

Health Worker Support as a Key Determinant of Exclusive Breastfeeding in Indonesia

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ABSTRACT

Exclusive breastfeeding for the first six months is recommended by the World Health Organization and UNICEF because it provides optimal nutrition and immune protection for infants. However, the coverage of exclusive breastfeeding in Indonesia remains below the global target. Support from health workers is considered an important factor influencing breastfeeding practices, yet previous studies have reported inconsistent results. This study aimed to estimate the pooled effect size of the association between support from health workers and exclusive breastfeeding among infants aged 0–6 months in Indonesia, thereby providing robust empirical guidance for national maternal health policy. This systematic review and meta-analysis was conducted in March 2026 following PRISMA guidelines. A literature search was conducted in Google Scholar, PubMed, ScienceDirect, and Garuda databases for articles published between 2021 and 2026. Data analysis was performed using Review Manager 5.4 with the Odds Ratio (OR) effect size and 95% confidence interval using the Mantel–Haenszel method with a random effects model. Sensitivity analysis was performed using Review Manager 5.4. Publication bias was analyzed using funnel plots and Egger's test. A total of 11 cross-sectional studies were included in this study. Meta-analysis showed that support from health workers significantly increased the likelihood of exclusive breastfeeding [5.77 (95% CI: 3.88–8.57)]. Sensitivity analysis using the leave-one-out method demonstrated robust pooled estimates, with ORs ranging consistently from 5.39 (95% CI: 3.60–8.08) to 6.47 (95% CI: 4.13–10.14) across all iterations. Risk of bias was mostly moderate. Egger's test indicated publication bias ($p = 0.0126$). In conclusion, health worker support is a high-impact intervention that significantly increases exclusive breastfeeding in Indonesia. While family and sociocultural factors also play a role, structured professional support remains a primary driver of successful breastfeeding.

Keywords: exclusive breastfeeding; health worker support; breastfeeding counseling; maternal health services; Indonesia

INTRODUCTION

World Health Organization and UNICEF recommend exclusive breastfeeding for infants during the first six months of life. Infants are advised to receive only breast milk without any additional food or drink, except for vitamins or medications prescribed by a physician [1]. Breast milk has two main benefits: providing complete nutritional support and fostering emotional bonding between mother and infant. Its nutritional composition is naturally tailored to the infant's needs and contains antibodies that protect against infections. Particularly in developing countries, exclusive breastfeeding can reduce infectious diseases such as pneumonia and diarrhea [2].

Despite the well-established benefits of exclusive breastfeeding, its coverage in Indonesia has not yet reached the World Health Organization target (>70%). Data from the 2023 Indonesian National Health Survey indicate that only 55.5% of infants under six months of age receive exclusive breastfeeding [3]. Factors that hinder exclusive breastfeeding include primiparity, family pressure, and lack of support from healthcare providers. Healthcare providers are often perceived as delivering inconsistent information regarding exclusive breastfeeding [4].

There are discrepancies between study findings: Widiastuti et al. (2023) reported a strong association between healthcare provider support and exclusive breastfeeding [5], whereas Putri et al. (2025) found no significant relationship [6]. These differences may be influenced by the quality of support provided by healthcare professionals. Meanwhile, Ojantausta et al. (2023) emphasized that healthcare provider competence in breastfeeding counseling includes knowledge, skills, and attitudes to ensure that the support delivered is protective, promotive, and supportive of exclusive breastfeeding practices [7].

These inconsistencies highlight the need to synthesize local evidence, which remains scattered across Indonesia. World Health Organization and UNICEF emphasize that high-quality lactation counseling, prenatal education, and direct clinical support during childbirth, provided by health workers throughout pregnancy and the postpartum period, are key factors in increasing the coverage of exclusive breastfeeding [1]. A systematic review and meta-analysis are urgently needed to resolve these empirical inconsistencies and estimate a definitive pooled effect size at the national level. Therefore, this study aimed to estimate the pooled effect size of the association between support from health workers and exclusive breastfeeding among infants aged 0–6 months in Indonesia, thereby providing robust empirical guidance for national maternal health policy.

METHODS

This systematic review was conducted in March 2026 and registered in PROSPERO (CRD420261342102). The literature search employed a combination of keywords with Boolean operators based on the PICO framework: Patient (mothers), Intervention (healthcare provider support), Comparator (mothers without healthcare provider support), and Outcome (exclusive breastfeeding). The inclusion criteria were: (1) articles published within the last five years (2021–2026), (2) studies examining the relationship between healthcare provider support and exclusive breastfeeding in Indonesia, (3) cross-sectional studies, and (4) articles published in Indonesian or English. The exclusion criteria were: (1) grey literature, conference abstracts, and letters to the editor, and (2) articles without full-text access. We restricted our selection to cross-sectional studies because this design represents the vast majority of peer-reviewed primary research on maternal healthcare utilization in Indonesia, ensuring a highly comparable and representative pooled sample for meta-analysis, given the extreme scarcity of local cohort or experimental studies on this topic.

The article selection process was conducted systematically following PRISMA guidelines using databases including Google Scholar, PubMed, ScienceDirect, and Garuda. The process was carried out by two authors (UAH and SS), and any disagreements were resolved through discussion with SAPA. First, all retrieved articles were collected and duplicates were removed. Second, articles were screened based on title and abstract, and those not meeting the study criteria were excluded. Third, articles were screened based on accessibility, and those without full-text access were excluded. Fourth, full-text screening was conducted, and articles not meeting the eligibility criteria were excluded. Eligible articles underwent data extraction, including author, year of publication, study design, analysis, sample size, location, and outcomes. Data extraction was performed by SAPA, SS, GAL, and INW.

Meta-analysis was conducted using Review Manager 5.4. The effect size used was Odds Ratio (OR) with a 95% confidence interval. Data were pooled using the Mantel–Haenszel method with a random-effects model. The random-effects model was selected to account for potential clinical and methodological heterogeneity across studies, reflected in differences in settings (primary healthcare centers, independent midwifery practices, and integrated health posts), population characteristics, and variations in healthcare provider support. Additionally, the use of a random-effects model in meta-analyses with a limited number of studies is recommended as it provides more conservative and generalizable estimates. The results of the meta-analysis were presented using a forest plot.

Sensitivity analysis was conducted using the leave-one-out method in Review Manager 5.4 to assess the stability of the overall effect estimate and identify any study with a dominant influence on the meta-analysis results. In each iteration, one study was sequentially removed, and the pooled OR was recalculated using the random-effects Mantel–Haenszel method. Visualization was performed using R Studio 4.5.2.

Publication bias was assessed using Review Manager 5.4 and presented with a funnel plot. Statistical confirmation was performed using Egger's test in R Studio 4.5.2. A p-value <0.05 was considered statistically significant, indicating potential publication bias.

Risk of bias was assessed using the JBI Critical Appraisal Checklist for Cross-Sectional Studies. To facilitate quantitative synthesis, each checklist item was scored as follows: 'Yes' (+) received 1.0 point, 'Unclear' (?) received 0.5 point, and 'No' (-) received 0 points. Summed scores represented the overall methodological quality (maximum score of 8.0). Methodological risk was categorized into low risk of bias (score > 6.0), Intermediate risk (score 4.0 to 6.0), and high risk (score < 4.0).

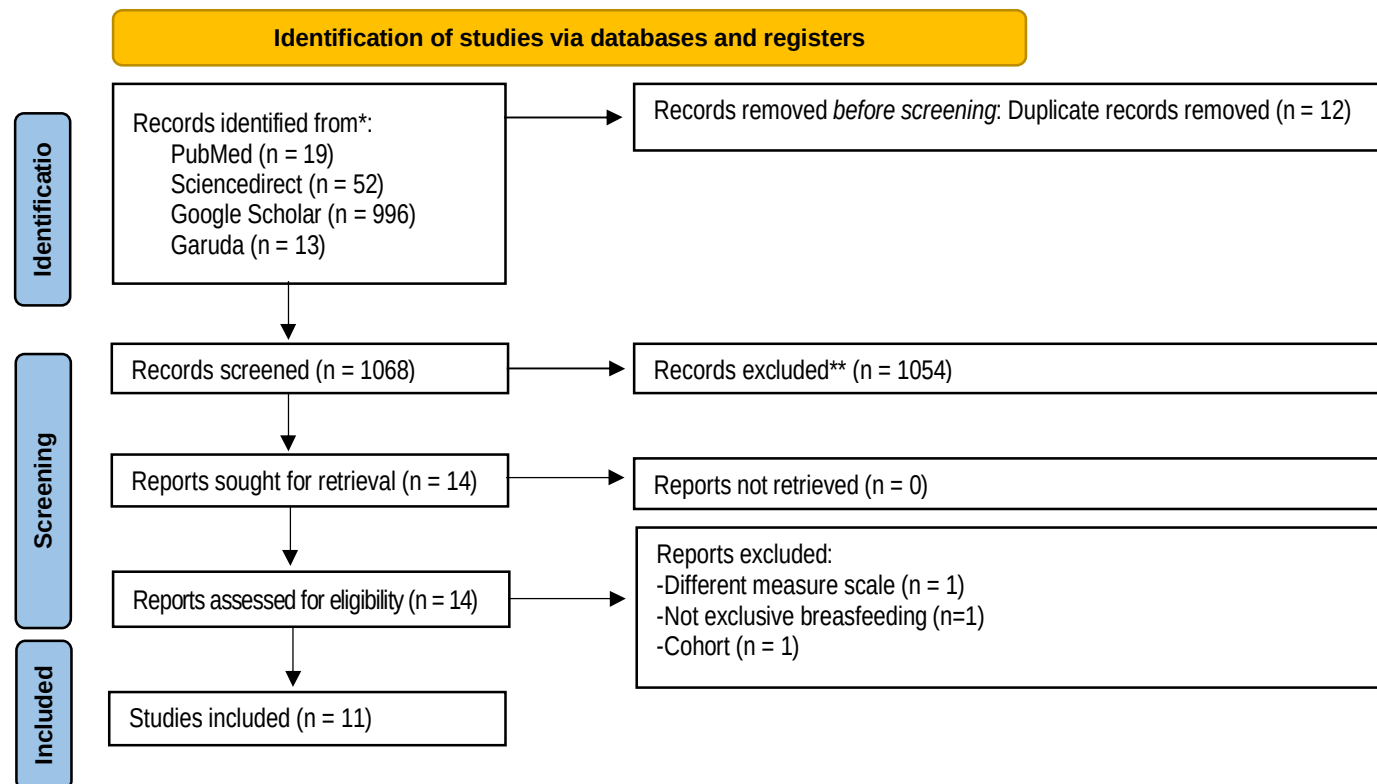


Figure 1. PRISMA flowchart

RESULTS

As shown in Figure 2 (Forest Plot), the odds ratios (OR) of individual studies showed a universally positive association, ranging from a minimum effect size of 3.83 (95% CI: 1.64–8.93) reported by Aprila & Astiningsih (2022) to a maximum effect size of 29.00 (95% CI: 3.95–212.89) reported by Anggriani & Prananingrum (2023). Despite these differences in magnitude, all 11 included studies pointed to a positive direction, confirming the stability of the pooled effect size of 5.77 (95% CI: 3.88, 8.57).

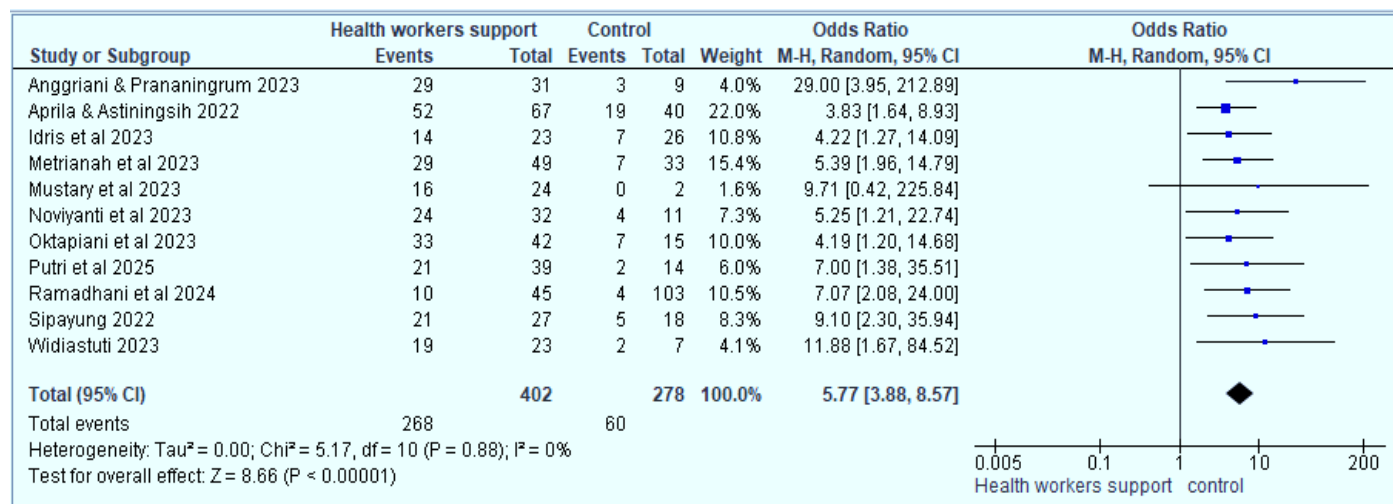


Figure 2. Forest plot

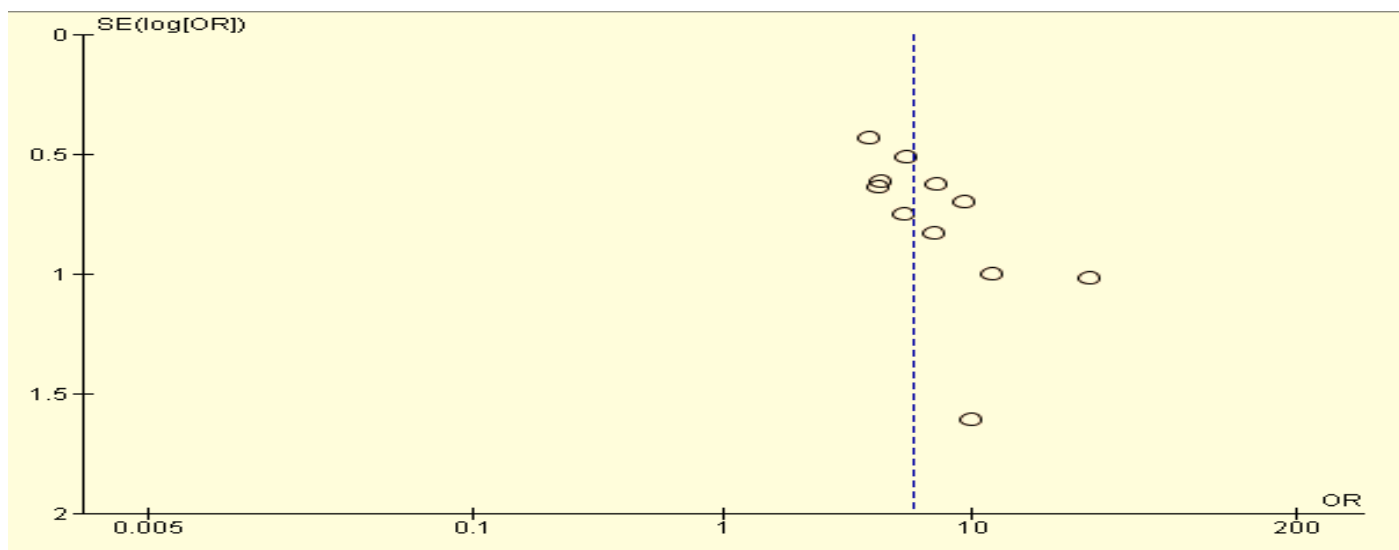


Figure 3. Funnel plot

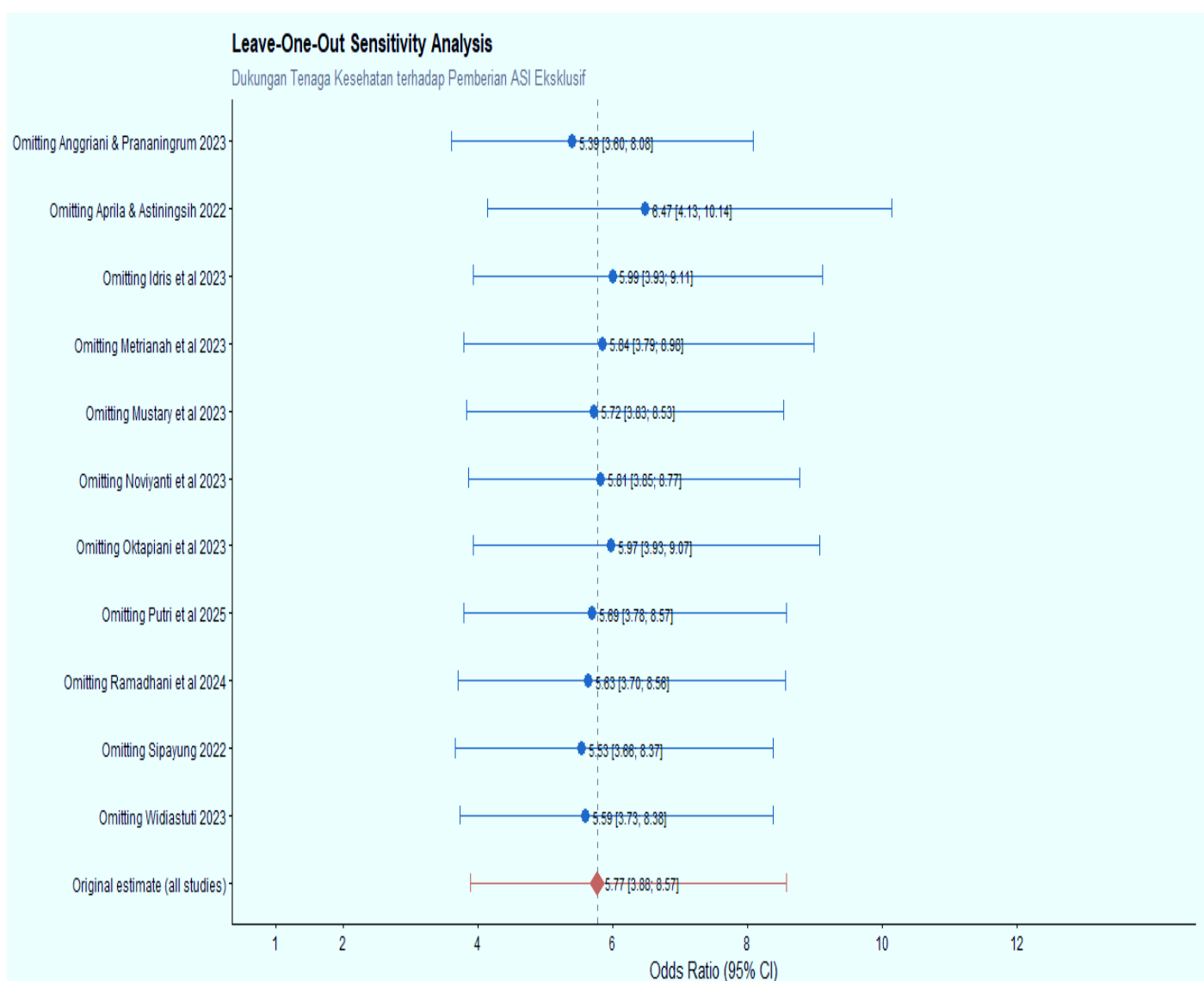


Figure 4. Sensitivity analysis

Table 1. Egger's test

Exposure	Outcome	Egger test	
		Intercept	p value
Healthcare provider support	Exclusive breastfeeding	1.6317	0.0126

Table 2. Data extraction

Author, Year	Design	Analysis	Sample	Location	Findings
Widiatusti (2023) [5]	Cross-sectional	Chi-Square	30	PMB Nuradina Widiastuti	Midwife support was associated with exclusive breastfeeding (p = 0.014)
Sipayung (2022) [8]	Cross-sectional	Chi-Square	45	Tajurhalang Primary Health Center	Midwife support was associated with exclusive breastfeeding (p = 0.001)
Ramadhani et al. (2024) [9]	Cross-sectional	Chi-Square	60	Bulango Ulu Primary Health Center	Healthcare provider support was associated with exclusive breastfeeding (p = 0.002)
Putri et al. (2025) [6]	Cross-sectional	Chi-Square	53	Banjar Agung Primary Health Center, Serang City	No association between healthcare provider support and exclusive breastfeeding (p = 1.000)
Oktapiani et al. (2023) [10]	Cross-sectional	Chi-Square	57	Midwife Elis Clinic, Keposang Village, Toboali District, South Bangka Regency	There was an association between midwife support and exclusive breastfeeding (p = 0.045)
Noviyanti et al. (2023) [11]	Cross-sectional	Chi-Square	43	Kertapati Primary Health Center	There was a significant association between healthcare provider support and exclusive breastfeeding (p = 0.031)
Mustary et al. (2023) [12]	Cross-sectional	Chi-Square	26	Village Health Post (Pustu) Mottangin, Bonti-bonti Hamlet, Mattoangin Village, Bantimurung District, Maros Regency	No association between healthcare provider support and breastfeeding (p = 0.069)
Metrianah et al. (2023) [13]	Cross-sectional	Chi-Square	82	Muara Enim Primary Health Center, Muara Enim City	There was a significant association between healthcare provider support and exclusive breastfeeding (p = 0.002); OR = 5.386, indicating respondents receiving positive support were 5.386 times more likely to practice exclusive breastfeeding
Idris et al. (2023) [14]	Cross-sectional	Chi-Square	49	RSD dr. H. Soemarno Sosroatmodjo	There was an association between husband support and healthcare provider support with exclusive breastfeeding (p = 0.035)
Aprila & Astiningsih (2022) [15]	Cross-sectional	Chi-Square	107	Posyandu in the working area of Harapan Baru Primary Health Center, Samarinda	There was an association between healthcare provider support and exclusive breastfeeding (p = 0.003; OR = 3.823), and between maternal education and exclusive breastfeeding (p = 0.001; OR = 4.399)
Anggriani & Prananingrum (2023) [16]	Cross-sectional	Chi-Square	40	PMB	There was a significant association between husband support and exclusive breastfeeding (p = 0.001 < 0.05), and between healthcare provider support and exclusive breastfeeding (p = 0.001 < 0.05)

Table 3. Risk of bias

No	Researcher	Method	1	2	3	4	5	6	7	8	Total ccore	Risk of bias
1.	Widiatusti (2023) [5]	CS	?	+	+	?	-	-	?	+	4.5	Intermediate
2.	Sipayung (2022) [8]	CS	?	?	?	?	-	-	?	+	3.0	High
3.	Ramadhani et al. (2024) [9]	CS	?	+	?	?	-	-	?	+	4.0	Intermediate
4.	Putri et al. (2025) [6]	CS	+	+	+	+	+	-	?	+	7.0	Low
5.	Oktapiani et al. (2023) [10]	CS	?	+	?	?	-	-	?	+	4.0	Intermediate
6.	Noviyanti et al. (2023) [11]	CS	?	+	?	-	-	-	?	+	3.5	High
7.	Mustary et al. (2023) [12]	CS	?	+	-	-	-	-	?	+	3.0	High
8.	Metrianah et al. (2023) [13]	CS	?	+	?	?	-	-	?	+	4.0	Intermediate
9.	Idris et al. (2023) [14]	CS	?	?	?	?	?	-	?	+	4.0	Intermediate
10.	Aprila & Astiningsih (2022) [15]	CS	+	+	?	?	-	-	?	+	4.5	Intermediate
11.	Anggriani & Prananingrum (2023) [16]	CS	?	+	?	?	-	-	?	+	4.0	Intermediate

CS: Cross-sectional study; (+) = Yes/Met Criteria (score 1.0); (-) = No/Did Not Meet Criteria (score 0); (?) = Unclear (score 0.5)

DISCUSSION

This meta-analysis shows that mothers who receive support from healthcare providers are 5.77 times more likely to practice exclusive breastfeeding. The consistency of findings across studies indicates that healthcare providers play a strategic role as sources of information and motivation for mothers. This support is generally provided in the form of education, counseling, and assistance from pregnancy through the breastfeeding period, including psychological and motivational support [8,14,16].

In terms of education and counseling, healthcare providers hold a strategic position as primary sources of information regarding the benefits of breastfeeding, proper breastfeeding techniques, and the importance of exclusive breastfeeding during pregnancy and the postpartum period [5]. Adequate knowledge supports mothers in becoming more motivated to practice exclusive breastfeeding and to better understand breastfeeding techniques [10]. Continuous education provided from pregnancy through the breastfeeding period can further enhance maternal understanding of the importance of exclusive breastfeeding [8]. This indicates that healthcare provider support is a key factor in promoting exclusive breastfeeding. This finding aligns with health behavior theories such as the Health Belief Model, which suggests that health behavior is influenced by perceived benefits,

perceived barriers, and external cues to action. Education and support from healthcare providers can increase perceived benefits while reducing perceived barriers to breastfeeding, thereby encouraging mothers to make more positive decisions regarding exclusive breastfeeding practices [17].

Educational interventions can be delivered through face-to-face counseling [18]. In addition to direct counseling, educational media such as pocketbooks have also been utilized. A study by Sukriani & Wahyuni (2024) demonstrated that pocketbook media is effective in improving maternal knowledge, as it is easy to understand, practical to carry, and contains illustrations that help mothers better comprehend health information [19].

Regarding assistance during pregnancy and breastfeeding, support from healthcare providers, particularly midwives, can strengthen maternal confidence in continuing breastfeeding [12]. Furthermore, professional support from healthcare providers can help mothers address negative perceptions about breastfeeding, such as concerns about milk supply or body changes after breastfeeding, and assist in preparing maternal physical readiness [15]. These findings are consistent with the concept of breastfeeding self-efficacy, defined as a mother's confidence in her ability to breastfeed. Studies show that maternal confidence is a crucial psychological factor influencing the success of exclusive breastfeeding. Healthcare provider support can enhance maternal self-efficacy through the provision of information, motivation, and practical assistance during breastfeeding. Mothers with higher self-efficacy are more capable of overcoming breastfeeding difficulties and maintaining exclusive breastfeeding practices [20,21].

Although most studies demonstrate a positive association between healthcare provider support and exclusive breastfeeding, some studies report different findings. Studies by Mustary et al. (2023) and Putri et al. (2025) found no significant association between healthcare provider support and exclusive breastfeeding practices [6,12].

These differences may be explained by several factors. One major factor is the dominance of family support, particularly from husbands and other family members. In sociocultural contexts, a mother's decision to breastfeed is influenced not only by healthcare providers but also by close family members. Family support can act as a determining factor in breastfeeding success, as family members directly influence daily infant care practices. Other studies have shown that strong family support can increase maternal motivation to practice exclusive breastfeeding [22].

Additionally, access to healthcare services may influence study outcomes. The study by Putri et al. (2025) suggests that the absence of a relationship between healthcare provider support and exclusive breastfeeding may be due to the low frequency of maternal visits to healthcare facilities, limiting access to optimal information and education from healthcare providers [6]. This indicates that the effectiveness of healthcare provider support depends heavily on the intensity of interaction between providers and mothers.

Other contributing factors include socioeconomic conditions and maternal employment. Working mothers often face time constraints for breastfeeding or expressing breast milk, making exclusive breastfeeding more challenging. Moreover, maternal knowledge and family support also play important roles in determining the success of exclusive breastfeeding [23].

The variation in findings across studies indicates that exclusive breastfeeding is a multifactorial phenomenon, influenced not only by healthcare provider support but also by family, cultural, knowledge, and socioeconomic factors. Therefore, interventions aimed at increasing exclusive breastfeeding coverage should not focus solely on mothers but also involve families and the broader social environment.

The massive pooled effect size 5.77 (95% CI: 3.88, 8.57) underscores that healthcare provider support is not merely a supportive element but a primary prerequisite for exclusive breastfeeding in Indonesia. Clinically, this warrants the formal integration of standardized Lactation Counseling Protocols within the primary health center framework. Midwives and community health volunteers (*kader*) should undergo mandatory, structured breast milk management training. Furthermore, maternal health programs must be redesigned to mandate family-inclusive counseling sessions, ensuring that the health worker's professional advice is reinforced rather than countered by home environments."

This study has several limitations. First, the relatively small sample size. Although our analysis showed zero statistical heterogeneity ($I^2 = 0\%$), Egger's test revealed significant publication bias ($p = 0.0126$). This suggests that the apparent homogeneity might be an artifact of a small sample size. [24]. Heterogeneity metrics like I^2 tend to underestimate true variance when the pooled analysis contains fewer than 11 studies or limited total events. To address this potential underestimation and ensure clinical generalizability, we proactively applied a random-effects model, which provides more conservative and realistic estimates than a fixed-effects model

CONCLUSION

Healthcare provider support substantially increases exclusive breastfeeding in Indonesia, with a pooled effect of OR 5.77. This impact stems from structured education, counseling, and continuous clinical assistance that strengthen maternal knowledge and confidence. However, the evidence should be interpreted cautiously due to publication bias and limited study numbers. Exclusive breastfeeding remains multifactorial, influenced by family dynamics, access to care, employment, and socioeconomic conditions. Strengthening national policy through a mandatory, standardized lactation counseling protocol, integrating prenatal and early postpartum sessions and involving key family members is recommended. Future research with larger samples and stronger longitudinal designs is needed to produce more robust and generalizable evidence.

Ethical consideration, competing interest and source of funding

- The ethical approval: This study no need ethical clearance because only comparing results of some studies that had been published open before (information of public domain). Every result of the involved studies had been mentioned in the citation and references, include the name of the authors, title of the journal and year of publication.
- There is no conflict of interest related to this publication.
- Source of funding is authors.

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