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The role of social support in exclusive breastfeeding: a cross-sectional survey of emotional, informational, instrumental and appraisal support in the Eastern Cape, South Africa

Zukiswa Theodorah Dasheka
zdasheka@ufh.ac.za
University of Fort Hare
Ntombana Mc'Deline Rala
University of Fort Hare
Nonceba Mercy Vellem
University of Fort Hare
Hlokoma Mangqalaza
University of Fort Hare
Hlengiwe Gwebu
University of Fort Hare
Davison Moyo
Desmond Kuupiel
University of Fort Hare

Research Article

Keywords: Exclusive breastfeeding, Social support, Emotional support, Informational support, Instrumental support, Appraisal support

Posted Date: July 28th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-10021959/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

Exclusive breastfeeding (EBF) is a cornerstone of infant health, yet South Africa's national EBF rate of 32% remains well below global targets. In the Eastern Cape, socio-economic challenges and high HIV prevalence create complex barriers to EBF. While social support is a known determinant of breastfeeding success, there is a lack of quantitative data regarding which specific functional domains emotional, informational, instrumental, or appraisal best predict breastfeeding confidence in this context.

Methods

This cross-sectional survey utilised a quantitative approach to examine 397 perinatal women in the Eastern Cape. Participants were recruited from Midwifery-Led Units, postnatal wards, and primary healthcare clinics. Data were collected via researcher-administered electronic questionnaires and analysed using R. The study employed Pearson's Chi-squared tests, correlation analysis, and multivariable regression to assess how different support domains influence breastfeeding confidence indices.

Results

The sample was predominantly Black African (92.7%), single (80.6%), and low-income (83.4%). Most participants (67.3%) reported moderate breastfeeding confidence. Correlation analyses showed that breastfeeding confidence was significantly associated with informational ($r = 0.32$), instrumental ($r = 0.23$), and appraisal support ($r = 0.17$). Emotional support showed a weaker independent association. Multivariable regression revealed that HIV status, education levels, and household size significantly influenced access to these support domains. Specifically, HIV-positive status was significantly associated with higher informational and appraisal support ($p < 0.05$).

Discussion

The study highlights that functional, task-oriented support (information and practical help) and affirmative feedback (appraisal) are more critical to maternal confidence than general emotional encouragement. To improve EBF rates, interventions must transition from generic counselling to structured, skills-based support. A decentralised, household-centred approach linking Primary Health Care facilities with Ward-Based Outreach Teams is recommended to provide the instrumental and appraisal support necessary to sustain EBF for the recommended 6 months.

Background

Exclusive breastfeeding (EBF) for the first six months of life is widely recognised as a cornerstone of maternal and child health, with strong evidence linking optimal breastfeeding practices to reductions in infant morbidity and mortality and to improved developmental and long-term health outcomes [1]. Infants who are exclusively breastfed experience lower risks of infectious diseases, while mothers benefit from reduced risks of certain cancers and improved birth spacing [2]. In recognition of these benefits, global recommendations continue to prioritise EBF for the first six months, followed by sustained breastfeeding alongside appropriate complementary feeding [3].

Despite sustained global and national advocacy, EBF prevalence remains below recommended levels in South Africa. EBF rates decline sharply as infant age increases, creating a significant gap in reaching the global nutritional target of 50%. Nationally, the average for exclusive breastfeeding through the six-month mark stands at only 32% [4]. A study that examined the rate of EBF discontinuation and the lived experiences of 159 breastfeeding mothers at postnatal conducted in the Northwest Province, showed that EBF dropped from 34% at 8 weeks to just 9.7% by 24 weeks [5]. By 24 weeks, food feeding rose from 3% to 54.2% [5]. Barriers to continued EBF were attributed to the mother's wellbeing, experiences and the state of relationships. This was coupled with pressure from family, limited privacy, and the encouragement of traditional remedies. Difficult breastfeeding in public spaces was also a contributing factor in discouraging mothers from EBF [5].

Findings from the South Africa Demographic and Health Survey (SADHS) 2016 indicate that fewer than half of infants younger than six months are exclusively breastfed, reflecting persistent challenges in translating policy into practice [6]. While national breastfeeding policy reforms, particularly following the Tshwane Declaration, have contributed to improvements in early breastfeeding indicators, substantial variation persists across provinces and population groups [7], [8]. These disparities highlight the importance of examining breastfeeding practices within specific provincial contexts, such as the Eastern Cape, where socio-economic vulnerability and health-system constraints may intensify barriers to sustained EBF.

For example, evidence from a different study conducted in KwaZulu-Natal, on a cohort of 22 mothers, showed that while 100% intended to EBF, only 23% (5 out of 22) were successful for six months [9]. This was driven by factors such as the mothers' HIV status, cultural beliefs and high self-efficacy. EBF was encouraged by health workers' infant feeding advice and support. However, all mothers experienced some form of challenges related to inappropriate breastfeeding advice from health care workers, mother and baby feeding challenges, family encouraging the mother to use traditional medicine and the introduction of complementary food before the 6th month after the birth of the baby [9].

Breastfeeding decisions and practices are deeply embedded within women's social environments, making social support a critical determinant of EBF [10]. Social support encompasses multiple functional dimensions, including emotional reassurance and encouragement, informational guidance, practical or instrumental assistance, and appraisal support that reinforces confidence and decision-making [11]. These support functions operate through both direct pathways, such as assistance with infant care, and indirect pathways by reducing stress and enabling women to persist with breastfeeding when challenges

arise [10], [12]. In breastfeeding contexts, the presence or absence of specific forms of support can influence initiation, early problem-solving, and continuation of EBF.

A substantial body of international evidence demonstrates that structured breastfeeding support improves breastfeeding outcomes. Syntheses of randomised and quasi-experimental studies show that women who receive additional breastfeeding support, whether from health professionals, trained peers, or community-based supporters, are more likely to continue exclusive breastfeeding compared with those receiving standard care alone [13], [14]. In sub-Saharan Africa, peer-counselling approaches have shown measurable benefits for EBF promotion; the cluster-randomised PROMISE-EBF trial, which included South African sites, demonstrated that structured peer support can improve EBF practices in community settings [15]. However, these effects vary depending on the nature, timing, and type of support provided, underscoring the need to disaggregate social support into its functional components.

While prior research has established that “support matters” for breastfeeding outcomes, far fewer studies have empirically examined which types of support are most strongly associated with EBF, particularly in resource-constrained settings. In the Eastern Cape, qualitative work suggests that women navigate complex and sometimes contradictory support environments in which emotional encouragement, practical help, and advice are not always aligned [16]. Quantitative evidence that differentiates emotional, informational, instrumental, and appraisal support and assesses their independent relationships with EBF is therefore essential for informing targeted interventions that extend beyond health facilities to partners, families, and communities. In 2023, the Eastern Cape Province recorded the highest unemployment rate in the country at 41.3%, with the average household size remaining at 3.9. In addition, challenges related to water supply systems failing to meet quality standards consistently, as well as high levels of paraffin use in Buffalo City Metropolitan Municipality, reflect prevailing socio-economic conditions that may influence maternal choices regarding infant feeding practices. This study addresses this gap by examining the association between functional domains of social support and exclusive breastfeeding among perinatal women in the Eastern Cape [17].

Methods

This study adopted a quantitative research approach, utilising a survey design to explore the influence of social support on exclusive breastfeeding (EBF) among mothers during the initiation and maintenance phases of breastfeeding within the first six months of an infant’s life in the Eastern Cape Province, South Africa.

The study included mothers aged 18 years and above who had chosen exclusive breastfeeding during pregnancy, irrespective of their breastfeeding status at the time of data collection, who initiated breastfeeding in hospital postnatal wards and Midwifery-Led Units (MLUs), and who were exclusively or partially breastfeeding after birth at primary healthcare clinics. Mothers who had experienced premature and/or complicated childbirth, as well as those whose newborns were admitted to a neonatal intensive care unit during the first month of life, were excluded from the study. A non-probability convenience sampling technique was employed on the designated data-collection days.

A researcher-administered electronic questionnaire comprising closed-ended questions was used to collect data from 412 mothers. The tool was adapted from Boateng's et al, 2018 Breastfeeding Support Scale [18], with a confidence index validated using Cronbach's Alpha Scale at 84.9%. Participants were recruited from three standalone Midwifery-Led Units (MLUs) and two hospital postnatal wards to assess breastfeeding initiation, and from five randomly selected primary healthcare clinics to examine the maintenance of exclusive breastfeeding. Data collection took place between May and December 2024 and was guided by Vaux's Supportive Theoretical Framework. Following data cleaning, 397 completed questionnaires were included in the final analysis, while 15 were excluded due to incomplete responses.

Data analysis was conducted using the R statistical method to identify and describe relationships among the breastfeeding confidence indices. Descriptive statistics were initially used to summarise the sample's demographic characteristics. Pearson's Chi-squared test was subsequently used to examine associations between categorical variables, ensuring that the assumptions of independence and equal expected cell frequencies were met.

Furthermore, correlation analysis was performed to determine the strength and direction of the relationship between self-confidence levels. Regression analysis was also conducted to assess whether informational, emotional, appraisal, and instrumental support significantly predicted breastfeeding confidence while controlling for potential confounding variables.

Results

Sociodemographic Characteristics of Respondents

The study included 397 perinatal women (Table 1). Most respondents identified as Black African (92.7%), while 7.3% identified as Coloured. Nearly half had completed secondary education (44.6%), and 38.3% held a certificate qualification. A smaller proportion had completed a diploma (10.6%), while 6.3% had attained a bachelor's degree or higher. Most participants reported low household income, with 83.4% earning between R200 and R5,000 per month, and 4.0% reporting monthly earnings above R10,000. Most respondents were single (80.6%), followed by those who were married (17.9%). Regarding HIV status, 74.1% reported HIV being negative, and 6.5% reported unknown status.

Table 1
Sociodemographic characteristics of respondents among perinatal women in the Eastern Cape, South Africa (N = 397)

Variable	Sub-categories	n	%
Race	Black	368	92.7
	Coloured	29	7.3
Education	Secondary	177	44.6
	Certificate	152	38.3
	Diploma	42	10.6
	Bachelor's Degree	18	4.5
	Masters	4	1.0
	Honours Degree	3	0.7
	Primary	1	0.3
Income	R200 - R5 000	331	83.4
	R5 001 - R10 000	50	12.6
	R10 000+	16	4.0
Marital Status	Single	320	80.6
	Married	71	17.9
	Naver Married	4	1.0
	Separated	2	0.5
HIV Status	HIV Negative	294	74.1
	HIV Positive	77	19.4
	Not Known	26	6.5

Categorical distribution of perceived social support by age of child

The categorical distribution of social support domains by age of the child is presented in Table 2. Among mothers of infants aged 5–6 months, 69.9% reported good instrumental support and 64.0% reported good emotional support. Informational support was most frequently reported at a moderate level among mothers of infants aged 3–4 months (64.0%), with only 6.2% reporting good informational support at 5–6 months. Good appraisal support was reported by 54.2% of mothers of infants aged 5–6 months.

Table 2
Categorical distribution of social support domains among perinatal women in the Eastern Cape, South Africa

Support Category	Age of Child (Months)	Frequency (n)	Percentage (%)
Instrument Support			
Low Instrument Support	0–2	68	17.3
Moderate Instrument Support (3–4 months)	3–4	50	12.8
Good Instrument Support (5–6 months)	5–6	274	69.9
Emotional Support			
Low Emotional Support	0–2	63	16.2
Moderate Emotional Support	3–4	77	19.8
Good Emotional Support	5–6	249	64.0
Informational Support			
Low Informational Support	0–2	117	29.8
Moderate Informational Support	3–4	251	64.0
Good Informational Support	5–6	24	6.2
Appraisal Support			
Low Appraisal Support	0–2	96	25.4
Moderate Appraisal Support	3–4	77	20.4
Good Appraisal Support	5–6	205	54.2

Distribution of breastfeeding confidence levels among perinatal women in the Eastern Cape, South Africa

The distribution of breastfeeding confidence levels is presented in Table 3. Most participants reported moderate breastfeeding confidence (67.3%), while 23.2% had low confidence and 9.5% reported high confidence.

Table 3
Distribution of breastfeeding confidence levels among perinatal women in the Eastern Cape, South Africa (N = 397)

Breastfeeding Confidence Index	Score Range	Frequency	Percentage (%)
Low confidence	8–19	92	23.2
Moderate confidence	20–30	267	67.3
High confidence	31–40	38	9.5

Note. Breastfeeding confidence was measured using the Breastfeeding Confidence Index (possible score range: 8–40).

Distribution and internal consistency of social support domain scales among perinatal women in the Eastern Cape, South Africa

Mean social support scores varied across domains (Table 4). Emotional support recorded the highest mean score (4.91 ± 2.18; range: 0–7), followed by instrumental support (4.32 ± 1.58; range: 0–6) and informational support (3.96 ± 1.82; range: 0–8). Appraisal support had the lowest mean score (2.72 ± 1.59; range: 0–4). All social support scales demonstrated acceptable to good internal consistency, with KR-20 coefficients ranging from 0.64 to 0.88.

Table 4
Mean scores and distribution of social support domains among perinatal women in the Eastern Cape, South Africa

Social support domain	n	No. of items	Mean	SD	Range	KR-20	Reliability
Instrument Support	392	6	4.32	1.58	0–6	0.76	Acceptable
Emotional Support	389	7	4.91	2.18	0–7	0.82	Good
Informational Support	392	9	3.96	1.82	0–8	**0.64**	Moderate
Appraisal Support	378	4	2.72	1.59	0–4	0.88	Good

Note: Reliability calculated using Kuder-Richardson 20 Method

Correlations between social support domains and breastfeeding confidence

Correlation analyses revealed several statistically significant associations between social support domains and breastfeeding confidence (Fig. 1). Breastfeeding confidence was positively correlated with informational support (r = 0.32), instrumental support (r = 0.23), and appraisal support (r = 0.17), with corresponding 95% confidence intervals excluding zero. Significant intercorrelations were also observed among social support domains, including a strong positive correlation between emotional and appraisal support (r = 0.72), and moderate correlations between emotional and informational support (r = 0.46) and between informational and appraisal support (r = 0.47).

Associations between socio-demographic characteristics, social support domains, and breastfeeding confidence

Results from the multivariable regression analyses are summarised in Table 5. Results and Supplementary Fig. 1A, B, C, D, and E. Household size was significantly associated with instrumental support ($p = 0.011$). Single marital status showed significant associations with both emotional support ($p = 0.018$) and appraisal support ($p = 0.041$). Low household income (R200–R5,000) was significantly associated with informational support ($p = 0.034$). HIV-positive status was significantly associated with informational support ($p = 0.026$), appraisal support ($p = 0.017$), and breastfeeding confidence ($p = 0.021$), while unknown HIV status was also significantly associated with informational support ($p = 0.017$). With respect to education, secondary education, certificate, diploma, and master's levels of education were significantly associated with breastfeeding confidence (all $p < 0.05$). No other socio-demographic variables demonstrated statistically significant associations across the outcomes examined.

Table 5
P-values from multivariable regressions examining associations between socio-demographic predictors and social support domains

Predictor	Instrumental support	Emotional support	Informational support	Appraisal support	Breastfeeding confidence
Maternal age (years)	0.539	0.428	0.522	0.483	0.814
Ethnicity: Coloured (Ref: Black African)	0.817	0.462	0.313	0.655	0.937
Education level					
Primary education (Ref: No formal education)	0.754	0.788	0.983	0.490	0.868
Secondary education	0.660	0.390	0.729	0.314	0.032*
Certificate	0.419	0.554	0.343	0.668	0.036*
Diploma	0.555	0.429	0.987	0.570	< 0.001***
Honours degree	0.348	0.559	0.548	0.912	0.138
Master's degree	0.831	0.610	0.303	0.351	0.038*
Household income					
R200–R5,000 (Ref: ≥R10,000)	0.118	0.217	0.034*	0.345	0.512
R5,001–R10,000	0.198	0.522	0.237	0.572	0.576
Marital status					
Single (Ref: Married)	0.522	0.018*	0.336	0.041*	0.404
Never married	0.322	0.458	0.087	0.817	0.468
Separated	0.187	0.740	0.905	0.685	0.837
Household and reproductive characteristics					
Household size (number of members)	0.011*	0.183	0.810	0.352	0.121
Number of children	0.130	0.103	0.806	0.978	0.213
Number of pregnancies	0.910	0.319	0.869	0.935	0.997
HIV status					

Note. Values shown are p-values from multivariable regression models. * p < 0.05; ** p < 0.01; *** p < 0.001. Reference categories are indicated where applicable.

Predictor	Instrumental support	Emotional support	Informational support	Appraisal support	Breastfeeding confidence
HIV positive (Ref: HIV negative)	0.717	0.078	0.026*	0.017*	0.021*
HIV status unknown	0.161	0.401	0.017*	0.288	0.511

Note. Values shown are p-values from multivariable regression models. * p < 0.05; ** p < 0.01; *** p < 0.001. Reference categories are indicated where applicable.

Discussion

This study examined the distribution and determinants of multidimensional social support and its relationship with breastfeeding confidence among perinatal women in the Eastern Cape, South Africa. The findings demonstrate that informational, instrumental, and appraisal support were significantly associated with breastfeeding confidence, whereas emotional support alone showed a weaker association. In addition, household composition, breastfeeding stage, marital status, income level, and HIV status differentially shaped women's access to specific support domains. These findings reinforce socio-ecological perspectives on breastfeeding, which emphasise that breastfeeding behaviours are embedded within interpersonal, household, and structural contexts rather than driven solely by individual maternal motivation [7], [19](5, 13).

A key contribution of this study is the domain-specific understanding of how social support influences breastfeeding confidence. The stronger associations observed for informational, instrumental, and appraisal support align with evidence suggesting that breastfeeding-specific, functional support has a greater impact on maternal confidence than general emotional encouragement. For example, [12] demonstrated in northern Uganda that structured breastfeeding support enhanced maternal self-efficacy, which in turn mediated exclusive breastfeeding outcomes [19]. Similarly, Cochrane review evidence indicates that multi-component support—combining information, practical assistance, and feedback delivered by trained health workers or peer counsellors improves exclusive breastfeeding initiation and duration in low- and middle-income settings [13]. The role of appraisal support, reflecting affirmation and positive feedback, is consistent with self-efficacy theory, which posits that confidence is strengthened through mastery experiences and social reinforcement [20], [21]. In contrast, emotional support in isolation may be insufficient to address the practical challenges women face in sustaining breastfeeding, particularly in contexts of socio-economic hardship and health-system constraints.

The findings further highlight the importance of household and structural conditions in shaping breastfeeding support. Lower income and larger household size were associated with reduced support in some domains, echoing evidence that economic insecurity, competing caregiving demands, and food insecurity undermine breastfeeding confidence and practices [22], [23]. In South Africa, persistent socio-economic inequities and uneven implementation of breastfeeding policies have been identified as contributors to continued suboptimal breastfeeding outcomes despite strong policy commitments [5]. Evidence from African settings suggests that engaging family members, male partners, and community

networks can strengthen breastfeeding support environments and mitigate some of these structural barriers [24]. Collectively, these findings underscore the need for context-responsive approaches that extend breastfeeding support beyond the health facility into households and communities.

From a policy and practice perspective, the results have important implications for strengthening breastfeeding support within primary health care (PHC) and PMTCT services in South Africa. The strong associations observed for informational, instrumental, and appraisal support suggest that breastfeeding programmes should move beyond generic counselling to structured, skills-oriented, and feedback-driven support, delivered consistently across the antenatal and postnatal continuum. Integrating breastfeeding confidence-building strategies—such as problem-solving, tailored information, and practical demonstrations —into routine maternal and child health visits may be particularly important during the 4–6 month postpartum period, when pressures to introduce complementary feeding often increase. Emotional support remains important but may be most effective when combined with practical guidance and affirmation that directly address mothers' lived breastfeeding challenges.

To maximise the impact of breastfeeding interventions, awareness must extend beyond the mother and the Primary Health Care (PHC) facility to the household [10]. By adopting the Miller et al. (2022) [10] framework, support can be effectively decentralised into the home through family-centred awareness programs. This framework facilitates a holistic support structure by engaging partners and cohabitating family members in three key areas: informational support, by equipping the family with relevant facts and advice to guide the mother. Appraisal support by providing verbal encouragement that fosters positive self-evaluation and confidence. Instrumental support is offered through tangible, physical assistance to reduce the mother's daily workload. This could be implemented through information sharing, where mothers share clinical pamphlets with their families, thereby shifting breastfeeding from an individual task to a collective household responsibility. A PHC–community linkage framework, aligned with South Africa's Ward-Based Outreach Team (WBOT) strategy and PMTCT programme, offers a pragmatic pathway for operationalising multidimensional breastfeeding support. At the PHC facility level, professional nurses and midwives can deliver structured antenatal and postnatal counselling integrated within Maternal, Child and Women's Health (MCWH) and PMTCT services, with a focus on informational and appraisal support. Women identified as having low breastfeeding confidence, limited social support, or living with HIV can be systematically referred to WBOTs using existing clinic–community referral mechanisms.

Maleki-Sagooni et al. (2022) [25] identified appraisal support in the form of affirmation and approval from others, particularly from the partner, family members, and health personnel, as very crucial during this period. The appraisal process entails the mother having a sense of belonging and hope and being kept motivated further creates confidence. Mothers who were living with HIV reported that appraisal support, coupled with informational support, resulted in improved breastfeeding confidence. This finding of informational and appraisal support is consistent with Jama et al. (2017) [9] observation that mothers living with HIV were more likely to breastfeed for longer due to health workers' infant feeding advice and support. However, this finding contradicts the Naicker et al. (2024) [26] that nurses did not show interest

in breastfeeding coaching while some demonstrated unpleasant attitudes towards mothers living with HIV.

At the community level, WBOT community health workers, under appropriate supervision, are well-positioned to provide instrumental and appraisal support through scheduled household visits, reinforcing facility-based messages, addressing practical breastfeeding challenges, and facilitating early identification of difficulties. Ensuring bidirectional communication between PHC facilities and WBOTs through standardised referral tools, supervisory meetings, and routine monitoring indicators may enhance continuity, accountability, and responsiveness of breastfeeding support within existing health-system structures.

Strengths and limitations

This study has several strengths. It draws on a large community-based sample of perinatal women in a historically under-researched province, enhancing its relevance for PHC and community-based breastfeeding support in South Africa. The use of multidimensional social support measures, with acceptable to good internal consistency, allowed for a nuanced examination of how different support domains relate to breastfeeding confidence. Moreover, the combined use of descriptive, correlational, and multivariable regression analyses strengthened the robustness of the findings by accounting for key socio-demographic and contextual factors.

However, several limitations should be acknowledged. The cross-sectional design limits causal inference about the relationship between social support and breastfeeding confidence. All measures were self-reported, introducing potential recall and social desirability bias. Categorisation of breastfeeding confidence and social support, while enhancing interpretability, may have reduced variability compared with continuous measures. Finally, the study was conducted in a single province, which may limit generalisability, although the findings remain highly relevant to similar low-resource and high-HIV-burden contexts. Future research should prioritise longitudinal and intervention studies to examine causal pathways and evaluate the effectiveness of integrated PHC–WBOT breastfeeding support models across diverse South African settings.

Conclusion

This cross-sectional study examined the association between multidimensional social support and exclusive breastfeeding, including its relationship with breastfeeding confidence among perinatal women. Findings showed that informational, instrumental, and appraisal support were significantly associated with breastfeeding confidence, whereas emotional support demonstrated a weaker independent association. Key socio-demographic and contextual factors, including HIV status, educational attainment, household composition, and household income, further shaped access to specific support domains.

Overall, the results indicate that interventions aimed at strengthening exclusive breastfeeding should move beyond generic emotional encouragement but instead prioritise functional, breastfeeding-relevant support, particularly the delivery of practical guidance, tailored information, and affirming feedback across the antenatal and postnatal continuum. To sustain breastfeeding confidence and improve exclusive breastfeeding outcomes, strengthened coordination between primary healthcare services and community-based support structures is recommended, with targeted follow-up for women experiencing reduced access to support, including women living with HIV.

Declarations

Ethics approval and consent to participate

The Declaration of Helsinki underpinned the ethical principles for this research by emphasising voluntary participation, minimising risks, and protecting participants' rights. The principles of autonomy through clear information about the study purpose, procedures, potential benefits, and possible inconveniences, followed by written informed consent and the ability to withdraw at any time without any penalty. Justice, Beneficence and Non-maleficence were considered. Confidentiality and participants' privacy were safeguarded by the use of pseudonyms. The study received ethical approval from the University of Fort Hare, Faculty of Health Ethics Committee (Ref # 2021=09=06=Vellem NM). Permissions from the Eastern Cape Health Research Committee, relevant hospital authorities, and the Buffalo City Metropolitan Health District were obtained. Data was collected for research purposes from May to December 2024 without any information that could identify individual participants during or after data collection.

Consent to participate

Clear, participant-friendly information about the study purpose, procedures, potential benefits, and possible inconveniences was explained, followed by written informed consent (consent form signing) with literacy limitations; participants were reminded that they could withdraw at any time without any effect on access to routine health services or penalties in any form.

Consent for publication

Not applicable

Clinical trial number

Not applicable.

Availability of data and materials

The datasets generated and analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper

Funding

Research reported in this article was supported by the South African Medical Research Council (SAMRC) through its Division of Research Capacity Development under the Research Capacity Development Initiative from funding received from the South African National Treasury. The content and findings reported/illustrated are the sole deduction, view and responsibility of the researchers and do not reflect the official position and sentiments of the SAMRC.

Authors' contributions

Conceptualisation, Z.T.D., N.M.R. and N.M.V.; methodology, Z.T.D., N.M.R. and N.M.V.; analysis, Z.T.D., N.M.R., N.M.V., D.M, and D.K. Writing, original draft preparation, Z.T.D., N.M.R., N.M.V., H.K., H.G., D.M, and D.K. All authors reviewed and edited the manuscript and approved the final version of the manuscript. Coordination, Z.T.D.

Acknowledgements

The authors would like to thank the mothers who voluntarily participated in this the study, the hospital staff who willingly assisted, and the field workers collecting data.

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Figures

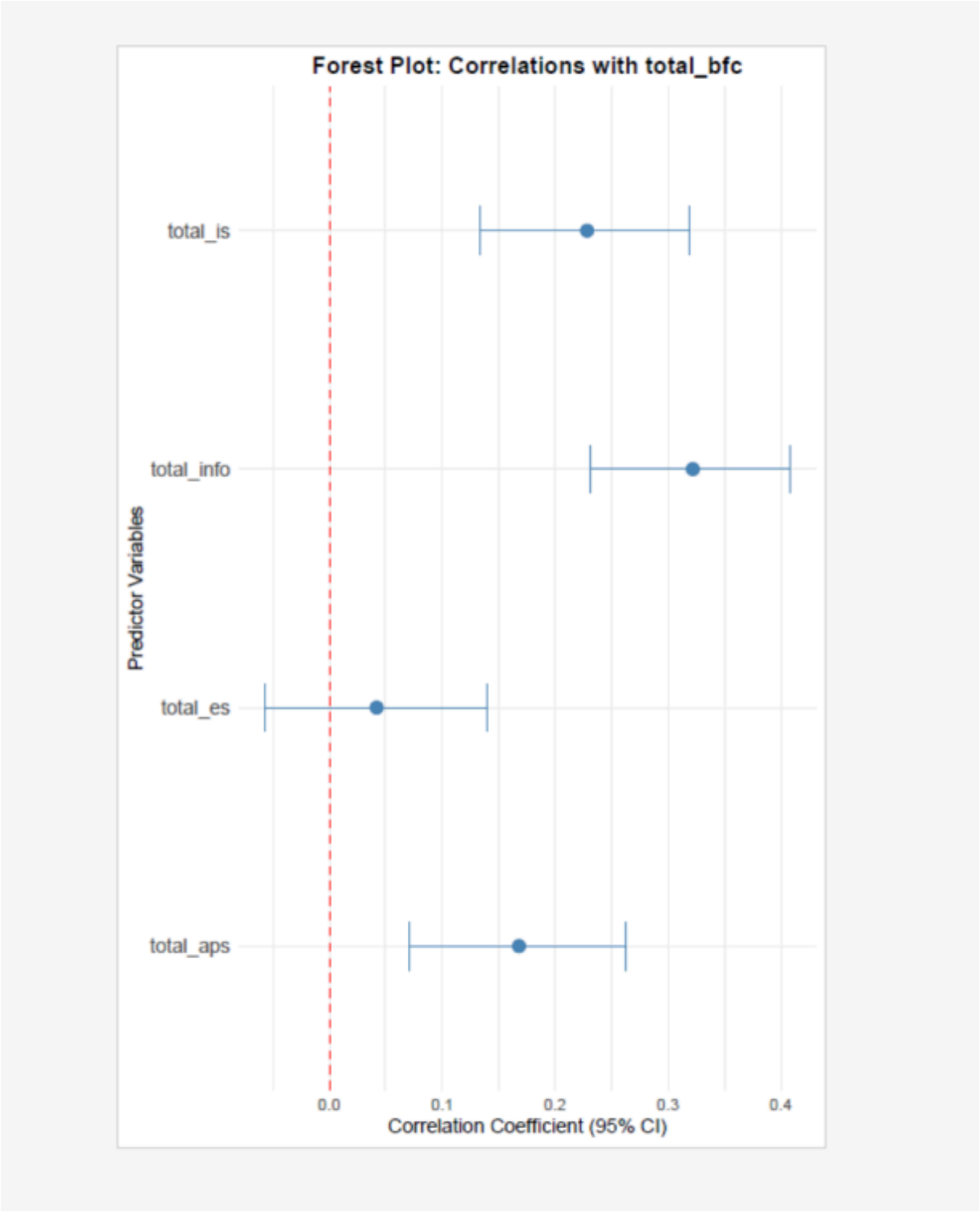


Figure 1

Forest plot of correlations between social support domains and breastfeeding confidence among perinatal women in the Eastern Cape, South Africa

Supplementary Files

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- FINALEBFQuestionnaire2021.docx
- Supplementary.docx