HATUTAN Baseline: Health and Nutrition Brief

Timor-Leste

HATUTAN Education and Nutrition Program

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HATUTAN Baseline 2019; Author: Lisa Burton

Key Findings: Health and Nutrition

Results from the HATUTAN baseline contribute to the understanding of the health and nutrition landscape and largely validates findings found in existing literature.

1. The HATUTAN Program

HATUTAN (*Hahán ne'ebé Atu Fó Tulun ho Nutrisaun no Edukasaun*, or Continue and Support Food for Nutrition and Education) is a program funded by the US Department of Agriculture (USDA) McGovern-Dole Food for Education initiative in Timor-Leste. HATUTAN seeks to improve literacy outcomes for primary school children and increased use of improved health, nutrition and dietary practices in 440 schools and surrounding communities in the municipalities of Ainaro, Ermera, Liquica and Manatuto. It is being implemented by CARE International, Mercy Corps and Water Aid in partnership with the Ministries of Education, Youth and Sports (MEYS), Health (MOH), Agriculture and Fisheries (MAF) and KONSANTIL, between 2018 and 2023. HATUTAN uses a quasi-experimental evaluation design to assess the impact of its intervention on education, health and nutrition outcomes in treatment schools, compared to the regular progress observed through time in a set of matching comparison schools not exposed to similar interventions. HATUTAN's baseline study, conducted in February-April 2019, collected data from 189 schools and respective communities, including 99 treatment and 90 comparison schools.

2. Background

There are ongoing efforts on Timor-Leste to improve the health and nutrition status as demonstrated in the National Health Strategic Plan 2011-2030 which defines key health and nutrition priorities. However, malnutrition remains a pressing development challenge. A key strategic objective under HATUTAN is to increase use of health, nutrition and dietary practices. Uptake of promoted health practices at schools is anticipated to decrease health-related absences thus improving school attendance and improving literacy. While uptake of promoted health practices such as latrine use, hand washing with soap, exclusive breastfeeding, and dietary diversity at the community and household level can aid in breaking the cycle of malnutrition. This remains a problem in Timor-Leste as half (46%) of all children under five are malnourished according to the 2016 Demographic Health Survey (DHS).

3. Key findings from baseline

General Health: Information on health knowledge rather than health behaviors was collected, recognizing that knowledge is just one step in adoption of key promoted behaviors. Parents possess knowledge of several key positive health and hygiene practices, safe food preparation and storage, as well as nutrition practices; however, this knowledge does not always lead to

practice. Parents listed illness as the main reason why their child missed school. Severe anxiety was also prevalent which can impact health. Only 27% of households say they could afford preventative health services all the time. Savings and loans are not consistently used for medical expenses. Although government clinics are free there is often a cost associated with transport to the clinics.

WASH: Water, sanitation and hygiene plays a critical role in improving nutrition outcomes. Findings show that most households obtain water from a public tap (35%) followed by piped water into the yard (23%) and spring water through bamboo pipes (15%)[1]. At the school, 63% had clean water available to prepare school meals but only 37% had a handwashing station. 16% of schools indicated no water source or it was too far away, while more than half (53%) said they had piped water at the school. At least one toilet was available in 69% of schools with fewer than half (47%), having a specific toilet for girls; rates were higher in urban versus rural areas. Toilet access of some kind was available for 82% of households which is slightly higher than the 2016 DHS which indicates 73% of households have access to some type of sanitation facility. Households that had a toilet at their home also had a higher level of health related knowledge and were more likely to afford clinic visits as compared to their peers without toilets.

Most parents were able to identify healthy hygiene practices. Knowledge on critical times to wash hands was high but existing studies inform us the practice is low. Knowledge on hygiene practices was met by 86% of respondents however two negative practices were often falsely identified as healthy (1) keeping livestock in the house or kitchen and (2) throwing trash outside on the ground. These two practices may need deeper exploration for interpretation. Knowledge on promoted Infant and Young Child Feeding Practices indicates room for improvement. About half (49%) of respondents could name three important feeding practices for young children with the number one response (53%) identifying the importance of a variety of nutritious local foods. It is important to note this reflects only knowledge of the best practice, it does not reflect the participants' own practices as noted with the low dietary diversity scores. A theme of focus group discussions was that women are too overloaded to pay attention to hygiene practices; however, they also stressed hygiene at schools was a concern.

Nutrition: Mothers recalled what they ate and what they fed their young children in the previous 24 hours. Nearly all women of reproductive age indicated carbohydrates are the most widely consumed food group followed by Vitamin A-rich green leafy vegetables (85%). Much smaller percentages ate legumes, beans, nuts or seeds (12.5%), eggs (11.2%), flesh foods (8.5%) and dairy products (1.9%). The portion of these women consuming a diverse diet (5 or more of the 9 food groups) is 10%, the average was 3.3 food groups. In summary, the majority of the households are nutrient deficient and living on a carbohydrate-based diet.

A child's food consumption mimics that of the mother with almost all children (96%) consuming predominately grains, roots or tubers, and about half (47%) eating Vitamin A-rich fruits and vegetables. Very few children consumed dairy products excluding sweetened condensed milk (14%), eggs (12%), legumes and nuts (5%), and flesh foods/meat (5%). The portion of children breastfeeding and non-breastfeeding consuming a diverse diet (4 of the 7

[1] DHS 2016 data indicate that 78% of the population now have access to at least basic drinking water (70% rural and 98% urban).

food groups) is 6%, the average was 1.9 food groups. This is much lower than what is seen in the 2016 DHS where 34% of all children 6-23 months met standards for a minimum diverse diet.

Of students interviewed, 87% said they had eaten that day (interviews mostly in the morning period). Interviews with parents gave a different picture, with 93% saying they went without eating for an entire day in the last 30 days.[2]

Exclusive breastfeeding was the third most listed recommended feeding practice for infants and young children mentioned by respondents (30%). Exclusive breastfeeding rate for children under 6 months was 69%, considerably higher than the 2016 Demographic Health Survey (50%), however it was based on a small sample.

4. Exploring the Issue: Potential Drivers to the Health and Nutrition Situation

Agriculture practices are strongly linked to nutrition outcomes, food available for school feeding and the dietary diversity scores previously referenced. Most household in rural areas depend on subsistence agriculture and lack of sufficient cash income to buy food especially in the hungry season.

Household Economic Status Half of households (50%) indicated someone in the house had savings or a loan. Only 17% indicated using money for health care (the low number may be due to availability of free public health care). Most (85%) stated savings are used for education expenses followed by food with the same to categories being the priority for loans. Savings used for agricultural inputs which would increase production are only mentioned by 27% of respondents.

Gender Dynamics connecting gender workload of women to health was clear. For example, two community health volunteers in Liquica said that some mothers do not breastfeed their children because they are too busy. Workload of women was also linked to poor child care and hygiene practices. Caregivers mentioned Illness of parents, particularly mothers, as a reason to keep children (particularly girls) home from school to do domestic chores and look after the younger siblings.

> *Mothers are very busy taking care of babies. Fathers go to the farm and come back late, so the mothers [are too busy] to wash their hands every time they do something. They cannot wash their hands because they are busy holding the baby or cleaning the baby.* [Father, Manatuto]

Baseline respondents noted a **lack of access** to markets, clean water, sanitation, healthcare and food preparation and storage equipment. Focus groups noted a lack of **access to food** in the right quantity and quality as challenging especially for schools and accessing larger markets was difficult. **Access to sanitation** at both home and schools is a challenge. Increased access requires investments at the household level and at schools otherwise, health and nutrition outcomes will not improve.

[2] See thematic paper on hunger.

5. What this means for HATUTAN

1. In collaboration with MAF, promote sustainable private sector led, government promoted agricultural solutions for dietary diversity, build capacity of farmers regarding production of quality non-staple foods including fruits, vegetables, meat, and fish. Strengthen linkages between institutional buyers, such as schools, and local farmers.
2. Generate a project SBC communication strategy in partnership with MoH that promotes dietary diversity, building on locally appropriate behavior change activities, such as promotion of kitchen gardens and cooking demonstrations both at schools and in the communities to increase uptake of consumption of nutrition rich foods.
3. Support the school feeding program to deepen integration of nutrition promotion, including capacity building of non-nutrition personnel such as teachers, school cooks, parents, and students as agents of change. Train school cooks on hygienic food preparation and dietary diversity and their role in supporting child health through a hygienically prepared nutritious meal for a child and build capacity around practical skills to link schools to farmers.
4. *Lafaek* magazine was repeatedly mentioned as a main tool to support reading. It is widely available, trusted and read by teachers, students and parents. HATUTAN can utilize *Lafaek* as a platform for SBC interventions for shifting hygiene, sanitation, nutrition and health behaviors.
5. Leverage community health workers as a trusted source of information by integrating them into the SBC strategy and building their capacity to move beyond information sharing to motivational communications.
6. Work with the large body of evidence showing women's empowerment in agriculture is needed to achieve better dietary outcomes. HATUTANs activities with farmers should incorporate a strong gender focus and ensure that activities do not increase workload for women.
7. Shift away from the away from the WASH approaches that use shame and pride and utilize more innovative approaches using materials that are motivating, emotionally based and gender positive.
8. In collaboration with MEYS and MoPW, host workshops to share WASH in School and Rural Water Supply National Guidelines to both national and municipal stakeholders and schools. This platform can be an opportunity to identify opportunities to improve WASH at schools and gain feedback.
9. Given the high levels of demand for sanitation and knowledge of WASH behaviors, move beyond information sharing to focus on barriers and obstacles to action at institutional and household level, considering gender integrated practical financial and advocacy related activities.
10. Utilize the recently launched School Health Manual to create an enabling environment for improving health, boosting educational achievements and promoting gender equity. Schools allow the platform to reach large numbers at one time with health and hygiene events that link in the local health clinic. The School Health Manual connects all the elements to create the ideal school environment.