



Knowledge of Lactation Management, Workplace Support, and Breastfeeding Behavior among Working Mothers in East Aceh, Indonesia: A Cross-Sectional Study

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Abstract

Returning to work is a critical point at which many mothers stop exclusive breastfeeding. In Indonesia, exclusive breastfeeding is lower among working mothers than non-working mothers, yet evidence from rural primary health care settings in Aceh is scarce. This study examined whether knowledge of lactation management and workplace support were associated with breastfeeding behavior among working mothers. An analytical cross-sectional study was conducted at Ranto Peureulak Community Health Center, East Aceh Regency, from November 2023 to May 2024. Forty-five working mothers of children aged 7–24 months were selected by simple random sampling from 81 eligible mothers. Data were collected through structured interviews and analyzed using the chi-square or Fisher's exact test, with crude odds ratios (ORs) and 95% confidence intervals (CIs). Only 20 mothers (44.4%) practiced exclusive breastfeeding. Knowledge was good in 33.3%, sufficient in 37.8%, and poor in 28.9% of mothers, and 93.3% reported a supportive workplace. Exclusive breastfeeding was slightly more frequent among mothers with good or sufficient knowledge than among those with poor knowledge (46.9% vs. 38.5%; OR = 1.41; 95% CI: 0.38–5.26), but the association was not significant ($\chi^2 = 0.27$; $df = 2$; $p = 0.876$). Workplace support was also not associated with breastfeeding behavior (42.9% vs. 66.7%; OR = 0.38; 95% CI: 0.03–4.46; Fisher's exact $p = 0.577$). Low exclusive breastfeeding despite widely reported workplace support suggests that general knowledge and nominal permission are insufficient without practical lactation skills, functional facilities, and adequate leave. The small sample limited statistical power. Neither knowledge of lactation management nor perceived workplace support was significantly associated with breastfeeding behavior, and exclusive breastfeeding remained suboptimal. Skills-based lactation counseling and functional workplace lactation support should be strengthened and tested in larger multi-site studies.

Keywords: Breastfeeding, Lactation, Knowledge, Women, Working, Workplace.

INTRODUCTION

Breastfeeding is one of the most cost-effective interventions for child survival, growth, and development. The World Health Organization (WHO) recommends early initiation of breastfeeding within one hour of birth, exclusive breastfeeding for the first six months of life, and continued breastfeeding with safe complementary foods up to two years of age or beyond (World Health Organization, 2023). However, only 48% of infants under six months of age are exclusively breastfed worldwide (Organization & UNICEF, 2023). The 2023 *Lancet* Breastfeeding Series emphasized that this gap is not merely a matter of individual maternal choice, but the result of market-driven pressures, aggressive marketing of commercial milk

formula, and insufficient protection of women's work and care (Baker et al., 2023; Pérez-Escamilla et al., 2023; Rollins et al., 2023). For employed women, the return to work after maternity leave is a particularly critical period, because short leave, heavy workload, and a lack of occupational policies frequently interrupt exclusive breastfeeding (Franzoi et al., 2024; Lubis et al., 2024).

In Indonesia, the 2023 Indonesian Health Survey reported that 68.6% of infants aged 0–5 months were exclusively breastfed (Badan Kebijakan Pembangunan Kesehatan, 2023). National socioeconomic survey data show a persistent gap by maternal employment: exclusive breastfeeding reached 75.92% among non-working mothers but only 69.48% among working mothers (Statistik, 2023). An analysis of the 2021 Indonesian Nutritional Status Survey found that only 51.9% of working mothers practiced exclusive breastfeeding (Syahri et al., 2024). Qualitative evidence from formally employed Indonesian mothers identified inflexible schedules, short maternity leave, stigma, and inconsistent caregiving as key barriers, whereas partner and coworker support, flexible policies, and lactation-friendly facilities acted as facilitators (Prastita et al., 2025). Law No. 4 of 2024 on Maternal and Child Welfare in the First 1,000 Days of Life now guarantees working mothers at least three months of maternity leave, which may be extended by up to three months under specific conditions, as well as opportunities and facilities for breastfeeding during working hours (Undang-Undang Republik Indonesia, 2024). Whether these rights translate into practice in rural areas remains unclear.

A preliminary survey at the child health clinic of Ranto Peureulak Community Health Center in November 2023 identified 81 working mothers with children aged 7–24 months. Of the eight working mothers interviewed, six had not breastfed exclusively; they reported only three months of paid leave, limited knowledge of how to express and store breast milk, and not being allowed to bring their infants to work, and therefore considered formula feeding more practical.

Two complementary frameworks explain why working mothers may or may not sustain breastfeeding. According to the Theory of Planned Behavior, knowledge shapes attitudes and perceived behavioral control, which act through breastfeeding intention to influence actual behavior (Huang et al., 2023; Wu et al., 2025). The Social-Ecological Model further positions maternal behavior within interpersonal, organizational, community, and policy environments (Pérez-Escamilla et al., 2023; Snyder et al., 2021). Within this model, the workplace is a key organizational level: designated lactation spaces, paid milk-expression breaks, supportive supervisors, and written policies have been shown to improve breastfeeding outcomes (Litwan et al., 2021; Tomori et al., 2022; van Dellen et al., 2021; Vilar-Compte et al., 2021).

Nevertheless, the relative importance of individual knowledge and workplace support remains inconsistent. Maternal knowledge and awareness were strong predictors of exclusive breastfeeding in general populations (Kalhor et al., 2025; Sabo et al., 2023), whereas work-related conditions such as flexible schedules were decisive among formally employed mothers (Mkono et al., 2024). Moreover, Indonesian evidence has come mainly from national surveys or urban formal-sector workers (Laksono et al., 2021; Prastita et al., 2025; Syahri et al., 2024), leaving a gap regarding rural primary health care settings, where many working mothers are traders, laborers, or informal employees with different access to workplace support.

Mothers of children aged 7–24 months were targeted because their children had completed the entire six-month exclusive breastfeeding window, which usually overlaps with the mother's return to work after three months of maternity leave; thus, breastfeeding behavior across the full recommended period could be assessed. This study aimed to examine the association between working mothers' knowledge of lactation management and workplace support and their breastfeeding behavior at Ranto Peureulak Community Health Center. We hypothesized a priori that (H1) mothers with better knowledge of lactation management and (H2) mothers who perceived their workplace as supportive would be more likely to practice exclusive breastfeeding.

METHODS

This study used an analytical cross-sectional design and is reported in accordance with the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) statement. The study was conducted at Ranto Peureulak Community Health Center, Ranto Peureulak District, East Aceh Regency, Aceh Province, Indonesia, a primary health care facility serving a predominantly semi-rural population. Data were collected between November 2023 and May 2024.

The source population comprised all 81 working mothers with children aged 7–24 months who were registered at the child health and immunization services of the health center. Inclusion criteria were: (1) working outside the home in formal or informal employment; (2) having a healthy child aged 7–24 months; and (3) providing written informed consent. Mothers whose children had infectious diseases that might affect breastfeeding decisions (e.g., hepatitis B or tuberculosis) and mothers who declined participation were excluded. The sample size was calculated using the Slovin formula with a 10% margin of error [$n = N/(1 + N \cdot e^2) = 81/(1 + 81 \times 0.1^2) = 44.8$], yielding 45 respondents. Participants were selected by simple random sampling from the register of eligible mothers using a computer-generated random number list or lottery

method. Because the Slovin formula does not account for statistical power, the minimum detectable effect was calculated post hoc: with the achieved group sizes, the study had 80% power ($\alpha = 0.05$) to detect only large differences in proportions (Cohen's $h \geq 0.92$) (Serdar et al., 2021). The participant flow is shown in Figure 1.

The independent variables were knowledge of lactation management and workplace support; the dependent variable was breastfeeding behavior. Knowledge of lactation management was defined as the mother's understanding of exclusive breastfeeding, breastfeeding technique, milk expression, storage of expressed breast milk, and feeding expressed breast milk to the infant. It was measured using 15 true/false items (correct = 1, incorrect = 0) and categorized as good (76–100% correct), sufficient (56–75%), or poor ($\leq 55\%$). Workplace support was defined as the availability of facilities, policies, and support at work that enable breastfeeding, including a lactation room, equipment and time for expressing milk, information, and encouragement from supervisors and coworkers. It was measured using five items yes = 1/no = 0 and categorized as supportive ($\geq 50\%$ of the maximum score) or not supportive ($< 50\%$).

Breastfeeding behavior was defined as the mother's practice of feeding her child only breast milk, with no other food or fluid except medicines and vitamins, during the first six months of life. It was measured using five items scored as often (3), sometimes (2), or never (1), including a key item on whether any other food or fluid had been given before six months of age. Breastfeeding behavior was categorized as exclusive or non-exclusive total score $\geq X$ or a "yes" answer to the key item. The term "breastfeeding behavior" is used consistently throughout this article to refer to this outcome.

Primary data were collected through face-to-face structured interviews conducted by the first author in a private room at the health center after the purpose, procedure, voluntary nature, and confidentiality of the study had been explained. To reduce recall bias, the recall period was limited to children aged 24 months or younger, questions were anchored to concrete events (e.g., the child's age when any other food or fluid was first given and the date of return to work), and responses were cross-checked with the Maternal and Child Health (KIA) handbook. To reduce social desirability bias, questions were worded neutrally, and interviewers were not the mothers' regular health care providers. Secondary data on eligible mothers were obtained from the records of the child health unit.

Data were checked for completeness, coded, and analyzed using IBM SPSS Statistics 26. Univariate analysis described the frequency and percentage of each variable. Bivariate associations were tested using Pearson's chi-square test when no more than 20% of cells had

expected counts below five; otherwise, Fisher's exact test was used. Crude odds ratios (ORs) with 95% confidence intervals (CIs) were calculated, with knowledge also dichotomized as good/sufficient versus poor. Cramér's V and the phi coefficient were reported as effect sizes. Statistical significance was set at $\alpha = 0.05$. Multivariable logistic regression was planned for variables with $p < 0.25$ in bivariate analysis; because neither independent variable met this criterion and the number of outcome events was small ($n = 20$), multivariable modeling was not performed. There were no missing data for any study variable.

The study protocol was approved by the Health Research Ethics Committee of 11206/UN5.2.9.D2/PT/2025. Permission was obtained from the East Aceh District Health Office and Ranto Peureulak Community Health Center. All participants provided written informed consent, and the study was conducted in accordance with the Declaration of Helsinki.

RESULTS

Participant characteristics

All 45 randomly selected mothers completed the interview and were included in the analysis (Figure 1). Most respondents were aged 20–30 years (82.2%), had completed senior high school (71.1%), and worked as private employees (42.2%) or traders (26.7%) (Table 1).

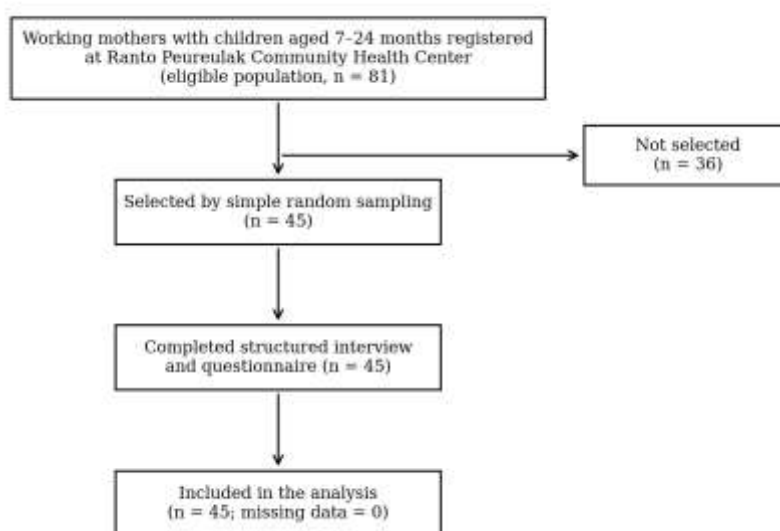


Figure 1. Flow of Participant Selection

Table 1. Characteristics of Respondents (n = 45)

Characteristic	n	%
Age (years)		
20–30	37	82.2
31–40	8	17.8
Education		
Elementary school	0	0.0
Junior high school	6	13.3
Senior high school	32	71.1
College/university	7	15.6
Occupation		
Private employee	19	42.2
Trader	12	26.7
Laborer	8	17.8
Civil servant	6	13.3

Knowledge, workplace support, and breastfeeding behavior

Overall, 37.8% of mothers had sufficient knowledge of lactation management, 33.3% had good knowledge, and 28.9% had poor knowledge. Almost all mothers (93.3%) perceived their workplace as supportive. Only 20 mothers (44.4%) practiced exclusive breastfeeding, whereas 25 (55.6%) did not (Table 2).

Table 2. Distribution of Knowledge of Lactation Management, Workplace Support, and Breastfeeding Behavior (n = 45)

Variable	n	%
Knowledge of lactation management		
Good	15	33.3
Sufficient	17	37.8
Poor	13	28.9
Workplace support		
Supportive	42	93.3
Not supportive	3	6.7
Breastfeeding behavior		
Exclusive	20	44.4
Non-exclusive	25	55.6

Association of knowledge and workplace support with breastfeeding behavior

The proportion of exclusive breastfeeding was similar among mothers with good (46.7%) and sufficient (47.1%) knowledge and slightly lower among those with poor knowledge (38.5%). This difference was not statistically significant ($\chi^2 = 0.27$; $df = 2$; $p = 0.876$; Cramér's $V = 0.08$). Compared with poor knowledge, the odds of exclusive breastfeeding were 1.41 times higher among mothers with good or sufficient knowledge, but the confidence interval was wide and included one (95% CI: 0.38–5.26). Exclusive breastfeeding was practiced by 42.9% of mothers with a supportive workplace and by two of the three mothers (66.7%) without workplace support. Because two cells had expected counts below five, Fisher's exact test was

applied; the association was not significant ($p = 0.577$; $OR = 0.38$; 95% $CI: 0.03–4.46$; $\phi = 0.12$) (Table 3). Therefore, hypotheses H1 and H2 were not supported.

Table 3. Association of Knowledge of Lactation Management and Workplace Support with Breastfeeding Behavior (n = 45)

Variable	Exclusive n (%)	Non- exclusive n (%)	Total n	Crude OR (95% CI)	p- value
Knowledge of lactation management					0.876 ^a
Good	7 (46.7)	8 (53.3)	15	1.40 (0.31–6.33)	
Sufficient	8 (47.1)	9 (52.9)	17	1.42 (0.33–6.17)	
Poor	5 (38.5)	8 (61.5)	13	1.00 (reference)	
Good/sufficient vs. poor	15 (46.9)	17 (53.1)	32	1.41 (0.38–5.26)	0.745 ^b
Workplace support					0.577 ^b
Supportive	18 (42.9)	24 (57.1)	42	0.38 (0.03–4.46)	
Not supportive	2 (66.7)	1 (33.3)	3	1.00 (reference)	
Total	20 (44.4)	25 (55.6)	45		

Percentages are row percentages. OR = odds ratio; CI = confidence interval (Woolf method). ^aPearson chi-square test ($\chi^2 = 0.27$; $df = 2$; Cramér's $V = 0.08$). ^bFisher's exact test (two-sided); $\phi = 0.12$ for workplace support.

DISCUSSION

This study found that fewer than half of working mothers at a rural primary health care center in East Aceh practiced exclusive breastfeeding, and that neither knowledge of lactation management nor perceived workplace support was significantly associated with breastfeeding behavior. These findings do not support the assumption that improving knowledge or securing general workplace approval is, by itself, sufficient to sustain exclusive breastfeeding among working mothers.

Knowledge of lactation management and breastfeeding behavior

The direction of the association between knowledge and exclusive breastfeeding ($OR = 1.41$) was consistent with previous studies, but its magnitude was much smaller and not significant. In Nigeria, correct knowledge of exclusive breastfeeding was associated with more than fourfold higher odds of exclusive breastfeeding (Sabo et al., 2023), and a recent meta-analysis identified maternal awareness of breastfeeding benefits as one of the strongest predictors (Kalhor et al., 2025). Several mechanisms may explain this weaker association. First, the Theory of Planned Behavior suggests that knowledge influences behavior mainly indirectly through attitudes, perceived behavioral control, self-efficacy, and intention (Huang et al., 2023; Wu et al., 2025). For working mothers, the decisive factor may be practical competence—expressing, storing, and feeding breast milk while away from the infant—rather than knowledge of the benefits of breastfeeding; self-efficacy has been shown to be closely linked to the establishment and maintenance of exclusive breastfeeding (Saavedra Sanchez et al., 2024). Second, among employed mothers, occupational constraints may override individual

knowledge; in Tanzania, flexible work schedules more than doubled the odds of exclusive breastfeeding (Mkono et al., 2024). Third, the instrument assessed factual knowledge with true/false items, which may not capture applied skills, and the modest sample produced imprecise estimates.

Workplace support and breastfeeding behavior

A striking finding was that 93.3% of mothers perceived their workplace as supportive, yet only 42.9% of these mothers breastfed exclusively. This pattern suggests that perceived support was largely nominal—general permission rather than functional provision. Evidence shows that the effect of workplace support depends on its quality and the mechanisms it activates: designated and adequately equipped lactation spaces, protected milk-expression breaks, and supportive workplace cultures (Litwan et al., 2021; Vilar-Compte et al., 2021). Among Dutch working mothers, objectively higher lactation room quality was associated with greater ease of milk expression and greater perceived support from supervisors and coworkers (van Dellen et al., 2021). In Indonesia, internal factors such as maternal determination and knowledge interact with external factors such as maternity leave, lactation facilities, and on-site childcare (Azizah et al., 2024; Prastita et al., 2025). In the present setting, 44.5% of mothers were traders or laborers, many of whom work outside formal institutions where lactation policies are rarely implemented. For such mothers, a “supportive” workplace may simply mean the absence of prohibition, without private space, refrigeration, or protected time. In addition, only three mothers reported no workplace support; this very small group made the estimate unstable (95% CI: 0.03–4.46), and the counterintuitive direction of the point estimate should not be interpreted as a true negative effect.

Suboptimal breastfeeding behavior in a multilevel context

The prevalence of exclusive breastfeeding in this study (44.4%) was lower than the national figure for working mothers (69.48%) (Statistik, 2023) and the 51.9% reported in a national survey of working mothers (Syahri et al., 2024), although differences in measurement and sampling limit direct comparison. From a social-ecological perspective, breastfeeding outcomes are shaped simultaneously by individual, interpersonal, organizational, community, and policy factors (Pérez-Escamilla et al., 2023; Snyder et al., 2021). Large-scale improvements therefore require coordinated interventions across health services, workplaces, and policy, rather than messages directed only at mothers (Tomori et al., 2022). The perception that formula feeding is more practical for working mothers, reported in the preliminary survey, is consistent with evidence that the marketing of commercial milk formula exploits parents’ time constraints and anxieties (Baker et al., 2023; Rollins et al., 2023). The extended maternity

leave guaranteed by Law No. 4 of 2024 offers an opportunity to align leave with the six-month exclusive breastfeeding period ((Undang-Undang Republik Indonesia, 2024), but its effect will depend on implementation, particularly for informal-sector workers.

In practice, lactation counseling at the health center should move from information delivery toward skills-based preparation before mothers return to work, including hands-on training in expressing and storing breast milk, planning feeding with caregivers, and strengthening breastfeeding self-efficacy. For policy, the district health office and local labor authorities should monitor the implementation of Law No. 4 of 2024 and support employers, including small businesses and markets, in providing functional lactation spaces and protected time for milk expression.

This study provides evidence from an under-researched rural primary health care setting and reports effect sizes and confidence intervals rather than p-values alone. However, several limitations must be considered. First, the cross-sectional design measured exposure and outcome at the same time; temporal order cannot be established, and no causal inference can be drawn. Second, the sample was small and was determined using the Slovin formula rather than a power calculation; the study was therefore underpowered to detect small-to-moderate associations, and the non-significant results should not be interpreted as evidence of no association. Third, breastfeeding behavior was reported retrospectively for children up to 24 months of age; recall bias and social desirability bias are likely to have led to over-reporting of exclusive breastfeeding. If this misclassification were similar across exposure groups, it would bias the associations toward the null. Fourth, workplace support was self-reported using five items and dichotomized, and very few mothers reported an unsupportive workplace, limiting variability. Fifth, potential confounders such as maternal age, parity, education, early initiation of breastfeeding, duration of maternity leave, family support, and self-efficacy were not controlled for, because multivariable analysis was not feasible. Finally, the findings come from a single semi-rural health center with a mix of formal and informal workers and cannot be generalized to formally employed mothers nationwide or to urban settings.

CONCLUSION

Fewer than half of working mothers at Ranto Peureulak Community Health Center practiced exclusive breastfeeding. Contrary to the study hypotheses, neither knowledge of lactation management nor perceived workplace support was significantly associated with breastfeeding behavior. However, the limited sample size reduced the power to detect modest

associations. These findings indicate that general knowledge and nominal workplace approval are unlikely, on their own, to secure exclusive breastfeeding among working mothers.

Health services should therefore provide skills-based lactation preparation before mothers return to work, while local health and labor authorities should translate the breastfeeding rights guaranteed by Law No. 4 of 2024 into functional lactation facilities and protected time at work. Larger multi-site studies using validated instruments and multivariable analysis are needed. Ultimately, sustained breastfeeding among working mothers depends on the synergy between maternal lactation literacy and a truly enabling workplace ecosystem.

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