

Husband and Family Support as Determinants of Successful Early Initiation of Breastfeeding and Exclusive Breastfeeding in a Rural Area

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ABSTRAK

Studi pendahuluan di wilayah kerja Puskesmas Rambipuji menunjukkan rendahnya cakupan Inisiasi Menyusu Dini (45%) dan ASI eksklusif (35%), dengan dukungan suami dan keluarga yang baik masing-masing hanya 40% dan 45%. Penelitian ini bertujuan menganalisis pengaruh dukungan suami dan keluarga terhadap praktik IMD dan pemberian ASI eksklusif pada bayi baru lahir. Desain penelitian adalah cross-sectional analitik observasional. Populasi target seluruh ibu yang memiliki bayi usia 6-12 bulan di wilayah Puskesmas Rambipuji (N=267). Sampel sebanyak 87 orang diambil dengan simple random sampling. Pengumpulan data menggunakan kuesioner terstruktur yang telah divalidasi (Cronbach's alpha 0,87-0,89) dan dianalisis menggunakan regresi logistik berganda. Hasil penelitian menunjukkan sebanyak 64,4% ibu melakukan IMD dan 56,3% memberikan ASI eksklusif. Dukungan suami yang baik (OR=4,21; 95% CI=1,78-9,96; p=0,001) dan dukungan keluarga yang baik (OR=3,56; 95% CI=1,54-8,23; p=0,003) secara signifikan berhubungan dengan praktik IMD. Pola serupa ditemukan pada ASI eksklusif. Saran yang diberikan adalah intervensi berbasis keluarga sangat diperlukan dalam program promosi menyusui di puskesmas.

Kata kunci : ASI eksklusif, dukungan keluarga, dukungan suami, inisiasi menyusui dini

ABSTRACT

A preliminary study conducted in the working area of Rambipuji Primary Health Center revealed low coverage of early initiation of breastfeeding (45%) and exclusive breastfeeding (35%), with good spousal and family support reported by only 40% and 45% of respondents, respectively. This study aimed to analyze the influence of husband and family support on early initiation of breastfeeding and exclusive breastfeeding practices among newborns. An observational analytic cross-sectional design was employed. The target population comprised all mothers with infants aged 6-12 months in the Rambipuji area (N=267). A sample of 87 participants was selected using simple random sampling. Data were collected using structured questionnaires that had been validated (Cronbach's alpha 0.87-0.89) and analyzed using multiple logistic regression. The results revealed that 64.4% of mothers practiced early initiation of breastfeeding, while 56.3% provided exclusive breastfeeding. Good husband support (OR=4.21; 95% CI=1.78-9.96; p=0.001) and good family support (OR=3.56; 95% CI=1.54-8.23; p=0.003) were significantly associated with early initiation of breastfeeding. Similar patterns were observed for exclusive breastfeeding. Family-based interventions are urgently needed in breastfeeding promotion programs at primary health centers.

Keywords : Breastfeeding exclusive, family support, husband support, sucking behavior.

1. INTRODUCTION

On a busy morning in the postpartum ward of Rambipuji Primary Health Center, a young mother appeared confused as the midwife placed her baby on her chest. The infant crawled toward the nipple searching for milk, but the mother hesitated. Her husband standing beside her

remained silent, while her mother-in-law whispered from outside the room, "Just wait until your milk comes out abundantly." Scenes like this are not fiction. They represent a small snapshot of the major challenges faced in efforts to improve Early Initiation of Breastfeeding (EIB) and exclusive breastfeeding at the community level, particularly in areas with strong sociocultural

characteristics such as Rambipuji Subdistrict, Jember Regency.

Before the main study was conducted, the research team carried out a preliminary study in March 2026 involving 20 mothers with infants aged 6-12 months in the Rambipuji Primary Health Center working area. The results were quite concerning: only 45% of mothers practiced EIB, and exclusive breastfeeding coverage was even lower at 35%. These figures fall not only below the national target (80%) but also below the district average (Dinas Kesehatan Kabupaten Jember, 2024). Furthermore, good husband support was reported by only 40% of respondents, while good family support was reported by only 45%. Among the 11 mothers who did not practice EIB, one-third (36.4%) admitted that their babies were immediately taken away by health workers without being given the opportunity for early contact. Meanwhile, among the 13 mothers who did not provide exclusive breastfeeding, nearly 40% felt their breast milk was "insufficient" and 30.8% followed family advice to give formula milk.

Data from the Jember District Health Office for 2024 indeed showed that EIB coverage at Rambipuji Primary Health Center reached only 58.2% and exclusive breastfeeding 52.7% (Dinas Kesehatan Kabupaten Jember, 2024). However, our preliminary findings (45% and 35%) suggest a possible overestimation in routine health center data, or perhaps a decline in performance over the past two years. These figures have even tended to stagnate over the last three years. Yet, failure of EIB and exclusive breastfeeding contributes to increased risks of acute respiratory infections, diarrhea, and malnutrition in infants (Horta & Loret de Mola, 2017; Victora et al., 2016). Globally, increasing exclusive breastfeeding coverage to 90% is estimated to prevent 823,000 child deaths annually (Rollins et al., 2016).

Why does a practice with medically proven benefits remain so difficult to implement, even appearing to worsen at the study location? Many intervention programs to date have focused on individual education for mothers, neglecting the fact that breastfeeding mothers live within a social ecosystem. Her decision to practice EIB or provide exclusive breastfeeding is strongly influenced by those around her: her supporting husband, advising parents, criticizing in-laws, or

neighboring role models (Negin et al., 2016; Taveras et al., 2014). Our preliminary study confirmed this: 18.2% of mothers did not practice EIB due to family prohibitions, and 23.1% did not provide exclusive breastfeeding because of family suggestions.

Several previous studies have highlighted the role of social support. A meta-analysis by Meedya et al. (2016) concluded that support from health workers and families increases breastfeeding duration by up to two-fold. In Indonesia, a study in Yogyakarta by Isnaeni et al. (2025) found that husband support was the strongest predictor of exclusive breastfeeding success. However, most of these studies were conducted in urban areas or referral hospitals, with relatively educated samples who had easy access to information. Almost no studies have explicitly presented preliminary data as justification, especially in peri-urban areas like Rambipuji with strong Javanese sociocultural characteristics. To date, no study has specifically analyzed the simultaneous influence of husband support and family support on EIB and exclusive breastfeeding practices in the working area of Rambipuji Primary Health Center. Based on this background, this study aimed to analyze the influence of husband and family support on Early Initiation of Breastfeeding (EIB) and exclusive breastfeeding practices among newborns in the working area of Rambipuji Primary Health Center, Jember Regency.

2. METHOD

This study employed a cross-sectional design with an observational analytic approach. Measurements of independent variables (husband support, family support) and dependent variables (EIB practice, exclusive breastfeeding practice) were conducted simultaneously. Before the main study, a preliminary study was conducted in March 2026 involving 20 mothers with infants aged 6-12 months in the working area of Rambipuji Primary Health Center to test questionnaire readability, estimate initial proportions of main variables, and calculate a more accurate sample size. The main study was conducted from April to May 2026 across the entire working area of Rambipuji Primary Health Center, which covers 7 villages. The target population was all mothers with infants aged 6-12

months at the time of data collection. Based on health center registration data, the population size was 267 individuals. Sample size calculation used the Slovin formula with a 10% margin of error ($n=73$) and was confirmed using the two-proportion hypothesis testing formula based on preliminary study proportions ($p_1=45\%$ for EIB, $p_2=35\%$ for exclusive breastfeeding), which yielded a minimum required sample of 82. To anticipate dropouts, a final sample of 87 was selected using simple random sampling. Inclusion criteria were mothers willing to become respondents, residing in the health center area for at least 1 year, and having infants in healthy condition without congenital abnormalities. Exclusion criteria were mothers with a history of breast surgery or medical conditions contraindicated breastfeeding. The research instrument was a structured questionnaire consisting of maternal demographic characteristics, husband support questionnaire (10 items, Likert scale 1-4, Cronbach's alpha 0.89), family support questionnaire (12 items, Cronbach's alpha 0.91), and questions about EIB and exclusive breastfeeding practices. Validity and reliability testing was conducted on 20 preliminary study respondents, with Cronbach's alpha values of 0.87 for the husband support questionnaire and 0.89 for family support. Data collection began with coordination with the Head of Rambipuji Primary Health Center and health cadres. After obtaining ethical approval, the researcher and two trained enumerators conducted home visits to respondents' addresses. Questionnaires were administered through face-to-face interviews. Data were analyzed using SPSS version 25. Univariate analysis described frequencies and percentages of each variable. Bivariate analysis used Chi-square tests. Multivariate analysis used multiple logistic regression (enter method) to control for confounding factors (maternal age, education, parity). Significance level was set at $p<0.05$ with 95% confidence intervals. This study received ethical approval from the Health Research Ethics Committee of ITSK RS dr. Soepraoen Malang with number: 87/KEPK/ITSK/IV/2026..

3 RESULT

Of the 87 questionnaires distributed, all

were returned and could be analyzed (100% response rate). The mean maternal age was 28.4 years ($SD=5.2$), ranging from 17 to 41 years. The majority of mothers were in the healthy reproductive age group (20-35 years), comprising 71.3%. Educational background: 41.4% completed elementary school or equivalent, 35.6% completed junior high school, 18.4% completed senior high school, and only 4.6% had completed university education. Occupation: 67.8% of mothers were not employed (housewives), 18.4% worked as farm laborers, and 13.8% worked in other informal sectors. Parity: 48.3% were primiparous, 37.9% multiparous (2-3 children), and 13.8% grandmultiparous (≥ 4 children). Of all respondents, 64.4% ($n=56$) reported that their infants received EIB, while 56.3% ($n=49$) successfully provided exclusive breastfeeding for a full 6 months. The main reasons for not practicing EIB were "the baby was immediately taken by the nurse to be cleaned" (22.6%), "the mother felt too tired" (19.4%), and "family did not allow it" (16.1%). For not providing exclusive breastfeeding, the most common reasons were "breast milk felt insufficient/only a little came out" (34.2%), "the baby was constantly fussy" (23.7%), and "given family suggestions to add formula milk" (21.1%).

Tabel 1. Distribution of Husband and Family Support among Respondents

Support Variable	Category	Frequency (n)	Percentage (%)
Husband Support	Poor (<60% of maximum score)	38	43.7
	Good ($\geq 60\%$ of maximum score)	49	56.3
Family Support	Poor (<60% of maximum score)	41	47.1
	Good ($\geq 60\%$ of maximum score)	46	52.9

In bivariate analysis, mothers who received good husband support had a 4.6 times greater

tendency to practice EIB compared to those with poor support ($p=0.001$). Similarly, good family support was associated with a 3.9-fold increase in EIB practice ($p=0.003$). After controlling for maternal age, education, and parity in multiple logistic regression, husband support remained the most dominant factor ($OR=4.21$; 95% $CI=1.78-9.96$; $p=0.001$), followed by family support ($OR=3.56$; 95% $CI=1.54-8.23$; $p=0.003$). Maternal education also showed a significant relationship ($p=0.042$; $OR=1.87$), but age and parity were not statistically significant.

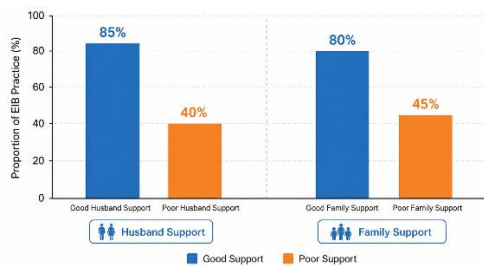


Figure 1. Proportion of EIB Practice by Level of Husband and Family Support

Tabel 2. Logistic Regression Analysis of Factors Associated with EIB Practice

Variable	B	Wald	P-value	OR	95% CI
Husband support (good vs poor)	1.437	10.892	0.001	4.21	1.78 - 9.96
Family support (good vs poor)	1.271	8.776	0.003	3.56	1.54 - 8.23
Maternal education (high vs low)*	0.625	4.132	0.042	1.87	1.02 - 3.42

*Note: high education = senior high school and above; low education = junior high school and below. Model Nagelkerke R Square = 0.324

A nearly similar pattern was found for the exclusive breastfeeding outcome. Mothers with good husband support had a 4.2 times greater chance of providing exclusive breastfeeding compared to those with poor support ($p=0.002$). Good family support increased the chance by 3.3 times ($p=0.008$). After multivariate analysis, husband support ($OR=3.89$; 95% $CI=1.66-9.11$; $p=0.002$) and family support ($OR=3.12$; 95% $CI=1.35-7.21$; $p=0.008$) remained significant.

No confounding variables (age, education, parity) reached significance in the model for exclusive breastfeeding.

Tabel 3. Logistic Regression Analysis of Factors Associated with Exclusive Breastfeeding

Variable	B	Wald	P-value	OR	95% CI
Husband support (good vs poor)	1.359	9.446	0.002	3.89	1.66 - 9.11
Family support (good vs poor)	1.139	7.031	0.008	3.12	1.35 - 7.21

Model Nagelkerke R Square = 0.287

4 DISCUSSION

The main findings of this study are quite clear: mothers who received full support from their husbands and families had a much higher tendency to practice EIB and provide exclusive breastfeeding. Husband support even emerged as the strongest factor, with the highest odds ratio for both outcomes. This finding aligns with reports from several other regions in Indonesia (Ratnasari et al., 2017), but there is a unique aspect when interpreted within the sociocultural context of Rambipuji, which remains highly collective.

Why is husband support so decisive? During labor and the early postpartum period, the husband is usually the first person to interact with the mother and infant. In the low-privacy delivery room of Rambipuji Primary Health Center, a husband who actively encourages his wife to breastfeed immediately can make a major difference between whether EIB is implemented or not. A study in Bangladesh by Sandhi et al. (2020) also reported that husband involvement in childbirth accompaniment increased early breastfeeding practice by 2.7 times. Our findings strengthen this evidence with a larger effect size ($OR=4.21$). This difference may reflect the cultural context where the husband's role as decision-maker in traditional Javanese families remains very dominant, so his support carries more weight than in other cultures (Laksono et al., 2021).

On the other hand, family support (especially from mothers-in-law) has an equally important influence but its direction can be either positive or negative. In interviews, several respondents revealed that even though husbands were

supportive, pressure from mothers-in-law to give bananas or honey on the first day would thwart exclusive breastfeeding. This phenomenon reflects what Susilowati and Kusumawati (2023) describe as intergenerational conflict in infant feeding: the older generation brings different breastfeeding experiences (often with practices not based on scientific evidence) and tend to be resistant to new information. Thus, "good" family support in this study is not merely physical presence, but families willing to listen to health worker recommendations and not impose incorrect traditions. This finding is also supported by Laksono et al. (2021), who reported that in rural Indonesian areas, the influence of the nuclear family (especially mothers-in-law) could be stronger than husband support in terms of infant feeding practices.

An interesting point emerging from spontaneous qualitative data during interviews was the difference in support patterns between the husband's family and the wife's family. Unfortunately, our study did not quantitatively separate these two categories, a limitation that must be acknowledged. However, anecdotally, respondents more frequently mentioned interference from the husband's family (mother-in-law, husband's siblings) as obstacles compared to their own biological families. This finding indicates that interventions to improve family support need to be tailored to the power structure within traditional Javanese families, which tend to be patrilineal. Comparison with a study in Ethiopia by Tarekegn et al. (2018) demonstrates that social support is a cross-cultural predictor. However, the effect size in Ethiopia was smaller (OR around 2.0-2.5), possibly due to differences in healthcare systems and gender roles. Therefore, breastfeeding promotion programs at health centers should no longer target mothers separately but should involve couples as an inseparable dyad (Isnaeni et al., 2025). The first limitation of this study is its cross-sectional design, which cannot definitively establish causal relationships. Second, the measurement of support using subjective questionnaires is vulnerable to social desirability bias. Third, this study did not measure the quality of support in depth. Despite these limitations, our findings make an important contribution to the development of breastfeeding programs based on social ecology, not merely

individual education

5. CONCLUSION

Husband and family support significantly influence Early Initiation of Breastfeeding and exclusive breastfeeding practices in the working area of Rambipuji Primary Health Center. Mothers with good husband support have a much greater chance of practicing EIB and providing exclusive breastfeeding compared to those with poor support, and similarly, good family support significantly increases the chance of success for both practices. The implications of these findings are very concrete: breastfeeding promotion programs at health centers should no longer target only individual mothers but must involve husbands and nuclear family members, especially mothers-in-law, as equal intervention targets. Forms could include antenatal classes for couples, home visits with cadres using materials specifically designed for families, or development of visual communication media easily understood by families with low education levels. We also recommend that midwives receive lactation counseling training that includes communication skills with extended families. Future research is advised to use cohort designs, expand locations to areas with higher ethnic diversity, and develop instruments that measure support more objectively, such as through observation or daily diaries.

6. REFERENCES

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