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Breast Feeding Practices among Working Mothers Presenting in Immunization Clinic of Tertiary Care hospital in Nepal

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ABSTRACT

Background

Exclusive breastfeeding for the first six months of life is strongly recommended by the World Health Organization for optimal infant growth, immunity, and survival. However, its practice remains suboptimal, particularly among working women, due to employment-related constraints. In Nepal, where female workforce participation is increasing, balancing employment with breastfeeding continues to be challenging. This study aimed to assess breastfeeding practices among working mothers and identify factors influencing exclusive breastfeeding in Nepal.

Methods

A descriptive cross-sectional study was conducted among 150 working mothers with children aged 6-24 months attending the immunization center of Kathmandu Medical College from August 2024 to August 2025. Data were collected using a semi-structured questionnaire through consecutive sampling. Analysis was performed using SPSS version 25. Descriptive statistics and Chi-square tests were applied, with $p < 0.05$ considered statistically significant.

Results

Among working mothers, 77.3% practiced exclusive breastfeeding. Among those who did not, the main barriers were lack of privacy and absence of childcare facilities, each reported by 21.3%. Significant associations were observed between exclusive breastfeeding and maternal knowledge regarding recommended breastfeeding duration ($p = 0.001$) and bonding ($p = 0.011$), availability of workplace nurseries ($p = 0.018$), and ability to breastfeed at work ($p = 0.004$). Mothers able to breastfeed at work had higher exclusive breastfeeding rates than those who could not (87% vs 67.1%).

Conclusions

Maternal knowledge and workplace support are key determinants of exclusive breastfeeding among working mothers.

Keywords: Exclusive breast feeding; Working mothers; Work place; Challenges.

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INTRODUCTION

The World Health Organization recommends exclusive breastfeeding (EBF) for the first six months to provide complete nutrition, immunological protection, and improved cognitive development, alongside lower risks of chronic diseases.[1, 2] Despite its benefits for infants and maternal health,[3] global EBF prevalence is suboptimal,[4] with employment factors like short maternity leave and poor workplace support hindering practices.[5] In Nepal, rising female workforce participation coincides with a decline in EBF among infants under six months, dropping from 70% in 2011 to 56% in 2022.[6] Balancing employment with breastfeeding is challenging, making it critical to understand the factors influencing working women to improve health outcomes.[5] This study aimed to explore breastfeeding practices among working women and identify factors influencing EBF practices.

METHODS

Study Area

Kathmandu Medical College and Teaching Hospital (KMCTH) immunization centre. This approach was adopted due to its feasibility to access the target population of mothers with infants aged 6-24 months irrespective of place of delivery and the ability to efficiently recruit an adequate sample within the study period.

Study Design

A descriptive cross-sectional study was conducted among working women with children aged 6-24 months presenting to Kathmandu Medical College and Teaching Hospital (KMCTH) immunization centre.

Sample size and sampling

The sample size was calculated using the formula: $n = Z^2 \times p (1 - p) / e^2 = (1.96)^2 \times 0.11 \times 0.89 / (0.05)^2 = 150.4 \approx 150$, where n is the expected sample size, Z is the standard normal variate at 95% confidence level (1.96), p is the estimated prevalence of breastfeeding women in the workplace [6] q is 1 p, and e is the allowable margin of error (0.05). A total of 150 working mothers were included using consecutive sampling.

Data Collection

The duration of study was from August 2024 to August 2025. Ethical approval was taken from Institutional Review Committee of Kathmandu Medical College-Teaching Hospital (Ref. No.:12082024/02). Informed consent was taken from each respondent before the interview, and confidentiality and anonymity were maintained. Inclusion criteria were all working mothers of babies aged 6 months to 2 years, while non-working mothers and those who did not provide consent were excluded. The questionnaire captured information on socio-demographic characteristics, natal history, breastfeeding practices, and availability of maternity-related facilities. Content validity of the questionnaire was ensured through an extensive literature review and consultation with the statistician and subject matter experts. The questionnaire was pretested among 10% of the calculated sample prior to the main study, and its reliability was confirmed with a Cronbach's alpha coefficient of 0.8. Exclusive breastfeeding is defined as an infant's consumption of human milk with no supplementation of any type (no water, no juice, no nonhuman milk, and no foods) except for vitamins, minerals, and medications for the first six months of life.[7] WHO also recommends that breastfeeding should continue for up to two years of age or beyond while complementary foods are integrated. Breastfeeding knowledge was assessed using four structured questions examining: (1) breastfeeding as a bonding mechanism, (2) its role in providing immunity, (3) initiation within the first 24 hours, and (4) the importance of exclusive breastfeeding for six months. Each question offered three response options -'Yes,' 'No,' and 'Not Sure.' To improve recall accuracy, mothers were asked specific probing questions regarding the introduction of water, formula milk, animal milk, and complementary foods.

Data Analysis

Data were analysed using SPSS version 25. Descriptive statistics were computed, and Chi-

square tests were applied to examine associations between independent variables and exclusive breastfeeding status. A p-value of <0.05 was considered statistically significant. Data were expressed in the form of frequency and percentage.

RESULTS

There were 150 women enrolled in this study, with a mean age of 29.65 years. Regarding parity, one-third of participants had one child, 51 (34%), while half had two children, 75 (50%). A smaller proportion had three children, 20 (13.3%) and a very small proportion had four children, 4 (2.7%).

Table 1: Socio demographic Variable (n=150).

Characteristics	Frequency n (%)
Number of children	
1	51 (34)
2	75 (50)
3	20 (13.3)
4	4 (2.7)
Education	
Illiterate	1 (0.7)
Read and write	13 (8.7)
Primary School	22 (14.7)
Secondary School	43 (28.7)
Institute	16 (10.7)
College	55 (36.7)
Housing	
Owned	58 (38.7)
Partially owned	18 (12)
Rented	11 (7.3)
Others	63 (42)
Work sector	
Public	49 (32.7)
Private	101 (67.3)
Work-place	
Hospital	22 (14.7)
School	22 (14.7)
University	7 (4.7)
Others	99 (66.0)
Work-type	
Office	101(67.3)
Manual	49 (32.7)
Workhours	
< 5	20 (13.3)
5-9	115 (76.7)
10-14	13 (8.7)
15-19	1 (0.7)
20-24	1 (0.7)

Among 150 participants, more than one-third had completed college 55 (36.7%), followed by secondary education 43 (28.7%). Smaller proportions had primary education, vocational training, and functional literacy without formal schooling and were illiterate.

In terms of employment, 101 (67.3%) were engaged in private sector work, while 49 (32.7%) worked in the public sector; the same distribution was observed for job type, with 101 (67.3%) in office-based roles and 49 (32.7%) in manual labor. Most participants, 115 (76.7%) reported working 5-9 hours per day (Table 1).

When asked about breastfeeding at the workplace, 77 (51.3%) reported practicing it, while 73 (48.7%) did not. Among those who did not breastfeed at work, the most commonly reported barriers were lack of privacy and absence of childcare facilities 32 (43.84%). Other reported reasons included insufficient milk production and lack of family support 3 (4.11%), absence of a breast pump 2 (2.74%), and workplace restriction 1 (1.36%).

Workplace support systems were limited. There were 36 (24.0%) reported to have access to a nursery, 66 (44.0%) had a designated breastfeeding room, 16 (10.7%) had access to a breast pump, and 32 (21.3%) had facilities for storing expressed breast milk.

Exclusive breastfeeding was not universal, with only 116 (77.3%) of respondents reporting that they practiced exclusive breast feeding (Table 2).

Table 2: Breastfeeding practices frequency table (n=150).

Characteristics	Frequency n (%)
Breastfeeding in workplace	
Yes	77 (51.3)
No	73 (48.7)
Cause for not breastfeeding (n=73)	
Lack of privacy	32 (43.84)
Lack of childcare facilities	32 (43.84)
No access to breast pump	2 (2.74)
Inadequate milk production	3 (4.11)
Lack of family support	3 (4.11)
Workplace restriction	1 (1.36)
Workplace facilities (Yes)	
Nursery	36 (24)

Breastfeeding room	66 (44)
Breast pump	16 (10.7)
Refrigerator	32 (21.3)
Time of initiation of breast feeding	
Immediately after birth	30 (20)
1 hour after delivery	36 (24)
2 hours after delivery	23 (15.3)
24 hours within delivery	32 (21.3)
2nd day of delivery	24 (16)
3rd day of delivery	5 (3.3)
Exclusive breast feeding	
Yes	116 (77.3)
No	34 (22.7)
Delivery mode	
Vaginal	94 (62.7)
Cesarean	56 (37.3)

Knowledge and environmental factors showed varying associations with exclusive breastfeeding. Awareness of breastfeeding as a bonding mechanism was significantly associated with exclusive breastfeeding, with 81.5% of knowledgeable participants practicing it compared to 20% among those without such knowledge (χ^2 = 13.259, p = 0.001). Similarly, knowledge regarding six months of exclusive breastfeeding was associated with higher practice rates (82% vs. 33.3%; χ^2 = 9.093, p = 0.011). However, knowledge regarding immune benefits (χ^2 = 3.709, p = 0.157) and initiation within 24 hours (χ^2 = 0.903, p = 0.637) did not show statistically significant associations.

Mode of delivery showed a non-significant trend, with higher exclusive breastfeeding among vaginal deliveries (81.7%) compared to cesarean sections (69.6%) (χ^2 = 2.895, p = 0.089).

Workplace facilities demonstrated clearer associations. Access to a nursery was significantly associated with higher exclusive breastfeeding rates (91.7% vs. 72.8%; χ^2 = 5.552, p = 0.018). Access to a feeding room (χ^2 = 3.797, p = 0.051) and breast pump (χ^2 = 2.754, p = 0.097) showed borderline associations.

Workplace breastfeeding support was also strongly associated with exclusive breastfeeding practice, with higher rates among those able to breastfeed at work (87%) compared to those without such opportunity (67.1%) (χ^2 = 8.457, p = 0.004) (Table 4).

Overall awareness of breastfeeding benefits was high among participants. The majority, 130 (86.7%) correctly identified breastfeeding as a bonding mechanism between mother and child, and 109 (72.7%) recognised its role in providing immunity to the child. Similarly, a substantial proportion, 110 (73.3%) knew that breastfeeding should be initiated within the first 24 hours after birth, and 122 (81.3%) correctly understood the concept of exclusive breastfeeding (Table 3).

Table 3: Frequency table of Breastfeeding knowledge area (n=150).

Characteristics	Frequency n (%)
Breastfeeding increases bond between mother and baby	
Yes	130 (86.7)
No	5 (3.3)
Not sure	15 (10)
Breastfeeding improves immunity in the baby	
Yes	109 (72.7)
No	3 (2)
Not sure	38 (25.3)
Breastfeeding in the first 24 hours is important	
Yes	110 (73.3)
No	5 (3.3)
Not sure	35 (23.3)
Exclusive breastfeeding should be done in the first 6 months	
Yes	122 (81.3)
No	3 (2)
Not sure	25 (16.6)

Table 4: Association of several factors with exclusive breastfeeding (n=150).

Characteristics	Exclusive breastfeeding		Chi-square value	P-value
	Yes (%)	No (%)		
Knowledge of breastfeeding as bonding factor				
Yes	106 (81.5)	24 (18.5)	13.259	**0.001**
Not sure	9 (60)	6 (40)		

No	1 (20)	4 (80)		
Knowledge of breastfeeding for immunity				
Yes	84 (77.1)	25 (22.9)		
Not sure	31 (81.6)	7 (18.4)	3.709	0.157
No	1 (33.3)	2 (66.7)		
Knowledge of breastfeeding's importance within 24 hours of birth				
Yes	86 (78.2)	24 (21.8)		
Not sure	27 (77.1)	8 (22.9)	0.903	0.637
No	3 (60)	2 (40)		
Knowledge of exclusive breastfeeding for 6 months				
Yes	100 (82)	22 (18)		
Not sure	15 (60)	10 (40)	9.093	0.011
No	1 (33.3)	2 (66.7)		
Mode of delivery				
Vaginal	77 (81.9)	17 (18.1)	3.015	0.082
Cesarean section	39 (69.6)	17 (30.4)		
Facility of nursery				
Yes	33 (91.7)	3 (8.3)	5.552	0.018
No	83 (72.8)	31 (27.2)		
Facility of separate feeding room				
Yes	56 (84.8)	10 (15.2)	3.797	0.051
No	60 (71.4)	24 (28.6)		
Facility of breast pump				
Yes	15 (93.8)	1 (6.3)	2.754	0.097
No	101 (75.4)	33 (24.6)		
Facility of refrigerator for milk storage				
Yes	26 (81.3)	6 (18.8)	0.356	0.551
No	90 (76.3)	28 (23.7)		
Breastfeeding in workplace				
Yes	67 (87)	10 (13)	8.457	0.004
No	49 (67.1)	24 (32.9)		

DISCUSSION

This study examined breastfeeding practices among working women and workplace-related factors influencing these behaviors. Participants were largely well-educated, with most having at least secondary-level education, and the majority were employed in the private sector in office-based roles. Despite these characteristics, only about half reported breastfeeding at the workplace. This finding suggests that educational attainment and formal employment alone may not fully explain the persistence of structural and environmental constraints affecting breastfeeding practices in professional settings in Nepal.

Comparable rates have been reported in other settings, including Danso's study in Ghana, where 53% of employed mothers breastfed at work, while lower levels (32%) were reported among nurse mothers in Karachi.[8, 9] In Nepal, a systematic review and meta-analysis reported a pooled prevalence of exclusive breastfeeding of 43% during the first six months (95% CI: 34-53),[10] situating the present findings within a broader pattern of suboptimal breastfeeding continuity. The variability across studies likely reflects contextual differences, including maternity protection legislation, workplace infrastructure, sociocultural norms, and the extent to which health systems actively support breastfeeding among working women.

A statistically significant association was observed between mothers' understanding of breastfeeding as a bonding mechanism and exclusive breastfeeding practice (χ^2 = 13.259, p = 0.001). This finding is consistent with Udo and Ajayi, who reported that higher breastfeeding knowledge was associated with greater likelihood of exclusive breastfeeding practice.[11] Similarly, *Gebeyehu et al.,* identified maternal breastfeeding education as a strong correlate of exclusive breastfeeding in Ethiopia, a setting with comparable resource constraints.[12] Knowledge of the recommended six-month duration of exclusive breastfeeding was also significantly associated with practice in this study (χ^2 = 9.093, p = 0.011), consistent with *Hasan et al.,* who found that better-informed mothers were more likely to adhere to recommended breastfeeding durations.[13] Collectively, these findings suggest that maternal health literacy is a potentially modifiable correlate of breastfeeding behavior. In the Nepalese context, this underscores the potential value of strengthening antenatal and postnatal counseling, particularly for women preparing to return to work.

Workplace facilities were also significantly associated with breastfeeding outcomes. Availability of an on-site nursery was associated with higher exclusive breastfeeding rates (χ^2 = 5.552, p = 0.018). These findings are in line with *Gebrekidan et al.,* and *Shrestha et al.,* who reported that workplace accommodations such as lactation rooms and adequate maternity leave were associated with improved breastfeeding continuity among employed mothers.[14, 15] A possible explanation is that on-site childcare may allow mothers to breastfeed more frequently during working hours, reducing reliance on formula feeding or early supplementation.

The mode of delivery was not significantly associated with exclusive breastfeeding in this study (χ^2 = 3.015, p = 0.082). This finding contrasts with prior evidence reporting that cesarean delivery is associated with delayed initiation of breastfeeding, shorter breastfeeding duration, and lower exclusivity rates, as demonstrated in prospective cohort studies by *Özer Aslan İ et al.,* and *Chen C et al.* [16, 17] Proposed mechanisms include delayed skin-to-skin contact, effects of anesthesia, postoperative pain, and disruption of early lactogenesis. However, *Shrestha et al.,* noted that although vaginal delivery has generally been associated with higher breastfeeding rates, improved postnatal lactation support may attenuate this relationship in some settings.[15] The lack of association observed in the present study may reflect increasing availability of lactation counseling, early breastfeeding support, and rooming-in practices after cesarean delivery. It is also possible that the sample size was insufficient to detect smaller differences between delivery groups. The rising cesarean section rate in urban private facilities in Nepal makes this an important area for further investigation.

Among the study's most noteworthy findings was the significant association observed between the ability to breastfeed at the workplace and exclusive breastfeeding practice (χ^2 = 8.457, p = 0.004). Mothers who were able to breastfeed at work reported higher exclusive breastfeeding rates (87%) compared to those without this opportunity (67.1%). This is consistent with findings from Wanyoni in Kenya and *Guendelman et al.,* in the United States, both of whom reported associations between supportive workplace policies and improved breastfeeding outcomes.[18, 19] It is plausible that workplace breastfeeding access reduces practical barriers that contribute to early supplementation or cessation; however, as this study is cross-sectional, reverse causation and unmeasured confounding (such as maternal motivation or home support) cannot be excluded. Among mothers who did not exclusively breastfeed, perceived insufficient milk supply, lack of privacy, and absence of childcare facilities were the most frequently reported barriers. Perceived insufficient milk supply has been widely recognized as a major contributor to early breastfeeding cessation. *Huang Y et al.,* reported that this perception is often not due to true physiological lactation failure but is instead associated with modifiable factors such as suboptimal breastfeeding technique, infrequent feeding, and maternal

anxiety.[20] *Pradhan et al.,* similarly identified concerns regarding milk supply as a major barrier in comparable South Asian contexts. [21] These findings suggest that addressing misconceptions regarding milk sufficiency, alongside practical breastfeeding support, may be important in improving continuation among working mothers. Structural barriers such as lack of privacy and childcare reinforce the role of workplace environment in shaping breastfeeding behavior, highlighting the importance of supportive institutional frameworks within the broader maternity protection context in Nepal.

Limitations

This study has a few limitations that should be considered when interpreting the findings. The single-center sampling approach may introduce selection bias and limits the generalizability of the results to other settings. The cross-sectional design also precludes causal inference, as exposure and outcome were assessed simultaneously. Future studies should use multicenter designs across different regions of Nepal with larger sample sizes and prospective approaches to reduce recall bias and strengthen temporal interpretation of associations.

Conclusions

This study found that maternal knowledge, workplace support, and access to enabling facilities such as workplace nurseries and the ability to breastfeed at work are associated with exclusive breastfeeding practices among working mothers. Developing appropriate policies to enable breastfeeding in working mothers is vital to improve the trend of breastfeeding in Nepal.

Ethics approval: Ethical approval was taken from Institutional Review Committee of Kathmandu Medical College-Teaching Hospital (Ref. No.:12082024/02). Informed consent was taken from each respondent before the interview, and confidentiality and anonymity were maintained.

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Author contributions

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REFERENCES

1. World Health Organization. Nutrition: breastfeeding. Geneva: WHO. [Link]
2. World Health Organization. Continued breastfeeding for healthy growth and development of children. 2017. [Link]
3. Centers for Disease Control and Prevention. Breastfeeding benefits both baby and mom. Atlanta (GA): CDC; 2025 May 5. [Link]
4. Ministry of Health (Nepal). Nepal Demographic and Health Survey 2022. Kathmandu: Ministry of Health; 2022. [Link]
5. Sahu B, Thakur A, Gupta D, Singh MP, Shrivastava A, Diwakar P, Sabin LL. Factors associated with exclusive breastfeeding knowledge and practices in a tertiary hospital of Central India. [DOI]
6. Ali SM, Saleh AM. Breastfeeding practices among working mothers at the workplace in Erbil city: A cross-sectional study. Zanco Journal of Medical Sciences (Zanco J Med Sci). 2022 Apr 25;26(1):49-57. [DOI]

7. Eidelman AI, Schanler RJ. Breastfeeding and the use of human milk. Pediatrics. 2012 Mar 1. [DOI]
8. Danso J. Examining the practice of exclusive breastfeeding among professional working mothers in Kumasi metropolis of Ghana. International journal of nursing. 2014 Jun;1(1):11-24. [Link]
9. Zafar SN, Bustamante-Gavino MI. Breastfeeding and working full time experiences of nurse mothers in Karachi, Pakistan. International Journal of Caring Sciences. 2008 Sep 1;1(3):132. [Link]
10. Wasti SP, Shrestha A, Dhakal P. The prevalence of exclusive breastfeeding practice in the first six months of life and its associated factors in Nepal: A systematic review and meta-analysis. Sexual & Reproductive Healthcare. 2023 Sep 1;37:100863. [DOI]
11. Udoudo IO, Ajayi PH. Working Mother Attitude and Practices of Exclusive Breastfeeding in Amac, Fct-Abuja. International Journal of Research in Sociology and Anthropology. 2015;1(1):28-36. [Link]
12. Gebeyehu NA, Bekele Y, Molla W, et al. Knowledge, attitude, practice and determinants of exclusive breastfeeding: a systematic review and meta-analysis in Ethiopia. J Clin Nurs. 2023;32(9-10):1561-75. [DOI]
13. Sultana M, Dhar S, Hasan T, Shill LC, Purba NH, Chowdhury AI, Shuvo SD. Knowledge, attitudes, and predictors of exclusive breastfeeding practice among lactating mothers in Noakhali, Bangladesh. Heliyon. 2022 Oct 1;8(10). [DOI]
14. Gebrekidan K, Plummer V, Fooladi E, Hall H. Work-related factors affecting exclusive breastfeeding among employed women in Ethiopia: managers' perspective using a qualitative approach. International journal of women's health. 2020 Jun 22:473-80. [DOI]
15. Shrestha M, Adhikari S, Shrestha N, Budha Magar G, Pokhrel BR. Breastfeeding and workplace support in Nepal. PLOS Global Public Health. 2025 Aug 14;5(8):e0005059. [DOI]
16. Özer Aslan İ, Aslan MT, Can N, Sevinç Ergül Ö, Çallıoğlu N. Impact of delivery method on initiation and continuation of breastfeeding: a prospective cohort study. Children. 2025 Jul 23;12(8):966. [DOI]
17. Chen C, Yan Y, Gao X, Xiang S, He Q, Zeng G, Liu S, Sha T, Li L. Influences of cesarean delivery on breastfeeding practices and duration: a prospective cohort study. Journal of Human Lactation. 2018 Aug;34(3):526-34. [DOI]
18. Huang Y, Liu Y, Yu XY, Zeng TY. The rates and factors of perceived insufficient milk supply: A systematic review. Maternal & child nutrition. 2022 Jan;18(1):e13255. [DOI]
19. Wanyonyi MN. Barriers to exclusive breastfeeding and nutritional status of non–exclusively breastfed infants in Eldoret municipality, Kenya (Doctoral dissertation, Msc. Thesis Kenyatta University). [Link]
20. Guendelman S, Kosa JL, Pearl M, Graham S, Goodman J, Kharrazi M. Juggling work and breastfeeding: effects of maternity leave and occupational characteristics. Pediatrics. 2009 Jan 1;123(1):e38-46.[DOI]
21. Pradhan R, Karn BK, Chaudhary R, Yadav U, Bhandari S. Perceived Hindering Factors of Exclusive Breastfeeding among Lactating Mothers of Itahari. Journal of College of Medical Sciences-Nepal. 2022 Nov 4;18(3):235-43. [DOI]

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