

A Deep Dive Exclusive Breastfeeding

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CONTENT

Slides 1-4: Framing (why EBF, why now, why this approach)	Slides 5-10: Core empirical findings (age, region, SES)
Slide 11: Policy pivot	Slides 12-16: Institutional architecture
Slide 17: Methodological integrity	Slide 18: Closing

This presentation begins with a broad retrospective of Ethiopia's quarter-century of demographic and health change, then narrows to a focused deep dive on exclusive breastfeeding (EBF)

EBF is singled out because of its persistent stagnation despite strong progress in other domains.

The presentation establishes why EBF matters

It does so by outlining its substantial benefits for infant survival, nutrition, and development, as well as maternal health, and the corresponding risks when exclusivity is not maintained.

The analysis then reframes EBF as a behavioral system rather than a structural outcome, demonstrating that the commonly cited national average (~58%) obscures a steep age-driven decline.

From Broad Trends to Deep Dive Trends in Exclusive Breastfeeding –EBF

- ❑ Started with 8 domains of demographic & health change (25 years)
- ❑ Identified EBF as a priority for deeper analysis
- ❑ Conducted in-depth analysis of EDHS 2016 (R-based workflow)
- ❑ Applied descriptive, stratified, behavior-focused approach
- ❑ Synthesized findings into this presentation for policy action

Why was EBF singled out?

EBF was singled out because of its relative stagnation over time.

Unlike other domains—such as child mortality, immunization, or aspects of maternal health—which showed **clear and sustained improvement**, EBF exhibited:

Limited upward movement over the quarter-century

A pattern of **plateauing rather than continuous progress**

This stagnation made EBF analytically important—not just as an outcome, but as a **potential constraint on further gains in child survival and nutrition.**

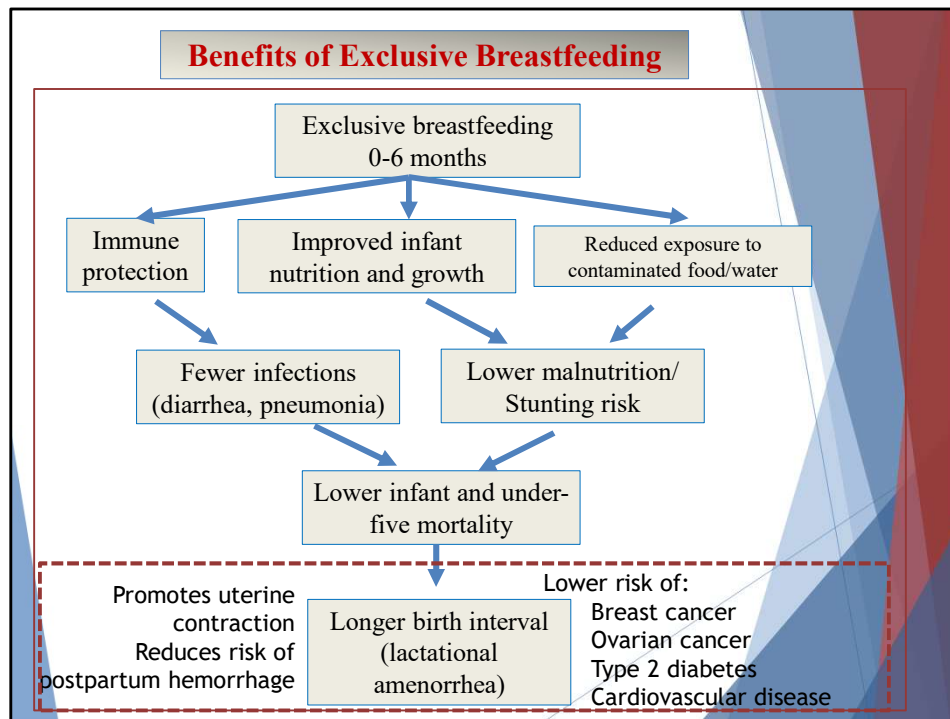
A closer look at the data then revealed something even more interesting.

Unlike more structural domains such as education or mortality decline, EBF displayed:

Strong short-term variation driven by infant age

Weak and non-linear socioeconomic gradients

And patterns consistent with a **time-sensitive, behaviorally driven process**



Before we move into the analysis, I would like to briefly ground our discussion in **why exclusive breastfeeding—EBF—matters so fundamentally**, both for infants and for mothers.

A. Benefits of Exclusive Breastfeeding For the Infant

Exclusive breastfeeding during the first six months of life provides:

1. Optimal nutrition

Breast milk is uniquely tailored to the infant’s needs
 It contains the right balance of nutrients for growth and development
 It adapts over time as the infant grows

2. Immune protection

Breast milk contains antibodies and bioactive compounds
 It protects against:

- Diarrheal diseases
- Acute respiratory infections

These are leading causes of infant morbidity and mortality

3. Reduced risk of malnutrition

Helps prevent:

Stunting

Wasting

Underweight

4. Long-term developmental benefits

Associated with improved:

Cognitive development

School performance

Reduced risk later in life of:

Obesity

Diabetes

Chronic disease

For the Mother

Exclusive breastfeeding also confers important maternal benefits:

1. Postpartum recovery

Promotes uterine contraction

Reduces risk of postpartum hemorrhage

2. Birth spacing

Delays return of fertility through lactational amenorrhea

3. Reduced long-term disease risk

Lower risk of:

Breast cancer

Ovarian cancer

Emerging evidence for reduced risk of:

Type 2 diabetes

Cardiovascular disease

4. Psychosocial benefits

Strengthens mother–child bonding

Can support maternal well-being

B. Risks of Non-Exclusive Breastfeeding

For the Infant

When exclusive breastfeeding is not maintained:

1. Increased exposure to infection

Early introduction of:

Water

Other liquids

Foods

Increases risk of contamination

Leads to higher rates of:

Diarrhea

Respiratory illness

2. Increased mortality risk

Non-exclusively breastfed infants are significantly more likely to die in the first months of life, especially in low-resource settings

3. Nutritional compromise

Breast milk is displaced by less optimal substitutes

Risk of undernutrition and impaired growth

For the Mother

The risks are less direct but still important:

1. Loss of protective health effects

Reduced duration of breastfeeding is associated with:

Higher risk of breast and ovarian cancers

Reduced metabolic protection

2. Shorter birth intervals

Earlier return to fertility

Potential implications for maternal and child health

Transition to the Analysis

So, when we talk about exclusive breastfeeding, we are not discussing a marginal behavior.

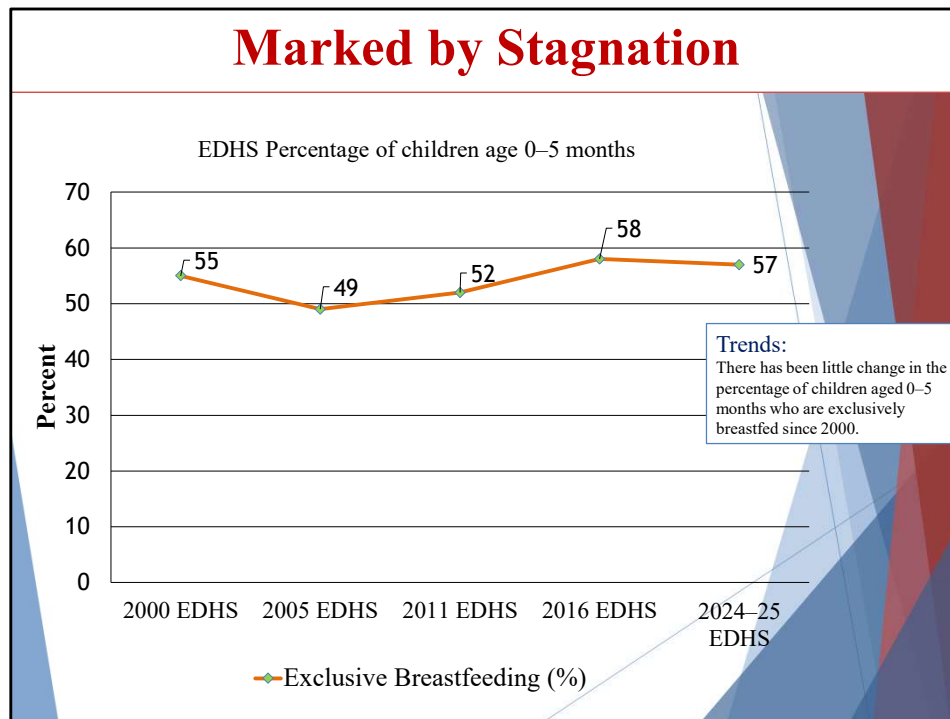
We are discussing one of the most powerful interventions for improving both **child survival and maternal health**.

And yet—despite its benefits—progress in Ethiopia has been **limited over time**.

That is what motivated this deep dive.

The question we will now turn to is:

If the benefits are so clear, why is exclusive breastfeeding not being sustained through the first six months—and what does the data tell us about how to change that?



Three ways to sum up EBF in Ethiopia over the last 25 years:

1. High-impact,
2. Low-cost,
3. Underutilized

Exclusive breastfeeding is one of the **most powerful and cost-effective public health interventions**, yet it has **stagnated at around 50–60%** in Ethiopia over the past quarter-century.

This stagnation represents a **missed opportunity** to accelerate **progress across multiple domains**.

This slide presents trends in **exclusive breastfeeding (EBF)** among children aged **0–5 months** across five EDHS surveys.

Key Trend: Gap between current levels and global recommendations

WHO recommends EBF rates of **at least 70%**.

Ethiopia’s current level is ~57%.

Exclusive Breastfeeding (EBF) in Ethiopia

- ▶ An in-depth analysis appears to show that EBF in Ethiopia is a behavioral system, not a structural outcome

What “A behavioral system, not a structural outcome” means (in this EBF analysis)

1. What is a “structural outcome”?

A **structural outcome** is something primarily determined by **long-run, slowly changing conditions**, such as:

- Education systems
- Income/wealth
- Infrastructure
- Institutional access

Examples:

- Women’s education levels
- Poverty rates
- Health service coverage

These outcomes:

Change **gradually over years or decades**

Show **clear, monotonic gradients** (e.g., higher education → better outcomes)

Are relatively **stable across short time horizons**

2. What is a “behavioral system”?

A **behavioral system**, by contrast, is:

Time-sensitive (changes quickly)

Context-dependent (varies by local norms and situations)

Shaped by **daily decisions and constraints**

Influenced by **social interactions and perceptions**

It is not fixed—it **evolves over days, weeks, and months.**

Core Message

- ▶ EBF \approx 57% nationally
- ▶ But this is misleading
- ▶ The real story is a rapid decline with age (EDHS 2016 Analysis)

This slide presents what appears to be the **headline finding**: that approximately **57 percent of infants under six months in Ethiopia are exclusively breastfed**.

This 58 percent is not a stable condition—it is an average across very different moments in an infant’s early life.

What the national figure does is:

- Combine infants who are **just born**, where EBF rates are very high
- With infants who are **approaching six months**, where EBF rates drop sharply
- So the average masks a **steep internal gradient**.

This is a classic case of what we might call **aggregation bias**:

The summary statistic looks moderate and stable

But the underlying process is **rapidly changing over time**

And that matters enormously for interpretation.

If we take the 57 percent at face value, we might conclude:

“EBF is moderately strong—perhaps we need incremental improvements.”

But once we disaggregate—and this is what we will do in the next slide—we see that:

The system is not stable at all; it is characterized by rapid drop-off.

So the takeaway from this slide is very precise:

- The national estimate is **correct**
- But it is **not sufficient for understanding the problem**
- And if used alone, it can **misdirect policy attention**

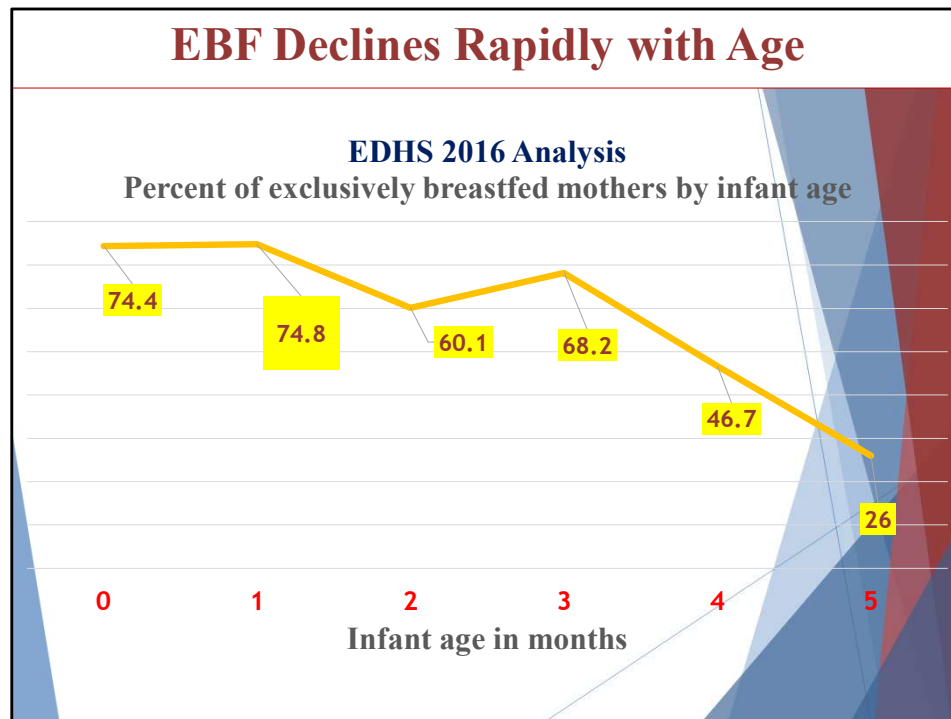
This is why the rest of the analysis shifts from:

levels → to trajectories

averages → to patterns over time

And specifically, we now turn to the most important driver in the entire analysis:

infant age.



This slide is the **analytical core of the entire presentation**.

What you see here is exclusive breastfeeding plotted by **infant age in completed months**, from birth through month five.

And the pattern is immediately clear—and quite striking.

- In the **first months of life**, EBF levels are very high—around **74 to 75 percent**
- By **month two**, we already begin to see a decline
- By **month four**, EBF has dropped to below 50 percent
- And by **month five**, it falls to approximately **26 percent**

So what appears, at the national level, as a **moderate 58 percent in 2016**, is actually the result of averaging:

- Very high adherence early on
- With very low adherence just a few months later

This is not a gradual decline—it is a **steep behavioral drop-off over a very short time window**.

Substantively, this is the most important finding in the analysis.

It tells us that:

- **Mothers overwhelmingly initiate exclusive breastfeeding**
- But **continuation becomes increasingly difficult as the infant ages**

This fundamentally reframes the problem.

- The issue is not lack of awareness or failure to start breastfeeding.
- The issue is **attrition—loss of exclusivity over time.**

Now, it is also important to interpret this curve correctly.

This is not just a statistical pattern—it reflects a **behavioral trajectory shaped by real-world pressures**, including:

Perceptions that breast milk alone is no longer sufficient as the infant grows

- Early introduction of water or other liquids due to cultural norms
- Increasing maternal workload or return to employment
- Influence of family members or community practices around feeding

You may also notice a slight fluctuation around month three.

This should not be over-interpreted—it likely reflects **sampling variability**, not a true behavioral reversal.

The dominant pattern remains unequivocal:

Exclusive breastfeeding declines sharply with infant age

From a policy standpoint, this is where the implications become very concrete.

If we want to improve EBF outcomes, the priority is not:

Broad messaging about starting breastfeeding

But rather:

Targeted support to sustain exclusivity, especially between **months two and five**, where the drop-off is most pronounced

So, to summarize this slide in one sentence:

EBF in Ethiopia is not failing at the start—it is failing over time.

And that insight will help us reinterpret everything that follows, including regional variation and socioeconomic patterns.

Interpretation

- ▶ **Initiation is not the problem**
- ▶ **Continuation is the problem**
- ▶ **Critical drop after month 2–3**

Mothers are **starting breastfeeding appropriately**

Early postnatal practices are, in general, aligned with recommended guidance
So from a policy standpoint, this is important:

Between months two and five, several pressures begin to intensify:

Biological perceptions:

Mothers may perceive that breast milk alone is no longer sufficient as the child grows

Cultural practices:

Early introduction of water, herbal liquids, or other supplements may be encouraged

Household dynamics:

Advice from older family members—especially grandmothers—can influence feeding decisions

Economic and time constraints:

Mothers may return to work or face increasing workload demands, making exclusive breastfeeding more difficult

Service gaps:

Postnatal care and breastfeeding support often decline after the early weeks,

precisely when support is most needed

So what we are observing is not random decline—it is a **structured transition from a supported early phase to a less-supported later phase.**

This is why framing EBF as a **behavioral system** is so important.

Unlike structural indicators, where change is evolutionary:

Behavior

- Changes quickly
- Is sensitive to daily constraints
- Requires **continuous reinforcement**, not one-time intervention

Now, from a programmatic perspective, this leads to a very clear implication:

If interventions focus primarily on **initiation—such as facility delivery or early breastfeeding counseling—they will miss the point.**

Instead, the critical window for intervention is:

After the first month

Especially **months two through five**, where we see the steepest decline

So the policy pivot is:

From **“Start breastfeeding.”**

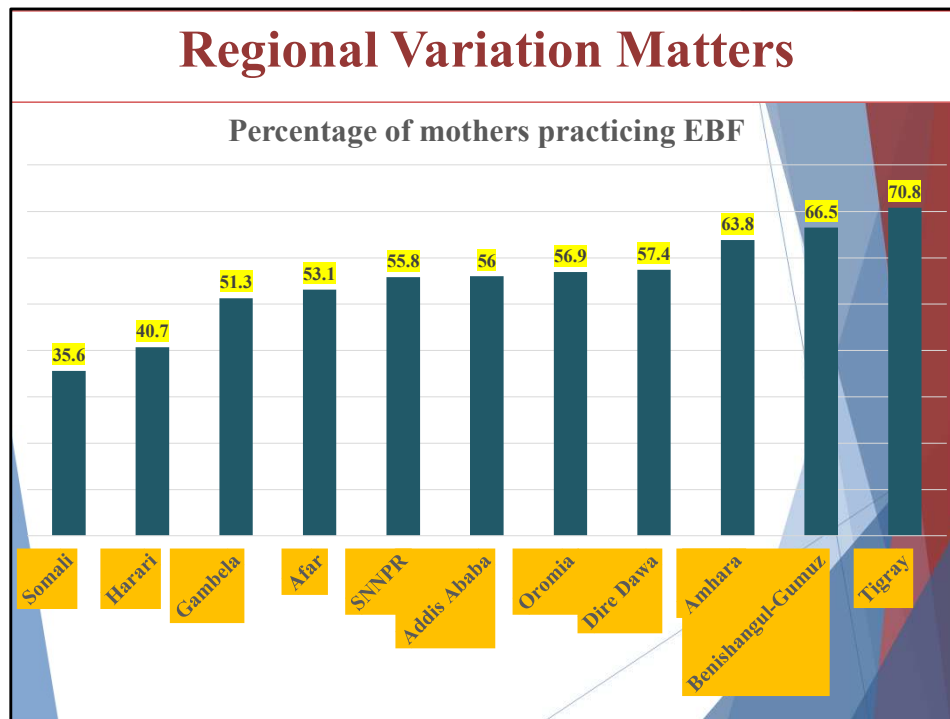
→ to

“Help mothers continue exclusive breastfeeding under real-life conditions.”

This reframing is essential because it shifts both:

Where we intervene, and

How do we design those interventions



This slide shifts the focus from time—infant age—to **place**, specifically regional variation in exclusive breastfeeding across Ethiopia.

What we see here is a **wide range of EBF prevalence across regions**:

At the higher end, regions such as **Tigray** and **Benishangul-Gumuz** show levels above **65–70 percent**

At the lower end, regions such as **Somali** and **Harari** fall closer to **35–40 percent**

And several large regions—**Oromia**, **SNNPR**, **Addis Ababa**, **Dire Dawa**—cluster around the national average

So the first takeaway is straightforward:

EBF is not evenly distributed across Ethiopia—regional context clearly matters.

However—and this is where the analysis becomes more nuanced—**the pattern does not follow a simple or intuitive geographic logic.**

For example:

Urban vs. rural does not explain the variation:

Addis Ababa, the most urbanized region, is not at the top

Harari, also largely urban, is among the lowest

Pastoralist vs. non-pastoralist livelihoods do not explain it either:

Afar shows moderate EBF levels

Somali, with a broadly similar livelihood structure, shows much lower levels

This tells us something very important:

There is no single structural or geographic axis that explains regional differences in EBF.

Instead, what we are likely observing is the result of **localized combinations of factors**, including:

- Cultural norms around infant feeding
- Community-level beliefs about breast milk sufficiency
- Access to and quality of maternal and child health services
- Strength of community support systems
- Local program implementation differences

In other words, **region is acting as a proxy for context**, not as a causal factor in itself.

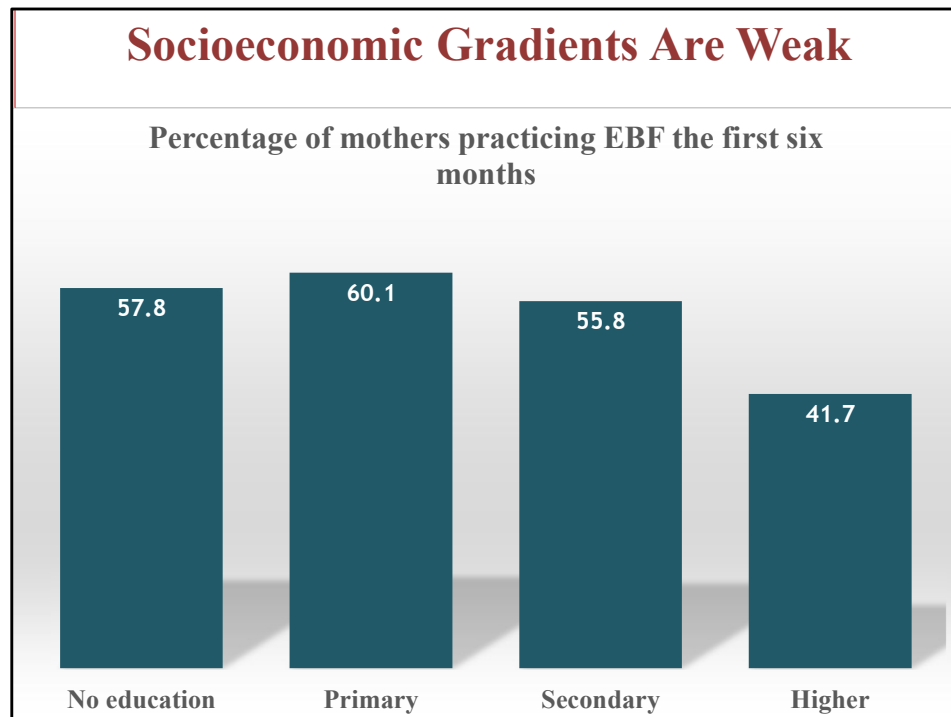
This has two important implications.

First, analytically:

We should be cautious about interpreting regional differences as inherently “better” or “worse” without understanding the underlying mechanisms

Second, from a policy perspective:

One-size-fits-all national strategies are unlikely to be effective.



This slide turns to a set of variables that are often assumed—almost by default—to be strong determinants of health behaviors:

maternal education and, by extension, socioeconomic status.

In many areas of public health, we expect to see a **clear, positive gradient**:

Higher education → better health behaviors

Lower education → poorer outcomes

But what we observe here for exclusive breastfeeding is quite different.

The pattern is **weak and non-linear**:

Mothers with **no education** and those with **primary education** show relatively similar—and even slightly higher—levels of EBF

As we move to **secondary education**, EBF does not increase—it declines slightly

And among mothers with **higher education**, EBF drops more noticeably

So instead of a steady upward gradient, what we see is:

A flattened—and even inverted—relationship

This is a critical finding, because it challenges a very common assumption:

That improving education alone will automatically improve breastfeeding outcomes.

Now, it is important to interpret this carefully.

This does **not** mean that education is unimportant.

Rather, it means that **education operates through competing pathways.**

On the one hand, higher education is associated with:

- Better access to health information
- Greater exposure to recommended practices
- Increased interaction with health services

These would tend to **support EBF.**

But on the other hand, higher education is also associated with:

- Greater likelihood of **formal employment**
- **Time constraints** and earlier return to work
- Urban lifestyles where alternatives to breastfeeding are more accessible

These factors tend to **undermine sustained exclusive breastfeeding.**

So what we are observing is the **net effect of opposing forces**, which results in:

A weak and non-linear overall pattern

This reinforces a central argument of the presentation:

EBF is not primarily structured by long-run socioeconomic position in the way many other health outcomes are.

Instead, it is shaped more strongly by:

- **Time dynamics (infant age)**
- **Contextual and behavioral factors**

From a policy perspective, this has important implications.

If we assume that:

Education alone will drive improvements in EBF

We risk missing the actual constraints that mothers face.

Instead, interventions need to address:

- **Practical feasibility**
- **Workplace conditions**
- **Time and support systems**

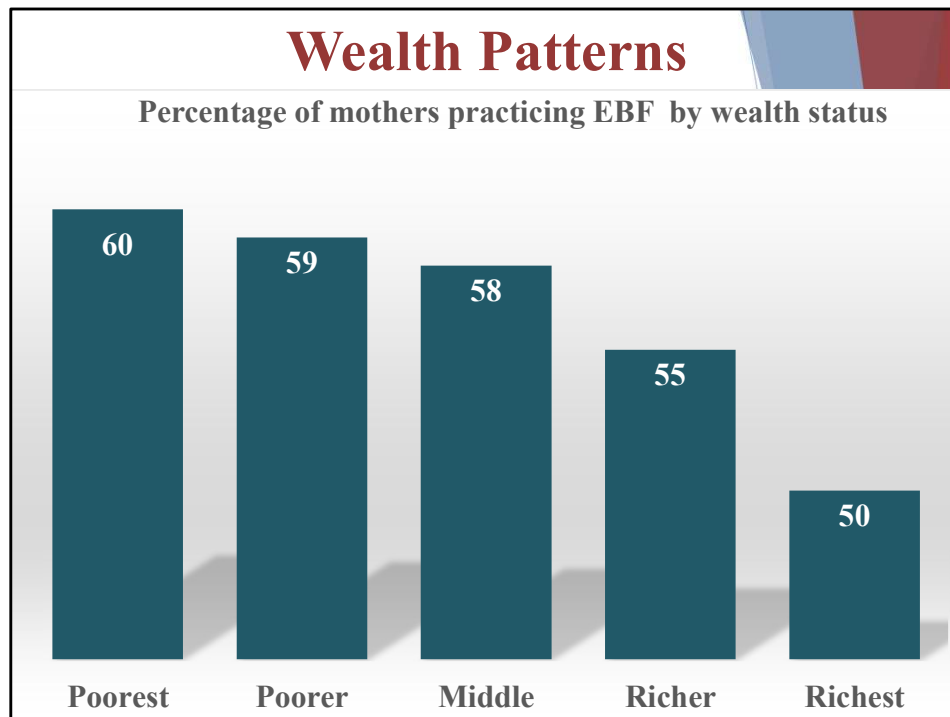
So to summarize this slide:

Socioeconomic gradients in EBF are **present but weak**

The relationship is **non-linear and sometimes counterintuitive**

And this further supports the conclusion that:

EBF is a behavioral system, not a structurally determined outcome



This slide extends the socioeconomic analysis by focusing specifically on **household wealth**.

Here again, if we were dealing with a typical health outcome, we would expect to see a **clear positive gradient**:

Higher wealth → better outcomes

Lower wealth → worse outcomes

But the pattern for exclusive breastfeeding is, once again, **surprisingly modest and somewhat counterintuitive**.

What we observe is:

EBF levels are **highest among the poorest households**, at around 60 percent

There is a **gradual decline** as we move up the wealth distribution

By the richest quintile, EBF falls to roughly **50 percent**

So the gradient exists—but it is:

Shallow, and in the opposite direction of what we might expect

Now, this does not mean that wealth negatively “causes” lower breastfeeding. Rather, it reflects the **different environments and choices available across wealth levels**.

Let’s unpack the mechanisms.

Among poorer households:

- Breastfeeding is often the **default and necessary option**
- Limited access to alternatives such as formula or other foods
- Stronger reliance on traditional infant feeding practices

These conditions tend to **support continued exclusive breastfeeding**, even in the absence of formal knowledge or services.

Among wealthier households:

- Greater access to **breastmilk substitutes and complementary foods**
- Higher likelihood of **urban residence and formal employment**
- Increased exposure to **marketing and social norms** that may favor early supplementation

These factors can **erode exclusivity over time**, even when knowledge levels are higher.

So, similar to education, wealth operates through **competing pathways**:

Enabling access and information on one side

Introducing constraints and alternatives on the other

The net result is:

A weak, slightly negative gradient

Why this matters analytically

Taken together with the education findings, this reinforces a key conclusion:

Socioeconomic status does not strongly structure EBF outcomes in Ethiopia.

This is very different from outcomes like:

- Child mortality
- Nutritional status
- Educational attainment

Where wealth and education typically show **strong, monotonic gradients**.

Policy implications

This has direct implications for how we design interventions.

If we assume:

“Target the poorest” → we improve EBF

We may miss the fact that:

Drop-off is occurring across all groups, including the better-off

And that:

The mechanisms differ:

Among poorer groups → structural constraints

Among richer groups → substitution, time pressure, and lifestyle factors

So effective policy needs to be:

Differentiated, not uniform

Support for **continuation under workload constraints**

Regulation or guidance around **early introduction of substitutes**
Tailored messaging that addresses **different behavioral drivers across groups**

Bottom line for this slide

Wealth gradients exist but are **weak and slightly negative**

Higher wealth does not translate into better EBF outcomes

And this further strengthens the overarching conclusion:

Exclusive breastfeeding is shaped more by behavioral and contextual factors than by socioeconomic position alone



Institutional Ownership/Leadership

Addis Ababa University (AAU), Department of Sociology

- Reframe EBF as a behavioral and social system
- Generate region-specific evidence (age × context)
- Lead community-based interventions (months 2–5)
- Train next-generation practitioners & researchers
- Convene policy dialogue (MoH, regions, NGOs)
- Monitor progress toward $\geq 70\%$ EBF

The starting point is alignment with the central finding of this analysis:

EBF is a behavioral and social system, not simply a clinical or informational issue.

That positioning places Sociology in a natural leadership role.

1. Reframing EBF as a Social System

The Department of Sociology can lead a national reframing of EBF:

Move the discourse from **individual choice** to **socially embedded behavior**

Examine how norms, household dynamics, gender roles, and informal advice networks shape feeding decisions

Identify how these factors change between **month 1 and months 2–5**, where the drop-off occurs

This reframing is essential for designing interventions that are **realistic and culturally grounded**.

2. Generating Region-Specific Evidence

A major contribution AAU Sociology can make is to deepen the analysis beyond

national averages:

Produce **region × age profiles of EBF**

Distinguish clearly between:

- Initiation problems** (low at month 0–1)

- Continuation problems** (steep decline after month 2)

Conduct **qualitative and mixed-method studies** in low-performing regions such as Somali and Harari to understand:

- Beliefs about breast milk sufficiency

- Norms around early supplementation

- Decision-making within households

This evidence base becomes the foundation for **precision policy**, not generic messaging.

3. Leading Community-Based Interventions (Months 2–5)

Given that the problem is a continuation, AAU Sociology can pilot and evaluate interventions focused on the **critical window (months 2–5)**:

Community dialogue models involving:

- Mothers

- Fathers

- Grandmothers and elder women

Behavioral reinforcement strategies:

- Peer support groups

- Home-based counseling

- Norm-shifting communication

Testing different models across regions to determine:

- What works

- For whom

- Under what conditions

The goal is to move from **theory to → tested intervention packages.**

4. Training the Next Generation

AAU's long-term influence comes through **training**:

Integrate EBF as a case study in:

- Social determinants of health

- Behavioral science

- Public health sociology

Train students in:

- DHS data analysis

- Mixed-methods research

- Program evaluation

Develop a cohort of graduates who understand:

How to translate data into actionable, context-sensitive interventions

5. Convening Policy Dialogue

AAU Sociology can act as a **neutral convening platform**:

Bring together:

- Ministry of Health

- Regional health bureaus

- NGOs and development partners

Facilitate translation of research into:

- Policy guidance

- Program design

- Implementation strategies

This helps bridge the persistent gap between **evidence and practice**.

6. Monitoring Progress Toward $\geq 70\%$ EBF

Finally, AAU Sociology can support a national target:

Raising EBF to 70 percent or higher

This involves:

Establishing **monitoring frameworks**

Tracking:

- Age-specific EBF trends

- Regional performance

Providing an independent evaluation of program impact

In closing, AAU Sociology's role is not just to study breastfeeding—but to understand and reshape the social systems that determine whether exclusive breastfeeding is sustained.

Ministry of Health (MoH)

- Shift KPI: initiation to → 6-month continuation
- Build a months 2–5 service package
- Strengthen HEW-led follow-up & home support
- Enable facility → community continuity of care
- Address work/time constraints & substitutes
- Implement real-time monitoring (age × region)

The central directive is a programmatic pivot:

Reorient EBF policy from initiation metrics to sustained exclusivity through six months.

1. Shift the key performance indicator - KPI: From Initiation to Continuation

Current systems often emphasize:

Early initiation within 1 hour

Counseling at delivery

These remain important—but they are **insufficient**.

The MoH should adopt a **primary performance indicator** of:

EBF at 4–5 months and at 6 months, not just at birth or early weeks

This single shift will realign:

Supervision

Reporting

Incentives

Program focus

toward **where the losses actually occur**.

2. Build a “Months 2–5” Service Package

The data point to a clear intervention window.

MoH can formalize a **standardized continuation package**, including:

Scheduled **postnatal contacts at 1, 2, 3, and 4 months**

Focused counseling on:

Perceived milk insufficiency

Managing infant growth without supplementation

Practical guidance for:

Feeding during maternal workload

Expressing and storing breast milk (where feasible)

The key is **structured, repeated contact**, not one-time advice.

3. Strengthen Health Extension Worker (HEW) Follow-up

Ethiopia’s **Health Extension Program** is a major asset.

The MoH can leverage it by:

Prioritizing **home-based follow-up visits in months 2–5**

Using HEWs to:

Identify early signs of drop-off

Provide corrective counseling

Engage family members influencing feeding decisions

This shifts support **from facilities to households**, where behavior is actually determined.

4. Ensure Facility → Community Continuity of Care

One major gap is the drop in support after the immediate postnatal period.

MoH can institutionalize **handoffs**:

From **facility delivery** → to **HEW follow-up lists**

Ensure every newborn is **tracked and revisited** beyond the first weeks

This creates a **continuous care pathway**, rather than a front-loaded system.

5. Address Work, Time, and Substitution Pressures

Continuation fails not only because of knowledge gaps, but because of **practical constraints**.

MoH, in coordination with other sectors, can:

Promote **breastfeeding-friendly workplace practices**

Provide guidance on:

Feeding schedules under workload constraints

Strengthen regulation and messaging around:

early introduction of water and breastmilk substitutes

The goal is to **make continued EBF feasible**, not just recommended.

6. Implement Real-Time Monitoring (Age × Region)

Monitoring systems should move beyond a single national average.

MoH should track:

EBF by infant age (0–5 months)

EBF by region

This allows:

Early identification of **where drop-off is occurring**

Targeted program adjustments

Accountability at regional and district levels

Closing Line for the Slide

The Ministry's role is to convert a high-initiation system into a high-continuation system—by building sustained support into routine service delivery.

When you're ready, we can develop the third institutional slide—ideally the **frontline system (Health Extension Program) or community platform**, to complete the ecosystem:

Academia (AAU) → MoH (delivery) → Community/HEW (implementation).

What does KPI stand for in "Shift KPI: initiation → 6-month continuation "

KPI stands for Key Performance Indicator.

In this context, it refers to the **specific metric the Ministry of Health uses to track program success.**

So when the slide says:

“Shift KPI: initiation → 6-month continuation”

it means:

Current focus (typical KPI):

% of infants who **start** breastfeeding (e.g., early initiation)

Proposed focus (new KPI):

% of infants who are **still exclusively breastfed at 4–5 months or at 6 months**

Why this matters

A KPI is not just a measurement—it **drives behavior in the system:**

What gets **measured** gets **managed**

What gets **reported** gets **prioritized**

What gets **rewarded** gets **done**

So shifting the KPI:

Moves attention from **starting breastfeeding**

To **sustaining exclusive breastfeeding over time**

Plain-language alternative (if you prefer for the slide)

If “KPI” feels too technical for your audience, you could say:

“Shift program focus: from starting breastfeeding → to sustaining it through six months”

or

“Measure success by continuation, not just initiation”

Frontline Implementation — Health Extension Program (HEP)

- Prioritize months 2–5 home follow-up
- Use risk-based household tracking
- Deliver targeted counseling (continuation barriers)
- Engage family influencers (fathers, grandmothers)
- Activate peer support groups & model mothers
- Feed real-time data → woreda & MoH

This slide focuses on the **Health Extension Program as the frontline delivery platform**—the point where policy becomes **actual behavior change**.

If the Ministry sets direction, the Health Extension Program ensures that: **Mothers receive sustained, practical support in the settings where feeding decisions are made—at home and within the community.**

1. Prioritize Months 2–5 Through Home Follow-Up

The evidence is clear: the sharpest decline in exclusive breastfeeding occurs between **months two and five**.

So, the Health Extension Program should:

Move beyond early postnatal visits

Institutionalize **scheduled home visits during months 2, 3, 4, and 5**

This is the **critical window** where continuation either holds—or breaks down.

The emphasis shifts from:

“Did breastfeeding start?”

to

“Is exclusive breastfeeding still being maintained?”

2. Implement Risk-Based Household Tracking

Not all households face the same risks of early drop-off.

Health Extension Workers (HEWs) can use simple criteria to identify:

Mothers returning to work early

Households where:

- Water or other liquids are introduced early

- Family members influence feeding decisions

Infants showing signs of:

- Growth concerns

- Feeding difficulties

These households can be flagged for:

More frequent follow-up and targeted support

This ensures efficient use of limited frontline capacity.

3. Deliver Targeted Counseling on Continuation Barriers

At this stage, counseling must go beyond general messages.

HEWs should focus on **specific, common barriers**, including:

Perceived milk insufficiency (“the baby is still hungry”)

Managing breastfeeding alongside **maternal workload**

Addressing beliefs around:

- Water supplementation

- Early complementary feeding

The goal is:

Problem-solving, not just messaging

Each visit should help mothers **navigate real-life constraints**.

4. Engage Family Influencers

Breastfeeding decisions are rarely made by the mother alone.

Key influencers include:

Grandmothers and elder women

Fathers

Other household members

HEWs should:

- Include these individuals in counseling sessions

- Address their concerns directly

- Align household support with recommended practices

This is essential because:

Norms and advice within the household can either reinforce or undermine exclusive breastfeeding.

5. Activate Peer Support and Model Mothers

Community-based reinforcement is critical.

The program can leverage:

Mother-to-mother support groups

Model mothers who successfully maintain EBF

These platforms:

Normalize sustained breastfeeding

Provide practical, experience-based advice

Reduce isolation and uncertainty among new mothers

This shifts support from **one-to-one counseling** → **to community reinforcement**.

6. Feed Real-Time Data Back into the System

Finally, the Health Extension Program plays a key role in **data generation and feedback**.

HEWs can:

Track EBF status by infant age during visits

Report simple indicators:

EBF at 2 months

EBF at 4–5 months

This information can be aggregated at:

Woreda level

Regional level

National level

Creating a **real-time picture of continuation performance**, not just national averages.

In closing, the Health Extension Program's role is to make exclusive breastfeeding sustainable—by supporting mothers where behavior is shaped: in households, over time, and within communities.

Public Health Leadership — Schools of Public Health (ACIPH & AAU SPH)

- Define national EBF continuation package (months 2–5)
- Lead implementation science & impact evaluation
- Build data systems (age × region dashboards)
- Train health workforce (HEWs, clinicians, managers)
- Guide quality improvement & supervision models
- Translate evidence → policy standards & scale-up

This slide positions the two schools of public health—the Addis Continental Institute of Public Health and the Addis Ababa University School of Public Health—as the **bridge between evidence and national scale**.

If Sociology helps us understand behavior, and the Ministry and Health Extension Program deliver services, then the Schools of Public Health ensure that:

What is delivered actually works—reliably, efficiently, and at scale.

The two institutions will:

1. Define the National “Continuation Package” (Months 2–5)

The first role is to **formalize what the system should deliver** during the critical drop-off period.

This includes designing a standardized, evidence-based package:

Timing and content of **follow-up contacts (1–5 months)**

Structured counseling protocols addressing:

Perceived milk insufficiency

Early supplementation pressures

Practical guidance for:

Breastfeeding under workload constraints

Household engagement

The goal is to move from:

General recommendations to → **Operational protocols that can be implemented nationwide**

2. Lead Implementation Science and Impact Evaluation

The two institutions are uniquely positioned to answer:

What works, for whom, and under what conditions?

They can:

Design and test **pilot interventions** across diverse regions

Compare different delivery models:

- HEW-led home visits

- Group-based counseling

- Facility-linked follow-up systems

Use rigorous methods:

- Quasi-experimental designs

- Randomized trials where feasible

This ensures that scale-up is based on:

Evidence of effectiveness—not assumptions

3. Build Data Systems (Age × Region Monitoring)

A major gap identified in this analysis is the reliance on **aggregate indicators**.

Schools of Public Health can support the MoH in developing:

Routine monitoring systems that track:

- EBF by infant age (0–5 months)

- EBF by region and woreda

Simple dashboards that allow:

- Early detection of drop-off

- Targeted response

This transforms monitoring from:

Static reporting to → **Dynamic program management**

4. Train the Health Workforce

Sustained improvement requires **capacity building at multiple levels**:

Health Extension Workers (HEWs):

- Practical counseling skills

- Identifying and addressing continuation barriers

Facility staff:

- Continuity of care from delivery to community follow-up

Program managers:

- Using data for decision-making

- Supervising continuation-focused programs

Training should emphasize:

Behavioral problem-solving, not just technical knowledge

5. Guide Quality Improvement and Supervision

Schools of Public Health can design and institutionalize:

Quality improvement (QI) cycles:

- Identify drop-off points

- Test small changes

- Scale what works

Supportive supervision tools that focus on:

- Continuation metrics

- Counseling quality

- Follow-up coverage

This ensures that programs **improve continuously**, not just operate.

6. Translate Evidence into Policy and Scale-Up

Finally, these institutions play a critical translation role:

Convert research findings into:

National guidelines

- Training curricula

- Standard operating procedures

Support the Ministry in:

- Scaling proven interventions

- Avoiding ineffective approaches

In this sense, they ensure that:

Innovation becomes institutionalized practice

In closing, the two Schools of Public Health ensure that Ethiopia not only promotes exclusive breastfeeding but also systematically learns how to sustain it and then scales what works.

THE END

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