narra j

Original Article

Mothers' perception of husband support during breastfeeding: A qualitative study in Indonesia

Eko Mardiyaningsih[1,2], Widyawati Widyawati[3*] and Elsi D. Hapsari[3]

[1]Doctoral Program of Medicine and Health, Faculty of Medicine, Public Health, and Nursing, Universitas Gadjah Mada, Yogyakarta, Indonesia; [2]Departement of Maternity and Pediatric Nursing, Universitas Ngudi Waluyo, Semarang, Indonesia; [3]Department of Pediatric and Maternity Nursing, Faculty of Medicine, Public Health, and Nursing, Universitas Gadjah Mada, Yogyakarta, Indonesia

*Corresponding author: widyawati.poernomo@ugm.ac.id

Abstract

The coronavirus disease 2019 (COVID-19) pandemic has significantly impacted maternal and perinatal healthcare worldwide, including in Indonesia. Restrictions on access to health services have forced mothers to adapt to new challenges in breastfeeding during the pandemic. The aim of this study was to evaluate mothers' breastfeeding experiences and the role of husbands in providing support during this period. This qualitative research used a phenomenological approach. Data were collected from August to October 2022 through a focus group discussion (FGD). Participants were selected using maximum variation sampling, with eight mothers participating in the FGD. Data were analyzed using qualitative content analysis, revealing four main themes: (1) not all husbands fully supported mothers' efforts to provide exclusive breastfeeding; (2) supportive and inhibiting factors help to provide exclusive breastfeeding; (3) mothers understood the benefits and identified the causes of failure in providing exclusive breastfeeding and complementary food for breast milk; and (4) various stressors experienced by mothers did not impede breastfeeding efforts. In conclusion, the findings highlight the need for healthcare workers, especially maternity nurses, to encourage continued breastfeeding and emphasize the importance of husbands' support in providing exclusive breastfeeding initiatives. Interventions should be designed to actively involve husbands in supporting exclusive breastfeeding practices.

Keywords: Breastfeeding, exclusive, husband, support, qualitative study

Introduction

The coronavirus disease 2019 (COVID-19) pandemic significantly impacted maternal and perinatal healthcare globally [1]. Indonesia was also affected by COVID-19, caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The first case of COVID-19 in Indonesia was detected on March 2, 2020. On March 31, 2020, the Indonesian government issued a decree establishing the COVID-19 Public Health Emergency and implemented large-scale social restrictions on April 1, 2020, to combat the spread of the COVID-19 virus [2,3]. The COVID-19 pandemic disrupted access to essential health services, including breastfeeding counseling in hospitals, clinics, and through home visits, resulting in decreased breastfeeding coverage rates worldwide [4].

The World Health Organization (WHO) emphasized the importance of continuing breastfeeding during the pandemic and encouraged governments to support mothers. Breastfeeding mothers could be supported by improving the quality of counseling and providing

Received: July 10, 2024 - Accepted: October 10, 2024 - Published online: October 30, 2024

accurate information [5]. Previous research from the United Kingdom pointed out the importance of breastfeeding during the COVID-19 pandemic because it offers crucial protection against illnesses and infectious diseases, and it remains recommended even if the mother is COVID-19 positive [6]. However, the pandemic limited mothers' access to sources of advice and support [6], and they experienced various challenges, such as understaffed postpartum wards, early discharges, and a lack of breastfeeding support, raising concerns about long-term consequences such as postpartum depression [6,7].

Breastfeeding support was a significant concern for new mothers during the pandemic [4]. However, mothers did not receive breastfeeding support from health professionals, either in the hospital or at home [4,8]. Primary healthcare facilities were the primary sources of support after hospital discharge. Mothers often felt insecure due to the lack of knowledge about average breastfeeding experiences, exacerbated by strict pandemic restrictions. Despite this gap in support from health professionals, mothers received assistance from partners, family, and peers [9].

Partner support, particularly from husbands, was highly valuable for breastfeeding mothers during the pandemic and acted as a protective shield. Husbands could help with food preparation, housework, baby care, and provide breastfeeding encouragement [10]. However, some studies revealed that while husbands were concerned about their breastfeeding wives, they did not always assist with housework or other home activities and sometimes suggested using formula milk instead [11-15]. This lack of support and experience left mothers feeling unsure about their ability to breastfeed successfully [16]. Strengthening husband support is essential to promote continued breastfeeding during a pandemic [17]. Considering the importance of husbands' support of breastfeeding during the pandemic, a study on the experiences of breastfeeding mothers during the pandemic should be conducted based on the mothers' perspective about the husbands' support. Therefore, the aim of this study was to evaluate the experiences of breastfeeding mothers during the pandemic from their perspective.

Methods

Research design

This qualitative study employed a phenomenological approach to understand and describe the experiences of breastfeeding mothers and the meanings they ascribed to these experiences [18]. This method provided detailed descriptions and insights into participants' lived experiences [19].

Setting and participants

This study was carried out at one of the public health centers in Central Java, Indonesia. The study participants were eight mothers who were breastfeeding during the COVID-19 pandemic, specifically from March 2020 to July 2022. Data collection occurred between August 2 and October 31, 2022. Although the Indonesian president declared the official end of the pandemic on June 21, 2023 [20,21]. The challenges faced during the pandemic remained relevant for this study. Purposive sampling was used to obtain samples, with maximum variation sampling was used to select participants based on their education level and number of children. Inclusion criteria included breastfeeding mothers living with their husbands, who had babies aged 6–12 months, and who were willing to participate in the study. Meanwhile, the exclusion criterion was breastfeeding mothers with mental disorders such as depression or other mental disorders, as determined by the medical team at the community health center or hospital. The researchers coordinated with local midwives after obtaining data from the community health center to ensure that potential participants met the inclusion criteria.

Data collection

Data were collected through a focus group discussion (FGD) between August 2 and October 31, 2022. The FGD guidelines, developed based on the Sherriff concept, consisted of 16 questions addressing knowledge of exclusive breastfeeding, experiences during the pandemic, support received, and anticipated support from husbands [22]. Some examples of the questions included: (1) What do you know about exclusive breastfeeding? (2) How did you feel/experience when

breastfeeding during the pandemic? (3) Who assisted you in overcoming difficulties with breastfeeding during the pandemic? (4) What type of support/assistance did you anticipate from your husband during the breastfeeding process? and (5) What did your husband do when you experienced difficulties in breastfeeding?

Due to the pandemic, the data collection process was carried out via online meetings. Six informants participated in the online meeting from home, two from their workplaces, and the researchers participated from home. During the data collection process, the researchers were assisted by two research assistants with at least a bachelor's degree in nursing and who had previously conducted qualitative research. After all participants had informed consent, a single FGD with all eight participants was conducted for approximately 1.5 hours. The FGD took longer because problems arose during the FGD, such as a slow internet connection. The discussions were recorded, transcribed, and analyzed.

Analytical approach

Qualitative content analysis was performed to analyze data, involving coding and classification to identify systemic themes or patterns [18]. The analysis began with three researchers independently reading the transcripts to understand the data. Initial coding was carried out by one researcher using NVivo software, version 14 (QSR International Pty Ltd, Melbourne, Australia), and then three researchers manually reviewed the coding results. Disagreements in coding were resolved through discussion among the three researchers to ensure consensus. This approach aimed to generate insights and understanding about the phenomenon under investigation [18,23]. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used to guide the reporting of the research [24].

Trustworthiness

The researchers maintained the trustworthiness of the research results by conducting member-checking to ensure credibility by displaying transcripts of the participant's responses during the FGD process and the themes discovered. Data source triangulation was achieved by comparing participants' responses with their husbands (3 persons), in-laws (1 person), and healthcare professionals (1 person), thus involving a total of 5 additional individuals for triangulation. Transferability was determined by describing the participants' characteristics and research setting. The duration of the FGD was explained to maintain consistency (dependability). The principle of neutrality (confirmability) was applied by involving research assistants to collect data during the FGD. The research team had prior experiences in qualitative research processes and data collection using FGDs.

Results

Socio-demographic data

All participants were breastfeeding mothers, with an average age of 33.9 years. Most participants had a high school or undergraduate education. Meanwhile, the number of working mothers and stay-at-home moms was balanced. The average age of a breastfed babies was 8.25 months, and the highest number of children per participant was three (**Table 1**).

Table 1. Socio-demographic summary of participants included in the study

Characteristics	Frequency	Percentage
Age (years), mean	33.9	
Education		
High school	3	37.5
Diploma 3 graduates	1	12.5
Bachelor degree	3	37.5
Master degree	1	12.5
Occupation		
Housewife	4	50
Working	4	50
Age of breastfeed child (months), mean	8.25	
Number of children		
1	2	25
2	3	37.5
3	3	37.5

Analysis of findings

The analysis revealed four themes: (1) not all husbands fully supported mothers' efforts to provide exclusive breastfeeding; (2) supportive and inhibiting factors helped provide exclusive breastfeeding; (3) mothers understood the benefits and identified the causes of failure in providing exclusive breastfeeding and complementary food for breast milk; and (4) various stressors experienced by mothers did not impede breastfeeding efforts.

Not all husbands fully supported mothers' efforts to provide exclusive breastfeeding

The first theme in this study identified two subthemes: the husband's support did not fully meet the mother's expectations, and the mother attempted to understand her husband's situation. Several participants reported that their husbands provided emotional, physical, informational, and assessment support.

"During breastfeeding, what I feel is that my husband wants to help me with my tasks, ma'am, but those are not completed in the afternoon or the morning…if…what, in the morning or afternoon, he wants to help me with housework such as washing, drying clothes, etc., what is it called, reducing my burden like that." (P4)

P4 husband's statement also confirmed that he helped with household activities, such as washing, mopping, and tidying up the children's toys. Although husbands provided support, participants expected more emotional, physical, informational, and assessment support.

"For me, I would rather be cared for and loved, and sometimes men are too shy to give us affection, right? When they express it, sometimes they feel proud and shy, like that." (P7)

When a mother needed assistance, she had to understand her husband's situation by communicating, maintaining the husband's mood, and comprehending the significance of the husband's support for mental health.

"If I'm more into this, ma'am, it's like helping with homework and then giving more attention, and then I'm also being asked more often, what do you want, what do you want to do, and what do you need help with, because I think that's important for maintaining mental health, especially for those who are fulltime housewifes, a housewife at home, ma'am, because I'm bored from morning to evening to evening again to morning and that's routine, then I never leave the house, like that. Yes, he accompanies me to stay up late, if there's housework that can be done, he will help, that's more like that, ma'am." (P1)

Supportive and inhibiting factors help provide exclusive breastfeeding

The second theme was formed based on three subthemes: internal inhibiting factors to breastfeeding, external supports, external inhibiting factors, and cultural beliefs in society. Internal inhibiting factors to breastfeeding expressed by participants included concerns that the mothers would not be able to breastfeed since pregnancy, variations in time regarding the mother's ability to provide exclusive breastfeeding, and family experiences.

"The problem with breastfeeding was that at the age of three months, ma'am, there was little breast milk, the baby was fussy, I tried squeezing the nipple, and no milk came out; I tried using a breast milk buster but still, it seemed like the baby was still hungry, still thirsty." (P5)

"Even though I was still persistent in not giving my child food, my mother-in-law still fed my child, ma'am, and said, how could you bear the baby crying and not being fed, even though the baby was not yet six months old, ma'am." (P1)

These findings are supported by P5 husband's statement that the child stopped drinking breast milk because it stopped coming out and that his wife had taken supplements to help the milk flow smoothly. P1's mother-in-law then stated that she had suggested giving food other than

breast milk because her grandchild was crying due to hunger. Participants also received external support from healthcare workers, integrated service posts, parents, and friends.

"Well, I happen to have a friend, ma'am, who is pretty kind, and has two children, so she's very experienced, who helped me instead of my husband, but my friend, ma'am." (P1)

"When I went to see midwife, it happened that at that time my nipples were sore, so I was taught how to latch on the nipples to the baby because my child was three weeks old, if I'm not mistaken, and it was getting sore again, ma'am, so I was taught to latch on to the baby's lip so that my nipple wouldn't hurt, then I was told, basically, if the mother used to feel comfortable breastfeeding her baby, then the baby just had to follow her, like that." (P7)

Participants perceived external inhibiting factors to breastfeeding, including in-laws' perceptions of breast milk and expressed breast milk, as well as less supportive husbands, parents, and healthcare workers.

"Actually, there is no role of healthcare workers at integrated service post, ma'am; I mean, there's no advice, no guidance for a mother to breastfeed like this and that, so I was only going to the integrated service post to check my baby's weight, and then I was given additional food, and then went home, like that, no advice or anything else, except if I went to the clinic, closest clinic when my baby was sick and we went there for treatment. Actually, there have not been any suggestions from healthcare workers so far." (P7)

The healthcare statement confirms that not all integrated service posts provide breastfeeding counseling. Education is given to toddlers with decreasing weight. Regarding cultural beliefs in society, restrictions on drinking cold drinks, eating spicy food, and the early introduction of solid food were mentioned.

"Yes, my mother-in-law prohibited me from drinking ice; it happened when my breastmilk did not come out, then just like that, my mother-in-law asked me to drink herbal medicine and prohibited me from drinking ice; I should not have cold drinks, eat spicy food, and before the baby was three-month-old, she even asked me to feed my baby food until full, yes, so the baby did not cry anymore, did not fuss anymore." (P5)

Mothers understood the benefits and identified the causes of failure in providing exclusive breastfeeding and complementary food for breast milk

This third theme consisted of three subthemes: the benefits of exclusive breastfeeding, causes of failure in exclusive breastfeeding, and the decision to give or not give formula milk based on the mother and baby's condition. Participants understood the color, content, and benefits of colostrum, as well as the times, benefits, impacts, and challenges associated with exclusive breastfeeding.

"It has a great influence on baby's health; my first and second children were easily fussy and caught cold and fever easily, so I think I need to try giving my third child exclusive breast milk; who knows, perhaps his immune system will be better than that of my other older siblings, like that ma'am." (P2)

Maternal and infant factors caused the failure of exclusive breastfeeding included working mothers, insufficient breast milk, and the inability to produce milk. In contrast, infant factors included the use of a pacifier for drinking formula milk.

"My breast milk did not come out for a few days, maybe two days if not three days, it did not come out, so I gave the baby formula milk, ma'am." (P1)

Meanwhile, the decision to give or not give formula milk was associated with the condition of the mother and baby. Participants noted factors such as working mother, insufficient breast

milk, or breast milk that did not flow smoothly, and baby's preference for a pacifier, wanting to breastfeed directly, being easily irritable, getting cold and fever quickly, not wanting formula milk, being hungry, and losing weight.

"*Perhaps from the experience of my first child, ma'am, my child often got sick; the immune system was also lacking, so from that experience, I try to maximize breast milk for this second child, like that, ma'am.*" *(P4)*

"It's just that because there's not enough breast milk, then I ended up using formula milk, but I'd done everything, and I'd also followed all the midwife's recommendations before." (P5)

These were confirmed by P4 husband's statement that exclusive breastfeeding was optimal for six months. P5's husband also stated that the child refused to consume breast milk at the age of two months and had been given formula milk; then, the baby eventually wanted to drink breast milk again.

Various stressors experienced by mothers did not impede breastfeeding efforts

The fourth theme of this study consisted of three subthemes: various stressors, mothers' efforts to continue providing exclusive breastfeeding, and the adaptation to COVID-19 pandemic rules. Mothers faced multiple stressors, both physical and psychological. Physical stressors included the mother's fatigue and sleepiness, differences in breastfeeding experience, decreased breast milk production, and issues with breastfeeding positions.

"(My baby) wants to stand up (when having breast milk) because of my baby's habit of using a milk pacifier with the babysitter during the day, so I also breastfeed the baby standing up, ma'am; the baby does not want to lie down, maybe those are the problems, the challenges, ma'am." (P4)

Meanwhile, participants' psychological stressors included guilt over not having enough breast milk, the baby's refusal to breastfeed, staying up late alone, experiencing baby blues, different parenting styles between parents, restrictions from parents, and parents' opinions about breast milk.

"As for my problem, I think it's because I am stressed because I have a different opinion from my mother; we have different parenting styles, and parenting style today is different from parenting style in the past. So, I am stressed, the baby cries easily, and my mom thinks that's because of spoiled breast milk." (P7)

Mothers made both physical and psychological efforts to continue providing exclusive breastfeeding. Physical efforts included practicing breast care, sharing with friends, pumping breast milk, planning work schedules, practicing breastfeeding techniques, drinking breast milk enhancers, eating more vegetables, remaining enthusiastic about breastfeeding, being confident in her parenting style, explaining problems to parents, breastfeeding directly, and looking for breastfeeding information.

"I've tried using breast milk buster, but still, it seems like the baby is still hungry, still thirsty." (P5)

"Hmm, sharing, sharing my problems, ma'am, looking for someone to talk to so that I am not feeling lonely, looking for support from the environment around me, ma'am." (P1)

The mother made psychological efforts by ignoring stressors and staying to maintain positive thinking.

"Yes, (what people say) just accept it, just ignore it. I am also an indifferent person, so I do not really want to worry about it, so it comes back to us, so if, for example, we do not want to be

stressed, then there's no need to worry about it because if I think about it too much, it will affect my breast milk." (P7)

Two environmental factors forced mothers to adapt to COVID-19 rules while breastfeeding. First, maternal factors included feeling healthy, worrying about infection, enjoying breastfeeding, no cough, and exposure to COVID-19. Second, infant factors involved keeping a distance from the baby and the baby's potential exposure to COVID-19.

"I was sad, ma'am, because I gave birth and was declared still positive for COVID, ma'am, even though before I gave birth, I was negative, ma'am, but at the hospital, there was another test, and then the result was different, it became positive." (P4)

"Well, I mostly stay at home, ma'am; in the past, my first and second children were usually still small and they were taken out for a walk. During this pandemic, never, just stay at home, and if, for example, people come, they have to wash their hands, use hand sanitizer, and do not get close to my baby yet." (P5)

The P5 husband's statement also confirmed that to prevent COVID-19 transmission, everyone had to wash their hands, use hand sanitizer, and wear a mask before holding the baby. He emphasized that they also maintained physical distancing to protect their baby from further potential exposure.

Discussion

This study investigated the combined impact of the COVID-19 pandemic and the role of husbands in supporting exclusive breastfeeding. This study offers a detailed analysis within the Indonesian context during significant global disruption. By employing a phenomenological approach and focusing on the unique challenges posed by the pandemic, this research sheds light on the complex dynamics between mothers and their partners, revealing both the supportive and inhibitory factors affecting exclusive breastfeeding. The findings provide novel insights into how husbands' support or lack thereof impacts breastfeeding outcomes and identify internal and external factors contributing to or hindering successful breastfeeding. The emphasis on the pandemic's specific context and the role of husbands in breastfeeding support offers a fresh perspective on maternal and perinatal healthcare, which is critical for designing effective interventions to promote exclusive breastfeeding during global health crises.

The research yielded four critical themes. Firstly, it was observed that not all husbands fully supported mothers' efforts to provide exclusive breastfeeding. This study reported that the husbands did not offer verbal support, did not accompany their wives during breastfeeding at night, ignored their wives, played with mobile phones while their wives were breastfeeding, did not help with housework, did not initiate seeking information about breastfeeding, was more inclined to prioritize their own mothers' opinions on feeding choices over their wives' preferences, and was less sensitive to their wives' breastfeeding needs. These findings align with existing literature that documents the lack of support from partners in breastfeeding initiatives [11]. An exploratory qualitative design with purposive sampling was used to evaluate eight mothers who had been breastfeeding for less than three months. This approach provided insights into the dynamics and challenges these mothers faced in the early stages of breastfeeding. Husbands were often indifferent to the needs of breastfeeding mothers. This condition made mothers unsure about their breast milk production. In some cases, husbands even encouraged their wives to discontinue breastfeeding and switch to formula milk because they believed babies were constantly crying due to hunger and the mother's milk production was low [13-15]. Some husbands refused to assist their wives with housework or other household tasks [14,15]. If mothers do not receive support during breastfeeding, they may become uncertain about their breast milk production and may eventually decide to discontinue breastfeeding [4,15]. However, breastfeeding remains the most effective way to provide immunity to babies during a pandemic. Babies will become immune because of breast milk, which any milk cannot replace. Breastfeeding

is also less expensive than buying formula milk. Besides providing immunity to babies, breastfeeding can help save money during a pandemic when income is reduced [25].

The study found that some participants received support from their husbands. Mothers received verbal support by encouraging them to breastfeed, assisting with household chores, assisting in taking care of older children, purchasing breast milk boosters, ensuring the mothers' nutritional needs, accompanying them to stay up late, taking the initiative to learn about breast milk, advising to maximize exclusive breastfeeding, and following their wives' best decisions regarding baby feeding. A husband needs to support his wife while breastfeeding. Necessary supports are both verbal and nonverbal, more demonstrated by concrete actions. A previous study has shown that husbands who actively support and encourage mothers by assisting with tasks such as baby positioning, bringing snacks, and changing diapers had a significant impact on the mother's confidence in breastfeeding [26]. Another study highlighted that restrictions during a pandemic can be frightening for mothers, making the husband's support even more critical. The study provides an example of a husband who supports his wife by giving her a back massage and using techniques learned from sources such as YouTube videos. This action not only comforts the mother but also boosts the breast milk supply. The COVID-19 pandemic, while posing challenges, allowed mothers to understand better the importance of the support they receive from their surroundings, particularly their husbands. In times of constraint and uncertainty, such support is critical for maternal well-being and infant development [9].

Education level was found to play a significant role in shaping mothers' perceptions and practices regarding breastfeeding [27,28]. Mothers with higher education levels, such as those with a bachelor's or master's degree, demonstrated a better understanding of the benefits of exclusive breastfeeding and were more proactive in seeking information and support [28]. Conversely, those with lower education levels, such as high school graduates, were more likely to rely on traditional knowledge and familial advice, which sometimes conflicted with best practices for breastfeeding [27,28]. This disparity highlights the need for targeted educational interventions to ensure that all mothers, regardless of their academic background, receive adequate information and support to breastfeed successfully.

The second theme explored supporting and inhibiting factors related to exclusive breastfeeding, focusing on internal and external influences. The internal inhibiting factor to breastfeeding was the mother's fear of not being able to breastfeed since pregnancy. This occurred because data collection was conducted during the COVID-19 pandemic. A study explained that the COVID-19 pandemic had psychosocial consequences for pregnant women, including frequent reports of stress, depression, and panic disorders [29]. Besides the mother's concern, timing variations were associated with the mother's ability to provide exclusive breastfeeding, which is recommended for 1, 2, 3, and 6 months and consistent with the finding of a study indicating that the average duration of exclusive breastfeeding during the COVID-19 pandemic was 1, 3, and 6 months [30]. Family dynamics also played a role, as some mothers experienced challenges due to traditional and familial advice, such as in-laws feeding the baby before the recommended six-month period [31].

External factors also significantly influenced exclusive breastfeeding practices. Healthcare workers provide essential support by offering practical advice on breastfeeding techniques and providing emotional encouragement, which is crucial given that mothers often face unexpected difficulties despite their initial commitment to breastfeeding [32]. Additionally, parents and friends provided additional external support while breastfeeding during the pandemic, a finding consistent with that of a previous study. For example, family members who help breastfeeding mothers the most are parents and friends. Parents often advise breastfeeding for up to six months, whereas friends encourage pumping and storing breast milk before returning to work. [33]. However, some external factors acted as barriers; negative attitudes from in-laws and inadequate support from healthcare workers hindered exclusive breastfeeding efforts. For instance, mother-in-laws perceived that if the baby cried, the breast milk would be spoiled, and extracting breast milk would be complicated. This led to situations where mothers, lacking parental support, eventually gave formula milk. Another previous study revealed that grandmothers' negative attitudes toward breastfeeding influence mothers to either not start breastfeeding after giving birth or to stop breastfeeding [34]. Meanwhile, healthcare workers were unhelpful because some

of them were not educated about breastfeeding. This finding aligns with that of a previous study in which healthcare workers did not support and help mothers' situations by pressuring them to continue breastfeeding and not providing solutions to the mothers' problems [35,36]. This emphasizes the importance of healthcare workers' understanding and appropriate responses to the mothers' needs and feelings when facing breastfeeding challenges. [32]. Despite these obstacles, some mothers turned to herbal medicine, believing it could enhance milk production and support breastfeeding efforts, which is consistent with research showing that herbal remedies can improve breast milk production and maternal health [37].

The third theme explored mothers understanding of exclusive breastfeeding benefits and their experiences of failure. Mothers demonstrated a strong understanding of exclusive breastfeeding advantages, such as colostrum's nutritional and immunological benefits and the importance of maintaining exclusive breastfeeding. These findings are consistent with studies that assess maternal knowledge about breastfeeding [38-40]. However, practical challenges, such as returning to work and introducing pacifiers, were significant obstacles to exclusive breastfeeding. These results are consistent with Tsai's study results in 2022, which observed a decrease in breastfeeding rates once mothers returned to work, with rates dropping to 21.5% for 1-6 months and 17.9% for more than six months [41]. Working mothers frequently faced difficulties in providing exclusive breastfeeding, particularly when their children were familiar with pacifiers, which can decrease their willingness to breastfeed. This aligns with previous research indicating that breastfeeding continuity requires both support and adaptation in the workplace [42]. Many mothers struggled to find babysitters who can effectively manage non-pacifier breastfeeding methods, which adds to the challenges of maintaining exclusive breastfeeding.

Furthermore, the mother's and infant's conditions influenced the decision to give formula milk. Mothers' unique circumstances, such as those who are working, led them to choose formula milk. Other studies explained that mothers give formula milk because they have to work [43-45]. Formula milk was thought to be easier and more practical than breastfeeding, which was regarded as extra work besides caring for children, cooking, and cleaning the home. Moreover, the workplace environment makes it difficult for mothers to continue breastfeeding, such as a lack of room for pumping breast milk and limited rest time [46]. On the other hand, concerns about formula milk's impact on infants' immune systems and overall health also played a role in the decision-making process. Breast milk is recognized for its superior nutritional components that promote infant growth and immune development compared to formula milk [47].

The fourth theme revealed that mothers faced various stressors, yet these did not prevent their commitment to exclusive breastfeeding. Mothers experienced physical and psychological stressors. Physical stressors included reduced breast milk production and fatigue, while psychological stressors involve feelings of guilt and stress related to breastfeeding difficulties [48,49]. Despite these stressors, mothers demonstrated a strong commitment to breastfeeding, often seeking support from peers and adapting to the challenges of the pandemic. This resilience aligns with previous studies that highlight how mothers navigate breastfeeding challenges and seek support during times of adversity [14,44,50].

The mothers should adapt to the COVID-19 pandemic environment, including maternal and infant factors. Maternal factors associated with breastfeeding during the pandemic included being afraid and concerned that their child would be infected, so mothers always had to wear masks as preventive actions. This finding is consistent with a previous study reporting that postnatal mothers experienced stress and frustrations during the COVID-19 pandemic because they had to care for their babies alone [51–55]. The restrictions on prenatal, birth, and postnatal visits for family members and partners caused sadness and discomfort because of the consistent wearing of masks [56]. Other studies also indicated that the COVID-19 pandemic has hurt lives and exacerbated the stress levels of pregnant and postpartum women [51–53]. Postnatal mothers were concerned about their children's welfare and health, as well as how to care for them during the COVID-19 pandemic [57]. Meanwhile, environmental factors affecting the baby, such as colostrum, should be avoided, and early breastfeeding initiation should not be provided immediately after birth during the pandemic. A previous study described postnatal care and breastfeeding during the pandemic, in which mothers were not supported for skin-to-skin

contact, were not encouraged to breastfeed as soon as possible after birth, were not given information about expressing breast milk, and did not receive breastfeeding support in the hospital [58].

This study has several limitations, including a small sample size, which may not represent all breastfeeding mothers. The data were collected during the COVID-19 pandemic, which may have influenced the findings due to the period's unique stressors and restrictions. Additionally, the study relied on self-reported data, which can be subject to bias. Future research should include more extensive, diverse samples and consider the long-term impact of external support on breastfeeding practices.

Conclusion

The study identified four critical themes related to the breastfeeding experience, emphasizing the importance of optimizing husbands' roles during breastfeeding. To enhance breastfeeding outcomes, it is crucial to involve husbands in breastfeeding promotion efforts, ensuring they provide verbal and practical support, address and overcome obstacles and failures by educating and empowering both mothers and their partners, and reduce stressors related to breastfeeding by fostering supportive environments and providing resources for managing physical and psychological challenges. Future interventions should focus on creating comprehensive support systems that involve husbands, healthcare providers, and the broader community to promote successful breastfeeding practices and ensure the well-being of both mothers and infants.

Ethics approval

The Medical and Health Research Ethics Committee of the Faculty of Medicine, Public Health, and Nursing, Universitas Gadjah Mada, Yogyakarta, Indonesia, granted this study an ethical permit with the number KE/FK/0931/EC/2022, dated July 15, 2022.

Acknowledgments

The authors are grateful to all participants, healthcare workers, midwives, and nurses for permitting us to undertake this study.

Competing interests

All the authors declare that there are no conflicts of interest.

Funding

This study was supported by the Ministry of Education, Culture, Research and Technology, Indonesia.

Underlying data

Derived data supporting the findings of this study are available from the corresponding author on request.

How to cite

Mardiyaningsih E, Widyawati W, Hapsari ED. Mothers' perception of husband support during breastfeeding: A qualitative study in Indonesia. Narra J 2024; 4 (3): e1149 - http://doi.org/10.52225/narra.v4i3.1149.

References

1. Chmielewska B et al. Effects of the COVID-19 pandemic on maternal and perinatal outcomes: A systematic review and meta-analysis. Lancet Glob Health 2021;9(6):759-772.
2. Jaya I. Penguatan Sistem Kesehatan dalam Pengendalian COVID-19. Direktorat Jenderal Pencegah Dan Pengendali Penyakit Kemenkes RI 2021. Available from: http://p2p.kemkes.go.id/penguatan-sistem-kesehatan-dalam-pengendalian-covid-19/. Accessed: 15 May 2024.

3. Yulia R, Syafiq A, Pratomo H, *et al.* Dampak COVID-19 Pada layanan kesehatan ibu dan anak (KIA) di Kota Depok. J Ilmu Kesehat Masy 2021;17(2):87-95.
4. Lubbe W, Niela-Vilén H, Thomson G, *et al.* Impact of the COVID-19 pandemic on breastfeeding support services and women's experiences of breastfeeding: A review. Int J Womens Health 2022:14:1447-1457.
5. World Health Organization. Pekan menyusui dunia: UNICEF dan WHO menyerukan pemerintah dan pemangku kepentingan agar mendukung semua ibu menyusui di indonesia selama COVID-19. Available from: https://www.who.int/indonesia/news/detail/03-08-2020-pekan-menyusui-dunia-unicef-dan-who-menyerukan-pemerintah-dan-pemangku-kepentingan-agar-mendukung-semua-ibu-menyusui-di-indonesia-selama-covid-19. Accessed: 19 July 2024
6. Costantini C, Joyce A, Britez Y. Breastfeeding experiences during the COVID-19 lockdown in the United Kingdom: An exploratory study into maternal opinions and emotional states. J Hum Lact 2021;37(4):649-662.
7. Vik ES, Kongslien S, Nedberg IH, *et al.* Women's experiences and views on early breastfeeding during the COVID-19 pandemic in Norway: Quantitative and qualitative findings from the IMAgiNE EURO study. Int Breastfeed J 2023;18(1):1-12.
8. Chertok IA, Artzi-Medvedik R, Arendt M, *et al.* Factors associated with exclusive breastfeeding at discharge during the COVID-19 pandemic in 17 WHO European Region countries. Int Breastfeed J 2022;17(1):83.
9. Antoniou E, Tzitiridou-Chatzopoulou M, Voyatzaki C, *et al.* What are the implications of COVID-19 on breastfeeding? A synthesis of qualitative evidence studies. Children 2023;10(7):1-14.
10. Nuampa S, Ratinthorn A, Patil CL, *et al.* Impact of personal and environmental factors affecting exclusive breastfeeding practices in the first six months during the COVID-19 pandemic in Thailand: A mixed-methods approach. Int Breastfeed J 2022;17(1):1-13.
11. Okinarum GY, Rochdiat W. Breastfeeding experience during COVID-19 pandemic in Indonesia: Strengthening and weakening elements. Malays J Med Sci 2022;29(3):110-121.
12. Demontigny F, Gervais C, Larivière-Bastien D, *et al.* The role of fathers during breastfeeding. Midwifery 2018;58:6-12.
13. Pontes CM, Osório MM, Alexandrino AC. Building a place for the father as an ally for breast feeding. Midwifery 2009;25(2):195-202.
14. Matare CR, Craig HC, Martin SL, *et al.* Barriers and opportunities for improved exclusive breast-feeding practices in Tanzania: Household trials with mothers and fathers. Food Nutr Bull 2019;40(3):308-325.
15. Datta J, Graham B, Wellings K. The role of fathers in breastfeeding: Decision-making and support. Br J Midwifery 2012;20(3):159-167.
16. Snyder K, Worlton G. Social support during COVID-19: Perspective of breastfeeding mothers. Breastfeed Med 2021;16(1):39-45.
17. Pranita E. Pandemi corona berdampak pada ibu hamil dan menyusui. Available from: https://www.kompas.com/sains/read/2020/05/28/130500823/pandemi-corona-berdampak-pada-ibu-hamil-dan-menyusui-ini-3-rekomendasi. Accessed: 19 July 2024.
18. Utarini A. Penelitian kualitatif dalam pelayanan kesehatan. Yogyakarta: Gadjah Mada University Press; 2020.
19. Streubert HJ, Carpenter DR. Qualitative research in Nursing: Advancing the humanistic imperative. 5th ed. Lippincott: Williams and Wilkins; 2011.
20. The Jakarta Post. Jokowi lifts COVID-19 emergency status. Society 2023. Available from: https://www.thejakartapost.com/indonesia/2023/06/21/breaking-jokowi-lifts-covid-19-emergency-status.html. Accessed: 19 July 2024.
21. Cabinet Secretariat of The Republic of Indonesia. Goverment issues policies following COVID-19 endemic transition 2023. Available from: https://setkab.go.id/en/govt-issues-policies-following-covid-19-endemic-transition/. Accessed: 19 July 2024.
22. Sherriff N, Hall V, Panton C. Engaging and supporting fathers to promote breast feeding: A concept analysis. Midwifery 2014;30(6):667-677.
23. Creswell JW. Research design: Qualitative, quantitative, and mixed methods approaches. 4th ed. California: SAGE Publications; 2014.
24. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. Int J Qual Health Care 2007;19(6):349-357.
25. Nuampa S, Kuesakul K, Prasong S, *et al.* Social support for breastfeeding practice during the COVID-19 second wave in Thailand: A cross-sectional study. J Hum Lact 2023;39(2):206-216.

26. Mannion CA, Hobbs AJ, McDonald SW, *et al.* Maternal perceptions of partner support during breastfeeding. Int Breastfeed J 2013;8(1):1-7.
27. Banu B, Khanom K. Effects of education level of father and mother on perceptions of breastfeeding. J Enam Med Coll 2012;2(2):67-73.
28. Betzold CM, Laughlin KM, Shi C. A family practice breastfeeding education pilot program: An observational, descriptive study. Int Breastfeed J 2007;2:1-6.
29. Kotlar B, Gerson E, Petrillo S, *et al.* The impact of the COVID-19 pandemic on maternal and perinatal health: A scoping review. Reprod Health 2021;18(1):10.
30. Ukoli F, Leavell J, Mayo A, *et al.* Encouraging and reinforcing safe breastfeeding practices during the COVID-19 pandemic. Int J Environ Res Public Health 2023;20(3):1-18.
31. Mohammed S, Yakubu I, Fuseini AG, *et al.* Systematic review and meta-analysis of the prevalence and determinants of exclusive breastfeeding in the first six months of life in Ghana. BMC Public Health 2023;23(1):1-18.
32. Spannhake M, Jansen C, Görig T, *et al.* Well-informed and willing, but breastfeeding does not work: A qualitative study on perceived support from health professionals among German mothers with breastfeeding problems. Healthc Switz 2022;10(6):1-14.
33. Badr H, Alghamdi S. Breastfeeding experience among mothers during the COVID-19 pandemic. Int J Environ Res Public Health 2022;19(8):1-10.
34. Negin J, Coffman J, Vizintin P, *et al.* The influence of grandmothers on breastfeeding rates: A systematic review. BMC Pregnancy Childbirth 2016;16(1):1-10.
35. Brown A, Raynor P, Lee M. Healthcare professionals' and mothers' perceptions of factors that influence decisions to breastfeed or formula feed infants: A comparative study. J Adv Nurs 2011;67(9):1993-2003.
36. Johnson AM, Kirk R, Rooks AJ, *et al.* Enhancing breastfeeding through healthcare support: Results from a focus group study of African American mothers. Matern Child Health J 2016;20:92-102.
37. Sayuti NA, Atikah N. The pattern of herbal medicines use for breastfeeding mother in Jogonalan, Klaten, Indonesia: A mini survey. BMC Complement Med Ther 2023;23(1):1-17.
38. Manjapallikkunnel SR, Nair ANK, Sujatha C. Knowledge, attitude and practices among mothers of infants regarding breastfeeding. J Fam Reprod Health 2023;17(3):136-141.
39. Tamiru D, Mohammed S. Maternal knowledge of optimal breastfeeding practices and associated factors in rural communities of Arba Minch Zuria. Int J Nutr Food Sci 2013;2(3):122-129.
40. Suárez-Cotelo M del C, Movilla-Fernández MJ, Pita-García P, *et al.* Breastfeeding knowledge and relation to prevalence. Rev Esc Enferm USP 2019;53:e03433.
41. Tsai SY. Shift-work and breastfeeding for women returning to work in a manufacturing workplace in Taiwan. Int Breastfeed J 2022;17(1):1-10.
42. Silva IA, Silva CM, Costa EM, *et al.* Continued breastfeeding and work: Scenario of maternal persistence and resilience. Rev Bras Enferm 2023;76(1):1-9.
43. Luthuli S, Haskins L, Mapumulo S, *et al.* 'I decided to go back to work so I can afford to buy her formula': A longitudinal mixed-methods study to explore how women in informal work balance the competing demands of infant feeding and working to provide for their family. BMC Public Health 2020;20(1):1847.
44. Sulaiman Z, Liamputtong P, Amir LH. The enablers and barriers to continue breast milk feeding in women returning to work. J Adv Nurs 2016;72(4):825-835.
45. Worobey J. Why some mothers stop breast-feeding: Self-reported reasons for switching to formula. Top Clin Nutr 2011;26(3):229-233.
46. Jefferson UT, Reed AE, Rabbitte M. African American mothers' decision to discontinue breastfeeding and switch to formula. West J Nurs Res 2022;44(1):15-22.
47. Chong HY, Tan LTH, Law JWF, *et al.* Exploring the potential of human milk and formula milk on infants' gut and health. Nutrients 2022;14(17):1-25.
48. Gianni LM et al. Breastfeeding difficulties and risk for early breastfeeding cessation. Nutrients 2019;11(2266):1-10.
49. Nagel EM, Howland MA, Pando C, *et al.* Maternal psychological distress and lactation and breastfeeding outcomes: A narrative review. Clinthera 2023;44(2):215-227.
50. Yip KH, Yip YC, Tsui WK. The lived experiences of women without COVID-19 in breastfeeding their infants during the pandemic: A descriptive phenomenological study. Int J Environ Res Public Health 2022;19(15):1-18.
51. Jones K, Harrison V, Moulds ML, *et al.* A qualitative analysis of feelings and experiences associated with perinatal distress during the COVID-19 pandemic. BMC Pregnancy Childbirth 2022;22(1):572.

52. Baran J, Leszczak J, Baran R, *et al.* Prenatal and postnatal anxiety and depression in mothers during the COVID-19 pandemic. J Clin Med 2021;10(14):3193.
53. Jackson L, De Pascalis L, Harrold JA, *et al.* Postpartum women's psychological experiences during the COVID-19 pandemic: A modified recurrent cross-sectional thematic analysis. BMC Pregnancy Childbirth 2021;21:1-16.
54. Kusuma IY, Pratiwi H, Khairunnisa SF, *et al.* The assessment of Twitter discourse on the new COVID-19 variant, XBB. 1.5, through social network analysis. Vaccine X 2023;14:100322.
55. Kusuma IY, Suherman S. The pulse of long COVID on Twitter: A social network analysis. Arch Iran Med 2024;27(1):36.
56. Tangbe PE, Shaw-Ridley M, Cannon-Smith G, *et al.* Prenatal, delivery and postpartum care experiences among black women in Mississippi during COVID-19 pandemic 2020–2021. Women 2023;3(2):295-309.
57. Hadjigeorgiou E, Vogazianos P, Christofi MD, *et al.* Experiences, concerns, and needs of pregnant and postpartum women during the COVID-19 pandemic in Cyprus: A cross-sectional study. BMC Pregnancy Childbirth 2022;22(1):685.
58. Brown A, Shenker N. Experiences of breastfeeding during COVID-19: Lessons for future practical and emotional support. Matern Child Nutr 2021;17(1):1-15.