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# Towards A Comprehensive Breastfeeding-Friendly Workplace Environment: Insight From Selected Health Facilities In The Central Region of Ghana

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# Abstract

### Background

In the last three decades, Ghana has championed the objectives of the Baby Friendly Hospital Initiative to provide pregnant women and nursing mothers with skills and support necessary for optimal breastfeeding. Yet, little is known about practical interventions to promote breastfeeding friendly work environment in healthcare facilities. This study explores the extent to which healthcare facilities in Effutu Municipality provide breastfeeding friendly workplace environment to breastfeeding frontline health workers.

### Methods

A descriptive mixed-method approach was employed to collect data from healthcare facility representative and breastfeeding frontline health workers. Self-administered questionnaire with structured responses and interview guide were used to collect data. Thematic analysis was used to analyze interview responses. Survey responses were processed with SPSS version 23.0 and presented using frequencies and percentages.

### Results

Three main themes, namely, Standpoints on workplace breastfeeding support; Breastfeeding support, suggested future directions and six sub-themes, including backings for workplace breastfeeding support; perceived benefits of breastfeeding support; factors of poor breastfeeding workplace support; maternity protection benefits; workplace support gaps, and awareness creation on benefits were identified to explain the extent to which health facilities provide breastfeeding friendly workplace environment. Breastfeeding frontline health workers said their hospitals have no breastfeeding policy (96%), no breastfeeding facility (96%), do not go to work with baby (96%), but went on 12 weeks maternity leave (96%) and work half-day (70%) on return to work.

### Conclusion

Health facilities in the study do not provide breastfeeding friendly work environment except the privileges provided by the Labor Act. Continuous advocacy on breastfeeding workplace support and stakeholder engagement to build consensus on the mix of strategies suitable to cushion breastfeeding frontline health workers against work-breastfeeding stress and minimize its negative impact on optimal breastfeeding among frontline health workers is recommended.


# Background

Optimal breastfeeding practice is known to improve infant and child health and enhance cognitive ability in children [1]. In Ghana, breastfeeding practice is universal among mothers. Fifty-two percent (52%) of infants age 0-6 months are exclusively breastfed [2]. However, the country's effort to improve optimal

breastfeeding is hampered by insufficient information on breastfeeding, inadequate support systems, rapid urbanization, and associated formalization of women's work and poor family support [3]. Exclusive breastfeeding takes a dip during the third month of infants' life because of women returning to work after 3 months of maternity leave [1]. The dip in breastfeeding in the third month of infants' life is in part a reflection of insufficient organizational-level support systems and individual mother's attitudes and values [4]. While some employee mothers believe that extension of maternity leave would do the magic, other mothers are of the view that prioritizing home and workplace support systems for breastfeeding should be the approach to protect and promote optimal breastfeeding [5]. Thus, strategies to scale up optimal breastfeeding practice require harmonization of all elements for promoting, protecting, and improving breastfeeding appropriately.

In Ghana, breastfeeding program is based on a multi-partnership approach with the Ministry of Health (MOH) and the Ghana Health Service (GHS) at the forefront of policy and strategy development. Ghana began implementing the Innocenti Declaration of 1990 five years after it has been launched. This involved the implementation of "*Ten Steps*" to successful breastfeeding and the breastfeeding code. The aim of the Baby-Friendly Hospital Initiative (BFHI) in Ghana has been to socialize midwives to become aware of information and skills for breastfeeding and to provide nursing mothers with skills and support necessary for optimal breastfeeding. Becoming Breastfeeding Friendly (BBF) assessments conducted in Ghana shows that the country has a moderate breastfeeding scale-up environment [4, 6, 7]. The BFHI has been revived and relaunched to achieve its aim.

The BFHI is perceived by stakeholders as one of the sure ways to protect and promote breastfeeding. However, maternal work, particularly paid work is limiting optimal breastfeeding practice in emerging industrial economies such as Ghana, making breastfeeding and childcare support intervention necessary. If BFHI is a vital element of breastfeeding promotion and support in Ghana, then the extension of this initiative to workplaces cannot be overemphasized. Today, most Ghanaian health facilities are accredited as baby friendly. Though baby-friendly protocols and strategies dominate maternity services, there is little empirical evidence of how these protocols and policies translate into a breastfeeding friendly workplace environment for breastfeeding frontline health workers. We test this assertion by exploring the extent to which healthcare facilities in the Effutu Municipality in the Central Region of Ghana provide a breastfeeding friendly workplace environment for breastfeeding frontline health workers using a descriptive mixed-method approach. To achieve this aim, we asked three main questions: 1). To what extent do healthcare facilities in Effutu Municipality provide a breastfeeding-friendly workplace environment for breastfeeding frontline health workers? 2). What views do breastfeeding frontline health workers in the Effutu Municipality share on breastfeeding workplace support? 3). What coping strategies do breastfeeding frontline health workers employ to balance work and breastfeeding challenges in Effutu Municipality? By breastfeeding frontline health workers, we refer to breastfeeding clinical and non-clinical health workers in health facilities.

## Work, Breastfeeding, and Workplace Support in Ghana

Maternal work and breastfeeding incompatibility have received some level of attention from infant feeding researchers in Ghana. It is suggested that women in self-employment and paid work experience tension between work and breastfeeding and are unable to practice exclusive breastfeeding. However, work-breastfeeding tension is experienced differently depending on the type of work a mother does. In some cases, the conflict between work and breastfeeding has led some mothers to withdraw from work or spend less time with babies [8, 9]. Also, it has been found that poor recommendations of exclusive breastfeeding from health workers and shorter duration of maternity leave are partly the reasons behind the decline in exclusive breastfeeding at six months [10]. This has led some scholars to explore the availability and effectiveness of breastfeeding support mechanisms at workplaces. For instance, Mensah [11], studied the role of social support in improving breastfeeding and employee commitment and found that breastfeeding mothers that received social support appeared more satisfied and committed to their jobs compared to those with no or less social support.

Recent studies have also investigated the lived experiences and views of breastfeeding mothers in paid work and tertiary institutions and have identified some individual and organizational-level factors that affect optimal breastfeeding practice. Abekah-Nkrumah and colleagues [12], found factors such as lack of knowledge and understanding of exclusive breastfeeding, negative lived experiences of working mothers, and unsupportive organizational environment to affect exclusive breastfeeding. A study of institutional-level support for breastfeeding among tertiary students also found a stern conflict between breastfeeding and academic work due to lack of breastfeeding support for student-mothers. In this study, student-mothers used unapproved and unsafe places as breastfeeding facilities [8].

Even though the above studies suggest a general lack of breastfeeding workplace support, other studies also identify maternity leave, peer support, and breastfeeding break as basic workplace breastfeeding support available in tertiary institutions and healthcare facilities to support working mothers to breastfeed [13]. While the above studies provide evidence of inadequate workplace breastfeeding support in Ghana and breastfeeding mothers' lived experience of work-breastfeeding tensions, they only present workplace breastfeeding support from employees' perspective and do not bring to bear the views of employers on breastfeeding workplace support. The concept of breastfeeding workplace support has economic implications for employers; limiting the discussion to the lived experiences of employees clouds our ability to appreciate the differentiated interests at stake and may result in biased policy initiatives. Vilar-Compte and colleagues [14] also estimated the cost of maternity leave extension and found that the mean cost of extending maternity leave for two weeks in formal employment in Ghana was $109 purchasing power parity international. This suggests that the perspective of employers on organizational-level support for breastfeeding is crucial in providing a balanced perspective for workplace breastfeeding support agenda building and policy.

## Theoretical framework.

Workplace breastfeeding support may facilitate optimal breastfeeding and protect employee mothers from the stress of work and family responsibilities. Assessing breastfeeding support in healthcare

facilities at the Effutu Municipality would illuminate further our understanding of organizational-level factors that impede breastfeeding practice in Ghana. Several theoretical and conceptual frameworks, including the maternal role-incompatibility hypothesis [15], social-ecological theory [12]; work-family conflict framework [16] have been used in studies on work-childcare conflict. This study is predicated on the Social Support Theory (SST). Although the social support theory is mostly used in health and well-being studies [17, 18, 19]. This study draws on the stress and coping perspective off the SST as explained by Lakey and Cohen [19] to argue that breastfeeding workplace support can act as a stress buffer to support mothers to balance breastfeeding, work stress and burnout, while improving optimal breastfeeding among mothers in paid work.

The social support theory is a broad construct with several definitions [20, 21, 22, 23]. It highlights the different forms of aid and assistance provided by family members, friends, neighbors, among others, and often involves a myriad of social interactions [22]. SST is grounded in three different theoretical perspectives, namely; the stress and coping perspective, which states that social support contributes to health by protecting people from the dangers of stress. The second perspective is grounded in social constructionism and proposes a direct relationship between support and health without consideration for stress. The third is the relational perspective, which predicts that the relationship between social support and health cannot be considered without recourse to the relational process that accompanies support [19]. The stress and coping perspective of the SST has principles useful in emphasizing the importance of breastfeeding workplace support to optimal breastfeeding practice.

The values of the modern-day workplace are at variance with those of breastfeeding, often resulting in work-breastfeeding tension, which compromises optimal breastfeeding. Breastfeeding support practices such as breastfeeding-friendly work environment, maternity leave, breastfeeding breaks, and organizational breastfeeding policy can act as buffers to reduce the stressfulness of mothering and the inconsistencies between work and breastfeeding. Providing such support would promote optimal breastfeeding among working mothers. Evidence shows that the provision of breastfeeding rooms, breaks, reduced workloads, and encouragement for breastfeeding mothers promote continuous breastfeeding on return to work [24]. In a community-based cohort study in Taiwan, it was found that mothers with extended maternity leave breastfed longer than those with shorter maternity leave. Lower breastfeeding initiation was also found among mothers returning to work at one month [25]. A longitudinal birth cohort study in the US also found that mothers with longer duration of maternity leave had higher odds of breastfeeding initiation and continuous breastfeeding beyond six months [26]. Just as social support contributes to health and wellbeing, these pieces of evidence beacon to us the buffering effect of breastfeeding workplace support in minimizing the negative impact of work-breastfeeding stress and inconsistencies on optimal breastfeeding practice.

# Methods

### Study Area

The study was rolled out in the Effutu Municipality in the Central Region of Ghana. The municipality has a population of 79,411 projected from the 2010 population census and a growth rate of 3.2% per annum [27]. Administratively, the municipality is divided into four sub-municipalities, namely, South-East Winneba, South-West Winneba, Essuekyir-Gyahadze, and Kojo-Bedu North Low-Cost. The municipal health system is organized at the municipal, sub-municipal, and community levels. Each sub-municipality is further divided into communities for purposes of organizing public health services and other health-related services activities. Winneba is the municipal capital and the only urban settlement among the four sub-municipalities.

Using exploratory research design, a mixed-method approach was adopted to explore and describe verbal reports of representatives of hospital management and breastfeeding frontline health workers in Effutu municipality on breastfeeding-friendly workplace environment. The selection of the Effutu Municipality proved convenient for two key reasons. First, the municipality was selected based on anecdotal accounts of breastfeeding frontline health workers' challenges of keeping up with the demands of work and mothering. Second, it was selected based on proximity and cost. The study population included all health facilities and breastfeeding frontline health workers in Effutu Municipality. Sampling was done in three stages. In the first stage, four healthcare facilities were purposefully selected based on the number of female employees (20 or more female employees). Selected healthcare facilities included two public healthcare facilities, one private for-profit, and one mission-based healthcare facility. Each facility appointed one representative to respond to our in-depth interviews. The second stage involved 50 breastfeeding frontline health workers with babies between 3-23 months. The lead researcher was introduced to managers of participating health facilities by her affiliated institution. Lists of breastfeeding frontline health workers were obtained from participating hospitals. Breastfeeding frontline health workers with babies between 3-23 months were purposefully selected. Mothers in this category were selected because they had fresh lived experiences of work and breastfeeding

Both secondary and primary data were used for the study. Secondary data were sourced mainly from reports, handbooks, and published articles. Primary data were gathered through field data collection. In all, a list of sixty-two (62) breastfeeding frontline health workers were obtained, and 50 mothers consented to participate in the study. Quantitative data were collected using a self-administered questionnaire with close-ended questions and Likert-type questions. Qualitative interviews were collected with the use of an interview guide. Questionnaires were used to gather data from breastfeeding front-line health workers while in-depth interviews were used to gather data from representatives of healthcare facilities in the study. Research instruments were developed by authors based on literature review [8, 14, 16, 28, 29, 30], (see supplementary file for details). After obtaining written consent from the frontline health workers, questionnaires were given to participants to complete. Questionnaires were picked up after one week, followed by interviews conducted by the lead researcher and assisted by a research assistant. Interviews were conducted in the English language and were recorded using field notes and an audio recorder. Each interview lasted between 40-45 minutes. Data for the study were collected between April and May 2018.

### Data Management and Analysis

Qualitative and quantitative analyses were used. The questionnaires were coded into Statistical Package for Social Science (SPSS, version 23.0) and analyzed using descriptive statistics. Results on the one hand were presented based on frequencies/percentages and measures of central tendencies. On the other hand, the study used thematic analysis to analyze interview responses. Audiotapes were manually transcribed verbatim and validated to guarantee accuracy of the transcribed data by with the audio tapes. Codes were developed from the transcribed data to describe their content. Relevant sentences and phrases were identified and highlighted from the transcript to support the code. Common patterns were identified among the codes and selected themes were established based on developed codes. To ensure that the established themes were representative of the data, the themes were compared against the data set and necessary revisions were made to the initial themes. The themes were redefined to make them useful and coherent.

## Results

Three main themes emerged from the interviews conducted to explore the extent to which health facilities in the study provided breastfeeding workplace environment, comprising: 1). Standpoints on workplace breastfeeding support. 2). Breastfeeding support and 3). Suggested future directions. Standpoints on workplace breastfeeding support had three sub-themes, namely, backings for workplace breastfeeding support, perceived benefits of breastfeeding support and factors of poor breastfeeding workplace support. Breastfeeding support also had three sub-themes, including maternity protection benefits, workplace support gaps and awareness creation on benefits. Verbatim quotations were used to support the themes and provide evidence. Details of the main themes and sub-themes are discussed followed by the quantitative results.

### Characteristics of Participants

Table 1 presents the characteristics of the study participants. All 50 questionnaires were completed and returned giving a response rate of 100%. Fifty-four (54) respondents participated in the study, four out of them were representatives of healthcare facilities in the study. The mean age of participants was 32. All participants were females, the majority of whom were married with children between the ages of 4-21months. The mean age of babies of mothers in the study was 11 months with a good number (30%) of the babies at 4 months. Sixty-one percent (61%) of breastfeeding frontline health workers interviewed were clinical staff and 39% were support staff.

### Standpoints on workplace support for Breastfeeding

Representatives of health facilities interviewed shared their facilities' perceived positions on workplace breastfeeding support and accentuated the importance of providing such support for frontline health workers. The three sub-themes that follow presents the details.

### Backings for Workplace Breastfeeding Support

Respondents in this study had extensive knowledge of workplace support for breastfeeding and shared some views on workplace support for breastfeeding. Breastfeeding workplace support such as the creation of breastfeeding rooms where breastfeeding frontline health workers can keep their babies while working was emphasized by all the respondents. The need for a national policy on a breastfeeding-friendly workplace environment was also mentioned. Respondents believed this would help provide a standardized workplace support culture across industries and workplaces. The representative of hospital 3 shared her views on the need for a breastfeeding-friendly work environment in the following statement:

*Workplaces must have very very well-equipped places for breastfeeding. For instance, in this hospital, there should be a place where working mothers can go and breastfeed. Possibly, there should be a nurse at the place to take care of the babies so that even if the mother is not visiting… and there is bottle feeding, it would be expressed breast milk. It should be a very hygienic place that can take care of babies.*

### Table 1: Demographic characteristics of respondents

| Description | Freq. | % | Description | Freq. | % |
|---|---|---|---|---|---|
| ***Age Respondents*** | | | ***parity*** | | |
| Mean age | 32±5 | | 1 | 17 | 34 |
| 24 – 28 | 14 | 26 | 2 | 13 | 26 |
| 29 – 33 | 17 | 31 | 3 | 12 | 24 |
| 34 – 38 | 9 | 17 | 4 | 6 | 12 |
| 39 – 43 | 9 | 17 | 5 | 2 | 4 |
| 44+ | 5 | 9 | ***Total*** | ***50*** | ***100*** |
| Total | ***54*** | ***100*** | Work experience | | |
| ***Marital Status*** | | | 1 – 4 | 30 | 60 |
| Married | 43 | 79 | 5 – 8 | 14 | 28 |
| Single | 8 | 15 | 9+ | 6 | 12 |
| Divorced | 2 | 3 | ***Age of Baby (in Months)*** | | |
| Widowed | 2 | 3 | Mean age of babies | 11±5 | |
| ***Total*** | ***54*** | ***100*** | 4 – 6 | 15 | 30 |
| ***Religion*** | | | 7 – 9 | 6 | 12 |
| Christian | 32 | 58 | 10 – 12 | 11 | 22 |
| Muslim | 23 | 42 | 13 – 15 | 7 | 14 |
| ***Total*** | ***54*** | ***100*** | 16 – 18 | 5 | 10 |
| ***Staff Category*** | | | 19 – 21 | 6 | 12 |
| Clinical staff | 33 | 61 | ***Total*** | ***50*** | ***100*** |
| Support staff | 21 | 39 | | | |
| ***Total*** | ***54*** | ***100*** | | | |
| | | | | | |

*Source: constructed by authors using data from the field*

**The Perceived benefits of breastfeeding Workplace Support**

The representative of hospital 4 shared the benefits employers stand to gain when they implement breastfeeding workplace support and said:

*If we have healthy children…. I mean, if a mother can breastfeed so that the child does not have diarrhea and other illnesses, then the mother will not lose working days to go and take care of a sick baby. Once a child is healthy on breast milk, the employee saves money and time for work. So, it is good for mothers in employment and employers as well.*

It is clear from the above statement that creating a breastfeeding-friendly workplace can be thought of as a good business or an aspect of hospitals' corporate social responsibility. Most respondents were of the view that breastfeeding workplace support has triple benefits that may outweigh the cost involved in providing the support, particularly, loss of man-hours that may arise from the indisposition of infants because of inappropriate feeding practice. The representative of hospital 2 shared this with us.

*Breast milk has nutrients that protect the child from illness, so employers must support it. In this way, working mothers will not need to take days off work to care for their babies because of illness. Mothers will always be present at work to discharge their duties. I believe employers stand to benefit if their employees are always present work.*

### Factors of Poor Breastfeeding Workplace Support

In this study, an array of factors was outlined by respondents to limit efforts in providing breastfeeding support for breastfeeding frontline health workers. They included lack of funding to create breastfeeding friendly workplace environment, limited office space, and inadequate staff. Two of the respondents retorted that it is difficult to promote breastfeeding supportive work culture, particularly when more frontline health workers have to be provided with such support at the same time. The representative of hospital 2 shared this with us:

*Hmm…it is quite difficult. Sometimes we have issues of limited staff. Supposing you are on a ward which requires ten (10) staff but only eight (8) are on duty and you have some of the staff taking off two (2) hours to breastfeed….. this situation puts pressure on the other remaining staff if the workplace is busy, they are forced to do the work of those breastfeeding in addition to theirs. especially when the breastfeeding mothers decide to take some time off their schedules to breastfeed. Other times too, you may have situations where more than three mothers would be on maternity leave at the same time in a unit. This gives more work and stress to the other staff who may be at work.*

### Breastfeeding Support

All health facilities in the study had some form of breastfeeding support in place for frontline health workers, predominantly, those that are guaranteed by the maternity protection provision of the Labor Act of Ghana. The details are discussed in the sub-themes below.

### Maternity Protection Benefits

As part of the conditions of work of frontline health workers, breastfeeding mothers are granted 12 weeks paid maternity leave in the case of spontaneous vagina delivery (SVD) and 24 weeks for those with assisted delivery such as cesarean section. Breastfeed frontline health workers also enjoy paid breastfeeding breaks. Respondents from both private and public hospitals mentioned that the conditions of work capture all the maternity protection provisions provided by the labor laws of Ghana. Further, breastfeeding frontline health workers are placed on morning shift only until the baby is 26 weeks and morning and afternoon shifts until the baby is 52 weeks old, as well as casual leave where necessary.

### Workplace support Gaps

The gaps in breastfeeding workplace support identified in the health facilities studied are summed up in the statements of the representatives of hospital 1 and three as follows:

*Our clients breastfeed in the wards……. I mean our postnatal inpatients are entitled to breastfeed on the ward. For our staff, we do not have a lactating site for them. A breastfeeding staff must leave her baby at home and when it is time to breastfeed, she goes home to breastfeed. If they are fortunate to have a babysitter who will come to work with them, then they can bring their babies along to breastfeed at work…… maybe sit under the tree where they believe would be comfortable for them. But as to getting a place that is so conducive for breastfeeding, no, not at all.*

*When they come to work, depending on the workload for the day… you know, there are days that the workplace is very busy and there are days that the workplace is less busy. On out busy days, when we monitor and realize that the tension has reduced, we give them the time to go and breastfeed. Sometimes, when the workplace is busy, they communicate with their babysitters and ask, 'is the baby in need of breast milk?', 'is it time for breastfeeding?' 'is baby showing any signs of lactating?' If it comes out like that then the person goes and then breastfeeds.*

This statement highlights the plight of breastfeeding frontline health workers and the work-breastfeeding discrepancies that are likely to result from it. Almost all hospitals in the study did not have breastfeeding facilities or an on-site creche for kids of frontline health workers. Only one out of the four hospitals was constructing an onsite creche at the of the study.

### Awareness Creation on Breastfeeding Workplace Support

Even though healthcare facilities in the study did not have most of the essential breastfeeding friendly workplace environment, those provided in the condition of services of frontline health workers, such as maternity leave, casual leave, working half-day, and other staff welfare packages were disseminated among frontline health workers through staff orientation, memos, website, and staff meetings. Also, respondents assumed that breastfeeding frontline health workers are well informed of issues related to optimal breastfeeding practice due to the breastfeeding education they received as part of maternity care during pregnancy.

### Suggested Future Direction

Respondents were united in their views regarding the way forward. They called for a revision of the Labor Act, Act 651 of 2003 to define the essentials of the workplace breastfeeding policy. On the flipside, representatives of the mission-based and private hospitals expressed a preference for a policy guideline that would leave details of action for promoting a breastfeeding friendly workplace environment to employers to formulate and implement based on organization-specific circumstances. The representative of hospital 4 explained further and said.

*A national policy would be helpful. Yes, they would guide the hospitals to formulate their action plans. I think a policy framework must come from the top and then translated down to all healthcare facilities. Individual hospitals can have their strategic plans which will have considerations for specific needs related to breastfeeding mothers.*

To obtain a balanced view of the extent of support for workplace breastfeeding, front-line health workers were interviewed. Table 2 presents breastfeeding frontline health workers views of breastfeeding workplace support and breastfeeding practice. Participants' views on breastfeeding workplace support were consistent with Responses from the interviews. Ninty-six percent (96%) of the participants said they went on 12 weeks maternity leave, breastfeeding break (80%), and 70% indicated that they enjoyed five-day 20-hour work week (5/20) (i.e. half-day) after returning to work instead of the usual five-day 40-hour work week (5/40). Participants specified staff orientation (44%) and workshops (16%) as the main sources of maternity protection benefits information.

The results also established several shortfalls in the breastfeeding workplace support of the hospitals. Ninety-six percent (96%) of breastfeeding frontline health workers indicated a lack of breastfeeding policy and breastfeeding facilities (94%) in their hospitals. Even though 90% said their workplace policy allows them to go to work along with baby, only 14% go to work with their babies possibly due to the lack of breastfeeding facility or creche at the hospitals. However, reasons offered for not going to work with baby were no place to keep baby (28%) and to concentrate on work (16%). A little above half of the participants failed to provide reasons. All (100%) breastfeeding frontline health workers in the study had knowledge about the benefits of breastfeeding and did initiate breastfeeding. Yet, about 34% of them supplemented breastfeeding with artificial milk (4%), water (18%), and porridge and water (12%). Averagely, participants indicated that they reported to work at 8:00am and closed at 3:00pm each day. Feeding strategies upon return to work included expressed breast milk (34%), breastfeed only when at home (40%) and expressed breast milk and porridge (26%). Twenty percent of the participants indicated that their closing and reporting time affected breastfeeding and 96% said that they will prioritize work over breastfeeding in circumstance of work-breastfeeding tension. A good number (34%) of breastfeeding frontline workers also indicated the sustained separation between them and their baby can make them wean baby earlier than planned.

Table 3 presents the mothers' evaluation of coping strategies adopted to manage breastfeeding-work tension. Breastfeeding mothers in organizations where no breastfeeding support is available are likely to experience stress and burnout from demands of work, breastfeeding, and childcare. In such a situation,

distinct interventions are required to support mothers to navigate daily challenges related to work, breastfeeding, and childcare. The results of this study identified social support such as support from husbands and relatives (median = 3) as highly supportive in mitigating the inconsistencies between work and childcare. Flexible work arrangement (median = 2) and support from coworkers (median = 2) were deemed by breastfeeding frontline health workers as moderately supportive for coping with the challenges of work breastfeeding, and childcare. Regarding the challenges of work and breastfeeding, undue stress resulting from conflicts between work and breastfeeding (median = 3) was extremely challenging. Insufficient breast milk arising from the separation between mother and baby (median = 2), difficulties in expressing milk (median = 2), work overload (median = 2), and work duration (median = 2) were considered moderately challenging.

**Table 2.0: Mothers' Views on Workplace Support.**

| *Breastfeeding Policy at Workplace* | *Freq.* | *%* | *Mothers' Feeding Strategies* | | *%* |
|---|---|---|---|---|---|
| Yes | 0 | 0 | Expressed breast milk | 17 | 34 |
| No. | 48 | 96 | Breastfeed when at home | 20 | 40 |
| No response | 2 | 4 | Breast milk and porridge | 13 | 26 |
| ***Paid Maternity Leave*** | | | ***Feeding Strategy below 6 Months*** | | |
| Yes | 48 | 96 | Expressed breast milk | 18 | 36 |
| No. | 2 | 4 | Artificial milk | 2 | 4 |
| ***Paid Breastfeeding Break*** | | | Breast milk and water | 9 | 18 |
| Yes | 40 | 80 | porridge, water and breast milk | 6 | 12 |
| No. | 10 | 20 | No response | 15 | 30 |
| ***Worked Half-Day*** | | | ***Had Breastfeeding Education when Pregnant*** | | |
| Yes | 35 | 70 | Yes | 47 | 94 |
| No | 5 | 10 | No | 3 | 6 |
| No response | 10 | 20 | ***Aware of Breastfeeding Benefits*** | | |
| ***Sources of Maternity Benefits Information*** | | | Yes | 50 | 100 |
| HR handbook | 3 | 6 | No. | 0 | 0 |
| Facility's website | 3 | 6 | ***Initiated Breastfeeding*** | | |
| Orientation | 22 | 44 | Yes | 50 | 100 |
| Workshop | 8 | 16 | No | 0 | 0 |
| Memos/circulars | 4 | 8 | ***Reporting/Closing Time Affected Breastfeeding*** | | |
| No. response | 10 | 20 | Yes | 20 | 40 |
| ***Policy Allows Going to Work with Baby*** | | | No | 30 | 60 |
| Yes | 45 | 90 | ***Would sacrifice work to breastfeed*** | | |
| No | 5 | 10 | Yes | 48 | 96 |
| ***Go to Work Along with Baby*** | | | No | 2 | 4 |
| Yes | 7 | 14 | ***Possible effect of effect of separation on breastfeeding*** | | |
| No. | 43 | 86 | Insufficient breast milk | ***8*** | ***16*** |
| ***Breastfeeding Facility at Workplace*** | | | Early winning | 17 | 34 |

| | | | | | |
|---|---|---|---|---|---|
| Yes | 3 | 6 | Decision not to breastfeed | 4 | 8 |
| No. | 47 | 96 | No response | 21 | 42 |
| ***Reasons for Leaving Baby at Home*** | | | ***Common breastfeeding Challenges*** | | |
| To concentrate at work | 8 | 16 | Work overload | 19 | 38 |
| No place to keep baby | 14 | 28 | Insufficient breastmilk | 11 | 22 |
| wants baby to be at creche | 2 | 4 | Breast milk contamination | 10 | 20 |
| No response | 26 | 52 | Breast milk expression | 10 | 20 20 |
| Mean reporting time to work | 8:00am | | ***Common Copping Strategies*** | | |
| Mean closing time from work | 3:00pm | | Husband/relatives support | 35 | 70 |
| | | | Colleagues support | 9 | 18 |
| | | | Closing at unapproved time | 7 | 12 |

*Source: constructed by authors using field data.*

**Table 3: Mothers' Evaluation of Copping Strategies of Childcare, Work and Challenges**

| Description | Frequency | | | | | |
|---|---|---|---|---|---|---|
| ***Challenges*** | Least Challenging (1) | Most Challenging (2) | Highly Challenging (3) | NR | Total | Median |
| Difficulties in expressing milk | 12 | 17 | 5 | 16 | 50 | 2.0 |
| Inadequate breast milk due to infrequent feeding | 9 | 16 | 10 | 15 | 50 | 2.0 |
| Breastmilk contamination | 14 | 10 | 9 | 17 | 50 | 2.0 |
| Work overload | 7 | 15 | 21 | 7 | 50 | 2.0 |
| Work duration | 12 | 15 | 9 | 14 | 50 | 2.0 |
| Conflicting responsibilities | 11 | 12 | 15 | 12 | 50 | 2.0 |
| Stress and burnout | 5 | 15 | 21 | 9 | 50 | 3.0 |
| Poor concentration at work | 6 | 14 | 17 | 13 | 50 | 2.0 |
| Difficulties in meeting timelines | 10 | 12 | 11 | 17 | 50 | 2.0 |
| ***Copping Strategies*** | Least Supportive (1) | Moderately Support (2) | Highly Supportive (3) | No Response | Total | Median |
| Avoiding workplace responsibilities | 18 | 13 | 2 | 17 | 50 | 1.0 |
| Reporting to work late | 15 | 10 | 4 | 21 | 50 | 1.0 |
| Leaving workplace before approved closing time | 17 | 8 | 4 | 21 | 50 | 1.0 |
| Support from husband and relatives | 3 | 7 | 34 | 6 | 50 | 3.0 |
| Flexible work arrangement | 6 | 22 | 9 | 13 | 50 | 2.0 |
| Breast milk expression | 7 | 10 | 19 | 14 | 50 | 3.0 |
| Support from colleagues | 2 | 18 | 11 | 19 | 50 | 2.0 |

*Source: constructed by authors using field data.*

# Discussion

In this study, we assessed the extent to which health facilities in Effutu Municipality provide a breastfeeding friendly workplace environment for frontline health workers, their views on the breastfeeding support they receive, and the copping strategies used in managing work-breastfeeding challenges. Even though the study recorded 100% response rate, it must be noted that some of the questionnaire items recorded non-response possibly because participants had limited time to complete the questionnaires. It is likely that the results have some amount of nonresponse bias. The results established that hospital leaders have a positive standpoint on breastfeeding workplace support that have practical value. However, their standpoints are at best rhetoric, and not backed by pragmatic effort. The challenge with this situation is that children do not have fully developed immune system, exposing them to the hospital environment has the potential to compromise their health. Breastfeeding sites and onsite creches in hospitals could be a haven for preventing infants and kids of frontline health workers from hospital-acquired infections. Other gaps included a lack of education on strategies for returning to work and balancing childcare and work.

Systems at the workplace to promote optimal breastfeeding among mothers returning to work are an important aspect of the International Labor Organization's (ILO) recommendation for maternity protection benefits [29]. Women have right to work and children have right to appropriate feeding and nutrition. It is therefore important that pragmatic steps are taken to promote breastfeeding workplace environment in Ghana. Even though the conditions of work of frontline health workers subscribes to the maternity protection benefits enshrined in Labor Act, the provisions are not enough to support and protect optimal breastfeeding upon return to work.

None of the hospitals in this study had a breastfeeding policy. Health facility representatives interviewed blamed their inability to provide such an environment to lack of resources. They believe that if their hospitals were to have adequate resources and implementation guidelines, they could undertake such initiatives for staff. It stands to reason that employers are unlikely to provide breastfeeding support at the workplace in the absence of a policy directive that obliges them to do so. On this basis, a national policy in this regard can help promote a breastfeeding workplace culture in healthcare institutions. The stances of respondents on the triple benefits of providing breastfeeding workplace support corroborates the argument that breastfeeding workplace support is cost-effective compared to the extension of maternity leave. It reduces absenteeism, improves employee retention, and increases employee morale and loyalty [30, 31, 32].

Poor breastfeeding workplace environment in this study may well be the bane of optimal breastfeeding practice as breastfeeding frontline health workers may find it an enormous task to continue breastfeeding upon return to work [33]. Smith and colleagues in their study found a significant association between awareness of breastfeeding support policy and higher rates of exclusive breastfeeding among Australian

working mothers. Supportive work culture such as a flexible work arrangement for breastfeeding mothers varied across the hospitals. The arrangements were unofficial and were granted based on exigencies at the workplace and the discretion of unit heads and managers. Such an arrangement is unlikely to support exclusive breastfeeding. Evidence from Durban, USA, shows that women in workplaces that had supportive work culture exclusively breastfeed 4 months and longer than those in workplaces with poor supportive work culture [33].

The results of this study and the literature in Ghana seems to suggest that breastfeeding break and maternity leave are the common forms of breastfeeding support culture of organizations in Ghana.

Breastfeeding frontline health workers' access to maternity leave and breastfeeding break corroborate research findings from the USA and Ghana [34, 13]. Due to the lack of breastfeeding facility and the desire of to concentrate at work, a good number of breastfeeding frontline health workers breastfed only when at home. This practice was also found in some universities in Nigeria where most breastfeeding employee-mothers breastfeed before and after work only [35].

All the participants indicated receiving breastfeeding education during pregnancy and having knowledge about the benefits of exclusive breastfeeding. Yet, 34% supplemented breastfeeding with water, artificial milk and porridge on return to work, when baby was below 6 months. This situation could be attributed to the negative effect of maternal work on breastfeeding. Most women are eager to work in return for economic benefit. As evident in this study, 70% of the participants indicated that they would not sacrifice work for breastfeeding in situations where breastfeeding interferes needlessly with work. This situation confirms earlier research in Ghana [15]. It was found that maternal work affected breastfeeding in situations where income from maternal work was needed to supplement the family budget. The income of mothers in this study may constitute a significant proportion of their family's budget.

Averagely, the participants spent 6–7 hours at the workplace and some (40%) believed that time spent in the workplace affected breastfeeding. This makes breastfeeding frontline health workers the most affected in the absence of workplace breastfeeding policy. They have a dual duty to fulfill their gendered role of infant nursing and work to support their families. Breastfeeding and childcare support at the workplace bothers on employee welfare. Under this circumstance, the Ghana Nursing and Midwifery Council, the Health Service workers Union and the Ghana Medical Association can play a vital role in pressing home the urgent need for breastfeeding support policy in hospitals. Support from husbands and relatives were supportive in coping with stress and burnout arising from work and breastfeeding. This result is consistent with research findings in Ghana, where family support was supportive of exclusive breastfeeding practice among working mothers [8].

Future directions suggested by respondents point to the need for extensive stakeholder consultation in arriving at a national workplace breastfeeding and childcare support policy. For instance, there were divergent views on the extension of maternity leave from 3–6 months further to WHO's push for an increase in maternity leave. While the Ghana Medical Association, Nutritionists, and some mothers were in favor of such a policy, other women in paid employment were more interested in the institutionalization

of baby-friendly workplace environments to enable them to return to work for fear of losing their jobs [5]. The opinions shared by stakeholders in the literature and this study provide deeper insights into what should be the content of future policy on workplace breastfeeding policy. Most importantly, the process for such a policy must entail extensive stakeholder engagement. Workplace support policies that provide equal benefit to employers and employees would be most appreciated.

# Limitations Of The Study

The questionnaire used in this study recorded some level of item non-response. Non-probability sampling was used, and data analysis was more descriptive which do not allow for generalization of results of the study. The data collected only allowed for the description of mothers' views on workplace breastfeeding support but could not capture mothers' lived experiences of navigating the difficult terrine of modern employment and child nursing.

## Conclusion

The study examined the extent to which hospitals in Effutu Municipality provide breastfeeding-friendly work environment to breastfeeding frontline health workers. The study also assessed breastfeeding frontline health workers' views on workplace breastfeeding support. Breastfeeding support provided for breastfeeding frontline health workers are those enshrined in the Labor Act. Health facilities in the study do not provide breastfeeding friendly work environment for frontline health workers. The BFHI has no bearing on the working conditions of staff in the frontline of implementation of the initiative. Consistent with the social support theory, support from relatives was perceived as the most effective buffer against stress from work-breastfeeding tension. Continuous advocacy on breastfeeding workplace support and stakeholder engagement to build consensus on the mix of strategies suitable to cushion breastfeeding frontline health workers against work-breastfeeding stress and minimize its negative impact on optimal breastfeeding among frontline health workers is recommended.

## Abbreviations

MOH
Ministry of Health
GHS
Ghana Health Service
BFHI
Baby Friendly Hospital Initiative
SST
Social Support Theory

## Declarations

### *Ethics Approval and Consent for Participation*

Research procedure in my faculty do not require studies of this nature to undergo ethical review. The protocols for the research were presented at the biweekly seminar of the Faculty of Science Education, University of Education, Winneba for ethical suitability regarding data collection and publication. This seminar brings together faculty members and research fellows to review research protocols and papers intended for publication. Management of participating health facilities was informed about the purpose and details of the study in writing and approval was obtained before the commencement of the study. All participants were briefed about the purpose of the study and those who provided written informed consent were included in the study. Participation was voluntary and data were anonymously analyzed such that results were untraceable to participants.

### *Consent for Publication*

Not applicable.

### *Availability of data and materials*

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request

### Competing Interest

The authors declare that the work contained in this article is their original work and there is no conflict of interest concerning authorship and publication of the article. The manuscript is currently not under review with any journal.

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### *Authors' Contribution*

We declare that we are the sole authors of this manuscript. The study was conceptualized together with literature review and instrument development by all authors. Research instruments were developed by the first author (J.N.) in addition to data collection. Analysis of data and manuscript preparation were done by the first and third authors (J.N. and R.B.N) Review and editing of the manuscript was done by the first authors (A.A.A. and J.N.). All authors have read and approved the manuscript.

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