THE COMMITTEE ON THE RIGHTS OF THE CHILD

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REPORT ON THE SITUATION OF INFANT AND YOUNG CHILD FEEDING IN LESOTHO

IBFAN

defending breastfeeding

April 2018

Data sourced from:

Lesotho Demographic and Health Survey 2009
Lesotho Demographic and Health Survey 2014
Lesotho WBTi report 2012
UNICEF
WHO

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SUMMARY

The following obstacles/problems have been identified:

- Child and maternal mortality rates are still very high; Infant and Young Child Feeding practices are not monitored on a regular and systematic way;
- The national nutrition policies depend on external funding because the budget allocations are insufficient; no information available on the mandate and activities of the National Breastfeeding Committee;
- Only drafted measures concerning the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA Resolutions; no information available on the status of such draft measures;
- The Baby-Friendly Hospitals Initiative is not implemented in the country; resources allocated for the BFHI are insufficient and there is no system of monitoring for reaccreditation of health facilities;
- Maternity leave is unpaid and covers only 12 weeks, i.e. less than the minimum recommended by the ILO Convention on Maternity Protection 183 (2000); Lesotho has not ratified ILO C183;
- Training of health professionals on IYCF and HIV, and on the International Code of Marketing of Breastmilk Substitutes is not adequate and does not cover all the categories of health care workers at community level;
- Infant Feeding in Emergencies (IFE) is not mentioned in the national disaster preparedness plan.

Our recommendations include:

- **Take measures to reduce child and maternal mortality rates; regularly monitor IYCF practices and related rates using WHO/UNICEF indicators.**
- **Allocate more resources for the implementation of the national nutrition policy and define a clear mandate for the National Breastfeeding Committee.**
- **Include all the provision of the International Code and subsequent WHA resolutions in the national legislation;** provide for training of health professionals on the Code and Resolutions and on their role in supporting Code implementation.
- **Re-launch the BFHI** and set up a system of assessment of health facilities through external evaluation.
- **Increase the duration of maternity leave and provide for relevant cash benefits; extend the maternity protection rights to women working in the informal sector. Ratify ILO C183 on Maternity Protection.**
- **Ensure that all the categories of health workers at community level receive updated training on IYCF, especially on the national policy for infant feeding and HIV.**
- **Add IFE to the disaster preparedness plan and possibly design it based on the Operational Guidance on IFE, developed by the ENN.**

1) General points concerning reporting to the CRC

In 2018, the CRC Committee will review Lesotho's 2nd periodic report.

At the last review in 2001 (session 26), the CRC Committee referred specifically to child mortality and malnutrition in its Concluding Observations to Lesotho, noting with concern "*the poor health situation of children in the State party and in particular the limited access to basic health care for children (especially in rural and mountainous areas), high maternal, child and infant mortality rates, low and decreasing immunization levels, high rates of malnutrition, poor sanitation and limited access to safe drinking water, especially in rural communities*." (§ 43)

Therefore the Committee recommended Lesotho to "*allocate appropriate resources and develop comprehensive policies and programmes to improve health infrastructure, to increase the number of trained health and welfare, including mental health, professionals, to improve the health situation of children, to facilitate greater access to primary health services,* ***to reduce the incidence of maternal, child and infant mortality, to prevent and combat malnutrition, especially in vulnerable and disadvantaged groups of children****, and to improve access to safe drinking water and sanitation."* (§ 44, emphasis added)

2) General situation concerning breastfeeding in Lesotho

General data[1]

	2014	2015	2016
Annual number of birth, crude (thousands)	-	61	-
Neonatal mortality rate (per 1,000 live births)	39.6	39.1	38.5
Infant mortality rate (per 1,000 live births)	74.5	74.5	72.4
Under-5 mortality rate (per 1,000 live births)	98.3	97.9	93.5
Maternal mortality ratio (per 100,000 live births)	-	487	-
Delivery care coverage (%):			
Skilled attendant at birth	77.9	-	-
Institutional delivery	77	-	-
C-section	10	-	-

[1] UNICEF data

Stunting (under 5 years)	33.2%	-	-
Severe wasting (under 5 years)	0.6%	-	-
Wasting (under 5 years)	2.8%	-	-
Overweight (under 5 years)	7.4%	-	-
Underweight (under 5 years)	10.3%	-	-

The rates of neonatal, infant, under-five and maternal mortality are still extremely high in Lesotho. Stunting is another worrying rate, with over 30% of children aged 0-5 years stunted.

Breastfeeding data[2]

	2009	2014
Early initiation of breastfeeding (within one hour from birth)	49.8%	65.3%
Exclusive breastfeeding under 6 months	52.9%	66.9%
Introduction of solid, semi-solid or soft foods (6-8 months)	78%	83%[3]
Bottle-feeding	26%	NA
Continued breastfeeding at 2 years	35.1%	29.5%
Median duration of breastfeeding (months)	17	16.6

4) Government efforts to encourage breastfeeding [4]

National policies

There is a national comprehensive nutrition policy in Lesotho, including Infant and Young Child Feeding (IYCF), but there is no adequate funding for its activities, which rely on external donors funding.[5] There is no information available on the actual role and activities of the National Breastfeeding Committee.

Promotion campaigns

The government of Lesotho has a national comprehensive Information, Communication and Education (IEC) strategy for improving infant and young child feeding. However, an important

[2] Lesotho Demographic and Health Survey (DHS) 2009; Lesotho DHS 2014.
[3] Source: World Breastfeeding Trends Initiative (WBTi) assessment report for Argentina (2017), available at: www.worldbreastfeedingtrends.org/GenerateReports/countrysubmit.php?country=AR
[4] Information in this section was mainly retrieved from the Lesotho World Breastfeeding Trends Initiative (WBTi) assessment report of 2012.
[5] Source of information : Food and Nutrition Coordination Office report 2010.
National Nutrition Policy and Strategic Plan 2011

segment of the population has no access to any means of public information[6] (radio, TV, internet etc) and for this reason the IEC material that is produced may not reach the entire population.

The International Code of Marketing of Breastmilk Substitutes

As of 2016, there are only drafted measures concerning the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA Resolutions. There is no information available on the status of such measures.[7] It has been reported that the health professionals are receive no specific training concerning the International Code and their role in supporting its implementation.[8]

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

Training of health workers is inadequate, with specific regards to infant feeding and HIV, as well as on the Code, as mentioned above. In particular, it has been highlighted that extension workers are not included in trainings intended for community workers on updated information on HIV and infant feeding.[9]

5) Baby-Friendly Hospital Initiative (BFHI) [10]

According to the WBTi assessment report of 2012, implementation of the BFHI has been completely neglected in Lesotho, after its launch. Training of health personnel on the BFHI has been interrupted and the whole BFHI programme has not been included in the national health and nutrition plan. Financially, the implementation of the BFHI has been depending on the UN Agencies[11].

There is an urgent need to re-launch the BFHI in the country and to affect financial resources for its implementation. A system of regular external evaluation should also be set up, to guarantee that facilities meet the BFHI criteria.

[6] 25% of women and 33% of men, according to the DHS 2009
[7] Source of information: State of the Code by Country (2016), International Code Documentation Center, IBFAN-ICDC
[8] Lesotho WBTi report 2012
[9] See above
[10] See above
[11] *National Implementation of the Baby-Friendly Hospital Initiative* (2017), World Health Organization, available at www.who.int/nutrition/publications/infantfeeding/bfhi-national-implementation2017/en/

6) Maternity protection for working women[12]

Maternity protection in Lesotho is regulated by the Labour Code, Order No. 24, 1992, amended to Labour Code Act, 2006.

Scope: Maternity protection under the Labour Code covers employed women in the public and private sectors, including apprentices, but excluding certain types of public servants. The Labour Code does not apply to: a) Any person (other than a person employed in a civil capacity) who is a member of the Royal Defense Force; the Royal Lesotho Mounted-Police; or any other disciplined force; b) Such category or class of public officer, such public authority or employee thereof as the Minister may by order specify and to the extent therein specified.

Maternity leave:

Conditions: A pregnant female employee shall give notice of her anticipated confinement by delivering to her employer a written certificate signed by a medical officer or a registered nurse or midwife certifying that the employee's confinement will probably take place within 6 weeks from the date of that certificate. Within 21 days immediately after her confinement, a female employee shall deliver to her employer a written certificate signed by a medical officer or a registered nurse and midwife certifying the date of confinement.

Length: **Total of 12 weeks**, 6 before and 6 after confinement upon production of a medical certificate (pre-natal and post-natal leave).

Compulsory leave: 6 weeks after confinement.

Cash benefits: **Maternity leave is unpaid**. There is no legal obligation for employers to pay wages during maternity leave, although the contract of employment may provide for paid maternity leave.

Health protection:

Night work: Pregnant workers may not be required to work at night for a period of at least 3 months before the expected date of confinement and at least 3 months after childbirth. Alternative work schedules must be made available to them. This cannot reduce the woman's protection and benefits connected with maternity leave.

Overtime is not prohibited either for pregnant workers or breastfeeding mothers.

[12] ILO working conditions database, 2012, accessible at: www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---travail/documents/publication/wcms_235155.pdf

Work on rest days is not prohibited either for pregnant workers or breastfeeding mothers.

Dangerous work: There are no special legal provisions to protect pregnant workers or breastfeeding mothers from risks at working places. It is the employers' general duty to ensure as far as is reasonably practicable, the safety, health and welfare at work of all their workers.

No woman can be employed for underground work in any mine except with the written approval of the Labour Commissioner in the case of women holding a managerial position, or employed in health and welfare services, or who, in the course of their studies, spend a period of training in the underground parts of a mine; and any others who may occasionally have to enter the underground part of a mine for the purpose of a non-manual occupation.

No special provisions for pregnant/lactating workers concerning work involving exposure to biological, chemical or physical agents. However, for all employees, who may during the course of their work inhale, ingest or otherwise absorb any substance specified in the Sixth Schedule to the Code, shall be medically examined free of charge at intervals of not more than 6 months or as otherwise specified. Employees will be informed of risks due to their work. Special attention is made to food that cannot be eaten in dangerous premises (dust, fumes, etc.). Maximum permissible limits of exposure to substances hazardous to health are defined.

Breastfeeding breaks

Mothers are entitled to nursing breaks up to 1 hour a day for 6 months immediately after returning to work after maternity leave. Nursing breaks are counted as working hours and thus are paid.

Lesotho has not ratified the ILO Convention 183 (2000) on Maternity Protection.

7) HIV and infant feeding

In 2015, the estimate number of pregnant women living with HIV in Argentina was 12'000, according to UNICEF data. Among them, 8'061 women had received antiretroviral therapy (ART) for prevention of mother-to-child transmission (PMTCT), meaning 70% of the total pregnant women living with HIV. In the same year, the estimated number of newly infected children (aged 0-14 years) was 1'300 and the rate of mother-to-child transmission (MTCT) was 11%.

There are National Guidelines for the prevention of MTCT but, as highlighted previously, not all the health personnel received the same training on infant feeding and HIV.

8) Infant feeding in emergencies (IFE)

The national guidelines for feeding in emergencies do not specifically include infant feeding. Therefore, there is no communication around how to ensure protection and support of optimal IYCF practices in case of emergencies, and no national coordinator in charge of supervising the operations. There are no representatives from the Nutrition department in the organisational structure of National Contingency Plan for Emergencies for the Health Sector Chapter.

A National Core Group on Emergencies has been established by the Disaster Management Authority in 2012. There is no information available on whether the Core Group is planning to design a national policy for IFE. Such policy could be based on the ENN Operational Guidance for Emergency Relief Staff and Programme Managers[13], to ensure that *"decision-makers, planners and donors meet their responsibilities set out in the UNICEF/WHO Global Strategy on Infant and Young Child Feeding, in article 24 of the Convention of the Rights of the Child and the Call for Action contained in the Innocenti Declaration 2005 on Infant and Young Child Feeding, welcomed unanimously by the 2006 World Health Assembly"*[14].

[13] The full text of the IFE Operational Guidance is available at : https://www.gifa.org/infant-and-young-child-feeding-in-emergencies-operational-guidance-version-3-0/

[14] Text quoted from the Mandate of the OG-IFE.