Journal of Public Health and Development
Vol. 13 No. 3 September-December 2015

ORIGINAL ARTICLE

Prevalence and associated factors of exclusive breastfeeding among mothers in Pan-Ta-Naw township, Myanmar

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Received: *31 May 2015* ***Revised:*** *1 February 2016* ***Accepted:*** *9 February 2016*
Available online: *February 2016*

Abstract

Kyi L.W, Mongkolchati A, Chompikul J and Wongsawass S.
Prevalence and associated factors of exclusive breastfeeding among mothers in Pan-Ta-Naw township, Myanmar
J Pub Health Dev.2015;13(3):81-94

This cross sectional study aimed to explore the prevalence and predictors of exclusive breastfeeding practices in Pan-Ta-Naw Township, Ayyerwaddy Region, Myanmar. Two-stage stratified sampling was used to randomly select a sample of 403 mothers who have a child aged 6-12 months. They were interviewed both in rural and urban hospitals. The research instrument was consisted of 43 questions.Chi-square tests and multiple logistic regressions were performed to examine factors associated with exclusive breastfeeding.

The prevalence of the first six-month exclusive breastfeeding was 15%. This study found that most mothers introduced water and rice to their infant as well as breast feeding, and very few mothers used formula milk, juice or cow's milk. The following factors were significant associations with exclusive breast feeding: place of residence (Adj.OR=5.88, 95%CI=2.02-17.12), marital status (Adj.OR=6.34, 95%CI=1.76-22.90), mother's education(Adj.OR=6.72, 95%CI=1.52-29.61), mother's occupation (Adj.OR=5.94, 95%CI=2.23-15.81), places of delivery (Adj.OR=7.29, 95%CI=2.48-21.38), ANC visit at least 4 times (Adj.OR=27.02, 95%CI=7.57-96.49), and knowledge about breastfeeding (Adj.OR=10.84, 95%CI=3.11-37.77). The strongest predictor was making ANC visits at least 4 times.

This study found that mothers in both rural and urban area were likely to have little understanding about exclusive breast feeding; hence, health education regarding to this issue should be promoted. As the frequency of ANC visits has been showed to be the strongest significant factors, enhancing the mother's knowledge about breastfeeding should be considered to include in the ante-natal period of services in health centres.

Keywords: Exclusive breastfeeding, antenatal care, feeding practice, infant feeding

วารสารสาธารณสุขและการพัฒนา
ปีที่ 13 ฉบับที่ 3 กันยายน-ธันวาคม 2558

ความชุกและปัจจัยที่มีความสัมพันธ์กับการเลี้ยงลูกด้วยนมแม่อย่างเดียวของแม่ในเมืองปันตานาว ประเทศพม่า

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ความชุกและปัจจัยที่มีความสัมพันธ์กับการเลี้ยงลูกด้วยนมแม่อย่างเดียวของแม่ในเมืองปันตานาว ประเทศพม่า
ว.สาธารณสุขและการพัฒนา.2558;13(3):81-94

วัตถุประสงค์ของการศึกษาแบบภาคตัดขวางนี้เพื่อสำรวจความชุกและปัจจุยที่สามารถทำนายการเลี้ยงลูกด้วยนมแม่อย่างเดียวในเมืองปันตานาว แขวงอิรวาดี ประเทศพม่า โดยการสุ่มตัวอย่างแบบชั้นภูมิสองขั้นตอน ได้ตัวอย่างที่เป็นมารดาซึ่งมีบุตรอายุ 6 – 12 เดือน จำนวน 403 คน เก็บข้อมูลโดยการสัมภาษณ์ที่โรงพยาบาลในเขตเมืองและชนบท เครื่องมือในการวิจัยประกอบด้วยคำถาม 43 ข้อ วิเคราะห์ข้อมูลด้วยไคสเควร์และการถดถอยลอจิสติคพหุคูณเพื่อสำรวจปัจจัยที่มีความสัมพันธ์กับการเลี้ยงลูกด้วยนมแม่อย่างเดียว

ความชุกของการเลี้ยงลูกด้วยนมแม่อย่างเดียวช่วง 6 เดือนแรกของชีวิตเท่ากับ 15% การศึกษานี้พบว่ามารดาส่วนใหญ่ให้ลูกกินน้ำและข้าวพร้อมกับนมแม่และมีมารดาบางคนที่ให้ลูกกินนมขวด น้ำผลไม้และนมวัวปัจจัยต่อไปนี้มีความสัมพันธ์อย่างมีนัยสำคัญกับการเลี้ยงลูกด้วยนมแม่อย่างเดียว สถานที่อยู่อาศัย (Adj OR = 5.88, 95% CI = 2.02 – 17.12) สถานภาพสมรส (Adj OR = 6.34, 95% CI = 1.76 – 22.90) การศึกษาของมารดา (Adj OR = 6.72, 95% CI = 1.52 -29.61) อาชีพของมารดา (Adj OR = 5.94, 95% CI = 2.23 – 15.81) สถานที่คลอดบุตร (Adj OR = 7.29, 95% CI 2.48 – 21.38) การไปรับบริการที่คลินิคฝากครรภ์อย่างน้อย 4 ครั้ง (Adj OR = 27.02, 95% CI = 7.57 – 96.49) และความรู้เกี่ยงกับการเลี้ยงลูกด้วยนมแม่ (Adj OR = 10.84, 95% CI 3.11 – 37.77) ปัจจัยที่ทำนายการเลี้ยงดูลูกด้วยนมแม่อย่างดียวได้ดีที่สุดคือการไปคลินิคฝากครรภ์อย่างน้อย 4 ครั้ง

การศึกษานี้พบว่ามารดาทั้งในชนบทและเมืองมีความรู้เข้าใจเรื่องการเลี้ยงลูกด้วยนมแม่อย่างเดียวน้อยมาก ควรส่งเสริมการให้สุขศึกษาเกี่ยวกับการเลี้ยงลูกด้วยนมแม่ เนื่องจากการไปคลินิคฝากครรภ์อย่างน้อย 4 ครั้ง เป็นตัวทำนายที่ดีที่สุด ดังนั้นจึงควรส่งเสริมการให้ความรู้เกี่ยวกับการเลี้ยงลูกด้วยนมแม่อย่างเดียวในคลินิกฝากครรภ์ที่สถานีอนามัยต่างๆ

คำสำคัญ: การเลี้ยงลูกด้วยนมแม่อย่างเดียว คลินิคฝากครรภ์ พฤติกรรมการให้อาหาร การให้อาหารทารก

Introduction

Human milk is considered to be an ideal food for nourishing a baby. For centuries, babies have thrived well on mother's milk. Breastfeeding is also considered the safest and most desirable method of providing the baby a healthy beginning in life. There are many positive reasons for women to breastfeed their babies, Breast milk is the best and most nutritious food, protecting them from illness and ensuring healthy physical and psychological development[1]. Exclusive Breastfeeding (EBF) reduced both mortality and morbidity of diarrhea and pneumonia in small children[2]. Many of the research findings have strengthened views of the advantages of breastfeeding over other methods of infant feeding[3]. It is widely recommended that only breast milk should be fed to infants the first six months of life. Certainly in developing countries where the risks of complementary feeding usually outweigh any possible advantages, breastfeeding alone up to six months of life is of utmost importance[3, 4]. Others benefits of breastfeeding include its economic advantages, as well as promoting mother-infant bonding, better cognitive development in children and lower incidence of infection in infants[3].

Globally, in 2003-2007 there was about 38% of infant in developing countries receive exclusive breast milk for six months of life and about 6% of infants are never breastfed. Remarkably, most of the countries in Asia Pacific region had reached EBF greater than the world average. Women from Industrialized countries who breastfeed less were likely to be younger, single, from a low socioeconomic status, or with lower level of education[5]. However, there was only 25.6% of mothers had EBF in Myanmar in 2010[6]. According to Statistics of Ayerwaddy region in 2012, only 7.5% of infant get exclusively breastfeeding which is relatively low down compared with national situation[6].

A recent survey showed that the main causes of mortality were due to respiratory infections, diarrhoea, brain infections, etc which could be prevented by breastfeeding as intervention[6]. Although improvements in the health status of children have been noted, much more needs to be done to sustain the gains made and contribute to the achievement of health-related Millennium Development Goals by 2015; to improve the quality of health care in order to reduce morbidity and mortality of neonates, infants and children under five, and to achieve normal growth and development of children[7].

There are substantial evidences from systematic review reporting factors associating with initial breastfeeding and duration of exclusive breastfeeding in both in developed and developing countries[8]. In Nigeria, Mothers with higher education, older mothers and mothers from higher income family were more likely to breastfed exclusively. Additionally, more frequent ANC visits promoted EBF practices 7. On the contrary, a longitudinal study in Canada, only mothers' age and education were identified as significant determinants[9]. In summary, these socio-demographic characteristics such as child gender, age of mothers, ethnicity, marital status, paternal occupation, educational level[10] and income level[10], previous experience of breastfeeding; paternal characteristics; grandma support; peer support; frequency of ANC visit that influencing EBF varying in certain contextual cultures[7,9,11]. For example, EBF between urban and rural settings, were not much or less then same in Philippines and Cambodia[11].

There was a few studies regarding to this issue has been conducted in Myanmar in particular region. This study aimed to describe the prevalence of exclusive breastfeeding practices and to determine the factors associated with exclusive breastfeeding practices in Pan-Ta-Naw Township, Ayarwaddy region, Myanmar. This research would provide the valuable information to improve the quality of children health in this region.

Methods

A community based cross-sectional study was carried out to explore the prevalence of breastfeeding practices and the factors affecting on breastfeeding practices. The study area was the Pan-Ta-Naw Township, Ayeyawady Region, Myanmar where the diversity of socio-demographic factors present. The mother who had only the child aged 6-12 months registered in Pan-Ta-Naw Township Hospital for urban area and those who registered in a station hospital for rural area. Data were collected from February 1 to February 25, 2012 by using stratified sampling. Only 50% of mothers who had children aged 6-12 months who inclusive breast feeding were included in this study. Total of 386 mothers were included in this study. The respondents were excluded from the study if the mother who had baby with severe medical condition or congenital malformations, the baby was placed in the neonatal intensive care unit after delivery and the respondents who didn't understand the local language. The methods to collect the data were interview and observation by using structured questionnaire. The questionnaire consisted of mother& father characteristics (14 questions), socio-economic status (2 questions), infant characteristics (5 questions), knowledge about breastfeeding (10 statements), breastfeeding practices (6 questions) and the family supports (6 questions). The questionnaires were sent to the experts to examine the validity, and then translated to Myanmar local language before performing the pre-test. The questionnaire was being prê-test for the reliability in 30 cases. Kuder Richardson 20 Coefficient was used for reliability test of Knowledge and the KR 20 coefficient for the reliability was 0.75.

Dependent variable was the exclusive breastfeeding which means to the mother who giving only breast milk to newborn for the first six months of life and the independent variables were mother's age (<20, ≥20); ethnicity (Burmese, non-Burmese); marital status (married, separated and widow); occupation (housewife, agriculture/shop/worker/staff); previous experience of breastfeeding (yes or no); socio-economic status; income (<70000 kyats, ≥70000 kyats, approximately 80 US$); place of residence (urban, rural); maternal knowledge about breastfeeding; parity of infant (first born or not); place of delivery (at home, health facilities); birth attendance (trained health personnel, traditional birth attendance); paternal education; paternal support; support from peer; grandma support and frequency of ANC visit (< 4 times, ≥ 4 times).

This proposal was approved by Pan-Ta-Naw Township and Mahidol University ethical approval. After received permission, 10 assistant researchers were trained to introduce how to use the questionnaire and later to practise how to interview and collect the data. For confidentially and anonymously of the subject, the questionnaire was covered by a consent form letter. The data was conducted by face to face interviewing, and after collecting data, the questionnaires sheet was immediately checked for its completeness and accuracy. Finally, finishing data

collection, the interviewers had to allow the mothers to ask question if any or some feedback. Questionnaire was coded and data were analysed by using SPSS program. The chi-square tests were used to assess an association between each factor and breastfeeding practices. Multiple logistic regression was used to examine associations between independent variables and dependent variable, which the significant level was set at 0.05.

Results

This study found that half of the respondents were teenage mothers (less than 20 years of age). Majority of them (57%) were living in urban area. Nearly 90% were married and lived together with their husbands. Approximately 56% of mothers had primary school education. Among them about 32% were housewives, and the rest were shopkeepers, government servants, and general workers. Concerning to the financial status, less than half (47%) got the monthly income of lower than 70000 kyats (approximately 80US$). The half of respondents was Burmese ethnic whilst another half was non-Burmese, including Karin, Chinese and Indian. 28% of respondents had good knowledge about breastfeeding while 28% and 43% had fair and poor knowledge respectively. Most of them, 80% received emotionally support from their husbands. 69% of respondents received support from their mothers in breastfeeding. 68.2% delivered at their home. Trained health personnel such as doctors, nurses, and midwives did as birth attendance in 73%. Concerning ANC visits, about half of the respondents had attended ANC less than 4 times.

Based on the criteria that mentioned in operational definition, the prevalence of exclusive breastfeeding was 14.9%. About 15% of mothers practiced 6 months of exclusive breast feeding. After 6 months, most respondents gave water and rice to their infants. On the other hand, 163 (40%) used rice or cereal as complementary food. Only 7 mothers gave bottle milk (formula) and 8 mothers gave cow milk while 2 mothers gave juice as complementary food. There is no one who stopped breastfeeding in this study as shown in Table 1.

Table 1 Types of feeding practices of children aged 6-12 months during the first 6 months

Type of feeding practices	n	Percent
Frequency of EBF		
Exclusive breast feeding	60	14.9
Not exclusive breast feeding	343	85.1
Breast milk and Bottle milk		
Yes	7	1.7
No	396	98.3
Breast milk and rice or cereal		
Yes	163	40.4
No	240	59.6
Breast milk and Juice		
Yes	2	0.5
No	401	99.5

Table 2 shows that mothers lived in rural area were 1.91(95%CI 1.1-3.34) times more likely to get exclusive breastfeeding than urban area. Separated or widow mothers were 10.6 (95%CI 5.28-21.27) times higher in exclusive breastfeeding than married ones. Higher in education of mothers had the times of 5.8(95%CI 3.05-11.22) compared to those with low education. Non-dependent mothers were 2.36(95%CI 1.9-4.72) times to breastfeed exclusively than dependent mothers. Burmeses were 1.5 (95%CI 0.90-2.76) times than non-Burmeses in exclusive breastfeeding. Higher income mothers had 4.2(95%CI 2.19-8.31) times than low income group. The mothers who had the good knowledge were 23.85(95%CI 4.09-62.56) times and fair knowledge were 2.57 (95%CI 0.82-8.05) times than those with poor knowledge. High husband education had 8.9 (95%CI 4.38-18.26) times of exclusive breastfeeding than low education. Mothers who gave birth in health facilities were 11.69(95%CI 6.03-22.9) times more likely to have exclusive breastfeeding than those who gave birth at home. Mothers who delivered by the health personnel was 5.9 (95%CI 2.09-16.77) times higher to have exclusive breastfeeding than those giving a birth by TBA. Mothers who went to ANC 4 times or more was 14.8 (95%CI 5.79-38) times more likely to breastfeed exclusively compared to those who went less than 4 times.

Table 2 Crude odds ratios of determinants of exclusive breastfeeding

Factors	n	EBF (%)	Crude OR	95%CI	P-value
Age of mother					
<20	222	31(13.9)	1		
20-35	181	29(16)	1.17	0.68-2.04	0.564
Residency					
Urban	230	26(11.3)	1		
Rural	173	34(19.6)	1.91	1.10-3.34	0.020*
Marital Status					
Married	361	37(10.2)	1		
Separated and Widow	42	23(54.8)	10.6	5.28-21.27	<.001***
Education of respondents					
Primary and below	225	13(5.8)	1		
Middle and above	178	47(26.4)	5.8	3.05-11.22	<.001***
Occupation					
Housewife	130	11(8.5)	1		
Professional staff	273	49(17.9)	2.36	1.19-4.72	0.010*
Ethnic group					
Non Burmese	200	24(12.0)	1		
Burmese	203	36(17.7)	1.5	0.90-2.76	0.100
Family income					
≤70000	189	12(6.3)	1		
> 70000	214	48(22.4)	4.2	2.19-8.31	<.001***
Knowledge about BF					
Poor	289	13(4.5)	1		
Good	114	47(41.2)	14.89	7.62-29.09	<.001***
Education of Husband					
Primary and below	230	10(4.3)	1		
Middle and above	173	50(28.9)	8.9	4.38-18.26	<.001***
Emotional Support from Husband					
No	330	32(9.6)	1		
Yes	73	28(38.3)	5.7	3.19-10.52	<.001***
Birth order					
Second and above	269	38(14)	1		
First birth order	134	22(16.4)	1.19	0.67-2.12	0.543
Place of Birth					
At Home	275	13(4.7)	1		
At other health facilities	128	47(36.7)	11.69	6.03-22.69	<.001***
Birth Attendance					
Traditional Birth Attendant	106	4(3.8)	1		
Trained health personnel	297	56(18.9)	5.93	2.09-16.77	<.001***
ANC visit at least 4 times					
No	202	5(2.5)	1		
Yes	201	55(27.4)	14.84	5.79-38.00	<.001***
Supported by their mother**					
No	125	6(4.8)	1		
Yes	278	54(19.4)	4.78	1.99-11.44	<.001***

***p-value<0.05, **p-value<0.01, ***p-value<.001**

*****Supported by their mother refers to respondents who grandmother help her to take care the children*

Table 3 indicates that mothers who lived in rural area was 6 times (95% CI =2.02-17.12) more likely to give EBF than those living in an urban area. The mother who was separated from her husband and widow was 6 times to give EBF compared to married women, (95% CI= 1.76-22.90). Regarding to occupation, housewife were 6 times more likely to have EBF than those being a agriculturer/shopkeeper/ worker/staff (95% CI =I 2.23-15.81). The mother who delivered in health facilities had 7 times the chance of EBF than home delivery (95% CI =2.48-21.38). Those who went to ANC visit at least 4 times had 27 times (95% CI = 7.57-96.49) more likely to give EBF than those who went less than 4 times. Mothers who had good level of knowledge were 10 times more likely to give EBF than those with poor level.

Table 3 Adjusted odds ratio of determinant factors of exclusive breastfeeding

Factors	Adj.OR	95%CI		P-value
		Lower	Upper	
Residency				
Urban	1			
Rural	5.88	2.02	17.12	<.001**
Marital status				
Married	1			
Separated and widow	6.34	1.76	22.90	<.001**
Education of Mother				
Primary and Below	1			
Middle and above	6.72	1.52	29.61	0.012*
Occupation of Mother				
Housewife	1			
Agriculture/shop/worker/staff	5.94	2.23	15.81	<.001***
Place of Delivery				
At home	1			
At health facilities	7.29	2.48	21.38	<.001***
ANC visit at least 4 times				
No	1			
Yes	27.02	7.57	96.49	<.001***
Knowledge Level				
Poor and Fair	1			
Good	10.84	3.11	37.77	<.001***

***p-value <0.05, **p-value<0.01, ***p-value<.001**

Discussion

According to this study, 15% of respondents gave exclusive breastfeeding. This result was the same as the WHO report. However, it differed from the neighbour like Thailand which had about 40% of EBF[12]. Additionally, a study done in Vietnam explored that the exclusive breastfeeding rate was only 4.9%[13] which was lower than the result in this study. It is might be possible that the difference of the campaign of breast feeding program among those countries.

This study found that mothers in rural area were more likely to do exclusive breastfeeding than urban area and was strongly associated with exclusive breastfeeding. A study in America showed that people in Hawaii were more likely to exclusive breast feed than the whole country[14]. It might be due to the fact that people in urban area were easy to access additional food rather than mother milk. Moreover, increasing urbanization made mothers to go for work and failed in exclusive breastfeeding.

There was no significant association between family income and breastfeeding practices in this study. Previous study in Myanmar also documented that no association was found between family income and duration of breastfeeding[15]. However, a study in Arab community found that low family income or low socio-economic villages were the risk of early starting complementary food[16]. It can be interpreted that the income not as important in Myanmar for the EBF.

The evidence of association between a mother's education level and the duration of breastfeeding also varied[17-19]. In this study, mothers who finished middle school education or higher level were more likely to breastfeed exclusively than primary or lower education. That was the same with a study done in Hyderabad where education was statistically significant association with feeding practices[20]. However, breastfeeding practices should be further promoted through health education to enhance awareness of mothers up to community and the grass root level. According to the finding, mother who had good knowledge were higher likelihood of exclusive breastfeeding. One study in Australia showed that mothers who were aware and had knowledge of the WHO EBF recommendations were about five times more likely to intend to breastfeed exclusively compared to those without EBF awareness[21].

This study found that ANC visit ≥ 4 times is the strongest association with EBF. Antenatal counselling on breastfeeding and postnatal lactation support are likely to improve rates of exclusive breastfeeding[22]. Mothers who went to ANC visits four or more than four times were significantly more likely to engage to exclusive breastfeeding. Besides, there was a significant association between frequencies of ANC visit regarding exclusive breastfeeding. It is similarly to a study in Nigeria which showed that mothers who had four or more ANC visits were more likely to have positive breastfeeding practices[23]. Similarly, breastfeeding support through an early, routine, preventive visits in the offices of trained primary care physicians had also been found to be effective in France[24]. A study in Kenya showed that infant who delivered out of health facilities were more like to fail in EBF[25]. As a developing country, there was limitation regarding health facilities which is similar to a previous study in Kenya[26]. Hence, antenatal counselling by trained health personnel might

be a role in promotion of breastfeeding. Regarding ante-natal care practices, health personnel should aim to enhance mothers to visit ANC care at least 4 times during pregnancy. Moreover, the health professional could play a role in promoting breastfeeding during prenatal and immediate postpartum periods, by encouraging and preparing women to breastfeed. Furthermore, traditional birth attendance should be well-trained by government programs.

In this study, the mothers delivered in health facilities were more likely to have exclusive breastfeeding than home delivery with a significant association. A study about patterns and determinants of breastfeeding and complementary practices showed that mother who delivered in home were more likely to introduce complementary foods earlier than those who delivered in health facilities[25]. That might be due to the health services as health facilities were limited, coupled with financial constraints[26-27]. Moreover, the one who delivered outside health facilities were failed to conduct exclusive breastfeeding[28]. Furthermore, mothers who delivered in health services received breastfeeding counselling.

It was found that there was no significantly association between age of women and EBF. A study in Glasgow found that; by increasing maternal age, it was also having greater risk of choosing not to breastfeed[29]. But some studies indicated that mother age did not confer any advantage on breastfeeding practices[28, 30]. It probably might be traditional beliefs such of breast milk is the best nutrients for infant growth. Burmese mothers were more likely to have exclusively breastfeeding than non-Burmese. In United States, foreign-born Mexican-origin was most likely to breastfeed for 6 months[30]. But, there was no significant association between ethnicity and EBF in this study. This could be happened because even this study were have some different ethnic groups, but mostly have same culture (lived in the same province with more than 85% same religion)[31-32].

The main reason for declining in breastfeeding was returning to work[33-35]. But the present study documented that infants of agricultural workers, government staffs, shopkeepers, and general workers were more likely to have EBF than those of housewives. There was a significant association between occupation of mother and EBF in this study. Additionally, evidence from the study indicated that housewives were more likely to have cereal than any mothers in this study including agricultural worker, staff, and general workers with a significant association.

Generally, mothers who had previous experience of breastfeeding were more likely to give EBF[33-35]. All new mothers experience doubts about their ability to care for a helpless new-born. Breastfeeding mothers harbour additional fears about the adequacy of their milk supply or the correctness of their breastfeeding technique, or their ability to overcome lactation problems. Furthermore, a study indicated that mother age did not bestow any advantage on breastfeeding practices[28]. This was understandable, because this study was conducted in difference area, cultural concerning among the target population was similar as the previous studies.

Fathers identified their unique roles as team members ensuring that their babies received the benefits of breastfeeding. A primary fathering role was that of supporting breastfeeding by becoming breastfeeding savvy[36]. This study established that husbands with higher education were more likely to have exclusive

breastfeeding than those with lower education. In a previous study, it was mentioned that higher paternal education was associated with increased odd in breastfeeding[16]. But in this study, Separated and widow were more likely to have EBF than married and it was found the association between marital status and EBF (p-value=0.024)[16]. In the previous study, single parent status could be the risk for declining exclusive breastfeeding[37-38]. It might probably be due to influence of father's role in practice of breastfeeding very strong in the past. In the present time, mothers who married and lived together with their husband were forced to give other food rather than breastfed by their husband. The business of infants supplementary feeding product may also have influenced maternal choice of exclusive breast feeding. Previously, one study documented that there was a strong association between grandmother's influence and failed in exclusivity of breastfeeding[35]. However, this study resulted that the maternal grandmother was the most important source of information about breastfeeding for the majority. It might be grandmother's help enabled the mother to practice more care-giving behaviours[35]. Precisely, maternal grandmothers were the people with the greatest influence on the feeding of infants[34-35]. In conclusion, it was found that grandma influence in the practices of breastfeeding is not rare and familiar in Myanmar culture.

This study suggested that maternal education is an important factor, the government should try to promote the education sector so that everyone could go to school as education is one of the factors correlated to exclusive breastfeeding. Opportunities for breastfeeding at work place should be given in both government and civil sites. The government should make an effort to promote health facilities, in both rural and urban areas as well as the partnership between breastfeeding promoting teams such as Myanmar Maternal and Child Welfare Association (MMCWA). Government health services policy should be strengthened and focused more on breastfeeding practices.

This research design was a cross-sectional study and this study found many factors related to breast feeding in this population, conducting of qualitative research particularly regarding the reasons why they stopped of the exclusive breast feeding at 2, 3, 4 and 5 moths. This information will be more additional benefits for policy implementation. Furthermore, this study was done in one study area, hence it limited to only in one township level. Further research is recommended to expand more information regarding breastfeeding practices and factors which might affect breastfeeding practices at national level.

Acknowledgments

The researcher would like to thank the mothers who participated in this study and the Director and the staff of Pan-Ta-Naw Township, Hospital for their kind assistance and cooperation.

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