

FACTORS ASSOCIATED WITH EXCLUSIVE BREASTFEEDING AMONG INFANTS IN THE SERVICE AREA OF THE MAIWA COMMUNITY HEALTH CENTER ENREKANG REGENCY

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ABSTRACT

Breast milk is regarded as the most complete and ideal source of nutrition for infants, supplying every nutrient required for healthy early growth and development. Within the working area of the Maiwa Community Health Center (Puskesmas) in Enrekang Regency, exclusive breastfeeding coverage remained low at 56.2% in 2024, well short of the 61% national benchmark. This research set out to examine the factors linked to exclusive breastfeeding practices among infants in that same service area. A quantitative, cross sectional design was applied. The study population comprised all mothers of infants aged 0-6 months, amounting to 157 individuals, from which 113 respondents were drawn through simple random sampling. Data were gathered via questionnaire and examined through univariate description and bivariate chi-square testing. Findings revealed that 60.2% of respondents exclusively breastfed their infants. A significant relationship emerged between maternal knowledge and exclusive breastfeeding ($p < 0.001$), as well as between family support and exclusive breastfeeding ($p < 0.001$), whereas the association between the role of health workers and exclusive breastfeeding was not significant ($p = 0.564$). The study concludes that maternal knowledge and family support are significantly related to exclusive breastfeeding, while the health worker's role did not reach statistical significance in this sample. The Maiwa Community Health Center is therefore advised to strengthen the quality of its lactation counseling and to engage the whole family in exclusive breastfeeding education efforts.

Keywords: Exclusive breastfeeding, family support, breastfeeding practices, maternal knowledge, role of health workers.

INTRODUCTION

As an infant's most complete nutritional source, breast milk supplies the full range of nutrients needed for healthy early development. Exclusive breastfeeding refers to a feeding pattern in which an infant receives only breast milk, with no other liquids or solid foods introduced, apart from medically necessary medications, vitamins, or mineral supplements. Both the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) advise that infants be exclusively breastfed for the first six months of life, with breastfeeding initiated within the first hour after birth (WHO, 2025).

Nationally, Indonesia's exclusive breastfeeding indicators have shown notable improvement over time, with coverage for infants under six months climbing from 52% in 2017 to 68% in 2023. Even so, the 2023 Indonesian Health Survey (SKI) recorded exclusive breastfeeding coverage among infants aged 0-6 months at only 55.5%,

considerably below the 80% target set by Primaya Hospital. More recent figures place national coverage at 66.4% in 2024, a level that, despite the upward trend, still falls short of both national and global targets (Kemenkes, 2023).

Three factors are generally considered essential to successful exclusive breastfeeding: how much mothers know about it, the support they receive from family, and the involvement of health workers. Despite the upward trend in coverage nationally, considerable gaps persist particularly in mothers' grasp of correct breastfeeding practice, in the assistance provided by health workers, and in family encouragement toward breastfeeding. In the newborn period specifically, only 27% of babies were put to the breast within the first hour of life, roughly one in five received something other than breast milk during their first three days, and merely 14% experienced at least an hour of skin-to-skin contact right after delivery. Such figures point to persistently limited maternal awareness of early initiation, health workers' still-inadequate role in supporting early initiation and exclusive breastfeeding education, and family support that continues to fall short in motivating and practically assisting breastfeeding mothers (Aliska et al., 2023).

Enrekang Regency's terrain hilly and mountainous across roughly 84.96% of its land area creates distinct obstacles to meeting exclusive breastfeeding targets. Such geography can restrict mothers' exposure to health information and breastfeeding education, while also narrowing their access to lactation counseling offered by health workers. It can likewise reduce how often health workers are able to visit and support breastfeeding mothers, and at the same time erode the social and family support structures that normally underpin a mother's breastfeeding success (Buwana et al., 2024).

Registration data from Maiwa Public Health Center recorded 157 infants aged 0-6 months within its service area during the study year, matching the number of mothers with infants in that age range meaning every registered infant could be linked to complete maternal information. The Slovin formula, applied with a 5% margin of error, yielded a sample of 113 respondents from this population. Among the 113 sampled infants, 68 had been exclusively breastfed, while the remaining 45 had not. This gap points to the continued need to strengthen maternal knowledge, optimize the health worker's role, and reinforce family support within the exclusive breastfeeding program.

Because exclusive breastfeeding coverage in the Maiwa Community Health Center's service area still falls short of the 61% national target, infants there face a heightened risk of infectious illnesses such as diarrhea and acute respiratory infection a consequence of diminished immunological protection from breast milk combined with early complementary feeding that carries contamination risk where clean water access is limited, as is common in mountainous terrain. This also carries consequences for infants' growth and nutritional status more broadly, since exclusive breastfeeding is recognized as a key determinant within the first 1,000 days of life (Anantha et al., 2020). Local sociocultural conditions compound this low coverage, particularly an extended-family structure that tends to encourage early complementary feeding a

pattern consistent with this study's finding that the health worker's role was not significantly related to exclusive breastfeeding, underscoring family support as a central point for intervention in the region. A preliminary study the researchers carried out through interviews with 35 mothers of infants aged 0-6 months in the Maiwa Community Health Center's service area in December 2024 found that 57.1% of mothers had insufficient knowledge of exclusive breastfeeding, 28.6% had adequate knowledge, and only 14.3% demonstrated good knowledge. Among these 35 mothers, only 18 (51.4%) practiced exclusive breastfeeding, while the remaining 17 (48.6%) had already given complementary food or drink before their infants turned six months old (Sahrani et al., 2025).

This gap in maternal knowledge relates closely to how well health workers deliver education and counseling on exclusive breastfeeding, and to the shortage of family encouragement that would otherwise motivate mothers to breastfeed. Preliminary observation suggests that the exclusive breastfeeding education offered at the Maiwa Community Health Center is still fairly generic and lacks a clear structure, and that lactation counseling has not yet reached every pregnant and breastfeeding mother in the area. Several mothers noted receiving insufficient guidance on correct breastfeeding technique, on expressing and storing milk while working, and on managing difficulties such as sore nipples or a perceived shortage of milk. Compounding this, weak support from husbands and other relatives left many mothers without the practical help and emotional reassurance they needed during the breastfeeding period (Prihatini et al., 2023). Some mothers even described being pressured by family members to give supplementary food or drink because the baby seemed unsatisfied evidence that family members, too, may not fully appreciate why exclusive breastfeeding matters.

Health workers' capacity as lactation counselors could be strengthened through structured training for midwives and community health workers that begins during pregnancy and continues via postpartum home visits, given how the hilly, scattered geography of the Maiwa service area restricts mothers' access to health facilities. Posyandu volunteers, as an extension of the health workforce, could also be better mobilized to bring education down to the hamlet level. Family involvement, meanwhile, calls for education that reaches husbands and parents-in-law as well, since the region's extended-family structure shapes decisions about early complementary feeding, alongside the establishment of village-level breastfeeding support groups. Combining stronger health-worker competency with stronger family support is expected to sustainably raise exclusive breastfeeding rates in the region (AS et al., 2023; Febrianti et al., 2025).

The theoretical framework adopted here is the PRECEDE-PROCEED model developed by Lawrence Green and Kreuter. Whereas earlier research tended to examine maternal knowledge, family support, and the health worker's role as separate factors, this study brings all three together under the model's predisposing, reinforcing, and enabling categories. Because this framework has not previously been applied to exclusive breastfeeding within the Maiwa Community Health Center's service area, the

present research offers a fresh contribution to behavior-based health promotion strategy development in the region. According to the model, health behavior is shaped by predisposing factors knowledge, attitudes, beliefs, and values; reinforcing factors social support from family and the surrounding environment; and enabling factors the availability of resources, access to health services, and supporting facilities (Kurniati et al., 2025).

Accordingly, this study sets out to examine the relationships among maternal knowledge, family support, and the health worker's role with respect to exclusive breastfeeding within the Maiwa Community Health Center's service area, Enrekang Regency, with the expectation that its findings can inform efforts to raise exclusive breastfeeding coverage locally

RESEARCH METHOD

A cross-sectional design was selected because the research aimed to establish associations between maternal knowledge, family support, and the health worker's role on one hand and exclusive breastfeeding on the other, rather than to establish causality. Independent and dependent variables were therefore measured at a single point in time using a questionnaire, consistent with the study population's characteristics and the descriptive-analytic approach adopted, and this choice also reflected considerations of time and resource efficiency. While a cross-sectional design cannot establish the temporal ordering between exposure and outcome, it remains fit for purpose here, since the goal was to detect relationships among variables rather than to test cause and effect. Data collection took place in the Maiwa Community Health Center's (Puskesmas) service area, Enrekang Regency (Mardhatillah et al., 2020).

The study population comprised all mothers of infants aged 0-6 months registered within the Maiwa Community Health Center's service area 157 infants in total from which 113 respondents were drawn via simple random probability sampling. Testing the questionnaire's validity with Pearson's Product-Moment correlation on 30 pilot respondents confirmed all 30 items as valid (r values ranging 0.378-0.810, exceeding the table r value of 0.3494), and Cronbach's Alpha reliability testing produced a coefficient of 0.945, categorized as very high. Primary data came from the structured questionnaire completed directly by the 113 respondents, while secondary data were drawn from the health center's official records. Analysis combined univariate description of each variable's distribution with bivariate Chi-Square testing ($\alpha = 0.05$) to assess the relationships between maternal knowledge, family support, and the health worker's role with exclusive breastfeeding (Al Hakim et al., 2021).

Inclusion criteria comprised: mothers of infants aged 0-6 months registered within the Maiwa Community Health Center's service area, Enrekang Regency; mothers who consented to participate and signed the informed consent form; and mothers able to read and write. Exclusion criteria comprised: mothers absent during data collection; mothers who declined to cooperate or withdrew from the study; and infants with chronic illness or congenital conditions affecting nutritional status.

RESULTS AND DISCUSSION

Results

Respondent Characteristics

Respondents in this study were characterized according to maternal age, the child's birth order, highest educational attainment, and occupation, as summarized in Table 1.

Table 1. Respondent Characteristics

Variable	N	(%)
Mother's Age		
20-30 years	60	53.1
31-40 years	50	44.2
41-45 years	3	2.7
Total	113	100.0
Child's Age		
1-3 Months	31	27.4
4-6 Months	82	72.6
Total	113	100.0
Child No.		
1	40	35.4
2	32	28.3
3	21	18.6
4	17	15.0
5	1	0.9
6	1	0.9
7	1	0.9
Total	113	100.0
Highest Education Level		
Diploma (D1/D2/D3)	4	3.5
Bachelor's Degree (S1)	18	15.9
High School/Equivalent	56	49.6
Junior High School or Equivalent	30	26.5
Elementary School/Equivalent	5	4.4
Total	113	100.0
Occupation		
Civil Servant / State Civil Apparatus (PNS/ASN)	16	14.1
Private Sector	1	0.9
Housewife	96	85.0
Total	113	100.0

Table 1, shows that most mothers fell in the 20-30 year age bracket (53.1%), had children aged 4-6 months (72.6%), and worked as housewives (85.0%). Most children were the firstborn (35.4%), though the sample also included mothers with up to seven children. Regarding education, nearly half of respondents (49.6%) had completed high school or its equivalent.

Univariate Analysis

Table 2. Frequency Distribution of Study Variables

Variable	Category	N	(%)
Exclusive Breastfeeding	Not Exclusive Breastfeeding	45	39.8
	Exclusive Breastfeeding	68	60.2
	Total	113	100.0
Mothers' Knowledge	Insufficient	41	36.3
	Good	72	63.7
	Total	113	100.0
Family Support	Insufficient	50	44.2
	Good	63	55.8
	Total	113	100.0
The Role of Healthcare Workers	Insufficient	49	43.4
	Good	64	56.6
	Total	113	100.0

Source: Primary Data, 2026

As shown in Table 2, 60.2% of respondents exclusively breastfed their infants. A majority also demonstrated good knowledge (63.7%), reported good family support (55.8%), and rated the health worker's role as good (56.6%).

Bivariate Analysis

Table 3. Relationship Between Maternal Knowledge, Family Support, and the Role of Healthcare Workers with Exclusive Breastfeeding

Variable	Category	Not Breastfed n (%)	Breastfeeding n (%)	Total n (%)	p-value
Maternal Knowledge	Insufficient	31 (75.6)	10 (24.4)	41 (100)	<0.001
	Good	14 (19.4)	58 (80.6)	72 (100)	
	Total	45 (39.8)	68 (60.2)	113 (100)	
Family Support	Insufficient	29 (58.0)	21 (42.0)	50 (100)	<0.001
	Good	16 (25.4)	47 (74.6)	63 (100)	
	Total	45 (39.8)	68 (60.2)	113 (100)	
Role of Healthcare Workers	Insufficient	21 (42.9)	28 (57.1)	49 (100)	0.564
	Good	24 (37.5)	40 (62.5)	64 (100)	
	Total	45 (39.8)	68 (60.2)	113 (100)	

Source: Analysis Results, 2026

Chi-square testing, summarized in Table 3, confirmed a significant relationship between maternal knowledge and exclusive breastfeeding ($\chi^2 = 34.388$; $df = 1$; $p < 0.001$): 80.6% of mothers with good knowledge exclusively breastfed, compared with just 24.4% of those with insufficient knowledge. Family support likewise showed a significant relationship with exclusive breastfeeding ($\chi^2 = 12.365$; $df = 1$; $p < 0.001$), with 74.6% exclusive breastfeeding among mothers reporting good family support versus 42.0% among those with poor support. The health worker's role, however, was not significantly related to exclusive breastfeeding ($\chi^2 = 0.332$; $df = 1$; $p = 0.564$): exclusive breastfeeding rates were fairly close between mothers who rated the role as “good” (62.5%) and those who rated it “poor” (57.1%), suggesting that perceptions of health worker involvement did not meaningfully shift breastfeeding status in this sample. Overall, then, exclusive breastfeeding practice in this study was driven more by maternal knowledge and family support than by the health worker's role.

Discussion

The Relationship Between Maternal Knowledge and Exclusive Breastfeeding

Field data show that mothers with limited knowledge largely failed to exclusively breastfeed their infants, while those with good knowledge more often sustained exclusive breastfeeding across the full six-month period. The Chi-square analysis conducted for this relationship confirmed a significant association between maternal knowledge and exclusive breastfeeding among infants in the Maiwa Public Health Center's working area, Enrekang Regency, leading to acceptance of the study's alternative hypothesis (H_{a1}). This indicates that among infants who were exclusively breastfed, maternal understanding functioned not as a mere supporting factor but as a fundamental determinant of breastfeeding practice. Because the p-value fell well under the 0.05 significance threshold, the gap in exclusive-breastfeeding success between mothers with good versus insufficient knowledge is unlikely to be attributable to chance, supporting the statistical conclusion that maternal knowledge meaningfully contributes to exclusive breastfeeding practice in this setting.

This result aligns with Fariningsih et al. (2022), who similarly found a significant relationship between maternal knowledge and exclusive breastfeeding among infants aged 0-6 months ($p = 0.004$), with better-informed mothers more likely to breastfeed exclusively. Sabriana et al. (2022) reported comparable results ($p < 0.05$), attributing exclusive breastfeeding success to maternal knowledge and attitude together, while (Sari & Farida, 2020) study in Jombang Regency likewise found a significant link between mothers' understanding of breast milk's benefits and their practice of exclusive breastfeeding.

Notably, although 63.7% of respondents demonstrated good knowledge, a portion of them (19.4%) still did not practice exclusive breastfeeding, suggesting that knowledge alone does not guarantee the behavior. Practical obstacles likely play a role physical discomfort associated with breastfeeding, a perceived shortage of milk supply, work-related constraints for employed mothers, and cultural norms that still favor

introducing supplementary food or drink before six months. This mirrors Dukuzumuremyi et al. (2020), who observed that exclusive breastfeeding practice does not always track mothers' knowledge and attitudes because of such external influences.

The Relationship Between Family Support and Exclusive Breastfeeding

The analysis found family support to be significantly associated with exclusive breastfeeding among infants in the Maiwa Public Health Center's working area, Enrekang Regency, and points to several dimensions of that support worth reinforcing. The first is emotional support patience and encouragement from husbands and parents which matters most when mothers feel exhausted or struggle during the early postpartum weeks, given that exclusive breastfeeding demands a full six-month commitment and is often shadowed by worry over insufficient milk supply. The second is instrumental support, where family members ease the mother's burden by taking on household chores or caring for other children, freeing her time and energy to breastfeed on demand a pattern especially relevant in the extended, multigenerational households common to mountainous areas. The third is informational support aligned with health-worker guidance, particularly from figures who carry weight in family decisions husbands, mothers, or mothers-in-law discouraging practices such as giving honey, water, or other prelacteal foods before six months, which helps counter traditional beliefs still held in parts of Enrekang Regency. The fourth is appraisal support, in which family members' appreciation and recognition of the mother's breastfeeding effort bolsters her confidence, especially against social pressure or the perception that breast milk alone cannot meet the infant's nutritional needs.

This is broadly consistent with Naufal et al. (2023), who identified emotional family support as the single most influential factor for exclusive breastfeeding, with a moderate correlation ($r = 0.41$) reinforcing the idea that good maternal knowledge alone cannot compensate for inadequate family backing. Silaen et al. (2022) similarly found that mothers with full husband support were 3.2 times more likely to practice exclusive breastfeeding than those without it.

That 42.0% of mothers with insufficient family support still managed to exclusively breastfeed suggests other factors are also at work a mother's own motivation, her knowledge, or support she receives from health providers. Nonetheless, the wide gap between exclusive-breastfeeding success under good family support (74.6%) and under insufficient support (42.0%) reinforces family support's status as a key determinant. The mountainous terrain and strong extended-family structure characteristic of the Maiwa service area can therefore function as either an asset or a barrier, depending on what family members themselves know and believe about exclusive breastfeeding.

The Relationship Between the Role of Health Workers and Exclusive Breastfeeding

No significant association was found between the health worker's role and exclusive breastfeeding among infants in the Maiwa Public Health Center's working

area. This non-significant result should not be read as evidence that health workers contribute nothing to exclusive breastfeeding success; rather, it more plausibly reflects shortcomings in how their role was actually carried out in the field at the time of the study, not a dismissal of the role's conceptual importance.

This lack of significance ($p = 0.564$) is likely attributable to several factors : the relatively narrow gap between groups (62.5% versus 57.1%), the mountainous terrain that hampers equitable service delivery, and a lactation education program that remains unstructured consistent with PRECEDE-PROCEED theory, which treats the health worker's role as an enabling factor that operates indirectly, through reinforcing knowledge and family support rather than acting on its own. This study's novelty lies precisely in integrating all three determinants of exclusive breastfeeding within the PRECEDE-PROCEED framework (Green & Kreuter), with its central finding being that the enabling factor's effectiveness hinges on the quality of implementation rather than mere presence. This helps reconcile conflicting results across the literature : some studies report a significant relationship between the health worker's role and exclusive breastfeeding success (Hayati & Aziz, 2023), while others find no significance despite seemingly adequate support, whether due to weak follow-up education (Putri et al., 2025) or mothers leaning more on family support instead (Mustary et al., 2023). The present findings suggest that what actually drives successful exclusive breastfeeding is the intensity and continuity of education delivered, not simply how often contact occurs.

Three points support this interpretation. First, the gap in exclusive-breastfeeding rates between mothers who rated the health worker's role as “good” (62.5%) and “poor” (57.1%) amounts to only 5.4 percentage points too small a difference in perception to yield statistical significance. Second, the Maiwa service area's mountainous geography, spanning 21 villages and one urban sub-district, likely affects how frequently and intensively health workers can engage breastfeeding mothers, leaving the role unevenly and sub-optimally delivered across the region. Third, while 56.6% of respondents rated the health worker's role favorably in numerical terms, this figure alone does not necessarily reflect whether the counseling provided meets the standard of comprehensive lactation support.

For public health practice and policy in geographically challenging areas like Maiwa, these results suggest prioritizing maternal education and active family involvement, alongside optimizing the health worker's role through more equitable lactation-counseling access in mountainous terrain and higher service standards overall. More broadly, sustaining exclusive breastfeeding programs calls for a multisectoral approach that simultaneously strengthens individual education, family support, and the health system itself, rather than relying on any single factor in isolation (Nie et al., 2023).

CONCLUSION

Drawing on data from 113 respondents in the Maiwa Community Health Center's (Puskesmas) service area, Enrekang Regency, in 2026, this study found that 68

respondents (60.2%) practiced exclusive breastfeeding while 45 (39.8%) did not. Good knowledge of exclusive breastfeeding was reported by 72 respondents (63.7%), against 41 (36.3%) with insufficient knowledge; 63 respondents (55.8%) received good family support compared with 50 (44.2%) who received insufficient support; and 64 respondents (56.6%) rated the health worker's role as “good,” versus 49 (43.4%) who rated it “insufficient.” Bivariate Chi-Square analysis confirmed significant associations between exclusive breastfeeding and both maternal knowledge ($p < 0.001$) and family support ($p < 0.001$), but found no significant association with the health worker's role ($p = 0.564$). Overall, maternal knowledge and family support emerge as factors associated with exclusive breastfeeding, while the health worker's role does not show a statistically significant association with exclusive breastfeeding in the Maiwa Community Health Center service area, Enrekang Regency, in 2026.

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