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ANALYSIS OF BREASTFEEDING WITH PROFESSIONAL WORKING MOTHERS IN BISHANPUR OF MANIPUR

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ABSTRACT
This article examines the exclusive breastfeeding practices of working mothers in Bishanpur district. The research design used in this study is a cross-sectional study. The population of the research consisted of professional working mothers aged 40 and under working full time in Bishnupur, Manipur. Purposeful sampling and random sampling were also used, with a sample size of 1000 people. The research tool used in this study is a questionnaire. The results of the study showed that although participants knew a lot about exclusive breastfeeding, 48% of working mothers were able to breastfeed exclusively and 52% of working mothers could not, according to the National Institutes of Health recommends exclusive breastfeeding. just turning to breastfeeding. In the study, it was concluded that working mothers had difficulty in breastfeeding their babies only, and the effect of full-time work and family members negatively affected breastfeeding. Agree that government must ensure, through appropriate procedures, that there is no harassment and discrimination in the workplace against women who love to breastfeed, and that employers must provide and provide breastfeeding and breastfeeding workplaces for workers who breastfeed. it should be clean, comfortable, private and equipped with laundry and dairy facilities.

Keywords: *Breastfeeding, nutrition, breast milk, working mother*

INTRODUCTION
Over the last two decades, there has been a growing attention in the endorsement of exclusive breastfeeding as the recommended feeding practice for newborns. This, to a great degree, has been encouraged by increasing scientific substantiation on the significance of exclusive breastfeeding in reducing infant morbidity and mortality. Exclusive breastfeeding is the most efficient type of infant feeding for the first six months of life. The United States Breastfeeding Committee (USBC) and the American Academy of Pediatrics (AAP) declare that breastfeeding is the physiologically normal form of infant and child feeding (Labbok & Taylor, 2008; AAP, 2012).
As such, breastfeeding should be fostered and encouraged by health care professionals and public health campaigns in order to normalize it within our culture. Numerous organisations endorse breast milk as the optimal source of nutrition for infants (American Academy of Family Physicians [AAFP], 2008; AAP, 2012; USBC, 2009; United States Department of Health and Human Services [USDHHS], 2011; World Health Organization [WHO], 2001). These organisations support exclusive breastfeeding for the first six months of an infant's life for multiple reasons. In resource inadequate settings where deprived and sub-optimal breastfeeding practices regularly result to child undernourishment which is a key cause of more than half of all child deaths (Sokol et al. 2007), exclusive breastfeeding is regarded as crucial for infants' continued existence. Undeniably, of the 6.9 million under five children who were reported dead globally in 2011, an estimated 1 million lives could have been saved by

undemanding and accessible practices such as exclusive breastfeeding (WHO, 2012). Subsequently, the WHO and UNICEF (1990) have recommended exclusive breastfeeding for six months, followed by beginning of complementary foods and sustained breastfeeding for 24 months or more.

The practice of not giving breast milk has been connected with unexpected infant death syndrome and other neonatal morbidity and mortality. Breastfeeding can save premature infants from life intimidating gastro-intestinal diseases such as necrotizing enterocolitis. It lessens the occurrence of otitis media, severe bacterial infections such as meningitis, bacteremia, lower respiratory infections and botulism (Feldman, 1999).

In developing countries, there is a tendency to extend breastfeeding for longer periods in time. In Manipur, women breastfeed for a median duration of 22 months with 53.4% of women breastfeeding their young babies. Regrettably, the rates of exclusive breastfeeding are less than overall breast feeding rates due to the practice of giving complementary feedings. The addition of additional foods and liquidscauses higher rates of diarrheal illness and higher mortality rates (Aidam, Perez-Escamilla & Lartey, 2005).

Infants and children in developing countries are inexplicably affected by life threatening diseases, poor health care, and lack of potable water, malnutrition, poverty, and war. In an endeavour to give these children a chance at survival, it is imperative that breastfeeding be promoted and supported by government organizations and the medical establishment.

BENEFITS OF EXCLUSIVE BREASTFEEDING FOR INFANTS AND MOTHERS

Breastfeeding is an unsurpassed method of providing ideal food for the healthy growth and development of infants. It is also a fundamental part of the reproductive process with imperative implications for the health of mothers. Breastfeeding served and continues to serve as an appropriate method through which newborns are offered essential nutrients necessary for optimal growth and intellectual development.

Breast milk is regarded as ideal, natural and protective food for newborns. Given that prolonging people's lives (by reducing mortality) and preventing disease (by reducing morbidity) are some of the goals of public health (Brulde, 2011), breastfeeding or exclusive breastfeeding has been recognised as an efficient advance to the achievement of these goals. In a study by Vennemann and colleagues (2009) breastfeeding was found to be protective against sudden infant death syndrome by reducing the risk by 50% at all ages during infancy; these benefits have been reported to exhibit dose- response relationship, that is, health gains increases with increases in duration and exclusivity.

Infants when exclusively breastfeed for the optimal duration of six months are considerably protected against the major childhood diseases conditions viz. diarrhoea, gastrointestinal tract infection, allergic diseases, diabetes, obesity, childhood leukaemia and lymphoma, inflammatory and bowel disease (WHO, 2012; American Academy of Pediatrics,2012). In particular, the risk of hospitalization for lower respiratory tract infections during the first year of life is reduced by 72% when infants are exclusively breastfed for more than 4 months (American Academy of Pediatrics, 2012, p. 828). Duncan et al (2009, p. 867) also found exclusive breastfeeding to be protective against single and recurrent incidences of otitis media. Infants who were given supplementary foods prior to 4 months had 40% more episodes of otitis media than their counterparts.

Breast milk promotes sensory and cognitive development, and protects the infant against infectious and chronic diseases. Exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhoea or pneumonia, and helps for a quicker recovery during illness. These effects can be measured in resource-poor and affluent societies (*Kramer et al, 2001).* Breastfeeding contributes to the health and well-being of mothers; it helps to space children, reduces therisk of ovarian cancer and breast cancer, increases family and national resources, is a secure way of feeding and is safe for the environment (WHO, 2001).

Breastfeeding reduces the mother's risk of fatal postpartum hemorrhage and premenopausal breast and ovarian cancer. Frequent and exclusive breastfeeding contributes to a delay in the return of fertility and helps protect

women against anemia by conserving iron. Breastfeeding provides frequent interaction between mother and infant, fostering emotional bonds, a sense of security, and stimulus to the baby's developing brain (WHO, 2001)

SOURCES AND KNOWLEDGE OF EXCLUSIVE BREASTFEEDING INFORMATION

Formal breastfeeding policies in hospitals, staff and physician training in breastfeeding management, and rooming-in have been shown to positively affect breastfeeding promotion efforts (Kovach, 2002). Strategies such as the Baby-Friendly Hospital Initiative (BFHI), peer counselling, paternal support, and education of the mothers and health care professionals have been used to promote breastfeeding in the U.S. (Martens, 2000; Philipp et al., 2001). A study showed that a 1.5-hour mandated breastfeeding education intervention of nursing staff significantly increased the compliance of the BFHI and breastfeeding beliefs over a 7-month period at the intervention site compared to control site. The rates of EBF also increased by 23% (31% vs.54%), and fewer nurses offered supplementation (45% vs. 87%) after the intervention (Martens, 2000). Although breastfeeding promotion or intervention programs have focused on educating the mothers, family members, and employers about the benefits of supporting breastfeeding, not much attention has been paid to the health professionals influencing these target groups. Surveys evaluating health care professionals' knowledge and attitudes about breastfeeding revealed that these professionals do stronglyadvocate to their clients that breastfeeding is the optimum method of infant feeding (Pascoe et al., 2002).

Support from governmental programmes, health professionals, and education in schools is very significant for the promotion of exclusive breastfeeding and for bringing about changes in person's behaviour. Valuable educational efforts require knowledgeable health professionals to compel these efforts; consequently, students majoring in health sciences such as public health, nutrition and home economics should be comprehensively educated and trained to support and advocate breastfeeding.

PROFESSIONAL WORKING MOTHERS AND EXCLUSIVE BREASTFEEDING

Numerous studies have revealed that one of the barriers to breastfeeding is work status. With enlarged urbanization and industrialization, more and more women have joined the work force. An estimated 50% of women employed in the workplace are of reproductive age and return to work within one year of their infants' births (Wyatt, 2002). The Bureau of Labor Statistics reported that in 2002, "51% of U.S. women with children under 1 year of age were employed outside the home" (p. 247, Libbus & Bullock, 2002), and according to the Ross Mother's Survey, only 22% of women employed full-time breastfed their infants compared to 35.4% of mothers who were not employed (Libbus & Bullock, 2002).

Researchers examined the 1988 National Maternal and Infant Health Survey (NMIHS) to investigate the association between employment factors associated with breastfeeding initiation and duration. Of the 26,355 mothers sampled in the NMIHS, only 1,506 cases of employed breast-feeding women were used. Results showed that maternal employment was not responsible for low rates of breastfeeding initiation. However, it was observed that breastfeeding women who returned to work weaned their infants earlier compared to breastfeeding women who did not work. The negative association between employment and duration of breastfeeding was strongest in white women, and duration of maternity leave was significantly (P<0.01) associated with duration of breastfeeding (Visness & Kennedy, 1997).

Survey data from 10,530 women in Bristol, U.K., were analyzed to determine the association between breastfeeding and employment. Results showed that 79% (n=8,316) of the women initiated breastfeeding, and of the 4,837 mothers who planned to work postpartum, 83.5% of them initiated breastfeeding compared to 75.2% of the 5,693 mothers who did not plan to work postpartum (P=0.001). However, mothers who planned to return to work before six week postpartum were significantly (P<0.05) less likely to initiate breastfeeding compared to

mothers who were not planning to return to work (Noble, 2001)

EXCLUSIVE BREASTFEEDING TRENDS IN THE DEVELOPING WORLD

In acknowledgment of the indispensable responsibility of exclusive breastfeeding in respect of infants' continued existence strategies, numerous actions have gone into scaling up the rates in developing countries where prevalence of child malnutrition and mortality is still soaring. Nonetheless, successes in increasing the levels of exclusive breastfeeding have relatively been modest. In an analysis of data on exclusive breastfeeding from 38 developing countries between 1990 and 2000. Labook et al. (2006) reported an increase rate exclusive breastfeeding from 46% to 53% among infants younger than4 months and from 34% to 39% for those younger than 6 months. Higher growth was acknowledged in urban areas (30% to 46%) than rural ones (42% to 48%). Even though there were increases in all the regions studied viz. Middle East/ North Africa (29% to 34%), South Asia (49% to 56%), East Asia/Pacific (57% to 65%); the most remarkable increment, on the other hand, was found in Sub Sahara Africa where the rate almost doubled from 18% in 1990 to 38% in 2000 (p. 275).

Current analysis by Cai, Wardlaw & Brown (2012) on the global incidence across 140 countries, also reported an increase in the developing world from 33% in 1995 to 39% in 2010 among infants aged 0 - 5 months. Increases from West and Central Africa were more than twofold i.e. from 12% in 1995 to 28% in 2010. There had also been substantial improvements from 35% in 1995 to 47% in 2010 along with countries in Eastern and Southern Africa while those in South Asia witnessed a modest surge from 40% in 1995 to 45% in 2010. Despite the fact that it is still lower than the other regions, the brisk increase in West and Central Africa is in all probability not an astonish since it previously had and continues to have one of the lowest rates of exclusive breastfeeding in the developing world for which motivation thorough efforts were prepared to increase the practice in the very last two decades.

Even though the rates of exclusive breastfeeding for the past twenty years have been increasing, it is unquestionably apparent yet that the path to a world in which 90% coverage of exclusive breastfeeding will be reached remains a challenging undertaking. This is obvious in the current low occurrence in much of the developing world particularly in West and Central Africa which happens to have one of the uppermost rates of malnutrition in the world (Sokol et al., 2007). Evenas underlying declarations about the humble successes that have been accomplished all the way through the 1990s and early part of the 21st century are fairly easier said than done to make, some (Labbok et al. 2006) still, have related the monitored improvements in exclusive breastfeeding rates tothe efficacies of global and national policy efforts in the 1980s including International Code of Marketing of Breast milk Substitute, Hospital and Baby Friendly Initiative among other.

EXCLUSIVE BREASTFEEDING PRACTICES IN MANIPUR

Contrasting exclusive breastfeeding, breastfeeding is usually not predicament in Manipur. This is witnessed by the reality that as high as 98% of all infants younger than six months are being breastfed; and still at age12 -15 months, 95% of children go on to obtain breast milk alongside with complementary foods. Exclusive breastfeeding on the other hand is short lived with an estimated 84% ofchildren younger than 2 months being exclusively breastfed. Even though primarily higher, the percentage of children who go on to receive exclusive breastfeeding by age 4 to 5 months plummets to about 49%.

In general, the exercise of colostrums has turn out to be widespread as early commencement of breastfeeding is improving. Particularly, children in urban areas (55%) are to be expected to be breastfed within the first hour after delivery in dissimilarity to infants in rural and deprived areas (50%).Average length of breastfeeding nevertheless, is a bit higher among children in rural and deprived areas (21 months), compared with 19 months for those in urban areas.

Unlike countries including Namibia, Nigeria, Tunisia, and Sudan, where the rate of bottle- feeding is as high as 30% (Sante, 2002), the percentage of bottle-fed infants in Manipur is estimated at 5% among infants younger than 2 months and 21% among those aged 6-8 months (GSS & ICF Macro p,188).

RESULTS AND DISCUSSION

Age of Respondents

One thousand professional working mothers (N= 1000) completed the questionnaire and Participants ranged in age from 20 to 40 years (see Table 1). Respondents within the ages of 31 – 35 constituted 40.6 %, and those between the ages of 26 – 30 were 30.4% and professional working mothers within the ages of 36 – 40 represented 22.5%. Professional working mothers within the ages of 26 – 35 constituted the majority of the respondents representing 71%.

Table 1: Age of Respondents

Responses	Frequency	Percentage
20-25	65	6.5
26-30	304	30.4
31-35	406	40.6
36-40	225	22.5
Total	1000	100

Source: Field Survey, 2018

Educational Qualification of Respondents

From table 2, respondents sampled for the study, 37% of them have possessed bachelor's degree, 32% of the respondents had various Diplomas, and 18.5% had certificates for various professional requirements and masters qualifications and above were 12.5%. It is assumed respondents' educational status would provide in-depth information regarding the practice of exclusive breastfeeding among professional working mothers.

Table 2: Educational Background of Respondents

Responses	Frequency	Percentage
Certificate	185	18.5
Diploma	320	32
1st Degree	370	37
Master's and above	125	12.5
Total	1000	100

Source: Field Survey, 2018

Categories of Respondents' Occupation

Various categories of professional working mothers were selected to be part of this study and answer the questionnaire. According to the results, almost all the various occupations that can be found in Bishanpurboth public and private were involved in the study (Table 3).

Table 3: Categories of Respondents' Occupation

Response	Frequency	Percentage
Education	130	13
Health	120	12
Banking, Finance and Insurance	115	11.5
Telecommunication	55	5.5
Media/ Information	85	8.5
Civil Societies	90	9
NGO's	70	7
Ministries	170	17

Security Agencies	85	8.5
Others	80	8
Total	1000	100

Source: Field survey, 2018

Respondents' knowledge on Exclusive Breastfeeding

All the professional working mothers (100%) in the study were found to be well knowledgeable on exclusive breastfeeding practice and were able to defined exclusive breastfeeding according to the WHO definition as 'that the infant receives only breast milk. No other liquids or solids are given – not even water – with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines'.

Sources of Exclusive Breastfeeding Information

All the respondents said that the main source of exclusive breastfeeding information originated from health care professionals when they visit clinics, health centres and hospitals. To a great extent of the sources of exclusive breastfeeding information from health care professional is targeted at nursing mothers particularly during postpartum. Apart from the health care professionals, the respondents said they learnt exclusive breastfeeding from reading, mass media, and through school, friends and other relatives.

Benefits of Exclusive Breastfeeding

From the analysis of the data, all the respondents were able to state three or more benefits of exclusive breastfeeding. They said exclusive breastfeeding practice protects against common and widespread childhood diseases such as diarrhoea and pneumonia, reduces infant mortality and may also have longer-term benefits such as lowering mean blood pressure and cholesterol, and reducing the prevalence of obesity and type-2 diabetes. Again, others stated that exclusive breastfeeding contributes to the health and well-being of mothers owing to the fact it supports to space children, decreases the riskof ovarian cancer and breast cancer, and maintains family' income.

Barriers to exclusive breastfeeding among professional working mothers.

Respondents were asked to state the barriers that undermine them in terms of practicing exclusive breastfeeding. From table 4, it can be found 90.5% of the respondents said that the main challenge that hinders exclusive breastfeeding practice is their working status and 7.5% stated family members influence them to follow the old practice of breastfeeding with water and other food supplements

In this study, work status and family members' influence on exclusive breastfeeding negatively affect the efforts and decisions for professional working mothers to exclusively breastfeed their babiesin spite of the adequate information on exclusive breastfeeding feeding and its benefits for the babies and mothers themselves.

Table 4: Barriers to Exclusive Breastfeeding Working Mothers

Responses	Frequency	Percentage
Work status	905	90.5
Family influence	75	7.5
Mother's health	15	1.5
Others	5	0.5

Source: Field Survey, 2018

CHALLENGES WORKING MOTHERS FACE AT WORKPLACES

Professional working mothers are supposed to return to work after they have exhausted their three months maternity leave. From Table five, more than half of the respondents (51%) said they leave their children at home to their families due to work pressure and go to breastfeed their children when they have break or family members regularly bring the children to the Work places for them to breastfeed their babies. Furthermore, 30.5% of the

respondents said they do not have adequate time to breastfeeding their children and 17.5 % said there are no proper place for them to breastfeed their children at their various work places.

Table 5: Challenges Working Mothers at Workplaces

Responses	Frequency	Percentage
Inadequate time at work to breastfeed	305	30.5
No proper place to breastfeed	175	17.5
Child at home due to work pressure	510	51
Others	10	1

Source: Field Survey, 2018

EXCLUSIVE BREASTFEEDING PRACTICE AMONG PROFESSIONAL WORKING MOTHERS

In line with the main objective of the study, respondents were asked to state if they were able to practice the recommended exclusive breastfeeding according to the World Health Organisation standardwith their current breastfeeding babies and with their various professional works. From Table 6, 48% of professional working mothers were able to practice exclusive breastfeeding and 52% could not practice exclusive breastfeeding according to WHO recommended practice of exclusive breastfeeding. Even though it is time and again thought that a breastfeeding woman with sufficient information on exclusive breastfeeding and its rewards for the children and breastfeeding mothers will be more right to practice it than their counterparts with less information. This study confirms earlier research findings that type of work and hours of work have shown to influence breastfeeding (Visness & Kennedy, 1997).

CONCLUSION

This study was to examine the practice of exclusive breastfeeding among professional working mothers in Manipur. From this study, it can be concluded professional working mothers find it extremely difficult to exclusively breastfeed their babies according to the recommendation of World Health Organisation. Professional working mothers are well knowledgeable on exclusive breastfeeding practicewith its benefits but their full time employment status and family members' influence undermine and impede the practice of exclusive breastfeeding. Even though initial breastfeeding is fairly common in developing worlds, exclusive breastfeeding for 6 months is regularly not the normal practice.

Future research ought to investigate the effect of policies ensuring and guaranteeing breaks from work for professional working mothers to breastfeeding babies particularly the time frame for exclusive breastfeeding.

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