**Supplementary Table 2. Summary of studies reporting associations between duration of exclusive breastfeeding and infection**

***Author Setting & Infant feeding exposure Outcome(s) Reported results***

***Population classification used***

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Perkin 201613 RCT. UK infants EBF at 3 mo Randomised to early Parent-reported infection URTI significantly more common in EIG.

exposure to 6 allergenic recorded as adverse event: No significant difference for LRTI,

foods from 3-4mo (EIG) v URTI, LRTI, diarrhoea, bronchiolitis, other infections,

avoidance until at least 6mo bronchiolitis, other infections, hospitalisations.

Continued BF both groups hospitalisation for period Diarrhoea days affected:

Median duration EBF 4-6mo EIG 0.62 (SE0.06) v SIG 0.66 (0.08),

16 v 24 weeks p=0.7

Kramer9 Observational cohort nested EBF for 3mo/partial BF>6mo Physician confirmed aOR for EBF6mo v 3mo:

2003 within PROBIT trial, Belarus (n=2862) EBF≥6mo (n=621) infections (GI, respiratory, GI infection 0.61 (0.41,

AOM) 0.93) for 0-12mo; 0.35 (0.13,0.96) for 3-6mo

Paricio Talayero 36 Spain (Alicante) Hospitalisation for OR for hospital admission

2005 1385 healthy term infants followed 0-12mo No BF infection (from hospital compared to 6mo FBF:

In child health clinics FBF for 1,2,3,4,5,6 mo records) No BF 7.11

0-<1mo 4.37

1-<2mo 4.13

2-<3mo 3.70

3-<4mo 1.03

4-<5mo 1.27

5-<6mo 1.23

30% of admissions prevented

per additional month of FBF.

56% admissions avoided by 4moFBF

Chantry 200637 US NHANESIII Pneumonia Comparing 4-5 v ≥6mo

Nationally representative cross-sectional Full FF (n=1149) ≥3 episodes AOM Unadjusted:

Home survey 1988-94 FBF<1mo (n=426) ≥3 episodes cold/influenza Pneumonia: 6.5% v 1.6%

Healthy infants FBF1-3mo (n=343) Wheezing past 12 mo Adjusted OR:

FBF4-<6mo (n=223) AOM below 12 mo Pneumonia 4.27 (1.27,14.35)

FBF≥6mo (n=136) ≥3 AOM 1.95 (1.06,3.59)

Quigley38 UK Millenium Cohort Study Feeding classified each mo: Parent reported aOR for each month EBF:

2007 Infants born 2000-2002 No BF, Partial BF, EBF hospital admission for Diarrhoea 0.37 (0.18,0.78) diarrhoea or LRTI LRTI 0.66 (0.47,0.92)

53% adm for diarrhoea and 27% adm

for LRTI prevented for each month of EBF

Rebhan39 Bavaria, Germany No BF or <4mo (n=619) ≥1 episode gastroenteritis aOR for EBF≥6mo v 0/<4moBF

2009 Healthy term infants born April 2005 FBF/EBF 4-<6mo (n=870) from 0-9mo 0.6 (0.44,0.82)

EBF≥6mo (n=475)

Duijits40 Dutch prospective population based birth Never BF (n=519) Doctor attendance for aOR for EBF4mo v neverBF:

2010 Cohort (part of Generation R) Partial BF<4mo (n=1182) URTI, LRTI or GI infection URTI 0.65 (0.51,0.83)

Partial BF 4-6mo (n=1166) LRTI 0.50 (0.32,0.79)

EBF4mo then no BF (n=80) GI 0.41 (0.26,0.64)

EBF4mo then partial BF (n=1037) aOR for EBF6mo v never BF:

EBF6mo (n=58) URTI 0.37 (0.18,0.74)

Ladomenou41 Prospective observational cohort No or partial BF (n=835) Parent report aOM, EBF duration negatively

2010 Representative sample born in Crete EBF 6mo (n=91) ARI, GI thrush, UTI correlated with infection

During 2004 conjunctivitis,0-12mo episodes (r=-0.07, p=0.02) and hospitalisations (r=-0.06, p=0.04)

aOR for EBF6mo v rest: ARI 0.58 (0.36,0.92)

Li 201442 US IFPSII born 2005-7 EBF>0-<4m (n=868) Infections in the past 12mo: Trend for fewer ear, throat

Follow-up at age 6 years EBF>4-<6mo (n=195) (maternal report) & sinus infections with

EBF≥ 6mo (n=43) Respiratory, ear, throat, more prolonged EBF(p<0.01)

sinus aOR for EBF6 v 0-4\*: ear 0.37 (0.14,0.98), throat 0.23 (0.07,0.76), sinus 0.13 (0.02,0.97); ≥2 sick visits 0.33 (0.15,0.75)

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All studies/analyses apart from Perkin 2016 are observational. All studies included healthy term infants. Abbreviations: EBF Exclusive breastfeeding; FBF full breastfeeding;

FF formula feeding; aOR adjusted odds ratio; AOM acute otitis media; GI gastrointestinal infection; URTI upper respiratory tract infection; LRTI lower respiratory tract infection;

mo months: \*Statistical comparison between 4-<6 v 6mo EBF not made in the paper