

Examining the Practice of Exclusive Breastfeeding among Professional Working Mothers in Kumasi Metropolis of Ghana

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Abstract

This study examined the practice of exclusive breastfeeding among professional working mothers in Kumasi Metropolis of Ghana. The study design used for this research was cross-sectional survey. The study population consisted of professional working mothers, aged 40 or younger, who were in full-time employment and working in Kumasi metropolis of Ghana. Purposive and random samplings were also used and sample size was 1000. Questionnaire was the research instrument used in this study. From the study findings, even though the respondents were well-informed about exclusive breastfeeding, 48% of professional working mothers were able to practice exclusive breastfeeding and 52% could not practice exclusive breastfeeding according to World Health Organisation recommended practice of exclusive breastfeeding. The study concluded that professional working mothers find it difficult to exclusively breastfeed their babies and full time employment status and family members' influence undermine the practice of exclusive breastfeeding. It was recommended that government must guarantee that workplace is free of harassment and discrimination against women who prefer to breastfeed their babies through appropriate mechanisms and employers must provide breastfeeding and expressing facilities at the work place to be used by breastfeeding employees and these facilities have to be hygienic, comfortable and private and include hand washing and milk storage facilities.

Keywords: Exclusive breastfeeding, infant nutrition, breast milk, working mother

1.0 Introduction

Over the last two decades, there has been a growing attention in the endorsement of exclusive breastfeeding as the recommended feeding practice for newborns. This, to a great degree, has been encouraged by increasing scientific substantiation on the significance of exclusive breastfeeding in reducing infant morbidity and mortality. Exclusive breastfeeding is the most efficient type of infant feeding for the first six months of life. The United States Breastfeeding Committee (USBC) and the American Academy of Pediatrics (AAP) declare that breastfeeding is the physiologically normal form of infant and child feeding (Labbok & Taylor, 2008; AAP, 2012).

As such, breastfeeding should be fostered and encouraged by health care professionals and public health campaigns in order to normalize it within our culture. Numerous organisations endorse breast milk as the optimal source of nutrition for infants (American Academy of Family Physicians [AAFP], 2008; AAP, 2012; USBC, 2009; United States Department of Health and Human Services [USDHHS], 2011; World Health Organization [WHO], 2001). These organisations support exclusive breastfeeding for the first six months of an infant's life for multiple reasons.

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In resource inadequate settings where deprived and sub-optimal breastfeeding practices regularly result to child undernourishment which is a key cause of more than half of all child deaths (Sokol et al. 2007), exclusive breastfeeding is regarded as crucial for infants' continued existence. Undeniably, of the 6.9 million under five children who were reported dead globally in 2011, an estimated 1 million lives could have been saved by undemanding and accessible practices such as exclusive breastfeeding (WHO, 2012). Subsequently, the WHO and UNICEF (1990) have recommended exclusive breastfeeding for six months, followed by beginning of complementary foods and sustained breastfeeding for 24 months or more.

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

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

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

1.1 Statement of Problem

The benefits of exclusive breastfeeding for both mother and child are universally acknowledged by health providers, global health agencies, and lay people. In Ghana, an estimated 84% of children younger than 2 months are being exclusively breastfed. By age 4 to 5 months, nevertheless, only 49% continue to receive exclusive breastfeeding (Ghana Statistical Service & ICF Macro, 2009 p. 187). Many attempts and hard work to promote exclusive breastfeeding have achieved less than desired outcomes and in order to comprehend and appreciate the dynamics of the practice, a number of studies have been conducted in Ghana and in many parts of the world. Much of these studies have focused on factors and barriers to exclusive breastfeeding (Aidam et al. 2005; Otoo et al. 2009; Senarath et al. 2010). Several studies have looked at the health outcomes of exclusive and non exclusive breastfeeding (Duncan et al. 1993; Coutosoudis et al.1999; Kramer, 2003); whereas others have also considered the prospective position of husbands in breastfeeding decisions (Arora et al.2000; Susin, et al. 2008). Much less attempts however, have been made at examining the practice of exclusive breastfeeding among professional working mothers particularly in sub Saharan Africa. This research is therefore an undertaking to realise the present knowledge gaps.

1.3 Objectives of the Study

The main objective of the study was to examine the practice of exclusive breastfeeding among professional working mothers in Kumasi Metropolis of Ghana. The specific objectives of the study were the following:

1. To examine the sources and knowledge of exclusive breastfeeding information among professional working mothers Kumasi Metropolis.

2. To determine if professional working mothers know the benefits of exclusive breastfeeding practice.
3. To assess if employment status affect exclusive breastfeeding practice among professional working mothers.
4. To identify the extent of exclusive breastfeeding practice among professional working mothers.
5. To offer recommendation to help the realisation of exclusive breastfeeding practice.

1.4 Research Questions

The main research question for the study was what is the rate of practice of exclusive breastfeeding among professional working mothers in Kumasi Metropolis of Ghana?

Specific questions were the following:

1. What are the sources and knowledge of exclusive breastfeeding information among professional working mothers in Kumasi Metropolis?
2. Do professional working mothers know the benefits of exclusive breastfeeding practice?
3. Does employment status affect exclusive breastfeeding practice among professional working mothers?
4. What is the extent of exclusive breastfeeding practice among professional working mothers?

1.5 Significance of the Study

Millennium Development Goals item four of the eight is completely and totally dedicated to reducing child mortality by two-thirds between 1990 and 2015; with few years to 2015, nonetheless, steps forward in a lot of Africa countries is deficient in accomplishing this goal. Poor feeding practices such as sub-optimal breastfeeding is still pervasive and frequently leads to undernourishment which is a foremost cause of more than half of all child deaths (Sokol et al. 2007). Through research and identifying the practice of exclusive breastfeeding among professional working mothers in Ghana will add to an enhanced appreciative of how indispensable health interventions with established and confirmed empirical effectiveness including as exclusive breastfeeding can be enhanced and promoted. Again, it is believed that this research's findings will add to the rising body of scientific understanding and knowledge on newborn feeding practices and how to plan and position health interventions among professional working mothers. Additionally, this research will certainly provide a basis for future research.

2.0 Literature Review

2.1 What is Exclusive Breastfeeding?

According to World Health Organization exclusive breastfeeding means 'that the infant receives only breast milk. No other liquids or solids are given – not even water – with the exception of oral rehydration solution, or drops/syrups of vitamins, minerals or medicines'.

Breast milk is the natural and original first food for babies, it provides all the energy and nutrients that the infant needs for the first months of life, and it continues to provide up to half or more of a child's nutritional needs during the second half of the first year, and up to one-third during the second year of life.

WHO recommends 'that infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. Thereafter, infants should receive nutritionally adequate and safe complementary foods, while continuing to breastfeed for up to two years or more'. Breast milk contains all the nutrients infant requirements in the first six months of life.

It protects against common and widespread childhood diseases such as diarrhoea and pneumonia, and may also have longer-term benefits such as lowering mean blood pressure and cholesterol, and reducing the prevalence of obesity and type-2 diabetes.

To enable mothers to establish and sustain exclusive breastfeeding for 6 months, WHO and UNICEF recommend:

- Initiation of breastfeeding within the first hour of life
- Exclusive breastfeeding – that is the infant only receives breast milk without any additional food or drink, not even water
- Breastfeeding on demand – that is as often as the child wants, day and night
- No use of bottles, teats or pacifiers

2.2 Benefits of Exclusive Breastfeeding for Infants and Mothers

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

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

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

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

Breastfeeding reduces the mother's risk of fatal postpartum hemorrhage and premenopausal breast and ovarian cancer. Frequent and exclusive breastfeeding contributes to a delay in the return of fertility and helps protect women against anemia by conserving iron. Breastfeeding provides frequent interaction between mother and infant, fostering emotional bonds, a sense of security, and stimulus to the baby's developing brain (WHO, 2001).

2.3 Sources and Knowledge of Exclusive Breastfeeding Information

Formal breastfeeding policies in hospitals, staff and physician training in breastfeeding management, and rooming-in have been shown to positively affect breastfeeding promotion efforts (Kovach, 2002). Strategies such as the Baby-Friendly Hospital Initiative (BFHI), peer counselling, paternal support, and education of the mothers and health care professionals have been used to promote breastfeeding in the U.S. (Martens, 2000; Philipp et al., 2001).

A study showed that a 1.5-hour mandated breastfeeding education intervention of nursing staff significantly increased the compliance of the BFHI and breastfeeding beliefs over a 7-month period at the intervention site compared to control site. The rates of EBF also increased by 23% (31% vs.54%), and fewer nurses offered supplementation (45% vs. 87%) after the intervention (Martens, 2000). Although breastfeeding promotion or intervention programs have focused on educating the mothers, family members, and employers about the benefits of supporting breastfeeding, not much attention has been paid to the health professionals influencing these target groups. Surveys evaluating health care professionals' knowledge and attitudes about breastfeeding revealed that these professionals do strongly advocate to their clients that breastfeeding is the optimum method of infant feeding (Pascoe et al., 2002).

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

2.4 Professional Working Mothers and Exclusive Breastfeeding

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

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

Survey data from 10,530 women in Bristol, U.K., were analyzed to determine the association between breastfeeding and employment. Results showed that 79% ($n=8,316$) of the women initiated breastfeeding, and of the 4,837 mothers who planned to work postpartum, 83.5% of them initiated breastfeeding compared to 75.2% of the 5,693 mothers who did not plan to work postpartum ($P=0.001$). However, mothers who planned to return to work before six week postpartum were significantly ($P<0.05$) less likely to initiate breastfeeding compared to mothers who were not planning to return to work (Noble, 2001).

Other studies have also shown a competition between breastfeeding and work. In general, if a mother decides to return to work within six weeks postpartum, she is less likely to initiate breastfeeding (Meek, 2001; Roe et al., 1999; Scott & Binns, 1999).

Type of work and hours of work have also been shown to influence breastfeeding (Visness & Kennedy, 1997). For example, African-American women and white women returning to professional jobs breastfed longer compared to breastfeeding mothers in clerical jobs (Kurinij et al., 1989; Meek, 2001). Findings from a separate study of 1,179 (668 black and 511 white) women showed that women who intended to return to work did so by the month after delivery. Black women who intended to return to full-time employment (63%) had the lowest rate of breastfeeding, and those women who did not return to work until seven months postpartum breastfed their infants longer compared to those women who returned to work earlier.

Moreover, among black women those who intended to return to part time employment were twice as likely to initiate breastfeeding in the hospital compared to those women returning to full-time employment. However, this association was not noted among white women (Kurinij et al., 1989). Contrary to these findings, Visness & Kennedy (1997) found that white women in service occupations breastfed for a significantly longer duration compared to women in professional jobs, even after controlling for duration of maternity leave. Planning to be employed postpartum or being employed full-time decreased breastfeeding initiation and duration (Frank, 1998), while women working part-time increased breastfeeding initiation and duration as compared to women working full-time (Auerbach & Guss, 1984; Fein and Roe, 1998).

2.5 Exclusive Breastfeeding Trends in the Developing World

In acknowledgment of the indispensable responsibility of exclusive breastfeeding in respect of infants' continued existence strategies, numerous actions have gone into scaling up the rates in developing countries where prevalence of child malnutrition and mortality is still soaring. Nonetheless, successes in increasing the levels of exclusive breastfeeding have relatively been modest. In an analysis of data on exclusive breastfeeding from 38 developing countries between 1990 and 2000. Labook et al. (2006) reported an increase rate exclusive breastfeeding from 46% to 53% among infants younger than 4 months and from 34% to 39% for those younger than 6 months. Higher growth was acknowledged in urban areas (30% to 46%) than rural ones (42% to 48%). Even though there were increases in all the regions studied viz. Middle East/ North Africa (29% to 34%), South Asia (49% to 56%), East Asia/Pacific (57% to 65%); the most remarkable increment, on the other hand, was found in Sub Sahara Africa where the rate almost doubled from 18% in 1990 to 38% in 2000 (p. 275).

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

Despite the fact that it is still lower than the other regions, the fast increase in West and Central Africa is perhaps not a shock given that it thus far had and continues to have one of the least possible rates of exclusive breastfeeding in the developing world for which grounds exhaustive efforts were made to increase the practice in the last twenty years.

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

2.6 Exclusive Breastfeeding Practices in Ghana

Contrasting exclusive breastfeeding, breastfeeding is usually not predicament in Ghana. This is witnessed by the reality that as high as 98% of all infants younger than six months are being breastfed; and still at age 12 -15 months, 95% of children go on to obtain breast milk alongside with complementary foods. Exclusive breastfeeding on the other hand is short lived with an estimated 84% of children younger than 2 months being exclusively breastfed. Even though primarily higher, the percentage of children who go on to receive exclusive breastfeeding by age 4 to 5 months plummets to about 49% (Ghana Statistical Service & ICF Macro, 2009 p.186 - 188).

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

Unlike countries including Namibia, Nigeria, Tunisia, and Sudan, where the rate of bottle-feeding is as high as 30% (Sante, 2002), the percentage of bottle-fed infants in Ghana is estimated at 5% among infants younger than 2 months and 21% among those aged 6-8 months (GSS & ICF Macro p,188). At about six months of age and beyond an estimated 68% of Ghanaian breastfeeding children are given both solid and semisolid foods.

Most of these complementary foods are prepared from grains, meat, egg, fish, fruits, and vegetables (ibid).

3.0 Methodology

3.1 Study Design

In this study, the design used was cross-sectional, with data collected at a single point in time (Fink, 1995; Polit & Hungler, 1995). Cross-sectional study is straightforward in design and is designed at finding out the prevalence of a phenomenon, problem, attitude or issue by taking a picture or cross-section of the population.

3.2 Study Area

Kumasi metropolis is located in the transitional forest zone and is about 270km north of the national capital, Accra. It is between latitude 6.35o – 6.40o and longitude 1.30o – 1.35o, an elevation which ranges between 250 – 300 metres above sea level with an area of about 254 square kilometres. The unique centrality of the city as a traversing point from all parts of the country makes it a special place for many to migrate to.

The metropolitan area shares boundaries with Kwabre East District to the north, Atwima District to the west, Ejisu-Juaben Municipal to the east and Bosomtwe to the south. (Ministry of Local Government and Rural Development).

The Kumasi metropolis is the most populous district in the Ashanti Region. During the 2000 Population Census it recorded a figure of 1,170,270. It has been projected to have a population of 1,625,180 in 2006 based on a growth rate of 5.4% per annum and this accounts for just under a third (32.4%) of the region's population. During 2010 Population Census it also recorded 2,035,064 (Ghana Statistical Service). Kumasi has attracted such a large population partly because it is the regional capital, and also the most commercialised centre in the region. Other reasons include the centrality of Kumasi as a nodal city with major arterial routes linking it to other parts of the country.

3.3 Study Population

The population for this study consisted of professional working mothers, aged 40 or younger, who were in full-time employment and working in Kumasi Metropolis of Ghana.

3.4 Sampling Technique and Sample Size

Purposive sampling was used to select the professional working mothers in Kumasi Metropolis. The objective is to choose a group of participants who possess the characteristics of the population of interest so that the study results can be generalized. Random sampling was used in this study to increase the reliability of the survey estimates for obtaining samples that are unbiased and representative of the target population. Sample size of 1000 was used in this study.

Inclusion and Exclusion Criteria

In order to examine exclusive breastfeeding practice the study only integrated mothers with infants over 6 months postpartum and mothers with infants under 24 months when maternal recall exclusive breastfeeding practice is to be expected to be reliable and valid. Mothers of preterm children, and children with multiple gestations, birth defect or chronic disease were not involved in the study.

3.5 Research Instrument

A questionnaire was used in this study because it could be administered to larger numbers of respondents concurrently, with uniform instructions and explanations. The respondents were able to complete the questionnaire in a confidential setting, therefore diminishing possible bias connected to researcher presence, and devoid of instant time constraints.

3.6 Ethical Considerations

Ethical approval for the study was obtained the Ghana Health Service prior to data collection. Cautious thoughtfulness was given to protecting the respondents during the study, including during the production of the written report. The ethical decision making principles of respect for persons, beneficence and justice guided the research process (Ghana Health Service Code of Ethics, 7) *'All Service personnel shall respect confidential information obtained in the course of their duties. They shall not disclose such information without the consent of the patient/client, or person(s) entitled to act on their behalf except where the disclosure of information is required by law or is necessary in the public interest'*.

The study, along with the issue of voluntary participation, was explained in the introductory letter that contained the questionnaire.

The study was introduced with a statement welcoming participation, followed by an account of the following factors to guarantee that ethical considerations were being met: (a) investigator, (b) introduction/purpose, (c) procedure, (d) risk/side effects, (e) benefits, (f) voluntary participation/withdrawal and (g) confidentiality.

4.0 Results and Discussion

4.1.1 Age of Respondents

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

Table 1: Age of Respondents

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

Source: Field Survey, 2013

4.1.2 Educational Qualification of Respondents

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

Table 2: Educational Background of Respondents

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

Source: Field Survey, 2013

4.1.3 Categories of Respondents' Occupation

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

Table 3: Categories of Respondents' Occupation

Response	Frequency	Percentage
Education	130	13
Health	120	12
Banking, Finance and Insurance	115	11.5
Telecommunication	55	5.5
Media/ Information	85	8.5
Civil Societies	90	9
NGO's	70	7
Ministries	170	17
Security Agencies	85	8.5
Others	80	8
Total	1000	100

Source: Field survey, 2013

4.1.4 Respondents' knowledge on Exclusive Breastfeeding

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

4.1.5 Sources of Exclusive Breastfeeding Information

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

4.1.6 Benefits of Exclusive Breastfeeding

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

4.1.7 Barriers to exclusive breastfeeding among professional working mothers.

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

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

Table 4: Barriers to Exclusive Breastfeeding Working Mothers

Responses	Frequency	Percentage
Work status	905	90.5
Family influence	75	7.5
Mother's health	15	1.5
Others	5	0.5
Total	1000	100

Source: Field Survey, 2013

4.1.8 Challenges Working Mothers Face at Workplaces

Professional working mothers are supposed to return to work after they have exhausted their three months maternity leave. From Table five, more than half of the respondents (51%) said they leave their children at home to their families due to work pressure and go to breastfeed their children when they have break or family members regularly bring the children to the Work places for them to breastfeed their babies. Furthermore, 30.5% of the respondents said they do not have adequate time to breastfeeding their children and 17.5 % said there are no proper place for them to breastfeed their children at their various work places.

Table 5: Challenges Working Mothers at Workplaces

Responses	Frequency	Percentage
Inadequate time at work to breastfeed	305	30.5
No proper place to breastfeed	175	17.5
Child at home due to work pressure	510	51
Others	10	1
Total	1000	100

Source: Field Survey, 2013

4.1.8 Exclusive Breastfeeding practice among Professional Working Mothers

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

Table 6 Exclusive Breastfeeding Practice

Response	Frequency	Percentage
Yes	480	48
No	520	52
Total	1000	100

Source: Field survey, 2013

5.0 Conclusion

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

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

5.1 Recommendations

Based on the findings of the research, the following recommendations are made:

1. The government must guarantee that workplace is free of harassment and discrimination against women who prefer to breastfeed their babies through appropriate mechanisms.
2. Ministry of Employment must address women's right to breastfeed in the workplace as an unambiguous constituent of workplace training and ethics.
3. Employers must be legally fulfil to provide breastfeeding and expressing facilities at the work place to be used by breastfeeding employees and these facilities have to be hygienic, comfortable and private and include hand washing and milk storage facilities.
4. Professional working mothers must initiate and arrange childcare for the infant close to the mother's workplace to enable their babies to be brought to the workplace or breastfeeding mothers to go to the childcare facility at breastfeeding period.
5. Healthcare providers should continue to embark on educating general populace regarding the significance of exclusive breastfeeding to remove family negative influence particularly women in their prenatal period.
6. In order for mothers to exclusively breastfeed their babies, mothers require to appreciate the reasons that exclusive breastfeeding is best and they require to get positive messages about exclusive breastfeeding from friends and family members.

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