THE CONVENTION ON THE RIGHTS OF THE CHILD

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

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Data sourced from:
World Breastfeeding Trends Initiative (WBTi), *Country report: Thailand*, 2010
ICDC, *State of the Code by country*, 2011.
ILO, *Maternity protection database,* 2011
UNICEF, *State of the World's Children*, 2010.
UNICEF, *Status of Baby-Friendly Hospital Initiative*, 2002

1) General points concerning reporting to the CRC

Thailand's 3rd and 4th periodic report will be reviewed by the CRC Committee. At the last review in 2006 (session 41), IBFAN presented an alternative report.

In its last concluding observations, the CRC Committee was concerned by malnutrition, iodine and iron deficiencies, and the low rate of exclusive breastfeeding. It recommended ***" that the State party undertake all necessary measures:…(b) to continue it efforts to improve prenatal care and reduce maternal, infant and under-five mortality rates…;(c) to improve the nutritional status of children inter alia, through introducing legislation and policies…; (d) to continue to encourage exclusive breastfeeding for six months after birth, with the addition of an appropriate diet thereafter, taking into account the support needed for working mothers…***"

Little progress seems to have been made in the improvement of breastfeeding rates, which remain very low, as shown by the data below.

1) General situation concerning breastfeeding in Thailand

General data [1]

Neonatal mortality rate (per 1000 live births)	8 (2009)
Infant mortality rates (per 1000 live births)	12 (2009)
Under 5 mortality rate (per 1000 live births) Rank	14 (2009) 125
% of children suffering from low birth weight	9 (2005-2009)
% of children under 5 suffering from underweight (moderate and severe)	9 (2003-2009)
% of population using improved drinking water sources (rural urban, 2006)	98 (99, 97)
Maternal mortality ratio (per 100'000 live births) reported adjusted	12 (2005-2009) 110 (2009-2009)
Delivery care coverage (%): Skilled attendant at birth Institutional delivery	(2005-2009) 97 97
Antenatal visits for woman (at least once)	98

Breastfeeding data[2]

	2005-2009
Early initiation of breastfeeding	***50%***
Children exclusively breastfed at 0 months 3 months 6 months	 ***No data*** ***No data*** ***5%***

[1] UNICEF, State of the World's children 2011
[2] Ibid.

Children who are breastfed with complementary foods: 6- 9 months	**43%**
Continued breastfeeding at 20-23 months	**19%**

Breastfeeding initiation is very low and seems to indicate very active promotion of artificial milk to all levels of the population**. Exclusive breastfeeding at 6 months is very low** (worldwide levels approach 45%) and calls for strong measures to end this deplorable situation.

Given plain water, non milk liquid and early introduction of complementary feeding combined with breastfeeding is the common practices among Thai mothers.
The percentage receiving **complementary feeding** in the appropriate age of 6-9 months is also lower than the developing world average of 59%[3]. Appropriate complementary feeding education should be implemented in the hospitals and communities.

Another point the Committee may want to bring up is the need for comprehensive and regular data allowing to note progress – or lack of it.

3) Government efforts to encourage breastfeeding

International Code of Marketing of Breastmilk Substitutes

Thailand has no national law protecting mothers, parents and infants against aggressive and unethical marketing of breastmilk substitutes, but has only a number of voluntary measures[4].

- The **Thailand Code of Marketing of Foods for Infants & Young Children and Related Products 2008**, which implements the *WHO International Code of Marketing of Breastmilk Substitutes*, is only a proclamation of the MOPH. It is not a law, nor a regulation.
- The **1979 Thailand Food Act** contains a regulation from the Thailand FDA known as the **Advertising Code**. The Food Act covers food composition and safety, including that of infant foods, but does not cover the marketing of foods.

This lack of regulation of the marketing activities for breastmilk substitutes may be at the root of the low rates of breastfeeding as seen above. This calls for a strong national law as well as implementing and monitoring regulations.

National policy, programme and coordination

In 2008, a national maternal and child health strategy was developed by the Department of Health which was a combination of work including Safe Motherhood Hospital, Baby-Friendly Hospital, the Parenting School and community participation.
Recommendations:

- The national MCH committee should meet regularly and respond to the problems sent from the provincial MCH boards.

[3] http://www.childinfo.org/breastfeeding_status.html
[4] ICDC, 2011, State of the Code by Country 2011.

- Improved coordination with other sectors especially local government for establishing baby-friendly communities.

Health and Nutrition Care System

There is **no standard curriculum on breastfeeding training** for undergraduate and postgraduate health professionals. Given the very high levels of institutional births (as shown by the data), it is necessary that health professionals become breastfeeding advocates as clearly they hold a key role in the promotion, protection and support of breastfeeding. Indeed they are the people mothers meet while pregnant, at the moment of giving birth and during their stay at the hospital. There should be a clear focus on educating them, and ridding them of any industry-related incentives.

Also standards and guidelines for mother-friendly childbirth procedures and support do not exist.

4) Baby Friendly Hospital Initiative (BFHI)

The UNICEF 2002 report on the number of BFHI hospitals states the high number of **780** facilities that are certified as baby-friendly in Thailand, which represent 53.1% of hospitals and maternity facilities in the country. BFHI reassessment has been launched since 2007, more than 50% of the hospitals have been reassessed and almost all of them can maintain BFHI.

It would be necessary that the reassessment process be continued, so as to determine the correct figures. Given the very low breastfeeding rates in the country, the CRC Committee may wish to ask the delegation why is there such a discrepancy between the low rates of breastfeeding initiation and the high number of BFHI hospitals.

Moreover, **the health personnel need to be trained again and on a regular basis** so as to become breastfeeding supporters and protectors and better understand the 10 steps to certification. Clearly there is a discrepancy between high numbers of certified hospitals and low breastfeeding rates, on which the CRC Committee may want to investigate further.

5) Maternity protection for working women

Scope: Maternity protection under labour protection legislation covers employees in general, with some exceptions: employees who work for central, provincial and local administrations, state enterprises under the law governing state enterprise labour relations, employees who perform agricultural work, housework, or work that is not intended to seek economic profit; work in private schools under the law governing private schools, but only in respect to headmasters and teachers.

Duration of maternity leave: 90 days for each pregnancy.

Cash benefits: 50% of salary paid by employer for 45 days per year; 50% of salary paid by social security for 90 days to same categories of women as those entitled to maternity leave.

For the part the Social Security Fund shall pay, the insured person must have paid contributions for not less than 7 months during the period of 15 months before the date of receiving medical benefits.
Cash benefits are paid for a maximum of two children.

Medical benefits are paid by the Social Security fund and consist of: medical examinations and child bearing expenses; medical treatment; medicine and medical supplies; confinement; lodging, meals and treatment in hospital; new-born baby nursing and treatment expenses; ambulance or transportation for patients and other necessary expenses.
Health protection: no night work or overtime for most pregnant employees; no dangerous or unhealthy work for a pregnant employee (temporary change in her duties before or after delivery), and the employer shall consider changing her duties to more suitable work for such an employee.

Anti-discrimination measures: male and female employees shall be treated equally unless the description or nature of the work prevents such treatment.
Protection from discriminatory dismissal**:** An employer shall not terminate the employment of a female employee on the grounds of her pregnancy.

Breastfeeding breaks: there is no mention of these in the Thai law.

The maternity protection law is weak on several points that need to be strengthened:
Scope should be extended to include all categories of workers with special attention to workers in the informal economy which is particularly developed in Thailand. **Length of the leave** is relatively short at less than 13 weeks (ILO C183 stipulates at least 14 weeks). **Cash benefits** do not cover the whole period of leave and are paid in part by the employer whose interest is to not employ women of reproductive age: all payment should be from the Social Security Fund. There is no mention of **breastfeeding breaks** which would enable mothers to breastfeed their infants for a longer period of time (important given the low rates of breastfeeding).

6) Obstacles and recommendations

The following problems have been identified:

- Very low breastfeeding rates, especially initiation of breastfeeding and exclusive breastfeeding up to 6 months.
- Discrepancy between low breastfeeding rates and high level of institutional births.
- Very weak protection against unethical marketing of breastmilk substitutes: only few voluntary measures in place.
- Discrepancy between low breastfeeding rates and numerous BFHI facilities.
- Weak maternity protection legislation.

Our recommendations include:

- Ensure regular and comprehensive **data collection** that allows registering progress/lack of progress in fields related to optimal infant and young child feeding practices.

- Raise public awareness on the harms of bottle feeding on child health and **promote breastfeeding as the norm** to feed infants, through information, education and communication means.
- Ensure effective **training of health personnel on infant and young child feeding**. In particular, include training on breastfeeding support in the curricula to prevent constant and costly re-training.
- Draft and implement **a strong law on the marketing of breastmilk substitutes**, which fully incorporates the provisions of the WHO International Code of Marketing of Breastmilk Substitutes. The law should also include provisions on monitoring and sanctions.
- **Finalize the re-assessment of BFHI** in the country and follow-up on a regular basis.
- **Strengthen maternity protection legislation**, in particular regarding the scope of the law, the length of leave, the amount of cash benefits, and the inclusion of breastfeeding breaks.