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Coparenting Model to Preventing the Incidence of Postpartum Blues and Increasing the Success of Exclusive Breastfeeding

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ABSTRACT

Breastfeeding difficulties can increase the risk of postpartum blues and hinder exclusive breastfeeding success. Husband and family support are key factors in reducing postpartum blues. This study aimed to identify determinants of exclusive breastfeeding and evaluate the effect of a Balinese culture-based coparenting model in preventing postpartum blues to improve breastfeeding success. A mixed methods approach with an explanatory sequential design was used, involving 11 informants (7 married couples and 4 experts) and 60 respondents divided into intervention and control groups. The intervention applied the Balinese coparenting model "Asah, Asih, Asuh," involving husbands and in-laws in supporting breastfeeding mothers. Quantitative data were analyzed using Wilcoxon, Mann-Whitney, and Chi-square tests ($\alpha<0.05$). Results showed a 70% reduction in postpartum blues incidence in the intervention group, with no decrease in the control group. Exclusive breastfeeding success reached 76.7% in the intervention group, with a significant difference ($p=0.032$). The coparenting model was implemented from pregnancy through postpartum to support exclusive breastfeeding. This study concludes that the Balinese culture-based coparenting model effectively reduces postpartum blues and increases exclusive breastfeeding success.

INTRODUCTION

The World Health Organization (WHO) recommends that all babies throughout the world be exclusively breastfed for the first 6 months of life for optimal health and development. However, very few women worldwide meet these recommendations. One of the factors that is thought to be predictive is psychological factors [1,2]. Based on UNICEF data, many countries in the world have experienced progress in providing exclusive breastfeeding to babies aged 0-6 months over the last 15 years. At the global level, the prevalence of exclusive breastfeeding increased by only around 7%, and it was found that only 49.8% breastfed exclusively for 6 months according to WHO recommendations [2], whereas based on the 2018 Riskesdas results, the proportion of breastfeeding patterns in babies aged 0-6 months in Indonesia, 37.3% are exclusively breastfed, 9.3% are partial breastfed and 3.3% are predominantly breastfed. Formula

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breastfeeding is still very high at 79.8% [3]. In Bali Province, exclusive breastfeeding coverage of 59.7% has reached the target. However, several cities/districts have not reached the target, namely Jembrana Regency (47.6%), and Denpasar City (47.6%). The districts with the highest achievements were Badung District (69.5%) and Buleleng District (69.2%). This figure meets the WHO target and the Ministry of Health's Strategic Plan for 2019 of 50% [4].

Difficulty in breastfeeding has been identified as a contributing factor to the development of postpartum depression, particularly in the form of postpartum blues. This condition represents a transitional period for mothers, during which they experience significant physical, psychological, emotional, and social changes [5]. Postpartum blues typically manifests as emotional distress following childbirth, characterized by symptoms such as anxiety, panic attacks, fatigue, self-blame, and a perceived inability to care for the newborn [6]. Contributing challenges include sore nipples, exhaustion, and concerns related to breastfeeding adequacy. Additional signs and symptoms associated with postpartum blues include alterations in eating and sleeping patterns, frequent crying, feelings of worthlessness, and a sense of hopelessness [7].

The prevalence of postpartum blues varies throughout the world. The incidence of postpartum blues in several regions in Indonesia, namely in Jakarta, Surabaya and Yogyakarta, the incidence of postpartum blues reaches 11-30%. The high incidence of postpartum blues in postpartum mothers can have a significant impact on the mother's psychological state [8]. Postpartum blues maternal anxiety reduces the release of oxytocin during breastfeeding, problems in postpartum blues mothers which can cause anxiety and depression will suppress oxytocin production [9]. High levels of stress are closely related to a decrease in breast milk production in postpartum mothers [10].

Breastfeeding is a time-intensive activity, mothers need various types of support for optimal initiation and continuation of exclusive breastfeeding. The most important support system in breastfeeding is the father [11]. In reality, fathers' involvement in supporting the success of exclusive breastfeeding is still lacking, one of the reasons is because culturally there is a division of roles where the father acts as the breadwinner and household matters are entirely the mother's business [12]. Some treatments that can be done to prevent postpartum blues are by providing support from the husband or family. A literature review conducted by Pope and Mazmanian [13] shows that husband's support can prevent postpartum blues while increasing breastfeeding by preparing pregnant women in the third trimester to take action so that breast milk production can increase during breastfeeding later. Research conducted by Rinata and Syahilda Hamdi [14] stated that preparation during the third trimester of pregnancy can increase breastfeeding success.

Coparenting is a term for the concept of teamwork where mothers and fathers work together for the best health and influence for their children [15]. The coparenting care model involving the role and support of the father is thought to be able to prevent stress in the mother after giving birth so that breast milk production will increase. Fathers certainly have a unique role in influencing and supporting mothers in breastfeeding. According to Talitha et all [16], parenting patterns can influence breast milk production, where support from the family, especially the husband, will increase breast milk production. According to Makagingge et all [17] child care occurs in the interaction between the caregiver and the child and the source of care, where in this case the child becomes the center of all components in care, so that everything that is prepared, implemented and achieved is directed at the situation and conditions. and the child's growth and development needs.

Culture is an important factor that influences parents in how to educate children. Most parents learn parenting practices from their own parents. Some of these practices they accept, but others they abandon or sometimes bring different views regarding child care [18,19], in the cultural context, there is one factor that cannot be ignored in pregnancy period, namely the existence of beliefs from several regions regarding pregnancy and postpartum, such as postpartum mothers not being allowed to leave the house for 42 days [20]. In the Bali area, especially the city of Denpasar, there is a belief that the newborn baby is the reincarnation of an ancestor so must be cared for well. Other pregnancy and postpartum cultures are still often found in Indonesia in accordance with regional customs, but only differ in their expression which is influenced by the physical and social environmental conditions of each [21,22,23].

A preliminary study conducted on March 4, 2021, using interviews with 10 Balinese couples (pregnant women and their husbands), revealed that 70% of the participants reported that pregnant women

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were not consistently accompanied by their husbands. This was primarily due to the husbands' involvement in religious ceremonies (*ngayah*). In addition, limited emotional support was observed, particularly when the gender of the unborn child did not align with the couple's expectations. Nonetheless, the husbands remained responsible for fulfilling the material needs of their wives and babies. The coparenting model used in the research places more emphasis on Indonesian culture, especially Balinese culture, which is still strong with a patriarchal system and the existence of ngayah (mutual cooperation activities) in traditional villages. This coparenting model is wrapped in the teachings of asah, compassion and nurturing which have the meaning of educating each other, loving each other and developing each other.

METHOD

The study begins with a brief overview of the research design, specifying whether it employs a cross-sectional, cohort, or other methodological approach to ensure clarity in the interpretation of the findings. The approach used in this research is a mixed method with an explanatory sequential design where the data collection method begins with quantitative data collection and then continues collecting qualitative data to help analyze the data obtained quantitatively, so that the results of research with this design are to explain a general picture (generalization). The qualitative method used in this research is used to determine the basis for developing a coparenting model that will be implemented in Denpasar City based on regional culture. The quantitative method used in this research is Quasi Experimental while the research design is non equivalent Control Group Design, namely where subjects in each group are selected based on criteria that have been determined by the researcher.

In the research there were two groups, namely one experimental group and one control group which began with a pretest given to both groups and then given treatment. The research ended with a final test (posttest) which was also given to both groups. In this research, the treatment group was given education based on a coparenting model which included creating a discussion forum on the WhatsApp application, displaying educational material via video, while the control group was treated by providing education through conventional methods obtained through pregnant women's classes and modules. The research was conducted in Denpasar City, involving 11 Community Health Centers, spanning approximately 8 months from November to July 2021. Stage 1 encompassed one month and involved focus group discussions with seven couples and four experts, followed by qualitative coding and model preparation. In the final two weeks, a model trial was conducted with two pairs of primigravida mothers and midwives. The coparenting model implementation begins postpartum, preceded by a screening for postpartum blues within the first 7 days post-birth. Subsequently, a pretest assessed knowledge, attitudes, and support. The treatment group received coparenting modules and videos via WhatsApp, while the control group focused on exclusive breastfeeding follow-ups.

The study focused on primigravida pregnant women in the early third trimester within Denpasar City Health Center's work area. A total of 11 informants participated, including couples attending pregnant women's classes and experts. Among them, 7 were couples, and 4 were experts. The quantitative sample comprised 60 pairs of mothers and husbands, divided into treatment and control groups of 30 respondents each. Sampling techniques were employed, grouping participants based on geographic region. Community health centers in the north and west of Denpasar constituted the control group, while those in the east and south comprised the treatment group. Data analysis included univariate and bivariate tests to assess differences in mean variables pre- and post-treatment, covering knowledge, attitudes, family support, and health worker support. Parametric tests such as paired sample t-tests and chi-square tests were used for normally distributed data, while non-parametric tests like Wilcoxon and Mann Whitney tests were used for non-normally distributed data.

RESULTS AND DISCUSSION

This study employed a qualitative approach utilizing Focus Group Discussions (FGDs) with experts to explore and identify an appropriate coparenting model tailored to the sociocultural context of married

couples in Denpasar, Bali. The co-parenting model scheme that will be implemented is adopted from Feinberg's ecological model of coparenting and the results of FGDs with married couples and expert health workers such as midwives, doctors and psychologists. After the module was declared suitable for testing, the quantitative stage was then carried out on 60 respondents. The distribution of respondent data characteristics is as follows:

Table 1. characteristic responden

Variable	Group				Amount	
	Treatment		Control			
	n	%	N	%	n	%
Mother's age						
Risky	5	16.7	3	10	8	13.3
No Risk	25	83.3	27	90	52	86.7
Total	**30**	**100**	**30**	**100**	**60**	**100**
Wife's Employment Status						
Doesn't work	13	43.3	15	50.0	28	46.7
Work	17	56.7	15	50.0	32	53.3
Total	**30**	**100**	**30**	**100**	**60**	**100**
Husband's Employment Status						
Doesn't work	4	13.3	2	6	6	10
Work	26	86.7	28	94	54	90
Total	**30**	**100**	**30**	**100**	**60**	**100**
Wife's Educational Status						
Low education	5	16.7	7	23.3	12	20
higher education	25	83.3	23	76.6	48	80
Total	**30**	**100**	**30**	**100**	**60**	**100**
Husband's Educational Status						
Low education	2	6	4	13.3	6	10
higher education	28	94	26	86.7	44	90
Total	**30**	**100**	**30**	**100**	**60**	**100**
Family Income						
< 2.5 Million	14	46.7	17	56.7	31	51.7
2.5 – 5 million	12	40	12	40	24	40
> 5 Million	4	13.3	1	4.3	5	8.3
Total	**30**	**100**	**30**	**100**	**60**	**100**
Family Type						
Main family	10	33.3	12	40	22	36.7
Nuclear family & others	20	66.7	18	60	38	63.3
Total	**30**	**100**	**30**	**100**	**60**	**100**
Pregnancy Status						
mother wanted	5	16.7	2	6	7	10.6
desired by mother & husband	25	83.3	28	94	59	89.4
Total	**30**	**100**	**30**	**100**	**60**	**100**

The majority of respondents in both groups fell within the non-risk age category, comprising 83.3% in the treatment group and 90% in the control group. Regarding the employment status of their wives, a higher proportion of respondents in the treatment group reported that their wives were employed (56.7%), whereas in the control group, employment and unemployment among wives were equally distributed (50% each). Furthermore, most respondents reported that the current pregnancy was planned and desired by both the mother and her husband, with 83.3% in the treatment group and 94% in the control group affirming this

Table 2. Mean maternal knowledge score in the treatment group and control group, before and after treatment in Denpasar City in 2022

Group	Pre-Test	Post-Test	p-value
Treatment	73.33 ± 13.22	80.67 ± 10.15	0.022*
Control	71.33 ± 17.17	70.67 ± 16.39	0.680*
p-value	0.866**	0.023**	

Source: Primary Data, 2022
***---Wilcoxon u test**
**** ----- Mann Whitney test**

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Table 2 shows that in the treatment group, there was an increase in the pre-test knowledge score, namely 73.33 compared to the post-test, namely 80.67. The results of statistical tests using the Wilcoxcon test showed that there was a significant difference between the pretest and posttest (P= 0.022, smaller than 0.05). In the control group, there was a decrease in the knowledge score on the pre-test, namely 71.33, compared to the post-test, namely 70.67. The statistical test results showed that there was no significant difference between the pre-test and post-test (p=0.680, greater than 0.05). Furthermore, in the comparison of knowledge between the treatment and control groups in the pretest there was no significant difference between the treatment and control groups (p=0.866 greater than 0.005) while in the posttest group the results of statistical tests using the Mann Whitney test showed there was a significant difference between the treatment and control groups. (p=0.023 greater than 0.05) so it can be concluded that there is an influence of the coparenting model on knowledge

Table 3 Mean attitude scores of the treatment group and control group, before and after treatment in Denpasar City in 2022.

Group	Pre-Test	Post-Test	p-value
Treatment	71.47 ± 9.64	86.00 ±10.73	0,000*
Control	70.80 ± 12.76	70.47 ± 11.26	1,000*
p-value	0.853**	0,000**	

Source: Primary Data, 2022
*--U Mann Whitney test
**-- Wilcoxon test

Table 3 shows that in the treatment group, the pre-test score was 71.47, compared to the post-test score, namely 86.00. Meanwhile, in the control group, the pre-test score was 70.80, compared to the post-test score, namely 70.47. The results of statistical tests using the Wilcoxcon test showed that there was a significant difference between the pretest and posttest (P= 0.000, smaller than 0.05). In the control group, there was a decrease in the knowledge score on the pre-test, namely 70.80, compared to the post-test, namely 70.47. The statistical test results showed that there was no significant difference between the pre-test and post-test (p=1,000 greater than 0.05). Furthermore, comparing attitudes between the treatment and control groups in the pretest there was no significant difference between the treatment and control groups (p=0.853 greater than 0.005) while in the posttest group the results of statistical tests using the Mann Whitney test showed that there was a significant difference between the treatment and control groups. (p=0.000 greater than 0.05) so it can be concluded that there is an influence of the coparenting model on attitudes

Table 4. The influence of the coparenting model in preventing the incidence of postpartum blues in Denpasar City, 2022

Group	Post-Partum Blues		Total n(%)	p-value	OR (95% CI)
	Yes n(%)	No n(%)			
Treatment	9 (30.0)	21 (70.0)	30 (100)		
Control	22 (73.3)	8 (26.7)	30 (100)	0.001	6,417 (2,084-19,755)
Total	31 (51.7)	29 (48.3)			

Source: Primary Data, 2022

Table 4 shows that the incidence of postpartum blues was more in the control group, namely (73.3%) compared to the treatment group, namely (30.0%). The statistical test results show that the p-value=0.001<0.05 means that there is an influence of the coparenting model in preventing the incidence of postpartum blues. The OR value obtained is 6.417, meaning that providing a coparenting model 6 times has the potential to reduce the incidence of postpartum blues compared to those who are not given a coparenting model.

Table 5 shows that in the treatment group, there were more respondents with exclusive breastfeeding, namely (76.6%) compared to the control group, namely (50.0%). The statistical test results show the p-value=0.032<0.05. The OR value obtained is 3.286, meaning that giving the coparenting model 3 times has the potential to increase exclusive breastfeeding compared to those not given the coparenting model.

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Table 5 The influence of the coparenting model in increasing the success of exclusive breastfeeding in Denpasar City, 2022

Group	breast milk		Total n(%)	p-value	OR (95% CI)
	No n(%)	Yes n(%)			
Treatment	7 (23.3)	23 (76.7)	30 (100)	0.032	3,286 (1,085 -9,952)
Control	15 (50.0)	15 (50.0)	30 (100)		
Total	22 (36.7)	38(63.3)			

Source: Primary Data, 2022

The model developed in this research highlights Balinese culture, especially in Denpasar City, by emphasizing *Asah, Asih* and *Asuh* culture. The expected final result based on this model is a reduction in the incidence of postpartum blues and an increase in the success of exclusive breastfeeding. This research was conducted on the pretest and posttest on the knowledge and attitudes of husband couples and postpartum mothers. The knowledge of respondents in the control and treatment groups during the pretest had scores that were not much different, so it was concluded that there was no difference in knowledge scores in the pretest for the treatment and control groups. The pretest results show that the mother's knowledge is quite good in giving exclusive breast milk. This is different from the results obtained from the posttest where the mother's knowledge score increased significantly.

The results of the Focus Group Discussion (FGD) conducted with expert professionals and respondents reveal the parenting model already practiced by parents, the obstacles encountered in providing exclusive breastfeeding, and the factors triggering postpartum blues. Based on these FGD results, a coparenting model will be developed and implemented for husbands and pregnant mothers in Denpasar city. The success of increasing maternal knowledge in this study is also in line with the research of Iliadou [24] which states that after treatment, women in the treatment group have greater knowledge than the control group (14.6% versus 13.1%, p-value <0.001). The results of the study in the control group showed also a significant change in knowledge but not as strong as the significant meaning value in the treatment group. Increased knowledge in the control group can be obtained from the respondents' media exposure. This is further supported by Wallenborn [25] who found that paternal acknowledgment of responsibility for child-rearing led to improved maternal mental health and higher rates of breastfeeding initiation, demonstrating the importance of family involvement in educational interventions.

Comparison of attitude scores in the control and treatment groups shows that there is no difference in attitude scores in the pre-test of the treatment and control groups. After the post test was carried out, there was a significant difference in attitude scores between the two groups, which shows that the coparenting model can increase the respondents' attitude scores. Attitudes regarding exclusive breastfeeding are a factor that determines someone's willingness or readiness to provide exclusive breastfeeding. Mothers already have a strong attitude in providing exclusive breastfeeding, so their behavior becomes more consistent. The mother's attitude towards exclusive breastfeeding before and after treatment has different differences. This shows that before treatment was given, even though the mother already had a good perception regarding exclusive breastfeeding, it was not balanced with the latest information developments. Most mothers agree that breastfeeding should not be given any additional drinks until 6 months of age. Mothers also do not agree if breast milk is given if the baby cries.

In several studies, the factors that influence postpartum blues are mothers who are susceptible to experiencing a greater risk, especially the lack of attitude of their partners, especially women who have just experienced the postpartum period and have not been able to adapt to changes in new roles and functions in their family, so this is an influence for postpartum blues to occur [26, 27]. Good attitudes and knowledge can prevent postpartum blues in pregnant women. In this study, it was found that the treatment group with good knowledge reduced the incidence of postpartum blues (p value 0.049). Damsarsan [28] emphasized that high levels of spousal support significantly reduce postpartum depression and improve the quality of life for mothers, reinforcing the importance of a supportive partner in mitigating the challenges of new motherhood. Together, these findings highlight the multifaceted role of partner support in the postpartum

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period, underscoring the need for both emotional support and confidence-building interventions to improve maternal health and breastfeeding outcomes

Sulistiyanti [29] which says that most respondents who experience baby blues are not ready to become parents because of the role changes they experience, where this unpreparedness can affect the mindset and attitude of the mother and partner. Because of these task changes. This is in line with research by Maliszewska [30] that a correlation was found between the attitudes of spouses and baby blues mothers, but no definite causation was found. Attitudes in addition to influencing the decrease in the incidence of postpartum blues also affect the increase in exclusive breastfeeding. The existence of the coparenting model has increased the number of respondents who provide exclusive breastfeeding to 23 people. The teachings of care, love and nurture will certainly have an impact on the attitude of couples in supporting exclusive breastfeeding.

Research by Li further supports the idea that a lack of emotional support from a partner can increase the likelihood of postpartum depression, which negatively affects breastfeeding practices [27]. Similarly, Yamada [31] showed that couples' emotional and practical support plays a key role in mitigating postpartum emotional challenges, which indirectly supports breastfeeding initiation and continuation. Shinohara [30] added that positive partner attitudes can moderate the effects of fear of childbirth and postpartum depression, which in turn influences the success of exclusive breastfeeding. Furthermore, Mithani [32] explored how the role of fathers in breastfeeding practices can significantly enhance breastfeeding rates, especially when fathers are involved in the nurturing role and provide emotional support to the mother.

Recent studies underscore the vital role of partner support in enhancing maternal mental health and breastfeeding success. Basaran [34] found that women who received emotional support from their partners exhibited higher breastfeeding self-efficacy and a reduced risk of postpartum depression, with 90% of participants at risk for depression, showcasing the transformative impact of support. Similarly, Uğurlu et al' [35] revealed that while partner support alleviated postpartum depression, it didn't directly improve breastfeeding confidence, indicating that emotional support is critical for mental well-being but may require additional strategies to boost breastfeeding success. Vieira et al [36] also highlighted that mothers with higher breastfeeding self-efficacy were significantly more likely to exclusively breastfeed, reinforcing the importance of building mothers' confidence to achieve positive health outcomes. Together, these findings emphasize the need for both emotional and practical support to empower mothers, improve breastfeeding practices, and promote overall maternal health.

Conclusion

In conclusion, this study sheds light on post partum blues by providing valuable insights into coparenting models. The comprehensive analysis of our results in the context of existing literature contributes to the body of knowledge in international health. Our findings have implications for healthcare practices, policies, or parents, and future research efforts should build upon these foundations to further advance our understanding of child-mother issues

This research recommends, For healthcare institutions, it is hoped that making the Balinese culture-based coparenting model a program to increase exclusive breastfeeding behavior and prevent postpartum blues, namely in the form of providing modules to mothers, family (husband) assistance and mother-in-law assistance. The coparenting model is implemented from the time the mother is pregnant, the mother gives birth until she successfully provides exclusive breastfeeding.

Author Contributions

Authors contributions to the research and development of the manuscript.

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