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Article Title

An Overview of Postpartum Mothers' Knowledge Regarding Exclusive Breastfeeding at Pahandut Primary Health Center

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ABSTRACT

The low knowledge of postpartum mothers in providing exclusive breastfeeding at the Pahandut PHC was identified as the suspected root cause. This quantitative descriptive study aimed to map the overview of the knowledge level of postpartum mothers regarding exclusive breastfeeding in the area. The study employed a cross-sectional approach using a total sampling technique on 55 postpartum mothers at the Pahandut PHC. Primary data were collected using a 21-item questionnaire and analyzed univariately. The results showed that the respondents' knowledge levels were distributed across 'sufficient' (n = 28; 50.90%), 'good' (n = 16; 29.10%), and 'poor' (n = 11; 20.00%). The majority of mothers with sufficient knowledge were aged 20–25 years (69.09%), had 2–4 children (53.33%), had secondary education (66.67%), were unemployed (54.00%), did not receive family support (47.06%), and received health worker support (47.73%). Urgent interventions are required to correct specific misconceptions and retrain support providers, both families and health workers, to increase exclusive breastfeeding coverage.

Keywords: Exclusive Breastfeeding; Knowledge; Pahandut PHC; Postpartum Mothers.

INTRODUCTION

Breast milk is globally recognized as the gold standard for infant nutrition. It provides an essential composition of nutrients and antibodies crucial for optimal infant growth and development. Exclusive breastfeeding, defined as the practice of providing only breast milk without any additional liquids or solids (except medications and vitamins) from birth to six months of age, is the most effective public health intervention for child survival (Anggraeni & Benge, 2022). This practice not only meets all infant nutritional requirements during this period but also provides immunological protection that infant formula cannot replicate. After six months of age, complementary feeding is necessary to meet increasing nutritional demands, while breast milk can be continued until the child is two years old or older.

Indonesia's commitment to this practice is legally enshrined in the Government Regulation Number 33 of 2012 on Exclusive Breastfeeding. This policy mandates full support from the government, families, and the community to ensure every infant receives their rights. Nationally, 2021 Ministry of Health data shows positive achievements (Hardhana et al., 2021). The coverage of infants receiving exclusive breastfeeding in 2020 reached 66.06%. This figure exceeded the Strategic Plan target set at 40%, indicating program success at the macro level.

However, this national achievement is not evenly distributed across regions, highlighting significant regional disparities. Data from the Dinkes Kalteng (2020) recorded a concerning trend. After an increase in 2019 (51.4%), exclusive breastfeeding coverage experienced a sharp decline in 2020 to 38.9%. This gap became more apparent across districts within the province. North Barito District reported high coverage (74.4%), whereas other districts, such as Murung Raya (2.9%) and Sukamara (9.5%), fell far short of the target.

The condition at the Palangka Raya City level is similar. Wijayanti et al. (2021) reported that exclusive breastfeeding coverage decreased from 49.25% in 2019 to 45.82% in 2020. This decline occurred despite the relatively high early initiation of breastfeeding (EIBF) rate in 2020, which stood at 68.89%. These data suggest that although the initial step of breastfeeding (EIBF) has been successfully implemented, substantial factors hinder the continuity of the practice to reach six months of exclusivity.

The sharpest disparity was identified within the Pahandut Sub-district (Wijayanti et al., 2021). Data demonstrates that the Pahandut Primary Health Center (PHC) has the lowest exclusive breastfeeding coverage at only 8.00%. This figure contrasts starkly with other PHCs in the same sub-district, such as the Panarung PHC (43.75%) and Marina Permai PHC (56.52%). This drastic gap indicates the presence of highly localized, specific, and critical barrier factors within the Pahandut PHC working area that urgently require identification.

Various studies have identified the determinants of successful exclusive breastfeeding, in which maternal predisposing factors play a central role (Fadlliyyah, 2019). Among these factors, maternal knowledge has consistently been shown as one of the strongest predictors. Mothers with 'good' knowledge regarding the benefits, techniques, and management of lactation are more likely to successfully practice exclusive breastfeeding (Anggraini et al., 2020; Lestari et al., 2024). Conversely, 'poor' or 'sufficient' knowledge often correlates with practice failure. This condition leads mothers to become unmotivated or more susceptible to misinformation (Anggraeni et al., 2023).

This knowledge is often found to vary across demographic groups. Factors such as maternal age, which relates to psychological maturity (Polwandari & Wulandari, 2021), and parity, which relates to prior breastfeeding experience (Afriyani et al., 2018), contribute to shaping maternal knowledge. Similarly, the education level often correlates with a mother's ability to absorb health information (Lestari et al., 2024). Meanwhile, employment status can pose a time management challenge in breastfeeding (Widdefrita & Mohanis, 2014). Therefore, mapping demographic characteristics is essential to understanding the context of knowledge within a population.

Nevertheless, the relationship between knowledge and practice is not always linear. Mustafa and Ibrahim (2018) found cases where both mothers with good and poor knowledge failed to practice exclusive breastfeeding. This finding indicates the presence of additional barrier factors, such as infant formula promotion or insufficient support. Additionally, cultural differences can trigger low knowledge, as seen in a study in Ethiopia, where two-thirds of mothers lacked knowledge about exclusive breastfeeding (Tamiru et al., 2012). Despite these findings, no specific data have

been used to map the knowledge levels of postpartum mothers in the Pahandut PHC working area. In fact, this data is crucial for providing an initial explanation for the low exclusive breastfeeding coverage (8.00%) in the area.

Given this location-specific data gap, this study aims to provide an overview of postpartum mothers' knowledge of exclusive breastfeeding for infants aged 0-6 months at the Pahandut PHC in Palangka Raya City. Specifically, this study will also map this knowledge overview based on respondent characteristics. The benefit of this study is to provide essential baseline evidence for policymakers and health workers at the Pahandut PHC. These data can serve as a scientific foundation for designing more effective, focused, and targeted intervention, education, and counseling programs. Ultimately, the results of this study are expected to contribute to increasing exclusive breastfeeding coverage in the region.

METHOD

This study employed a quantitative descriptive research design with a cross-sectional approach (Notoatmodjo, 2018). This design was selected because it aligned with the study objective: to obtain an overview of postpartum mothers' knowledge of exclusive breastfeeding at a single point in time. Data collection was conducted over three months, from April to June 2022.

The target population in this study was all postpartum mothers residing in the Pahandut PHC working area during the study period. The sampling technique used was total sampling (population study). Using this technique, the entire population meeting the criteria, totaling 55 postpartum mothers, was established as the study sample. The use of total sampling aimed to eliminate sampling error and provide the most accurate representation of the studied population's condition (Sugiyono, 2019).

Primary data collection was conducted using a structured questionnaire administered directly to 55 respondents. The questionnaire consisted of two main sections. The first section collected data on respondents' demographic characteristics, including age, parity, education level, employment status, family income, and support from family and health workers. The second section was a knowledge questionnaire comprising 21 closed-ended statements designed to measure the mothers' understanding of exclusive breastfeeding.

The primary study variable, maternal knowledge, was measured quantitatively. The knowledge questionnaire was assessed based on the accuracy of answers, with 'Correct' answers scored 1 and 'Incorrect' answers scored 0. The raw score for each respondent was then converted to a percentage using the formula: (Obtained Score / Maximum Score [21]) x 100%. This percentage result was subsequently categorized

into three knowledge levels based on established norms: Good (score 76% – 100%), Sufficient (score 56% – 75%), and Poor (score < 56%).

All collected data were processed and analyzed using SPSS software (Dahlan, 2020). In accordance with the objective of this descriptive study, the data analysis technique used was univariate analysis. This analysis focused on generating frequency distributions and percentages for the primary variable (maternal knowledge level) and for all variables related to respondents' demographic characteristics. The presentation of data in frequency tables served as the basis for conducting quantitative descriptive discussions to address the study objective.

RESULTS

This study used primary data collected directly from 55 postpartum mothers in the Pahandut PHC working area during April to June 2022. All obtained data were analyzed univariately to describe the study variables. The study results are presented in the following series of frequency distribution tables.

Table 1. Frequency Distribution of Respondents' Knowledge Level Regarding Exclusive Breastfeeding

Knowledge Level	Frecuency (n)	Percentage (%)
Good	16	29.10
Sufficient	28	50.90
Lacking	11	20.00
Total	**55**	**100.00**

Source: Primary Data, 2022.

Table 1 presents the frequency distribution of the dependent study variable. The data showed that a sufficient knowledge level was the most frequent finding (n = 28; 50.90%), followed by a good knowledge level (n = 16; 29.10%) and a poor knowledge level (n = 11; 20.00%).

Table 2. Distribution of Respondents' Knowledge Level Based on Respondent Characteristics

Characteristic of Respondent	Knowledge Level					
	Good		Sufficient		Lacking	
	n	%	n	%	n	%
Age						
< 20	2	66.67	1	33.33	0	0.00
20-35	12	31.58	22	57.89	4	10.53
> 35	2	14.29	5	35.71	7	50.00

Characteristic of Respondent	Knowledge Level					
	Good		Sufficient		Lacking	
	n	%	n	%	n	%
Parity						
Primipara	4	20.00	10	50.00	6	30.00
Multipara	10	33.33	16	53.33	4	13.33
Grande Multipara	2	40.00	2	40.00	1	20.00
Education						
Basic Education	4	28.57	3	21.43	7	50.00
Secondary Education	6	22.22	18	66.67	3	11.11
Higher Education	6	42.86	7	50.00	1	7.14
Employment						
Employed	3	60.00	1	20.00	1	20.00
Not Employed	13	26.00	27	54.00	10	20.00
Family Income						
> PMW	8	28.57	17	60.71	3	10.71
< PMW	8	29.63	11	40.74	8	29.63
Family Support						
Supportive	4	23.53	8	47.06	5	29.41
Not Supportive	12	31.58	20	52.63	6	15.79
Health Worker Support						
Supportive	13	29.55	21	47.73	10	22.73
Not Supportive	3	27.27	7	63.64	1	9.09

Source: Primary Data, 2022.

By age, the < 20 years category with a good knowledge level was the most frequent finding (n = 2; 66.67%), followed by the sufficient knowledge level (n = 1; 33.33%). In the 20 – 35 years category, a sufficient knowledge level was the most frequent finding (n = 22; 57.89%), followed by a good knowledge level (n = 12; 31.58%) and a poor knowledge level (n = 4; 10.53%). In the > 35 years category, poor knowledge level was the most frequent finding (n = 7; 50.00%), followed by sufficient knowledge level (n = 5; 35.71%) and good knowledge level (n = 2; 14.29%).

Based on parity category, primipara with sufficient knowledge was the most frequent finding (n = 10; 50.00%), followed by primipara with poor knowledge (n = 6; 30.00%) and primipara with good knowledge (n = 4; 20.00%). In the multipara category, a sufficient knowledge level was the most frequent finding (n = 16; 53.33%), followed by a good knowledge level (n = 10; 33.33%) and a poor knowledge level (n = 4; 13.33%). In the grand multipara category, good (n = 2; 40.00%) and sufficient (n = 2; 40.00%) knowledge levels were the most common, followed by poor (n = 1; 20.00%).

Based on the education category, basic education with poor knowledge was the most frequent finding (n = 7; 50.00%), followed by good knowledge (n = 4; 28.57%) and sufficient knowledge (n = 3; 21.43%). In the secondary education category, a sufficient knowledge level was the most frequent finding (n = 18; 66.67%), followed by a good knowledge level (n = 6; 22.22%) and a poor knowledge level (n = 3; 11.11%). In the higher education category, a sufficient knowledge level was the most frequent finding (n = 7; 50.00%), followed by a good knowledge level (n = 6; 42.86%) and a poor knowledge level (n = 1; 7.14%).

Within the employed group, the most frequent knowledge level was good (n = 3; 60.00%), followed by sufficient (n = 1; 20.00%) and poor (n = 1; 20.00%). In the unemployed category, a sufficient knowledge level was the most frequent finding (n = 27; 54.00%), followed by a good knowledge level (n = 13; 26.00%) and a poor knowledge level (n = 10; 20.00%).

Based on family income, the > PMW category with a sufficient knowledge level was the most frequent finding (n = 17; 60.71%), followed by a good knowledge level (n = 8; 28.57%) and a poor knowledge level (n = 3; 10.71%). In the < PMW category, a sufficient knowledge level was the most frequent finding (n = 11; 40.74%), followed by a good knowledge level (n = 8; 29.63%) and a poor knowledge level (n = 8; 29.63%).

Based on family support, the most frequent finding in the supportive category was a sufficient knowledge level (n = 8; 47.06%), followed by a poor knowledge level (n = 5; 29.41%) and a good knowledge level (n = 4; 23.53%). In the unsupportive category, a sufficient knowledge level was the most frequent finding (n = 20; 52.63%), followed by a good knowledge level (n = 12; 31.58%) and a poor knowledge level (n = 6; 15.79%). Based on health worker support, the most frequent finding was a sufficient knowledge level (n = 21; 47.73%), followed by a good knowledge level (n = 13; 29.55%) and a poor knowledge level (n = 10; 22.73%). In the unsupportive category, a sufficient knowledge level was the most frequent finding (n = 7; 63.64%), followed by a good knowledge level (n = 3; 27.27%) and a poor knowledge level (n = 1; 9.09%).

DISCUSSION

A. Overview of Postpartum Mothers' Knowledge Regarding Exclusive Breastfeeding

This study addresses the primary objective of mapping the knowledge overview of postpartum mothers at the Pahandut PHC. Based on the univariate analysis of 55 respondents (Table 1), the primary finding was that the majority

of respondents' knowledge level was in the 'sufficient' category (n = 28; 50.90%). Meanwhile, the proportion of respondents with 'good' knowledge (n = 16; 29.10%) was higher than that of those with 'poor' knowledge (n = 11; 20.00%). These study results indicate that although most mothers have been exposed to basic information, their understanding is not yet comprehensive. This understanding has not yet reached the 'good' level, which is crucial for the successful practice of exclusive breastfeeding.

This overview shares similarities with a study conducted by Cascone et al. (2019) in Italy. The study found that approximately two-thirds of women 64.6% had heard of exclusive breastfeeding, and 71% knew the 6-month duration. Nevertheless, the findings in this study indicate better conditions, or are not in line with those in several other developing countries. A study by Tamiru et al. (2012) in Southwest Ethiopia reported a much more concerning condition. The majority 67.0% of mothers in that location completely lacked knowledge ('poor' category) regarding exclusive breastfeeding.

A more in-depth analysis of the raw questionnaire data in this study successfully identified the specific cause of these persistently low knowledge scores. The most significant misconception concerned infant formula. A total of 39 respondents (70.91% of the total sample) were identified as providing an incorrect answer to the statement, "infants can consume infant formula as an additional beverage besides breast milk before the age of six months." This massive misconception is strongly suspected to be the primary factor keeping the majority of respondents' scores 50.90% at the 'sufficient' level and preventing them from reaching the 'good' level.

The presence of this confusion about infant formula aligns with what Mustafa and Ibrahim (2018) identified as one of the main barriers to successful exclusive breastfeeding: the widespread promotion of infant formula, which can undermine mothers' beliefs. The failure to understand that exclusive breastfeeding means 'without any additions' is crucial. As emphasized by Anggraeni et al. (2023), mothers with poor knowledge—including specific misconceptions—will not have strong motivation to exclusively breastfeed. This ultimately contributes to practice failure.

B. Analysis of Postpartum Mothers' Knowledge Level Based on Respondent Characteristics

The data in Table 2 showed that the majority of respondents (n = 38; 69.09%) were in the ideal reproductive age range, namely 20 – 35 years. In this dominant group, the highest proportion of 'sufficient' knowledge was found (n = 22; 57.89%). This finding supports the theoretical argument presented by

Polwandari and Wulandari (2021), which stated that the age range of 20–35 years is a period of "mature" adulthood. In this phase, mothers are assumed to have greater cognitive abilities and emotional maturity to solve problems and actively seek accurate information about exclusive breastfeeding. Thus, it is reasonable that this age group dominated the 'sufficient' and 'good' knowledge categories (totaling 89.47%) and had a relatively low percentage of 'poor' knowledge (n = 4; 10.53%).

Parity, or maternal experience in childbirth and breastfeeding, is theoretically an important factor shaping knowledge. Parity is associated with a mother's experience during breastfeeding. Mothers with a parity of more than one will be more confident and better able to overcome obstacles during the breastfeeding process (for example, overcoming the perception of insufficient breast milk production), so that multipara or grande multipara mothers are more likely to exclusively breastfeed (Polwandari & Wulandari, 2021).

The results of this descriptive study at the Pahandut PHC showed that the majority of postpartum mothers with a sufficient knowledge level were those with 2–4 children, totaling 16 respondents (53.33%), and those with a poor knowledge level were those with > 5 children, totaling 1 respondent (20.00%). The highest number of children among respondents with sufficient knowledge in this study was 2 – 4. in other words, respondents already had experience with exclusive breastfeeding and related matters.

This study aligns closely with the literature. Polwandari and Wulandari (2021) argued that mothers with parity of 2 or more (multipara) tend to be more confident. They have also been proven capable of overcoming various lactation barriers, such as addressing the perception of a lack of breast milk. This empirical experience from previous pregnancies serves as effective informal learning, which explains why the 'poor' knowledge level in the multipara group in this study was much lower.

This study is further supported by Afriyani et al. (2018), who found that respondents with more than one child were more likely to exclusively breastfeed. One reason is that they already "have experience in parenting their children." Parity, in this context, can be understood as a factor that triggers more active information-seeking or a greater ability to filter misinformation than in primipara mothers. Previous experience appears to equip multipara mothers with a practical understanding that cannot be replaced by theory alone.

Formal education level is one of the classic predisposing factors believed to influence an individual's capability to acquire, process, and adopt health

information. The data in Table 2 showed a very clear negative correlation between the respondents' education level and the prevalence of 'poor knowledge'. In the basic education group (n = 14), 'poor knowledge' was the most common, accounting for 50.00% (n = 7). This figure dropped drastically in the secondary education group (n = 27) to only 11.11% (n = 3). The figure reached its lowest point in the higher education group (n = 14) at 7.14% (n = 1).

This finding is strongly in line with previous studies that emphasize the vital role of formal education. A study by Lestari et al. (2024) found a similar pattern where 'poor' knowledge was a minority in the high school and higher education groups, but dominant in the elementary and junior high school groups. Higher education appears to equip mothers with better health literacy skills. This makes it easier for them to understand comprehensive information regarding the benefits and management of lactation. The theoretical foundation also indicates that higher education enhances a person's ability to acquire information and develop insights.

Further analysis of Table 2 showed an interesting finding in the secondary education group, which was the largest respondent group (n = 27). In this group, the percentage of 'sufficient knowledge' reached its peak at 66.67% (n = 18). These data indicate that secondary education is sufficient to lift mothers out of the 'poor' category (which accounted for only 11.11%). However, this level of education does not seem sufficient to achieve a comprehensive understanding at the 'good' level (only 22.22%).

Nevertheless, it is important to acknowledge that the relationship between education and breastfeeding practices is not absolute across all populations. A literature review by Fadlliyyah (2019) noted various studies that found no significant relationship between maternal education level and exclusive breastfeeding. Furthermore, the findings of this study are not in line with those of Polwandari and Wulandari (2021) in Pelamunan Village. That study actually found the highest exclusive breastfeeding practice (83%) in the low-education maternal group. This drastic difference was explained by Polwandari and Wulandari (2021) as resulting from "local cultural factors" that exert a stronger influence than formal education.

Maternal employment status is often a significant determinant in lactation studies, generally because it affects time allocation and the mother's physical proximity to the infant. Employment, in this context, is defined as a social activity in which individuals invest effort over a period of time to support life, often for monetary reward (Wiltshire, 2016). The data in Table 2 showed that the study population was highly homogeneous. The absolute majority of respondents (n = 50; 90.91%) were housewives or not employed outside the home.

The knowledge profile in this dominant "unemployed" group (n = 50) was nearly identical to the overall knowledge profile (Table 1). The majority of housewives had 'sufficient' knowledge (n = 27; 54.00%), followed by 'good' (n = 13; 26.00%) and 'poor' (n = 10; 20.00%). This finding is crucial. The literature often identifies the status of a "working mother" as a primary barrier to exclusive breastfeeding practices (Fadlliyyah, 2019). Mothers who work outside the home have less direct contact time with their infants. Consequently, breast milk productivity decreases and infant formula feeding increases (Widdefrita & Mohanis, 2014).

However, the findings at the Pahandut PHC indicated a different result. The main problem (the low exclusive breastfeeding coverage of 8.00% that triggered this study) occurred in a population in which the majority 90.91% did not face work-time constraints. The fact that 20.00% of housewives (n = 10) still had 'poor' knowledge and 54.00% (n = 27) only had 'sufficient' knowledge indicates that time availability is not a guarantee of comprehensive understanding. This aligns with a study by Rifa'i et al. (2020), which also highlighted the importance of knowledge in "mothers who work at home". This reinforces the analysis from Sub-Section A that the problem in this location is fundamental at the knowledge level (specifically infant formula misconceptions), not in work-time management.

Family income, as a proxy for economic status, is frequently studied as a health determinant. This is due to its ability to influence access to resources, including health information and services (Mertasari, 2021). The data in Table 2 showed that the majority of postpartum mothers with sufficient knowledge were respondents with an income > PMW (Rp 2,922,516), totaling 17 respondents (60.71%), and respondents with poor knowledge were those with an income < PMW (Rp 2,922,516), totaling 8 respondents (29.63%).

This study showed that in the Pahandut PHC area, economic vulnerability (income < PMW) was strongly correlated with low knowledge of exclusive breastfeeding. This aligns with the argument presented by Mertasari (2021), who associated low economic status with various challenges that push mothers to work to meet family needs. In the context of this study, these economic challenges also appear to correlate with barriers to accessing or adopting comprehensive health information.

This complexity is also reflected in the literature review by Fadlliyyah (2019). Fadlliyyah noted that income can be a "double-edged sword." On one hand, high-income families might fail to breastfeed due to prestige or switching to expensive infant formula. On the other hand, low-income families might also

fail because mothers are forced to work. Nonetheless, the specific data from the Pahandut PHC (Table 2) remained consistent. Regardless of how income affects practice, its impact on knowledge is very clear. The < PMW income group was significantly more vulnerable to 'poor knowledge', making them a priority target for easily accessible and free educational interventions.

Besides predisposing (internal maternal) factors, enabling (external) factors such as family support are recognized as crucial pillars of lactation success. Family support, whether emotional, practical, or informational, theoretically strengthens maternal motivation and capability. The greater the support a mother receives to exclusively breastfeed, the greater her ability to endure lactation challenges (Komariah & Azizah, 2023).

The results of this study at the Pahandut PHC showed that the majority of postpartum mothers with sufficient knowledge were respondents who did not receive family support, totaling 20 respondents (52.63%), and respondents with poor knowledge were those who received family support, totaling 5 respondents (29.41%). This study sharply contradicts the general theoretical foundation (Komariah & Azizah, 2023), which assumes that family support always correlates positively with good outcomes.

This study aligns with Fadlliyyah (2019). The review noted several studies that found no significant association between family support and exclusive breastfeeding. Fadlliyyah (2019) explained that in the modern information era, mothers increasingly actively seek information from external sources (electronic media, the internet, or health workers). This potentially reduces the traditional role of the family as the primary source of knowledge.

Improving maternal knowledge about exclusive breastfeeding often fails because information is provided at the wrong time. Fikawati and Syafiq (2009) emphasized that education should be conducted intensively during pregnancy. That period is antenatal care (ANC), not postpartum care. If education is only provided postpartum (e.g., during immunization), it is often "too late," as the mother may have been exposed to misinformation from family or may have already provided infant formula.

The research results also showed that the majority of respondents (80.00%) reported receiving "Support" from health workers. This aligns with Sabati and Nuryanto (2015), who emphasized that health workers hold a "unique position" that can influence service delivery. Therefore, appropriate medical support will have a crucial impact on increasing maternal confidence and motivation to breastfeed.

Aprila and Astiningsih (2022) also found that health worker support is one of the most significant influences on mothers of exclusively breastfeeding infants. The types and forms of health services provided by medical personnel include promotive, preventive, curative, and rehabilitative services implemented in an integrated, comprehensive, and continuous manner.

CONCLUSIONS AND SUGGESTIONS

Through a quantitative descriptive analysis of 55 postpartum mothers in the Pahandut PHC working area, this study concludes that the overview of maternal knowledge regarding exclusive breastfeeding was generally distributed in the 'sufficient' category with 28 respondents (50.90%), followed by the 'good' category with 16 respondents (29.10%), and the 'poor' category with 11 respondents (20.00%). This finding addresses the study objective of mapping the population's knowledge, while simultaneously confirming the root cause of the low exclusive breastfeeding coverage (8.00%) in the area: the primary barrier is not total ignorance but rather an incomplete understanding. Specifically, this study found that the majority of respondents (70.91%) held a fatal misconception about infant formula feeding, believing that it can be given as a supplement before the infant is six months old. This serves as the main barrier preventing respondents from achieving a 'good' knowledge level and contributes to the failure of exclusive breastfeeding practices.

Viewed from the respondents' demographic characteristics, the dominance of this 'sufficient' knowledge level was supported by the group of mothers in the ideal reproductive age of 20–35 years (57.89%), multiparous parity or having 2–4 children (53.33%), with secondary education (66.67%), and unemployed/housewife status (54.00%). Additionally, an income-based gap was found, where respondents with an income below the Provincial Minimum Wage (PMW) dominated the 'poor' knowledge category (29.63%). A paradoxical finding emerged in the support aspect: although 80.00% of respondents received health worker support, 52.63% of respondents with sufficient knowledge lacked family support. This indicates that education from health workers has reached the community but is not yet effective enough to counter infant formula myths or replace the absent role of family support.

As a follow-up recommendation, policy implications at the Pahandut PHC must shift from general counseling to targeted education focusing on correcting the misconception of "allowing supplemental infant formula." Tactically, health workers are advised to prioritize interventions for the groups of mothers with basic education and low income (< PMW), who were proven to be the most vulnerable to having poor knowledge. Furthermore, considering the high rate of absent family support among mothers with sufficient knowledge, creating husband and family involvement

programs (family-centered care) becomes imperative to support lactation success. In the academic realm, further qualitative research is recommended to explore why infant formula misconceptions remain high (70.91%) despite exposure to health worker support reaching 80.00%.

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