Review Article

Advocating Breastfeeding: From Hospital to Home

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ABSTRACT

The first 1,000 days of life represent a critical window for establishing optimal health, growth, and neurodevelopment. Breastfeeding plays a central role during this period, conferring well-documented benefits for infant survival, immunity, cognitive development, and long-term metabolic health, while also improving maternal health outcomes. This review aims to examine the current epidemiology of breastfeeding at global, national, and local (Sarawak) levels; to evaluate the effectiveness of initiatives bridging the hospital-to-home transition—including Baby-Friendly clinics, longhouse-based peer programs, and digital platforms—against comparable international evidence; and to identify the structural levers, including workplace and maternity-leave protection and WHO Code enforcement, needed to sustain breastfeeding across this transition, with attention to the barriers facing employed mothers. Many mothers experience early breastfeeding cessation, particularly during the transition from hospital discharge to community and home settings. Advocacy should begin from the pre-pregnancy period, through pregnancy, and continue to be supported through the early childhood years. Achieving and sustaining optimal breastfeeding requires coordinated action with sustained political commitment, targeted community support, workplace and maternity-leave protection, rigorous evaluation of existing local initiatives, and enforcement of the International Code on Marketing of Breast-Milk Substitutes.

Keywords: breastfeeding; exclusive breastfeeding; breastfeeding promotion; Baby-Friendly Hospital Initiative; Malaysia; maternity leave; community support

INTRODUCTION

Breastfeeding is universally recognized as the optimal nutritional strategy for infants and young children. The World Health Organization (WHO) and UNICEF jointly recommend exclusive breastfeeding for the first six months of life, followed by continued breastfeeding alongside appropriate complementary foods up to two years of age or beyond [1,3,4]. These recommendations reflect extensive evidence that breastfeeding reduces infant morbidity and mortality from infectious and non-communicable disease, and confers additional maternal health benefits, including reduced lifetime risk of breast and ovarian cancer [3,5]. Despite this recommendation and decades of global advocacy, breastfeeding rates have improved only modestly, and significant regional disparities persist [6].

Multiple factors contribute to this shortfall in breastfeeding rates, including early cessation of breastfeeding following hospital discharge, limited community and workplace support, and the ongoing marketing of commercial milk formula [6,7].

Breastfeeding advocacy should begin from the pre-pregnancy period and be sustained through each stage of the perinatal journey and into early childhood. The transition from hospital to home is particularly critical, as this is when many mothers experience cessation of breastfeeding.

This review has three aims: to examine the current epidemiology of breastfeeding at global, national, and local (Sarawak) levels; to evaluate the uptake, effectiveness, and implementation gaps of existing hospital- and community-based initiatives; and to identify the structural levers — community support, maternity-leave protection, and WHO Code enforcement — needed to sustain breastfeeding across the hospital-to-home transition. Based on this analysis, practical recommendations are proposed for strengthening breastfeeding support at the health-system, community, and policy levels.

METHODS

This narrative review integrates current evidence and practice regarding breastfeeding advocacy across the perinatal continuum, with particular attention to the hospital-to-home transition and the Malaysian and Sarawak context. Relevant literature was identified through targeted searches of PubMed and Google Scholar, supplemented by publications from the World Health Organization, UNICEF, the International Labour Organization, the OECD, the United States Centers for Disease Control and Prevention, and the Malaysian Ministry of Health, using search terms including breastfeeding, exclusive breastfeeding, hospital discharge, breastfeeding support, maternity leave, and formula marketing. A general online search was performed for market prices of formula feeding accessories. No systematic search protocol or formal quality appraisal was applied, consistent with the narrative, author's-perspective nature of this review in addition to the author's clinical and program experience within Sarawak's state health services.

Global Epidemiology of Breastfeeding

Rates of exclusive breastfeeding (EBF) in the first six months of life have increased by approximately 10 percentage points over the past decade, representing meaningful progress but falling short of population-level targets. The global EBF rate reached 48% in 2023, approaching the World Health Assembly (WHA) target of 50% by 2025 [1].

The Global Breastfeeding Collective (GBC), launched in August 2017 through a WHO–UNICEF partnership, represents a coordinated international effort to increase political and financial commitment to breastfeeding. The GBC's annual Breastfeeding Scorecard assesses national policy environments across ten indicators, including breastfeeding rates, policies, programs, and promotional spending [1]. The 2023 Scorecard identifies Malaysia as among the Asian countries demonstrating a greater than 10% increase in EBF rates since 2017, alongside China and Viet Nam [1]

Breastfeeding rates remain low or poorly documented in Central Asia and parts of Europe, with Azerbaijan reporting 18%, Montenegro 19.5%, Belarus 22%, and Uzbekistan 25%. Only 53% of infants in these regions are

breastfed within the first hour of birth [2]. Data on direct breastfeeding versus expressed milk feeding are not routinely captured in most global and regional surveillance systems, including for the figures cited above. This is a significant gap, as evidence indicates the two practices are not clinically equivalent: infants fed expressed milk follow different weight-gain trajectories than those fed directly at the breast, and expressed feeding is independently associated with shorter overall breastfeeding duration [8]. In the United States, the CDC's 2022 Breastfeeding Report Card, reflecting the 2019 birth cohort, found that 83.2% of infants had ever been breastfed—a measure that encompasses the hospital discharge period—declining to 55.8% at six months and 35.9% at twelve months. [9].

Malaysia: National Breastfeeding Statistics

In Malaysia, the 2022 National Health and Morbidity Survey (NHMS) provides the most recent national data on breastfeeding practices [10]. While initiation rates are relatively high, EBF at six months remains a significant challenge. The national prevalence of early initiation of breastfeeding stands at 64.3%, while the prevalence of any breastfeeding at 12–24 months is 50.6%. Notably, breastfeeding rates at 12–24 months differ markedly among ethnic groups. Malays (55.7%), other Bumiputera groups—indigenous and native ethnic communities other than Malay—(50.3%), and other groups (58.6%) recorded rates at or above the national average of 50.6%, while Chinese (27.1%) and Indian (22.4%) mothers recorded rates below the national average. The NHMS report itself notes that further research is warranted to elucidate the social and cultural determinants underlying these differences [10].

In Sarawak, the proportion of six-month-old infants receiving exclusive breastfeeding was tracked annually from 2019 to 2023, against a state target of ≥70% by 2023. Rates plateaued between 46.8% (2019) and a peak of 49.7% (2021), falling short of the state target across all years reviewed (Sarawak State Health Department, unpublished programme monitoring data).

Despite decades of multi-sectoral initiatives, the plateauing of breastfeeding rates in Malaysia reflects persistent barriers at the individual, family, and community levels. Perceived insufficient milk supply remains one of the most commonly cited reasons for early cessation. This is often compounded by inconsistent lactation assistance and counselling in the immediate postnatal period. Pressure from family members in some ethnic groups—particularly grandmothers and other senior relatives who encourage early introduction of complementary feeds—continues to shape infant-feeding decisions, reflecting the strong influence of intergenerational caregiving norms in Malaysian households. Culturally embedded myths further undermine breastfeeding confidence, including the belief that breastfeeding may precipitate neonatal jaundice, or that colostrum is nutritionally inadequate. Cultural stigma around breastfeeding in public, together with a lack of supportive infrastructure in public spaces and workplaces, compounds these difficulties. Addressing these deeply rooted barriers will require culturally sensitive health education delivered antenatally and reinforced throughout the postnatal period, rather than generic breastfeeding-promotion messaging alone.

Benefits of Breastfeeding

The scientific evidence supporting the health benefits of breastfeeding for both infants and mothers is extensive and robust [3,5]. Breastfed infants demonstrate significantly lower rates of common childhood infections, including acute diarrheal illness, lower respiratory tract infections, and acute otitis media, attributable to the immunoprotective constituents of human milk—including secretory IgA, lactoferrin, lysozyme, and human milk oligosaccharides [3]. Of particular clinical relevance is the well-evidenced protection against necrotizing enterocolitis in preterm neonates [5]. Breastfeeding is further associated with optimal weight gain, protection against later obesity, higher IQ scores, and improved cognitive development [11], as well as a reduced risk of sudden infant death syndrome (SIDS) [3].

The maternal health benefits of breastfeeding are frequently underemphasized in public health communications. Lactation is associated with a significant reduction in lifetime risk of breast cancer, with evidence suggesting each year of breastfeeding reduces risk by approximately 4.3% [5]. Similarly, the risk of epithelial ovarian cancer is reduced in women who have breastfed, with longer cumulative lactation duration conferring greater protection [5].

The economic burden of not breastfeeding is also significant. Infant formula imposes a significant financial cost on Malaysian families, particularly those of lower socioeconomic status. By the author's calculation, a standard 900 g tin provides approximately 6,960 ml of reconstituted formula—equivalent to approximately 29 bottles of 240 ml—sufficient for only approximately 11 days of feeding for a one-month-old infant (consuming 600 ml/day) and 8–9 days for a three-month-old (consuming 800 ml/day). A survey of Malaysian retail and e-commerce platforms conducted by the author in 2026 found feeding bottles ranging from approximately RM3 to over RM120 each, a price range that may induce some families to seek cheaper but less safe alternative bottles and teats.

Bridging the Gap: From Hospital to Home

The transition from hospital to home represents a critical and vulnerable period for breastfeeding continuity. WHO/UNICEF guidelines stipulate that before discharge from a maternity facility, a mother should be able to demonstrate competent breastfeeding technique, recognize signs that feeding is progressing well, and be connected to ongoing support resources [12]. In many government hospitals in Malaysia, the early discharge of postnatal mothers within 48 hours of uncomplicated deliveries due to high bed occupancy rates allows very little contact time for breastfeeding support by health care workers.

This practice of early discharge, while often necessary from a bed-management perspective, effectively transfers the responsibility for consolidating breastfeeding support from the hospital to the community—mainly to Maternal and Child Health (MCH) clinics. However, MCH clinics and community nursing services in Malaysia are widely recognized to be understaffed and overloaded. Community nurses and midwives frequently manage heavy workloads that limit the time available for individualized breastfeeding counseling during postnatal home

visits and clinic follow-up. This reality should be explicitly acknowledged rather than ignored. Practical measures to strengthen community-level capacity could include focused post-discharge, early home visits for mothers identified as being at higher risk of breastfeeding difficulty; enhancing establishment of trained community-based support groups or peer counsellors working in coordination with community nurses; continuing professional education to refresh community-based staff on practical lactation-support skills, including hands-on positioning and attachment techniques. Without such targeted measures, early discharge policies risk becoming a transfer of an unmet need rather than a genuine continuum of care.

Following hospital discharge, the primary sources of breastfeeding support available to Malaysian mothers include family members (particularly mothers and mothers-in-law, whose own breastfeeding experiences significantly influence practice), primary care and community health workers (including community nurses and midwives at public health clinics), and mother-to-mother peer support groups [12,13].

A systematic review and meta-analysis of lactation consultant and counselor interventions found significantly higher odds of breastfeeding initiation (OR 1.35), continuation to one month (OR 1.49), and exclusivity to one month (OR 1.71) [14]. In Malaysia, professional lactation support is limited and remains concentrated in urban centers and private practice, with limited formal integration into public-sector post-discharge care pathways.

Step 10 of the Baby-Friendly Hospital Initiative (BFHI) specifically mandates that facilities 'foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.' This step operationalizes the transition from institutional to community-based care [12]. In Malaysia, this function is primarily fulfilled by a network of Maternal and Child Health (MCH) clinics. In Sarawak, the Klinik Rakan Bayi (KRB/ Baby-Friendly Clinic) is a state-wide program which extends breastfeeding promotion and support beyond BFHI-accredited hospitals, as an extension of the Klinik Rakan Bayi program by the Ministry of Health, with all Sarawak MCH clinics attaining KRB status by 2019.

Community-Based Support Strategies

The WHO technical document on breastfeeding states that 'the key to best breastfeeding practices is continued day-to-day support for the breastfeeding mother within her home and community.' This necessitates a shift from a medicalized model of support toward one that empowers families, communities, and peer networks [13].

Kenya provides a good example of the impact of community-integrated breastfeeding support programs. As part of Kenya's Baby-Friendly Community Initiative (BFCI), a cluster-randomized controlled trial in Koibatek Sub-County, Baringo County, found that structured community-based counseling and peer support, delivered from pregnancy through six months postpartum, increased exclusive breastfeeding at six months among HIV-negative mothers from 42.2% in the control group to 81.7% in the intervention group [15].

In Malaysia, breastfeeding support groups exist at both community and hospital levels, with non-governmental organizations playing an active role in peer-counselor training and support-network facilitation. A notable innovation from Sarawak is the *Rumah Panjang Mesra Bayi* (Baby-Friendly Longhouse) initiative, implemented by the Nutrition Section of the Sarawak State Health Department. Traditional longhouses are communal dwelling structures shared by extended communities among the indigenous ethnic groups of Sarawak, including the Iban, Bidayuh, Melanau, and Orang Ulu peoples [16].

The program was formally launched at Rumah Milai anak Balai, Panggang, Lubok Antu, Sri Aman Division in 2018, with subsequent expansion to Rumah Cherida, Meradong, Sarikei Division in 2019. The initiative involves community mobilization, training of longhouse members as breastfeeding peer supporters, and the creation of breastfeeding-friendly environments in communal areas. Documented activities from the 2018–2019 cycle demonstrate both the feasibility and community acceptability of this model [16].

Rigorous evaluation of these Malaysian initiatives remains limited: a 2025 scoping review of a decade of Malaysian breastfeeding research found no peer-reviewed studies formally assessing the implementation or effectiveness of major national programs, including the Baby-Friendly Hospital Initiative and its community-based extensions, despite Malaysia having adopted BFHI since 1992 [17]. Where Malaysian peer-support interventions have been formally evaluated, results are encouraging: a randomized trial of a breastfeeding peer-counsellor program found exclusive breastfeeding at six months of 46.7% in the intervention group compared with 32.1% in controls, and continuation of any breastfeeding of 73.3% versus 50.0% [18]—consistent with a Cochrane review of 73 trials internationally, which found that additional breastfeeding support, whether from lay counsellors, professionals, or both, reduces the risk of stopping exclusive breastfeeding by six months by 12% (RR 0.88, 95% CI 0.85–0.92) [19]. Set against the Kenya comparison above, the Rumah Panjang Mesra Bayi initiative itself lacks a published outcome evaluation, and several implementation questions remain open: what proportion of eligible longhouse mothers are reached and sustain engagement; whether the initiative measurably shifts direct breastfeeding rates specifically, a distinction of growing clinical relevance given evidence that directly breastfed infants show more favourable growth trajectories than those fed expressed milk [8]; and what resource or logistical barriers have constrained its expansion beyond the original Sri Aman and Sarikei sites over the seven years since launch. A formal, published evaluation—benchmarked against models such as Kenya's—would substantially strengthen the case for scaling this and comparable Malaysian community initiatives.

The Rumah Panjang Mesra Bayi initiative has not been expanded beyond its original implementation sites in Sri Aman and Sarikei Divisions since its inception, despite longhouse-dwelling communities forming a substantial proportion of the Sarawak population across many divisions. Only the Sarikei program remains active at present. This situation likely reflects a combination of factors, including falling birth rates across Sarawak [20], the human-resource and logistical demands of training and supervising peer supporters across Sarawak's dispersed and often remote longhouse settlements, the absence of dedicated recurrent funding beyond the initial pilot, and the lack of a formal evaluation framework to generate the evidence needed to justify wider state-level investment.

Social media platforms are significant channels for breastfeeding peer support, particularly among younger, urban, and digitally-savvy mothers. However, the digital presence of Malaysian breastfeeding support communities remains limited, with few Facebook and Instagram pages garnering more than a few hundred followers. Social media therefore represents a substantially underutilized platform for breastfeeding promotion. The effectiveness of such platforms for improving direct breastfeeding rates specifically has not been formally evaluated in the Malaysian setting, an evidence gaps consistent with that identified more broadly for local breastfeeding initiatives [17]. At present, most parents who use social media and electronic platforms for breastfeeding information do so largely on their own initiative, while hospitals and public health clinics continue to rely predominantly on traditional print materials such as pamphlets and posters—a format that may not reach younger parents. There is some concern that much of the available content is generated by unverified sources, contributing to the spread of misinformation and myths.

There is a clear opportunity for hospitals and clinics to shift proactively toward digital engagement—directing mothers to verified, evidence-based information, including the annual World Breastfeeding Week which provides continued public visibility for breastfeeding advocacy but relies on traditional broadcast and print media. However, digital information cannot stand alone; it requires integration into routine antenatal education and postnatal assistance.

Protecting Breastfeeding for Employed Women

The GBC has identified maternal employment as one of the most significant structural barriers to sustained breastfeeding [21]. The International Labour Organization (ILO) Convention C183 mandates a minimum of 14 weeks of paid maternity leave to safeguard maternal and child health, nutrition, and development; ILO Recommendation R191 calls for at least 18 weeks of fully paid leave, funded from public resources, to facilitate EBF for the recommended six-month duration [22,23].

According to the OECD Family Database, countries with the most generous paid maternity leave provisions include Bulgaria (58.6 weeks), Greece (56.0 weeks), the United Kingdom (39.0 weeks), Slovakia (34.0 weeks), and Croatia (30.0 weeks) [24]—each offering substantially extended leave relative to Malaysia's current provision of 98 days (approximately 14 weeks), which meets the ILO Convention C183 minimum but falls short of the Recommendation R191 threshold of 18 weeks [22,23]. Effective 1 January 2023, Malaysia extended statutory maternity leave for all private-sector employees—under the Employment Act 1955 (Amendment) 2022—aligning private-sector entitlement with the public sector [25]. However, this expanded entitlement may not translate into full utilization and effective breastfeeding support. Enforcement among smaller employers, coverage of contract and gig-economy workers who fall outside standard employment protections, and awareness of entitlements among both employers and employees have not been systematically evaluated.

A 2024 systematic review examining the association between maternity-leave length and breastfeeding duration in the United States found that longer maternity leave was generally associated with longer breastfeeding

duration [26]. However, the same review also identified substantial variation by maternal race and ethnicity, with certain groups demonstrating shorter breastfeeding duration despite comparable or longer leave entitlements—highlighting the complex sociocultural, economic, and structural factors that confound the relationship between leave policy and breastfeeding outcomes. In Malaysia, which has a similarly complex multiethnic society, where ethnic disparities in breastfeeding practice are already documented locally [10], whether extending maternity leave would translate into improved breastfeeding rates, remains unknown and represents an area for future local research.

Beyond leave duration, the workplace environment is a critical determinant of post-return breastfeeding continuity. Malaysia currently has no statutory requirement mandating paid lactation breaks or employer-provided breastfeeding rooms: nursing mothers largely rely on informal arrangements or individual employer goodwill. China provides a notable policy precedent. The 2024 GBC Report Card documents that China's EBF rate increased from 20.8% in 2013 to 35.1% in 2017, coinciding with an extension of national maternity leave from 12 to 14 weeks (with some provinces offering up to 178 days), mandatory employer-provided paid one-hour breastfeeding breaks, and the 2016 'Guiding Opinions on Accelerating the Construction of Maternal and Child Facilities', which requires 80% of targeted public places to provide breastfeeding rooms [27].

At the regulatory level, the International Code of Marketing of Breast-Milk Substitutes (the WHO Code), adopted in 1981, provides the primary regulatory framework for restricting commercial promotion of infant formula, feeding bottles, and teats [28]. Full domestic legal implementation and robust enforcement of the WHO Code is essential to counteract the marketing activities of the multi-billion-dollar global infant formula industry, which disproportionately targets vulnerable populations. The Ministry of Health Malaysia reinforced this policy with a circular from Director General of Health in 2023, disallowing gifts and sponsorships from the infant formula companies to health professional associations and non-governmental organizations for events, meetings and campaigns. [29] This circular is binding on public healthcare institutions and Ministry-endorsed associations; its reach into private hospitals, private clinics, and privately organized practitioner events—where infant formula marketing activity is reportedly more visible—depends on voluntary compliance and professional self-regulation.

Confinement centres represent a rapidly expanding and largely unregulated post-natal care sector. An online search conducted by the author in September 2026 identified a directory of 1,044 centres across 17 states/territories and 241 towns, with standard-to-premium packages costing approximately RM 8,000 to over RM 30,000 for a 28-day stay. While some centres offer lactation services, others may promote formula feeding. Given that a growing proportion of mothers spend their early postnatal weeks in these facilities, they represent both a critical opportunity for and a potential risk to breastfeeding success. A framework for voluntary or mandatory lactation competency standards, aligned with BFHI principles, could substantially improve breastfeeding outcomes. This sector warrants attention and action from health authorities, municipal government, and federal legislators.

The Ministry of Health Malaysia has also pursued BFHI accreditation of private hospitals. As of mid-2025, 31 of 180 private hospitals had achieved Baby-Friendly accreditation, with 15 hospitals in the final stages of training by the National Lactation Centre and a further 65 in initial training (Ministry of Health Malaysia, unpublished programme data, mid-2025).

Conclusion

Breastfeeding represents one of the most impactful and cost-effective preventive health interventions available to public health, yet Malaysia faces specific, addressable challenges in sustaining breastfeeding through the critical hospital-to-home transition and into community life.

Current and future measures to sustain and improve breastfeeding rates in Malaysia should encompass the following:

- Strengthening public healthcare delivery in terms of funding and human resources. This includes investment in peer-to-peer support groups and breastfeeding-counsellor training programs at the primary care and community level, including culturally adapted models for rural and indigenous communities in Sarawak and Sabah.

- Following the 2023 extension of maternity leave to 98 days for all private-sector employees, priority should also be given to legislating mandatory paid lactation breaks and workplace breastfeeding facilities—matters currently left to employer discretion in Malaysia—and to monitoring enforcement and awareness among smaller employers and non-standard workers.

- Domestic legal enforcement of the WHO Code on Marketing of Breast-Milk Substitutes should be extended, with binding force, from public healthcare institutions to private hospitals, private clinics, and practitioner events, where compliance currently relies on voluntary self-regulation [28].

- Engagement of the rapidly growing confinement centre sector through targeted accreditation and regulatory frameworks.

- Leveraging social media and digital platforms strategically to reach younger mothers paired with local efforts to counsel and assist in breastfeeding.

- Finally, systematic political advocacy—engaging legislators and community leaders to elevate breastfeeding as a public health and economic priority, using the Global Breastfeeding Scorecard as an advocacy tool—remains essential.

The achievement of optimal breastfeeding rates is not a clinical challenge alone, but one that requires the sustained engagement of governments, employers, communities, families, and health systems working in concert.

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