Timor-Leste Breast-feeding Promotion Policy

Ministry of Health
Timor-Leste

10th April, 2009
List of acronyms

BFHI  Baby Friendly Hospital Initiative
CBO  Community based organisation
IBFAN  International Breastfeeding Action Network
IYCF  Infant and young child feeding
MTCT  Ministry of Tourism, Commerce and Trade
MOH  Ministry of Health
MSS  Ministry of Social Solidarity
MSG  Mothers’ Support Group (of the Alola Foundation)
NGOs  Non-Government Organisations
SAMES  Servico Autonomo de Medicamentos e Equipamentos de Saude

Definitions

*Breastmilk substitute* means any food being marketed or otherwise represented as a partial or total replacement for breastmilk, whether or not suitable for that purpose.

*Complementary foods* means foods provided from the household to children from 6-23 months of age and given in addition to breastmilk.

*Exclusive breast-feeding to six months* means breastmilk only is fed to the baby from birth to six months (no water, sugar water, or any other fluids or foods).

*Health care system* means governmental, nongovernmental or private institutions or organisations engaged, directly or indirectly, in health care for mothers, infants and pregnant women; and nurseries or childcare institutions. It also includes health workers in private practice.

*Infant formula* means a breastmilk substitute, formulated industrially in accordance with applicable Codex Alimentarius standards to satisfy the normal nutritional requirements of infants up to four to six months of age and adapted to their physiological characteristics. Infant formula may also be prepared at home, in which case it is described as "home prepared."

*Supplementary Foods* means foods provided to nutritionally vulnerable groups such as children 6-59 months and pregnant and lactating women from sources outside of the family or community.

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Executive Summary

The improvement of the nutritional health of vulnerable groups of Timor-Leste’s population is a priority area in the Timor-Leste Health Sector Strategic Plan 2008-2012.

The goal of this policy is to contribute to the reduction in neonatal and infant mortality, malnutrition and morbidity through substantially improving breastfeeding practices.

Throughout the world malnutrition is responsible, directly or indirectly, for 60% of deaths of children under five years. More than two thirds of these deaths occur during the first year of life and are linked to inappropriate feeding practices – breastfeeding and complementary feeding.

The benefits of breastfeeding for the infant, mother, family and the nation include:
- Better health and survival for breast fed infants compared with bottle-fed infants
- Initiation of breastfeeding reduces postpartum bleeding
- Exclusive breastfeeding delays the return of fertility. In Timor-Leste child spacing of less than 2 years reduces infant survival.
- Children who have been breastfed children appear to do better on tests of motor and intellectual development than non-breastfed children
- Breastfed children are likely to be less susceptible to chronic diseases (such as diabetes, heart disease, cancer) later in life
- The economic cost of using infant formula is high for the family and the nation
- Breastmilk is safe. Infant formula can be contaminated by bacteria and harmful additives.

The need for a breastfeeding policy for Timor-Leste
- Timor-Leste has a very high prevalence of malnutrition in children under five years, which contributes to a high infant mortality rate.
- Due to a combination of traditional beliefs and lack of education, a high proportion of lactating women in Timor-Leste practice sub-optimal breastfeeding practices – particularly late initiation of breastfeeding, throwing away of colostrum, and a low rate of exclusive breastfeeding to six months. Throughout the world optimal breastfeeding practices have been demonstrated to have the largest impact of any intervention on reducing infant mortality.
- Timor Leste has a high rate of malnutrition in women (wasting, stunting and anemia). This contributes to poor growth of the fetus during pregnancy and to maternal mortality. Breastfeeding women are not consuming enough food to meet the extra energy requirements of milk production.
- In general, Timor-Leste’s health personnel’s knowledge about the benefits of breastfeeding and their ability to counsel women who are experiencing problems in breastfeeding is weak.
- Many health professionals do not appreciate the fact that very few women cannot successfully breastfeed.
- Training in the benefits of breastfeeding and appropriate use of infant formula milk has been limited mainly to midwives with little follow-up reinforcement and supervision. All health professionals require training and supervision on these subjects.
- There is also misinformation about the relative risk of an HIV positive woman breastfeeding versus the risk of diarrhoea and possible infant death, if using infant formula.
There is a need to bring together clear guidelines for staff for feeding infants in “exceptionally difficult circumstances” - infants separated from their mothers, or whose mothers have died, and for whom there is no wet nurse, HIV infected mothers, or other rare medical conditions of the mother or child affecting ability to breastfeed.

It is not illegal to advertise breastmilk substitutes in Timor-Leste; advertisements for infant formula have appeared in newspapers, and infant milk is readily available in many food shops. In other countries advertising of breastmilk substitutes has led to many women believing that these products are better for their children than their own breastmilk, which has resulted in sharp rises in diarrhoeal diseases and mortality. Hence many countries have banned the advertising of these products. Timor-Leste similarly needs to ban advertising of infant formula.

Donors (small and large) have sometimes provided unsolicited infant formula to the MOH, to health facilities or individuals. This unasked for provision of infant formula has put infants at risk of diarrhoea.

To reduce child mortality and child malnutrition, improvements are needed in breastfeeding and complementary feeding practices and maternal nutrition. Much has already been put in place to improve complementary feeding.

The Nutrition Working Group has developed guidelines for complementary feeding for children 6-23 months and thirteen infant and young child feeding (IYCF) messages for health personnel, NGOs and others to use in education with mothers and communities. The Nutrition Working Group has developed and begun implementing a two year Behaviour Change Communication Strategy for Improvement in Child Nutrition. Implementing the breastfeeding promotion policy will be an important component of this behaviour change communication strategy.

For improving maternal nutrition, the MOH also has a number of services such as de-worming, vitamin A and iron folate supplementation and a supplementary feeding program for mild-moderate malnourished pregnant and lactating women. Many of the strategies in this policy will be carried out in conjunction with activities to improve complementary feeding practices and maternal nutrition.

Promoting and protecting breastfeeding in Timor-Leste requires a separate policy.

**Strategies**

1. **Building an institutional environment in Timor-Leste which promotes and supports breastfeeding**
   1) Re-formation of the national breastfeeding association to include a broad public health professional membership and registering it as an association with a clear procedures for its operation (articles of association) in order to be able to effectively oversee the implementation of this policy.
   2) Enacting of a Code of marketing of infant formula which demonstrates that the highest leaders see this as a health and development priority; prohibits advertising of infant formula, enforces health warnings on labels on infant formula
   3) Re-commence Baby Friendly Hospital accreditation and re-accreditation work at hospitals and inpatient facilities
   4) Support the MSS and others in achieving maternity leave for women working in the public and private sectors and for time out to breastfeed infants during the working day.
   5) An MOH decree regulating the acceptance, procurement and distribution of infant formula within the health sector
2. Education and training of all relevant health staff including private health service providers
   1) Development of training packages (including how to improve maternal nutrition, breastfeeding information and promotion, protocols for infants in extremely difficult circumstances)
   2) Inservices for all health facility staff with information, promotion and protocols, related to breastfeeding
   3) Inclusion of information, promotion and protocols related to breastfeeding in the pre-service of health professionals
   4) Inclusion of breastfeeding promotion and counseling in MCH-Nutrition supervision tools
   5) Training for selected health and NGO staff in breastfeeding and complementary feeding counselling

3. Protection and Promotion of Breastfeeding in the Community
   1) Provision to individuals and communities of correct and consistent information on optimal breastfeeding practices; the advantages of breastfeeding for the child, mother, family, and nation, and the dangers of bottle-feeding
   2) Promotion of breastfeeding through the use of mass media and events, such as the annual breastfeeding week in August
   3) Increase in the number of Mother Support Groups and greater use of these groups to support optimal breastfeeding practices
   4) Trained breastfeeding and complementary feeding counselors operating in all sub-districts providing direct counseling as well as technical back-up for the Mother Support Groups, other CBOs, NGOs, and health personnel
   5) Operational research on the feasibility of provision of infant formula under supervision in particular cases of need

Monitoring of the policy
Implementation of the strategies of the policy will be continuously monitored and reported on bimonthly by the National Breastfeeding Association.

Progress towards and achievement of Baby Friendly Hospital Initiative status will be an important indicator of implementation.

The responsibility for monitoring the implementation of the Timor-Leste Code of Marketing of Breastmilk Substitutes lies jointly with the Bureau of Inspection and Vigilance of the Ministry of Tourism, Commerce and Trade and with the Ministry of Health, through the National Breastfeeding Promotion Committee.

Periodic multiple indicator cluster surveys and demographic and health studies will provide information on changes in breastfeeding practices using standard breastfeeding practices indicators.
1. Introduction

1.1 The link between child mortality, child malnutrition and inappropriate infant feeding practices

Every year throughout the world 11 million children under 5 years die. Malnutrition is responsible, directly or indirectly, for 60% of these deaths. More than two thirds of these deaths occur during the first year of life and are linked to inappropriate feeding practices. Malnourished children who survive are often sick and many suffer throughout their lives from the consequences of poor physical, mental and psychological development. High rates of malnutrition, particularly among young children and women, contribute to poor health status, poor educational performance, and low productivity which affects the development of the nation as a whole.

Data from the Timor-Leste Demographic and Health Survey (DHS), 2003, show that the problem of malnutrition begins in the first year of life. Growth faltering occurs due to inappropriate (sub-optimal) infant feeding practices, both breastfeeding and complementary feeding. After a child reaches two years, it is very difficult to make up for this lost physical and mental growth and development. Therefore it is very important to prevent malnutrition during the first two years of life in particular, by promoting good breastfeeding and complementary feeding practices for both healthy and sick children.

The nutritional health of mothers and children are closely linked. In order to reduce the problem of malnutrition in children, we also need to improve the nutritional health of girls and women throughout all stages of their life cycle.

1.2 The benefits of breast-feeding for the infant, mother, family and the nation

1) The greatest and most obvious benefits are for the health and survival of the infant: Rates of diarrhea, respiratory tract infections, and otitis media are all lower in breastfed babies compared with non-breastfed infants. In the first six months, the rates are also lower for exclusively breastfed than for partially breastfed babies.

2) Initiation of breastfeeding immediately after delivery stimulates the release of oxytocin, which helps the contraction of the uterus and expulsion of the placenta and reduces postpartum bleeding.

3) Exclusive breastfeeding delays the return of fertility and hence delays the risks to maternal health of having children spaced too closely together.

In the Timor-Leste Demographic and Health Survey (2003), child spacing of less than two years was the most significant factor in reducing infant survival. It was associated with a five times increase in the risk of infant mortality.
4) Many studies confirm that children who are breastfed do better on tests of intellectual and motor development than children who are not breastfed. This is thought to be associated with the long-chain polyunsaturated fatty acids, which are found in breastmilk, and which are known to be important for brain growth and development.

5) A number of studies suggest that breastfed babies are less susceptible to chronic diseases such as allergies, obesity, diabetes, hypertension, and cancer. Treating these diseases has an enormous cost for a national health budget. (1)

6) The economic cost of using infant formulas is high - both for the family and the nation. Two nations in our region that have calculated the economic costs of not breastfeeding are Papua New Guinea at Independence (2), and Indonesia in 1982 (3). Both nations examined the cost to the individual, especially poor families, the cost of the imports to the nation, the costs associated with lost work days with mothers looking after sick children, and the extra costs to the health system of caring for illnesses, which could be attributed to poor preparation of infant formula. The Indonesian study calculated that mothers produced a billion litres of breastmilk annually. If this was replaced by commercial milk the cost at that time would have been in excess of USD400 million. Additionally, saving in health costs and reduced fertility rates related to breastfeeding were estimated to be another USD120 million.

7) The safety of breastmilk: Infant formula can be contaminated by a bacterium called Enterobacter sakazkii. This bacterium has caused outbreaks of sepsis, meningitis or necrotizing enterocolitis, leading to severe ongoing complications and sometimes death for newborns. (4). In September 2008, some infant milks produced in China were found to contain the poison melamime, which had been added to increase the quantity of nitrogen in the milk. This resulted in death in a few cases and in severe illness for many thousands of Chinese infants. (5)

1.3 Improving complementary feeding and maternal nutrition

To reduce child mortality and child malnutrition, improvements are needed in breastfeeding and complementary feeding practices and maternal nutrition. Improving infant and young child feeding practices begins with improving the nutritional health of women throughout all stages of their life cycle.

The Nutrition Working Group has developed guidelines for complementary feeding for children 6-23 months and thirteen infant and young child feeding (IYCF) messages for health personnel, NGOs and others to use in education with mothers and communities. These thirteen messages cover both breastfeeding and complementary feeding. The Nutrition Working Group has developed and begun implementing a two year Behaviour Change Communication Strategy for Improvement in Child Nutrition (6). Implementing the breastfeeding promotion policy will be an important component of this behaviour change communication strategy.

The MOH also has a number of other services aimed at improving infant and maternal nutrition, such as vitamin A and iron folate supplementation and a supplementary feeding program for pregnant and lactating women and children 6-59 months. The MOH has begun a program for...
the treatment of severe acute malnutrition in the community. For all of these interventions, guidelines and training have been provided to health personnel and NGO partners.

Promoting and protecting breastfeeding in Timor-Leste requires a separate policy. Many of the strategies in this policy will be carried out in conjunction with activities to improve complementary feeding practices and maternal nutrition.

1.4 The Health Sector Strategic Plan 2008-2012 and the Breastfeeding Promotion Policy

The Health Sector Strategic Plan 2008-2012 (7) provides the framework to guide efforts of the Ministry of Health and its partners in improving the health of the people of Timor-Leste. Nutritional improvement is accorded a high priority in the plan. The nutrition objective in the plan is to: *Implement a range of appropriate interventions that will improve the nutritional status of all citizens in Timor-Leste, in particular vulnerable population sub-group.*

There are five strategies under this objective. These are to:

1) Raise awareness of the seriousness of the nation’s major nutritional health problems and their consequences and recommend potential solutions at international and national levels, across government agencies, NGO, UN agencies, other development partners, the media, and most importantly, with communities and families
2) Implement appropriate nutrition services (as part of the Basic Package of Health Services) to help to prevent low birth weight and promote optimal infant and young child feeding practices
3) Engage with communities in the development of locally appropriate activities and caring behaviours that help to prevent low birth weight and promote optimal infant and young child feeding practices
4) Improve the nutritional status of pregnant and lactating women (including the reduction of iron deficiency anaemia, Vitamin A deficiency,) and of women of reproductive age generally
5) Improve food security

The effective implementation of this Breastfeeding Promotion Policy will contribute significantly to the realization of strategies 1-3.

Soon after the 4th Constitutional Government came into being, the Ministry of Health introduced a new program; *Servisu Integradu Saude iha Communitaria – SISCa* (8), which aims to make integrated prevention and curative health services more accessible to the most vulnerable members of the population. Nutritional improvement is one of the five priority areas of this program. SISCa offers the opportunity to provide clear, consistent, and accurate information and education on the benefits for mother, child and the nation of optimal breastfeeding practices.

1.5 The process of development of the Breastfeeding Promotion Policy

The Alola Foundation, a non-government organisation, was established in 2002, with a focus on improving maternal and child health. It commenced the National Breastfeeding Association (*Klibur Susubeen Inan Nian ba Kosok Oan*) in February 2003, to promote exclusive
breastfeeding in order to help reduce infant mortality. A Memorandum of Understanding was signed between the Ministry of Health and the Alola Foundation, authorising the NBFA to carry out breastfeeding promotion activities on behalf of the Ministry. The NBFA has carried out a number of trainings for health professionals, established Mothers’ Support Groups in many sub-districts, and conducted advocacy events and community education programs.

In 2006, one of the staff of Alola, Dr Quintao carried out a literature review drawing on experiences in several other developing countries to improve the low rate of exclusive breastfeeding. The review recommended:

- The development of a Code of Marketing of Breastmilk Substitutes for Timor-Leste
- Improving the quality of training and supervision of health service providers on the advantages of breastfeeding and how to successfully breastfeed
- Use of peer counseling: breastfeeding women supporting other breastfeeding women, to breastfeed successfully. (9)

Following this study, the Nutrition Working Group, which is convened by the Nutrition Department of the MOH and comprises UN and NGO members working on food and nutrition improvement, began to draft a *Code of Marketing of Breastmilk Substitutes*. However, the Code alone cannot address all of the issues relating to poor breastfeeding practices, which are described in section 2 below. Hence there was a need to develop a comprehensive breastfeeding policy. The policy was developed over a period of 14 months from March 2008, building on the work previously undertaken by the Alola Foundation and the MOH and the research of Dr Quintao. The draft was reviewed extensively by the Breastfeeding Promotion Committee, MCH, Health Promotion and Planning and Policy Departments, and the wider Nutrition Working Group. The Ministries of Tourism, Commerce and Trade and Social Solidarity were also consulted.

The National Breastfeeding Association has achieved much, and is needed to continue its advocacy and community education work, but with its present structure and membership, it cannot implement this policy. The association needs to be re-formed to include a broad public health professional membership and to become registered as an association with a clear procedures for its operation (articles of association) in order to be able to effectively oversee the implementation of this policy.

2. Situational analysis: The Need for a Breastfeeding Promotion Policy

2.1 Infant malnutrition in Timor-Leste

The nutritional status of both children and adults in Timor-Leste remains far below acceptable world standards. The National Nutritional Strategy, 2004 (10) notes that a combination of poverty, low employment, limited education, poor infant feeding practices, widespread food insecurity and poor hygiene and sanitation, inadequate family attention to childhood illnesses, poor maternal health, and high fertility rates (particularly for teenage women) has led to under-nutrition rates for young children that are among the highest in the world. In the region, malnutrition is estimated to contribute to over half of all under five deaths\(^1\). Findings of the

\(^1\) The infant mortality rate in Timor-Leste is estimated at 60 per 1,000 live births and the under five mortality rate at 83 per 1,000 live births in the Demographic and Health Survey, 2003.

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Timor-Leste Demographic and Health Survey (DHS), 2003 (11), and more recent surveys (12) highlight the enormity of the problem of malnutrition in young children and women in particular. For children under 5 years old:

- Almost 50% are underweight for their age
- Almost 50% of children are stunted (short for their age) – chronic malnutrition
- Almost 30% are severely stunted – severe chronic malnutrition
- Approximately 15% are wasted (thin) – moderate acute malnutrition, and
- 3% are very wasted, severe acute malnutrition

2.2 Interventions which reduce infant and child mortality

The MOH of Timor-Leste has an evidence-based approach to policy development and program implementation. In early 2008, *The Lancet*, published a list of interventions that have been shown to produce the greatest impact in reducing infant and child mortality (13). These measures are:

1) Improved food intake during pregnancy. This reduces low birth weight by about 32%.
2) **Giving of colostrum and exclusive, adequate breastfeeding to 6 months significantly reduces infant mortality**
3) Adequate complementary feeding results in an increase of 1-3 cms in length at 18 months.
4) Appropriate management of severe malnutrition through timely referral to a facility and good care there, and through appropriate, timely treatment of severe malnutrition (where there are no complications) in the community
5) 6 monthly supplementation with vitamin A reduces infant mortality rate (by 22% if at least 2 doses are received).
6) Use of zinc reduces diarrhea and stunting.
7) Universal consumption of iodized salt reduces the prevalence of iodine deficiency disorders by about 41%.
8) Maternal iron supplementation reduces anemia and maternal death.
9) De-worming, hand-washing and improved hygiene reduce diarrhoea, stunting and the infant mortality rate.

As part of its Basic Package of Services, the MOH of Timor-Leste is striving to increase the coverage of interventions #4, 5, 6, 8 and 9 at health facilities and through outreach services at mobile clinics and at Servisu Saude Integradiu iha Communidade (SISCa). The universal iodisation of salt is in the MOH’s workplan for 2009. Interventions #1-3 are necessarily more difficult because they require behaviour changes in women and families, improved knowledge about infant and young child feeding practices of health personnel, and, importantly, improved interpersonal skills of health staff.

2.3 Sub-optimal Infant and young child feeding practices in Timor-Leste

While most babies (97%) in Timor-Leste have been breast-fed for at least some period of time – “ever breastfed” (14), many breast-feeding practices in Timor-Leste are sub-optimal. There are several indicators which are used to assess breast-feeding practices. Selected indicators and their rate in Timor-Leste in 2003 are in Table 1 below.
Table 1: Indicators of breastfeeding practices in Timor-Leste 2003 Demographic and Health Study

<table>
<thead>
<tr>
<th>Breast-feeding indicators for children 0 – 23 months</th>
<th>Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Early initiation: baby put to the breast within an hour of birth</td>
<td>46</td>
</tr>
<tr>
<td>2. Exclusive breast-feeding to six months: breastmilk only is fed to the baby from birth to six months (no water, sugar water, or any other fluids or foods)</td>
<td>31</td>
</tr>
<tr>
<td>3. Continued breast-feeding to one year</td>
<td>72</td>
</tr>
<tr>
<td>4. Continued breast-feeding to two years</td>
<td>33</td>
</tr>
<tr>
<td>5. Timely introduction of complementary foods</td>
<td>82(^2)</td>
</tr>
<tr>
<td>6. Bottle-feeding <em>(Urban: 20%, Rural West, 5%, Rural Central, 12% and Rural East, 12%)</em></td>
<td>13</td>
</tr>
</tbody>
</table>

Adapted from: Dibley et al., 2007

Early initiation and exclusive breast-feeding indicators (1 and 2 in Table 1) were poor at 46% and 31% respectively.

Bottle-feeding\(^3\) rates of 20% in urban and 12% in rural central and rural west are of great concern. Breastmilk is nutritionally superior to formula milk and, importantly, it is safe. In Timor-Leste, with poor water supplies and sanitation, even in urban areas, the use of infant formulas poses a high risk to babies of contracting diarrhea through unhygienic preparation and storage.

Additionally, as noted above, the use of infant formulas has a high cost for the individual family and the nation. In other countries this high cost has led to infant formula being diluted to make it last longer and hence resulting in the baby receiving less nutrients. It is likely that this also happens in Timor-Leste.

It is a common traditional practice in Timor-Leste not to give colostrum as it is believed to be unclean or harmful. Instead babies are often given water and sugar during the first week of life to cleanse the intestines, with the belief that this practice will prevent jaundice. This advice comes not just from relatives and friends but may also come from health workers.(9) Apart from denying the infant the nutrients in colostrum, this practice exposes the baby to unsafe water.

There are other widespread beliefs and practices contributing to poor breastfeeding practices. These include lactating women feeling they do not have enough milk; that a woman should not continue breastfeeding if she has become pregnant as it will harm the foetus; the belief that infants need other fluids or solids before six months because the baby is growing fast and the breastmilk will not be sufficient.(9)

Very often women who have cracked nipples, engorgement or mastitis report that there is no assistance available at community level to assist them with these problems (15).

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\(^2\) While the timing of introducing complementary foods is reasonably high, simple observation reveals that the quality and quantity of foods provided and the frequency of feeding them is very inadequate.

\(^3\) “Bottle-feeding” includes all the practices from using bottles occasionally, bottle-feeding with breast-feeding to bottle-feeding only.
2.4 Maternal malnutrition and maternal mortality

The 2003 DHS revealed that 38% of non-pregnant women had a low Body Mass Index indicating chronic energy deficiency. One third of pregnant and lactating women were anemic and 13% of women of reproductive age had short stature (less than 145 cms), a risk factor for difficult delivery and delivering a low birth weight baby. Poor nutritional status contributes to maternal mortality rate (MMR) which is very high in Timor-Leste. Using the MMR and projected births, an estimated 275 women may die in child birth each year. This is a terrible loss of life. Further, the newborn is left without a mother and access to breastmilk.

2.5 The need to improve health personnel's knowledge and practices

a. Inadequate health professional knowledge and promotion of breastfeeding

There has been a number of usually one-off training for health staff, mainly for midwives, concerning the benefits of breast-feeding and the potential dangers of using formula milks. However, this topic is not firmly in the pre-service curriculum of all health staff in Timor-Leste. It needs to be. Additionally, there has been very little follow-up of such trainings. The 2003 Demographic and Health Survey found initiation of breastfeeding within the first hour was significantly lower in births that took place in a health facility and births assisted by health professionals. Hence there is a need to ensure that health staff have the knowledge and motivation to assist women to initiate breastfeeding within the first hour.

Along with training, supportive supervision of staff at health facilities is essential for improvement in all health services. Over a three year period exclusive breastfeeding for children 0-5 months of age rose from 29% to 68% in districts in which Health Alliance International has been providing supportive supervision to health facility staff for antenatal and neonatal care. (16)

Health staff need to be knowledgeable about breastfeeding – for example how to stimulate greater production, through the baby’s frequent sucking, and the importance of breastfeeding women eating more because their energy and other nutrient requirements are much higher than that of a non-lactating woman.

b. Inappropriate giving of therapeutic milks to take home

There have been instances of health staff providing F75 and F100 (specially fortified milks for malnourished children) to parents to take home to give to their malnourished children. The Timor Leste protocol for the inpatient treatment of children with malnutrition warns against this practice. All health facility staff need to be aware of the policy and its basis and provide therapeutic milks only under supervision at health facilities.

c. Inappropriate provision of infant formulas to malnourished children:

There have also been instances of health staff providing infant formula to moderately malnourished children, using funds provided by a community-based organization, and CBOs directly providing milk powder to mothers to take home for their malnourished children. This is a highly dangerous practice for two reasons: these commercial preparations are unsuitable for

4 The Maternal Mortality Rate in Timor-Leste was estimated at 660-680/100,000 (DHS, 2003).
malnourished children, and there is the added real danger of the milk being mixed with contaminated water or to the wrong strength – too weak or too strong. The health staff may have felt that they had no alternative if there was no government-supported supplementary feeding program available at their health facility. Health staff may feel they are not doing enough if they only provide advice on good infant and young child feeding practices, and not any food. However, the infant formula or milk powder is likely to do more harm than good, and health staff need to know this and not carry out this harmful practice.

d. **Lack of guidelines on when it is appropriate for health professionals to provide infant formula to infants**

Almost all babies can be successfully breastfed. A very small number may require short-term feeding of infant formulas or donated breastmilk, and fewer still may require feeding by these means for up to six months or more.

The need to use a substitute for the mother’s own breastmilk may be due to:
- the baby being very sick, or born prematurely
- the mother having certain illnesses or conditions, or being separated from her child for lengthy periods of time
- the mother having died.

There are very few medical reasons why a mother cannot breastfeed, and most of these cannot be diagnosed in Timor Leste. As noted above the maternal mortality ratio is very high in Timor-Leste. If there is no lactating woman who is willing to breastfeed a baby whose mother has died as well as breastfeed her own child, then the caregiver needs access to a regular supply of infant formula. The caregiver needs to be shown how to prepare the formula to the correct strength, using good hygiene and using a cup and spoon.

Staff at health facilities are not sure under what circumstance and how they may safely provide commercial infant formula to caregivers. Anecdotal evidence suggests that some babies whose mother has died are being fed sub-optimally on infant formula substitutes because their caregiver cannot afford to buy sufficient quantities of infant formula. Health staff need to know that in such situations they can order infant formula from SAMES. When a baby requires long-term feeding on infant formula, there needs to be a mechanism in place to provide the caregiver with sufficient supplies of formula until the child is 6 months old and regular monitoring by trained personnel on its correct and safe preparation and use. This may not necessarily be a health provider but could be a person trained in this area.

### 2.6 Breastfeeding and HIVAIDS: misinformation about relative risks

Timor-Leste has a low prevalence of HIV (0.3% in the general population\(^5\)), and the outlook for keeping this prevalence rate low is good if the MOH and partners are able to carry out an effective HIV education program.

Both the general community and health personnel in Timor-Leste, have many misperceptions about the risk of an HIV-positive mother infecting her baby.

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\(^5\) Personal communication from the HIVAIDS section of the Communicable Diseases Department, MOH
About a third of HIV-positive women may pass the virus to their babies either during pregnancy or during childbirth. In addition some babies may become infected through breastfeeding. The risk of receiving HIV through breastmilk increases with the duration of breastfeeding and is around 15% if the child is breastfed to two years and there is no intervention put in place to prevent HIV transmission. If the child is exclusively breastfed to six months only, the transmission rate will be much less. These facts show that the majority of HIV-positive women do not pass on the virus through their breastmilk, but there is still a substantial risk of infection and it is not possible to predict which baby may become infected (17).

This risk needs to be compared with the risk of death if a child is fed infant formula. For example, a study in Brazil showed a mortality rate at 2 months of 23% for infants fed formula milk and 1% for breastfed infants. In such situations, the risk of dying through the use of infant formula is far greater than the risk of death to a child being exclusively breastfed by an HIV-positive mother. (18) Evidence shows that there is no difference in the numbers of infants who have HIV mothers, and who do not have HIV at seven months, between infants who were breastfed exclusively and those who were fed infant formula from birth. (13)

Timor-Leste women who are diagnosed with HIV need to be counseled and provided with correct, clear information on the risks of transmission, the risks of using infant formula, and their options, so that the woman herself can make an informed choice.

For most HIV-positive women in Timor-Leste the best option will be to breastfeed only to six months, and to breastfeed exclusively. It is very important not to give anything other than breastmilk, as giving other foods or drinks increases the risk of mother-to-child transmission. A second feeding option is for a non-HIV-positive lactating woman to breastfeed both her own child and the child of the HIV-positive woman. A third option is to give the baby, infant formula, but ONLY if it is acceptable, affordable, feasible, sustainable and safe.

This policy endorses the WHO HIV and Infant Feeding Technical Consultation Consensus statement (19), of which the key points are in Annex 1.

2.8 Donor practices: inappropriate and un-asked for donations of infant formula

a. Bilateral and multilateral un-asked for donations of breastmilk substitutes

Since the vote on the referendum in 1999, Timor-Leste has had a series of crises resulting in displacement of people, with up to 150,000 living in camp conditions at the peak of disturbances. The world community has responded with a range of assistance, including, on occasion, the provision of unsolicited breastmilk substitutes. Several general misconceptions have led to donors sending unasked for donations of breast-milk substitutes. These include a perception that stress will “dry up” breastmilk, that malnourished mothers cannot breastfeed, and that breastfeeding cannot be resumed after the mother has stopped for a period of time. To counter such misconceptions, in 2006 the Nutrition Working Group developed guidelines on Infant and Young Child Feeding in emergencies (20), including guidelines on breast-feeding.

The UN has also responded to the misinformation amongst donors on this subject and has included the following clauses in its statement on the supply of foodstuffs in emergencies (21):

UNHCR will not accept unsolicited donations of breastmilk substitutes, bottles and teats and commercial ‘baby’ foods …….. UNHCR will work with the co-ordinating agency to limit the risks of unsolicited donations that end up in circulation in refugee settings.
UNHCR will actively discourage the inappropriate distribution and use of breastmilk substitutes (BMS) in refugee settings. UNHCR will uphold and promote the provisions of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA resolutions.

b. As noted above (2.5b) there have been instances in the past two years in Timor Leste of community-based organisations with good intentions providing infant formula or money for its purchase, either through government health facilities or in the community to mothers of malnourished children.

c. The MOH has a Guideline for Donations of Drugs, Consumables, Equipment and Assets to the Democratic Republic of East Timor, June 2003. (22) Under A1, this guideline states:

\[
\text{All donations should be based on an expressed need and be relevant to the disease and treatment pattern in the Democratic Republic of East Timor. Except for a call for supplies in acute emergency situations, declared by the Government of East Timor, supplies should not be sent without prior clearance by the East Timor authorities.}
\]

This clause needs strengthening. In emergency situations, the MOH should still authorise what supplies arrive and are then distributed. The policy should be clear on this and have a mechanism to enforce the policy.

2.8 Advertising by commercial companies selling infant formula

In many countries of the world, commercial companies that produce infant formula have used advertising campaigns to induce women to believe that infant formulas are better for their children than breastmilk. In many countries in Africa in the 1970’s, this practice had a very deleterious effect, directly contributing to sharp rises in infant morbidity and mortality. (23) The development by member countries of the World Health Assembly of The International Code of Marketing of Breastmilk Substitutes was a direct response to this serious problem. To date in Timor-Leste, there has not been a large-scale marketing campaign by commercial infant feeding companies, although breastmilk substitutes are readily available in food shops. Under Timor-Leste law it is not illegal to advertise infant formula, and there have been instances of advertisements in local newspapers.

Under the Code, advertising is not permitted. The Code does not prevent supplies of infant formula and other infant foods being available in shops but does prohibit any form of advertising, and prohibits the promotion of infant formula through health facilities.

The Code also stipulates that certain parts of the label are in the local language so that consumers know what they are buying, the dangers of using infant formula if proper care is not taken in preparing it, and how to prepare and use the product safely.
Most infant formula arrive in Timor-Leste from Indonesia with labeling in Bahasa Indonesia. Usually they carry no health warning since Indonesia has not passed the Code of Marketing of Breastmilk Substitutes, although it does have some regulation of the marketing of these products.

**Problem analysis of factors contributing to sub-optimal breastfeeding practices in Timor-Leste**

- Low rates of breastfeeding initiation
- Colostrum commonly discarded
- Low rates of exclusive breastfeeding to six months
- Time of each breastfeeding session usually too short
- Potential for increasing use of infant milk formula and bottles
- Insufficient support for women encountering problems with breastfeeding
- Insufficient assistance to infants in especially difficult circumstances related to breastfeeding

**Traditional beliefs and practices and lack of knowledge of the advantages of breastmilk over infant formula**

**Service providers (government, NGO, CBO) without sufficient knowledge, training, motivation and resources to promote and support breastfeeding**

**Unsupportive Institutional Environment**
- Insufficient awareness at high levels within government of the problem
- Lack of an effective national body to coordinate efforts
- No laws stopping advertising of infant milk formula
- Donors and others sometimes providing infant milk
- Lack of clear guidelines to support nutritional needs of infants in exceptionally difficult circumstances

**Conclusion**

*In order to resolve all of the above issues, a comprehensive policy is required that promotes breastfeeding throughout the healthcare system and in the community and which provides clear guidance on the circumstances under which infant formula can be provided for infants by government health facilities and private health providers.*
3. Goal, Objectives and Purpose of the Policy

Goal

The goal of this policy is to contribute to the reduction in neonatal and infant mortality and morbidity through improving substantially breastfeeding practices.

Objectives are to significantly increase

1) the percentage of babies receiving their first breastfeed as soon as possible after birth and preferably within one hour of delivery.

2) The percentage of babies receiving colostrum during the first days

3) The percentage of women practicing exclusive breastfeeding for the first six months

4) The percentage of women who are providing complementary food and continuing breastfeeding up to two years and beyond, and

5) Provision of appropriate and timely advice and support from health staff or trained community workers for

   (i) lactating women experiencing problems with breastfeeding

   (ii) mothers or carers of babies, 0-6 months old, who are in exceptionally difficult circumstances, such as:

       a. a mother and infant who have been temporarily separated
       b. an infant’s mother has died and there is no wet nurse available
       c. a mother is HIV positive, or
       d. there are other medical reasons to do with the mother or the baby, which prevent breastfeeding

Purpose

In order to achieve the goal and objectives above, the purpose of the policy is to guide the work of persons and organizations dedicated to promoting safe and adequate nutrition for Timor-Leste infants, by providing:

   o a framework with clear strategies addressing the issues raised in the situational analysis
   o an explanation of how the strategies will be implemented – what activities will be carried out, within what timeframe, and the roles and responsibilities of the various agencies or organisations
   o how implementation will be monitored and how activities will be coordinated amongst the many implementers.
4. Policy Statement and Strategies

Policy statement

Numerous social and economic factors affect breastfeeding. The MOH will work with other ministries, in particular the Ministries of Social Solidary and Tourism, Commerce and Trade, to create an environment that encourages breastfeeding, provides appropriate family and community support, and protects mothers from factors that discourage breastfeeding.

Health care systems, and the health professionals and other health workers serving in them, have essential roles to play in guiding infant feeding practices, encouraging and facilitating breastfeeding, and providing objective and consistent advice to mothers and families about the superior value of breastfeeding or, where needed, on the proper use of infant formula, whether manufactured commercially or prepared at home.

The MOH will ensure that all relevant health staff -- doctors, midwives and nurses at health facilities; Maternal and Child Health, Nutrition, Health Promotion, Non-Communicable Diseases and Environmental Health staff of Community Health Services; and, all district health team staff -- are provided with objective and consistent information at pre-service, inservice and on-the-job, on the superiority of breastfeeding, the correct use of therapeutic milks and infant formula, and protocols for feeding infants in exceptionally difficult circumstances.

The MOH will ensure that its hospitals comply with the Baby Friendly Hospital Initiative (BFHI) requirements. Considerable progress has been made at both the national hospital and Baucau to achieve an environment that is supportive of breastfeeding in line with the WHO/UNICEF Baby Friendly Hospital Initiative.

The MOH will ensure that members of the public receive clear and consistent information on breastfeeding and the potential dangers of using breastmilk substitutes.

Harmful traditional practices which interfere with the breastfeeding promotion are passed from generation to generation and are deeply rooted within the community; therefore this issue must be addressed in intervention strategies.

Mothers should have access to skilled support provided by trained health workers to initiate and sustain appropriate infant and young child feeding practices and to prevent or overcome possible difficulties. Community-based networks offering mother-to-mother support, and trained infant and young child feeding counselors working within or closely with the health care system also have an important role to play in this regard.

Families, communities, the educational system, women’s organisations and other non-governmental organisations have a special role to play in the protection and promotion of breastfeeding and in ensuring the support needed by pregnant women and mothers of infants and young children, whether breastfeeding or not.
Strategy 1: Create an environment in Timor-Leste which promotes, supports and protects breastfeeding.

**Strategy 1.1 Re-formation of the National Breastfeeding Association (NBFA) such that it includes a representative from each of the following organisations:**

- Nurses Association
- Midwives Association
- Medical Association
- The Nutrition Department
- The Alola Foundation
- Institute of Health Sciences
- A doctor, midwife or nurse from the Paediatric Department of Guido Valadares National Hospital involved in the Baby Friendly Hospital Initiative
- Office for the Promotion of Equal Opportunity
- An NGO dealing with infant nutrition or childcare
- WHO and UNICEF

The Nutrition Department with assistance from the Alola Foundation will develop articles of association and obtain official registration of the association.

The Minister of Health or his delegate, will appoint a Chairperson and Secretary, who will be responsible for ensuring that bimonthly meetings are held, with minutes written and provided in a timely way to all members.

The NBFA will act as the focal point and coordinator for activities to be undertaken by the health care system under the Code and the Breastfeeding Promotion policy, including implementation of the *Baby Friendly Hospital Initiative*.

A suitably qualified staff of the Alola Foundation should be seconded to the Nutrition Department of the MOH to act as a secretariat for the NBFA. The role of this staff will include coordination of the development and delivery of training packages.

Within six months of the Code becoming law the National Breastfeeding Association should present to the Minister of Health a plan for implementing the Code throughout the health care system, with a focus on the education of all health professionals on their responsibilities under the Policy and the Code.

The Association will report at least six monthly to the Minister on the implementation of the Code, and in a timely way bring to the attention of the Minister any serious breaches of the Code.

**Strategy 1.2: Presentation of the Timor-Leste Code of Marketing of Breastmilk Substitutes** to the Council of Ministers for enactment, by the Minister of Health and the Minister of Tourism, Commerce and Trade.

The Code will:

a) Direct nursing and medical staff to use their training (in component 1) to provide correct and consistent advice to individual and groups of ante-natal women and mothers of infants on breastfeeding and, when necessary, the correct and safe use of infant formula.
b) Prohibit the promotion of infant formula at health facilities

c) Ensure that the public is not subjected to advertising which promotes infant formula, by prohibiting such advertisements

d) Ensure that infant formula sold in Timor-Leste carry a statement in Bahasa Indonesian or Tetun on the superiority of breastfeeding, that the product should be used only on the advice of a doctor and used properly, and that it carries instructions for appropriate preparation and a warning against the dangers to health of inappropriate preparation.

The Draft Code of Marketing of Infant Formula for presentation to the Council of Ministers is at Annex 2.

**Strategy 1.3: Ensure that all health facilities become or remain baby-friendly.**

Annex 3 provides a summary of the 10 requirements for achieving a hospital environment supportive of breastfeeding. Considerable work has already been carried out on the BFHI in Dili and Baucau hospitals. Guidelines for how to achieve BFHI status are available in Tetun and several health professionals and Alola staff are able to carry out BFHI training and assessment and will lead this activity.

The national hospital, Baucau, and all other referral hospitals in Timor-Leste will achieve accreditation or re-accreditation of Baby Friendly Hospital Initiative status within 18 months of this policy being authorized and will maintain this status.

**Strategy 1.4. Legislation for maternity leave and time for working women to breastfeed**

Provision of adequate maternity leave and time each day on return to work is required to enable working women to breastfeed their babies at least twice during work hours. The Ministry of Social Solidarity is the lead ministry on this and is currently examining maternity leave conditions and workplace arrangements that allow working women to achieve exclusive breastfeeding for 6 months. The MSS is consulting with the MOH, the Office for the Promotion of Equal Opportunity, local and international NGOs, the Chamber of Commerce and receiving advice from the International Labour Organisation. It is expected that the MSS will make recommendations to the Public Service Commission and Chamber of Commerce on this matter within 12 months.

**Strategy 1.5: Ensure that guidelines on acceptance, procurement and distribution of infant formula and therapeutic milks are explained to relevant staff and are implemented**

i. This guideline will be explained in inservice and preservice training and as needed during supervisory visits to health facilities

ii. The director-general of SAMES will ensure that relevant staff at SAMES understand and comply with the guidelines.

iii. Relevant staff of UN, NGO, CBO partners and friendship organizations working in the health sector in Timor-Leste will be oriented on the guidelines via the members of the National Breastfeeding Association.

These guidelines are at Annex 4.
Strategy 2: Strengthen the capacity of health workers to provide breast feeding promotion services

**Strategy 2.1 Development of information and training packages**
Training packages suitable for inservice and preservice training, will be produced by the National Breastfeeding Association. Annex 5 provides an outline of the content of the information package. Packages will be tailored to the needs of different health professionals.

**Strategy 2.2 Development and implementation of an inservice training plan**
The NBFA will develop a training plan for implementation over the next 18 months, so that all of the above-mentioned staff are trained and provided with the guidelines and relevant medical protocols.

**Strategy 2.3 Development and implementation of a pre-service training plan**
The Institute of Health Sciences with assistance from the Nutrition Department and other members of the NBFA will develop breastfeeding information and promotion materials in pre-service courses and plan for introduction into these courses.

**Strategy 2.4 Inclusion of breastfeeding promotion and advice in supervision tools**
Nutrition and MCH Departments (all units) will include breastfeeding promotion, protocols and counseling into supportive supervision and monitoring tools. Supervisors will provide feedback and ongoing support to health personnel improve their performance in this area.

**Strategy 2.5 Training for breastfeeding and complementary feeding counseling and monitoring**
IYCF and master trainers will be provided with resources to enable them to provide direct counseling services to lactating women in need of support who have been identified by health staff. Master trainers will be used to train more IYCF counselors and advanced training to Mother Support Groups. At present the numbers of these counselors and trainers are limited to approximately 20 people. Training materials from IBFAN are already available in Tetun. Within three years the aim should be to have one counselor per sub-district, i.e. a total of 65.

Strategy 3: Promotion of optimal breastfeeding practices in the community

**Strategy 3.1 Promotion in communities of the breastfeeding messages**
Health personnel, Family Health Promotors, MSGs, and other NGOs will include the IYCF messages in relevant activities in the community

**Strategy 3.2 Promotion through the mass media, National Breastfeeding Week and other events**
As part of the Nutrition Communication Strategy radio and TV spots are being developed for promoting improved infant and young child feeding practices including breastfeeding. National Breastfeeding week will continue to be used as an opportunity to reach both leaders and community members to promote the importance of optimal breastfeeding practices.
**Strategy 3.3  Expansion and greater use of Mother Support Groups**

The number of these groups will be increased and they will be provided with further training, resources and supervision to expand their outreach.

Health staff will be encouraged to refer to Mother Support Groups women with infant and young child feeding (IYCF) problems, including breastfeeding problems, mastitis, engorgement, etc., including infants, who after assessment by a midwife or a doctor are assessed to have a legitimate need for infant formula. Members will be trained in how to provide advice and regular support to the caregivers in the safe and correct preparation and giving of the formula to the infant.

In those sub-districts where there are no Mother Support Group members or IYCF counselors, health personnel are encouraged to train volunteers, members of NGOs and CBOs to provide correct and clear advice and ongoing support for breastfeeding.

**Strategy 3.4  Trained breastfeeding and complementary feeding counselors in each sub-district**

Refer to 2.5 above. These staff would provide direct counseling services and support and assist in the supervision of the work of those members of MSGs who have been trained to provide counseling.

**Strategy 3.5  Operational research**

Carry out operational research to investigate:
- Survival and health outcome for infants whose mothers have died in 2008
- the feasibility of the government providing infant milk formula for infants 0-6 months who have been deemed by a midwife or doctor to need milk formula.

A research plan needs to be developed and carried out. The research would identify the benefits, costs and risks, and a mechanism for funding infant formula, the logistics of supplying, supervising and monitoring the use of the infant formula over the time during which it is provided. This research could be commissioned jointly by the MOH and the MSS.
Conceptual framework for the Timor-Leste Breastfeeding Promotion Policy

Objectives

- Improved breastfeeding practices
  - Initiation of breastfeeding within one hour
  - Giving of colostrum
  - Exclusive breastfeeding to six months
  - Breastfeeding to 2 years or beyond with complementary feeding

- Reduction in malnutrition in infants
  - Reduction in infant morbidity
  - Reduction in infant mortality
  - Reduction in chronic diseases later in life
  - Improvement in maternal nutrition

Strategies

**Supportive Environment**
- 1.1 Re-formation of national breastfeeding association
- 1.2 Code (law) of marketing infant formula
  - Prohibiting advertising infant milk formula
  - Enforcing labelling with health warnings on infant formula
  - Council of Ministers' support
- 1.3 Baby Friendly Hospital Initiative in all hospitals and inpatient health facilities
- 1.4 Maternity leave and time during working hours to breastfeed
- 1.5 MOH regulation on procurement, acceptance and distribution of infant formula

**Training**
- 2.1 Development of Training packages (to include protocols for infants in extremely difficult circumstances)
  - 2.2 Inservices
  - 2.3 Presservices
- 2.4 Supportive supervision and monitoring
- 2.5 Counselling training and monitoring

**Promotion in communities and counselling services**
- 3.1 Promotion in communities
- 3.2 Promotion through mass media and events
- 3.3 Expansion of and greater use of Mother support groups
- 3.4 Trained counsellors for lactating women and carers of infants in exceptionally difficult circumstances
- 3.5 Operational research: feasibility of provision of infant milk with supervision in certain cases
5. Institutional arrangements and responsibilities under the policy

5.1. Implementation of the Code of marketing of infant forumula throughout the health care system

The Code of Marketing of Infant formula has been developed by the Nutrition Department and Nutrition Working Group after reviewing similar codes from other countries, and in consultation with the Bureau of Vigilance of the Ministry of. The Code will be jointly presented by the Minister of Tourism, Commerce and Trade and the Minister of Health to the Council of Ministers for approval as law.

The Minister of Health delegates authority for implementing the Code throughout the health care system to the Timor-Leste National Breastfeeding Association (NBFA).

Within the MOH the following departments and institutes will work together to develop and help deliver preservice and inservice education packages for the various health professional groups:

- Department of Nutrition
- Department of Maternal and Child Health
- Department of Health Promotion
- Institute of Health Sciences

Members of the Nutrition Working Group and Child Health Group are to be provided with the training packages, and in turn will ensure that NGOs, relevant community-based organizations and friendship groups are made aware of the policy, protocols, and training packages and are encouraged to promote breastfeeding through community education programs.

The Alola Foundation is recognised as having specialist expertise and community peer group networks (Mothers Support Groups) that can be utilized to provide individual support to mothers, who are breastfeeding or who, for medical reasons, may need to use infant formula, or to carers of infants whose mothers have died. The Alola Foundation will be encouraged to provide regular support and follow-up to these groups so that they can function effectively.

IYCF counselors and master trainers will also be used as referral points for mothers in need of counseling and to train health professionals, including doctors in IYCF optimal practices.

5.2. Medical Protocol for the prescribing of infant formula in Timor-Leste

The Timor-Leste Medical Association, Child Health Group of the MOH and the Director of the Cuban Brigade are tasked with ensuring that all doctors practicing in Timor-Leste are familiar with this protocol. The Nurses and Midwives Associations and MCH Department are tasked with ensuring that all nurses practicing in Timor-Leste are familiar with the protocol and know when to refer an infant to a doctor for assessment of medical need for infant formula.
5.3. Ministerial decree on donations, acceptance procurement, distribution, and use of infant formula

The Nutrition and MCH Departments and SAMES are tasked with ensuring that all their staff are familiar with the guidelines. The chief of district health services are tasked with ensuring that district health teams are fully briefed on the decree and in turn brief staff of the health facilities under their supervision on the guidelines.

UNICEF and WHO will be responsible for ensuring dissemination of the decree throughout the UN system and monitoring UN compliance.

5.4 Responsibilities of NGOs and CBOs and friendship groups working in the health sector

They are responsible for:
- implementing guidelines and adhering to the decree in this policy
- providing clear and consistent information to communities on breastfeeding and the potential dangers of using infant formula
- Ensuring that no infant formula is given to carers to take home
6. Monitoring and Evaluation

Implementation of the strategies of the policy will be continuously monitored and reported on bimonthly by the National Breastfeeding Association.

Progress towards and achievement of Baby Friendly Hospital Initiative status will be an important indicator of implementation.

The responsibility for monitoring the implementation of the *Timor-Leste Code of Marketing of Breastmilk Substitutes* lies jointly with the Bureau of Inspection and Vigilance of the Ministry of , Tourism, Commerce and Trade and with the Ministry of Health, through the National Breastfeeding Promotion Committee.

Periodic multiple indicator cluster surveys and demographic and health studies will provide information on changes in breastfeeding practices using standard breastfeeding practices indicators (24).

**Table 6.1: Evaluation of attainment of objectives (practices)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition/Targets</th>
<th>Frequency of collection</th>
<th>Possible sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early initiation of breastfeeding</td>
<td>Percentage of infants breastfed within one hour of birth</td>
<td>3-5 yearly</td>
<td>DHS MICs</td>
</tr>
<tr>
<td>Proportion of infants less than 6 months who received colostrums</td>
<td>Percentage of infants 0-6 months who received colostrum</td>
<td>3-5 yearly</td>
<td>DHS MICs</td>
</tr>
<tr>
<td>Proportion of infants less than 6 months who are exclusively breastfed</td>
<td>Number of infants less than 6 months who are exclusively breastfed in the last 24 hours/ Number of infants less than 6 months of age</td>
<td>3-5 yearly</td>
<td>DHS MICs</td>
</tr>
<tr>
<td>Proportion of infants 6-9 months of age who are receiving breast milk and complementary foods</td>
<td>Infants 6-9 months of age who are receiving breast milk and complementary foods/ Infants 6-9 months of age</td>
<td>3-5 yearly</td>
<td>DHS MICs</td>
</tr>
<tr>
<td>Continued breastfeeding for up to 2 years</td>
<td>Children 6-23 months who were breastfed in the last 24 hours/ Children 6-23 months of age</td>
<td>3-5 yearly</td>
<td>DHS MICs</td>
</tr>
<tr>
<td>Bottle feeding rate</td>
<td>Children &lt;12 months of age who were bottle fed in the last 24 hours/ Children &lt;12 months</td>
<td>3-5 yearly</td>
<td>DHS MICs</td>
</tr>
</tbody>
</table>
### Table 6.2: Table of indicators for monitoring of implementation of strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Indicator</th>
<th>How verified</th>
<th>Frequency of collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Re-formation of the NBFA</td>
<td>Approved by Minister Members and Chair appointed</td>
<td>Is meeting: observation and minutes</td>
<td>Bi-monthly</td>
</tr>
<tr>
<td>1.2 Code of marketing of infant formula</td>
<td>Code is enacted by Council of Ministers Implementation and enforcement</td>
<td>Formal signing Surveys of shops, media advertisements</td>
<td>Once Bi-monthly</td>
</tr>
<tr>
<td>1.3 All TL hospitals and inpatient facilities are accredited as Baby Friendly</td>
<td>There is already in Tetun all the documentation for accrediting and re-accrediting facilities as Baby Friendly</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>1.4 Maternity Leave a condition of service for government staff; and government and private sector provide time off during working day for breastfeeding</td>
<td>Maternity leave and breastfeeding time is legislated Government depts. And private sector comply</td>
<td>Law Survey</td>
<td>Once Twice per year</td>
</tr>
<tr>
<td>1.5 MOH Decree on procurement, acceptance and use of infant formula</td>
<td>Decree issued by minister Decree included in inservice and pre-service training package Decree distributed to NGOs and CBOs working in health sector Non-complying organizations sent a warning letter by NBFA</td>
<td>Decree Observation at trainings Organizations receive and read Copy of letter</td>
<td>Once Ongoing Ongoing Ongoing</td>
</tr>
<tr>
<td>2.1 Development of training packages for different types of health personnel</td>
<td>Existence of the packages</td>
<td>Copy of the packages</td>
<td>Once</td>
</tr>
<tr>
<td>2.2 Inservices for all health facility staff</td>
<td>Use in training courses</td>
<td>Observation</td>
<td>ongoing</td>
</tr>
<tr>
<td>2.3 Breastfeeding information and promotion inserted into pre-service training for health personnel</td>
<td>Topics developed</td>
<td>Observation</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Strategy</td>
<td>Indicator</td>
<td>How verified</td>
<td>Frequency of collection</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>2.4 Breastfeeding information, promotion, counseling inserted into supervision tools</td>
<td>Topics are in tools</td>
<td>Check tools</td>
<td>Once, Ongoing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Check supervision</td>
<td></td>
</tr>
<tr>
<td>2.5 Training for counseling in breastfeeding and complementary feeding</td>
<td>Courses developed and implemented</td>
<td>Observation Feed-back</td>
<td>ongoing</td>
</tr>
<tr>
<td>3.1 Promotion of breastfeeding in communities</td>
<td>Home visits Group Sessions conducted</td>
<td>Observation Reports</td>
<td>ongoing</td>
</tr>
<tr>
<td>3.2 Promotion and advocacy through events and mass media</td>
<td>Print materials, radio and TV spots, dramas, songs Events</td>
<td>Observation Feed-back</td>
<td>ongoing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>from public</td>
<td></td>
</tr>
</tbody>
</table>
| 3.3 Expansion of and greater use of Mother Support Groups               | Number of groups and members Types and frequency of breastfeeding related activities | Observation Supervision Reports Feed-back from health personnel and individuals | ongoing |}
| 3.4 Trained counselors providing services in all sub-districts          | Counselling sessions provided                                             | Reports Feed-back from users | ongoing                 |
| 3.5 Operational research: feasibility of provision by government of infant formula in special circumstances | Research plan developed, implemented, findings discussed within MOH and MSS and decisions made | Plan Report of finding   | Once                    |
References

5. INFOSAN, September, 2008, Melamine Alert No. 5.
8. MOH, 2007, Sistema Integrado Saude iha Communidade (SISCa): Guidelines for implementation
11. MOH, Timor-Leste, 2003, Demographic and Health Study
14. Dibley, M., Senarath, U., Agho, K., 2007, Infant and Young Child Feeding Practices and Factors affecting these practices in East Asia: A review of Demographic and Health Survey (DHS) and Multiple Indicator Country Survey (MICs) and selected National Nutrition Survey data
22. MOH, 2003, SAMES, Revised guidelines for donations of drugs, consumables, equipment and assets to the Democratic Republic of East Timor
23. War on Want, 1974, The Baby Killer
Annex 1: Summary Consensus Statement on HIV and breastfeeding

The most appropriate infant feeding option for an HIV-infected mother should continue to depend on her individual circumstances, including her health status and the local situation, but should take greater consideration of the health services available and the counseling support she is likely to receive.

Exclusive breastfeeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe for them and their infants before that time.

When replacement feeding is acceptable, feasible affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended.

At six months, if replacement feeding is still not acceptable, feasible, affordable, sustainable and safe, continuation of breastfeeding with additional complementary foods is recommended, while the mother and baby continue to be regularly assessed. All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.

Whatever the feeding decision, health services should follow-up all HIV-exposed infants, and continue to offer infant feeding counseling and support, particularly at key points when feeding decisions may be reconsidered, such as the time of early infant diagnosis and at six months of age.

Breastfeeding mothers of infants and young children who are known to be HIV-infected should be strongly encouraged to continue breastfeeding.

Annex 2: Summary of the main provisions of the Timor-Leste Code of Marketing of Infant Formula

PURSUANT TO Section 18, which guarantees to our children special protection by families, communities and by the State, and the enjoyment of universally recognised rights, as well as all those rights that are enshrined in international conventions, such as the Convention of the Rights of the Child, which has been ratified by the Government of Timor-Leste;

AND Section 53 which affirms that consumers have the right to truthful information and protection of their health, safety and economic interests; and that advertising shall be regulated by law, and indirect or misleading advertising are prohibited;

CONSCIOUS that breastfeeding is the best way of providing ideal food for the healthy growth and development of infants; that it forms a unique biological and emotional basis for the health of both mother and child; that the anti-infective properties of breast milk help to protect infants against disease;

RECOGNISING the vulnerability of infants in the first months of life, that Timor-Leste has a high prevalence of malnutrition in infants and young children, that inappropriate feeding practices are an important contributor to infant malnutrition, morbidity and mortality in Timor-Leste; and that elsewhere in the world improper practices in the marketing of breastmilk substitutes and related products have contributed to infant malnutrition, and wanting to prevent that happening in Timor-Leste;

The Code seeks to encourage and protect breastfeeding and to control inappropriate marketing practices used to promote products for artificial feeding.

The Code applies to artificial milks for babies, other products used to feed babies, especially when they are marketed for use in a feeding bottle, and to feeding bottles and teats.

The Code includes these ten important provisions:

1) No advertising of any of these products to the public
2) No free samples to mothers
3) No promotion of products in health care facilities
4) No company nurses to advise mothers
5) No gifts or personal samples to health workers
6) No words or pictures idealizing artificial feeding, including pictures of infants on the labels of the products
7) Information to health workers should be scientific and factual
8) All information on artificial feeding, including the labels, should explain the benefits of breastfeeding, and the costs and dangers associated with artificial feeding
9) Unsuitable products such as sweetened condensed milk, should not be promoted for babies
10) All products should be of a high quality and take account of the climatic and storage conditions of the country where they are used.
Annex 3: Baby Friendly Hospital Initiative: *The ten steps to successful breastfeeding*

Step 1: Have a written Policy that is routinely communicated to all healthcare staff
Step 2: Train all healthcare staff in the skills necessary to implement the breastfeeding Policy
Step 3: Inform all pregnant women about the benefits and management of breastfeeding
Step 4: Help mothers initiate breastfeeding soon after birth
Step 5: Show mothers how to breastfeed and how to maintain lactation, even if they should be separated from their infants
Step 6: Give newborn infants no food or drink other than breast-milk, unless medically indicated
Step 7: Practice rooming-in to allow mothers and infants to remain together 24 hours a day
Step 8: Encourage breastfeeding on demand
Step 9: Give no artificial teats or dummies to breastfeeding infants
Step 10: Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital
Annex 4: MOH Decree on donations, acceptance, procurement, distribution, monitoring of stocks and appropriate use of therapeutic milk and infant formula

Donations and procurement
1. Donations of therapeutic milks or breastmilk substitutes will not be accepted by the GoTL unless specifically requested by the MOH with authorisation by the Director of Community Health services or his supervisors.
2. Where donations are made without a request from the MOH, they will be returned at the sender’s expense or destroyed.
3. Where donations are made from any donor at the request of the MOH, and purchased outside of the SAMES system, an invoice must be provided with the cost, full information of quantities, expected time of arrival in country, confirmation of arrival and copies of arrival advice, to SAMES, to be entered onto their stock control program, and such information should also be provided to the Nutrition Department.
4. All donations must comply with SAMES labeling requirements: the label must be in English, and include manufacturer’s name and address, batch number, and have an expiry date of a minimum of one year.
5. The donor shall also be responsible for clearing the goods with customs and delivering the goods to SAMES, and for the cost of storage and distribution.
6. Annually, the Nutrition Department will estimate requirements at inpatient health facilities for therapeutic milks, and the MOH’s requirement for infant formula, prepare a budget, and place an order with SAMES or UNICEF (in the case of therapeutic milks), and advise SAMES of which budget to charge.

Provision of Monitoring reports to the Nutrition Department
7. SAMES will provide monthly monitoring information on the supplies of therapeutic milks and infant milk formula that have been distributed, supplies on hand and supplies expected in the next quarter.

Storage, preparation and appropriate use of therapeutic milks and infant formula
8. The manager of each inpatient health facility or the senior hospital nutritionist/senior paediatric nurse will ensure that therapeutic milks are stored and prepared correctly, will place orders with SAMES so that supplies are adequate to patient needs. He/she will also ensure that therapeutic milks are not provided for take home use.
9. Decisions concerning the use of infant formula for short or longer term will be based on a doctor’s decision using the Medical Protocol for prescribing infant formula in Timor-Leste at Annex 6.
10. Infants identified in the community as in need of infant formula should be assessed immediately by a doctor using the protocol. If assessed as needing infant formula, the nearest health facility should immediately order an appropriate quantity of infant formula from SAMES and arrange pick-up of the order in a timely way.
11. Whether an infant is identified in a health facility or in the community and assessed by a doctor as being in need of infant formula, health personnel must ensure the
caregiver receives, at no cost, an adequate supply of the infant formula for the length of time determined by the doctor.

12. Referral hospitals and District Health Services should keep a small emergency supply of infant formula on hand based upon needs.

13. Before providing a caregiver with a supply of infant formula, health personnel must ensure that the caregiver is able to correctly and safely prepare and feed the child with it. The health personnel is also responsible for monitoring the use of the infant formula through home visits. Where the health personnel cannot himself/herself do this, he/she must ensure that a suitably trained volunteer, mother’s support group member, or other appropriate person does this, especially in the early days of using infant formula.

14. Implementation of this component of the policy will be monitored in an ongoing way and reported on quarterly by the Nutrition Department.
Annex 5: Outline of the content of the information package for health personnel

- The benefits and superiority of breastfeeding, including as an aid to contraception
- Common myths and misperceptions
- The breastfeeding messages #1-5 of the nutrition messages
- Problems caused by using infant formula as well as breastfeeding
- The financial cost of using breastmilk substitutes
- How to help a woman re-commence lactation
- Maternal nutrition (extra nutrient and fluid needs) and the preparation for and maintenance of breastfeeding. The importance of taking nutritional supplements: iron folate, vitamin A or micronutrient sprinkles
- Common difficulties in breastfeeding and how to resolve them
- Breastfeeding and HIV/AIDS
- Summary of the Protocol for the prescribing of breastmilk substitutes in Timor-Leste for non-medical staff; full protocol for doctors
- The guideline on Donations, acceptance, procurement, distribution, and appropriate use of therapeutic milks and breastmilk substitutes
Annex 6: Protocol for the prescribing of infant formula in Timor-Leste

Introduction
Exclusive breastfeeding is a key child survival intervention. In resource-poor countries, feeding newborns and infants with breastmilk substitutes instead of breastmilk has been associated with greatly increased incidence of morbidity (diarrhea and other infectious diseases) and increased infant mortality.

It is not uncommon for mothers to stop breastfeeding their infants for reasons that are not justified from a health perspective. Both mothers and health staff are sometimes misinformed. The decision to stop breastfeeding may have devastating consequences for the baby.

Almost all babies can be fully breastfed. A very small number require short-term feeding by other means, and fewer still require a longer-term feeding alternative. This protocol provides a list of situations when breastfeeding may not be possible or recommended. In most of these situations the indication is temporary, and exclusive breastfeeding should be re-commenced as soon as the condition or situation is resolved.

When infant formula substitute is prescribed, the health staff must give the mother clear instructions on safe preparation and feeding of the milk. She must be made aware of the dangers associated with incorrect preparation of the milk and also of the dangers of bottle feeding. She should be taught and encouraged to cup-feed her baby.

Definitions for the purposes of this protocol

Breastmilk substitute means any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not suitable for that purpose.

Infant formula means a breastmilk substitute formulated industrially in accordance with applicable Codex Alimentarius standards, to satisfy the normal nutritional requirements of infants up to four to six months of age, and adapted to their physiological characteristics. Infant formula may also be prepared at home, in which case it is described as "home prepared."

A wet nurse is a lactating woman, other than the mother, who is able to fully breastfeed the baby as if it were her own. A wet nurse may be currently feeding her own child or may have recently ceased breastfeeding her own child. As breastmilk is produced in proportion to demand (sucking), a woman can produce sufficient milk to fully feed two babies. It is best if a wet nurse is a family member or is known to the family. She must be healthy and well nourished. Encourage her to extra food and a variety of foods and to drink plenty of fluids.
<table>
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<tr>
<th>Indication</th>
<th>Recommended action</th>
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<tr>
<td>Mother has died</td>
<td>1) Wet-nurse or 2) Infant formula fed by cup and spoon</td>
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<tr>
<td>Mother is temporarily separated from infant due to illness or logistical reasons</td>
<td>1) Mother expresses milk and sends the expressed milk to the baby (refrigerate or freeze en route) to feed by cup and spoon or 2) Mother expresses milk to maintain production and baby is fed breastmilk substitute by cup and spoon, or breastfed by a wet nurse, until baby is reunited with mother.</td>
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<tr>
<td>Mother is taking medications that may be transmitted through the milk with harmful consequences for the baby (anti-metabolites, chemotherapy drugs)</td>
<td>1) Consider whether alternative medications can be given to the mother (check WHO list). 2) If there is no alternative medication, stop breastfeeding for the duration of the therapy. Mother should express and discard her milk. Expressing maintains her milk production. And 3) Temporarily use breastmilk substitute and give by cup and spoon, or wet nurse. 4) Restart breastfeeding as soon as it is safe to do so (wait how many days?? for the medication metabolites to be cleared from the mother’s body after the medication is ceased).</td>
</tr>
<tr>
<td>Mother has severe malnutrition (Body Mass Index less than 16)</td>
<td>1) Ensure mother receives correct nutritional supplementation (food supplement: energy, protein, vitamins) and medical care as needed. 2) Ensure baby’s growth is assessed and treat malnutrition if present as per protocol. 3) CONTINUE TO BREASTFEED the baby 4) Baby may need to receive milk supplementation from wet nurse or a breastmilk substitute until the mother’s nutritional status is normalized and her milk supply increased.</td>
</tr>
<tr>
<td>Mother is very ill - heart failure, serious kidney liver or lung disease</td>
<td>1) If possible, assist the mother to express milk??????? 2) If expressed milk is unavailable for the baby, then temporarily feed with breastmilk substitute (give with a cup and spoon) or breastmilk from a wet nurse. 3) The mother may need additional support to re-establish her milk supply when she is well again.</td>
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<td>Mother has psychosis or severe post-natal depression</td>
<td>1) The safety of the baby needs to be assessed (psychiatric assessment) – does the baby need to be separated from the mother or does the mother need to be supervised when together with her baby. 2) If mother is on medications these may affect feeding – see above. 3) Baby can be breastfed if mother is not on medications that may affect the baby and if it is considered safe for her to do so.</td>
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### Mother has an infectious disease

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| Breast abscess                                         | 1) Do not feed from the affected breast but drain it by expressing.  
2) Treat the mother by draining the abscess and administering antibiotics.  
3) Continue to feed the baby from the other breast.  
4) Restart feeding from the affected breast once the abscess is drained and antibiotics are started. |
| Herpes simplex lesions on the breast                   | 1) Do not feed from the affected breast until the lesions have completely cleared.  
2) Continue to feed from other breast.  
3) Ensure that the mother uses strict infection prevention to prevent contamination of the baby from the affected skin on the affected breast.  
4) Cover breast lesions                                   |
| HIV/AIDS                                               | 1) Mother and family must receive counseling for mother-to-child transmission.  
2) Give replacement breastmilk substitute ONLY if it is acceptable, affordable, feasible, sustainable and safe.  
3) Otherwise, support exclusive breastfeeding for the first 6 months.  
4) Do not give mixed feeding as this increases the risk of mother-to-child transmission. |
| Varicella zoster                                        | 1) Do not breastfeed until the mother is non-infectious. Express and discard the mother’s milk during this time.  
2) Feed the baby with breastmilk substitute or donated milk (by cup) or wet nurse until the mother is non-infectious. |

### Conditions which are NOT contraindications to breastfeeding

- Maternal tuberculosis (unless the mother is actively unwell and has not yet started treatment) – even if only discovered at birth, treat mother, INH, give BCG vaccination to baby and breastfeed
- Mastitis (continue feeding while mother takes antibiotics – if sucking is too painful then express)
- Hepatitis B or C (vaccinate the baby)
- Fever (unless cause as per above) e.g. Urine tract infection
- CMV positive (unless baby is very low birth weight; in this situation you need to consider the relative risks of infection vs the risks of not breastfeeding)
- Twin births
- Inverted nipples (assist mother to improve attachment using inverted syringe technique)
- Another pregnancy
## Baby reasons that may interfere with breastfeeding

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| Baby is very sick                                                        | 1) Depending on the baby’s condition, feeds may need to be temporarily withheld (use IV fluids) or the baby may be too sick to feed at the breast (abdominal condition, respiratory distress, neurological depression)  
2) Mother to express milk  
3) Give expressed milk by spoon, cup or tube until the baby is recovered and can breastfeed. |
| Baby has oral abnormalities (e.g. cleft lip and palate) that interfere with sucking | 1) Carefully assess whether baby can safely feed at the breast (risk of aspiration); babies with only cleft lip can usually breastfeed – mothers may learn to improve seal on the breast by closing off the defect with their breast. Some babies with cleft palate can also breastfeed. Babies with extensive cleft lip / palate can be fed expressed milk with spoon, cup or syringe. The technique is to safely deliver the milk to the back of the pharynx. Special teats or bottles (designed to close or cover the palatal defect) can also be used but using bottles requires extreme emphasis on sterility.  
2) The baby must receive close follow-up to ensure weight gain is satisfactory as surgery will only be done if the baby’s nutritional status is good.  
3) Babies with cleft lip are usually repaired at ~ 3 months and with cleft palate at ~ 1 year. Breastfeeding can be commenced following surgery. |
| Very low birthweight (<1500g) or very preterm (<32weeks)                  | 1) Sustain maternal milk production by expressing breastmilk.  
2) Give the expressed milk by tube or cup / spoon until the baby is mature enough and strong enough to breastfeed.  
3) Provide additional nutrition with donor milk or breastmilk substitute if needed for growth. Fortification of the expressed milk with fat / carbohydrate is an alternative to using breastmilk substitutes. If the baby is preterm, using infant formula (rather than breastmilk) increases the risk of necrotizing enterocolitis. |
| Baby is at risk of hypoglycaemia or is dehydrated and enough breastmilk is not immediately available | 1) Treat according to hypoglycaemia protocol – level of blood sugar dictates whether baby should receive intravenous dextrose or enteral feed.  
2) If insufficient breastmilk is available feed with donated breastmilk, a wet nurse or breastmilk substitute (by cup) until the risk of hypoglycaemia is resolved and / or maternal milk is available. |

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**Risk of hypoglycaemia** - Small for gestational age, preterm, infant of diabetic mother, macrosomic baby (>4kg), asphyxia, severe haemolysis, sick baby (sepsis) on intravenous fluids, hypothermia
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| Infants who have severe malnutrition and who still receive some breastmilk | 1) Babies with malnutrition should be supplemented with diluted F100 or breastmilk substitute (see protocol on the inpatient treatment of malnutrition) until their nutritional status is improving and breastmilk is sufficient to sustain and maintain adequate growth.  
2) Breastfeeding must be continued throughout the rehabilitation and techniques such as ‘supplemental sucking’ may be needed to improve supply.  
3) Treat maternal malnutrition if present.                                                                                                                                 |
| Breastmilk jaundice                                                       | 1) If this diagnosis is seriously considered AND the bilirubin is in harmful range, temporarily stop breastfeeding (mother continues to express) and substitute with milk formula to confirm the diagnosis. IF bilirubin drops significantly when the baby is not drinking breastmilk then this is proof of the diagnosis. If bilirubin does not drop significantly, restart breastfeeding and consider alternative reasons for jaundice.  
2) Breastmilk jaundice does not affect the baby in a harmful way. Recommence breastfeeding and monitor the jaundice.                                                                                                                                 |
| Baby has had recent surgery                                               | 1) Mother should express milk whilst baby is unable to be fed.  
2) As soon as feeds are to be started give expressed milk by tube or breastfeeding the baby, depending on surgeon's instructions.                                                                                                                                 |
| Rare metabolic diseases eg galactosaemia and phenylketonuria              | 1) These babies require special milks. Babies with galactosaemia require lactose free milk (consider soy milk). Babies with phenylketonuria may be fed breastmilk if levels of phenylalanine are monitored and they subsequently require low-phenylalanine formula (note it is not currently possible to measure phenylalanine levels in Timor).  
2) As these special formulas are currently unavailable in Timor-Leste, special advice must be sought.                                                                                                                                 |

**Currently most of these conditions cannot be diagnosed in Timor-Leste.**

**References**

1) Annex 4 of the BFHI Hospital self-appraisal: *Acceptable medical reasons for supplementation.*


3) Report of a Joint WHO/Unicef consultation concerning *Infants who have to be fed on breastmilk substitutes* WHO/MCH/NUT/86.1
