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Original Article

Husband support and exclusive breastfeeding among breastfeeding mothers

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Abstract:
Exclusive breastfeeding for the first six months is essential for infant growth, infection prevention, and maternal health. Husband support is one factor that can strengthen maternal confidence and consistency in breastfeeding. This study aimed to analyze the relationship between husband support and exclusive breastfeeding among breastfeeding mothers in Batursari Village, Batangan District, Pati Regency. This quantitative analytic study used a cross-sectional design. The population was 40 breastfeeding mothers, and 36 respondents were selected using purposive sampling. Husband support was measured using a structured questionnaire and categorized as good or less support. Exclusive breastfeeding was categorized as yes, or no. Data were analyzed using frequency distribution and the chi-square test. Most respondents received good husband support (66.7%), and most respondents provided exclusive breastfeeding (58.3%). Among mothers with good husband support, 79.2% provided exclusive breastfeeding. Among mothers with less husband support, 83.3% did not provide exclusive breastfeeding. The chi-square test showed a significant relationship between husband support and exclusive breastfeeding (p = 0.001). The calculated odds ratio was 19.00 (95% CI = 3.11-116.08). Husband support was significantly associated with exclusive breastfeeding among breastfeeding mothers in Batursari Village. Breastfeeding promotion should involve husbands through informational, emotional, instrumental, and appraisal support.

Keywords:
husband support, exclusive breastfeeding, breastfeeding mothers, family support, maternal health

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INTRODUCTION

Exclusive breastfeeding is a core maternal and child health practice because it provides optimal nutrition, immunological protection, and developmental support during the first six months of life. The World Health Organization defines exclusive breastfeeding as feeding an infant only breast milk, without additional food or drinks, including water, except oral rehydration solution, drops, syrups, vitamins, minerals, or medicines. Breast milk contains balanced macronutrients, bioactive compounds, antibodies, enzymes, and growth factors that support infant growth and protect infants

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from common infections. Evidence from global breastfeeding research shows that breastfeeding reduces infant morbidity and mortality, improves child development, and provides long-term health benefits for mothers, including a lower risk of some cancers and metabolic disorders (Victora et al., 2016; WHO, 2024).

Although the benefits are well established, exclusive breastfeeding remains difficult to sustain in many communities. The practice requires more than maternal willingness. Mothers need correct information, early initiation support, confidence, time, rest, emotional stability, and a home environment that protects breastfeeding from competing pressures. The Lancet breastfeeding series emphasizes that breastfeeding is shaped by structural, social, cultural, family, and health system factors, not only by individual choice (Rollins et al., 2016). In Indonesia, exclusive breastfeeding has been protected by Government Regulation Number 33 of 2012. This regulation states that infants should receive breast milk from birth until 6 months without other foods or drinks, except for medicines, vitamins, and minerals. However, national and local implementation still faces barriers related to maternal employment, family beliefs, formula promotion, low lactation support, and limited involvement of fathers in breastfeeding preparation.

Husband support is a key reinforcing factor in exclusive breastfeeding. In many Indonesian households, husbands influence family decisions, daily care arrangements, household spending, acceptance of health advice, and the emotional climate experienced by the mother. Support from a husband can take several forms. Informational support includes reminding the mother about exclusive breastfeeding, helping her understand the benefits of breastfeeding, and discussing advice from health workers. Emotional support includes empathy, praise, encouragement, and reassurance when the mother feels tired or anxious. Instrumental support includes helping with infant care, household tasks, transport to health services, and provision of nutritious food. Appraisal support includes positive feedback that strengthens the mother's confidence. These forms of support can reduce maternal stress and improve self-efficacy, which are important for maintaining lactation and breastfeeding behavior.

Recent studies support the role of husband and family support in breastfeeding outcomes. A systematic review and meta-analysis found that high husband support significantly increased the likelihood of exclusive breastfeeding, with pooled evidence from multiple countries and cross-sectional studies (Widiantoro et al., 2024). A mixed-method study in West Java found that low paternal support was associated with exclusive breastfeeding failure at three months, and qualitative findings showed that fathers often needed clearer knowledge and practical guidance to support mothers (Sartika et al., 2024). Research in Palu also reported that informational, emotional, instrumental, and appraisal support from the family were significantly related to exclusive breastfeeding behavior (Fadjriah et al., 2021). In a midwifery setting, husband support was associated with exclusive breastfeeding across informative, emotional, instrumental, and appraisal dimensions (Maulina et al., 2022).

Studies also strengthen this argument. Pakilaran et al. (2022) concluded that family support, including husband support, can increase maternal confidence, comfort, oxytocin production, and the ability to maintain exclusive breastfeeding. Safira and Luthfiyana (2024) reported that exclusive breastfeeding in Situbondo was related not only to maternal characteristics but also to wider barriers, including the need for stronger husband and family participation. Wanadi et al. (2023) showed that maternal knowledge is associated with exclusive breastfeeding behavior, which implies that family

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support should also include accurate communication and shared understanding. Musviro et al. (2024) emphasized that postpartum parenting and attachment promotion, including education on breastfeeding techniques, can improve readiness to become parents. Kurniyawan et al. (2023) showed that family support improves health awareness among farming families, including exclusive breastfeeding, nutrition, and routine health checks.

In Batursari Village, Batangan District, Pati Regency, breastfeeding mothers have varying levels of husband support. Preliminary interviews in the original study indicated that some mothers chose to breastfeed exclusively because their husbands provided attention, practical help, and motivation. Other mothers did not give exclusive breastfeeding because they worked, felt less confident, or rarely received their husband's attention due to work demands. No previous local studies have been reported in Batursari Village on husband support and exclusive breastfeeding. This creates a practical research gap at the community level. The present study aimed to analyze the relationship between husband support and exclusive breastfeeding among breastfeeding mothers in Batursari Village, Batangan District, Pati Regency. The findings are expected to support village health cadres, midwives, and primary health services in designing breastfeeding promotion that includes husbands as active partners.

METHOD

This study used a quantitative analytic design with a cross-sectional approach. The cross-sectional design was selected because the study measured husband support and exclusive breastfeeding status at the same point of observation. This design was appropriate for determining whether there was a statistical association between the independent and dependent variables in the study population. The study was conducted in Batursari Village, Batangan District, Pati Regency. The population consisted of 40 breastfeeding mothers living in the study area. The sample comprised 36 breastfeeding mothers who met the eligibility criteria and were selected purposively.

The inclusion criteria were breastfeeding mothers with infants in the exclusive breastfeeding assessment age range, living in Batursari Village, willing to participate, and able to answer the questionnaire. Mothers who were not present during data collection, declined consent, or provided incomplete questionnaire data were excluded from the final analysis. The independent variable was the husband's support for breastfeeding mothers. The dependent variable was exclusive breastfeeding. Husband support was assessed using a structured questionnaire covering four domains: informational, emotional, instrumental, and appraisal. Informational support involved the husband's role in providing or reinforcing information about exclusive breastfeeding. Emotional support refers to attention, encouragement, empathy, and praise. Instrumental support referred to practical help, such as helping care for the baby or assisting with household tasks. Appraisal support referred to positive evaluation and reinforcement of the mother's breastfeeding efforts. The final score was categorized as good support or less support according to the predetermined scoring scheme used in the original study.

Exclusive breastfeeding was measured by asking whether the infant received only breast milk without additional food or drink during the first six months, except for medicines, vitamins, or minerals. The response was categorized as yes or no. Data were collected using direct questionnaire

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administration. Before filling in the questionnaire, respondents received an explanation about the study objective, voluntary participation, confidentiality, and their right to withdraw. The researcher checked each questionnaire for completeness after collection. Incomplete responses were clarified during data collection when possible.

Data were processed through editing, coding, data entry, cleaning, and analysis. Univariate analysis was used to describe the frequency and percentage of husband support and exclusive breastfeeding. Bivariate analysis was used to test the relationship between husband support and exclusive breastfeeding. Because both variables were categorical, the chi-square test was used. The level of statistical significance was set at $p < 0.05$. The original analysis reported a p-value for the Continuity Correction of 0.001. To strengthen interpretation, an odds ratio was also calculated from the 2 x 2 table. The odds ratio compared the odds of exclusive breastfeeding among mothers with strong husband support to those with weaker husband support. The calculated odds ratio was 19.00 with a 95% confidence interval of 3.11-116.08. This additional estimate provides a sense of the magnitude of the association, but it should be interpreted with caution because the sample size was small and the confidence interval was wide. The study was reported according to the structure of an observational article, including background, method, results, discussion, conclusion, conflict of interest, and references.

RESULTS

The results are presented in three tables. Univariable analysis describes husband support and exclusive breastfeeding status. Bivariate analysis presents the relationship between husband support and exclusive breastfeeding among breastfeeding mothers in Batursari Village, Batangan District, Pati Regency.

Table 1. Distribution of husband support and exclusive breastfeeding among breastfeeding mothers (n=36)

Variable	Frequency	Percentage (%)
Husband support		
Good	24	66.7
Less	12	33.3
Exclusive breastfeeding		
Yes	21	58.3
No	15	41.7

Table 1 shows that most breastfeeding mothers received strong support from their husbands. Twenty-four respondents (66.7%) were categorized as having good support, while 12 respondents (33.3%) were categorized as having less support. It also shows that 21 respondents (58.3%) provided exclusive breastfeeding, while 15 respondents (41.7%) did not.

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Table 3. Relationship between husband support and exclusive breastfeeding

Husband support	Exclusive breastfeeding				Total		p-value
	Yes		No		f	%	
	n	%	n	%			
Good	19	79.2	5	20.8	24	100.0	0.001
Less	2	16.7	10	83.3	12	100.0	
Total	21	58.3	15	41.7	36	100.0	

Note. OR = 19.00; 95% CI = 3.11-116.08.

Table 3 shows that mothers with good husband support mostly provided exclusive breastfeeding, namely 19 respondents (79.2%). In contrast, mothers with less husband support mostly did not provide exclusive breastfeeding, namely 10 respondents (83.3%). The chi-square test showed p = 0.001, indicating a significant relationship between husband support and exclusive breastfeeding. The odds ratio was 19.00 with a 95% confidence interval of 3.11-116.08.

DISCUSSION

The study found a significant relationship between husband support and exclusive breastfeeding among breastfeeding mothers in Batursari Village, Batangan District, Pati Regency. Mothers who received strong husband support were more likely to provide exclusive breastfeeding than those who received less support. The data show that 19 of 24 mothers with good husband support gave exclusive breastfeeding, while only 2 of 12 mothers with less husband support did so. The chi-square test produced a p-value of 0.001, indicating a statistically significant association. The calculated odds ratio was 19.00, indicating that mothers with strong husband support had much higher odds of exclusive breastfeeding than mothers with weaker support. However, the confidence interval was wide, so the result should be interpreted as a strong community-level signal that still needs confirmation in a larger sample.

The finding is consistent with the theory that breastfeeding behavior depends on more than maternal intention. Exclusive breastfeeding occurs within a family system. A mother may know the benefits of breast milk, but she still needs time, rest, confidence, and practical help to maintain breastfeeding every day. The husband is often the closest adult who can provide this support. In the present study, strong support was reflected in husband actions, such as providing information about breast milk only from birth to six months, and praising mothers who consumed nutritious food to support milk production. Less support was reflected in limited praise for exclusive breastfeeding and limited help in caring for the baby. These items show that husband support in this village was not only emotional. It also involved information, appreciation, and direct assistance.

The results align with the meta-analysis by Widiantoro et al. (2024), which found that high husband support was associated with increased exclusive breastfeeding. This agreement is important because the present study has a small local sample, while the meta-analysis summarizes broader evidence. The result also supports the mixed-methods findings of Sartika et al. (2024), which showed that low paternal support was associated with increased exclusive breastfeeding failure at 3 months in West Java. Sartika et al. (2024) also found that fathers may want to support mothers

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but lack the knowledge and concrete role description needed to act. This point is relevant for Batursari Village. If husbands believe breastfeeding is only the mother's responsibility, they may not provide enough practical support even when they support the idea of breastfeeding in general.

The result also aligns with Fadjriah et al. (2021), who found that family social support, including informational, instrumental, emotional, and appraisal support, was associated with exclusive breastfeeding behavior. This framework helps explain the current result. Informational support helps mothers recognize that breast milk alone is enough for the first six months. Emotional support reduces stress and improves maternal confidence. Instrumental support reduces fatigue by helping with household work and baby care. Appraisal support strengthens the mother's belief that she is doing the right thing. These forms of support may work together. A mother who receives information but no help at home may still stop exclusive breastfeeding because she is exhausted. A mother who receives help but no correct information may still give water, formula, or early complementary foods because of family myths.

Pakilaran et al. (2022) reported that support from husbands and other family members can increase maternal comfort and confidence and may influence oxytocin production, which supports breastfeeding. Safira and Luthfiyana (2024) noted that barriers to exclusive breastfeeding in Situbondo include insufficient husband and family participation, lack of trained breastfeeding counseling personnel, formula promotion, and myths that do not support exclusive breastfeeding. These barriers are relevant to community settings where health information is often shared through family networks. Wanadi et al. (2023) highlighted the relationship between maternal knowledge and exclusive breastfeeding behavior. This means that husband support should not stand alone as emotional encouragement. It should also reinforce accurate knowledge. Musviro et al. (2024) showed that parenting promotion and attachment promotion can improve readiness to become parents in postpartum care. This supports the idea that breastfeeding interventions should target the couple as a parenting unit, not the mother alone.

The inclusion of Kurniyawan et al. (2023) is useful for strengthening the family support perspective. Although the study focused on farming family health awareness, it stated that family support can increase awareness of nutrition, exclusive breastfeeding, treatment adherence, and routine health checks. This is relevant because exclusive breastfeeding is a family health behavior. It requires shared awareness and repeated reinforcement in daily life. The study suggests that health workers should strengthen family communication and social functioning, rather than just deliver individual counseling to mothers.

The present study also shows that husband support does not fully determine exclusive breastfeeding. Five mothers with supportive husbands did not provide exclusive breastfeeding. The original explanation indicates that some mothers worked and could not breastfeed during working hours. This finding is consistent with the broader evidence that employment can affect breastfeeding continuity if mothers lack time, facilities, pumping skills, storage knowledge, or workplace support. Conversely, two mothers with less husband support still provided exclusive breastfeeding. These mothers were not working and had more time to breastfeed directly at home. This pattern shows that exclusive breastfeeding results from an interaction between husband support, employment, knowledge, maternal confidence, family norms, and access to health services.

The physiological pathway may also explain the association. Breastfeeding depends on milk production and milk ejection. Stress, anxiety, fatigue, and lack of support can disturb maternal

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comfort and affect the oxytocin reflex. Sari et al. (2023) and other lactation studies emphasize that oxytocin-related interventions and supportive conditions can help breast milk production among postpartum mothers. A supportive husband can reduce the mother's burden, help her rest, encourage her to eat nutritious foods, and create a calmer breastfeeding environment. These factors may help the mother maintain breastfeeding. Still, physiological explanations should be stated carefully, as this study did not directly measure oxytocin, milk volume, stress, or breastfeeding self-efficacy.

The implication for practice is clear. Breastfeeding education in Batursari Village should involve husbands from pregnancy, postpartum visits, posyandu activities, and home visits. Midwives and cadres can explain the four support domains in simple actions. Husbands should know that support includes reminding the mother of the importance of exclusive breastfeeding, protecting the mother from early formula use unless medically indicated, helping with household work, accompanying the mother to health services, ensuring adequate food and fluids, praising breastfeeding efforts, and helping the mother manage expressed breast milk if she works. Education should also address common myths, such as the belief that infants need water before six months or that crying always means breast milk is insufficient.

This study has limitations. The cross-sectional design cannot prove causality. The sample size was small and limited to one village, so generalization should be cautious. The study used self-reported data, which may be affected by recall bias and social desirability bias. The husband support categories were based on questionnaire scores, but the original manuscript did not provide detailed validity and reliability information. Future studies should use a larger sample, validated instruments, and multivariable analysis to control for employment status, maternal education, parity, infant age, delivery method, breastfeeding self-efficacy, and exposure to formula promotion. Qualitative interviews with husbands may also identify practical barriers that prevent fathers from giving support. Despite these limitations, the result provides a useful local evidence base for husband-inclusive breastfeeding promotion in Batursari Village.

CONCLUSION

There was a significant relationship between husband support and exclusive breastfeeding among breastfeeding mothers in Batursari Village, Batangan District, Pati Regency. Most mothers who received strong husband support provided exclusive breastfeeding, whereas most mothers with weaker husband support did not. Husband support should be strengthened through simple, practical actions, including providing accurate breastfeeding information, helping mothers care for their babies, assisting with household tasks, offering emotional encouragement, and expressing appreciation for breastfeeding efforts. Primary health services, midwives, and health cadres should include husbands in breastfeeding education during pregnancy, postpartum care, and posyandu activities.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

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