JAMA | US Preventive Services Task Force | EVIDENCE REPORT

Interventions to Support Breastfeeding
Updated Evidence Report and Systematic Review for the US Preventive Services Task Force

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IMPORTANCE Interventions to support breastfeeding may help individuals and families initiate breastfeeding or breastfeed exclusively or for a prolonged period of time.

OBJECTIVE To systematically review the evidence on the benefits and harms of breastfeeding interventions to support the US Preventive Services Task Force in updating its 2016 recommendation.

DATA SOURCES Studies included in the previous review were reevaluated for inclusion and updated searches in MEDLINE, CINAHL, Cochrane Central Register of Controlled Trials, and PsycINFO through June 3, 2024. Surveillance for new evidence in targeted publications through January 24, 2025.

STUDY SELECTION Randomized clinical trials that evaluated a primary care–relevant intervention designed to support breastfeeding. Of 290 full-text articles reviewed, 90 met inclusion criteria.

DATA EXTRACTION AND SYNTHESIS Independent critical appraisal of all provisionally included studies. Data were independently abstracted by one reviewer and confirmed by another.

MAIN OUTCOMES AND MEASURES Child and maternal health outcomes, prevalence, and duration of any and exclusive breastfeeding, and harms related to interventions.

RESULTS Ninety trials (N = 49 597) reported in 125 publications were included. The evidence represented individuals from diverse backgrounds and interventions that varied in timing, delivery, and duration. There was limited and mixed evidence on the effectiveness of breastfeeding support interventions on infant health outcomes (10 trials [n = 6592]) and maternal symptoms of anxiety, depression, and well-being (9 trials [n = 2334]). Pooled analyses indicated beneficial associations between breastfeeding support interventions and any or exclusive breastfeeding for up to and at 6 months (any breastfeeding: risk ratio, 1.13 [95% CI, 1.05-1.22]; 37 trials [n = 13 579] and exclusive breastfeeding: risk ratio, 1.46 [95% CI, 1.20-1.78]; 37 trials [n = 14 398]). There was no relationship between interventions and breastfeeding initiation or breastfeeding at 12 months.

CONCLUSIONS AND RELEVANCE The updated evidence confirms that breastfeeding support interventions can increase the prevalence of any or exclusive breastfeeding up to and at 6 months. Future efforts should focus on how to best provide this support consistently for all individuals making feeding decisions for their infants.

Editorial

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Multiple US and international organizations recommend that infants be exclusively fed breast milk for the first 6 months of life, followed by continued breastfeeding for up to 2 years as mutually desired by mother and infant while complementary foods are introduced.[1-7] In the United States, there is a sharp decline in breastfeeding as infants age, with breastfeeding the most prevalent from initiation to shortly after birth and steadily dropping off throughout the first year of the infant's life.[8] Additionally, data continuously show a lower prevalence of breastfeeding among certain groups of individuals, including Black women and those with lower education and income.[8-11] While most individuals express a desire to breastfeed their infants,[12] numerous barriers may hinder their ability to do so exclusively or for an extended time. Interventions to support breastfeeding may address these barriers by providing psychological and social support (eg, encouragement, reassurance, discussing questions and problems) and direct support during breastfeeding observations (eg, helping with the positioning of the infant, observing latching), addressing misconceptions around the benefits of breastfeeding, and providing support during transitional periods (eg, return to work, daycare attendance).

It is important to continue to understand to what extent interventions designed to support individuals and families may help increase the prevalence and duration of breastfeeding and affect health outcomes and any potential harms that might be associated with these interventions. The purpose of this review was to update the US Preventive Services Task Force (USPSTF) review[13,14] on the benefits and harms of behavioral counseling interventions to support breastfeeding among pregnant women and persons who feed their infants. It was conducted to help the USPSTF update its 2016 B recommendation[15] that clinicians provide interventions during pregnancy and after birth to support breastfeeding.

Methods

Scope of Review

This review addressed 3 key questions (KQs) (**Figure 1**). Within this review, "breastfeeding" referred to both feeding at the breast and feeding expressed breast milk (including shared, donated, and purchased human breast milk). A full research plan was published prior to conducting the review.[17] Methodological details including study selection, a list of excluded studies, additional data analysis methods, detailed study-level results for all outcomes, and contextual observational data are available in the full evidence report.[18]

Data Sources and Searches

To identify studies published since the previous review,[13] literature searches were conducted in MEDLINE, PsycINFO, CENTRAL, and CINAHL for English-language articles published from 2016 through June 3, 2024 (eMethods in the Supplement). Additional studies were sought by reviewing reference lists of other systematic reviews and included studies. Ongoing surveillance using targeted searches of journals with a high impact factor was conducted to identify newly published studies that might affect the findings of the review. The last surveillance on January 24, 2025, identified no new studies.

Study Selection

Two reviewers independently evaluated citations and full-text articles from the literature searches against prespecified inclusion criteria (eTable 1 in the Supplement). Disagreements were resolved by discussion and consensus. The review was limited to fair- and good-quality randomized clinical trials (RCTs, including cluster RCTs) that evaluated the effectiveness of breastfeeding support interventions that were initiated in, feasible for, or referable from primary care settings. Studies could be conducted during the prenatal, peripartum (ie, at or around the time of delivery), or postpartum period or any combination of these periods. Studies of interventions offering support that was supplementary to the standard care offered in that setting and included interventions provided by professionals, laypersons, or through digital modes of delivery were eligible for inclusion. Interventions could be delivered as stand-alone breastfeeding support interventions (ie, where the focus was on breastfeeding only) or as part of a wider maternal or infant health intervention if the intervention included a component focused on supporting breastfeeding (eg, maternal weight gain prevention).

Unlike the previous review,[13] health system-level interventions and policies, such as hospital rooming-in policies or implementation of the Baby Friendly Hospital Initiative that may not be applicable to or within the purview of primary care clinicians to implement or recommend, were excluded. Interventions had to have been conducted in countries with "very high" human development according to the United Nations[19] and to report at least 1 breastfeeding outcome (eg, initiation, duration, intensity, or exclusivity), health outcome (eg, maternal mental health symptoms, infant or child gastrointestinal symptoms), or adverse event (eg, maternal anxiety related to infant feeding, newborn dehydration).

Data Extraction and Quality Assessment

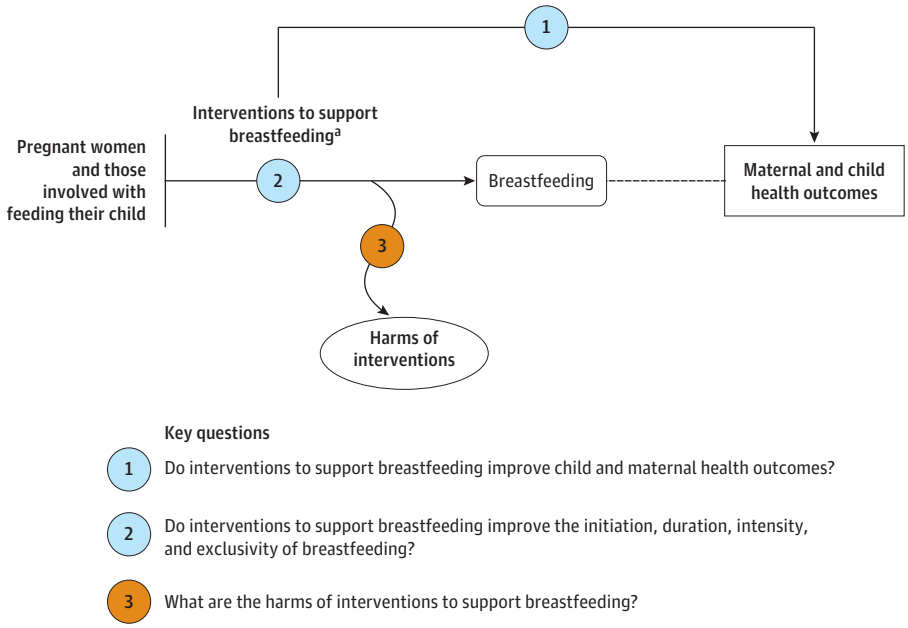
Two reviewers independently assessed the methodological quality of each study as good, fair, or poor using predefined criteria (eTable 2 in the Supplement). Discrepancies were resolved through consensus. Poor-quality studies with critical methodological limitations were excluded and typically had several major risks of bias, including very high or differential attrition between groups (generally >40% overall or >20% difference between groups), substantial lack of baseline comparability between groups without adjustment for those variables, or other issues judged to considerably bias the results (eg, possible selective reporting, inappropriate exclusion of participants from analyses).

One reviewer abstracted data about each study's design, population, interventions, and outcomes; a second reviewer checked data abstraction for accuracy.

Data Synthesis and Analysis

Data were synthesized separately for each KQ. The data on health outcomes (KQ1) and harms (KQ3) did not allow for quantitative pooling due to the limited number of contributing studies, so those data were summarized in tables and narratively. For breastfeeding outcomes (KQ2), random-effects meta-analyses were conducted using the restricted maximum likelihood estimate with the Knapp-Hartung adjustment[20] to calculate a pooled risk ratio (RR) and 95% CI for the prevalence of breastfeeding initiation and any and exclusive breastfeeding at various time points. The prevalence of breastfeeding was grouped into the following points: breastfeeding initiation (ie, from birth to 1 week postpartum), less than 3 months, 3 months to less than 6 months, 6 months, and 12 months. The results by exact reported time points are presented in tabular format in the full report.[18] When provided in the original publication, we used author-reported

Figure 1. Analytic Framework: Interventions to Support Breastfeeding



Evidence reviews for the US Preventive Services Task Force (USPSTF) use an analytic framework to visually display the key questions (KQs) that the review will address to allow the USPSTF to evaluate the effectiveness and safety of a preventive service. The questions are depicted by linkages that relate interventions and outcomes. A dashed line indicates a health outcome that immediately follows an intermediate outcome. Refer to the USPSTF Procedure Manual for interpretation of the analytic framework.[16] For all KQs, *breastfeeding* refers to feeding at the breast or feeding expressed breast milk. *Breast milk* refers to human milk. When adequately delineated in source studies, precise language (eg, feeding at the breast or feeding expressed breast milk) will be used when describing the evidence.

RRs, favoring adjusted results over unadjusted. If study-reported RRs were unavailable, we calculated crude RRs based on the number of people meeting the event criterion in each treatment group and the total number of participants randomized to each group. In these cases, the RR reflects the risk of breastfeeding, where values greater than 1.0 indicate greater breastfeeding among individuals in the intervention group compared with the control group.

The presence of statistical heterogeneity among the studies was assessed using standard χ^2 tests, and the magnitude of heterogeneity was estimated using the I^2 statistic. Meta-regression and stratified analyses were conducted to explore whether there were population or intervention characteristics associated with larger effect sizes for breastfeeding outcomes. The distribution of trial results was examined with funnel plots, and the Peters test was run to assess whether there was evidence of small-study effects.[21] Stata version 16.1 (StataCorp) was used for all analyses. All significance testing was 2-sided, and results were considered statistically significant if $P < .05$.

The strength of evidence was rated for each KQ using the approach described in the Methods Guide for Effectiveness and Comparative Effectiveness Reviews,[22] based on the number, quality, and size of studies as well as the consistency (ie, similarity of effect direction and size) and precision (ie, degree of certainty around an estimate) of the results between studies.

Results

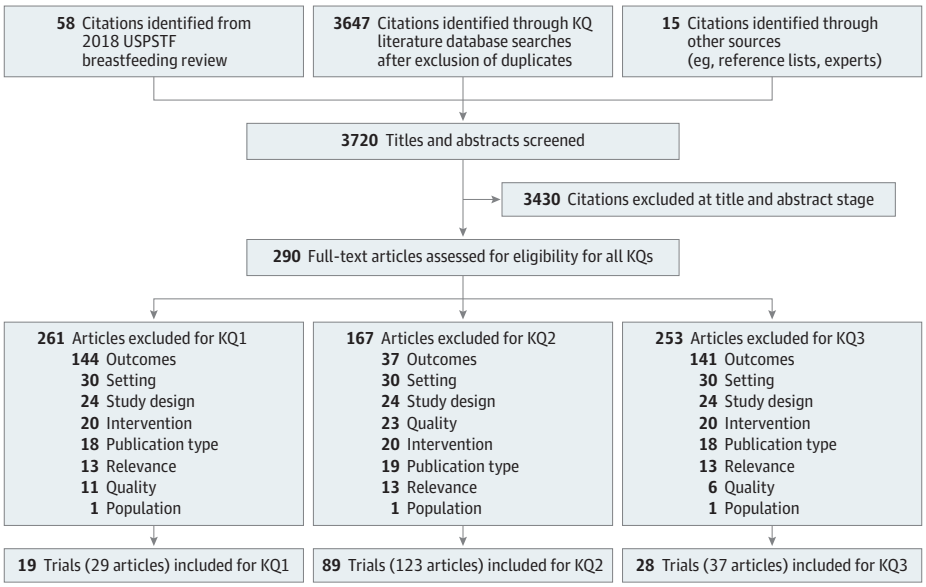
Two reviewers evaluated 3720 citations and 290 full-text articles against inclusion criteria, and 90 RCTs[23-111] (reported in 125 articles[23-146]) were included (**Figure 2**). A complete list of the included studies, including each ancillary publication, can be found in the full evidence report.[18] Details of each included study, including its quality rating, can be found in eTable 3 in the Supplement.

Just more than one-third of studies took place in the United States (33); the remaining studies took place in settings in Europe (23 studies), Asia (17 studies), Australia or New Zealand (10 studies), or Canada (7 studies). Sample sizes for the included trials ranged from 39 to 9675 participants, and the median sample size was 253. Most studies recruited women during pregnancy (57 studies) or shortly after delivery within the birthing facility (29 studies). Almost one-half the studies (40) required that women be intending to breastfeed to be eligible for study inclusion; in the remainder of studies that reported it, most women reported an intention to breastfeed at the beginning of the trials.

Trials included a wide range of populations in terms of demographic and social characteristics, and few studies comprehensively reported this data. Of the 33 studies taking place in the US, 2 were limited to Black women,[45,73] 4 were limited to Hispanic or Latina women,[31,56,74,77]; in the remaining studies, participants were predominantly Black and/or Hispanic and Latina women.[27, 30, 32, 33, 35, 40, 43, 48, 57, 60, 61, 64, 72, 75, 84, 93, 107] Three studies limited enrollment to adolescents or women younger than 20 years[43,92,107]; in the remaining trials the mean age across all participants was 28 years.

Of the 90 included trials, most (75) provided interventions focused specifically on breastfeeding education and support, while 15 focused on broader maternal and infant well-being, including a breastfeeding education and/or support component. A summary of the interventions and detailed intervention characteristics for each trial can be found in eTable 4 in the Supplement and the full report.[18] Most of the breastfeeding support interventions provided formal education and/or support given by a professional, such as nurses, midwives, physicians, and/or lactation care providers.[23, 24, 26, 28-30, 32-39, 44, 46, 49, 51-54, 58, 60, 63, 64, 66-69, 71, 72, 75, 76, 78-84, 86-88, 90, 91, 94-97, 101-103, 105, 106, 109-111] Eight trials explicitly stated that the lactation care providers involved in the intervention were International Board Certified Lactation Consultants or held some other lactation support

Figure 2. Literature Search Flow Diagram: Interventions to Support Breastfeeding



Reasons for exclusion: Outcomes: Study did not report relevant outcomes. Setting: Study was not conducted in a country with a "very high" development score, not relevant to US practice, or was not conducted in a setting generalizable to primary care (eg, workplace, inpatient hospital units, nursing homes). Study design: Study was not a randomized clinical trial. Intervention: Study did not include a behavioral counseling intervention designed to support breastfeeding and/or the consumption of breast milk. Publication type: Publication was not a peer-reviewed article (eg, editorial, conference proceeding) or was not available in the English language. Relevance: Study aim not relevant. Quality: Study was rated as poor quality. Population: Study did not include person(s) involved with or making decisions about feeding their child. KQ indicates key question.

certification.[32,37,38,83,88,94,105] In 14 trials, breastfeeding support was provided by trained peers.[27,31,40-43,47,50,55,62,74,85,93,107] In these cases, peer counselors were recruited specifically for the study; they were chosen to represent the sample population (eg, adolescents, Special Supplemental Nutrition Program for Women, Infant, and Children recipients) and had previous breastfeeding experience.

The timing, duration, and number of sessions of the interventions varied widely. In one-half of the study groups, the intervention occurred in a single period, either during the prenatal period, during the hospital stay, or during the postpartum period, while interventions spanned across or were delivered in more than 1 time period in the remaining one-half of studies. The total duration of interventions also varied widely and ranged from 1 day (1 session) to more than 1 year of ongoing support, and most interventions had 6 or fewer sessions (median, 4 [range, 1-20]).

Most of the interventions included an in-person component, with many including additional telephone, electronic, or printed components, and the remaining one-fourth of studies were delivered fully remotely (eg, via interactive smartphone app, online modules, telephone calls only). Intervention content focused on general breastfeeding education, including the maternal and infant benefits of breastfeeding and the importance of exclusive breastfeeding; advice on proper latching and other techniques to reduce breastfeeding problems; and messages designed to increase breastfeeding self-efficacy. Most interventions also provided emotional and instrumental support, which often included hands-on support to assist with proper infant positioning.

Almost all of the studies included usual care control groups, although what constituted usual care was not fully described or was highly variable given the various settings, countries, and time frames in which the interventions took place. In all cases, families in both the intervention and the control groups received usual care. The intervention components were either provided in addition to usual care services or replaced specific components of care (eg, more intensive lactation support than routinely provided).

Benefits on Health Outcomes

Key Question 1. Do interventions to support breastfeeding improve child and maternal health outcomes?

Nineteen of the 90 included trials reported a health outcome (n = 11 415).[27,30,33,35,40,41,51,53,57,59,60,65,70,77,86,91,96,97,101] Ten trials (n = 6592) reported on infant health outcomes, which included gastrointestinal outcomes (2 trials),[27,33] otitis media (1 trial),[33] the number of health care visits for respiratory tract illnesses (1 trial),[33] and rates of infant health care utilization (7 trials),[35,40,53,60,70,86,91] childhood illness (1 trial),[91] or minor infant health outcomes (1 trial).[96] Infant health outcomes were reported from the time of birth for up to 1 year in some studies. In all cases, more favorable effects were seen on these outcomes among infants born to intervention vs control group parents. However, very few reported these differences to be statistically significantly different between groups. In cases in which differences were seen in infant health outcomes, there were no apparent differences in rates of any or exclusive breastfeeding that seemed to be driving these effects. Furthermore, in some cases, the interventions included postpartum in-home nursing support, which could help protect against poor infant health outcomes, independent of their effect on breastfeeding.

Nine trials (n = 2334) reported maternal symptoms of anxiety, depression, or well-being at up to 6 months postpartum. Most of the studies reported better symptom scores among intervention mothers vs control mothers; however, very few of the differences between groups were statistically different.[30,41,53,57,65,77,97,101,118]

Narrative, detailed results for each study noted above are described in the full report[18] and in eTables 5 and 6 in the Supplement.

Benefits on Breastfeeding Outcomes

Key Question 2. Do interventions to support breastfeeding improve the initiation, duration, intensity, and exclusivity of breastfeeding?

All but 1[101] of the 90 included trials (N = 49 597) reported the effects of an intervention on at least 1 measure of breastfeeding. In meta-analyses, there was a statistically significant association

Table 1. Pooled Results of Any and Exclusive Breastfeeding, for Individual-Level Breastfeeding Support and Education Interventions (KQ2)

Follow-up time point, mo	No. of studies	No.	RR (95% CI)	I^2, %
Any breastfeeding				
Initiation[a]	37	15 006	1.01 (1.00-1.02)	13.2
<3	47	15 663	1.06 (1.03-1.08)	55.1
3 to <6	40	17 580	1.09 (1.04-1.12)	42.6
6	37	13 579	1.13 (1.05-1.22)	73.4
12	8	4607	1.04 (0.91-1.18)	0.0
Exclusive breastfeeding				
Initiation[a]	27	10 622	1.16 (1.05-1.29)	75.6
<3	51	17 431	1.21 (1.14-1.28)	36.6
3 to <6	40	11 032	1.31 (1.17-1.46)	66.6
6	37	14 398	1.46 (1.20-1.78)	76.8
12	0	NA	NA	NA

Abbreviations: KQ, key question; NA, not applicable; RR, risk ratio.

[a] From birth to 1 week postpartum.

between participating in a breastfeeding support intervention and the prevalence of any and exclusive breastfeeding at less than 3 months, 3 months to less than 6 months, and 6 months (**Table 1**). The forest plots for all pooled analyses can be found in eFigures 1 through 9 in the Supplement. For example, at 6 months, the likelihood of any breastfeeding and exclusive breastfeeding was associated with a 13% higher prevalence (RR, 1.13 [95% CI, 1.05-1.22]; I^2 = 73.4%; 37 studies [n = 13 579]) and 46% higher prevalence (RR, 1.46 [95% CI, 1.20-1.78]; I^2 = 76.8; 37 studies [n = 14 398]), respectively, among infants born to mothers in the intervention compared with control groups. The median differences in absolute prevalence of breastfeeding between groups ranged from 1 to 7 percentage points at various time points for any and exclusive breastfeeding, with slightly larger effects for exclusive vs any breastfeeding. No effect was seen on the prevalence of breastfeeding initiation, but the absolute proportion of participants beginning to breastfeed in the first week of life was high among both intervention (median, 94.4%) and usual care (median, 90%) groups, indicating a potential ceiling effect on outcomes. A meta-analysis of 8 trials (n = 4607) found no statistically significant association with receiving a breastfeeding support intervention and any breastfeeding at 12 months, compared with usual care (RR, 1.04 [95% CI, 0.91-1.18]; I^2 = 0.0%).[24,33,56,59,71,77,99,108]

In the subset of trials that reported continuous measures of time to stopping breastfeeding, all trials reported that infants born to participants in the intervention groups were breastfed longer than those in the control groups, although most did not report these differences to be statistically significantly different.

Across all breastfeeding outcomes, there was no consistent evidence that the results varied by any prespecified population or intervention characteristics. Detailed results for the prevalence of breastfeeding for all time points by study can be found in eTable 7 in the Supplement.

Harms of Breastfeeding Interventions

Key Question 3. What are the harms of interventions to support breastfeeding?

Seven of the 90 included trials (n = 1404) commented on the occurrence of adverse events or lack of adverse events[41,42,56,75,77,82,94]; 5 of these studies reported that no adverse events were reported or that none occurred and no additional details were provided. In the remaining 2 studies, there was no evidence of increased feelings of anxiety, depressive symptoms, suicidal ideation, or suspicions of child abuse among intervention participants compared with those receiving usual care.[42,77] Additionally, there was no evidence of differences in the prevalence of breastfeeding "problems" between those in the intervention vs usual care groups in 22 studies that reported these measures (n = 13 815).[24,25,29,35,36,50,53,55,58,60,62,67-69,76,79,82,86,91,100,101,106]

Discussion

The results of this review are consistent with those from the 2016 USPSTF review of this evidence[13] and indicate that interventions delivered by professionals and peers and those delivered remotely can increase the proportion of women who continue any breastfeeding or exclusive breastfeeding up to 6 months postpartum (**Table 2**). Only a minority of the included studies evaluated the effects of interventions on infant and maternal health outcomes. However, a robust evidence base of observational research outside this review supports the association between prolonged and exclusive breastfeeding and a host of infant[147] and maternal health[148] outcomes. There was no evidence of increased harm from taking part in the interventions, although potential harm was not routinely reported. While the goals of these interventions focused on empowering and helping individuals to both initiate and continue breastfeeding, it is important that interventionists respect families' individual decisions and remain flexible in supporting new parents and their feeding choices to not inflict undue harm.

The included RCTs represented women from developed countries, with differences in age, primiparity, race and ethnicity, and socioeconomic status. Approximately one-third of the trials were conducted in the United States, and most specifically enrolled Black or Hispanic women and those from socioeconomically disadvantaged backgrounds, who historically have lower prevalence of breastfeeding initiation and continuation. Most of the participants enrolled in the studies intended to initiate breastfeeding; therefore, it is unclear how applicable this evidence is to a wider population who may not be firm in their feeding intentions or decisions.

Table 2. Overall Summary of Evidence by Key Question

No. of RCTs (No. of observations)	Study quality	Major limitations (includes reporting bias)	Consistency	Applicability	Summary of findings
KQ1: Do interventions to support breastfeeding improve child and maternal health outcomes?					
19 RCTs (n = 11 175)	Good: 5 Fair: 14	Infant health outcomes variably reported Most outcomes based on maternal recall Considerable range in follow-up from 4 wk to 1 y	Infant health outcomes: NA Maternal well-being: consistent, precise	Represents data from the US and abroad; US trials represent predominantly Black and Hispanic low-income individuals	Mixed results for the effects on infant gastrointestinal outcomes (2 trials): 1 trial (n = 182) found greater risk of ≥1 diarrheal episodes over 3 mo in usual care vs intervention groups (RR, 2.15 [95% CI, 1.16-3.97]), while the other trial (n = 338) found no difference between intervention and control groups at 1 y (22.7% vs 25.7%) One trial (n = 338) found no difference in risk of otitis media (43.6% vs 54.9%) or the number of health care visits for respiratory tract illnesses (76% vs 83.4%) at 1 y Eight trials reported lower rates of health care visits and hospitalizations among infants in intervention groups at up to 6 mo, although differences between groups were not statistically significant Nine trials (n = 2334) reported minimal differences between groups in maternal well-being at up to 3 mo postpartum
KQ2: Do interventions to support breastfeeding improve the initiation, duration, intensity, and exclusivity of breastfeeding?					
89 RCTs (n = 49 597)	Good: 28 Fair: 61	Clinical variation in samples Lack of detail regarding measurement of breastfeeding, including recall period and definition of exclusivity Sparse reporting of breastfeeding at 12 mo	Consistent, precise	US trials (n = 33 [37% of trials]) represent predominantly Black and Hispanic low-income individuals Non-US trials have unclear applicability to US settings, given differences in usual care and underlying social and cultural differences	Breastfeeding support interventions were associated with a higher likelihood of exclusive breastfeeding initiation and of any and exclusive breastfeeding up to and at 6 mo There was no apparent effect on any breastfeeding initiation, but rates of breastfeeding initiation were relatively high in both intervention and control groups Few studies reported rates of breastfeeding at 1 y Any breastfeeding: Initiation: pooled RR, 1.01 (95% CI, 1.00-1.02); 37 trials (n = 15 006) <3 mo: pooled RR, 1.06 (95% CI, 1.03-1.08); 47 trials (n = 15 663) 3 mo to <6 mo: pooled RR, 1.09 (95% CI, 1.04-1.12); 40 trials (n = 17 580) 6 mo: pooled RR, 1.13 (95% CI, 1.05-1.22); 37 trials (n = 13 579) 12 mo: pooled RR, 1.04 (95% CI, 0.91-1.18); 8 trials (n = 4607) Exclusive breastfeeding: Initiation: pooled RR, 1.16 (95% CI, 1.05-1.29); 27 trials (n = 10 622) <3 mo: pooled RR, 1.21 (95% CI, 1.14-1.28); 51 trials (n = 17 580) 3 mo to <6 mo: pooled RR, 1.31 (95% CI, 1.17-1.46); 40 trials (n = 11 032) 6 mo: pooled RR, 1.46 (95% CI, 1.20-1.78); 37 trials (n = 14 398)
KQ3: What are the harms of interventions to support breastfeeding?					
28 RCTs (n = 15 011)	Good: 8 Fair: 20	Only 7 trials reported harms, and details about specific harms were lacking Problems or difficulties related to breastfeeding could be a harm (due to increased breastfeeding) or could be improved because of the intervention	Consistent, precise	Unclear applicability, given proportion of trials reporting harms	Six trials reported "no adverse events" related to the intervention One trial reported greater feelings of anxiety, decreased confidence, or concerns of confidentiality among intervention mothers and not among control group mothers Twenty-two trials reported the incidence of breastfeeding problems, generally finding that women in the intervention groups experienced fewer problems or difficulties than women in the usual care control groups

Abbreviations: NA, not applicable; RCT, randomized clinical trial; RR, risk ratio.

There was no single optimal or representative intervention identified in this review. Rather, there was a wide range of approaches that were shown to improve rates of breastfeeding and are likely applicable to infant and maternal care in the United States. The interventions offered were diverse. Some consisted of only group prenatal education sessions. Some included only in-person support at and around the time of birth. Some consisted of telephone support alone. Some used text- and app-based contact. Some included intense home visits. And some included multiple one-on-one sessions spanning the prenatal and postpartum periods. There was no evidence that the effects of the interventions were modified based on the individual intervention components, including who provided the intervention. It is likely that the effectiveness of any given intervention is dependent on the broader context of the target population and setting in which the support takes place.

Although the review was limited to interventions implemented at an individual level, there are several health care– and policy-level programs in the United States designed to help facilitate access to and equitable support. Such programs include the Ten Steps to Successful Breastfeeding and the Baby-Friendly Hospital Initiative[149]; the US Department of Agriculture's Special Supplemental Nutrition Program for Women, Infant, and Children[150]; and the Nurse Family Partnership funded by US Medicare and individual State Health Departments.[151] Systematic reviews and individual studies on the effectiveness of these interventions have shown mixed results,[152-157] but such programs may offer additional support that may help reduce disparities in access to the types of interventions reviewed here.

Limitations

This review was limited to fair- and good-quality RCTs evaluating breastfeeding support interventions that were provided in or feasible for primary care and did not include strategies such as hospital or workplace policies or strategies which are beyond the purview of a primary care clinician or practice. These supports, as well as primary care interventions that continue to support women beyond the immediate postpartum period and during major transitions (eg, return to work or placement in childcare), deserve further evaluation. Last, research is lacking on the impact that interventions may have on the mental health and well-being of the breastfeeding women and support persons. Routine collection of this information should be emphasized in ongoing research on breastfeeding support interventions.

Conclusions

The updated evidence confirms that breastfeeding support interventions can increase the prevalence of any and exclusive breastfeeding up to and at 6 months. Future efforts should focus on how to best provide this support consistently for all individuals who are making feeding decisions for their infants.

ARTICLE INFORMATION

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Concept and design: All authors.
Acquisition, analysis, or interpretation of data: All authors.
Drafting of the manuscript: Patnode, Coppola, Iacocca.
Critical review of the manuscript for important intellectual content: Patnode, Senger, Coppola.
Statistical analysis: Patnode, Coppola, Iacocca.
Obtained funding: Patnode, Senger.
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Supervision: Patnode.

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Editorial Disclaimer: This evidence report is presented as a document in support of the accompanying USPSTF recommendation statement. It did not undergo additional peer review after submission to *JAMA*.

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