CHRISTIAN SERVICE UNIVERSITY COLLEGE

DEPARTMENT OF NURSING

THE KNOWLEDGE AND PRACTICE OF EXCLUSIVE BREASTFEEDING AMONG MARKET WOMEN: A SURVEY AT BANTAMA

YAW OPOKU AGYEI-MENSAH

CHARITY YEBOAH

SEIDU ZEINABU

A PROJECT SUBMITTED TO THE DEPARTMENT OF NURSING IN PARTIAL FULFILLMENT FOR THE REQUIREMENTS FOR THE AWARD OF BACHELOR OF SCIENCE IN NURSING

MAY, 2017

DECLARATION

We hereby declare that this project is our own work, carried out at the Department of Nursing of Christian Service University College, Kumasi in partial fulfillment for the award of BSc. Degree in Nursing. All references are acknowledged.

NAME	INDEX NUMBER	SIGNATURE	DATE
YAW OPOKU AGYEI-MENSAH	10001007	--------------	----------
CHARITY YEBOAH	10000899	---------------	----------
SEIDU ZEINABU	50000028	----------------	-----------

SUPERVISOR'S DECLARATION

I hereby declare that the preparation and presentation of the project work were supervised in accordance with the guidelines on the supervision of project laid down by the Christian Service University College, Kumasi.

Supervisor's Name	Signature	Date
Mr. JOHN ANTWI	……………………….…	………….……….

Head of Department	Signature	Date
Mrs. THERESA SARPONG	…………………	……………….……….

DEDICATION

This dissertation is dedicated to our beloved parents whose shoulders all the burden of our undergraduate studies have been on, and our brothers and sisters for their continuous support and encouragement.

ACKNOWLEDGEMENT

All thanks and praises to our Almighty God for helping us through the difficult times, fulfilling our needs and for keeping us alive to conduct this study: surely he has seen us through. We would like to appreciate and thank our supervisor, Mr. John Antwi for his guidance and support for this study and his patience. Thanks to our colleagues who gave us all the good advice regarding to our study. Not forgetting our dear mother, Nana Kyeiwaa, and sister, Juliet Amponsah at Bantama market who assisted us through the data collection period and helped us with the information we needed.

TABLE OF CONTENTS

Title Page……………………………………………………………………...… i

Declaration…………………………………………………………….……… ii

Dedication…………………………………………………………………….… iii

Acknowledgement……………………………………………………………… iv

Table of Contents……………………………………………….…………….…v

List of Tables…………………………………………………………….….... viii

List of figures……………………………………………………………..…… ix

CHAPTER ONE

Introduction………………………………………………………………………1

1.1 Problem Statement……………………………………………………...……4

1.2 Research Questions …………………………………………….………… 4

1.3 Specific Questions ………………………………………………….….… 4

1.4 Objective of the Study ………………………………………………………. 4

1.5 Significance of the Study………………………………………………………5

1.6 Anticipated Limitations……………………………………………………….. 5

1.7 Operational Definitions & Abbreviations……….…………..………….........6

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction…………………………………………………………….…..……7

2.1 The Knowledge and Sources of Information on Exclusive Breastfeeding……..8

2.2 Benefits of Breastfeeding for Infants and Mothers ……………..…………... 8

2.2.1 Breastfeeding Benefits for Infants ………………………………………… 10

2.2.2 Breastfeeding Benefits for Mothers ……………………………….……10

2.3 The Challenges of Exclusive Breastfeeding Practice……………………….… 12

2.4 The Practices of Exclusive Breastfeeding ……………………………..…… 13

CHAPTER THREE

METHODS

3.1 Research Design and Instrument……………………………………….…… 14

3.2 Data Collection Method……………………………………………...……15

3.3 Pretesting (Validity and Reliability) ………………………………...… 15

3.4 Study Area……………………………………………………………………16

3.5 Sample Population and Sampling Technique…………………………..… 17

3.6 Ethical Consideration…………………………………………...……17

3.7 Data Analysis……………………………………………………...……17

CHAPTER FOUR

RESULTS

Background Information………………………………………………………18

4.1.1 Age of Respondents…………………………………………………..… 18

4.1.2 Number of Children…………………………………………..…… 18

4.1.3 Marital Status………………………………………………………………19

4.1.4 Level of Education…………………………………………………………19

4.1.5 Religion……………………………………………………………… 20

4.1.6 Ethnicity……………………………………………………………………20

4.2 Knowledge and Sources of Information…………………………..…… 21

4.2.1 Respondents' Knowledge on Exclusive Breastfeeding……………………… 21

4.2.2 Sources of Exclusive Breastfeeding Information…………………………… 22

4.2.3 Respondents' Knowledge on Exclusive Breastfeeding……………………… 22

4.2.4 Benefits of Exclusive Breastfeeding……………………………………… 23

4.5 Practice of Exclusive Breastfeeding among Market Women at Bantama………24

4.5.1 Exclusive Breastfeeding Practice among Bantama Market Women………… 24

4.6 Challenges on Exclusive Breastfeeding among Market Women at Bantama…. 25

4.6.1 Challenges Market Women Face………………………………..………25

CHAPTER FIVE

DISCUSSION, SUMMARY, CONCLUSION AND RECOMMENDATION

Discussion…………………………………………………………………..…28

Summary………………………………………………………………………28

Conclusion……………………………………………………………….…… 28

Recommendations…………………………………………………………..…29

Study Limitation…………………………………………………………...…… 29

References…………………………………………………………………..…30

Appendix………………………………………………………………………39

LIST OF TABLES

Table 1 Age of respondents……………………………………………………………… 18

Table 2 Number of Children………………………………………………………………. 18

Table 3 Level of Education………………………………………………………….….. 19

Table 4 Sources of Exclusive Breastfeeding Information……………………………….…… 21

Table 5 Exclusive Breastfeeding Practice…………………………………………….…… 23

Table 6 Challenges Market Women face…………………………………………..…… 24

LIST OF FIGURES

Figure 1 Marital Status………………………………………………………… 19

Figure 2 Religion………………………………………………………………. 20

Figure 3 Ethnicity……………………………………………………………… 20

Figure 4 Respondents Knowledge on Exclusive Breastfeeding…………………… 21

Figure 5 Benefits of Exclusive Breastfeeding…………………………………….. 22

CHAPTER ONE

1.0 INTRODUCTION

Every infant and child has the right to good nutrition according to the "Convention on the Rights of the Child 2015". Globally in 2015, 156 million children under 5 were estimated to be stunted, 50 million were estimated to be wasted, and 42 million were overweight or obese. About 43% of infants 0–6 months old are exclusively breastfed. Few children receive nutritionally adequate and safe complementary foods; in many countries less than a fourth of infants 6–23 months of age meet the criteria of dietary diversity and feeding frequency that are appropriate for their age. Over 800 000 children's lives could be saved every year among children under 5 years, if all children 0–23 months were optimally breastfed (WHO Facts Sheet, 2015). WHO and UNICEF recommend: early initiation of breastfeeding within 1 hour of birth; exclusive breastfeeding for the first 6 months of life; and introduction of nutritionally-adequate and safe complementary (solid) foods at 6 months together with continued breastfeeding up to 2 years of age or beyond(WHO Facts Sheet, 2015) . Exclusive breastfeeding for 6 months has many benefits for the infant and mother. Chief among these is protection against gastrointestinal infections which is observed not only in developing but also industrialized countries.

Early initiation of breastfeeding, within 1 hour of birth, protects the newborn from acquiring infections and reduces newborn mortality (WHO facts sheet, 2015). The risk of mortality due to diarrhoea and other infections can increase in infants who are either partially breastfed or not breastfed at all. Breast-milk is also an important source of energy and nutrients in children aged 6–23 months. It can provide half or more of a child’s energy needs between the ages of 6 and 12 months, and one third of energy needs between 12 and 24 months (WHO Facts Sheet, 2015). Breast-milk is also a critical source of energy and nutrients during illness, and reduces mortality

among children who are malnourished. Children and adolescents who were breastfed as babies are less likely to be overweight or obese; additionally, they perform better on intelligence tests and have higher school attendance; exclusive breastfeeding is associated with higher income in adult life (Bryce et al., 2015). Improving child development and reducing health costs results in economic gains for individual families as well as at the national level. Longer durations of breastfeeding also contribute to the health and well-being of mothers: it reduces the risk of ovarian and breast cancer and helps space pregnancies–exclusive breastfeeding of babies under 6 months has a hormonal effect which often prevents a lack of menstruation. This is a natural (though not fail-safe) method of birth control known as the Lactation Amenorrhoea Method. However, many infants and children do not receive optimal feeding. For example, according to W.H.O and UNICEF statistics only about 36% of infants aged 0–6 months worldwide were exclusively breastfed over the period of 2007-2014.

Ghana on the other hand recorded an estimated 68% Exclusive Breastfeeding rate (GHS Annual Review, 2012) but has dropped drastically to 52% (GHS Annual Review, 2015). This extreme drop is worrying and may indicate inadequate knowledge of the practice or wrong sources of information about Exclusive Breastfeeding among nursing mothers and especially the market women who also play an important role in the nation's population. In addition, there might be challenges to the practice of Exclusive Breastfeeding among market women which contributes to this reduction in Exclusive Breastfeeding rate and therefore needs to be attended to. A research to provide the right source of information on EXCLUSIVE BREASTFEEDING knowledge and the enhancing of EXCLUSIVE BREASTFEEDING practice among market women will undoubtedly improve the rate of EXCLUSIVE BREASTFEEDING in Ghana.

1.1 Problem Statement

Recent figures of EXCLUSIVE BREASTFEEDING practice are estimated to be 52% (Ghana Health Service Annual Review, 2015).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). 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; Coutsoudis et al.1999; Karmer, 2003), whereas others have also considered the prospective position of husbands in breastfeeding decisions (Arora et al.2000; Susin et al., 2008). Not much attempts however, have been made at examining the knowledge and practice of exclusive breastfeeding among market women who also play major role in a country's development, particularly in sub Saharan Africa. According to Boateng (2012), females form major part of Bantama's population and most of them are traders in their market. Women here have strong beliefs in their traditional ways eg. Infant feeding practices (Akuamoa-Boateng, 2012). The current rate of exclusive breastfeeding till 6 months of age at Bantama is an estimated 13.9% (Ayawine et al. 2015). This therefore may be an indication that their work status, their knowledge level and their traditional beliefs may be a hindrance to the

practise of optimal EBF hence; this research was therefore carried out to fill the present knowledge gaps.

1.2 research questions

The main research question for the study is what is the rate of knowledge and practice of exclusive breastfeeding among Bantama market women in Kumasi Metropolis of Ghana?

1.3 specific questions are the following:

1. What are the sources and knowledge of exclusive breastfeeding information among market women in Bantama-Kumasi Metropolis?
2. Do market women know the benefits of exclusive breastfeeding practice?
3. Does the work in the market affect exclusive breastfeeding practice among the market women in Bantama-Kumasi Metropolis?

1.4 objective of the study

The main objective of the study was to examine the knowledge and practice of exclusive breastfeeding among market women in Bantama.

The specific objectives of the study are the following:

1. To examine the knowledge and sources of information on exclusive breastfeeding among market women in Bantama.
2. To identify the practice of exclusive breastfeeding practice among Bantama market women.

3. To identify the challenges on exclusive breastfeeding practice among Bantama market women.

1.5 Significance of the Study

The study will contribute to enriching current education programs on exclusive breastfeeding. In addition, the findings of the study will help shape policies on exclusive breastfeeding and assist market women and the society to understand and support the practice of EXCLUSIVE BREASTFEEDING. Thus helping in the attainment of MDGs 4 and 5 which stipulates; a reduction by two thirds the mortality rate among children under five and a reduction by three quarters the maternal mortality ratio respectively. 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 implement health interventions among market women. Additionally, this research will certainly provide a basis for future research.

1.6 Anticipated Limitations

The study will be conducted at Bantama market in the Kumasi Metropolis-Ashanti Region. The focus will be on all the market women with children from 7 months to fewer than 5 years at the time of the survey, however due to vastness of the area, time, fewer personnel, and financial constraints, this study would be limited to 60 mothers. Despite the interest to conduct this study, a larger sample size could not be used as a result of the aforementioned limitations. Also, since the questionnaire would be administered by the interviewer, this can result in inaccurate translation which might affect the findings.

1.7 Abbreviations

EBF – Exclusive Breastfeeding

WHO - World Health Organization

UNICEF - United Nations International Children Emergency Fund

GHS – Ghana Health Service

MDGs – Millennium Development Goals

Operational Definitions

KNOWLEDGEABLE - Respondents ability to state key words in W.H.O's definition of E.B.F

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter covers related researches that have been conducted on this topic. It also justifies the need to carry out this research. It consists of the following sub headings:

The knowledge and sources of information on exclusive breastfeeding

Benefits of breastfeeding for Infants and Mothers

The challenges of exclusive breastfeeding practice

The practices of exclusive breastfeeding

2.1 The knowledge and sources of information on exclusive breastfeeding

Exclusive breastfeeding is defined as the act of feeding infants with only breast milk without any additional food or drink, not even water for the first six (6) months of life (WHO, 2001).The United Nations International Children's Fund (UNICEF, 2001) also defines exclusive breastfeeding as feeding a baby with breast milk only for the first six months after birth. Breastfeeding should continue up to two years of the infant's life with increasing amount of prelacteal feeds after the 6th month.

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 counseling, paternal support, and education of the mothers and health care professionals have

been used to promote breastfeeding in the U.S. (Philipp et al., 2001). A study showed that a 1.5-hour mandated breastfeeding education intervention of nursing staff significantly increased the compliance of breastfeeding over a 7-month period at the intervention site compared to control site increasing the rates of EXCLUSIVE BREASTFEEDING by 23% (Martens, 2000).

Various studies in Ghana have also revealed very good knowledge of mothers concerning EXCLUSIVE BREASTFEEDING practise. A research in the Kumasi Metropolis showed that all respondents were knowledgeable on EXCLUSIVE BREASTFEEDING practise and most of the respondents' sources of information were from health professionals (Janet et al, 2014). A study by Esther Nsiah also revealed that 95% of the mothers interviewed on EXCLUSIVE BREASTFEEDING were able to explain EXCLUSIVE BREASTFEEDING according the recommendation of W.H.O and had their information from the hospital (Nsiah et al., 2014).

2.2 Benefits of Breastfeeding for Infants and Mothers

Breastfeeding has short-term and long-term benefits for infants and mothers. The following sections explain these benefits in detail and provide statistics to show the importance of breastfeeding.

2.2.1 Breastfeeding benefits to infants

The components of breast milk provide the needed nutrition for babies, and boost the baby's immune system. These breast milk components are easier to absorb and digest than baby formula because it contains living growth factors, hormones and enzymes which help a baby to easily

digest all the goodness from every feeding (The Office on Women's Health, 2012). Breast milk composition starts as colostrum then changes to mature milk, which gives the child the appropriate nutrition for his/her development process from newborn to older infant (Powe, et al., 2011). One of the most important benefits of breast milk is that it contains living components such as infection fighting antibodies, white blood cells, red blood cells, and anti-viral factors (Taylor, 2013). In the United States, infants who are breastfed have lower mortality rates compared to infants who were not breastfed (Chen & Rogan, 2004). Also, breastfeeding is associated with decreasing acute illnesses such as gastrointestinal infections, lower respiratory tract diseases and acute otitis media (Mountford & Salcines, 2006). Further, in developed countries researchers found that for infants who were not breastfed risk of dying from infectious diseases in the first month is six times greater than infants who were breastfed (Chen & Rogan, 2004). Similarly, breastfeeding has been linked to the decrease in the risk of gastrointestinal infections, lower respiratory tract diseases and acute otitis media for infants in developed countries (Stanley et al., 2007). Also, according to Stanley and colleagues (2007), breastfeeding practice plays a significant role in reducing the rates of childhood obesity, certain allergic conditions, type-2 diabetes and leukemia.

However, a published report from WHO claimed that breastfeeding has a small association with preventing obesity (Horta & Victoria, 2013). Breastfeeding reduced the percentage for obesity at school age by about 20%, after modifying for related factors such as infant birth weight, parental overweight, parental smoking, dietary factors, physical activity and maternal socioeconomic status (Owen et al., 2005). In addition, breastfeeding has other long-term benefits for infants, such as such as higher cognitive outcome in full-term infants, less cardiovascular mortality in

adults and lower adult blood pressure (Stanley et al., 2007). However, these benefits could be achieved if the other risk factors have been considered (Stanley et al., 2007).

2.2.2 Breastfeeding benefits to mothers

Practicing breastfeeding helps mothers lose weight after pregnancy and stimulates the uterus to return to its previous position before pregnancy (The Office on Women's Health, 2012). Also, breastfeeding helps in decreasing the risk of type 2 diabetes, breast cancer (Collaborative Group on Hormonal Factors in Breast Cancer, 2002) and ovarian cancer (Rosenblatt & Thomas, 1992). A study about the association between duration of lactation and incidence of type 2 diabetes was conducted with two groups of mothers in the Nurses' Health Study (NHS). For the first group, without history of gestational diabetes, the risk of developing type 2 diabetes was reduced 4% for each additional year of breastfeeding. For the second group with gestational diabetes, the risk of developing type2 diabetes was reduced 12% for each additional year of breastfeeding (Stuebe et al., 2005). Another advantage for breastfeeding is decreasing the risk of breast cancer among breastfeeding mothers. According to Collaborative Group on Hormonal Factors in Breast Cancer (2002), there is an association between breastfeeding and breast cancer, and the longer women breastfeed the more they are protected against breast cancer. The researchers found that the risk of breast cancer decreased by 4.3% for every 12 months of breastfeeding, and 7% for each birth. Furthermore, many studies also reviewed the link between breastfeeding and reduction in the risk of ovarian cancer. Specifically these studies concluded that the women who breastfeed had 21% less risk of ovarian cancer compared to mothers who never breastfed (Stanley et al., 2007).

2.3 The challenges of exclusive breastfeeding practice

Challenges of Exclusive Breastfeeding practices may be different or even similar among individuals, ethnic groups, religions, age groups, countries and even across continents (Atindanbila et. al 2014). Numerous studies have revealed that most challenges women face concerning EXCLUSIVE BREASTFEEDING is the family and their cultural background. Despite the women been well informed and knowledgeable on EXCLUSIVE BREASTFEEDING practices their willingness to follow the optimal way of breastfeeding are often counteracted by other ideas and problems, a study has shown that in Ghana, prelacteal feeds like "koko" (Porridge), mashed "kenkey" (a type of Ghanaian dish prepared with maize and wrapped in Kola leaves or maize husks) are highly in use because elderly females in the family (grandparents) play a major role in influencing the practice of breastfeeding (Yadavannavar & Sailaja, 2011). Again, Awumbila (2003) observed from some cultural background that mothers add shea butter (to fill stomach) or herbs (to stop navel pains) to the water to give to the infant. Other substances given are gripe water (to stop naval/stomach pains) and special water washed from a slate on which Islamic verses had been inscribed, for protection against diseases. Some reasons assigned for giving water at this tender age include; fill the stomach and induce sleep, promote abdominal comfort, stop navel pains, stop heartburns and hiccoughs, quench thirst after struggling during labour period, lubricate/moisten the throat of the baby and welcome the baby into the world since every living thing must be given water (Awumbila et al, 2003). Time related to work status has also been found to be a consistent challenge to the practise of EXCLUSIVE BREASTFEEDING among mothers; the results from the study at the Kumasi Metropolis by Janet Danso (2014) confirms that more than half (51%) of

the mothers said they do not have ample time to breastfeed because of work status and pressure (Janet Danso et al, 2014).

2.4 The practices of exclusive breastfeeding

Exclusive breastfeeding 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 is about 49% (Ghana Statistical Service & ICF Macro, 2009). 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 2009). At about six months of age and beyond an estimated 68% of Ghanaian breastfeeding children are given both solid and semisolid foods. A study revealed that in Ghana, the percentage of women who reported to have exclusively breastfed by World Health Organization's standard was reported to be 51.3% (Aidam et al, 2005). Another study in the Kumasi Metropolis by Janet Danso, 2014 shows clearly that, 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 Organization recommended practice of exclusive breastfeeding (Danso et al, 2014). A research revealed very good knowledge among the nursing mothers at Nkawie in the Atwima Nwabiagya District on the exclusive breast feeding practice but examining the mothers, 52% of the population samples were able to practise the EXCLUSIVE BREASTFEEDING and the remaining 48% did not

practise exclusive breastfeeding (Nsiah et.al 2014). The poor results exclusive breastfeeding practices revealed by these studies support the fact that most mothers in our community and the world at large still have not grasped the whole concept of Exclusive Breast Feeding hence much attention and effort is still needed in this field of study. Within this context, this research examines the knowledge and practice of Exclusive Breast Feeding among Bantama market women in the Kumasi Metropolis.

CHAPTER THREE

Methods

Chapter three describes the research design and research method in detail. The methodology includes the research design, research setting, research population, sampling, data collection, reliability and validity of the study and ethical issues.

3.1 Research Design and Instrument

In this study, the design used was cross-sectional, with data collected at a single point in time (Fink et al., 1995). This type of research design does not require follow-up, therefore, it is less costly and less time intensive than other designs. Descriptive statistics including frequencies, and other statistical measures were use to analyze quantitative data collected.

3.2 Data Collection Method

Data was collected through the administration an interviewer-administered questionnaire. The questionnaire gave accurate description of activities and processes and ensured maximum objectivity in the research procedure. An Introductory statement was given to describe the purpose of the study and questionnaire which also assured the respondents of anonymity and confidentiality. Demographic questions were asked first because they are easy to answer and also serve as ‘warm up’. Questions asked included age, religion, occupation and employment. Actual questions were direct questions about Exclusive Breast Feeding that are easily answered by the respondents. In this study, the questionnaire consisted of a section B part in which the six (6) questions there were mainly on the knowledge and sources of EXCLUSIVE

BREASTFEEDING, a section C part on the practise of EXCLUSIVE BREASTFEEDING and a section D part on the challenges of EXCLUSIVE BREASTFEEDING. The questions at the section B part were to examine the respondents' knowledge on and sources of EXCLUSIVE BREASTFEEDING. The criteria to assess the level of knowledge of the respondents were if they are able to explain the EXCLUSIVE BREASTFEEDING as stated by W.H.O.

3.3 Pretesting (Validity and Reliability)

Validity of a test instrument is the extent to which the test instrument measures what it is supposed to measure.

Reliability is the degree to which an instrument gives similar results for the same purpose each time it is used (can be reproduced). This is made possible by using a language common to all the subjects and the absence of ambiguity.

Fifteen (15) samples of the questionnaires which is the research instrument was sent to Bantama market prior to the commencement of the main research activity in order to test the validity and reliability of this research instrument and to avoid ambiguity.

3.4 Study Area

Bantama is a sub-metro suburban area of the Kumasi Metropolitan, the Ashanti capital. Bantama is both a residential and commercial area in the Kumasi metropolitan assembly. It is in the centre of the Ashanti capital, Kumasi. Bantama has weather details of; 24°C temp, Wind SW at 6km/h, 94% Humidity and is 912ft (278m) elevated. Bantama is in the Greenwich Meridian Time zone and has coordinates: 6°39'N 1° 37'W. Its body is the Manhyia Palace headed by Nana Otumfo

Osei Tutu II, the Ashanti King. It has a population of about 327,965 (fourth most populated sub metropolis in Kumasi) and the majority is females forming 52.2% predominantly Ashanti with significant concentration of people from the northern sector. Most of the people are primary school graduates with a literacy rate of 40%. 90% of both males and females are into retail trading. While the males are mostly found in stores dealing with secondhand goods, the majority of the females are in the market selling agricultural produce, cosmetics and processed goods (msaudcolumbia.org, 2012). According the Ghana Health Service statistics of the Kumasi Metropolis which Bantama forms a major part, the number of infants who die per 1000 live birth each year continues to grow. It increased from 21 in 2003 to 29 in 2004 and 36 in 2005 representing an increase in percentage of 27.6 and 19.4 respectively. The indicated figures analyses that the maternal mortality rates in the periods under review have been high. In 2003 it was 3.7% of every 100,000 live births. It increased to 4.2% in 2004 and took a slight nose dive in 2005 thereby settling at 3.9%.

3.5 Sample Population and Sampling Technique

The target population for the study consists of biological mothers of infants from 7 months to fewer than 5 years at Bantama Market. A simple random technique was used to select 60(sixty) participants since not all the market women fall within the criterion. As the study sets out to explore the knowledge and practice of EXCLUSIVE BREASTFEEDING among market women, the following inclusion and exclusion criteria will be used to purposively select the participants. The participant; Must be a nursing mother with an infant from 7 months to fewer than 5 years, Must be resident in Bantama or any of its environs in the Kumasi metropolis, Must be the

biological mother of the baby and a citizen of Ghana.

3.6 Ethical Consideration

An introductory letter was sought from the Nursing Department of Christian Service University College and sent to the head of the Market Women Association at Bantama market for the authorization of the research in the market. Participants were given a brief introduction to the study and its relevance while reassuring them that their responses will be treated confidentially. They were encouraged to partake without compulsion.

3.7 Data Analysis

SPSS version 20 was used to analyze the data and for meaningful and simplified data, frequency, percentages and pie charts were selected in presenting the data.

CHAPTER FOUR

RESULTS

4.1 Background Information

4.1.1 Age of respondents

Sixty (60) respondents were recruited to complete the questionnaire and Participants ranged in ages from 18 to 52 years (see Table 1).Most, 23 (38.2%) were within 32-38 years, and the least 5 (8.3%) were within the ages of 46-52 years.

Table 1: Age of respondents

PERCENTAGE (%)	FREQENCY	AGE
13.3	8	**18 – 24**
28.3	17	**25 – 31**
38.2	23	**32 – 38**
11.7	7	**39 – 45**
8.3	5	**46 – 52**
100	60	**TOTAL**

4.1.2 Number of children

With the number of children, most of the respondents, 15(25%) had 3 children while only 2(3.4%) had 6 and 7 children.

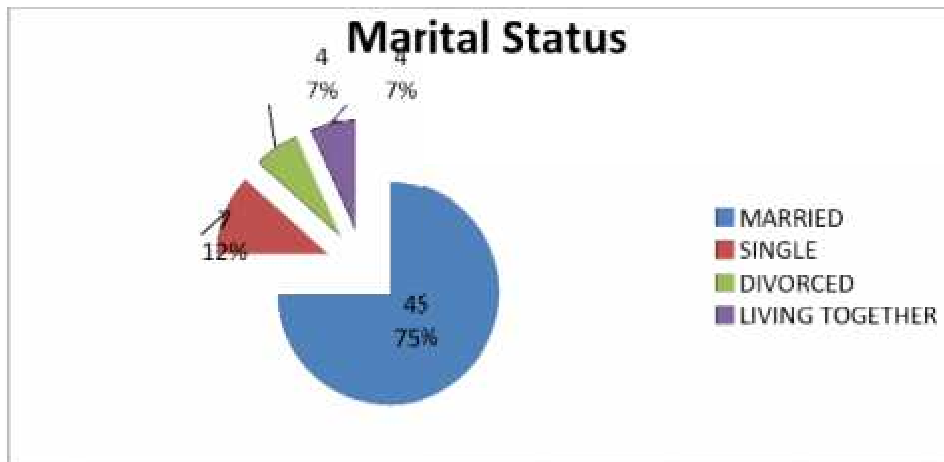
Table 2: Number of children

Percent (%)	Frequency (f)	Children (number)
18.3	11	1
23.3	14	2
25.0	15	3
23.3	14	4
6.7	4	5
1.7	1	6
1.7	1	7.00
100.0	60	Total

4.1.3 Marital Status

Most of the respondents were married, 45(75%) and the least recorded were those living together those divorced, 4 (6.7%) at par.

Figure 1



4.1.4 Level of education

Most of the respondents were JHS leavers- 29 (48.3%) and the least recorded were Primary school leavers – 4 (6.7%).

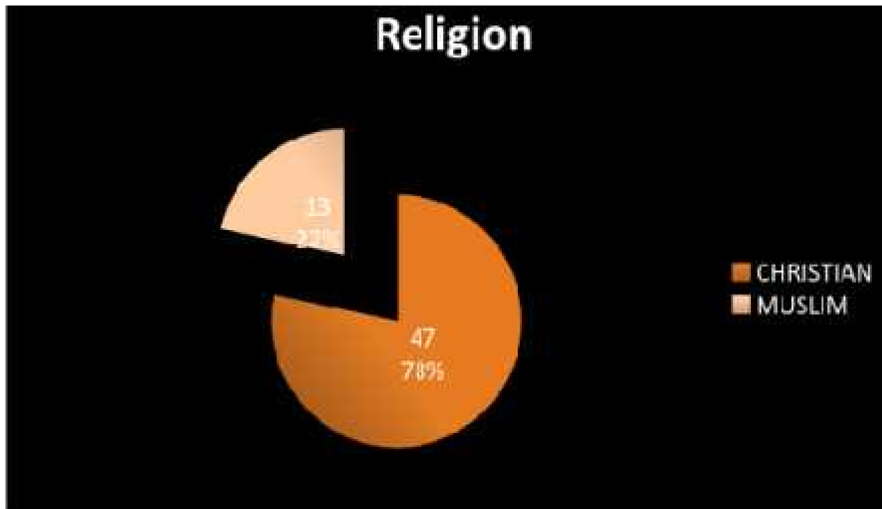
Table 3: Level of education

Percent (%)	Frequency	
6.7	4	PRIMARY
48.3	29	JHS
13.3	8	SHS
31.7	19	NON-FORMAL
100.0	60	Total

4.1.5 Religion

47 (78.3%) of the respondents were Christians and the remainder, 13 (21.7%) were Muslims.

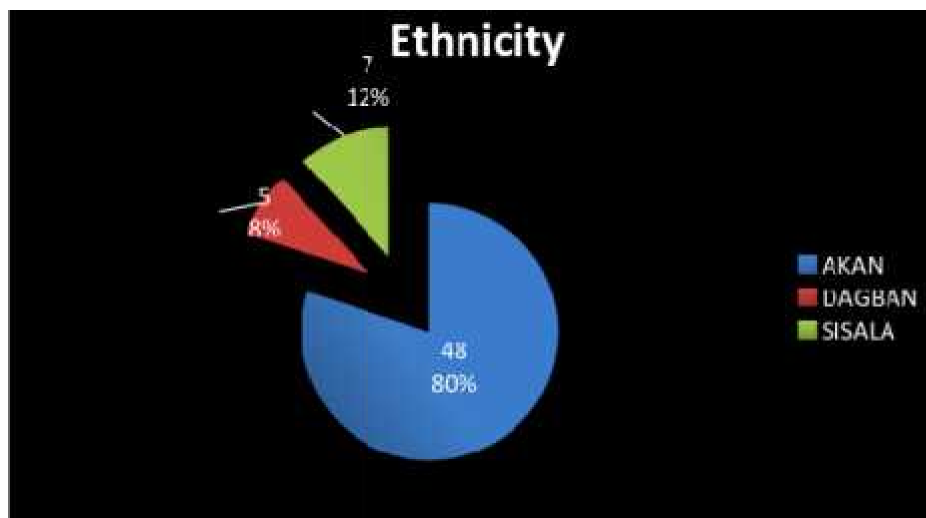
Figure 2



4.1.6 Ethnicity

In terms of the respondents ethnic origin, majority - 48 claimed to be Akans whiles Sisala and Dagban recorded the least of the participation, 5 (8.3%) and 7 (11.7%) respectively.

Figure 3

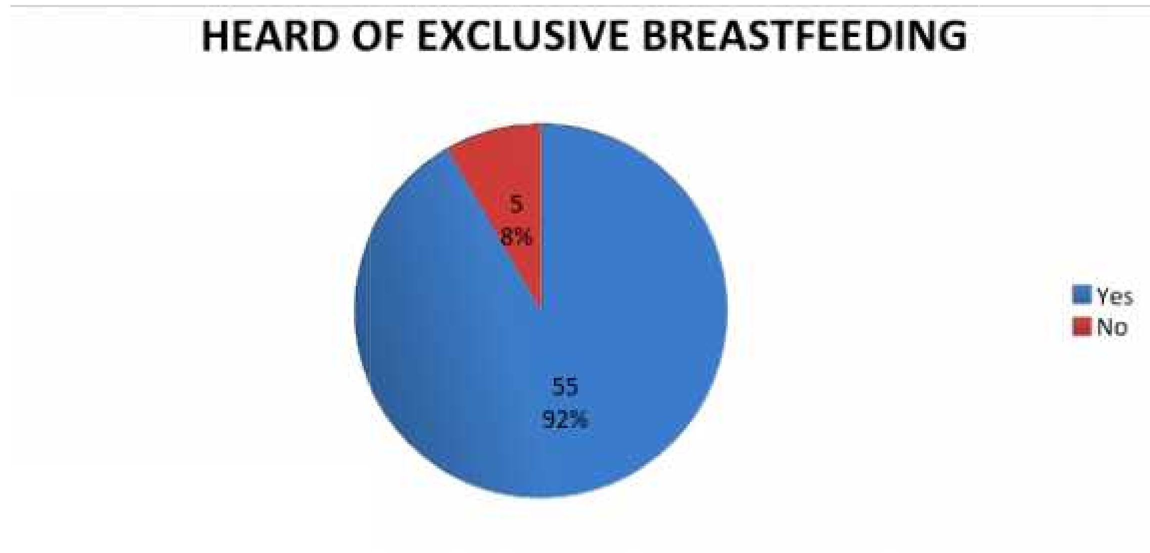


SECTION B

4.2. Knowledge and Sources of Information

4.2.1 Respondents' knowledge on Exclusive Breastfeeding.

Figure 4



According to figure 4, 55 (92%) out of the respondents said they have heard and have knowledge on EXCLUSIVE BREASTFEEDING and the remaining 5 (8%) said they do not have knowledge on EXCLUSIVE BREASTFEEDING.

4.2.2 Sources of Exclusive Breastfeeding Information

Table 4: Sources of Exclusive Breastfeeding Information

Percent	Frequency	SOURCE
3.6	2	RADIO
89.1	49	HEALTH PERSONNEL
7.3	4	HOME (OTHERS)
100.0	55	Total

From table 4, out of the 55 (92%) who said yes, 2 (3.6%) of them heard the information from the radio stations, 49 (89.1%) had theirs from Health centers and 4 (7.3%) had their information from family and friends at home.

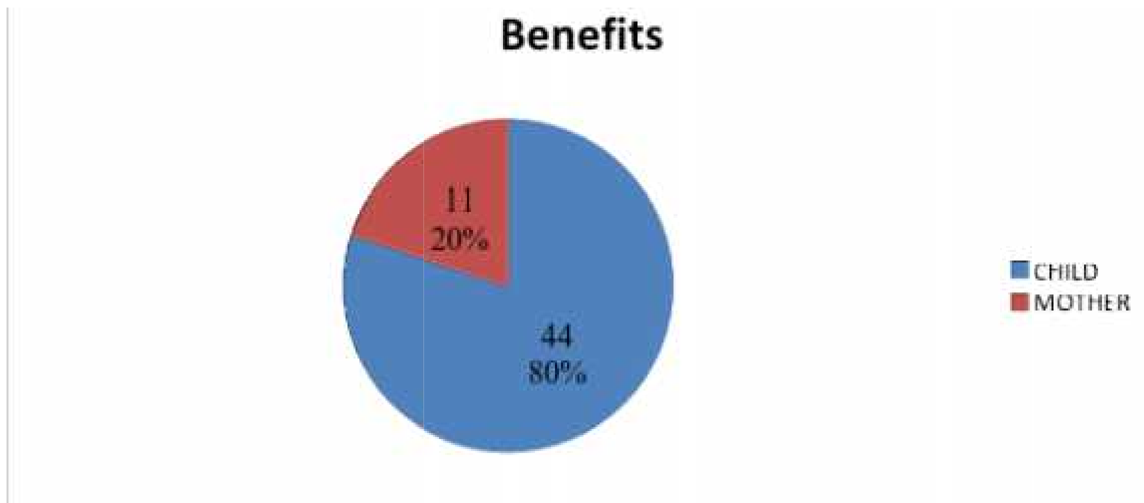
4.2.3 Respondents' knowledge on Exclusive Breastfeeding

All 55 (92%) who had heard of exclusive breastfeeding were found to be well knowledgeable on exclusive breastfeeding practice and were able to explain exclusive breastfeeding according to the WHO definition '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 for the first six months of life'.

4.2.4 Benefits of Exclusive Breastfeeding

From the data analyzed, only 11 (20%) respondents out of the 55 (100%) who said yes, knew the benefits of exclusive breastfeeding to the mother but the remaining 44 (80%) knew only the benefits of exclusive breastfeeding to their children.

Figure 5



SECTION C

4.5 Practice of Exclusive Breastfeeding among Market Women at Bantama.

4.5.1 Exclusive Breastfeeding practice among Bantama market women

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 table 5, 33 (60%) of the 55 respondents who had knowledge on EXCLUSIVE BREASTFEEDING said they were able to practice the recommended exclusive breastfeeding and the rest of them, 22 (40%), said they were not able to practice the recommended exclusive breastfeeding.

Table 5: Exclusive Breastfeeding Practice

PERCENTAGE (%)	FREQUENCY (f)	RESPONSE
60	33	YES
40	22	NO
100	55	TOTAL

Upon further query, 10 (30.3%) out of the 33 who said yes were seen to have lapses in the practise of the recommended exclusive breastfeeding practice and the remaining 23 (69.7%) of the 33 respondents were genuinely able to practise the recommended exclusive breastfeeding. From the data analyzed, 23 (41.8%) out of the total 55 respondents were able to practise exclusive breastfeeding but 32 (58.2%) were not able to practise breastfeeding by W.H.O. Now, with regards to the total 60 respondents, 23 (38.3%) were able to practise exclusive breastfeeding and the remaining 37 (61.7%) were not able to practise exclusive breastfeeding.

SECTION D

4.6.0 Challenges on Exclusive Breastfeeding among Market Women at Bantama.

4.6.1 Challenges market women face

According to the data collected, the respondents experienced some challenges during their time of exclusive breastfeeding. Forty-nine (49) out of the 55 respondents faced challenges from their grandparents, twenty-two (22) out of the 55 did not have enough time to breastfeed, sixteen (16) out of the 55 did not have support of from their spouses. The 5 who said they are ignorant of exclusive breast feeding are missing / invalid.

Table 6: Challenges market women face

PERCENTAGE (%)	FREQUENCY (f)	CHALLENGES
56.4	31	**GRANDPARENTS ONLY**
25.4	14	**AMPLE TIME ONLY**
18.2	10	**NO SUPPORT FROM SPOUSE ONLY**
100	55	**TOTAL**

CHAPTER FIVE

DISCUSSION, SUMMARY, CONCLUSION AND RECOMMENDATION

The chapter consists of the final section of the main body of the report. It discusses and interprets the results, draws conclusions and implications and makes recommendations.

5.1 Discussion

The study focused on knowledge and practices of exclusive breastfeeding among market women at Bantama. We managed to collect data from the 60 respondents (100%) with the respondents' age ranging from 18-52 years. Majority, 23 (38.2%) were within 32-38 years, and the least, 5 (8.3%) were within the ages of 18-24 years. With the number of children, most of the respondents, 15 (25%) had 3 children while only 2(3.4%) had 6 and 7 children. Most of the respondents were married, 45(75%) and the least recorded were those living together those divorced, 4 (6.7%) at par. Most of the respondents were JHS leavers- 29 (48.3%) and the least recorded were Primary school leavers – 4 (6.7%).47 (78.3%) of the respondents were Christians and the remainder, 13 (21.7%) were Muslims. In terms of the respondents ethnic environ, majority - 48 proved to be Akans whiles Sisala and Dagban recorded the least participation, 5 (8.3%) and 7 (11.7%) respectively.

The level of knowledge of the respondents was very high, reaching 92% of the population sample and most of them reported their source to be the health professionals. This is a confirmation on earlier studies conducted by different researchers who have had similar findings. Nsiah (2014) revealed that 95% of the mothers at Atwima Nwabiagya District were knowledgeable, and Janet Danso reported that all respondents were knowledgeable on Exclusive Breastfeeding practise and most of the respondents' source of information was health

professionals. This may be due the hard work of nurses during antenatal clinics, the willingness of the mothers, and the higher participation of the mothers during antenatal clinics. Thirty-eight percent (38.3%) out of the total population sample exclusively breastfed their infants for the first six months. This finding is higher than the initial report that the current rate of exclusive breastfeeding till 6 months of age at Bantama is an estimated 13.9% by Ayawine (2015). This showsa significant increase of EBF rate from 2015 to 2017. Contrasting the earlier study by Danso (2014), who reported an EBF rate of 48% among working mothers at the Kumasi Metropolis, the rate of EBF has dropped. Again, Nsiah (2014) found that 52% of the mothers at in the Atwima Nwabiagya District were able to practise Exclusive Breastfeeding and this clearly shows a lower outcome of EBF practise at Bantama. This can be attributed to the fact a larger number of the interviewed respondents (80%), knew the benefits of EBF to the child but not to the mother even though they proved to be knowledgeable on the optimal EBF practise; recording a massive 92% on the knowledge level. In addition, the family and traditional beliefs were the reasons for the poor outcome of EBF rate among the market women. Interference from the family especially the grandmothers was the most challenge the respondents faced (82%) and this then is in support of Yadavannavar (2011) and Awumbila (2003) previous finding that prelacteal feeds like “koko” (Porridge), mashed “kenkey” are highly in use because elderly females in the family (grandparents) play a major role in influencing the practice of breastfeeding (Yadavannavar & Sailaja, 2011), and, mothers from some cultural backgrounds add shea butter (to fill stomach) or herbs (to stop navel pains) to the water to give to the infant during the first six months of the child’s life (Awumbila et al, 2003) respectively. Ample time was another factor but no a major problem as Janet Danso found earlier in her research that more than half (51%) of

the working mothers at the Kumasi Metropolis said they do not have ample time to breastfeed because of work schedule and pressure (Danso et al., 2014). Only 32% of the total number of respondents in our study had challenges with ample time.

5.2 Summary

In this study we assessed the knowledge and practice of EBF among 60 market women at Bantama with infants above 6 months to fewer than 5 years. It was realized that the participants were much aware and were knowledgeable on the practice of EBF. Again, most women knew the benefits of EBF to the child but not much was known about its importance to the breastfeeding mother. The commonest problem the participants face was the involvement and the interruption of the aged in the family concerning the practice of EBF; most could not practice because of the challenge from the grandmothers.

5.3 Conclusion

It can be concluded that there is a low rate of EBF practice among market women at Bantama and this confirms an earlier study by Janet Danso on the rate of EBF practise among working mothers at Kumasi (Danso et al., 2014). Hence, the educational strategies on EBF should be intensively modified and much attention should be paid to letting the mothers know that EBF is also of benefits to them, the mother, such as reducing the risk of ovarian cancer, decreasing the risk of type-2 diabetes, and breast cancer.

5.4 Recommendations

1. More training and awareness campaigns should be done to be able to attain high rate of exclusive breastfeeding

2. House to house survey need to be conducted to establish more in-depth understanding on the practices and knowledge of exclusive breastfeeding at Bantama.

3. The nurses should not only teach but find ways to enforce it involving the grandmothers in the family during talks on the need to exclusively breastfeed through home visits, specially organized programs for the elderly.

4. More studies should be conducted on the knowledge and practice of exclusive breastfeeding.

5. More awareness should be created on the benefits of EBF for the mother, the family and the nation as a whole.

5.5 Study Limitations

1. Recall bias; some of the mothers were not able to recall all the details of their practices in the first six months.
2. Since the questionnaires were administered by the interviewers, there might have been inaccurate translation which could have affected the findings.
3. Being well informed, respondents might give the desired answers even if they do not practice.
4. The population studied might not represent the whole Metropolis, as sample size was small.

REFERENCES

Abenaa Akuamoa-Boateng, 2012.West Africa Coordinator of the Millennium Cities Initiative, the Earth Institute, available at http://msaudcolumbia.org/spring/2012/2012/05/bantama/ (Accessed 29-10-2016).

Aidam, B.A., Perez-Escamilla, R., Lartey, A., & Aidam, J. (2005). Factors associated with exclusive Breastfeeding in Accra, Ghana. European Journal of Clinical Nutrition 59, 789796.

Alice Ayawine, k. A. (2015). Determinants of exclusive breastfeeding: a study of two sub-districts in the atwima Nwabiagya District of Ghana. *The Pan African Medical Journal.* , 22-248.

American Academy of Pediatrics- AAP. (2001). Breastfeeding and the use of human milk.

Arora, S., Mcjunkin, C., Wehrer, J. & Kuhn, P., 2000.Major factors influencing breastfeeding rates: mother's perception of fathers attitude and milk supply. Pediatrics 10: e67

Awumbila, M. (2003). Social dynamics and infant feeding practices in northern Ghana. *International Journal of Humanities Social Sciences and Education (IJHSSE)* , 85-98.

Bryce J, Terreri N, Victoria CG, Mason E, Daelmans B, and Bhutta ZA, et al. Count down to 2015: tracking intervention coverage for child survival. Lancet 2006;368:1067-1076

Chen, A., & Rogan, W. J. (2004). Breastfeeding and the risk of post neonatal death in the United States. Journal of the American Academy of Pediatrics, 113, 435-439.

Collaborative Group on Hormonal Factors in Breast Cancer. (2002). Breast cancer and breastfeeding: Collaborative reanalysis of individual data from 47 epidemiological studies in 30 countries, including 50,302 women with breast cancer and 96,973 women without the disease. The Lancet, 360, 187-195.

Coutsoudis, A., et al., 1999. Influence of infant feeding patterns on early mother-to-child transmission of HIV-1 in Durban, South Africa: a prospective cohort study. Lancet 354: 471-76

Dr. Samuel Atindanbila, D. M.-N. (2014). Attitudes and Practices Associated with Exclusive Breast Feeding (EBF) of Nursing Mothers in Bolgatanga Municipality. *International Journal of Humanities Social Sciences and Education (IJHSSE)* , 114-120.

Duncan, B. (1993). Exclusive breastfeeding for at least 4 months protects against otitis media. *Pediatrics* , 95 (5).

ESTHER NSIAH, Y. A. (2014). Assessment Of The Level Of Knowledge And Barriers To Exclusive Breastfeeding among Nursing Mothers At Nkawie In The Atwima Nwabiagya District. 1-39.

Fink, A. (1995). The survey kit. Thousand Oaks, CA: Sage.

Ghana Health Service Annual Review, 2012.Rates of exclusive breastfeeding. Ghana, available at http://www.ghanahealthservice.org/ghs-category.php?cid=5(Accessed 29-10-2016)

Ghana Health Service Annual Review, 2015.Rates of exclusive breastfeeding. Ghana, available at http://www.ghanahealthservice.org/ghs-category.php?cid=5(Accessed 29-10-2016)

Ghana Statistical Service and ICF Macro. (2009). Ghana Demographic and Health Survey Report 2008. Calverton, Maryland: GSS & ICF Macro

Horta, B. L., & Victoria, C. G. (2013). Long-term effects of breastfeeding. Pelotas: World Health Organization WHO.

Janet Danso (2014) Examining the Practice of Exclusive Breastfeeding among Professional Working Mothers in Kumasi Metropolis of Ghana. International Journal of Nursing Vol.

1, No. 1; June 2014.

Kovach AC (2002). A 5-year follow-up study of hospital breastfeeding policies in the Philadelphia area: a comparison with the ten steps. J Hum Lact; 18(2):144-154.

Karmer, M.S (2003), *Promotion of Breastfeeding Intervention Trial*

Martens PJ. (2000) Does breastfeeding education affects nursing staff beliefs, exclusive breastfeeding rates, and Baby-Friendly Hospital Initiative compliance? The experience of a small, rural Canadian hospital. J Hum Lact; 16(4):309-318.

Mountford, M., & Salcines, M. (2006, July 1). Infant feeding and chronic diseases. Retrieved from Infant Feeding & Nutrition: http://www.infantformula.org/news-room/press releases-and-statements/infant-feeding-and-chronic-diseases

Otoo, G.E., Lartey, A. A. and Pérez-Escamilla, R., 2009. Perceived incentives and barriers to exclusive breastfeeding among peri-urban Ghanaian Women Journal Human of Lactation 25: 34 DOI: 10.1177/0890334408325072

Owen, C. G., Martin, R. M., Whincup, P. H., Smith, G. D., & Cook, D. G. (2005). Effect of infant feeding on the risk of obesity across the life course: A quantitative review of published evidence. Journal of the American Academy of Pediatrics, 115, 1367-1377.

Powe, C. E., Allen, M., Puopolo, K. M., Merewood, A., Worden, S., Johnson, L., Welt, C. K. (2011). Effects of recombinant human prolactin on breast milk composition. American Academy of Pediatrics, 127, 359-366.

Rosenblatt, k. A., & Thomas, D. B. (1992). Lactation and the risk of epithelial ovarian cancer. International Journal of Epidemiology, 22, 192-197.

Santé (Montrouge France). 2002. Breastfeeding in Africa: will positive trends be challenged by

AIDS epidemic? PMID 12 (1) Abstract only. Available at http://ukpmc.ac.uk/abstract/MED/11943640/reload=0;jsessionid=faLTKT8Ge1LiR6ZTGTmc.2

Senarath, U., Dibley, M.J. & Agho, K.E., 2010. Factors associated with nonexclusive breastfeeding in 5 East and Southeast Asian countries: A Multilevel Analysis. Journal of Human Lactation 2010 26: 248 DOI: 10.1177/0890334409357562

Stanley, L., Mei, C., Gowri, R., Priscilla, C., Maqula, N., Deirdre, D., Joseph, L. (2007). Breastfeeding and maternal and infant health outcomes in developed countries. Rockville: AHRQ Publication No. 07-E007.

Stuebe, A. M., Rich-Edwards, J. W., Willett, W. C., Manson, J. E., & Michels, K. B. (2005). Duration of lactation and incidence of type 2 diabetes. JAMA: The Journal of the American Medical Association, 294, 2601-2610.

Susin, L.R. O., & Giuglian, E. R.J., 2008. Inclusion of fathers in an intervention to promote breastfeeding: impact on breastfeeding rates. Journal Human of Lactation 24:386

Taylor, S. (2013, September 18). Plymouth laych-on breastfeeding groups. Retrieved from Plymouth Laych-on Breastfeeding Groups: http://www.plymouth latchon.org.uk/id14.html

The Office on Women's Health. (2012, April 5). Breastfeeding. Retrieved October 19, 2016, from Womenshealth.gov: http://www.womenshealth.gov/breastfeeding/

World Health Organization. Fifty-Fourth World Health Assembly. (2001). Global strategy for infant and young child feeding: The optimal duration of exclusive breastfeeding. Geneva, Switzerland: World Health Organization.

World Health Organization & UNICEF. (2001). Protecting, promoting and supporting breast feeding: The special role of maternity services. Switzerland: World Health Organization & UNICEF.

World Health Organization (2015). 10 facts on child health. Geneva, Available at http://www.who.int/features/factfiles/child_health2/en/index.html (Accessed 19-10-2016)

Yadavannar, M. C., Shailaja, S. P. (2011). Sociocultural factors affecting breastfeeding practices and decisions in rural women. Int. Journal of plant, animal and environmental sciences.Vol.1. Issue 2. 2231-4490.

APPENDIX

INTERVIEW SCHEDULE

THE KNOWLEDGE AND PRACTICE OF EXCLUSIVE BREASTFEEDING AMONG MARKET WOMEN AT BANTAMA.

QUESTIONNAIRE

We are students of Christian Service University College, Kumasi, carrying out a research to determine the Knowledge and Practice of Exclusive Breastfeeding among market women at Bantama.

Please we are counting on your co – operation for adequate information to make our research a success. We promise to confidentially keep all information provided. Therefore kindly answer the questions below as frank as you can.

Do you consent (verbally) to this survey? NAME (initials)....................

YES NO

SECTION A: BACKGROUND INFORMATION

1. Age

a. 18- 24 years b. 25 – 31 c. 32-38 d. 39-45 e.46-52. d.53-59

2. Number of children…………………….

3. Marital Status

a. Married b. Single Divorced e. Living together

f. Other specify………………….

4. What is your highest level of education?

a. Primary b. JHS c. SHS d. Tertiary

f. Non formal

5. Religion

a. Moslem b. Christian c. Traditionalist d. Others Specify…………

6. Ethnicity……………………………

SECTION B: KNOWLEDGE AND SOURCES OF INFORMATION ON EBF AMONG MARKET WOMEN AT BANTAMA.

1. Have you ever heard of exclusive breastfeeding?

[ ] Yes [ ] No

2. If yes, what was your source of information?

[ ] TV [ ] Radio [ ] Health Personnel [ ] others specify……………….

3. What should be given to a baby immediately after a safe delivery?

[ ] Breast milk

[ ] Any other milk

[ ] Plain boiled water

[ ] Other (specify) …………………..

4. How soon should the baby be put on breast milk if the delivery is normal?

[ ] Within 1 hour after birth

[ ] 2 hours or more after delivery

[ ] Don't know

[ ] Other (specify)……………………………………………………

5. Why is breastfeeding important to you? Tick all applicable

[ ] Provides babies with substances that help to fight diseases

[ ] Provides optimal growth

[ ] It helps the mother in one way or the other

[ ] Do not know

[ ] Other specify ……………………………………………………

SECTION C: PRACTICE OF EXCLUSIVE BREASTFEEDING AMONG MARKET WOMEN AT BANTAMA

1. Did you get time at the market place to breastfeed your child?

[ ] Yes [ ] No

2. If yes, how often did you breastfeed your baby?

[ ] On demand

[ ] By routine

[ ] When I get time

[ ] Other specify ……………………………

3. Mothers who practice exclusive breastfeeding are less likely to experience breast problems.

[ ] Agree

[ ] Neutral

[ ] Disagree

4. Correct positioning of the baby helps to achieve effective breastfeeding.

[ ] Agree

[ ] Neutral

[ ] Disagree

5. Giving water to the baby is encouraged after every breastfeeding.

[ ] True

[ ] False

SECTION D: CHALLENGES ON EXCLUSIVE BREASTFEEDING AMONG MARKET WOMEN AT BANTAMA.

1. Were there any challenges that made exclusive breastfeeding difficult for you? kindly tick either YES or No in cases where it is applicable.

NO	YES	Statement
		Grandparents didn't support Exclusive Breastfeeding
		Exclusive breast feeding is time consuming
		No support from partner or spouse to help with exclusive breastfeeding
		Inadequate information on exclusive breastfeeding and it's benefits
		I do not have ample time to breastfeed the baby because of customers

2. Others
   Specify………………………………………………………………………………

THANK YOU VERY MUCH FOR YOUR TIME.