

THE RELATIONSHIP BETWEEN THIRD-TRIMESTER PREGNANT WOMEN'S KNOWLEDGE AND READINESS FOR EARLY INITIATION OF BREASTFEEDING IMPLEMENTATION

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ABSTRAK

Latar Belakang: Inisiasi Menyusu Dini (IMD) berperan penting dalam menurunkan angka kematian neonatal, meningkatkan keberhasilan ASI eksklusif, dan mencegah stunting. Cakupan IMD dunia tahun 2025 baru mencapai 48%, sedangkan di wilayah kerja UPTD Puskesmas Kalianda sebesar 61,8%. Studi pendahuluan pada 10 ibu hamil menunjukkan 80% ibu primigravida belum memahami IMD secara lengkap dan 40% ibu belum siap melaksanakan IMD.

Tujuan: Mengetahui hubungan pengetahuan ibu hamil trimester III dengan kesiapan pelaksanaan Inisiasi Menyusu Dini (IMD) di wilayah kerja UPTD Puskesmas Kalianda Kabupaten Lampung Selatan.

Metode: Penelitian kuantitatif dengan rancangan cross sectional. Populasi seluruh ibu hamil trimester III di wilayah kerja UPTD Puskesmas Kalianda sebanyak 46 orang, dengan sampel 46 responden yang diambil secara total sampling. Data dikumpulkan menggunakan kuesioner pengetahuan dan kesiapan pelaksanaan IMD, dianalisis secara univariat dan bivariat menggunakan uji Chi-Square.

Hasil: Sebanyak 30 responden (65,2%) memiliki pengetahuan baik tentang IMD dan 29 responden (63,0%) siap melaksanakan IMD. Terdapat hubungan yang signifikan antara pengetahuan ibu hamil trimester III dengan kesiapan pelaksanaan IMD (p -value = 0,021; OR = 5,476).

Kesimpulan: Pengetahuan ibu hamil trimester III berhubungan signifikan dengan kesiapan pelaksanaan IMD.

Saran: UPTD Puskesmas Kalianda disarankan meningkatkan konseling IMD pada kelas ibu hamil, mengoptimalkan media edukasi, serta melibatkan suami dan keluarga dalam persiapan persalinan.

Kata kunci: Pengetahuan, Ibu Hamil Trimester III, Kesiapan, Inisiasi Menyusu Dini (IMD)

ABSTRACT

Background: Early Initiation of Breastfeeding (EIBF) is an important strategy to reduce neonatal mortality, improve exclusive breastfeeding success, and prevent stunting. Global EIBF coverage in 2025 reached only 48%, while coverage in the working area of Kalianda Public Health Center was 61.8%. A preliminary study on 10 pregnant women showed that 80% of primigravida mothers did not fully understand EIBF and 40% were unprepared to perform it after delivery.

Objective: To determine the relationship between third-trimester pregnant women's knowledge and readiness for EIBF implementation in the working area of Kalianda Public Health Center, South Lampung Regency.

Methods: This quantitative study used a cross-sectional design. The population comprised 46 third-trimester pregnant women in the working area of Kalianda Public Health Center, with a sample of 46 respondents selected through total sampling. Data were collected using a knowledge questionnaire and an EIBF readiness instrument, then analyzed using univariate and bivariate analysis with the Chi-Square test.

Results: Most respondents (65.2%; n=30) had good knowledge of EIBF, and 63.0% (n=29) were ready to implement EIBF. A significant relationship was found between knowledge and readiness for EIBF implementation (p-value = 0.021; OR = 5.476).

Conclusion: Knowledge among third-trimester pregnant women is significantly related to readiness for EIBF implementation.

Suggestions: Kalianda Public Health Center is recommended to strengthen EIBF counseling in maternal classes, optimize educational media, and involve husbands and families in birth preparation.

Keywords: Knowledge, Third-Trimester Pregnant Women, Readiness, Early Initiation of Breastfeeding (EIBF)

INTRODUCTION

Early Initiation of Breastfeeding (EIBF) is a crucial first step in the life of a newborn, namely the process of self-initiated breastfeeding immediately after birth through skin-to-skin contact with the mother for at least the first hour.

Global data show that EIBF coverage remains low, at approximately 46% in 2023 and increasing to 48% in 2025, meaning that more than half of newborns worldwide do not receive breast milk during the first hour of life.² In Indonesia, national EIBF coverage in 2025 reached 92.52%,³ with coverage in Lampung Province at 91.6% and South Lampung Regency at 85.7%.⁴ However, EIBF coverage in the working area of UPTD Puskesmas Kalianda has only reached 61.8%, which remains below the district and provincial coverage and indicates that EIBF implementation in this area still requires attention.^{4,5}

The low coverage of EIBF may be related to inadequate preparation of mothers during pregnancy. Preparation for EIBF includes understanding the definition, benefits, timing, procedures, and the importance of immediate skin-to-skin contact after birth. Mothers who lack adequate knowledge may be less prepared to participate actively in EIBF implementation and may not understand the importance of requesting or maintaining skin-to-skin contact immediately after delivery. In addition, previous childbirth experiences do not always guarantee adequate readiness for EIBF, particularly when mothers have experienced delivery interventions such as cesarean section or have not previously received appropriate information about EIBF.

Inadequate preparation and unsuccessful implementation of EIBF may have consequences for the continuation of breastfeeding and the health of newborns. Failure to initiate breastfeeding early may reduce opportunities for early breastfeeding establishment and may interfere with the optimal initiation of exclusive breastfeeding.⁶ Furthermore, delayed skin-to-skin contact and breastfeeding initiation may reduce the opportunity for newborns to receive colostrum early, while successful EIBF provides benefits related to breastfeeding initiation, maternal-newborn bonding, and newborn adaptation.⁶ Therefore, maternal readiness before delivery is an important aspect that needs to be prepared during pregnancy.

Various factors may influence maternal readiness to implement EIBF, including predisposing factors such as knowledge and attitudes, enabling factors such as health facilities and antenatal education, and reinforcing factors such as support from husbands, families, and health workers. Among these factors, knowledge is an important fundamental factor because it provides the basis for understanding the benefits and procedures of EIBF and can contribute to the formation of positive attitudes and behavioral readiness. Mothers with adequate knowledge are more likely to understand the importance of EIBF and prepare themselves for its implementation than mothers with inadequate knowledge.⁷

The third trimester of pregnancy is an important period for providing education about EIBF because mothers are increasingly focused on preparation for childbirth and infant care. At this stage, providing information regarding the benefits, procedures, and preparation for EIBF can help mothers develop better readiness before delivery.⁸ However, the condition in the working area of UPTD Puskesmas Kalianda indicates that adequate preparation has not been achieved by all pregnant women. A preliminary study conducted among 10 pregnant women in the working area of UPTD Puskesmas Kalianda showed that 80% of primigravida mothers did not fully understand the concept of EIBF and 40% of mothers stated that they were not ready to implement EIBF after delivery. In addition, some multigravida mothers who had previously undergone cesarean section also reported not having experienced immediate skin-to-skin contact after birth. These findings indicate that previous childbirth experience alone does not necessarily ensure adequate knowledge and readiness for EIBF.

The gap identified in this study is the discrepancy between the expected preparation of pregnant women for EIBF and the actual condition found in the working area of UPTD Puskesmas Kalianda. Although EIBF coverage at the national, provincial, and district levels is relatively high, the coverage in the Kalianda Public

Health Center working area remains substantially lower. At the same time, the preliminary findings demonstrate that some third-trimester pregnant women have limited knowledge and are not yet ready to implement EIBF. This indicates that the problem is not only related to whether EIBF is implemented after delivery, but also to whether mothers have sufficient knowledge and preparation before childbirth. However, the relationship between third-trimester pregnant women's knowledge and their readiness to implement EIBF in the working area of UPTD Puskesmas Kalianda has not been specifically described. Therefore, scientific evidence is needed to determine whether maternal knowledge is associated with readiness for EIBF implementation.

This study aimed to determine the relationship between third-trimester pregnant women's knowledge and readiness for Early Initiation of Breastfeeding (EIBF) implementation in the working area of UPTD Puskesmas Kalianda, South Lampung Regency. The findings are expected to provide evidence that can support UPTD Puskesmas Kalianda in developing more targeted antenatal education and preparation programs to improve maternal readiness for EIBF.

RESEARCH METHODS

This study was a quantitative study with an analytical cross-sectional design, in which the independent and dependent variables were measured at the same time.⁹ The study was conducted in the working area of UPTD Puskesmas Kalianda, South Lampung Regency. The research was conducted from February to July 2026, covering the preparation stage, instrument preparation and testing, data collection, data processing and analysis, and report preparation. The preparation stage was carried out from February to April 2026, while data collection was conducted in May–June 2026, followed by data processing, analysis, and report preparation in July 2026.

The study population consisted of all third-trimester pregnant women in the working area of UPTD Puskesmas Kalianda based on the delivery pocket data for May–June 2026, totaling 46 women.¹⁰ The sample was selected using total sampling, so the entire population became the study sample ($n=46$).⁹

The independent variable in this study was the knowledge of third-trimester pregnant women about EIBF, while the dependent variable was readiness for EIBF implementation.¹¹ Data were collected using a knowledge questionnaire and an EIBF implementation readiness questionnaire that had been tested for validity and reliability among 30 respondents at Puskesmas Wayurang with similar characteristics. The validity test used Product Moment correlation ($r_{\text{table}} = 0.361$; $\alpha = 5\%$), showing that all items of the knowledge instrument (30 items; $r = 0.401\text{--}0.978$) and readiness instrument (25 items; $r = 0.372\text{--}0.931$) were valid. The Cronbach's Alpha reliability test showed that the knowledge instrument ($\alpha = 0.967$) and readiness instrument ($\alpha = 0.959$) were highly reliable.

Data analysis was performed univariately to describe the frequency distribution of each variable, while bivariate analysis using the Chi-Square test was conducted to examine the relationship between third-trimester pregnant women's knowledge and readiness for EIBF implementation, with a significance level (α) of 0.05.¹²

Ethics and Participant Protection

This study obtained ethical clearance from the Health Research Ethics Committee of Universitas Malahayati, Number 5355/EC/KEP-UNMAL/V/2026. Written informed consent was obtained from all respondents who agreed to participate in this study.

RESEARCH RESULTS

Respondent Characteristics

Table 1. Respondent Characteristics ($n=46$)

Characteristics	n	%
Age		
20–35 years	40	87.0
>35 years	6	13.0
Education		
Elementary School Education	2	4.3
Junior High School Education	12	26.1
Senior High School Education	25	54.3
Higher Education	7	15.2
Occupation		
Housewife	33	71.7

Employed (Teacher/Honorary/Civil Servant/Entrepreneur)	13	28.3
Parity		
Primigravida	13	28.3
Multigravida	33	71.7

Table 1 shows that the majority of respondents were aged 20–35 years, with 40 respondents (87.0%). Regarding education, most respondents had a senior high school education, accounting for 25 respondents (54.3%). Most respondents were housewives (33 respondents; 71.7%), while 13 respondents (28.3%) were employed. Based on parity, the majority of respondents were multigravida, with 33 respondents (71.7%), while 13 respondents (28.3%) were primigravida.

Univariate Analysis

Table 2. Frequency Distribution of Knowledge of Third-Trimester Pregnant Women about EIBF

Knowledge	n	%
Poor	16	34,8
Good	30	65,2

Table 3. Frequency Distribution of Readiness for EIBF Implementation

Readiness for EIBF Implementation	n	%
Not Ready	17	37,0
Ready	29	63,0

Of the 46 respondents, 30 respondents (65.2%) had good knowledge and 16 respondents (34.8%) had poor knowledge about EIBF. A total of 29 respondents (63.0%) were categorized as ready to implement EIBF, while 17 respondents (37.0%) were not ready.

Bivariate Analysis

Table 4. Relationship between Knowledge of Third-Trimester Pregnant Women and Readiness for EIBF Implementation

Knowledge	Not Ready n	%	Ready n	%	p
Poor	10	62,5	6	37,5	
Good	7	23,3	23	76,7	0,021

Of the 16 respondents with poor knowledge, 10 respondents (62.5%) were not ready to implement EIBF and 6 respondents (37.5%) were ready to implement EIBF. Of the 30 respondents with good knowledge, 7 respondents (23.3%) were not ready and 23 respondents (76.7%) were ready to implement EIBF. The Chi-Square test resulted in a p-value of 0.021 ($p < \alpha = 0.05$), indicating a significant relationship between third-trimester pregnant women's knowledge and readiness for EIBF implementation in the working area of UPTD Puskesmas Kalianda. The Odds Ratio (OR) of 5.476 indicates that mothers with poor knowledge had a 5.476 times greater risk of being unready to implement EIBF compared with mothers with good knowledge.

DISCUSSION

The majority of third-trimester pregnant women in the working area of UPTD Puskesmas Kalianda had good knowledge of EIBF, particularly regarding its definition, benefits, objectives, timing, and implementation procedures. This level of knowledge may have been supported by the respondents' characteristics and their exposure to health information. Sources of information obtained from health workers, maternal classes, social media, maternal and child health books (KIA), and previous pregnancy experiences may contribute to mothers' understanding of EIBF. According to Notoatmodjo, knowledge is the result of a person's sensory process toward

an object that produces understanding; adequate knowledge facilitates an individual's ability to receive, understand, and apply new information in daily life.¹⁰

The characteristics of the respondents provide additional context for interpreting these findings. Most respondents were in the healthy reproductive age group of 20–35 years. Mothers in this age range are generally in a period of reproductive maturity and are more likely to be actively involved in preparing for pregnancy, childbirth, and newborn care. Age may also be related to the ability to receive and process health information, although age alone does not determine a mother's level of knowledge. In addition, most respondents had an educational background ranging from senior high school to higher education. Education may facilitate the ability to understand information regarding EIBF, including its benefits, timing, and procedures. However, educational level should not be interpreted as the sole determinant of knowledge because access to information, interest in seeking information, and the quality of health education received may also influence maternal understanding.

Parity and previous pregnancy experience also provide important context. Multigravida mothers may have greater opportunities to obtain information and experience related to childbirth, breastfeeding, and newborn care. Previous interactions with health workers during antenatal care and childbirth may provide additional exposure to information about breastfeeding practices. However, previous childbirth experience does not automatically mean that mothers have adequate knowledge of EIBF. This is illustrated by the preliminary findings and the presence of respondents who still had poor knowledge despite having previous pregnancy or childbirth experience. Therefore, EIBF education should be provided consistently to both primigravida and multigravida mothers rather than relying solely on previous experience.

Despite the relatively high proportion of respondents with good knowledge, 34.8% of respondents still had poor knowledge. This finding indicates that the availability of information does not necessarily ensure that all pregnant women understand EIBF adequately. Limited participation in maternal classes, inadequate utilization of KIA books, differences in access to information, and limited interaction with health workers may contribute to this condition. Therefore, antenatal education during the third trimester needs to be provided repeatedly using information that is easy to understand and focused on practical aspects of EIBF, including the importance of immediate skin-to-skin contact, timing of breastfeeding initiation, and the mother's role in requesting and supporting EIBF implementation.

Regarding readiness, 63.0% of respondents were categorized as ready to implement EIBF after delivery. This finding indicates that most third-trimester pregnant women had prepared themselves to participate in EIBF implementation. Maternal readiness may be influenced by several interconnected factors, including knowledge, attitudes, previous experiences, psychological preparation, family support, and support from health workers. Respondents in the healthy reproductive age group and those with previous pregnancy experience may have had greater exposure to childbirth and infant care information, which could contribute to their preparation for EIBF. Nevertheless, these characteristics should be interpreted as contextual factors rather than direct determinants of readiness.

The educational background of respondents may also provide context for the readiness findings. Mothers with higher educational exposure may have greater opportunities to access and understand health information, including information about EIBF. However, readiness is a behavioral and psychological condition that cannot be explained by education alone. A mother may have sufficient knowledge but still feel anxious about childbirth, lack support from her husband or family, or have concerns about the implementation of EIBF. Thus, the finding that 37.0% of respondents were not ready indicates that increasing knowledge needs to be accompanied by psychological preparation, counseling, and family involvement.

These findings are consistent with previous studies emphasizing that maternal knowledge is an important predisposing factor in the formation of attitudes and readiness for health behaviors, including EIBF implementation.^{16,18} Knowledge regarding the benefits of skin-to-skin contact, the appropriate timing of EIBF, and its implementation procedures can increase maternal awareness and confidence in preparing for breastfeeding immediately after delivery. Conversely, inadequate knowledge may result in misconceptions, such as concerns that skin-to-skin contact may cause the newborn to become cold or the belief that breastfeeding can be delayed without affecting the newborn. Such perceptions may reduce maternal motivation to prepare for EIBF.

The relationship between knowledge and readiness in this study, however, was not absolute. Six respondents with poor knowledge were still categorized as ready to implement EIBF, while seven respondents with good knowledge were categorized as not ready. This finding demonstrates that maternal readiness is a multidimensional condition and cannot be explained by knowledge alone. Support from husbands and families, previous childbirth experiences, psychological conditions approaching delivery, interactions with health workers, and the mother's confidence may contribute to readiness. In addition, certain delivery procedures, including

cesarean section, may affect the implementation of EIBF because the immediate skin-to-skin process can be influenced by maternal and newborn conditions as well as clinical procedures.¹⁷ Therefore, efforts to improve EIBF readiness should not focus solely on transferring knowledge but should also include counseling, birth preparation, family involvement, and coordination between mothers and health workers.

The characteristics of the respondents also need to be considered when interpreting the relationship between knowledge and readiness. Although most respondents were aged 20–35 years, had senior high school to higher education, and included mothers with previous pregnancy experience, variations in these characteristics may contribute to differences in how mothers receive information and prepare for EIBF. The presence of respondents with poor knowledge and respondents who were not ready despite having good knowledge suggests that maternal characteristics and contextual factors interact in shaping EIBF readiness. Therefore, antenatal education should be tailored to the individual needs of pregnant women, considering their educational background, parity, previous childbirth experience, access to information, and psychological preparation.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, the analytical cross-sectional design measured knowledge and readiness at the same period, so the observed relationship cannot be interpreted as a causal relationship. Second, the study was conducted in only one working area of a public health center with a relatively small sample size of 46 respondents. Therefore, the findings may not be directly generalized to pregnant women in other health center areas or populations with different characteristics.

Third, this study focused primarily on the relationship between maternal knowledge and readiness for EIBF implementation and did not analyze other factors that may influence readiness in greater depth. These factors include husband and family support, previous childbirth experience, anxiety or psychological preparation before delivery, and support from health workers. In addition, clinical factors during delivery, such as delivery method and maternal or newborn condition, may influence the actual implementation of EIBF but were not analyzed as independent factors in this study. Future studies could involve a larger sample and consider these additional factors to provide a more comprehensive understanding of the determinants of maternal readiness and EIBF implementation.

CONCLUSION

Most third-trimester pregnant women in the working area of UPTD Puskesmas Kalianda had good knowledge about EIBF (65.2%) and were categorized as ready to implement EIBF (63.0%). The results also showed a significant relationship between third-trimester pregnant women's knowledge and readiness to implement EIBF (p -value = 0.021). These findings indicate that third-trimester pregnant women's knowledge about EIBF is significantly related to their readiness to implement EIBF.

RECOMMENDATIONS

UPTD Puskesmas Kalianda is recommended to increase EIBF counseling in maternal classes, optimize educational media, and involve husbands and families in childbirth preparation to improve readiness for EIBF implementation.

DECLARATIONS

Ethics Approval and Informed Consent

Ethical approval for this study was obtained from the Health Research Ethics Committee of Universitas Malahayati, Number 5355/EC/KEP-UNMAL/V/2026. Written informed consent was obtained from all respondents who participated in this study.

Author Contribution

Desliana contributed to the conceptualization of the study, development of the research methodology, preparation of the research instruments, data collection, data analysis, and preparation of the manuscript.

Suharman contributed to the supervision of the research process, review of the research methodology, interpretation of the findings, and critical revision of the manuscript.

Neneng Siti Lathifah contributed to research supervision, review and validation of the manuscript, provision of academic input, and final approval of the manuscript.

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Conflict of Interest

The authors declare that there is no conflict of interest in this study.

Artificial Intelligence Declaration

The authors declare that artificial intelligence (AI), including generative AI, was not used in the preparation of this manuscript.

Data Availability Statement

Data supporting the findings of this study are available from the corresponding author upon reasonable request, subject to applicable ethical, privacy, and confidentiality requirements.

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