

HYPNOBREASTFEEDING EDUCATION FOR HUSBANDS AS A FAMILY-CENTERED STRATEGY IN SUPPORTING EXCLUSIVE BREASTFEEDING: A REVIEW FROM MIDWIFERY SERVICES

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Abstract

Exclusive breastfeeding is the single most cost-effective intervention for infant survival, growth, and long-term health, yet national coverage in Indonesia remains below the target set for maternal and child health programmes. Two determinants recur across the literature: the psychological condition of the mother during the postpartum period, which regulates the oxytocin-dependent milk ejection reflex, and the support provided by the husband as the closest person to the breastfeeding mother. Hypnobreastfeeding, a non-pharmacological relaxation method combining deep breathing, visualisation, and positive affirmation, addresses the first determinant, while father-inclusive education addresses the second. This descriptive literature review examines how these two lines of evidence intersect and asks what is known about positioning the husband, rather than the mother, as the direct recipient of hypnobreastfeeding education. Articles published between 2018 and 2026 were retrieved from PubMed, ScienceDirect, and Google Scholar and analysed thematically. The findings indicate that maternal anxiety, fatigue, and low self-confidence consistently inhibit milk ejection; that hypnobreastfeeding improves milk output, reduces anxiety, and increases breastfeeding motivation among postpartum mothers; and the interventions targeting fathers substantially increase the likelihood of exclusive breastfeeding at six months while improving paternal support behaviours. However, studies in which husbands themselves receive structured hypnobreastfeeding education, with knowledge and attitude measured as outcomes, remain very limited. The review concludes that husband-targeted hypnobreastfeeding education is a plausible, low-cost, and culturally acceptable model of complementary midwifery care for primary-level services, and recommends that it be developed, standardised, and evaluated empirically within midwifery practice, education, and policy.

Keywords: exclusive breastfeeding, family-centered midwifery care, hypnobreastfeeding, husband support, knowledge and attitude.

INTRODUCTION

Breast milk remains the optimal source of nutrition for infants during the first six months of life, and the benefits of exclusive breastfeeding extend well beyond immediate nutritional adequacy. Evidence synthesised at global level shows that breastfeeding protects against infectious morbidity in infancy, is associated with better cognitive development, and reduces the risk of overweight and several non-communicable diseases later in life, while also conferring maternal benefits such as faster uterine involution and a lower risk of breast and ovarian cancer (Hu et al., 2026). Because of this combined biological, economic, and developmental value, the World Health Organization and UNICEF consistently recommend exclusive breastfeeding for six months, initiated within the first hour after birth (World Health Organization, 2025).

Despite this consensus, national coverage in Indonesia has not reached programme targets. The Indonesian Health Survey reported that the proportion of infants aged 0-6 months receiving exclusive breastfeeding was 55.5 per cent, still considerably below the national target of 80 per cent mandated for the acceleration of stunting reduction. Complementary reporting by WHO and UNICEF notes that although exclusive breastfeeding during the first six months has risen over the past decade, critical weaknesses persist in the newborn period: early initiation of breastfeeding within the first hour was achieved by only around a quarter of newborns, and one in five infants received food or fluids other than breast milk within the first three days of (World Health Organization, 2024). These figures indicate that the problem is not a lack of recommendation but a gap in the support system surrounding the mother during the earliest and most fragile phase of lactation.

One determinant of that fragility is psychological. Milk production and expulsion depend on prolactin and oxytocin, and oxytocin release is particularly sensitive to the emotional state of the mother. Anxiety, stress, exhaustion, and low self-confidence during the postpartum period inhibit the let-down reflex, so that milk flow becomes irregular even when production is physiologically adequate. Mothers then interpret the difficulty as insufficient milk, and this perception is one of the most frequent reasons for early introduction of formula (Gozali & Pratiwi, 2025; Zahra, 2024). Postpartum fatigue in particular has been shown to reduce the motivation of mothers to continue breastfeeding, creating a cycle in which tiredness lowers confidence, lowered confidence disrupts the reflex, and disrupted flow deepens the fatigue.

Hypnobreastfeeding has emerged in Indonesian midwifery practice as a simple response to this psychological determinant. It is a relaxation technique in which positive suggestion or affirmation is given while the mother is in a calm and focused state, combining deep breathing, visualisation, and reassuring statements about her capacity to nourish her baby. Studies conducted in various settings report that

hypnobreastfeeding improves milk expression among postpartum mothers, reduces anxiety, and increases motivation to breastfeed (Gaparini et al., 2024; Hanum, 2021; Triswanti et al., 2025). Because the method requires no drugs, no equipment, and no invasive procedure, it fits the profile of complementary midwifery care that can be delivered in primary-level facilities such as independent midwifery practices.

A second determinant lies outside the mother herself. The husband is the person physically and emotionally closest to a breastfeeding woman and, in many Indonesian households, the principal decision maker regarding infant feeding. Research consistently links husband support with the success of exclusive breastfeeding: emotional, informational, instrumental, and appraisal support all increase maternal motivation and resilience during the postpartum period (Indra et al., 2026; Muchsin, 2024; Syaiful et al., 2021). Paternal involvement has also been shown to sustain exclusive breastfeeding under difficult circumstances, including among mothers recovering from caesarean section (Budiati et al., 2021), and family support more broadly is associated with continued breastfeeding through the first year (Yanhari et al., 2023).

Interventional evidence goes further than association. A systematic review and meta-analysis of experimental studies found that infants whose fathers participated in a breastfeeding promotion intervention were approximately twice as likely to be exclusively breastfed compared with infants whose fathers did not, with reduced risk of full formula feeding and fewer lactation-related problems in the intervention groups (Hergholi et al., 2026)(Samiun et al., 2026). A later systematic review of partner-inclusive perinatal interventions similarly concluded that including fathers improves breastfeeding initiation, duration, and exclusivity (Abbass-Dick et al., 2019). Fathers are therefore not merely bystanders to be informed but a legitimate and effective target of health education.

The gap becomes visible when these two lines of evidence are placed side by side. Hypnobreastfeeding has been studied almost exclusively with mothers as recipients, while father-inclusive interventions have generally delivered conventional lactation information rather than relaxation and affirmation techniques. Yet the logic of hypnobreastfeeding points directly at the husband: the affirmations that calm a mother are most powerful when they come from the person she trusts most, and the quiet, unhurried home atmosphere the method requires is something a husband is uniquely positioned to create. Studies that make husbands the direct recipients of hypnobreastfeeding education, and that measure the resulting change in their knowledge and attitude, remain very limited, particularly in the West Sumatra context.

This article aims to review the literature on the psychological determinants of lactation, the effectiveness of hypnobreastfeeding, and the contribution of husband support to exclusive breastfeeding, and to synthesise these strands into an argument for husband-targeted hypnobreastfeeding education as a family-centred model of midwifery care. The review also considers how such education should be structured,

how its effects can be measured, and what implications it carries for midwifery practice, education, and policy at the primary service level.

RESEARCH METHOD

This study used a literature review as a qualitative research method, adopting a descriptive literature review design. As Snyder (Snyder, 2019) notes, a well-conducted review provides a foundation for advancing knowledge and supporting theory development, particularly in fields where evidence is scattered across disciplines and publication languages. The review therefore synthesised findings from peer-reviewed journal articles, empirical studies, and institutional reports published within the last ten years.

Articles published between 2018 and 2026 were retrieved from PubMed, ScienceDirect, and Google Scholar, supplemented by nationally accredited Indonesian journals indexed in Garuda and SINTA in order to capture the substantial body of hypnobreastfeeding research published in Indonesian. Search terms were combined in English and Indonesian, including hypnobreastfeeding, relaxation and breast milk production, husband support, father involvement breastfeeding, exclusive breastfeeding, and knowledge and attitude breastfeeding education.

Literature was included if it addressed the psychological determinants of lactation, the implementation or effect of hypnobreastfeeding, the role of husbands or fathers in breastfeeding, or educational interventions measuring knowledge and attitude among family members. Studies were excluded if they did not directly address these themes or lacked an adequate empirical or theoretical foundation. Thematic analysis was used to identify and organise recurring patterns across the selected literature, with particular attention to the points at which the hypnobreastfeeding literature and the paternal-support literature converge.

RESULT AND DISCUSSION

Maternal Psychological Condition and the Milk Ejection Reflex

The literature is consistent on one point: lactation is a neuroendocrine process that is highly responsive to emotional state. Prolactin governs milk synthesis, while oxytocin governs its expulsion from the alveoli towards the nipple. Oxytocin release is mediated by higher brain centres and is therefore readily inhibited by anxiety, pain, fear, and exhaustion. A mother who is tense does not necessarily produce less milk, but she may release it less efficiently, and the practical result at the breast is identical: the infant appears unsatisfied, the mother concludes that her milk is insufficient, and formula is introduced.

Empirical work supports this mechanism. Anxiety among postpartum mothers has been shown to correlate significantly with disrupted milk expression, with mothers experiencing higher anxiety reporting less fluent breastfeeding (Izzah et al., 2022). Studies conducted in Indonesian primary care settings similarly report that maternal

fatigue in the early postpartum period lowers motivation to sustain breastfeeding (Gozali & Pratiwi, 2025), while case-based midwifery reports document that perceived insufficient milk is among the most common presenting problems in independent midwifery practices (Zahra, 2024).

Two implications follow. First, interventions that address only technique, namely positioning, attachment, and feeding frequency, are incomplete if the psychological state of the mother is left unattended. Second, and more importantly for this review, the psychological state of a postpartum woman is not fully within her own control. It is shaped by the atmosphere of the household, the division of domestic labour, and the presence or absence of reassurance from the people around her. This is precisely where the husband enters the causal chain, and it explains why a purely mother-centred intervention has structural limits.

Hypnobreastfeeding as Complementary Non-Pharmacological Midwifery Care

Hypnobreastfeeding responds directly to the psychological determinant. The method places the mother in a relaxed and receptive state through deep breathing and visualisation, and then introduces positive affirmations that build confidence in her ability to nourish her child. It is holistic in orientation, attending to mind, body, and emotion rather than to the breast alone, and it is deliberately simple enough to be practised at home without professional supervision after an initial guided session.

Findings across Indonesian studies converge. Quasi-experimental research using one-group pretest-posttest designs reports significant improvement in milk expression among postpartum mothers after hypnobreastfeeding (Gaparini et al., 2024; Hanum, 2021), and community-based implementation has been reported to optimise exclusive breastfeeding practice among breastfeeding mothers (Triswanti et al., 2025). Work examining fatigue and motivation found that hypnobreastfeeding reduced fatigue and increased motivation to breastfeed from the third postpartum day onwards (Watna et al., 2023). Reviews of relaxation therapy in the perinatal period place hypnobreastfeeding alongside music therapy as effective in stimulating milk production and prolactin secretion in postpartum mothers, situating the Indonesian findings within a broader international literature on relaxation and lactation.

Several features make hypnobreastfeeding well suited to primary midwifery services. It is non-pharmacological and carries minimal risk, so it does not compete with or displace standard postpartum care. It is inexpensive, requiring only a quiet room, a facilitator, and printed guidance materials. It is culturally congruent, since affirmation and reassurance within the family are familiar practices rather than foreign impositions. And it is transferable: unlike clinical procedures, the technique can be taught to a lay person in a single session and then rehearsed at home. This last characteristic is what makes the shift of recipient from mother to husband technically feasible.

Husband Support as a Determinant of Exclusive Breastfeeding Success

The second strand of the literature concerns the husband. Support is generally described in four forms: emotional support through attention, reassurance, and affection; informational support through the provision of accurate advice; instrumental support through practical help with domestic work and infant care; and appraisal support through praise and recognition of the effort of the mother. Indonesian studies report significant associations between the presence of these forms of support and the success of exclusive breastfeeding (Indra et al., 2026; Muchsin, 2024; Syaiful et al., 2021), while family support more broadly has been linked with continued breastfeeding among infants aged 6-12 months (Yanhari et al., 2023).

The mechanism is best understood as indirect. A husband does not produce milk, but he governs many of the conditions under which milk is released. When he takes on night-time settling, household tasks, or the care of older children, maternal fatigue falls. When he expresses confidence in the capacity of his wife to breastfeed, her self-efficacy rises. When he declines to suggest formula at the first sign of difficulty, a common pathway to early cessation is closed. Research on mothers recovering from caesarean section illustrates the point with particular clarity, showing that paternal involvement sustains exclusive breastfeeding in circumstances where maternal mobility and comfort are compromised (Budiati et al., 2021).

Empirical evidence firmly establishes husband support as a critical determinant of exclusive breastfeeding success, demonstrated by a 17% increase in early breastfeeding initiation, a nearly threefold higher likelihood of sustained exclusive breastfeeding at four months and up to a 46% reduction in premature breastfeeding cessation over the first six months postpartum, alongside positive gains in maternal breastfeeding self-efficacy. By mitigating maternal anxiety, bolstering confidence, and offering practical caregiving assistance, structured paternal interventions, such as father-targeted telephone counselling, effectively bridge the gap between maternal intention and prolonged breastfeeding adherence, positioning the partner not merely as an observer but as an indispensable pillar of perinatal healthcare delivery (Ngai et al., 2026; Samiun et al., 2026).

Two qualifications deserve mention. Some literature cautions against assuming that all forms of paternal involvement are beneficial, noting that practical support has occasionally been associated with shorter breastfeeding duration in high-income cohorts, presumably because it can facilitate bottle feeding. Others have questioned whether favourable paternal attitudes translate into changed practice in every cultural setting. These findings do not overturn the overall pattern, but they suggest that the content of father-directed education matters: involvement must be oriented towards supporting breastfeeding specifically, not merely towards general participation in infant care.

Husbands as the Direct Target of Education: Knowledge and Attitude as Outcomes

If husbands are to support breastfeeding effectively, they must first understand it. Knowledge and attitude are the standard proximal outcomes in health education research because they sit immediately downstream of the intervention and immediately upstream of behaviour. A husband who does not know that maternal anxiety inhibits the let-down reflex has no reason to protect the calm of his wife; a husband who believes that breastfeeding is entirely a matter for women has no motivation to participate, whatever his knowledge.

The available literature indicates that both are modifiable. Community-based intervention studies among fathers report measurable change in knowledge, attitude, and involvement following structured breastfeeding education, and reviews of father-inclusive programmes consistently find improvement in paternal support and attitudes towards breastfeeding after intervention (Abbass-Dick et al., 2019; Mahesh et al., 2018). Health education directed at families more generally has likewise been shown to improve family knowledge and attitude in supporting maternal and child health.

What is absent is the combination. Hypnobreastfeeding studies have almost invariably recruited mothers; father-focused studies have almost invariably delivered conventional lactation content. A programme that teaches husbands the physiology of milk production, the psychological determinants of milk flow, and the practical technique of guiding relaxation and delivering affirmation to their wives occupies an intersection that is theoretically well grounded but empirically thin, particularly in the Indonesian and West Sumatran context. This is the gap that justifies further primary research, and it is a gap that can be addressed with a modest, low-risk design.

Measurement in such a study is straightforward. Knowledge can be assessed with a dichotomous true-or-false instrument covering exclusive breastfeeding, lactation physiology, the role of prolactin and oxytocin, the concept and technique of hypnobreastfeeding, and forms of husband support, with results categorised as poor, adequate, or good. Attitude can be assessed with a Likert-scale instrument containing both favourable and unfavourable statements about the willingness of the husband to accompany, assist, reassure, and advocate for his wife during breastfeeding. Both instruments require validity testing against the product-moment table and reliability testing with a Cronbach alpha threshold of 0.7 on a sample outside the study population before use.

Designing Hypnobreastfeeding Education for Husbands in Primary Midwifery Practice

The literature suggests several design principles for such a programme. Delivery should be face to face and in small groups, since group formats permit discussion among men facing similar circumstances and were among the more effective formats identified in reviews of father-inclusive interventions. A session of approximately ninety to one hundred and twenty minutes with eight to ten participants allows time for

explanation, demonstration, and rehearsal without exceeding the attention and availability of working husbands.

The content should move from rationale to technique. Explanation of the benefits of exclusive breastfeeding and the physiology of milk production establishes why the behaviour of the husband matters; discussion of the influence of maternal psychological state on the let-down reflex converts that rationale into a specific target; presentation of the hypnobreastfeeding concept, comprising relaxation, deep breathing, visualisation, and positive affirmation, supplies the method; and demonstration followed by paired role-play converts information into a practised skill. Discussion of everyday forms of support closes the loop between technique and daily household life.

Take-home materials and a follow-up mechanism matter as much as the session itself. Reviews of communication and education interventions repeatedly note that a single exposure produces improvements that decay without reinforcement. A printed module and leaflet, a simple daily self-monitoring sheet covering a two-week practice period, and a mid-point reminder by telephone or messaging application provide structure between the session and the post-test, and they extend the intervention into the home where the affirmation must actually be delivered.

Finally, the affirmations themselves should be short, concrete, and phrased in the language of the household rather than of the clinic. Statements that reassure the mother about the sufficiency of her milk, that express pride in her effort, that invite her to breathe slowly while her husband stays beside her, and that offer rest while he cares for the baby, translate the four theoretical forms of support into sentences a husband can actually say.

Implications for Midwifery Services, Education, and Policy

For midwifery services, the model reframes the unit of care. Postpartum counselling in Indonesia is typically directed at the mother, with the husband present as an observer if present at all. Treating the husband as a co-recipient of education positions the family, rather than the individual, as the object of midwifery care, and does so without additional clinical risk or significant cost. Independent midwifery practices are a logical setting: they already serve a continuous population of postpartum couples, they possess waiting areas suitable for small-group sessions and consultation rooms suitable for private questionnaire completion, and their midwives already hold the trust of the families concerned.

For midwifery education, the model implies that competence in complementary care and in family-oriented health education should be taught alongside clinical skills. A midwife who can guide a relaxation exercise, facilitate a small group of men, and design a simple take-home module possesses capabilities that are not usually formalised in curricula but are essential to family-centred practice. Standard operating procedures

and validated modules are the mechanism through which such practice becomes transferable rather than dependent on individual initiative.

For policy, exclusive breastfeeding programmes that address only mothers address only part of the causal system. Including husbands as a defined target group in breastfeeding promotion at the primary care level is consistent with the international evidence on father-inclusive interventions and with national efforts to accelerate stunting reduction. Given the modest cost of the intervention and the magnitude of the effect reported in the interventional literature, the model warrants evaluation as a candidate component of routine postpartum service delivery.

CONCLUSION

This review indicates that the success of exclusive breastfeeding is determined not only by maternal technique but by the psychological condition of the mother and by the support surrounding her. Anxiety, fatigue, and low self-confidence inhibit the oxytocin-mediated milk ejection reflex; hypnobreastfeeding, through relaxation and positive affirmation, addresses this psychological determinant and has been reported to improve milk expression, reduce anxiety, and strengthen breastfeeding motivation. In parallel, husband support in its emotional, informational, instrumental, and appraisal forms is consistently associated with exclusive breastfeeding success, with father-targeted interventions demonstrated to substantially increase the likelihood of sustained breastfeeding across the first six months postpartum.

The two bodies of evidence have developed separately. Hypnobreastfeeding education directed at husbands, with knowledge and attitude measured as outcomes, therefore represents a theoretically coherent but empirically under-examined approach, particularly in the Indonesian context. Because such education is simple, inexpensive, non-pharmacological, culturally acceptable, and deliverable within a single session at an independent midwifery practice, it is a realistic candidate for family-based complementary midwifery care.

It is recommended that midwives be prepared to deliver family-oriented complementary education supported by standardised modules and operating procedures; that further quasi-experimental and controlled research be conducted to test the effect of husband-targeted hypnobreastfeeding education on the knowledge and attitude of husbands and, subsequently, on the duration of exclusive breastfeeding; and that breastfeeding promotion policy at the primary care level explicitly include husbands as a target group rather than as an audience.

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