

Systematic Review

THE IMPACT OF MATERNITY LEAVE DURATION ON EXCLUSIVE BREASTFEEDING IN WORKING MOTHERS: A SYSTEMATIC REVIEW

Eman Abbas Zaher¹, Wafa Romaih Alromaih², Huda Mohammed Alqahtani³, Faisal Alosaimi⁴, Abdullah Jomah Obaidullah⁵

^{1,2}Department of Family Medicine, King Abdulaziz Medical city, Riyadh, Saudi Arabia

³Department of Family Medicine, Prince Sultan Military Medical City, Riyadh, Saudi Arabia

⁴Department of Family Medicine, Security Forces Hospital, Riyadh, Saudi Arabia

⁵Department of General Surgery, Security Forces Hospital, Riyadh, Saudi Arabia

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Corresponding Author:

Dr. Eman Abbas Zaher,
Department of Family Medicine, King
Abdulaziz Medical City, Riyadh, Saudi
Arabia.
Email: emanzaher@icloud.com

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ABSTRACT

Background: Exclusive breastfeeding (EBF) for six months is recommended for health, but working mothers face challenges due to limited maternity leave and workplace constraints. Despite efforts, EBF rates stay below targets, emphasizing the need to understand factors like leave duration. The objective is to systematically evaluate the association between maternity leave duration and the rate of exclusive breastfeeding among working mothers, and to identify key barriers and facilitators influencing breastfeeding practices.

Materials and Methods: A systematic review was conducted following PRISMA guidelines. A comprehensive search of PubMed, Scopus, and Web of Science databases was performed to identify relevant studies investigating the association between maternity leave duration and breastfeeding practices among working mothers. Eligible studies included original research involving working mothers and reporting outcomes related to breastfeeding practices. Study selection was based on predefined inclusion criteria, and 29 studies were included after screening. Risk of bias was assessed using the ROB 2.0 tool.

Results: Findings indicate a consistent positive association between longer paid maternity leave and higher rates and duration of EBF. Countries offering extended paid leave (e.g., ≥ 26 weeks) demonstrated significantly better breastfeeding outcomes compared to those with shorter or unpaid leave. Workplace support measures, including lactation breaks and breastfeeding-friendly environments, further enhanced EBF continuation. Conversely, inadequate policies, workplace constraints, and socio-cultural barriers were major contributors to early cessation.

Conclusion: Extended and adequately paid maternity leave is a critical determinant of successful EBF among working mothers. Policymakers and employers must implement supportive policies and workplace interventions to improve breastfeeding outcomes and promote maternal and child health globally.

Keywords: Exclusive breastfeeding; Working women; Maternity leave; Workplace policies; Public health policy; Breastfeeding continuation.

INTRODUCTION

Exclusive Breastfeeding (EBF) is defined by the World Health Organization (WHO) as the exclusive provision of breast milk in the absence of other liquids and solids. EBF is the indispensable mode of nourishment to the infant, and it provides countless

communications in the areas of physical and emotional bonding.

According to the WHO and UNICEF, it is recommended that breastfeeding be initiated within an hour after delivery and continued over the first six months of age. Interventions of EBF have been positively interlinked with amended brain development, reduced infant mortality, and lower

infection rates in later life for both mothers and their offspring.^[1] Reduced breastfeeding length has been associated with an exponentially increased risk of maternal sicknesses, including type II diabetes, heart disease, and various types of cancer.^[2]

Unfortunately, as they are unable to get paid maternity leave, today's working moms are essentially denied the opportunity to breastfeed. This increases the risk of acute and chronic diseases for both their children and themselves.^[3] Worldwide EBF statistics are still below the threshold level, despite these established recompenses; only over 44% of babies between 0 and 6 months are entirely breastfed, which is significantly less than the 70% goal set by 2030. In addition to this, various studies have shown that exclusive breastfeeding percentage are still far less from current goals.^[4]

EBF practice can be drastically compromised by various factors, of which employment is one of the most crucial ones. Maternal employment with very limited sustenance has previously been well documented as a prominent barrier to breastfeeding.^[5] Employed mothers, especially in the absence of sufficient maternity protection, have been steadily associated with early termination of breastfeeding. For example, in Taiwan, 87–90% of working mothers began feeding their babies during maternity leave, but after returning to work, breastfeeding rates fell sharply, with only 21.5% of shift workers and 24.1% of non-shift workers continuing to breastfeed for one to six months after giving birth.^[6]

Similar patterns may be seen across the world; Mothers in the US who took fewer than three months of leave were far less likely than those who took more time to maintain breastfeeding at two and three months. In low- and middle-income countries (LMICs), extending paid maternity leave by just one month was associated with a 5.9 percentage point increase in EBF and a 2.2-month increase in overall breastfeeding duration.^[7] Across the Gulf countries, extensive research is needed to support more solid, evidence-based government policies, given that there aren't many comprehensive studies conducted in the area.^[8,9]

Despite efforts to encourage EBF-friendly policies, practical challenges persist. Previous research revealed that even when lactation spaces and breaks are mandated, many women face barriers such as a lack of privacy, inadequate support from employers or colleagues, and rigid work schedules that discourage milk expression.^[6] Furthermore, cultural stigma, job insecurity, and lack of awareness about maternity entitlements contribute to the underutilization of available support. These structural and psychosocial obstacles are especially pronounced in settings where informal employment is prevalent.^[10]

The International Labour Organization (ILO) promoted paid breastfeeding breaks and six weeks of unpaid maternity leave during its inaugural meeting in 1919. Friendly work environments, such as paid

maternity leave, access to high-quality baby care, nursing breaks, and dedicated lactation spaces, have now been promoted by UNICEF and WHO.^[11,12] According to the 2000 ILO Convention, women shall be entitled to at least 14 weeks of paid leave with a proper salary structure that is adequate to guarantee that both the mother and her newborn baby can live comfortably and in good health.^[13]

The number of nations that have adopted these standards has barely changed from 2014 (from 72 in 2014 to 83 in 2022). The ILO Convention also advocates for the implementation of laws that provide 18 weeks of maternity leave with 100% pay, in addition to the right to have 14 weeks of paid leave with two-thirds salary (R191). No country in Africa or Oceania complied with this set of guidelines in 2022, and only 10% of nations did so.^[14,15]

The current systematic review discusses the effects of maternity leave duration among working mothers on the rate of exclusive breastfeeding. Furthermore, this research attempts to provide practical insights for employers, healthcare professionals, and policymakers looking to address the gap between optimal infant feeding practices and maternal employment policies.

MATERIALS AND METHODS

Search Strategy: A comprehensive literature search was conducted across three major databases, PubMed, Scopus, and Web of Science, to identify studies investigating the association between paid maternity leave, breastfeeding practices, and maternal-child health outcomes among working women. The search strategy included both free-text and controlled vocabulary terms to maximize sensitivity and coverage. Search terms included various combinations and synonyms such as “exclusive breastfeeding,” “parental leave,” “maternity leave,” “paid leave,” “work leave,” “employed women,” “breastfeeding duration,” “breastfeeding initiation,” “working mothers,” and “occupational women.” For policy-level and cross-country comparative analyses focusing on psychosocial health outcomes, additional terms included “maternity leave policy,” “parental leave legislation,” “paid maternity leave,” “breastfeeding rates,” “exclusive breastfeeding prevalence,” “cross-country comparison,” “global health policy,” “maternity leave duration,” “length of leave,” “mother-infant bonding,” “attachment,” “postpartum mental health,” and “maternal mental health.”

Protocol registration: The review protocol was developed prior to study initiation. However, the protocol was not prospectively registered in PROSPERO. The review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) guidelines.

Study Question and PICO Framework: The present systematic review was undertaken to evaluate

the association between maternity leave duration and exclusive breastfeeding practices among employed mothers. The review question was formulated

according to the Population, Exposure, Comparator, and Outcome (PICO) framework as follows [Table 1].

Table 1: Population, Exposure, Comparator, and Outcome (PICO) framework.

Component	Description
Population (P)	Working mothers with infants
Exposure (I/E)	Longer duration of paid maternity leave
Comparator (C)	Shorter maternity leave duration or early return to work
Outcome (O)	Exclusive breastfeeding prevalence and breastfeeding duration

The primary objective was to determine whether longer paid maternity leave was associated with improved exclusive breastfeeding outcomes among working mothers.

Inclusion Criteria

The included studies met the criteria of original, full-text publications in English involving working women who breastfed. No lower publication year restriction was applied, and studies published up to November 2025 were considered eligible for inclusion. The included literature specifically analysed factors related to breastfeeding sustainability.

Study Selection Process: Two reviewers independently screened the titles and abstracts of all retrieved records for potential eligibility. Full-text articles of potentially relevant studies were subsequently assessed against the predefined inclusion and exclusion criteria. Any disagreements regarding study eligibility were resolved through discussion and consensus. Studies meeting all eligibility criteria were included in the final qualitative synthesis.

Data Extraction: Data was extracted using a standardized data extraction form. Information collected from each included study comprised author name, year of publication, country, study design, sample size, duration of maternity leave, workplace breastfeeding support measures, exclusive breastfeeding outcomes, breastfeeding duration, and key study findings. Extracted data were independently reviewed for accuracy and consistency prior to synthesis.

Article Screening: The screening process involved initial title and abstract review to assess relevance, followed by application of predefined inclusion and exclusion criteria. Eligible studies were then evaluated using the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) guidelines, as illustrated in the search flowchart.

Risk of Bias Analysis: The risk of bias for the included studies (29) was assessed using appropriate tools depending on study design. Risk of bias was assessed using the ROB 2.0 tool and summarized graphically. The overall quality assessment was presented narratively and visually through risk-of-bias figures.

The initial search yielded 2871 articles in total. After applying inclusion and exclusion criteria, 850 articles were deemed eligible for the two-stage assessment process. Following title and abstract screening in the

first phase, 195 papers met the requirements and proceeded to the second phase of full-text evaluation. Using PRISMA guidelines, 29 publications ultimately qualified for analysis and synthesis.^[17–19]

RESULTS

A comprehensive search of PubMed, Scopus, and Web of Science databases identified 2,871 records. Following removal of duplicate records and application of predefined inclusion and exclusion criteria, 850 records were considered potentially eligible for further assessment. After title and abstract screening, 195 studies underwent full-text evaluation. Ultimately, 29 studies met the eligibility criteria and were included in the final qualitative synthesis [Figure 1].

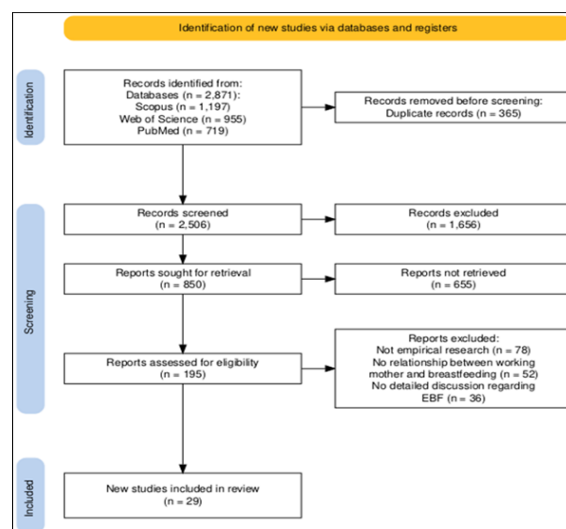


Figure 1: Flowchart for article selection and filtration

Methodological quality assessment demonstrated generally satisfactory quality among the included studies. Most studies exhibited low to moderate risk of bias across assessed domains. Some limitations were identified with respect to participant selection, outcome assessment, and reporting practices. Overall, the included studies were considered suitable for qualitative synthesis. Overall, the included studies were considered to have satisfactory methodological quality [Figure 2-3].

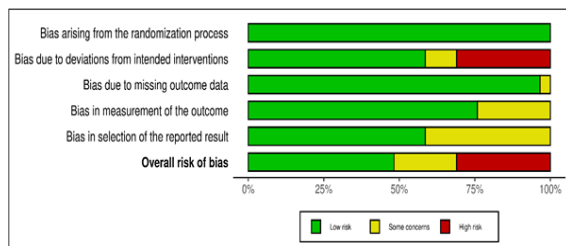


Figure 2. Representing risk of bias items as percentages across all included studies

Characteristics of Included Studies: The 29 included studies represented a wide range of geographical settings including Asia, Europe, Africa, North America, South America, Oceania, and the Middle East. The evidence base comprised cohort studies, cross-sectional studies, longitudinal studies, qualitative studies, quasi-experimental studies, interrupted time-series analyses, policy analyses, and systematic reviews [Table 2].

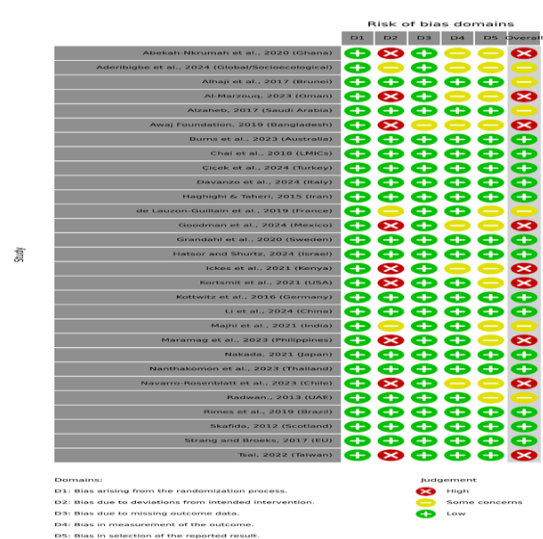


Figure 3. Tabular illustration of risk of bias (ROB) in individual studies.

Table 2: Characteristics of Included Studies

Characteristic	Findings
Total studies included	29
Databases searched	PubMed, Scopus, Web of Science
Publication period	2010–2025
Regions represented	Asia, Europe, Africa, North America, South America, Oceania, Middle East
Study designs	Cohort, Cross-sectional, Longitudinal, Qualitative, Quasi-experimental, Interrupted Time-Series, Policy Analysis, Systematic Reviews
Main outcome	Exclusive breastfeeding and breastfeeding duration among working mothers

Substantial variation in maternity leave duration and wage replacement policies was observed among the included countries. Paid maternity leave ranged from 6 weeks in Thailand,^[36] to 55.4 weeks in Sweden.^[35] Several countries, including France,^[16] India,^[18] Brazil,^[19] and China,^[23] provided 26 weeks of paid maternity leave, whereas shorter leave durations were

reported in Oman⁸ (7.1 weeks), Taiwan (8 weeks),^[6] Japan (8 weeks),^[30] Saudi Arabia (10 weeks),^[9] Israel (12 weeks),^[27] Bangladesh (13 weeks),^[32] Ghana (13 weeks),^[26] and the United States (13 weeks).^[20] Details of maternity leave policies reported in the included studies are summarized in [Table 3].

Table 3: Maternity Leave Duration and Wage Replacement Across Included Countries

Country	Year	Study Design	Sample Size	Maternity Leave Duration (Weeks)	Optional additional leave	Percentage of wages	References
France	2019	Cohort Study	8,000 mother-infant pairs	26	-	100%	Lauzon- Guillaing et al. 2019, ^[16]
Brunei	2017	Longitudinal Study	2,500 working mothers	15	-	100%	Alhaji et al. 2017, ^[17]
India	2021	Cross-Sectional Study	150 working mothers	26	-	100%	Majhi et al. 2021, ^[18]
Brazil	2019	Cross-sectional study	429 mothers	26	-	100%	Rimes et al. 2019, ^[19]
United States	2021	Cross-Sectional Study	12,301 postpartum women	13	-	100 %	Kortsmit et al. 2021, ^[20]
Australia	2022	Online Cross-Sectional Study	3026 women	20	-	National minimum wage	Burns et al. 2023, ^[21]
Bangladesh	2019	Case study	100 women	13	-	100%	Awaj Foundation. 2019, ^[22]
China	2024	Cross-Sectional Study	1292 women	26	-	100%	Li et al. 2024, ^[23]
Chile	2023	Interrupted time series analyses	Aggregated data from public healthcare users nationwide (80% of the Chilean population)	24	12 weeks	100%	Navarro - Rosenblatt et al. 2023, ^[24]

Germany	2016	Cohort Study	20,000 participants	52	2 months	67 %	Kottwitz et al. 2016, ^[25]
Ghana	2020	Qualitative study	20 working mothers	13	-	100 %	Abekah-Nkrumah et al. 2020, ^[26]
Israel	2025	Analysis of administrative data	76,194 households	12	-	100 %	Hatsor and Shurtz, 2025, ^[27]
Iran	2015	Cross-sectional	257	24	-	~66%–100% (government dependent)	Haghighi & Taheri, 2015, ^[28]
Italy	2024	a pre-intervention study	-	21	25 weeks	80 %	Davanzo et al. 2024, ^[29]
Japan	2021	Quasi-experimental design	48 (program group), 46 (pamphlet group), 47 (comparison group)	8	44 weeks	67%	Nakada 2021, ^[30]
Kenya	2020	Qualitative study	150 working mothers	14	None	100 %	Ickes et al. 2021, ^[31]
Mexico	2024	In-depth interviews	15 key informants representing government agencies (n = 6 organizations), NGOs (n = 4), international organizations (n = 2), and academia (n = 2)	12	None	100 %	Goodman et al. 2024, ^[32]
Oman	2022	Cross-sectional (Quantitative)	148	7.1 weeks (50 days as per Omani law)	52 weeks (unpaid)	100% (for 50 days)	Al-Marzouq, 2023, ^[8]
Philippines	2021	Desk review of policies and In-depth interviews	87 working mothers	15	None	100 %	Maramag et al. 2023, ^[33]
Saudi Arabia	2017	Cross-sectional (multiple)	906 working mothers	10 weeks (70 days, paid)	Up to 3 years (unpaid, public)	50–100% (varies by employer)	Alzaheb, 2017, ^[9]
Scotland	2012	Cohort Study	5,217 mothers	-	-	-	Skafida, 2012, ^[34]
Sweden	2020	Cross-Sectional Study	1626 mothers	55.4	16.0 weeks	-	Grandahl et al 2020, ^[35]
Thailand	2023	Cross-Sectional Study	110 mothers	6	6 weeks (Without pay)	50 %	Nanthakomon et al. 2023, ^[36]
Turkey	2024	Demographic and Health Surveys (TDHS)	3490 (Child-mother pairs)	16	104 weeks (Without pay)	100 %	Çiçek et al. 2024, ^[37]
Taiwan	2022	Retrospective survey	715 mothers	8	None	100 %	Tsai 2022, ^[6]
UAE	2013	Cross-sectional	587 mothers	45 days (~6.4 weeks)	None officially	100% (public), 33%–100% (private)	Radwan, 2013, ^[38]
LMICs	2018	Comparative Policy Analysis	National-level data from 38 countries	Various national policies (8-52 weeks)	-	-	Chai et al. 2018, ^[7]
EU	2017	Systematic Review & Meta-Analysis	-	Various national policies (8-52 weeks)	-	-	Strang and Broeks 2017, ^[39]
Global	2021	Systematic Review & Meta-Analysis	15 studies analysed	Various durations (6-26 weeks)	-	-	Aderibigbe et al. 2024, ^[40]

Across the included studies, longer paid maternity leave was consistently associated with improved breastfeeding outcomes and prolonged breastfeeding duration. Countries with more generous maternity

leave provisions generally reported better continuation of exclusive breastfeeding than countries offering shorter leave periods.

Evidence from Brunei demonstrated that extension of paid maternity leave from 8 weeks to 15 weeks was associated with a 12% increase in exclusive breastfeeding prevalence.^[17] A large comparative analysis involving 38 low- and middle-income countries reported that each additional month of paid maternity leave was associated with a 5.9 percentage-point increase in exclusive breastfeeding prevalence and a 2.2-month increase in overall breastfeeding duration.^[7]

Studies conducted in France (8,000 mother-infant pairs),^[16] Germany (20,000 participants),^[25] Sweden (1,626 mothers),^[35] China (1,292 women),^[23] Brazil (429 mothers),^[19] and India (150 working mothers),^[18] reported favourable breastfeeding outcomes in settings characterized by longer maternity leave provisions. In contrast, a cross-sectional study involving 12,301 postpartum women in the United States indicated that earlier return to work was associated with reduced breastfeeding continuation [Table 4].^[20]

Table 4: Key Findings Relating Maternity Leave Duration and Breastfeeding Outcomes

Study/Country	Sample Size	Key Finding
Brunei ¹⁷	2,500 working mothers	Extension of leave from 8 to 15 weeks associated with 12% increase in EBF prevalence
LMICs (38 countries) ⁷	National-level data	Each additional month of paid leave associated with 5.9 percentage-point increase in EBF and 2.2-month increase in breastfeeding duration
France ¹⁶	8,000 mother-infant pairs	Longer paid leave associated with improved breastfeeding continuation
Germany ²⁵	20,000 participants	Longer parental leave associated with breastfeeding support
Sweden ³⁵	1,626 mothers	Longer shared parental leave associated with prolonged breastfeeding duration
China ²³	1,292 women	Positive breastfeeding outcomes reported
Brazil ¹⁹	429 mothers	Positive breastfeeding outcomes reported
India ¹⁸	150 working mothers	Extended paid leave supported breastfeeding continuation
United States ²⁰	12,301 postpartum women	Earlier return to work associated with reduced breastfeeding continuation

Several studies identified workplace-related barriers that negatively affected breastfeeding continuation among employed mothers. The most consistently reported challenge was the decline in breastfeeding after mothers returned to work.

In Taiwan, although 87–90% of working mothers initiated breastfeeding during maternity leave, breastfeeding continuation after return to work declined substantially, with only 21.5% of shift workers and 24.1% of non-shift workers continuing breastfeeding between one and six months postpartum.^[6]

Additional barriers included lack of dedicated lactation facilities, absence of breastfeeding breaks, inflexible work schedules, heavy workloads, maternal fatigue, limited employer support, inadequate breastfeeding counselling, and poor awareness of breastfeeding rights and maternity entitlements. These barriers were reported across studies from Asia (Taiwan,^[6] China,^[23] Japan,^[30] Philippines,^[33] Saudi Arabia),^[9] Africa (Ghana,^[26] Kenya),^[31] the Middle East (Oman,^[8] UAE),^[38] and Latin America (Brazil,^[19] Mexico,^[32]) [Table 5].

Table 5. Workplace-Related Barriers Identified Across Included Studies

Barrier	Impact on Breastfeeding
Early return to work	Reduced breastfeeding continuation
Lack of lactation facilities	Difficulty expressing and storing breast milk
Absence of breastfeeding breaks	Reduced breastfeeding opportunities during work hours
Inflexible work schedules	Early breastfeeding cessation
Heavy workload	Reduced breastfeeding sustainability
Maternal fatigue	Negative effect on milk expression and feeding frequency
Limited employer support	Reduced breastfeeding continuation
Inadequate breastfeeding counselling	Reduced maternal confidence and persistence
Poor awareness of maternity rights	Underutilization of available support measures

Regional variation in breastfeeding practices was observed across the included studies. Studies from Middle Eastern countries including Oman,^[8] Saudi Arabia,^[9] and the United Arab Emirates,^[38] reported breastfeeding rates below global recommendations. Only 20.5% of infants in the region were reported to be exclusively breastfed for the first six months of life, while early initiation of breastfeeding was reported in 34.3% of newborns.^[38]

Globally, 96.7% of infants were reported to be exclusively breastfed immediately after birth; however, breastfeeding rates declined progressively as infants aged.^[40] These findings suggest that workplace constraints, cultural factors, and limited implementation of breastfeeding-supportive policies continue to influence breastfeeding practices among working mothers [Table 6].^[6,8,9,26,31-40]

Table 6. Regional Breastfeeding Indicators

Indicator	Finding
Exclusive breastfeeding immediately after birth	96.7%
Exclusive breastfeeding in Middle East during first 6 months	20.5%

Early initiation of breastfeeding in Middle East	34.3%
Countries reporting low breastfeeding rates	Oman, Saudi Arabia, UAE

DISCUSSION

The present systematic review highlights the important role of maternity leave policies in supporting exclusive breastfeeding among working mothers. Across diverse geographical settings and healthcare systems, the findings consistently suggest that longer and adequately compensated maternity leave facilitates breastfeeding continuation, whereas shorter leave periods and premature return to work create substantial barriers to optimal infant feeding practices. Evidence from the included studies consistently demonstrated that favourable maternity leave provisions were associated with improved breastfeeding outcomes, longer breastfeeding duration, and enhanced maternal wellbeing across diverse healthcare and socioeconomic settings.

The relationship between maternity leave and breastfeeding appears to be multifactorial. Extended leave provides mothers with sufficient time to establish breastfeeding, adapt to infant feeding demands, recover from childbirth, and develop confidence in breastfeeding practices. In addition to supporting infant nutrition, longer leave periods may reduce maternal stress and facilitate healthier adjustment to the postpartum period. The findings of this review therefore support the concept that maternity leave should be viewed not merely as an employment benefit but as an important public health intervention that promotes maternal and child wellbeing.

However, the findings also demonstrate that maternity leave duration alone is insufficient to ensure successful breastfeeding continuation. Several studies identified workplace-related constraints that persist even when maternity leave provisions are available. Tsai SY^[6], highlighted the importance of workplace environments in influencing breastfeeding behaviour after mothers return to work. Lack of dedicated lactation facilities, absence of breastfeeding breaks, inflexible work schedules, heavy workloads, maternal fatigue, and limited employer support were repeatedly identified as obstacles to sustained breastfeeding. These findings emphasize that maternity leave should be complemented by workplace policies that actively support breastfeeding continuation.

The review further highlights the important contribution of healthcare systems in promoting breastfeeding among working mothers. Adequate counselling during antenatal and postnatal periods can improve maternal knowledge, confidence, and preparedness for breastfeeding after returning to employment. Conversely, insufficient access to professional lactation support may diminish the benefits of otherwise favourable maternity leave policies. The observations reported by Sinaga MS et al^[41] reinforce the importance of evidence-based breastfeeding education and timely lactation

counselling as components of comprehensive breastfeeding support programmes.

An important observation from the included studies is the considerable variation in breastfeeding outcomes across different social, economic, and cultural settings. Countries with well-established parental leave systems frequently combine maternity leave with broader supportive measures such as workplace lactation facilities, community health services, breastfeeding promotion programmes, and family-friendly employment policies. The experiences reported by Grandahl M et al,^[35] and Davanzo et al^[29] suggest that integrated approaches combining policy support, healthcare services, and family-centred practices may provide greater benefits than maternity leave policies alone.

The findings from Middle Eastern countries deserve particular attention, as breastfeeding indicators in several countries within the region remain below international recommendations. Workplace constraints, cultural factors, inconsistent implementation of breastfeeding-supportive legislation, and limited public awareness may contribute to these suboptimal breastfeeding outcomes. The available evidence suggests that strengthening maternity protection policies and improving workplace support systems may represent important opportunities to improve breastfeeding outcomes throughout the region.

The review also highlights important differences between high-income and lower- and middle-income settings. While high-income countries often provide more structured maternity leave policies, breastfeeding outcomes remain influenced by broader social and workplace factors. Conversely, some lower- and middle-income countries may benefit from stronger family and community support networks despite having less comprehensive formal maternity protection. The observations reported by Chai Y et al^[7] suggest that maternity leave policies should be considered within the wider context of family support systems, workplace culture, gender roles, and healthcare infrastructure. Effective breastfeeding promotion therefore requires coordinated action across multiple sectors rather than reliance on maternity leave policies alone.

Beyond breastfeeding outcomes, maternity leave has broader implications for maternal wellbeing, family welfare, workplace equity, and social development. As discussed by Heymann J et al^[42] maternity protection contributes to family stability, supports women's participation in the workforce, and aligns with wider public health and social development objectives. Adequate maternity leave may therefore generate benefits that extend beyond breastfeeding by promoting healthier families, stronger communities, and more equitable employment environments.

The findings of the present review are consistent with World Health Organization recommendations advocating exclusive breastfeeding for the first six months of life. The observed association between extended maternity leave and improved breastfeeding continuation suggests that maternity protection policies may play an important role in achieving global breastfeeding targets and improving maternal and child health outcomes. A major strength of this review is the inclusion of studies from diverse geographical regions and healthcare settings, providing a broad overview of the relationship between maternity leave and breastfeeding practices among working mothers. The review incorporates evidence from multiple study designs, enabling assessment of maternity leave policies across different social, economic, and cultural contexts. Several limitations should also be acknowledged. Considerable heterogeneity existed among the included studies with respect to study design, population characteristics, maternity leave provisions, workplace environments, and breastfeeding outcomes. Differences in national legislation, healthcare systems, cultural practices, and socioeconomic conditions may independently influence breastfeeding behaviour and limit direct comparison between studies. Furthermore, most included studies were observational in nature, restricting the ability to establish causal relationships. These limitations should be considered when interpreting the findings of this review.

Recommendations

EBF is a mother's right, and working mothers shouldn't have to decide between working and taking care of their children. This involves offering flexible, all-encompassing leave policies that take into consideration different situations (e.g., premature delivery, adoption), as well as sufficient paid leave (preferably 26 weeks with 100% pay, with a minimum of 18 weeks as per ILO standards). The responsibility for paid leave should be enforced and implemented by the government. Support for breastfeeding working moms should be enforced in all governmental and private sectors, which include well-equipped and comfortable breastfeeding rooms and flexible work schedules (part-time, remote, on-site daycare, and rules allowing babies to be at work), as well as specific areas and break times for milk expression. To help people in vulnerable circumstances, governments should also think about giving families one-time compensation for each newborn baby. Mothers who are caring for severely sick newborns should receive extra care, which includes making accommodations for them to be close to their newborn infants.

Finally, the government's policy should align with the WHO breastfeeding recommendations, which recommend EBF for the first six months and continued breastfeeding for two years or longer. This should be supported by all policies pertaining to maternity leave, workplace accommodations, childcare, and flexible work schedules.

CONCLUSION

The findings of this systematic review demonstrate that longer paid maternity leave and supportive workplace policies are important determinants of successful exclusive breastfeeding among employed mothers.

For families with young children, the existing economic gaps and low earnings raise serious concerns. Governments and public health authorities across the world must create and execute a comprehensive, exclusive strategies that protect and encourage EBF in light of these convergent issues. Collective access to qualified lactation consultants, suitable paid maternity leave, workplace spaces for EBF for working mothers, and intensive support for low to middle-income families must all be included in these policies to ensure feasible and supported breastfeeding practices.

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