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RESEARCH ARTICLE

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Challenges and coping strategies of nurses and midwives after maternity leave: A cross-sectional study in a human resource-constrained setting in Ghana

Kennedy Dodam Konlan[1] | Joyce Batagidewe Paladaga Pwavra[2] | Mavis Armah-Mensah[3] | Kennedy Diema Konlan[4] | Rita Aryee[5] | Stephen Narkotey[6]

[1]Department of Adult Health, School of Nursing and Midwifery, University of Ghana, Accra, Ghana

[2]Department of Maternal and Child Health, School of Nursing and Midwifery, University of Ghana, Accra, Ghana

[3]Department of Health Policy, School of Public Health, University of Ghana, Accra, Ghana

[4]Department of Public Health Nursing, School of Nursing and Midwifery, University of Allied Health Sciences, Ho, Ghana

[5]Nursing Directorate, Korle-Bu Teaching Hospital, Accra, Ghana

[6]School of Peri-operative and Critical Care Nursing, Accra, Ghana

Correspondence
Kennedy Dodam Konlan, Department of Adult Health, School of Nursing and Midwifery, University of Ghana, Accra, Ghana.
Email: kennedy.konlan@gmail.com

Abstract

Aim: This study examined the challenges and coping strategies adopted by nurses and midwives after child birth when they return to work.

Design: A cross-sectional design was used.

Method: Two hundred nurses and midwives with history of maternity leave were recruited from the Korle-Bu Teaching Hospital to take part in this study. Data were collected using a pre-tested self-administered questionnaire. The data were analysed with the aid of Stata 13.0.

Results: Most of the respondents claimed that they received support from relatives, day care centres and paid house helps while they resumed work. Seventy percent of the respondents indicated that they were given off day when they needed to send their child for postnatal care. Nurses and midwives depend on family members, paid house helps and day care centres to help them cater for their babies. It is recommended that hospitals set-up day care centres and breastfeeding bays attached to the institutions.

KEYWORDS
coping, Ghana, maternity leave, nurses and midwives

1 | INTRODUCTION

Globally, evidence (Asamani et al., 2019; Asiedu, Annor, Amponsah-Tawiah, & Dartey-Baah, 2018; Barreiro-Lucas & Lucas, 2019) shows that balancing work with family responsibilities such as breastfeeding has adverse consequences for both individual mothers and the organizations that they work in as it affects not only work output but also the psychosocial well-being of the mother and the new child and the entire family of the woman (Brief & Weiss, 2017; Danso, 2014). The dual role of being a mother and having to resume full duties at work puts serious demands on women post maternity leave (Dapaah, 2014; Dubale et al., 2019; Gladzah, 2013). It may further lead to elevated job stress, depression, burnout and a reduction in job, marital and life satisfaction (Asamani et al., 2019; Barreiro-Lucas & Lucas, 2019; Mbanga et al., 2018). The situation becomes dire for health care professionals such as nurses and midwives who are required to provide a continuous service around the clock for the benefit of all citizens in any country (Nuhu, Ainuson-quampah, & Brown, 2020). This has the propensity to place stress on nurses and midwives after maternity leave (Atinga, Domfeh, Kayi, Abuosi,

& Dzansi, 2014) and could trigger burnout and turnover (Dubale et al., 2019).

In Ghana, more than 60% of women in formal employment are in their fertile ages and these women are likely to get pregnant (Asamani et al., 2019). Ghana's labour law of 2003 (Act 651) stipulates in section 57 (1) that "A woman worker, on production of a medical certificate issued by a medical practitioner or a midwife indicating the expected date of her confinement, is entitled to a period of maternity leave of at least twelve (12) weeks in addition to any period of annual leave she is entitled after her period of confinement." This means that the maximum period a nursing mother can stay home to nurse her baby is 3 months aside the annual leave. The statutory maternity leave for new mothers in Ghana is inadequate considering the demands of caring for the new born alongside other members of the family particularly in Ghana where home maintenance is skewed towards the female sex (Asiedu et al., 2018). Most working women seek help from relatives particularly mothers, aunties and sisters to help them cater for their new born babies as they resume work (Danso, 2014). Others recruit "unprofessional baby-carers" often called "house helps" to help maintain the home and care of their new born baby (Asiedu et al., 2018). Also, others make use of day care centres and neighbours to care for their babies while they go to work post their maternity leave (Barreiro-Lucas & Lucas, 2019). The use of all these strategies to help care for the new born and cope with the dual role of motherhood and work is often associated with poor baby care with associated morbidities (Asiedu et al., 2018).

According to Asiedu et al. (2018), Atindanbila, Abasimi, and Anim (2012), Danso (2014) and Dapaah (2014), majority of mothers in Ghana cope with the difficult situation of having to care for their new born babies and work by getting assistance from their parents to help care their new born babies. This support have positive impact on these nursing mothers and as revealed by Asiedu et al. (2018); Atinga et al. (2014); Gladzah (2013); Nuhu et al. (2020), who report that women who have parents and spouses who offer support and nurturance after maternity leave will be less likely to experience stress in the family and work domain, leading to lower work–family conflict and they will also experience less job-related burnout. However, these social support systems may not be generally available to segments of the population and hence many may feel psychologically stressed and ill-disposed during this period (Danso, 2014). The situation may become more depressing for nurses and midwives who are the largest working group in the health system in Ghana and hence their services are all the time needed (Asamani et al., 2019). It is even direr because majority of nurses and midwives are females and will likely get pregnant, give birth, exhaust their maternity leave and expected to return to work (Asiedu et al., 2018).

Nurses are the largest group of health professionals in Ghana (Asamani et al., 2019). As health care providers, nurses are obliged to work during day and night to cater for needs of sick people. This can only be possible if nursing services are provided around the clock. About 90% of nurses and midwives give birth while working (Asiedu et al., 2018). When they give birth, they are expected to practice exclusive breastfeeding and effectively care for their babies but their work demands might not allow them to do so (Atinga et al., 2014; Blakeley & Ribeiro, 2008; Dapaah, 2014). Many of them have to work on shift basis; however, shift work has been empirically linked to a variety of diseases (Asiedu et al., 2018). The situation may further be worse for nurses and midwives who are nursing mothers who may have to combine nursing their babies and working in a challenging health environments (Asiedu et al., 2018; Barreiro-Lucas & Lucas, 2019; Mbanga et al., 2018).

The labour law of Ghana (Act 651) stipulates in section 57 (6) that "nursing mother is entitled to interrupt her work for an hour during her working hours to nurse her baby," a thorough review of the entire section 57 does not place obligation on employers to provide extra facilities or support systems at the workplace for nursing mothers. This has led to many working environments in Ghana not having support systems for nursing mothers and the health sector is no exception. With Ghana missing the Millennium Development Goals 4 and 5, lack of support systems for nursing mothers may even lead to failure in the post 2015 framework, which seeks to improve maternal and child health by 2030 (Asamani et al., 2019).

Researchers (Brief & Weiss, 2017; Gilles, Burnand, & Peytremann-Bridevaux, 2014; Grohman & Lamm, 2009; Kresheena, 2009) have investigated the challenges facing pregnant employees and their experiences following maternity leave in advanced countries such as the United States of America, Australia and the Czech Republic and the results are interesting but in developing countries like Ghana, there has been little research on this subject. This is occurring against the backdrop of persistent complaints from managers of hospitals about inadequate nursing and midwifery staff coupled with sub-optimal care particularly by health workers returning from leaves (Asiedu et al., 2018; Danso, 2014; Dapaah, 2014).

1.1 | Aim

This study aimed to determine the challenges and coping strategies adopted by nurses and midwives after maternity leave in balancing their motherly duties and work in a human-resource-constrained setting in Ghana.

2 | METHODS

2.1 | Study design

This study involved a descriptive cross-sectional survey of the challenges and coping strategies of nurses and midwives immediately after maternity leave following child birth at the Korle-Bu Teaching Hospital.

2.2 | Setting

The study was conducted among nurses and midwives in the 17 departments of the Korle-Bu Teaching Hospital (KBTH), the national

referral hospital in Ghana (KBTH, 2016). The Korle-Bu Teaching Hospital which was established in 1923 has grown from an initial 200 to 2,000 beds and 17 clinical and diagnostic Departments (KBTH, 2016). The hospital is traditionally known to receive huge numbers of referral cases from across the country with daily average patient attendance of 1,500 with an average daily admission of 250 people (KBTH, 2016). The hospital has a staff strength of 4,333 with 2,175 being nursing and midwifery staff (KBTH). However, only 1,513 of the nurses and midwives at the KBTH had history of maternity leave in the past 6 months as at the time of data collection (March 2018 to July 2018).

The Korle-Bu Teaching Hospital was chosen for the study because of persistent complains from management of the hospital about inadequate number of nursing and midwifery staff for work (KBTH, 2016) and considering the fact that maternity leave tend to reduce the number of nurses and midwives available to manage complicated cases referred to the national hospital of Ghana. This is further compounded by the fact that staff returning from maternity leave may perform below optimal levels.

2.3 | Selection of participants and data collection

We included only female nurses and midwives who were adults aged 18 years and above as required by law for informed consent in Ghana with a history of maternity leave in the past 6 months as at the time of the data collection (March 2018 to July 2018). Information from the nursing directorate of the hospital revealed that 1,513 of the nurses and midwives at the KBTH had history of maternity leave in the past 6 months as at the time of data collection (March 2018 to July 2018). Thus, nurses and midwives who were working in the hospital with history of maternity leave in the past 6 months from March 2018 were purposively selected to take part in the study. Nurses and midwives who had never gone on maternity leave before were not included in the study. The data collection period was from March 2018 to July 2018.

The sample size for the study was determined using Krejcie and Morgan (1970) sample size formula and this corresponded to a sample size of 205 based on the eligible population as stated supra. Ten percent was added to the sample size to take care of non-response and this increased the sample size to 226 nurses and midwives.

After determining the sample size, a list of the eligible nurses and midwives was obtained from the nursing directorate to serve as a sampling frame. The actual respondents were selected using the probability sampling technique of balloting without replacement. Here, each eligible staff was given a unique code and these unique codes were written on small pieces of paper and put in a covered container and shaken thoroughly, after which the pieces of papers were picked at random from the container. The staff whose unique codes appeared on the chosen papers from the covered container after shaking were contacted at their respective departments or units for written informed consent and enrolment to take part in the study.

2.4 | Instrument

Data were collected using a self-administered questionnaire which was developed by the researchers taking into consideration the peculiar issues at the study area. The tool included open-ended questions (to elicit a description of the situation) and closed-ended questions (to elicit specific information). The first part of the questionnaire collected socio-demographic information of the participants such as age, sex of child, religion and highest educational qualification. The second part of the questionnaire also addressed challenges faced by nurses and midwives at their workplace immediately after maternity leave. The third part collected information on the challenges faced by the nurses and midwives in the area of child care. The fourth part of the questionnaire collected information on strategies used by the nurses and midwives in coping with work and child care and the last part collected information on the nature of support systems available to nurses and midwives after maternity leave.

The tool was pre-tested among nurses and midwives with history of maternity leave at the Dansoman polyclinic, Accra prior to being used in the study site. Necessary modifications and clarifications of questions were done to the tool before it was used in the main study. Each respondent spent averagely 30–45 min to complete the study by filling out the questionnaire.

2.5 | Data collection

Data collection took place between the months of March 2018 to July 2018 (22 weeks). The data were collected by trained research nurses with a minimum qualification of postgraduate certification. These research nurses were staff of the Training and Research Unit of the Nursing Directorate at the Korle Bu Teaching Hospital. Once selected and written informed consent obtained as per the procedure described in the previous section, the participants were given the study questionnaire by the research nurses. The questionnaire elicited information on; socio-demographics, challenges at work after maternity leave, challenges with child care, coping strategies after maternity leave and support systems available after maternity leave for nurses and midwives. This information was necessary to answer the key research questions which guided the study: What are the challenges nurses and midwives face after maternity leave? What local coping strategies are adopted by nurses and midwives after maternity leave? And what support systems are available for nurses and midwives resuming duty after maternity leave? The role of each participant was to complete and return the study questionnaire. Respondents were given a week to complete the questionnaires. All questionnaires were returned in a sealed brown envelope (which was provided by the investigators). Respondents were told to drop the sealed brown envelopes containing the questionnaire in a designated box provided by the investigators at each department. No other interventions or treatment were administered to any of the participants and no manipulation of the respondents or study

environment were done. The participants kept a copy of the signed informed consent form.

2.6 | Data analysis

The data were analysed using Stata version 13. After the data collection, the questionnaires were inspected for completeness. The data were entered into Microsoft word 2016 and imported into Stata 13.0 for the analysis. Descriptive statistical analysis of the data were carried out and the findings were presented using charts and tables in order to answer the research questions that guided the study.

3 | RESULTS

3.1 | Socio-demographic characteristics

The socio-demographic characteristics of the participants in this study are presented in Table 1. A total of 200 nurses and midwives returned their filled questionnaire and this pointed to a response rate of 88.5%. The results indicated that 76 of the respondents claimed they had a male child and 124 said they had a female child in their last delivery. Nursing mothers who participated in this study were in the age groups of 25–29 and 30–34 years with the former forming a greater proportion of the women (23%), while those who were 40 years or older were only 14 (7%). Also, most of these women were Christians (78%) while a few (22%) were Muslims and none of them were of the African traditional religion. With respect to their marital status, more than half of them were married, while about a quarter of them (22%) being single. The others were either divorced (10%) or separated (10%).

3.2 | Challenges faced by nurses at their workplace post the 3 months (12 weeks) maternity leave period

Table 2 depicts the type of shift work respondents had engaged-in post their 3 months (12 weeks) maternity leave period. Respondents could choose more than one option as this aimed at eliciting information as the predominant shift for staff returning from maternity leave. Eighty-five percent of the respondents had engaged in morning shift post maternity leave with 82% claiming to have engaged in afternoon shifts for the past 1 year post maternity leave. However, only 31% of the respondents had gone on night shifts after the maternity leave.

3.3 | Attendance to personal issue when at work

Respondents were asked if they attended to personal issues when at work post their return from the mandatory 3 months leave. All the respondents (n = 200, 100%) indicated that they attended to personal issues when they were at work. The respondents were then asked to individually respond to each item; whether or not how many attended to personal calls, sneaked out of work, attended to baby, took naps at work and left work to pay personal bills. Again, respondents could choose more than one option in this section.

TABLE 1 Distribution of the demographic characteristics of the participants

Participant's information	Category	Frequency	Percentage
Sex of the child	Male	76	38%
	Female	124	62%
	Grand Total	200	100%
Age groups	20–24 years	32	16%
	25–29 years	64	32%
	30–34 years	46	23%
	35–39 years	44	22%
	40 years and above	14	7%
	Grand Total	200	100%
Religion	Christian	156	78.0
	Islam	44	22.0
	African traditional religion	0	0.0
	Grand Total	200	100%
Educational Level	Certificate	24	12%
	Diploma	22	11%
	Advanced Diploma	30	15%
	Degree	124	62%
	Grand Total	200	100%

One hundred and ninety-seven (97%) of the respondents received personal calls not related to work but about their children and 90% sneaked-out of the workplace to shop for items to be used at home for their children and significant others. Again, more than half (68%) of the respondents said they attended to their baby, 3% said they took naps at work and 32% said they sneaked out to pay bills. All the respondents (n = 200, 100%) said these issues affected their work output (Table 3).

3.4 | Challenges faced in the area of child care

Table 4 depicts information on whether respondents received support towards child care. From the analysis, more than half (74%) of the respondents indicated that they received support while 26% indicated that they did not receive any support. Among those who received support towards child care (148), as shown in Figure 1, 32% of the respondents received support from their mothers, 30% sent their children to day care centres away from the hospital, 24% said they received support from their sisters and 8% said they received support from house helps. Furthermore, on the issue as to which type of support they received as given in Table 5, 45.27% said they receive support in terms of child care, 33.11% said they received support in relation to household chores and 21.62% said they received support in terms of cooking.

3.5 | Strategies used by nurses and midwives in coping with work and child care

Respondents were asked about strategies they employed to cope with work and childcare. Table 6 revealed that only 6% had employed someone to take care of the child with 94% combining nursing task with child care. Again, on the question of how they coped with combining child care and work, the respondents indicated that it is the support they receive from relatives, day care centres and paid house helps that helped them to cope after child birth.

3.6 | Nature of support systems available to nurses and midwives after maternity leave at the workplaces

Respondents were asked about the nature of support systems available to them after maternity leave. The analysis revealed that more than half (66%) of them said that they worked normal working hours just like anybody else with 37% indicated that they do not work normal working hours. One hundred and forty of the respondents (70%) indicated that they are given off day when they sent their child for postnatal care. Thirty-four percent of the respondents indicated that they were not given only morning shifts because of the fact that they are nursing mothers. On the question of whether they are allowed to bring their babies to the workplace, only 10% answered in the affirmative with 90% answering in the negative. Again, all the respondents indicated that there is no day care run by the hospital (Table 7).

3.7 | Allowed to bring child to work place

Only 10% said they brought their children to work with the majority claiming their children were far away from their workplace and that made them not to concentrate at work (Table 8).

4 | DISCUSSION

4.1 | Socio-demographics

The results revealed that majority of the nurses and midwives are females and this has been stated by similar studies in Ghana that found females to be the dominant nursing and midwifery staff (Asamani et al., 2019). Majority of the respondents were less than 40 years of age and this point to the fact that most of them are still in the fertile age and could get pregnant any time soon (Asiedu et al., 2018). Also, majority of the respondents were Christians. Furthermore, most of the respondents had their Bachelor's degree and this point to improvement in the educational level of nurses and midwives in Ghana (Nuhu et al., 2020) and this could mean an improvement in the quality of care as improved education leads to improved care.

TABLE 2 Types of shift worked after maternity leave

Variable	Frequency	Percentage
I have worked morning shift	170	85%
I have worked afternoon shift	164	82%
I have worked night shift	62	31%

TABLE 3 Personal issues respondents attend to while at work

Variable	Frequency	Percentage
Receive personal phone calls	194	97%
Attend to my baby	136	68%
Sneak out to shop for items to be used at home	180	90%
Take a nap	6	3%
Sneak out to pay bills	64	32%

4.2 | Challenges of nurses and midwives after maternity leave

The results revealed that most nurses and midwives experienced challenges about having to resume work and also caring for their new born babies. Most of the respondents felt insecure having to leave their babies at home and come to work to take care of others. They also had challenges with practicing exclusive breastfeeding. This is in line with the findings of Asiedu et al. (2018), Atinga et al. (2014), Asare et al. (2018), and Dapaah (2014) where it was found that working women tend to have challenges practicing the advocated six-months exclusive breastfeeding since their work schedules did not allow for breastfeeding at work. Also, caring for the new born baby was a demanding task which made nurses and midwives resuming work after maternity leave tired before even going to work and this usually affected their performance. Similarly, Blakeley and Ribeiro (2008), Barreiro-Lucas & Lucas, (2019), Brief and Weiss (2017) observed that being a mother was a demanding task which resulted in poor work performance post resumption of duties after maternity leave. Even at work, most of these nurses and midwives upon resumption of duty post maternity leave still were concerned about home issues and spend a good proportion of work time trying to solve home problems or making calls to their homes to find out the state of their children (Asiedu et al., 2018).

The study showed that all the respondents indicated that they attend to personal issues when they are at work. Majority of the respondents received personal calls and sneaked out to shop for items to be used at home. This outcome is consistent with findings of Asiedu et al. (2018), Danso (2014), and Dapaah (2014), who showed that the majority of breastfeeding mothers who work tend to find means to cope with their dual roles by sacrificing work time for their personal needs and in doing this they strengthen their familial roles (Asiedu et al., 2018) while under-performing on the job (Nuhu et al., 2020). They deal with work–life issues by making adjustments in their work schedules for their own personal or familial benefits. This obviously results in sub-optimal care (Gilles et al., 2014).

Several strategies have been found to be used by nurses and midwives to help them cope with work after maternity leave such as the use of relatives such as mothers of the nurses and midwives and the use of paid helpers and day care centres. This study showed that only 6% claimed to have employed someone with professional skills to take care of their child, whereas the others indicated that they received support from relatives, day care centres away from the work place and paid house helps who had no professional knowledge on child care. The results are in line with the findings of Asiedu et al. (2018); Guendelman et al. (2009); Stratton and Henry (2011) who reported that the majority of breastfeeding working mothers used the support from either their spouses or any family members when they were at work. Another consistent finding was reported by Blakeley and

TABLE 4 Support offered by family in childcare

Family support	Frequency	Percentage
Yes	148	74%
No	52	26%
Grand Total	200	100%

FIGURE 1 Persons who provide support to respondents towards child care

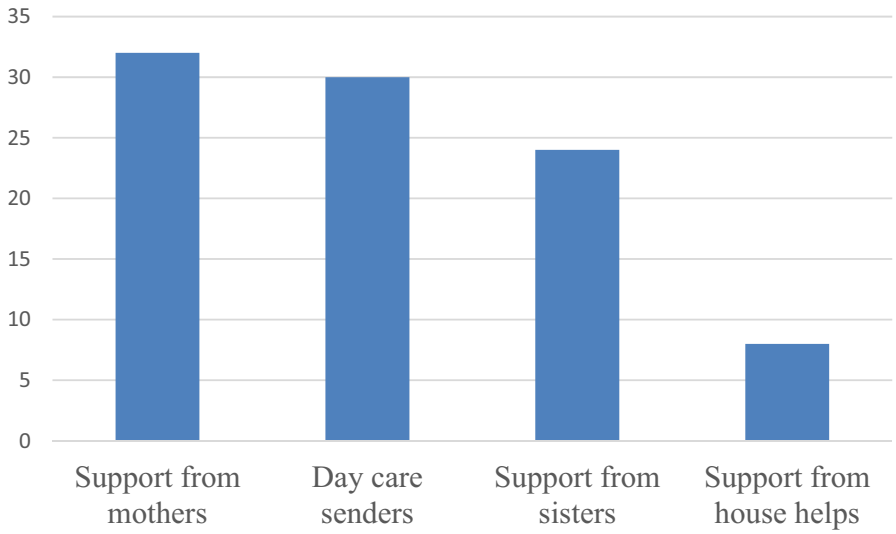

TABLE 5 Type of support respondents who claimed to have received support

Type of support	Frequency	Percentage
Taking care of the baby	67	45.27%
Helping me with the house chores	49	33.11%
Cooking	32	21.62%
Total	148	100

TABLE 6 Employed services of anyone

Employed any service	Frequency	Percentage
Yes	12	6%
No	188	94%
Grand Total	200	100%

TABLE 7 Work on normal working hours

Normal working hours	Frequency	Percentage
Yes	132	66%
No	68	34%
Grand Total	200	100%

TABLE 8 Allowed to bring child to work place

Bring child to workplace	Frequency	Percentage
Yes	20	10%
No	180	90%
Grand Total	200	100%

Ribeiro (2008), Grohman and Lamm (2009) and Lucas (2012), who reported that the working women employed a domestic helper as a source of coping with their dual- role of being a mother and worker. However, using paid house helps could come with serious consequences as most of them care-less about the welfare of the children entrusted in their care and also some were immature to effectively care for the babies. Similarly, Asiedu et al. (2018) claimed the use of baby sitters by women to cope with work was not advisable as most of whom are not matured enough to take good care of the babies.

Also, day care centres provide a good avenue to get educated personnel to take care of the child while the nurses and midwives are engaged at work post their return from maternity leave (Danso, 2014). However, the associated cost of sending a child to the day care centres could be a deterring factor (Asiedu et al., 2018). Also, the distance to the day care centres from the place of work could deter most mothers from sending their child to such centres (Stratton & Henry, 2011). Institutions such as hospitals can find innovative ways of establishing day care centres attached to the hospitals in order to provide avenues for nurses and midwives and other health professionals to have their babies receive professional care post their return from maternity leave for them to concentrate and work for improved patient outcomes.

4.3 | Nature of support systems available for nurses after maternity leave

This study revealed that more than half (66%) of the respondents indicated that they work normal working hours just like anybody else. Again, 70% of the respondents indicated that they were given off day when they sent their child for postnatal care but were not given only morning shifts because of the fact that they were nursing mothers. On the question of whether they were allowed to bring their babies to the workplace, only 10% answered in the affirmative with 90% answering in the negative. This finding is consistent with finding by Mbanga et al. (2018) who reported that nursing mothers who were nurses stated that they did not have any facilities about day care centre attached to their health facility. They complained that to bring the baby in the unit was too risky, because the wards were not safe for babies. This situation is not line with spirit of the Ghana's Labour law of, 2003 (Act 651) which stipulates in section 57 (6) that "nursing mother is entitled to interrupt her work for an hour during her working hours to nurse her baby." If nursing mothers are prevented from bring their babies to work and are allowed to work as anybody else including doing night duties, it defeats the spirit and letter of section 57 (6). The situation is even worse when there is no day care centre attached to the hospital. This is worrying because the health sector is supposed to mentor and serve as guide to the entire population on the need for mothers to practice exclusive breastfeeding. However, the findings show even worse conditions among health professionals and could be terrible among other professional working sectors. If Ghana is to achieve universal coverage of exclusive breastfeeding practice which will help improve maternal and child health, then a concerted effort is needed to provide adequate and enough support for working mothers to enable them breastfeed their babies at the workplace while not compromising on the heath of the babies by exposing them to hospital infections.

4.4 | Limitations of the study

The study used a cross-sectional design making it difficult to infer causation. Also, the analysis approach was largely descriptive making it difficult to make inferences. In addition, since the study depended on a pre-tested questionnaire which largely depended on the respondents' responses and recall, there is high possibility of recall bias. However the participants were entreated to give honest responses to the questions in the questionnaire and this in a way helped to reduce any bias.

5 | CONCLUSION

The results showed that there is not enough support system available for nurses and midwives after maternity leave. Most nurses and midwives depend on family members, paid house helps and day care centres far from their places of work to help them cater for their babies upon their resumption of duties after maternity leave. It is recommended that health care institutions (hospitals) need to set-up day care centres and breastfeeding bays attached to the institutions so that nurses and midwives who work at such facilities will have the required piece of mind to balance work and child care after maternity leave.

AUTHOR CONTRIBUTIONS

KKD contributed to conception, design, data analysis, drafting the manuscript and bears the primary responsibility for the content of the manuscript. JBP revised the manuscript. KDK, RA, and SN were involved in the data collection. KKD was involved in the revision of the manuscript. All the authors read and approved the content of the manuscript.

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CONFLICT OF INTEREST

The authors declare that they have no any competing/financial interests.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICAL APPROVAL AND CONSENT TO PARTICIPATE

Ethical approval was granted by the Scientific and Technical Committee and Institutional Review Board of the Korle Bu Teaching Hospital (KBTH–IRB 08/2017). Written informed consent was also obtained from each eligible nurse and midwife before recruitment into the study. Each respondent was informed of his/her right to withdraw from the study at any time without suffering any negative consequences. Names of the respondents were not revealed in the study report and all information gathered from the study participants were treated confidentially as all questionnaires were placed in a special cabinet under lock and only accessible by the researchers.

CONSENT FOR PUBLICATION

Not applicable.

ORCID

Kennedy Dodam Konlan https://orcid.org/0000-0003-0588-5496

Kennedy Diema Konlan https://orcid.org/0000-0002-1994-3792

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