

**REPORT ON THE SITUATION OF
MATERNAL HEALTH AND WORK-RELATED ISSUES
IN ITALY**



April 2017

Prepared by:
IBFAN Italia

The right to health of women through the protection, promotion and support of breastfeeding

Working women that become mothers hold a double role that is not always easy to bear. Recognizing “the great contribution of women to the welfare of the family and to the development of society [...] [and] the social significance of maternity” (CEDAW Preamble) means acknowledging that it is a collective responsibility to create an **enabling environment for women to fulfil both roles of mother and worker**. Indeed, both maternity and work are means for women’s empowerment and emancipation.

Women should be given the correct information as well as the legislative and institutional support to act in their children’s best interest while continue working and being active in public life. To this end, **maternity protection** at work, and **adequate paid maternity leave** in particular, are critical interventions that States have the obligation to implement in order to realize the right of women to work, and at the same time the right to health of women and their children, allowing new mothers to rest, bond with their child and establish a sound breastfeeding routine. Therefore, working mothers are also entitled to healthy surroundings at their workplace, and more specifically, to breastfeeding breaks and to breastfeeding facilities.

Breastfeeding is an essential part of women’s reproductive cycle: it is the third link after pregnancy and childbirth. It protects mothers’ health both in the short and long term by, among others, reducing postpartum bleeding, aiding the mother’s recovery after birth (synchronization of sleep patterns, enhanced self-esteem, lower rates of post-partum depression, easier return to pre-pregnancy weight), offering the mother protection from iron deficiency anaemia, delaying the return of fertility thus providing a natural method of child spacing (the Lactational Amenorrhea Method - LAM) for millions of women that do not have access to modern form of contraception, and decreasing the incidence of osteoporosis and the risk of ovarian-, breast- and other reproductive cancers later in life. For these reasons, **promoting, protecting and supporting breastfeeding is part of the State obligation** to ensure to women appropriate services in connection with the post-natal period and more generally, realize **women’s right to health**. In addition, if a woman cannot choose to breastfeed because of external conditions, she is stripped of bodily integrity and denied the opportunity to enjoy the full potential of her body for health, procreation and sexuality. The right to breastfeed does not disappear with the fact that some women may choose alternative methods of feeding their children.

Optimal breastfeeding practices as recommended by WHO global strategy for infant and young child feeding¹ (early initiation of breastfeeding within one hour after birth, exclusive breastfeeding for 6 months followed by timely, adequate, safe and appropriate complementary feeding practices, with continued breastfeeding for up to 2 years or beyond) also provide the key building block for child survival, growth and healthy development². Enabling women to follow such recommendations means empowering them by giving them the opportunity and support to best care for their child.

Breastfeeding and human rights

Several international instruments make a strong case for protecting, promoting and supporting breastfeeding, and stipulate the right of every human being, man, woman and child, to optimal health, to the elimination of hunger and malnutrition, and to proper nutrition. These include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), in particular art. 1 and 5 on gender discrimination on the basis of the reproduction status (pregnancy and lactation), art. 12 on women’s right to health and art. 16 on marriage and family life, the International Covenant on Economic, Social and Cultural Rights (CESCR), especially art. 12 on the right to health, including sexual and reproductive health, art. 11 on the right to food and art. 6, 7 and 10 on the right to work, the Convention on the Rights of the Child (CRC), especially art. 24 on the child’s right to health. Adequately interpreted, these treaties support the claim that **‘breastfeeding is the right of both the mother and her child, and is essential to fulfil every child’s right to adequate food and the highest attainable standard of health’**. As duty-bearers, States have the obligation to create a protective and enabling environment for women to breastfeed, through protecting, promoting and supporting breastfeeding.

¹ WHO 2002, Global Strategy on Infant and Young Child Feeding,
<http://www.who.int/nutrition/publications/infantfeeding/9241562218/en/index.html>

² IBFAN, What Scientific Research Says?, <http://www.ibfan.org/issue-scientific-breastfeeding.html>

General situation concerning breastfeeding in Italy

WHO recommends: 1) **early initiation of breastfeeding** (within an hour from birth); 2) **exclusive breastfeeding** for the first 6 months; 3) **continued breastfeeding** for 2 years or beyond, together with adequate and safe complementary foods.³

Despite these recommendations, globally more than half of the newborns are not breastfed within one hour from birth, less than 40% of infants under 6 months are exclusively breastfed and only a minority of women continue breastfeeding their children until the age of two.

General data

	2013	2014	2015	2016
Annual number of birth, crude (thousands)	-	503	486	474
Neonatal mortality rate (per 1,000 live births)	2.2	2.1	2.1	-
Infant mortality rate (per 1,000 live births)	3.1	3.0	2.9	-
Under-5 mortality rate (per 1,000 live births)	3.7	3.6	3.5	-
Maternal mortality ratio (per 100,000 live births)	-	-	4 ⁴	-
<i>Delivery care coverage (%)</i> :			100%	
Skilled attendant at birth			99%	
Institutional delivery			97%	
C-section			36%	

Breastfeeding data

	2013	2015	2016
Early initiation of breastfeeding (within one hour from birth)	39%	-	-
Exclusive breastfeeding under 6 months	43%	-	-
Introduction of solid, semi-solid or soft foods (6-8 months)	73%	-	-
Bottle-feeding (0-12 months)	-	-	-
Continued breastfeeding at 2 years	-	-	-
Median duration of breastfeeding (in months)	6	-	-

National data are available from a survey on “Health conditions and use of health services” carried out by the Italian National Institute of Statistics in 2013. Results show disparities: better breastfeeding rates

³ www.who.int/topics/breastfeeding/en/

⁴ A record-linkage study carried out between 2000 and 2007 in five regions showed a 63% under-reporting of maternal deaths, leading to a MMR of 11.8, compared to the official figure of 4.4 per 100,000 (www.ncbi.nlm.nih.gov/pubmed/21392245)

and practices in the north of Italy and among women with higher education. **The national survey is supposed to be repeated every 5 years; therefore, no national data are available for subsequent years.** If previous positive trends continue, rates and practices are probably slightly better now, but gaps by region and by social class persist, as shown by available local data (not reported).

1) Maternity protection for working women

The main reason given by majority of working mothers for ceasing breastfeeding is their return to work following maternity leave. It is therefore necessary to make adjustments in the workload of mothers of young children so that they may find the time and energy to breastfeed. This should not be considered the mother's responsibility, but rather a collective responsibility. States should adopt and monitor an adequate policy of maternity protection in line with ILO Convention 183 (2000)⁵ that facilitates six months of exclusive breastfeeding for women employed in all sectors, and facilitate workplace accommodations to feed and/or to express breastmilk.

As of 2015, 47.2% of women aged between 15 and 64 years old were working.⁶

Maternity leave

Scope: Women in the formal sector. Women in the informal sector are accorded some protective measures, but much less than what women formally employed have the right to.

Duration: A total of 20 weeks with full salary, but with no extras. The maternity leave can be extended with a progressively decreasing salary up to 52 weeks.

Benefits: The benefits are paid partly by the employer and partly by the specific national insurance.

Paternity leave

Scope: Only men in the formal sector are included.

Duration: Two (compulsory) plus two (facultative) days from birth, until the age of five months.

Benefits: The four days of leave are considered as worked days.

Breastfeeding breaks

Mothers with the right to a maternity leave have the right to two 1-hour feeding breaks per working day (they can be cumulated) until the baby is one year old. These breaks are considered as working time and are paid as part of the salary.

Italy has ratified the ILO Convention 183 (2000) on Maternity Protection in 2001.

⁵ ILO, C183 - Maternity Protection Convention, 2000 (No. 183)

⁶ Source: http://www.istat.it/it/files/2016/04/Cap_3_Ra2016.pdf

2) International Code of Marketing of Breastmilk Substitutes

Evidence clearly shows that a great majority of women can breastfeed and will do so if they have the accurate and full information and support, as called for by the Convention on the Rights of the Child. However, **direct industry influence** through advertisements, information packs and contact with sales representatives, as well as indirect influence through the public health system, submerge women with **incorrect, partial and biased information**.

The International Code of Marketing of Breastmilk Substitutes (the International Code) has been adopted by the World Health Assembly in 1981. It is a **minimum global standard** aiming to protect appropriate infant and young child feeding by requiring States to regulate the marketing activities of enterprises producing and distributing breastmilk substitutes in order to avoid misinformation and undue pressure on parents to use such products when not strictly necessary. Even if many countries have adopted at least some provisions of the International Code in national legislation, the implementation and enforcement are suboptimal, and violations persist.

Evidence clearly shows that a great majority of women can breastfeed and will do so if they have the accurate and full information and support, as called for by the Convention on the Rights of the Child. However, direct industry influence through advertisements, information packs and contact with sales representatives and indirect influence through the public health system; submerge mothers with incorrect, partial and biased information that weaken women's agency in choosing how to care for their babies.

International Code of Marketing of Breastmilk Substitutes is partially implemented in Italy, as in many other member states of the European Union (EC Directive of 2006; implemented as ministerial decree n. 82/2009). There is a sanctioning mechanism for reported violations (of the ministerial decree, not of the International Code), but there is no monitoring by the government. Violations can be reported by anybody (citizens, parents, health workers, etc).

Common Code violations are: routine formula prescription at discharge from maternity units, complementary foods labelled from 4 months, ads and claims for follow-on formulae, companies sponsoring professional events (courses, conferences), promotional sales of infant formula in some shops and chains.

3) Baby Friendly Hospital Initiative (BFHI) and training of health workers

Lack of support for women to breastfeed by the health care system and its health care professionals further increase difficulties in adopting optimal breastfeeding practices. The Baby Friendly Hospital Initiative (BFHI), which consists in the implementation by hospitals of the 'Ten steps for successful breastfeeding', is a key initiative to "*ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period*"⁷, including breastfeeding support within the health care system. However as UNICEF support to this initiative has diminished in many countries, the implementation of BFHI has significantly slowed down. Revitalization of BFHI and expanding the Initiative's application to include maternity, neonatal and child health services and community-based support for lactating women and caregivers of young children represents an appropriate action to address the challenge of adequate support.

⁷ CEDAW, art. 12.2

At the end of 2016, there were 25 (out of 598 maternity hospitals, 121 of which are private) accredited Baby-Friendly Hospitals in Italy, covering slightly more than 5% of all births. There were also 6 accredited Baby Friendly Communities (local health authorities), covering a population of almost 2.5 million people. Baby Friendly Hospitals and Communities are periodically (3-5 years) reassessed. The overall quality of implementation in accredited hospitals and communities is good.

The Baby Friendly initiative is mentioned in the Ministry of Health plans, but is not supported with regular funds and/or technical support by the Ministry. It is supported in an episodic way in some regions. It is coordinated by the Italian Committee for UNICEF and by a task force of health professionals (as volunteers). Training, monitoring and evaluations are carried out in many regions and local health authorities on an ad hoc basis.

4) HIV and infant feeding

The HIV virus can be passed from mother to the infant through pregnancy, delivery and breastfeeding. The 2010 WHO Guidelines on HIV and infant feeding⁸ call on national authorities to recommend, based on the AFASS⁹ assessment of their national situation, either breastfeeding while providing antiretroviral medicines (ARVs) or avoidance of all breastfeeding. The Guidelines explain that these new recommendations do not remove a mother's right to decide regarding infant feeding and are fully consistent with respecting individual human rights.

In 2015, 3444 new HIV cases (all ages) were notified, corresponding to an incidence rate of 5.7/100,000. The AIDS cases were 789 (1.4/100,000). Cases in infants are very rare, 3-5 per year, thanks to testing and treatment of pregnant women.

The existing policy on HIV and infant feeding provides for formula feeding in cases of HIV-positive mothers, but the very limited number of cases in which the policy is applied means no effect at all on overall breastfeeding rates. Regarding the training of health personnel on this issue, there are no targeted or specialized courses on HIV and infant feeding, because it is not felt like a problem in the country.

5) Government measures to protect and promote breastfeeding

Adopted in 2002, the *Global Strategy for Infant and Young Child Feeding* defines 9 operational targets:

1. Appoint a **national breastfeeding coordinator** with appropriate authority, and establish a multisectoral **national breastfeeding committee** composed of representatives from relevant government departments, non-governmental organisations, and health professional associations.
2. Ensure that every facility providing maternity services fully practises all the “Ten steps

⁸ 2010 WHO Guidelines on HIV and infant feeding: http://whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf

⁹ Affordable, feasible, acceptable, sustainable and safe (AFASS)

to successful breastfeeding” set out in the WHO/UNICEF statement on breastfeeding and maternity services.

3. Give effect to the principles and aim of the **International Code of Marketing of Breastmilk Substitutes** and **subsequent relevant Health Assembly** resolutions in their entirety.
4. Enact imaginative **legislation protecting the breastfeeding rights of working women** and establish means for its enforcement.
5. Develop, implement, monitor and evaluate a **comprehensive policy on infant and young child feeding**, in the context of national policies and programmes for nutrition, child and reproductive health, and poverty reduction.
6. Ensure that the health and other relevant sectors **protect, promote and support** exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to the support they require – in the family, community and workplace – to achieve this goal.
7. Promote timely, adequate, safe and appropriate **complementary feeding with continued breastfeeding**.
8. Provide guidance on feeding infants and young **children in exceptionally difficult circumstances**, and on the related support required by mothers, families and other caregivers.
 - Consider what **new legislation or other suitable measures may be required**, as part of a comprehensive policy on infant and young child feeding, to give effect to the principles and aim of the International Code of Marketing of Breastmilk Substitutes and to subsequent relevant Health Assembly resolutions.

There is a national policy on breastfeeding since 2008 and the promotion and support of breastfeeding is included in national and regional plans of action. Courses for the Baby-Friendly Hospital Initiative led to an increasing number of trained health professionals, though in a rather patchy way. The number of mother-to-mother support groups is also increasing. All this is leading to improved consciousness on the importance of breastfeeding and to better practices and increasing rates, though not at the desired pace.

Despite the existence of policies and plans on breastfeeding, resources have to be allocated by regional and local health authorities, and this does not occur with regularity. **Much of the observed progress can be attributed to the commitment of some individuals and groups, not to a systematic government-led support. Protection of breastfeeding is reasonable as far as maternity protection is concerned, but weak as far as the application of the International Code is concerned.**

Neonatal, infant, child and maternal mortalities are low thanks to economic development and to universal access to health care. Specific resources for breastfeeding have never been allocated at national level, but there is some allocation at regional level. Except for the above mentioned accredited Baby Friendly Communities, there are no outreach activities related to IYCF.

The WBW is celebrated by NGOs and groups scattered all around the country. The Ministry of Health celebrates breastfeeding in a national day that does not correspond, nor is it related to the WBW.

6) Recommendations on breastfeeding by the Committee on the Rights of the Child

The **Convention on the Rights of the Child** has placed breastfeeding high on the human rights agenda. Article 24¹⁰ mentions specifically the importance of breastfeeding as part of the child's right to the highest attainable standard of health. Better breastfeeding and complementary feeding practices, the right to information for mothers and parents, the protection of parents by aggressive marketing of breastmilk substitute products – through the implementation of and compliance with the International Code of Marketing of Breastmilk Substitutes (WHO/UNICEF, 1981) - as well as the need for strong and universal maternity protection are now systematically discussed during State parties reviews by the CRC Committee.

At the last review in 2011 (Session 58), in its Concluding Observations, the CRC Committee expressed its concerns over the ***“low rate of exclusive breastfeeding for the first six months, and the practice of providing complementary foods to infants from the age of four months; [...] the unregulated marketing of food for infants, young children and adolescents, and inadequacies in the monitoring of the marketing of breast-milk substitutes.”*** (§ 49, emphasis added) For this reason, the Committee recommended Italy to ***“take action to improve the practice of exclusive breastfeeding for the first six months, through awareness-raising measures including campaigns, information and training for relevant Government officials, particularly staff working in maternity units, and parents.”*** It further recommended that ***“the State party strengthen the monitoring of existing marketing regulations relating to food for children and regulations relating to the marketing of breast-milk substitutes, including bottles and teats, and ensure that such regulations are monitored on a regular basis and action is taken against those who violate the code.”*** (§ 50, emphasis added)

The recommendations issued by the Committee have not been implemented by the Ministry of Health. The Annual Breastfeeding Awareness Day does not result in activities leading to better breastfeeding practices. Training, for undergraduate and postgraduate health professionals, is carried out almost completely without government support. And nothing has changed as far as application of the International Code is concerned.

¹⁰ “States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: [...] (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents.” Art 24.2 (e), CRC

About the International Baby Food Action Network (IBFAN)

IBFAN is a 37-year old coalition of more than 250 not-for-profit non-governmental organizations in more than 160 developing and industrialized nations. The network works for better child health and nutrition through the protection, promotion and support of breastfeeding and the elimination of irresponsible marketing of breastmilk substitutes. IBFAN is committed to the Global Strategy on Infant and Young Child Feeding (2002) – and thus to assisting governments in implementation of the International Code of Marketing of Breastmilk Substitutes (International Code) and relevant resolutions of the World Health Assembly (WHA) to the fullest extent, and to ensuring that corporations are held accountable for Code violations. In 1998, IBFAN received the Right Livelihood Award “for its committed and effective campaigning for the rights of mothers to choose to breastfeed their babies, in the full knowledge of the health benefits of breastmilk, and free from commercial pressure and misinformation with which companies promote breastmilk substitutes”.