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**BARRIERS TO EXCLUSIVE BREAST-FEEDING AND NUTRITIONAL
STATUS OF EXCLUSIVELY AND NON-EXCLUSIVELY BREASTFED
INFANTS IN TERKIDI REFUGEE CAMP, GAMBELLA, WESTERN
ETHIOPIA**

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**A MSW DISSERTATION PROPOSAL SUBMITTED TO THE IGNOU FOR THE
AWARD OF MASTERS DEGREE IN SOCIAL WORK**

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1. Background of the Study

1.1. Introduction

Breastfeeding is appreciated as an optimal way to feed infants for the first six months of life by many international organizations like WHO and UNICEF. They have developed various guidelines and strategies to promote infant and young child feeding practices. They have also established a clear indicator to measure the prevalence of infant feeding practices, and some of these indicators include: breast feeding initiation just a few hours after a birth, rate of exclusive breastfeeding up to the first 6months, introduction of complementary feeding at 6months with continuous breast feeding up to two years, etc.

The research under study mainly focuses on the breast feeding practices for the first 6months of life as breast feeding initiation, frequency of feeding, and exclusive breast feeding and the various determinants or major influencing factors which can hamper the effectiveness of the feeding practices and how this could critically influence or contribute to the nutritional status of infants. Though many researchers have been done on the prevalence of malnutrition especially for children 6-59 months, there is almost no significant research done on causal factors which can determine the rate of exclusive breastfeeding as well as the possible effect of these determinants on the rate of child under nutrition and which intervention mechanism can best address the critical challenges affecting children, in particular infants under 6 months of age in refugee camp setting.

(Debra J Hector, March 2005), indicated that the barriers to exclusive breastfeeding (EBF) can be illustrated in to different categories by using conceptual framework. The framework is designed in to three levels namely; individual, group and society. From this framework, we can generate premises about the determinants of breastfeeding, especially EBF and the types of interventions that might be used to address them. Accordingly, the individual level factors connote directly to the mother, infant, and the 'mother-infant dyad'. These factors include the mother's intention to breastfeed, her knowledge, skills and parenting experience, the birth experience, health and risk status of mothers and infants, and the nature of early interaction between mother and infant. Each of this can directly influence the initiation and duration of breastfeeding, and are frequently correlated with social and demographic variables.

Group level factors are environmental factors in which the mothers and infants, and infants find themselves, or something that can enable mother to breastfeed. Environments with a direct influence on mothers and infants include: the hospital and health facilities environment, or the facilities where services are given and infant friendly environment like baby friendly center in which practices and procedures such as infants routinely rooming-in with mothers to allow demand feeding, postpartum skin-to-skin contact and providing professional support with breastfeeding technique difficulties influence the early feeding experience and the follow-up care and support, the home and peer environment, where physical and social factors such as size of household, parity, family circumstances, partner attitudes and support, and peer support affect the time, energy and resolve that mothers have for breastfeeding and also the work environment, in which policies, practices and facilities such as work hours and flexibility, facilities and policies that enable on-site expressing and storing of breastmilk influence mother's ability to combine work and breastfeeding and the community environment, which signals the extent to which breastfeeding is recognized as a norm, and reinforced by facilities and policies in public places, for example parenting rooms in shopping centers and entertainment venues, 'breastfeeding friendly' public transport, restaurants, etc. are among others. The public policy environment, which modifies how each of these environments influence mother's feeding decisions, have a significant impact on the hospital, home, and work environments that in turn, influence infant feeding decisions directly.

Societal level factors are broad level factor as a basic factor which influence the acceptability and ex-petitions about breastfeeding and provide the background or the context in which mothers' feeding practices occur. These include cultural norms regarding breastfeeding, child feeding, and parenting; the role of women in society, including how working outside the home is valued; the degree to which men's social role includes support for breastfeeding mothers; the extent to which exposing breasts for feeding is complicated by cultural norms regarding sexuality; and the economic importance of products such as breastmilk substitutes and complementary foods in the food system.

Generally, group level and societal level influences may interact in either positive or negative ways with maternal knowledge and skills. For example, a mother may be predisposed to breastfeed, but a non-supportive environment in the hospital or other facility level may lead to

her deciding to stop breastfeeding early. Similarly, lack of support at home or in the community, etc. may also lead to her stopping early. Again, broader societal attitudes about sexuality, and especially breasts, can influence the manner and degree of community support.

Globally, new estimates for the year 2004 found that stunting, severe wasting, and fetal growth restriction together were responsible for 2.2 million deaths of children under five years. Deficiencies of vitamin A and Zinc were estimated to be responsible for 0.6 million and 0.4 million deaths, respectively; and sub-optimum breastfeeding for 1.4 million deaths, Black (al, 2008).

Lancet Series Report (June, 2013) on the Maternal and Child undernutrition, indicated a conceptual framework analysis that illustrate how child undernutrition is caused by multiple interrelated causal factors. Accordingly, child undernutrition has three interrelated causal factors: the immediate factors, the underlying factors, and the root causes or basic factors. For first instance, child undernutrition is an outcome of the balance between food intake and food requirements, which is influenced by disease and care. Inadequate energy and nutrient intake, infectious disease and inadequate care are thus the proximal risk factors for child undernutrition. Specifically, chronic energy and/or nutrient depletion in young children leads to slowed skeletal growth and a loss of, or failure to accumulate, muscle mass and fat and deficiencies of specific nutrients. Because of the dependent status of infants and young children (under 2 years of age), food intake and disease are very strongly influenced by the feeding, care-giving, and health care-seeking practices of the caregiver. As a result, it is not conceptually meaningful to separate, for example, food intake from feeding practices.

Inappropriate infant and young child feeding practices have a negative impact on child nutrition status. The World Health Organization recommends breastfeeding initiation within 1 hour of birth, exclusive breastfeeding for the first 6 months, and appropriate complementary feeding beginning at 6 months, with breastfeeding continued for 2 years and beyond. Where these practices are not followed, negative impacts on child nutrition and health can result.

Similarly, (G Victora MD, 2016) indicated that Breastfeeding could save 820,000 lives annually, which means, preventing 13% of all deaths of children under five years. Breastfeeding reduces one-third of respiratory infections and about half of all diarrhea episodes in low- and middle-

income countries. The other factors that contributed to the high level of child undernutrition was the lack of food diversity and access to food and lower position of women in income level and education which was attributed to the root cause of poverty, and socio-cultural factors at the community and society level such as family support, but our main focus here is to the relationship between factors affecting exclusive breastfeeding and how this could in turn affect child undernutrition and survival.

In Ethiopia, several studies have also shown that exclusive breastfeeding for the first six months plays a great role in preventing morbidity and mortality. However, a study by (Tesfaye Setegn, 2012) in Bale Goba District, southeast Ethiopia, has shown that a large portion of infants is not exclusively breastfed and according to the infant feeding recommendations, the prevalence rate on EBF was 71.3%. In addition, similar studies has been done in Ethiopia by (Tewodros Alemayehu, 2009) to assess the determinants that influence breast feeding and accordingly, the overall rates of exclusive and full breastfeeding were 49.0% and 68.2% respectively. Hence, it was found that maternal education, marital status, wealth index and age of the child were closely associated with EBF practices, nonetheless, in the hierarchical analysis; being not married, middle/ richer/ richest wealth index, and child age 0-1and 2-3 month were retained as the predictors of EBF ($P < 0.05$). This show that still the rate of breast feeding practice is very low.

In the same manner, a study of the nutrition survey result 2016 at Terkidi refugee camp, indicate that timely initiation of breast-feeding was 82% and the rate of EBF was 84.8% while introduction of solid semi solid food at 6months was 78% respectively. From the survey result, even though the result of breast-feeding seems to have be good, there is still a gap of more than 5% and there is no research done about the major determinants that can affect EBF and the likely relationship between rate of EBF and child undernutrition. There also need a research on the detail status of breast-feeding in terms of people's knowledge, attitude, etc. and other related issues. In addition, the rate of child undernutrition for infants less than 6 months was not done and that age group was overlooked.

Therefore, the output of this research is partially intended to the gaps of existing breastfeeding challenges in the study area.

1.2. Statement of the Problem

In Terkidi Refugee Camp, the Annual Standardized Enhanced Nutrition Survey (SENS) result of 2014-2016 for the children 6-59 months of age indicated that even though there is slight reduction from 30.3 in 2014 to 24.4 in 2016 respectively, the Global Acute Malnutrition (GAM) Rate is still very high and is above the threshold of 15%.

Francisco (2010), indicated that child mortality has been reduced for the last several decades and these “changes” according to him was due the change in general malnutrition. This indicates that there is a direct relation between nutrition and child survival. Child survival, which is related to the infant’s nutrition mainly from exclusive breastfeeding, has helped them. Therefore, if there is a change in EBF practice there is a change in child survival. Child mortality, which is related to the low practice of EBF, is caused by breastfeeding determinants such as social, economic and health related risks.

The (CSA, 2016) indicated that *only* 58% of infants were exclusively breastfed for the first six months. With regard to the refugee setting, (Millicent Kavosa, 2016) nutrition survey indicated that timely initiation of breast-feeding was 82% and the rate of EBF was 84.8% while introduction of solid semi solid food at 6months was 78% respectively. From the survey result, even though the result of breast-feeding seems to have be good, there is still a gap of more than 5% and there is no research done about the major determinants that can affect EBF and the likely relationship between rate of EBF and child undernutrition. There also need a research on the detail status of breast-feeding in terms of people’s knowledge, attitude, etc. and other related issues. In addition, the rate of child undernutrition for infants less than 6 months was not done and that age group was overlooked.

In addition to the above, the Nutrition Survey 2016, the rate of child under up 10th June nutrition (GAM rate was about 24.4% for children 6 to 59months and any figure > 15% is critical as per the sphere standard) and this has been the main concern and most challenging issues, which requires more integrated intervention approach from the humanitarian agencies even if there are different services giving response to the crises. On top of that, out of the current total population of 70, 0024, the newly arrived refugees between September 1st, 2016 to March 21st 2017 was 14,528, which are currently in a deteriorated living condition, this makes the camp to be in an

emergency situation, where the overall rate of breast feeding condition also disrupted and changes the previous prevalence of EBF (UNHCR, 2017). Hence, lack of current data on EBF for new arrivals and any changes in living style also makes complex to identify the likely determinants of EBF and in turn affects the nutritional status of infants in this age group. This means, the negative impact in the rate of EBF, affecting child undernutrition, also affects the rate of malnutrition for the other age category, especially children 6-59 months, which accounts for 18.1% of the population in the camp. The presence of complex health risks and other issues in the camp along with poor infant feeding practices exacerbate the severity of child undernutrition that requires urgent solution.

Most of the research been conducted in the camp in particular nutrition survey mainly focus on the general indicators which is mostly quantitative and doesn't exactly describe the real picture of the breast feeding status and no other research been carried out especially on the relationship between poor infant feeding practices and nutritional status of infants which could be a cause for the later. Therefore, understanding the factors that influence the prevalence of exclusive breastfeeding (which is hence termed as determinants or barriers to breastfeeding) is crucial in planning for effective intervention strategy and the research is planned to fill these gaps and provide feasible recommendation on the best workable solution.

1.3. Research Objectives

1.3.1. General Objective

The main objective of this study will be to examine: the major determinants of exclusive breastfeeding and how it will influence effective practice of exclusive breastfeeding as well as the relationship between breastfeeding and nutritional status of infant who are exclusively breastfeed and non-exclusively breastfeed.

The impact of barriers to exclusive breastfeeding is measured in terms of mothers' level of knowledge, attitude, and practice on exclusive breastfeeding and the nutritional status of infants.

1.3.2. Specific Objectives

- To investigate the major barriers influencing exclusive breastfeeding.

- To examine the relationship between exclusive breastfeeding and the nutritional status of infants who are exclusively breastfed and not.
- To assess the mothers' knowledge and attitude and practice towards exclusive breastfeeding.

1.4. Research Questions

- This research study will answer the following questions:
- What are the major barriers influencing effective practice of exclusive breastfeeding?
- What are relationship between exclusive breastfeeding and the nutritional status of infants who are exclusively breastfeed and not?
- What are the mothers' level of understanding and attitude towards EBF?

1.5. Research Design and Methodology

1.5.1. Research Design

In this study, a mixed research method is designed to be utilized where data will be collected using both qualitative and quantitative data gathering tools are designed mixed with in the questionnaire. Under qualitative method, data will be gathered using interview schedule, focus group discussion as well as key informant interviews and field observation whereas the quantitative method utilizes an open ended interview schedule to be administered to gather the data at the existing nutritional facilities. Further, the researcher is intended to utilize a descriptive Cross-sectional study using documentary data analysis, which is designed at finding out the prevalence of a phenomenon, problem, attitude, or issue by taking a picture or cross-section of the population.

1.5.2. Study area

This research study is carried out at Terkidi refugee camp, which is one of the seven refugee Camps in Gambella region. The camp is located 48kms away from the Gambella town but around 7.5km away from Itang town.

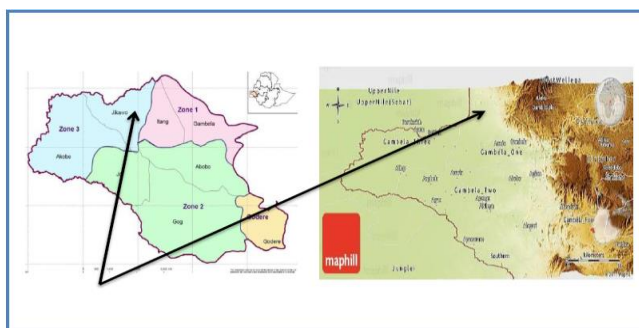


Figure1. Map of Study area in Gambella Regional State Administrative.

The camp is located within the administrative zone of Itang town, which located 8° 12'00'' N and 34° 16'00''E and altitude of 480meters.

1.6. Universe of the Study

The universe of the study will consists of all lactating mothers with children less than 0-6 months of age and who are currently breastfeeding and live in all zones of Terkidi refugee camp from which samples will be taken. Totally, about 250 mothers will be contacted for this study. This number of target group is taken to get large sample size, where those lactating mothers who completed 6months can also be inclusive in the study.

1.7. Sampling Method and Sample Size

The sampling method will be mixed, such as simple random sampling to give equal chances for all targeted lactating mothers, and then using systematic random sampling as the Camp arrangement is similar and systematic. For this to carry out, all households with lactating mothers less than six months will be counted by giving number from 1 to n_0 , where n_0 will be the sample frame from which n samples will be selected and using systematic random sampling, every lactating mother will be interviewed at an equal interval.

The arrangement of Terkidi refugee camp is divided in to 4 zones: A, B, C and D whereas each zone in turn is divided in to Blocks and currently: zone A= 14blocks, zone B= 9blocks, zone C=13blocks, and zone D= 10blocks. Further, each block is subdivided in to communities, in average 1block = 8 communities, then each community is finally subdivided in to households, 1 community = 16households (HHs).

Sample size calculation has been done by different persons and different researchers use different formula and that is based on their interest because of budget and sampling technique, etc. However, for this study, the Sample Size will be calculated by using (COCHRAN, 1977).

The Cochran equation:

$$n_0 = \frac{z^2 p(1-p)}{e^2}$$

Where:

n_0 = required Sample Size,

Z^2 is The abscissa of the normal curve that cuts off an area α at the tails;

$(1 - \alpha)$ - Equals the desired confidence level, (e.g., 95%)

P = the estimated proportion of an attribute that is present in the population, q is 1-p.

e = the level of required precision;

The value for z is found in the statistical tables, which contain in the area under the normal curve. E.g. z=1.96 for 95% level of confidence. If a non-response rate with no replacement is considered, the sample will be increased by adding that amount percentage on the sample formula. Based on the above, Cochran provided the formula for the sample making correction

$$\text{for finite population (N<10000) as: } n = \frac{n_0}{1 + \left(\frac{n_0}{N}\right)}, \text{ from this, } \mathbf{n} = \frac{\frac{z^2 p(1-P)}{e^2}}{1 + \left(\frac{z^2 p(1-P)}{N}\right)}$$

Therefore, if the total population of lactating mothers with children 0-6months (N) currently in the camp are reported to be 551(Ethiopia, 2017)then the number of lactating mothers to be contacted during data an interview will be calculated by using the following formula as follows:

$$N = 551, p = 0.5, e = .05, Z = 1.96 \text{ at a confidence level of } 95\%. \text{ So, } n_0 = \frac{z^2 p(1-P)}{e^2}, \mathbf{n_0} = \frac{(1.96)^2 * 0.5(1-0.5)}{(0.05)^2}, = \frac{3.8416 * 0.25}{0.0025}, \mathbf{n_0} = \frac{0.9604}{0.0025} = \mathbf{384.16}.$$

$$\text{But for } N < 10,000, \text{ using the formula above the sample will be: } \mathbf{n} = \frac{\frac{z^2 p(1-P)}{e^2}}{1 + \left(\frac{z^2 p(1-P)}{N}\right)} = \frac{\frac{(0.5 * 0.5)(1.96)^2}{(0.05)^2}}{1 + \left(\frac{(0.5 * 0.5)(1.96)^2}{(0.05)^2 * 551}\right)} = \frac{\mathbf{384.16}}{1 + \left(\frac{\mathbf{384.16}}{551}\right)} = \frac{\mathbf{384.16}}{\mathbf{1 + 0.697}} = \frac{\mathbf{384.16}}{\mathbf{1.697}} = \mathbf{226.38},$$

When we rounded off the result will be **227**. Similarly, if non-response rate of 10% (.01) is considered the formula will be $n_f = (n + 0.1n) = 227 + (227 * 0.1)$, $n_f = 249.7$. When rounded off this will be **250**.

Generally, in this study the final sampling unit will be the household. The HH to be visited during data collection will be that in which lactating mothers with children less than six months. The total the number of families with children less than 6 months in each block will be performed by conducting census prior to the survey and numbering of the (HHs) in each community will be conducted, from the respective strata proportional samples will be taken and HHs will be taken as a final sampling units. After selecting a random starting point, by using

systematic random sampling technique, HHs from this starting point and one eligible from the HHs will be interviewed.

1.8. Data Collection and Analysis Procedures

1.8.1. Data Collection Method

The methods of data collection in this study will depend on the research objectives set and in this regard, different method will be employed to full-fill the research objectives. As previously indicated under the methodology, the data collection method is composed of both qualitative and quantitative. In order to answer the research objectives, semi structured interview containing both open ended and closed ended questionnaires will be prepared and utilized to collect detail of data required. For instance, to collect data for the nutritional status of infants, the method contains measuring the current weight, birth weight and the height of infants, using salter or digital scale and measuring board. In addition, the questionnaire for data collection is administered for individual infants in the target age group of less than 6months. The care taker of infants for which interview is held should be the resident of the camp of study and currently living in the camp.

The data collected will help to assess the nutritional status of infants which will be determined with the Z-Score Standard deviation, which is calculated using Weight-for -height reference tables, girls and boys, World Health Organization Growth Standards (WHO-GS, 2006). According to the growth standards, underweight or the value from the table is indicated in to 3 categories as: < -3 Z-Score for the severely malnourished, ≥ -3 and < -2 Z-Score showing moderately malnourished and ≥ -2 Z-Score is categorized as normal.

1.9. Tools for Data Collection

In order to satisfy the requirement of reliable data that contain the necessary detail as per research objectives understudy, the key tools for data collection will be interview schedule that will be assisted by additional tools.

1.9.1. Interview Schedule

Interview schedule to collect data under this study is prepared containing a mix of questionnaires of both closed ended and open end. Each questionnaire is also contains a pre-coded alternatives responses.

It is also structured in to different sections I, II, III&IV to directly collect the data required by each objective. For instance, the section I&IV contain all data about the determinants influencing breast-feeding and is the part of the questionnaire that answers the first research objective. The section II is about the infants' nutritional status, which contain data that will answer the second research objective. The other section III is a transitional section that will collect the data, which will answer the third research objective, which is the knowledge gap of the respondent.

The research tools to be used in this study is pretested in the field, then after will be standardized and prepared for final use. Copies of tentative interview schedule and key informant interview questionnaires will be given at Appendices A, B, etc.

1.9.2. Documentary Analysis

In addition to interview schedule, documentary analysis will be utilized to gather very crucial information on the subject matter. For this purpose, all published and unpublished research materials, dissertations, theses, research reports, progress reports, web-based files, and others will be analyzed to strengthen the information obtained and to verify some of the issues under investigation, which might not be adequately captured through the descriptive cross-sectional survey. So, these documents will be thoroughly read in order to identify subject of the research questions and the objectives of the study under investigation.

1.9.3. Observation Guide:

For this study, the researcher will utilize, for some complementary issues non-participant observation or direct observation can be applied while in some cases secondary data will be utilized and field level observation of how services are carried out in the study area will be conducted. This will help to triangulate the validity of data with that found during interview of data with that found during interview.

1.9.4. Interview Guide:

In order to collect relevant information for the research, this interview guide will help the investigation to give respondents enough time to give response on what is being. Therefore, the following points to be followed:

- Before asking the detail make sure that informed consents are agreed up on by respondents and continue once they understood why the objective of survey is done and how it not affect them and their responses are kept confidential.
- Asking question at a time and repeat question & wait for response,
- Make sure that respondents understand the question and verify this through their nonverbal communication,
- First start with introductory question, then transformational and ask the very sensitive question at the end
- Listen carefully, while asking and waiting for responses and take note
- During interview to maintain the eye contact, tone of voice, facial expression, and gesture of respondents,
- Also not to lead with answers but to probe what they think about on the subject,
- During interview avoid pre-judgmental attitude and use tact full skills in handling the interview
- During interview to sit clearly with respondents in a one-to-one contact with no barriers between them.
- Use very clear language, for this data collectors are trained in advance on how to do interview and internalize all the questions in the interview guide,
- Finally, thanking the respondents for their response.

1.9.5. Focus Group Discussion Guide

In this study focus group, discussion guide will be used for data collection on the subject matter, conducted in a group of people with 8 to 12 members, and involves collecting gaining of information about their views and experience of a topic. The interviewing procedure for the group is carried out with the questionnaires designed with open-ended questions and which can seek similar information that will be collected using interview schedule but this is used mostly

to collect from individuals of different experience and part of community leadership structure, professional workers at the nutrition sites.

Once the data completed will be coded, scrutinized, edited, and analyzed, it will be used to triangulate the data been collected with questionnaire. Before the data is collected from the group, consent will be requested to be agreed and that confidentiality of data will remain private and not used for other purpose and if agreed and possible recording of interview may be conducted. In general, about 3 to 4 focus group discussion will be conducted at the community centers as well as nutrition facilities.

1.10. Data Processing and Analysis

In this study, data analysis will be done based on the measurement of indicators of independent variables, which mainly influence the successful practice of EBF, which are the dependent variables. There will be an indicator to be measured in terms of mothers' knowledge, attitude, and practice that will be described in percentage. The relationship between major barriers as well as mothers' socio-demographic factors and exclusive breastfeeding will be analyzed.

In addition, the impacts of EBF on the nutritional status of infants that were exclusively breastfeed and not, will be studied, analyzed and interpreted to provide with successful to towards good practice of EBF, that may have benefit to the nutritional services as well as other stakeholders

For the indicators of this study, the primary data will be collected from lactating mothers who are the direct beneficiaries at the nutritional Services of the Terkidi refugee camp and currently living in the camp at the time of interview. Further, the anthropometric data of infants with these lactating mothers will also be collected using weight measuring scale and height board for height measurement and will be crosschecked with the secondary data of infants from the Community Based management of Acute Malnutrition in infants (0-6) months that were already available in these nutrition facilities.

The anthropometric data to be collected, will be entered in to the computer using Emergency Nutrition Assessment (ENA) software with a version updated in 2015 and analysis and interpretation will be done to differentiate the nutritional status of infants, being described

using the WHO Z-Score growth standard deviation (WHO, 2006). The Z-Score standard deviation result indicators include stunting, underweight, and wasting. For the result, less than -3 indicate severe wasting, and from -3 to -2 indicate moderate malnutrition, while that greater than or equal to -2 indicate normal nutritional status. This result is still to be analyzed in comparisons with those exclusively breast-feed and not breast-feed.

Finally, for the data collected from the respondents, regarding the barriers, or sociodemographic data, descriptive statistics such as frequency, percentage, mean, or standard deviation as well as inferential statistics such as: chi-square, binary logistic regression or bivariate or multivariate will be utilized for analysis depending on the research objective to be attained.

1.11. Chapterization

The **first** chapter will describe the main concept of exclusive breast feeding, background, detail nature of the problems associated.

The **second** chapter will focus on the conceptual framework of the present study and the review of the literature and other important issues.

The **Third** Chapter will deal with the research design and Camp profile and so on.

The **fourth** chapter will describe about Data Analysis and interpretation

The **fifth** chapter will focus on main findings and detail discussions, conclusions.

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Appendix

A. Time Table Schedule

Table 1. Timetable for Conducting Research

| Activities | Timeline for Accomplishing Research Activities During 2017-2018 | | | | | | | | | | | | | | |
|--|---|----------|----------|----------------------------|-----------|----------|----------|-----------|----------|----------|----------|-----------|----------|----------|-----------|
| | Mar 2017 | Apr 2017 | May 2017 | Jun 2017 | July 2017 | Aug 2017 | Sep 2017 | Oct 2017 | Nov 2017 | Dec 2017 | Jan 2018 | Feb 2018 | Mar 2018 | Apr 2018 | May 2018 |
| Developing a Research Proposal with Data Collection Tools and Submit to the School of Social Work at IGNOU | By Mar 15 | | | | | | | | | | | | | | |
| Dealing with all stakeholders about the research to be conducted and gain Acceptance | | By 31 | | | | | | | | | | | | | |
| Preparing Final Data Collection Tools, reviewing and editing and completing for Final use and gain approval from the advisor | | | April 30 | | | | | | | | | | | | |
| Preparing Data Collection training for enumerators, Preparing lists of Sampling Frame, and final Sampling, Pilot data collection using the tools, and testing the tools prior to the final data collection | | | | Up to May 18 th | | | | | | | | | | | |
| Carrying out Final Data Collection from the Field and prepare for entry to in to database | | | | | May 31 | | Aug 15 | | | | | | | | |
| Conducting Data Entry using Computer from the already collected along with Coding of questionnaire, analyzing it and Prepare for Interpretation | | | | | | | | Aug 16 to | Oct 15 | | | | | | |
| Reviewing of similar literature and preparing a draft research Report and submit to Advisor for correction | | | | | | | | | | | | By Feb 15 | | | |
| Reviewing and completing the final research Report to the Advisor for finishing | | | | | | | | | | | | | | | By may 15 |

B. Budget Break Down

Table 2. Budget breakdown for the research

| S.N | Items/Research Activities | unit | Target (Plan) | Duration | Unit Cost in ETB | Total Cost |
|-----|---|-------------|---------------|----------|------------------|------------|
| 1 | Research Assistant | Persons | 1 | 6 Months | 4,000.00 | 24,000.00 |
| 2 | Data Collectors/ Enumerators | Persons | 7 | 10days | 90.00 | 6,300.00 |
| 3 | Translators | Persons | 2 | 10days | 90.00 | 2,000.00 |
| 4 | Fees for Data Entry and Editing Binding of Report | No of pages | 300 | 1month | 20.00 | 6000.00 |

| | | | | | | |
|---|--|-------|------|---|-------------|------------------|
| 5 | Stationary for (Duplication paper& Paper printing/copying, etc.) | Pages | 800 | - | 1.50 | 1,200.00 |
| 6 | Training Cost& other overhead costs | ETB | 2000 | - | - | 2,000.00 |
| 7 | Contingency (which is 10% of 1-6 above) | ETB | - | - | - | 4,150.00 |
| | Total Costs | | | | | 45,650.00 |