

Exclusive Breastfeeding Practices in The Northern Regions of Bangladesh: A Comprehensive Assessment

Dr. Mahbubur Rahman^{*1}, Dr. Dilruba Ibrahim Dipti²,
Dr. Meherdad Yousuf Ahmed³

¹Associate Professor, Department of Pediatric Cardiology, Bangladesh Shishu Hospital & Institute, Dhaka, Bangladesh

²Assistant Professor, Department of Pediatric Cardiology, Bangladesh Shishu Hospital & Institute, Dhaka, Bangladesh

³Registrar, Department of Pediatric Cardiology, Bangladesh Shishu Hospital & Institute, Dhaka, Bangladesh

Abstract

Background: Despite the well-documented benefits of exclusive breastfeeding (EBF), its prevalence in Bangladesh has fluctuated over the years, with rates varying across regions and declining to 47% in 2019.[8] The purpose of this study was to evaluate exclusive breastfeeding practices in the northern regions of Bangladesh, including prevalence, influencing factors, and barriers.

Aim of the study: The aim of the study was to assess exclusive breastfeeding practices in the northern regions of Bangladesh, including prevalence, influencing factors, and barriers.

Methods: This cross-sectional study in Santhia Upazila, Pabna, Bangladesh (July–December 2020) recruited 100 mothers with infants ≤ 6 months via purposive sampling. Data from structured interviews covered sociodemographic, breastfeeding practices, and barriers. SPSS 22 was used for descriptive analysis and chi-square tests ($p < 0.05$). Informed consent ensured confidentiality.

Results: The study on 100 mothers in Northern Bangladesh found that only 39.0% practiced exclusive breastfeeding (EBF), with delayed initiation in 61.0%. EBF was significantly associated with rural residence, higher education, vaginal delivery, and employment status. Key barriers included perceived insufficient milk supply (39.3%), family pressure (21.3%), maternal illness (19.7%), and returning to work (19.7%).

Conclusion: Targeted education, workplace support, and family engagement are needed to improve exclusive breastfeeding rates in Northern Bangladesh, addressing key barriers like milk supply misconceptions and cultural pressures.

Keywords: Exclusive Breastfeeding, Prevalence, Barriers.

Corresponding Author: Dr. Mahbubur Rahman, Associate Professor, Department of Pediatric Cardiology, Bangladesh Shishu Hospital & Institute, Dhaka, Bangladesh

Date of Submission: 01-04-2025

Date of Acceptance: 11-04-2025

I. Introduction

Exclusive breastfeeding (EBF) is widely recognized as one of the most effective nutritional practices for infant health, supporting balanced growth, immune function, and the prevention of infectious and chronic diseases.[1] The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) recommend that infants be exclusively breastfed for the first six months,[2] receiving no other food or drink, not even water.[3] EBF significantly reduces the risk of infant mortality, particularly from common childhood illnesses such as diarrhea and pneumonia,[4] which remain major causes of child mortality in low- and middle-income countries.[5] Moreover, EBF has been shown to lower the risk of mother-to-child HIV transmission and contribute to improved long-term health outcomes, including cognitive and motor development.[6] Globally, it is estimated that exclusive breastfeeding could prevent over 800,000 infant deaths annually.[5] Despite these benefits, only 41% of infants under six months of age are exclusively breastfed worldwide, with rates varying across regions.[7]

In Bangladesh, the prevalence of exclusive breastfeeding remains a significant public health concern, with rates falling short of WHO and UNICEF recommendations. According to the Bangladesh Demographic and Health Survey (BDHS), the EBF rate rose from 36% in 2006 to 64% in 2011, then fluctuated over the years, reaching 65% in 2018 before declining to 47% in 2019.[8] These trends underscore the challenges in maintaining optimal breastfeeding practices, particularly in rural areas, where cultural and socioeconomic factors play a crucial role.[9] Various studies indicate that factors such as delivery practices, maternal education, and family support

significantly influence EBF adherence. Additionally, healthcare workers, who hold a respected position in Bangladeshi society, play a key role in promoting breastfeeding through education and guidance.[10,11] Despite some positive trends, Bangladesh continues to struggle with sustaining optimal EBF rates needed to reduce infant mortality and improve overall child health outcomes.

Multiple barriers hinder EBF practices, spanning maternal, social, cultural, and healthcare-related factors. Maternal characteristics such as place of residence, age, education level, employment status, and access to mass media strongly impact EBF prevalence, particularly in developing countries like Bangladesh.[12,13,14] While rural communities traditionally uphold strong breastfeeding practices, a gradual decline has contributed to malnutrition and poor child health outcomes. Social and cultural influences further contribute to disparities, as evident in the variation of EBF rates between rural and urban areas. In some rural communities, only 36% of infants are exclusively breastfed,[15] compared to the national rate of 55%.[16] Healthcare-related challenges also affect EBF adherence, including inconsistencies in healthcare practices and a lack of awareness about the WHO’s EBF definition, which stresses the need for exclusive breast milk intake without additional liquids or solids. In many rural healthcare settings, this definition is not always effectively communicated or implemented, further hindering optimal breastfeeding practices.[17] These factors collectively highlight the complex barriers to achieving and sustaining recommended breastfeeding rates.

While several studies have examined EBF rates in Bangladesh, most have focused on national trends or urban populations, leaving a gap in research on rural and northern regions. Existing data suggest significant regional disparities in EBF prevalence, yet there is limited recent evidence on the specific challenges faced by mothers in northern Bangladesh. Additionally, the fluctuating EBF rates reported in national surveys indicate the need for updated, region-specific data to identify key influencing factors and barriers. Understanding these localized trends is essential for developing targeted interventions that address maternal, social, and healthcare-related challenges to EBF adherence. The purpose of this study was to evaluate exclusive breastfeeding practices in the northern regions of Bangladesh, including prevalence, influencing factors, and barriers.

Objective

- The aim of the study was to assess exclusive breastfeeding practices in the northern regions of Bangladesh, including prevalence, influencing factors, and barriers.

Methodology & Materials

This cross-sectional study was conducted in Santhia Upazila, Pabna, Bangladesh, from July 2020 to December 2020. A total of 100 mothers with infants aged six months or younger were recruited for the study using a purposive sampling method.

Inclusion Criteria:

- Mothers with infants aged ≤6 months.
- Mothers willing to participate and provide informed consent.
- Mothers capable of recalling their breastfeeding practices.

Exclusion Criteria:

- Mothers with severe illness or medical conditions preventing participation.
- Infants with congenital anomalies or medical conditions affecting breastfeeding.
- Mothers who had stopped breastfeeding due to infant mortality.
- Mothers unwilling to participate or unable to provide consent.

Data were collected through structured face-to-face interviews using a pretested questionnaire covering sociodemographic characteristics, breastfeeding initiation, EBF practices, influencing factors, and barriers. Independent variables included maternal age, place of residence, education level, mode of delivery, and occupation, while the dependent variable was exclusive breastfeeding up to six months. Barriers to EBF were assessed based on self-reported factors such as perceived insufficient milk supply, maternal health issues, social pressure, and work-related challenges. Data were entered and analyzed using SPSS version 22, with descriptive statistics summarizing participant characteristics and chi-square tests assessing associations between sociodemographic factors and EBF practices, considering $p < 0.05$ as statistically significant. Informed consent ensured confidentiality and voluntary participation.

II. Results

Table 1: Sociodemographic Characteristics of the Study Participants (n=100)

	Variable	Frequency (n)	Percentage (%)
Age (In years)	18-22	15	15.0%
	23-27	20	20.0%

	28-32	25	25.0%
	33-37	20	20.0%
	38-42	10	10.0%
	43-47	10	10.0%
	Mean \pm SD	31.0 \pm 7.52	
Place of Residence	Rural	69	69.0%
	Urban	31	31.0%
Education	No Schooling	28	28.0%
	Primary or no formal education	19	19.0%
	Secondary or higher education	53	53.0%
Mode of Delivery	Vaginal	69	69.0%
	Cesarean	31	31.0%
Occupation	Housewife	60	60.0%
	Service holder	40	40.0%

Table 1 presents the sociodemographic characteristics of the study participants, including age distribution, place of residence, education level, mode of delivery, and occupation. The mean age of the mothers was 31.0 ± 7.52 years, with the majority (25.0%) falling within the 28–32 years age group. Most participants resided in rural areas (69.0%), while 31.0% lived in urban areas. In terms of education, 53.0% had secondary or higher education, whereas 28.0% had no formal schooling. The mode of delivery showed that 69.0% of mothers had vaginal deliveries, and 31.0% underwent cesarean sections. Regarding occupation, 60.0% of the mothers were housewives, while 40.0% were employed as service holders.

Table 2: Exclusive Breastfeeding Practices and Initiation in the Study Population (n=100)

Variable		Frequency (n)	Percentage (%)
Initiation of breast feeding	Early Initiation (<1 hr)	39	39.0%
	Delayed Initiation (>1 hr)	61	61.0%
Exclusive Breastfeeding (EBF)	EBF	39	39.0%
	Non-EBF (Additional Feeds)	61	61.0%
Type of Additional Feeds	Breast Milk/Mixed Feeding	43	43.0%
	Formula Milk	18	18.0%

A majority of participants (61.0%) experienced delayed initiation of breastfeeding, while 39.0% practiced early initiation. In terms of exclusive breastfeeding, 39.0% of the participants adhered to EBF, and the remaining 61.0% introduced additional feeds. Among those who introduced additional feeds, a significant portion (43.0%) used breast milk/mixed feeding, while 18.0% opted for formula milk.

Table 3: Sociodemographic Factors Influencing Exclusive Breastfeeding Practices

Variable	Category	EBF (n=39)	Non-EBF (n=61)	p-value
Place of Residence	Rural	22 (56.4%)	47 (77.0%)	0.029
	Urban	17 (43.6%)	14 (23.0%)	
Education	No Schooling	5 (12.8%)	23 (37.7%)	0.022
	Primary	8 (20.5%)	11 (18.0%)	
	Secondary or higher	26 (66.7%)	27 (44.3%)	
Mode of Delivery	Vaginal	32 (82.1%)	37 (60.7%)	0.025
	Cesarean	7 (17.9%)	24 (39.3%)	
Occupation	Housewife	18 (46.2%)	42 (68.9%)	0.024
	Service holder	21 (53.8%)	19 (31.1%)	

Table 3 presents the relationship between sociodemographic factors and exclusive breastfeeding (EBF) practices among mothers in the study. It highlights the significant differences in EBF rates based on place of residence, education level, mode of delivery, and occupation. Rural mothers were more likely to exclusively breastfeed (56.4%) compared to urban mothers (43.6%), with a p-value of 0.029. Similarly, mothers with higher educational levels (secondary or higher education) had higher EBF rates (66.7%) compared to those with no schooling (12.8%) or primary education (20.5%), with a p-value of 0.022. The mode of delivery also played a role, as vaginal deliveries were associated with higher EBF rates (82.1%) than cesarean deliveries (60.7%) ($p = 0.025$). Lastly, occupation significantly influenced breastfeeding practices, with housewives showing higher EBF rates (46.2%) compared to service holders (31.1%) ($p = 0.024$).

Table 4: Barriers to Exclusive Breastfeeding Among Non-Practicing Mothers (n=61)

Barrier	Frequency (n)	Percentage (%)
Perceived insufficient milk supply	24	39.3%
Maternal illness/medication	12	19.7%

Pressure from family members	13	21.3%
Returning to work	12	19.7%

This table highlights the various barriers faced by mothers in the Northern Regions of Bangladesh that prevent them from practicing exclusive breastfeeding. The most common barrier identified was perceived insufficient milk supply, affecting 39.3% of mothers. Other significant barriers included maternal illness or the use of medication (19.7%), pressure from family members (21.3%), and returning to work (19.7%).

III. Discussion

This study examines the prevalence, influencing factors, and barriers associated with exclusive breastfeeding (EBF) practices among mothers in the northern regions of Bangladesh. Despite the well-documented benefits of EBF, the findings reveal a lower-than-optimal adherence rate, with a significant proportion of mothers introducing additional feeds within the first six months. Sociodemographic factors such as place of residence, education level, mode of delivery, and occupation were found to significantly impact EBF rates. Additionally, barriers like perceived insufficient milk supply, maternal illness, family pressure, and work-related challenges further hindered EBF adherence. These results emphasize the need for targeted interventions and support systems to promote and sustain exclusive breastfeeding practices in this region.

In this study, the mean age of mothers was 31.0 ± 7.52 years, with the highest proportion (25.0%) falling within the 28–32 years age group, a crucial reproductive period that influences breastfeeding practices and child nutrition. This aligns with Hossain et al.[18], who reported a mean maternal age of 31.02 ± 9.22 years, indicating a similar trend. The majority of participants (69.0%) resided in rural areas, where breastfeeding practices and healthcare access differ from urban settings, a pattern also observed by Islam et al.[19] and Giashuddin et al.[20]. The mode of delivery showed that 69.0% of mothers had vaginal deliveries, which is often associated with early breastfeeding initiation, similar to findings by Islam et al.[19]. Education, a key determinant of breastfeeding awareness, revealed that 28.0% of mothers had no formal schooling, while 53.0% had secondary or higher education, reflecting trends reported by Rana et al.[21] regarding the impact of maternal education on infant feeding practices. Additionally, 60.0% of mothers were housewives, which may support better adherence to exclusive breastfeeding, as observed in Rana et al.[21]. These findings emphasize the role of maternal demographics in shaping breastfeeding behaviors and align with previous research, reinforcing the representativeness of this study's population.

In our study, we found that a majority of participants (61.0%) had delayed initiation of breastfeeding, with only 39.0% practicing early initiation within the first hour. This highlights a significant gap in the timely initiation of breastfeeding, which could have implications for infant health and breastfeeding success. When it comes to exclusive breastfeeding, 39.0% of mothers adhered to EBF practices, while the remaining 61.0% introduced additional feeds, indicating a high prevalence of non-EBF practices. Among those introducing additional feeds, a notable portion (43.0%) chose Breast milk/mixed feeding, while 18.0% opted for formula milk, suggesting a preference for alternatives to breast milk. These findings echo those of Das et al.[22], who reported similar trends in delayed initiation and the introduction of non-breast milk feeds, indicating a regional challenge in promoting exclusive breastfeeding from birth.

In this study, we observed significant associations between various sociodemographic factors and exclusive breastfeeding (EBF) practices, similar to findings from several studies. The data revealed that rural residents were more likely to practice EBF (56.4%) compared to their urban counterparts (43.6%), with a p-value of 0.029, suggesting a significant difference. This is in line with the findings of Giashuddin et al.[20], who also reported higher EBF rates in rural areas. Hasan et al.[23] highlighted the role of education in promoting breastfeeding, and our study found that mothers with secondary or higher education had significantly higher EBF rates (66.7%) compared to those with no schooling (12.8%) or primary education (20.5%), with a p-value of 0.022. This aligns with Kazaura et al.[24] and Alemayehu et al.[25], who also noted the positive impact of education on EBF practices. Additionally, Hasan et al.[23] found that vaginal delivery is associated with higher breastfeeding rates, which corresponds with our findings, where 82.1% of EBF mothers had a vaginal delivery compared to only 60.7% among non-EBF mothers ($p = 0.025$). Similarly, Kazaura et al.[24] emphasized the influence of occupation, noting that housewives were more likely to practice exclusive breastfeeding. Our study also found that housewives had higher EBF rates (46.2%) compared to service holders (31.1%), with a significant p-value of 0.024. These findings underscore the importance of sociodemographic factors such as residence, education, mode of delivery, and occupation in shaping breastfeeding practices in the northern regions of Bangladesh.

In the context of the Northern Regions of Bangladesh, this study identified several barriers to exclusive breastfeeding, with the most common being perceived insufficient milk supply, reported by 39.3% of mothers. This aligns with findings from the American Academy of Pediatrics, which found that approximately 50% of mothers stopped breastfeeding due to concerns over milk supply. Maternal health issues, including illnesses or

medication, were cited as a barrier by 19.7% of mothers,[26] a trend also noted by Piccolo et al.[27], who highlighted the role of maternal health challenges in hindering exclusive breastfeeding. Additionally, 21.3% of mothers reported pressure from family members as a significant barrier, reflecting the social dynamics discussed by Olalere et al.[28], who emphasized how family expectations can influence breastfeeding decisions. Finally, returning to work emerged as another barrier for 19.7% of mothers, a concern that resonates with Thet et al.'s [29] findings on the impact of labor demands and health-related factors on breastfeeding practices. These barriers in the Northern Regions of Bangladesh highlight the multifaceted challenges faced by mothers, reinforcing the need for targeted interventions addressing both health and social factors to promote exclusive breastfeeding.

IV. Limitations Of The Study

This study had some limitations:

- The sample was not randomly selected.
- The study's limited geographic scope may introduce sample bias, potentially affecting the broader applicability of the findings.

V. Conclusion

This study highlights significant challenges to exclusive breastfeeding in Northern Bangladesh, where only a minority of mothers (39%) maintain the practice. Key barriers include widespread misconceptions about milk supply, cultural pressures from families, and work-related constraints. The findings reveal that breastfeeding outcomes are strongly influenced by education levels, delivery methods, and rural/urban divides. Mothers with more education, those who had vaginal births, and working women showed better adherence. These results call for community-based interventions that address misinformation, provide workplace support, and engage family networks to promote breastfeeding. The study underscores the need for culturally sensitive strategies tailored to this region's specific socioeconomic context.

References

- [1] World Health Organization. Global Strategy For Infant And Young Child Feeding: The Optimal Duration Of Exclusive Breastfeeding. Geneva: WHO. 2001 May.
- [2] Infant And Young Child Feeding. Who.Int. Available From: <https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding>.
- [3] Akinyinka MR, Olatona FA, Oluwole EO. Breastfeeding Knowledge And Practices Among Mothers Of Children Under 2 Years Of Age Living In A Military Barrack In Southwest Nigeria. *International Journal Of MCH And AIDS*. 2016;5(1):1.
- [4] New York State Department Of Health. Breastfeeding: Why Breastfeeding Is Important. Available From: <https://www.health.ny.gov/prevention/nutrition/wic/breastfeeding/importance.htm>
- [5] Black RE, Victora CG, Walker SP, Bhutta ZA, Christian P, De Onis M, Ezzati M, Grantham-Mcgregor S, Katz J, Martorell R, Uauy R. Maternal And Child Undernutrition And Overweight In Low-Income And Middle-Income Countries. *The Lancet*. 2013 Aug 3;382(9890):427-51.
- [6] Iliff PJ, Piwoz EG, Tavengwa NV, Zunguza CD, Marinda ET, Nathoo KJ, Moulton LH, Ward BJ, Humphrey JH, ZVITAMBO Study Group. Early Exclusive Breastfeeding Reduces The Risk Of Postnatal HIV-1 Transmission And Increases HIV-Free Survival. *Aids*. 2005 Apr 29;19(7):699-708.
- [7] World Health Organization, UNICEF. Global Breastfeeding Scorecard, 2018: Enabling Women To Breastfeed Through Better Policies And Programmes. World Health Organization; 2018. Available From: <https://www.who.int/nutrition/publications/infantfeeding/global-bf-scorecard-2018.pdf?ua=1>
- [8] National Institute Of Population Research And Training (NIPORT), ICF. Bangladesh Demographic And Health Survey 2017-18. Dhaka, Bangladesh, And Rockville, Maryland, USA: NIPORT And ICF; 2020. Pages 1–511.
- [9] Aziz SB, Marcel B, Franck G, Zeynab K, Soumaila C, Joseph CD, Evrard S. Knowledge, Opinions And Attitudes Of Mothers About Breastfeeding And Child Feeding In Rural Areas Of Burkina Faso: A Study In Ouargaye's District Health Facilities. *Journal Of Family Medicine And Health Care*. 2018;4(3):13-9.
- [10] Fjeld E, Siziya S, Katepa-Bwalya M, Kankasa C, Moland KM, Tylleskär T, PROMISE-EBF Study Group Thorkild. Tylleskar@ Cih. Uib. No. 'No Sister, The Breast Alone Is Not Enough For My Baby'a Qualitative Assessment Of Potentials And Barriers In The Promotion Of Exclusive Breastfeeding In Southern Zambia. *International Breastfeeding Journal*. 2008 Nov;3:1-2.
- [11] Shirima R, Greiner T, Kylberg E, Gebre-Medhin M. Exclusive Breast-Feeding Is Rarely Practised In Rural And Urban Morogoro, Tanzania. *Public Health Nutrition*. 2001 Apr;4(2):147-54.
- [12] Ssenyonga R, Muwonge R, Nankya I. Towards A Better Understanding Of Exclusive Breastfeeding In The Era Of HIV/AIDS: A Study Of Prevalence And Factors Associated With Exclusive Breastfeeding From Birth, In Rakai, Uganda. *Journal Of Tropical Pediatrics*. 2004 Dec 1;50(6):348-53.
- [13] Simopoulos AP, Grave GD. Factors Associated With The Choice And Duration Of Infant-Feeding Practice. *Pediatrics*. 1984 Oct 1;74(4):603-14.
- [14] Morisky DE, Kar SB, Chaudhry AS, Chen KR, Shaheen M, Chickering K. Breastfeeding Practices In Pakistan. *Pakistan Journal Of Nutrition*. 2002;1(3):137-42.
- [15] Joshi PC, Angdembe MR, Das SK, Ahmed S, Faruque AS, Ahmed T. Prevalence Of Exclusive Breastfeeding And Associated Factors Among Mothers In Rural Bangladesh: A Cross-Sectional Study. *International Breastfeeding Journal*. 2014 May;9:1-8.
- [16] National Institute Of Population Research And Training (NIPORT), Mitra And Associates, ICF International. Bangladesh Demographic And Health Survey 2014. Dhaka, Bangladesh, And Rockville, Maryland, USA: NIPORT, Mitra And Associates, ICF International; 2016.
- [17] World Health Organization (WHO). Indicators For Assessing Breastfeeding Practices. Report Of An Informal Meeting. Geneva, Switzerland: WHO; 1991 June 11-12.

- [18] Hossain M, Islam A, Kamarul T, Hossain G. Exclusive Breastfeeding Practice During First Six Months Of An Infant's Life In Bangladesh: A Country Based Cross-Sectional Study. *BMC Pediatrics*. 2018 Dec;18:1-9.
- [19] Islam MJ, Baird K, Mazerolle P, Broidy L. Exploring The Influence Of Psychosocial Factors On Exclusive Breastfeeding In Bangladesh. *Archives Of Women's Mental Health*. 2017 Feb;20(1):173-88.
- [20] Giashuddin MS, Kabir M, Rahman A, Hannan MA. Exclusive Breastfeeding And Nutritional Status In Bangladesh. *The Indian Journal Of Pediatrics*. 2003 Jun;70:471-5.
- [21] Rana MM, Islam MR, Karim MR, Islam AZ, Haque MA, Shahiduzzaman M, Hossain MG. Knowledge And Practices Of Exclusive Breastfeeding Among Mothers In Rural Areas Of Rajshahi District In Bangladesh: A Community Clinic Based Study. *Plos One*. 2020 May 8;15(5):E0232027.
- [22] Das S, Dey SR, Islam KT. Breast Feeding Practice In A Selected Peri Urban Area Of Bangladesh. *Bangladesh Journal Of Medicine*. 2022 Aug 30;33(3):274-9.
- [23] Hasan M, Hassan MN, Khan MS, Tareq MA, Afroj MS. Prevalence, Knowledge, Attitudes And Factors Associated With Exclusive Breastfeeding Among Mothers In Dhaka, Bangladesh: A Cross-Sectional Study. *Population Medicine*. 2021 Sep 7;3(September):1-7.
- [24] Kazaura M. Exclusive Breastfeeding Practices In The Coast Region, Tanzania. *African Health Sciences*. 2016 Mar;16(1):44.
- [25] Alemayehu T, Haidar J, Habte D. Determinants Of Exclusive Breastfeeding Practices In Ethiopia. *Ethiopian Journal Of Health Development*. 2009;23(1).
- [26] U S Department Of Health And Services. The Surgeon General's Call To Action To Support Breastfeeding 2011. *Northern House Media*; 2011.
- [27] Piccolo O, Kinshella ML, Salimu S, Vidler M, Banda M, Dube Q, Kawaza K, Goldfarb DM, Nyondo-Mipando AL. Healthcare Worker Perspectives On Mother's Insufficient Milk Supply In Malawi. *International Breastfeeding Journal*. 2022 Feb 23;17(1):14.
- [28] Olalere O, Harley C. Why Women Discontinue Exclusive Breastfeeding: A Scoping Review. *British Journal Of Midwifery*. 2024.
- [29] Thet MM, Khaing EE, Diamond-Smith N, Sudhinaraset M, Oo S, Aung T. Barriers To Exclusive Breastfeeding In The Ayeyarwaddy Region In Myanmar: Qualitative Findings From Mothers, Grandmothers, And Husbands. *Appetite*. 2016 Jan 1;96:62-9.