

Original Article

Factors associated with exclusive breastfeeding among mothers of infants aged 7–12 months in Bandar Lampung, Indonesia: A cross-sectional study

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Abstract

Background: Exclusive breastfeeding is an important maternal and child health practice, but coverage can vary markedly within the same administrative area. Pinang Jaya Public Health Center reported lower coverage than the Bandar Lampung city estimate, indicating a need for local evidence.

Objective: To identify maternal and contextual factors associated with exclusive breastfeeding among mothers of infants aged 7–12 months in the working area of Pinang Jaya Public Health Center, Bandar Lampung, Indonesia.

Methods: This cross-sectional study included all 40 eligible mothers registered in the health-center working area in November 2025. Knowledge was measured with 20 dichotomous items (score 0–20; good = 15–20). Attitude was measured with six five-point Likert items (score 6–30; positive = 23–30), and sociocultural support was measured with ten five-point Likert items (score 10–50; supportive = 38–50). Exclusive breastfeeding was determined using a structured infant-feeding history and checked against maternal and child health records when feeding information was available. Continuity-corrected Chi-square tests were used when expected cell counts were adequate; Fisher's exact test was used for maternal age because the minimum expected count was 2.85. Odds ratios (ORs) and 95% confidence intervals (CIs) were calculated for the odds of exclusive breastfeeding.

Results: Exclusive breastfeeding was reported by 21 mothers (52.5%). Significant associations were observed for good knowledge (OR = 11.900; 95% CI = 2.674–52.959; $p = 0.002$), being unemployed compared with employed (OR = 16.800; 95% CI = 3.417–82.603; $p < 0.001$), high education (OR = 8.960; 95% CI = 2.140–37.522; $p = 0.005$), positive attitude (OR = 10.667; 95% CI = 2.308–49.306; $p = 0.003$), and supportive sociocultural conditions (OR = 10.667; 95% CI = 2.308–49.306; $p = 0.003$). Maternal age and parity were not significantly associated with exclusive breastfeeding.

Conclusion: Knowledge, employment status, education, attitude, and sociocultural support were associated with exclusive breastfeeding in this small health-center population.

Background

Exclusive breastfeeding refers to feeding an infant only breast milk from birth through the first six months, without other liquids or foods, except oral rehydration solution, vitamins, minerals, or medicines when medically indicated. Breast milk provides nutrients, immunological protection, and bioactive components that support infant growth and early development. National health information also emphasizes benefits for maternal recovery and mother–infant bonding (Kementerian Kesehatan Republik Indonesia, 2024; Herlinah, 2024).

Exclusive breastfeeding remains an international and national public health priority. UNICEF and the World Health Organization reported that 48% of infants younger than six months were exclusively breastfed globally in 2024. Indonesia has reported improvement, but mothers continue to require equitable counseling, family support,

protection from inappropriate breast-milk substitute promotion, and breastfeeding-compatible work environments (UNICEF & World Health Organization, 2024; World Health Organization, 2025).

Exclusive breastfeeding has also been examined in relation to childhood pneumonia and stunting, reinforcing its relevance to child health beyond early nutrition (Hutapea et al., 2023; Rilyani et al., 2021). A literature review further showed that discontinuation reflects interacting maternal, infant, social, and service-related barriers rather than a single cause (Olalere, 2024).

Lampung Province reported that 76.20% of infants aged 0–5 months received exclusive breastfeeding in 2023 (Badan Pusat Statistik Provinsi Lampung, 2024). Routine service reporting in Bandar Lampung indicated 92% coverage in 2024, whereas Pinang Jaya Public Health Center recorded 51% coverage among 74

infants aged 0–6 months (Bandar Lampung City Health Office, 2024; Pinang Jaya Public Health Center, 2025). These figures originate from different reporting levels and denominators and should not be interpreted as directly comparable prevalence estimates. They nevertheless indicate a substantial local service gap that warrants investigation.

Maternal knowledge, educational attainment, employment, attitude, and family or sociocultural support are repeatedly linked with infant-feeding decisions. Health-promotion frameworks position knowledge and attitude as important determinants of behavior while recognizing that enabling and reinforcing conditions affect whether recommended practices are sustained (Notoatmodjo, 2018; Wawan & Dewi, 2019). Knowledge can help mothers distinguish evidence-based recommendations from misinformation, while education can facilitate access to health information (Junaedah, 2020; Aulia, 2025; Wihiyawari et al., 2025; Nurdalifah et al., 2023). Employment may restrict direct breastfeeding and milk expression when break time, storage facilities, and organizational support are inadequate (Farida et al., 2022; Harissa, 2022). Attitudes and cultural norms can either reinforce breastfeeding confidence or encourage early provision of water, honey, formula, or complementary foods (Butarbutar & Sinaga, 2025; Sabriana et al., 2022; Astutik & Pratama, 2023; Wahyuni Siregar, 2019).

Breastfeeding support is not limited to information provision. Community cadres, family members, and primary care professionals can reinforce practical skills and confidence, while management of common lactation problems, including milk stasis, low milk production, and breast swelling, may help mothers continue breastfeeding (Deswani et al., 2025; Fitriani et al., 2024; Rosa et al., 2025; Zelharsandy et al., 2026). Recent Indonesian studies continue to identify interacting maternal and contextual factors, underscoring the importance of locally specific assessment rather than relying solely on aggregate coverage (Aluman et al., 2025; Muthiatulsalimah et al., 2025; Siregar, 2025; Sitorus et al., 2025).

A preliminary survey conducted on October 3–4, 2025, in the Pinang Jaya service area found that five of ten interviewed mothers reported exclusive breastfeeding. Local evidence was therefore needed to describe the distribution of maternal factors and their statistical associations with exclusive breastfeeding. This study aimed to identify factors associated with exclusive

breastfeeding among mothers of infants aged 7–12 months in the working area of Pinang Jaya Public Health Center, Bandar Lampung, Indonesia, in 2025.

Methods

Study Design

This quantitative analytic study used a cross-sectional design. The study was conducted in the working area of Pinang Jaya Public Health Center, Bandar Lampung, Indonesia, in November 2025. The design was used to estimate associations between maternal characteristics, knowledge, attitude, sociocultural support, and reported exclusive breastfeeding at one observation period. It does not establish temporal sequence or causality.

Population and Sampling

The target population comprised mothers with infants aged 7–12 months who were registered in the health-center working area. The accessible population consisted of 40 mothers, and all eligible mothers were invited using total sampling. Inclusion criteria were residence in the service area, an infant aged 7–12 months, willingness to participate, and ability to communicate during data collection. Mothers were excluded when the infant had a medical condition that prevented meaningful assessment of usual feeding practice or when the questionnaire was incomplete. All 40 eligible mothers completed the study.

Variables and Instruments

The dependent variable was exclusive breastfeeding. Independent variables were maternal knowledge, employment status, education, age, parity, attitude, and sociocultural support. Demographic information was collected using a structured form. Employment was categorized as employed when the mother reported formal, informal, self-employed, or other paid work, and unemployed when she did not report paid work. Education was categorized as high when the mother had completed senior high school or higher and low when she had completed junior high school or lower. Age was categorized as <20 years and ≥20 years. Parity was categorized as primiparous or multiparous.

Maternal knowledge was measured using 20 items adapted from Junaedah (2020), comprising 17 positively worded and three negatively worded

statements. Each correct response received 1 point and each incorrect response received 0 points after reverse coding of negatively worded items. Total scores ranged from 0 to 20. Scores of 15–20 ($\geq 76\%$ of the maximum score) were categorized as good knowledge, and scores of 0–14 were categorized as poor knowledge.

Maternal attitude was measured using six items adapted from Harissa et al. (2022), comprising five positive and one negative statement. Responses used a five-point Likert scale from strongly disagree to strongly agree. Positive items were scored 1–5, while the negative item was reverse scored 5–1. Total scores ranged from 6 to 30. Scores of 23–30 ($\geq 76\%$ of the maximum score) were categorized as a positive attitude, and scores of 6–22 were categorized as a negative attitude.

Sociocultural support was measured using ten items adapted from Wahyuni Siregar (2019), comprising three positive and seven negative statements about family beliefs, customary feeding practices, and social approval of exclusive breastfeeding. Responses used a five-point Likert scale. Positive items were scored 1–5 and negative items were reverse scored 5–1. Total scores ranged from 10 to 50. Scores of 38–50 ($\geq 76\%$ of the maximum score) were categorized as supportive, and scores of 10–37 were categorized as not supportive. The adapted questionnaires were reviewed for wording and contextual relevance before administration.

Exclusive breastfeeding was assessed using a structured feeding-history questionnaire based on the definition of breast milk only from birth until completion of six months, except medicines, vitamins, and minerals. Mothers were asked whether the infant had received formula, water, honey, other liquids, or solid or semi-solid foods before six months and the age at first introduction. A mother was classified as having practiced exclusive breastfeeding only when all responses were consistent with the definition. Information in the Maternal and Child Health Handbook (Buku KIA), community health-post notes, or health-center records was reviewed when feeding information was available. Because documentary records did not consistently contain complete infant-feeding histories, maternal recall remained the primary source of outcome classification.

Data Collection

After informed consent, eligible mothers completed the questionnaires in a private area during health-center or community maternal-infant service activities. The researcher checked each questionnaire for completeness and clarified unanswered items without directing the respondent's answer. Data were coded, double-checked against the completed forms, entered into IBM SPSS Statistics, and screened for out-of-range values before analysis.

Data Analysis

Frequencies and percentages were used for descriptive analysis. Associations between each independent variable and exclusive breastfeeding were examined in 2×2 tables. Continuity-corrected Pearson Chi-square tests were used when all expected cell counts were at least 5. Fisher's exact test was used when this assumption was not met. The minimum expected count was calculated and reported for each analysis. Crude ORs and 95% CIs were expressed consistently as the odds of exclusive breastfeeding in the comparison category relative to the stated reference category. Statistical significance was set at $p < 0.05$. No multivariable model was fitted because the census sample was small and several cells were sparse; therefore, the reported estimates are unadjusted and may be affected by confounding.

Ethical Considerations

Ethical approval was obtained from the Malahayati University Health Research Ethics Committee (No. 5078/EC/KEP-UNMAL/XI/2025). Each participant received an explanation of the study purpose, procedures, voluntary participation, confidentiality, and the right to withdraw. Written informed consent was obtained before data collection. Identifying information was separated from the analytical dataset.

Results

The results are presented in two parts. Table 1 summarizes the distribution of exclusive breastfeeding and maternal characteristics, while Table 2 presents the bivariate associations between each maternal factor and exclusive breastfeeding.

Table 1. Distribution of respondent characteristics and study variables

Variable	Category	n	%
Exclusive breastfeeding	Exclusive	21	52.5
	Not exclusive	19	47.5
Knowledge	Good	22	55.0
	Poor	18	45.0
Employment	Employed	17	42.5
	Unemployed	23	57.5
Education	High	21	52.5
	Low	19	47.5
Maternal age	<20 years	6	15.0
	≥20 years	34	85.0
Parity	Primiparous	17	42.5
	Multiparous	23	57.5
Maternal attitude	Positive	17	42.5
	Negative	23	57.5
Sociocultural support	Supportive	17	42.5
	Not supportive	23	57.5

More than half of the respondents reported exclusive breastfeeding (52.5%), had good knowledge (55.0%), were unemployed (57.5%), had high education (52.5%), were aged ≥20 years

(85.0%), and were multiparous (57.5%). Positive attitudes and supportive sociocultural conditions were each reported by 42.5% of respondents.

Table 2. Associations between maternal factors and exclusive breastfeeding

Variable	Comparison category	Reference category	Not exclusive n (%)	Exclusive n (%)	Test; minimum expected count	p-value	Crude OR (95% CI) for exclusive breastfeeding
Knowledge	Good	Poor	5 (22.7)	17 (77.3)	CC Chi-square; 8.55	0.002	11.900 (2.674–52.959)
Employment	Unemployed	Employed	5 (21.7)	18 (78.3)	CC Chi-square; 8.08	<0.001	16.800 (3.417–82.603)
Education	High	Low	5 (23.8)	16 (76.2)	CC Chi-square; 9.03	0.005	8.960 (2.140–37.522)
Maternal age	≥20 years	<20 years	16 (47.1)	18 (52.9)	Fisher exact; 2.85	1.000	1.125 (0.198–6.386)
Parity	Multiparous	Primiparous	13 (56.5)	10 (43.5)	CC Chi-square; 8.08	0.313	0.420 (0.115–1.527)
Maternal attitude	Positive	Negative	3 (17.6)	14 (82.4)	CC Chi-square; 8.08	0.003	10.667 (2.308–49.306)
Sociocultural support	Supportive	Not supportive	3 (17.6)	14 (82.4)	CC Chi-square; 8.08	0.003	10.667 (2.308–49.306)

* CC = continuity corrected. The ORs consistently compare the stated comparison category with the stated reference category and use exclusive breastfeeding as the outcome.

Good knowledge, unemployment, high education, positive attitude, and supportive sociocultural conditions were significantly associated with greater odds of exclusive breastfeeding. Maternal age and parity were not statistically significant. The age table had two cells with expected counts below 5 and a minimum expected count of 2.85; Fisher's exact test was therefore used. All other tables met the expected-count assumption for the continuity-corrected Chi-square test.

Maternal attitude and sociocultural support produced identical 2 × 2 cell distributions and therefore identical p-values, ORs, and CIs. The statistics were recalculated separately from the reported cell counts. The variables were measured using distinct questionnaires and are reported separately because they represent different constructs.

Discussion

This study identified significant bivariate associations between exclusive breastfeeding and maternal knowledge, employment status, education, attitude, and sociocultural support. Maternal age and parity were not significantly associated. The estimates describe relationships in a census of 40 mothers registered in one health-center working area. They should not be interpreted as independent predictors or causal effects because no multivariable adjustment was performed and exposure and outcome information were assessed within a cross-sectional framework.

Mothers with good knowledge had higher odds of exclusive breastfeeding than mothers with poor knowledge. Knowledge can support recognition of the six-month recommendation, the meaning of exclusive breastfeeding, and the potential consequences of early supplementation. Similar relationships have been reported in Indonesian studies and reviews, although the strength of association varies across settings (Junaedah, 2020; Aulia, 2025; Wihyawari et al., 2025; Nurdalifah et al., 2023; Aluman et al., 2025). The wide CI in the present study indicates considerable uncertainty, so the numerical magnitude should be interpreted cautiously.

Employment status was also associated with exclusive breastfeeding. After standardizing the reference direction, unemployed mothers had 16.8 times the crude odds of exclusive breastfeeding compared with employed mothers. This finding is compatible with evidence that paid work can limit opportunities for direct breastfeeding or milk expression when maternity protection, break time, lactation space, and safe storage are insufficient (Farida et al., 2022; Harissa, 2022). Employment itself should not be viewed as a biological barrier; the relevant issue is whether workplace and family arrangements enable continued breastfeeding.

Higher education was associated with exclusive breastfeeding. Education may facilitate access to information and communication with health professionals, but it can also be intertwined with employment, income, autonomy, and access to health services. Previous Indonesian studies have reported associations between education and breastfeeding, while others have found that education is not sufficient when practical and

social barriers remain (Farida et al., 2022; Nurdalifah et al., 2023; Muthiatulsalimah et al., 2025). The crude association in this study may therefore partly reflect unmeasured or uncontrolled factors.

Positive maternal attitude was associated with greater odds of exclusive breastfeeding. Attitude reflects confidence, perceived value, willingness to continue, and beliefs about milk sufficiency. Research has similarly linked favorable attitudes with breastfeeding practice (Butarbutar & Sinaga, 2025; Sabriana et al., 2022). Counseling may be more useful when it addresses concerns, confidence, and problem solving in addition to factual knowledge. Practical lactation support may also help mothers manage discomfort, breast swelling, or perceived low milk production (Fitriani et al., 2024; Rosa et al., 2025; Zelharsandy et al., 2026).

Breastfeeding programs should remain integrated within broader breast-health services while preserving condition-specific evidence. Structured education and individualized care have shown value in other breast-health contexts, including breast self-examination and breast-cancer wound management, but those findings cannot be directly extrapolated to exclusive breastfeeding outcomes (Aisyah et al., 2026; Siahaan et al., 2026).

Supportive sociocultural conditions were associated with exclusive breastfeeding. Family approval, husband and grandparent support, and community norms may reinforce breastfeeding, whereas customary early introduction of water, honey, formula, or food may undermine exclusivity. This interpretation is consistent with studies on family and sociocultural influences in Indonesia (Astutik & Pratama, 2023; Wahyuni Siregar, 2019; Siregar, 2025; Sitorus et al., 2025). Community cadres and family-inclusive education may be useful delivery channels, although their effectiveness should be evaluated rather than assumed (Deswani et al., 2025).

Maternal age and parity were not significantly associated with exclusive breastfeeding. The absence of statistical significance does not prove the absence of a relationship, particularly because only six respondents were younger than 20 years and the CI for age was wide. Previous experience among multiparous mothers may help with breastfeeding, but each pregnancy and infant can

present different challenges. The small sample limited statistical power to detect modest associations and prevented stable adjusted analysis.

The identical results for attitude and sociocultural support arose because the two categorized variables produced the same cross-tabulated cell counts in this sample. Separate calculation confirmed the reported statistics, but identical bivariate distributions do not demonstrate that the constructs are interchangeable. Dichotomization can also conceal variation within total scores. Future studies should retain continuous scores where appropriate, examine construct validity, and evaluate collinearity before multivariable modeling.

This study has several limitations. Maternal recall at infant age 7–12 months may have caused recall or social-desirability bias, and feeding documentation was not uniformly available for verification. The sample was limited to 40 mothers in one health-center area, resulting in wide CIs and limited generalizability. The cross-sectional design did not establish temporal sequence, and the crude analyses did not control for income, maternity leave, breastfeeding difficulties, mode of delivery, early initiation, family structure, formula exposure, or health-worker support. The use of dichotomized instrument scores may have reduced information. These limitations require cautious interpretation of both significance and effect size.

Conclusion and Recommendation

Knowledge, employment status, education, maternal attitude, and sociocultural support were associated with exclusive breastfeeding among mothers of infants aged 7–12 months in the Pinang Jaya Public Health Center working area. Maternal age and parity were not significantly associated. These findings represent unadjusted cross-sectional associations and do not demonstrate that the measured factors caused breastfeeding outcomes.

Primary health-care teams may use the findings to refine breastfeeding assessment and counseling by addressing knowledge gaps, maternal confidence, family and cultural beliefs, and barriers experienced by employed mothers. Workplace engagement and family-inclusive counseling are reasonable program considerations, but their effectiveness should be

tested through adequately powered longitudinal or experimental studies. Future research should use larger samples, prospective feeding records, validated continuous scale scores, and multivariable analysis to assess independent associations and improve estimate precision.

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Declaration of conflict of interest

The authors declare no competing interests.

Declaration on the Use of AI

No AI tools were used in the preparation of this manuscript.

Data Availability Statement

Data sharing is not applicable to this article.

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