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Mothers' Agency in Managing Breastfeeding and Other Work in Dar es Salaam, Tanzania and New Delhi, India

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Abstract
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Combining breastfeeding and other forms of work is desirable from both public health and labour productivity perspectives. This is often challenging, especially in low- or middle-income fast-growing urban settings. The aim of this thesis was to gain a deeper understanding of mothers' perspectives on combining breastfeeding and other work in the urban contexts of Dar es Salaam, Tanzania, and New Delhi, India. Individual semi-structured interviews were conducted with community mothers (n=8) and health worker mothers (n=12) in Dar es Salaam, and mothers working in the health (n=10) and education sectors (n=10) in New Delhi. The methods of analysis were: qualitative content analysis, grounded theory approach, and directed and general inductive content analyses. Mothers' agency manifested in several ways. Striving to integrate or segment the competing domains of home and work was a goal of these mothers to reduce conflicts in managing breastfeeding and other work. Spatial and time constraints led mothers to engage in an array of carefully planned actions and troubleshooting tactics that included ways of ensuring proximity between them and their baby and efficient time managing. The timing of these strategic actions spanned from pregnancy, over maternity leave, to the return to employment. Managing breastfeeding and work triggered emotions such as stress, frustration and guilt, but also satisfaction and joy. Mothers negotiated with family, employers, colleagues and informal networks to gain support for their strategies, displaying both individual, collective and proxy agency. Changing family structures and roles highlight the potentially greater supportive role of the partner/husband. Work/Family Border Theory and Bandura's agency constructs provided frameworks for a deeper understanding of mothers' perspectives, but using existing family relationship constructs would better diffentiate between various modes of agency. Workplaces and maternity protection conditions were generally inadequate. Interventions are required: to strengthen the breastfeeding mother's own agential capacity using an individual approach; to provide information to families and communities; to improve regulatory, structural and attitudinal conditions at workplaces, and to strengthen health and social services to adequately support mothers in managing breastfeeding and other work.

Keywords: Breastfeeding, Women, Mothers, Work, Employment, Agency, Tanzania, India

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Dedicated to my children, Josef, Amira and Jakob

"When everything feels like an uphill struggle,
just think of the view from the top"
Unknown author

List of Papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals.

I Omer-Salim A, Persson LA, Olsson P. Whom can I rely on? Mothers' approaches to support for feeding: an interview study in suburban Dar es Salaam, Tanzania. *Midwifery* 2007; **23**: 172–183.

II Omer-Salim A, Olsson P. How do health workers balance infant feeding and employment? *African Journal of Midwifery and Women's Health* 2008; **2**: 46–52.

III Omer-Salim A, Suri S, Dadhich JP, Faridi MM, Olsson P. Negotiating the tensions of having to attach and detach concurrently: A qualitative study on combining breastfeeding and employment in public education and health sectors in New Delhi, India. *Midwifery* 2015; **31**: 473–481.

IV Omer-Salim A, Suri S, Dadhich JP, Faridi MM, Olsson P. Theory and social practice of agency in combining breastfeeding and employment: A qualitative study among health workers in New Delhi, India. *Women and Birth* 2014; **4**: 298–306.

Contents

Abbreviations

ANC	Antenatal Care
BPNI	Breastfeeding Promotion Network of India
EBF	Exclusive Breastfeeding
GSIYCF	Global Strategy for Infant and Young Child Feeding
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ILO	International Labour Organisation
IMCH	International Maternal and Child Health
MCH	Maternal and Child Health
MUCHS	Muhimibili College of Health Sciences
MDG	Millennium Development Goals
QCA	Qualitative Content Analysis
SES	Socio-economic Status
TFNC	Tanzania Food and Nutrition Centre
UNICEF	United Nations Children's Fund
UU	Uppsala University
WFC	Work-Family Conflict theory
WHO	World Health Organisation

Preface

The inspiration for this journey started in my early years, being reminded of my Sudanese aunts working their daily chores, caring for my sisters and me on weekends or whenever my working parents needed a break. Sewing and cooking for other families in the neighbourhoods of Omdurman were additional tasks that generated some income for my aunts. They were not formally educated and they were childless themselves, but they were very busy with all their daily tasks, including taking care of us children! When I moved to Sweden and started my own family, combining academic studies, paid extra work, domestic work and breastfeeding was a challenge. On one of my rare visits back to Sudan, my favourite aunt wondered whether I was still breastfeeding, as this was our culture! Yes, I was, but exclusive breastfeeding was hard when having to leave the child because of other work and studies, I replied. My aunt thought that now that I had a child that I was probably a housewife and could somehow manage. Little did she know and little did I reveal.

Studying nutrition and public health, I have always sought to understand the underlying reasons why the conditions for women's work globally look so different, yet the challenges appear rather similar. Obviously, the contextual factors determine our experience. As a nutritionist and advocate for women's right to breastfeed, I searched for perspectives from health providers, policy makers, civil society, trade unions and academia. In the mid-1990s, I obtained deeper insights about the problem and about the commonalities, despite different cultural contexts, through a Tanzanian nutritionist, Restituta Shirima, who asked me, "You know how we zealously promote exclusive breastfeeding, Amal? How do we expect mothers to listen to our preaching when we can hardly do it ourselves?"

That spurred my interest further and to take the opportunity to conduct research in Dar es Salaam, Tanzania within an ongoing postpartum health collaboration between Uppsala University (UU) and Muhimbili College of Health Sciences (MUCHS). The voices of the women themselves seemed to be a perspective that was often missing in breastfeeding advocacy and research. We started by studying community women and found the strong influence of diverse support systems. Some of the community women engaged in paid work and this led me back to the question of how employed mothers manage. Hence, we embarked on the health worker study in Dar es Salaam, which highlighted women's creativity in managing to combine in-

fant feeding and paid employment against a backdrop of 84 days' maternity leave. A few years later, the opportunity arose to be involved in a project in India, together with the Breastfeeding Promotion Network of India. Evidence-based advocacy on maternity protection was the topic. The lack of women's perspectives in the existing scientific evidence (once again) inspired us to investigate the factors involved in combining breastfeeding and work in the urban context of New Delhi. In 2008, the Government of India legislated six months of paid maternity leave for central government employees and the socio-cultural context was different to that in Tanzania. Perhaps we could better understand the phenomenon of how women manage their multiple roles by studying it in another context? We saw women's timely planning and strategizing alongside the extended family play out. Could this be a reflection of mothers' agency that had been "lurking" in the previous studies? And if so, what does agency look like? This led to a focused investigation of manifestations of agency among health workers.

All along, the importance of using scientific methods to analyse the empirical worlds and being mindful of my own experiences have been both challenging and motivating to continue the work of this thesis. It has been a long journey with many lessons learnt. My hope is that this thesis will provide deeper insights into an age-old dilemma, raise some new questions, and bring a few practical recommendations for policy, practice and further research. The value of women's work is indispensable, though often demanding. Hopefully we can collectively improve prevailing conditions and support women's own efforts to achieve a better balance, equity and, in the longer term, sustainable development.

Introduction

The thesis builds on data from three studies conducted in two large cities; Dar es Salaam, The United Republic of Tanzania (2) and New Delhi, The Republic of India (1).

Combining Breastfeeding and Other Work

Breastfeeding is part of infant feeding and the focus of this thesis. Hence, the term, 'breastfeeding', is used consistently unless otherwise stated. Combining optimal breastfeeding, domestic work and employment outside the home is often a challenge for women in any part of the world.[1] Women often have to combine their reproductive and productive roles, whether they have support from the communities in which they live or not. Women increasingly work outside the home to generate income for themselves and their families.[2] However, the economic advancement of women is often at the price of separation from their infants. This separation may pose challenges to optimal breastfeeding.

Breastfeeding is a central part of women's reproductive roles and rights.[3] The public health implications of curtailed breastfeeding are significant for women and their children's health, development and survival.[4] Women should not have to choose between these two important roles, as it then becomes a gender inequality issue.[5]

Traditionally, communities have supported women in the postpartum period with, for example, a confinement period as in East Asian societies, 40 days of postpartum rest in the Muslim world and other parts of the world.[6] Since 1919, the International Labour Organisation (ILO) has recognised that women need support for at least six weeks after giving birth by providing a period of maternity leave. In 1952, the maternity leave standard was increased to twelve weeks, and in 2000, the minimum amount of leave was set at 14 weeks in the ILO Maternity Protection at Work Convention (C 183). Interestingly, the ILO Recommendation (R 191) specifies that the maternity leave entitlement is to be increased to 18 weeks with breastfeeding breaks to be provided during the working day with additional supportive measures at the workplace.[7]

Many countries have followed the ILO standard and provide a maternity leave of 12 weeks or more.[8] Just as adequate maternity protection measures

are essential to enable women to combine their reproductive and productive roles, mothers need consistent and relevant support from all quarters of their environment. This thesis examines the interface between breastfeeding and other work, whether domestic or employment, in two diverse urban settings; Dar es Salaam, Tanzania and New Delhi, India.

Urbanisation, Health and Gender

More than half of the world's population live in cities, and the proportion is growing rapidly. Predictions for 2050 indicate that about two-thirds of the population will be living in urban areas, largely concentrated in Asia and Africa.[9] Megacities with populations of more than 10 million are similarly growing in number, with Tokyo, Delhi and Shanghai as the top three. In Africa, there are currently three megacities; Cairo, Kinshasa and Lagos, but by 2030, Dar es Salaam, Johannesburg and Luanda are expected to join this category.[9]

Urbanisation is associated with socio-economic changes which can lead to improvements in education, health, employment and political participation opportunities. On the other hand, urbanisation can also lead to greater inequalities, sub-standard living conditions, unsustainable production and consumption patterns, pollution and environmental degradation. Urban slums, such as high density areas in Dar es Salaam or New Delhi, coincide with more affluent low density areas in the same city. Although there is a large diversity in the urban cities of the world, there are a number of general mechanisms that may explain how living in an urban city environment can affect health. These mechanisms are related to the population characterstics, governance, the physical, social and economic environments, food security, and the availability and access to health and social services.[10]

The gender differentials of urbanisation are also at play. Despite that women contribute to the prosperity of urban areas through their paid and unpaid work, they are disadvantaged in relation to access to equitable work and living conditions, health and education, resources and representation. This is a problem for society at large. Unpaid caring work, typically done by women, ensures that the most vulnerable segments of the population, such as children and elderly, sick and disabled people, are cared for.[11] Urban environments often pose great environmental, physical and structural challenges that lead to enormous amounts of women's time spent in ensuring that the basic needs of their families are met. Women's need of income often entails taking low-paid jobs, long working hours and having to travel long distances to the place of work. Urbanisation also has an impact on the social environment, including changes in family structure and socio-demographic patterns.[12]

Dar es Salaam

Dar es Salaam is one of the fastest-growing cities in Africa, with a population of approximately 2.5 million in 2002 increasing to 4.5 million in 2012.[13] It is the political, educational and executive capital of the United Republic of Tanzania, which is the largest country in East Africa. Tanzania is categorized by the World Bank as a low-income country with 28% of the population living below the poverty line.[14] Dar es Salaam is divided into three districts or municipalities, namely Illala, Kinondoni and Temeke. It has been described as both a formal and informal city. About 75% of the inhabitants of Dar es Salaam live in unplanned informal settlements with unreliable access to the water, sanitation, infrastructure and health services provided by the municipality. A mix of middle- and low-income populations live in these settlements and engage in different types of work, ranging from formal to informal sector work.[15] The housing situation is high density with commercial, informal income and domestic activities taking place side by side. The proportion of female unemployment is 29.5% as compared to that for men, which is 16.4%. The continuous influx of migrants from the rural areas compounds the already congested traffic and transport systems.[16] The two Tanzanian studies in this thesis were conducted in the Temeke (highest percentage of informal settlement) and Illala (high population density) districts. Key development indicators for Dar es Salaam are presented in Table 1.

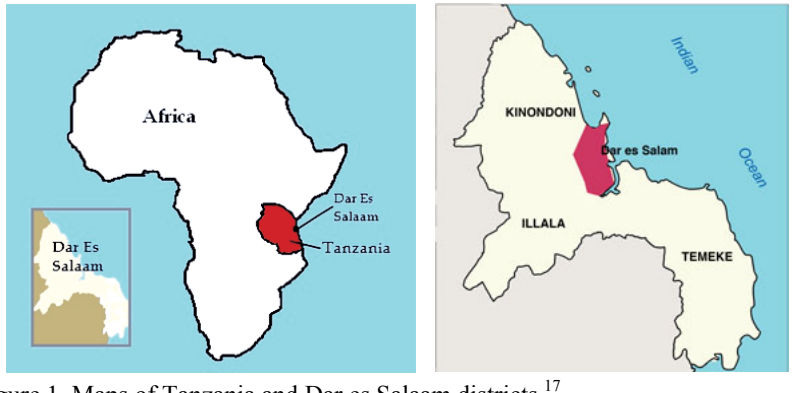

Figure 1. Maps of Tanzania and Dar es Salaam districts [17]

New Delhi

The national capital of the Republic of India, New Delhi, is the second most populous city in the world and is the executive, legislative, judiciary and commercial hub of India. India is the second most populous country in the world. New Delhi is one of eleven districts of the state of Delhi, and also serves as the centre of the government of the National Capital Territory of

Delhi. India is considered a lower middle-income country, but the inequities between the states are vast.[14] The growing middle class constitutes about 20% of the population of the state of Delhi, and this proportion is expected to rise. Yet, about half of the population of the state of Delhi lives in urban slums. The female to male ratio is skewed, with 866:1000, respectively. The rural to urban migration to New Delhi was about 16.9% in 2010, but is on the decline due to increasing costs of living and lack of employment for certain sectors. About 85% of workers in the state of Delhi are employed in the informal sector.[18] Although transport is available in the form of rikshas, minibuses, buses, metro, railway and cars, the sprawling nature of the city makes traffic and transportation a time-consuming effort. The female employment rate is on the decline.[2] One of the reasons behind this declining rate is the incompatibility of domestic work with employment.[19] The third study in this thesis was conducted in New Delhi. Key development indicators for Delhi are presented in Table 1.

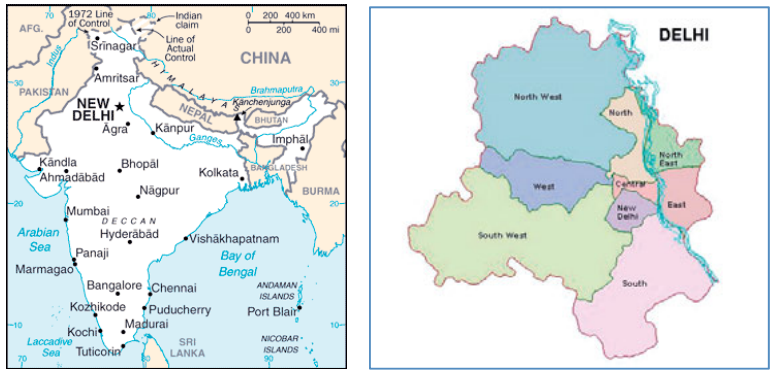

Figure 2: Maps of India and Delhi districts, including New Delhi (Wikipedia)

Table 1. Key development indicators for Dar es Salaam[13, 20] and Delhi[21, 22]

Indicator	**Dar es Salaam**	**Delhi***
Population (millions)	4,364,541	16,753,235
Female literacy	89%	75%
Total fertility rate (TFR)	3.5	2.1
Infant mortality rate (IMR)	56/1000 live births	40/1000 live births
Stunting prevalence under 5 yrs	19%	43%
Skilled attendance at delivery	91%	65%
Adult HIV prevalence (national)	5.1%	0.28%
Maternal mortality ratio (MMR)	454/100,000 live births**	104/100,000 live births
Female labour participation rate	68%	21%

* statistics for Delhi, but include New Delhi

** statistics for Tanzania

Breastfeeding and Other Work

The term, 'work', is used broadly in this thesis. It includes caring work, including breastfeeding, domestic work in the home, informal (paid but without a contract or unregulated) or formal (paid employment with a contract) sectors outside the home or based in the home.[2]

Significance of breastfeeding

Optimal infant and young child feeding means, according to the WHO, initiating breastfeeding within one hour of birth, exclusive breastfeeding (EBF) for the first six months of life and continuing to breastfeed for two years or beyond with adequate complementary feeding from six months of age.[23]

Breastfeeding has been shown to be the single most effective way to prevent infant death. It is a major factor in children's health and development, and significantly benefits the health of mothers, too.[23] Early and exclusive breastfeeding improves newborn care and reduces neonatal mortality, which is a major part of infant deaths. Exclusive breastfeeding during the first 6 months is especially important as 13 percent of under-5 deaths at the global level reportedly could be prevented if infants were exclusively breastfed for 6 months.[24] A further 6 percent of under-5 deaths could be prevented with adequate, safe and timely complementary feeding.[4, 25] The two primary causes of child deaths in developing countries are pneumonia and diarrhoea, both of which can be be prevented by breastfeeding.[26] Breastfeeding provides protection for children even in more developed countries.[27] The risks of infectious and non-communicable diseases, such as ear infections, asthma, obesity, diabetes, leukemia, and sudden infant death syndrome, are higher. The risks of not breastfeeding are also tangible for mothers, for example, postpartum haemorhage, decreased lactation amenhorrea, premenopausal breast cancer, ovarian cancer, type 2 diabetes, hypertension and metabolic syndrome.[27, 28]

State of breastfeeding

UNICEF highlights that only 39% of infants below the age of six months worldwide were exclusively breastfed.[29] Global prevalences of breastfeeding are relatively stagnant despite several countries experiencing significant increases in the last decade. At one year of age, 79% of children are breastfed and 58% of 20-23 month-olds benefit from the practice of continued breastfeeding.[30, 31] The prevalences of exclusive breastfeeding vary by region with about 20% in the sub-Saharan African region and 45% in the South Asia region.[30] Exclusive breastfeeding of children below six months of age in Dar es Salaam and New Delhi was 49.8% and 34.5%, respectively, ac-

cording to the latest national health surveys.[20, 21] These rates have only slightly improved in the last 5 years.[13, 20, 21]

The main determinants of breastfeeding include attitudes, socio-cultural factors, access to healthcare services, feeding counselling, availability of breastmilk substitutes and commercial influences, as well as women's work or employment situation.[32-34] Socio-demographic factors such as urban-rural residency, income and education levels cause wide disparities in breastfeeding rates. An analysis of 44 countries with the highest rates of maternal and child mortality showed large inequalities. The poorest income households were least likely to initiate breastfeeding. On the other hand, they were more likely to breastfeed exclusively for six months.[35]

Studies conducted in India and Tanzania confirm these patterns of breastfeeding across socio-demographic variables.[36] A study of the determinants of breastfeeding in Tanzania showed that despite almost universal breastfeeding (99%), certain socio-demographic factors were associated with less than optimal breastfeeding. Rural mothers from the Lake and Zanzibar regions were less likely to initiate timely breastfeeding after birth. Cultural practices of withholding colostrum and giving prelacteal feeds as well as delivieries attended by traditional birth attendants could be reasons for this observation. On the other hand, urban mothers with higher socio-economic status were less likely to exclusively breastfeed for six months, probably due to their employment status and exposure to breastmilk substitutes.[37] Similarly, in India, the exclusive breastfeeding patterns among higher income urban mothers were less optimal than other cohorts.[36]

Breastfeeding policies and guidelines

Progress towards the Millennium Development Goals (MDGs), particularly MDG 4 (reduce infant mortality) and MDG 5 (reduce maternal mortality/improve maternal health) involves increasing rates of early, exclusive and continued breastfeeding. Breastfeeding needs to be protected, promoted and supported in the context of women's empowerment, sexual and reproductive health and rights, gender equality and poverty reduction.[3] In the latter part of 2015, the new Sustainable Development Goals will replace the MDGs and work is ongoing to include breastfeeding targets in these new goals.[38]

A comprehensive international policy framework to support optimal breastfeeding is already in place; the Global Strategy on Infant and Young Child Feeding (GSIYCF).[23] The GSIYCF is embedded into several international policy instruments, and is accompanied by a substantial body of programmatic guidances and tools. However, there has been a lack of international commitment to provide the human and material resources necessary for widespread implementation of this policy framework, especially in the area of maternity protection.[39] This shows the gap between policy and practice at the global level.

In 2011, Tanzania implemented a National Nutrition Strategy 2011/12-2015/2016 which covers several targets related to breastfeeding. It includes the full implementation of the National Strategy on Infant and Young Child Nutrition (2004) which is based on the GSIYCF. In 1994, Tanzania adopted a National Regulation for Marketing of Breastmilk Substitutes and Designated Products.[40] The national Baby-Friendly Hospital Initiative only covered about 37% of the hospitals in Tanzania in 2010.[41] The National Guidelines for Comprehensive Care of Prevention of Mother-to-Child Transmission of HIV Services (2012) are in place, however, infant feeding counselling and support services are still urgently needed to optimize infant feeding practices in the context of HIV/AIDS.[42]

India enacted the Infant Milk Subsitutes Feeding Bottles and Infant Foods Act (IMS) in 1992. The Integrated Child Development Services and National Infant Feeding Guidelines are some of the Government policies that cover breastfeeding. The maternity leave entitlement for women employed in the formal sector is twelve weeks and two breastfeeding breaks per day under the Maternity Benefit Act (1961). In 2008, the central government extended the maternity leave entitlement for central government employees to 180 days with an additional Child Care Leave for a period of two years. A new scheme for pregnant and lactating women called "Indira Gandhi Matritva Sahyog Yojana (IGMSY)-Conditional Maternity Benefit" was launched to provide uniform benefits to both informal and formal sector women. There are National Guidelines for Prevention of Parent-to-Child Transmission of HIV (2013), however, there is a similar urgent need to upgrade the skills of health workers in infant feeding counselling and implementation and monitoring of the IMS Act.[43]

Trends in women's employment

According to the ILO, many more women nowadays have paid work outside of the home in the formal or informal sectors, although the actual female percentages of the total labour force have not increased significantly since 1980.[2] The gender gap between employment rates has increased since the global financial crisis, especially in Asia and Africa.[2] Several reasons are proposed for this gender gap, including factors related to differences in education, labour market segregation, types of employment contracts and career interruptions for child rearing and family commitments.[2] In Tanzania, the female labour force participation rate has been steady at 88% from 2010 to 2013.[44] The same rate in India has been declining from 29% in 2010 to 27% in 2013.[44] Reasons for this decline include an increase in the numbers of women in education programs and the perceived incompatibility of domestic work with employment.[19]

Unpaid work

In subsistence economies, women take on the tasks of maintaining the household, such as carrying water and collecting fuel wood. In many rural and urban areas of the world, women are also mainly responsible for the agricultural production or provision of family food. Domestic work is often unpaid work and includes tasks such as preparing food and caregiving, activities which directly impact on the health and overall well-being and quality of life of children and the household in general.[45] During difficult times, such as economic crisis or the HIV/AIDS pandemic, the need for women's unpaid work increases in comparison with that of men.[14] In a nutshell, poverty leads to more unpaid caring work for women, to longer hours of work and to women being forced to accept suboptimal working conditions, just to ensure that their families survive. Often women take on paid work/employment or self-employment enterprises in addition to unpaid caring work. According to current labour statistics, the proportion of women who are self-employed is rising.[46]

Impact of work and employment on breastfeeding

A negative association between employment and duration of exclusive breastfeeding have been demonstrated in the 'industrialised' world.[47-48, 49] There are several studies from other parts of the world, for example, Bangladesh, Thailand, Brazil and Kenya.[50-53] Returning to work during the early months after birth is considered to be a substantial barrier to breastfeeding.[54]

The evolving evidence is that modifying the type of work, the existence of shift work, providing options for part-time work and adjusting the work position will lessen the extent of the difficulties that women face in combining work and breastfeeding.[53, 55, 56] The provision of extended maternity leave beyond 12 weeks and increased flexibility in working conditions, as well as encouraging mothers to take their maternity leave, are important inferences from these studies that can be used in supporting working women in their breastfeeding efforts.[54] The maternity leave entitlement in Dar es Salaam is legislated as 84 days[40] and in New Delhi, amongst central government employees, it is six months.[57]

In addition to adequate maternity leave, other measures, such as the availability of good quality information and counseling support, are needed to support exclusive breastfeeding for six months.[58] Maternal motivation and confidence are important for overcoming obstacles and thus successful breastfeeding outcomes.[59] Payne and Nichols have shown that breastfeeding workers go to considerable effort and devise strategies to attempt to meet both the demands of being a good mother and a good worker, despite these great challenges.[60] Thus, it could be argued that some women show strong self-efficacy in managing the duality of paid work and breastfeeding.

Mothers and Other Care-givers

The human infant is more dependent on care and nurturing than other primates. Nature has evolved to ensure that a strong bond or attachment is formed between the infant and the mother to ensure its health and survival, through, for example, breastfeeding.[61] Motherhood/mothering, on the other hand, is not just a natural phenomenon but also a response to both nature and the environment, as evidenced by the disparity in how women approach motherhood across cultures.[61] From a historical perspective, women have always sought support for child rearing, especially when faced with the challenges of combining childcare and other work.[62] Lactation involves more time and energy of the mother than other child care activities and therefore, support during the breastfeeding period is likely to be even more important. The support could traditionally come from men and/or other women, kin or otherwise, who may then become alloparents, providing invaluable help for the mother and child.[61, 63] Wet nursing, where another woman provides breastmilk to the child, is a classic example of alloparenting. Wet nursing is an ancient practice throughout the world, documented as early as 2000 BC.[61] During the industrial revolution, wet nursing became more common among women of laboring classes. Many families migrated from the rural to the urban areas in search of work and wet nursing became an alternative feeding method whilst women were working for sustenance.[61] In modern times, wet nursing is still practiced in parts of the world, for example, in the Philippines, where daycare centers for factory workers may include wet nurses.[64, 65]

Family Support for Infant Care and Feeding

Social support from partners, family and friends is an important factor for breastfeeding success.[66, 67] In all cultures, families are a key social institution and potential support mechanism for women and children. According to family systems theory, several factors, such as the influence of the family environment, the complementary roles of family members, interaction and collective decision-making and hierarchical relationships between members of the household, provide evidence of this support.[68]

A review of research on family support for infant care and nutrition from Africa, Asia and Latin America points to three patterns related to the dynamics within the household and communities. First, grandmothers play a central role as advisors to younger women and caregivers to women and their children on matters related to health and nutrition, including feeding. Secondly, grandmother social networks set the norms and exert influence, specifically during pregnancy, and in the feeding and care of infants and children. Thirdly, men play a relatively limited role in the daily care of children.[67] However,

there are several studies and trials that show that involving fathers proactively in supporting breastfeeding can lead to increased rates of exclusive breastfeeding.[69, 70]

There is rather extensive research from various settings that show that grandmothers also influence infant feeding decisions and breastfeeding duration.[71, 72] Grandmothers can provide practical support, empathy and approval. Depending on the experience of the grandmother herself, she may be supportive or not of breastfeeding.[73] However, interventions that involve grandmothers have shown success in enhancing the support for breastfeeding.[74-76] Often the successful interventions build on traditional knowledge systems and integrate more up-to-date evidence-based knowledge of these systems.[75] Most nutrition and health policies and programs take a reductionist approach, targeting the mother-child dyad, largely ignoring the influence of multiple members and multiple generations that exist in many non-western societies.[67]

Theoretical Frameworks and Rationale

In this thesis I have used four different theoretical frameworks to discuss the findings of each individual paper and a further overarching framework to consolidate the findings of all of the papers together. In this section I provide a brief presentation of each of these frameworks, and in the discussion section I will expand on their utility.

Social Support Theory

In paper I, Social support theory[77] lent itself to the discussion of the findings related to different approaches to support. This theory describes the four elements of social support, namely, informational, instrumental, emotional, and appraisal support. Informational support describes the knowledge and advice given by persons in the social network. Instrumental support entails the tangible day-to-day support provided in terms of help with domestic duties or other tasks. Emotional support covers the sharing of experiences. Appraisal support includes feedback on events, thought processes and future plans that give the receiver perspective and provide learning opportunities.[77]

Time, Space/Proximity, Support and Gatekeepers Framework

Paper II used the time, space/proximity, support and gatekeepers framework to better understand the ways of managing infant feeding and employment. Bar Yam coined the framework of time, space/proximity, support and gatekeepers, to describe the main components of a mother-friendly workplace intervention.[78] The aspect of time is the time required for breastfeeding facilitated through a period of maternity leave, and time for breastfeeding or breastmilk expression upon return to work. Space/proximity relates to the physical space required to breastfeed or express breastmilk at the workplace. Gatekeepers refer to persons at the workplace or in the social environment who bring all the other components of the framework together.

Work-Family Conflict Theory

In paper III, Work-Family Conflict (WFC) theory provided a starting point for the discussion of the findings. Within the realm of Work and Family research, several theories have emerged, and Work/Family Conflict (WFC) theory is one of the most commonly used. It sets out the conflicts involved in combining multiple social roles. The conflicts can be divided into three types; time-based, strain-based and behavior-based.[79, 80]

Agentic Perspectives on Social Cognitive Theory

Agentic perspectives on social cognitive theory[81] was used deductively in paper IV to examine manifestations of agency. Several theorists have highlighted agency or capacity as being important for furthering health and well-being through empowerment.[82-84] Bandura is one of the theorists who have set the tone for defining agency in various realms and operationalizing the concept to the extent that it can be studied.[81, 85] Bandura defines agency as *"acts done intentionally"* and describes its four features as: intentionality, forethought, self-reactiveness, and self-reflectiveness.[81] Intentionality refers to intentions, or plans that may be individually or collectively crafted. Forethought includes the temporal aspect of thinking ahead, considering various options and discussing them with others. Self-reactiveness encompasses the construction and implementation of appropriate courses of action towards the intention or goal, as well as regulation and modification. Self-reflectiveness includes a self-examining, corrective adjustment and lessons learned. Bandura further delineates three modes of agency that may operate together; individual, proxy and collective. Individual agency is when the main agent performs her/himself. Proxy refers to the use of another person, who can act on her/his behalf. Collective agency is when several persons in the environment or social network work together to implement the intention.[81]

Work/Family Border Theory

The main theoretical framework used in the discussion of this thesis is Work/Family Border Theory. A relatively new variation of WFC called Border Theory was designed to explain how individuals manage and negotiate the work and family domains and borders between them to achieve balance. The key concepts of this theory are that work and family are two different domains that influence each other. They differ in purpose and culture, more or less depending on the type of work. Clark[86] defined the borders between the domains as being characterized by their three main forms: physical, tem-

poral and psychological. The physical borders define *where* the domain-relevant behavior takes place. Temporal borders, such as set working hours, determine *when* work activities take place in relation to family responsibilities. The psychological borders are self-created and relate to how individuals deem the appropriateness of thought and behavior patterns, and emotions in one domain or the other. People traverse between these two domains and their borders on a daily basis and are thus called border-crossers. They can adjust aspects of work and home domains and the borders in-between them to achieve the desired balance. Balance is defined by Clark as "satisfaction and good functioning at work and at home, with a minimum of role conflict." Border-keepers are also included in this theory as the sources of influence and support of persons within either of the domains.[86]

Rationale for the Thesis

Protecting, promoting and supporting optimal breastfeeding for better maternal and child health, development and survival requires an understanding of the challenges that women face in various settings and contexts. Often studies highlight the socio-demographic factors associated with curtailed breastfeeding without providing a full picture of the processes and nuances that lead to these sub-optimal practices. One of the key challenges from a global perspective is women's work, both in the home and outside the home. Maternity protection measures are meant to address this challenge by safeguarding both the woman's (and her child's) health and her job.[7]

Very few studies investigate how healthcare workers and other potential role models in society perceive the combination of breastfeeding and employment. In a general sense, healthcare workers need protection from workplace risks just as much as any other workers. They are often expected to sacrifice their own well-being for the sake of their clients. The studies that have been undertaken highlight the adverse conditions under which women in the health sector (and related sectors) have to work. The WHO has recognised that protecting and promoting the health of healthcare workers is a fundamental part of the strengthening of healthcare systems and can contribute to the retention of health workers, which is a world-wide problem.[87] At the forefront of this thesis are the research questions of how women experience and manage the combination of breastfeeding, domestic work and employment. The qualitative research design used in this thesis can help unravel the contextual factors that describe women's experiences and shed light on the underlying individual, familial, cultural and healthcare factors at play. This knowledge can be used to design appropriate interventions at different levels to facilitate the combination of the multiple roles women have.

Aim and Objectives

Aim

The overall aim of this thesis was to gain a deeper understanding of mothers' perspectives on combining breastfeeding and other work in the urban contexts of Dar es Salaam, Tanzania and New Delhi, India.

Objectives

The objectives of the thesis were to:

1. Describe Tanzanian community mothers' perceptions of infant feeding and approaches to support for infant feeding (paper I).

2. Describe Tanzanian female health workers' concerns about infant feeding and ways of handling infant feeding and work (paper II).

3. Explore the factors involved in combining breastfeeding and employment in the context of six months of maternity leave, among public sector employees in New Delhi, India (paper III).

4. Explore manifestations of agency in combining breastfeeding and employment amongst Indian health workers using Bandura's theoretical constructs of agency and women's experiences (paper IV).

Participants and Methods

Mothers in Dar es Salaam and New Delhi with experience of infant feeding were interviewed for this thesis. The interviews were recorded, transcribed and analysed with several methodologies (Table 2).

Table 2. Overview of the studies, papers, settings, methods and participants (n)

Study	Paper	Setting	Data collection method	Analysis method	Participants
1	I	Dar es Salaam Tanzania	Semi-structured individual qualitative interviews	Qualitative Content Analysis (QCA)	Community mothers (8)
2	II	Dar es Salaam Tanzania		Qualitative Content Analysis (QCA)	Health worker mothers (12)
3	III	New Delhi India		Grounded Theory approach	Health workers Education worker mothers (20)
	IV	New Delhi India		Deductive and inductive content analyses	Health worker mothers (10)

Data Collection and Handling

Individual, qualitative, semi-structured research interviews[88] were used for all three studies. They were conducted in Swahili, Hindi or English by trained research assistants or the primary author in a few cases when language allowed. The interviews were held at a convenient time and suitable place for the participants; either at clinic, workplace or home. To ensure privacy, interviews were conducted in a place away from the view and out of hearing reach of the other mothers and staff. The interviews followed a pretested and back-translated semi-structured interview guide comprising topics, probing questions and, in the case of study 3, a vignette[89] was used. The interviewer used additional probing questions to solicit further information when necessary or when clarifications were necessary. The interviews were audiotaped and lasted between 45 and 90 minutes each. The tapes were transcribed verbatim and translated from Swahili or Hindi to English by a second research assistant. The interviewer and the translator were chosen on the

basis of their specific experience of the task and their command of English and Swahili or Hindi languages. Validity of the translation procedure was ensured by different means. The interviewer read the transcript and translation of a sample of the interviews to check for incongruence in the translation. There were no major discrepancies between the tapes and the text. The relatively low complexity and use of everyday language in the interviews enabled subsequent immediate translation from Swahili or Hindi to English. In the attempt to capture the spirit of the language, the interview data were only slightly grammatically edited.

Setting, Recruitment and Participants

The community mothers study in Dar es Salaam (paper I)

The community study was undertaken in the Temeke district, Dar es Salaam, Tanzania in 2002. The area is characterised as being a suburban, high-density area with migrant populations from most areas of Tanzania. Temeke is a fast-growing suburban area with squalid living conditions, high unemployment, high violence/crime rates and poverty. General social problems are common features of the Temeke district.Temeke district is served by a number of maternal and child health (MCH) clinics providing antenatal and child health services, including immunisations, family planning and, in some cases, delivery care: there is also a district hospital that caters for referral cases. Mbagala Round Table Clinic is one of the larger MCH clinics in Temeke providing care during birth.[90] Clinic nurses and midwives work with antenatal, labour and delivery care and MCH activities. Information on baby feeding is usually conveyed at group sessions or health talks, rather than individually. Eight mothers were purposively selected from Mbagala Round Table clinic. With the assistance of midwives, eligible women were consecutively identified and informed, orally and in writing, of the study purpose and methodology. Criteria for selection included living in the area, having a baby aged 0–6 months and currently breastfeeding. The midwives were asked to invite both primiparae and multiparae women representing different ethnic groups. The participating women were aged 16–30 years, were either married or engaged to the father of the child, and all but one lived with the father of the child. Three women were primiparas and the remaining five had two or three children. The youngest baby was 1 month old and the oldest 6 months. Four women had no formal education, two had completed primary education and two had completed secondary education. Five of the women were homemakers and three were either formally employed or self-employed.

The health workers study in Dar es Salaam (paper II)

In 2002, individual interviews were conducted among female health workers at a major hospital in Illala district, Dar es Salaam, Tanzania. The recruitment of participants was based on a list of women employed at the hospital, who had delivered a baby in the previous two years and had returned from their maternity leave. The list, provided by the staff administration office at the hospital, comprised 56 staff members at the maternity department, including a blood bank. All of these working mothers were informed orally and in writing about this study and asked if they wanted to participate in an interview. After informed consent was obtained, a time for the interview was arranged at the convenience of each informant. Thirteen workers initially volunteered, but one desisted without giving notice, thus, 12 participated in the study.The following categories of staff were represented: Senior nurse-midwives (4); Junior nurse-midwives (3); Laboratory technicians (2); Nurse assistants (1); Nurse students (2). All women were married and aged between 25 and 42 years and had worked between one and ten years at the hospital. Two women had one child, three had two children, six had three, and one had seven.

The health and education workers study in New Delhi (papers III and IV)

The study was conducted in the city of New Delhi, India in early 2012. The urban study setting is relevant as urbanization is rapid and about half of the global population is urban.[10] The government sectors of healthcare and education were selected as they employ many women who are potential role models. The study sites (with numbers of participants in brackets) were: healthcare facilities at primary (6) and secondary/tertiary levels (4); and education facilities at primary (6), secondary (1) and university (3) levels. Purposive sampling was used to select participants of different cadres and positions at healthcare (10) and education (10) facilities within the different levels. The criteria were: first-time mother with one 8–12 month-old baby; has taken about six months' maternity leave; and is willing to participate after oral and written information is provided. Furthermore, we selected for sample variation in full and part-time work, and age and cadre/position at the workplace, as these characteristics have an impact on breastfeeding or indicate vulnerable groups.[91] Three women research assistants, fluent in Hindi and English, knowledgeable in breastfeeding and trained in qualitative research techniques, assisted in the recruitment, data collection and handling. After obtaining informed consent, the interviews were conducted in Hindi or English at a time and place chosen by the participant.

Qualitative Content Analysis

The method of analysis employed in papers I and II was qualitative content analysis, as described by Graneheim and Lundman.[92] The interview transcripts were read several times to provide an overview of the material. The subsequent analyses followed an iterative cycle that included division of the text into meaning units, which were condensed by shortening the original text while still preserving the core meaning. The condensed versions were coded and labelled. Different graphic methods, such as mapping, sorting and piling, were used to compare and contrast the data in both categories and themes. Two types of qualitative content analyses, focusing on different levels of the text, were used; manifest and latent.

Grounded Theory Analysis

The analysis for paper III followed the main steps of grounded theory: initial, focused and theoretical coding.[93] Grounded theory consists of a systematic, set of guidelines that allow flexibility for data collection, analysis and development of a grounded theory. The theory is often a constructed reality, not an exact picture of it.[93] Furthermore, constant comparison, theoretical sampling within the data set, and memo writing, were also employed. The first author coded, categorized, and integrated the transcribed texts into a model which was then reviewed and further refined by all authors. The field notes were read to contextualize the texts. Peer review was gained at seminars held at Uppsala University, Sweden, and at the Breastfeeding Promotion Network of India (BPNI) and the World Breastfeeding Conference in 2012 in New Delhi, India.

Directed Content Analysis

As the data generated from study 3 were extensive and could support a secondary analysis, paper IV involved a subset of the original dataset described above, namely the health worker subset. The analysis was carried out in two phases. In the first phase, a deductive, or more specifically, a directed content analysis[94] of the elements of Bandura's features and modes of agency was completed.[81] It was chosen because it lends itself well when the theoretical epistemology is abundant in the literature, as in the case of 'agency', and when the research questions seek to further assess and extend existing theoretical constructs, as in the present study. The directed content analysis was carried out in three steps. First, repeated readings of the interview text and field notes were made to get an overall understanding of the data. Second, expressions of agency features and their elements in the interview texts were

identified, described and organized according to Bandura's four categories of features of agency.[81] The elements of these features were organised as sub-categories. Third, different modes of agency; individual, collective and proxy; were identified in the interviews and integrated into the description of the features. Care was taken to explore alternative explanations of categories and sub-categories.

General Inductive Content Analysis

In the second phase of analysis of paper IV, a general inductive qualitative content analysis[95] of manifestations of agency in the women's accounts was undertaken. This methodology was chosen as it facilitates the identification of new categories grounded in the data and assists in the integration of categories with approaches. The second phase was initiated by re-reading the interviews with the following questions in mind; which manifestations of agency are forthcoming in the women's interviews? Which challenges are the women facing and what roles do the families have? The different manifestations of agency were grouped and labelled according to their similarities and differences which resulted in four different approaches with distinct characteristics. The first author carried out the primary detailed analysis, followed by discussions between all authors until consensus was reached.

Ethical Considerations

In all three studies the research team addressed the ethical principles of autonomy, beneficence, non-malevolence and justice outlined in the Declaration of Helsinki.[96] Ethical problems were considered to be minor in the studies involving adult, healthy participants with no additional dependency on the researchers. Potential risks that were identified, including the surfacing of negative experiences or repercussions of the interview, were assessed. However, the participants often expressed appreciation for the opportunity to have "someone listening attentively" to their stories. To minimize the risks, care was taken to inform participants orally and in written form about; the aims of the respective study, what their participation would involve, voluntary participation and the right to decline, and measures of confidentiality taken. After gaining informed consent, the data collection commenced. Ethical clearance was granted by the Muhimbili University College of Health Sciences in Dar es Salaam, Tanzania for the Tanzanian studies, and by the ethics committee at Guru Tegh Bahadur Hospital, New Delhi, India for the study in India. Furthermore, reviews were conducted by the Regional Ethical Review Board, Uppsala, Sweden for all of the studies.

Findings

The findings of this thesis are presented in three themes that are an integration of the findings of all four papers. For further details, see the reprints of papers I-IV appended to this thesis. Illustrative quotes are presented with reference to their respective work sectors and cities, but individuals have been provided with fictive names.

Balancing Competing Needs and Interests

Balancing competing needs and and interests included the various competing demands; adjusting to prevailing cultural infant feeding beliefs and doing good enough or satisficing. Infant feeding and care were spoken of as responsibilities added to and competing with household work, employment, family responsibilities, and social life (papers I-IV). The mothers struggled to balance these while optimizing trusted care and nutrition at home; meeting roles and responsibilities in the family and doing a good enough job or facing workplace conditions (papers II and III). To balance and adjust these demands and interests, mothers contemplated divergent needs, rules and beliefs. They recognized their own efforts and limitations and, at its best, this struggle rendered "satisficing or good enough actions" (paper III). Infant feeding patterns were thus based on what mothers deemed best for their babies, primarily breastfeeding, and the need to maintain their daily work and other activities.

> When I wake up I do general cleanliness, brushing teeth, sweeping, washing cutlery, child clothes and bathing. Then the baby will be awake, and I breast feed for a little. Then I make the baby's porridge, I make warm water for bathing the baby, after bathing the baby I do some activities, preparing food, if there are dirty dishes, my mother helps me to wash them. At night, I clean the nappies, I dry them, I go to bathe, if there is supper we eat. We then sit down to talk when we go to sleep. (Nibo, Community, Dar es Salaam)

Being employed was of utmost importance for those mothers who were (papers I-IV). The concerns expressed included integrating the many demands of the workplace: demands of being physically present at work, being on time, doing their duties satisfactorily, being a team player and ensuring job security and promotion (papers II and III). Sometimes the integration of in-

fant feeding with work outside the home created much discomfort and feelings of being "split". There was a competition between mothers' interests.

> I used to have so much trouble, I used to give her feed there (at home) ... and here (at work) I used to have so much trouble … When you will have milk (in the breasts) you will have pain and your baby is waiting for you at home … So you cannot forget that thing (the baby). The whole day she is on your mind. (Sonam, Health sector, New Delhi)

The many benefits of breastfeeding and the importance of practising exclusive breastfeeding were highlighted. However, the practice of giving water in addition to breastmilk and/or porridge at an early age was also described (papers I and II). Both cultural perceptions and professional knowledge influenced views on infant feeding and breastfeeding. A cue for giving water or porridge could be frequent crying by the baby, which was a sign of inherent hunger, an explanation intricately embedded in a traditional belief system.

> They say that the baby cries so often. This indicates he is hungry. They say that there are some worms that disturb the baby. But soon after giving him some porridge the worms ceases to disturb him. Because they will have eaten to their satisfaction hence they won't disturb the baby once more. (Diwa, Community, Dar es Salaam)

Using Time and Space Strategically

Using time and space strategically entailed timely planning across the continuum of pregnancy, maternity leave and return to work; features and elements of agentic action; the importance of knowledge in crafting plans; and types of strategies used to mitigate various challenges. Strategic actions in combining breastfeeding, domestic work and employment were visible as ways of managing (papers I and II), as were anticipatory strategies and tactics (paper III). The strategic actions all included importance of timely planning, but differed by the types of strategies used and which actors were involved. Mothers' ways of managing their own infant feeding and employment included: preparations during pregnancy and maternity leave; maximizing breastfeeding during time off work; creating breastfeeding possibilities during working hours; and finding someone else to feed the baby during their absence to attend work (paper II). Strategic action or agency was similarly displayed in paper IV. Here the importance of knowledge underpinning intentionality; forethought meaning being prepared; self-reactiveness, including collaboration; and self-reflectiveness giving perspective, were more elaborately divulged. Planning and strategizing could start start earlier, for example, in early pregnancy, and could continue throughout the maternity

leave. Infant feeding decisions, strategies and motivation were often based on knowledge about the importance of breastfeeding for the child.

> I had planned I would keep milk for my child, I would express out milk and I would keep in the freezer for him, obviously 6-12 hours that can work, I had planned this, surely I am going to breastfeed exclusively for 6 months without fail ... no qualm in that. (Nancy, Health sector, New Delhi)

Managing the combination of breastfeeding and work required planning and strategies, not only upon return to work, but also outside of the work space, working hours and during maternity leave. The various anticipatory strategies indicated the strong motivation and capability of mothers (paper III). Managing time and reducing the time away from the baby could be managed in various creative ways, planned well in advance.

> Aaa ... I bought a scooter ya ... And I learnt to drive it during my maternity leave (laughs). That (is) for my baby. Travelling (normally), it takes me two hours. So instead of that, my work (travel) will be done in half an hour. (Gaura, Education sector, New Delhi)

Having to return to work after a short maternity leave was mentioned as a reason for starting formula feeding or porridge much earlier than desired. Plans were made to start with other food early enough to get the baby adjusted at around two months of age before the mother returned to work (papers I and II). On the other hand, a longer period of leave could allow the mother to plan to exclusively breastfeed for six months or thereabouts (papers III and IV). However, various challenging life events expressed in the approach to agency, "Out of my control", could limit the actual amount of postnatal maternity leave available, thus possibly leading to an earlier introduction of other food in addition to breastmilk (paper IV).

> Things don't work as per plan … I thought that someone will take care of the baby but then I was more stressed ... my pregnancy was very traumatic emotionally. Aaa ... I saw the loss of my father … then I had to stay back with my mother, she was all alone so I took the (maternity) leave earlier ... (leaving her with only two months postnatal maternity leave). (Mukta, Health sector, New Delhi)

Generally, workplaces were not perceived as being particularly conducive to the successful combination of breastfeeding and employment. Issues of hygiene, safety and transport were identified as obstacles to bringing the baby to the workplace. Even if the baby was brought to the workplace for a breastfeed, it was up to the individual woman to find a suitable place, indicating structural, regulatory and attitudinal barriers (papers II and III):

> It is not that there is a place for you to breastfeed, you find if they bring the child you get out you look for the place perhaps in the office or for us close to the MCH. You go to MCH you ask for the place, you breastfeed the child and then the child is taken home.' (Bena, Health sector, Dar es Salaam)

The experience of combining breastfeeding and employment could sometimes be relatively smooth and satisfactory, as illustrated in the two approaches, "All within my stride or the knowledgeable navigator" and "Harder than expected but overall ok" (paper IV). Negotiating the tensions of having to attach and detach concurrently, illustrated both anticipatory and troubleshooting tactics (see Figure 3, paper III). This was not always easy, as mothers felt emotional stress and tension not knowing how the baby was faring whilst they were away at work. Sometimes calling home at regular intervals could be one tactic they used to reduce the tension. On the other hand, shutting off from matters at home whilst at work could be another way of managing the situation (paper III).

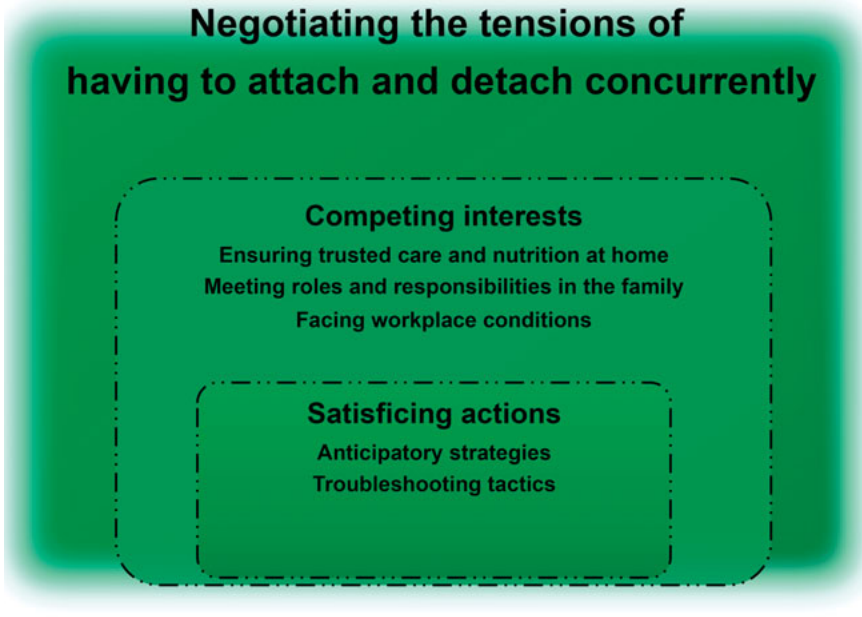

Figure 3. A model of combining breastfeeding and employment (paper III)

Upon reflection, mothers put their experiences in the larger perspectives (paper IV). Reflections on the experiences of motherhood, motivation, frustration and stress, knowledge and support, conditions at the workplace and what they would do next time, appeared sometimes rather conspicuously.

> The only thing I feel bad about is that we have left the child after six months only. It really hurts me … I want at least all should stay with their child at least for one year … after that we have to work for the entire life without being always there for our children. At least we can take care properly in that one year. So that he can become strong and healthy … this is my opinion. (Priya, Health sector, New Delhi)

Negotiating for Trustworthy Support

Negotiating for support included: the different approaches to and sources of support; extent of perceived support; the search for continuity and trustworthiness in support; and the role of the partner or husband and external caretakers (papers I-IV).

Four different approaches to support were revealed: adhering to diverse sources; relying wholeheartedly on a mother figure; working as a parental team; and making arrangements for absence from the child (paper I). These different approaches highlight the impact of the highly heterogeneous family structures existing in many urban areas, and the influence of expectations and experience on how support is sourced. Depending on context, support for managing the combination of infant feeding and employment could be solicited from colleagues at the workplace (paper II) or from the joint/extended family, including the in-laws (paper III). In this case, trusting that the family at home would be taking good care of the baby and shared responsibility was essential. This is an example of collective agency.

> So I have also shifted my responsibility (previously also responsible for care and play) to take care of his nutrition, the rest of the responsibility has been shared by the family members. (Seema, Health sector, New Delhi)

However, expected support was not always forthcoming.

> My mother-in-law said, 'we have also done that ... it's not such big task' … Most of the things I manage on my, own nobody else helps. (Priya, Health sector, New Delhi)

An interesting finding in these urban contexts was the mother's experience of support from the partner or husband. The couple could "work as a parental team" (paper I). The husband who reaffirmed and concurred with the mother's perceptions of infant feeding was important for building her self-confidence. The breastfeeding decision was thus mutually agreed, and this enabled the mother to persevere in the face of challenges.

> Everybody gave me his/her own advice. Others were telling me to introduce mixed feeds earlier; others told me to follow the advice given at the clinic. But at that time I had already talked to my husband and we agreed on what to

> do. Any other advice contrary to our agreement was not followed. The thing that enabled me to have breastfeeding spirit is the collaboration I receive from my husband. Yes. He is aged (the husband). (Pona, Community, Dar es Salaam)

Husbands or partners could be actively or passively supportive or totally unsupportive (papers I-IV). The more active husband partook in decision-making, supporting his wife in negotiating with other family members and the daily care of the baby (papers I-IV). The passively supportive husband was often willing to help with care of the baby, but required instructions (papers II and III). The unsupportive husband may have been physically present but did not prioritise the well-being of his wife (papers III and IV).

> My husband wants me to do all the (household) work. My family members also want me to do all the work in any case. My husband thinks that his mother has done all the work at her time ... (Now) it is my responsibility. (Gaura, Health sector, New Delhi)

If family was not present or unable to provide support, often the last resort was to find someone else to manage infant feeding during their absence to attend work. This approach to support was more prominent among employed mothers (papers I-III). This strategy entailed careful selection, recruitment and grooming of a house girl or maid who would then care for the baby whilst the mother was working outside the home. This was also not seen as the best solution, and if this option was chosen it would have to be someone who was deemed trustworthy, trained and perhaps overseen by a family member (Papers I-III). An overriding theme was that of continuity and trustworthiness, regardless of whichever support system was utilised (papers I-IV). As such, the woman's own mother or a mother figure provided both advice and support whenever possible. This was especially important for the first-time mother with little of her own experience. The role of the own mother was seen in the approach "relying wholeheartedly on a mother figure" (paper I) and is illustrated in the quote below from paper III.

> You get to know the reality only when the child is born then you handle the real situation … no planning as such. I am the elder child in the house and me and my siblings are not far apart so I have not seen any kids in my family. If you have seen your siblings' children growing you get some experience but here I did not have anyone to refer to! ... I picked up things from my mother, mother-in-law, husband and like that. They instructed me and I followed. One good thing about me is that I don't get scared from hard work. (Renu, Education sector, New Delhi)

Discussion

Managing breastfeeding and other work entails agential action by the mother and her collectives. These agential actions include three components; striving to integrate or segment competing domains; strategizing time and space; and negotiating to maximize support (see Figure 4). The components can be managed in different ways that reflect the different approaches to agency that were displayed. The outer circles depict the components which are, in turn, linked to the centre circle, or mothers' agency. The circular line indicates movement or dynamism in the agential process.

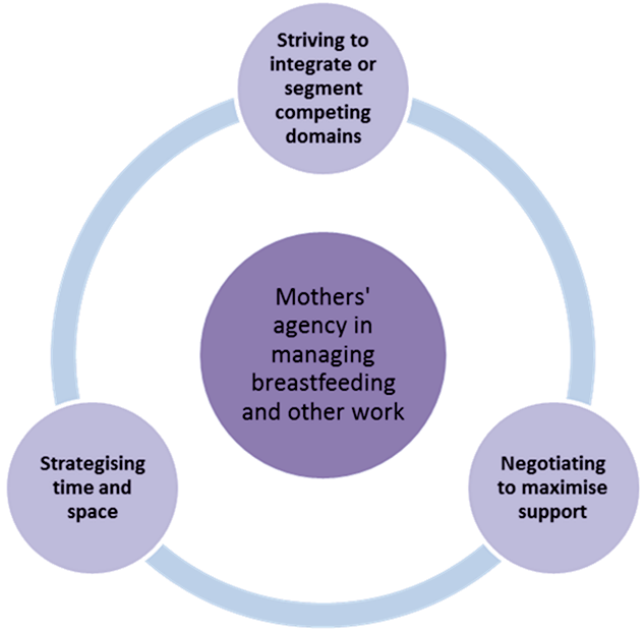

Figure 4. Proposed components of mothers' agency in managing breastfeeding and other work

Striving to Integrate or Segment Competing Domains

Integrating competing domains

Striving to integrate competing domains, the most obvious being work and home, could be seen as a goal among mothers. However, within the domains of work and home, there appear to be several sub-domains represented by the different tasks taking place. In the home, such tasks included care of the infant, including breastfeeding, domestic work and social functions. Similarly, in the work domain there were tasks that ranged from work performance, being a supportive colleague, and showing initiative to secure promotion in the job. The various domains and sub-domains may, in themselves, be in competition with each other.

Work/Family Border Theory[86] also delineates work and home as the two domains in this area. Clark further distinguishes them by their purposes, cultures, rules, expectations and behaviours. Conflicts between these two domains could be related to time, strain or behaviour.[80] Mothers in our studies describe all three types of conflicts between the two major domains, although there are also narratives of success by managing to integrate the various sub-domains.

Mothers described the time it takes for the baby to adjust to breastfeeding, and prior to their return to work, to another mode of feeding, as being problematic. If the maternity leave duration is short, the perceived conflict may be greater. However, such a situation may also lead mothers to modify their strategies and start feeding other foods earlier. The feelings of tension, frustration and guilt expressed by some employed mothers in our studies are reflective of the ongoing conflict between domains and within the sub-domains. These emotions may also reflect the discrepancy between their goals or intentions and reality.

Segmenting – the other end of the continuum

Segmenting as a goal, illustrated by "shutting off from family matters whilst at work", could also be gleaned from these studies. There is a continuum between integration and segmentation. An individual may be satisfied with a clear segmentation between work and family life because it gives a break from one or the other domain within which that person's energy can be renewed.[86] Interestingly, another study among Indian doctors' work-family conflicts were not perceived as problematic due to a culture that accepted long working hours and the existence of family support at home.[97] Following Clark's findings, this could be seen as another example of segmentation. The participants in that study were relatively better off than those in our studies, possibly indicating that strategies differ depending on class and caste. However, women's satisfaction with the experience in one domain appears to be

more important than the actual number of hours spent in that domain for achieving role balance.[98] This finding was corroborated in this thesis through the reflections that the mothers had regarding their satisfaction with support (paper IV).

Both integration and segmentation of domains could thus mitigate, or possibly worsen, the different types of domain and sub-domain conflicts among mothers combining breastfeeding and other work. Finding the optimal position along the integration-segmentation continuum requires taking into account several factors, including the duration of maternity leave availed, the nature of the support and resources available to the mother, and her satisfaction with them. Striving to integrate or segment multiple domains could also be seen as a reflection of forethought and intentionality[99] and thus of mothers' steps towards agency in mangaging breastfeeding and other work.

Strategising Time and Space

Managing spatial challenges to ensure proximity

The spatial challenges, those that must somehow be managed in a good enough or satificing manner, point to the need for proximity between mother and infant. The busy sprawling urban backdrops posed several challenges to these mothers on a daily basis. These included long distances between the domains of home and workplace compounded by transport issues which they negotiated in various ways. For those who lived closer to the workplace, could work from home, had ensured their own means of transport, or had a longer maternity leave, addressing the spatial gaps could be less problematic.

Adverse conditions at the workplaces often made it undesirable to bring the infant to the workplace for breastfeeding or breastmilk expression during working hours. If this happened, it often was up to the mother herself to find or negotiate a space, indicating agentic action. Alternatively, mothers could create informal possibilities for breastfeeding during the working day with the help of co-workers. One can differentiate between work that separates the mother and child for long periods of time and that which does not. In rural areas of Africa and Asia, the seasonal distribution of women's workload still accommodates the needs of the young infant, as she/he is usually taken along to the fields where the mother works.[100] Maternity leave is the main contemporary social protection measure to support working mothers.[7] A maternity leave of less than 12 weeks correlated with unfavourable breastfeeding outcomes.[56] There is abundant evidence that workplaces should and can support breastfeeding employed mothers, in a variety of contexts, with designated facilities.[55, 101-103] Bar Yam's framework also identifies space or

proximity as a key element in workplace support for breastfeeding mothers.[78]

Applying Work/Family Border theory,[86] the spatial challenges are manifestations of the physical borders between domains which are relatively impermeable and inflexible in the studied contexts, with a few exceptions. After a period of maternity leave, mothers were basically left to their own devices to ensure proximity through carefully planned actions or ad-hoc tactics within and between domains and borders. Ensuring an adequate length of maternity leave and safe and hygienic workplace facilities become all the more important as measures to facilitate proximity between mother and infant during the first year of life and thereby enabling continued breastfeeding.

Managing time for efficiency

Time management was among the key strategies used in combining breastfeeding and other work, especially amongst those mothers who worked long shifts. Mothers need to be efficient as they have many tasks competing for their time. They actively managed their time to accommodate and prioritise breastfeeding either during the working day or their off-time. Plans were sometimes made beforehand, during pregnancy or maternity leave. Sometimes plans for alternative infant feeding modes had to be made or modified due to prevailing circumstances. Having to work long scheduled work shifts is an example of inflexible temporal borders. Flexible working hours were rare; however, combining breastfeeding breaks during the working day with a reduction of working hours is an example of how mothers could modify their strategies under the given circumstances.

Time has already been identified as a key aspect of the conceptual framework for supporting breastfeeding amongst working women.[78] However, the framework does not really acknowledge mothers' own time management strategies. That being said, a longer leave of six months' time was still not enough for some mothers to adjust and optimize infant feeding, and mothers felt tension, frustration and guilt. The time cost of exclusive breastfeeding has recently been estimated to be six hours more per week than mixed feeding[104] and this has implications for mothers' time constraints. Mothers in the present studies used various anticipatory strategies and trouble-shooting tactics to satisfice, however, more time in the form of longer maternity leave would have been necessary for some. This would be especially relevant in the contexts of the relatively shorter maternity leave in Tanzania. In the Indian context, the women who availed themselves by taking their maternity leave antenatally shortened the period of postpartum leave, whereas a longer leave would have been beneficial to support them to breastfeed.

Once the women returned to work, they required time to breastfeed or express breastmilk at work. Breastfeeding breaks were available in both set-

tings, although the implementation of these breaks varied considerably. The implementation of breastfeeding breaks has been shown in a meta-analysis to be correlated with increase in the exclusive breastfeeding rate.[105, 106] The legislated breastfeeding breaks during the working day are available in several countries and this has increased over the past decade.[106] Although the same global survey shows that several categories of workers may be excluded from the legislative coverage at national level, the existence of the legislated breastfeeding breaks can serve to reinforce the norm and change attitudes in the society as a whole,[106] and thereby potentially benefitting, for example, informal sector workers.

Hence, providing flexible working hours, breastfeeding breaks or reduction of working hours would likely facilitate a more optimal combination of breastfeeding and other work. This would also enhance mothers' own time management plans and agentic strategies to be able to establish and continue breastfeeding once they return to work.

Negotiating to Maximize Support

Negotiating for support is also part of agency

Negotiations with family, employers, colleagues and informal networks for support to manage the combination of breastfeeding and other work were all found to be paramount in this thesis. All features of agency: intentionality, forethought, self-reactiveness and self-reflectiveness[81] were displayed both individually, collectively and by proxy, but to different extents. The approaches to agency further signify that there are several ways of being agentic. Despite their socio-economic status, mothers displayed agency, though often by proxy, for example, through "relying wholeheartedly on a mother figure" or other informal networks. Thus Clark's[86] posit of the pro-active rather than reactive border-crosser is reflected in our studies in various ways, as mothers often exhibited intentional actions as illustrated in the previous section. Finding an alloparent, a concerned partner, mother-in-law or external caretaker who can help with the care of the infant when the mother is at work[61] is confirmed in the urban contexts of this thesis. The alloparent concept then becomes a form of collective agency, mediated through shared intentions, discussions, reactiveness and reflection, as described by Bandura[81] and found in this thesis. The hierarchies of power within the patriarchal families[107] could also limit access to support or at least make it more difficult to negotiate, a conclusion that was reflected in our various studies.

Utility of Bandura's agency constructs

Bandura's agency constructs[81] enabled an adequate description of agentic features, their elements and modes in this thesis. However, they do not suffice to fully understand the linkages and distinctions between certain features, for example, between forethought and intentionality. Furthemore, agency appears to be more of a cyclical process in the contexts studied here rather than linear, as originally described by Bandura. Bandura's agency modes[81] also provide useful analytical constructs to understand how agency manifests itself across the continuum of individual to collective, but distinguishing between the different modes of agency is not absolutely clear. The work of Allendorf in similar South Asian contexts[108, 109] provides further insights into how the extended family dynamics and relationship quality could affect agency.[108] Her family and relationship constructs could provide support in differentiating between the different modes of agency described by Bandura.

When studying the different modes of agency among Indian health workers, we found that the proxy mode[81] was not directly evident. The absence of the proxy mode of agency (paper IV) was then explained in terms of it potentially being hidden under the collective agency mode. However, upon reflection, this could equally be a real observation. Bar Yam added the construct of gatekeepers at the workplace or in the social environment to the original conceptual framework of time, space/proximity and support.[78] This construct of gatekeepers underpins even further the findings that women rely on others and are recipients of social support and seemingly implies a more passive role of the woman herself. On the other hand, the gatekeeper construct could also be compared to the proxy mode of agency.

Negotiating with many within the context of changing family structures

The diversity in sources and nature of support from the social network, including partners, family, neighbours, and work colleagues and employers, was evident. Social support is crucial to the promotion of behavior change in many realms.[77, 110] The rapid urbanization scenarios create different family constellations that may or may not be supportive for young mothers or parents in general. Informal support networks composed of neighbours and friends were thus found to be strong and authoritative in a similar Tanzanian setting.[111] Furthermore, the nature of women's work changes rapidly in the urban African contexts.[5] The changes can be seen in both the nature of work, working conditions, job security and, ultimately, maternity protection. In the South Asian contexts, there are similar trends, however, the 'traditional' family structures appear to be more intact.[102] Hirani describes the supportive family environment that Pakistani mothers had for combining breastfeeding

and employment.[102] Similarly, the profiles of Indonesian working mothers who practiced exclusive breastfeeding included having family support.[112]

The role of men as fathers and supportive partners

Our findings that husbands and partners were influential in decisions, both supportively and less so, indicate that both parents should be supported through the healthcare and social protection systems. Nuclear families are a growing trend in all urban areas.[10] Mbekenga also found that the role of husbands and partners was heightened in peri-urban areas of Dar es Salaam and the potential to engage them proactively in postpartum healthcare should be encouraged.[113, 114] The changing family structures in urban areas perhaps create opportunities for women to have potentially more decision-making power but perhaps also afford them less access to social support from the extended family. Studies in similar settings indicate that new mothers and fathers need more than just informational support and to utilise their informal networks.[111, 113] This would then require interventions to modify the attitudes and practices of women's family, workplace and informal social networks to be more inclusive of men's roles. A broader approach to maternity protection would then be timely, for example, exploring paternity and parental leave in addition to maternity leave to facilitate shared responsibilities in the care of the infant, and in domestic and other work. Catering to the infant feeding counselling needs of both parents and other family members should be included in national health and nutrition policies and programmes throughought the reproductive continuum, starting with antenatal care (ANC). Although not explicitly mentioned in this thesis, the implications of the HIV/AIDS pandemic on breastfeeding warrant further attention at the national level. National policies on infant feeding should consider how to support appropriate infant feeding practices to enhance HIV-free survival in the context of women's work.

In conclusion, the mothers in these contexts appear to be able to negotiate the support they require to a large extent and, if not, modify their own intentions and strategies, implying that the process of gaining support could be considered as agentic action in itself, albeit not optimal. Explanatory frameworks need to acknowlege the agentic action, both individual and collective, and relationships and power dynamics within the domains of work and home, in negotiating maximum support for managing breastfeeding and other work.

Methodological Considerations

This thesis is based primarily on qualitative inductive reasoning processes where data are used to generate ideas through interpretation and

structuring.[115] In the fourth paper, a deductive directed approach[94] was also used as part of the qualitative design of the thesis.

In qualitative research, trustworthiness is addressed by using four criteria developed by Guba and accepted by many.[116] These criteria are credibility, transferability, dependability and confirmability. The criteria are described below, with examples of the provisions made in this thesis to help ensure each one was achieved in as far as possible. The final section deals with my own pre-understanding or reflexivity throughout the research process.

Credibility

This criterion corresponds to the congruency between the findings and reality.[117] To enhance the credibility of this study, several steps were taken. Well-established methods of data collection, handling and analysis were used throughought. The main data collection method was the qualitative semi-structured individual interviews described by Kvale and Brinkmann[88] as "an interview, whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena". Some issues concerning interviews as a data collection method require discussion. More than two-thirds of the interviews were conducted in Swahili or Hindi and subsequently translated to English for analysis. Inevitably, translation results in some loss of meaning of language. Generally, cross-cultural research poses both challenges and benefits.[118] These were addressed by having research teams that included those with knowledge of Swahili, Hindi, English, the socio-cultural context, outsider/insider perspectives, as well as various disciplines, including health, nutrition, midwifery and sociology. Care was taken to train and involve the research assistants in all aspects of data collection and handling. Field notes were taken in conjunction with the interviews and analysed together with the interview text and interviewer, typically enriching the interpretation of the ambience of the interview. We also attempted to select participants with different characteristics to contribute to triangulation and theoretical purposive sampling, which are other ways of ensuring credibility. In India, it proved to be difficult to find participants from the lower socio-economic levels (SES) as these women were often employed in more menial jobs and not covered by the six-month maternity leave policy. This would imply that our study findings in that setting would apply to relatively better-off and more educated segments of the population. Most likely, the experiences of women of lower SES would be more challenging. Regular peer-debriefing in the form of workshops, seminars and conference presentations helped to challenge interpretive assumptions and refine methodological choices made by the investigating team.

Transferability

Transferability is concerned with the extent to which the findings of one study can be applied to other situations, and is claimed at conceptual levels. To facilitate the readers' judgement of the transferability of the findings of this thesis, several measures have been taken. Provision of a rich contextual description of the study setting, recruitment, participants and analysis could enable the reader to draw similarities over contexts, settings and groups. The limitations of the study in terms of number and type of people involved in the research, both as participants and researchers, the data collection methods used, the number and length of the interviews and the time period over which the data collection took place, also provide the reader with boundaries within which transferability can occur.

Dependability

Dependability deals with the effect on the results of change over time in data collection and analysis.[117] The very essence of naturalistic inquiry entails changing phenomena over time and individuals.[116] For the purposes of the studies in this thesis, we have reported the consistency of procedures used both in the study design, sampling, data collection/analysis and issues of reflexivity. There is a balance between consistency and the use of new insights as the research process develops. Thus the reader may attempt to repeat the studies, albeit the findings and conclusions may not be exactly the same.

Confirmability

Confirmability deals with the extent that findings are grounded in the data and not unduly affected by researchers' pre-understanding.[117] Lincoln and Guba emphasize the connection between confirmability and dependability.[116] In this thesis, as in all qualitative research, data collection, interpretations and conclusions are a result of an interaction between the participants and the researchers. Thus, reflexivity was made an integral part of the research process to balance and make the contribution of these elements clear. To enable multiple perspectives on the studied phenomena, the research team was composed of persons belonging to different genders and ethnicity, speaking different languages, and members of different professions and age groups. Repeated discussions within the research group helped to ensure that both insider and outsider perspectives came forth and that the findings and conclusions reflect the participants' perspectives, primarily. An audit trail with raw data, major decisions, field notes, coding, and other analytical products have been saved and can be made available upon request.

Reflexivity

My own experience of being a working mother heavily influenced my interest in this topic. My own pre-understanding was laden with this personal experience, and training and work experience. In 2000, I was involved in the Maternity Protection Campaign for revision of the ILO Maternity Protection Convention. The work brought to light the many challenges that women face in various settings, but also a recognition of the efforts women themselves made to overcome these challenges and what might be needed to fill the gaps. During parts of the research process I felt overwhelmed with the multiple realities "out there" and could not see patterns and themes. These transient feelings usually susbided after regular discussions with my research colleagues and supervisors and reflecting over how my own pre-understanding developed through the research process. The use of different methods of analysis also helped to broaden my perspectives and keep an "open mind". Overall, I developed a deep respect for women's resiliency in the face of all the multi-layered challenges and also an acknowledgement that being an agent is a *process* rather than an inherent quality.

Conclusions and recommendations

Conclusions

This thesis concludes that managing breastfeeding with other work entails the balancing of multiple competing domains for mothers. Mothers strive along a continuum of integration and segmentation to reduce the perceived inter- and intra-domain conflicts. Mothers' perceptions on breastfeeding and other work are based on both their own knowledge and prevailing socio-cultural beliefs. Similarly, approaches to support for infant feeding display great diversity in heterogenous urban settings. Therefore, an individual approach must be taken.

Managing to combine breastfeeding and employment involves the active management of, primarily, the temporal and spatial constraints faced. This indicates agential action on the part of the mother and her collective environment.

Mothers in the studied contexts appear to be able to negotiate the support they require to a large extent. If they are not successful, they can modify their own intentions and strategies, implying that the process of garnering support could be considered as agentic action in itself, even if the support received is not optimal.

The various manifestations of agency, illustrated by timely planning, discussions, and creative collaborative actions of both anticipatory and trouble-shooting nature, deserve to be acknowledged and supported in health promotion and counselling interventions geared towards individual mothers, their partners, families and their communities.

Explanatory frameworks also need to acknowledge the agentic action, both individual and collective and by proxy, and relationships and power dynamics within the domains of work and home, in negotiating maximum support for balancing breastfeeding and other work.

In applying Work/Family Border theory, the temporal and spatial challenges are manifestations of the physical borders between domains which are relatively impermeable and inflexible in the studied contexts, with a few exceptions. After a period of maternity leave, mothers were basically left to their own devices to ensure proximity and manage their time through careful planned actions or ad-hoc tactics within and between domains and borders of home and work.

Recommendations

The individual and dynamic nature of perceptions, experiences and ways of managing require both diversity and flexibility in intervention approaches.

As the sources of influence and potential support for mothers vary depending on the mother's context, health and social services need to cater to fathers, parents, in-laws, and colleagues/friends. This means the wider promotion and support of these strategies than to just mothers, especially in the heterogeneous urban settings studied.

The investigations of both individual and collective agency constructs described by Bandura in combining breastfeeding and employment require both cognitive/rational and emotive assessments.

An adequate length of maternity leave and safe and hygienic workplace facilities become all the more important as measures to facilitate proximity between mother and infant during the first year of life, thereby enabling continued breastfeeding.

The provision of flexible working hours, breastfeeding breaks or reduction of working hours would likely facilitate a more optimal combination of breastfeeding and other work and enhance mothers' own agentic actions.

Strengthening women's own efforts and those of their families through community interventions could provide a sustainable complementary approach to that of strengthening healthcare service delivery. Structural barriers, such as low staffing, case load and logistical issues, would indicate that, in addition to the training of health workers in breastfeeding support, other urgent challenges must be overcome as well.

The existing paradigm of protect, promote and support breastfeeding is still valid, however, it may be time to change the messaging by using inform, educate and empower to promote a more optimal combination of breastfeeding and other work.

There is a need to assess the combination of breastfeeding and other work in other, both formal and informal, work sectors. A further investigation into how agency develops over the reproductive continuum would be warranted.

Intervention studies using community-based organisations targeting working mothers in various sectors are also timely.There is a need to explore the role of single-parent, nuclear versus large families in combining breastfeeding and other work.

Summary in English

The successful combination of womens' reproductive and productive roles can impact positively on their children's health, their own health, and contribute to increased empowerment and productivity. This is of significance globally, but especially in low or middle-income fast-growing urban settings and among women working either in the domestic, informal or formal employment spheres. There are long-term benefits for the society as a whole in terms of public health, gender equity and sustainable development. Combining breastfeeding and work is often a challenge due to the multiple demands on women's time and efforts and lack of adequate support at different levels. The aim of this thesis was to gain a deeper understanding of mothers' perspectives on combining breastfeeding and other work in the urban contexts of Dar es Salaam, Tanzania and New Delhi, India. We used semi-structured interviews for data collection and three methods for analysis. Firstly, Qualitative Content Analysis (QCA) was used for interviews with eight community mothers[1] and twelve health worker mothers in low-income districts of Dar es Salaam, Tanzania. Secondly, a Grounded Theory approach was used to analyse interviews with twenty women working in the governmental health and education sectors in New Delhi, India. Thirdly, deductive and inductive QCA were used to re-analyse the interviews with the ten Indian women health workers.

The first paper in this thesis describes the multiple approaches to support while adjusting infant feeding and work among the community mothers in Dar es Salaam. Understanding mother's perceptions of and approaches to support for infant feeding is important for designing culturally-relevant and effective counselling interventions. The mothers spoke of how infant feeding, housework and paid job have to adjust to each other. They perceived that breastfeeding has many benefits, however, water or breast milk can be given to quench a baby's thirst and that crying provides guidance for infant feeding. Mothers related in different ways to support, either by adhering to diverse sources; relying wholeheartedly on a mother figure; working as a parental team or by making arrangements for absence from the child. A counselling strategy should include an individual approach to the woman's perceptions of baby feeding, particularly in relation to baby crying and the role of significant others, more specifically the father. The timing and manner of giving advice should also be addressed.

The second paper describes the creative ways of managing infant feeding and employment among health workers in Dar es Salaam. Health workers are central in promoting optimal infant feeding practices and their own experiences of managing breastfeeding and employment are important in their own right as well as potentially impacting on their advice to mothers in the communities. The study described how health workers were concerned about optimising their infant feeding; doing a good enough job and making the best of their own ability. They managed infant feeding and employment in various ways. They made preparations during pregnancy and maternity leave; maximised breastfeeding during time off work; created time to breastfeed during the working day and found someone else to manage infant feeding during absence at work. These findings highlight the importance of acknowledging the efficacious role that employed mothers themselves play in handling their own infant feeding and paid work beyond the concepts coined by Bar Yam and frequently used; time, space/proximity, support and gatekeepers. Diverse workplace and family solutions are required to cater for their different needs.

The third paper showcases the "good enough" strategies in combining breastfeeding and employment among Indian health and education workers. A short duration of maternity leave with corresponding challenges revealed efficacious actions, among the Tanzanian health workers. Studying employed women in a different socio-economic and cultural setting with longer maternity leave such as India, could help to further understand the factors involved at various levels. A Grounded Theory model of how working women negotiate the tensions of having to attach and detach concurrently from their baby, family/social obligations and employment was revealed. To navigate these tensions, they used various satisficing or "good enough" strategies and tactics, both anticipatory and of a troubleshooting nature. Infant feeding/breastfeeding is part of ensuring trusted nutrition and care and includes much tension, negotiation and compromise in the social and work context. In spite of a relatively generous maternity leave of 6 months available to these women, several individual, socio-cultural and workplace factors interact to hinder or facilitate the process of combining breastfeeding and work. Interventions to improve exclusive breastfeeding practices need to address these factors at the individual, family, workplace and healthcare levels in addition to the provision of paid maternity leave.

The fourth paper examined the individual and collective agency in combining breastfeeding and employment among Indian health workers. The strategies and tactics revealed by the employed mothers in the previous paper[3] led us to investigate whether these could possibly be classified as manifestations of Agency and if so, what does Agency look like in this Indian health workers in a middle income setting? Understanding Agency and its variations is important in enhancing women's empowerment. This paper aimed at exploring manifestations of agency in combining breastfeeding and

employment amongst the sub-set of Indian health workers using Bandura's theoretical constructs of agency and women's experience.

The Agency constructs specify that intentionality is underpinned by knowledge, forethought means being prepared, self-reactiveness includes collaboration and that self-reflectiveness gives perspective. Agency in this context is manifested in four different approaches, entitled: 'All within my stride or the knowledgeable navigator'; 'Much harder than expected, but ok overall'; 'This is a very lonely job'; and 'Out of my control'. As such, agency features and their elements are complex, dynamic and involve family members. Bandura's theoretical agency constructs are somewhat useful in this context, but need the support of social practice constructs of family structure/relationship quality to better understand agency. The variation in individual approaches to agency has implications for supportive health and workplace services.

This thesis concludes that combining breastfeeding and other work entails managing multiple competing domains. Mothers strive along a continuum of integration and segmentation to reduce perceived inter- and intra-domain conflicts. Mothers' perceptions on breastfeeding and other work are based on both their own knowledge and prevailing socio-cultural beliefs. Similarly, approaches to support for infant feeding display great diversity in heterogenous urban settings. Therefore, an individual approach must be taken. Combining breastfeeding and employment involves the active management of, primarily, the temporal and spatial constraints faced. This indicates agential action on the part of the mother and her collective environment. Mothers in the studied contexts appear to be able to negotiate the support they require to a large extent and, if not, modify their own intentions and strategies, implying that the process of gaining support could be considered as agentic action in itself, albeit not optimal. The various manifestations of agency, illustrated by timely planning, discussions, and creative collaborative actions of both anticipatory and troubleshooting nature, deserve to be acknowledged and supported in health promotion and counselling interventions geared towards individual mothers, their partners, families and their communities. Explanatory frameworks also need to acknowledge the agentic action, both individual and collective and by proxy, and relationships and power dynamics within the domains of work and home, in negotiating maximum support for balancing breastfeeding and other work. In applying Work/Family Border theory, the temporal and spatial challenges are manifestations of the physical borders between domains which are relatively impermeable and inflexible in the studied contexts, with a few exceptions. After a period of maternity leave, mothers were basically left to their own devices to ensure proximity and manage their time through careful planned actions or ad-hoc tactics within and between domains and borders of home and work.

Summary in Swedish

Att framgångsrikt kombinera kvinnors reproduktiva och produktiva roller kan ha en positiv inverkan på deras barns hälsa, sin egen hälsa, och bidra till ökad egenmakt och produktivitet. Detta har betydelse globalt, men särskilt i snabbt växande stadsmiljöer med låg eller medelinkomst och bland kvinnor som arbetar antingen i hemmet, eller utanför. Det finns långsiktiga fördelar för samhället som helhet när det gäller folkhälsa, jämställdhet och hållbar utveckling. Att kombinera amning och arbete är ofta en utmaning på grund av höga krav på kvinnors tid och ansträngningar och brist på adekvat stöd på olika nivåer.

Syftet med denna avhandling var att få en djupare förståelse för mödrars perspektiv på att kombinera amning och annat arbete i storstäder som Dar es Salaam, Tanzania och New Delhi, Indien. Vi använde semistrukturerade intervjuer för datainsamling och tre metoder för analys. För det första användes kvalitativ innehållsanalys (QCA) för intervjuer med åtta mödrar och tolv hälsoarbetare i låginkomst distrikten i Dar es Salaam, Tanzania. För det andra användes en Grounded Theory metod för att analysera intervjuer med tjugo kvinnor som arbetade inom statliga hälso- och utbildningssektorerna i New Delhi, Indien. För det tredje, används deduktiv och induktiv QCA för att åter analysera intervjuerna med en subgrupp av de tjugo indiska kvinnorna, intervjuades tio vårdpersonal.

Den första artikeln i denna avhandling beskriver de olika förhållningssätten till stöd medan du justerar spädbarnsuppfödning och arbete bland mödrarna i Dar es Salaam. Att förstå mödrars uppfattningar om och förhållningssätt till stöd för spädbarnsuppfödning är viktigt för att utveckla kulturellt relevanta och effektiva rådgivningsinsatser. Mammorna talade om hur spädbarnsuppfödning, hushållsarbete och betalt arbete måste anpassas till varandra. De förstod att amning har många fördelar, men ansåg att vatten eller bröstmjölk kan ges för att släcka törst och att barnets gråtmönster ger vägledning för spädbarnsuppfödning. Mödrar relaterade på olika sätt till stöd, antingen genom att följa olika källor; förlita sig helhjärtat på en modersgestalt; arbeta som ett föräldralag eller genom att ordna med någon annan person inför frånvaro från barnet. En rådgivningsstrategi bör innehålla en individuell inställning till kvinnans uppfattningar om barn uppfödning, särskilt i förhållande till barnets gråt och den roll som närstående, mer specifikt fadern kan anta. Tidpunkten och sättet för att ge råd bör också anpassas.

Den andra artikeln beskriver de kreativa sätt att hantera spädbarnsuppfödning och sysselsättningen bland vårdpersonal i Dar es Salaam. Hälsoarbetarnas roll är central för att främja optimala praxis och deras egna erfarenheter av att hantera amning och sysselsättning är viktiga i sig, samtidigt som det potentiellt påverkar deras råd till mödrar i samhället. Studien beskriver hur hälsoarbetare var angelägna av att optimera sin egen spädbarnsuppfödning; gör ett tillräckligt bra jobb och göra det bästa av sin egen förmåga. De hanterade spädbarnsuppfödning och sysselsättning på olika sätt. De förberedde sig under graviditeten och mammaledigheten; maximerad amning under ledighet från arbetet; skapade tid att amma under arbetsdagen och hittade någon annan att handha spädbarnsuppfödning under frånvaro på jobbet. Dessa resultat understryker vikten av att erkänna den effektiva roll som anställda mödrar själva spelar i hanteringen av sin egen spädbarnsuppfödning och betald arbete bortom begreppen myntade av Bar Yam och vanligt förekommande; tid, utrymme/närhet, stöd och portvakter. Diverse arbetsplats och familjelösningar krävs för att tillgodose deras olika behov.

Den tredje artikeln visar upp de "tillräckligt bra" strategierna för att kombinera amning och sysselsättning som används av indiska kvinnor som är anställda inom hälso- och utbildnings sektorerna. En kort mammaledighet med motsvarande utmaningar avslöjade effektiva åtgärder, bland de tanzaniska hälsoarbetarna. Att studera anställda kvinnor i en annan socioekonomisk och kulturell miljö med längre mammaledighet som i Indien, skulle kunna bidra till en ytterligare förståelse av faktorerna på olika nivåer. En Grounded theory modell för hur arbetande kvinnor parerar konflikterna mellan att samtidigt tillgodose sina barn, skyldigheter mot familjen / och socialt och en anställning avslöjades. För att navigera dessa spänningar, använde de olika tillfredställande eller "tillräckligt bra" strategier och taktiker, både förebyggande och vid behov. Amning som en viktig del av att säkerställa god näring och omsorg omfattar mycket stress, förhandlingar och kompromisser i det sociala och på arbetsplatsen. Trots att dessa kvinnor hade en relativt generöst tilltagen mammaledighet på 6 månader till sitt förfogande, samverkade flera enskilda-, sociokulturella- och arbetsplatsmässiga faktorer för att hindra eller underlätta processen att kombinera amning och arbete. Interventioner för att förbättra exklusiv amning i praktiken måste ta itu med dessa faktorer på individ, familj, arbetsplats och sjukvårdsnivåer utöver tillhandahållandet av betald mammaledighet.

Den fjärde artikeln undersökte individuella och kollektiva åtgärder för att kombinera amning och anställning bland indisk vårdpersonal. De strategier och taktiker som uppdagades hos de anställda mödrarna i föregående artikel, fick oss att undersöka om dessa möjligen skulle kunna klassificeras som manifestationer av handlingskraft, och i så fall hur detta ser ut bland indiska hälsoarbetare? Att förstå handlingskraftighet och dess variationer är viktigt för att öka kvinnors självbestämmande. Denna uppsats syftar till att undersöka manifestationer av handlingskraft i att kombinera amning och syssel-

sättning hos en grupp indisk vårdpersonal genom att använda Banduras teoretiska konstruktioner för handlingskraft och kvinnors erfarenheter.

Banduras konstruktioner anger att intentionalitet stöds av kunskap, förtänksamhet innebär förberedelse, självagerande omfattar samarbete och att själv-reflektion ger perspektiv. Handlingskraft tar sig uttryck i fyra olika förhållningssätt benämnda som: "Allt inom räckhåll eller den kunniga navigatören '; "Mycket svårare än väntat, men ok överlag"; Detta är ett mycket ensamt jobb "; och "Utanför min kontroll". Som sådan är handlingskraft och dess beståndsdelar mycket komplexa, dynamiska och involverar familjemedlemmar. Bandura teoretiska handlingskraft-konstruktioner är i viss mån användbara i sammanhanget, men behöver stöd av sociala praxis konstruktioner av familjestruktur/ relationskvalitet för att bättre förstå konceptet handlingskraft. Variationen av enskilda förhållningssätt till handlingskraft har konsekvenser för stödjande hälso- och arbetsplatstjänster.

Denna avhandling drar slutsatsen att kombinera amning och annat arbete innebär att balansera flera konkurrerande domäner. Mödrar strävar längs ett kontinuum av integration och segmentering för att minska upplevda konflikter mellan och inom domänen. Mödrars uppfattning om amning och annat arbete bygger på både deras egen kunskap och rådande sociokulturella föreställningar. Likaså stöd till spädbarnsuppfödning visar på stor mångfald i heterogena stadsmiljöer. Därför krävs ett individuellt förhållningssätt. Att kombinera amning och sysselsättning kräver den aktiva förvaltningen av, i första hand, av de tidsmässiga och rumsliga begränsningar som mamman står inför. Detta indikerar handlingskraftigt agerande hos mamman och hennes närmaste omgivning.

Mammorna i de här sammanhangen tycks kunna förhandla det stöd de behöver i stor utsträckning, och, om inte, anpassar dom sina egna planer och strategier, vilket innebär att processen för att få stöd kan anses vara en handlingskraftig åtgärd i sig, även om stödet inte är optimalt.

De olika manifestationerna av handlingskraft, illustrerade av planering i god tid, diskussioner, och kreativa samarbetsåtgärder både förebyggande och vid behov, förtjänar att erkännas och stödjas i hälsofrämjande och rådgivningsinsatser riktade mot enskilda mödrar, deras partners, familjer och övriga samhället.

Konceptuella modeller bör också beakta handlingskraft och dess åtgärder, både på individuell och kollektiv nivå, och relationerna och maktdynamiken inom domänerna arbete och hem.

Vid tillämpningen av rådande teori om gränserna mellan arbete/ familj, är de tidsmässiga och rumsliga utmaningarna manifestationer av de fysiska och temporala gränserna mellan områden som är relativt ogenomträngliga och oflexibla i de studerade sammanhangen, med några få undantag. Efter en period av mammaledighet, får mödrarna i princip lämnas åt sitt öde för att säkerställa närhet och hantera sin tid genom noggrann planering inom och mellan domänerna hemmet och arbetet, och dess respektive gränser.

Abstract in Swahili

Uwezo wa kuambatanisha shughuli za kumnyonyesha mwana na kazi nyingine ina manufaa na ubora katika afya ya jamii na kwa uzalishaji wa mapato kutokana na ajira. Hii ni mara nyingi ni changamoto kwa akina mama ambao walio na kipato cha chini au cha kadiri. Lengo la utafiti huu (Thesis) ni kuchunguza na kuelewa jinsi ambavyo wamama huweza kulinganisha kunyonyesha na kazi zingine haswa katika mazingira ya mijini hasa mji wa Dar es salaam nchini Tanzania na New Delhi nchini India. Mahojiano ya moja-kwa-moja yalifanywa na akina mama wa jamii (n=8) na wamama wafanyikazi wa afya (n=12) katika mji wa Dar es salaam na wamama wanaofanya kazi katika sekta ya afya (n=10) na wanaofanya kazi katika sekta ya elimu (n=10) katika mji wa New Delhi. Mbinu tatu za uchambuzi zilitumika: Njia ya Ubora Uchambuzi wa Maudhui (Qualitative Content Analysis), Njia ya Msingi Nadharia (Grounded Theory and deductive/directed) na Njia ya kufuata ki ujumla (General inductive).

Lengo la hawa wamama ilikuwa kuunganisha ama kutenganisha baadhi ya kazi walizo nazo nyumbani na kazini, ili kupunguza migogoro inayoibuka wanapo unganisha kunyonyesha na kazi zingine walizo nazo. Vikwazo vya wakati vilifanya akina mama wajadialiane kuhusu mbinu wanazoweza kutumia ili kupunguza umbali kati yao na watoto wao na kuhakikisha kwamba wanaweza tumia wakati wao vyema. Mda wa kujipanga vizuri ilikuwa inalingana kutokea wakati mama anaposhika uja uzito mpaka atakapopata ruhsa ya kwenda kujifungua hadi atakaporudi kazini.

Likizo la uzazi lili changia pakubwa kuibua mbinu ambazo akina mama walitumia. walikubaliana kwamba kuunganisha kunyonyesha na kazi iliibua hisia kadha wa kadha kama vile huzuni, kuchanganyikiwa na pia furaha na hisia za kuridhika. Ili wapate msaada akina mama hawa walijadiliana na familia zao, waajiri na wenzao ili kuhakikisha kwamba walioajiriwa wana uwezo kutunza jamii zao.

Mabadiliko katika miundo ya familia na majukumu katika maeneo ya mijini inaonyesha kwamba usaidizi kutokana na jukumu la mpenzi au mume. Nadharia ya mpaka ya kazi/familia na elimu ya bandura (Bundura's agency) zilikuwa muhimu katika kutoa mfumo kwa kueleweka zaidi wa mitazamo wa mama, lakini zinahitaji maendeleo zaidi kutumia uhusiano zilizopo kwa familia ikionyesha ubora wa kubainisha aina tafatauti ya elimu(agency).Maeneo ya kazi na hali ya ulinzi uzazi kwa akina mama wa-

lioajiriwa ilionyesha wazi tofauti kubwa kati ya mahitaji iliyodhaniwa inapatikana na nini sasa inapatikana.

Hatua kadhaa zinahitajika ili: kuimarisha uwezo wa kina mama, kuwapa wanajamii na familia ujumbe, kuboresha hali ya kina mama wakiwa kazini na kuimarisha huduma za afya na jamii ili wamama waweze kusawazisha majukumu ya kunyonyesha na kazi zao.

Abstract in Hindi

जन–स्वास्थ्य और श्रम उत्पादकता दोनों लिहाज से स्तनपान करवाना एवं अन्य कार्य करना बहुत महत्वपूर्ण हैं। यह अक्सर माताओं, विशेषकर तेजी से फैलते शहरी माहौल में निम्न या मझोली आय वाली माताओं के लिए एक चुनौती होता है। इस धारणा का उद्देश्य दार एस सलाम (तंजानिया) और नई दिल्ली (भारत) के शहरी परिवेशों में स्तनपान करवाने के साथ अन्य कार्य करने के बारे में माताओं के नजरियों को गहराई से समझना है। दार एस सलाम में समुदाय की माताओं (n=8) एवं स्वास्थ्य कार्यकर्ता माताओं (n=12) और नई दिल्ली में स्वास्थ्य क्षेत्र में काम करने वाली माताओं (n=10) एवं शिक्षा के क्षेत्र में काम करने वाली माताओं (n=10) के साथ अर्द्ध–संरचित व्यक्तिगत साक्षात्कार किए गए। इनके विश्लेषण के तीन तरीके अपनाए गए : (1.) क्वालिटेटिव कंटेन्ट एनालिसिस यानी गुणात्मक सामग्री विश्लेषण (QCA), (2.) ग्राउंडेड थ्योरी अप्रोच एनालिसिस यानी बुनियादी सिद्धांत दृष्टिकोण, और (3.) डिडक्टिव/डायरेक्टेड एवं जनरल इंडक्टिव क्यू.सी.ए.यानी निगमनात्मक/निर्देशित एव एवं सामान्य प्रेरक गुणात्मक सामग्री विश्लेषण।

इन माताओं का एक उद्देश्य घर और कार्यस्थल पर कार्य के क्षेत्रों में एकीकरण या वर्गीकरण करना था ताकि स्तनपान करवाने और अन्य कार्य करने के बीच टकराव में कमी लाई जाए। समुचित स्थान और समय की कमी के चलते माताओं ने सावधानीपूर्वक नियोजित कदम और समस्या–निवारण के तरीके अपनाए, जिनमें उनके और उनके शिशु के बीच समीपता रखने और समय के कुशल प्रबंधन के तरीके भी शामिल हैं। उन्होंने गर्भावस्था से लेकर मातृत्व अवकाश और वापस नौकरी पर लौटने के समय के बारे में रणनीतिक कदमों का सहारा लिया। मातृत्व अवकाश की अवधि माताओं द्वारा अपनाए गए रणनीतिक कदमों में अनुकूल असर पैदा करती है। स्तनपान करवाने के साथ कार्यस्थल पर कार्य करने में न सिर्फ तनाव, कुंठा एवं ग्लानि जैसी भावनाएं, बल्कि संतुष्टि और खुशी भी शामिल होती हैं। माताओं ने समर्थन हासिल करने के लिए व्यक्तिगत, सामूहिक और प्रतिनिधि एजेंसी दोनों को दर्शाते हुए अपने परिवार, नियोक्ताओं, साथियों और अनौपचारिक नेटवर्क्स के साथ बातचीत की। शहरी इलाकों में बदलते पारिवारिक ढांचे और भूमिकाएं पार्टनर/पति के अधिक संभावित सहयोग को जाहिर करते हैं। काम/परिवार सीमा सिद्धांत और बंदुरा की एजेंसी द्वारा बनाई गई चीजें माताओं के दृष्टिकोणों के बारे में एक गहरी समझ की रूपरेखा देने में उपयोगी थीं, लेकिन एजेंसी के विभिन्न तरीकों के बीच अंतर करने के लिए मौजूदा पारिवारिक रिश्ते का इस्तेमाल करते हुए उसे आगे विकसित करना आवश्यक है। नौकरी कर रही महिलाओं के लिए कार्यस्थल और मातृत्व रक्षा की स्थितियों ने मान्य जरूरतों और वर्तमान में उपलब्ध सुविधाओं के बीच भारी अंतर जाहिर किए।

भिन्न–भिन्न स्तरों पर पहल करना आवश्यक है : कामकाजी महिलाओं की बढ़ती उम्र के मुताबिक क्षमता को मजबूत करना, परिवारों एवं समुदायों को सूचना देना, कार्यस्थल पर विनियमनकारी, संरचनात्मक और व्यवहार संबंधी स्थितियों में सुधार लाना और स्वास्थ्य एवं सामाजिक सेवाओं को मजबूत करना ताकि स्तनपान करवाने और अन्य कार्य करने के बीच संतुलन के लिए माताओं को पर्याप्त सहायता मिले।

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