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Original Article

Changes in knowledge and attitudes among exclusive breastfeeding supporters before and after Busui booklet education with whatsapp reminders: A one-group pre-experimental study

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Abstract

Background: Support from husbands and other family members is a social environmental factor associated with breastfeeding practices. BUSUI (Booklet Pendukung ASI Eksklusif, an exclusive breastfeeding support booklet) is used as an educational resource for individuals identified as supporters of mothers. This study evaluated changes in proximal outcomes—knowledge and attitudes—rather than exclusive breastfeeding practices.

Objective: To describe within-person changes in knowledge and attitude scores from baseline to 28 days after provision of the BUSUI booklet accompanied by WhatsApp reminder messages.

Methods: A one-group pretest–posttest pre-experimental study without a control group was conducted in the catchment area of Kemalaraja Community Health Center, East Baturaja District, Ogan Komering Ulu Regency, South Sumatra, Indonesia. Participants were recruited through convenience (accidental) sampling. Thirty-three participants completed the pretest on May 16, 2026; 30 (90.9%) completed the posttest on June 13, 2026, and were included in the complete-case analysis. Participants received a booklet to read over the 28-day interval and joined a WhatsApp group for communication and reminders. Knowledge and attitudes were assessed using the same questionnaires at both time points. Shapiro–Wilk tests were applied to paired difference scores, followed by Wilcoxon signed-rank tests.

Results: Among 30 participants with paired data, the mean (SD) knowledge score increased from 29.33 (3.36) to 30.00 (3.81), a mean difference of +0.67 points (p = 0.021). The mean attitude score increased from 65.70 (7.07) to 67.00 (7.32), a difference of +1.30 points (p = 0.512). Three participants (9.1%) did not complete the posttest. Confidence intervals for paired changes and effect sizes could not be reliably derived from the available summary data.

Conclusion: Over the 28-day observation period, a statistically significant difference was observed in knowledge scores, but not in attitude scores. The absence of a control group, nonprobability sampling, and limited implementation information preclude causal attribution of changes to BUSUI. Effects on family support behaviors or exclusive breastfeeding success were not assessed.

Background

Exclusive breastfeeding during the first six months of life supports infant and maternal health. Global epidemiological analyses have demonstrated the benefits of breastfeeding in reducing childhood morbidity and several maternal disease risks (Victora et al., 2016). However, efforts to promote breastfeeding must go beyond increasing individual knowledge because breastfeeding behaviors are shaped by family circumstances, healthcare services, social norms, and structural factors (Rollins et al., 2016; Pérez-Escamilla et al., 2023; Baker et al., 2023).

At the national level, WHO Indonesia reported that the proportion of infants younger than six months who were exclusively breastfed increased from 52% in 2017 to 66.4% in 2024; these figures describe Indonesia as a whole and should not be assumed to represent the Kemalaraja Community Health Center catchment area (WHO, 2025). The available study documents do not provide the numerator, denominator, measurement year, or official exclusive breastfeeding coverage target for Kemalaraja Community Health Center. Therefore, the original claim that coverage at this health center was below its target is not retained as a verified local fact. Research conducted in Ogan Komering Ulu Regency nevertheless remains relevant to exploring family-based health promotion in primary care (Novita et al., 2022).

Breastfeeding support involves more than providing information. Emotional assistance, practical help when mothers need rest, communication between partners, and assistance with lactation difficulties have all been highlighted in research involving fathers (Tohotoa et al., 2009; Rempel & Rempel, 2011; Brown & Davies, 2014). Grandmothers and extended family members may also facilitate or hinder breastfeeding practices depending on their views and breastfeeding experiences (Negin et al., 2016). Evidence from family-focused interventions suggests that education targeting fathers and partners can improve certain breastfeeding outcomes, although findings vary by program components, outcome measures, and follow-up periods (Pisacane et al., 2005; Maycock et al., 2013; Abbass-Dick et al., 2015; Mahesh et al., 2018; Abbass-Dick et al., 2019).

Printed materials, such as booklets, can provide information that readers can revisit. Nevertheless, findings from booklet-based education among pregnant or breastfeeding women cannot automatically be generalized to family supporters (Nurfatimah et al., 2023; Wulandari et al., 2023). Reviews of family engagement have identified heterogeneity in program designs and insufficient reporting of behavioral change mechanisms and relational contexts within households (Martin et al., 2021; Tomori et al., 2022). The relevant research gap is not an absence of studies involving fathers, but limited knowledge regarding changes in cognitive and affective outcomes among heterogeneous groups of maternal supporters when booklets and WhatsApp reminders are used in local primary care settings.

Conceptually, improved knowledge may be a prerequisite for developing beliefs and intentions, but it does not guarantee changes in attitudes or behaviors. The theory of planned behavior emphasizes attitudes, subjective norms, and perceived behavioral control (Ajzen, 1991), whereas social cognitive approaches highlight learning, self-efficacy, and environmental support (Bandura, 2004). These conceptual perspectives are used to interpret the findings, not to claim that BUSUI was originally developed using either theory in a formal manner. This study estimated within-person changes in knowledge and attitudes between pretest and posttest. Supportive behaviors and exclusive breastfeeding outcomes were not measured.

Methods

Study Design

This quantitative study used a one-group pretest–posttest pre-experimental design without a comparison group. A single-group design can provide an exploratory assessment of changes in scores before and after an intervention, but it is vulnerable to history effects, maturation, testing effects, regression to the mean, and other time-varying external factors. Reporting was informed by the TREND principles for nonrandomized evaluations and the TIDieR framework for intervention description (Des Jarlais et al., 2004; Hoffmann et al., 2014). There was no randomization, blinding, or estimation of causal effects relative to a control group.

Setting and study period

The study was conducted in the catchment area of Kemalaraja Community Health Center, East Baturaja District, Ogan Komering Ulu Regency, South Sumatra Province, Indonesia. The pretest was administered on May 16, 2026, and the posttest on June 13, 2026, a 28-day interval. The original report did not specify where the booklet distribution session took place or the individual schedules of participants.

Study population, participant definition, and recruitment

The participants analyzed were individuals enrolled as “exclusive breastfeeding supporters,” defined as respondents associated with pregnant women or women intending to breastfeed, including husbands, other family members, and close contacts. Among the 30 participants who completed the study, reported relationship categories included husband, younger sibling/cousin, older sibling/sibling-in-law, and “other.” The “other” category was not further specified. The source documents listed pregnant women as one of the inclusion categories; however, the available aggregate data do not establish whether pregnant women were themselves enrolled as respondents. Therefore, it would be inaccurate to describe all participants as “husbands/family members” without checking the original participant roster.

The inclusion criteria recorded in the initial manuscript were being a pregnant woman or a family member living in the same household as a

pregnant woman, willingness to participate and provide consent, ability to communicate, and adequate hearing. Inability to read was listed as an exclusion criterion. Details of the operational eligibility criteria (e.g., gestational age, parity, breastfeeding experience, and duration of co-residence) and whether more than one respondent was recruited per family were unavailable. Respondents were recruited using accidental (convenience) sampling. The complete screening log, detailed recruitment period, and identities of the recruiters were not documented in the available sources. Accordingly, the sample is considered a convenience sample rather than a random representation of residents of the community health center catchment area.

Thirty-three individuals completed the pretest. Three did not complete the posttest (attrition, 9.1%), leaving 30 participants (90.9%) with complete paired data. The source documents provide no information about an a priori sample size calculation based on a primary outcome, anticipated effect size, or statistical power. This study is therefore interpreted as an initial exploratory evaluation, not a trial demonstrated to have adequate statistical power.

Intervention

BUSUI is the Booklet Pendukung ASI Eksklusif (exclusive breastfeeding support booklet), distributed after the baseline assessment so that participants could read and learn about exclusive breastfeeding before the posttest. During the 28-day period, participants were added to a WhatsApp group to facilitate communication and remind them to read the booklet. Thus, the confirmed exposure comprised booklet distribution combined with WhatsApp communication/reminders; changes in outcomes cannot be attributed to the printed material alone.

The study report states only that the booklet contained information about exclusive breastfeeding. Its actual table of contents, version or revision date, length, development sources, involvement of lactation consultants or maternity nursing experts, language appropriateness assessment, and readability testing were not reported. Specific content concerning emotional support, instrumental assistance, husbands' roles, breastfeeding problems, or myths is not claimed to be verified booklet content. A proposed conceptual outline for a future version is presented separately in Table 1 and must not be interpreted as verified content of the booklet used in this study.

The available methods documentation does not specify who delivered the education, whether any face-to-face explanation was provided, the duration of explanations, opportunities to ask questions, the number and content of WhatsApp messages, whether participants discussed topics with each other, reading adherence, or implementation changes during the 28 days. There is no methodological basis for filling these gaps with assumptions. Limitations in intervention fidelity and the possibility of a digital communication co-intervention are explicitly acknowledged.

Table 1. Proposed family education content domains for future BUSUI standardization

Proposed domain	Main focus	Potential future outcome
Fundamentals of exclusive breastfeeding	Definition, recommended duration, benefits, and common barriers	Knowledge accuracy
Emotional support	Validating mothers' feelings and supportive communication	Emotional support behaviors
Practical support	Sharing household tasks and access to lactation counseling	Instrumental support behaviors
Husband/ family involvement	Shared decisions and problem-solving	Partner support self-efficacy
Breastfeeding myths and problems	Identifying misconceptions and referral to services	Actions taken to overcome difficulties

Outcome measurement

The first outcome was a knowledge score related to exclusive breastfeeding, and the second was an attitude score toward exclusive breastfeeding; both were measured at pretest and posttest using the same questionnaires. Operationally, the change in score was calculated for each participant

as the posttest score minus the pretest score and summarized among those with two measurements. Higher scores were assumed to reflect greater knowledge or more supportive attitudes, consistent with the interpretation in the original report; scoring rules for reverse-coded items could not be verified.

The source manuscript stated that the questionnaires had undergone validity and reliability testing but did not report the instruments' origins, numbers of items, response options, theoretical score ranges, answer keys, weighting schemes, categorization cutoffs, validation samples, validation methods, or reliability coefficients. The minimum–maximum scores in Table 3 are observed ranges, not theoretical score ranges. The value of 80 was the highest observed attitude score; therefore, a percentage calculated as 65.70/80 and an assertion of a measured ceiling effect are not justified without evidence of the scale maximum and participant-level distributions. Repeated administration of the same instrument creates a potential testing effect that should be considered in interpreting the findings.

Statistical analysis

Participant characteristics were summarized using frequencies/percentages and means, standard deviations, medians, and observed ranges. Normality was assessed for paired difference scores using the Shapiro–Wilk test, rather than solely for the score distributions at each time point. Because the difference scores were nonnormally distributed, the Wilcoxon signed-rank test was used to assess paired rank differences, with a two-sided significance threshold of 0.05, as reported in the source.

The original results tables provided only p values and marginal score summaries. The Wilcoxon W/Z statistic, numbers of positive, negative, and tied ranks, effect sizes, standard deviations of differences, and confidence intervals for within-person change cannot be validly reconstructed from pretest and posttest means and SDs because the paired correlations are unavailable. The statistical software and version were also not specified. Such additional estimates can only be supplied using the original paired data or statistical outputs; fabricated values have not been inserted.

Ethical considerations

The source manuscript reported that participants were willing to sign a research consent form. The name of the ethics committee, approval number and date, site permission, and mechanisms for protecting the confidentiality of WhatsApp data were not documented in the three source documents. These details must be confirmed against the original ethics documentation before journal submission.

Results

Three of the 33 initially enrolled participants did not complete the final assessment (9.1%). The analysis included 30 participants with complete pretest and posttest data. Ages ranged from 18 to 63 years, with a mean of 36.17 years (SD 12.96). Most participants had a secondary education (56.7%), and the largest relationship category was husband (43.3%). The "other" category accounted for approximately one-third of the sample but was not further specified; this heterogeneity in participant roles should be considered when interpreting the findings (Table 2).

Table 2. Respondent Characteristics

Characteristic	Category	n	%
Age	Late adolescence (17–25 years)	5	16.7
	Early adulthood (26–35 years)	10	33.3
	Late adulthood (36–45 years)	7	23.3
	Early older adulthood (46–55 years)	3	10.0
	Late older adulthood (56–65 years)	5	16.7
Education	Primary	9	30.0
	Secondary	17	56.7
	Higher education	4	13.3
Relationship to mother	Husband	13	43.3
	Younger sibling/biological sibling/cousin	4	13.3
	Older sibling/sibling-in-law	3	10.0
	Other (unspecified)	10	33.4

The normality assumption was not met for knowledge difference scores (Shapiro–Wilk W = 0.781; p < 0.001) or attitude difference scores (W = 0.887; p = 0.004). The mean knowledge score increased by 0.67 points and the mean attitude score by 1.30 points. The Wilcoxon test indicated a statistically significant difference in knowledge (p = 0.021), but not in attitudes (p = 0.512) (Table 3). Mean change is not a standardized effect size; its educational importance cannot be assessed without a justified theoretical score range or minimally important difference.

Table 2. Summary of pretest and posttest scores, complete-case analysis

Variable	Pretest, mean ± SD	Median (range)	Posttest, mean ± SD	Median (range)	Mean Δ	Wilcoxon p
Knowledge	29.33 ± 3.36	30.00 (16–33)	30.00 ± 3.81	31.50 (16–33)	+0.67	0.021
Attitudes	65.70 ± 7.07	64.00 (54–80)	67.00 ± 7.32	67.00 (54–80)	+1.30	0.512

Discussion

The primary finding was a small increase in knowledge scores over 28 days (p = 0.021), with no evidence of a statistically significant difference in attitude scores (p = 0.512). Methodologically, statistical significance in a paired test indicates a difference in score ranks, not certainty that the booklet caused the change. The mean knowledge change of +0.67 points also does not establish practical importance because the scale range and clinically or educationally meaningful difference are unknown. Statistical significance, magnitude of change, and the validity of causal inference must be clearly distinguished.

The knowledge findings are plausible in the context of repeated exposure to information that participants could revisit, but mechanistic interpretation remains limited. Several controlled studies have shown that involving fathers in education or support can improve support and some breastfeeding outcomes, although intervention formats vary widely (Pisacane et al., 2005; Maycock et al., 2013; Abbass-Dick et al., 2015; Mahesh et al., 2018). The BUSUI study differs in including a broader range of supporters and measuring short-term knowledge and attitudes rather than actual behavior. Accordingly, its findings should not be presented as effect estimates comparable to those from randomized trials that measured exclusive breastfeeding.

A nonsignificant change in attitudes may occur even when knowledge increases. Attitudes are influenced by personal experience, family norms, perceived behavioral control, and beliefs that may not be altered through brief access to reading materials alone (Ajzen, 1991; Bandura, 2004; Sheeran et al., 2016). Studies of fathers' experiences show that a desire to help may coexist with role uncertainty, a need for practical counseling, and feelings of exclusion from breastfeeding education (Brown & Davies, 2014; Rempel & Rempel, 2011). The heterogeneity of relationship categories in this study—husbands, younger siblings/cousins, older siblings/in-laws, and others—may be associated with different decision-making roles and educational responses. However, individual-level data were unavailable for subgroup comparisons.

Baseline attitude scores were relatively high compared with the highest observed score of 80, but this is insufficient to demonstrate a ceiling effect. Establishing a ceiling effect requires knowledge of the theoretical scale maximum and the proportion of participants scoring near that limit. In addition to limited room for improvement, poor instrument sensitivity or uncertain construct validity of the attitude measure are alternative explanations. Repeating the same questionnaire can produce improved knowledge scores because participants recognize its format or questions, regardless of whether understanding improves in a lasting way.

Exposure contamination is another source of uncertainty. WhatsApp was used for reminders and communication, but the frequency and nature of interactions were not documented. During the 28 days, participants could have received information from community health center staff, other family members, social media, or everyday experiences. Studies of digital interventions indicate that message content, duration, and intensity can influence educational exposure; therefore, the contribution of the WhatsApp group

within the BUSUI package cannot be discounted (Abbass-Dick et al., 2020; Fan et al., 2023). The TIDieR guide emphasizes the importance of reporting who delivered the intervention, how and at what intensity it was delivered, any tailoring, and actual adherence (Hoffmann et al., 2014).

In practice, the booklet may still be used as an adjunct to family education, provided it is not interpreted as an intervention proven in this study to improve exclusive breastfeeding success. Future research should standardize and test the booklet's readability, verify meaningful family engagement, document WhatsApp messages, and include a comparison group. Outcomes more directly related to service benefits could include emotional and instrumental support behaviors, shared decision-making, referral for breastfeeding difficulties, early initiation of breastfeeding, and exclusive breastfeeding measured using standardized definitions and follow-up periods (Abbass-Dick & Dennis, 2017; Martin et al., 2021; Tomori et al., 2022).

Strengths and limitations

Strengths of this study include paired measurements in the same participants and the separate assessment of knowledge and attitudes. Nevertheless, the uncontrolled design cannot rule out history effects, maturation, repeated testing, regression to the mean, or environmental changes; convenience sampling limits external validity. The three participants who missed the posttest, together with the absence of information about their reasons and characteristics, may have introduced attrition bias. The small sample without an a priori power calculation limits precision and the interpretation of nonsignificant results. The number of questionnaire items, validity, reliability, scale limits, and reading adherence were not documented. The lack of records on educational fidelity and WhatsApp activity prevents separation of the contributions of the booklet and digital communication. Supportive behaviors and exclusive breastfeeding practices were not measured. Claims about mechanisms of change and breastfeeding success should therefore be treated as hypotheses for future research.

Conclusion and Recommendation

Among 30 participants with complete pretest–posttest data, knowledge scores increased by a mean of 0.67 points over 28 days and showed a statistically significant difference; attitude scores increased by 1.30 points, but the difference was not significant. This study describes within-group changes among participants receiving the BUSUI booklet and WhatsApp reminders; it does not provide evidence of BUSUI's causal effectiveness. Controlled studies with fully documented instruments, measures of family support behaviors, and exclusive breastfeeding outcomes are needed to assess clinical and implementation benefits.

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Declaration of conflict of interest
The authors declare no competing interests.

Declaration on the Use of AI
No AI tools were used in the preparation of this manuscript.

Data Availability Statement
Data sharing is not applicable to this article.

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