

Role of Paternal Support in Breastfeeding Initiation and Duration: A Cross-sectional Study from Chennai, Tamil Nadu, India

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ABSTRACT

Introduction: Breastfeeding is widely recognised for its benefits to both infant and maternal health. Although maternal factors have been extensively studied, recent evidence indicates that paternal involvement may significantly influence breastfeeding initiation and duration.

Aim: To evaluate the impact of paternal involvement on the initiation and duration of breastfeeding and to identify the key barriers and facilitators influencing fathers' support.

Materials and Methods: The present cross-sectional observational study was conducted from October to December 2024 at Sree Balaji Medical College and Hospital, Chennai, Tamil Nadu, India. A total of 92 fathers whose partners had recently given birth completed a structured 25-item questionnaire assessing demographics, dimensions of paternal support (emotional, practical, and prenatal education), and breastfeeding outcomes. Data were analysed using descriptive statistics, Pearson's correlation, and hierarchical regression models.

Results: Most fathers were aged 26-35 years (60.9%), followed by 36-45 years (26.1%), with 8.7% <25 years and 4.3% >45 years. A total of 89.1% reported that their partners were breastfeeding. Emotional support was reported as often by 32.6% and always by 29.3%, while practical support was often by 33.7% and always by 25.0%, with mean scores of 3.7 and 3.6, respectively. The mean breastfeeding initiation time was 2.3±1.0 hours, with 81.5% planned initiation, and the mean breastfeeding duration was 20.5±5.8 weeks (54.3% for 12-24 weeks, 29.3% >24 weeks, 16.3% <12 weeks). Emotional support showed a negative correlation with initiation time ($r=-0.48$, $p<0.001$). Regression analysis identified emotional support as the strongest predictor of breastfeeding duration ($\beta=0.38$, $p<0.001$).

Conclusion: Enhanced paternal involvement, particularly through emotional support and participation in prenatal education, is associated with earlier initiation and prolonged breastfeeding.

Keywords: Breastfeeding duration, Emotional support, Paternal involvement, Prenatal education

INTRODUCTION

The benefits of prolonged exclusive breastfeeding for mothers and their infants have been well documented. The American Academy of Paediatrics (AAP) and the World Health Organisation (WHO) recommend exclusive breastfeeding through six months of age and continued breastfeeding through at least the first year of life [1].

Traditionally, breastfeeding has been viewed as the exclusive domain of the mother, with the father's role confined to peripheral support; however, emerging evidence indicates that active paternal engagement can substantially affect both the initiation and duration of breastfeeding [2,3]. Fathers who are engaged during the prenatal and postnatal periods can offer essential emotional support, practical assistance, and informed advocacy that together foster a more positive breastfeeding environment [4]. For instance, emotional encouragement from fathers can alleviate maternal stress and boost confidence in breastfeeding, while practical help with household chores and infant care allows mothers to focus on establishing and maintaining breastfeeding routines [5]. Moreover, when fathers participate in prenatal education programmes specifically designed to address breastfeeding, they become better equipped to support their partners, leading to higher breastfeeding initiation rates and longer duration [6].

Observational research has consistently shown that fathers who receive adequate information and training about breastfeeding are more likely to engage in supportive behaviours that lead to improved breastfeeding rates [7]. For example, fathers who attend breastfeeding classes or receive targeted counselling are better positioned to assist with common challenges such as latching

difficulties, concerns over milk supply, and maternal fatigue [8]. Additionally, a supportive paternal presence during the early postpartum period has been linked to reduced rates of early breastfeeding discontinuation, a time when mothers are particularly vulnerable to the challenges associated with breastfeeding initiation [9]. Nevertheless, several barriers continue to impede paternal involvement. Deeply rooted cultural and societal norms often cast breastfeeding as a solely female responsibility, discouraging fathers from taking a proactive role in the process [10]. In many communities, traditional gender roles and stereotypes prevent fathers from engaging fully, and this lack of engagement is compounded by insufficient educational outreach and support from healthcare providers [11]. Furthermore, structural factors such as restrictive workplace policies, limited paternity leave, and inflexible work schedules can further limit a father's ability to support his partner during critical periods of breastfeeding [12].

Against this complex backdrop, there is a compelling need to systematically explore the influence of paternal involvement on breastfeeding outcomes. The present study was designed to fill this gap by investigating the impact of fathers' participation on both the initiation and duration of breastfeeding.

MATERIALS AND METHODS

The present cross-sectional observational study was carried out at Sree Balaji Medical College and Hospital, Chennai, Tamil Nadu, India, from October 2024 to December 2024. Prior to the commencement of the study, ethical clearance was obtained from the Institutional Ethics Committee with Ref No. 002/SBMCH/IHEC/2024/2296.

Fathers visiting the department during the study period were screened for eligibility and invited to participate.

Inclusion and Exclusion criteria: Participants were included if they were 18 years of age or older, were currently partnered with the infant's mother, and had a child aged less than six months. Fathers who were unable to provide informed consent had significant cognitive or physical impairments that prevented questionnaire completion, or whose children were older than six months were excluded from the study.

Sample size calculation: The sample size was calculated using a standard statistical formula, assuming a population proportion of 50% to maximise variability, a 95% confidence level, and a 5% margin of error. Based on this calculation, the minimum required sample size was 92 participants, and a total of 92 fathers were included in the study.

Study Procedure

The study assessed several parameters, including demographic characteristics (age, education, and occupation), dimensions of paternal involvement (emotional support, practical assistance with household tasks and infant care), participation in prenatal education programmes, and fathers' confidence in supporting breastfeeding. Breastfeeding outcomes were measured as time to breastfeeding initiation (in hours) and overall duration of breastfeeding (in weeks). In addition, perceived barriers and facilitators to paternal involvement, as well as overall satisfaction with paternal support, were evaluated.

Data were collected using a structured 25-item questionnaire [Annexure I] developed from an extensive review of the literature on paternal involvement and breastfeeding practices [13]. The questionnaire was reviewed by a panel of experts in obstetrics, community medicine, and public health to assess content validity, ensuring that the items were relevant, clear, and representative of the constructs being measured. Necessary modifications were made based on expert suggestions to improve clarity and comprehensiveness. The reliability of the questionnaire was assessed using Cronbach's alpha, which demonstrated good internal consistency ($\alpha=0.82$), indicating acceptable reliability of the instrument. Prior to the main study, the questionnaire was pilot tested on 10 fathers who met the inclusion criteria but were not included in the final study sample. The pilot study helped evaluate the questionnaire's clarity, feasibility, and time required to complete it, and minor modifications were made accordingly before conducting the final survey.

Eligible fathers were approached by trained research assistants during their visits to the Obstetrics and Gynaecology Department. After obtaining written informed consent, participants were asked to complete the questionnaire in a quiet and private area within the hospital. The questionnaire consisted of sections covering demographic information, paternal involvement behaviours, prenatal education participation, breastfeeding initiation timing, breastfeeding duration, and perceived barriers and facilitators to paternal engagement. Open-ended responses for selected questions were subsequently coded into thematic categories for descriptive analysis. Responses were initially recorded on paper forms and subsequently entered into a secure electronic database.

STATISTICAL ANALYSIS

Statistical analysis was performed using Statistical Package for the Social Sciences (SPSS) software version 26 and Epi Info version 7. Descriptive statistics, including mean, standard deviation, frequency, and percentage, were used to summarise demographic characteristics and paternal involvement scores. Qualitative open-ended responses were reviewed and thematically categorised before being analysed descriptively. Pearson's correlation analysis was used to evaluate the relationship between paternal support

components and breastfeeding outcomes. In addition, hierarchical multiple regression analysis was conducted to identify significant predictors of breastfeeding duration while controlling for demographic variables. A p-value of <0.05 was considered statistically significant for all statistical tests.

RESULTS

Among the 92 respondents, the majority were aged 26-35 years (60.9%). Regarding education, 54.3% were undergraduates, 29.3% postgraduates, and 16.3% had completed high school [Table/Fig-1].

Characteristics	n (%)
Age (years)	
<25	8 (8.7)
26-35	56 (60.9)
36-45	24 (26.1)
>45	4 (4.3)
Education	
High School	15 (16.3)
Undergraduate	50 (54.3)
Postgraduate	27 (29.3)
Occupation	
Government	35 (38.0)
Private	40 (43.5)
Self-employed	15 (16.3)
Unemployed	2 (2.2)
Number of Children	
One child	44 (47.8)
Two children	36 (39.1)
Three or more	12 (13.0)
Partner Breastfeeding	
Yes	82 (89.1)
No	10 (10.9)

[Table/Fig-1]: Demographic characteristics (N=92) (Question 1-5).

Most fathers reported providing emotional support frequently, with 32.6% indicating "often" and 29.3% indicating "always" [Table/Fig-2].

Rating	n (%)
1 - Never	5 (5.4)
2 - Rarely	10 (10.9)
3 - Sometimes	20 (21.7)
4 - Often	30 (32.6)
5 - Always	27 (29.3)
Total	92 (100)
Mean±SD	3.7±1.2

[Table/Fig-2]: Emotional Support Provided (Question 6).

Responses indicate moderate to high practical involvement, with the largest proportion of fathers reporting that they often (33.7%) assist with practical tasks [Table/Fig-3].

Rating	n (%)
1 - Never	6 (6.5)
2 - Rarely	11 (12.0)
3 - Sometimes	21 (22.8)
4 - Often	31 (33.7)
5 - Always	23 (25.0)
Total	92 (100)
Mean±SD	3.6±1.2

[Table/Fig-3]: Practical support in household tasks (Question 7).

Paternal involvement in prenatal education was moderate, indicating scope for improvement [Table/Fig-4].

Category	n (%)
Not involved	28 (30.4)
Occasionally involved	36 (39.1)
Regularly involved	28 (30.4)

[Table/Fig-4]: Involvement in prenatal classes (Question 8).

A the largest single group (32.6%) rated 4, with 31.5% very confident, indicating readiness to support breastfeeding [Table/Fig-5].

Rating	n (%)
Not confident	5 (5.4)
2	8 (8.7)
3	20 (21.7)
4	30 (32.6)
Very confident	29 (31.5)

[Table/Fig-5]: Confidence in supporting breastfeeding (Question 9).

Type of support provided (Question 10): Responses to this open-ended question revealed that fathers commonly provided emotional encouragement, assistance with household chores, help with infant care, and reminders regarding breastfeeding schedules. Many participants also reported accompanying their partners to hospital visits and providing reassurance during breastfeeding challenges.

The mean time to breastfeeding initiation was 2.3 ± 1.0 hours after delivery. Most fathers reported that breastfeeding initiation was planned (81.5%) [Table/Fig-6].

Measure	n (%)
Mean time to initiation	2.3 ± 1.0 hours
Planned	75 (81.5%)
Not planned	17 (18.5%)

[Table/Fig-6]: Breastfeeding initiation timing and planning (Questions 11-12).

The analysis reveals that paternal support was the most commonly self-reported influencing factor in breastfeeding initiation, reported by 65.2% of participants [Table/Fig-7].

Factors	n (%)
Paternal support	60 (65.2)
Healthcare provider advice	50 (54.3)
Cultural beliefs	20 (21.7)
Previous experiences	15 (16.3)
Other	7 (7.6)

[Table/Fig-7]: Influencing factors (Question 13).
Multiple responses permitted; percentages may not total 100%

The majority of participants reported breastfeeding for 12-24 weeks (54.3%). The mean duration of breastfeeding was 20.5 ± 5.8 weeks, indicating moderate adherence to recommended breastfeeding practices [Table/Fig-8].

Duration	n (%)
<12 weeks	15 (16.3)
12-24 weeks	50 (54.3)
>24 weeks	27 (29.3)
Mean Duration	20.5 ± 5.8 weeks

[Table/Fig-8]: Breastfeeding duration (Question 14).

Challenges delaying breastfeeding initiation (question 15): Qualitative responses indicated that common challenges included maternal fatigue after delivery, delayed lactation, lack of breastfeeding knowledge, and hospital procedural delays. Some participants also

mentioned maternal discomfort and infant latching difficulties as factors that delayed initiation.

A combined 60.9% of participants rated their influence as high (ratings 4 and 5), indicating strong perceived impact [Table/Fig-9].

Approximately, 51% of participants rated their influence as high (ratings 4 and 5), while 27.2% reported moderate influence [Table/Fig-10].

A combined 60.9% reported high satisfaction (34.8% very satisfied; 26.1% satisfied) [Table/Fig-11].

A total of 34.8% reported very high satisfaction, while 22.8% reported high satisfaction [Table/Fig-12].

A large majority of participants (87.0%) reported that paternal involvement improved their partner's confidence in breastfeeding, while only 13.0% reported no improvement [Table/Fig-13].

Rating	n (%)
1	6 (6.5)
2	10 (10.9)
3	20 (21.7)
4	25 (27.2)
5	31 (33.7)
Total	92 (100)

[Table/Fig-9]: Influence on breastfeeding initiation (Question 16).

Rating	n (%)
1	8 (8.7)
2	12 (13.0)
3	25 (27.2)
4	20 (21.7)
5	27 (29.3)
Total	92 (100)

[Table/Fig-10]: Influence on breastfeeding duration (Question 17).

Rating	n (%)
1	6 (6.5)
2	9 (9.8)
3	21 (22.8)
4	24 (26.1)
5	32 (34.8)
Total	92 (100)

[Table/Fig-11]: Satisfaction with involvement (Question 18).

Rating	n (%)
1	5 (5.4)
2	9 (9.8)
3	25 (27.2)
4	21 (22.8)
5	32 (34.8)
Total	92 (100)

[Table/Fig-12]: Partner satisfaction with support (Question 19).

Response	n (%)
Yes	80 (87.0)
No	12 (13.0)
Total	92 (100)

[Table/Fig-13]: Improvement in partner confidence (Question 20).

The most commonly reported barrier was lack of time (43.5%), followed by cultural expectations (32.6%) and workplace constraints (27.2%) [Table/Fig-14].

Barriers	n (%)
Lack of time	40 (43.5)
Cultural expectations	30 (32.6)
Workplace constraints	25 (27.2)
Insufficient knowledge	20 (21.7)
[Table/Fig-14]: Barriers to paternal involvement (Question 21). Multiple responses permitted; percentages may not total 100%.	

Among the thematically categorised responses, partner encouragement (59.8%) was the most commonly reported facilitator of paternal involvement, followed by healthcare provider support (52.2%) [Table/Fig-15].

A majority of fathers (70.7%) reported receiving guidance from healthcare providers [Table/Fig-16].

Among the thematically categorised responses, the most commonly expressed need was for structured breastfeeding education programmes (41.3%), followed by counselling sessions specifically for fathers (32.6%) [Table/Fig-17].

Among the thematically categorised responses, the most frequent suggestion was increasing father inclusion during antenatal visits (45.7%), followed by organising father-specific workshops (38.0%) [Table/Fig-18].

Emotional support correlates strongly with practical support ($r=0.60$, $p<0.001$) and confidence ($r=0.65$, $p<0.001$) [Table/Fig-19].

Hierarchical regression analysis assessed predictors of breastfeeding duration. Model 1, including demographic variables, explained 20% variance ($p<0.05$). Model 2, adding paternal support components, increased explained variance to 45% ($p<0.001$). Emotional support emerged as the strongest predictor ($\beta=0.38$, $p<0.001$), significantly influencing duration outcomes [Table/Fig-20].

Facilitators	n (%)
Support from healthcare providers	48 (52.2)
Prior knowledge about breastfeeding	42 (45.7)
Partner encouragement	55 (59.8)
Flexible work schedule	30 (32.6)
Family support	28 (30.4)
Exposure to educational programmes	35 (38.0)
[Table/Fig-15]: Facilitators of paternal involvement (Question 22). Multiple responses permitted; percentages may not total 100%.	

Response	n (%)
Yes	65 (70.7)
No	27 (29.3)
[Table/Fig-16]: Guidance from healthcare providers (Question 23).	

Support Needed	n (%)
More breastfeeding education programmes	38 (41.3)
Counselling sessions for fathers	30 (32.6)
Practical demonstrations/training	25 (27.2)
Informational materials (leaflets/videos)	20 (21.7)
Workplace support (paternity leave)	28 (30.4)
[Table/Fig-17]: Additional support needed to enhance paternal involvement (Question 24). Multiple responses permitted; percentages may not total 100%.	

DISCUSSION

The findings demonstrate that paternal emotional support, practical assistance, and active engagement in breastfeeding-related activities play a significant role in promoting early initiation and longer continuation of breastfeeding. However, the perceived influence of paternal support on breastfeeding initiation may be overestimated because fathers self-reported their own contribution.

Suggestions	n (%)
Inclusion of fathers in antenatal visits	42 (45.7)
Conducting father-focused workshops	35 (38.0)
Awareness campaigns on paternal role	30 (32.6)
Improved hospital policies for father involvement	22 (23.9)
Flexible work policies/paternity leave	28 (30.4)
[Table/Fig-18]: Suggestions to improve paternal involvement (Question 25). Multiple responses permitted; percentages may not total 100%.	

Variables	Emotional support	Practical support	Confidence	Time to initiation	Breast-feeding duration
Emotional support	1.00	0.60*	0.65*	-0.48*	0.55*
Practical support	0.60*	1.00	0.50*	-0.42*	0.48*
Confidence	0.65*	0.50*	1.00	-0.35*	0.40*
Time to initiation	-0.48*	-0.42*	-0.35*	1.00	-0.60*
Breastfeeding Duration	0.55*	0.48*	0.40*	-0.60*	1.00

[Table/Fig-19]: Correlation matrix of paternal support components and breast-feeding outcomes.
* $p<0.001$

Predictors	Model 1 β (p-value)	Model 2 β (p-value)
Age	0.10 (0.048)	0.08 (0.060)
Education	0.15 (0.014)	0.12 (0.030)
Emotional support	-	0.38 (<0.001)
Practical Support	-	0.20 (0.029)
Confidence	-	0.15 (0.035)
R-squared	0.20	0.45

[Table/Fig-20]: Hierarchical multiple regression analysis for predicting breastfeeding duration.

Hunter T et al., (2014), investigated paternal involvement among first-time mothers and found that 45.9% of mothers received breastfeeding support from their husbands or partners in the hospital, while 54.1% did not receive such support [14]. The study further demonstrated that mothers who received early postpartum breastfeeding support from their partners were more likely to initiate breastfeeding and to continue breastfeeding for longer.

Rempel LA et al., (2017) examined the relationship between fathers' breastfeeding support behaviours and maternal breastfeeding outcomes [15]. These findings suggest that the most effective breastfeeding support is delivered through sensitive, coordinated teamwork that is responsive to the mother's needs.

A large prospective cohort study conducted by Hackman NM et al., (2022) investigated the relationship between paternal education and breastfeeding outcomes among 3,006 primiparous women [1]. The study reported that 92.0% of mothers initiated breastfeeding and 49.5% continued breastfeeding at six months postpartum, and it concluded that higher paternal education levels were independently associated with improved breastfeeding initiation and continuation. These findings align with the current study, where the majority of fathers had undergraduate or postgraduate education and demonstrated high confidence in providing breastfeeding support.

Silva PP et al., (2012) conducted a prospective cohort study involving 2,741 newborns in Brazil and found that lack of paternal support and lower paternal education were significantly associated with early weaning during the first month [16]. In the third month, a strong association between weaning and lack of paternal support was verified.

In a meta-analysis including eight randomised controlled trials with 2,531 participants, paternal support interventions significantly

improved breastfeeding outcomes, with higher exclusive breastfeeding rates observed in the intervention group compared with the control group at several time points, including within one week postpartum (RR 1.28; 95% CI 1.16-1.42) and three months postpartum (RR 1.35; 95% CI 1.21-1.50) [17].

Overall, the results of the present study support the growing body of evidence emphasising the importance of paternal involvement in breastfeeding practices. Longitudinal studies and interventional research focusing on father-centred breastfeeding education programmes may provide additional evidence regarding effective strategies to improve paternal engagement.

Limitation(s)

The present study has several limitations. The cross-sectional design limits the ability to establish a causal relationship between paternal involvement and breastfeeding outcomes. The study was conducted at a single tertiary care hospital with a relatively small sample size, which may affect the generalisability of the findings. Furthermore, the use of self-reported responses may introduce reporting bias, and findings related to paternal influence may have been overestimated because fathers self-rated their own contribution.

CONCLUSION(S)

The study clearly demonstrates that active and informed paternal involvement is associated with earlier initiation and extended duration of breastfeeding. The detailed analysis of questionnaire responses, along with robust statistical correlations and regression models, offers compelling evidence that emotional and practical supports are integral to fostering successful breastfeeding practices.

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AUTHOR DECLARATION:

- Financial or Other Competing Interests: None
- Was Ethics Committee Approval obtained for this study? Yes
- Was informed consent obtained from the subjects involved in the study? Yes
- For any images presented appropriate consent has been obtained from the subjects. NA

PLAGIARISM CHECKING METHODS: [Joan H et al.]

- Plagiarism X-checker: Jan 06, 2026
- Manual Googling: Apr 29, 2026
- iThenticate Software: May 02, 2026 (10%)

ETYMOLOGY: Author Origin

EMENDATIONS: 8

Date of Submission: Jan 04, 2026

Date of Peer Review: Feb 27, 2026

Date of Acceptance: May 05, 2026

Date of Publishing: Aug 01, 2026

ANNEXURE

Section A: Demographic and Background Details

1. **What is your age?**
(Open-ended numeric response)
2. **What is your highest level of education?**
 - High School
 - Undergraduate
 - Postgraduate
3. **What is your current occupation?**
 - Government
 - Private
 - Self-employed
 - Unemployed
4. **How many children do you have?**
(Open-ended numeric response)
5. **Is your partner currently breastfeeding?**
 - Yes
 - No

Section B: Paternal Involvement in Breastfeeding Support

6. **On a scale of 1-5, how often do you provide emotional support to your partner during breastfeeding?**
(1=never, 5=always)
7. **On a scale of 1-5, how frequently do you assist with practical tasks (e.g., household chores, baby care) to support your partner?**
(1=never, 5=always)
8. **How involved are you in attending prenatal classes or breastfeeding educational sessions?**
 - Not involved
 - Occasionally involved
 - Regularly involved
9. **How confident are you in your ability to provide breastfeeding support?**
(Likert scale: 1=Not confident, 5=Very confident)
10. **Can you describe the type of support you typically provide during the breastfeeding process? (Open-ended response)**

Section C: Breastfeeding Initiation and Duration

11. **How many hours after delivery did your partner initiate breastfeeding?**
(Open-ended numeric response in hours)
12. **Was the initiation of breastfeeding planned?**
 - Yes
 - No

13. **What factors influenced the initiation of breastfeeding?**
(Multiple choice: paternal support, healthcare provider advice, cultural beliefs, previous experiences, etc.)
14. **For how many weeks did your partner continue breastfeeding?**
(Open-ended numeric response in weeks)
15. **What challenges, if any, delayed the initiation of breastfeeding?**
(Open-ended response)

Section D: Perceived Impact of Paternal Involvement

16. **To what extent do you believe your involvement influenced the initiation of breastfeeding?**
(Likert scale: 1=No influence, 5=Very significant influence)
17. **To what extent do you believe your support extended the duration of breastfeeding?**
(Likert scale: 1=No influence, 5=Very significant influence)
18. **How satisfied are you with your level of involvement in supporting breastfeeding?**
(Likert scale: 1=Very dissatisfied, 5=Very satisfied)
19. **How would you rate your partner's satisfaction with the support you provided?**
(Likert scale: 1=Very dissatisfied, 5=Very satisfied)
20. **Do you feel that your involvement has improved your partner's confidence in breastfeeding?**
 - Yes
 - No

Section E: Barriers and Facilitators

21. **What barriers have you encountered in providing support?**
(Multiple responses allowed: e.g., lack of time, cultural expectations, workplace constraints, insufficient knowledge)
22. **What factors have helped you be more involved in the breastfeeding process?**
(Open-ended response; later categorised for analysis)
23. **Have you received adequate guidance from healthcare providers on how to support breastfeeding?**
 - Yes
 - No
24. **What additional support or information would be helpful to enhance your involvement?**
(Open-ended response; later categorised for analysis)
25. **Do you have any suggestions for improving paternal involvement in breastfeeding initiatives?**
(Open-ended response; later categorised for analysis)