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STRENGTHENING HOSPITAL-TO-HOME LACTATION CARE AFTER CAESAREAN BIRTH: A SCOPING REVIEW

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ABSTRACT

Aim: To map the characteristics, components, delivery modes, outcomes, and evidence gaps of post-discharge lactation support after caesarean birth. Design: Scoping review with evidence mapping. Methods: The review followed the JBI approach and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR). PubMed/MEDLINE and The Lens were searched from inception through July 2026, with backward and forward citation chasing. Eligible studies evaluated structured lactation support that remained active after discharge and reported caesarean-specific data. Two reviewers independently screened records. Randomised trials were appraised with RoB 2 and quasi-experimental studies with the revised JBI tool. Results: Of 1,250 records identified, 1,206 were screened and nine reports representing eight studies were included. Six studies were randomised trials and two were quasi-experimental. Repeated assessment, individualised problem solving, and responsive professional counselling showed the most consistent favourable patterns. Four randomised trials had high risk of bias. Conclusion: Post-discharge lactation support appears most promising when repeated, individualised, and responsive, but heterogeneity and methodological limitations preclude firm comparative-effectiveness conclusions.

Keywords: Caesarean birth; Breastfeeding; Lactation support; Post-discharge care; Scoping review

INTRODUCTION

Caesarean birth is associated with lower rates of early breastfeeding than vaginal birth, particularly after prelabour caesarean delivery, and mothers may experience more breastfeeding difficulties or require more support during the early postpartum period (Prior et al., 2012; Hobbs et al., 2016). The transition from surgery to newborn care can therefore make breastfeeding establishment more vulnerable at the point when mothers are also recovering physically and adapting to feeding cues.

Postnatal care recommendations emphasize breastfeeding counselling, responsive support, and continuity of care after discharge. The World Health Organization recommends additional postnatal contacts after facility discharge, including contact within 48-72 hours and home visits where feasible, so that maternal and newborn problems can be identified and managed promptly (World Health Organization, 2022). For breastfeeding, this matters because nipple pain, poor latch, engorgement, perceived insufficient milk, formula supplementation, and uncertainty about feeding may emerge or become more difficult to manage after the mother leaves the ward (Hobbs et al., 2016).

A range of approaches has been evaluated for women after caesarean birth, including online counselling, WeChat-based support, mobile applications, early home visits, continuity-of-care models, and residential postpartum care (Cho & Ahn, 2014; Hu et al., 2020; Wen et al., 2021; Doan et al., 2022; Karaahmet & Bilgiç, 2022; Kruse et al., 2023). These

programmes differ substantially in timing, provider, intensity, responsiveness, family involvement, and outcome measurement. Some provide mainly automated information, whereas others include repeated assessment and direct professional problem solving. This variation makes it difficult for maternity services to determine which components should be prioritized in a feasible hospital-to-home pathway.

A scoping review is appropriate when the purpose is to map the extent, characteristics, and gaps of a heterogeneous evidence base rather than to estimate a single pooled effect (JBI, 2024). The available interventions differ in delivery channel, provider, intensity, timing, responsiveness, family participation, and outcome measurement. This heterogeneity limitsndirect comparison but makes evidence mapping useful for identifying recurring service components and areas where hospital-to-home continuity remains poorly specified.

AIM

This review aimed to map the characteristics, components, delivery modes, outcomes, methodological quality, and evidence gaps of active post-discharge lactation support after caesarean birth, and to identify practical implications for continuity between hospital services, home follow-up, and primary care.

METHODS

Design and framework

This scoping review with evidence mapping was conducted using the JBI approach for scoping reviews (JBI, 2024) and reported in line with PRISMA-ScR (Tricco et al., 2018). The study-selection flow was reconciled using the updated PRISMA flow structure (Page et al., 2021). The population, concept, and context framework defined eligibility. The population was mothers after caesarean birth who were breastfeeding or intended to breastfeed. The concept was active post-discharge breastfeeding or lactation support, defined as structured support delivered beyond routine inpatient care and remaining active after the mother left hospital. Contexts included hospital-to-home, community, primary care, digital, home-visit, lactation-clinic, and postpartum-care settings.

Eligibility criteria

Eligible sources were primary intervention studies or evaluative programme reports describing structured lactation support with an active post-discharge component and reporting caesarean-specific outcomes. Randomised controlled trials, quasi-experimental studies, non-equivalent control-group studies, secondary analyses of trials, and programme evaluations were considered. Mixed-mode-of-birth studies were eligible only when caesarean-specific data were separately extractable. Studies were excluded when the population was not caesarean-specific, the intervention was drug-only, device-only, complementary-therapy-only, or hospital-only, or post-discharge follow-up consisted only of research outcome collection without active lactation support.

Search strategy

PubMed/MEDLINE and The Lens were searched from database inception through July 2026. Search concepts combined terms for caesarean birth, breastfeeding or lactation, structured support or counselling, and post-discharge delivery, including home visit, telephone, online, mobile application, WeChat, WhatsApp, telehealth, and follow-up. Boolean operators and spelling variants were used as appropriate to each platform. Backward citation chasing of included studies and forward citation checking were also conducted. Three additional records identified outside the two database exports during pilot or manual searching were incorporated into the identification count before final reconciliation of the PRISMA flow.

Study selection

Two reviewers independently screened records and verified eligibility decisions, with disagreements resolved through discussion and consensus. Reports that could not be obtained

after reasonable retrieval attempts were recorded as reports not retrieved rather than as full-text exclusions. A specific distinction was maintained between active post-discharge support and research-only follow-up so that outcome collection alone was not misclassified as continuity of lactation care. The final selection process was reconciled using the updated PRISMA flow structure (Page et al., 2021).

Evaluation of quality of articles

Randomised trials were assessed for the most relevant breastfeeding outcome using the Cochrane Risk of Bias 2 tool (RoB 2) (Sterne et al., 2019). Quasi-experimental studies were assessed using the revised JBI critical appraisal tool for quasi-experimental studies (Barker et al., 2024). No study was excluded solely because of appraisal findings. Appraisal results were used to qualify the interpretation of the evidence map rather than to create an eligibility threshold.

Data extraction and synthesis

Data were charted using a structured form covering author, year, country, design, sample, caesarean characteristics, intervention provider, start time, delivery channel, first post-discharge contact, frequency, duration, comparator, outcome domains, follow-up time points, key findings, and implementation notes. Data charting and methodological appraisal were completed by the primary reviewer and independently checked by the second reviewer. Results were synthesized descriptively by intervention modality, continuity components, outcome domains, follow-up timing, and evidence gaps. Meta-analysis was not performed because intervention content and dose, comparators, outcome definitions, and follow-up periods differed substantially across studies.

RESULTS

Search results and included studies

The reconciled selection process identified 1,250 records. After removal of 44 duplicates, 1,206 records were screened by title and abstract and 1,190 were excluded. Sixteen reports were sought for retrieval; six could not be retrieved, leaving 10 full texts assessed for eligibility. One full-text report was excluded because the intervention was hospital-based only. Nine reports were therefore included in the evidence map, representing eight underlying studies because Ding and Luo (2019) was treated as a companion report of Hu et al. (2020). The evidence base comprised six randomised controlled trials (RCTs) and two quasi-experimental studies from Türkiye, China, Vietnam, Denmark, and South Korea (Figure 1; Table 1).

The eight underlying studies were conducted in Türkiye, China, Vietnam, Denmark, and South Korea. The evidence base included six randomised controlled trials and two quasi-experimental studies, with sample sizes ranging from 53 completers in the residential postpartum-care study to 568 mothers in the mobile-application trial with a caesarean subgroup. Follow-up ranged from short-term assessment during the early postpartum period to six months after birth. This geographic, methodological, and temporal variation reinforced the decision to use descriptive evidence mapping rather than pooled effect estimation.

Intervention modalities

The interventions clustered into four practical delivery groups: digital or remote support, early home visiting, residential postpartum care, and midwife-led continuity of care with individualised breast management. Digital or remote support was the most common and included online counselling, WeChat, automated mobile-app messaging, and mobile-app-supported live counselling (Hu et al., 2020; Wen et al., 2021; Doan et al., 2022; Karaahmet & Bilgiç, 2022; Yikar et al., 2026). Kruse et al. (2023) evaluated early discharge followed by one midwife home visit, Cho and Ahn (2014) evaluated an intensive postpartum care-centre programme for breast engorgement, and Cai et al. (2025) evaluated midwife-led continuity plus individualised breast management. Support duration ranged from a single home visit to six months of online counselling, confirming substantial heterogeneity in intervention dose

and intensity.

Continuity components

Across modalities, the most recurrent continuity components were scheduled post-discharge contact, individualised counselling, assessment of breastfeeding problems, and access to a professional response. Wen et al. (2021) described the most complete continuity model, linking perioperative preparation, WeChat response, family and peer support, and a theory-based behaviour-change framework. Hu et al. (2020) also provided WeChat access with timely responses to home feeding problems, while Yikar et al. (2026) combined mobile educational content with live counselling. In contrast, the application evaluated by Doan et al. (2022) relied mainly on automated messages, and the intervention evaluated by Kruse et al. (2023) consisted of one study-specific home visit. Discharge transition plans, response-time standards, documentation, and escalation routes were less consistently reported (Table 2).

Breastfeeding outcomes

Programmes incorporating repeated assessment and responsive counselling showed the most consistent favourable patterns in breastfeeding outcomes. Karaahmet and Bilgiç (2022) reported higher breastfeeding rates at one and six months following early education plus online counselling. Wen et al. (2021) reported higher exclusive breastfeeding at five days, two weeks, and one month, together with fewer sore nipples at early follow-up. Hu et al. (2020) found higher exclusive breastfeeding and breastfeeding satisfaction at discharge, 42 days, and four months. By contrast, the automated application evaluated by Doan et al. (2022) improved breastfeeding during the hospital period but did not show a sustained significant difference at one, four, or six months in the caesarean subgroup, and Kruse et al. (2023) found no significant six-month breastfeeding benefit from early discharge plus one home visit.

Self-efficacy, comfort, and breastfeeding problems

Breastfeeding self-efficacy and comfort also showed favourable signals when professional interaction was sustained. Karaahmet and Bilgiç (2022) reported higher self-efficacy scores after online counselling, and Yikar et al. (2026) found higher breastfeeding self-efficacy at one and six weeks together with greater postpartum comfort in the mobile-application-supported counselling group. Kruse et al. (2023) did not find a significant self-efficacy difference after one home visit. Symptom-focused programmes also suggested benefits: Wen et al. (2021) reported fewer sore nipples, while Cho and Ahn (2014) reported lower breast discomfort, reduced breast size related to engorgement, lower breast-milk sodium, and a more favourable feeding pattern. Because instruments, timing, and outcome definitions varied, these findings were interpreted narratively rather than pooled.

Risk of bias and methodological limitations

Methodological quality limited the strength of the evidence. Four of six randomised trials were judged at high risk of bias and two had some concerns. Common issues included incomplete reporting of allocation procedures, participant awareness of intervention status, missing outcome data, reliance on self-reported breastfeeding outcomes, unclear intention-to-treat handling, or lack of accessible prespecified protocols. The two quasi-experimental studies also had important limitations, including baseline imbalance, sequential or unclear recruitment procedures, incomplete analysis, or inconsistent reporting of allocation. Appraisal results were therefore used to qualify interpretation rather than to exclude studies, and the evidence was treated as a map of promising service components rather than definitive comparative-effectiveness evidence.

DISCUSSION

Interpretation of principal findings

Across the eight included studies, repeated and responsive models produced more consistent favourable patterns than automated information alone or a single brief contact. This pattern should not be interpreted as proof that frequency or responsiveness is independently causal, because intervention intensity, provider contact, comparator care, outcomes, and risk

of bias differed substantially. Rather, the evidence map suggests that continuity is more likely to be clinically meaningful when mothers can be reassessed and receive individualised help as problems evolve. This interpretation is consistent with WHO postnatal-care guidance emphasizing breastfeeding counselling, timely postnatal contact, and continuity across facility and home settings (World Health Organization, 2022).

The evidence map also suggests that the delivery channel itself was not sufficient to explain favourable outcomes. Digital programmes varied from automated notifications to live professional counselling, while non-digital models ranged from one home visit to intensive residential support. The more consistent favourable signals were observed when the intervention allowed reassessment, individualized problem solving, and access to a professional response as breastfeeding difficulties evolved. This pattern is descriptive rather than causal, because these components were bundled with differences in intervention intensity, provider contact, follow-up duration, and comparator care.

At the programme level, the included studies illustrate several distinct forms of continuity. Karaahmet and Bilgiç (2022) linked early face-to-face education with online counselling extending to six months, while Wen et al. (2021) combined a theory-based intervention with WeChat, peer, and family support during the first month. Hu et al. (2020) used WeChat to respond to home feeding problems, and Yikar et al. (2026) paired mobile-app content with live professional counselling. By comparison, Doan et al. (2022) relied mainly on automated application notifications and did not demonstrate a sustained post-discharge breastfeeding difference in the caesarean subgroup, while Kruse et al. (2023) evaluated early discharge followed by a single midwife home visit and found no significant breastfeeding benefit at six months. Cho and Ahn (2014) focused on breast-engorgement management in residential postpartum care, whereas Cai et al. (2025) combined midwife-led continuity with individualized breast management. These contrasts support interpreting continuity as a combination of timing, repeated contact, responsiveness, and problem-solving capacity rather than as a single delivery modality.

Implications for integrated maternal-child care

A hospital-to-home perspective is relevant because breastfeeding problems after caesarean birth can emerge alongside postoperative pain, mobility limitations, uncertainty about infant intake, nipple trauma, engorgement, and formula exposure. A continuity pathway therefore needs more than discharge education alone. It requires a defined first contact, a method for reassessing feeding, a named professional or service able to respond, and a clear route for escalation when counselling is insufficient. This interpretation is consistent with WHO postnatal-care guidance emphasizing breastfeeding counselling, timely postnatal contact, and continuity across facility and home settings (World Health Organization, 2022).

Evidence gaps and review limitations

Important evidence gaps remain. Intervention dose, response time, provider competency, family participation, fidelity, documentation, and escalation criteria were inconsistently reported, and objective outcomes such as observed latch, infant weight trajectory, formula exposure, and documented problem resolution were less consistently measured than self-reported breastfeeding status. None of the included studies directly tested coordination between hospital and primary-care services in the Indonesian public-health context. This review also has limitations: searching was restricted to PubMed/MEDLINE and The Lens, although citation chasing was used to broaden retrieval; six reports could not be obtained; and caesarean-specific data were sometimes available only as subgroup or companion-report information. The small, heterogeneous evidence base and methodological limitations prevented meta-analysis and increase the possibility that relevant evidence was missed or incompletely represented.

The review additionally identified a reporting gap between clinical outcomes and implementation detail. Studies often reported whether breastfeeding improved but less consistently described who was responsible for post-discharge contact, how quickly

professionals responded, how adherence to the support protocol was monitored, or how unresolved problems were referred. These omissions limit transferability to routine maternity services because a programme can only be reproduced when its operational components are specified with sufficient precision.

Practical implications for service design

For maternity hospitals, these findings support a candidate service pathway rather than a proven protocol. Before discharge, assessment should identify breastfeeding position and latch, nipple condition, maternal pain, confidence, formula exposure, family support, and infant intake or weight concerns. A named contact and written feeding plan can clarify where the mother should seek help. Consistent with WHO postnatal recommendations, the first proactive post-discharge contact should occur early, ideally within 48-72 hours, followed by scheduled contacts with responsive access when problems arise (World Health Organization, 2022). Escalation to clinic review, home visit, primary care, or specialist lactation support should be available when routine counselling is insufficient.

Implementation should make responsibility visible at each step. The inpatient team identifies barriers before discharge; the first post-discharge contact reassesses feeding and maternal recovery; each subsequent contact documents the problem, action taken, response, and need for escalation. In an RSUD-to-home pathway, this documentation could support handover between the hospital, puskesmas, and community follow-up while also creating auditable indicators such as contact completion, response time, referral completion, and problem resolution. These elements are implementation proposals derived from the evidence map and should be tested locally before routine adoption.

For digital programmes, the studies suggest that technology is primarily a delivery channel rather than a sufficient active ingredient. WeChat and mobile platforms were most convincing when they created access to professional assessment and timely problem solving (Hu et al., 2020; Wen et al., 2021; Yikar et al., 2026). Automated messages can deliver information efficiently, but they cannot by themselves assess latch, infant intake, persistent breast pain, or nipple trauma. Future digital services should therefore define who responds, expected response times, red-flag criteria, documentation procedures, and the route for escalation when problems cannot be resolved remotely.

A proactive pathway may also reduce dependence on mothers having to identify a problem and seek help on their own. Women after caesarean birth differ in mobility, pain, health literacy, transport, family support, and access to lactation professionals. Standardized early contact, combined with flexible telephone, messaging, clinic, or home-based options, could improve access for mothers who might otherwise be missed. This equity implication is plausible but was not directly tested in the included studies and should therefore be evaluated as an implementation outcome rather than assumed as an established effect.

Implications for future research

Future studies should report intervention components with the same precision used for clinical outcomes. Authors should distinguish active support from research-only follow-up, identify the provider and training, specify counselling dose and duration, report adherence and attrition, and use consistent definitions of exclusive and predominant breastfeeding. Prespecified protocols, intention-to-treat analyses where appropriate, longer follow-up, and implementation outcomes such as acceptability, workload, cost, response time, and referral completion would allow future evidence syntheses to move beyond mapping toward stronger comparative conclusions about which continuity model works best, for whom, and under what service conditions.

Future evaluations should also distinguish service outcomes from breastfeeding outcomes. Alongside exclusive or any breastfeeding, studies should report whether scheduled contacts were completed, time to professional response, referral completion, resolution of

documented breastfeeding problems, formula exposure, infant weight trajectory, maternal workload, acceptability, and cost. Standardized reporting of these implementation outcomes would make it easier to compare continuity models and determine which elements are feasible for hospital, primary-care, and community settings.

CONCLUSION

Active post-discharge lactation support after caesarean birth has been delivered through online counselling, WeChat, mobile applications, home visits, continuity-of-care programmes, and residential postpartum support. The most promising pattern was observed in programmes that combined repeated assessment, individualised problem solving, and responsive professional counselling, whereas automated information alone or a single brief contact showed less sustained benefit. Because the evidence base was small, heterogeneous, and methodologically limited, these findings should be interpreted as an evidence map rather than a definitive estimate of comparative effectiveness. Future service models should define the first post-discharge contact, contact frequency and content, professional response arrangements, documentation, family involvement where appropriate, and escalation pathways linking hospital, home, primary care, and lactation services.

ETHICAL ASPECTS AND CONFLICT OF INTEREST

This scoping review analysed publicly available published studies and did not collect primary data from human participants. The author declares no conflict of interest.

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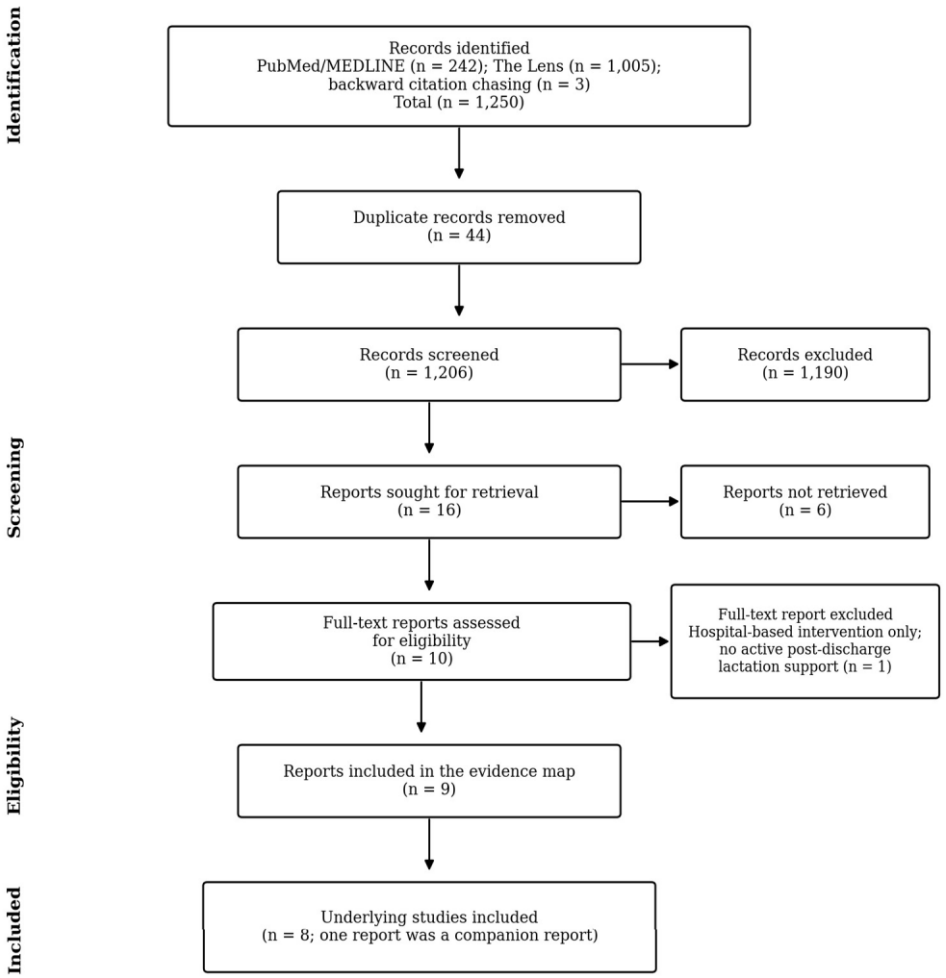
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Figure 1. Reconciled PRISMA-ScR flow diagram



Note. Nine reports represented eight underlying studies because one report was treated as a companion report of the same study cohort.

Table 1. Characteristics and main findings of included studies

Study	Design and sample	Post-discharge support model	Follow-up	Main finding
Karaahmet et al. (2022)	Türkiye; RCT; 151 primiparous mothers after caesarean birth	Face-to-face education within 24 h plus online counselling	Discharge, 1 month, 6 months	Higher breastfeeding rates at 1 and 6 months; self-efficacy higher at discharge, 4 weeks, and 6 months.
Wen et al. (2021)	China; RCT; 132 planned elective caesarean births	Theory of Planned Behavior intervention with WeChat and peer/family support	5 days, 2 weeks, 1 month	Higher exclusive breastfeeding at all follow-up points and fewer sore nipples.
Hu et al. (2020) / Ding & Luo (2019)	China; RCT; 346 women in the main report; companion report from the same cohort	Health Belief Model support with WeChat responses to home feeding problems	Discharge, 42 days, 4 months	Higher exclusive breastfeeding and satisfaction; companion report added behavioural and symptom detail.
Doan et al. (2022)	Vietnam; RCT caesarean subgroup; 568 mothers	Mobile application with automated breastfeeding notifications	Hospital stay, 1, 4, 6 months	Higher breastfeeding during hospital stay; no sustained significant post-discharge difference in the caesarean subgroup.
Cai et al. (2025)	China; quasi-experimental study; 120 mothers	Midwife-led continuity of care plus individualized breast management	48 h and 3 months	Early lactation outcomes favoured intervention; longer-term breastfeeding outcomes were not clearly reported.
Yikar et al. (2026)	Türkiye; RCT; 80 mothers after caesarean birth	Mobile application plus live professional counselling	Week 1 and week 6	Higher breastfeeding self-efficacy at weeks 1 and 6 and higher postpartum comfort.
Kruse et al. (2023)	Denmark; secondary RCT analysis; 143 parous women with planned caesarean birth	Early discharge plus one midwife home visit the next day	Week 1, week 4, 6 months	No significant difference in breastfeeding outcomes at 6 months.
Cho & Ahn (2014)	South Korea; non-equivalent quasi-experimental study; 53 completers	Residential postpartum care-centre programme for breast engorgement	Postpartum days 6-15	Lower breast discomfort and engorgement indicators and a more favourable feeding pattern.

Note. RCT = randomised controlled trial.

Table 2. Intervention components and service interpretation

Component	Reporting pattern	Interpretation
Repeated scheduled contact	Common	Present in online counselling, WeChat, mobile-app counselling, continuity-of-care, and postpartum care-centre models.
Individualized problem solving	Common but variably described	Frequently present in programmes with favourable breastfeeding or symptom outcomes; its independent effect cannot be isolated.
Responsive professional access	Inconsistent	Clearly reported in Wen, Hu, and Yikar; limited in automated-app or one-visit models.
Discharge transition plan	Underreported	Often unclear how breastfeeding problems were handed over from hospital care to post-discharge services.
Family or peer component	Uncommon	Most explicit in Wen; rarely incorporated systematically in the other interventions.
Referral or escalation pathway	Rarely explicit	Few studies specified escalation criteria for persistent pain, poor intake, weight concerns, engorgement, or mastitis risk.

Note. Reporting patterns summarize how consistently each continuity component was described across the included studies.