National Breastfeeding Policy
Preface

The Parliamentary Secretariat for Health holds child health and well being as a priority on its agenda. Children have the right to eat nutritious food from the initial stages of life to prevent and reduce future malnourishment and obesity. The Maltese government acknowledges this right and is putting all efforts to support the provision of healthy food from birth as an investment in the future health of the people. Together with the rest of Europe, Malta is facing a major problem with regards to childhood obesity and we are committed at addressing it.

Obesity puts children at a higher risk of developing non-communicable diseases such as Type 2 diabetes and cardiovascular disease as they grow older, therefore addressing this problem should be a priority not only for all sectors of Government, but also for society at-large.

Breastfeeding is recognized by the World Health Organization as the best feeding practice to nourish infants. It provides the right nutrients in the right quantities and proportion according to the infant’s needs. Exclusive breastfeeding is recommended for the first six months and then continued during complementary feeding up to the age of two and even beyond. Breastfed children are less likely to become obese and therefore develop ill health in later life.

This government is supportive of all measures that help encourage women to breastfeed. Over the years there have been a number of initiatives that support mothers to be with their baby to practice this learnt process. The aim of this consultation document is not only to increase the breastfeeding rate on hospital discharge but also to have it continued for the first six months. A successful increase in breastfeeding rates depends on the input of different stakeholders from all sectors of government and society, hence health professionals, government organizations, media and civil society are being invited to provide feedback to this consultation document.

Whilst it is my pleasure to present the updated breast feeding policy as a consultation document, I would like to commend the Health Promotion and Disease Prevention Directorate, the Parentcraft Services and the Breastfeeding walk-in clinic for their work in developing this policy and in promoting and supporting breastfeeding.

Hon Christopher Fearne
Parliamentary Secretary for Health
Executive Summary

The aim of the National Breastfeeding Policy is to update the previous policy in line with current scientific evidence on the benefits of breast feeding to the mother and child and to achieve higher exclusive breastfeeding rates for the first six months and thereafter with appropriate complementary foods. Malta has a low breastfeeding rate in comparison to other EU countries both at the time of discharge from hospital and within the first months of life. Rates of breastfeeding (exclusive and mixed) have increased since 1995 from 45% up to 71% in 2012. However exclusive breastfeeding remains at a level of around 55% at discharge.

Women who breastfeed have lower rates of breast cancer before menopause and reduced risks of ovarian cancer, osteoporosis and coronary heart disease. Babies who are breastfed have reduced risk of diarrhoeal and respiratory illness, as well as lower rates of chronic diseases such as diabetes, inflammatory bowel disease and have improved intellectual and motor development.

This policy presents evidence based actions for promoting the initiation and sustainment of exclusive breastfeeding among healthy babies. The evidence based policy initiatives include all population groups, different settings such as community, hospital or health centre and address issues of legislation, supportive environments and training for health professionals and other groups.
**List of Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>BFH</td>
<td>Baby Friendly Hospital</td>
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<td>BFHI</td>
<td>Baby Friendly Hospital Initiative</td>
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<td>MDH</td>
<td>Mater Dei Hospital</td>
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<td>MMDNA</td>
<td>Malta Memorial District Nursing Association</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>PSMC</td>
<td>Public Service Management Code</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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### Breastfeeding Policy Working Group

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<th>Name</th>
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### Acknowledgements

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1. Introduction

Malta adopted its first National policy on breastfeeding in 2000. This was based on the Innocenti Declaration of 1990 which appealed to governments to support, protect and promote breastfeeding\(^1\). The goal of the policy was to re-establish and reinforce a breastfeeding culture aimed at promoting breastfeeding from birth and improving infant and young child feeding practices. With advances in evidence based medicine and changes in cultures and society, the need for updating this policy was evident. This updated policy takes into account the latest developments, reviews progress in reaching the previous policy’s objectives, and recommends actions to further increase the breastfeeding rates in Malta. The updating of this Policy forms part of the implementation of the ‘A Healthy Weight for Life’ (2012-2020) strategy\(^2\).

The quality of feeding in childhood is a major determinant of the future health of the individual. The new breastfeeding policy is based on the Global Strategy for Infant and Young Child Feeding which was jointly developed by the World Health Organisation (WHO) and the United Nations Children’s Fund (UNICEF) in 2002\(^3\) and built on previous achievements such as the Baby Friendly Hospital Initiative (revised 2006)\(^4\), the International Code of Marketing of Breastmilk Substitutes (1981)\(^5\) and the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (1990)\(^1\) which was revised in 2005 to include the operational targets of the aforementioned WHO/UNICEF Global Strategy.
2. Background

2.1 The Benefits of Breastfeeding

The Global Strategy for Infant and Young Child Feeding states, “Appropriate evidence-based feeding practices are essential for attaining and maintaining proper nutrition and health.” The latest scientific and epidemiological evidence has contributed to our understanding of the role of breastfeeding in the survival, growth, and development of a child as well as the health and well-being of a mother.

WHO has published systematic reviews and meta-analyses regarding evidence on the long-term effects of breastfeeding and concludes that while modest, there are statistically significant long-term benefits from breastfeeding. Lower blood pressure, lower total cholesterol, higher performance in intelligence tests and a reduced incidence in obesity/overweight and type-2 Diabetes Mellitus were found in babies who were breast-fed. The magnitude of these effects was compared to other public health interventions, and it was found that especially for cholesterol levels and obesity, breastfeeding was similar if not more effective than dietary education and physical activity in later life.

According to the latest Cochrane systematic review, the optimal duration of exclusive breastfeeding is 6 months, while WHO recommends that thereafter infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond if desired.

2.1.1. Effect of Breastfeeding on Morbidity and Infant Mortality

Research has shown that exclusive breastfeeding provides immediate health benefits to the infant. It reduces the rate of respiratory tract infections, otitis media, diarrhoea, as well as deaths due to these diseases especially during the first six months of life.

A lower incidence and severity of the following conditions in children who have been breastfed has also been documented:

- Obesity
- Diabetes Mellitus
- Childhood leukaemia
- Inflammatory bowel disease
- Coeliac disease
- Childhood cancer
- Cardiovascular disease
- Allergic disease/Asthma
- Urinary Tract infections
- Necrotising enterocolitis
While benefits observed were greatest in younger infants in developing countries, research suggests that these health and survival benefits extend beyond infancy and also apply to developed populations.

2.1.2. Effect of Breastfeeding on Intellectual and Motor Development

While better outcomes in cognitive, oral and neurological development are not as evident, research has shown that breastfeeding still causes an observable effect after all confounders have been taken into account. The consistency of these findings together with a dose-response relationship suggests that this difference is real and has a biological basis even if this is not fully understood yet.

2.1.3. Effect of Breastfeeding on Noncommunicable Diseases

Only a few observational studies have been performed on the association between breastfeeding and a number of noncommunicable diseases. A European Commission report maintains that a reduction of chronic disease risk in later life can be promoted as an additional potential benefit of breastfeeding.

The associations studied include obesity, diabetes, and cancer.

2.1.4. Effect of Breastfeeding on Maternal Health

The initiation of breastfeeding has some immediate and short-term effects on the mother by stimulating the release of oxytocin which reduces the chance of postpartum haemorrhage through various pathways, while also delaying the return of ovulation reducing the risks associated with having another pregnancy shortly after a previous one. In the longer term, breastfeeding has been shown to help protect the mother from premenopausal breast cancer and ovarian cancer, osteoporosis and coronary heart disease. In addition, mothers who breastfeed also show an earlier return to pre-pregnancy weight.

2.1.5. Economic Benefits of Breastfeeding

Although different analyses provide different perspectives, the conclusions are unanimous: formula-feed infants are more likely to have higher costs of healthcare than breastfed babies. Apart from this, breastfeeding is the cheapest way for a household to provide nutrition to the infant as opposed to alternative feeding methods.
There is also a reduction in environmental costs as a result of the reduction in packaging, transport costs and wasteful by-products of both the production and use of artificial feeding.  

2.2. Factors affecting breastfeeding

The decision to breastfeed and the ability to carry this out depend on a series of complex and often interrelated factors. These include cultural factors affecting feeding patterns and growth monitoring based on formula feeding. Other factors include the effect of the media including the portrayal of bottle feeding as the norm and as safe. National factors such as insufficient education of health professionals, lack of education in schools and the lack of supportive environments outside the home and in the workplace come into play. Breastfeeding rates are lower for younger maternal age and lower education levels. Lower socio-economic status of mother and partner are associated with lower breastfeeding rates. Examples of individual factors include the attitudes and peer support provided by the partner, mother and peer group and the embarrassment and perceived difficulty of breastfeeding in public, especially for younger mothers. Individual factors such as painful breasts and nipples, and a perception of insufficient milk can affect the decision to stop. The existence of a national policy guaranteeing breastfeeding breaks until a child is at least 6 months old was associated with significantly higher rates of exclusive breastfeeding.

2.2.1. The situation in Europe

Overall, the rates of initiation of breastfeeding and rates of breastfeeding at 6 months have increased modestly in various countries since 2002. There are however still shortcomings with regards to data collection. This includes lack of national data, and lack of standardisation of definitions and methods used to monitor breastfeeding rates and duration of breastfeeding which make comparisons of these parameters between countries difficult.

The Baby Friendly Hospital Initiative (BFHI), launched in 1991, is the UNICEF/WHO’s primary intervention strategy for strengthening the capacity of national, regional and local health systems to protect and support breastfeeding. The BFHI has thus been incorporated into best practice initiatives in maternity services worldwide and has been shown to have achieved significant improvements in breastfeeding rates and practices wherever it is applied. WHO/UNICEF accredits hospitals with a “Baby Friendly” quality standard designation when they have made the institutional and practice changes necessary to meet the Initiative’s stringent assessment criteria. A Baby Friendly Hospital (BFH) is a health care facility where the WHO/UNICEF 10 Steps to Successful Breastfeeding are the standard for maternal and child care with the aim of effectively protecting, promoting and supporting exclusive breastfeeding from birth. Further details are found in Appendix 8.1.
There has been an increase in Baby Friendly Hospitals and the proportion of babies born in them, as have the number of countries who have developed a national breastfeeding policy and updated practice guidelines.  

2.2.2. The situation in Malta

Statistics

A study in 2002 reports feeding rates on discharge from hospital and at 30 days which includes exclusive breast and mixed feeding.  

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<tr>
<td>Days from birth</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Percentage of mothers breast/mixed feeding</td>
<td>45%</td>
<td>48%</td>
<td>64%</td>
<td>56%</td>
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Table 1. Percentage of infant feeding methods by time from birth 1995-2002 (National Obstetrics Information System)  

More recent data show a significant increase in this rate.

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<thead>
<tr>
<th>Year</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
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<tr>
<td>Days from birth</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Percentage of mothers breast/mixed feeding</td>
<td>66%</td>
<td>71%</td>
<td>68%</td>
<td>70%</td>
<td>71%</td>
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Table 2. Percentage Infant feeding methods at time of discharge for liveborn infants 2008-2012 (National Obstetrics Information System)  

The target set in the National Breastfeeding Policy of 2000 was of a rate of 90% exclusive breastfeeding on discharge and 80% at 4 months.

The figure below shows the distribution of exclusive and mixed breastfeeding in the first 48 hours after birth from the European Perinatal Health Report 2011.
Figure 1. Exclusive and mixed breastfeeding in the first 48 hours after birth by country.

The most recent data on exclusive breastfeeding at discharge from hospital shows a rate of around 55% (National Obstetrics Information System)\textsuperscript{61}.

Figure 2. Percentage exclusive breastfeeding at time of discharge from hospital (National Obstetrics Information System)\textsuperscript{61}
Rates of breastfeeding (exclusive and mixed) have increased since 1995 from 45% up to 71% in 2012; however they have remained relatively constant over the past 4 years. The rates of breastfeeding at 1 month after birth have also increased from 20% in 1995 to 35% in 2000. One study which was published in 2010 reports a 38% prevalence of mothers who breastfeed at 6 months. This indicates that rates have further improved.

Both rates for exclusive breastfeeding on discharge from hospital and mixed feeding are well below the targets from the previous Breastfeeding Policy. There is still much room for improvement.

A study conducted in 2010 found that 50% of mothers stopped breastfeeding because of incorrect advice from health professionals. If this can be remedied, there would be a significant improvement in ongoing breastfeeding rates.

**Legislation**

The Public Service Management Code (PSMC) regulates the employment of Civil Service employees. It covers statutory paid and other maternity leave, the use and availability of breastfeeding facilities and paternity leave. The relevant section of the PMSC is reproduced in Appendix 8.5.

Malta is in the process of enacting legislation which will prevent the inappropriate marketing of breast milk substitutes (Legal notice ‘Marketing of Breast milk substitutes and other related products Regulations, 2014’). The Legal Notice which will be issued under Chapter 465 of the Laws of Malta, seeks to protect infant health by preventing inappropriate marketing of breast milk substitutes, by specifying the content of information and educational material and by regulating the promotion and use of free samples within public and private health care settings.

**Policy and Governance**

The Breastfeeding Steering Committee within Mater Dei Hospital (MDH) is responsible for preparation and implementation of the hospital policy and has the lead in training maternity staff in breastfeeding management. Several Standing Operating Procedures (SOPs) have been drawn up in response to specific issues. The Committee includes representation from paediatrics, midwifery, nursing and hospital administration. MDH is in the process of fully implementing a Breastfeeding Policy and Practice Guidelines in line with the Baby Friendly Hospital Initiative (BFHI) which was launched in 2012. Currently this initiative is seeking formal BFHI accreditation.
Available services

Support is available during pregnancy and also when the mother and newborn are discharged from hospital.

Parentcraft Services within MDH

This is a free-standing Unit, forming part of the Mater Dei Hospital (MDH) Obstetric Department. Around 2800 mothers/couples (around 65% of pregnant mothers) make use of this service annually for education and support. Services are free of charge and mothers are given an application form to apply during their booking visit. During the courses mothers learn more about pregnancy and childbirth by being presented with the latest knowledge and research. Sessions are also held for student nurses, midwives and secondary or post-secondary students.

Parentcraft Courses include: Early Pregnancy Courses (starting from 10 weeks pregnancy) and Childbirth Courses (usually starting from 28 – 30 weeks pregnancy). The latter are also available for English Speaking Clients, parents with other children (refresher), and School-age clients (held at Ghozza*). Other specific courses are offered for parents expecting multiples, and for pre-adoptive couples.

The Childbirth Course contains a 3 hour session on breastfeeding including the benefits, advantages and disadvantages, technique and good latching, support and use of the breastfeeding clinic.

One-to-one sessions are offered to clients with special needs, such as partner abroad, single mothers with problems, social problems, drug abuse, low IQ; clients with impaired hearing or speech problems.

Other sessions are also held regularly, in liaison with other Departments. These include sessions about dental Care, childcare centres standards, stem cell collection, speech and language development, amongst others.

Besides lectures at MDH, parentcraft education is widely offered through the media, through various professional handouts and booklets, and through active participation and organization of conferences for the general public.

Parentcraft Services provides a very popular Support Telephone Helpline - 2545 5124, where clients can call in, to ask for help on any problem, both during pregnancy and after delivery. The telephone helpline is open to all, including those who have never attended, relatives, and anyone wishing to make use of this service. Calls vary from brief ones enquiring about the courses or about their applications, to complicated and intense ones, sometimes requiring referral to other health professionals.

*Unit Ghozza, provides a support service and an educational programme to unmarried pregnant minors, leading them to adopt a positive attitude towards motherhood while empowering them to pursue their career path.
**MDH Breastfeeding walk-in clinic**

The Breastfeeding Walk-in Clinic provides ongoing support to breastfeeding mothers following discharge from hospital. All breastfed babies are given an appointment by ten days of age to ensure return to their birth weight. Mothers can turn up on a walk-in basis which allows early intervention for breastfeeding problems. The clinic also serves as a point for reassurance in that mothers can have their baby weighed whenever they feel insecure about feeding habits and have access to lactation-trained midwives to discuss worries and concerns.

**Liason Nurse Community Service**

Midwives visit all mothers on the day following a normal or instrumental delivery and on the second day following a caesarean section. This visit consists of a general assessment of the mother and baby. The first home visit takes place on the first day post discharge. The duration of this visit is approximately one hour. During this visit the midwives assess the home environment in general, and if necessary, a referral to a social worker is made with the mother’s consent. A general postnatal examination of mother and baby is carried out to ensure that the baby is feeding well and look into hygienic practices. They carry out a baby bath demonstration and give general advice according to need. The second home visit is usually of shorter duration. Additional home visits are carried out according to need. The mothers are given an appointment to attend the Breastfeeding Walk-in Clinic on the third post-discharge day.

**MMDNA**

The Malta Memorial District Nursing Association (M.M.D.N.A) is a non-profit making organisation offering community nursing and midwifery services to the whole Maltese Islands, both to the Association members, as well as to all the Maltese community on behalf of the Health Ministry. The postnatal domiciliary midwifery service consists of four visits by an M.M.D.N.A midwife to the mother and her child after being discharged from Hospital, including the second day post discharge. If problems are still pending after the fourth visit extra visits are made. During these post natal visits, the midwife, apart from examining the mother and her child, answers any queries the mother may have.

**Parentcraft Services (fee-paying services)**

A number of private entities offer pregnancy, parentcraft skills and antenatal care within the community against a fee.
Human resources and training

MDH employs one Infant Feeding Specialist Midwife who is responsible for the day to day running of the Breastfeeding Walk-in Clinic and for overseeing more complex cases, the planning and delivery of staff training, and has a key role in the implementation of the BFHI.

The Breastfeeding Management Course is a compulsory course for all midwives and nurses working in maternity settings. The course has also been offered to community midwives and paediatric nurses although this is not a compulsory course in these settings. The course consists of 8 three-hour sessions which focus on the management of breastfeeding mothers. Attendance to all sessions is necessary to obtain a certificate which is given after assessment of practice during a 3-hour practical session at the Breastfeeding Walk-in Clinic.

Undergraduate training within the medical curriculum is part of the clinical attachment to the Obstetrics and Gynaecology and Paediatrics Department.

A Lactation Consultant Course is being piloted for midwives and nurses after being offered to the midwives working in the Breastfeeding Clinic and midwives and nurses on the Breastfeeding Steering Committee. If this course is successful, it will be extended to the whole maternity department.

The Bachelor of Science Course in Midwifery has been adapted to follow the European Union criteria for professional education in midwifery. A module is now included entitled ‘Trends in Infant Feeding’ which has a clinical placement to the Breastfeeding Walk-in Clinic. Following qualification, midwives spend their first years of service on rotation within the maternity department which now includes the Breastfeeding Clinic with the aim of providing good practices that can be taken into the ward setting.
3. Policy Aims and Objectives

Aims

This policy aims to update the National Breastfeeding Policy published in 2000 taking into account the latest recommendations from WHO, UNICEF and the European Commission regarding breastfeeding.

Objectives

To achieve optimal infant and young child feeding by supporting all mothers who decide to breastfeed in:

- Initiating breastfeeding,
- Breastfeeding exclusively for first six months and,
- Continuing breastfeeding with appropriate complementary foods until two years and beyond, or as long as the mother and baby wish.
4. Policy Initiatives

Breastfeeding is a choice that everyone will respect, protect and help families accomplish; however, mothers will not be obliged to breastfeed, as putting undue pressure on them to do so is as unacceptable as putting undue pressure to opt for formula feeding.

4.1. Enact legislation controlling the marketing of breast milk substitutes

Summary: All health, social and allied workers and institutions caring for mothers, infants and young children should fully comply with all the provisions of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA resolutions.

To ensure that there is no advertising or other form of promotion to the general public of products under the scope of the International Code, including the distribution of information materials produced/sponsored by these product manufacturers/distributors.

To develop national legislation based on the International Code, including mechanisms for enforcement and prosecution of violations, and a monitoring system that is independent of commercial vested interests.

To encourage the full implementation of the International Code even where EU regulations do not require this of member states.

To inform pre- and post-graduate health professionals and health service providers, including pharmacists, about their responsibilities under the International Code.

To develop a code of ethics covering the criteria for the acceptance of individual and institutional sponsorship for courses, educational materials, research, conferences and other activities and events, to avoid conflicts of interest that are known to adversely affect breastfeeding.

To disseminate information to the public on the principles, aims and provisions of the International Code and on procedures for monitoring compliance and censuring violations.

To phase out the distribution of free formula to low income families, where this is still in place, and to replace it with incentives and initiatives to promote and support breastfeeding within families living in poverty or otherwise marginalized.

To ensure that policy development, planning, implementation, monitoring and evaluation of activities are carried out under the scope of the International Code.
4.2. Enforce a breastfeeding policy in maternity hospitals based on the principles of the Baby Friendly Hospital Initiative (BFHI)

Summary: All hospitals, maternity units and primary health care facilities should adopt and implement effective strategies for the protection, promotion and support of breastfeeding, as outlined in the Baby Friendly Hospital Initiative (a WHO/UNICEF initiative).³

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<th>Ten Steps to Successful Breastfeeding</th>
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<td>Have a written breastfeeding policy that is routinely communicated to all health care staff.</td>
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<td>Train all health care staff in skills necessary to implement this policy.</td>
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<td>Inform all pregnant women about the benefits and management of breastfeeding.</td>
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<td>Help mothers initiate breastfeeding within one half-hour of birth.</td>
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<td>Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants.</td>
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<td>Give newborn infants no food or drink other than breast milk, unless medically indicated.</td>
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<td>Practice rooming in, that is, allow mothers and infants to remain together 24 hours a day.</td>
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<tr>
<td>Encourage breastfeeding on demand.</td>
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<tr>
<td>Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.</td>
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<td>Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.</td>
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To ensure that government, health authorities, professional associations and relevant NGOs implement the BFHI as a standard for best practice, and that all maternity and child care institutions and providers pursue the goal of achieving and maintaining the ‘Baby Friendly’ designation, including compliance with the local legislation.
To ensure adequate resources (funds, personnel and time) and technical support for training, change of practices, assessment and re-assessment of hospitals based on compliance with the BFHI

To ensure that maternity hospitals are implementing the practices described in the ‘10 steps’ as these represent best evidence-based practice

To incorporate the achievement of all the BFHI criteria into the standards for quality accreditation of maternity and paediatric health service providers. The Global Criteria for the Baby-Friendly Hospital Initiative serve as the standard for measuring adherence to each of the Ten Steps for Successful Breastfeeding and the International Code of Marketing of Breast-milk Substitutes 58

To develop a systematic approach to conveying breastfeeding information during antenatal care, consistent with relevant steps of the BFHI

To implement ‘step 10’ by improving cooperation between hospitals and other health and social care facilities and mother-to-mother groups so as to ensure the provision of optimum lactation support and counselling, especially during the crucial weeks after birth

To develop and implement the Baby Friendly Initiative for settings other than maternity hospitals, to include community health and allied social care settings, paediatric hospitals, doctors’ clinics, pharmacies and workplaces

4.3. Train health care professionals in the promotion and management of breastfeeding

Summary: All health, social and allied workers caring for mothers, infants and young children should get the education, training and skill development required to implement this policy.

To ensure that adequate resources and technical support for training and necessary changes in practice are provided so that community health and social services for women, infants and children effectively promote and support breastfeeding

To ensure that all health, social and allied workers caring for mothers, infants and young children shall not recommend formula feeding as an alternate or complement to breastfeeding unless there are legitimate medical reasons for doing so

To review a minimum standard (contents, methods, time) and competencies for pre- and post-graduate curricula on breastfeeding and lactation management for relevant health workers
To review course textbooks and training materials in line with the updated standard curricula and recommended policies and practices

To offer continuing interdisciplinary education based on WHO/UNICEF guidelines or other evidence-based courses on breastfeeding and lactation management, as part of induction and in-service education for all relevant health care staff, with particular emphasis on staff in frontline maternity and child care areas, including MMDNA nurses

To review training materials to be used for such interdisciplinary continuing education, ensuring that materials and courses are not influenced by manufacturers and distributors of products under the scope of the International Code

To encourage relevant health care workers to attend advanced lactation management accredited courses and to acquire certification shown to meet best practice criteria for competence

To encourage networking amongst breastfeeding specialists in order to increase knowledge and skills

To ensure that the skilled breastfeeding support provided by health and allied social care workers and mother-to-mother volunteers is confidence-building and empowering for mothers and their families

**4.4. Develop strategies for the promotion and support of breastfeeding in the community**

**4.4.1. Antenatal**

To ensure that all pregnant women and mothers are educated and get one-to-one counselling on optimal infant and young child feeding in antenatal classes/clinics and after the birth of their baby

To provide all expectant parents with evidence-based and objective (i.e. independent from commercial interests) infant feeding information in order to ensure they make an informed decision

**4.4.2. Post-natal**

To involve fathers and families to ensure appropriate support for mothers on discharge home

To ensure that women who stop breastfeeding before they had planned to are facilitated to examine why this happened in order to reduce feelings of loss or
failure they may be experiencing, and help them attain longer breastfeeding with a subsequent baby

To ensure that mothers with particular breastfeeding difficulties are individually assisted by skilled counsellors

To ensure that all mothers have free access to infant and young child feeding support services, including the services of appropriately qualified lactation consultants, or other equally competent health care staff, if problems arise

To provide mothers of ill or preterm infants with the support necessary to ensure that they are able to maintain their lactation and express sufficient breastmilk for their infant’s needs or to provide free safe donor breastmilk

To ensure that, before their infants reach six months, all parents will receive information and advice on appropriate complementary foods and when and how to introduce these in their infants’ diet while continuing breastfeeding

To ensure that, after six months, all parents will be advised to introduce and gradually increase the frequency, consistency and variety of healthy family foods, adapting them to the infant’s requirements and abilities, while avoiding sugary drinks and drinks with low nutrient value

4.4.3. In the community

To increase general population awareness about the benefits of breastfeeding, including the role of the father in supporting the lactating mother

To encourage breastfeeding friendly policies/facilities in workplaces and public service/amenity areas and to protect the right of women to continue breastfeeding for as long as they wish through enacting appropriate policies and legislation

To identify and address the particular support, information and skill needs of primiparae, immigrants, adolescents, single mothers, less educated women and others in society that are currently least likely to breastfeed, including mothers with previous difficult and/or unsuccessful breastfeeding experiences, and mothers of formula fed infants and young children

To use the international, national and local breastfeeding awareness weeks as an opportunity to stimulate public debate in different settings and media and to disseminate important information

To monitor, inform and use all organs of the media to promote and support breastfeeding and to ensure that it is at all times portrayed as normal and desirable
To give appropriate information and support to breastfeeding mothers, their partners and families, including contact details for recognised breastfeeding support networks, both statutory and voluntary

To encourage family support through public education and local projects, and through community programmes based on collaboration between voluntary and statutory community services providers

To coordinate breastfeeding initiatives with other public health and health promotion plans and activities

To present exclusive breastfeeding for six months and continued breastfeeding up to two years and beyond as the normal way to feed and nurture infants and young children in all written and visual materials

To identify and address the information needs of other family and kinship members, e.g. mother’s partner/infant’s father, infant’s grand-parents, siblings, etc.

To encourage collaboration between health workers, lactation consultants, other service providers and other support groups in the community

To encourage the media to represent breastfeeding and appropriate complementary feeding as the normal, natural and optimal way of feeding infants and young children

4.4.4. Support groups

To encourage the establishment and increase the coverage of support services provided by trained peer counsellors and mother-to-mother support groups, particularly in lower socio-economic groups and marginalised communities, where women are less likely to breastfeed

To develop or review/update curricula (contents, methods, materials, time) for peer counsellor and mother-to-mother support training

To strengthen the cooperation and communication between health workers based in different health facilities and trained peer counsellors and mother-to-mother support groups

4.4.5. At the workplace

To extend national maternity protection legislation in order to support mothers to achieve breastfeeding best practice recommendations
To ensure that sufficient legislative supports are in place to facilitate mothers in the paid workforce to exclusively breastfeed up to six months and to continue breastfeeding after that for as long as the mother and baby wish.

To extend maternity protection legislative provisions to women who are not currently entitled to these: e.g. women with short term contracts, casual and part-time workers, students and immigrants.

To ensure that employers, health workers and the public are fully informed about maternity protection and health and safety at work legislation as related to pregnant and breastfeeding women.

To inform employers of the benefits to them and their breastfeeding employees of facilitating breastfeeding following return to the workplace, and the facilities necessary to ensure that this is possible (flexible hours, time-off, and facilities for expressing and storing breastmilk).

4.5. Set targets, implement and monitor this policy

To collect comprehensive, timely and accurate data on breastfeeding rates and practices, using standard agreed definitions and methods, for use in planning, monitoring, evaluation and operational research.

To gather, in addition to breastfeeding rates, linked information on maternal age, education and socio-economic status to help identify the extent and nature of inequalities in the prevalence of breastfeeding.

To regularly monitor progress and periodically evaluate results of the national plan.

To monitor breastfeeding knowledge, attitudes and behaviour at societal level so as to take a more informed approach to effectively promoting, supporting and protecting it.

To monitor the coverage and effectiveness of in-service training.

To set up a monitoring system, independent of commercial interests, with responsibility for checking compliance with the International Code, investigating and if necessary prosecuting breaches, as well as producing information for the general public and the relevant authorities on any infringements that have taken place in the relevant jurisdiction.

To monitor the implementation, in both public and private sectors, of national policies and legislation, including maternity protection laws, relating to breastfeeding.

To draw up protocols and instigate procedures for the regular assessment of hospital and primary health care practices, based on standard best practice.
criteria as developed for the BFHI by WHO/UNICEF and by the national responsible committee

To put in place routine patient/client feedback through audit and satisfaction surveys to determine the quality of the breastfeeding information and support provided by maternity and paediatric service providers and primary health care practices

To designate a suitably qualified national coordinator with clear terms of reference related to policies and plans with the help of an intersectoral breastfeeding committee

To assign adequate human and financial resources for the protection, promotion and support of breastfeeding
5. Monitoring and Research

5.1. Indicators to be used to monitor this policy

Early initiation of breastfeeding: proportion of children born in the last 24 months who were put to the breast within one hour of birth

Exclusive breastfeeding under six months: proportion of infants 0-5 months of age who are fed exclusively with breast milk

Continued breastfeeding at 1 year: proportion of children 12-15 months of age who are fed breast milk
6. Conclusion

This National Policy builds on the work already carried out within the past twenty years by setting out the current situation in Malta and the latest research evidence on the benefits of breastfeeding to both the mother and the newborn. The policies identified are evidence-based or proposed by experts as contributing to the achievement of the aims and objectives of this policy. The policies are wide ranging, covering areas from hospital, primary and community care settings, to the training of health professionals and other relevant stakeholders, as well as the workplace setting and creating a supportive environment. Gaps within our surveillance system are identified, in order to better target National efforts. This policy requires a coordinated multisectoral approach in order to change culture and achieve behaviour change. It will direct National efforts till the year 2020, and aims to substantially increase exclusive breastfeeding rates for the first six months of life and for a longer period according to the wishes of the mother and child.
7. References


54. Dyson L et al . Promotion of breast feeding initiation and completion. NHS 2005


63. Gatt M. Dept. of Health Information, Malta (Personal communication 2013).

8. Appendices

Appendix 8.1: The Baby Friendly Hospital Initiative

The original BFHI guidelines were developed in 1992 by UNICEF and WellStart International. The guidelines were revised in 2006. The following are the revised 10 Steps to Successful Breastfeeding:

- Have a written breastfeeding policy that is routinely communicated to all health care staff.
- Train all health care staff in skills necessary to implement this policy.
- Inform all pregnant women about the benefits and management of breastfeeding.
- Help mothers initiate breastfeeding within a half-hour of birth.
- Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
- Give newborn infants no food or drink other than breastmilk unless medically indicated.
- Practise rooming in - allow mothers and infants to remain together - 24 hours a day.
- Encourage breastfeeding on demand.
- Give no artificial teats or pacifiers (dummies, soothers) to breastfeeding infants.
- Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

In many countries, the BFHI has been complemented by initiatives aimed at protecting, promoting and supporting breastfeeding:

- before and after childbirth through primary health care and community services;
- among sick and preterm infants in hospitals.

There are neither universal criteria nor guidelines for the BFHI, because each national project has been developed based on the local situation and organization of primary health care and community services.
Appendix 8.2: The International Code of Marketing of Breastmilk Substitutes

The International Code covers breastmilk substitutes, including “infant formula, other milk products, foods and beverages for use as a partial or total replacement for breastmilk, feeding bottles and teats”, and was adopted in 1981 at the WHA by the majority of Member States to stem the aggressive marketing of formula milk and the resultant rise in infant mortality. After the adoption of the International Code, the infant formula companies developed and began marketing follow-up formulae to ensure the continuing visibility of their brand names and products. In response, a 1986 WHA Resolution clarified that there is no clinical need for these products and that artificially fed infants should be fed standard infant formula to 12 months and thereafter should receive full fat unmodified cow’s milk as well as nutritious family foods. Subsequent WHA Resolutions have updated and clarified the International Code as necessary, to take account of new scientific knowledge and commercial product marketing trends. These Resolutions have the same status as the International Code, as reaffirmed by a technical endorsement from the WHO secretariat.

The main provisions of the International Code and subsequent relevant WHA Resolutions are:

- Governments have the responsibility to provide information on infant feeding.
- Donations of informational materials by manufacturers or distributors should only be made at the request and with the written approval of the appropriate government authority.
- No advertising of breastmilk substitutes to the public.
- No direct or indirect free samples or gifts to mothers or their relatives.
- No company sales representatives to contact mothers directly or indirectly.
- No gifts or personal samples to health workers. Samples provided are to be for professional evaluation or research at institutional level. Health workers should not give samples to pregnant women or mothers of infants and young children.
- Information to health workers should be scientific and factual.
- Financial support to health professionals should not create conflicts of interest.
- All information to mothers should include the benefits of breastfeeding and the costs and hazards of artificial feeding.
- No promotion of products covered by the International Code in health care facilities including no free supplies.
- No words like “humanized”, “maternalized”, or similar terms, pictures and text idealising artificial feeding on labels.
- Nutritional and health claims are not permitted for breastmilk substitutes, except where specifically provided for in national legislation.

Successful implementation of the International Code depends on countries incorporating and enforcing its provisions into their national/regional legislation. The International Code, however, states that irrespective of such incorporation, industries should monitor their own practice and conform to the principles and aims of the International Code itself. Although sponsorship of health programmes and health professionals, including training, is not prohibited by the International Code, the 1996 and 2005 WHA Resolutions cautioned against conflicts of interest. Health
professionals may feel they are immune to commercial promotional activities. Social science studies have concluded otherwise: even “small gifts” have an effect.

The International Code does not prohibit the sale of breastmilk substitutes but regulates their marketing. Advertisement and promotion of a product for sale may be a widely accepted practice in the commercial world but the marketing of breastmilk substitutes adversely affects the up-take and duration of breastfeeding and cannot be treated in the same way as other commercial products. The low rates of breastfeeding worldwide are a major public health concern and efforts to address this situation should not have to compete with commercial enterprises with increasingly more sophisticated marketing tools and massive budgets.

As health advocates, apart from urging the government to take action to address low breastfeeding rates, health workers have responsibilities under the provisions of the International Code. They can ensure that health care facilities are not used for product promotion. They can monitor and report violations to the relevant statutory bodies, as recommended by the WHA. At the very least, health workers should familiarise themselves with the spirit and provisions of the International Code and subsequent relevant WHA Resolutions so as not to inadvertently facilitate violations, to the detriment of the community health.

The European Union first transposed the International Code into a Directive of the European Commission in 1991 (Directive 91/321/EEC). This Directive was far from encompassing the International Code in its integrity insofar as it applied only to infant and follow-on formulae and limited their marketing only to infants under four months of age. In December 2006 the European Commission issued Directive 2006/141/EC to update and replace the 1991 Directive. The 2006/141/EC Directive represents very little improvement over the 91/321/EEC Directive: it just extends the marketing limitations to infants up to six months. Almost at the same time, the European Commission issued Directive 2006/125/EC on processed cereal-based foods and baby foods for infants and young children. Article 8.1.a of this Directive says that the label of these products must bear a statement as to the appropriate age from which the product may be used; it adds that “the stated age shall not be less than four months”, thus contradicting many national recommendations for exclusive breastfeeding up to six months. The Directives of the European Commission are to be transposed into national laws or regulations in all Member States.
Appendix 8.3: The Innocenti Declaration

The 1990 Innocenti Declaration on Protection, Promotion and Support of Breastfeeding

On 1st August 1990 in Florence, Italy, representatives from 30 national governments adopted the Innocenti Declaration, a document that established new strategic objectives to more effectively protect, promote and support breastfeeding. The four operational targets of the 1990 Innocenti Declaration were:

- to appoint a national breastfeeding coordinator and establish a multisectoral national breastfeeding committee;
- to ensure that every facility providing maternity services fully practices all the 10 Steps to Successful Breastfeeding;
- to give effect to the principles and aim of the International Code in their entirety; and
- to enact legislation protecting the breastfeeding rights of working women and establish means for its enforcement.

The 2005 Innocenti Declaration on Infant and Young Child Feeding

On 22nd November 2005 in Florence, Italy, an anniversary celebration was held entitled “Celebrating Innocenti 1990-2005: Achievements, Challenges and Future Imperatives”. Participating delegates adopted the Innocenti Declaration 2005. This consists of several urgent and necessary actions to ensure the best start in life for children, the realisation of the human rights for women and children, and the achievement of the MDG by 2015. The Declaration identifies roles and responsibilities of key players and emphasizes that these responsibilities need to be met to achieve an environment that enables mothers, families and other caregivers to make informed decisions about optimal infant feeding. This call for required actions includes:

All parties:
- Empower women;
- Support breastfeeding as the norm;
- Highlight the risks of artificial feeding;
- Ensure the health and nutritional status of women throughout their life;
- Protect breastfeeding in emergencies, including uninterrupted breastfeeding, appropriate complementary feeding, and avoid distribution of breastmilk substitutes;
- Implement the WHO HIV and Infant Feeding Guidelines.

All governments:
- 7. Establish or strengthen national infant and young child feeding authorities, coordinating committees and groups free from commercial influence and conflicts of interest;
- 8. Revitalise the BFHI, expanding the Initiative’s application to include maternity, neonatal and child health services and community-based support;
9. Implement all provisions of the International Code in their entirety as a minimum requirement, and establish enforcement mechanisms to prevent and/or address non-compliance;
10. Adopt maternity protection legislation that facilitates six months of exclusive breastfeeding;
11. Ensure that appropriate guidelines and skill acquisition are included in both pre-service and in-service training of all health care staff to provide a high standard of breastfeeding and complementary feeding management and counselling;
12. Ensure that all mothers are aware of their rights and have access to support, information and counselling;
13. Establish monitoring systems for infant and young child feeding patterns;
14. Encourage the media to support breastfeeding as the norm, to provide positive images of optimal infant and young child feeding, and to participate in WBW activities;
15. Take measures to protect populations, especially pregnant and breastfeeding mothers, from environmental contaminants and chemical residues;
16. Identify and allocate resources to implement actions called for in the Global Strategy;
17. Monitor progress and report periodically.

All manufacturers and distributors of products within the scope of the International Code:
18. Ensure full compliance with all provisions of the International Code and subsequent relevant WHA Resolutions in all countries;
19. Ensure that all processed foods for infants and young children meet applicable Codex Alimentarius standards.

Multilateral and bilateral organisations and international financial institutions:
20. Recognise that optimal breastfeeding and complementary feeding are essential to achieving the long-term physical, intellectual and emotional health of all populations and that inappropriate feeding practices and their consequences are major obstacles to poverty reduction and sustainable socio-economic development;
21. Identify and allocate sufficient human and financial resources to support governments in formulating, implementing, monitoring and evaluating their policies and programmes on optimal infant and young child feeding and BFHI;
22. Increase technical guidance and support for national capacity building in all areas set forth in the Global Strategy;
23. Support operational research;
24. Encourage the inclusion of programmes to improve breastfeeding and complementary feeding in poverty-reduction strategies and health sector development plans.

Public interest non-governmental organisations:
25. Give greater priority to protecting, promoting and supporting optimal feeding practices, including training of health and community workers, and increase effectiveness through cooperation and mutual support;
26. Draw attention to activities which are incompatible with the International Code’s principles so that violations can be effectively addressed in accordance with national legislation and regulations.
27. Any partnerships be governed by guidelines which ensure that they are appropriate and focus on clearly identified actions, in keeping with the principles for avoiding conflicts of interest and undue commercial influence.

The Innocenti Declaration 2005 was endorsed by the 2006 Annual Session of UN Standing Committee on Nutrition, and the WHA 2006 urged Member States to support actions contained in the Call for Action (WHA resolution 59.21).
### Appendix 8.4: Definitions of terms related to breastfeeding recommended by WHO

<table>
<thead>
<tr>
<th>Category of infant Feeding</th>
<th>Requires that the infant receive</th>
<th>Allows the infant to receive</th>
<th>Does not allow the infant to receive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive breastfeeding (EBF)</td>
<td>Breastmilk, including expressed breastmilk or from a wet nurse</td>
<td>Drops, syrups (vitamins, minerals, medicines)</td>
<td>Anything else</td>
</tr>
<tr>
<td>Predominant breastfeeding (PBF)</td>
<td>As above, as the predominant source of nourishment</td>
<td>As above plus liquids (water, water-based drinks, fruit juice, ritual fluids)</td>
<td>Anything else (in particular, non-human milk, food-based fluids)</td>
</tr>
<tr>
<td>Breastfeeding with complementary foods (CBF)</td>
<td>Breastmilk and solid or semisolid foods or nonhuman milk</td>
<td>Any food or liquid including non-human milk</td>
<td>Breastmilk, including expressed breastmilk or from a wet nurse</td>
</tr>
<tr>
<td>Non-breastfeeding (NBF)</td>
<td>No breastmilk</td>
<td>Any food or liquid including non-human milk</td>
<td></td>
</tr>
</tbody>
</table>

The sum of EBF+PBF is called full breastfeeding (FBF). The sum of EBF+PBF+CBF is called breastfeeding (BF). The sum of EBF+PBF+CBF+NBF in a given sample or population must equal 100% as these categories are mutually exclusive.

Note: this definition does not distinguish infants and children who take, in addition to breastmilk, formula only, non-human milk only, solid or semisolid foods only, or different combinations and proportions of the above; nor does it take into account the proportion of breastmilk on overall 24-hour food intake.
Appendix 8.5  Public Service Management Code

5.2.4 Maternity leave and Breastfeeding Facilities (page 208 – 211)

For the purposes of this Section the following definitions apply:
− ‘pregnant employee’ means an employee who formally informs her respective director of her pregnancy and of the expected date of confinement by means of a certificate issued by a registered medical practitioner or midwife;
− ‘breastfeeding employee’ means an employee who is breastfeeding during a period of twenty-six weeks after her date of confinement and who has informed her respective Director by means of a certificate issued by a registered medical practitioner or midwife.

5.2.4.1. Statutory entitlement
Female employees are entitled to paid maternity leave for absence from work because of pregnancy and confinement for a period of not more than 14 weeks as follows:
Applicable to public sector employees
a period of 6 weeks immediately after the date of confinement;
the remaining 8 weeks may be availed of immediately before or after confinement;
during pregnancy and during the 26 weeks starting from the date of confinement in the case of a live birth, and 14 weeks in the case of a still-born child, Directors should take measures to protect the health and safety of an employee, after a risk assessment has revealed a risk to the safety or health or an effect on the pregnancy or breastfeeding of the employee; and
if in such instances an employee cannot be given suitable alternative working arrangements, she shall be granted special maternity leave for the whole period necessary, up to the time-limits stipulated in (c) above. During the special maternity leave, the employee shall be paid a special allowance equivalent to the rate of sickness benefit payable in terms of the Social Security Act, for a period of 8 weeks. Any special maternity leave availed of beyond 8 weeks will be unpaid.
For the purpose of the preceding sub-paragraph, a confinement will be taken to mean the birth of a living child or the birth of a child whether living or stillborn after 7 months of pregnancy.

5.2.4.2. Applications for maternity leave
In order to be eligible for maternity leave, a female employee should, at least 3 weeks before such leave is about to begin or, if that is not reasonably practicable, as soon as practicable, give notice in writing to her Director that she will be absent from work because of pregnancy and confinement and, together with such notice, she should produce a signed medical certificate which indicates the expected date of confinement. After confinement, the Director responsible for corporate services should confirm the birth of the baby, if this was registered in Malta, through the Common Database (CDB). With regard to alternative duties, female officers should also give reasonable notification in order that adequate arrangements may be made. If the notice is not given as in the preceding paragraph the employee will be entitled only to that part of the maternity leave which includes the date in
which the confinement occurs and the period of 6 weeks which follow such date if
the birth of the baby is confirmed.
In cases where confinement does not occur within 8 weeks from the day on which
the maternity leave commences, the period after the 8 weeks till the date of
confinement should be covered by unpaid leave.

5.2.4.3. An employee who, having been granted maternity leave, is unable to resume
duties at the expiration of the maternity leave owing to a pathological condition
arising out of confinement will be entitled to a further period of absence of up to 5
weeks. Such further absence shall be deducted from the period of paid sick leave to
which the employee may be entitled at the time of the absence, any period of
absence in excess of the sick leave entitlement being reckoned as sick leave without
pay. The rules regarding sick leave (set out in section 4.3) including the
regulations concerning notification of sick absence, will apply.

5.2.4.4. Refund of salary on termination of service
An employee who has been granted paid maternity leave is required to work for an
uninterrupted period of 26 weeks. An employee who fails to resume duty at the
expiration of maternity leave or of the further period of absence referred to in the
preceding paragraph or who having resumed work resigns or abandons her
employment without sufficient cause within 6 months from the date of such
resumption, shall be liable to pay Government a sum equivalent to the salary she
received during the maternity leave. These 6 months must be actual service and
may not be covered by vacation, sick or other leave and may be worked either
before or after the utilisation of the parental leave on no pay. An employee on a
definite contract shall not be liable to refund the salary she received during maternity
leave if her contract of employment is not extended, at the employer’s discretion for
up to a period of time which is sufficient for her to fulfil the 6 month obligation.

5.2.4.5. Change in post
If an officer changes post after availing herself of maternity leave for another post in
the public service, she may render the 6 months service required after maternity
leave in her new post, provided there is no break of service. This applies also if the
new post is in a different career stream.

5.2.4.6 Breastfeeding Facilities
In line with Government’s policy to promote breastfeeding, the conditions of work of
breastfeeding employees should be facilitated through the temporary adjustment of
the work environment and, or the hours of work of the employee concerned.

5.2.4.6.1. In case of requests for breastfeeding facilities, Ministries should provide
employees with adequate, clean and private facilities for the expression and storage
of milk. The breastfeeding mother can opt to breastfeed in such facilities.
5.2.4.6.2. Time intervals, up to a maximum of 1 hour each working day, availed of by
breastfeeding employees for the expression of milk shall not incur loss of pay. Such
intervals may be taken in the form of:
One 60 minute interval;
Two 30 minute intervals;
Three 20 minute intervals.
5.2.4.6.3. Even where the Administration provides facilities as per paragraph 5.2.4.6.1. the employee may still request that she be allowed temporary adjustment to the working environment and, or the hours of work, including the possibility so long as this is technically possible, of reporting for work closer to home. A request to “work close to home” is to be considered “technically” viable only if it is possible for the individual to work within the same Department or Directorate but closer to home.

5.2.4.6.4. The alternative working arrangement to “work closer to home” is limited to a maximum period of 26 weeks from confinement of birth of a viable child who is being breastfed for the whole period.

5.2.4.6.5. Absences, up to a maximum of 1 hour each working day, availed of by breastfeeding employees to leave the place of work for breastfeeding shall not incur loss of pay. Such absences may be taken in the form of:
One 60 minute interval;
Two 30 minute intervals;
Three 20 minute intervals.

5.2.4.7 Administrative arrangements

5.2.4.7.1. The employee who is allowed to “work closer to home” is required to endorse an agreement which clearly spells out the conditions tied with the approval of the temporary alternative work arrangements, duration period and termination date, upon which the employee will be bound to resume one’s normal duties with the parent department. The agreement should be countersigned by the employee’s manager.

5.2.4.7.2. Any employee who refuses to return to the original work place at the end of the 26 week period shall be liable to disciplinary proceedings.

5.2.5. Release to attend ante-natal examinations
Pregnant employees are entitled to time-off, without loss of pay or any other benefit, to attend ante-natal examinations if these have to take place during working hours. The employee’s superior may request documentation which shows the appointment times for such examinations.

5.2.6. Paternity leave*
Male employees are entitled to two working days paid leave on the birth of each of their children. This leave is to be availed of at a stretch, within 15 days following the birth.