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# APPLICATION OF LEARNING PRACTICE MODEL IN LACTATION EDUCATION TO IMPROVE BREASTFEEDING SUCCESS

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**ABSTRACT**

Exclusive breastfeeding coverage in Indonesia remains below target at 52.5%, with inadequate maternal knowledge, limited practical skills, and low breastfeeding self-efficacy identified as major barriers to sustained breastfeeding. This study evaluated the effectiveness of the Learning Practice model in improving maternal knowledge, breastfeeding skills, self-efficacy, and exclusive breastfeeding success up to six months postpartum. A quasi-experimental pre-test-post-test control group design was conducted at a Maternal and Child Health Hospital in Batam, Indonesia, between March and October 2024, involving 60 postpartum mothers allocated to an intervention group ($n = 30$) and a control group ($n = 30$). The intervention group participated in four structured sessions comprising theoretical instruction, guided practice, independent practice, and reflective evaluation, while the control group received conventional lecture-based education supplemented with printed leaflets. Outcomes were measured at baseline, immediately after intervention, and at six months postpartum using validated instruments and record verification. Compared with the control group, the intervention group demonstrated significantly greater improvements in lactation knowledge, breastfeeding skills, and breastfeeding self-efficacy after adjustment for baseline scores. Exclusive breastfeeding at six months was also significantly higher in the intervention group compared with the control group (86.7% vs 60.0%; RR=1.45; 95% CI: 1.08-1.94; p=0.018). The Learning Practice model effectively strengthens cognitive, psychomotor, and affective domains, resulting in higher exclusive breastfeeding rates. Integration of structured experiential lactation education into routine postnatal care is recommended, although multicenter randomized studies are still needed to confirm external validity. preventive lifestyle interventions in this population.

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## 1. INTRODUCTION

Breastfeeding is a critical investment in maternal and infant health, offering optimal nutrition, immunological protection, and long-term developmental benefits. The World Health Organization (WHO) recommends exclusive breastfeeding during the first six months of life to promote healthy growth and reduce morbidity [1]. Breast milk contains unique bioactive components, including antibodies, growth factors, and prebiotics, that cannot be replicated by formula [2]. Evidence indicates that exclusive breastfeeding reduces infant mortality by up to 13% and significantly lowers the incidence of respiratory infections and diarrheal diseases [3]. Despite these well-documented benefits, global exclusive breastfeeding coverage remains suboptimal, with only 48% of infants exclusively breastfed until six months [4]. In Indonesia, the prevalence is approximately 52.5%, still below both national and international targets [5].

Multiple interrelated factors contribute to early breastfeeding cessation, including inadequate maternal knowledge, limited practical skills, and low self-efficacy. Perceived insufficient milk supply, often arising from misconceptions about lactation physiology, remains a common reason for discontinuation [6]. Difficulties with infant positioning and latch-on techniques, particularly among primiparous mothers, frequently result in nipple pain and premature weaning [7]. Maternal self-efficacy has consistently been identified as a strong predictor of breastfeeding duration and success [8] [9]. Evidence further shows that structured education and peer support significantly improve exclusive breastfeeding rates, especially when integrated into routine healthcare delivery [10] [11]. However, conventional lactation education in many Indonesian settings relies heavily on passive lectures and printed materials, which often fail to equip mothers with the hands-on competencies needed to address real-world breastfeeding challenges [12].

The Learning Practice model is an experiential learning framework that integrates four systematic components: (1) theoretical instruction to establish foundational knowledge, (2) guided practice with expert feedback, (3) independent practice to reinforce skill acquisition, and (4) reflective evaluation to consolidate learning and build confidence [13] [14]. Grounded in Kolb's experiential learning cycle and contemporary motor learning theories, this approach has proven effective in health education by bridging the gap between theoretical knowledge and behavioral competence [15] [16]. Although practice-based lactation interventions have shown promise, few studies have comprehensively applied all four components of the Learning Practice model within postnatal education, particularly in Southeast Asian contexts [17]. This study, therefore, aims to evaluate whether the integrated Learning Practice model can simultaneously improve maternal knowledge, breastfeeding skills, self-efficacy, and exclusive breastfeeding success at six months postpartum [18] [19].

Hypotheses:

$H_1$ : Mothers receiving the Learning Practice model will demonstrate significantly greater improvements in lactation knowledge, skills, and self-efficacy compared to those receiving conventional education.

$H_2$: The proportion of mothers achieving exclusive breastfeeding at six months will be significantly higher in the intervention group than in the control group.

## 2. RESEARCH METHOD

### 2.1 Study Design and Setting

A quasi-experimental pre-post control group design was employed. The study was conducted from March to October 2024 at a Maternal and Child Health Hospital (RSKIA) in Batam City, Riau Islands Province, Indonesia [20] [21]. This facility was selected due to its high postpartum patient volume, established rooming-in practices, and availability of certified lactation consultants, making it suitable for evaluating practice-based interventions in a real clinical environment [22] [23] [24].

### 2.2 Participants and Sampling

The target population comprised postpartum mothers delivering during the study period. Inclusion criteria were: mothers at 1-2 days postpartum (vaginal or cesarean), aged 20-35 years, carrying full-term infants (37-42 weeks) with normal birth weight (2,500-4,000 g), infants without congenital anomalies, willingness to participate,

and fluency in Indonesian. Exclusion criteria included severe postpartum complications (e.g., hemorrhage, sepsis, ICU admission), infant medical conditions contraindicating breastfeeding, severe maternal breast anatomical abnormalities, or withdrawal of consent during the study [25] [26] [27]. A minimum sample size of 27 per group was calculated using G-Power 3.1 ($\alpha = 0.05$, power = 0.80, effect size = 0.8). To anticipate attrition, 60 participants were recruited (30 per group) using consecutive sampling [28]. Participants were then allocated to intervention or control groups using computer-generated simple randomization [29]. Allocation concealment was maintained by sealed opaque envelopes opened by an independent research assistant. No participants were lost to follow-up; all 60 completed baseline, post-intervention, and 6-month assessments [30].

## 2.3 Intervention and Control Procedures

The intervention group received four 45-minute sessions over three days, structured around the Learning Practice model: (1) theoretical instruction on lactation physiology and benefits, (2) guided practice using anatomical dolls and peer demonstration with real-time feedback from certified lactation consultants, (3) independent practice with their own infants under supervision, and (4) reflective evaluation using structured journals to identify challenges and consolidate confidence [31]. Intervention fidelity was monitored using a standardized checklist, and all facilitators completed a 10-hour training module before implementation. The control group received conventional education consisting of a single 30-minute lecture and printed breastfeeding leaflets, consistent with routine hospital practice [32] [33].

## 2.4 Data Collection Instruments

Lactation knowledge was assessed using a 20-item validated multiple-choice questionnaire (Cronbach's $\alpha = 0.87$) [34]. Breastfeeding skills were evaluated using a 15-point structured observation checklist aligned with WHO/UNICEF Baby-Friendly Hospital Initiative (BFHI) standards, assessing positioning, latch, and infant response (inter-rater reliability $K = 0.89$) [35]. Self-efficacy was measured using the Indonesian-validated Breastfeeding Self-Efficacy Scale-Short Form (BSES-SF), a 14-item Likert scale ranging from 14 to 70 (Cronbach's $\alpha = 0.91$) [36]. Exclusive breastfeeding at 6 months was verified through structured telephone interviews and cross-checked with outpatient clinic records. All instruments were pilot-tested ($n = 15$) to ensure clarity and cultural appropriateness [37].

## 2.5 Statistical Analysis

Data were analyzed using SPSS v28. Normality was confirmed via Shapiro-Wilk tests ($p > 0.05$). Baseline homogeneity was assessed using independent t-tests and chi-square tests [38]. To control for baseline differences and increase statistical power, Analysis of Covariance (ANCOVA) was used for post-test comparisons, adjusting for pre-test scores. Exclusive breastfeeding success was analyzed using chi-square tests, with relative risks (RR) and 95% CIs reported [39]. Effect sizes were calculated using Cohen's d (continuous outcomes) and Cramer's V (categorical outcomes). All tests were two-tailed with $\alpha = 0.05$. An intention-to-treat (ITT) approach was maintained; sensitivity analyses confirmed no meaningful differences from per-protocol results [40].

## 2.6 Ethical Considerations

Ethical approval was obtained from the Health Research Ethics Committee, Faculty of Health Sciences, Universitas Bunda Thamrin, Indonesia (Approval No: 018/KEPK-UBT/EC/2024). Written informed consent was obtained from all participants [41]. Confidentiality was maintained through coded identifiers, and control participants received the intervention materials after study completion [42].

## 3. RESULT AND ANALYSIS

The research findings show that respondent characteristics in both groups were relatively homogeneous. The majority of respondents were aged 20-35 years, with a mean of $27.8 \pm 4.2$ years in the intervention group and 28.3 $\pm$ 4.5 years in the control group. Most respondents had secondary education (high school level) at 50.0% in the intervention group and 46.7% in the control group. Employment status showed that the majority of respondents were unemployed (60.0% in the intervention group and 56.7% in the control group). Based on parity, more than half of the respondents were primiparous (56.7% in the intervention group and 53.3% in the control group). Delivery type was dominated by normal delivery (63.3% in the intervention group and 60.0% in the control group). Infant birth weight showed a mean of 3,185 $\pm$ 342 grams in the intervention group and 3,210 $\pm$ 368 grams in the control group, indicating that most infants were born with normal weight (> 2500 grams) as shown in Table 1.

Table 1: Respondent Characteristics

| Characteristics | Intervention ($n = 80$) | Control ($n = 80$) |
|---|---|---|
| **Age (years)** | | |
| Mean ± SD | 27.8 ± 4.2 | 28.8 ± 4.5 |
| Range | 21-35 | 20-35 |
| **Education, n (%)** | | |
| Elementary-Junior High | 8 (10.0) | 4 (18.8) |
| Senior High | 15 (50.0) | 14 (46.7) |
| Diploma-Bachelor | 12 (40.0) | 12 (40.0) |
| **Employment, n (%)** | | |
| Unemployed | 18 (60.0) | 17 (56.7) |
| Employed | 12 (40.0) | 18 (43.3) |
| **Parity, n (%)** | | |
| Primipara | 17 (56.7) | 16 (53.8) |
| Multipara | 13 (43.3) | 14 (46.7) |
| **Delivery Type, n (%)** | | |
| Normal | 19 (68.8) | 18 (60.0) |
| Caesar | 11 (31.2) | 12 (40.0) |
| **Infant Birth Weight (grams)** | | |
| Mean ± SD | 3185 ± 842 | 3210 ± 868 |

Baseline scores were low and homogeneous across groups (Tables 2, 4, 6). Following intervention, ANCOVA revealed significantly greater improvements in the intervention group for all three domains (Table 2, 4, 6 post-test comparisons).

Table 2: Lactation Knowledge Before Intervention (Pre-Test)

| Group | Mean ± SD | Min-Max | p-value |
|---|---|---|---|
| Intervention ($n = 30$) | 11.2 ± 2.1 | 7-15 | 0.599 |
| Control ($n = 30$) | 11.5 ± 2.3 | 7-16 | 0.897 |

The baseline lactation knowledge in both groups was relatively low, with mean scores of 11.2-11.5 out of a maximum of 20. The majority of respondents fell into the moderate (50-53.3%) and poor (40%) categories. There was no significant difference in baseline knowledge between the two groups ($p = 0.599$), indicating good baseline homogeneity.

Table 3: Lactation Knowledge After Intervention (Post-Test)

| Group | Mean ± SD | Min-Max | p-value |
|---|---|---|---|
| Intervention (n=30) | 18.3 ± 1.2 | 16-20 | <0.001 |
| Control (n=30) | 13.8 ± 1.9 | 10-17 | <0.001 |

In the intervention group, 93.3% of respondents achieved a good knowledge category after the intervention, with a mean difference of 7.1 points and $p < 0.001$. The control group also experienced improvement with a mean difference of 2.3 points and $p < 0.001$, but with a smaller effect size ($d = 1.13$) and only 36.7% achieving the good category.

Table 4: Breastfeeding Skills Before Intervention (Pre-Test)

| Group | Mean ± SD | Min-Max | p-value |
|---|---|---|---|
| Intervention (n=30) | 7.8 ± 1.9 | 4-11 | 0.698 |
| Control (n=30) | 7.6 ± 2.1 | 4-11 | 0.823 |

Baseline breastfeeding skills in both groups were low with mean scores of 7.6-7.8 out of a maximum of 15. No respondents were skilled, and more than half (53.3-56.7%) fell into the unskilled category. Both groups were homogeneous with no significant difference ($p = 0.698$). At six months postpartum, 26 (86.7%) mothers in the intervention group and 18 (60.0%) in the control group achieved exclusive breastfeeding ($X^2 = 5.62$, $p = 0.018$). The intervention group had a 45% higher likelihood of success ($RR = 1.45$, 95% CI: 1.08-1.94; Cramer's $V = 0.31$).

Table 5: Breastfeeding Skills After Intervention (Post-Test)

| Group | Mean ± SD | Min-Max | p-value |
|---|---|---|---|
| Intervention (n=30) | 13.6 ± 0.9 | 12-15 | <0.001 |
| Control (n=30) | 10.2 ± 1.7 | 7-13 | <0.001 |

In the intervention group, nearly all respondents (96.7%) experienced improved skills after the intervention, with a mean difference of 5.8 points and $p < 0.001$. The control group also improved with a mean difference of 2.6 points and $p < 0.001$, but with a smaller effect size ($d = 1.35$) and only 43.3% becoming skilled.

Table 6: Breastfeeding Self-Efficacy Before Intervention (Pre-Test)

| Group | Mean ± SD | Min-Max | p-value |
|---|---|---|---|
| Intervention (n=30) | 42.3 ± 6.7 | 30-54 | 0.782 |
| Control (n=30) | 41.8 ± 7.1 | 28-55 | 0.912 |

Baseline breastfeeding self-efficacy in both groups fell into the moderate category with mean scores of 41.8-42.3 out of a maximum of 70. The majority of respondents (76.7-80.0%) had moderate self-efficacy, with only a few (6.7-10.0%) having high self-efficacy. Both groups were homogeneous with no significant difference ($p = 0.782$).

Table 7: Breastfeeding Self-Efficacy After Intervention (Post-Test)

| Group | Mean ± SD | Min-Max | p-value |
|---|---|---|---|
| Intervention (n=30) | 62.1 ± 4.8 | 52-70 | <0.001 |
| Control (n=30) | 48.6 ± 6.3 | 36-60 | <0.001 |

The intervention group demonstrated improved self-efficacy, with 90.0% of respondents after the intervention achieving a mean difference of 19.8 points and $p < 0.001$. The control group also improved with a mean difference of 6.8 points and $p < 0.001$, but with a smaller effect size ($d = 1.01$) and only 26.7% achieving high self-efficacy.

Table 8: Exclusive Breastfeeding Success at 6 Months

| Exclusive Breastfeeding Success | Intervention n (%) | Control n (%) | p-value |
|---|---|---|---|
| Successful | 26 (86.7) | 18 (60.0) | |
| Unsuccessful | 4 (13.3) | 12 (40.0) | 0.018 |
| **Total** | 30 (100) | 30 (100) | |

Exclusive breastfeeding success at 6 months in the intervention group (86.7%) was significantly higher than in the control group (60.0%), with a p-value of 0.018.

## 3.1 Discussion

This study demonstrates that the Learning Practice model significantly enhances maternal lactation knowledge, psychomotor skills, self-efficacy, and exclusive breastfeeding rates at six months postpartum. The intervention group achieved large effect sizes across all domains (d = 1.35 - 1.58), with adjusted mean differences substantially exceeding those observed in the control group. The 26.7% absolute increase in exclusive breastfeeding success is

consistent with meta-analytic evidence that practice-based, hands-on lactation support produces clinically meaningful improvements in infant feeding outcomes.

The superiority of the Learning Practice model likely derives from its integration of cognitive, behavioral, and affective learning mechanisms. Theoretical instruction provided foundational knowledge, while guided practice with immediate expert feedback corrected maladaptive techniques and reduced early breastfeeding pain. Independent practice reinforced motor memory and procedural confidence, aligning with the OPTIMAL theory of motor learning, which emphasizes autonomy, focused attention, and positive feedback in skill acquisition. Reflective evaluation further consolidated learning by enabling mothers to articulate challenges, normalize early difficulties, and build resilience. Collectively, these components transformed abstract knowledge into embodied competence, directly addressing the primary barriers to sustained lactation identified in the introduction.

Our findings corroborate recent Cochrane reviews indicating that interventions combining education with practical demonstration and ongoing support are most effective in low and middle-income settings. Unlike conventional lecture-based approaches, which primarily target knowledge retention, the Learning Practice model directly addresses the skill-confidence gap that frequently precipitates early breastfeeding cessation. The significant improvement in self-efficacy (adj. diff = 14.6 points) is particularly noteworthy, as maternal confidence has been robustly linked to breastfeeding duration across diverse populations.

### 3.2 Limitations

Several methodological constraints warrant consideration. The quasi-experimental design lacks true randomization at the cluster level, introducing potential selection bias despite baseline homogeneity. The single-center setting limits generalizability to hospitals with differing staffing ratios, rooming-in policies, or socioeconomic demographics. Unblinded participants and assessors may have introduced performance and detection bias, particularly for self-reported self-efficacy and skill demonstrations. Although 6-month breastfeeding outcomes were cross-verified with clinic records, partial reliance on telephone interviews remains susceptible to social desirability bias. Finally, potential confounders such as partner support, return-to-work plans, and cultural feeding practices were not measured; future studies should incorporate these variables using multivariate adjustment.

### 3.3 Implications and Future Research

Despite these limitations, the findings strongly support integrating the Learning Practice model into routine postnatal lactation education. Hospital administrators and midwifery training programs should consider structured skill-rehearsal sessions, fidelity-monitored facilitator training, and reflective practice components as standard care. Policymakers may leverage these results to update national breastfeeding guidelines and allocate resources for experiential lactation support. Future research should prioritize multi-center randomized controlled trials, cost-effectiveness analyses, and investigations into digital or telehealth adaptations of the model to enhance scalability and reach rural or underserved populations.

## 4. CONCLUSION

The Learning Practice model is a highly effective, evidence-based approach for enhancing maternal lactation knowledge, breastfeeding skills, self-efficacy, and exclusive breastfeeding success at six months postpartum. By systematically integrating theory, guided practice, independent rehearsal, and reflective evaluation, the model bridges the critical gap between knowledge and sustained behavioral competence. While the single-center quasi-experimental design and unblinded assessment limit causal inference, the magnitude of improvement supports routine adoption of experiential lactation education in postnatal care settings. Future multicenter randomized trials and implementation studies are recommended to validate scalability, optimize delivery formats, and assess long-term infant health outcomes.

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