



Mobility and Demographic Factors: A Study of Exclusive Breastfeeding in Indonesia

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Abstract. The background of exclusive breastfeeding in Indonesia has not been as expected although the Government has attempted thorough efforts. The aim of this research is to find out the determinant factors of exclusive breastfeeding for infants aged 0-6 months in Indonesia. The factors analyzed were the residence, education, the age at which the mother gave birth for the first time, migration, participation in the Family Planning and Birth Control (Keluarga Berencana) Program, as well as the infant's weight at birth. The method: quantitative approach with a cross-sectional approach which used secondary data from The National Socio-Economic Survey (SUSENAS) Kor 2020. The number of respondents was 2,175,672 breastfeeding mothers with data collection accomplished by interviews using a structured questionnaire. The data analysis was performed using a descriptive analysis through cross-tabulation and inferential analysis using binary logistic regression. The results shows that there are 63,7% or mother exclusively breastfed their babies. The characteristics of breastfeeding mothers were lived in urban areas, low educated and married at the ideal age of more than 20 years, have migrated, participated in family planning, and infants were born weighed less than 2,5 kg. The whole independent variables such as the residence, education, the age at which the mother gave birth for the first time, migration, contraceptive use, as well as the infant's weight at birth determined exclusive breastfeeding both in Indonesia in general and in border area of Indonesia.

Keywords: Demographic Factors, Exclusive Breastfeeding, Indonesia, Mobility.

1 Introduction

Exclusive breastfeeding is the provision of breast milk to infants for a period of 6 months continuously without the addition of other food or drinks except for medications and vitamins. This means that even after the age of 6 months, the baby continues to be breastfed, and breast milk remains given until the baby reaches 2 years old. Optimal exclusive breastfeeding is beneficial for both the baby and the mother. The study results showed that exclusive breastfeeding as the main intervention can prevent up to 13% of

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deaths in children under 5 years old [1], and breastfeeding practice also can prevent 12% of deaths in children under five every year [2]. Moreover, it can prevent babies from getting diarrhea and respiratory infections [3], and in the long term it will improve children's intelligence, avoid obesity, leukemia, and diabetes in childhood, while also preventing babies from stunting [2]. Meanwhile, mothers can avoid breast and ovarian cancer [3].

However, the implementation of exclusive breastfeeding remains lower than expected. According to the World Health Organization (WHO), the average rate of exclusive breastfeeding in the world is only around 38 percent [4]. In addition, the prevalence of exclusive breastfeeding is higher in low-income countries compared to developing and developed countries [2]. Although 96% of women in Indonesia breastfeed their children, only 42% practice exclusive breastfeeding [4]. The results of the IDHS also show that although more than half (52%) of children under 6 months receive exclusive breastfeeding, the percentage decreases with increasing age, from 67 percent at 0-1 months to 55 percent at age 2-3 months and only around 38 percent at the age of 4-5 months. Similar results were obtained from SUSENAS showing that although the percentage of infants aged 0-5 months who received exclusive breastfeeding tended to increase in the last 3 years, the practice was not evenly distributed, with the percentage being higher in infants who lived in rural areas and were female [5].

The government of Indonesia has made national efforts as stated in Government Regulation No. 33 of 2012 regarding the exclusive breastfeeding program. The goal is to ensure the fulfillment of the baby's right to exclusive breastfeeding and provide protection to the mother and increase the role and support of the family, community, and government. However, the results have not been optimal, with research in Semarang Regency showing that the exclusive breastfeeding program has not well performed with only socialization and advocacy that was performed out of several measures, because the exclusive breastfeeding program is not yet a priority program in Semarang Regency [6]. Moreover, the government has formed the ASI Support Group (KP-ASI). Mother's support group (KP- Mother) is a forum for exchanging experiences, discussing, and providing mutual support related to maternal and child health, especially around pregnancy, breastfeeding, and nutrition, guided or facilitated by motivators [7].

Previous research on the factors that influence exclusive breastfeeding in several countries shows that there are several factors that have a significant relationship including demographic, economic, biological, psychological, and sociocultural factors. Research in Beijing states that younger maternal age, previous breastfeeding experience, shorter separation time between mother and baby during treatment, and older age at pregnancy affect the exclusive breastfeeding [8]. Furthermore, a study found that many mothers stopped breastfeeding due to the feeling that breast milk was felt to be insufficient [9]. Meanwhile, research in China showed that several factors associated with exclusive breastfeeding are the length of birth of the neonate, mother's food intake before breastfeeding, infrequent sucking, intention to breastfeed, level of understanding of the benefits of breastfeeding, length of birth for the neonate, normal delivery, breast size, breastfeeding experience, bottle use, and support from family members [10]. Similar results were found in Mexico where the level of knowledge, bottle use, and occupation were associated with the discontinuation of exclusive breastfeeding [11]. The

results of other studies in Indonesia stated that there are various factors that affect breast milk production including the frequency of breastfeeding, birth weight, pregnancy age at delivery, stress and acute illness, alcohol consumption, contraceptive pills, and method of delivery of the baby [12].

2 Goals

This study aims to determine the factors associated with exclusive breastfeeding in infants aged 0-6 months in Indonesia. Factors discussed include demographic and non-demographic characteristics. Demographic characteristics include place of residence, education, age at first birth. Non-demographic factors are seen from migration, participation in family planning (contraceptive use) and infant weight.

3 Conceptual Framework

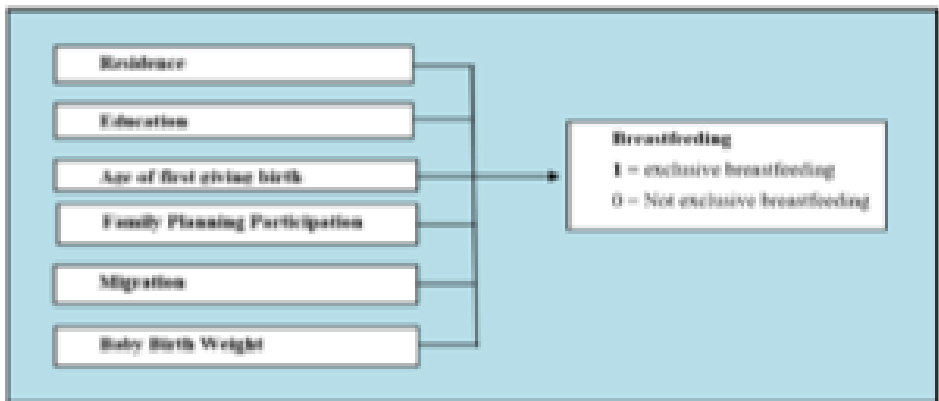


Fig. 1. Framework of mobility and demographic factors to breastfeeding.

4 Methodology

This study uses a quantitative approach with a cross-sectional approach. The data source uses secondary data from the National Socio-Economic Survey (SUSENAS) Kor 2020. Susenas Kor 2020 collects data regarding the welfare of household members such as education, health, fertility/family planning, and population data according to age group, gender, and marital status [13].

The target population of this study was all mothers who had babies 0-6 months who breastfed their babies. Inclusion criteria were mothers who gave birth less than 2 years ago with babies aged 0-6 months and have been given breast milk since birth and have never been given other drinks (liquids) or food other than breast milk in the SUSENAS

Cor 2020 sample. Exclusion criteria were incomplete data from various variables studied and mothers who did not weigh/don't know their baby's weight. Selected samples that meet the inclusion and exclusion criteria are 2,175,672 people.

The dependent variable was categorized, binomially, with code 1 for mothers who gave exclusive breastfeeding, and code 0 for non-exclusive breastfeeding. The independent variables consist of place of residence, education, recent migration, age at first delivery, birth weight, and participation in family planning (contraceptive use). The variable of residence is coded 1 for urban and code 0 for rural. Education is obtained through the composition of the highest education level obtained by the mothers and was coded as 1 for those who are never attended school, elementary, and junior high school (referred to as low education based on the 9 years of compulsory education) coded 2 for mothers who are educated high school (referred as middle education) and coded 3 for mothers educated from vocational degree up to doctoral degree (referred as high education). The migration variable was obtained by assigning a code of 1 to mothers who migrated within 5 years prior to the survey and coded 0 if there was no migration. Mother's age at first delivery was obtained through the composite of the age at first giving birth which ranged from 10-19 years with code 1 and code 0 for those aged equal 20 years or more. The baby weight variable was coded as 1 for babies born weighing less than 2.5 kg and code 0 for babies who were born weighed equal to 2.5 kg or more, respondents who answered they did not weigh the baby or did not know the weight of their babies were excluded from the analysis. Participation in family planning was coded 1 if never used contraception and coded 0 if have ever used a contraceptive method. The analysis in this study uses descriptive analysis through cross-tabulation and inferential analysis using binary logistic regression to determine the most influential variables among the observed variables.

5 Discussion

More than half of the respondents live in urban areas (53.4%) with elementary-junior high school education (45.5%), meaning that the respondents in this study have relatively low education. Education contributes to a person's basic ability to think for decision-making, including exclusive breastfeeding. This is because the knowledge obtained through formal education can enrich perception hence it also changes the behavior of exclusive breastfeeding. Most of the respondents (77.7%) were aged 20 years at the time of their first delivery, and this age was within the ideal age for women to be pregnant and to give birth. Most of the respondents did not migrate (95.9%), more than half had high family planning participation (66%), and most of the babies were born without LBW, namely 2.5 Kg (88.8 %).

Table 1. Characteristics of respondents.

Variable	n	%
Residence		
Rural	1.014.371	46,6
Urban	1.161.302	53,4
Education		
Low	990.975	45,5
Middle	763.988	35,1
High	420.709	19,3
Age of first giving birth		
≤ 19 Years	486.000	22,3
≥ 20 Years	1.689.672	77,7
Migration		
No migration	2.086.121	95,9
Migration	88.551	4
Contraceptive use		
No	740.626	34
Yes	1.435.046	66
Baby Birth Weight		
< 2,5 Kg	244.074	11,2
≥ 2,5 Kg	1.931.598	88,8
Area		
Border	154.813	7,1
Non-Border	2.020.859	92,9
Exclusive Breastfeeding Practice		
Indonesia	1.386.888	63,7
Indonesian Border	105.273	68,0
	2.175.672	100

Table 2. Results of bivariate dan multivariate analysis of determinants of exclusive breastfeeding 0-6 months in Indonesia.

Variable	Breastfeeding (%)		%	Total	P-Value Bivariate	AOR [LL-UL] (Multivariate)
	Non Exclusive	Exclusive				
Residence						
Rural	37	63	100	1.014.371	0,00	ref
Urban	36	64	100	1.161.302		1,049 (1,043-1,055)**
Education						
Low	36	64	100	990.975	0,00	1,092 (1,084-1,101)**
Middle	36	64	100	763.988		1,036 (1,027-1,044)**
High	37	63	100	420.709		ref
Age of first giving birth						
≤ 19 Years	37	63	100	486.000	0,00	ref
≥ 20 Years	36	64	100	1.689.672		1,014 (1,007-1,021)**
Migration						
No migration	36	64	100	2.087.121	0,00	ref
Migration	32	68	100	88.551		1,178 (1,161-1,195)**
Contraceptive use						
No	33	67	100	740.626	0,00	0,784 (0,779-0,789)**
Yes	38	62	100	1.435.046		ref
Baby Birth Weight						
< 2,5 Kg	33	67	100	244.074	0,00	0,842 (0,835-0,850)**
≥ 2,5 Kg	37	63	100	1.931.598		ref
				100	2.175.672	

** sig p < 0,001

Table 3. Results of bivariate analysis and multivariate analysis of the determinants of exclusive breastfeeding in infants 0-6 months in border area (Adjusted Odd Ratio).

Variable	Breastfeeding (%)		%	Total	P-Value Bivariate	AOR [LL-UL] (Multivariate)
	Non Exclusive	Exclusive				
Residence						
Rural	34	66	100	96.866	0,00	ref
Urban	28	72	100	57.947		1,486 (1,451-1,522) **
Education						
Low	32	68	100	55.456	0,00	1,405 (1.363-1.449) **
Middle	28	72	100	37.397		1.624 (1.574-1.675) **
High	38	62	100	21.741		ref
Age of first giving birth						
≤ 19 Years	29	71	100	37.730	0,00	1,236 (1,203-1,269) **
≥ 20 Years	33	67	100	117.083		ref
Migration						
No migration	32	68	100	14.8287	0,00	ref
Migration	35	65	100	6.526		1,174 (1,113-1,238) **
Contraceptive use						
No	31	69	100	66.994	0,00	ref
Yes	33	67	100	87.819		1,104 (1,080-1,128) **
Baby Birth Weight						
< 2,5 Kg	33	67	100	128.830	0,00	1,489 (1,444-1,535) **
≥ 2,5 Kg	25	75	100	25.983		ref
				100	154.813	

** sig p < 0,001

The results of the bivariate analysis in Table 2 and Table 3 show that area of residence, education, age at first birth, history of migration, contraceptives use, and baby's weight at birth have a relationship with exclusive breastfeeding practice ($p < 0.05$) both in Indonesia as general and in Indonesia's border areas. Therefore, all variables showing this significance were included in the multivariate analysis. Multivariate analysis indicates that Indonesian mothers living in urban areas performed exclusive breastfeeding as much as 1.049 (Indonesia) times higher compared to those who lived in rural areas. The odds of performing exclusive breastfeeding are almost 1,5 times higher among women living in urban areas compared to those in rural areas (border region). These results are in line with research in Nigeria and Laos that residence in both urban and rural areas is significant with the practice of exclusive breastfeeding [14-16], but differs from research in Bangladesh where the place of residence is one of the variables

that is not related to exclusive breastfeeding [17]. This is because mothers in Bangladesh are aware of good breastfeeding practices regardless of where they live, and they can gain this knowledge through interpersonal communication during home visits from health workers, community-based campaigns including group discussions and counseling at health centers, or message exposure through mass media [17].

Education is related to exclusive breastfeeding (table 2), P value <0.05. According to the characteristics of education, the percentage of mothers who give exclusive breastfeeding is similar between the low and high education, namely 64%. Interestingly, the study find that education shows an opposite correlation with the behavior of giving exclusive breastfeeding, with the number of mothers who practices exclusive breastfeeding is decreased among those highly educated. The study found that mothers with lower education are 1.092 times higher to exclusively breastfeed compared to those with higher education (95% CI = 1.084-1.101, $p < 0.001$). The odds off practicing exclusive breastfeeding among Mother with middle education are doubled in border region. This result is different from research in India in that mothers who are highly educated and who often contact health services are having a higher practice of exclusive breastfeeding [18]. Other research states that a mother's education and knowledge are important factors to support the success of exclusive breastfeeding, because the higher a person's education level, the easier it is to receive information so the more knowledge they have [19]. Ideally, the higher the level of education leads to the easier acceptance to and obtaining information, therefore, it will be more rational in making decisions, including the decision to give exclusive breastfeeding to the baby. The results of a similar study in Indonesia stated that the mother's education level had a positive effect on the practice of exclusive breastfeeding [15]. Likewise, in China, maternal education level is correlated with exclusive breastfeeding [20]. A study further stated that the level of education of breastfeeding mothers can affect mothers' knowledge because nutritional knowledge has an important role in the practice of selecting, processing, and regulating the daily intake of breastfeeding mothers so that breastfeeding mothers consume balanced nutritional foods every day [21]. The results of the study differ in Bangladesh and in Turkey, which indicated that the level of a mother's education is not significantly associated with exclusive breastfeeding to infants [17,22].

In general, mothers who gave exclusive breastfeeding gave birth for the first time at the age of 20 years by 64% (table 2). Age at first delivery was associated with exclusive breastfeeding with the chances of mothers giving exclusive breastfeeding who give birth at an ideal age (>20 years) being 1.014 times higher than those who give birth at a young age, and the chances increased to 1.234 times among women in the border area. These results are in accordance with the research which found that there is a significant relationship between age and the practice of exclusive breastfeeding [23,24]. Pregnancy is best occurring at the ideal age range of 20-30 years, so the woman would not be too young and not too old when giving birth for the first time. This is because women who are pregnant at the age of < 20 years will experience various effects, ranging from experiencing more symptoms of anxiety and depression as well as increasing mental health risks if women experience sexual coercion [25]. Furthermore, there is a high potential for frequent anemia, impaired fetal growth, and development, miscarriage, prematurity, low birth weight, labor disorders, preeclampsia, and antepartum bleeding

[26]. Meanwhile, women who are pregnant over the age of 30 are more likely to experience preeclampsia, have a low-birth-weight baby, and have premature delivery [27]. According to research results, women who were pregnant at the ideal age (20–35 years) gave more exclusive breastfeeding than women who were pregnant in the age risk group (<20 years and >35 years), this means that women at risky age have a greater chance of not giving exclusive breastfeeding [24].

Women who gave birth for the first time at the ideal age turned out to be more likely to give exclusive breastfeeding. This means that they increasingly understand the importance of exclusive breastfeeding for their babies. Therefore, it is important to provide early understanding to adolescents about maturing the age of marriage so that they become pregnant at the ideal age. One of the efforts made by BKKBN aimed at teenager is to intensify the GenRe (Generation Planning) program. Through GenRe, youth will be provided with various information, including but not limited to adolescent reproductive health, sexually transmitted diseases, HIV and AIDS, and family planning. It is hoped that the program will enhance future teenagers to be more prepared when forming their own families. For this reason, it is necessary to disseminate program information to young people in Indonesia. Because based on the results of research, adolescents who know information about GenRe will be able to plan for a better life in the future [28].

Migration in this study is a change of residence within a period of 5 years ago. The results showed that migration was associated with exclusive breastfeeding with Mothers with migratory status having a 1.178 times higher chance of exclusive breastfeeding than non-migratory mothers (1.174 times higher among migrated mothers in the border area). This study is in accordance with a study in Germany that migration background factors have an influence on exclusive breastfeeding behavior, with a migrant background is more likely to start breastfeeding than women non-migrated women with breastfeeding periods of up to 6 months [29]. A similar result of a study based on the experience of African immigrant mothers in high-income countries which find out that migration is proven to affect breastfeeding behavior, especially for those who come from low- and middle-income countries [30]. However, other studies have shown different results. Research on Brazilian immigrants in the United States shows that most mothers did not give exclusive breastfeeding because they use formula and breast milk simultaneously, this is because family and culture affect infant feeding beliefs and practices [31]. Similar results from a study on Chinese women who migrated to Spain turned out to have very low breastfeeding rates than local women [32]. Furthermore, the same results with Chinese women who migrated to Ireland show that they have a shorter duration of breastfeeding than Chinese women who did not migrate, this is because Chinese women who migrate experience cultural conflicts, lack of family support, language barriers, and low social and financial status of immigrant [33]. Conflict contributes to a mother's anxiety and insecurity during lactation [22]. Based on this, it can be said that the mothers who migrated in this study did not experience obstacles in their migration area, so they were able to provide full exclusive breastfeeding to their babies.

Based on statistical test results, family planning participation (contraceptive use) is related to exclusive breastfeeding with mothers using any contraceptive methods are having a 1.104 times higher chance of practicing exclusive breastfeeding compared to

those who non-contraceptive users. These results are in accordance with other research, that there is a relationship between the use of hormonal contraception and milk production in breastfeeding mothers because inappropriate use of hormonal contraception such as one that contains estrogens causes a decrease in breast milk production, resulting in the baby does not get the maximum amount of breast milk. The use of contraception for breastfeeding mothers should also be consulted with the midwife/doctor so that its use does not affect breast milk production. A study on contraception indicated that the use of combined contraceptives of the hormones estrogen and progesterone is associated with a decrease in the volume and duration of breast milk, hence the use of progesterone-only contraceptives is better because there is no impact on the volume of breastmilk [34]. However, the study finds that as many as 67% of respondents who gave exclusive breastfeeding did not use contraceptive methods, both hormonal and non-hormonal. Meanwhile, the potential risk of getting pregnant is very large if there is no initiation of using contraception [35]. Previous research stated that not using contraception and breastfeeding <24 months had a significant relationship with short birth spacing [36].

Based on the weight of the babies born, Infant weight at birth was associated with exclusive breastfeeding. In general, mothers who gave exclusive breastfeeding were mothers who gave birth to babies weighing < 2.5 Kg (67%). The results of this study are not much different from studies in Bangladesh and Nigeria [14,17]. Babies born with a weight < 2.5 Kg will experience motor and cognitive disorders or delays that are seen throughout childhood [37]. Furthermore, babies are at high risk for failure to thrive which results in developmental delays, delayed neurodevelopment, and even risk of death [38]. Therefore, babies who have LBW are highly recommended to get exclusive breastfeeding because LBW babies who were breastfed are having immune advantages, and even breast milk as the main source of nutrition [39]. For this reason, mothers with LBW babies need special support that aims to increase their ability to breastfeed and ensure exclusive breastfeeding. Moreover, it is necessary to improve breastfeeding education and care. On the other hand, health workers must also receive training [40].

5.1 Breastfeeding Practice in Indonesia's Border

Indonesia has several provincial areas that are directly bordered by other countries, both in the form of sea borders and land borders, the land border area consists of 5 provinces (East Nusa Tenggara, East Kalimantan, West Kalimantan, North Kalimantan, and Papua [41,42]. The result of the data analysis on the border region shows that the level of odds for practicing exclusive breastfeeding for each dependent variable is even greater in the border region compared to the national odds for exclusive breastfeeding practice. As many as 68% of the female respondents who live in the border area practiced exclusive breastfeeding, while only 63% performed exclusive breastfeeding nationally (Table 1). The results of this study show a higher proportion of exclusive breastfeeding compared to the results of previous studies in the Indonesia-Malaysia border region which showed that there was only around 57% exclusive breastfeeding in border areas [43]. The provision of exclusive breastfeeding in the border area is also higher than the national average of exclusive breastfeeding based on the results of the 2017 Indonesian

Health Profile data, namely 61.3% [44]. The high percentage of exclusive breastfeeding in this border area may be related to the difficulty of access to transportation, and the condition of border areas which are generally left behind and difficult to reach which causes the social and economic conditions of the community to be quite low compared to neighboring countries [42]. This is shown by several studies in which mothers with low economic levels are more likely to perform exclusive breastfeeding, especially if the provision of additional milk reduces the cost of family needs budgets [45], making it more likely for postpartum mothers to provide breastfeeding than give formula milk. Studies on the determinants of early feeding practice also show that being in a family with a high wealth index in rural areas is also associated with supplementary formula feeding in infants 0-6 months, which means that babies are no longer exclusively breast-fed [46]. Breastfeeding behavior is in large part shaped by various socio-cultural and religious influences taught by families, social networks, and religious communities [47]. Thus, the low level of exclusive breastfeeding in rural areas, both in Indonesia in general, and in border areas, is very likely influenced by the practice of giving supplementary food to babies in rural areas, which is more influenced by socio-culture in the area where mothers and babies live. Previous studies have shown that even though breastfeeding babies during the first 6 months of life, the practice of early feeding in infants aged 0-6 months is widely practiced in Indonesia, by providing formula milk, honey, water, and mashed bananas [46]. The results of further research show that early feeding to infants 0-6 months is influenced by the mother's perception of the low birth weight of the baby and is generally given by mothers who live in rural areas. Furthermore, studies show that giving other foods besides breast milk to 0-6 month infants is not affected by the mother's age, education, wealth index, or the sex of the baby [46].

6 Conclusion

All independent variables namely place of residence, education, age at first birth, history of migration, contraceptive use, and baby's weight at birth have a relationship with exclusive breastfeeding practice both in Indonesia as general and in Indonesia's border areas. The result of the data analysis on the border region shows that the level of odds for practicing exclusive breastfeeding for each dependent variable is even greater in the border region compared to the national odds for exclusive breastfeeding practice. Interestingly, mothers who live in urban areas and have low education have a higher proportion of practicing exclusive breastfeeding. Education about the importance of exclusive breastfeeding is needed for mothers with higher education so that they can be an example for mothers with higher education, both in urban and rural areas.

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