THE COMMITTEE ON THE RIGHTS OF THE CHILD

70th Session / September 2015

REPORT ON THE SITUATION OF INFANT AND YOUNG CHILD FEEDING IN TIMOR-LESTE

Submitted in August 2015

Data sourced from:
WBTi assessment 2014
http://www.worldbreastfeedingtrends.org/GenerateReports/countrysubmit.php?country=TL

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SUMMARY

*The following **obstacles/problems** have been identified:*

- Low rate of skilled attendant at birth (29.3%);
- Almost 7 children out of 10 are not breastfed until 2 years of age;
- Only 17.6% of children, between 6-23 months, are receiving timely and appropriate complementary food;
- The national guidelines for infant and young child feeding (IYCF) are not available and there is a lack of systematic monitoring of breastfeeding indicators;
- Need for more trained breastfeeding counsellors in health facilities;
- There is no comprehensive national IEC strategy for improving IYCF;
- The International Code of Marketing of Breastmilk Substitutes is not being implemented. There are no adequate mechanisms currently working neither an operational guideline to enforce the implementation of the BMS Code;
- Lack of a monitoring body devoted to breastfeeding;
- Low number of hospitals that are currently certified as baby-friendly;
- The duration of the maternity leave is insufficient and it is not allowed breastfeeding breaks;
- There is no specific programme on IYCF and HIV/AIDS;
- No emergency preparedness plan ensuring the protection and support of breastfeeding and IYCF guidelines.

***Our recommendations** include:*

- **Develop a breastfeeding programme** aimed at raising the breastfeeding rates and monitor breastfeeding key indicators on a regular and systematic basis;
- **Develop IYCF guidelines** in line with the revised National Nutritional Strategy 2014-2019 and **established the IYCF Committee**;
- **Develop comprehensive national Information, Education and Communication (IEC) strategy** for improving the recording and reporting of IYCF indicators;
- **Increase the number of trained breastfeeding counsellors in health facilities**, including training on HIV/AIDS and IYCF;
- **The International Code of Marketing and Breastmilk Substitutes needs to be finalized and fully implemented**;
- **Increase the number of Baby-Friendly certified health facilities** and comply with the 20 hours training for health professionals;
- **Extend the duration of the maternity leave and include the allocation of breastfeeding breaks** for working mothers, providing health protection for pregnant and breastfeeding mothers in the current legislation;
- **Develop an emergency preparedness plan ensuring the protection and support of breastfeeding** in cases of emergency and designate a reference person to coordinate activities.

1) General points concerning reporting to the CRC

In September 2015, the CRC Committee will review Timor-Leste's combined 2nd and 3rd periodic report.

At the last review in 2008 (session 47), the CRC Committee specifically referred to breastfeeding in its Concluding Observations. In particular, the Committee recommended Timor-Leste to *"(a) design a health policy based on a community structure to **ensure that mothers and children in all areas of the country have access to quality primary health care**, counselling and essential medicines; (b) ensure that appropriate resources are allocated for the health sector and develop and implement comprehensive policies and programmes for improving the health situation of children; (c) continue to **take measures to reduce infant and under-5 mortality**, inter alia, by guaranteeing access to quality pre- and post-natal health services and facilities**, including training programmes of midwives and traditional birth attendants**; (d) strengthen efforts to improve the nutritional status of children, on the basis of the national nutrition strategy, through education and promotion of healthy feeding practices, including through **promoting breastfeeding as an unequalled way of providing ideal food for the health, growth and development of children, in line with the International Code of Marketing of Breast-milk Substitutes."*** (§ 59, emphasis added)

2) Recommendations issued by the CEDAW Committee

In 2009 (session 44), the CEDAW Committee addressed maternal health and pre- and postnatal care in its Concluding Observations. Specifically, the Committee urged Timor-Leste to *"step up its efforts to **reduce the high rate of maternal and infant mortality**"* and *"make every effort to raise the awareness of, and increase women's access to, health-care facilities and **medical assistance by trained personnel**, especially in rural areas and **in the area of post-natal care in particular**."* (§ 38, emphasis added)

3) General situation concerning breastfeeding in Timor-Leste

General data

Childhood mortality levels are decreasing in Timor-Leste. During 2011, the infant mortality rate was 50 deaths per 1,000 live births compared with the deaths for 2012 and 2013, 48 and 46 deaths respectively per 1,000 live births.

Under-5 mortality levels also decreased from 59 deaths per 1,000 live births to 55 between 2011 and 2013. However, Timor-Leste is one of countries in the Asia-Pacific region with alarming nutritional situation. The Timor-Leste Food and Nutrition Survey 2013 (TLFNS 2013) reveal that 50.2% of children under-five are stunted, about 37.7% of them are underweight and around 11% of children are malnourished.[1]

[1]Data referring to the year 2013 were retrieved from the World Breastfeeding Trends Initiative (WBTi) Report 2014, available at: http://www.worldbreastfeedingtrends.org/GenerateReports/report/WBTi-Timor-Leste-2014.pdf, p. 5.

The WHO's 2002 Global Strategy for Infant and Young Child Feeding, stated that some of these deaths are often associated with inappropriate feeding practices during the first year of life. In Timor-Leste the underlying causes of malnutrition, poor feeding and caring practices are predominant. However, according to the TLFNS 2013, the percentage of children from 6 to 23 months old, who have received minimum acceptable diet, is equivalent to 17.6%.[2]

	2011	2012	2013	2014
Annual number of birth, crude (thousands)[3]	35.9	35.9	41	-
Neonatal mortality rate (per 1,000 live births)[4]	25	24	24	-
Infant mortality rate (per 1,000 live births)[5]	50	48	46	-
Infant – under 5 – mortality rate (per 1,000 live births)[6]	59	57	55	-
Maternal mortality ratio (per 100,000 live births)[7]	-	560	270	-
Delivery care coverage (%):[8]				
Skilled attendant at birth	29.3%	29.3%	-	-
Institutional delivery	22.1%	22.1%	-	-
C-section	1.7%	1.7%	-	-
Stunting (under 5 years)[9]	58.1%	58.1%	50.2%	-

The CRC Committee, during the 47th session held on 2008, in its concluding observations recommended the State party to *"design a health policy based on a community structure to ensure that mothers and children in all areas of the country have access to quality primary health care, counseling and essential medicines"* (§59a). Moreover, it also recommended guaranteeing access to quality pre and post-natal

[2]Idem.
[3] Data referring to the year 2012 were retrieved from UNICEF country statistics, available at : http://www.unicef.org/infobycountry/Timorleste_statistics.html; UN inter-agency Group for Child Mortality Estimation (IGME) data, 2014, available at: http://www.childmortality.org/; Data referring to the year 2013 were retrieved from UNICEF HIV and AIDS complete global database, available at: http://data.unicef.org/hiv-aids/global-trends
[4] Data referring to the year 2012 were retrieved from UNICEF country statistics, see above; UN inter-agency Group for Child Mortality Estimation (IGME) data, 2014, available at: http://www.childmortality.org/
[5]Idem.
[6]Idem.
[7] Data referring to the year 2012 were retrieved from UNICEF country statistics, see above; Data referring to the year 2013 were retrieved from the World Bank Data, available at: http://data.worldbank.org/indicator/SH.STA.MMRT
[8]Data referring to the year 2011- 2012 were retrieved from UNICEF country statistics, see above.
[9]Data referring to the year 2011- 2012 were retrieved from UNICEF country statistics, see above. Data referring to the year 2013 were retrieved from the WBTi Report 2014, see above, p. 5.

health services and facilities, including training programs of midwives and traditional birth attendants (§59c).

Despite these recommendations, the delivery care coverage figures are extremely low, especially the low coverage of institutional delivery (22.1%), which are key factors for promoting optimal breastfeeding practices among mothers right after delivery.

Breastfeeding data

	2011	2012	2013
Early initiation of breastfeeding (within one hour from birth)[10]	81.7%	81.7%	93.4%
Children exclusively breastfed (0-5 months)[11]	51.5%	51.5%	63.3%
Introduction of solid, semi-solid or soft foods (6-8 months)[12]	82.2%	82.2%	17.6%
Breastfeeding at age 2[13]	33.4%	33.4%	-
Median duration of breastfeeding = 17.5 months (2009/2010)			

Between 2011 and 2013, there has been an increase in the rate of early initiation of breastfeeding as well as of the percentage of children exclusively breastfed between 0-5 months.

In addition, the median total duration of breastfeeding still insufficient (17.5 months), despite the WHO recommendation on continued breastfeeding until 2 years or more.

- **Early initiation of breastfeeding**

In Timor-Leste, despite the low rate of mothers who give birth at health facility, because the majority deliver their baby at home (78%), early initiation of breastfeeding is very good, as 93.4% of babies received breastmilk within one hour of delivery.

The early breastfeeding rate, particularly within 1 hour after delivery, has increased from 81.7% in 2011 to 93.4% in 2013.

- **Exclusive breastfeeding under 6 months**

The rate of exclusive breastfeeding has shown some improvement in the past years. It has increased from 51.5% in 2011 to 63.3% in 2013.

[10]Data referring to the year 2011-2012 were retrieved from UNICEF country statistics see above; Data referring 2013 were retrieved from the WBTi Report 2014, see above, p.28.
[11]Data referring to the year 2011-2012 were retrieved from UNICEF country statistics, see above; Data referring 2013 were retrieved from the WBTi Report 2014, see above, p. 29.
[12]Data referring to the year 2011-2012 were retrieved from UNICEF country statistics, see above; Data referring 2013 were retrieved from the WBTi Report 2014, p. 32, see above;
[13]Data referring to the year 2011-2012 were retrieved from UNICEF country statistics, see above;

According to IBFAN WBTi report 2014 some recent research revealed that the mothers/caretakers provided breastmilk to their infants because they could not afford the breastmilk substitutes. Thus, there is a risk that this behaviour can be negatively influenced by strong promotion on the breastmilk substitute, especially when the households have little bit more money to buy the substitute.

- **Continued breastfeeding at 2 years**

The median duration of breastfeeding in Timor-Leste, according to the Demographic and Health Survey 2009-2010[14], is 17.5 months. Regarding the DHS from 2003 and the DHS from 2009/10, the median duration of breastfeeding had decreased from 17.7 months (DHS 2003) to 17.5 months (DHS 2009/10).[15]

Likewise, the country statistics released by UNICEF, in the period between 2008 and 2012, 33.4% of children are breastfed until the age of 2 years.

- **Bottle-feeding**

According to the Food and Nutrition Survey 2013, complementary feeding practice among young children is still alarming, when only 17.6% of children, between 6-23 months, are receiving timely and appropriate complementary food. Although the percentage of children of 6-8 months received complementary food quite high, 82% respectively (TLDHS 2009/10), it was mainly plain rice porridge, which does not contain enough protein for infants or mothers who are breastfeeding.[16]

The survey also found that 25.3% of babies, between 0 to 23 months, are bottle-fed.

Bottle-feeding has decreased from 12.7% to 7%, while the percentage of children 6-8 months receiving appropriate complementary food is alarming.

- **Main causes of death among infants and children**

According to the Demographic and Health Survey 2009-2010, malaria, neonatal tetanus and acute respiratory infections (especially pneumonia) are the main causes of death among infants and children.

[14] Timor-Leste Demographic and Health Survey, 2009-2010, available at: http://dhsprogram.com/pubs/pdf/fr235/fr235.pdf
[15] WBTi Report 2014, see above, p. 33.
[16] WBTi Report 2014, see above, p. 32.

4) Government efforts to encourage breastfeeding

National policies

According to the WBTi Report 2014, a National Breastfeeding Committee has not been established.

The national guidelines for infant and young child feeding (IYCF) are not available; therefore a National Plan of Action has not been developed yet, in order to enforce the IYCF policy.

However, the revised National Nutrition Strategy 2014-2019 (NNS 2014-2019) highlights the priority of IYCF intervention areas. The strategy also includes costed-prioritized interventions in the area of IYCF and it will be used as advocacy to mobilize financial support from donors.

Ministry of Health of Timor-Leste with support from UNICEF participated at a Regional IYCF Policy workshop in Bangkok in April 2014. The workshop discussed the country action plan toward endorsement and implementation of BMS Code, Maternity Leave, and strengthening health system for IYCF interventions. The Ministry of Health (MoH) of Timor-Leste with support of UNICEF and collaboration with Alola Foundation is continuing the efforts to have the code reviewed and endorsed by MoH and government.

With regard to IYCF programme monitoring, IYCF related indicators have been included in the Health Management Information System (HMIS) and District Health Information System (DHIS); (i.e % of community health centers and hospital achieving baby friendly status, % of suco/villages having community groups promoting nutrition related behavior and practices).

Promotion campaigns

The Government has established a" Basic Services Package" (BSP) where the service is provided by community health volunteers or *Promotor Saude Familia* (PSF). This service is also provided in the villages, where it is known under the name of SISCa, which works closely with Mother Support Group (MSG) to improve IYCF in all 13 districts of Timor-Leste. Among its monthly activities, health promotion and nutrition counseling are included.

The BSP package includes Skilled attendance during pregnancy, delivery and the immediate postpartum; Antenatal Care; Essential Newborn Care; Care of Sick and Small babies; Breastfeeding and complementary feeding; Micronutrient supplementation; Treatment of Children with Severe Malnutrition; Immunization of children and mothers; Integrated management of pneumonia, diarrhoea and malaria; and Insecticide treated bed nets.[17]

However, according to the WBTi Report, not all MSG and PSF have been trained in IYCF, revealing inadequate capacity in counseling and delivering the messages to the community. Moreover, it is important to highlight the lack of inter-sectoral approach for IYCF interventions.

[17] See http://www.basics.org/documents/1-Timor-Leste-BSP.pdf

Each year, the international commemoration of World Breastfeeding Week takes place between August 1st and 7th.[18] At this special event, Government partners, donors, and World Health Organization (WHO) representatives are invited to highlight the importance of breastfeeding and nutrition.

Babies are not appropriately fed and they fail to gain weight after the first 6 months. In order to address this issue, the ALOLA foundation runs Mother Support Groups (MSG) in all 13 districts of Timor-Leste. The ALOLA team with the support of the government healthcare staff carries out monthly health checks on mothers and infants during through their Mother Support Group and SISCa activities. They distribute medicine and health care advice and encourage best practices in breastfeeding and new born care among the community.[19]

Additionally, there is no comprehensive national IEC strategy for improving IYCF.

The International Code of Marketing of Breastmilk Substitutes

Although a new legislation implementing Code has been drafted by the government, it has not yet been endorsed by the MOH.

Moreover, there are no adequate mechanisms currently working neither an operational guideline to enforce the implementation of BMS Code.

Monitoring of national policies and legislation

Currently there is no monitoring body specifically devoted to breastfeeding, in charge of evaluating for instance the breastfeeding trends through official indicators, the BFHI implementation throughout the country and the Code enforcement in the national legislation. However, there is a 'National Breastfeeding Association' housed in the MOH.[20]

It is important to highlight the lack of monitoring key indicators of IYCF, since they are not integrated into the regular health management information system. This situation prevents the exercise of an adequate monitoring, collection of data on regular basis and measure outcomes related to IYCF programme activities.

In addition, no evaluation results, related to major infant and young child feeding programme activities, could be reported to key decision-makers.

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[18] ALOLA foundation celebrate World Breastfeeding Week in Liquica, available at: http://www.searo.who.int/timorleste/pr_alola_foundation_celebrate_wbw_liquica.pdf

[19] Idem.

[20] More information is available at: https://extranet.who.int/nutrition/gina/sites/default/files/TLS%202009%20Breast-feeding%20Promotion%20Policy_0.pdf

Courses / ***Training of Health Professionals***

According to the WBTi Report 2014 and taking into account a review of health provider schools and pre-service education programmes in the country, indicates that infant and young child feeding curricula or session plans are inadequate as well as in-service training programmes, which are supposed to provide knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers. This situation also reveals inappropriate health workers training in regard with the implementation of the Code, considered as a key input. Likewise, standards and guidelines for mother-friendly childbirth procedures and support have not been developed and disseminated to all facilities and personnel providing maternity care. Moreover, infant feeding-related content and skills are not integrated into training programmes focusing on relevant topics as diarrhoeal disease, well-child care, family planning, nutrition, the Code, HIV/AIDS, etc.

It is to be noted that MOH personnel have been trained in the IYCF counseling course by IBFAN Asia using the IBFAN Asia '4 in 1' training programme in the year 2010 in which national trainers were prepared.

5) Baby-Friendly Hospital Initiative (BFHI)

The insufficient skills of health workers indicate that revitalization of BFHI is necessary and its assessment should be carried out periodically to sustain this programme and contribute to increase in early initiation and exclusive breastfeeding.

Two out of six hospitals, 33.3% respectively, that provide maternity services have been designated "Baby Friendly" based on the global or national criteria.

Some 30% of the BFHI designated hospitals have been certified after a minimum recommended training of 18 hours for its entire staff working in maternity services.

In terms of quality, is important to highlight that there is no a standard monitoring system in place neither an assessment system which relies on interviews on mothers. Likewise, reassessment systems have not been incorporated at all in national plans.

5) Maternity protection

The current legislation (articles 59 to 62 of the Labour Code[21]) provides the following:

[21] See http://www.jornal.gov.tl/lawsTL/RDTL-Law/RDTL-Laws/Law%204-2012%20%20Labour%20Code.pdf

Maternity leave (article 59)

1. Female workers shall have the right to paid maternity leave for the minimum period of **12 weeks**, **10 weeks of which shall necessarily be taken after delivery**, without loss of remuneration and seniority rights.
2. The period of maternity leave shall neither affect the remuneration nor the length of the vacation period.
3. Without prejudice to maternity leave provided for in paragraph 1 above, female workers shall be entitled to leave of absence prior to delivery in situations of clinical risks for the worker or the new-born that hamper the exercise of her functions for the period of time established by medical prescription and deemed necessary for preventing such risks.
4. In case of interruption of pregnancy the worker shall have the right to a leave for 4 weeks.

Paternity leave (article 60)

1. Male workers shall have the right to a **five-day remunerated paternity leave** after the birth of their children without losing the right to seniority.
2. The period of paternity leave shall neither affect the salary nor the duration of the length of the vacation period.
3. In case of birth of a child followed by the death of the spouse or of a person with whom the worker lives in cohabitation, the worker shall have, at that very moment or up to two weeks after delivery, the right to the leave provided for in paragraph 1 of article 59 above, without loss of the remuneration and the right to seniority.

Leave of absence for medical consultation and breastfeeding (Article 62)

1. Female workers shall have the right to be away from work into order to breastfeed their children until such time as the latter reach 6 years of age, without loss of remuneration or of any rights.
2. For the purposes of the preceding paragraph, the worker shall have the right to two breastfeeding periods per day with the duration of one hour each.

Note: Women and men working in the informal sector are not covered. Dissemination of information about maternity protection laws, regulations, or policies, is not available to workers.

The country has not ratified the ILO Maternity Protection Convention No 183 nor has enacted laws equal or similar to this Convention.[22]

7) HIV and infant feeding

The member state has a comprehensive policy on infant and young child feeding that includes infant feeding and HIV. However, it does not give effect to the International Code.

[22] See http://www.ilo.org/dyn/normlex/en/f?p=1000:11300:0::NO:11300:P11300_INSTRUMENT_ID:312328

Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counseling and support. Nevertheless, Voluntary and Confidential Counseling and Testing (VCCT) is to some degree available and it is not offered routinely to couples who are considering pregnancy and to pregnant women and their partners.

Another issue is that support to mothers in making their infant feeding decisions with further counseling to make implementation of these decisions as safe as possible, is not adequate.

On-going monitoring is not functioning, thus determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices is complicated, including the overall health outcomes for mothers and infants.

8) Infant feeding in emergencies (IFE)

The country does not have a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies. Therefore, an appropriate teaching material on infant and young child feeding in emergencies could not be integrated into pre-service and in-service training for emergency management and relevant health care personnel.

Additionally, an emergency preparedness plan to undertake activities to ensure exclusive breastfeeding, appropriate complementary feeding and minimize the risk of artificial feeding, has been developed to some degree. Some persons, tasked with responsibility for national coordination with the UN, donors, military and NGOs regarding infant and young child feeding in emergency situations, have been appointed.