ASSOCIATION BETWEEN FAMILY SUPPORT AND EXCLUSIVE BREASTFEEDING PRACTICE AMONG MOTHERS OF INFANTS AGED 0-6 MONTHS IN BEKASI CITY

By
Marella[1], Helda[2], Ristina Rosauli Harianja[3]
[1]Diploma III Midwifery Study Program, Poltekkes Kemenkes Tanjungpinang, Indonesia
[2]Department of Epidemiology, Faculty of Public Health, Universitas Indonesia, Indonesia
[3]Undergraduate Public Health Study Program, Faculty of Public Health, Universitas Cenderawasih, Indonesia
Email: [1]marellaindra@gmail.com

Article History:
Received: 17-08-2025
Revised: 25-08-2025
Accepted: 20-09-2025

Keywords:
Breastfeeding Practice; Cross-Sectional Study; Exclusive Breastfeeding; Family Support; Maternal Health

Abstract: *Family support is an important reinforcing factor in the success of exclusive breastfeeding. Support from family members may include physical, emotional, psychological, instrumental, and informational assistance that helps mothers maintain breastfeeding during the first six months of an infant's life. This study aimed to examine the association between family support and exclusive breastfeeding practice among mothers of infants aged 0-6 months in the working area of Pengasinan Public Health Center, Bekasi City. This study used a cross-sectional design involving 194 mothers of infants aged 0-6 months who were registered at integrated health posts (Posyandu). Respondents were selected using simple random sampling and interviewed using a structured questionnaire. Data were analyzed using univariate analysis, chi-square tests, and multivariable analysis to assess the association between family support and exclusive breastfeeding practice after controlling for covariates. The results showed that 45.9% of mothers practiced exclusive breastfeeding, while 72.7% reported receiving good family support. Mothers who received good family support were more likely to practice exclusive breastfeeding than those who received inadequate family support. After adjustment for covariates, family support remained significantly associated with exclusive breastfeeding practice, with an adjusted prevalence ratio of 4.111 (95% CI: 1.994-8.476; p = 0.0001). The most frequently reported form of support was family encouragement for mothers to breastfeed their infants as early as possible. This study concludes that family support is significantly associated with*

exclusive breastfeeding practice among mothers of infants aged 0-6 months. Health care providers should actively involve family members in breastfeeding education and promotion programs to strengthen maternal support systems and improve exclusive breastfeeding coverage.

INTRODUCTION

Exclusive breastfeeding for the first six months of life is considered the optimal feeding practice for infants because breast milk contains bioactive components that support maternal and child health (WHO, 2015). Early initiation of breastfeeding and continued exclusive breastfeeding have been associated with substantial benefits for child survival, including the prevention of an estimated 800,000 child deaths annually when breastfeeding recommendations are implemented appropriately (Black et al., 2013). Evidence also suggests that exclusive breastfeeding supports infant growth and development; infants who receive exclusive breastfeeding are more likely to achieve age-appropriate development and normal growth than infants who are not exclusively breastfed (Fitri et al., 2014).

In Indonesia, exclusive breastfeeding coverage remains below the expected national target. National data have shown fluctuating coverage over time, indicating that the achievement of optimal infant feeding practices remains a persistent public health challenge (Kementerian Kesehatan RI, 2012; Kementerian Kesehatan RI, 2016). Low exclusive breastfeeding coverage may affect child health, family welfare, and broader public health outcomes.

Several factors may influence whether a mother practices exclusive breastfeeding, including maternal age, education, employment status, parity, knowledge, attitudes, delivery method, early initiation of breastfeeding, rooming-in, support from health care providers, exposure to infant formula promotion, and family support (Syafiq & Fikawati, 2009). Among these factors, family support has been consistently identified as a key reinforcing factor because mothers often make infant feeding decisions within a family and household context. Family support refers to assistance provided by family members to motivate mothers to provide only breast milk during the first six months of life. Such support may include emotional encouragement, practical assistance, psychological reassurance, nutritional support for breastfeeding mothers, and access to information (Friedman, 1998; Simbolon, 2017). Husbands, parents, parents-in-law, and other family members may either facilitate or hinder exclusive breastfeeding depending on their knowledge, beliefs, and daily involvement in infant care.

Bekasi City is one of the urban areas in West Java where exclusive breastfeeding coverage has remained below the national target. Previous local health reports described low and fluctuating exclusive breastfeeding coverage in Bekasi City, and Pengasinan Public Health Center was identified as one of the public health centers with relatively higher exclusive breastfeeding coverage although the figure remained below the national target (Dinas Kesehatan Provinsi Jawa Barat, 2012). Therefore, this study aimed to examine the association between family support and exclusive breastfeeding practice among mothers of infants aged 0-6 months in the working area of Pengasinan Public Health Center, Bekasi City.

ISSN 2798-3471 (Cetak)
ISSN 2798-3641 (Online)

LITERATURE REVIEW

Breast milk is a natural source of nutrition produced by the mammary glands and is considered the primary food for infants (Soetjiningsih, 1997). The World Health Organization describes breast milk as the first natural food for infants because it provides the energy and nutrients required during the first months of life and continues to contribute to child nutrition during the second year of life (WHO, 2014).

Exclusive breastfeeding is defined as providing only breast milk to infants for the first six months without any additional food or drink, including water, except for medicines, vitamins, minerals, drops, or syrups when medically indicated (WHO, 2014). In the Indonesian context, exclusive breastfeeding is commonly defined as giving only breast milk for six months without additional fluids or foods such as formula milk, honey, tea, water, bananas, biscuits, porridge, or other complementary foods (Kristiyansari, 2011).

The recommendation to provide exclusive breastfeeding for six months is supported by scientific evidence on infant survival, growth, and development. Exclusive breastfeeding protects infants from inappropriate early complementary feeding and potential exposure to unhygienic foods or fluids, which may increase the risk of illness during infancy (Yuliarti, 2010).

Exclusive breastfeeding is a form of health behavior. Human behavior is shaped by predisposing, enabling, and reinforcing factors, including knowledge, attitudes, beliefs, access to health services, and social support (Notoatmodjo, 2003; Syafiq & Fikawati, 2009). In breastfeeding, family support functions as a reinforcing factor that may strengthen a mother's motivation and capacity to maintain exclusive breastfeeding.

Family support reflects the attitudes, actions, and acceptance of family members toward an individual. Supportive family members are perceived as being available to provide assistance when needed (Friedman, 1998). In the context of breastfeeding, support may include instrumental assistance, emotional reassurance, informational guidance, and practical help with maternal nutrition, household tasks, and infant care (Simbolon, 2017).

Previous studies have reported a significant association between family support and exclusive breastfeeding. Mothers who receive strong family support are more likely to practice exclusive breastfeeding than those with inadequate support (Ida, 2012; Najah, 2017; Ratnasari et al., 2017). These findings indicate that breastfeeding promotion should not focus solely on mothers but should also engage husbands and other influential family members.

METHODS

This study used a cross-sectional design to examine the association between family support and exclusive breastfeeding practice after controlling for selected covariates. The study population consisted of 587 breastfeeding mothers who had infants aged 0-6 months in the working area of Pengasinan Public Health Center, Bekasi City.

The minimum sample size was calculated using three stages: a two-proportion hypothesis test, single population estimation, and extrapolation. Based on these calculations, 194 respondents were included in the study. Respondents were selected using simple random sampling with the assistance of an online randomization application.

Data were collected using a structured questionnaire. The exclusive breastfeeding variable was measured based on the definition and measurement approach for infant and young child

feeding indicators (WHO, 2010). Maternal attitude was measured using the Iowa Infant Feeding Attitude Scale (IIFAS) (Inoue et al., 2013). Maternal knowledge was assessed using the Infant Feeding Test Form-A (Grossman et al., 1990, as cited in Alonzo, 2016). Health worker support was assessed using the Baby-Friendly Hospital Initiative monitoring tools (WHO, 2009).

Data collection was conducted over nine days, from 24 May to 1 June 2018. Interviews were conducted at Posyandu with assistance from community health post supervisors and cadres. When selected respondents were not available at the Posyandu, the researcher and enumerators conducted home visits. Before each interview, mothers received information about the study and signed an informed consent form if they agreed to participate. Each interview lasted approximately 10 minutes. All selected respondents agreed to participate, and 194 questionnaires were included in the analysis.

Data analysis was conducted in three stages. Univariate analysis was used to describe family support, exclusive breastfeeding practice, and covariates. Bivariate analysis using the chi-square test was conducted to examine the association between family support and exclusive breastfeeding practice, as well as the association between covariates and exclusive breastfeeding practice. Multivariable analysis was then performed to assess the association between family support and exclusive breastfeeding practice after controlling for maternal age, education, employment status, parity, knowledge, attitude, delivery method, birth attendant, and health worker support.

RESULTS AND DISCUSSION

Table 1 presents the distribution of exclusive breastfeeding practice among mothers in the working area of Pengasinan Public Health Center, Bekasi City.

Table 1. Distribution of Exclusive Breastfeeding Practice among Mothers

Breastfeeding practice	n	%
Exclusive breastfeeding	89	45.9
Non-exclusive breastfeeding	105	54.1
Total	194	100.0

Of the 194 mothers interviewed, 89 mothers (45.9%) practiced exclusive breastfeeding, while 105 mothers (54.1%) did not. These findings indicate that the majority of mothers in the study area had not practiced exclusive breastfeeding during the first six months of their infant's life.

Table 2 shows the distribution of family support related to exclusive breastfeeding.

Table 2. Distribution of Family Support Related to Exclusive Breastfeeding

Family support	n	%
Good	141	72.7
Inadequate	53	27.3
Total	194	100.0

Most respondents reported receiving good family support for exclusive breastfeeding. Among 194 mothers, 141 mothers (72.7%) received good family support, while 53 mothers (27.3%) received inadequate family support.

Table 3 presents the association between family support and exclusive breastfeeding practice.

ISSN 2798-3471 (Cetak)
ISSN 2798-3641 (Online)

Table 3. Association between Family Support and Exclusive Breastfeeding Practice

Family support	Exclusive breastfeeding n (%)	Non-exclusive breastfeeding n (%)	Total n (%)	PR (95% CI)	p-value
Good	77 (54.6)	64 (45.4)	141 (100.0)	4.111 (1.994-8.476)	0.0001
Inadequate	12 (22.6)	41 (77.4)	53 (100.0)	Reference	

Mothers who received good family support were more likely to practice exclusive breastfeeding. Among mothers with good family support, 54.6% practiced exclusive breastfeeding, compared with 22.6% among mothers with inadequate family support. The association was statistically significant (p = 0.0001), and the confidence interval did not include 1. Mothers with good family support had a 4.111 times higher prevalence of exclusive breastfeeding practice than mothers with inadequate family support (95% CI: 1.994-8.476). Table 4 shows the association between selected covariates and exclusive breastfeeding practice.

Table 4. Association between Covariates and Exclusive Breastfeeding Practice

Covariate	Category	Exclusive breastfeeding n (%)	Non-exclusive breastfeeding n (%)	PR (95% CI)	p-value
Maternal age	20-35 years	79 (48.2)	85 (51.8)	1.859 (0.820-4.214)	0.194
	<20 and >35 years	10 (33.3)	20 (66.7)	Reference	
Maternal education	High	71 (47.7)	78 (52.3)	1.365 (0.693-2.688)	0.464
	Low	18 (40.0)	27 (60.0)	Reference	
Maternal employment	Not employed	71 (44.7)	88 (55.3)	0.762 (0.366-1.586)	0.589
	Employed	18 (51.4)	17 (48.6)	Reference	
Parity	>1 birth	59 (46.5)	68 (53.5)	1.070 (0.590-1.939)	0.943
	1 birth	30 (44.8)	37 (55.2)	Reference	
Maternal knowledge	Good	58 (48.7)	61 (51.3)	1.350 (0.753-2.419)	0.390
	Inadequate	31 (41.3)	44 (58.7)	Reference	
Maternal attitude	Positive	80 (46.2)	93 (53.8)	1.147 (0.460-2.862)	0.950
	Negative	9 (42.9)	12 (57.1)	Reference	
Delivery method	Vaginal delivery	73 (48.7)	77 (51.3)	1.659 (0.830-3.317)	0.205
	Caesarean section	16 (36.4)	28 (63.6)	Reference	
Birth attendant	Health worker	89 (46.1)	104 (53.9)	-	1.000
	Non-health worker	0 (0.0)	1 (100.0)	-	
Health worker support	Good	43 (58.1)	31 (41.9)	2.231 (1.236-4.027)	0.011
	Inadequate	46 (38.3)	74 (61.7)	Reference	

Based on bivariate analysis, health worker support was the only covariate significantly associated with exclusive breastfeeding practice (p = 0.011; PR = 2.231; 95% CI: 1.236-4.027). Mothers who received good support from health workers had a 2.231 times higher prevalence of exclusive breastfeeding practice compared with mothers who received inadequate support from health workers.

Table 5 presents the final multivariable model for the association between family support and exclusive breastfeeding practice.

Table 5. Final Multivariable Model

Variable	p-value	Adjusted PR	95% CI
Family support	0.0001	4.111	1.994-8.476

The final multivariable model showed that family support remained significantly associated with exclusive breastfeeding practice after controlling for covariates. Mothers who received good family support had a 4.111 times higher prevalence of exclusive breastfeeding practice than mothers who received inadequate family support (95% CI: 1.994-8.476; p = 0.0001).

Discussion

The proportion of mothers who practiced exclusive breastfeeding in the working area of Pengasinan Public Health Center was 45.9%. This finding indicates that exclusive breastfeeding coverage in the study area had not yet reached the expected national target. Although the proportion observed in this study was higher than the coverage reported in earlier local health center records, more than half of the mothers still did not practice exclusive breastfeeding. One possible explanation is misunderstanding regarding the definition of exclusive breastfeeding. Some mothers perceived themselves as practicing exclusive breastfeeding even though they had given water to their infants. This indicates that breastfeeding education should emphasize that exclusive breastfeeding excludes all foods and fluids other than breast milk, except medically indicated supplements or medicines (WHO, 2014).

Most mothers in this study received good family support. Forms of family support included encouraging mothers to breastfeed as early as possible, helping reduce maternal fatigue during infant care and breastfeeding, providing or recommending nutritious foods for breastfeeding mothers, and assisting mothers with breastfeeding positioning. These findings are consistent with previous studies reporting that many breastfeeding mothers receive instrumental and practical support from their families (Nurlinawati, 2014; Wijayanti, 2015; Najah, 2017).

The main finding of this study showed that family support was significantly associated with exclusive breastfeeding practice. Mothers who received good family support had a 4.111 times higher prevalence of exclusive breastfeeding practice than mothers who received inadequate family support. This result is consistent with Ida (2012), who reported that mothers with good family support had a higher likelihood of practicing exclusive breastfeeding. It is also in line with Ratnasari et al. (2017), who found that family support was associated with exclusive breastfeeding among employed mothers in Yogyakarta.

Family support may strengthen maternal confidence, reduce psychological stress, facilitate rest and recovery, and help mothers overcome practical barriers to breastfeeding. According to Friedman (1998), family support is an integral component of social support and may improve an individual's ability to adapt to life events. In the breastfeeding context, family support can stabilize maternal emotions and increase motivation to breastfeed (Simbolon, 2017).

The most frequently reported form of support was encouragement from family members for mothers to breastfeed their infants as soon as possible. This type of

ISSN 2798-3471 (Cetak)
ISSN 2798-3641 (Online)

encouragement may influence early breastfeeding behavior and reinforce the mother's decision to continue breastfeeding. Family members can act as informal advisors and decision-making partners, particularly in the early postpartum period when mothers may feel physically tired and emotionally vulnerable (Simbolon, 2017).

In contrast, informational support from family members was relatively low. Only a small proportion of families had searched for information or discussed infant food and drink with mothers. This finding suggests that many families may be willing to provide emotional or practical support but may lack sufficient knowledge regarding appropriate infant feeding. Therefore, breastfeeding promotion programs should include family-oriented education, not only mother-focused counseling. Health workers should actively invite husbands and other family members to participate in counseling sessions, antenatal classes, and community-based breastfeeding education.

This study also found that health worker support was significantly associated with exclusive breastfeeding practice in bivariate analysis. Mothers who received good support from health workers were more likely to practice exclusive breastfeeding than those who received inadequate support. This finding highlights the importance of coordinated support from both family and health care providers. Health workers play a crucial role in correcting misconceptions, strengthening family knowledge, and encouraging families to create a supportive environment for breastfeeding mothers (WHO & UNICEF, 2014).

Although this study provides important evidence regarding the role of family support in exclusive breastfeeding, several limitations should be considered. The cross-sectional design does not allow causal inference, and the information collected relied on maternal recall and self-report. Nevertheless, the findings indicate a strong and statistically significant association between family support and exclusive breastfeeding practice, suggesting that family involvement should be strengthened in breastfeeding promotion strategies.

CONCLUSION

The proportion of mothers who practiced exclusive breastfeeding among infants aged 0-6 months in the working area of Pengasinan Public Health Center, Bekasi City, was 45.9%. Most mothers received good family support for exclusive breastfeeding. Family support was significantly associated with exclusive breastfeeding practice after controlling for covariates. Mothers who received good family support had a 4.111 times higher prevalence of exclusive breastfeeding practice compared with mothers who received inadequate family support. Health worker support was also significantly associated with exclusive breastfeeding practice in bivariate analysis.

Recommendations

Public health authorities and health care providers should strengthen promotive and educational activities related to exclusive breastfeeding by actively involving family members. Breastfeeding education should not only target mothers but also husbands, parents, parents-in-law, and other influential family members. Health workers should emphasize the correct definition of exclusive breastfeeding, the importance of avoiding early introduction of water or other fluids, and the practical ways in which families can support breastfeeding mothers.

Health facilities and public institutions should also improve supportive environments for breastfeeding mothers, including providing breastfeeding-friendly spaces and encouraging workplace policies that support continued breastfeeding. Community members are encouraged to seek accurate information on exclusive breastfeeding and to participate actively in supporting mothers to breastfeed exclusively during the first six months of life.

REFERENCES

[1] Abbas, P., & Haryati, A. S. (2012). Hubungan pemberian ASI eksklusif dengan kejadian infeksi saluran pernapasan akut (ISPA) pada bayi. Fakultas Kedokteran Universitas Islam Sultan Agung.
[2] Abdullah, G. I. (2012). Determinan pemberian ASI eksklusif pada ibu bekerja di Kementerian Kesehatan RI tahun 2012. Universitas Indonesia.
[3] Alonzo, A. (2016). Infant feeding knowledge and breastfeeding-related measurement instruments. [Reference details to be completed by author].
[4] Astono, S. P. (2016). Analisis data pada bidang kesehatan. PT RajaGrafindo Persada.
[5] Black, R. E., et al. (2013). Maternal and child undernutrition and overweight in low-income and middle-income countries. The Lancet, 382, 427-451.
[6] Budiman. (2011). Penelitian kesehatan. PT Refika Aditama.
[7] Cai, X. (2012). Global trends in exclusive breastfeeding. International Breastfeeding Journal, 7, 12.
[8] Cai, X., Wardlaw, T., & Brown, D. W. (2012). Global trends in exclusive breastfeeding. International Breastfeeding Journal, 7, 12.
[9] Dahlan, M. S. (2009). Besar sampel dan cara pengambilan sampel dalam penelitian kedokteran dan kesehatan. Salemba Medika.
[10] Departemen Kesehatan RI. (2003). Ibu bekerja tetap memberikan air susu ibu (ASI). Direktorat Jenderal Bina Kesehatan Masyarakat, Direktorat Gizi Masyarakat.
[11] Departemen Kesehatan RI. (2006). Petunjuk praktis bagi kader dalam mendampingi ibu menyusui. Direktorat Jenderal Kesehatan Masyarakat, Direktorat Gizi Masyarakat, UNICEF.
[12] Dinas Kesehatan Provinsi Jawa Barat. (2012). Profil kesehatan Provinsi Jawa Barat tahun 2012. Dinas Kesehatan Provinsi Jawa Barat.
[13] Dixon, M., & Khan, L. (2011). Treatment of breast infection. BMJ, 342.
[14] Fahriani, R. (2013). Faktor yang memengaruhi pemberian ASI eksklusif pada bayi cukup bulan yang dilakukan IMD di salah satu rumah sakit sayang bayi di Jakarta. Universitas Indonesia.
[15] Fitri, D. I., Chundrayetti, E., & Semiarti, R. (2014). Hubungan pemberian ASI dengan tumbuh kembang bayi umur 6 bulan di Puskesmas Nanggalo. Jurnal Kesehatan Andalas, 3, 134-138.
[16] Friedman. (1998). Keperawatan keluarga: Teori dan praktik (Edisi 3). EGC.
[17] Friedman. (2010). Keperawatan keluarga: Teori dan praktik. Prentice Hall.
[18] Green, L. W., Krekreuter, M. W., Sigrid, G. D., & Patridge, K. B. (1980). Perencanaan pendidikan kesehatan: Sebuah pendekatan diagnostik. Proyek Pengembangan Fakultas Kesehatan Masyarakat, Departemen Pendidikan dan Kebudayaan RI.
[19] Grossman, L. K., et al. (1990). Infant Feeding Test Form-A. [Reference details to be

ISSN 2798-3471 (Cetak)
ISSN 2798-3641 (Online)

completed by author].
[20] Hidayat, A. A. (2007). Metode penelitian kebidanan dan teknik analisis data. Salemba Medika.
[21] Ida. (2012). Faktor-faktor yang berhubungan dengan pemberian ASI eksklusif 6 bulan di wilayah kerja Puskesmas Kemiri Muka Kota Depok. Universitas Indonesia.
[22] Inoue, M., Binns, C. W., Katsuki, Y., & Ouchi, M. (2013). Japanese mothers' breastfeeding knowledge and attitudes assessed by the Iowa Infant Feeding Attitudes Scale. Asia Pacific Journal of Clinical Nutrition, 22(2), 261-265.
[23] Kementerian Kesehatan RI. (2012). Situasi dan analisis ASI eksklusif. Kementerian Kesehatan RI.
[24] Kementerian Kesehatan RI. (2016). Profil kesehatan Indonesia tahun 2016. Kementerian Kesehatan RI.
[25] Kramer, M. (2001). Promotion of Breastfeeding Intervention Trial (PROBIT): A randomized trial in the Republic of Belarus. Journal of the American Medical Association, 285, 413-420.
[26] Kristiyansari, W. (2011). ASI, menyusui, dan SADARI. Mulya Medika.
[27] Najah. (2017). Hubungan dukungan keluarga dengan perilaku menyusui eksklusif pada ibu di Posyandu Kecamatan Mampang tahun 2017. Universitas Indonesia.
[28] Notoatmodjo, S. (2003). Pendidikan dan perilaku kesehatan. Rineka Cipta.
[29] Notoatmodjo, S. (2010). Metodologi penelitian kesehatan. Rineka Cipta.
[30] Nurlinawati. (2014). Hubungan dukungan keluarga dengan pemberian ASI eksklusif pada bayi di Kelurahan Kenali Besar Kota Jambi. Universitas Indonesia.
[31] Qiu, L. (2009). Initiation of breastfeeding and prevalence of exclusive breastfeeding at hospital discharge in urban, suburban and rural areas of Zhejiang, China. International Breastfeeding Journal, 4, 1-7.
[32] Ratnasari, D., Pramashanti, B. A., Haman, H., Yugistyowati, A., Astiti, D., & Nurhayati, E. (2017). Family support and exclusive breastfeeding among Yogyakarta mothers in employment. Asia Pacific Journal of Clinical Nutrition, 26(Suppl. 1), S31-S35.
[33] Sastroasmoro, S., & Ismail, S. (2008). Dasar-dasar metodologi penelitian klinis (Edisi 3). Sagung Seto.
[34] Setiadi. (2008). Konsep dan proses keperawatan keluarga. Pustaka Pelajar.
[35] Simbolon, P. (2017). Dukungan keluarga dalam pemberian ASI eksklusif. Deepublish.
[36] Soetjiningsih. (1997). ASI: Petunjuk untuk tenaga kesehatan. EGC.
[37] Soysa, P., et al. (1981). Menyusui dan kesehatan. Departemen Kesehatan, Direktorat Bina Gizi Masyarakat, UNICEF, dan Perdhaki.
[38] Syafiq, A., & Fikawati, S. (2009). Penyebab keberhasilan dan kegagalan praktik pemberian ASI eksklusif. Jurnal Kesehatan Masyarakat Nasional, 4(3), 236-239.
[39] Varney, H. Buku ajar asuhan kebidanan. EGC.
[40] VT, R. N. (2011). Efektivitas paket “Bunda Ceria” terhadap rasa nyeri dan pembengkakan payudara serta produksi ASI pada ibu postpartum di Jakarta. Universitas Indonesia.
[41] Walker, M., & Wetson, A. (2006). Breastfeeding management for clinicians: Using the evidence. Jones and Bartlett.
[42] Wawan, A., & Dewi, M. (2010). Teori dan pengukuran pengetahuan, sikap, dan perilaku

manusia. Nuha Medika.
[43] WHO. (2009). Baby-Friendly Hospital Initiative: Revised, updated and expanded for integrated care. World Health Organization and UNICEF.
[44] WHO. (2010). Indicators for assessing infant and young child feeding practices: Part 2, Measurement. World Health Organization.
[45] WHO. (2014). Exclusive breastfeeding. World Health Organization.
[46] WHO. (2015). Breastfeeding. World Health Organization.
[47] WHO & UNICEF. (2014). Global nutrition targets 2025: Breastfeeding policy brief. World Health Organization.
[48] Wibowo, A. (2014). Metodologi penelitian praktis bidang kesehatan. PT RajaGrafindo Persada.
[49] Wijayanti, W. (2010). Hubungan antara pemberian ASI eksklusif dengan angka kejadian diare pada bayi umur 0-6 bulan di Puskesmas Gilingan Kecamatan Banjarsari Surakarta. Universitas Sebelas Maret.
[50] Wijayanti, Y. (2015). Determinan pemberian ASI eksklusif pada tujuh hari pertama kelahiran di wilayah kerja Puskesmas Kelurahan Kaliabang Tengah Kota Bekasi tahun 2015. Universitas Indonesia.
[51] Yuliarti, N. (2010). Keajaiban ASI: Makanan terbaik untuk kesehatan, kecerdasan, dan kelincahan si kecil. Andi Offset.

ISSN 2798-3471 (Cetak)
ISSN 2798-3641 (Online)