-feeding, but may not convince mothers to breast-feed exclusively if the nurse-midwives work with private hospitals, because private hospitals believe in profit making. In addition, the private hospitals are the weak points for baby formula companies who provide gifts of all kinds for these companies to sell their products in the hospitals. Whatever the situation, the nurses and the mothers have to speak up until they are heard.

The majority of Tanzanian working women like to attend antenatal clinics together with other women who do not work outside their homes. It would be helpful if working women could be given extra visits just for themselves so that together with nurses they could explore ways of lifting off their shoulders the burden of combining working outside the home and exclusive breast-feeding.

The nurses at the clinic could invite some breast-feeding consultants to run these particular sessions. The breast-feeding consultant or lactation manager might bring up some options which the nurses and mothers might not be aware of. Experienced mothers could also be invited into the discussions. Mothers who were professional teachers, for example, had a better experience in breast-feeding than mothers in other professions, because they went to the school only when they had classes to teach. All class preparations were done at home instead of at the office. This could be shared as one of the options, in that a mother could arrange her work in such a way that she could work at home. In industrialized countries where the technology is high, electronic mail, home computers, modems, and fax machines make home offices options for many parents (Riordan & Auerbach, 1993). This technology is still in its infancy in Tanzania.

Post-natal care. Nurse-midwives in Tanzania provide continuous care to women, from pregnancy through child birth. There is, however, no follow-up after delivery. It is like working hard for something interesting and looking forward to the product, but once the product is seen the interest is lost. This attitude is common in the whole Tanzanian society. Usually the family and the health workers are tense during pregnancy, but once

the baby is born everyone relaxes and forgets about it, leaving the mother to deal alone with the processes of breast-feeding and infant care.

In fact, there are no established postpartum clinics specific for mothers. Instead, mothers are told to attend the under-5 clinics which are specifically meant for immunizing and weighing babies. Most of the infants are for the first time brought to the clinic at the age of 2 months. Obviously a mother will be uncomfortable to come to the clinic with a young and small infant while other infants are bigger. Consequently, mothers in their first few days of postpartum have nowhere to turn for personal postpartum problems other than going to the general gynaecological clinics. Thus, when faced with breast-feeding problems, mothers become confused, not knowing whether they should go to the MCH clinics or to gynaecological clinics to obtain professional help. In the midst of the confusion most of the time they decide to live with the problem. This study suggests and emphasizes that nurse-midwives should not leave new mothers to go through all these hurdles and contradictions alone.

As nurses work with employed new mothers, it must not be forgotten that the mothers have other roles which are equally pressing. These roles are the household and financial welfare of their families. The mothers will benefit if they are given opportunities to learn how to organize their time for the best outcome in a more comfortable way and to be allowed to give up their mother's projects to the man of the household.

Sharing of breast-feeding experiences among mothers. Recognizing that there is no one way to accomplish breast-feeding goals, one will find that sharing of experiences is the best method of learning. These are the principles of adult learning. For example, some

women may have a quick way of expressing milk while others may not need to express because they have other ways of reaching their infants during the working time. When mothers choose to express or pump their milk, for better success they may want to express once or twice during the day, a month before they return to work. This milk could be put in small, clean, and sterilize containers, enough for one feed at a time, and stored in the freezing chambers of their refrigerators at home. If they have freezers, the milk could be stored in it so that when the mother starts working outside the home the baby is fed milk from a cup and using a spoon after thawing and warming the milk, until the mother comes home again.

The working, breast-feeding mothers, who for some reasons do not want to express or pump their milk for the purpose of feeding their infants, may need to know that expressing milk may not be for feeding the baby only. Sometime they may require to express milk to avoid discomfort from full breasts and embarrassment caused by leaking/dribbling milk while they are working. Additionally, the act of expressing milk, even if the milk has to be thrown down the sink, maintains the feedback mechanism in which more milk is manufactured to replace the milk that was removed from the breasts. This way the mother will maintain flow of milk enough for the baby as she/he grows. The milk supply will decrease if it remains stagnant in the breast. The feedback mechanism can be reinforcing to mothers because people want to know what is going on in their bodies.

Some mothers, especially primiparas women, may be bewildered, not knowing what they could do to breast-feed exclusively and work outside the home at the same time. It is wise for women to share their different approaches. From the sharing of

experiences some women may, in addition to obtaining new skills, learn how to negotiate with their employers to get a few days off their work schedules or whatever will work for the mothers. Establishment and maintenance of good relationship between mothers, colleagues, and managers at their workplace could be influential in the success of negotiations. Changes of shifts between colleagues especially for breast-feeding nurses to suit their breast-feeding needs could work if relationships are good.

Recognition of babies' change of behaviour to suit their mothers' schedule. Mothers could benefit, also, if they are made to understand that babies of working mothers suckle a great deal more during the night than during the daytime. These babies learn about what is going on with their most significant person around them (mothers). A baby might decide to sleep most of the daytime because he/she realizes that the mother is not home. When the mother comes home, the baby starts off the suckling to get most of the best food and also the love from the mother. She/he may suckle for the whole night.

Many mothers complain about their infants' change of sleep patterns. It is a relief for a mother to realize that her infant is trying to compensate for the time he/she did not see her. The mother will definitely receive this unconditional love from her infant and continue the endurance. Probably infants are the only individuals who care and become really concerned about what is going on with the mother to the extent of physically changing their lifestyles.

Mothers might think that there is something wrong with the baby. One woman who belonged to a breast-feeding support network in Halifax, Canada (I was in attendance), told other mothers in the group how she had to send her baby to a doctor

because the baby was not sleeping in the night. Instead, he would suckle throughout the night. The woman was a single parent on social welfare and breast-feeding exclusively. The doctor, by sympathising with the mother, advised her to give some juice to top up the breast-milk. He thought that the baby was not getting enough milk. The woman who had planned to breast-feed exclusively for 6 months, because she had confidence in the doctor, reported giving her 2-month-old infant some apple juice to give herself a break. The baby liked the juice. Her milk flow had started to decrease because the baby was no longer emptying the breast frequently enough for the mother to continue manufacturing milk enough for the baby as he grew up. It was sad acknowledging that the woman was made to discard her best and cheapest way of feeding her baby for a problem that could be worked out by a person who knew what she/he was doing.

Physicians need more breast-feeding information to enable them to provide effective support to mothers. The need for physicians to have more breast-feeding information did not surprise the other women and the lactation manager in the network, because not many health professionals are knowledgeable about the whole issue of exclusive breast-feeding. It has been observed elsewhere that physician support increased breast-feeding rates (Freed et al., 1995). Anecdote reports from the Freed and coauthors' study, however, suggested that physicians are ill prepared for their roles in breast-feeding support, which causes them to make common errors such as inappropriate recommendations for breast-feeding termination or formula supplementation, a proven cause of failure in exclusive breast-feeding.

The network's response toward the doctor who advised the breast-feeding woman to give juice was to write a letter to the medical association asking to include some articles regarding exclusive breast-feeding in their newsletter which circulates to physicians. This was highly appreciated by the association.

Breast-feeding network in Tanzania. A breast-feeding support network could be established in Tanzania where working mothers could meet on a regular basis to discuss their successes and failures on combining exclusive breast-feeding and working outside the home. The meetings will require a nurse-midwife or a lactation manager to facilitate the discussions. It may not require any additional expenses other than the breast-feeding women's time. These networks could be organized in such a way that mothers come from neighbouring work places to meet at one point.

On-site daycare centers. The networks could propose ways of getting their babies near the mothers when they are working. Establishing on-site daycare in which the working mothers may need just a few moments off their desk to breast-feed their infants could be proposed. This may appear very complicated for the Tanzanian situation and indeed expensive, but if it is planned by the people in need, the chances of the centres working are high. What they will require is a place and the babysitters could come to the centre with the babies rather than babysitting at home. The opportunity which the mother would get from the on-site daycare services would be relaxing moments to her, thus causing her to be more productive at work and at home. For a baby to see his/her mother frequently is excellent for his/her development. The whole exercise would be beneficial to the family, workplace, and society as a whole.

On-site daycare centres would help the mother to get some sleep during the night. The baby would realize that there is no need to play the game of sleeping during the day, to have her/his mother all night. Sleepless nights can cause severe fatigue to a breast-feeding mother who, in addition, works outside the home, has other responsibilities, such as ensuring that her income-generating projects are viable, that the household is intact and that the house is meticulously clean.

Nurses could survey work places to determine what is available to facilitate on-site daycare centres if that is what the mothers require. Discussions with employers on the advantages of breast-feeding to them, and not necessarily to mothers only, may help the employers to value the breast-feeding task. Some employers may prove to be difficult. The nurses should not give up. Instead, they could use the media to convince society of the importance of providing support to breast-feeding women. This is to make sure that the mothers are not left to live with the hurdles and the contradictions of combining exclusive breast-feeding and working outside the home on their own. Nurses, the majority being women, have to help fellow women to be heard. The women have to tell everybody about the burden they have to carry on behalf of the whole society and demand support.

Facilities for breast-feeding at work places. Katcher and Lanese (1985) suggested that when hospitals provided facilities for breast-feeding and employed mothers in New Jersey hospitals, in the United States, these mothers were able to combine breast-feeding and work outside the home successfully. The authors found that the hospital provided a 3-month paid maternity leave and, on return to work, enough time was given for expression

of breast milk. A refrigerator was supplied for storing the breast milk and a breast-feeding consultant was available for advice.

Many work places in Tanzania can afford refrigerators to store milk, but the difficulty is with the attitudes of the employers. Hospital administrators, for example, may fire employees who forget to keep a refrigerator for vaccines closed. I am not disregarding the importance of vaccines, but these administrators fail to realize that breast milk is the best and creates immunity for the baby against many diseases, contrary to a vaccine which would be specific to one illness. This attitude has a great deal to do with the influence received from drug companies. To reverse this attitude, it will require a great deal of effort by women in telling the society about what they are going through. It is the woman, for example, who because she trusts her health professionals, makes long lines for vaccines, not knowing they are carrying the best vaccine in her breast milk.

The breast-feeding woman and formula/ feeding bottle companies. Nurses-midwives should help women to recognize that they could be manipulated by companies to discard their breast-feeding practice. Drug and baby food companies realize those breast-feeding women are their greatest competitors in the world feeding bottles and baby food markets. Companies, especially foreign ones from industrialized countries, recognize that breast-feeding decreases the developing countries' foreign exchange spent on breast milk substitutes and feeding bottles and the importation of drugs. Bottle-fed infants have a higher risk of being hospitalized for infection and malnutrition than their counterparts. Companies realize that exclusive breast-feeding women may not require contraceptive pills

for the first 6 months or more postpartum. In short, exclusive breast-feeding is a big threat to baby food and pharmaceutical companies' markets.

The companies recognize that in this competition the breast-feeding women are obviously winners since their baby food and vaccine are the best. To ensure those breast-feeding women lose their confidence in breast-feeding and consequently lose in the competition, these companies use health professionals whom the women trust for anything to do with health. These health professionals unknowingly or knowingly, but under the influence of baby food and drug companies, highly promote vaccines and baby formulas and indirectly discourage women from breast-feeding. That way, baby food and drug companies continue to boom at the expense of infants' health and development. In fact, working women are the targets for these companies because of their dilemma in combining employment and breast-feeding. In addition, even though they have shaky incomes, they are more likely to buy baby products than the unemployed women who stay with their infants at home.

Societal/cultural changes are necessary for successful breast-feeding. The working women were also dealing with the obstacles related to cultural norms on breast-feeding and society's view on gender roles. The solutions to problems of combining exclusive breast-feeding and work outside the home cannot be solved by mothers alone. Instead, society must offer economic and political support to the women and assist with childcare; daycare is one tangible support. Similar advocacy is presented by Olin et al. (1994) that if we are committed to the health and development of children, we need to recognize that

the vast majority of the world's women are working women. There is, therefore, a need for daycare advocacy and/or enough maternity leave.

The authors continued that when a mother returns to work, the standard of the International Labour Organization (ILO) should be applied, namely "... the care of children while parents are working cannot be ignored because it forms a focal point in which three main concerns of development policy -- work, health, and education -- converge" (Olin et al., 1994, p. 1085). It is not expected that Tanzanian society would operate differently from international childcare standards because we belong together.

Strategies for where the women could be heard. If society and employers are unaware of the burden these women have to carry, health professionals could increase public awareness of the advantages of combining exclusive breast-feeding and employment, for infants, mothers, families, and society as a whole. Strategies for where women themselves could be heard include women's discussion in groups in the community, run by nurse-midwives, and also situations where they could have a wider voice, for example, women's health column in a newspaper. It is unlikely that Tanzanian women could succeed in combining exclusive breast-feeding and work outside the home in the current situation. Van Esterik (1996) stressed, "The relationship between women's productive and reproductive work is more than a scheduling problem -- a matter of balancing mother-work and other-work" (p. 2).

Summary of What the Tanzanian Society Can Offer to Support Mothers in Combining Exclusive Breast-feeding and Employment Successfully

* Increase paid maternity leave until the infant is 4 months old. This is particularly possible if policy makers are convinced that breast-feeding is beneficial to the society.
* Provide flexible environment at the workplace for breast-feeding women when the need arises. Administrators could, for example, arrange for transport for a mother to go home to breast-feed during break hours if possible, or provide long breast-feeding breaks of about 2 hours per day, or arrange for job sharing in which another employee could work for the breast-feeding woman if she has to go to breast-feed.
* Provide on-site childcare services at the workplace. Neighbourhood work places could share one centre. A small affordable fee could be asked from the mothers for safe/hygienic and caring of the centres.
* Arrange for private rooms at the workplace where mothers could express or pump breast milk or sit breast-feeding if infants are around. Pumps could be available for the women to purchase at an affordable price for those who wish to pump. A refrigerator is a necessity for milk storage. The mothers will have to bring their own containers.
* Ensure that the breast-feeding rooms are clean and safe from contaminations which might cause infections to babies through contaminated milk. Mothers could be encouraged to clean up after themselves.

* Provide information to all women at the workplace of what is available to support them in the process of combining breast-feeding and working. This is usually overlooked, in that, where there are thousands of workers, some of them may not know what is available for them or their rights. For example, not all Tanzanian working mothers know about the two half-hour-breast-feeding-breaks, even though these breaks are useless because of the long distance between the women's homes and work places, coupled with lack of reliable transport.
* Establish a breast-feeding support network at the workplace in which mothers who combine breast-feeding and work outside the home could meet on a regular basis. They could meet once a week. This is mandatory because in such meetings the women will care, encourage, empower, and learn from each other through sharing of experiences. In these networks, mothers could also plan and implement proposals about how to obtain support they need from their workplace and society. A nurse-midwife who is supportive, interested, ready, and knowledgeable about combining breast-feeding and working outside the home will be eligible to facilitate the meetings.
* Make the public become aware of the breast-feeding resources in flyers that could be offered to women during the antenatal period or on discharge from the labour ward.
* Ensure that the breast-feeding week which is celebrated annually is known by everybody, and the public should acknowledge the contribution that women make to the society through breast-feeding.

* Nurse-midwives should establish breast-feeding information binders at places of work. The information should include all support resources available to breast-feeding women and their right to utilize these resources such as:

  - whom to contact in case they are denied their rights. Some immediate supervisors have denied women their rights to utilize the two half-hour breast-feeding-breaks for women who could make use of these short breaks because they lived near the workplace. These supervisors had the excuses that these breaks should be used when it is convenient and not otherwise (personal observation). The women, because they do not have a written document in hand at the moment, usually give up asking for permission.

  - the person who facilitates the breast-feeding support network if established, as their contact. The meeting schedule should also be included.

  - rooms where the mothers could breast-feed, express or store the milk.

  - the location of the on-site daycare centre if established and what is involved in running it.

* Stickers with loud colours alerting workers to read the binders should be posted on bulletin boards. The other alternative is to make pamphlets which could be distributed to mothers and relevant offices.

Nurses in hospitals and in communities have the mandate to utilize whatever is available even if is just word of mouth, to support women who are determined to do what is best for babies who are the future of the nation. The fact is, nurses understand the

women more than any other profession in the system. Nurses could help new fathers to assist their wives in the accomplishment of combining breast-feeding and work outside the home.

The majority of fathers, as mentioned earlier, have no idea of what is going on with their wives during pregnancy, delivery, or breast-feeding. These process are called women's issues. Traditionally or "culturally," Tanzanian fathers do not accompany their wives to antenatal clinics or stay with wives during labour and delivery as do their counterparts in industrialized countries. They are, however, not strictly to be blamed. It is the system which does not provide privacy to women when they are delivering babies. Thus, if men were present in the labour rooms, they would be embarrassed or would embarrass other women delivering openly, next to their wives.

Nurse-midwives could advocate women's privacy during delivery so that fathers are comfortable in attending to deliveries. Such experiences may cause men to appreciate what happens to their wives during the process of labour and delivery, hoping that they will offer more support during postpartum and breast-feeding. Husbands are also employers, policy makers, and part of society. A great deal of social support could, therefore, flow to women who combine exclusive breast-feeding and work outside the home if the process is supported and advocated by husbands.

## Conclusion

The theory of living with the hurdles and contradictions, which was generated in this study, provided a detailed description of experiences of Tanzanian women who combined exclusive breast-feeding and worked outside the home. The factors that the

women described as being hurdles and contradictions to combining exclusive breast-feeding were interactively within the women, workplace, and society at large. The descriptions given in this study, being personal experience, indicated that the problem existed in society and required intervention from the larger society.

The theory, however, could be tested through a survey that could cover a large number of working women who combine exclusive breast-feeding and employment. The results may be linked with and used in breast-feeding promotion support and protection programmes and in political settings. Additionally, the results from this study have important implications for nursing and midwifery education and practice. There is much to gain when women are provided with support to breast-feed exclusively, in that they become more confident, increase their self-esteem, and are able to provide quality care for their infants.

Breast-feeding strengthens the mother-child bonding relationship which persists all the days of their lives (fathers may not like such a bonding, but it is a fact). This is particularly important for women whose work separates them from their infants. Additionally, women who have breast-fed are less likely to develop ovarian and breast cancers than those who do not breast-feed. This is an additional reinforcement to nurses who are population health promoters.

Nurse-midwives, together with working women, have a responsibility to push society until they get the support they need, which includes affordable infant care centres, rooms to breast-feed or express/pump, flexible work-schedules and/or longer maternity leaves at the workplace. Considering that the women have additional responsibilities such

as generating extra income for their families, living with the hurdles and the contradictions of combining exclusive breast-feeding and working outside the home is a significant problem. Thus, a government policy to protect these women is a priority.

Finally, it is my desire to become an advocate for these mothers. If I can educate them to educate others, as a collective we can become a powerful force to bring about change. This is the essence of feminist research.