

**YANGON UNIVERSITY OF ECONOMICS**  
**MASTER OF PUBLIC ADMINISTRATION PROGRAMME**

**A STUDY ON AN EXCLUSIVE BREASTFEEDING  
PRACTICE AMONG WORKING MOTHERS IN MYANMAR  
(CASE STUDY: THINGANGYUN TOWNSHIP)**

**NEE SIN THWET AYE**  
**EMPA - 40 (16<sup>th</sup> BATCH)**

**DECEMBER, 2019**

**YANGON UNIVERSITY OF ECONOMICS**  
**MASTER OF PUBLIC ADMINISTRATION PROGRAMME**

**A STUDY ON AN EXCLUSIVE BREASTFEEDING PRACTICE**  
**AMONG WORKING MOTHERS IN MYANMAR**  
**(CASE STUDY: THINGANGYUN TOWNSHIP)**

A thesis submitted as a partial fulfillment towards the requirements for the degree of  
Master of Public Administration (MPA)

**Supervised by:**

Dr. Pwint Phyu Aung  
Associate Professor  
Department of Applied Economics  
Yangon University of Economics

**Submitted by:**

Nee Sin Thwet Aye  
Roll No. 40  
EMPA (16<sup>th</sup> Batch)  
(2017 - 2019)

**December, 2019**

**YANGON UNIVERSITY OF ECONOMICS**  
**MASTER OF PUBLIC ADMINISTRATION PROGRAMME**

This is to certify that this thesis entitled “**A STUDY ON AN EXCLUSIVE BREASTFEEDING PRACTICE AMONG WORKING MOTHER IN MYANMAR (CASE STUDY: THINGANGYUN TOWNSHIP)**” submitted as a partial fulfillment towards the requirements for the degree of Master of Public Administration has been accepted by the Board of Examiners.

**BOARD OF EXAMINERS**

1. Professor Dr. Tin Win  
Rector  
Yangon University of Economics  
(Chief Examiner)
2. Professor Dr. Ni Lar Myint Htoo  
Pro-Rector  
Yangon University of Economics  
(Examiner)
3. Professor Dr. Phyu Phyu Ei  
Programme Director and Head of Department  
Department of Applied Economics  
Yangon University of Economics  
(Examiner)
4. Professor Dr. Su Su Myat  
Department of Applied Economics  
Yangon University of Economics  
(Examiner)
5. Daw Khin Chaw Myint  
Associate Professor (Retired)  
Department of Applied Economics  
Yangon University of Economics  
(Examiner)

**December, 2019**

## **ABSTRACT**

Breastfeeding is beneficial for mothers and their infants. However, combining breastfeeding and working outside the home can be challenging for working mothers. The aim of this study is to analyze practices of working mothers towards exclusive breastfeeding in Thingangyun Township. To achieve these objectives, a quantitative case study design and descriptive method are used for this study. The structured questionnaires were used gathering data from (150) working mothers from Thingangyun Township. This study found that even though knowledge and practice of exclusive breastfeeding was high among working mothers in the study population, exclusive breastfeeding was not always practiced according to World Health Organization recommended practice of exclusive breastfeeding. Despite high knowledge and attitude of exclusive breastfeeding, in practice, mothers introduced water and other liquid before six months of age as most of them have to go back to work place. Workplace environment also plays a positive role to promote exclusive breastfeeding. It also found that most of the working places do not support for exclusive breastfeeding for working mothers and can lead to difficulties in workplace relating to breastfeeding. Based on the survey findings, the main barriers to an exclusive breastfeeding are lack of proper infant feeding practices and lack of supportive environment.

## ACKNOWLEDGEMENTS

First and foremost, I would like to express my deep gratitude to Professor Dr. Tin Win (Rector) and Professor Dr. Ni Lar Myint Htoo (Pro-Rector) of Yangon University of Economics for their kind permission to undertake this thesis.

I am also grateful to Professor Dr. Kyaw Min Htun, Pro-Rector (Retired) of Yangon University of Economics. My special thanks also go to Professor Dr. Phyu Phyu Ei, Programme Director and Head of Department of Applied Economics, Professor Dr. Cho Cho Thein, Head of Department of Economics and Dr. Zin Zin Naing, Associate Professor, Department of Applied Economics, Yangon University of Economics. Moreover, I would like to extend my greatest respect and heartfelt gratitude to my thesis supervisor Dr. Pwint Phyu Aung, Associate Professor, Department of Applied Economics, Yangon University of Economics for her encouragement, helpful suggestions, the intellectual guidance, valuable advices and editing this thesis paper. Without her, I will not be possible to complete this thesis.

I also deeply thank to board of examiners taking their time out to talk to me and gave their guidance about my thesis. My sincere thanks to all the professors and lecturers who have provided their greatest effort in teaching subjects during the study time.

I wish to acknowledge my thankfulness to the senior management team of Burnet Institute, for allowing me to study EMPA course and appreciate the moral support and encouragement of my team members. I offer deep gratitude and gratefulness to all respondents who gave me response answers for this thesis. I am also thankful to each and individual who has given me kind help throughout the compilation period of my thesis.

Last but not least, I would like to thank my family members, especially my daughter, for being patient with me and understand me during this time.

# TABLE OF CONTENTS

	<b>Page</b>
<b>ABSTRACT</b>	<b>i</b>
<b>ACKNOWLEDGEMENTS</b>	<b>ii</b>
<b>TABLE OF CONTENTS</b>	<b>iii</b>
<b>LIST OF TABLES</b>	<b>v</b>
<b>LIST OF FIGURES</b>	<b>vi</b>
<b>LIST OF ABBRIVIATIONS</b>	<b>vii</b>
<b>CHAPTER 1 INTRODUCTION</b>	<b>1</b>
1.1 Rationale of the Study	1
1.2 Objective of the Study	4
1.3 Method of Study	4
1.4 Scope and Limitations of the Study	4
1.5 Organization of the Study	5
<b>CHAPTER 2 LITERATURE REVIEW</b>	<b>6</b>
2.1 Breastfeeding in Historical Context	6
2.2 Theories Related to Breastfeeding Practices	8
2.3 The State of Breastfeeding Worldwide	10
2.4 Exclusive Breastfeeding Trends in Developing World	12
2.5 Benefits of Breastfeeding	14
2.6 Cost of Not Breastfeeding in Southeast Asia	17
2.7 Review on Previous Studies	21
<b>CHAPTER 3 MOTHERS' BREASTFEEDING TO BABIES IN MYANMAR</b>	<b>23</b>
3.1 Initiation of Breastfeeding	23
3.2 Breastfeeding Practice in Myanmar	23
3.3 Breastfeeding Working Mothers in Myanmar	29
3.4 Level of Child Malnutrition	32

<b>CHAPTER 4</b>	<b>SURVEY ANALYSIS</b>	<b>33</b>
4.1	Survey Profile	33
4.3	Survey Design	34
4.4	Survey Results	35
<b>CHAPTER 5</b>	<b>CONCLUSION</b>	<b>51</b>
5.1	Findings	51
5.2	Recommendations	54
<b>REFERENCES</b>		
<b>APPENDICES</b>		

## LIST OF TABLES

<b>Table No.</b>	<b>Title</b>	<b>Page</b>
2.1	Global Prevalence of EBF among Infants Younger than 6 Months	13
2.2	Breastfeeding Rates (%) of the Seven Countries in the Southeast Asia Region	18
3.1	Nutritional Statuses of Children	32
4.1	Data Summary for Demographic Characteristics	35
4.2	Understanding about Exclusive Breastfeeding	38
4.3	Delivery Type	41
4.4	Attitude towards Breastfeeding	42
4.5	Feeding in a Public Place	43
4.6	Plan to Breastfeed Prior to Delivery	44
4.7	First Time Feeding of Breast Milk	45
4.8	Plan to Feed in the First Six Month	45
4.9	First Feed for the New Born Baby	46
4.10	Breastfeeding during Maternity Leave Period	46
4.11	Breast Feed after Returning to Work	47
4.12	Efficient Support from Working Environment for EBF	47
4.13	Difficulties in Workplace Relating to EBF	49

## LIST OF FIGURES

<b>Figure No.</b>	<b>Title</b>	<b>Page</b>
2.1	Primary Sources Influencing on Breastfeeding Self-Efficacy	9
3.1	Breastfeeding Practices by Age	24
3.2	Becoming Breastfeeding Friendly (BBF): Five-Meeting Process	26

## **LIST OF ABBREVIATIONS**

ASEAN	Association of South East Asian Nations
BBF	Becoming Breastfeeding Friendly
BFHI	Baby Friendly Hospital Initiative
EBF	Exclusive Breastfeeding
GDP	Gross Domestic Product
ILO	International Labour Organization
IYCF	Infant and Young Child Feeding
MDHS	Myanmar Demographic and Health Survey
MICS	Multiple Indicators Cluster Survey
MOHS	Ministry of Health and Sports
NGOs	Non-governmental Organizations
NNC	National Nutrition Center
SCT	Social Cognitive Theory
SIDS	Sudden Infant Death Syndrome
SUN CSA	Secretariat of the Scaling up Nutrition Civil Society Alliance
UNICEF	United Nations International Children's Emergency Fund
USD	United States Dollar
WHO	World Health Organization
YSPH	Yale School of Public Health

# CHAPTER I

## INTRODUCTION

### 1.1 Rationale of the Study

Breast milk is the natural food for newborn. Breast milk contains the ideal nourishment for infants and provides a variety of antibodies and immune cells for disease prevention. Breastfeeding offers all children the healthiest begin in lifestyles. Children who have been breastfed perform better on intelligence assessments, are less in all likelihood to be overweight or obese, and less at risk of diabetes later in life. Mothers who breastfeed also lessen the chance of developing breast and ovaria cancers (Victoria et al., 2016).

Breastfeeding is a substantial public health strategy for improving infant and child morbidity and mortality, enhancing maternal morbidity, and assisting to control of society, the World Health Organization (WHO) and UNICEF recommend that every infant should be health care costs. To ensure the healthy growth and development of kids and to decorate their potential to face up to disease, study and come to be economically effective variety completely breastfed for the primary six months of life, with breastfeeding continuing for up to two years of age or longer. Exclusive breastfeeding has been recognized as an essential public health device for the primary prevention of infant morbidity and mortality. Reviews of studies from developing countries show that children who are not breastfed, are six to ten times much more likely to expire within first month of life than infants who are breastfed (WHO, 2000).

Exclusive breast feeding in the first six month of life arises babies' immune systems and protects them from diarrhea and acute respiratory infections. Breast feeding has a lot of benefits for both the infants and mothers. However, despite strong evidences in support of exclusive breastfeeding for the first six months of life , its occurrence has remained low global and it is estimated that approximately one-third of infants were exclusively breastfed for the first six months of life (Emmanuel, 2015).

Between 1995 and 2010, the percentage of infants 0–5 months exclusively breastfed throughout low and middle-income countries rose slightly from 33 to 39%

overall. Although the greatest improvements were attained in Africa, the rate in Asia only increased by three percentage points to 41%. The gradual improvement is positive, but the differences between countries and within countries are considerable. East Asia and the Pacific (excluding China) were the only UNICEF region that experienced a decline over the 15-year period, the exclusive breastfeeding rate reduced from 31 to 29% (Cai et al., 2012).

Breastfeeding rates, however, tend to decline as national income rises, although some countries have succeeded in retreating that trend (Victoria et al., 2016). Breastfeeding to six months (even if not exclusive) advises crucial cognitive advantages. The cognitive losses related with no longer being breastfed to six months are estimated as 0.49% of Global Gross National Income (Rollins et al., 2016).

Now, exclusive breast feeding for the first six months of life is considered as a global public health goal that is connected to reduction of infant morbidity and mortality, especially in the developing world. Promotion of exclusive breastfeeding is the best cost-effective intervention to lessen infant mortality in developing countries.

It is estimated that suboptimal breastfeeding, especially non-exclusive breastfeeding in the first six months also has long term effect, including poor school performance, impaired intellectual, reduced productivity and social development. It can also raise the risk of dying because of pneumonia and diarrhea among 0–5 month old infants by more than two-fold.

According to UNICEF (2011), only 23.6% of children are exclusively breastfed till the age of six months in Myanmar. Due to the strong governmental program it is increased to 51.2% in 2016. Low rates of exclusive breastfeeding are one of poor indicators of child health in Myanmar contributing to high rates of infant mortality and under-five mortality, (estimated at 41 and 52 deaths per 1000 live births, respectively) (UNICEF, 2013). Although understanding that breast milk is best for babies, Myanmar mothers continue to face difficulties and a lot of misinformation that is resulting in poor national exclusive breastfeeding rates.

In recent years, the participation of women in employment has been increased. There are about 830 million female workers around the world. Some may have a pregnant while in employment and subsequently give birth their babies. Women of pregnancy age represent a high proportion of the workforce and make significant assistances to national economies. In manufacturing countries where the collection of organised statistics permits the easy estimation of their numbers, women of pregnancy

age represent from 45% to 60% of the total labour force (ABS 2003; Statcan 2001; UK Office 2002; US Census 2002).

In developing countries such as Kenya, Bangladesh, Vietnam and Turkey, the exclusive breastfeeding rate for three months by working mothers ranges from 13% to 59%. In industrialized countries like Australia and the US, 54% and 41.1% of women exclusively breastfeed for three months, and 32% and 14.2% for six months, respectively (ABS 2004; CDC 2004). Generally, those rates are low.

Breastfeeding is beneficial for mothers and their infants. However, combining breastfeeding and working outside can be challenging. Difficulty in maintaining a milk supply and breast tenderness from breast pumping can be barriers for the mother. Emotional concerns such as feared disapproval from employers, co-workers, and family can also discourage employed mothers from breastfeeding. If these mothers do not get support from their families, employers and fellow employees, they can be separated from their babies, have difficulty expressing and storing milk and they may give up breastfeeding after returning to work. Women may decide to completely wean their children when returning to work if they are not supported (Arthur, 2003).

It is encouraging to know that most women have the desire to continue breast feeding after returning to work if they have access to facilities, work flexible hours and take rest breaks during working hours (Kosmala-Anderson, 2006). Furthermore, a large number of working mothers can keep breastfeeding for six months if their workplace is ideal and supportive (Cohen 1994; Ortiz 2004).

Most working women are not comfortable to do breastfeeding in public. Due to these factors, less number of working women who breastfeed their babies after the maternity leave period. Consequently, the duration of exclusive breastfeeding to the recommended age of the babies could be affected.

To reach the WHO's recommendation of six months of exclusive breastfeeding, the working women need a supportive environment from both family and workplace that protects and promotes breastfeeding. A better understanding of the breastfeeding practices and barriers of exclusive breastfeeding is important to increase exclusive breastfeeding rate and improve infant and child outcomes.

In Myanmar, the working-age population (aged 15 above) turned into 36,394 thousand, of which slightly more than one-half were women (Ministry of Labour, 2017). Many of them go back to work soon after the birth babies. But some of the workplaces have a poor support for breastfeeding. These include lack of comprehensive

maternity leave policies, rigid time schedules that do not allow for nursing breaks, no private place for breast-pumping, and no facilities for refrigeration to keep pumped breastmilk.

Breastfeeding exclusivity differs depending on the factors including personal, physical, psychosocial, economics and breastfeeding awareness. The purpose of this study is to analyze the knowledge and practice of working mothers towards exclusive breastfeeding in Thingangyun Township of Yangon East District, and to identify the possible difficult situation and experiences during exclusive breastfeeding period.

## **1.2 Objective of the Study**

The objective of this study is to analyze the practices of working mothers towards exclusive breastfeeding in Thingangyun Township, Yangon.

## **1.3 Method of Study**

The research methodology used in this study is the quantitative and descriptive method based on primary and secondary sources of data. The primary data was obtained by using well-structured questionnaire. The five wards out of thirty-eight in Thingangyun Township were randomly selected and the snow ball sampling method was used to get 150 samples of respondent from these five words. The sample population were the working mothers under the age of 45 with a child below five years of age.

Secondary data was based on the research papers, articles, printed books, regulations and policies, reports, publications which were issued by the regulators, INGOs, social phenomena publishers, researchers, and internet websites.

## **1.4 Scope and Limitations of the Study**

This research is mainly focus on the working mothers under the age of 45 with a child below five years of age in Thingangyun Township of Yangon East District, Myanmar. The study period was from May to June 2019. The area of this study was limited to working mothers from five wards of Thingangyun Township such as San Pya, Lay Daunt Kan, Kyi Pwar Ye, Nga Moe Yeik and Ga Gyi.

## **1.5 Organization of the Study**

This thesis is organized into five chapters. Chapter one is the introduction chapter, where rationale, objectives, method, scope and limitation, and organization of the study are presented. Chapter two is literature review on breastfeeding in historical context, theories related to breastfeeding practices, the state of breastfeeding worldwide, exclusive breastfeeding trends in developing world, benefits of breastfeeding, the cost of not breastfeeding in Southeast Asia and review on previous studies. Chapter three focuses on the initiation of breastfeeding, breastfeeding practice, workforce participation of mothers and levels of child malnutrition in Myanmar. Chapter four describes the empirical analysis. This part of the thesis deals with the result of questionnaires, the analysis on the practice of exclusive breastfeeding among working mothers in Myanmar and their difficulties at a work place. Finally, Chapter five concludes the study with findings and some recommendation.

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **2.1 Breastfeeding in Historical Context**

Inch (2003) describes human milk as a God-given natural phenomenon, in which the standard is fully valued in order to provide the comprehensive nutrition to the neonate. “In all class species the generative cycle contains both maternity and breast-feeding: within the absence of latter, none of those species, man included, could have survived”, wrote pediatrician Bo Vahlquist in 1981. Breastfeeding is an unrivalled manner of supplying first-class food for the healthful increase and development of babies, it is also an essential part of the reproductive process with significant implications for the health of mothers.

Suboptimal breastfeeding is accountable for the death of 1.4 million children and the disability of 44 million globally (Black et al., 2008). Therefore, UNICEF has recommended that all women should breastfeed their infants exclusively in the first six months and subsequently with supplementary feeding for two years for optimal growth and development (UNICEF, 2013).

Exclusive breastfeeding described by World Health Organization (WHO) as practice of feeding only breast milk (including expressed breast milk) and allows the infant to acquire vitamins, minerals or medicines and water, breast milk substitutes, different drinks and solid foods are excluded. Moreover, WHO recommends specific breastfeeding for six months, with introduction of complementary foods and persevered breastfeeding thereafter.

Avoiding colostrum and giving some pre-lacteal feed and bottle feeding are contributory factors for these preventable diseases which ultimately cause high infant mortality. (UNICEF, 2006) Exclusive breastfeeding throughout the initial months of life and sustained breastfeeding at least the first two year of life is related with significant reduction in the burden of disease and have a lot of beneficial effects on mother’s health as well.

To change mothers to line up and sustain exclusive breastfeeding for six months, World Health Organization and UNICEF advocate: (1) Commencement of breastfeeding within the primary hour of time period (2) Exclusive breastfeeding that is the baby only gets breast milk without any additional food or drink, not even water (3) Breastfeeding on demand – this is as frequently as the kid wishes, day and night and (4) No use of bottles, teats or pacifiers.

However, many infants did not get most appropriate feeding. For example, only about 36% of infants aged 0–6 months global were exclusively breastfed during the period of 2007-2014. (WHO, 2018). In 2008 more than millions of children under the age of five die each year, 41 % of this death happen in sub-Saharan Africa and another 34% in South Asia and the main reason of their death is poor breast feeding practice.

Globally, 60% of infant and young child deaths happens due to inappropriate feeding practices and communicable disease from that two third of those deaths are because of sub optimum infant feeding practices. Inappropriate infant feeding practice could take negative effect on child growth and development, especially in developing countries, where availability of basic health serves is not sufficient. (WHO & UNICEF, 2003).

Some studies (Aidam et al., 2005) reveal factors, absolutely related to exclusive breastfeeding, like higher maternal instructional level, fertilization age bigger than thirty-seven weeks and mothers with previous experience of breastfeeding. There also are studies that relate factors resulting in interruption of exclusive breastfeeding as well as low family earnings, low maternal age, prim parity and moms returning to work (Mascarenhas et al., 2006).

Several research supposed to define determinant variables within the success or failure of breastfeeding (Losch et al., 1995), that can be easy the planning of promotional strategies. Nevertheless, it is always prudent to consider that, as an eating practise, breastfeeding is fundamentally connected to social, cultural and traditional forms of a given population. This truth justifies need for local research that lets more efficient action in regard to measures for intervention, based on knowledge of local reality (WHO, 2002).

Breastfeeding is a child's right. The United Nations Convention on Rights of the Child states that governments have the obligation 'to make certain that all segments of society, specially parents and children, are informed, have access to education and are supported in the use of essential information of access to education via health and

nutrients, the benefits of breastfeeding, hygiene and environmental sanitation and the prevention of injuries (UNICEF, 1989). James, former UNICEF Executive Director said “Breastfeeding is a natural safety net against the worst effects of poverty. If a child survives the first month of life, the most risky period of early life, then for the following four months or so, exclusive breastfeeding is going a long way towards cancelling out the health difference among being born into poverty or being born into wealth. It is almost as if breastfeeding pulls the infant out of poverty for the ones few critical months with a view to give the child a fairer start in lifestyles and compensate for the injustices of the world into which it was born.”

Breastfeeding is the most effective ways to protect maternal and child health, promote healthy growth and development in early childhood. Empowering and assisting women to breastfeed should be at the heart of countries’ efforts to keep every child alive and to build healthy, smart and productive societies (UNICEF, 2018).

## **2.2 Theories Related to Breastfeeding Practices**

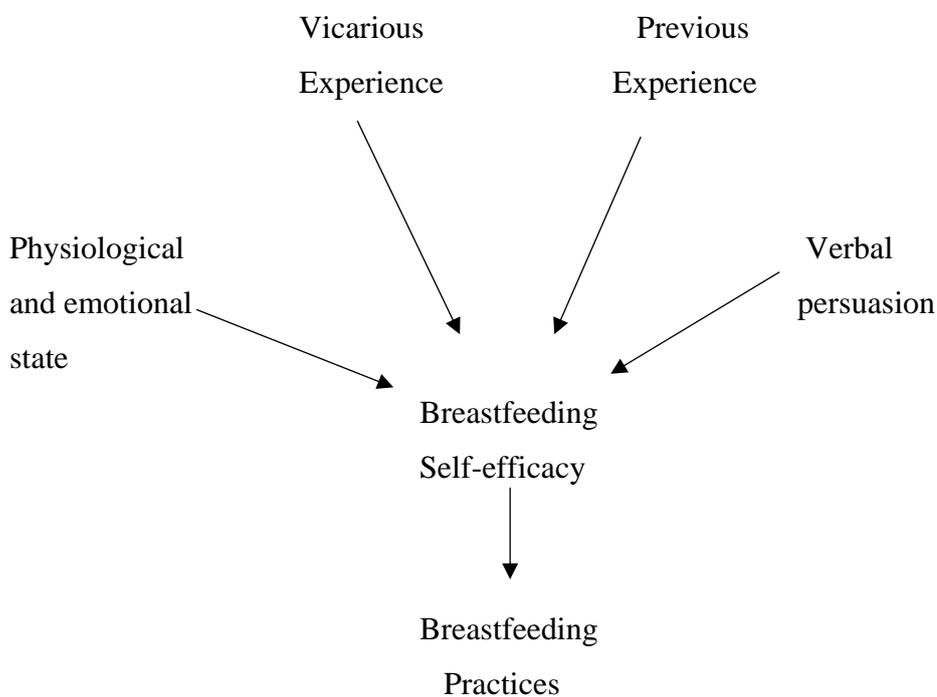
The concept breastfeeding practice refers to the actual process and methods followed by mothers to breastfeed their infants and children (WHO 2002). In recent years, Social Cognitive Theory (SCT) (Hill, 1991) and the theory of self-efficacy (Dennis, 2002) have been used to understand the factors that affect mother capacity to practice optimal breastfeeding behaviour.

According to SCT, human behaviour is described as “a triadic, dynamic, and reciprocal model in which behaviour, personal factors (including cognition), and environmental influences all interact”. Thus, people respond to environmental events and through cognition, they also practice control over their behaviour. People’s control of their behaviour impacts not only the environment but also their perception and biological state.

In Bandura’ Social Cognitive Theory, goals are defined as plans to acts or intentions to perform a behaviour. While outcome expectancy refers to the value attached to the anticipated consequences of a person’s behaviour. Therefore, SCT is a method to understanding human cognition, behaviour and environment that assumes that people are proficient of self-regulation and self-reflection and shape their own environment. A key concept of SCT is self-efficacy that is described as one’s judgment about his /her ability to perform specific tasks (Hill, 1991).

To promote the conceptual development of breastfeeding confidence and to give effective substantiating interventions, Dr Dennis incorporated Bandura's (1977) Social Cognitive Theory and developed the breastfeeding self-efficacy concept and theoretical model. Breastfeeding self-efficacy refers to a mother's self-assurance in her capacity to breastfeed her baby and it predicts: (1) whether a mom chooses to breastfeed or no longer; (2) how plenty attempt she will be able to expend; (3) whether she will be able to have self-improving or self-defeating idea patterns; and (4) how she will be able to emotionally respond to breastfeeding difficulties.

**Figure (2.1) Primary Sources Influencing on Breastfeeding Self-Efficacy**



Source: Breastfeeding self-efficacy by Dennis (1999)

In Figure (2.1), it is shown that breastfeeding self-efficacy is prompted by using four primary sources:

- (1) performance accomplishments (e.g., previous breastfeeding experiences);
- (2) vicarious experiences (e.g., seeing other women breastfeed);
- (3) verbal persuasion (e.g., inspiration from influential others such as friends, family, and lactation consultants); and
- (4) physiological responses (e.g., stress, anxiety, fatigue).

It is assumed that health specialists may also enhance a mother's breastfeeding confidence through changing these resources of self-efficacy data. Understanding the

effect of contextual factors on mothers' self-efficacy and therefore, her behaviour is important as many of our strategies to improve breastfeeding practices are designed to increase mothers' self-efficacy related to breastfeeding and have shown to be effective. Thus, people respond to environmental events and through cognition and they also work out control over their own behaviour. People's control of their own behaviour impacts not only the environment but also their cognitive and biological state. (Dennis, 2002).

### **2.3 The State of Breastfeeding Worldwide**

Globally, only 43 percent of babies younger than six months are exclusively breastfed (UNICEF 2016). Over 68 million children born that year will not be exclusively breastfed in low and middle income countries. Most of the children who are not exclusively breastfed consume water, milk formula, or complementary food in addition to breastmilk, often leading to infections in unsafe environments.

Moreover, only 45 percent of children are breastfed within an hour of birth and only 46 percent continue to breastfeed till the age of two (UNICEF 2016). The Global Nutrition Report recommends that 47 countries are off route for achieving the breastfeeding target, and a further 110 have missing data for this indicator (IFPRI 2016). However, rates of exclusive breastfeeding in some regions like South Asia and Eastern and Southern Africa have increased since the year 2000 and now exceed the 50 percent target (UNICEF, 2016).

The rates in other regions are below the target but are progressing slowly, with the exclusion of the East Asia and Pacific region, which has remained at around 30 percent over the past 15 years. Comparable data for many high income countries are not available, but where data are available the rates of exclusive breastfeeding rates are generally low. Although there have been modest gains in exclusive breastfeeding rates globally in recent years, these trends are not expected to maintain without investment in comprehensive breastfeeding strategies.

#### **2.3.1 Global Breastfeeding Target**

In 2012, the World Health Assembly established the target of increasing the rate of exclusive breastfeeding within the first six months to at least 50 percent (from 38 percent) by 2025 (WHO 2012). Reaching the global nutrition target of increasing

exclusive breastfeeding to 50 percent by 2025 will need an additional investment of \$5.7 billion over 10 years, or \$4.70 per new-born, for all low and middle income countries.

The costs of not creating this investment would be at least 520,000 child deaths and 105 million children not exclusively breastfed, plus additional morbidity from childhood diseases and cognitive losses.

Investing on this package deal will yield a \$298 billion in economic gains over 10 years throughout all low and middle income countries. Every \$1 invested is estimated to generate \$35 in economic returns, making a breastfeeding strategy one of the satisfactory investments a country could make.

The extension of paid maternity leave benefits to six months, which may increase breastfeeding rates and make other social, health, and developmental benefits, is estimated to cost an additional \$24.1 billion over 10 years.

Although reaching this target needs substantial effort and resources, it seems less ambitious than the other global nutrition targets. Analyses suggest that there may be possibility to go beyond the current target by way of 2025 or 2030. There are ten steps to successful breastfeeding:

- 1a. Comply fully with the International Code of Marketing of Breast-milk Substitutes and related World Health Assembly resolutions.
- 1b. Have a written baby feeding policy. This is regularly talked to staff and mother and father.
- 1c. Establish ongoing monitoring and data-management system.
2. Ensure that staff have adequate understanding, competence and capabilities to guide breastfeeding.
3. Discuss the importance and management of breastfeeding with pregnant mothers and their families.
4. Facilitate on the spot and uninterrupted skin-to- skin contact and support mothers to initiate breastfeeding as soon as feasible after delivery.
5. Support mothers to provoke and preserve breastfeeding and manipulate common difficulties.
6. Do not provide breastfed new-borns any meals or fluids apart from breast milk, except medically indicated.
7. Enable mothers and their babies to stay together and to guidance rooming-in 24 hours an afternoon.

8. Support mothers to understand and respond to their babies' cues for feeding.
9. Advice mothers on the use and risks of feeding bottles, teats and pacifiers.
10. Coordinate discharge in order that parents and their infants have timely access to on-going support and care.

There is great evidence that implementing the Ten Steps appreciably improves breastfeeding rates. A systematic overview of 58 research on maternity and new born care published in 2016 confirmed without a doubt that adherence to the Ten Steps influences early initiation of breastfeeding without delay after beginning, different breastfeeding and overall duration of breastfeeding. (WHO & UNICEF, 2018)

#### **2.4 Exclusive Breastfeeding Trends in Developing World**

In recognition of the indispensable responsibility of exclusive breastfeeding in respect of infants' survival strategies, numerous action has gone into scaling up the rates in developing countries where incidence of child malnutrition and mortality is still soaring. Nevertheless, achievements in increasing the levels of EBF have rather been moderated. In an analysis of data on EBF from 38 developing countries between 1990 and 2000 (Labbok et al., 2006) stated an increase EBF rate from 46% to 53% among infants younger than four months and from 34% to 39% for those younger than six months.

Higher growth was acknowledged in urban areas (30% to 46%) than rural ones (42% to 48%). Although there were increases in all the regions studied viz. Middle East/ North Africa (29% to 34%), South Asia (49% to 56%), East Asia/Pacific (57% to 65%); the most impressive improvement, but the rates were reduced in Sub Sahara Africa nearly doubled from 18% in 1990 to 38% in 2000. (Labbok et al., 2006).

Current analysis by Cai, Wardlaw and Brown (2012) on the global prevalence of EBF across 140 countries, also stated an increase in the developing world from 33% in 1995 to 39% in 2010 among infants aged 0-5 months (Table 2.1). Increases from West and Central Africa were more than doubled i.e. from 12% in 1995 to 28% in 2010. There had also been significant improvements from 35% in 1995 to 47% in 2010 among countries in Eastern and Southern Africa whereas those in South Asia observed a modest rise from 40% in 1995 to 45% in 2010. (Cai et al., 2012)

**Table (2.1) Global Prevalence of EBF among Infants Younger than 6 Months**

<b>Countries</b>	<b>Year</b>	
	<b>1995</b>	<b>2010</b>
West and Central Africa	12%	28%
East Asia and Pacific*	31%	29%
South Asia	40%	45%
Eastern and Southern Africa	35%	47%
Africa	22%	35%
Asia	38%	41%
Developing Countries*	33%	39%

Source: Adapted from Cai, Wardlaw and Brown (2012)

(\*Excluding China. Note: Trend analysis based on 66 countries covering 74% of developing world population excluding China).

Despite the fact that it is still lower than the other regions, the speedy increase in West and Central Africa is possibly not a surprise because it previously had and continues to have one of the lowest rates of EBF in the developing world for which purpose intensive efforts had been made to scale up the practice in the last two decades. It is certainly clear that although the rates of EBF for the past two decades have been increasing, the rates to a world wherein 90% coverage of EBF will be reached remains a demanding task. (Seidu, 2013)

This is evident that the current low prevalence in many developing world particular in West and Central Africa which takes place to have one of the highest rates of malnutrition in the world (Sokol et al., 2007). While causal declarations about the modest successes which have been achieved throughout the 1990s and early part of the 21st century are pretty tough to make some, however, have linked the observe improvements in EBF rates to the efficacies of global and national policy efforts in the 1980s e.g. International Code of promoting of Breast milk Substitute, Hospital and Baby Friendly Initiative among others.

### **2.4.1 Attitude towards Exclusive Breastfeeding**

Breastfeeding is the most appropriate way for feeding infants, with immediate and long-term health benefits (Ip et al., 2007). Mothers with positive attitudes toward breastfeeding are also more likely to breastfeed their babies to the end of the sixth month. (Forster et al., 2006). The higher levels of knowledge about breastfeeding and positive attitudes toward breastfeeding by parents are associated with higher breastfeeding initiation rates and longer duration. (Chung et al., 2008).

Breastfeeding in public can evoke negative reactions as well as engender a feeling of embarrassment in the mother (Hauck, 2004). Previous research has found that mothers may still feel vulnerable when breastfeeding in public places, such as shopping centres and restaurants, even if breastfeeding at that time does not evoke negative responses (Sheeshka et al., 2001). If a place to breastfeed discreetly were provided, the women may be more likely to breastfeed in public. Being able to breastfeed discreetly in public place may also make it easier for women to continue to breastfeed longer. Support for breastfeeding mothers, in community perceptions and in provision of breastfeeding facilities is required if improvements in duration are to be achieved.

## **2.5 Benefits of Breastfeeding**

Successful exclusive breastfeeding of a infant for six months contains numerous essential health advantages to every infant and mom (Grummer-Strawn, 1996; Gartner et al., 2005; Huffman, 1984; Imdad et al., 2011). Breastfeeding is extensively believed to be the most beneficial method of feeding for the health and well-being of most infants. Breast feeding is not only nutritionally sound but economically beneficial as well. Breast milk is free and does not add to the financial burden for families.

### **2.5.1 Benefit for Mother**

Exclusive Breastfeeding for six months is beneficial for mothers as it ensures better reproductive and postmenopausal health (NRDC, 2005). Breastfeeding has a beneficial consequence on the health of women. Studies have shown that breastfeeding supports in losing pregnancy weight quicker (Sanusi & Falana, 2013).

A study revealed that women who breastfed lost 4.4kg within a year, while those who did not breastfeed only lost 2.4 kg ( $P < 0.05$ ) (Dewey et al., 1993). This highlights the effectiveness of breastfeeding especially in reducing weight gain during pregnancy

if practiced exclusively in the first six months.

Breastfeeding helps shrink uterus back to normal size, reduces bleeding immediately after birth and promotes uterine involution (NRDC, 2005). Breastfeeding reduces the risk of type 2 diabetes and cardiovascular diseases (Davis et al., 2012). It also lowers the possibility of breast, endometrial and ovarian cancers (Labbok, 2001; NRDC, 2005; Centre for Community Child Health, 2006; Current breastfeeding rates avert approx. 19,000 annual breast cancer deaths and could avert a further 22,000 if scaled up (Lancet 2016).

Absence of menstruation due to breastfeeding serves as temporary birth control for some women. This is effective for some women who breastfed exclusively for six months (Kuti et al., 2007). Breastfeeding is cost effective as budget do not have to be set aside for infant formula (NRDC, 2005; Centre for Community Child Health, 2006). Breastfeeding offers women a sense of attachment with their babies (NRDC, 2005 ; Centre for Community Child Health, 2006) and promotes mental health of women (Davis et al., 2012).

### **2.5.2 Benefits for Infant**

Breastfeeding is also beneficial for the infant. Adequately breastfed infants grow more rapidly and are healthier than those who were no longer (Ukegbu et al., 2010; Gale et al., 2012). Breast milk confers a child with significant protection against many infectious diseases because it contains antibodies (immuno globulins) that strengthen the child's immunity (Ukegbu, 2010; Murimi et al., 2012; Lamberti et al., 2013).

Breastfeeding decreases the incidence of meningitis, malaria, asthma, respiratory diseases (such as pneumonia), diarrhoea, ear infection and urinary tract infection (Ukegbu, 2010; Murimiet et al., 2012; Ibadin et al., 2012; Lamberti et al., 2013). Kramer and Kakuma (2012) posited that in the first six months of life, exclusive breastfed infants are 2.5 times less likely to die from acute respiratory infection and 6 times less likely to die from diarrhoea.

Exclusive breastfeeding protects children from major chronic diseases which includes Type 2 diabetes, and obesity. The incidence of Type 2 diabetes is reduced by 40% in infants who were exclusively breastfed for at least 3 months, and adolescent and adult obesity by 15% and 30%, respectively compare to infants who received formula (Exclusive breastfeeding for six months protects babies from Sudden Infant

Death Syndrome (SIDS) and can lessen the risk of SIDS via 36% in comparison to the formulation-fed babies (Chung et al., 2007; Gartner et al., 2005). Also, the incidence of certain allergic diseases such as atopic dermatitis, clinical asthma, and eczema in positive family history are decreased in the first 2 years of babies' lifetime if they exclusively breastfed for three months, even in the low-risk population (Gartner et al., 2005; Greer et al., 2008).

Breastfeeding can lower the risk of allergy and improve brain development (Centre for Community Child Health, 2006). Infants exclusively breastfed for six months have higher IQ, lower risk of childhood obesity and of mental health problems, (UNICEF, 2010; Davis et al., 2012). Breastfed children have at least six times greater chance of survival in the early months than non-breastfed children (UNICEF, 2013). Early breastfeeding reduce infant morbidity and mortality as a result of the preventive benefits of breastfeeding in decreasing long term diseases (Emmanuel, 2015).

### **2.5.3 Social and Economic Benefits**

In addition to the health advantages of breastfeeding for mothers and their children, breastfeeding may provide significant economic benefits in terms of covering or reducing both direct and indirect costs. The direct costs that might be reduced or prevented would relate, of course, to physician, health centre, laboratory, and procedural fees. Other direct economic advantages to a family can be no or decreased expenses to buy infant formula for the first year after birth. Possible indirect prices may additionally relate to time and wages lost by parents (generally mothers) attending to an ill infant.

The direct costs that is probably decreased or prevented might relate, of course, to physician, clinic, hospital, laboratory, and procedural fees. Other direct economic benefits to a family may be no or decreased costs to buy infant formula for the first year after birth. Possible indirect costs may relate to time and wages lost by parents (primarily mothers) attending to an ill child. Really, attributing costs to time and wages lost by parents attending a sick child should be considered when estimating the possible economic benefits of breastfeeding

Many women go back to work earlier than a child is one year old (Cohen et al., 1995). When those women are absent from work, it is often for the reason that their infants are unwell. As breastfed infants have been shown to be less likely to get common infectious diseases than formula-fed infants, it is possible that mothers who breastfeed

might also leave out fewer days from work to care for a sick baby than mothers who feed formula (Weimer, 2001).

The economic consequences of inadequate breastfeeding are substantial, not only for children and their families but also for governments and the economy. Every year, over 12 400 child and maternal deaths can be attributed to inadequate breastfeeding in the seven Southeast Asian countries. Breastfeeding can prevent 50% of child deaths due to diarrhoea and pneumonia and 10% of deaths due to breast cancer. The savings in health care treatment costs from pneumonia and diarrhoea can assist offset the additional cost of breastfeeding promotion strategies.

Increased breastfeeding will reduce household indirect costs for treatment of childhood diseases. It should be noted that improvements in cognition alone, through higher IQ and earnings, doubtlessly amount to as much as 0.5% of Gross National Income in countries with the lowest breastfeeding rates below 6 months. (Dylan Walters, 2016).

It is estimated that world economic losses from lower psychological feature related to not breastfeeding reached over US\$ 300 billion in 2012, like zero.49% of the world's gross value. (WHO 2017). Even though the economic costs of not breastfeeding are generally considered to be highest for poor families and poor countries, the evident reveals that the impact in developed countries is also serious (Weimer, March 2001).

## **2.6 The Cost of Not Breastfeeding in Southeast Asia**

The following are the cost of not breastfeeding in Southeast Asia:

- (i) Inadequate breastfeeding consequences in economic costs for families and governments and substantial human loss and in Southeast Asia.
- (ii) Every year, more than 12400 child and maternal deaths can be accredited to inadequate breastfeeding in the seven Southeast Asian countries. Breastfeeding can prevent 10% of deaths due to breast cancer and 50% of child deaths due to diarrhoea and pneumonia.
- (iii) Savings in health care treatment expenses from reductions in diarrhoea and pneumonia from increased breastfeeding could support offset the additional cost of breastfeeding promotion.
- (iv) The potential improvements in cognition alone, through higher IQ and incomes, could amount to 0.5% of Gross National Income globally.

- (v) Based on findings from a programme implemented in 15 of 63 provinces and cities, a modelled breastfeeding promotion strategy at national scale in Viet Nam could return a benefit-cost ratio of \$2.39:1 or a return on investment of 139%.

Given the above-mentioned decline in breastfeeding rates in the region, this study focussed on seven countries in Southeast Asia: one low-income country, Cambodia; five lower-middle-income countries, Indonesia, Laos, Myanmar, Timor-Leste and Viet Nam, and one upper-middle-income country, Thailand (World Bank, 2015). Southeast Asia is a region of fast economic growth and in countries such as Thailand, women's labour market participation rates are amongst the highest in the world.

**Table (2.2) Breastfeeding Rates (%) of the Seven Countries in Southeast Asia Region**

<b>Southeast Asia Countries</b>	<b>Exclusive BF to 6 months</b>	<b>Some Bf to six months</b>	<b>Continued BF to 2 years</b>
Cambodia	74%	93%	41%
Indonesia	41%	89%	55%
Laos	26%	90%	47%
Myanmar	23%	98%	65%
Thailand	14%	61%	19%
Timor Leste	51%	98%	33%
Viet Nam	17%	98%	19%

Source: The cost of not breastfeeding in Southeast Asia, Dylan 2016

The rates of exclusive breastfeeding up to six months in this group of countries range from 15 to 17% in Thailand and Viet Nam, respectively up to 74% in Cambodia (Table 2.2). In this region, higher exclusive and some breastfeeding rates are more common in smaller and lower income countries (General Statistical Office 2011; National Institute of Statistics et al., 2011; UNICEF 2011; National Statistical Office et

al., 2013). In this region, most infants receive some breastmilk during the first six months. The percentages of infants getting some breast-milk range between 89% in Indonesia and 98% in Timor-Leste, except for Thailand at 61% (Statistics Indonesia et al., 2013).

### **2.6.1 Challenges of the Working Breastfeeding Mother**

According to the International Labour Organization's report: Maternity and Paternity Law and apply around the world, there has been a move towards increasing maternity leave durations that go more than the 14 weeks standard suggested by ILO. However the coverage is neither sufficient nor long enough for mothers before they need to go back to work.

Many of the countries in Southeast Asia will increasingly rely on female workers entering the workforce to maintain and expand economic growth and also plug a significant skills gap. The ability to offer sustainable employee benefits which includes maternity leave may be crucial in reaching the targets of governments and business alike going ahead.

Several studies have reported barriers accounting for this situation, including returning to work after delivery (Alina et al., 2012). Others have stated factors that determine the achievement of exclusive breastfeeding even upon go back to work, indicating that a supportive workplace and working environment are critical. (Amin RM, 2011). One of the studies stated that the challenge of balancing breastfeeding and paid work was an important reason for breastfeeding termination in the first six months (Guendelman et al., 2009).

The number of women who breastfeed their infants after returning to work is disappointingly low. Many women stop breastfeeding afterwards they return to work due to lack of preparation and support. The most significant problem encountered by breast-feeding mothers is lack of an adequate facility in which to pump (Corbett-Dick, 1997). Many women do not have their own offices, and corporate breakrooms are very public. This forces women to use public rest rooms. One study found this to be an unacceptable solution because of bacterial contamination (Thompson, 1997).

Another major problem is lack of time for pumping at work. Many women feel guilty for taking extra breaks to pump. Many are also fearful of or embarrassed about

discussing the subject with their employer. One study found 40% of working breastfeeding mothers were pumping without the knowledge of their employer (Thompson, 1997). If these mothers are not able to pump as often as necessary, it is likely that their milk supply will diminish. Mothers who pump regularly tends to nurse longer than those who do not (Greenberg, 1991). Both of these problems is directly related to the general lack of knowledge of the benefits of breastfeeding among the public.

If the mother works more than 4 hours, she should pump. Ideally, she should pump approximately every 3 hours, around the time the infant would eat. This provides an adequate "stockpile" and assures continued good milk production by the mother. The more she pumps, the more milk she will produce ((Davis, 1994); Greenberg, 1991). Regular pumping also prevents problems associated with breastfeeding such as engorgement, leaking, and mastitis (Greenberg, 1991).

A full size double pump is the excellent desire for the working mom. These pumps produce an motion maximum much like the way a baby nurses, and they may be faster and greater efficient than different pumps. The simultaneous bilateral pumping these pumps provide increases the levels of serum prolactin in the mother. This may also help the mother who returns to work earlier than the child is six weeks old to boom her milk supply. To be successful at breastfeeding and working, the mother needs five matters: a breast pump, a private room, good enough breaks to pump, a refrigerator to keep the milk, and most significantly, a supportive employer (Thompson, 1997).

Breastfeeding at work is possible to be unsuccessful if the employer is not supportive of the mother. It may be helpful to provide the employer within formation about breastfeeding, specifically cost savings to employees and employers (Davis, 1994). The professional health nurse can facilitate this relationship. The nursing role includes educating employers and employees about the benefits of breastfeeding and ensuring the mother's success. After employers are aware of breastfeeding issues, discussion with mothers can be encouraged. Employers may provide necessary equipment, environment, and break times.

Although most working mothers depart the maternity ward breastfeeding completely, the exercising is quickly abandoned, typically because of work and employment associated factors. Even though breastfeeding may not be completely abandoned, its exclusivity was mostly disturbed by these factors. Given the high breastfeeding initiation, upgraded policies about maternity leave and breastfeeding

friendly working environments are needed due to low EBF continuation rate among professional working mothers (Elvis et al., 2016).

Notably, promoting breastfeeding in a very geographic point could have advantages for the ladies, the baby and conjointly the leader. The benefits of breastfeeding also extend to employers, as it reduces work absenteeism and increases employee morale and retention (Cohen, 1994; Cohen, 1995). Similarly, if employers support breastfeeding in the workplace, Women who maintain to breastfeed after returning to work leave out much less time from work because of baby-related illnesses, and have shorter absenteeism once they do miss work (Cohen, 1995).

## **2.7 Review on Previous Studies**

Soomro (2015) emphasized on factors affecting breastfeeding practices in working women of Pakistan. This study found that knowledge regarding breastfeeding, self-commitment, and planning, social support apart from workplace support is needed to facilitate working women to continue with breastfeeding. It was also observed that the majority of the workplace sites lacked fundamental facilities to support mothers to combine breastfeeding with work such as breastfeeding breaks, lactation room, and nursery for service, breast milk pump, refrigerator and provision of lighter tasks.

Another study conducted by Dun-Dery and Laar (2016) was about exclusive breastfeeding among city-dwelling professional working mothers in Ghana. The study examined three components as determinants of EBF; people who failed to receive feeding recommendation from medical examiners were less possible to follow exclusive breastfeeding, mothers who had shorter period of maternity leave had been much less likely to practice exclusive breastfeeding and those who had a normal delivery were nearly 10 times as probably to practice exclusive breastfeeding. Given the excessive breastfeeding initiation, however low EBF continuation rate among professional working mothers, breastfeeding friendly work environments and improved policies around maternity leave are required.

Alhabas (2016) examined on breastfeeding among working mothers in Saudi Arabia. This study found that having and knowing about a policy supporting breastfeeding employees to breastfeed or express milk in their workplace was associated with lower discontinuance of breastfeeding. In addition, the risk of termination of any breastfeeding two months after return to work until one year working and early initiation of formula feeding after baby's birth significantly decreased with

having a policy facilitating breastfeeding workers to breastfeed or pump in their work. This study also revealed that not having policies that support breastfeeding employees to breastfeed or express milk in their workplace are significantly associated with decrease the duration of breastfeeding and increase early formula initiation.

“Barriers to exclusive breastfeeding within the Ayeyarwaddy Region in Myanmar” (May Me Thet, Ei Ei Khaing, Nadia, May, Sandar Oo & Tin Aung, 2016) research article examined the barriers to exclusive breastfeeding and the way totally different house members participate in decision-making. This study found out that respondents had high level of knowledge about exclusive breastfeeding, but low adherence. One of main barriers to exclusive breastfeeding was that mothers, grandmothers and husband thought that exclusive breastfeeding only was not sufficient for babies and water and solid foods were required. It was also observed that water and mashed up rice were commonly introduced before six months of age. Mothers also faced barriers to exclusive breastfeeding due to the need to return to work outside the home and health related problems.

A study done by Nukpezah, Nuvor, & Ninnoni (2018) was about knowledge and practice of exclusive breastfeeding among mothers in the Tamale metropolis of Ghana. The result was indicated that 39.4% initiated breastfeeding within one hour after birth. Majority of participants had detected of EBF 277 (70.5%), about 344 (87.5%) of participants believed that EBF should be practiced for 5 months in their locality. Although all the participants had some level of education background, a majority failed to have adequate information on EBF and EBF follow was low within the study community. This study also recommended that improved education at the child wellbeing clinics and the media should be used as a platform to educate women adequately about importance of EBF.

## **CHAPTER III**

### **BREASTFEEDING IN MYANMAR**

#### **3.1 Initiation of Breastfeeding**

Early initiation of breastfeeding is essential for both the mother and the child. The first breast milk contains colostrum that is quite nutritious and has antibodies that protect the new born from diseases. Early initiation of breastfeeding also encourages bonding among the mother and her new born, facilitating the production of regular breast milk. Thus, it is recommended that children be placed to the breast immediately or within 1 hour after birth and that pre lacteal feeding (i.e., feeding new born anything apart from breast milk before breast milk is regularly given) be discouraged.

The Ministry of Health and Sports (MOHS) encourages facility delivery and supports the Baby Friendly Hospital Initiative (MOHS, 2015), in which early initiation of breastfeeding and rooming-in practices to increase bonding and protect new-borns from harmful external environments are promoted. The MDHS results showed that 98% of last-born children in the two years before the survey had ever been breastfed; however, 20% received pre lacteal feeding. Myanmar complies with the National Strategy on Infant and Young Child Feeding (IYCF) (2011-2016), which encourages mothers to breastfeed exclusively until the child is age six months without any water, other liquids, or food (MOHS, 2011).

#### **3.2 Breastfeeding Practice in Myanmar**

It is recommended that children be exclusively breastfed in the first six months of their life, that is, they should be given nothing but breast milk. Complementing breast milk before age six months is unnecessary and is discouraged because the likelihood of contamination and the resulting risk of diarrheal disease are high. Early supplementation may reduce the output of breast milk because the production and release of breast milk is modulated by the intensity and frequency of suckling.

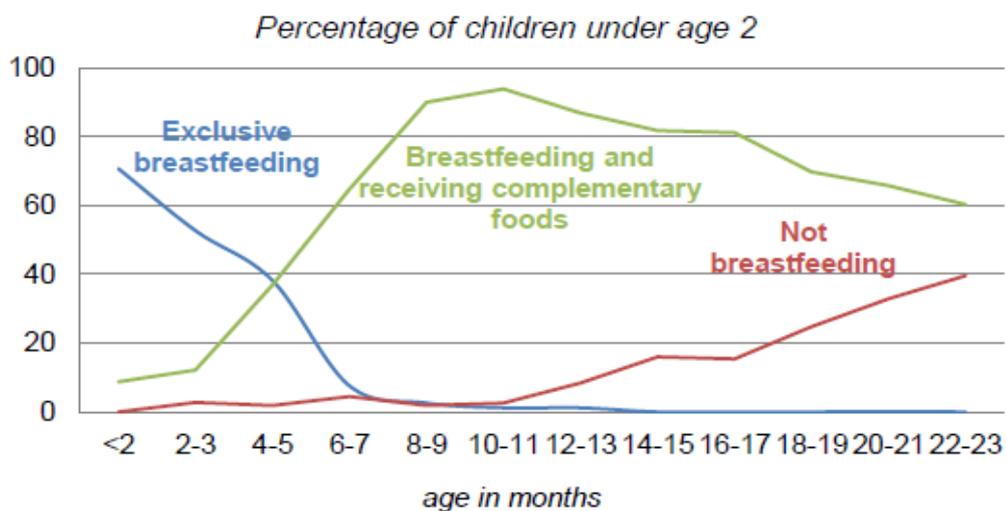
According to the Myanmar Demographic and Health Survey 2015-16, almost all (98%) of children in Myanmar are ever breastfed. One past study found that about

two – thirds 67.5% of women initiated breastfeeding within an hour as recommended and 83.2% fed colostrum to their new-borns. (Sandar, 2006) Twenty percent received a pre lacteal feed, though this is not recommended.

WHO recommends that children receive nothing but breastmilk (exclusive breastfeeding) for the primary six months of life. Just over half (51%) babies under six months are exclusively breastfed in Myanmar. Decisions and breastfeeding practices are influenced by a wide range of individual’s knowledge and attitude, cultural, and socioeconomic factors.

Figure 3.1 show breastfeeding practices according to the child’s age group. Only half of infants under age six months are exclusively breastfed (51%). Conversely, many children in this age group are given plain water (19%) and complementary foods (21%) in addition to breast milk. The 2009-10 MICS indicated that only 24% of children under age six months in Myanmar were exclusively breastfed (MNPED & MOH, 2011).

**Figure (3.1) Breastfeeding Practices by Age**



Source: Myanmar Demographic and Health Survey 2015-2016

The breastfeeding practices are related to the knowledge and attitude of individual. Women in Myanmar have high level of knowledge regarding exclusive breastfeeding. However, some mothers introduced water and mashed up rice before six months. Research into motivators of breastfeeding in Myanmar found that women breastfeed their children because of traditional beliefs that breast milk is most beneficial for new-borns (White et al., 2012). Other studies have found that solids and liquids have

been introduced frequently around 4-6 months, rather than after 6 months, as guidelines suggest (Chit, Kyi & Thwin, 2003).

Furthermore, some ethnic groups in Myanmar, particularly in more remote areas and areas with social unrest, have been discovered to be more likely of practicing early introduction of foods and liquids (during the first six months of life) (Mullany et al., 2008). A study of “Assessing Rates of Inadequate Feeding Practices Among Children 12–24 months in Myanmar”, reported that rural women were more likely to exclusively breastfeed, compared to urban women perhaps because rural women are much less possibly to work outside the home, or social norms and support systems in rural areas are more supportive of breastfeeding. (May Me Thet et al., 2016)

Most of the Myanmar women are shy and it is not convenient for them to breast feed their baby in public area. Dr. Myint Htwe, Union Minister, Ministry of Health and Sports (MOHS) said most of the foreign have separated areas for women to breastfeed, he said, and Myanmar should follow suit. “There are breastfeeding rooms in German airports,” U Myint Htwe said. “You can close the door and breastfeed your child. Our country should have that.” He highlighted the need for such areas to also be made available in hospitals and ministries. It is important that mothers be able to breastfeed in public places, like restaurants, supermarkets, and buses, without feeling shame, he said. “Breastfeeding is really important,” he said. “We support mothers’ breastfeeding their kids and should give them more respect.”

One of the main barriers to exclusive breastfeeding was a lack of knowledge of appropriate infant feeding practices and lack of supportive environment. Traditional infant feeding practices often influenced by myths and misconceptions, prevented mothers from practicing exclusive breastfeeding.

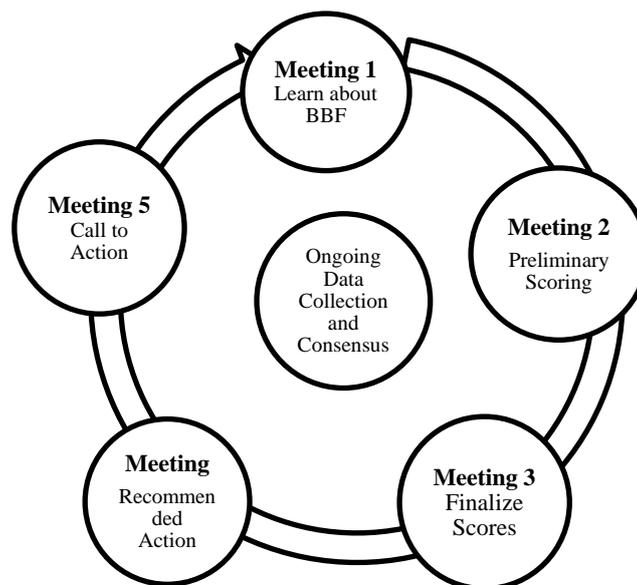
### **3.2.1 Becoming Breastfeeding Friendly (BFF) in Myanmar**

The Ministry of Health and Sports (MOHS) is committed to facilitating an enabling environment for breastfeeding. MOHS has approved WHO recommended breastfeeding practices by adopting the International Code of Breastmilk Substitutes, introducing a training package for the Community infant and Young Child Feeding (IYCF) Counselling, expanding the Baby Friendly Hospital Initiative (BFHI), and providing longer maternity leave for civil servants in collaboration with other stakeholders. In early 2017, MOHS and other nutrition stakeholders in Myanmar were introduced by the team from Yale School of Public Health (YSPH).

To implement the BBF in Myanmar with the leadership of the National Nutrition Center (NNC) of MOH, Myanmar nutrition stakeholders endorsed Save the Children Myanmar, host organization of the Secretariat of the Scaling up Nutrition Civil Society Alliance (SUN CSA). In July 2017, The Union Minister of MOHS approved to implement BBF in Myanmar and MOHS led the BBF initiative, launched in Myanmar in January 2018.

The National Nutrition Centre in the Ministry of Health and Sports, is partnering with Save the Children to implement the BBF process in Myanmar. A working group of 17 health and nutrition experts convened to implement and support the BBF initiative. Becoming Breastfeeding Friendly (BBF) assists countries to: (1) measure the current breastfeeding-friendly environment; and (2) develop a plan and recommendations to guide the scale up of national breastfeeding promotion, protection and support efforts. BBF provides countries with a toolbox that includes a 54-benchmark index to assess the 8 gears in the Breastfeeding Gear Model, as well as case studies and a five-meeting process that guides countries through the process of scaling up breastfeeding. Each of the 54 BBF benchmarks are scored as: 0 (not progress), 1 (minimal progress), 2 (partial progress), and 3 (major progress). Each benchmark has specific standard used to score.

**Figure (3.2) Becoming Breastfeeding Friendly (BBF): Five-Meeting Process**



Source: BBF A Guide to Global Scale-up, MOHS 2018

The five meeting process for Becoming Breastfeeding Friendly (BBF) are shown in Figure (3.2). The first meeting includes the orientation on the BBF process,

scoring methodology, the information of gear teams and data collection plan. During the second meeting, gear teams present their progress with the initial benchmark scoring and highlight preliminary gaps found within their gear. When the third meeting is held, gear teams present on final benchmark scores. By using the BBF Calculator, final benchmark scoring, gear and total BBF scores are calculated. During fourth meeting, the scores for each recommendation are presented and the committee discusses and reaches a consensus on the prioritized recommendations. The fifth meeting is Call to Action meeting in order that key decision makers and stakeholders can close to find out about BBF findings, hear recommendations as well as proposed actions plan, and discuss next steps and future commitment.

### **3.2.2 The Cost of Not Breastfeeding in Myanmar**

Breastfeeding is one of the best buys in global health to save lives and improve the health, social, and economic development of both individuals and for Myanmar as a nation. A 2015 study on the cost of not breastfeeding in Myanmar showed revealed that optimal breastfeeding practices could prevent 1,636 child deaths due to pneumonia and diarrhoea annually and save 3.38 million USD each year in health system expenditures. The same study revealed that optimal breastfeeding practices can save families up to 32.4 percent of their monthly income by not having to buy formula milk. Reducing out of pocket expense to treat diarrhoea and pneumonia will also increase family saving (Alive & Thrive, 2016).

According to Alive & Thrive the key findings in Myanmar were following. Optimal breastfeeding practices can: (1) Save 1,636 children's lives annually, an important contribution to reducing overall under-5 child mortality (2) Save 3,380,000 USD in expenditures of health system annually (3) Reduce families' out of pocket expenditures to treat diarrhoea and pneumonia and (4) Save families up to 32.4 percent of their monthly income by not having to buy formula.

The optimal breastfeeding improves human capital development and reduces health expenditures for families and Myanmar. Breastmilk is the first food for babies. Breastfeeding can reduce family expenditures on health care as babies are healthier. At the policy level, breastfeeding contributes significantly to national development. Thus, we need to encourage breastfeeding. ILO, according to Maternity Protection Convention 183, recommends longer duration of maternity leave'- Dr. Myint Htwe, Union Minister, Ministry of Health and Sports (MOHS).

Myanmar is a country in Southeast Asia with a population of approximately 51.49 million as of 2014 (Department of Population, 2014). The scientific evidence is clearly stated that breastfeeding provides all children the healthiest start in life. Although almost all mothers in Myanmar breastfeed, only 24 percent of babies are exclusively breastfed for six months as recommended by the World Health Organization and UNICEF in 2010, far below the global target of 50 percent (MNPED, 2011).

These low rates of exclusive breastfeeding amount to actual costs in life expectancy and quality of life, and will inhibit Myanmar's ability to transition to a middle-income economy that depends less on its natural resources and more on the skills and knowledge of its people. Despite improvement in recent years, the prevalence of undernutrition in Myanmar remain high with a stunting rate of 29.2% (MOHS, 2017).

The World Health Organization (WHO) and the Myanmar Ministry of Health and Sports (MOHS) recommend exclusive breastfeeding for the first six months of a child's life. Data from the 2009-10 Multiple Indicator Cluster Survey (MICS) and the recent Myanmar Demographic Health Survey (MDHS) shows that the prevalence of exclusive breastfeeding among children under six months of age increased from 23.6% in 2010 (MNPED, 2011) to 51.2% in 2016 (MOHS, 2017), demonstrating the country's potential to rapidly improve life-saving nutrition behaviours.

Despite progress, however, there was a decrease in the prevalence of other recommended breastfeeding practice during the same period: the prevalence of early initiation of breastfeeding declined from 75.8% to 66.8% while continued breastfeeding at one year declined from 91.0% to 87.9% and continued breastfeeding at two years from 65.4% to 63.1% (MNPED, 2011) (MOHS, 2017).

When children are not exclusively breastfed for six months, they are easily effected to pneumonia and diarrhea, the two leading causes of childhood death worldwide. Nearly 50 percent of under-2 child deaths resulting from diarrhea and pneumonia could be prevented annually, by supporting mothers to practice proper breastfeeding, across the ASEAN region in comparison to a situation with no breastfeeding. In Myanmar, 1,636 additional children's life could be saved annually by moving from the current levels of breastfeeding to World Health Organization guideline levels, contributing to overall under-5 child mortality reduction. Breastfeeding also supports protect the health of mothers. If 90 percent of mothers breastfed for two years,

10 percent of maternal deaths by breast cancer could be prevented annually across the ASEAN region.

By ensuring optimal breastfeeding, Myanmar could potentially eliminate diarrhea and pneumonia as a result inadequate breastfeeding and eventually save 3,380,000 USD in health care expenses per year, paid either by public or private sources, equivalent to 0.4 percent of the national health budget.

When children become ill due to diarrhea and pneumonia caused by inadequate breastfeeding, parents often incur expenses to take them to a health care facility to seek treatment. The economic losses that end result consist of absent productiveness and transportation costs. Studies from ASEAN nations like Timor-Leste and Indonesia imply that households can incur additional lost work and transportation costs up to twenty-five percent of the real cost to treat diarrhea and pneumonia.

As Myanmar achieves economic growth, increasing disposable earning will inappropriately attract businesses to market their breast milk substitute products to mothers to feed their babies. The costs to purchase economy brand infant formula can be significant for families, up to 32.4 percent of monthly earnings for workers in low income, formal sector jobs in Myanmar compared to breast milk, which is free, safe, and hygienic for all babies. (Alive & Thrive, 2016)

### **3.3 Breastfeeding Working Mothers in Myanmar**

Myanmar's economic system will extend at a faster fee than any other country in Asia in 2016-17, according to the Asian Development Bank, which forecast GDP growth of 8.4 percent. As the economy develops, more women will have to take part in the workforce to meet demands of the economy.

#### **3.3.1 Work Force Participation of Mothers**

In 2017, the working-age populace (aged 15 above) turned into 36,394 thousand of which slightly more than one-half had been women. The labour force participation rate was 61.5 percent. Employment totaled 21,912 thousand, with women accounting for 41.8 percent. (Ministry of Labour, 2017).

Women of childbearing age may become pregnant during employment and many of them return to work soon after delivering babies, and they need supportive national polices and legislation such as paid maternity leave and breastfeeding breaks to enable them to continue breastfeeding. There are also millions of women working

in the informal, seasonal or part-time economy who face even greater barriers to breastfeeding. Low-income girls are more likely than higher-income counterparts to return to work in advance and to be engaged in jobs that make it hard for them to keep breastfeeding.

According to many international research, working outside the home is associated with several boundaries to breastfeeding, which include inflexibility in work hours and constrained breaks at work, as well as inadequate or total loss of venues where the mom can pump breast milk at most workplaces. They need strong family and community assist to manage the demands of work and breastfeeding their babies.

### **3.3.2 Maternity Leave**

Maternity and parental leave are rights for working mothers in Myanmar. Maternity leave duration and working hours upon return-to-work greatly influence the exclusivity and duration of breastfeeding. Paid parental leave supports breastfeeding and mother-infant relationship.

According to the Myanmar Labour Law, every employed mother, whether or not they are covered by the Social Security Law (2012), is entitled to paid-maternity leave of six weeks before delivery and eight weeks after delivery. For a twin delivery, Mothers covered under the Social Security Law (2012) have the right to take an additional four weeks of paid leave after the statutory maternity leave for child care. Fathers are entitled to 15 days of paternity leave. Payment for such leave is the responsibility of the employer unless the worker contributes to the Social Security board scheme.

The Act also provides for leave of up to a maximum of six weeks in cases of miscarriage, provided the miscarriage was not caused by a termination, which is illegal in Myanmar. Some policy changes to support mothers have already been applied. Changes to the Civil Service Law enacted in March 2014 doubled the maternity leave for public servants, to six months which is the longest in Southeast Asia. Changes to the 1951 Factories Act that effected in January were also an ostensible breakthrough in supporting women who want retain working when they become mothers. The amendment requires the owners of factories employing quit 100 women with children aged under five to determine child day-care centers with the help of the Ministry of Relief, Resettlement and Social Welfare. However, only a few private companies have followed the example set by the government for its employees. Most provide the

minimum 14 weeks – six before confinement, and eight after as required in the Factories Act and Social Security Law, which was enacted in 2012.

Most of the private sectors and NGOs give maximum (3) months maternity leave. An exception is Telenor introduced six months' maternity leave for its employees worldwide starting from October 2015. Women comprise 40 percent of Telenor's employees in Myanmar. The working mothers in Myanmar wish that there was a law, not only for the government sector but also for the private sectors and for NGOs that provide mothers a full six months leave.

### **3.3.3 Difficulties of Working Mothers at Work Place**

Past qualitative research in Myanmar found that working outside the house was one among the most barriers that ladies faced to exclusive breastfeeding (May Me Thet et al., 2016). Working outside the house is related to a shorter length of breastfeeding, and intentions to work full time are notably related to lower rate of breastfeeding initiation and shorter duration. Women in skilled, unskilled or other family businesses, compared to being a housewife, were less likely to exclusively breastfeed.

Woman's go back to work has frequently been found to be a main factor to the early termination of breastfeeding. Ensuring paid breastfeeding breaks at work is one mechanism that would enhance mothers' opportunity to breastfeed within the workplace.

Thus, if employers do not seem to be supportive, mothers could also be more likely to wean infants earlier if they start working outside the house while breastfeeding.

Workplace environment can perform a positive role to promote breastfeeding. The breastfeeding-friendly workplace recognizes and supports the requirement of breastfeeding mothers to take time to precise (pump) her breast milk in a clean, comfortable, private space (not within the restroom) while she is separated from her baby during the workday.

If the workplace is not mother friendly, then it is not easy for a mother to continue with breastfeeding. In Myanmar, most workplaces do not have the supportive environment for breastfeeding. This may probably end in discontinuation of milk and breastfeeding.

### 3.4 Levels of Child Malnutrition

Under-nutrition may be a public ill health in Myanmar. According to the 2015-16 MDHS, 29% of children under age 5 are stunted and eight are severely stunted, indicating chronic undernourishment. Seven percent are wasted and 1% is severely wasted, indicating acute under nutrition. Stunted refers to low height for age and wasting is low weight for height. Nineteen percent of kids under age 5 are underweight, and 4% are severely underweight. Only one percent of children under age 5 are overweight (Table 3.1).

**Table (3.1) Nutritional Statuses of Children**

(Percentage of children under age 5 classified as malnourished)

	<b>Moderate</b>	<b>Severe</b>	<b>Total</b>
Stunning	21	8	29
Wasting	6	1	7
Underweight	15	4	23
Overweight	1	-	1

Source: Myanmar Demographic and Health Survey 2015-2016

These figures imply that there has been some recent improvement in child under nutrition; the results of the 2009-10 Multiple Indicators Cluster Survey (MICS) showed that out of 4100 children under age of 5 in Myanmar, 35% were stunted. Similarly, 8% were wasted and 23% were underweight (MNPED, 2011 )

Myanmar is among the 24 High burden countries with the largest number of children under 5 years who are moderately or severely stunted. Although there are numerous causes for stunted growth and development, the short term and long term results affect increased mortality and morbidity, decreased cognitive and motor development, increased economic burden, and decreased work capacity and productivity as adults. Low exclusive breastfeeding rates negatively affect breastfeeding duration rate so that children are not receiving breast milk until two years and beyond, as recommended by WHO/UNICEF.

## **CHAPTER IV**

### **SURVEY ANALYSIS**

#### **4.1 Survey Profile**

This survey was conducted in Thingangyun Township which was located in the East District of Yangon Region. The township measured 11.4 km<sup>2</sup> (4.44 sq mi) and comprised 38 wards. It shared borders with South Okkalapa Township in the north, North Dagon Township in the east, Yankin Township and Tamwe Township in the west, and Thaketa Township in the south. The township had 40 primary schools, 4 middle schools and 5 high schools. University of Dental Medicine, Yangon and Thingangyun Education College were located in Thingangyun Township. The city's main sporting venues, the Thuwunna Stadium and the Thuwunna Indoor Stadium were situated in the western side of the township. Kyaikkasan Pagoda, St. Joseph Church and Thanyok Monastery are the landmarks of Thingangyun Township.

According to 2014 census data, there were 43,320 households with a total populations of 209,486 were living in Thingangyun Township. Among them, there were 98,698 male and 110,788 female. The gender ratio was 89 males per 100 females. In Thingangyun Township, the population density was 18,383 persons per square kilometer and the township had 100% urban population. There were 4.6 persons living in each household in Thingangyun Township. This was slightly higher than the Union average.

Regarding the age group in Thingangyun Township, the population by aged 1-14 was 20 percent, 15-64 was 73 percent and 65 above was 7 percent. The literacy rate of those aged 15 and over in Thingangyun Township was 96.9 per cent. It was higher than the literacy rate of Yangon Region (96.6%) and the Union (89.5%). Female literacy rate was 95.8 per cent and for the males it was 98.3 per cent (Ministry of Labour, 2017).

The labour force participation rate for the population aged 15-64 was 56.1 percent in Thingangyun Township. The labour force participation rate of females was 40.2 percent and was much lower than that of their male counterparts which was 74.5 percent. The labour force participation rate for the population aged 10-14 was 5.2

percent. In Thingangyun Township, 31.7 percent of the employed persons aged 15-64 were services and sales workers and was the highest proportion, followed by 19.4 percent in craft and related trades workers. The unemployment rate for those aged 15-64 in Thingangyun Township was 4.8 percent (Ministry of Labour, 2017).

#### **4.1.1 Survey Profile of Five Wards**

This survey was conducted in five wards in Thingangyun Township. These wards are San Pya, Lay Daunt Kan, Nga Moe Yeik Kyi Pwar Yay, and Ga Gyi. In San Pya Ward. According to the data of Thingangyun Township General Administration Department (2019), there were 1092 households with a total population of 12379, male 5775 and female 6604. The number of male was lower than the female in this ward. There were two Primary Schools. The famous Yang Myo Aung Pagoda is situated in this ward.

In Lay Daunt Kan Ward, 2817 households with a total population of 10924, male 4923 and female 6001 were living. There are (1) High School and (1) Middle School. Nga Moe Yeik Ward has 3083 households with a total population of 12,381, male 5656 and female 6725.

Kyi Pwar Yay Ward 3155 households with a total population of 13649, male 6450 and female 7199. There was a famous monastery named “Shwe Thu Won”. Ga Gyi Ward had 1634 households with a total population of 7346, male 3505 and female 3841. There was one Primary School.

Among (5) Wards, San Pya, Lay Daunt Kan, Nga Moe Yeik and Kyi Pwar Yay were the most populated and Ga Gyi Ward was the least. The number of female was higher than male in each ward.

#### **4.2 Survey Design**

There were (38) Wards in Thingangyun Township in which five Wards were randomly selected. The total population of under five years old children from those five wards were 763 in San Pya Ward, 628 in Lay Daunt Kan Ward, 958 in Kyi Pwar Ye Ward, 729 in Nga Moe Yeik Ward and 585 in Ga Gyi Ward (Thingangyun Township Health Dept.,2019). The sample population were the working mothers under the age of 45 with a child below five years of age. The sample size was 150 and snow ball sampling method was used to get (30) samples of respondents from each of those five words. Data collection for this survey was conducted during May and June 2019.

The structured questionnaire was constructed which consist of five main parts. The first section, question number 1 to 7, was to obtain the demographic characteristics of the respondents. The second section, question number 1 to 9 was relating to the knowledge of respondents toward EBF. The third section, question number 1 to 5 was about the attitude of respondents towards EBF. The fourth section, question number 1 to 6 was regarding the practice of respondents toward EBF. The fifth section, question number 1 to 7 was concerning with maternity related facilities at respondents workplace.

### 4.3 Survey Results

The survey findings were analyzed and shown as characteristics of respondents, knowledge, attitude and practice of the respondents on exclusive breastfeeding and maternity related facilities at respondent’s workplace. The survey was conducted in five Wards of Thingangyun Township. A total number of 150 respondents were participated in this interview. The collected data was processed by SPSS and the results were presented by percentage. For 4 points Likert scale questions, mean scores were calculated.

#### 4.3.1 Demographic Characteristics of the Respondents

Total 150 respondents were involved in this study. The findings of demographic characteristics of respondents were presented in Table (4.1).

**Table (4.1) Data Summary for Demographic Characteristics**

<b>Variables</b>	<b>Number of Respondents</b>	<b>Percentage</b>
<b>Age Group</b>		
18-20 years	3	2
21-30 years	57	38
31-40 years	74	49
40 <45 years	16	11
<b>Total</b>	<b>150</b>	<b>100</b>

**Table (4.1) Data Summary for Demographic Characteristics (Continued)**

<b>Variables</b>	<b>Number of Respondents</b>	<b>Percentage</b>
<b>Education Level</b>		
Illiteracy	-	-
Primary School	2	1
Middle School	13	9
High School	42	28
Graduate	93	62
Total	<b>150</b>	<b>100</b>
<b>Job Position</b>		
Assistant	15	10
Officer	11	7
Manager	9	6
Director	7	5
Others	108	72
Total	<b>150</b>	<b>100</b>
<b>Type of Employment</b>		
Full Time	140	93
Part Time	10	7
Total	<b>150</b>	<b>100</b>
<b>Age of Respondents' Youngest Child</b>		
0.1-1 year	68	45
1.1-2 years	48	32
2.1-3 years	17	11
3.1-4 years	10	7
4.1-5 years	7	5
Total	<b>150</b>	<b>100</b>
<b>Family Type</b>		
Nuclear Family	62	41
Extended Family	88	59
Total	<b>150</b>	<b>100</b>
<b>Family Average Monthly Earnings</b>		
Less than 100,000 Ks	1	1
100, 000 - 300,000 Ks	19	12
300,001- 600,000 Ks	64	43
600,001-1,000,000 Ks	39	26
Above 1,000,000 Ks	27	18
Total	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

As in Table (4.1), among the total of (150) respondents, 3 respondents (2%) were in the age group of 18-20, 57 respondent (38%) were in the age group of 21-30, 74 respondents (49%) were in the age group of 31-40 and 16 respondents (11%) were in the age group of 40 and above. The majority of respondents were age between 31-40 years old which showed that they were mature enough to make reliable decisions.

Regarding the education level of respondents, there was no respondent in illiteracy group, 2 respondents (1%) were in primary school level, 13 respondents (9%) were in middle school level, 42 respondents (28%) were in high school level and 93 respondents (62%) were graduate level. The majority of this survey respondents' education level were graduate level and there was no illiteracy respondent. It was assumed that respondents' educational status would provide in-depth information regarding the practice of exclusive breastfeeding among working mothers.

The job position showed that 15 respondents (10%) were Assistant, 11 respondents (7%) were Officer, 9 respondents (6%) were Manager, 7 respondents (5%) were Director and 108 respondents (72%) were other job positions like Doctor, Teacher, Nurse, Reporter, Editor, Accountant, Clerk, Garment workers, Factory workers, Sales, Helper and Cashier. Among them most of the respondents were Sales (17 respondents), Teacher (18 respondents) and Clerk (16 respondents). According to the survey data, the majority of respondents were Teachers from private and public sectors.

Among 150 respondents, 140 respondents (93%) were working full time and 10 respondents (7%) were working part-time. Survey findings showed that the majority of respondents were working full time and they had to spend more time in their workplace.

Regarding the age of respondents' youngest child, 68 respondents (45%) were in the age group of 01-1 year, 48 respondents (32%) were in the age group of 1.1-2 year, 17 respondents (11%) were in the age group of 2.1-3 year, 10 respondents (7%) were in the age group of 3.1-4 year and 7 respondents (5%) were in the age group of 4.1-5 year. The majority of respondents' youngest child were in the age group of 0.1-1 year, It showed that they had the recent experience and remembered very well about breast feeding to their kids so they could provide accurate answers.

Out of 150 respondents, 62 respondents (41%) were from nuclear family type and 88 respondents (59%) were from extended family. The family average monthly earning of respondents were 1 respondent (1%) earned less than 100,000 Ks, 19

respondents (12%) earned 100,000-300,000 Ks, 64 respondents (43%) earned 300,001-600,000 Ks, 39 respondents (26%) earned 600,001-1,000,000 Ks and 27 respondents (18%) earned 1,000,000 Ks above. The majority of respondents' family average monthly earning were 100,000-300,000 Ks, 64 respondents (43%). As the family income level was important, women need to decide whether to go back to work immediately after giving birth or not.

#### **4.3.2 Analysis on Knowledge of Working Mothers towards Exclusive Breastfeeding**

During Survey, data was collected from the questions which concern the knowledge of working mothers towards breastfeeding and findings were mentioned as below.

**Table (4.2) Understanding about Exclusive Breastfeeding**

<b>Variables</b>	<b>Number of Respondents</b>	<b>Percentage</b>
<b>Do you know about exclusive breast feeding?</b>		
Yes	149	99
No	1	1
Total	<b>150</b>	<b>100</b>
<b>Right time to give breast milk</b>		
Don't know	5	3
Between 30 minutes and 1 hour	123	87
Between 1 hour and 4 hours	14	10
Total	<b>150</b>	<b>100</b>
<b>Exclusive breast feeding is needed up to</b>		
3 months	3	2
6 months	143	95
1 year	4	3
Total	<b>150</b>	<b>100</b>

**Table (4.2) Understanding about Exclusive Breastfeeding (Continued)**

<b>Variables</b>	<b>Number of Respondents</b>	<b>Percentage</b>
<b>Is breast milk alone being enough for an infant</b>		
Yes	123	82
No	27	18
Total	<b>150</b>	<b>100</b>
<b>Breast feeding helps in mother and child bonding.</b>		
Yes	148	99
No	2	1
Total	<b>150</b>	<b>100</b>
<b>Breast feeding can prevent breast cancer</b>		
Yes	124	83
No	15	10
Don't know	11	7
Total	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

Table (4.2) shows the analysis of understanding about exclusive breastfeeding. Regarding the survey data for, “Do you know about exclusive breast feeding?”, the respondents who knew about it was 149 respondents (99%) and only 1 respondent (1%) who did not know about that. Therefore, it showed that most of the respondents had a high knowledge of EBF.

From the survey data, most mothers fed their child between 30 minutes and one hour with 87%. 10 % of mother fed their child between 1 hour and 4 hours and only 3% did not know about the right time to give breast feeding. Therefore, most of the mothers have knowledge about colostrum and its benefit so they fed their child within 30 minutes and 1 hour.

Breastfeeding was the essential for infants. However, mother should know the exact meaning of exclusive breastfeeding and the right duration of EBF. Then, mother would breast their child effectively and efficiently according to the WHO guideline. Concerning with the question about the duration of EBF, it showed that out of 150, 143

respondents (95%) breastfed their child up to 6 months, 4 respondents (3%) breastfed until 1 year and the rest 3 respondents (2%) stopped breastfeeding at 3 months. With this data, most of the mothers aware that exclusive breastfeeding was needed until 6 months.

Regarding the questions about “Is breast milk alone being enough for an infant?”, it also confirmed that 123 respondents (82%) agreed on breast milk alone was being enough for an infant during the first 6 months of life whereas 27 respondents (18%) did not agree. In previous question about “Do you know about exclusive breast feeding?” the respondents who knew about it was 149 respondents (99%) but 27 respondents (18%) did not agree that breast milk alone was being enough for an infant. It showed that even though the majority of the respondents knew about the exact meaning of EBF, only a few respondents did not know about that. Thus, they need to be educated about the exact meaning of EBF.

Child and mother bonding was created when a mom breastfeed her baby. Breastfeeding was associated with numerous health benefits to offspring and mothers and may improve maternal-infant bonding. Breastfeeding can improve child neurodevelopment as well as mother and child bonding was created. From the survey data, it was proved that 148 respondents (99%) were agreed on breast feeding helps in mother and child bonding. Only 2 respondents (1%) answered that it was not.

A lot of researchers have found that breastfeeding can prevent from breast cancer. As a result of survey data, 124 respondents (83%) aware that breastfeeding could prevent breast cancer. However, 15 respondents (10%) answered that breastfeeding cannot be prevented from breast cancer. 11 respondents (7%) did not have awareness about this matter.

**Table (4.3) Delivery Type**

<b>Variables</b>	<b>Number of Respondents</b>	<b>Percentage</b>
<b>Was your baby born in the hospital or at home?</b>		
Hospital	149	99
Home	1	1
<b>Total</b>	<b>150</b>	<b>100</b>
<b>Type of Delivery</b>		
Normal	73	49
Caesarean (the use of surgery)	77	51
<b>Total</b>	<b>150</b>	<b>100</b>
<b>Did you have a single child or twins in your pregnancy?</b>		
Single Birth	149	99
Twin	1	1
<b>Total</b>	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

In Table (4.3), the analysis on the type of delivery and pregnancy was shown. Regarding the question about the child delivery place, out of 150 respondents, 149 respondents (99%) born their baby in the hospital and only 1 respondent (1%) born at home. By looking at this, the respondents had a proper knowledge about the safety of giving birth at hospitals. In addition, if the respondent gave birth at hospital she could have an appropriate training on how to breastfeed the baby and what were the benefits of breastfeeding were already introduced.

According to survey data, 73 respondents (49%) had a normal delivery and 77 respondents (51%) had caesarean section. In Yangon, women prefer to have caesarean section because they could choose their preferable time and date. By knowing the exact time and date they have more time to prepare necessary arrangements. The data showed, 149 respondents (99%) carried a single pregnancy and 1 respondent (1%) carried a twin pregnancy.

#### 4.4.3 Attitude of Mothers towards Exclusive Breastfeeding

During survey, attitude of the respondents toward exclusive breastfeeding was accessed and results were mentioned below.

The assessment of Attitude towards breastfeeding based on Likert scale was shown in Table (4.4).

**Table (4.4) Attitude towards Breastfeeding**

Description	Number of respondents				Average Score
	SA	A	D	SD	
Giving breast milk for a new born immediately within an hour after birth is important?	116 78%	32 21%	2 1%	0 0%	3.8
Is the first milk or colostrum important before giving breast milk to a new born?	131 87%	18 12%	1 1%	0 0%	3.9
Giving only breast milk may be sufficient and a child does not need water and other fluids to prevent thirst up to six months.	34 23%	41 27%	60 40%	15 10%	2.6
Starting complementary foods to a child should not be before six months.	40 27%	61 41%	34 22%	15 10%	2.8
<b>Overall Average Scores</b>					<b>3.3</b>

Source: Survey Data, 2019

(Note: SA=Strongly Agree= 4 Likert scale, A=Agree= 3 Likert scale, D=Disagree =2 Likert scale, Strongly Disagree =1 Likert scale. Neutral was not included to get more precise answer.)

In Table (4.4), among 150 respondents, 116 (78%) strongly agreed that the statement of “Giving breast milk for a new born immediately within an hour after birth is important” whereas 32 respondents (21%) agreed. In contrast, 2 respondents (1%) disagreed on it. But there was no respondent who has strongly disagree for this statement. As a result, the average score for the respondents’ attitude towards breast

feeding was 3.8. It could be said that the respondents fairly agree with the importance of breast milk for new born.

Regarding to question “Is the first milk or colostrum important before giving breast milk to a new born? the result of mean score was 3.9. This was because the most of the respondents were strongly agreed with 87% by 131 respondents and 12 % by 18 respondents with general agreed. The average score was higher than 3 and it could be assumed that the respondents’ attitude on the importance of first milk or colostrum to a new born was moderately high.

Concerned with “Giving only breast milk may be sufficient and a child does not need water and other fluids to prevent thirst up to six months”. 15 respondents (10%) strongly disagreed and 60 respondents (40%) disagreed with this statement. As a result, the average score for this statement was 2.6 and it is moderately low. It showed that giving only breast milk was sufficient and no need water or other fluid up to six months should be educated to mothers.

The questions of “Starting complementary foods to a child should not be before six months.” among the result of 150 respondents, 15 respondents (10%) strongly disagreed to start complementary foods before six months and 34 respondents (22%) disagreed. As a result, the average score for this statement was 2.8 and it could be said that the attitude of respondents about the right time to start complementary foods to a child was moderately low. The overall average score for attitude of mothers towards exclusive breastfeeding was 3.3 and it could be concluded that the attitude of the respondents was moderately high.

**Table (4.5) Feeding in a Public Place**

<b>Since your baby was born, have you ever feed him/her in a public place?</b>	<b>Number of Respondents</b>	<b>Percentage</b>
No, I never fed in a public place	24	16
Yes, breastfed in a public place	108	72
Yes, bottle fed infant formula in a public place	10	7
Yes, bottle fed expressed breast milk	8	5
<b>Total</b>	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

The survey result of attitude on feeding in a public place was shown in Table (4.5). Obtained from 150 respondents per Table (4.5), 16% of respondents never breast feed in public place but 5% fed their kids with expressed breast milk from bottle. However, 72% breast in public places. Only 7% fed infant formula in public place. Therefore, it could be assumed that most of the mothers fed their kids in public places even though it was not convenient.

#### 4.4.4 Practice of Working Mothers towards Exclusive Breast

The practice of the respondents toward exclusive breastfeeding was accessed during survey and results were mentioned below.

**Table (4.6) Plan to Breastfeed Prior to Delivery**

<b>Did you plan to breastfeed prior to delivery/birth of your baby?</b>	<b>Number of Respondents</b>	<b>Percentage</b>
No	15	10
Yes (planned to only pump and give breast milk in bottles)	9	6
Yes (planned to breastfeed for several weeks)	25	17
Yes (planned to breastfeed for several months or more)	101	67
<b>Total</b>	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

Table (4.6) shows the question of “Did you plan to breastfeed prior to delivery/birth of your baby?”, the respondents did not plan ahead was 15 respondents (10%), who planned to only pump and give breast milk in bottles was 9 respondents (6%). 25 respondents (17%) planned to breastfeed for several weeks and 101 respondents (67%) planned to breastfeed for several months or more. According to the data, the majority of respondents planned to breastfeed for several months or more prior to the birth of their baby.

**Table (4.7) First Time Feeding of Breast Milk**

<b>When did you FIRST let your baby to have breast milk?</b>	<b>Number of Respondents</b>	<b>Percentage</b>
Within the first hour after delivery	122	81
Within the first day	22	15
After the first day but within a week	5	3
My baby had breast milk only in bottles	1	1
<b>Total</b>	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

From Table (4.7), 122 respondents (81%) let the baby to have breast feed within the first hour after delivery. 22 respondents (15%) within the first day, 5 respondents (3%) after the first day but within a week and only 1 respondent had breast milk with bottle. This result showed that the majority of respondents fed breast milk to their babies within the first hour after delivery.

**Table (4.8) Plan to Feed in the First Six Month**

<b>How did you plan to feed him/her in the first six months?</b>	<b>Number of Respondents</b>	<b>Percentage</b>
Breast milk	98	65.3
Formula	2	1.3
Combination of breast and formula	49	32.7
I didn't have any plans	1	.7
<b>Total</b>	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

From the data shown in Table (4.8), 98 respondents with (66 %) plans to breast feed and only 2 respondents (1%) plan to fed formula. 49 respondents (33%) plan to give combination of breast and formula but only 1 respondent didn't have any plans. So, it showed that a lot of respondents planned to feed breast milk in the first six months as they had the proper knowledge and good attitude on exclusive breastfeeding.

**Table (4.9) First Feed for the New Born Baby**

<b>What did you give to baby for his/her first feed?</b>	<b>Number of Respondents</b>	<b>Percentage</b>
Breast milk	142	94.7
Formula	8	5.3
<b>Total</b>	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

According to Table (4.9), 142 respondents with (95%) gave breast milk to their baby as first feed but 8 respondents (5%) gave formula. Therefore, most respondents gave breast milk to baby for his/her first feed. This is because most of the respondents gave birth at hospital and she could have a guidance on the first feed for the new born baby.

**Table (4.10) Breastfeeding during Maternity Leave Period**

<b>Did you breastfeed (only breast milk) to your baby during maternity leave?</b>	<b>Number of Respondents</b>	<b>Percentage</b>
Yes	149	99
No	1	1
<b>Total</b>	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

According to the data shows in Table (4.10), among 150 respondents, 149 respondents (99%) did EBF to their babies during maternity leave and only 1 respondent did not do. Therefore, it was clear that almost all working mothers breast feed their child during their maternity leave period. This high percent represents that when the mothers were on maternity leave they had a change to stay with their baby and could do EBF. If the respondents got longer maternity leave, they could do EBF to their babies longer.

**Table (4.11) Breast Feed after Returning to Work**

<b>Did you continue to breastfeed after returning to work?</b>	<b>Number of Respondents</b>	<b>Percentage</b>
Yes Breast milk only (Exclusive breastfed my baby)	67	44.7
Yes Breast milk and formula (Mixed-fed my baby)	76	50.7
No (Fed only formula)	7	4.7
<b>Total</b>	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

In this Table (4.11), 67 respondents (45%) continued to do EBF after returning to work and 76 respondents (51%) fed both breast milk and formula. There were only 7 respondents (4%) rely only on formula milk. This result proved that if the respondents got longer maternity leave, they could do EBF to their babies longer.

#### **4.4.5 Maternity Related Facilities at Workplace**

The survey findings on maternity related facilities as workplace were as follow.

**Table (4.12) Efficient Support from Working Environment for EBF**

<b>Variables</b>	<b>Number of Respondents</b>	<b>Percentage</b>
<b>How long was your maternity leave?</b>		
Nil	26	17
1 month	5	3
2 months	23	16
3 months	75	50.0
6 months & above	21	14.0
<b>Total</b>	<b>150</b>	<b>100</b>
<b>Other Maternity Benefit</b>		
Yes	67	45
No	83	55
<b>Total</b>	<b>150</b>	<b>100</b>

**Table (4.12) Efficient Support from Working Environment for EBF (Continued)**

<b>Does your employer provide facilities at work for you to express milk or breastfeed your baby if you want to?</b>		
Yes (to express milk)	2	1
Yes (to breastfeed)	10	7
No (neither)	138	92
Total	<b>150</b>	<b>100</b>
<b>Does your job allow you to have breastfeeding/pumping hours during work</b>		
Yes	28	19
No	121	81
Total	<b>150</b>	<b>100</b>
<b>Is there a breast feeding/ pumping room (not a restroom or lunchroom) at your work place?</b>		
Yes	9	6.0
No	141	94.0
Total	<b>150</b>	<b>100</b>
<b>Does it provide refrigerator for milk storage?</b>		
Yes	8	5
No	142	95
Total	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

Table (4.12) represented the efficient support from working environment for exclusive breastfeeding. According to the survey data, 26 respondents (17%) did not have any maternity leave. Only 5 respondents (3%) got 1 month maternity leave and 23 respondents (16%) got 2 months, 73 respondents (50%) got 3 months maternity leave. The rest 21 respondents (14%) got 6 months and above maternity leave. Due to the survey result, the majority got 3 months maternity leave but surprisingly 26 respondents (17%) did not have any maternity leave. Almost all the respondents who got 6 months and above maternity leave were working in the public sector.

Regarding the facilities at work to express milk or breastfeed, the survey data proved that only 2 respondents (1%) got support to express milk at work and 10 respondents (7%) proved that they got support to breastfeed at work. However, the

majority 138 respondents (92%) did not have a support from the employers or did not have an efficient supportive environment for EBF.

In terms of maternity benefits, 67 respondents (45%) got other maternity benefit like financial support and small gift but 83 respondents (55%) did not get other maternity benefit. It shown that among 150 respondents, only 28 respondents with (19%) were allowed to breastfeed/pump during work time and 121 respondents (81%) did not have a chance to breastfeed/pump during work time. It was very clear the majority of respondents were not allow to breastfeeding/pumping during work time.

It also revealed that the majority workplace did not have a proper private area for breastfeeding or pumping room (94%) and only (6%) of respondents have proper areas for EBF in work place. According to the survey finding, even though (19%) of respondents were allowed to breastfeed/pump during work time, (94) % of workplace did not have a proper private area for breastfeeding or pumping room. Most respondents pumped their breast milk at the rest room. Therefore, employer should provide a clean and private space for the breastfeeding working mothers.

In addition, only 8 respondents (5%) had a refrigerator to store the express breast milk and most workplace did not have refrigerator which was high (95%). Thus, if employers were not supportive, mothers may be more likely to wean infants earlier if they begin working outside the home while breastfeeding. In terms of maternity benefits, 67 respondents (45%) got other maternity benefit like financial support and small gift but 83 respondents (55%) did not get other maternity benefit.

**(a) Difficulties in Workplace Relating to Breastfeeding**

Table (4.13) showed the results on the difficulties in workplace relating to breastfeeding.

**Table (4.13) Difficulties in Workplace Relating to EBF**

<b>Any Difficulties in workplace relating to EBF</b>	<b>Number of Respondents</b>	<b>Percentage (%)</b>
Too Difficult	65	43
A little difficult	45	30
Not difficult	22	15
Absolutely not difficult	18	12
<b>Total</b>	<b>150</b>	<b>100</b>

Source: Survey Data, 2019

In Table (4.13), among 150 respondents, 65 respondents (43%) had a lot of difficulties in workplace due to EBF, 45 respondents (30%) had a little difficulties. 22 respondents (15%) did not have much difficulties as they fed their babies not only breast milk but also formula milk and other supplement. 18 respondents (12%) did not have any difficulties as they got the maternity leave for six months. After six months they could start complementary food to their babies. So, when they come back to work, they didn't have any difficulties at their workplace. It proved that the majority of working mothers were having difficulties due to EBF at workplace. It could be concluded that if the workplace was not mother friendly, then it was hard for a mother to continue with breastfeeding.

## **CHAPTER V**

### **CONCLUSION**

#### **5.1 Findings**

This study investigates the practices of working mothers towards exclusive breastfeeding and the difficulties of exclusive breastfeeding for working mother. In order to fulfill the objectives of this study, questionnaires were distributed to working mothers at the age of 18 years to under 45 years with a child below five years of age were selected as the focused area. Moreover, as the study main objective is to find out the EBF in working mothers, survey was conducted and quantitative data was collected from the respondents. The survey was conducted with 150 sample from working mothers who were living in five wards of Thingangyun Township such as San Pya, Lay Daunt Kan, Kyi Pwar Ye, Nga Moe Yeik and Ga Gyi

As indicated in 150 respondents' makes up of 150 females who were working mothers. The majority of respondents were age between 31-40 years old (49%), followed by respondent's age between 21-30 years (38%). Working mothers age 41<45 above (11%) and lastly age group between 18-20 years (2%). Therefore, it showed that most of the working mother's age is between 31 -40 years.

Within 150 respondents, 93 respondents (62%) were graduated, 42 respondents (28%) were in high school, 13 respondents (9%) were in middle school and 2 respondents (1%) were in Primary school level. In this study it is important to seek information on education level because it is assumed that the respondents who were more educated has proper work and they have more awareness on EBF.

Most of the respondents were full time employees (93%) and only (7%) work as a part time. Therefore, it indicates that most women were working full time and they have to spend more time in their workplace. In addition, working part time is not very popular as both employees and employers prefer full time as an efficient work position with good income.

In terms of working position, 15 respondents (10%) were assistant, 11 respondents (7%) were officers, 9 respondents (6%) were managers, 7 respondents (5%)

were managers and 108 respondents (72%) were working as other positions includes Doctor, Teacher, Nurse, Reporter, Editor, Accountant, Clerk, Garment workers, Factory workers, Sales, Helper and Cashier, etc.

Within 150 respondents, 64 respondents (43%) got 300,001-600,000 Kyats with highest family average monthly earnings and 1 respondent (1%) got less than 100,000 Kyats. The family income might be one of the factors for a woman to decide whether to go back to work immediately after giving birth or not.

According to the result based on respondents' knowledge towards EBF, it showed that 149 respondents (99%) gave birth at hospitals and only 1 respondent (1%) gave birth home. The mothers who gave birth at hospitals could have more chance to receive obstetric and postnatal care, nutritional education and counseling on the benefits of breastfeeding, correct positioning, and attachment. With this data it proved that most of the working mothers has proper knowledge about the safety delivery at hospitals.

The survey data also show that almost all of the respondents, 149 respondents (99%) know the exact meaning of EBF. In addition, out of 150 respondents, 122(82%) fed breast milk to the new born baby between 30 minutes to 1 hour with the rate of (87%). This high result is due to a factor that most of the respondents gave birth at hospitals which reinforce all mothers to give only breastmilk to new born baby. By doing this it will be beneficial for mothers and babies in terms of safety.

According to the data, most respondents have knowledge about the duration of EBF should be up to 6months is confirmed with (95%) 143 respondents agreed, followed by 4 respondents (3%) agree to EBF up to 1 year. Moreover, 123 respondents (82%) stated breast milk alone is being enough for an infant during the first 6months of life and only 27 respondents (18%) did not agree with this statement. Out of 150 respondents, 148 (99%) confirmed that breast feeding help mother and child bonding as well as 124 respondents (83%) confirmed for breast feeding can prevent breast cancer. However, a few respondents (7%) and (1%) do not know and agree for the benefits gained by breast feeding.

According to result from attitude of working mothers towards EBF, the majority of respondents strongly agreed to provide breast milk for a new born immediately. Within an hour after birth is important as well as the first milk or colostrum is important for a new born baby. However, there is a equal agreement and disagreement percentages on the statement "for giving only breast milk is sufficient and a child does not need water and other fluids to prevent thirst up to six months" is (50%) each. For "starting

complementary foods to a child should not be before six months” has (68%) agreement. Therefore, it has a prove that most respondents have a strong desire to have EBF and have knowledge about the benefit of EBF but due to some circumstances it lead them to give other complementary food and fluids. Within the 150 respondents, 24 respondents (16%) never fed in a public place. In contrast, 108 respondents (72%) breast fed in public place, 10 respondents (7%) bottle fed infant formula in a public place and only 8 respondents (5%) fed expressed breast milk with bottle in public places. From this result, it can conclude that most respondents have a good attitude towards EBF.

Practice of working mothers towards EBF data showed that out of 150 respondents, 101 respondents (67%) planned to breast feed for several months on more prior to delivery of their baby, followed by (17%) planned to breast feed for several weeks,9 respondents (6%) planned to give breast milk in bottle and 15 respondents (10%) do not have any plan. From the survey findings most of the respondents fed their baby breast milk within the first hour after delivery is (81%) and only (1%) fed breast milk in bottle. So, the respondents’ have not only a good knowledge to feed the new born baby within an hour but also they practice precisely by feeding breast milk for new born baby is (95%).

The highest percent of respondents who can breast feed their babies during maternity leave period is (99%) from 149 respondents. This high percent represents that when the mothers were on maternity leave they have a change to stay with their baby and can do EBF. It is proved that breast feeding can be perform well during maternity leave period because after returning to work only (30%) can breast feed their babies. Therefore, maternity leave plays an important role for a mother to breast feed to the child and it proved that if the mother gets longer maternity leave, they can breast feed their babies longer.

The data results on maternity related facilities at workplace indicate that 75 respondents (50%) can get 3months maternity level, 21 respondents (14%) get maternity leave for 6 months and above, 23 respondents (16%) get 2months maternity leave and 5 respondents (3%) get 1month maternity leave. Surprisingly, 26 respondents (17%) did not get any maternity leave at all. Furthermore, efficient support from working environment for EBF show low according to data analysis with (80%) and 121 respondents (81%) did not have allowance for breast feeding during working time, followed by 141 respondents (94%) did not have private area for EBF at workplace, no

refrigerator to keep milk at work place is 142 respondents (95%) and 83 respondents (55%) cannot get other maternity benefits. Due to those largest percent of respondents answers, it is proved that most of the working places do not support for EBF for working mothers and can lead to difficulties in workplace relating to breast feeding percentage has reached to (43%) according to survey data. The main barriers to exclusive breastfeeding involved a lack of proper infant feeding practices and lack of supportive environment.

## **5.2 Recommendations**

In respect to the result findings, it is obvious that even though knowledge and practice of exclusive breastfeeding was high among working mothers in the study population, exclusive breastfeeding was not always practiced according to World Health Organization recommended practice of exclusive breastfeeding. Despite high knowledge of exclusive breast-feeding, in practice, mothers introduced water and other liquid before 6 months of age as most of them have to go back to work place.

Breastfeeding breaks are important for working mothers' ability to exclusively breastfeed during the first six months of life, Duration of maternity leave is one of the main factor for EBF. If the mother gets more maternity leave, she has more chance to be with their child all the day so that she can provide her breast milk to her child as per needed. The most common reason for working mothers to start supplementary feeding earlier than six months of child's age was early return to work. Even though in Myanmar Labour Law, it is stated that every employed mother, whether or not they are covered by the Social Security Law (2012), is entitled to pay maternity leave of six weeks before confinement and eight weeks after confinement, (17%) of respondents do not get the maternity leave. So the government should take a strict enforcement on Myanmar Labour Law, to get every employer the minimum standard maternity leave.

Workplace environment also plays a positive role to promote exclusive breastfeeding. Mothers who continue breastfeeding after returning to work place need the support of their co-workers, supervisors, etc. within the workplace. In the workplace, programs specifically considered to support breastfeeding women are often a crucial factor in their ability to continue to provide breastmilk for their infants.

Supporting breastfeeding employees creates a higher productivity, loyalty and positive public image. Breastfeeding employees miss work less actually because breastfed infants are healthier. Employers should provide flexible time for

breastfeeding and expressing facilities at the work place to be used by breastfeeding employees and these facilities have to be hygienic, comfortable and private location for milk expression and breastfeeding and hygienic storage options for the mother to store her breast-milk. At work place, facilities and support for breastfeeding should be improved.

Therefore, proper knowledge and awareness about exclusive breastfeeding and provision of facilities for exclusive breastfeeding (EBF) by the employers can play a significant role to promote EBF among working mothers. In addition, policy makers should also consider promotion of infant-friendly work environment among employers and the establishment of work-site breast feeding room to promote exclusive breastfeeding.

## REFERENCES

- ABS (2004). "Breastfeeding in Australia"
- ABS, (2001). "Census, working population profile"
- Aidam, B.A., Perez-Escamilla, R., Lartey, A., and Aidm, J., (2005). "Factors associated with exclusive breastfeeding in Accra, Ghana"
- Alhabas, M. S. (2016). "Breastfeeding Among Working Mothers in Saudi Arabia"
- Alina, T., Sulaiman, Z., Jalil, R. & Manan, W., (2012). "Breast milk expression among formally employed women in urban and rural Malaysia", *International Breastfeeding Journal* 7.
- Alive and Thrive, & U. (2016). "The Economic Cost of Not Breastfeeding on Human Capital"
- Amin RM, S. Z. (2011). "Work related determinants of breastfeeding discontinuation among employed mothers in Malaysia", *International Breastfeeding Journal* 6.
- Arthur, C.R., Saenz, R.B. and Replogle, W.H., (2003). "The employment-related breastfeeding decisions of physician mothers". *Journal of the Mississippi State Medical Association*.
- Australian Bureau of Statistics (ABS), (2003). "Census, working population profile"
- Bandura, A., (1977). "Self-efficacy: Toward a unifying theory of behavioral change". *Psychological Review* ,84 191–215
- Black, R.E., Allen, L.H., Bhutta, Z.A, Caulfield, L.E., Onis, M., Ezzati, M., Mathers, C. & Rivera, J., (2008). "Maternal and child undernutrition: global and regional exposures and health consequences"
- Breastfeeding works, (2006). "The role of employers in supporting women who wish to breastfeed and work in four organizations in England"
- Cai, S., Deryk, S., Beal, Satrajit, S.k, Ghosh, Mark, K., et al, (2012). "Weak Responses to Auditory Feedback Perturbation during Articulation in Persons Who Stutter: Evidence for Abnormal Auditory-Motor Transformation"
- Cai, X., Wardlaw, T. & Brown, D.W., (2012). "*International Breastfeeding Journal*"
- Cambodia Demographic and Health Survey, (2010).
- CDC, (2004). "National Centre for Chronic Disease Prevention and Health Promotion". Breastfeeding practices: results from the 2003 National Immunization Survey.

- Centre for Community Child Health, (2006). "Breastfeeding promotion"
- Chit, T. M., Kyi, H., & Thwin, A. (2003). "Mothers' beliefs and attitudes towards child weight, child feeding and related practices in Myanmar". *Nutrition and Health*, 17(3), 231e254.
- Chung M, Raman G, Trikalinos T, Lau J, Ip S. (2008). "Interventions in primary care to promote breastfeeding: an evidence review for the US Preventive Services Task Force".
- Cohen R, Mrtek MB, (1994). "The impact of two corporate lactation programs on the incidence and duration of breast-feeding by employed mothers" *American Journal of Health Promotion*
- Cohen, R., Mrtek, M.B. & Mrtek, R.G., (1995). "Comparison of Maternal Absenteeism and Infant Illness Rates Among Breast-Feeding and Formula-Feeding Women in Two Corporations, *American Journal of Health Promotion*, Vol. 10, pp. 148-153.
- Corbett - Dick,P., and Bezek, S. K.(1997). "Breastfeeding promotion for the employed mother". *Journal of Paediatric Health Care*
- Davis, (1994). "Back at work and breastfeeding. American Baby: For Expectant & New Parents"
- Davis, S.K., Stichler, J.F. & Poeltler, D.M. (2012). "Increasing Exclusive Breastfeeding Rates in the Well-Baby Population". *Nursing for Women's Health*. 16(6): 460-470.
- Davis,R.R., Hofferth, S.L., Shenassa,E.D., (2014). "Gestational weight gain and risk of infant death in the United States". *Am J Public Health*
- Dennis, C.L. (2002). "Breastfeeding initiation and duration:1990-2000 literature review". *Journal of Obstetrics Gynecology and Neonatal Nursing*
- Department of Population. (2014). "The 2014 Myanmar Population and Housing Census"
- Dewey, K.G., Heinig, M.J. & Nommsen, L.A. (1993). "Maternal weight-loss patterns during prolonged lactation". *The American Journal of Clinical Nutrition*. Vol.58(2): 162-166.
- Dun-Dery, E.J., Laar, A.K(2016). "Exclusive breastfeeding among city-dwelling professional working mothers in Ghana". *International Breastfeeding Journal* Vol.11, Article number: (23)
- Dylan, W., (2016). "The cost of not breastfeeding in Southeast Asia". *Health Policy and Planning*, Vol. 31 No. 8.

- Elvis J., Dun-Dery & Amos, K. Laar., (2016). “Exclusive breastfeeding among city-dwelling professional working mothers in Ghana”, *International Breastfeeding Journal* volume 11, Article number: 23
- Emmanuel, A. (2015). “A Literature Review of the Factors That Influence Breastfeeding: An Application of the Health Believe Model”. *International Journal of Nursing and Health Science* Vol. 2, No. (3),28-36.
- Emmanuel, O.B., (2015). “The impact of teamwork on employee performance”
- Forster, D. A., McLachlan, H. L., & Lumley, J. (2006). “Factors associated with breastfeeding at six months postpartum in a group of Australian women”. *International Breastfeeding Journal*, 1, 18.
- Gale, C., Logan, K.M., Samankumaran, S., Pakinson, J.R., Hyde, M.J and Modi, N., (2012). “Effect of breastfeeding compared with formula feeding on infant body composition”
- Gartner, L.M., Morton, J., Lawrence R.A., Naylor, A.J., O'Hare, D., Schanler, R.J. and Eidelman, A.I., (2005). “Breastfeeding and the use of human milk”
- General Statistical Office, (2011). “Viet Nam Multiple Indicator Cluster Survey 2011”, Final Report. Hanoi, Viet Nam.
- Greenberg, C. K. (1991). “Anticipatory guidance for the employed breastfeeding mother”. *Journal of Paediatric Health Care*.
- Greer, F.R., Sicherer, S.H. and Burks, A.W., (2008). “Effects of early nutritional interventions on the development of atopic disease in infants and children: the role of maternal dietary restriction, breastfeeding, timing of introduction of complementary foods, and hydrolyzed formulas”
- Guendelman, S., Kosa, J.L., Pearl, M., Graham, S., Goodman, J. & Kharrazi, M., (2009). “Juggling work and breastfeeding: Effects of maternity leave and occupational characteristics”. *Pediatrics*. PEDIATRICS Volume 123, Number 1.
- Gummer-Strawn, L.M., (1996). “The Effect of Changes in Population Characteristics on Breastfeeding Trends in Fifteen Developing Countries”. *International Journal of Epidemiology*, Volume 25, Pages 94–102
- Hauck, Y., (2004). “Factors influencing mothers’ decision to breastfeed in public”
- Hill, P. & Aldag, J., (1991) “Potential indicators of insufficient milk supply syndrome”. *Research in nursing and health*
- Huffman, S.L., (1984). “Determinants of breastfeeding in developing countries: overview and policy implications”

- Ibadin, O., Ofili, N., Morrison, O. & Nkwuo, E., (2012). “Exclusive Breastfeeding and Malaria in Early Infancy: Experience from Benin City, Nigeria”. *Journal of Medicine and Biomedical Research*.
- IFPRI, (2016). “From Promise to Impact: Ending Malnutrition by 2030”
- Imdad, A., Yakoob, M.Y. & Bhutta, Z.A., (2011). “Impact of maternal education about complementary feeding and provision of complementary foods on child growth in developing countries”
- Inch, S. 2003. Myle’s Textbook for midwives: Feeding. 14th edition. Livingston Churchill publisher. London, United Kingdom
- Ip, S., Chung, M., Raman, G., Chew, P., Magula, N., Vine, D., Trikalinos, T. & Lau, J., (2007). “Breastfeeding and maternal and infant health outcomes in developed countries”, *Journey of America Medical association, breast feeding*.
- Kosmala-Anderson J. and Wallace, L.M., (2006). “The role of employers in supporting women who wish to breastfeed and work in four organizations in England”
- Kramer, M. & Kakuma, R., (2012). “Optimal duration of exclusive breastfeeding”
- Kramer, M.S., and Kakuma, R., (2012). “Optimal duration of exclusive breastfeeding”
- Kuti, O., Adeyemi, A.B. & Owolabi, A.T., (2007). “Breast-feeding pattern and onset of menstruation among Yoruba mothers of South-west Nigeria”. *European Journal of Contraception and Reproductive Healthcare*.
- Labbok, M.H., (2001). “Effects of breastfeeding on the mother”. *Pediatric Clinics of North America*. 48(1): 143-158.
- Labbok, M.H., Wardlaw, T., Blanc, A., Clark, D. & Terreri, N. (2006). “Trends in exclusive breast feeding: findings from the 1990s”. *Journal of Human Lactation*.
- Lamberti, L.M., Zakarija-Grković, I., Walker, C.L.F., Theodoratou, E., Nair, H., Campbell, H. & Black, R.E., (2013). “Breastfeeding for reducing the risk of pneumonia morbidity and mortality in children under two: a systematic literature review and meta-analysis”
- Lamberti, L.M., Zakarija-Grković, I., Walker, C.L.F., Theodoratou, E., Nair, H., & et al, (2013). “Breastfeeding for reducing the risk of pneumonia morbidity and mortality in children under two: a systematic literature review and meta-analysis”. *BMC Public Health*. 13(3): 1-8.
- Losch, M., Dungy, C.I., Russell D. & Dusdieker, L.B. (1995), “Impact of attitudes on maternal decisions regarding infant feeding”, *The Journal of Pediatrics*, 126 (4), pp. 507-514.

- Mascarenhas, O.A., Kesavan, R. and Bernacchi, M., (2006). “Lasting customer loyalty: a total customer experience approach”, *Journal of Consumer Marketing*, ISSN: 0736-3761
- May Me Thet, et al. (2016). “Assessing Rates of Inadequate Feeding Practices Among Children 12–24 months”: Results from a Cross-Sectional Survey in Myanmar. New York.
- Ministry of Health and Sports (MOHS), (2011). “National Strategy on Infant and Young Child Feeding”, (IYCF) (2011-2016). Nay Pyi Taw, Myanmar: Ministry of Health and Sports, Myanmar.
- Ministry of Health and Sports (MOHS), (2015). “Training Modules on Baby Friendly Hospital Initiative (2015)”. Nay Pyi Taw, Myanmar: Ministry of Health and Sports, Myanmar.
- Ministry of Labour, (2017). “Annual Labour Force Survey-2017”, Quarterly Report, 1st Quarter, January-March 2017. Nay Pyi Taw.
- Ministry of National Planning and Economic Development and Ministry of Health, (2011). “Myanmar Multiple Indicator Cluster Survey 2009-2010 Final Report”. Nay Pyi Taw, Myanmar: Ministry of National
- MNPED, M. &. (2011). “Myanmar Multiple Indicator Cluster Survey, Nay Pyi Taw”
- MOHS, (2017). “Demographic and Health Survey”, Nay Pyi Taw
- Mullany, L. C., Lee, C. I., Yone, L., Paw, P., Shwe Oo, E. K. M., Cynthia, L., et al. (2008). “Access to essential maternal health interventions and human rights violations among vulnerable communities in Eastern Burma”. *PloS Medicine*, 5(12), e242.
- Murimi, M., Pope, J., Dodge, C.M., Erickson, D., (2012). “Factors that Influence Breastfeeding Decisions among Special Supplemental Nutrition Program for Women, Infants, and Children Participants from Central Louisiana”
- Myle’s Textbook for midwives, (2003). 14th edition. Livingston Churchill publisher. London, United Kingdom.
- National Institute of Statistics, Directorate General for Health & ICF Macro, (2011). “Cambodia Demographic and Health Survey 2010 Phnom Penh, Cambodia and Calverton, Maryland”, USA: National Institute of Statistics, Directorate General for Health, and ICF Macro.
- National Statistical Office, United Nations Children’s Fund, Ministry of Public Health (2013). “Thailand Multiple Indicator Cluster Survey 2012” Bangkok, Thailand: National Statistical Office.

- National Statistical Office, United Nations Children’s Fund, Ministry of Public Health et al., (2013). “Thailand Multiple Indicator Cluster Survey 2012. Bangkok, Thailand: National Statistical Office”
- Natural Resource Defence Council, (2005). “Benefit of Breastfeeding”
- NRDC, (2005). “Benefit of breastfeeding”
- Nukpezah, R.N., Nuvor, S.V. & Ninnoni, J. (2018). “Knowledge and practice of exclusive breastfeeding among mothers in the tamale metropolis of Ghana”
- Ortiz, J., McGilligan, K. & Kelly, P. (2004). “Duration of breast milk expression among working mothers enrolled in an employer-sponsored lactation program”
- Planning and Economic Development and Ministry of Health.
- Rollins, N., Bhandari, N., Hajebehoy, N., & Horton, S., (2016). “Breastfeeding in the 21st Century: why invest, and what will it take to improve breastfeeding practices”
- Rollins, N.C., Bhandari, N., Hajebehoy, N., Horton, S., Lutter, C.K., et al, (2016). “Review Why invest, and what it will take to improve breastfeeding practices?”
- Sandar, M. (2006). “Influence of maternal factors on duration of breastfeeding: Case study of Pyay district of Myanmar (Masters)”. Mahidol University.
- Sanusi, R. & Falana, O., (2013). “The Nutritional Status of Mothers Practicing Breast Feeding in Ibadan, Nigeria”. *African Journal of Biomedical Research*.
- Seidu, I. (2013). “Exclusive Breastfeeding and Family Influences in Rural Ghana”.
- Sheeshka, J., Potter, B., Norrie, E., Valaitis, R., Adams, G. & Kuczynski, L. (2001). “Women’s experiences breastfeeding in public places”
- Sokol, E., Clark, D, Aguayo, V.M., (2007). “Protecting breastfeeding in West and Central Africa”: 25 years implementing the international code of marketing breast milk substitutes. UNICEF Publication.
- Soomro, Ahmed, J., (2015). “Factors affecting breastfeeding practices in working women of Pakistan”
- Statistics Canada, (2001). “Experienced labour force 15 years and over by class of worker, by provinces and territories”
- Statistics Canada, (Statcan), (2001). “Experienced labour force 15 years and over by class of worker, by provinces and territories”
- Statistics Indonesia, (2013). “National Population and Family Planning Board, Ministry of Health Indonesia & MEASURE DHS”

- Thet, M.M., Khaing, E.E., Diamond-Smith, N., Sudhinaraset, M., Oo, S. & Aung, T. (2016). “Barriers to exclusive breastfeeding in the Ayeyarwaddy region in Myanmar”: Qualitative findings from mothers, grandmothers, and husbands.
- Thompson, P. P. (1997). “Breastfeeding in the workplace”: How to succeed. Issues in Comprehensive Pediatric Nursing.
- UK Office for National Statistics, (2002). “Trends in female employment 2002. Labour market trends”
- Ukegbu, A., Ukegbu, P., Onyeonoro, U. & Ubajaka, C., (2010). Determinants of breastfeeding patterns among mothers in Anambra State, Nigeria”. *South African Journal of Child Health*.
- UNICEF, (1989). “Convention on the Rights of the Child”
- UNICEF, (2006). “Progress for Children: A Report Card on Nutrition (No. 4)”
- UNICEF, (2010). “*ANNUAL REPORT 2010*”
- UNICEF, (2011). “Infant and Young Child Feeding”
- UNICEF, (2013). “Breastfeeding on the worldwide agenda: findings from a landscape analysis on political commitment for programmes to protect, promote and support breastfeeding”
- UNICEF, (2016). “From the First Hour of Life: Making the case for improved infant and young child feeding everywhere”
- UNICEF, (2018). “BREASTFEEDING: A Mother's Gift, for Every Child”
- US Census Bureau, (2002). “Labor force status of the civilian population 16 years and over by sex”
- US Census, (2002). “Labour force status of the civilian population 16 years and over by sex”
- Victora, C.G., Bahl, R., Barros, A.J., França, G.V., Horton, S., et al, (2016). “Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect”; Lancet Breastfeeding Series Group
- Victora, C.G., Horta, B.L., Mola, C.L., (2015). “Association between breastfeeding and intelligence, educational attainment, and income at 30 years of age”: a prospective birth cohort study from Brazil. *The Lancet Global Health* 3: 199–205
- Weimer, J., (2001). “The Economic Benefits of Breastfeeding”: A Review and Analysis. Food Assistance and Nutrition Research Report No. 13.

- White, A. L., Carrara, V. I., Paw, M. K., Malika, Dahbu, C., Gross, M. M., et al. (2012). “High initiation and long duration of breastfeeding despite absence of early skinto-skin contact in Karen refugees on the Thai-Myanmar border”: a mixed methods study. *International Breastfeeding Journal*, 7(1), 19.
- WHO, (2000). “The world health report 2000, Health systems: improving performance”
- WHO, (2002). “The world health report 2002 - Reducing Risks, Promoting Healthy Life”
- WHO, (2012). “Global Health Observatory (GHO) data”
- WHO, (2017). “Frequently Asked Questions” (2017 Update) Geneva, Switzerland, World Health Organization.
- WHO, (2018). “Infant and young child feeding”
- WHO, UNICEF, (2003). “Global Strategy for Infant and Young Child Feeding”, Geneva, Switzerland.
- WHO, UNICEF, (2018). “Protecting, promoting, and supporting breastfeeding in facilities providing maternity and new born services”
- World Bank, (2015). “Country and lending groups”

## WEBSITES

[http://www.unicef.org/infobycountry/myanmar\\_statistics.html](http://www.unicef.org/infobycountry/myanmar_statistics.html).

<https://doi.org/10.1002/14651858.CD006177.pub3>

<https://publichealth.yale.edu/bfci/howto>

<https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/8E65D6253E10F802CA256DA40003A07C>

<https://www.aliveandthrive.org/wp-content/uploads/2018/07/Myanmar-CONB-brief-Jan-2016.pdf>

## APPENDIX

### Survey Questionnaire

Hello, my name is Nee Sin and I am MPA student from Yangon Economic University of Applied Economics. I am writing my thesis about **A Study on an Exclusive Breastfeeding Practice among Working Mothers in Myanmar**. I would be very grateful if you could answer my questions on this questionnaire. A towel will be raffled among all who return the filled in questionnaire.

This is a survey questionnaire for my thesis. These answers will need to complete it probably takes 15-20 minutes. The information collected is “private and confidential” and will not be used for assessment. No part will be revealed without consent.

**Section A: Questions about Demographic Information.** Please tick (✓) only your answer.

1. Respondent's Age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	18-20	21-30	31-40	41 <45	
2. Respondent's Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Primary	Middle	High	University	
3. Respondent's Job Position	<input type="checkbox"/>				
	Assistant	Officer	Manager	Director	Other
4. Type of Employment	<input type="checkbox"/>		<input type="checkbox"/>		
	Full time		Part time		
5. Age of the respondents' youngest child	<input type="checkbox"/>				
	0.1-1	1.1-2	2.1-3	3.1-4	4.1-5

6. Family

Composition

Nuclear family

Expanded family

7. Family

Average Monthly  
Earning

Less than  
100,000 Ks

100,000 -  
300,000 Ks

300,001-  
600,000 Ks

600,001-  
1,000,000 Ks

Above  
1,000,000 Ks

**Section B: Questions about Knowledge of Mothers towards Exclusive Breast Feeding.** Please tick (✓) only your answer.

1. Do you know about  
exclusive breast  
feeding?

Yes

No

2. Right time to give  
breast milk?

Less than  
30 minutes

Between 30  
minutes and  
1 hour

Between 1  
hour and 4  
hours

More than four  
hours after  
delivery

3. Exclusive breast  
feeding is needed up to

3 months

6 months

1 year

4. Is breast milk alone  
being enough for an  
infant during the first 6  
months of life?

Yes

No

I don't know

5. Breast feeding helps  
in mother and child  
bonding.

Yes

No

I don't know

6. Breast feeding can prevent diseases affecting breast  Yes  No  I don't know
7. Was your baby born in the hospital or at home?  Hospital  Home
8. Type of delivery  Normal  Cesarean (the use of surgery)
9. Did you have a single child or twins in your pregnancy?  Single birth  Twin

**Section C: Questions related to Attitude of Mothers towards Exclusive Breast Feeding**

Please tick (✓) only your answer.

1. Giving breast milk for a new born immediately within an hour after birth is important?  Strongly Agree  Agree  Disagree  Strongly Disagree
2. Is the first milk or colostrum important before giving breast milk to a new born?  Strongly Agree  Agree  Disagree  Strongly Disagree
3. Giving only breast milk may be sufficient and a child does not need water and other fluids to prevent thirst up to six months  Strongly Agree  Agree  Disagree  Strongly Disagree

4. Starting complementary foods to a child should not be before six months?

Strongly Agree      Agree      Disagree      Strongly Disagree

5. Since your baby was born, have you ever feed him/her in a public place?

No, I never fed in a public place.      Yes, breastfed in a public place      Yes, bottle fed infant formula in a public place      Yes, bottle fed expressed breast milk.

**Section D: Questions related to Practice of Working Mothers towards Exclusive Breast Feeding.** Please tick (✓) only your answer.

1. Did you plan to breastfeed prior to delivery/birth of your baby?

No      Yes      Yes      Yes

(planned to only pump and give breast milk in bottles)      (planned to breastfeed for several weeks)      (planned to breastfeed for several months or more)

2. When did you FIRST let your baby to have breast milk?

Within the first hour after delivery      Within the first day      After the first day but within a week      My baby had breast milk only in bottles

3. How did you plan to feed him/her in the first six months?

Breast milk      Formula      Combination of breast and formula      I didn't have any plans

4. What did you give to baby for his/her first feed?

Breast milk.

Formula

Others

5. Did you breastfeed (only breastmilk) your baby during maternity leave?

Yes

No

6. Did you continue to breastfeed after returning to work?

Yes

Yes

No

Breast milk only  
(Exclusive breastfed my baby)

Breast milk and formula (Mixed-fed my baby)

(Fed only formula)

### Section E: Questions related to Maternity related Facilities at Workplace.

Please tick (✓) only your answer.

1. How long was your maternity leave?

Nil

1month

2 months

3 months

6 months & above

2. Does your employer provide facilities at work for you to express milk or breastfeed your baby if you want to?

Yes

(to express milk)

Yes

(to breastfeed)

No

(neither)

3. Does your job allow you to have breastfeeding hours during work time?

Yes

No

4. Is there a breast feeding/  
pumping room (not a  
restroom or lunchroom) at  
your work place?

Yes

No

5. Does it provide  
refrigeration for milk  
storage?

Yes

No

6. Other Maternity Benefit

Yes

No

7. Any Difficulties in  
workplace relating to  
Breastfeeding

Too  
Difficult

A Little  
Difficult

Not  
Difficult

Absolutely not difficult

Thank you very much for your participation.

Nee Sin Thwet Aye

Roll No (40)

EMPA 16<sup>th</sup> Batch