



The Effectiveness of Breastfeeding Support in Improving Exclusive Breastfeeding Practices Among Postpartum Mothers

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Abstract. Exclusive breastfeeding remains a central strategy for improving infant survival, growth, immunity, and maternal health, yet many postpartum mothers discontinue exclusive breastfeeding before six months because of pain, perceived insufficient milk, low confidence, limited family support, early formula exposure, and difficulty accessing professional lactation assistance. This systematic review aimed to synthesize recent evidence on the effectiveness of breastfeeding support in improving exclusive breastfeeding practices among postpartum mothers. A systematic search framework was developed using PubMed, ScienceDirect, CINAHL, ProQuest, Google Scholar, and relevant organizational reports published between 2021 and 2025. Eligible evidence included randomized trials, quasi-experimental studies, cohort studies, and systematic reviews evaluating professional, peer, family-based, group, digital, and community breastfeeding support. The synthesis indicates that structured support improves exclusive breastfeeding initiation, continuation, maternal self-efficacy, breastfeeding technique, problem-solving, and timely access to counseling. Interventions combining antenatal preparation, immediate postpartum assistance, follow-up after discharge, partner involvement, and responsive counseling showed stronger potential than one-time education. The findings support the integration of continuous, respectful, and culturally sensitive breastfeeding support into routine maternal and child health services.

Keywords: Breastfeeding Counseling; Exclusive Breastfeeding; Lactation Support; Postpartum Mothers; Systematic Review.

1. INTRODUCTION

Exclusive breastfeeding is defined as feeding an infant only breast milk, without any additional food or drink, including water, except for oral rehydration solution, drops, syrups, vitamins, minerals, or medicines when medically indicated (Alissa & Alshareef, 2024). The first six months after birth represent a sensitive developmental period in which infant nutrition, maternal recovery, family adaptation, and health-service continuity intersect (Permatasari, Simbolon, & Yunita, 2024). International recommendations consistently emphasize early initiation of breastfeeding within the first hour after birth, exclusive breastfeeding for the first six months, and continued breastfeeding with complementary feeding thereafter (Kapti, Arief, & Azizah, 2023). The rationale is not limited to nutrition. Breast milk provides immunological protection, contributes to gut maturation, reduces exposure to contaminated substitutes, supports mother-infant bonding, and offers long-term maternal and child health benefits. Nevertheless, the movement from intention to sustained exclusive breastfeeding is often fragile (Sosseh, Barrow, & Lu, 2023). A mother may enter the postpartum period with a strong desire to breastfeed but face sore nipples, engorgement, delayed lactogenesis, cesarean recovery, infant latch difficulties, fatigue, anxiety, misinformation from relatives, formula marketing, or pressure to return to work. These challenges make breastfeeding support not an optional addition but a core component of postpartum care (Florida Boa & Agustine, 2022).

Global data indicate improvement in exclusive breastfeeding but also reveal that progress remains incomplete. UNICEF and WHO reported that global exclusive breastfeeding rates had increased to approximately 48%, close to the World Health Assembly target of 50% by 2025, but this still leaves many infants without the full benefits of exclusive breastfeeding (WHO and UNICEF, 2003). Recent evidence syntheses also show that breastfeeding support interventions are associated with higher rates of any and exclusive breastfeeding up to six months postpartum (Abi Khalil, Hawi, & Hoteit, 2022). These findings are especially relevant for health systems where postpartum care is fragmented and where mothers receive intense attention during delivery but much less structured guidance after discharge. The postpartum period is a transition from facility-based care to home-based decision-making. If support stops at hospital discharge, mothers may be left to solve breastfeeding problems alone at the precise moment when difficulties become most apparent.

The urgency of this topic is strengthened by three interrelated gaps. Many mothers have heard that exclusive breastfeeding is recommended, yet knowledge alone does not guarantee effective latch, confidence, pain management, milk-expression skills, or resistance to unnecessary formula supplementation (Gu et al., 2025). In many settings, breastfeeding begins soon after birth but declines during the first weeks and months (Krikirat et al., 2023). This suggests that interventions focused only on antenatal education or immediate post-delivery advice may be insufficient unless they are followed by continuous support (Kayode, Oyedeji, & Alabi, 2023). The third gap is the gap between individual responsibility and social ecology. Breastfeeding is often described as a maternal behavior, but it is shaped by family norms, partner involvement, workplace policies, health-worker communication, community beliefs, and access to skilled lactation assistance. Therefore, effective breastfeeding support must address mothers not as isolated individuals but as members of families and communities (Sukmawati, Wijaya, & Hilmanto, 2024).

The novelty of this article lies in its focused synthesis of breastfeeding support for postpartum mothers by organizing recent evidence from 2021-2025 into a practical continuum of care (Zeng et al., 2024). Rather than viewing breastfeeding counseling as a single educational session, this review conceptualizes support as a multi-component intervention that includes emotional reassurance, technical assistance, anticipatory guidance, peer and partner engagement, digital follow-up, and referral for complex lactation problems (Tahiru, Amoako, & Apprey, 2024). This framing is important because the evidence increasingly suggests that the most effective support is proactive, repeated, individualized, and responsive to maternal needs. The review also highlights the importance of respectful counseling that protects

breastfeeding while avoiding coercive messages, blame, or pressure when mothers experience difficulties (Mituki-Mungiria, Tuitoek, Varpolatai, Ngotho, & Kimani-Murage, 2020).

The objective of this systematic review is to synthesize recent evidence on the effectiveness of breastfeeding support in improving exclusive breastfeeding practices among postpartum mothers. Specifically, this article aims to identify the types of support used in recent studies, describe their effects on exclusive breastfeeding and related maternal outcomes, analyze mechanisms that explain effectiveness, and formulate implications for midwifery, nursing, community health, and maternal-child health policy.

2. THEORETICAL STUDY

The theoretical foundation of breastfeeding support can be understood through maternal self-efficacy theory, social support theory, and the continuum-of-care model. Breastfeeding self-efficacy refers to a mother's confidence in her ability to breastfeed and manage challenges (Filippi-Arriaga et al., 2025). A mother with high self-efficacy is more likely to initiate breastfeeding, continue despite temporary problems, seek help early, and interpret infant behavior more accurately. Support interventions strengthen self-efficacy by providing mastery experiences, verbal encouragement, observation of successful breastfeeding techniques, and reassurance that common problems can be managed. Studies of group support and counseling show that increases in self-efficacy are closely related to the maintenance of exclusive breastfeeding (Rodríguez-Gallego et al., 2024; Sabogal et al., 2021). This theoretical link explains why technical information alone is less effective when it is not accompanied by confidence-building and practical assistance.

Social support theory explains breastfeeding as a behavior influenced by emotional, informational, instrumental, and appraisal support. Emotional support includes empathy, encouragement, and normalization of difficulties. Informational support includes accurate guidance on latch, positioning, milk production, feeding cues, and signs of adequate intake (Ross & Wosidlo, 2022). Instrumental support includes help with household tasks, workplace accommodations, assistance in attending services, or availability of lactation tools when appropriate. Appraisal support includes feedback that helps mothers evaluate whether breastfeeding is going well and whether the infant is receiving sufficient milk. Partner and family support are particularly important because relatives may either protect exclusive breastfeeding or unintentionally undermine it through early formula suggestions, traditional prelacteal feeding, or anxiety about infant crying. Evidence on paternal involvement and family-centered interventions indicates that breastfeeding support is stronger when fathers or

partners understand their roles in protecting maternal confidence and reducing household burdens (Tadesse et al., 2021; Abbass-Dick et al., 2022).

The continuum-of-care model emphasizes that breastfeeding support should begin during pregnancy, become intensive immediately after birth, and continue after the mother returns home. During pregnancy, counseling prepares mothers and families for realistic expectations, birth-related feeding plans, and recognition of early warning signs. During childbirth and the first hour after birth, support promotes skin-to-skin contact, early initiation, and avoidance of unnecessary separation. During the first two to seven days postpartum, support focuses on latch, positioning, management of engorgement, nipple pain, infant weight monitoring, and maternal rest. During the first six weeks, support must address common reasons for discontinuation, including perceived insufficient milk, fatigue, night feeding stress, and family pressure. From six weeks to six months, support shifts toward sustaining exclusivity during return to work, milk expression, storage, workplace communication, and continued maternal motivation. The continuum perspective is consistent with evidence showing that repeated contact and post-discharge follow-up can be more meaningful than a single educational encounter (Gavine et al., 2022; Lojander et al., 2024; Patnode et al., 2025).

Breastfeeding support can be delivered through several models. Professional support involves midwives, nurses, physicians, lactation consultants, nutritionists, or trained community health workers. Its strength lies in clinical accuracy, ability to observe breastfeeding directly, and capacity to manage problems such as painful latch, mastitis risk, delayed lactogenesis, or infant weight concerns. Peer support uses trained mothers or community volunteers who provide encouragement and culturally familiar problem-solving. It may reduce social isolation and increase acceptability, particularly in communities with limited professional access. Group support creates a learning environment in which mothers share experiences, reduce anxiety, and observe breastfeeding norms. Digital support, including telephone counseling, messaging, video consultation, and mobile applications, can extend access beyond facility walls; however, evidence suggests that digital tools are most useful when they complement human counseling rather than replace it (Ziebart et al., 2024; UNICEF Indonesia, 2024).

Previous studies have generally found positive associations between support interventions and breastfeeding outcomes, but the magnitude of effect varies according to intervention intensity, target population, timing, provider training, and baseline breastfeeding context. The 2022 Cochrane review found that breastfeeding support may reduce cessation of exclusive breastfeeding and any breastfeeding, although certainty varied across outcomes

(Gavine et al., 2022). The 2025 updated evidence review for the United States Preventive Services Task Force found that support interventions increased the prevalence of exclusive breastfeeding at several time points up to six months, with stronger effects for exclusivity than for initiation (Patnode et al., 2025). A systematic review on lactation consultants reported beneficial effects on breastfeeding outcomes, particularly when consultants offered individualized professional support (D'Hollander et al., 2023). A randomized clinical trial of postpartum support groups found that midwife-led group intervention improved exclusive breastfeeding and perceived self-efficacy at six months (Rodríguez-Gallego et al., 2024). Together, these studies suggest that breastfeeding support is most effective when it combines evidence-based information, skilled observation, emotional reassurance, continuity, and family engagement.

Despite these promising findings, several theoretical and practical issues remain. First, breastfeeding support must avoid a deficit perspective that frames mothers as lacking motivation. Many mothers discontinue breastfeeding not because they reject its value but because the system fails to provide timely, skilled, and compassionate support. Second, interventions must be sensitive to social inequality. Mothers with low income, limited maternity leave, early return to work, or limited access to lactation services may require more intensive and flexible support. Third, support must be culturally safe. Counseling should acknowledge local beliefs while correcting harmful misinformation. Fourth, outcomes should extend beyond exclusive breastfeeding rates to include maternal confidence, satisfaction, mental well-being, perceived autonomy, and absence of breastfeeding-related harm. These considerations provide the theoretical basis for interpreting the evidence synthesized in this review.

3. METHODS

This study used a systematic review design to synthesize recent evidence on breastfeeding support and exclusive breastfeeding practices among postpartum mothers. The review question was formulated using the PICO framework. The population was postpartum mothers and their infants during the first six months after birth. The intervention was breastfeeding support, including lactation counseling, professional assistance, peer support, partner or family support, group-based support, community follow-up, telelactation, mobile health, or combined education and counseling. The comparison was usual care, standard education, lower-intensity support, or no structured support. The primary outcome was exclusive breastfeeding practice, initiation, continuation, or prevalence up to six months

postpartum. Secondary outcomes included breastfeeding self-efficacy, maternal knowledge, maternal satisfaction, breastfeeding problems, and continuation of any breastfeeding.

The literature search framework covered publications from January 2021 to December 2025 to align with the requirement for recent references and to capture evidence after the rapid expansion of digital health and telehealth during and after the COVID-19 pandemic. Databases and sources included PubMed/MEDLINE, CINAHL, ScienceDirect, ProQuest, Google Scholar, Cochrane Library, JAMA Network, and reports from WHO and UNICEF. Search terms were combined using Boolean operators and included: breastfeeding support, lactation counseling, exclusive breastfeeding, postpartum mothers, postnatal support, peer support, partner support, breastfeeding self-efficacy, telelactation, mobile health, systematic review, randomized controlled trial, and quasi-experimental study. Manual searching was also used to identify relevant organizational reports and key references cited in recent reviews.

Studies were considered eligible when they met the following inclusion criteria: publication year between 2021 and 2025; focus on breastfeeding support for pregnant or postpartum mothers with outcomes relevant to exclusive breastfeeding; empirical study, randomized trial, quasi-experimental study, cohort study, mixed-method study, systematic review, meta-analysis, or authoritative organizational report; and availability of sufficient methodological or outcome information for narrative synthesis. Studies were excluded when they focused only on complementary feeding after six months, donor human milk in neonatal intensive care without maternal breastfeeding support, biochemical composition of breast milk without behavioral outcomes, or opinion papers without clear evidence basis. Articles not directly related to postpartum breastfeeding support were also excluded.

The review process followed four stages: identification, screening, eligibility assessment, and inclusion. Titles and abstracts were screened for relevance to breastfeeding support and exclusive breastfeeding. Full texts or detailed abstracts were reviewed to determine whether the study addressed the review question. Information extracted from eligible studies included author, year, country or setting, study design, population, type of support, mode of delivery, timing, outcome measures, and key findings. Because the included literature was heterogeneous in design, interventions, and outcome measurement, a narrative synthesis approach was used rather than a new statistical meta-analysis. The synthesis grouped evidence by intervention type and mechanism of effect: professional support, peer and group support, family/partner support, digital support, and integrated continuum-of-care support.

Methodological quality was considered by examining study design, clarity of intervention description, outcome measurement, follow-up period, comparison group, and risk

of bias indicators. For systematic reviews and meta-analyses, attention was given to search strategy, eligibility criteria, study appraisal, and clarity of pooled results. For trials, attention was given to allocation, follow-up completeness, intervention fidelity, and outcome definitions. The review did not conduct a separate numerical meta-analysis because of variations in intervention components and outcome time points, but it prioritized higher-level evidence from randomized trials and systematic reviews when formulating conclusions.

4. RESULT AND DISCUSSION

The reviewed literature indicates that breastfeeding support generally improves exclusive breastfeeding practices among postpartum mothers, especially when the support is structured, repeated, and responsive to individual needs. Evidence from recent systematic reviews shows that support interventions improve both any breastfeeding and exclusive breastfeeding up to six months postpartum. Patnode et al. (2025) reported that support interventions were associated with increased exclusive breastfeeding at initiation, at less than three months, at three to less than six months, and at six months. The effect at six months was particularly notable for exclusive breastfeeding, suggesting that support may be more influential for maintaining exclusivity than for simply initiating breastfeeding. Gavine et al. (2022) similarly concluded that support can reduce cessation of breastfeeding, although certainty varies because interventions differ in provider, frequency, content, and setting. These findings are consistent with the practical reality that breastfeeding continuation requires repeated problem-solving, not only initial motivation.

Table 1 summarizes the major categories of breastfeeding support identified in the review and their practical implications for postpartum services.

Tabel 1. Synthesis of Breastfeeding Support Interventions and Implications.

Intervention category	Main components	Observed contribution to exclusive breastfeeding	Implication for postpartum care
Professional lactation support	Direct observation, latch correction, positioning, management of pain and engorgement, individualized counseling	Improves technical skills, early problem solving, maternal confidence, and continuation after discharge	Ensure every mother receives breastfeeding assessment before discharge and scheduled follow-up
Peer and group support	Support groups, trained peer counselors, sharing of experiences, midwife-led discussions	Reduces isolation, normalizes challenges, strengthens self-efficacy and motivation	Develop community-based groups connected to health facilities
Partner and family support	Education for fathers, grandmothers, and household members; practical and emotional support	Reduces conflicting advice, protects maternal rest, and supports decision-making at home	Include key family members in counseling and discharge planning
Digital and remote support	Telephone follow-up, messaging platforms, video consultation, mobile applications	Improves access between visits but works best when linked to human counseling	Use telelactation as a complement to face-to-face care
Integrated continuum support	Antenatal preparation, birth support, post-discharge follow-up, workplace transition counseling	Addresses changing barriers from birth to six months postpartum	Design breastfeeding support as a structured pathway rather than a one-time session

Source: Synthesized by the authors from recent studies and reviews (2021-2025).

Professional lactation support was one of the strongest categories of intervention. It includes direct observation of breastfeeding, correction of positioning, management of nipple trauma, assessment of milk transfer, counseling on feeding frequency, and referral for complex problems. The clinical advantage of professional support is that it translates general breastfeeding advice into individualized action. A mother who is told to breastfeed exclusively may still fail if the baby cannot latch effectively or if pain makes feeding unbearable. Professional support addresses this gap by diagnosing the specific barrier and providing immediate skill-based assistance. Reviews of lactation consultant interventions indicate that professional counseling can improve breastfeeding outcomes, particularly when it is

individualized and available during critical periods (D'Hollander et al., 2023). The importance of skilled support is also evident in studies showing that early postpartum difficulties after discharge are strongly associated with reduced exclusivity (Lojander et al., 2024).

Peer and group support contribute through mechanisms that are different from but complementary to professional support (Sukmawati, 2024; Sukmawati, Imanah, & Suwariyah, 2021). Group interventions create social normalization and reduce the perception that breastfeeding difficulties are personal failures. A multicenter randomized clinical trial by Rodríguez-Gallego et al. (2024) found that a postpartum breastfeeding support group intervention improved exclusive breastfeeding and perceived self-efficacy. This suggests that peer interaction and group learning can strengthen the psychological dimension of breastfeeding. Mothers may learn not only from health professionals but also from seeing other mothers overcome similar problems. Group support is particularly valuable when it is led by trained midwives or nurses who can prevent misinformation while preserving the emotional benefits of shared experience (Maretalinia et al., 2023).

Family and partner support emerged as a critical determinant of exclusive breastfeeding. Breastfeeding decisions often occur in family spaces where partners, grandparents, and relatives influence feeding choices (Khomsah & Sukmawati, 2022). Mothers may receive contradictory messages: health workers recommend exclusive breastfeeding, while relatives interpret infant crying as hunger and advise formula. Partner involvement can help protect exclusive breastfeeding by reducing maternal workload, reinforcing confidence, and supporting decisions during moments of doubt. Evidence on paternal involvement suggests that fathers who understand breastfeeding are better able to provide emotional and practical support (Tadesse et al., 2021). Family-centered counseling should therefore include partners and key household decision-makers whenever possible. The message should shift from “the mother must breastfeed” to “the family must support breastfeeding.”

Digital and remote support has become increasingly relevant, especially after the expansion of telehealth. Telephone calls, messaging applications, video consultations, and mobile apps can help mothers access support quickly after discharge. Digital support may be particularly useful for mothers who live far from facilities, feel embarrassed to seek face-to-face help, or need reassurance outside office hours. However, evidence for mobile applications alone is still mixed. Ziebart et al. (2024) reported that evidence remains insufficient to confirm sustained beneficial effects of mobile apps on breastfeeding rates when apps are used as stand-alone tools. This finding implies that digital technology should be designed as an extension of human care. A message platform can remind mothers, provide educational content, and

facilitate referral, but it cannot fully replace a trained provider who observes latch or responds empathetically to distress. UNICEF Indonesia's tele-counseling initiative illustrates the potential of digital support to connect lactating mothers with counselors through accessible communication channels (UNICEF Indonesia, 2024).

The most effective pattern identified across the evidence is integrated support across the maternal-child health continuum. Interventions that begin antenatally may increase preparedness, but support must continue through the immediate postpartum period and after discharge. The first days after birth are often decisive because mothers encounter pain, fatigue, sleep deprivation, and uncertainty about milk adequacy. The first month is also a high-risk period for formula supplementation, especially when mothers misinterpret normal infant cluster feeding as insufficient milk. Between one and six months, mothers face a different set of barriers, including return to work, lack of pumping facilities, social pressure, and declining follow-up contact. Continuous support is therefore more logical than one-time education. It allows health workers to anticipate problems before they cause discontinuation (Lackey et al., 2021).

A major mechanism explaining effectiveness is improvement in breastfeeding self-efficacy. Mothers who believe they can breastfeed successfully are more likely to persist, seek help, and interpret temporary difficulties as manageable (Manyeh, Amu, Akpakli, Williams, & Gyapong, 2020). Counseling improves self-efficacy when it combines clear information with affirmation, skills practice, and realistic problem-solving. Interventions that only list the benefits of breastfeeding may unintentionally increase guilt if mothers struggle. In contrast, supportive counseling acknowledges difficulty and provides concrete strategies. For example, rather than saying “exclusive breastfeeding is best,” a counselor can say, “Many babies feed frequently in the evening; this does not always mean your milk is insufficient. Let us check the latch and signs of adequate intake.” This type of counseling protects both breastfeeding and maternal confidence (CDC, 2021).

Another mechanism is early identification and management of breastfeeding problems. Pain, engorgement, cracked nipples, mastitis symptoms, perceived insufficient milk, and infant sleepiness can rapidly lead to supplementation. Professional support can prevent escalation by correcting latch, encouraging frequent feeding, teaching hand expression, and explaining normal newborn behavior. The evidence review by Patnode et al. (2025) noted that many interventions include direct support during breastfeeding observations, psychological support, and discussion of questions and problems. This combination is important because breastfeeding problems are both physical and emotional. Pain can reduce confidence; anxiety can reduce

persistence; family pressure can amplify doubts. Effective support treats these dimensions together.

The findings also show that breastfeeding support should be equity-oriented. Mothers with limited resources may face barriers that are not solved by information alone. They may return to work early, lack private pumping spaces, have limited transportation to clinics, or live in communities where formula is perceived as modern and convenient (Panahi et al., 2022). Working mothers require counseling on milk expression and storage, but they also need workplace support and policy protection. Studies on barriers among working mothers emphasize that exclusive breastfeeding is shaped by structural conditions, not merely individual motivation (Prastita et al., 2025). Health services should therefore collaborate with employers, community leaders, and policymakers to make exclusive breastfeeding feasible.

The role of midwives is especially central because midwives often maintain close contact with mothers during pregnancy, birth, postpartum visits, and community-based maternal care. Midwife-led breastfeeding support can integrate clinical competence with relational continuity. In many contexts, mothers trust midwives because they are present during intimate moments of childbirth and early mothering (Abate et al., 2025). This trust can be used to provide anticipatory guidance, screen for breastfeeding difficulties, involve families, and refer mothers for advanced lactation care. However, midwives also require training, workload support, and institutional policies that allow sufficient counseling time. Breastfeeding support cannot be effective if health workers are expected to provide individualized counseling within an overcrowded service environment without tools, supervision, or referral pathways (Theodorah & Mc'Deline, 2021).

The synthesis of evidence has several implications for service design. First, breastfeeding support should be standardized as a routine postpartum intervention, not offered only when mothers ask for help. Many mothers hesitate to seek help because they think difficulties are normal, feel ashamed, or do not know where to go. A proactive follow-up schedule can identify problems earlier. Second, counseling should be individualized. Mothers differ in parity, birth mode, infant condition, family support, work demands, culture, and previous breastfeeding experiences. Third, documentation should include breastfeeding assessment, not only infant weight or maternal vital signs. Health workers should document latch, pain level, feeding frequency, milk transfer signs, supplementation, maternal confidence, and follow-up plan. Fourth, services should combine face-to-face and remote support. Face to face care is essential for observation and skill correction, while remote support increases accessibility between visits (Mohamed, Ochola, & Owino, 2020).

The review also highlights the need for respectful communication. Breastfeeding promotion sometimes becomes overly prescriptive, causing mothers who experience difficulties to feel judged. This can be harmful, especially for mothers with postpartum anxiety, depression, traumatic birth experiences, or medical complications. Effective support should maintain a balance between promoting exclusive breastfeeding and respecting maternal autonomy. The goal is to empower mothers with accurate information, practical skills, and emotional support, not to blame them for barriers beyond their control. Counseling should use language that is affirming, culturally appropriate, and solution-focused (Chetwynd, Demirci, & Yourkavitch, 2025).

Although the overall evidence supports breastfeeding support, several limitations must be considered. Intervention components vary widely, making it difficult to identify which element produces the strongest effect. Some studies combine education, counseling, peer support, and follow-up, while others examine single components. Outcome definitions also vary. Exclusive breastfeeding may be measured at discharge, at six weeks, at three months, or at six months, and some studies rely on maternal self-report. Context matters as well. An intervention effective in a setting with strong maternity leave and community health infrastructure may not have the same effect where mothers return to work early or where formula marketing is widespread. Therefore, program adaptation is necessary (Jama et al., 2020).

The implications for future research include the need for more high-quality trials in low- and middle-income settings, greater attention to fathers and grandmothers as intervention targets, stronger measurement of maternal mental health outcomes, and economic evaluations of lactation support programs. Future studies should also examine digital support blended with professional counseling, because this model may be scalable while preserving human connection. Research should report intervention fidelity, provider training, number and duration of contacts, and subgroup effects for mothers with cesarean birth, preterm infants, low socioeconomic status, or early return to work. Such details are necessary for translating evidence into real-world programs. The reviewed evidence supports the conclusion that breastfeeding support is effective in improving exclusive breastfeeding practices among postpartum mothers, but effectiveness depends on how support is delivered. The strongest model is not simply information transfer but continuous, skilled, family-inclusive, and responsive support. Exclusive breastfeeding is more likely to be sustained when mothers receive practical help during difficulties, emotional reassurance during uncertainty, family

support at home, and accessible follow-up after discharge. In this sense, breastfeeding support is both a clinical intervention and a social intervention.

5. CONCLUSION AND SUGGESTIONS

This systematic review concludes that breastfeeding support is effective in improving exclusive breastfeeding practices among postpartum mothers, particularly when support is structured, continuous, individualized, and integrated across the postpartum continuum. The evidence indicates that professional lactation counseling, midwife-led support groups, peer encouragement, partner and family involvement, and digital follow-up can strengthen exclusive breastfeeding by improving maternal knowledge, self-efficacy, breastfeeding technique, early problem-solving, and confidence to continue breastfeeding despite common challenges. Support appears especially important after discharge, when mothers encounter practical difficulties and must make feeding decisions within family and community contexts. The findings suggest that maternal and child health services should make breastfeeding support a routine component of postpartum care. Health facilities should ensure early initiation support, direct observation of breastfeeding before discharge, scheduled follow-up, referral pathways for lactation problems, and accessible counseling through both face-to-face and remote channels. Midwives, nurses, and community health workers should be trained not only to deliver breastfeeding information but also to provide empathetic, culturally sensitive, and family-centered counseling. Involving partners and household decision-makers because exclusive breastfeeding is influenced by family norms and practical support at home. The included evidence varies in design, intervention intensity, provider type, and outcome measurement, making it inappropriate to claim a single universal effect size. Some studies rely on self-reported breastfeeding outcomes, and the effectiveness of interventions may differ across cultural, economic, and workplace contexts. Future research should evaluate integrated support models in diverse settings, compare different intensities of support, examine cost-effectiveness, and measure maternal well-being alongside breastfeeding outcomes.

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