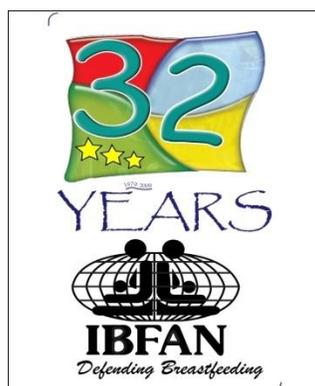


THE CONVENTION ON THE RIGHTS OF THE CHILD

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REPORT ON THE SITUATION OF INFANT AND YOUNG CHILD FEEDING IN CONGO BRAZZAVILLE



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Obstacles and recommendations

The following obstacles/problems have been identified:

- Inadequate infant feeding practices co-exist with high rates of child (infant and neonate) mortality and malnutrition. A low percentage of children initiate breastfeeding early (39%), only around one child in 10 is exclusively breastfed till 6 months, while 22% of under-five children suffer stunting and 93 children die before the age of five for every 1000 live births.
- High rates of child stunting kick in when breastfeeding is stopped and children are weaned. The nutritional status of children is also affected by the nutritional status of the mother. The risk for children whose mothers are thinner is higher than for those whose mothers are thicker. There are regional disparities in breastfeeding practices and also due to the economic status of women.
- Lack of adequate training of health care workers and health professionals.
- There is no infant and young child feeding policy in place.
- Congo Brazzaville does not have a law that regulates the marketing of breastmilk substitutes, as it has not yet enacted the International Code on the Marketing of Breastmilk Substitutes.
- The percentage of pregnant HIV+ women receiving ARVS is very low.

Our recommendations include:

- Improve the knowledge and strengthen the capacity of mothers/caregivers and also of health care professionals on adequate breastfeeding practices: early continuation within one hour, exclusive breastfeeding for 6 months and continued breastfeeding until 2 years or beyond.
- Improve the knowledge and strengthen the capacity of mothers/caregivers and also of health care professionals on adequate use of family and local foods in order to prepare nutritious diets for complementary feeding of breastfed infants and weaned children up to two years, and adequate feeding of older children.
- Accelerate adoption and implementation of the national draft law which enacts the International Code of Marketing of Breastmilk Substitutes (and relevant WHA resolutions). Ensure effective implementation through monitoring and sanctions in cases of violations.
- Ensure a social protection system for women working in the informal and agricultural sector, so as to enable all women to be protected during maternity and lactation.
- Take measures to address discriminatory practices and violence against women
- Adopt a national policy on infant and young child feeding and assign sufficient resources to the implementation of these policies and programmes.
- Implement the Baby-Friendly Hospital Initiative throughout the country in order to make sure that even though health professionals are lacking, the existing ones have capacities to support long-term sustainable infant feeding practices.
- Increase support to HIV + mothers with ARVs in order to prevent mother-to-child transmission.

1) General points concerning reporting to the CRC

In 2014, the CRC Committee will review Congo Brazzaville's combined 2nd and 4th periodic report.

At the last review in 2006 (session 43), the CRC Committee recommended Congo Brazzaville in its last [Concluding Observations](#), in para 59, to: *“(b)urgently address the issue of infant and child mortality, especially by focusing on preventive measures and treatment, including vaccination uptakes, **improved nutrition and the prevention of communicable diseases and malaria**; (c) increase efforts to further reduce maternal mortality throughout the country; (d) **adopt and implement a national law on marketing of breast-milk substitutes and promote exclusive breastfeeding for at least six months**; (e) **ensure that all segments of the society are informed, have access to health education and are supported in the use of basic knowledge of child health and nutrition, including the advantages of breastfeeding**; (i) provide adequate water sanitation and access to clean drinking water throughout the country.”*

The situation of women in Congo

As the CESCR Committee pointed out, there are sharp inequalities between women and men in Congo Brazzaville. Women experience not only discrimination but also occupational segregation in the informal sector, leading to lack of social security or other benefits. Moreover, women - and especially those from minority groups - do not have the right to access social services and health care services.

During the last review of Congo Brazzaville, the CESCR Committee put an emphasis also on the need to prevent violence against women – especially harmful traditional practices including levirate and pre-marriages before the legal age for marriage and female genital mutilation.

The CEDAW Committee has pointed to the persisting high levels of mortality rates and the necessity to combat its causes. Women do not receive sufficient information on sexual and reproductive health and rights and family planning. As abortion is criminalized in Congo Brazzaville, it leads women to seek unsafe and illegal abortion. The issue on sexually transmitted diseases such as HIV/AIDS is not raised and very small portion of the population received sufficient information related to this issue.

2) General situation concerning breastfeeding in Congo Brazzaville

General data

	2010 ¹	2011 ²	2012 ³
Annual number of birth	142,000		
Neonatal mortality rate (per 1000 live births)	29	32	
Infant mortality rate (per 1000 live births)	61		
Infant – under 5 – mortality rate (per 1000 live births)	93	99	
Maternal mortality ratio (per 100,000 live births) (adjusted)	580		
Delivery care coverage (%):			
Skilled attendant at birth			94
Institutional delivery			92
C-Section			3
Stunting (under 5 years)			24%
18-23 months			37%

In rural areas, 86.8% of pregnant women received prenatal care by a trained health staff against 95.9% in urban areas. According to the DHS (Demographic Health Survey), women from poor backgrounds are only 83.5% to enjoy prenatal care against 99.2% for the richest part of the Congolese society. However, since 2005, the proportion of women from poor economical background enjoying prenatal care has increased (77% in 2005 to 84% in 2011-12).

According also to the DHS, 10% of the new born infants are underweight (less than 2.5 kg). This is the case especially for firstborns whose mothers are under 20 years old: 12.2% weight less than 2.5kg.

Breastfeeding data

	(2007-2010) ⁴
Early initiation of breastfeeding (within one hour from birth)	39%
Children exclusively breastfed (0-5 months)	19%
Introduced to solid food (6-8 months)	78%
Continued breastfeeding at 12-15 months	60.7%
Breastfeeding at age 2	21%

Exclusive breastfeeding practices are not very well widespread in Congo Brazzaville. Indeed, less than one out of 5 children under 6 months is exclusively breastfed.

¹ <http://www.childinfo.org/files/maternal/DI%20Profile%20-%20Congo.pdf>

² http://www.unicef.org/infobycountry/congo_statistics.html

³ http://www.unicef.org/infobycountry/congo_statistics.html

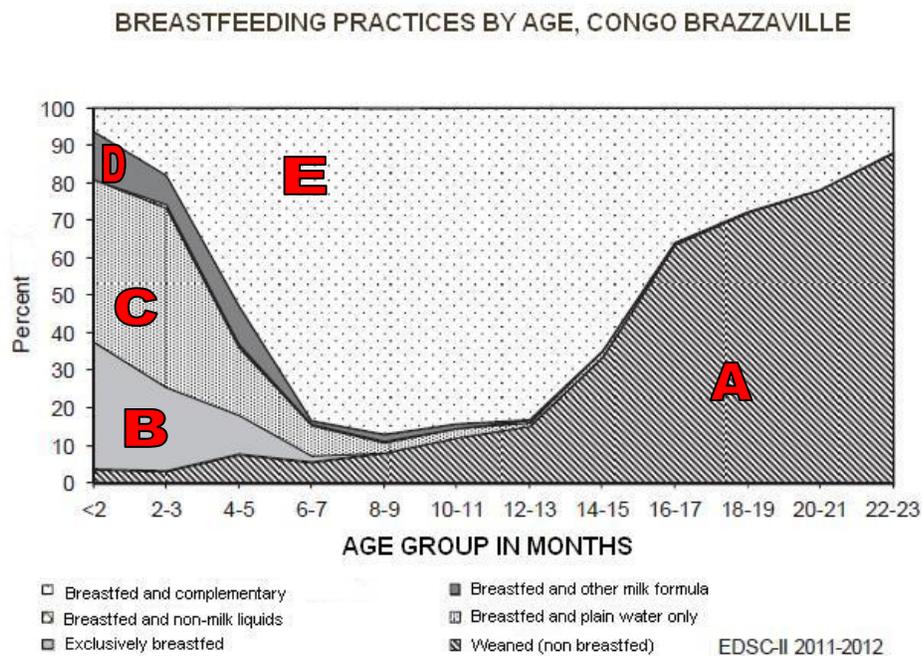
⁴ http://www.unicef.org/infobycountry/congo_statistics.html

Early initiation to breastfeeding (breastfeeding within one hour from birth) rate is extremely low – only 39% of newborns. Within the first day after delivery the percentage of children breastfed is of 76.3% in rural areas, against 65.8 % for urban areas.

Moreover, a great percentage of children are fed with other food than human milk during the first 3 days after delivery: 42.8% in rural areas and 31.5% in urban areas.

One of the reasons that often lie behind such inadequate feeding practices is the lack of adequate information and inadequate traditional practices on infant feeding. The role that health care workers can play to provide mothers and families with the correct information in these cases is crucial. However, it is necessary that health workers be sufficiently trained; otherwise their influence may negatively affect infant and young child feeding practices.

For example, the DHS (2011-12) showed that when women gave birth at home and when the health staff assisting the delivery was not enough trained, more than 50% of the children received other food than breastmilk.



Source: DHS 2011-12

The graph above provides a presentation of the overall feeding patterns among children 0-23 months for 2012, in Congo Brazzaville.

In an ideal situation, before 6 months of age, children would be fed only with breastmilk which means that there would be no other colour than the plain light gray colour (letter B) until 6-7 months.

At 6 to 7 months, adequate complementary food (solid, semi solid and soft food) is introduced at this age, while breastfeeding continues until 2 years of age. For our graph, it means that any other colour other than white with dots (letter E) is not desirable.

In the case of Congo Brazzaville, the problematic feeding patterns to be changed are:

- A large portion of children under 6 months are being fed with breastmilk and plain water (letter **C**), or formula milk (letter **D**) or not breastfed at all (letter **A**).
- A considerable portion of children under 6 months are fed with breastmilk and with complementary food (solid, semi solid, and soft food) – letter **E**. This shows that complementary food is introduced earlier than the recommended 6-9 months; a considerable increase of complementary food occurs at the age of 2-3 months.
- The portion of children that are weaned prematurely, that is not breastfed but fed only with other food (letter **A**), increases at 6-7 months and then rapidly at 12-13 months. Ideally, weaning should start at 22-23 months.

The 2012 DHS shows that stunting increases considerably after the first six months (9%) to reach 21% at the age of 9-11 months and the peak of 37% at the age of 18-23 months, which is higher than the average stunting rate of 24% for children under 5.

This increase in stunting at 9-23 months coincides with the time when breastfeeding is stopped increasingly and children are weaned and fed with other food (see the growing space lettered A in the graph above). In addition to being deprived of the nutrients and protective agents provided by breastmilk, these children may not be receiving an adequate and nutritionally rich diet. These two factors contribute to a higher risk of stunting for children under two.

The use of feeding bottles has increased these last 6 years (2006-2012). Babies between 0-1 month fed with a bottle are already 12%. The use increases with the months (15% between 4-5 months) and after 5 months, it decreases due to the change in food.

According to the DHS, there are differences also between women from poor economical background and those who are richer. Women of the poorest economical background are 78.1% to breastfeed their children, whereas rich women are 63.9% to breastfeed.

The main causes of death among infants and children are pneumonia, diarrhoea and malaria. Despite efficient and cheap treatments existing in Congo, diarrhoea is still the main cause of death in Congo Brazzaville⁵. The bad water sanitation, especially in rural areas, contributes to the infections.

3) Government efforts to encourage breastfeeding

Congo agreed with the WHO directives on optimal breastfeeding and has adopted at the World Health Assembly the 2002 Global Strategy on Infant and Young Child Feeding.

However, it seems that breastfeeding has not been protected and promoted as it should have been and Congo Brazzaville has not implemented the International Code of Marketing of Breastmilk Substitutes

(including relevant WHA resolutions) as the CRC Committee already recommended to the government in 2006. According to the International Code Documentation Centre (IBFAN-ICDC), Congo Brazzaville has only a drafted measure for the Code which waits for consideration from the Ministry and the Parliament. This measure has been drafted in the 1990's and since then, there have been no further actions from the government to consider this draft law.

4) Baby Friendly Hospital Initiative (BFHI)

There is no up-to-date information on the number and quality of the baby-friendly hospitals and health facilities in Congo. The only available data goes back to 2000.

We invite the CRC Committee to request more information on the state of implementation of the Baby-Friendly Hospital initiative in the country.

5) Maternity protection for working women

The Labour Code (Act No. 45/75), and the Social Security Act (Act n. 004-86) state that maternity leave applies to every pregnant worker whose condition has been medically attested and who has the right to interrupt her work without notice and without having to pay for the termination of the contract.

Duration: Every woman is entitled to interrupt work for a period of 15 consecutive weeks, of which 9 should be taken after the birth. This interruption can be extended to another 3 weeks, in cases of attested disease resulting from the pregnancy.

Financing of benefits: Maternity benefits amount to 100% of the salary: half of which is paid by the employer and the other half of the salary and free medical care by the social security system.

Breastfeeding breaks: During a period of 15 months after the birth of the child, the female worker has the right to breastfeeding breaks. This break shall not exceed one hour per day, and can be divided in two smaller breaks of half an hour each. It is not specified if the breaks are paid or not.

Health protection: Pregnant women are protected in some work fields such as in plants, factories, mines, mining sites, workshops and outbuildings. They may not be employed for night work and dangerous and unhealthy work. The Inspector of Labour and Social Legislation may require the examination of women and children by a licensed physician, to ensure that the work which they are performing is not beyond their physical capacity. This requirement is based on the interests of the workers. Finally, it is forbidden for pregnant women to work during the 15 weeks of maternity leave⁶.

However, in 2002, only 2'786 of the women living in Congo Brazzaville were working in the formal sector⁷ and thus able to benefit from the maternity protection laws above. This represents only a small fraction of active working women in Congo, the majority of which is employed in the informal sector. Lack of any form of social protection makes it difficult for a woman to provide adequate care and nutrition to her children.

⁶http://www.ilo.org/dyn/travail/travmain.sectionReport1?p_lang=en&p_countries=CG&p_sc_id=2000&p_year=2011&p_structure=3

⁷ Mbaloma E, 2011. Accès des femmes sur le marché du travail au Congo Brazzaville : contraintes et perspectives, available at <http://uaps2011.princeton.edu/papers/110199>, pp 6.

In 2012, the CEDAW Committee pointed to the occupational segregation of women in the informal sector, as one of the major issues related to employment of women in Congo, which results in a lack of social security or other benefits for this category of working women. That is why the CEDAW Committee recommended to the government of Congo to “**extend the national social security fund to informal sector workers, including women, or develop a separate national social protection scheme for those workers.**”⁸

The CESCR Committee has also highlighted this issue during its review of Congo in 2012, where it expressed concern that a majority of the population who works in the informal sector is deprived of social security. Congo was given the recommendation to “**expand social security coverage to include disadvantaged and marginalized groups and individuals and persons who work in the informal sector of the economy and their families.**”⁹

6) HIV and infant feeding

The prevalence of HIV/AIDS in the country is 3.3% (2011): 2.6 % young women (15-24 years) and 1.2% young men (15-24 years) (2009). In 2011, UNICEF estimated that 92,000 people of all ages are living with HIV.

According to UNICEF, women are only 8% to have comprehensive knowledge of HIV infection against 22% of men. Therefore, the number of young men using a condom with multiple partners is of 40% and only 26% for young women.

Since 2005, the number of pregnant women having received anti retroviral (ARV) in order to prevent mother-to-child transmission of the virus has decreased from 29% to 16% in 2010. Progress is to be made in this field.

Data sourced from:

http://www.childinfo.org/country_profiles.php?input=445

<http://www.childinfo.org/files/maternal/DI%20Profile%20-%20Congo.pdf>

https://www.aho.afro.who.int/profiles_information/index.php/Congo:Nutrition_of_mother_and_child

<http://www.measuredhs.com/pubs/pdf/FR267/FR267.pdf>

<http://www.ilo.org/dyn/travail/travmain.byCountry2>

http://www.unicef.org/infobycountry/congo_statistics.html

⁸ Para 34, Concluding Observations 2012, available at

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fCOG%2fCO%2f6&Lang=en

⁹ Para 17, Concluding Observations 2012, available at

http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=E%2fC.12%2fCOG%2fCO%2f1&Lang=en