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HEALTH INFORMATION, EXCLUSIVE BREASTFEEDING AND CAREER-ORIENTED LACTATING MOTHERS: AN ASSESSMENT OF ORGANISATIONAL SENSITIVITY TO BREASTFEEDING-FRIENDLY WORKPLACES IN A DEVELOPING COUNTRY

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Abstract

This study investigated the extent career-oriented mothers in Anambra State are enabled to practise exclusive breastfeeding by their organisations. The objectives of the study were to discover the extent the career-oriented ladies are informed about exclusive breastfeeding; the extent they practise it; the extent of sensitivity of their organisations to breastfeeding-friendly workplace; and whether there is significant difference in attitude to breastfeeding-friendly workplace between government and private organizations in Anambra State. The study was designed as a survey. The population of study was married working women within the childbearing ages in Anambra State. A sample of 400 was selected and questionnaire was used in collecting data. Findings showed as follows:That career-oriented mothers in Awka are well informed about exclusive breastfeeding; That practice of exclusive breastfeeding is, however, very rare among the career-oriented mothers;That organisations in Anambra State have largely failed to show sensitivity to exclusive breastfeeding; and, that there is no significant difference in attitude to breastfeeding-friendly workplace between government and private organisations in Anambra State.

Keywords: Exclusive breastfeeding, Career-oriented lactating mothers, Breastfeeding-friendly workplaces, Developing country

INTRODUCTION

Breastfeeding is beneficial to the health of both women and infants. Women who breastfeed have longer intervals between births and, as a result, a lower risk of maternal morbidity and mortality, as well as lower rates of breast cancer rates before menopause.

Breastfeeding has been the natural and normal means of feeding infants. In fact, it is one of the defining characteristic of being a mammal. The importance of breastfeeding before civilization was so pronounced that, wet nurses were contracted for infants of the wealthy and royal families who were not able to lactate successfully (Wickies, 1953). Wet nursing has been in continual existence from earliest times although its popularity has been inconsistent. In England and Europe in the fifteenth and sixteenth centuries, the middle class began employing wet nurses, a luxury formerly afforded only to the elite. By the latter part of the 1700s wet nursing was on the decline in North America and England, largely due to increased public concern regarding the moral character of wet nurses and the care they provided. (Golden, 1996)

Before the last few hundred years, alternatives to breastfeeding were rare. Attempts in 15th century Europe to use cow or goat's milk were not very positive. In the 18th century, flour or cereal mixed with broth was introduced as substitutes for breastfeeding, but this did not have any favourable outcome, either. True commercial infant formula appeared on the market in the mid-19th century but their use did not become wide spread until after World War II. This was the period when the working pattern of women was rapidly changing; a resultant effect of the industrialization process. This was the beginning of artificial feeding of infants (Wickes, 1953). As the superior qualities of breast-milk became better established in medical literature, breastfeeding rates have increased and countries have enacted measures to protect the rights of infants and mothers to breastfeed.

Exclusive breastfeeding of babies especially from birth to at least six (6) months is recommended in the primary health care services provided in the healthcare sector in Nigeria and the world over. A very important aspect of the primary health care system is the education of women and the general public about the importance of exclusive breastfeeding that is, feeding babies with breast milk only till they are at least six (6) months old. This education includes providing information on the components of breast milk and its nutritional benefits to the babies as well as their mothers. The reaction of the public to the introduction of exclusive breastfeeding is mixed depending on the social status of people.

Breastfeeding is an ultimate bio-cultural phenomenon; in humans, breastfeeding is not only a biological process but also a culturally determined behaviour (Stuart-Macadam and Dettwyler, 1995: pp.5-6). In Nigeria, about 97 per cent of children begin breastfeeding from birth and continue to four (4) months (National Demographic and Health Survey, 1990). By 12 months, the proportion of children exclusively breastfed is higher in Uganda than in Nigeria. Ugandan children less than six (6) months of age, approximately 57 percent are exclusively breastfed compared to approximately 1 percent of Nigerian children. (World Health Organisation, 1996).

The benefits of exclusive breastfeeding are numerous. Breastfeeding, a primary means of promoting and supporting good nutrition in developing countries, is universally high in Nigeria; however, exclusive breastfeeding during the first 6 months of life as recommended by the World Health Organisation (WHO) is far less common. According to the National Demographic and Health Survey (NDHS) 1990, only 38 percent of women in Nigeria initiated breastfeeding within the first hour of delivery and less than one-fifth (17 per cent) of infants under 6 months of age are exclusively breastfed.

Breastfeeding protects against diarrhea, pneumonia and malnutrition – the leading cause of child deaths worldwide. But despite all the benefits, only 35 percent of babies worldwide are exclusively breastfed. Lack of information, social barriers and unsupportive work arrangements are among the reasons women do not breastfeed.

In the early years of human species, breastfeeding was common as it was for other mammals feeding their young. There were no alternative foods for the infants and the mother along with other lactating females had no choice but to breast feed the children (Fray and Kathy, 2005).
The Egyptian, Greek and Roman empires saw women feeding only their own children but later, the royalty considered breastfeeding as something to be done by the lower cadre of the society as such wet nurses were employed to breastfeed their children.

In the late 15th century formula feeding first became popular as such many mothers substituted cow or goat milk for their own breast milk which was helpful especially to working mothers who did not have the time to breastfeed their child. This practice was later stopped when the problems associated with formula milk became noticeable.

A study by Penny (2001) revealed that in the early 1900s babies were breastfed quite alright but at the same time solid food were offered as early as the first week of life. This practice, according to him, was because of the popular belief at the time that solid food would not only improve infant's nutrition but would also help babies sleep through the night sooner.

According to the same author change was in place in the late 1900s. Breast feeding was becoming increasingly popular, partly because it reflected the "back to nature" movement of the time and partly because it was discovered to have unrecognized emotional and health benefits for baby and mother. Breastfeeding is the first step in life which ensures that infants and young children get a healthy and nutritious start in life.

It is one of the few consistent sources of energy-dense food, even into the second year of life. Exclusive Breastfeeding for 6 months is the optimal way of feeding infants. Therefore, infants should receive complementary foods with continued breastfeeding up to 2 years or beyond 5 Exclusive breastfeeding refers to the feeding of the infant with only breast milk, without any additional food or drink, not even water.

Breastfeeding exclusively for 6 months is not a common practice in developed countries and appears to be rarer still in developing countries. A limitation to the

uniform recommendation of exclusive breastfeeding for the first 6 months of life is the lack of understanding of reasons for marked attrition rates in exclusive breastfeeding, even among the highly motivated women, in the lactation period of interest.

Steps to Successful Breastfeeding

1. Every facility providing material service about care for newborn infants should:

2. Have a written breastfeeding policy that is routinely communicated to all health care staff.

3. Train all healthcare staff in skills necessary to implement this policy.

4. Inform all pregnant women about the benefits and management of breastfeeding.

5. Help mothers initiate breastfeeding within a half hour of birth.

6. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants.
7. Give newborn infants no food or drink other than breast milk unless medically indicated.
   Practice rooming-in: allow mothers and infants to remain together--24 hours a day.
   Encourage breastfeeding on demand.
8. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

STATEMENT OF THE PROBLEM

Returning to work is the most cited problem for discontinuing breastfeeding. Maternity leave in Nigeria varies widely despite the family medical leave Act (FMLA), which provides most working mothers up to 12 weeks.

In recent years there has been a rise in the participation rate of women in employment. Some may become pregnant while in employment and subsequently deliver their babies. Some may decide to return early to work after giving birth for various reasons. Unless these mothers get support from their employers and fellow employees, they might give up breastfeeding when they return to work. As a result, the duration and exclusivity of the breastfeeding recommended age of the babies would be affected. Workplace environment can play a positive or negative role to promote breastfeeding.

The financial incentive in providing a workplace breastfeeding program can also be considerable:

- Women who continue to breastfeed after returning to work are absent less often due to baby-related illnesses and they have shorter absences when they do miss work, compared with women who do not breastfeed.

- Working mothers who continue nursing after returning to work have higher morale and tend to return to work earlier from maternity leave.

- $13 billion in direct health care costs could be saved each year if 90 percent of women would breastfeed exclusively for six months.

Employers who support workplace breastfeeding see lower turnover rates, enhanced employer-of-choice status, and an advantage in the competition for talent and benefit from valuable public relations opportunities. Notwithstanding home and support networks, nursing mothers struggle with the difficulty of combining breastfeeding with employment or work. Having to express milk in a toilet stall is a barrier to continued breastfeeding after a return to work and can lead to premature weaning.

This study therefore sought to assess current lactation accommodations in a workplace environment and to examine the association between the different dimensions of support and the duration of exclusive breastfeeding. It also, sought to ascertain which of the organizations in Anambra state are breastfeeding-friendly to their lactating mothers.

Against this backdrop, the study sought answers to the following research questions:

1. How much are career-oriented mothers in Anambra State informed about exclusive breastfeeding?

2. To what extent do career-oriented mothers in Anambra State actually practise exclusive breastfeeding?

3. To what extent do organisations in Anambra State allow their lactating workers opportunity for exclusive breastfeeding?

4. Is there significant difference in attitude to exclusive breastfeeding between government and private organisations in Anambra State?

KNOWLEDGE, ATTITUDE AND PRACTICE OF EXCLUSIVE BREASTFEEDING

According to a research carried out in Keffi Local government Hospital (Nassarawa, Nigeria), there was a general lack of awareness of some major recommended practices in the hospitals that will promote and sustain breastfeeding. There is therefore, the need for policy changes and BFHI training for the staff of these health facilities to respond to the concern and growing need for proper infant/ young child feeding.

From the study, only 20.8% of the health workers were aware of the need to initiate breastfeeding, within 30 minutes of birth. Also, a low proportion (36.8%) was aware of the existence and duties of breastfeeding support groups. These 2 practices in the hospital have been shown to enhance initiation and maintenance of breastfeeding.

From a study done on working class mothers in Enugu metropolis, Nigeria, 91% of the subjects knew that breast milk was ideal for their baby, while 8.5% felt that infant formula was best and 0.5% considered others namely pap as ideal. These indicate a high level of awareness among mothers, of exclusive breastfeeding and the importance of breastfeeding.

The question now is; do they put what they know or have learnt into practice? From the study on working class mothers in Enugu, despite the high level of awareness of breastfeeding, only 15.5% of the mothers actually practiced exclusive breastfeeding.

The research in Keffi local government hospital, revealed that only 5.2% of the healthy workers interviewed were able to demonstrate correct positioning of the baby for breastfeeding and only 19.2% believed that babies less than 6 months of age should not be given water.

From the foregoing, it is evident that despite the high level of awareness of exclusive breastfeeding and breastfeeding in general, very few put it into practice. It becomes necessary to try to find out why this is so.

ATTITUDES AND FACTORS AFFECTING THE PRACTICES OF EXCLUSIVE BREASTFEEDING

Most of the working class women in Enugu who don't practice exclusive breastfeeding put the blame on constraints from work while others blamed cultural practices. Tradition and career were the strongest factors affecting the attitude of the mothers in Enugu towards exclusive breast feeding.

Women with higher education and higher income were less likely to breastfeed. Similarly, employed mothers, mothers with lower numbers of children and those who delivered by caesarean section were less likely to fully breastfeed. It is also important to note that independent of maternal socioeconomic, demographic and biomedical characteristics, maternal pregnancy overweight and obesity have been identified as factors that reduce the duration of breastfeeding. It is therefore the intention of this research to assess the knowledge, attitudes and practices of exclusive breastfeeding among nursing mothers in Enugu Urban and to find out the factors that influence these.

EXCLUSIVE BREASTFEEDING

Exclusive Breastfeeding according to World Health Organization (WHO, 2008) is the practice of feeding an infant only with breast milk (including expressed breast milk) and allowing the baby to receive vitamins, mineral supplement or

medicine with the exception of other liquids and solid food. That is exclusive breastfeeding means that no water, milk or solid food should be offered to the baby.

Exclusive breastfeeding is now a widely accepted from of nutrition for infants to ensure a good start of life. (www.healtcare.a2z.org) . This is because breast milk provides all the nutrients a baby needs for the first six months of life.

The World Health Organization 2008 also states that only breast milk is the best possible food or drink for a baby and that no other food or drink is needed for the first six months of life.

BREAST MILK

The human breast milk is produced by the mammary glands. The breast milk is an alkaline fluid, bluish white in colour, with a specific gravity of 1031. The breast milk is produced by the action of Oxytocin and prolactin which is stimulated by sucking reflexes.

Types of Breast Milk Colostrum: This is the milk produced in first few days after delivery, it is thick and yellowish in colour. It contains more protein, more antibodies more white blood and anti-infective proteins than mature milk. (Azubuike et al., 2007).

Transitional milk: It is milk with a yellowish tint higher in fat and calories and lower in protein. (Penny, 2001).

Mature Milk: Is produced usually by the end of the first week of breast feeding. It is bluish white and contains more calories.
There are two types milk that are produced when a baby is feeding. They are:

Fore milk: It is a greyish milk that is produced early in a feed, it is produced in large amount and contains more water.

Hind Milk: It is yellowish in colour that is produced at end the feed and contains more fat for satiety. (Azubuike et al., 2007).

Components of Breast Milk
The components of breast milk include;
Water: Is the largest constituent of breast milk (about 87.6%).
Fats: accounts for about half of the calories in breast milk that 50%.
Carbohydrates: Lactose (Milk sugar) is the primary form of carbohydrate in breast milk. Breast contain 5.3% of carbohydrate.
Proteins: The primary protein is whey and it is 40% in breast milk.
Vitamins and Minerals: Examples include vitamin D, Iron, fluoride etc breast milk contain about 10.1% of vitamins and more minerals.
Other component includes; Antibodies, enzymes, growth factor and hormones. (Azubuike et al., 2007).

BREASTFEEDING AND MATERNAL EMPLOYMENT

From an economic perspective, the negative relationship between breastfeeding and maternal employment is the result of the fact that breastfeeding is an activity which is intensive in maternal time and therefore in direct competition with other uses of it, including market work. This implies that the opportunity cost of breastfeeding can be measured in terms of the costs of absence from work. Within a standard neoclassical framework, the optimal amount of breastfeeding will be chosen so that its marginal benefit equals its marginal cost. As it is assumed (perhaps incorrectly) that the marginal benefits of breastfeeding diminish over time, while the marginal costs of not working increase over time, there is a simple theoretical justification for the observed negative relationship between the duration of breastfeeding and the duration of maternity leave. If, in addition to this, it is also assumed that breastfeeding entails some fixed-costs, such as the costs of purchasing special clothes, attending classes, and psychological adjustments (Chatterji and Frick 2005), then a negative relationship between maternal labour supply and breastfeeding initiation might also arise.

Work and Breastfeeding

Employment of mothers outside the home, especially full-time employment, has a negative influence on duration of breastfeeding. (Employment appears to have a less deleterious effect on initiation of breastfeeding.) Among mothers of infants in their first year, 35.5% work full time and 16.1% work part time outside the home; for mothers of children aged 12 to 24 months, the rates are 40% and 17%, respectively. Therefore, improving the ability of mothers to breastfeed or to express and store milk in the workplace would likely contribute to higher Nigerian breastfeeding rates.

Why work outside the home shortens breastfeeding duration is not completely clear, but factors related to the time surrounding return to work appear critical. One study of women at high risk for not breastfeeding found that those who made plans to return to full-time work during the month before actually doing so had 1.34 times the odds of terminating breastfeeding as mothers who, during the same month, did not plan to return to work. In the month she returns to work, a mother has 2.18 times the odds of quitting breastfeeding as do her non-working counterparts, in the first month after she starts work, her odds of terminating breastfeeding are 1.32 times that of her nonworking counterparts.

However in the second month after returning to work her odds of terminating breastfeeding do not differ significantly from those of a woman not working in the same month postpartum. Thus, if employment conditions encourage women to initiate and continue breastfeeding through the first 2 months of work, they may be more likely to extend breastfeeding duration as recommended through at least the first year.

Women frequently attribute early weaning to unsupportive work environments. Lack of privacy and adequate time to express breast milk are cited as barriers. Other impediments include employers' perception that the presence of infants in the workplace reduces mothers' productivity, regulations and other rules that bar children from the workplace, and a lack of child care close to the workplace.

Fein et al. compared strategies women use to continue breastfeeding while working and found that breastfeeding an infant directly during working hours was associated with the longest duration, and pumping milk during working hours was the second most successful strategy; neither breastfeeding nor pumping during work hours was associated with the shortest duration.

Women's experience of workplace-related barriers to breastfeeding varies by occupation. Professional women have significantly greater success in breastfeeding than do women in such occupations as retail sales, administrative support, and construction trades. Professional women typically have more autonomy, enabling greater privacy to breastfeed and greater freedom to accommodate the timing demands of lactation. They also may have greater access to employer-sponsored lactation programs than do nonprofessional women, even in the same company. Another study found that women in food and health service occupations did not differ greatly in breastfeeding from professional women; these women likely had flexibility in arranging their work schedules.

Attempts to encourage breastfeeding in the workplace sort into 3 types: employers' voluntary initiatives, support services offered by non-profit and other private entities, and government encouragement and requirements. Evidence suggests employers may reap net economic benefits by enabling women to combine work with breastfeeding. The US Department of Health and Human Services' Business Case for Breastfeeding reports that in addition to improving retention of experienced employees, breastfeeding leads to lower health care spending, decreased absenteeism, increased productivity, improved morale, and positive company image. A study of a corporate lactation program voluntarily offered by 5 employers found it successful in enabling women to express milk in the workplace. These corporations felt offering a lactation benefit was important as a recruitment tool and in retaining female employees. Although such approaches can help, the persistence of low US breastfeeding rates calls for active exploration of additional approaches, including supportive laws that can reach a broader class of employees than do voluntary efforts.

BENEFITS OF BREASTFEEDING

According to La Leche League International, mothers may also reap the benefits of breast-feeding, such as a decreased risk of breast and ovarian cancers, better iron profiles from less menstrual blood loss, and a potentially lower risk of developing osteoporosis later in life. Mothers who breast-feed also have a faster recovery postpartum and may return to their pre-pregnancy weight sooner than women who bottle-feed.

The health benefits for both mother and baby play an important role in women’s attendance at work. Breast-feeding employees may require fewer sick days and days off to care for an ill child. Most full-time working mothers require some form of child care while they are away from home, and several choose day care facilities, where exposure to germs and illness is high. Breast-fed infants benefit from the antibodies present in breast milk and may be less susceptible to catching germs from other children in a day care setting.

Because most women are at least somewhat familiar with the health benefits of breast-feeding, the initiation rates have increased over the past 20 years. However, the rates of exclusive nursing have not changed, and mixed feedings (formula and breast milk) have increased, with factors such as insufficient family and societal support, maternal employment outside of the home, and improper interruption of breast-feeding among the reasons.

The benefits of breastfeeding are both to the baby, mother, family and community. Azubuike, (2007). States that breast milk is beneficial for the baby because it contains just right balance of nutrients, it is readily available, it provide antibodies that help to boost the baby immunity against infection, it is easily digested, enhances the development of brains, reduces the incidences of some chronic conditions that may occur late in life, like ulcerative colitis, Crohn's disease and aid proper developments of both teeth and speech organs.

Additionally, breastfeeding reduces the incidence and severity of diseases and infections such as ear infection, respiratory infection, urinary tracts infection. It also reduces symptoms such as diarrhea and vomiting (Penny, 2001).

For the mother, Penny, (2001) believes that breastfeeding helps child spacing, saves time, help the mother return to her previous weight as the fat accumulated during pregnancy is used in milk production and it frequency delays the return of menstruation. It aids involution (the return of uterus to its normal size), reduces postpartum bleeding and reduces the risk pre-menopausal breast cancer and ovarian cancer. It also promotes attachment and a close, nurturing relationship between mother and baby.

For the family and community, Azubuike (2007) states breastfeeding is less expensive and more convenient, it saves family and national resources, it is safe for the environment that is no litters in terms of cans and other wastes.

WORK AND INFANT FEEDING

Notwithstanding home and support networks, nursing mothers struggle with the difficulty of combining infant feeding with employment or work. Socialist feminism emphasizes how the social system of capitalist patriarchy limits options available to women economically and politically (Abramovitz, 1988). Breastfeeding among infants is a time-consuming behaviour characteristic of the domestic arena. The primary empirical finding concerning working mothers and breastfeeding is that the intention to return to a job does not hinder initiation of breastfeeding but does hinder duration of breastfeeding (Auerbach & Guss, 1984). A secondary finding is that the sooner a mother returns to work the less likely she is to maintain breastfeeding (Bick, Macarthur & Lancashire, 1998; Lindberg, 1996). Galtry (1997), in line with socialist feminist perspectives, argued that breastfeeding methods are as much a function of structural conditions expanding or limiting women's options as they are a function of women's attitudes.

2.8. Empirical Review

A study conducted by Dykes, Morm, Burt and Edward (2003) in Northwest England evaluated the experience and support needs of adolescent mothers who

had commenced breastfeeding. This study revealed that breastfeeding experiences included feeling watched and judged, lack of confidence, tiredness, discomfort and sharing accountability. Quinn et al., (2005) reported that in 2003 breastfeeding rate in Ghana jumped from 32 to 62% and dropped to 40% by the last survey when the programme shifted emphasis to support for pre-service review and capacity building in other areas.

According to Barber et al, (2007) in a study conducted in America reported that breastfeeding rates rapidly decline in the initial 4 to 8 weeks postpartum with less than 35% of mothers exclusively breastfeeding at 4 months.
In a study carried to evaluate the attitude and behaviour of 55 teenage mothers in relation to older mothers in America it was revealed that 50% of teenage mothers chose not to breastfeed while 20% of teenage mothers had given up before the day three after birth before the flow of milk has been established (Ineichen et al., 2007).

The study aimed at investigating the barriers to the successful practice of exclusive breastfeeding among rural and urban nursing mothers in Edo State of Nigeria. The population of this study constitutes all nursing mothers in the rural and urban areas of the state. The study adopted structured and in-depth interview procedure. Four hundred and ninety six (496) urban and rural nursing mothers constitute the sample of the structured interview, while 40 nursing mothers: 20 urban and 20 rural were involved in the in-depth interview. The results revealed that 98% of both urban and rural nursing mothers started breast-feeding almost immediately after delivery.

The practice of exclusive breastfeeding by lactating women in Owerri metropolis Imo State Nigeria was studied. Structured and validated questionnaires were used to obtain information on the socio-economic characteristics, correct knowledge and practice of exclusive breastfeeding as well as the constraints to the practice. The results of the survey show that about 91% of the lactating women have correct knowledge of exclusive breastfeeding. Also, the survey revealed that not all that have the knowledge are practicing it (66.41%) in the area. However some constraints were identified to be responsible which include, lack of time, lack of knowledge, lack of support from the husband and family members and some do not believe that only breast milk is enough to sustain their baby of less than 6months as well as many other excuses. Most importantly, there are some of them about 18% that are not ready to practice it on their subsequent child birth due to their belief. This therefore necessitates a more intensified effort in the teaching and implementation of Baby Friendly Initiative (BFI) guidelines for successful breastfeeding in all health institutions and clinics.

Oniyongi, Oyerinde and Olowore (2011) carried out a research to investigate the utilization of exclusive breastfeeding among nursing mothers in Ilorin -South Local Government Area of Kwara State. Related literature were reviewed on the useful ideas and the benefits of breastfeeding to nursing mothers. The population used for the study consists of only nursing mothers who are attending the infants welfare clinics which include civil servants, traders and artisans. The instrument used for the study was questionnaire. Two hundred subjects were randomly selected among the population of nursing mothers within the local government area used for the study. The data were collected

using a well self liken structure instrument which was well validated by experts in the area of study and tested for the reliability of study using split half. A spearman rank order was used to analyse the result. A correlation coefficient of (0. 74r)
was obtained which indicated that the instrument is reliable for the study.

The instrument was administered by the researcher and research assistance. An inferential statistics of chi-square was used to analyse the result. The study revealed that most of the respondents are not aware of the benefits of exclusive breastfeeding, the nature of their job does not permit them to give exclusive breastfeeding. It is therefore recommended that appropriate awareness through campaign jingles should be carried out, waiver should be given to nursing mother to attend to their babies at home to give them exclusive breastfeeding during work by their employers Introduction Many generations ago, babies were almost universally breast fed; about forty year.

According to Ani Samuel, Ezekekwu Chinedu, Njeze Obianuju and Nnorom Ezinne, in a study conducted at the college of medicine, University of Nigeria, Enugu campus Nigeria. A total of 150 questionnaires were distributed, collected and analyzed during the study. The mean age of the respondents was 28.7 years. Majority of the respondents, 140(93.3%) were aware of exclusive breastfeeding and 96(64%) of the mothers actually breast fed exclusively for 6 months. 36(24.0%) of the mothers do not practice exclusive breastfeeding and the reasons ranged from work schedule to the false cultural belief that it is insufficient for the baby. Also 109(72.7%) of the respondents were of the opinion that breastfeeding is a good way to decrease family expenses.

Again, majority of the respondents, 125(83.3%) accepted or appreciated the value of exclusive breastfeeding and would recommend it to friends and relatives. The role of nursing mothers towards national development is indispensable, hence the need for the improvement in the norms of exclusive breastfeeding. This will ensure that these mothers contribute to the building and strengthening of the foundation at the tender stages and hence, the building of a stronger and healthier nation.

In conclusion, it is expected that the result of this study will assist programme managers and policy makers to institute effective measures to counter and eliminate the bad cultural practices and beliefs that mitigate against the practice of exclusive breastfeeding.

According to Aluko-Arowolo, Sunday Olusola, Adekoya, and James Adeniyi. Optimal duration to breastfeed the new born baby is one of the crucial public health issues that the World Health Organization (WHO) keeps constant in its campaign for all round healthcare delivery for mother and child. To be sure, there is consensus on the need for exclusive breast feeding for the baby. This is believed to enhance the child social development and biological growth. However, at what social and economic cost to the mother? The study investigates challenges being faced by the mothers, which are sometime inconsistent to their socioeconomic pursuits, growth and material well being. Other objectives include understanding of the pathways to mothers' healthcare consumption, such as postpartum lactation amenorrhea during the period of breastfeeding. Other challenges include lack of support/ encouragement from

employers (for those in the formal employment) and husbands' contribution to sustain the practice.

The study adopted qualitative approach to probe the extent of EBF among the mothers between the ages of 15 and 49 years and their husbands of ages between 18 and 60 in Ijebu-Yoruba South Western Nigeria, involving the mixed urban (i.e. informal and informal sectors) and the rural societies. The methods of data collection were Focus Group Discussions (FGDs) and in-depth (IDI) interviews. There were eight (8) FGDs for mothers and the husbands and 10 in-depth interviews for mothers, father, health givers and opinions leaders. The data were analysed through content and descriptive method. Data revealed significant, but inverse relationship between the extent of breastfeeding and nutritional support for the mothers. There are also incongruous relationship between the mother's job and the extent of breastfeeding. Furthermore, it was revealed that, there was correlation between the health of the mother and the child and the extent of breastfeeding. Fourthly, mothers are believed to lose their prime and kinky body frame to sagging and unattractive frame, which makes their husbands to look elsewhere for other attractive women.

It is therefore suggested that government, international agencies and concerned non-governmental organization (NGOs) should intensify effort to open up rural and mixed urban settlements to Human Development Amenities (HAD) and bring about a strong intervention to Labour Law to bring about adequate period for maternity leave.

METHOD

Survey was chosen here given that the data sought in the study could best be extracted by studying the concerned population. The area of study was Anambra State, South-East Nigeria. It comprises 21 local government areas made up of largely rural towns. The state also hosts a few towns which include Onitsha, Nnewi, Awka and Ekwulobia. The study population was married women within the childbearing ages in Anambra State. This group numbers 1,102,032, according to the data supplied by the National Primary Health Care Development Agency (NPHCDA, 2013). The sample size used was approximately 400.

The sampling procedure was multi-stage technique which involves following a series of logical steps in selecting sample units. At the first stage, the researcher began by purposively selecting two towns from Anambra State as follows: Awka and Onitsha. Awka was selected due to the large presence of government-owned organisations in it, while Onitsha was selected for the large presence of private organisations therein.At the second stage, the researcher randomly chose 40 government organisations (comprising ministries, departments and agencies) from Awka. Similarly, she chose 40 private organisations (comprising banks, media houses and manufacturing firms) from Onitsha. This gave a total of 80 organisations. At the third stage, the researcher chose five married women of childbearing age from each of the 80 organisations in Anambra State. This finally yielded the sought 400 respondents. The data collection instrument was the questionnaire. The questionnaire comprised entirely close-ended questions. A set of questions were designed to relate to particular research questions. The

questionnaire had five sections: Section I had questions seeking the respondents' demographic information; Section II had questions on knowledge of exclusive breastfeeding; section III had questions on practice of exclusive breastfeeding; while Section IV had questions organisation's sensitivity to exclusive breastfeeding.

RESULTS

A total of 400 copies of the questionnaire were distributed among the respondents. Out of this total, 391 representing 97.8% were recovered while nine representing 2.2% were not recovered. Therefore, the response rate stood at 97.8%.

Demographic Variables

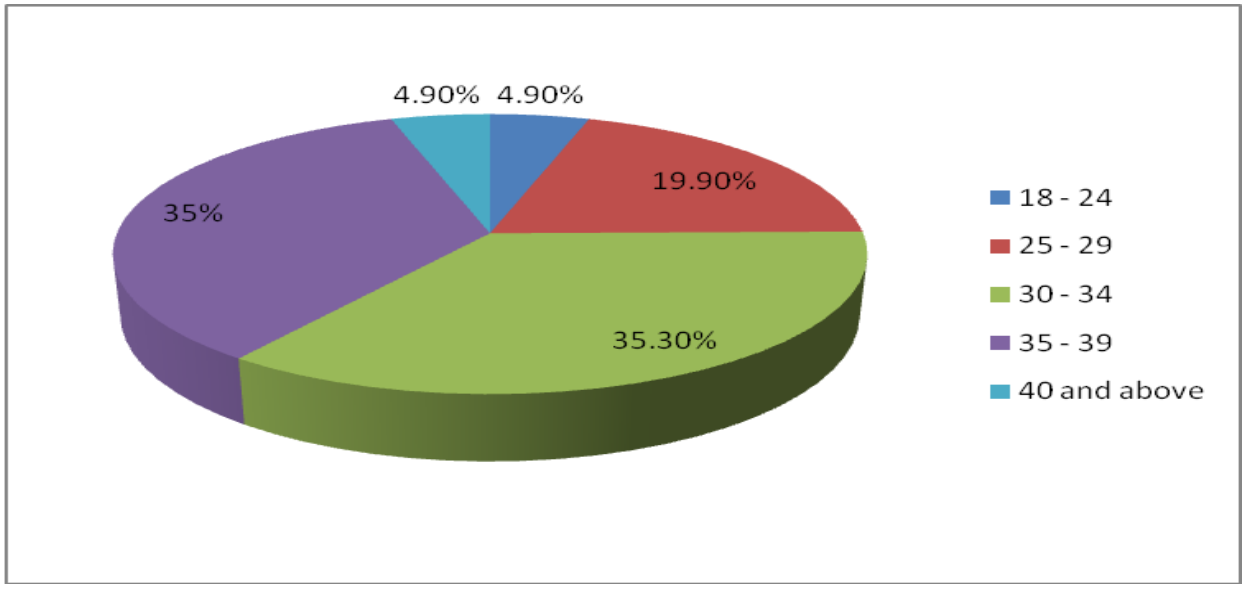

Figure 1: Respondents' Age Bracket

Figure 1 shows that 4.9% of the respondents were 18 – 24; 19.9% were 25 – 29; 35.3% were 30 – 34; 35% were 35 – 39; while 4.9% were 40 and above.

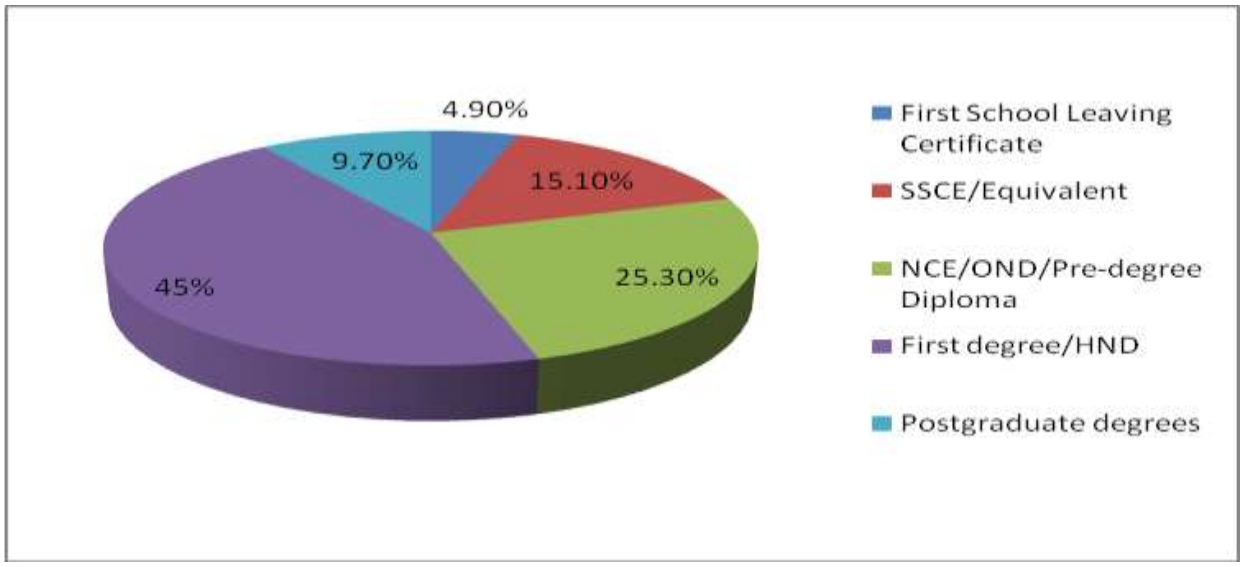

Figure 2: Respondents' Highest Educational Qualification

Figure 2 shows that 4.9% of the respondents had First School Leaving Certificate; 15.1% had SSCE/equivalent; 25.3% had NCE/OND/Pre-degree diploma; 45% had first degree/HND; while 9.7% had postgraduate degrees.

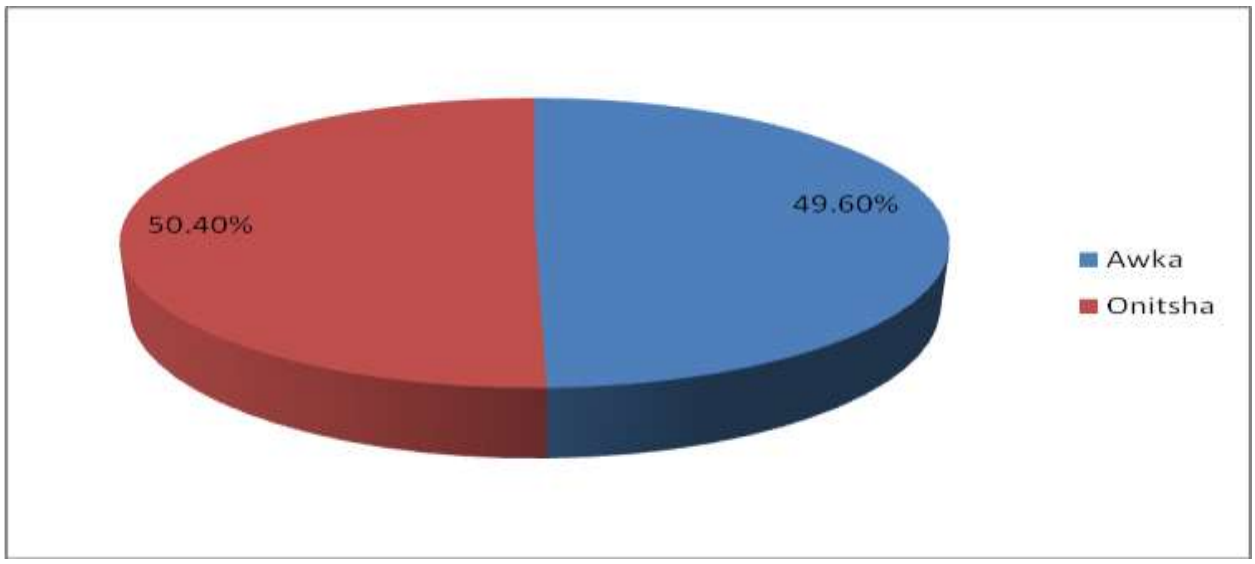

Figure 3: Respondents' Place of Work

Figure 3 shows that while 49.6% of the respondents work Awka, 50.4% work at Onitsha.

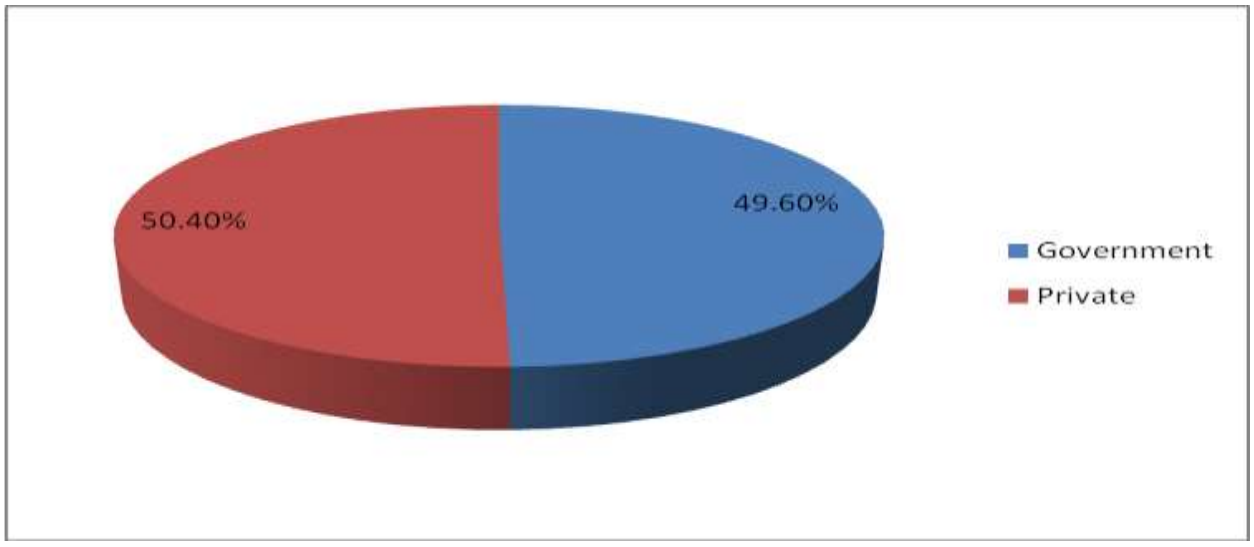

Figure 4: Ownership of Respondents' Place of Work

Figure 4 shows that while 49.6% of the respondents work in government establishments, 50.4% work with private firms.

Table 1: *Knowledge of Exclusive Breastfeeding*

	Exclusive breastfeeding involves feeding the baby only with breast milk in the first 6 months after birth	**Exclusive breastfeeding helps keep the baby healthy**	**Exclusive breastfeeding helps the mother shed after-birth weight**	**Exclusive breastfeeding helps prevents pregnancy until the mother is ready to wean**
True	89.8% N = 351	85.2% N = 333	80.1% N = 313	55% N = 215
False	10.2% N = 40	14.8% N = 58	19.9% N = 78	45% N = 176
TOTAL	**100% N = 391**	**100% N = 391**	**100% N = 391**	**100% N = 391**

Table 1 shows that 89.8% of the respondents know that exclusive breastfeeding involves feeding the baby with breast milk alone for the first six months following birth; 85.2% know that the practice helps keep the baby healthy; 80.1% know that it helps the mother shed after-birth weight; while 55% know that exclusive breastfeeding helps the mother to avoid pregnancy until she is ready to wean.

However, the above data were further distilled by categorizing the respondents who got 3 to 4 correct answers as having "high" knowledge of exclusive breastfeeding; those that got two correct answers as having "average" knowledge; and those with 0 to 1 correct answer as having "low" knowledge. This is shown in the chart below.

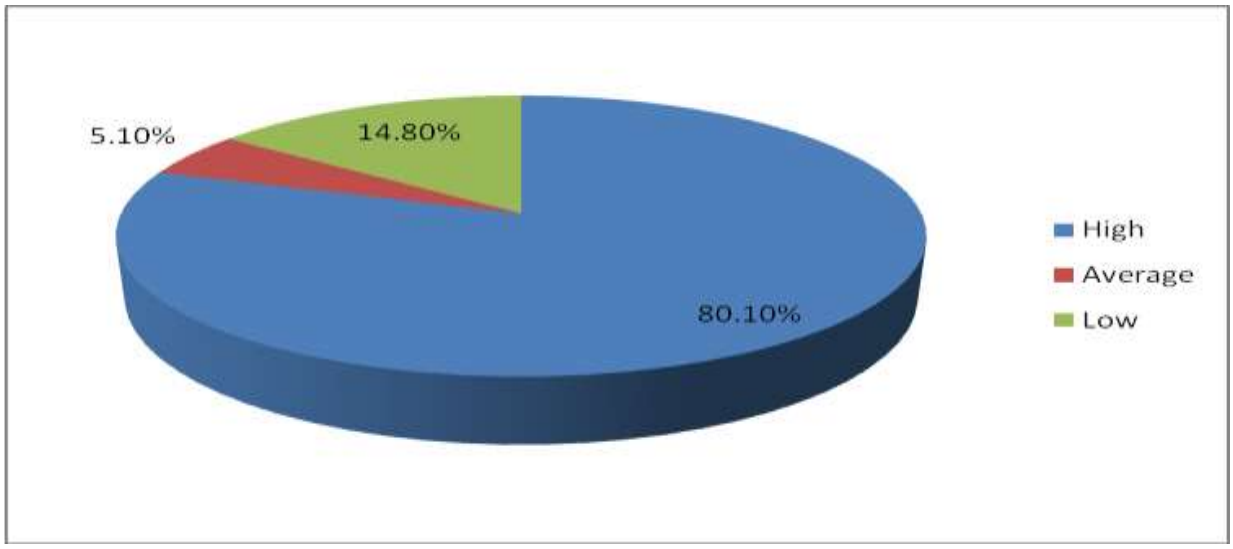

Figure 5: Knowledge of Exclusive Breastfeeding

Figure 5 shows that 80.1% of the respondents have high knowledge of exclusive breastfeeding; 5.1% have average knowledge; while 14.8% have low knowledge.

Table 2: *Practice of Exclusive Breastfeeding*

	I have attempted exclusive breastfeeding	**I was successful in my attempt at exclusive breastfeeding**	**I am ready to experiment exclusive breastfeeding again**
True	74.7% N = 292	9.7% N = 38	55% N = 215
False	25.3% N = 99	90.3% N = 353	45% N = 176
TOTAL	**100% N = 391**	**100% N = 391**	**100% N = 391**

Data in Table 2 show that 74.7% of the respondents have attempted exclusive breastfeeding; 9.7% have been successful with this; while 55% are determined to experiment with it once more.
However, to have a clearer picture, respondents who gave "True" answers to three of the questions above were categorized as having "high" practice of exclusive breastfeeding; those that gave two were categorized as having "low" practice; while those that gave zero or one were categorized as having "low" practice of exclusive breastfeeding. This is shown in Figure 6 below.

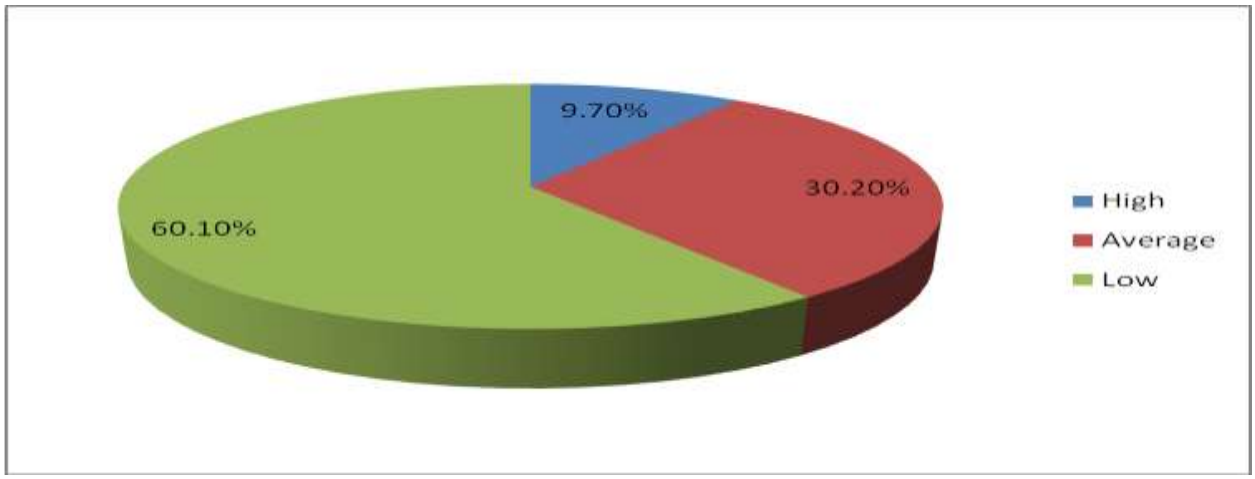

Figure 5: Practice of Exclusive Breastfeeding

Data in Figure 6 shows that 9.7% of the respondents scored high in the practice of exclusive breastfeeding; 30.2% average in that; while 60.1% scored low.

Table 3: *Workplace Sensitivity to Exclusive Breastfeeding*

	Maternity Leave long enough for exclusive breastfeeding	**Permission to come to work with baby**	**Free periods for regular breastfeeding**	**Space for breastfeeding privacy**
Yes	0% N = 0	40.2% N = 157	35.3% N = 138	10.2% N = 40
No	40.2% N = 391	59.8% N = 234	64.7% N = 253	89.8% N = 351
TOTAL	**100% N = 391**	**100% N = 391**	**100% N = 391**	**100% N = 391**

Table 3 shows that 0% of the respondents enjoys maternity leave that is long enough for exclusive breastfeeding; 40.2% have permission to come to work with their babies; 35.3% have free periods that allow for regular breastfeeding; while 10.2% have the space for breastfeeding privacy at their workplaces.

However, the above figures are further distilled by categorizing the workplaces of respondents who gave 3 – 4 "Yes" answers as having "high" sensitivity to exclusive breastfeeding; those that gave two "Yes" answers as having "average" sensitivity; and those that gave 0 – 1 "Yes" answer as having "low" sensitivity to exclusive breastfeeding. Figure 7 below shows this.

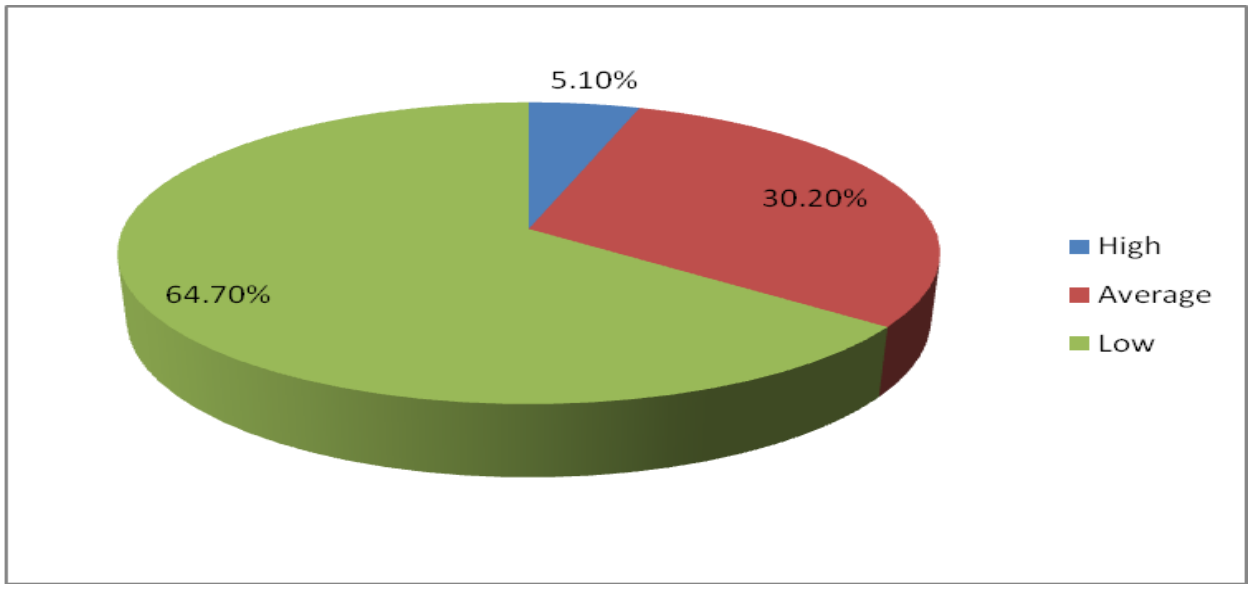

Figure 6: Workplace Sensitivity to Exclusive Breastfeeding

Data in Figure 6 show that 5.1% of the respondents work in organizations with "high" sensitivity to exclusive breastfeeding; 30.2% work in those with "average" sensitivity; while 64.7% work in those with "low" sensitivity to exclusive breastfeeding.

Table 4: *Cross-Tabulation Showing the Relationship between Ownership of Respondents' Organisations and Workplace Sensitivity to Exclusive Breastfeeding*

	Workplace Sensitivity to Exclusive Breastfeeding			**TOTAL**
	High	Average	Low	
Government	5.2% N = 10	29.9% N = 58	64.9% N = 126	**100%** **N = 194**
Private	5.1% N = 10	30.5% N = 60	64.5% N = 127	**100%** **N = 197**

X^2=0. 015; df 2; p<.993

Table 4 shows that irrespective of whether an organisation is government establishment or privately owned, sensitivity to exclusive breastfeeding is largely low. There is no significant difference between the degree of sensitivity and ownership of a workplace.

Table 5: *Cross-Tabulation of Some Key Dependent and Independent Variables*

	Educational Qualification	Town of Work	Ownership of Workplace	Knowledge of Exclusive Breastfeeding	Practice of Exclusive Breastfeeding	Workplace Sensitivity to Exclusive Breastfeeding
Educational Qualification	1	-.006	-.006	.279**	.359**	.184**
Town of Work		1	1.000**	-.011	.013	-.003
Ownership of Workplace			1	-.011	.013	-.003
Knowledge of Exclusive Breastfeeding				1	-.162**	.090
Practice of Exclusive Breastfeeding					1	-.127*
Workplace Sensitivity to Exclusive Breastfeeding						1

**. Correlation is significant at the 0.01 level (2-tailed).
*. Correlation is significant at the 0.05 level (2-tailed).

Table 5 shows that educational qualification correlates positively with knowledge of exclusive breastfeeding (r = .279), practice of exclusive breastfeeding (r = .359) and workplace sensitivity to exclusive breastfeeding (r = .184). Also, town of work correlates positively with ownership of workplace (r = 1.000). Knowledge of exclusive breastfeeding correlates negatively with practice of exclusive breastfeeding (r = -.162) while practice of exclusive breastfeeding correlates negatively with workplace sensitivity to exclusive breastfeeding (r =.-127).

Analysis of the Research Questions

Research Question 1: How much are career-oriented women in Anambra State informed about exclusive breastfeeding?

To answer this research question, reference was made to Table 1 and Figure 5 above. The data in Table 1 show that majority of the respondents generally have knowledge of what exclusive breastfeeding means and its implications to the mother and child. Figure 5 then indicates that cumulatively, 80.1% of the respondents scored "high" in terms of knowledge of exclusive breastfeeding. Consequently, the first research question is answered by stating that career-oriented mothers in Awka are well informed about exclusive breastfeeding.

Research Question 2: To what extent do career-oriented women in Anambra State actually practise exclusive breastfeeding?

To answer this research question, Table 2 and Figure 5 were referred to. Data in Table 2 show that while majority of the respondents had attempted exclusive breastfeeding, only a very small minority were actually successful at this. However, Figure 5 indicates that more than 60% of the respondents scored low in the practice of exclusive breastfeeding. Therefore, in answer to the second research question, it is stated that practice of exclusive breastfeeding is very rare among career-oriented mothers in Anambra State.

Research Question 3: To what extent do organisations in Anambra State allow their lactating workers opportunity for exclusive breastfeeding?

To answer this research question, we made reference to Table 3 and Figure 6 above. Table 3 shows that most of the respondents indicated that their organisations have not made any of the indicated provisions that would help exclusive breastfeeding at workplace. For this reason, the data in Figure 6 show that based on the answers of the respondents organisations largely scored (64.7%) scored "low" in terms of being sensitive to exclusive breastfeeding. Consequently, the third research question is answered by admitting that organisations in Anambra State have largely failed to show sensitivity to exclusive breastfeeding.

Research Question 4: Is there significant difference in attitude to breastfeeding-friendly workplace between government and private organisations in Anambra State?

Reference to Table 4 and 5 above helped to answer this research question. Table 4 shows that there is no significant difference between ownership of organisations and their extent of sensitivity to exclusive breastfeeding. In the same vein, Table 5 shows that no correlation (positive or negative) exist between these two variables. Therefore, it is stated, in answer to the fourth research question, that there is no significant difference in attitude to breastfeeding-friendly workplace between government and private organisations in Anambra State.

CONCLUSION

The findings of this study generally indicate that exclusive breastfeeding would fare little among career-oriented mothers in Anambra State. This Conclusion is hinged on the fact that organisations where they work are largely insensitive to breastfeeding-friendly workplace. Apparently, a great deal of enlightenment is required to re-orientate these organisations towards improving the situation.

RECOMMENDATIONS

Based on the findings of this study, the following recommendations were made:

i. Government should come out with a clear policy that will ensure greater breastfeeding-friendly workplace in government institutions. Such policy should be followed up with firm implementation with appropriate sanctions applied in the case of non-compliance.

ii. Similarly, private organisations should be persuaded through continuous campaign to make their workplace more breastfeeding-friendly. This effort could be aided by introducing some form of incentive to complying organisations.

iii. There is also need to enlighten career-oriented mothers themselves on the essence of exclusive breastfeeding. This is with the view to persuading them to take advantage of whatever breastfeeding space offered by their respective organisations towards pursuing exclusive breastfeeding.

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