ADDIS ABABA UNIVERSITY

COLLEGE OF DEVELOPMENT STUDIES

CENTER FOR POPULATION STUDIES

FACTORS OF EXCLUSIVE BREASTFEEDING PRACTICE AMONG WOMEN WORKING IN THE FORMAL AND INFORMAL SECTORS:

THE CASE OF BOLE & ADDIS KETEMA SUB - CITIES, ADDIS ABABA, ETHIOPIA

BY

ADDISU TESFAYE

A Thesis Submitted to the Center for Population Studies, College of Development Studies of Addis Ababa University for the Partial Fulfillment of Degree of Masters of Science in Population Studies (Reproductive Health)

November/2020

Addis Ababa, Ethiopia

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Factors of Exclusive Breastfeeding Practice among Women Working in the Formal and Informal Sectors:

The Case of Bole & Addis Ketema Sub - Cities, Addis Ababa, Ethiopia

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DECLARATION

I declare that this research is my original work and that the work has not been submitted for any other degree or any other award in any other University. All sources of material used for the study have been duly acknowledged.

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This thesis has been submitted for examination with my approval as a University advisor.

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DEDICATION

I would like to dedicate this research to my loving sister I lost recently, Amsalework Tesfaye, I wish her soul to rest in eternal peace. In addition, this thesis is dedicated to my family, who supported me in my educational career. Thank you so much for the prayers, love, and support you have accorded me throughout this process.

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LIST OF ACRONYMS

AAU ---- Addis Ababa University

CSA ---- Central Statistical Agency

EBF ---- Exclusive Breastfeeding

EDHS ---- Ethiopian Demographic and Health Survey

EMOH ---- Ethiopian Ministry of Health

ILO ---- International Labor Organization

NGO ---- Non - Governmental Organizations

PAHO ---- Pan American Health Organization

SSA ---- Sub-Saharan Africa

TPB ---- Theory of Planned Behavior

UN ---- United Nation

UNICEF ---- United Nations International Children's Emergency Fund

WABA ---- World Alliance for Breastfeeding Action

WHO ---- World Health Organizations

ABSTRACT

Breast milk is the best food and the safest option to ensure good health and ideal growth of young children. Exclusive breastfeeding indicates that a child should be fed breast milk alone during the first six months of life. However, 41% of Ethiopian infants do not receive exclusive breastfeeding and the median duration of this breastfeeding was 2.9 in months in Addis Ababa. Therefore, this study aims to determine the practice and associated factors of exclusive breastfeeding focusing on working mothers in Bole and Addis Ketema sub-cities, Addis Ababa, Ethiopia. An institution-based cross-sectional study was conducted among 389 randomly selected breastfeeding mothers with infants aged 6 to 11-months old from June to July 2020. A semi-structured interview-based questionnaire was used for data collection. The data were entered and analyzed using STATA version 14.2 and R version 3.6.1. Descriptive statistics, t-tests for difference of proportions, and multilevel binary logistic regression were applied in the analysis. A total of 389 (192 formally and 197 informally employed) mothers were interviewed. The overall mean and median duration of exclusive breastfeeding was 127 and 120 days, respectively. The prevalence of exclusive breastfeeding practice for all working mothers was 46.53% (40.10% formally and 52.79% informally employed). The multilevel analysis revealed that working mothers with cesarean delivery (AOR = 0.32, 95% CI: 0.184, 0.563), low birth weight (AOR = 0.30, 95% CI: 0.134, 0.689), and insufficient milk production (AOR = 0.364, 95% CI: 0.216, 0.614) were significantly less likely to engage in exclusive breastfeeding while mothers with high breastfeeding support (AOR = 12.03, 95% CI: 5.593, 25.910) was significantly more likely to engage in exclusive breastfeeding. Maternal type of employment (being formal and informal) showed an effect on exclusive breastfeeding with intra-class correlation (ICC) = 0.0632 (0.0067, 0.4006). The overall median duration of EBF was short. However, informally employed mothers breastfed better than formally employed ones. Therefore, there is a need in providing childcare services in the workplace, working on breastfeeding support, and designing strategies to better support formally employed mothers are recommended.

Keywords: Breastfeeding, Exclusive breastfeeding, Formal and informal employment

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Breast milk is the best food and the safest option to ensure good health and ideal growth of young children (PAHO/WHO, 2019). The World Health Organization (WHO) recommends that breastfeeding should be initiated within one hour of birth, the practice of exclusive breastfeeding (EBF) for the first six months of life, and continued breastfeeding for up to two years or beyond, along with nutritionally adequate and safe complementary foods during infancy and early childhood (WHO, 2009). In contradiction to this, from 2013 to 2018 globally 43% of newborns initiate breastfeeding within one hour of birth; only 41% of infants less than six months of age are exclusively breastfed while 70% of women continue to breastfeed their infant for at least one year, by two years of age, breastfeeding rates declines to 45% (WHO/UNICEF, 2019).

According to the United Nations Children's Fund (UNICEF), in 2017 alone, an estimated 78 million infants had to wait more than an hour to start breastfeeding. This means from five children only two of them, most of them in low-and middle-income countries, were found to initiate breastfeeding within the first hour of life (UNICEF, 2018). Increasing breastfeeding could prevent 823,000 annual deaths in children under five and 20,000 maternal deaths each year, and inadequate breastfeeding rates result in economic losses of about US $302 billion annually (WHO/UNICEF, 2019).

Sustainable development goals are completely and totally dedicated to ensure healthy lives and promote well-being for all at all ages (UN, 2015). By 2030, this goal targeted to end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1000 live birth (UN, 2015). But, as UNICEF recently reported, Sub-Saharan African (SSA) countries remain the region with the highest under-five mortality rates in the world. In 2017, the SSA region has an average mortality rate of 76 deaths per 1,000 live births (UNICEF, 2018). So, based on the above findings there are still poor feeding practices that lead to undernourishment which is the foremost cause of child deaths.

The Ethiopian Ministry of Health established the National Nutrition Program to promote optimal feeding and care practices as the main interventions to follow international recommendations, among others the program supports breastfeeding working mothers to exclusively breastfeed until the child is six months old (EMOH, 2015). According to the 2016 Ethiopian demographic and health survey (EDHS) almost all children, 97% were breastfed at some point among these 58% (CSA, 2017) of infant's breastfed exclusively, which is contrary to the recommendation level. In this survey, the percentage of feeding mothers in the early months of postpartum was relatively high but, gradually decreases as months of EBF go. For instance, infants less than one month who received this feeding were 73.2%, but in the last month of exclusivity, it becomes 58.8% (CSA, 2019). Reasons for this was, 14%, 1%, 8%, and 13% of infants under age six months consume plain water, non-milk liquids, other milk, and complementary foods, respectively (CSA, 2019). As the 2016 EDHS report, in Addis Ababa, the median duration of EBF in months was 2.9 compared to 4.6 recorded in Benishangul-Gumuz which was the highest in comparison to the rest of the regions of Ethiopia.

Exclusive breastfeeding varies with mothers working status. Many studies showed returning to work, after having a child, as the principal barrier that determine abandoning breastfeeding (C.Horwood, et al., 2018; Haya, Monique, Matilda, Rawan, & Hibah, 2013; Maria, et al., 2018; Mariana & Martins, 2014). For instance, a study conducted in Gonder town, Northwest Ethiopia, found that EBF prevalence was higher among unemployed mothers, which were 48% among unemployed and 20.9% among employed (Dawit, Gashaw, Yalemzewod, & Yayehirad, 2017). A similar study conducted in Hawassa, Ethiopia, identified that housewife's practice EBF more than employed mothers (Henok, Yifru, Fikadu, & Bethlihem, 2017).

Undertaking empirical studies will help to identify the barriers that can shorten the duration of EBF. Such studies will help greatly to implement interventions that can speed up government efforts which in turn decrease the rates of infant morbidity and mortality due to the absence of this practice. Therefore, this study aimed to assess the practices, durations, and barriers associated with EBF among women working in the formal and informal sectors in Addis Ababa by taking the case of Bole and Addis Ketema sub-cities.

1.2 Statement of the Problem

Lack of EBF is the major contributor to infant and child morbidity and mortality. According to WHO, lack of EBF attributes 45% of neonatal infectious deaths, 30% of diarrhea deaths, and 18% of acute respiratory deaths. Breastfeeding can significantly reduce the burden of under-five death in Africa, specifically, SSA where 41% of global under-five death occurs mainly due to inadequate breastfeeding practices in combination with high levels of diseases (WHO, 2009; UNICEF, 2009).

Despite all the recognized advantages and efforts deployed by governments, donors, NGOs, and other stakeholders to protect, support, and promote EBF; still there exists an inadequate practice of EBF, which is far from the internationally recommended level. It is as low as 36% globally, 39% in developing countries, and 31% in SSA countries among under six-month infants (WHO, 2012; UNICEF, 1999). According to WHO and UNICEF's latest estimation, Ethiopian early initiation of breastfeeding was 73.3% (WHO/UNICEF, 2018) while EBF 58% (CSA, 2017). Even though Ethiopia's EBF rate is relatively better compared to the above regional findings, still it needs further improvement to harness the full benefits of breastfeeding, particularly EBF.

Even though many studies have been undertaken in an attempt to find factors influencing EBF practice, as one way to get at the bottom of the problem, there are hardly any studies focusing on EBF variations by women's type of work as formal and informal (Eskezyiaw, Desta, & Genet, 2017; Dawit, Gashaw, Yalemzewod, & Yayehirad, 2017; Laykewold, Amha, Amha, & Etagegnehu, 2017; Kedir, Andrew, Amit, & Felix, 2019) rather empirical literature focuses on EBF of employed and unemployed mothers. For instance, a study conducted in Davangere city, India, and in Gonder town, Ethiopia showed a big difference between working and non-working mothers in EBF practice. In the former study 62% of at-home mothers and 16% working mothers, and in the latter study 48% of unemployed and 20.9% of employed mothers breastfed exclusively (Dawit, Gashaw, Yalemzewod, & Yayehirad, 2017; Shubha & Navinkumar, 2015).

The problems of EBF practice are multi factorial in nature. Studies have limitations in digging out the principal influencers for an undesirably short duration of EBF among working mothers particularly by their type of employment as formal and informal workers.

Therefore, this study has aimed to carry out an in-depth assessment and provide recommendations that can help health policy-makers to understand the key current factors of EBF practice of formal and informal working mothers at present in selected public health institutions of Addis Ketema and Bole sub-cities of Addis Ababa, Ethiopia.

1.3 Objectives of the Study

1.3.1 General Objective

The general objective of the study is to determine factors of exclusive breastfeeding practice among women working in the formal and informal sectors during the first six months of postpartum.

1.3.2 Specific Objectives

The specific objectives of the study were:

- To assess EBF knowledge and practice of formal and informal working mothers.
- To examine the duration of EBF among formal and informal working mothers.
- To identify barriers associated with EBF among formal and informal working mothers.

1.4 Research Questions

The general research question of the study is: What are the factors affecting EBF during the first six-month period of postpartum among women working in the formal and informal sectors during the first six months of postpartum?

The specific research questions, the study answers were:

- What proportion of mothers knows EBF?
- What is the prevalence of EBF practice among formal and informal working mothers?
- Who has the longest duration of EBF, formal or informal working mothers?
- What are the factors of EBF of formal and informal working mothers?

1.5 Significance of the Study

The significance of this study is:

- It adds information and knowledge that can guide evidence-based health interventions.
- It informs pertinent health professionals, nurses, or midwives, and contributes to better counseling during antenatal care visits.
- It can contribute to improve the level of practice and compliance with EBF, thus reduce infant morbidity and mortality.
- It provides baseline information for future researchers in relevant topics.
- This study also adds scientific knowledge on infant feeding practices and provides information for public health advisors, nutritionists, planners, policymakers, international organizations, and NGOs concerning barriers to a longer duration of EBF practice between formal and informal working mothers.

1.6 Scope and Limitations of the Study

The study was based on the experience of formal and informal working mothers, regarding their knowledge, practice, and factors of EBF, who seek health care services in selected public health institutions in Bole and Addis Ketema sub-cities of Addis Ababa, Ethiopia. These sub-cities are expected to have a sufficient number of women who have formal and informal work engagements.

The current global issue, Covid-19, exerted huge difficulties in the data collection process from mother-infant pairs at health institutions level, because the behavior of the pandemic made difficulties in conducting an interview-based questionnaire. Moreover, conducting in-depth interviews and focus group discussions, to collect qualitative data, were canceled. Besides, due to this pandemic, the number of nurses and midwives was limited in each selected private hospital, so difficult to get data collectors from nurse staff. Accordingly, these conditions posed a major challenge to collect data.

1.7 Organization of the Study

This study was organized into five major chapters. The first chapter deals with an introduction that includes the background of the study, statement of the problem, research objectives, research questions, significance of the study, scope, and limitations of the study.

Theoretical and empirical literature, conceptual framework, and synthesis of the literature are discussed in the second chapter. The third chapter is about the research methodology applied and the fourth chapter describes in detail the results of the research and discussion, and the last chapter discusses the conclusion and recommendations set out by the researcher.

1.8 Definition of Key Terms

Breastfeeding Initiation: Putting newborns to the breast within the first hour of life (WHO/UNICEF, 2018).

Exclusive Breastfeeding: The infant has received only breast milk from his/her mother or a wet nurse, or expressed breast milk and no other liquids, or solids, except for drops or syrups consisting of vitamins, minerals, supplements, or medicines for the first six months of life (WHO/UNICEF, 2010).

Maternal Work: This refers to economic activities of mothers either on full-time or part-time to earn a living or support the home (Jacqueline, 2017).

Formal Employment: Formal work refers to work in which a company hires an employee under an established working agreement that includes, salary or wages, health benefits, and defined work hours and workdays (ILO, 2018).

Informal Sector: The informal sector consists of units engaged in the production of goods or services with the primary objective of generating employment and incomes to the persons concerned (ILO, 2018).

Informal Employment: Comprising all jobs in informal sector enterprises, or all persons who, during a given reference period, were employed in at least one informal sector enterprise, irrespective of their status in employment and whether it was their main or a secondary job (ILO, 2003).

Duration of breastfeeding: "Duration is the length of time for any breastfeeding, including breastfeeding through the initial stage of exclusive breastfeeding and any period of complementary feeding until weaning" (Joy & Myles, 2012).

Self-efficacy: People's beliefs in their ability to succeed in particular situations (Albert, 1998).

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter focuses on reviewing relevant theoretical and empirical literature on EBF, particularly focusing on the practices and predictors of it among working mothers during the first six months of postpartum. The review was made, considering EBF mothers attending immunization and child care services in the study area. Therefore, reviewing takes place under the following sub-topics: theoretical literature, empirical literature, conceptual framework, and synthesis of the review.

2.2 Theoretical Literature

To create a theoretical framework for this study, potentially relevant theoretical literature done regarding the theory of planned behavior (TPB), social cognitive theory, and breastfeeding self-efficacy (BFE) were reviewed. These theories are the most frequently used frameworks in studies related to breastfeeding because they are useful to identify modifiable factors that trigger behavioral changes to promote breastfeeding initiation and continuation. Interventions based on the former two theories accounted for social and environmental factors, whereas the latter theory used widely in individualized interventions (Yeon, Soyoung, & Kaitlin, 2019).

There are two dimensions of thought regarding whether or not TPB is used as a framework or not by different researchers. The first thought has a common idea regarding the theoretical base of such studies. For instance, a study done by Peter Heywood, argues that studies like factors that affect EBF have a fundamental limitation in the lack of a conceptual or theoretical base. So, he concludes that there is no accepted, comprehensive overview of acknowledged factors to guide researchers in planning their studies or to assist readers to interpret results of studies in a broad context (Heywood, 2014).

Another study conducted at the University of Wollongong agrees with Peter's findings but in different perspectives in that, in the absence of a clear, women-centered theoretical framework it is difficult for health professionals to influence mothers to achieve the required breastfeeding after their postpartum (Shahla, Kathleen, Jenny, & Jacqui, 2015).

In contrast to these findings, another study believes that this theory has a useful framework in predicting and guiding breastfeeding behavior (Yeon, Susan, & Alyce, 2009). According to this theory, breastfeeding knowledge, attitude, subjective norm, and practice control are factors that influence breastfeeding outcomes. However, it is still unknown which factor is more important than others, but a study conducted in China identified breastfeeding knowledge, as the most important factor contributing to EBF (Zhihong, Yu, Lijuan, & Hongwei, 2018), whereas in Sterling, United Kingdom, subjective norms were an important determinant among factors mentioned by TPB (Vivien, 2004). Vivien Swanson, in his study of initiation and continuation of breastfeeding, found some new findings which were not well known by TPB such as, social normative pressure varied at different time points after birth, women's mothers were less supportive of breastfeeding at six weeks than at the baby's birth. He also found that the views of nurses and midwives were rated as very important by breast feeders and bottle-feeders, which underlines the importance of health care professionals supporting women to initiate and continue breastfeeding (Vivien, 2004).

Intervention studies based on the theory of self-efficacy have evaluated the effects of breastfeeding self-efficacy and skills on improved breastfeeding duration and exclusivity. This theory is concerned with people's beliefs in their capabilities to exercise control over their functioning and events that affect their lives (Albert, 1998). Beliefs in personal efficacy affect life choices, level of motivation, quality of functioning, resilience to adversity, and vulnerability to stress and depression (Albert, 1998). For this theory, the reason to discontinue breastfeeding is due to perceived difficulties rather than maternal choice. Therefore, to effectively address low breastfeeding duration rates, health care professionals should identify high-risk mothers based on modifiable variables, maternal confidence, that will guide the development and evaluation of interventions rather than non-modifiable demographic and socio-economic variables (Cindy-Lee, 1999).

There are studies conducted to see the link between maternal confidences with breastfeeding durations. For instance, in breastfeeding self-efficacy interventions conducted in Canada, Japan, and China to improve breastfeeding identified that, women with high breastfeeding self-efficacy are more likely to have longer breastfeeding duration and increased rates of exclusivity, compared to mothers with low breastfeeding confidence (Karen, Cindy-Lee, Robyn, & Cameron, 2010; Keiko, et al., 2013; Di, Jie, Thomas, & Jimmy, 2013).

A literature review conducted by Cindy-Lee from 1990 to 2000 in North America identified that mothers wean breastfeeding before the recommended time for the reasons of perceived difficulties rather than due to maternal choice. In this study, the least likely breastfeed women are those young, have a low income, unsupported, employed full time, and have a negative attitude toward breastfeeding (Cindy - Lee, 2001).

Breastfeeding is not a one-woman job rather she needs support from the government, health systems, workplaces, communities, and families to make it work effectively (UNICEF, 2016). Therefore, to study these determinants it is crucial to use social cognitive theory as a theoretical framework for this study in addition to the above theories. This theory was developed by Bandura in 1977 (Albert, 1998) and helps to identify social determinants of feeding and important for improving our knowledge of infant feeding in the community.

A study conducted by Anteneh and Makombo in Addis Ababa, Ethiopia based on Social-Cognitive predicators, identified 39.1% of mothers' belief and have confidence in their ability to exclusively breastfeed where us 51.4% of mothers have the belief and expectation from exclusively breastfeeding their child for six months and 6.5% of them have supportive social and environmental factors that affect breastfeeding practices (Anteneh & Makombo, 2016).

Generally, based on the theoretical review and results of this study knowledge and background variables from TPB, breastfeeding support from social cognitive theory, and breastfeeding experience, professional assistance, and breastfeeding counseling from self-efficacy theory were found the factors forcing women to stop feeding.

2.3 Empirical Literature

2.3.1 Breastfeeding

Breast milk contains all the nutrients needed by children in the first six months of life and it is an uncontaminated nutritional source (WABA, 2018). Breast milk, for WABA, is a natural, renewable food that is environmentally safe and green because it is produced and delivered to the consumer without pollution, packaging, or waste. Complementing breast milk before age six months is unnecessary and is discouraged because of the likelihood of contamination and the resulting high risk of diarrheal diseases (WABA, 2018).

2.3.2 Benefits of Breastfeeding

Several studies found numerous health benefits of early initiation and EBF for both mother and infant. Breastfeeding protects infants against morbidity and mortality due to infectious diseases and keeps infants safe from unhygienic environments and contaminants in foods that can cause diarrhea and lead to nutrient loss and under nutrition (UNICEF, 2016). Further, breastfed children have higher intelligence scores than children breastfed for shorter periods or not breastfed (WHO/PAHO, 2019). Breastfeeding reduces the probability of an infant with non-communicable diseases such as cardiovascular, diabetes, obesity, and hypertension later in their lives, and it encourages increased resilience against infections, boosts infants neurodevelopment (Riyadh, 2017; Iftekhar, 2014; Haya, Monique, Matilda, Rawan, & Hibah, 2013; WHO, 2009). Infants' mother also benefits from breastfeeding, as longer duration of breastfeeding substantially reduce risk of breast and ovarian cancer, decreased postpartum bleeding, an earlier return to pre-pregnant weight, improved birth spacing and may also have a lower risk of diabetes (Haya, Monique, Matilda, Rawan, & Hibah, 2013; Iftekhar, 2014; Elizabeth, Francis, & Bonfiace, 2017; C.Horwood, et al., 2018; WHO/PAHO, 2019).

Because of these practical benefits of breastfeeding to infants, mothers, society, and the whole nation, WHO and UNICEF recommend breastfeeding, particularly EBF for six months of postpartum because it is the safest and healthiest option for children everywhere, which provide only breast milk to infants from birth until six months of age, with no other food or liquids (UNICEF, 2016).

2.3.3 Breastfeeding and Maternal Employment

In 2018, the global working age-population, comprising women and men aged 15 years and above was 5.7 billion, of which 3.3 billion people were in employment and two billion of the world's employed population aged 15 and over, earn their livelihoods in the informal economy (ILO, 2019). The proportion of informal employment varies in different regions (ILO, 2018). For instance, in SSA'n countries over 90% of women are more exposed than men to informal employment. In contradicting to this, in Ethiopia, as the 2018 urban employment unemployment survey, 1,343,194 persons were working in the informal sector, out of the total 6,184,590 urban employed population.

In Addis Ababa 1,609, 840 populations aged ten years and above were employed, of which 742,788 were females and 1,274,144 persons were working in the informal sector of which 536,081 were females (CSA, 2018).

Prior research shows a significant negative relationship between maternal employment and breastfeeding duration. In a study of breastfeeding practices among working women conducted in Davangere, Karnataka, India 60% had initiated breastfeeding within an hour and 51.06% of them had given EBF to their infants. The barriers were short duration of leave and non-availability of child care centers (Ashoka, Mahesh, & T.K, 2016).

2.3.4 Initiation of Breastfeeding

The initiation of breastfeeding is vital for both the mother and the child. The first breast milk contains colostrum, which is highly nutritious and rich in antibodies that protect the newborn from diseases and death (CSA, 2017; UNICEF, 2016). Immediate skin-to-skin contact and initiating breastfeeding early keeps a baby warm, builds his/her immune system, promote bonding, boost a mother's milk supply, and increases the chances that she will be able to continue EBF (UNICEF, 2016). Thus, children are put to the breast immediately within the first hour of birth and exclusively breastfeeding for the first six months of life to give them the best chance to survive, grow and develop to their full potential (WHO/UNICEF, 2018).

Although, WHO and UNICEF recommend as early initiation of breastfeeding has important benefits for both the baby and mother, most of the world's newborns are left waiting too long to begin breastfeeding. According to UNICEF, in 2017 alone, an estimated 78 million infants had to wait more than an hour to start breastfeeding. This means from five children only two of them, most of them in low-and middle-income countries, were found to initiate breastfeeding within the first hour of life (UNICEF, 2018). This practice also varies across countries. For instance, in a study conducted in Saudi Arabia, the majority of mothers' breastfeeding initiation was found 95% in contrast to low exclusivity (Fouzia, et al., 2008), whereas in South Sudan, 76.8% of them initiated breastfeeding in the first hour of delivery and mother's skin to skin contact with their babies immediately after birth was also found 70% (Elizabeth, Francis, & Bonfiace, 2017). In Ethiopia and the capital city, Addis Ababa, the practices of early initiation of breastfeeding within the first hour of birth were found 73.4% and 67.5%, respectively (CSA, 2017).

A study conducted in six low- and middle-income countries (Kenya, Zambia, India, Pakistan, Argentina, and Guatemala) identified cesarean section, low birth weight, and failure to place baby on the mother's chest after delivery as factors associated with failure to initiate breastfeeding early (Archana, et al., 2015). Delivering the health facility, vaginal delivery, and singleton births were the factors identified for timely initiation of breastfeeding in Malawi (Owen, Peter, Victor, Edith, & Amit, 2019), and in Ethiopia, informal maternal employment, frequent antenatal care visits, and cesarean birthing were associated with delayed initiation of breastfeeding while birthing in the health facility and residing in the metropolis region were associated with timely initiation of breastfeeding identified in a study conducted based on EDHS from 2000 to 2016 (Kedir, Andrew, Amit, & Felix, 2019).

2.3.5 Exclusive Breastfeeding

The various benefits of breastfeeding for the infant, mother, society, and the whole world forced leading international health organizations, like WHO and UNICEF, to recommend early initiation of breastfeeding soon delivery and EBF for the first six months of infant life, and provision of nutritionally adequate and safe complementary foods starting from the age of six months with continued breastfeeding up to two years of age or beyond globally for optimal infant feeding (WHO, 2010; UNICEF, 2009; UNICEF, 2018). But, contrary to this recommendation, worldwide it is estimated that less than 39% of infants, in the first four months of life, breastfed exclusively (Tembol, Ngoma, Maimbolwa, & Akakandelwa, 2015). Developing countries particularly, most SSA, are known to have the highest under-five mortality rates due to the limitations of access to clean water, adequate sanitation, and basic health and social services (Frankie, Behesheh, Diddy, Chidiebere, Eric, & Agneta, 2016). This makes it difficult to practice optimal breastfeeding, above all EBF (Kedir, Andrew, Amit, & Felix, 2019).

Therefore, it is important to review these barriers identified by empirical research findings for practicing EBF in Ethiopia and the world at large.

2.3.6 Determinants of Exclusive Breastfeeding

2.3.6.1 Determinants of Exclusive Breastfeeding in Globally

Studies conducted in different parts of the world showed that the practice of EBF was low. For instance, a study performed by UNICEF on 123 countries around the world showed that most babies were breastfed at some point in their life. However, this rate varies widely between low and middle income and high-income countries. Four percent of low-and middle-income countries and 21 percent of high-income countries never receive breast milk (UNICEF, 2018). This is due to different influencing factors.

A community-based study in Madrid among participants in Eloin indicates that the prevalence of EBF at six months was 25.4%, which is low for the reasons of insufficient milk and incorporation to work (Maria, et al., 2018) while a study conducted in Indonesia, at Public Health Center, Pasar Sentral found that job description, knowledge, social, cultural and mother attitude were the dominant factors for not breastfeed exclusively (Mariana, A.L.Rantetampang, Bernard, & Anwar, 2018).

There is literature with almost similar EBF prevalence, but with contrary research findings by mothers' work status. For instance, studies conducted in Tabuk, Saudi Arabia, and Beirut, Lebanon found 31.4% and 27.4% of EBF practice, respectively. According to these studies, mothers' awareness of recommended EBF duration was well known, but maternal work was the common barrier in both studies (Haya, Monique, Matilda, Rawan, & Hibah, 2013). In addition, Riyadh identified factors such as Saudi nationals, and babies born via cesarean delivery, and low birth weights were the barriers in Saudi Arabia (Riyadh, 2017). In contrary to these findings, a study conducted at the health institution level in South Sudan by Elizabeth, Francis, and Boniface found that except for mothers' level of education, there was no statistically significant association between maternal occupation, age of mother, mode of delivery, and EBF (Elizabeth, Francis, & Bonfiace, 2017).

Studies conducted in Ghana and South Africa identified differing factors for EBF from the above South Sudanese findings in that, maternal employment was not the factor for breastfeeding an infant exclusively. For instance, a study done by Elvis and Amos in regional capitals of Ghana found that awareness of EBF among professional working mothers recorded 99% though the EBF rate at six months was 10.3% the reason being a shorter duration of maternity leave (Elvis & Amos, 2016).

Another study done by Jacqueline in Efutu Municipal, Ghana identified there was a significant difference in EBF between mothers in the formal (16%) and informal (84%) sectors of employment. In addition, this study established a significant difference in breastfeeding frequency between mothers in the formal (9%) and informal (91%) sectors of employment. There was also a breastfeeding frequency difference between mothers that go to work with their infants (64%) and without infants (36%) (Jacqueline, 2017). In a study conducted in KwaZulu, South Africa, mothers' returning to work was associated with less EBF (C.Horwood, et al., 2018).

2.3.6.2 Exclusive Breastfeeding and its Determinants in Ethiopia

The Ethiopian Ministry of Health established the National Nutrition Program to promote optimal feeding and care practices as the main interventions to follow international recommendations, among others the program supports working mothers to exclusively breastfeed until the child is six months old (EMOH, 2015). According to 2016 EDHS almost all children, 97% are breastfed at some point (CSA, 2017) but, only 59% of infants fewer than six months are exclusively breastfed (CSA, 2019) which is contrary to the national and international recommendations. Reasons for this was, 14%, 1%, 8%, and 13% of infants under age six months consume plain water, non-milk liquids, other milk, and complementary foods, respectively (CSA, 2019). According to the 2016 EDHS, the median duration of EBF in Addis Ababa was 2.9 compared to 4.6 recorded in Benishangul-Gumuz which was the highest in comparison to the rest regions. Therefore, this calls for understanding the factors that hinder EBF practice by first reviewing local studies.

There are several research studies conducted regarding the practice and factors influencing EBF in Ethiopia. Studies conducted in three big cities of Ethiopia Gonder, Hawassa, and Addis Ababa, in one way or another way, found similar and contrary findings related to barriers of EBF practice. (Dawit, Gashaw, Yalemzewod, & Yayehirad, 2017; Henok, Yifru, Fikadu, & Bethlihem, 2017; Laykewold, Amha, Amha, & Etagegnehu, 2017).

According to the study, in Gondar town, the mean duration of exclusive breastfeeding was 47.7% months, in Hawassa it was 60.9%, and in the latter city, which was conducted among mothers attending in private pediatric and child clinics, it was 44.2%. In Gondar city, EBF is more than twice among unemployed 48.0% than employed 20.9%. In this study, there is a significant statistical association between parity of three children and above, and having

social support with EBF while a negative association between wealth index of the medium level and poor knowledge with EBF among employed mothers (Dawit, Gashaw, Yalemzewod, & Yayehirad, 2017). In Hawassa, housewives were more likely to practice EBF than employed mothers, and other factors associated with EBF were: mothers with cesarean section were less likely to practice EBF than mothers who gave birth via normal delivery (Henok, Yifru, Fikadu, & Bethlihem, 2017; Laykewold, Amha, Amha, & Etagegnehu, 2017).

2.4 Synthesis of the Review

Theoretical and empirical literatures were reviewed. Theory of planned behavior, self-efficacy, and social cognitive theories were found relevant theoretical frameworks for this study due to individual, group, and social factors for not exclusively breastfeed were identified in these theories. Most empirical literature conducted on EBF throughout the world found a low rate of EBF practices, which is far from the international recommended level, though breastfeeding has numerous health benefits for the mother and an infant. Accordingly, the barriers identified were: mode of delivery, maternal employment, insufficient milk, social, and cultural factors, maternal attitude, and absence of support from family and community to mention a few. There is also contrary study findings reviewed. For instance, a study conducted in South Sudan, found a maternal occupation, age of the mother, and mode of delivery haven't any relation with EBF.

As a result, it is possible to say that, research findings identified the level, practice, and duration of EBF throughout the world showing varying patterns and factors that hinder mothers to exclusively breastfeed. In Ethiopia, the prevalence of EBF showed improvement from year to year based on the Ethiopian EDHS report, but the practice is still far from the needed level. The health benefit of breastfeeding for minimizing the rate of morbidity and mortality of infants and under-five children is found to be crucial, though the recommended level was not met due to various reasons.

Even though many studies have been undertaken in an attempt to find factors influencing EBF practice, as one way to get at the bottom of the problem, there are hardly any studies focusing on breastfeeding, particularly EBF variations by women's type of work as formal and informal.

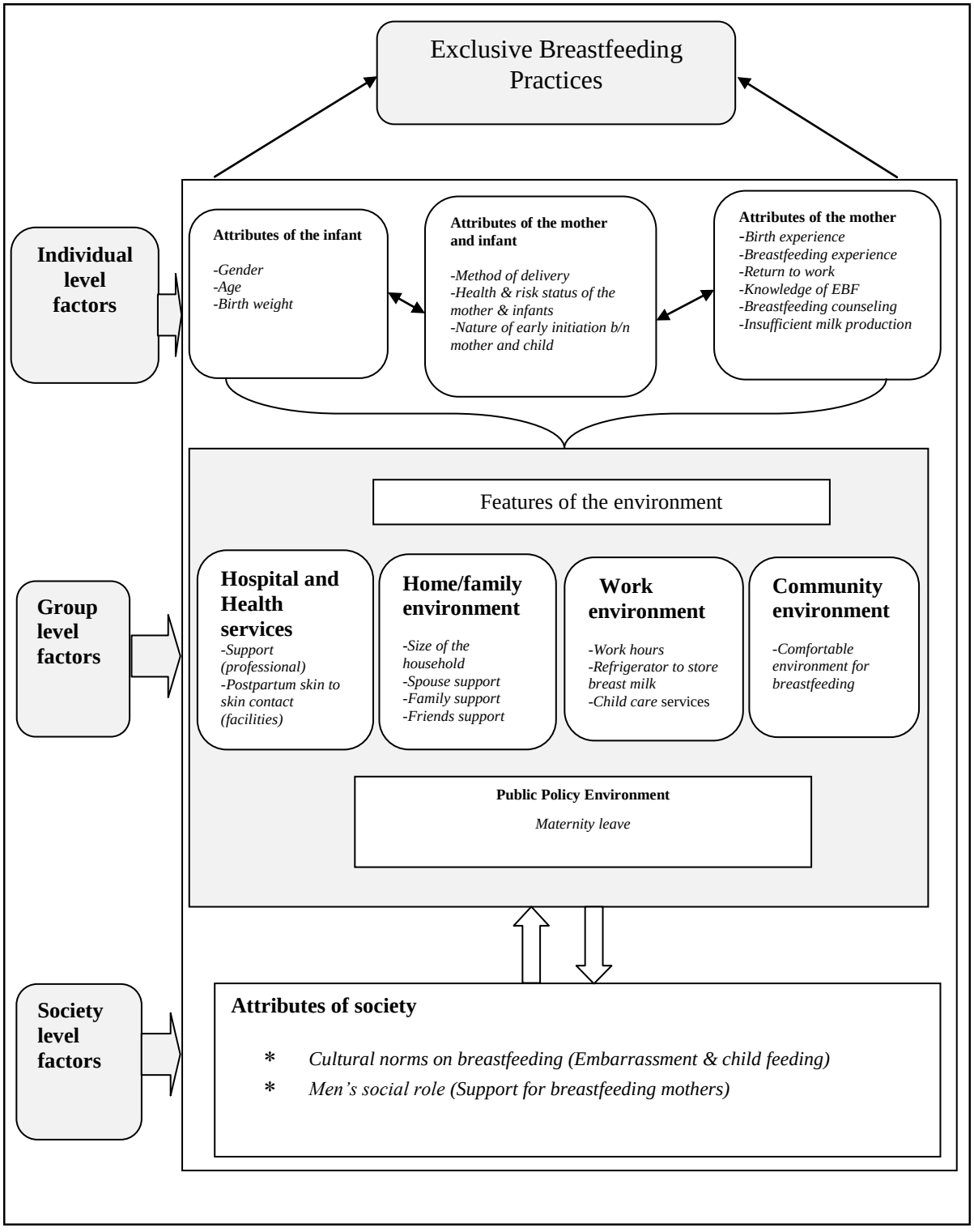
Therefore, this study attempted to fill this gap and identify the barriers of EBF among working mothers.

2.5 Conceptual Framework

Different studies identified factors that affect the practice of EBF. The conceptual framework used to guide this research has individual, group, and society levels of factors that influence EBF practices:

According to the conceptual framework developed by Peter Heywood, individual-level factors include: mother's knowledge of EBF, breastfeeding counseling, birth experience, breastfeeding experience, skills and parenting experience, health and risk status of mothers and infants, and the nature of early interaction between mother and infant and group-level factors are hospital and health facilities environment, the home and peer environment, the work environment, the community environment, and the public policy environment. The societal level factors include cultural norms, child feeding, and support for breastfeeding mothers (Heywood, 2014) (Figure 1).

Figure 1: Conceptual framework for determinants of exclusive breastfeeding practice of formal and informal working mothers.



Adopted and modified from: (Heywood, 2014)

CHAPTER THREE

METHODS AND MATERIALS

3.1 Introduction

The purpose of this study is to provide descriptive and inferential analysis of the knowledge and practice of EBF of working mothers. Besides, the study identified barriers that influence the duration of EBF in the formal and informal work environment of working mothers. To conduct this research, data were collected from a sample of mothers using a survey questionnaire. This chapter explains the methods employed to answer the research questions of the study. Research design and methods, sample size and sampling procedures, data collection and analysis procedures, and ethical concerns are the issues discussed in this chapter.

3.2 Research Design, Study Area and Period

In this study, an institution-based cross-sectional survey study design was carried out from June to July/2020. The study was conducted in four public health centers in Bole and Addis Ketema sub-cities of Addis Ababa, Ethiopia.

3.3 Research Approach

A quantitative research method was employed for this study. Quantitative data were collected using semi-structured and pretested interviewer-administered questionnaires. They were adopted from standard questionnaires on EBF knowledge, duration, factors, and practices (CSA, 2017). The units of analysis were mothers with 6 to 11-months old infants attending immunization and child health services.

3.4 Geographical Scope of the Study

Addis Ababa, the capital city of Ethiopia and the seat of many continental and international organizations including the African Union, houses ministry offices, headquarters of financial institutions, and also the major center of informal trade activities of the country. It has a formal government, NGOs and private institutions, and informal businesses with an increasing number of working women in these institutions (CSA, 2018).

According to the 2015/16 Ethiopian Household Consumption-Expenditure Survey, the estimated total population of Addis Ababa was 3,243,514. Among these Addis Ketema and Bole, sub-cities were 218,187 and 446,825 of these around 80,750 and 163,620 are women in the reproductive age group dwelling in these sub-cities, respectively (CSA, 2018).

Addis Ababa city administration is organized into ten sub-cities and one hundred and sixteen districts. This study was conducted in the sub-cities of Bole and Addis Ketema in selected public health centers. Even though both formal and informal working mothers reside in both sub-cities, it is believed that informal working mothers are expected to be available more in Addis Ketema sub-city, because it is the home of a business center like 'Merkato', whereas formal working mothers are expected to present more in Bole sub-city.

3.5 Study Population

The target population was all mothers with children aged 6 to 11 months attending immunizations and child care services in selected public health centers in Addis Ketema and Bole sub-cities, Addis Ababa, Ethiopia. According to data obtained from Addis Ababa city administration Health Bureau, Bole sub-city has 10 public health institutions and Addis Ketema sub-city has 12 public health institutions. Among these Amoraw and woreda 17 health centers from Bole sub-city, Millennium and Addis Ketema health centers from Addis Ketema sub-cities were selected for this study.

3.5.1 Inclusion Criteria

- Mothers having a child aged 6 to 11 months attending immunization and child care services.
- Mothers who are willing to participate in the study.
- Mothers who have formal or informal work engagement before child birth.

3.5.2 Exclusion Criteria

- Mothers who are not willing to participate in the study.
- If either of the mother or baby was seriously ill.
- Physical problems of mother or baby that made breastfeeding impossible.
- Non-working mothers.

Figure 2: Map of the study area

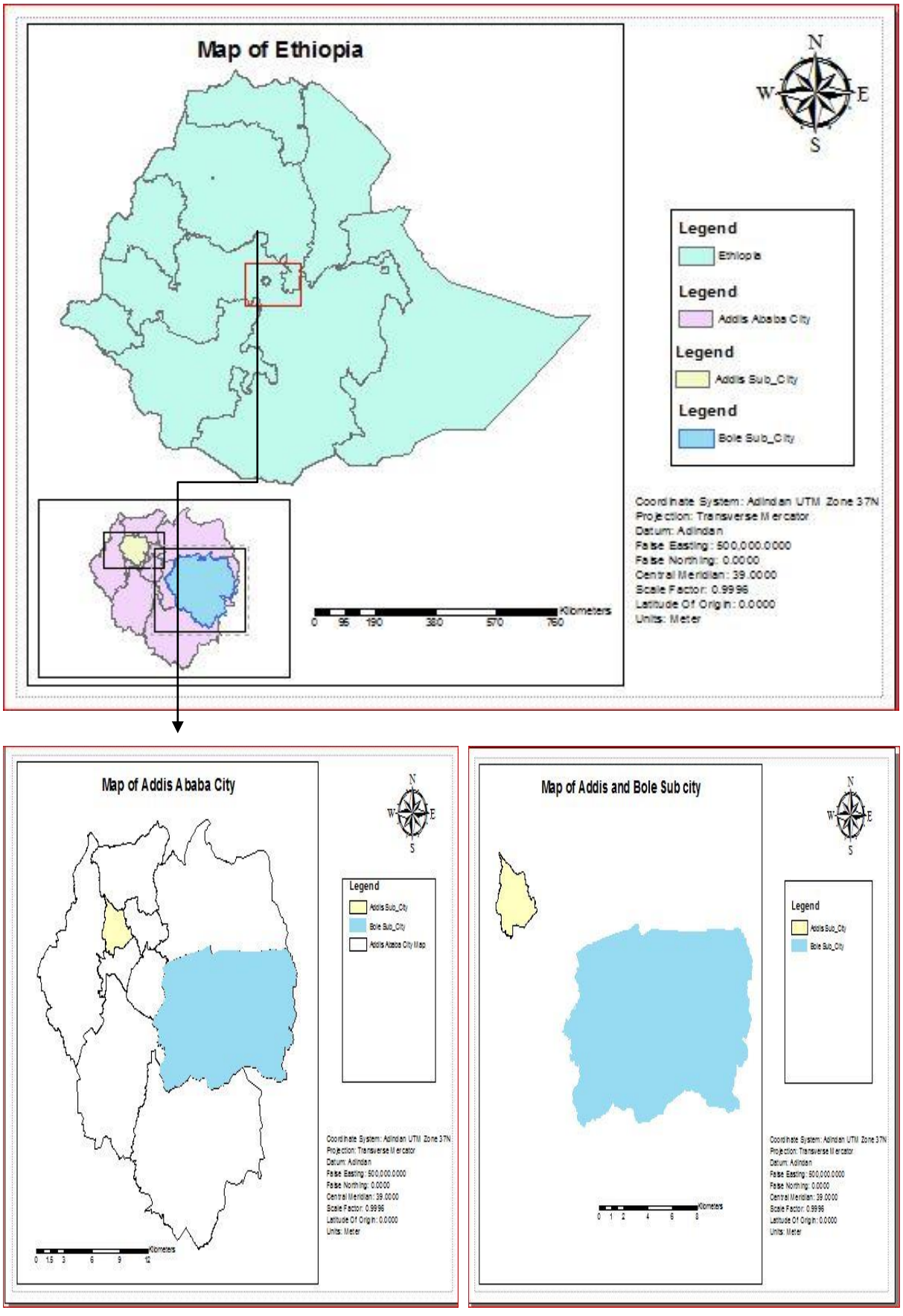


Table 1: Descriptions of variables and measurements

No	Variables	Definition	Measurements
Part I: Outcome variable			
1	Exclusive breastfeeding	The infant has received only breast milk from his/her mother or a wet nurse or expressed breast milk and no other liquids, or solids, except for drops or syrups consisting of vitamins, minerals, supplements, or medicines for the first six months of life (WHO/UNICEF, 2010).	A value of 1 assigned if a woman is an exclusive breast feeder; and 0 assigned for non-exclusive breast feeder *(the default reference is 0(No)).*
Part II: Independent Variables			
Socio-demographic and economic variables			
1	Maternal age at delivery	Completed number of years since the birth of a woman	Below 25, 25-29, 30-34, and above 35
2	Infant gender	Gender of the infant	0 assigned for male and 1 for female *(The reference is female for the overall model)*
3	Religion	The religion of the mother	A value of 1 assigned if a woman is a follower of Orthodox, 2 if Muslim, and 3 if Other (Protestant, Catholic, and Others)
4	Marital status	Marital status of the mother	A value of 1 is assigned for married women and 2 for not currently married women (Single, divorced, and widowed)
5	Education	Educational attainment (the number of grades completed)	A value 1 is assigned for primary school and lower, 2 for secondary school and diploma, and 3 for degree and above
6	Type of employment	**Formal Employment:** An employment with a written employment agreement, with and without employment time limit, and with permanent and contract work type.	A value of 0 is assigned if a woman formally employed (Government, NGO, and PLC) and a value 1 is assigned if she is informally employed (Temporary PLC, household employee, self-
		Informal Employment: An employment with an oral	

No	Variables	Definition	Measurements
		agreement or no agreement at all with the organization, with and without employment time limit, and with temporary and occasional work type.	employed and employer) *(Informal is the reference group in the overall model)*
7	Income	Maternal monthly income (Ethiopian birr)	1 is assigned for less than 2500 birr, 2 for 2501- 6500 birr, and 3 for greater than 6501 birrs.
Health-related and other variables			
1	Method of birth	Method of birth is the ending of pregnancy where one or more babies leave the uterus by passing through the vagina or by Caesarean section.	0 assigned for cesarean section delivery and 1 for normal delivery *(vaginal delivery is the reference group in the overall model while cesarean section in the formal and informal model)*
2	Infant birth weight	Birth weight is the first weight of the fetus or newborn obtained after birth.	A value of 1 assigned if a woman delivered an infant with low birth weight (<2500g), 2 for medium birth weight (2500-4000g), and 3 for large birth weight(>4000g) *(The medium birth weight is the reference group in the overall model, the low for formal and the high birth weight for informal).*
3	Insufficient milk production	Is the production of breast milk in daily volumes that do not fully meet the nutritional needs of her infant	A value of 0 is assigned if a woman hadn't enough milk production and 1 if she had enough milk production *(No is the references group*).
4	Return to work	Breastfeeding mothers return to work before the end of EBF period.	A value of 0 is assigned if a woman returns to work while 1 is assigned if she has not returned to work *(The base is no)*
5	Child care services at work place	The care of children especially as a service while parents are working	A value of 0 is assigned if a woman lacks child care services in the workplace while 1 is assigned if she had child care service in the workplace *(No is the reference in all models).*

No	Variables	Definition	Measurements
Composite Indexes			
1	Breastfeeding counseling	Received antenatal care on breastfeeding counseling, particularly on benefits of breastfeeding, the importance of breastfeeding soon after delivery, and the importance of EBF for six months after birth.	Value of 1, 2, and 3 assigned if a woman had received a poor, medium, and good breastfeeding counseling, respectively *(poor is the reference group in the overall model).*
2	Knowledge of EBF	Knowledge of mothers on putting the infant on the breast within the first hour immediately after birth, feeding the infant in the first two days after birth and importance of feeding the baby the first yellowish milk (provides the babies with substances that help to fight diseases, infections and illnesses, and the baby will not feel hungry because it is heavy)	Value of 1, 2, and 3 assigned if a woman had poor, medium, and good EBF knowledge, respectively *(poor is the reference group in the overall model).*
3	Breastfeeding support	Support from spouse & family, friends, and surrounding communities, the culture of the community, and the comfort ability of the environment you dwell for breastfeeding.	Values of 1, 2, and 3 assigned if a woman had received high, medium, and low support on breastfeeding, respectively *(low is the reference group in the overall model while high for the formal and informal model).*
4	Other barriers	Barriers such as stressful, time-consuming, concern of breastfed babies had smaller volume and will not receive adequate nutrition, embarrassment, painful nipples, poor laching on, use of harmful medication by the mother, lack of breastfeeding experience, lack of information whom to contact during breastfeeding challenges and lack of information on the benefits of breastfeeding for both infants and mothers.	Values of 1, 2, and 3 were assigned for high, medium, and low-level barriers on EBF, respectively.

3.6 Sample Size Determination

The sample size is determined using the single population proportion formula by considering the prevalence of EBF practice 59% (p) (CSA, 2019), 5% degree of precision (d), assuming 95% confidence level, and allowing a 10% non-response rate.

$$n = (z_{\alpha/2})^2 p (1-p) /d^2 = \frac{(1.96)^2 (0.59) (0.41)}{(0.05)^2} = 371$$

Where**:** n - minimum sample size required, p - an estimate of the proportion of infants those exclusively breastfeed, d – margin of error for sampling, and z $\alpha_{/2}$ - the standard normal value at (100% - α). After adding 10% non-response rate the final sample size became = 408

3.7 Sampling Techniques

The study is based on the experience of mothers who seek health care services at public health centers in two selected sub-cities in Addis Ababa, which were selected by purposive sampling technique. Of these, a sample size of two public health centers from each sub-city was sampled by a purposive sampling procedure based on location and population size, and by using a simple random sampling technique from the list of mothers with child 6 to11 months. Using this technique 408 women were selected from a total of 244, 370 reproductive-age women in both sub-cities.

3.8 Pilot Study

Eighteen breastfeeding mothers were selected randomly for a pilot study from the study areas of public health institutions to answer the survey questions. Based on this, questions were well defined, clearly understood and presented in a consistent manner.

3.9 Data Collection

Of 408 eligible mothers for an interview, 389 completed the questionnaire while attending public health institutions, resulting in a response rate of 95.3%. The questionnaire was divided into seven sections: Mothers' and infants' socio-demographic data, history of pregnancy, postnatal history, breastfeeding knowledge, duration of breastfeeding, breastfeeding support, and factors of EBF were the information gathered for this study.

Data were collected involving the principal investigator and research assistants. The assistants were female nurses and midwives, selected from the nursing staff. These assistants believed in having closed contact with breastfeeding mothers and able to speak and communicate easily with them. Six research assistants were trained by the principal investigator on sampling procedures, inclusion and exclusion criteria, data gathering questionnaires, and management. Accordingly, mothers were interviewed by trained female nursing staff, who can communicate with them easily.

3.10 Data Analysis

The collected data were entered and analyzed using STATA version 14.2 and R version 3.6.1 (for graphical analysis). Both descriptive and inferential statistics were employed in the analysis of the study. Multilevel binary logistic regression technique was employed to determine EBF. A two level hierarchical analysis model was employed. Workers were nested into working groups. The first level was workers (mother-infant pairs) while the second level was working groups (formally and informally employed mothers). The estimated intra-class correlation (ICC) was checked after post estimation statistics.

Univariate, bivariate, and multivariable analyses were performed. The predictors included in the multilevel binary logistic regression were selected based on two procedures. First, the association of predictor variables with the duration of breastfeeding was checked using Pearson's chi-squared test. Second, bivariate multilevel binary logistic analyses for all potential explanatory variables were made and those associated with EBF with p-value < 0.25 were selected for multivariable multilevel binary logistic regression to fit the model.

The odds ratio for EBF and its 95% confidence interval were estimated for the socio-demographic and health-related characteristics associated with EBF for the model. An odds ratio of 1.00 was considered to indicate the baseline category for each variable in the multivariate analysis. An odds ratio greater than 1.00 was taken to indicate more likely to engage in EBF than the reference category and an odds ratio of less than 1.00 was taken to indicate a less likely to practice exclusively breastfeed.

3.11 Ethical Considerations

Crucial ethical issues were considered in all stages of this survey, the most important were: Ethical approval of the research proposal was obtained from Addis Ababa University, College of Development Studies, and Center for Population Studies. An official letter was prepared by the College to the concerned office.

Ethical clearance was obtained from the Ethical Review Committee of Addis Ababa public health research and emergency management directorate. Each study participant was adequately informed about the objective of the study and the anticipated benefit of the study by data enumerators. Verbal consent was obtained from study participants for protecting autonomy and ensuring confidentiality. Respondents were also told of in the right not to respond to the questions, if they don't want to respond or to terminate the interview at any time they need. Finally, the results of the study will be disseminated to Addis Ababa public health research and emergency management directorate and concerned bodies.

CHAPTER FOUR

RESULT AND DISCUSSION

4.1 Results

From a total of 408 questionnaires distributed to breastfeeding infant-mother pairs attending immunization and postnatal services at health institutions, a total of 389 (95.3%) working mothers have participated in the study while 19 mothers were not fully replied to the questionnaires correctly.

4.1.1 Demographic Profile of Participants

The mean age of mothers who participated in the study was 30 (Standard deviation, 5.0) years. Most of the participants were between 25-29 years (43.2%), were married (82.8%), half of them were followers of Orthodox Christianity (50.1%) followed by Muslim (31.1%), had secondary school and diploma (42.2%), were government employee (28.0%) followed by self-employed (26.5%) and earned above 6,501 birr (43.2%) per month. The mean age of infants studied were 9 months and their sex distributions were almost equal, (49.6%) males and (50.4%) females (Table 3).

4.1.2 Exclusive Breastfeeding Counseling and Knowledge

Almost forty percent of the participants (39.6%) had received a medium level of breastfeeding counseling, had good knowledge about EBF (54.8%) followed by medium knowledge of EBF (25.7%). The proportion of having good knowledge had no significant difference between formal and informal working mothers (Table 5).

4.1.3 Exclusive Breastfeeding Practice

Of all working mothers who participated in the study, the majority of them (60.41 %) had initiated breastfeeding in less than an hour, while the rest (39.59) initiated in greater than an hour after delivery. A total of (58.85%) formal working mothers in the formal sector and (61. 93%) informal working mothers in the informal sector initiated breastfeeding in less than an hour, which are close findings to each other (Table 5).

The overall prevalence of EBF practice, in the first six months from birth, among working mothers was (46.53%), while the rest (53.47%) did not practice it. A total of (40.10%)

formally employed mothers and (52.79%) informally employed mothers practiced EBF (Table 5) (Figure 3).

The overall mean, median and inter quartile range, that infants received breast milk only, was 127.40 (95% CI: 121.93 - 132.86), 120 and 90 days, respectively. The mean, median and inter quartile range of EBF practice for formally employed mothers were 117.19 (95% CI: 109.06 – 125.30), 120 and 120 days respectively, whereas the mean, median and inter quartile range duration of EBF of informally employed mothers were 137.36 (95% CI: 130.22 - 144.49), 180 and 90 (the time by which half of the children for informally employed mothers have stopped EBF) days, respectively (Table 2).

Mothers in the age group 30-34 had a shorter duration of EBF (118 days) compared to the rest age groups while mothers below 24 and above 35 age groups had a longer duration. The average duration of EBF was 137 days for mothers who gave birth normally compared to 107 days for those who delivered by caesarian section. Mothers who had female infants exclusively breastfeed slightly longer (132 days) than those who had male infants (122 days). Mothers who got a monthly salary below 2500 birr had a longer mean and median duration of EBF (134 days and 180) than mothers above 2501 birr (Table 2).

Married women had a slightly shorter mean duration of EBF (127 days) compared to those who were not currently married (129 days). The average duration of EBF was found 97 days for infants with low birth weight (<2500g) compared to 133 days for medium birth weight infants (2500g - 4000g). Mothers who had a primary and lower level of schooling exclusively breastfeed longer (131 days) than those who had a degree and above educational level (122 days). Self-employed mothers had longer EBF experience (137 days) than a government employee (111 days) (Table 2).

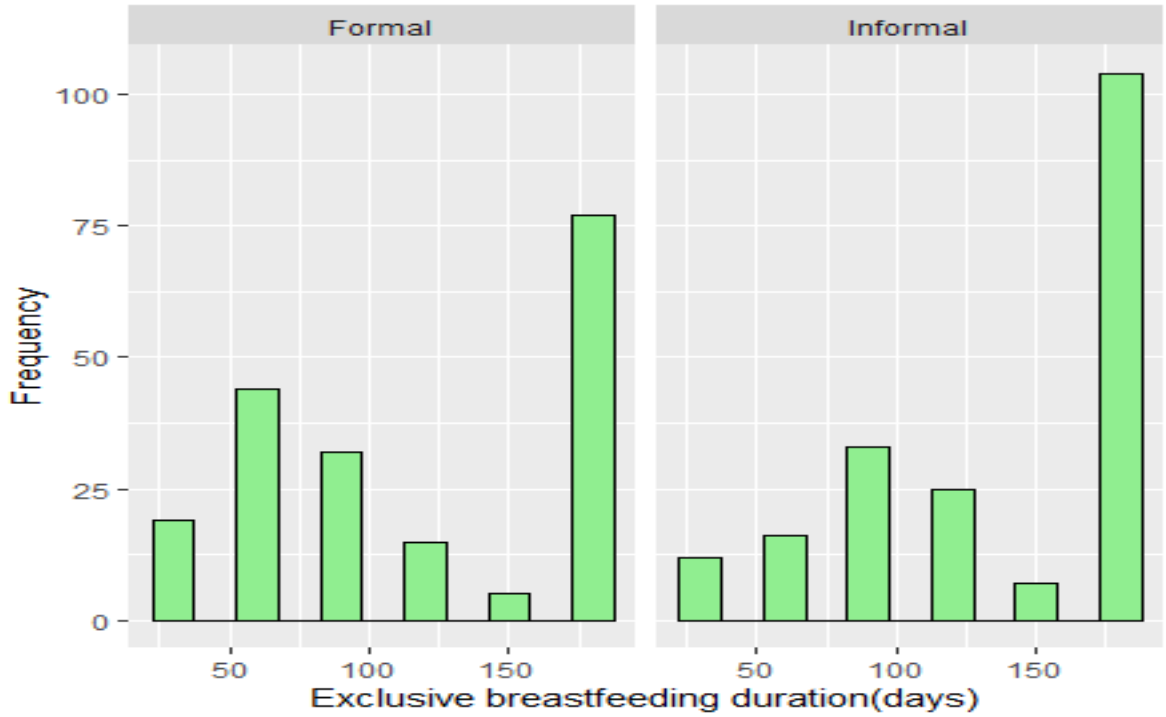
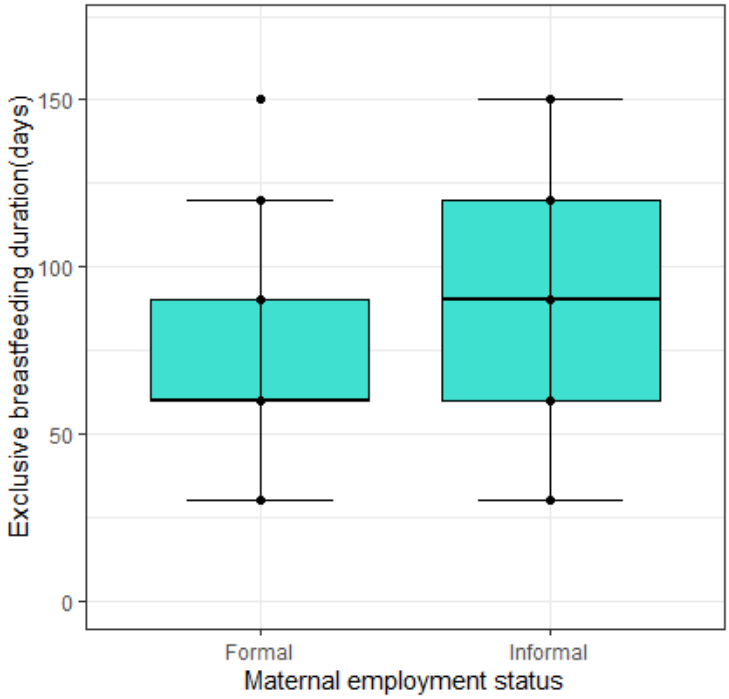


Figure 3: Distributions of EBF duration for formal and informal working mothers



The estimated median duration of EBF was longer for informally employed mothers compared to formally employed mothers. The median EBF duration for the infants aged less than six months was 90 days for informally employed mothers, while 60 days for formally employed. The 25th percentile for informally employed mothers was 60 days while the 75th percentile was 120 days. The 25th percentile for formally employed mothers was 60 days while the 75th percentile was 90 days (the box plot was made by taking out extreme values in both groups i.e. 180 days) (Figure 4).

Figure 4: Exclusive breastfeeding duration for formal and informal working mothers

Table 2: Mean and median duration of exclusive breastfeeding (in days) by socio-economic, demographic, and health-related characteristics, Addis Ketema and Bole sub-cities, Addis Ababa, Ethiopia, June 2020

Variables	***Number***	***Percentage***	***Duration of EBF (in days)***		
			Mean	***Median***	***Interquartile range (IQR)***
Age at birth					
below 24	57	14.7	132.63	150	90
25-29	168	43.2	128.21	150	90
30-34	88	22.6	118.29	120	120
above 35	76	19.5	132.23	135	90
Infant gender					
Male	193	49.6	122.18	120	120
Female	196	50.4	132.55	180	90
Religion					
Orthodox	195	50.1	126.46	120	120
Muslim	121	31.1	123.97	120	120
Others	73	18.8	135.61	180	90
Marital status					
Married	322	82.8	126.99	120	90
Not currently married	67	17.2	129.40	150	90
Education					
Primary school and lower	93	23.9	131.29	150	90
Secondary and diploma	164	42.2	129.32	150	90
Degree and above	132	33.9	122.27	120	120
Type of employment					
Formal	192	49.36	117.19	120	120
Informal	197	50.64	137.36	180	90
Occupation					
Government Employee	109	28	111.47	90	120
NGO	19	4.9	118.42	90	120
Private Employee	85	21.9	132.00	150	90
Household Employee	46	11.8	134.34	180	90
Self Employed	103	26.5	137.18	150	90
Employer	27	6.9	134.44	180	90
Income					
Below 2500	89	22.9	134.16	180	90
2501-6500	132	33.9	122.50	120	120
Above 6501	168	43.2	127.68	120	90
Method of delivery					
Normal vaginal	266	68.4	136.80	180	90
Caesarean section	123	31.6	107.07	90	90
Birth weight					
<2500g	62	15.9	96.77	90	60
2500-4000g	303	77.9	133.47	180	90
>4000g	24	6.1	130.00	180	105
Overall working mothers					
	389	100	127.40	120	90

Table 3: Socio-economic and demographic characteristics of mothers attending immunization and postnatal care services by type of work in Addis Ketema and Bole sub-cities, Addis Ababa, Ethiopia, June 2020

Characteristics		Maternal employment (up to first six months)								Total	
		Formal				Informal					
		Exclusive breastfeeding				Exclusive breastfeeding					
		Yes		No		Yes		No			
		Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Maternal age at birth (years)	Below 24	8	10.4	18	15.7	20	19.2	11	11.8	57	14.7
	25-29	40	51.9	52	45.2	43	41.3	33	35.5	168	43.2
	30-34	17	22.1	30	26.1	17	16.3	24	25.8	88	22.6
	Above 35	12	15.6	15	13	24	23.1	25	26.9	76	19.5
Infant sex	Male	35	45.5	64	55.7	47	45.2	47	50.5	193	49.6
	Female	42	54.5	51	44.3	57	54.8	46	49.5	196	50.4
Religion	Orthodox	47	61	70	60.9	44	42.3	34	36.6	195	50.1
	Muslim	17	22.1	31	27	36	34.6	37	39.8	121	31.1
	Others	13	16.9	14	12.2	24	23.1	22	23.7	73	18.8
Marital status	Married	70	90.9	100	87	79	76	73	78.5	322	82.8
	Not currently married	7	9.1	15	13	25	24	20	21.5	67	17.2
Mothers' education	Primary school and lower	8	10.4	12	10.4	37	35.6	36	38.7	93	23.9
	Secondary and diploma	30	39	46	40	49	47.1	39	41.9	164	42.2
	Degree and above	39	50.6	57	49.6	18	17.3	18	19.4	132	33.9
Occupation	Government employee	40	51.9	69	60					109	28.0
	NGO	8	10.4	11	9.6					19	4.9
	Private employee	29	37.7	35	30.4	13	12.5	8	8.6	85	21.9
	Household employee					26	25	20	21.5	46	11.8
	Self-employed					51	49	52	55.9	103	26.5
	Employer					14	13.5	13	14	27	6.9
Maternal monthly income	Below 2500	10	13	18	15.7	37	35.6	24	25.8	89	22.9
	2501-6500	33	42.9	46	40	26	25	27	29	132	33.9
	Above 6501	34	44.2	51	44.3	41	39.4	42	45.2	168	43.2
Total		77	100	115	100	104	100	93	100	389	100

Table 4: Two-sample test of proportions of exclusive breastfeeding for formal and informal working mothers, in Addis Ketema and Bole sub-cities, Addis Ababa, Ethiopia, June 2020

Variable	Mean	Std. Err.	z	P>|z|	[95% Conf. Interval]	
Formal	0.4010	0.0353			0.3317	0.4703
Informal	0.5279	0.0355			0.4582	0.5976
diff	-0.1268	0.0501			-0.2251	0.0285
	Under Ho:	0.0505	-2.51	0.112		
Diff = prop (Formal) – prop (Informal)					z = -2.5083	
Ho: diff = 0 Ha: diff < 0 Pr(Z < z) = 0.0061		Ha: diff! = 0 Pr(|Z| > |z|) = 0.0121			Ha: diff > 0 Pr(Z >z) = 0.9939	

The equality of EBF proportion of mothers in the two-employment status groups (formal and informal) was tested. The two-sample test of proportions indicated that the null hypothesis should be rejected. Therefore, there is significant difference in the proportion of EBF between formal and informal working mothers (Table 4).

4.1.4 Reasons for Having a Short Duration of Exclusive Breastfeeding

The main reasons for stopping EBF were due to insufficient milk production 108 (51.92%), return to work 161 (77.4%), lack of child care services in the work place or near the work place 170 (81.73%), having low EBF support 64 (30.77%), having poor knowledge on EBF 40 (19.23%), and having poor breastfeeding counseling 71 (34.13%) for breastfeeding mothers without considering employment status (Table 5).

The reasons for ceasing EBF among formally employed mothers were due to insufficient milk production 48 (41.7%), return to work 95 (82.6%), lack of child care services 106 (92.2%), low breastfeeding support 15 (13%), poor knowledge on breastfeeding 24 (20.9%), and poor breastfeeding counseling 41 (37.5%). Whereas among informal working mothers the reasons for a short period of EBF were insufficient milk production 60 (64.5%), return to work 66 (71%), lack of child care services 64 (68.8%), low EBF support 49 (52.7%), poor knowledge on EBF 16 (17.2%), and poor breastfeeding counseling 30 (32.3%) (Table 5).

Table 5: Factors associated with exclusive breastfeeding among formal and informal working mothers, in Addis Ketema and Bole sub-cities, Addis Ababa, Ethiopia, June 2020

Characteristics		Maternal employment by work status (up to first six months)								Total	
		Formal				Informal					
		Exclusive breastfeeding				Exclusive breastfeeding					
		Yes		No		Yes		No			
		Freq.	%	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Breastfeeding counseling	poor	31	40.3	41	35.7	43	41.3	30	32.3	145	37.3
	medium	32	41.6	46	40	39	37.5	37	39.8	154	39.6
	good	14	18.2	28	24.3	22	21.2	26	28	90	23.1
Mode of delivery	Normal	63	81.8	71	61.7	88	84.6	44	47.3	266	68.4
	Caesarean Section	14	18.2	44	38.3	16	15.4	49	52.7	123	31.6
Infant birth weight	<2500g	3	3.9	26	22.6	8	7.7	25	26.9	62	15.9
	2500-4000g	65	84.4	84	73	92	88.5	62	66.7	303	77.9
	>4000	9	11.7	5	4.3	4	3.8	6	6.5	24	6.2
Breastfeeding initiation	<1 hour	37	48.1	76	66.1	69	66.3	53	57.0	234	60.4
	>1 hour	40	51.9	39	33.9	35	33.7	40	43.0	154	39.6
Knowledge on EBF	poor	18	23.4	24	20.9	18	17.3	16	17.2	76	19.5
	medium	19	24.7	23	20	35	33.7	23	24.7	100	25.7
	good	40	51.9	68	59.1	51	49	54	58.1	213	54.8
Having EBF support	high	47	61.0	34	29.6	65	62.5	13	14.0	159	40.9
	medium	26	33.8	66	57.4	28	26.9	31	33.3	151	38.8
	low	4	5.2	15	13	11	10.6	49	52.7	79	20.3
Insufficient milk production	Yes	18	23.4	48	41.7	35	33.7	60	64.5	161	41.4
	No	59	76.6	67	58.3	69	66.3	33	35.5	228	58.6
Return to work	Yes	60	77.9	95	82.6	58	55.8	66	71	279	71.7
	No	17	22.1	20	17.4	46	44.2	27	29	110	28.3
Lack of child care services	Yes	61	79.2	106	92.2	65	62.5	64	68.8	296	76.1
	No	16	20.8	9	7.8	39	37.5	29	31.2	93	23.9
Other EBF barriers	high	15	19.5	19	16.5	15	14.4	25	26.9	74	19.0
	medium	25	32.5	52	45.2	48	46.2	53	57	178	45.8
	low	37	48.1	44	38.3	41	39.4	15	16.1	137	35.2
Total		77	40.10	115	59.90	104	52.79	93	47.21	389	100

4.1.5 Multilevel Binary Logistic Model

The EBF and significant factors affecting it were analyzed using multilevel binary logistic regression. The purpose is to identify the independent effect of each factor variable on the EBF, by controlling other factors. Predictors such as method of delivery, low birth weight, women who had got breastfeeding support, and insufficient milk production were found statistically significant with the outcome at a p-value less than or equal to 0.05.

Mothers who delivered by cesarean section had a 68% reduced likelihood of practicing EBF compared to women who had birth by normal delivery (AOR = 0.322, p = 0.000 [95% CI = 0.184, 0.563]). Infants born with low birth weight had a 70% less likelihood of being exclusively breastfed compared to medium birth weight infants (AOR = 0.304, p = 0.010 [95% CI: 0.134, 0.689]).

The infants of women with high EBF support were twelve times more likely to be exclusively breastfed than the infants of mothers who had low breastfeeding support (AOR = 12.039, p = 0.000 [95% CI: 5.593, 25.910]) and mothers with medium breastfeeding support were almost three times more likely to exclusively breastfed compared to mothers who had low breastfeeding support (AOR = 2.728, p = 0.008 [95% CI: 1.292, 5.755]). Women with insufficient milk production had a 64% less likelihood of being exclusively breastfed compared to women with sufficient milk production (AOR = 0.364, p = 0.000 [95% CI = 0.216, 0.614]).

The overall variance was found at 22%. This estimate indicates the degree to which the exclusive breastfeeding practice of working mothers varies across the two employment sectors. In addition, the likelihood ratio test (LRT) indicates significant variation in exclusive breastfeeding exists among women by type of employment (being formal and informal worker) and the results of intraclass correlation (ICC) showed 6.32% variation in EBF practice was determined by maternal type of employment (Table 6).

Table 6: Relation between exclusive breastfeeding and social, demographic and health-related factors in a multilevel logistic model in Addis Ketema and Bole sub-cities, Addis Ababa, Ethiopia, June 2020

Independent Variables	N	COR (95% CI)	AOR (95% CI)	SE	p-value
Fixed effect (Level 1)					
Infant gender					
Male	193	0.723 (0.485, 1.080)	0.868 (0.527, 1.432)	0.221	0.581
Female	196	1 (base)	1 (base)		
Mode of delivery					
Vaginal/normal	266	1 (base)	1 (base)		
Cesarean section	123	0.246 (0.152, 0.396)	0.322 (0.184, 0.563)	0.091	0.000
Birth weight					
< 2500g	62	0.200 (0.100, 0.400)	0.304 (0.134, 0.689)	0.127	0.010
2500-4000g	303	1 (base)	1 (base)		
>4000g	24	1.099 (0.477, 2.530)	0.677 (0.251, 1.822)	0.342	0.440
Knowledge on EBF					
Poor	76	1 (base)	1 (base)		
Medium	100	1.304 (0.717, 2.371)	1.117 (0.536,2.327)	0.418	0.724
Good	213	0.829 (0.490, 1.402)	0.933 (0.488, 1.784)	0.309	0.835
Breastfeeding support					
High	159	10.167 (5.269, 19.620)	12.039 (5.593, 25.910)	4.708	0.000
Medium	151	2.375 (1.236, 4.565)	2.728 (1.292, 5.755)	1.039	0.008
Low	79	1 (base)	1 (base)		
Insufficient milk production					
Yes	161	0.383 (0.251, 0.583)	0.364 (0.216, 0.614)	0.097	0.000
No	228	1 (base)	1 (base)		
Return to work					
Yes	279	0.547 (0.349, 0.854)	0.638 (0.329, 1.239)	0.216	0.185
No	110	1 (base)	1 (base)		
Lack of childcare services					
Yes	296	0.512 (0.319, 0.822)	0.811 (0.402, 1.635)	0.29	0.559
No	93	1 (base)	1 (base)		
Random effect (Level 2)					
Type of Employment					
Variance(Constants)		*0.222 (0.225, 2.199)*			
Intraclass correlation (ICC)		*= 0.063 (0.007, 0.400)*			
Likelihood Ratio Test		*p = 0.0019*			

4.2 Discussion

Several studies have found that, numerous health benefits of early initiation and EBF for both mother and infant. Breastfeeding protects infants against morbidity and mortality due to infectious diseases and keeps infants safe from unhygienic environments and contaminants in foods that can cause diarrhea and lead to nutrient loss and under nutrition (UNICEF, 2016). This paper aims to examine factors of EBF among working mothers during the first six months of postpartum.

The majority of mothers who participated in this study (60.41 %), had initiated breastfeeding in the first hour of delivery, lower than the National (Ethiopia) (73.3%), and the capital city (Addis Ababa) (67.5%) findings (CSA, 2017). Also, this value was slightly lower than that found in Juba, South Sudan (76.8%) (Elizabeth, Francis, & Bonfiace, 2017) and Malawi (76.9) (Owen, Peter, Victor, Edith, & Amit, 2019). This might be due to the characteristics of the sampled population of the present study.

Almost similar findings in breastfeeding initiation among formal (59%) and informal working mothers (61%) were found, which is consistent with a study conducted in Singapore (Gray, Mabel, Foo, & Tai, 2005). The finding of the present study that, considerable proportion of mothers not initiating breastfeeding after birth, was far away from UNICEF's recommendation on the initiation of breastfeeding, where the latter is believed to greatly help to harness the benefits of keeping a baby warm, builds his/her immune system, promote bonding, boosting a mother's milk supply, and increasing the chances of breastfeeding mothers to continue breastfeeding exclusively (UNICEF, 2016).

In the present study, the prevalence of EBF practice was found 46.53%, lower than the national findings (Ethiopia) 58.8% (CSA, 2019), but consistent with a study conducted in the capital city (Addis Ababa) 44.2% (Laykewold, Amha, Amha, & Etagegnehu, 2017). This is not representative of the prevalence of the study area, as the present population consisted of formal and informal working mothers only. This finding is higher compared to previous studies conducted in Udupi taluk, Karnataka in India (17.5%) and Gonder (20.9%) but lower in a study conducted in Efutu Municipal Ghana (72%) (Swastika, Arathi, & Guddattu, 2018; Dawit, Gashaw, Yalemzewod, & Yayehirad, 2017; Jacqueline, 2017).

Besides, the prevalence of EBF was found 40.10% and 52.79% among formally and informally employed mothers, respectively. In contrast to this finding, a study conducted by

Jacqueline in Efutu Municipal, Ghana on maternal work and EBF showed only 16% among formal and 84% among informal working mothers (Jacqueline, 2017).

The multilevel binary logistic regression showed 6.32% of the variation in exclusive breastfeeding was determined by maternal work status (being formal and informal). A similar study conducted in Ghana and Ethiopia showed consistent results with the present study (Elvis & Amos, 2016; Kedir, Andrew, Amit, & Felix, 2019).

Suggested reasons may be employment rules and regulations for formally employed mothers, such as less maternity leave (four months in Ethiopian context), lack of child care services at the workplace, or nearer to their workplace. Also, formally employed mothers have no flexible situations to be on and off from the irregular work to breastfeed their infants like informally employed mothers. In contrast to this, informal work provides an opportunity for mothers to be with their children longer due to their work have more flexibility to breastfeed. Therefore, such women are more likely to exclusively breastfeed and elongate their duration of breastfeeding compared to their counterparts.

Regarding support for EBF, women who had got high-level breastfeeding support were associated with a lower risk of terminating EBF compared to mothers who had got low breastfeeding support regardless of their employment status. This finding is in agreement with studies conducted in Gonder town in Ethiopia (Dawit, Gashaw, Yalemzewod, & Yayehirad, 2017).

Employed mothers, in the present study, who delivered by cesarean section were associated with a 68% more likelihood of stopping EBF than those who delivered by normal delivery. This finding was consistent with a study conducted in Tabuk, Saudi Arabia (Riyadh, 2017), in Ethiopia based on EDHS from 2000 to 2016 (Kedir, Andrew, Amit, & Felix, 2019), and in Hawassa, Ethiopia (Henok, Yifru, Fikadu, & Bethlihem, 2017).

The reasons identified were: a significantly greater number of breastfeeding problems was observed during the postpartum period (Yuksel, Zeynep, Ozlem, & Eren, 2016), and 41% of women who delivered by emergency cesarean section were found to have a higher proportion of breastfeeding difficulties (Army, Cynthia, Sheila, Meredith, & Suxanne, 2016).

In the current study, although knowledge of breastfeeding was not found to be a significant predictor of EBF in the multilevel model, around 50.28% of working mothers had good knowledge to breastfeed their babies exclusively. Similar findings have been reported in

research conducted in Gonder town (Dawit, Gashaw, Yalemzewod, & Yayehirad, 2017) and a study conducted in Debre Markos, Northwest, Ethiopia (Getnet & Edris, 2015).

This study also revealed that low birth weight was a significant predictor of EBF. Babies with low birth weight (<2500g) were 70% less likely to get EBF than babies with average or medium birth weight. Similar findings were found in Tabuk, Saudi Arabia (Riyadh, 2017). The reasons for this might be because low-birth-weight infants have sucking difficulties compared to their counterparts. In addition, mothers may feel that their babies cannot get sufficient milk and nutrition from breast milk only as the babies' weight is low.

In general, according to this study, 53.47% of working mothers (59.9% formal and 47.21% informal) did not practice EBF. Findings from this study are in line with the experiences of Ghana (Jacqueline, 2017), in which the employment type of the women, particularly being an informal and formal working mother, had a significant impact on the duration of EBF.

In contrast, a study from South Sudan conducted by Elizabeth, Francis, and Boniface highlighted that maternal occupation was not the factor for not exclusively breastfeed an infant among working mothers, especially for those working outside their home (Elizabeth, Francis, & Bonfiace, 2017).

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

This study attempted to assess knowledge and practice of EBF, examine the duration of EBF, and identify barriers associated with EBF among mothers working in the formal and informal sectors, in Addis Ketema and Bole sub-cities, Addis Ababa, Ethiopia.

The study showed that in the study area more than fifty percent of working mothers' babies were not exclusively breastfed, and the practice for EBF was below that of UNICEF and WHO recommendation, and the target set by Ethiopian National Nutrition Program. The study has indicated that formally employed women are more likely to terminate the continuation of EBF earlier compared to informally working mothers.

This study has found that cesarean section delivery, low birth weight, and insufficient milk production were significant contributors to the decrease in EBF while high breastfeeding support was associated with lower rates of EBF among working mothers.

The present study addresses an important gap in the scholarly empirical literature, as it is the first to examine the effect of mothers being employed in the formal and informal sector on their breastfeeding practice as related to duration of EBF in the study area.

5.2 Recommendations

Based on the results of the study, the following recommendations are forwarded

- Workplaces may need to provide or construct child care centers, where breastfeeding working mothers could attend to their babies and maintain EBF.
- Information on breastfeeding should be given before and after delivery to working mothers so that they are reminded of the importance of EBF.
- Breastfeeding training to spouses, family, and community at large, as well as on the importance of breast milk should be given to increase support that breastfeeding mothers need and there by maintain high prevalence of EBF.
- Employers both in the formal and informal sector need to be sufficiently informed and guided on ways to support breastfeeding working mothers.
- Conducting community-based surveys to establish a more in-depth understanding of the practices, knowledge, and duration of EBF for formal and informal working mothers is recommended.
- Working mothers in the informal work engagements should be supported more for further improvement of breastfeeding and sustainable work environments.
- Policies and strategies need to consider establishing and strengthening facilities for child care services that enable working women to combine work and breastfeeding in the work environment.
- Breastfeeding should be recognized as a norm and reinforced by facilities and policies in public places (Parenting rooms in shopping centers and markets, entertainment venues, public transports, restaurants, etc…).

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APPENDIXES

Questionnaire

Title: Factors of Exclusive Breastfeeding Practice among Women Working in the Formal and Informal Sectors: The Case of Bole & Addis Ketema Sub-Cities, Addis Ababa, Ethiopia

Dear mothers, I am a graduate student at Addis Ababa University, college of development studies, center for population studies, currently working a thesis on title factors of exclusive breastfeeding practice among women working in the formal and informal sectors. The main aim of this study will be to identify the practice, duration and determinants of exclusive breastfeeding of formal and in-formal working mothers in Bole and Addis Ketema Sub cities, Addis Ababa Ethiopia.

This study is for academic purpose only. The information you provide will be anonymous and confidential. You will not record your name anywhere on this survey. This survey only completed once, if you have already taken this survey please do not take it again. Participation is done on a completely volunteer basis. The information you provide can be viewed only by the researcher and authorized research staff members. Please circle the appropriate response for questions where options have been provided and write out the appropriate where applicable.

Yours Sincerely,

Thank you very much for your kind cooperation.

June, 2020

For any question you have you can contact by the address:

Mobile – 0910319128

Email: addisite8@gmail.com

Part I

Section 1.1: Socio - Demographic Data			
1	What is your age? (Insert last birth day)		_____
2	How many alive children do you have?		_____
	2.1	Now, the numbers of children live with you?	_____
	2.2	Now, the numbers of children live in another place?	_____
	2.3	The numbers of children passed away after birth?	_____
3	How old are you when this baby was born?		_____
4	How many people live in your house?		_____
5	What is your religion?		1) Orthodox 2) Muslim 3) Catholic 4) Protestant 5) Other (Specify)_____
6	What is your marital status?		1) Married 2) Single (Never Married) 3) Divorced 4) Widowed
7	What is the highest educational level you attained?		1) No formal education 2) Primary School 3) Secondary School 5) Diploma 6) Degree and above
8	What is your main job condition?		1) Government Employee 2)Government Development employee 3) NGO 4) Private Employee 5) Household employee 6) Self-employed 7) Employer 8) Other(Specify)_____
9	What is your main job work type?		1) Permanent employee 2) Temporary employee 3) Contract 4) Occasional 5) Other(Specify)_____
10	How often you do your main job?		1) Daily 2) Rarely 3) Seasonally 4) As obtained
11	What is the employment agreement you have with the organization/Agency?		1) Written with employment time limit 2) Written without employment time limit 3) Oral agreement with employment time limit 4) Oral agreement without employment time limit 5) No any employment agreement
12	What is the range of your family monthly income?		1) Less than 1500 birr 2) 1501 – 2500 birr 3) 2501 – 4500 birr 4) 4501 – 6500 birr 5) 6501 – 8500 birr 6) Above 8501birr
Section 1.2: Baby's Basic Information			
1	What is your last baby's gender?		1) Male 2) Female
2	How old is your last baby?		_____
Section 1.3: History of Pregnancy			
1	Have you ever been pregnant before?		1) Yes 2) No

2	Did you attend antenatal clinic during this pregnancy?	1) Yes 2) No
3	If yes, where did you receive antenatal care for this pregnancy?	1) Home 2) Public Health Institutions 3) Private Health Institutions 4) Both 5) Other _____
4	If no, why?	_____
5	If yes at what age of pregnancy did you start attending antenatal clinic (enter age of pregnancy in weeks)?	1) _____ 2) Don't know
6	Gestational age(at birth)	1) Less than 37 weeks 2) 37 to 42 weeks 3) More than 42 weeks
7	How many times did you receive antenatal care during this pregnancy?	1) _____ 2) Don't Know
8	Have you ever received breastfeeding counseling during these antenatal visits?	1) Yes 2) No
9	If yes, what kind of information where you given on breastfeeding?	1) Benefits of breastfeeding 2) Importance of breastfeeding soon after delivery 3) Importance of exclusive breastfeeding for six months after birth
10	Who gave you this information?	1)Health Workers 2) Health information posters at the health institutions 3) Brochures distributed at health institutions 4) Other (Specify) _____
Section 1.4: Postnatal History		
1	Where did you deliver your baby?	1) Home 2) Health Center 3) Private Hospital/Clink 4) Public Hospital 5) Other (Specify)_____
2	What is the method of childbirth?	1) Normal Vaginal 2) Caesarean Section 3)Other (Specify)_____
3	What is your child birth weight	1) < 2500g 2) 2500 – 4000 g 3) > 4000g
	If no, what was his/her volume at birth?	1) Low 2) Medium 3) Large
4	Is this your first baby?	1) Yes 2) No
5	If no, did you breastfeed your previous child/children?	1) Yes 2) No
Section 1.5: Breastfeeding Knowledge		
1	After your baby was born, how long did you stay in the hospital/health center? (If you born in home skip to question no 4)	1) < 1 day 2) 1 day 3) 2 days 4) 3 days 5) >3 days 6) Don't know
2	Did you receive any help, while in health institutions, from staffregarding feeding your baby?	1) Yes 2) No
3	If yes, how useful was the help that you received with feeding your baby?	1) Very useful 2) useful 3) Not useful 4) Not very useful
4	How soon after birth did you try to breastfeed your baby for the first time?	1) Less than one hour after birth 2) 1-3 hours after birth 3) 4-11 hours after birth 4) 12-23 hours after birth 5) 24 hours or more after birth 6) Don't know/don't remember
5	Why should the baby be put on the breast within the first hour immediately after birth? (Circle all applicable responses)	1) To create a strong bond between mother and baby 2) To stimulate milk production 3) Baby is hungry after the birth process 4) To give the baby the first yellowish milk for protection 5) I do not know 6) Any other (specify) _____
6	In the first two days after your baby was born, what was your baby fed?	1) Breast milk at all feedings 2) Combination of milk and other fluid 3) Formula at all feedings 4) Other please explain _____ 5) Don't know
7	Was your baby fed anything other than breast milk after you started breastfeeding?	1) Yes 2) No 3) Don't know/don't remember
8	If yes, what was fed to your baby?	1) Formula 2) Cow milk 3) 'Atmit or Abish' 4) Other please specify_____ 5) Don't know
9	When you had your baby, did you have any medical condition that required avoidance of breastfeeding?	1) Yes 2) No
10	Is there any importance in feeding a baby the first yellowish milk	1) Yes 2) No
11	If yes, why do you think so? Circle all that apply	1) Provides babies with substances that help to fight diseases 2) Provides babies with protection against infections and illnesses 3) The baby will not feel hungry because it is heavy 4) Don't know 5) Other (Specify) _____
Section 1.6: Duration of Breastfeeding		
1	How often should a baby be breastfed per day on average for the past six months?	1) Less than 8 times 2) From 8 to 12 times3) More than 12 times 4) Do not know 5) Other (specify) _____
2	Baby should be allowed to breastfeed for at least 10- 20 minutes for each feeding?	1) Yes 2) No
3	How long was the child exclusively breastfeed?	1) One month 2) Two month 3) Three months 4) Four months 5) Five month 6) Six month
4	Do you intend to give your baby formula milk in the first six months of life?	1) Yes 2) No

5	What age is appropriate to start giving solid foods to a baby?	1) Less than one month 2) Between 2-3 months 3) Between 4-5 months 4) 6 months 5) Above six months
Section 1.7: Support from Family and Employer		
	For employed mothers only	
1	How many hours do you work in a day?	1) Less than six hours 2) 6-8 hours 3) 8-10 hours 4) 10-12 hours 5) More than twelve hours
2	Were you given maternity leave when you delivered your baby?	1) Yes 2) No
3	If yes, how long was the maternity leave?	1) One month 2) Two month 3) Three month 4) Four month 5) Over four months
4	Does your workplace provide a private place to breastfeed?	1) Yes 2) No
5	Does your workplace provide a refrigerator to store breast milk?	1) Yes 2) No
	For self - employed mothers only	
6	After delivery, for how many days you leave from your work?	_____(Insert in months)
7	Reasons for leaving your work?	1)For rest 2) For looking the child 3) For breastfeeding 4) For not having support 5) Other (specify)_____
	For all mothers engaged in all types of work	
8	Has your spouse & your family members been supportive of you breastfeeding your baby?	1) Yes 2) No
9	If yes, does they	1) Offer help with chores to ensure you get enough rest to breast feed 2) Encourage you to breastfeed 3) Ensure you have adequate nutrition to enable you breast feed 5) Other(Please specify) _____
10	Have your friends and surrounding communities been helpful in assisting you to breastfeed your child?	1) Yes 2) No
11	Is the environment you dwell comfortable to breastfeed your baby?	1) Yes 2) No
12	Is the culture of the community you dwell encourages you to breastfeed your baby?	1) Yes 2) No

Part II

Section 1.1: Barriers for continuation of exclusive breastfeeding among working mothers.

If you breastfed your infant for any length of time during the first weeks after delivery, what were the barriers prevented you in continuing exclusive breastfeeding? Check and tick all that apply

No	Variables	Yes	No
1	Not enough breast milk production		
2	Concern that baby will not receive adequate nutrition		
3	Stressful		
4	Time consuming		
5	Concern that breastfed babies are smaller compared to formula fed babies		
6	Returned to work		
7	Embarrassment		
8	Painful nipples		
9	Poor latching on		
10	Use of medications harmful to the baby by the mother		
11	Failure in the Previous breastfeeding experience		
12	Lack of child care services in the work place		
13	Lack of information about whom to contact for help when faced with challenges with breastfeeding		
14	Lack of information that exclusive breastfed babies have less chances of developing different diseases compared to formula feeding infants.		
15	Lack of information that breastfeeding mothers have less risk of developing different diseases.		

Thank you very much for your participation

በአዲስ አበባ ከተማ አስተዳደር በቦሌና በአዲስ ከተማ ክፍለ ከተማ በተመረጡ የጤና ተቋማት ለሚደረግ ጥናት የተዘጋጀ መጠይቅ

ውድ እናቶች ፣ እኔ አዲሱ ተስፋዬ የአዲስ አበባ ዩኒቨርሲቲ ፣ የህዝብ ጥናት ማዕከል ፣ የድህረ ምረቃ ተማሪ ስሆን ፤ አሁን "Factors of Exclusive Breastfeeding Practice among Women Working in the Formal and Informal Sectors: The Case of Bole & Addis Ketema Sub-Cities Addis Ababa, Ethiopia" በሚል ርዕስ የመመረቂያ ጽሑፌን እያዘጋጀሁ እገኛለሁ፡፡የጥናቱ ዋና ዓላማ በአዲስ አበባ ከተማ አስተዳደር በቦሌና በአዲስ ከተማ ክፍለ ከተማ በመደበኛ እና በኢ - መደበኛ የስራ ዘርፍ ሲሰሩና እየሰሩ የሚገኙ እናቶች ከወሊድ በኃላ ለስድስት ወራት ጡት ብቻ የማጥባት ልምምዳቸውን፣ለማጥባት የሚወስድባቸውን የቆይታ ግዜ እና እንዳያጠቡ የሚያግዷቸውን ምክንያቶች መለየት ነው፡፡

ይህ ጥናት ለትምህርት ፍጆታ ብቻ የሚውል ሲሆን ፤ እርሰዎ የሚሰጡት መረጃ ሚስጢራዊነቱ የተጠበቀ ነው፡፡ተሳታፊነትዎ ሙሉ በሙሉ በፍቃደኝነት ላይ የተመሠረተ ነው፡፡ በዚህ መጠይቅ ስሞን በማንኛውም ቦታ መመዝገብ አይጠበቅብዎትም፡፡ይህንን መጠይቅ እንዲሞሉ የሚጠበቅብዎት አንድ ግዜ ብቻ ነው ፤ ምን አልባት ቀድመው ሞልተው ከሆነ እባክዎ ደግመው በመውሠድ አይሙሉ፡፡የሚሰጡት መረጃ ሊታይና ሊስተዳደር የሚችለው በዋናው የጥናቱ ባለቤትና ፍቃድ ባላቸው የማዕከሉ የጥናት ክፍል አባላት ብቻ ነው፡፡ ስለዚህ ፤ ተገቢነው የሚሉትን መልስ በባዶ ቦታው በመሙላት እና ከተቀመጡት አማራጮች መርጦ በማክበብ እንዲመልሱና ለጥናቱ የራስዎን አሻራ እንዲያሳርፉ በታላቅ አክብሮትና ትህትና እጠይቃለሁ፡፡

አመሠግናለሁ!

ጥያቄ ካለዎ ይህን አድራሻ መጠቀም ይችላሉ

ሞባይል: 0910319128

ኢሜይል: addisite8@gmail.com

ክፍል 1

ክፍል 1.1፡የሥነ - ህዝብመረጃ			
1	ዕድሜዎ ስንት ነው? (የመጨረሻውን ልደት ያስገቡ)		_____
2	በህይወት የወለዷቸው ስንት ልጆች አለዎት?		_____
	2.1	አሁን ከርሶዎ ጋር የሚኖሩት ስንት ናቸው?	_____
	2.2	አሁን በሌላ ቦታ የሚኖሩ ስንት ናቸው?	_____
	2.3	ከተወለዱ በኃላ በሞት የተለዩ ካሉ ስንት ናቸው?	_____
3	የመጨረሻው ልጅ ሲወለድ ዕድሜዎ ስንት ነበር?		_____
4	ከእርሶዎ ጋር የሚኖሩ የቤተሰብ አባላት ብዛት ስንት ናቸው?		_____
5	የየትኛው ሃይማኖት ተከታይ ነዎት?		ነ) ኦርቶዶክስ ተዋሕዶ 2) ሙስሊም 3) ፕሮቴስታንት 4) ካቶሊክ 5) ሌላካለይገለፀ _____
6	የጋብቻ ሁኔታዎ?		ነ) ያገባች 2) ያላገባች 3) የፈታች 4) ባል የሞተባት 5) ሌላካለይግለፀ_____
7	የትምህርት ደረጃዎ?		ነ) ያልተማረ 2) መሠረተ ትምህርት 3) የመጀመሪያ ደረጃ 4) ሁለተኛደረጃ 5) ዲፕሎማ 6) ዲግሪ 7) ማስተርስና ከዚያ በላይ
8	የዋነኛ ሥራዎ የቅጥር ሁኔታ ምንድን ነው?		ነ) የመንግስት ተቀጣሪ 2)የመንግስት ልማት ድርጅት ተቀጣሪ 3) መንግስታዊ ላልሆነ ድርጅት ተቀጣሪ (NGO) 4) የግል ድርጅት ተቀጣሪ 5) የግለሠብ ቤት ተቀጣሪ 6) በግል ሥራ የሚተዳደሩ 7)ቀጣሪ 8) ሌላ ካለ ይግለፁ _____
9	የዋነኛ ሥራዎ የቅጥር ዓይነት ምንድን ነው?		ነ) ቋሚ ተቀጣሪ 2) ጊዜያዊ ተቀጣሪ 3) ኮንትራት 4) እንደተገኘ 5) ሌላ ካለ ይግለፁ _____
10	ዋነኛ ሥራዎን የሚሠሩት በየስንት ግዜ ነው?		ነ)በየቀኑ] 2) አልፎ አልፎ 3) ወቅትን ጠብቆ 4) እንደተገኘ
11	ከድርጅቱ /ከስራመስኩ/ጋር ያለዎት የቅጥር ስምምነት ምን ዓይነት ነው?		ነ)በጽሁፍ ሆኖ የቅጥር የግዜ ገደብ ያለው 2) በጽሁፍ ሆኖ የቅጥር የግዜ ገደብ የለውም 3) የቃል ስምምነት የግዜ ገደብ ያለው 4) የቃል ስምምነት የግዜ ገደብ የሌለው 5) ድርጅቱ/የስራ መስኩ/ የግሌ ስለሆነ የቅጥር ስምምነት የለኝም 6)ምንም ዓይነት የቅጥር ስምምነት የለኝም
12	ጠቅላላ ወርሐዊ የቤተሰቦዎ ገቢ ምን ያህል ነው?		ነ) ከ1500 ብር በታች 2) 1501 – 2500 ብር 3) 2501– 4500 ብር 4) 4501 – 6500 ብር 5) 6501 – 8500 ብር 6) ከ8500 ብርበላይ
ክፍል 1.2፡የህፃኑ መሠረታዊ መረጃዎች			
1	የመጨረሻ ልጅዎ ፆታ ምንድን ነው?		ነ) ወንድ 2) ሴት
2	የመጨረሻ ልጅዎ ዕድሜ ስንት ነው? /በወር/		_____
ክፍል 1.3፡ የቅድመ ወሊድ ሁኔታ			
1	ከዚህ በፊት ነብሰ ጡር ሆነው ያውቃሉ?		ነ) አውቃለሁ 2) አላውቅም
2	በእርግዝናዎ ወቅት የቅድመ ወሊድ ክትትል አድርገዋል?		ነ) አድርጌአለሁ 2) አላደረኩም
3	ክትትል አድርገው ከሆነ፣አገልግሎቱን የት ነው ያገኙት?		ነ) መኖሪያ ቤት 2) የህዝብ ጤና ተቋም 3) የግልጤናተቋም/ክሊኒክ 4) የህዝብና የግል ጤና ተቋማት 5) ሌላካለይገለፅ _____
4	ክትትል ካላደረጉ ለምን?		_____
5	የቅድመ ወሊድ ክትትል የጀመሩት በየትኛው የእርግዝና ወርዎት ነው?		ነ) ____ (ወሩን ያስገቡ) 2) አላውቅም/አላስታውስም
6	የእርግዝና ቆይታዎ ምን ያህል ነበር?		ነ) ከ 37 ሳምንታት በታች 2) ከ 37 - 42 ሳምንታት 3) ከ 42 ሳምንታት በላይ
7	በእርግዝናዎ ወቅት ስንት ግዜ የቅድመ ወሊድ ክትትል አድርገዋል?		ነ) _____ 2) አላውቅም/አላስታውስም
8	በቅድመ ወሊድ ክትትሎዎ ግዜ፤ጡት የማጥባት የምክር አገልግሎት ወስደው ያውቃሉ?		ነ) አውቃለሁ 2) አላውቅም

9	ወስደው ካወቁ ምን ዓይነት መረጃ ተሰጥቶዎት ነበር? /ተገቢ የሆኑትን መልሶች ሁሉ ያክብቡ/	ነ) ጡት የማጥባት ጥቅሞች 2) ከወሊድ በኃላ ወዲያውኑ ጡት ማጥባት ያለውን ጥቅም 3) ከወሊድ በኃላ ጡት ብቻ ለስድስት ወር ማጥባት ያለውን ጥቅም
10	ይህንን መረጃ እንዴት አገኙት?	ነ) ከጤና ባለሙያዎች 2) በጤና ተቋማት ከተለጠፉ የጤና መረጃዎች 3) በጤና ተቋማት ከተበተኑ ብሮሸሮች 4) ሌላ ካለ ይግለፁ _____
ክፍል 1.4: የድህረ ወሊድ ሁኔታ		
ነ	ልጆዎን የትነው የተገላገሉት?	ነ) መኖሪያ ቤት 2) ጤና ተቋም 3) የግል ሆስፒታል/ክሊኒክ 4) የመንግስት ሆስፒታል 5) ሌላ ካለ ይግለፁ _____
2	ሕፃኑ የተወለደበት ሁኔታ/ዘዴ?	ነ) በማሕፀን በር/በምጥ 2) በቀዶ ጥገና
3	3.ነ ልጅዎ ሲወለድ የነበረው ክብደት?	ነ) 2500ግ በታች 2) 2500 – 4000 ግ 3) 4000 ግበ ላይ
	3.2 ክብደቱን ካላወቁ ሲወለድ የነበረው መጠን?	ነ)ዝቅተኛ 2) መካከለኛ 3) ከፍተኛ
4	ይህ/ይቺ ሕፃን የመጀመሪያ ልጅዎ ነው/ናት ?	ነ) አዎ 2) አይደለም
5	ካልሆነ ከዚህ በፊት ልጆዎን/ልጆቾዎን ጡት አጥብተው ያውቃሉ?	ነ) አውቃለሁ 2) አላውቅም
ክፍል 1.5፡ ጡት የማጥባት ዕውቀት		
ነ	ልጆዎን ከተገላገሉ በኃላ በጤና ተቋሙ ምን ያህል ቀን ቆይተዋል? (በቤቶዎ ከወለዱ ወደ ጥያቄ ቁጥር 4 ይሻገሩ)	ነ) ከአንድ ቀን በታች 2) አንድ ቀን ብቻ 3) ሁለት ቀናት 4) ሶስት ቀናት 5) ከሶስት ቀናት በላይ 6) አላውቅም
2	በጤና ተቋም ቆይታዎ እንዴት ማጥባት እንዳለብዎ ከጤና ባለሙያዎች እገዛ አግኝተዋል?	ነ) አግኝቻለሁ 2) አላገኘሁም
3	ያገኙት እገዛ ምን ያህል ጠቃሚ ነው?	ነ) በጣም ጠቃሚ 2) ጠቃሚ 3) ጠቃሚ አይደለም 4)በጣም ጠቃሚ አይደለም
4	ከወሊድ በኃላ ወዲያው ጡት ለማጥባት ምን ያህል ሰዓት ወሰደቦት?	ነ) ከአንድ ሰዓት ያነሰ 2) ከ ነ – 3 ሰዓት 3) ከ 4 – ነነ ሰዓታት 4) ከ 12 – 23 ሰዓታት 5) 24 ሰዓታት እና ከዚያ በላይ 6)አላውቅም
5	ህፃኑ/ኗ ከወሊድ በኃላ በመጀመሪያው ሰዓት ወዲያውኑ ጡት እንዲጠባ/እንድጠባ የሚደረገው ለምንድ ነው? /ተገቢ የሆኑትን መልሶች ሁሉ ያክብቡ/	ነ) በእናቱና በሕፃኑ መካከል ጥብቅ የሆነ ግንኙነት ለመፍጠር 2) የጡት ወተት እንዲመረት ስለሚያበረታታ 3) ሕፃኑ ከወሊድ ሂደት በኃላ ስለሚርበው 4) እንገር ወተት መስጠት ሕፃኑን ከተለያየ በሽታ ስለሚከላከል 5) አላውቅም 6) ሌላ ካለ ይግለፁ _____
6	ልጅዎ ከተወለደ ከሁለት ቀናት በኃላ የሚመገበው ምን ነበር?	ነ) የእናት ጡት ብቻ 2) ወተት እና ሌላ ፈሳሽ ምግብ 3) ፎርሙላ ወተት ብቻ 4) ሌላ ካለ ይግለፁ _____ 5) አላውቅም
7	በመጀመሪያዎቹ ስድስት ወራት ልጆዎ ጡት ከጠባ በኃላ ተመግቦ ያውቃል?	ነ) አዎ 2) የለም 3) አላውቅም/አላስታውስም
8	ለጥያቄ ቁጥር 7 መልሶዎ አዎ ከሆነ፣ምን ነበር ሲመግቡት የነበር?	ነ) ፎርሙላ ወተት 2) የላም ወተት 3) አጥሚት/አብሽ 4) ሌላ ካለ ይግለፁ _____ 4) አላውቅም/አላስታውስም
9	ልጆዎ እንደተወለደ ለመጀመሪያዎቹ ስድስት ወራት፣ከጡቶዎ ባሻገር ሌላ ምግብ እንዲመገብ ያስፈለገበት የጤና ሁኔታ ነበረብዎ?	ነ) አዎ 2) የለም
10	ዕንገር ወተት ለልጆዎ ማጥባቶ ጥቅም አለው ብለው ያስባሉ?	ነ) አዎ ጥቅም አለው 2) ጥቅም የለውም
ነነ	ለጥያቄ ቁጥር 10 መልሶዎ አዎ ጥቅም አለው ከሆነ፣ለምን ይመስልዎታል? /ተገቢ የሆኑትን መልሶች ሁሉ ያክብቡ/	ነ) ልጆችን ከበሽታ ለመከላከል የሚረዳ ንጥረ ነገር ስለሚሰጣቸው 2) ልጆችን ተላላፊ ከሆኑ ህመሞችና በሽታዎች ስለሚጠብቃቸው 3) ሕፃኑ የረሐብ ስሜት እንዳይሰማው ስለሚያደርግ 4) አላውቅም 5) ሌላ ካለ ይግለፁ _____
ክፍል 1.6: የጡት ማጥባት የቆይ ታግዜ		
ነ	ልጆዎ ከተወለደ/ች ጀምሮ ላለፉት ስድስት ወራት በየቀኑ በአማካኝ ምን ያህል ግዜ ጡት ይጠባ/ትጠባ ነበር?	ነ) ከ 8 ግዜ በታች 2) ከ8 እስከ ነ2 ግዜ 3) ከነ2 ግዜ በላይ 3) አላውቅም 4) ሌላ ካለ ይግለፁ _____
2	ልጆዎ በትንሹ ከ 10-20 ደቂቃ እንዲጠባ ሊደረግ ይገባል?	ነ) አዎ 2) አይደለም
3	የእናት ጡት ብቻ ምን ያህል ግዜ ለሕፃኑ/ኗ መግበው ያውቃሉ?	ነ) ለአንድ ወር 2) ለሁለት ወር 3) ለሶስት ወር 4) ለአራት ወር 5) ለአምስት ወር 6) ለስድስት ወር
4	በየትኛው የሕፃኑ/ኗ ዕድሜ ነው ፈሳሽ ያለሆኑ ምግቦችን መጀመር ትክክለኛ የሚሆነው?	ነ) ከአንድ ወር በታች 2) ከ 2 - 3 ወራት 3) ከ 4 – 5 ወራት 4) ከ 6 ወራት በታች 5) ከ 6 ወራት በላይ
ክፍል 1.7፡ከቤተሰብ ፣ ከቀጣሪዎች ፣ ከጓደኞች ፣ ከማሕበረሰብ እና ከሚኖሩበት አካባቢ ለእናቶች የተደረገ ድጋፍ		
ተቀጣሪ ለሆኑ እናቶች		
ነ	በቀን ውስጥ ምን ያህል ሰዓት ይሰራሉ?	ነ) ከ 6 ሰዓታት በታች 2) 6 – 8 ሰዓታት 3) 8 – ነ0 ሰዓታት 4) ነ0 – ነ2 ሰዓታት 5) ከ ነ2 ሰዓታት በላይ
2	ከስራ ቦታዎ የወሊድ ፍቃድ አግኝተዋል?	ነ) አዎ 2) የለም
3	ለጥያቄ ቁጥር 2 መልሶዎ አዎ ከሆነ፣የወሊድ ፍቃዱ ምን ያህል ወራት ነበር?	ነ) ነ ወር 2) 2 ወራት 3) 3 ወራት 4) 4 ወራት 5) ከ 4 ወራት በላይ
4	በስራ ቦታዎ ነፃ የማጥቢያ ቦታ ተሰጥቶዎታል?	ነ) አዎ 2) የለም
5	መስሪያ ቤቶዎ የጡትዎትን ወተት የሚያስቀምጡበት ማቀዝቀዣ አቅርቦሎዎታል?	ነ) አዎ 2) የለም
የግል ስራ ለሚሰሩ እናቶች		
6	ከወሊድ በኃላ ምን ያህል ግዜ ሥራ አቆሙ?	_____ (በወር ይግለፁ)
7	ስራ ያቆሙት ለምንድ ነው?	ነ) ለእረፍት 2) ህፃን እንክብካቤ 3) ጡት ለማጥባት 4)አጋዥ ስለሌለኝ 6) ሌላ ካለ ይግለፁ_____
በሁሉምስራዘርፍለተሰማሩእናቶች		
8	ባለቤቶዎ እና የቤተሰብ አባላት ልጆዎን ጡት እንዲያጠቡ ድጋፍ ያደርጉልዎታል?	ነ) አዎ ያደርጉልኛል 2) አይ አያደርጉልኝም
9	ለጥያቄ ቁጥር 8 መልሶዎ አዎ ከሆነ፣በምን ሁኔታ ድጋፍ ያደርግልዎታል?	ነ) የቤት ውስጥ ሥራ በማገዝ ልጆዎን በቂ ግዜ ወስደው እንዲያጠቡ ይረድዎታል 2) ጡት ለማጥባት እንዲረዳዎት ተመጣጣኝ ምግብ ማግኘት እንዳለብዎ ያረጋግጣሉ 3) ጡቴን እንዳጠባ ያበረታቱኛል 4) ጡቴን ለማጥባት ችግር ሲያጋጥመኝ እርዳታ እንዳገኝ ያበረታቱኛል 5) ሌላ ካለይገለፀ_____
ነ0	ጓደኞቾዎ እና የአካባቢዎ ማሕበረሰብ ጡት እንዲያጠቡ ድጋፍ ያደርጉልዎታል?	ነ) አዎ ያደርጉልኛል 2) የለም አያደርጉልኝም
ነነ	የሚኖሩበት አካባቢ ልጆዎን ለማጥባት የተመቻቸ ሁኔታ አለው ብለው ያስባሉ?	ነ)አለው 2) የለውም
ነ2	የሚኖሩበት ማሕበረሰብ ባህል ልጆዎን ጡት እንዲያጠቡ የሚያበረታታዎ ነው?	ነ) አዎ 2) አይደለም

ክፍል 2

ክፍል 2.1: በመደበኛ እና በኢ መደበኛ የሥራ ዘርፍ የሚሰሩ እናቶች ከወሊድ በኃላ ለመጀመሪያዎቹ ስድስት ወራት ጡታቸውን ብቻ በቀጣይነት እንዳያጠቡ የሚከለክሉ ምክንያቶች፡፡ ልጅዎን ከወሊድ በኃላ ለመጀመሪዎቹ ሳምንታት ማጥባት ከጀመሩ በኃላ እስከ ስድስት ወር በቀጣይነት ጡትዎን ብቻ እንዳያጠቡ የከለከለዎት ምክንያቶች ምንድን ናቸው? /ተገቢ የሆኑትን መልሶች ሁሉ 'X'ምልክት ያድርጉ/

ተ.ቁ	Variables	አዎ	አይደለም
1	የጡት ወተት በበቂ አለመኖር		
2	ሕፃኑ በቂ ምግብ ከወተት ብቻ ላያገኝ ይችላል የሚል ስጋት መኖር፡፡		
3	በንሮ ውጥረት ምክንያት		
4	ጡት ማጥባት ግዜ አባካኝ መሆን		
5	የእናት ጡት የሚጠቡ ሕፃናት ፎርሙላ ወተት ከሚጠቡ ሕፃናት ሲነፃፀሩ ያለመፋፋት ስጋት መኖር፡፡		
6	ወደ ሥራ መመለስ		
7	ጡት ለማጥባት ሰው ማፈር		
8	የጡት ጫፍ ሕመም		
9	የጡት አጠባብ ዘዴ በደንብ አለማወቅ		
10	እናት የሕፃኑን ጤና የሚጎዳ ምግብ እና መድኃኒት መጠቀም		
11	ጡት የማጥባት ልምድ አለመኖር		
12	በስራ ቦታ የሕፃናት ማቆያ አገልግሎት አለመኖር		
13	ከጡት ማጥባት ጋር የተያያዙ ችግሮች ሲፈጠሩ ማንን ለእርዳታ ማናገር እንደሚያስፈልግ መረጃ አለመኖር		
14	የእናት ጡት ብቻ የሚጠቡ ሕፃናት ፎርሙላ ወትት ከሚጠቀሙ ሕፃናት ለተለያዩ በሽታዎች የመያዝ እና በኃላ በሒይወታቸው የማደግ ዕድሉ ዝቅተኛ መሆኑን ግንዛቤ አለመኖር፡፡		
15	ጡት የሚያጠቡ እናቶች ለተለያዩ በሽታዎች አነስተኛ የመጋለጥ ዕድል እንዳላቸው ግንዛቤ አለመኖር፡፡		

ግዜዎን ሰጥተው ምላሽ ስለሰጡ በጣም አመሰግናለሁ!