THE COMMITTEE ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN

Session 60 / February 2015

REPORT ON THE SITUATION OF MATERNAL HEALTH AND WORK-RELATED ISSUES IN KYRGYZSTAN

April 2014

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The right to health of women through the protection, promotion and support of breastfeeding

Working women that become mothers hold a double role that is not always easy to bear. Recognizing "the great contribution of women to the welfare of the family and to the development of society [...] [and] the social significance of maternity" (CEDAW Preamble) means acknowledging that it is a collective responsibility to create an **enabling environment for women to fulfil both roles of mother and worker**. Indeed, both maternity and work are means for women's empowerment and emancipation.

Women should be given the correct information as well as the legislative and institutional support to act in their children's best interest while continue working and being active in public life. To this end, **maternity protection** at work, and **adequate paid maternity leave** in particular, are critical interventions that States have the obligation to implement in order to realize the right of women to work, and at the same time the right to health of women and their children, allowing new mothers to rest, bond with their child and establish a sound breastfeeding routine. Therefore, working mothers are also entitled to healthy surroundings at their workplace, and more specifically, to breastfeeding breaks and to breastfeeding facilities.

Breastfeeding is an essential part of women's reproductive cycle: it is the third link after pregnancy and childbirth. It protects mothers' health both in the short and long term by, among others, reducing postpartum bleeding, aiding the mother's recovery after birth (synchronization of sleep patterns, enhanced self-esteem, lower rates of post-partum depression, easier return to pre-pregnancy weight), offering the mother protection from iron deficiency anaemia, delaying the return of fertility thus providing a natural method of child spacing (the Lactational Amenorrhea Method - LAM) for millions of women that do not have access to modern form of contraception, and decreasing the incidence of osteoporosis and the risk of ovarian-, breast- and other reproductive cancers later in life. For these reasons, **promoting, protecting and supporting breastfeeding is part of the State obligation** to ensure to women appropriate services in connection with the post-natal period and more generally, realize **women's right to health**. In addition, if a woman cannot choose to breastfeed because of external conditions, she is stripped of bodily integrity and denied the opportunity to enjoy the full potential of her body for health, procreation and sexuality. The right to breastfeed does not disappear with the fact that some women may choose alternative methods of feeding their children.

Optimal breastfeeding practices as recommended by WHO global strategy for infant and young child feeding[1] (early initiation of breastfeeding within one hour after birth, exclusive breastfeeding for 6 months followed by timely, adequate, safe and appropriate complementary feeding practices, with continued breastfeeding for up to 2 years or beyond) also provide the key building block for child survival, growth and healthy development[2]. Enabling women to follow such recommendations means empowering them by giving them the opportunity and support to best care for their child.

Breastfeeding and human rights

Several international instruments make a strong case for protecting, promoting and supporting breastfeeding, and stipulate the right of every human being, man, woman and child, to optimal health, to the elimination of hunger and malnutrition, and to proper nutrition. These include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), in particular art. 1 and 5 on gender discrimination on the basis of the reproduction status (pregnancy and lactation), art. 12 on women's right to health and art. 16 on marriage and family life, the International Covenant on Economic, Social and Cultural Rights (CESCR), especially art. 12 on the right to health, including sexual and reproductive health, art. 11 on the right to food and art. 6, 7 and 10 on the right to work, the Convention on the Rights of the Child (CRC), especially art. 24 on the child's right to health. Adequately interpreted, these treaties support the claim that '**breastfeeding is the right of both the mother and her child, and is essential to fulfil every child's right to adequate food and the highest attainable standard of health**'. As duty-bearers, States have the obligation to create a protective and enabling environment for women to breastfeed, through protecting, promoting and supporting breastfeeding.

[1] WHO 2002, Global Strategy on Infant and Young Child Feeding, http://www.who.int/nutrition/publications/infantfeeding/9241562218/en/index.html

[2] IBFAN, What Scientific Research Says?, http://www.ibfan.org/issue-scientific-breastfeeding.html

1) General situation concerning breastfeeding in Kyrgyzstan

WHO recommends: 1) **early initiation of breastfeeding** (within an hour from birth); 2) **exclusive breastfeeding** for the first 6 months; 3) **continued breastfeeding** for 2 years or beyond, together with adequate and safe complementary foods.[3]

Despites these recommendations, globally more than half of the newborns are not breastfed within one hour from birth, less than 40% of infants under 6 months are exclusively breastfed and only a minority of women continue breastfeeding their children until the age of two.

Rates on infant and young child feeding:

- ***Early initiation:*** Proportion of children born in the last 24 months who were put to the breast within one hour of birth
- ***Exclusive breastfeeding:*** Proportion of infants 0–5 months of age who are fed exclusively with breast milk
- ***Continued breastfeeding at 2 years:*** Proportion of children 20–23 months of age who are fed breast milk

Complementary feeding: Proportion of infants 6–8 months of age who receive solid, semi-solid or soft foods

General data[4]

	2010	2011	2008-2012
Annual number of birth	130,000		
Neonatal mortality rate (per 1000 live births)	19	16	
Infant mortality rate (per 1000 live births)	33	27	
Infant – under 5 – mortality rate (per 1000 live births)	38	31	
Maternal mortality ratio (per 100,000 live births) (adjusted)	71[5]		
Delivery care coverage (%): Skilled attendant at birth Institutional delivery			 99.1 98.9
Stunting (under 5 years)			22.6

Breastfeeding data

	2008-2012[6]
Early initiation of breastfeeding (within one hour from birth)	65%
Children exclusively breastfed (0-5 months)	32%
Introduced to solid food (6-8 months)	60%
Breastfeeding at age 2	26%

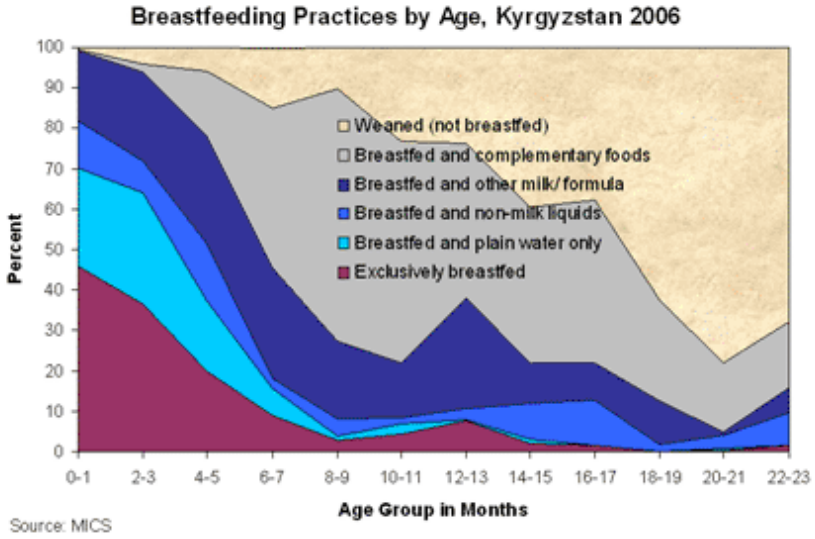
[3] www.who.int/topics/breastfeeding/en/

[4] Data for 2010 were retrieved from UNICEF, Kyrgyzstan, Maternal, Newborn& Child Survival, 2012, available at: www.childinfo.org/files/maternal/DI%20Profile%20-%20Kyrgyzstan.pdf; Data for 2011 and for 2008-2012 were retrieved from UNICEF, Country Statistics, available at: www.unicef.org/infobycountry/kyrgyzstan_statistics.html

[5] Ibid.

[6] Ibid.

According to UNICEF, almost two thirds of the children are breastfed within an hour after birth, which is a very low rate considering the fact that 99% of women are assisted by skilled attendant and that 98.9% are delivering in institutional delivery. What is more, only one child out of three is breastfed until the age of 6 months indicating a **lack of knowledge of adequate breastfeeding practices** in the country. Indeed, UNICEF points out in an article[7] that there is **no work being done** by health professionals to provide mothers and families correct information. This influences negatively child feeding practices.



The graph above provides a presentation of the overall feeding patterns among children 0-23 months for 2006, in Kyrgyzstan. It shows that a large portion of children under 6 months are being fed with breastmilk and plain water, or formula milk or not breastfed at all. In addition, a considerable portion of children under 6 months are fed with breastmilk and with solid, semi-solid and soft complementary food. 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, increases at 4-5 months and then rapidly at 8-9 months. Ideally, weaning should start at 22-23 months.

[7] Olga Grebennikova, Protecting the health and well-being of future generation, UNICEF, available at: http://www.unicef.org/ceecis/reallives_11199.html

However, a 2012 Demographic Health Survey (DHS) highlighted changes in breastfeeding practices.[8]

Table 11. Breastfeeding status by age

Percent distribution of youngest children under age 2 who are living with their mother, by breastfeeding status, the percentage currently breastfeeding; and the percentage of all children under age 2 using a bottle with a nipple, according to age in months, Kyrgyz Republic 2012

	Percent distribution of youngest children under age 2 living with their mother, by breastfeeding status										
Age in months	Not breast-feeding	Exclusively breastfed	Breast-feeding and consuming plain water only	Breast-feeding and consuming non-milk liquids[1]	Breast-feeding and consuming other milk	Breast-feeding and consuming comple-mentary foods	Total	Percentage currently breast-feeding	Number of youngest children under age 2	Percentage using a bottle with a nipple	Number of all children under age 2
0-1	5.3	75.0	14.4	0.0	4.4	0.9	100.0	94.7	99	2.8	99
2-3	1.3	61.1	21.4	2.0	4.6	9.6	100.0	98.7	168	14.2	169
4-5	2.7	38.0	21.6	9.0	4.6	24.2	100.0	97.3	149	16.7	152
6-8	4.9	14.0	15.0	3.8	5.0	57.3	100.0	95.1	225	30.7	230
9-11	12.4	10.0	4.0	1.7	1.1	70.9	100.0	87.6	259	31.8	263
12-17	30.4	4.0	0.4	1.2	1.1	62.9	100.0	69.6	409	23.9	426
18-23	60.1	2.2	1.5	1.1	0.0	35.1	100.0	39.9	343	18.0	406
0-3	2.8	66.2	18.8	1.2	4.5	6.4	100.0	97.2	268	10.0	268
0-5	2.7	56.1	19.8	4.0	4.6	12.8	100.0	97.3	417	12.4	421
6-9	5.6	13.0	11.2	3.1	4.4	62.7	100.0	94.4	318	30.6	325
12-15	31.7	3.6	0.5	0.8	1.6	61.7	100.0	68.3	282	25.8	293
12-23	43.9	3.2	0.9	1.1	0.6	50.3	100.0	56.1	753	21.0	832
20-23	63.0	1.3	1.6	1.2	0.0	32.8	100.0	37.0	228	17.2	282

Note: Breastfeeding status refers to a "24-hour" period (yesterday and last night). Children who are classified as breastfeeding and consuming plain water only consumed no liquid or solid supplements. The categories of not breastfeeding, exclusively breastfed, and breastfeeding and consuming plain water, non-milk liquids, other milk, or complementary foods (solids and semisolids) are hierarchical and mutually exclusive; thus, the percentages in these categories add to 100 percent. Note that children who receive breast milk and non-milk liquids and who do not receive other milk and who do not receive complementary foods are classified in the non-milk liquid category even though they may also get plain water. Any children who get complementary food are classified in that category as long as they are breastfeeding as well.

[1] Non-milk liquids include juice, juice drinks, clear broth, or other liquids.

Indeed, exclusive breastfeeding between 0-1 months increased from 45% in 2006 to 75% in 2012. Besides, the portion of babies being fed with plain water and breastmilk as well as the use of complementary food decreased between 2006 and 2012. Nevertheless, **exclusive breastfeeding rate at 4-5 months (38%) shows that almost 2 children out of 3 are not breastfed until the age of 6 months** and **60.1% of the children are weaned between 18 to 23 months**, which means that only 4 children out of 10 are breastfed until the age of 2 years.

These rates show that a lot has been done by the government regarding the promotion of breastfeeding practices, regarding early initiation of breastfeeding and the use of complementary food. Yet, there is still work to be done, especially in terms of protection and support of breastfeeding practices.

2) Maternity protection for working women

> The main reason given by majority of working mothers for ceasing breastfeeding is their return to work following maternity leave. It is therefore necessary to make adjustments in the workload of mothers of young children so that they may find the time and energy to breastfeed. This should not be considered the mother's responsibility, but rather a collective responsibility. States should adopt and monitor an adequate policy of maternity protection in line with ILO Convention 183 (2000)[9] that facilitates six months of exclusive breastfeeding for women employed in all sectors, and facilitate workplace accommodations to feed and/or to express breastmilk.

The Labor Code of the Kyrgyz Republic (2003) states that women are entitled to a general duration of the **maternity leave of 126 days** (70 days prior to birth and 56 days after birth). **Women are paid 100**

[8] DHS, Kyrgyz Demographic and Health Survey 2012, Preliminary report, available at: http://www.measuredhs.com/pubs/pdf/PR27/PR27.pdf

[9] ILO, C183 - Maternity Protection Convention, 2000 (No. 183)

per cent of the salary for the first 10 working days. Then, the maternity benefits decreased to 46 per cent of the wage. Mothers can extend their maternity leave up to three years but the extend is unpaid. The maternity leave is financed by the State (the employer pays the benefits from his own funds, and is later reimbursed by the State). Employers are required to provide the employee with the same job when women return from maternity leave. According to the Law on Breastfeeding and Marketing Substitutes of Kyrgyzstan, employers should provide break time for nursing mothers. Dismissal of pregnant women is penalized[10].

In 2008, during its 42nd session, the Committee on Elimination of Discrimination Against Women (CEDAW) addressed the issue of gender equality at the workplace and urged Kyrgyzstan to : *"take **measures to ensure equal opportunities** for women and men in the labour market; to ensure that all **employment-generation programmes are gender-sensitive** and that women effectively benefit from all programmes to support entrepreneurship; introduce measures to **narrow and eliminate the existing gap** between the wages of women and men; take measures allowing for the **reconciliation of family and employment responsibilities** be strengthened and further measures implemented to **promote the sharing of domestic and family responsibilities** between women and men."* (para 36)

3) International Code of Marketing of Breastmilk Substitutes

Evidence clearly shows that a great majority of women can breastfeed and will do so if they have the accurate and full information and support, as called for by the Convention on the Rights of the Child. However, **direct industry influence** through advertisements, information packs and contact with sales representatives, as well as indirect influence through the public health system, submerge women with **incorrect, partial and biased information**.

The International Code of Marketing of Breastmilk Substitutes (the International Code) has been adopted by the World Health Assembly in 1981. It is a **minimum global standard** aiming to protect appropriate infant and young child feeding by requiring States to regulate the marketing activities of enterprises producing and distributing breastmilk substitutes in order to avoid misinformation and undue pressure on parents to use such products when not strictly necessary. Even if many countries have adopted at least some provisions of the International Code in national legislation, the implementation and enforcement are suboptimal, and violations persist.

Evidence clearly shows that a great majority of women can breastfeed and will do so if they have the accurate and full information and support, as called for by the Convention on the Rights of the Child. However, direct industry influence through advertisements, information packs and contact with sales representatives and indirect influence through the public health system; submerge mothers with incorrect, partial and biased information that weaken women's agency in choosing how to care for their babies. *The International Code of Marketing of Breastmilk Substitutes (the Code)* has been adopted by the World Health Assembly in 1981. It is a minimum global standard aiming to protect appropriate infant and young child feeding by requiring States to regulate the marketing activities of enterprises producing and distributing breastmilk substitutes in order to avoid misinformation and undue pressure on parents to use such products when not strictly necessary. Even if many countries have adopted at least some provisions of the Code in national legislation, the implementation and enforcement are suboptimal, and violations of the Code persist.

[10]The World Bank, Kyrgyz Republic, early childhood development, 2013, available at : http://wbgfiles.worldbank.org/documents/hdn/ed/saber/supporting_doc/CountryReports/ECD/SABER_ECD_Kyrgyz_Republic_CR_Final_2013R.pdf

The Parliament passed the Law on Breastfeeding and Marketing Substitutes of Kyrgyz Republic in December 2008, which is based on the International Code of Breast Milk Substitutes and subsequent WHA resolutions (the Code).

The government adopted a new law on the promotion of breastfeeding practices in March 2009, limiting at the same time advertisement and promotion of infant formulas. It also planned to train health professionals to breastfeeding practices because **doctors seem to be corrupted by baby food industry** and contribute therefore to the opinion that breastmilk contains less vitamins and mineral substances than infant formulas[11]. Due to conflicts of interests, **mothers are not receiving the adequate information about their milk** and receive **free samples** of articles of baby food producers. UNICEF emphasizes in its article that there are 21 companies from 15 countries producing breastmilk substitutes in Kyrgyzstan[12]. It also highlights that there is **no program in place to monitor the new law** that has been adopted in 2009.

According to the International Code Documentation Centre, Kyrgyzstan has implemented many of the provisions of the Code as legally enforced measures. However, not all of them have been implemented.

4) Baby Friendly Hospital Initiative (BFHI) and training of health workers

> Lack of support to for women to breastfeed by the health care system and its health care professionals further increase difficulties in adopting optimal breastfeeding practices. The Baby Friendly Hospital Initiative (BFHI), which consists in the implementation by hospitals of the 'Ten steps for successful breastfeeding', is a key initiative to "*ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period*"[13], including breastfeeding support within the health care system. However as UNICEF support to this initiative has diminished in many countries, the implementation of BFHI has significantly slowed down. Revitalization of BFHI and expanding the Initiative's application to include maternity, neonatal and child health services and community-based support for lactating women and caregivers of young children represents an appropriate action to address the challenge of adequate support.

According to the WHO[14], there were 43 baby-friendly hospitals in Kyrgyzstan in 2006. However, there was no record of the total amount of maternity wards in the country. Additionally, in 2012 UNICEF[15] wrote a report, in the perspective of launching a country action plan with the Kyrgyz government. This plan will especially focus on maternal and child health and schedules that over 75% of maternity staff would be trained on effective prenatal and neonatal care.

[11] Grebennikova, Protecting the health and well-being of future generation, UNICEF, available at http://www.unicef.org/ceecis/reallives_11199.html
[12] Ibid.
[13] CEDAW, art. 12.2
[14] Dr. Ivan Lejnev and Aigul Kuttumuratova, Approches to an integrated supervisory system in Kyrgyzstan for better maternal and child health, 2009, available at: http://www.euro.who.int/__data/assets/pdf_file/0004/82534/KYRG_integrated_MCH.pdf
[15] UNICEF, Country Programme Action Plan Between The Government Of The Kyrgyz Republicv And United Nations Children's Fund, 2012, available at: http://www.unicef.org/kyrgyzstan/CPAP_2012_2016_English.pdf

5) HIV and infant feeding

The HIV virus can be passed from mother to the infant though pregnancy, delivery and breastfeeding. The *2010 WHO Guidelines on HIV and infant feeding*[16] call on national authorities to recommend, based on the AFASS[17] assessment of their national situation, either breastfeeding while providing antiretroviral medicines (ARVs) or avoidance of all breastfeeding. The Guidelines explain that these new recommendations do not remove a mother's right to decide regarding infant feeding and are fully consistent with respecting individual human rights.

UNICEF reported that the prevalence of people of all age living with HIV/AIDS was of 12% in 2011[18]. According to the 2012Demographic Health Survey, there are slight differences between the knowledge of AIDS within the Kyrgyz population. Rural areas tend to know less about AIDS (88.1%) than urban areas (94.4%). Globally, the different regions have well informed their population (between 90.9 to 98.9%), except for Djalal-Abad (86.7%) and Osh Oblast (75.4%). The survey also underlines that people from urban areas are more likely to be aware of safe sexual practices than those living in the rural areas. The majority of HIV infections are due to intravenous drug use.

According to UNICEF[19], in 2011, **78% of the HIV-positive pregnant women received antiretroviral treatment** in order to prevent mother-to-child transmission. There is **no information regarding provision of breastmilk substitutes to HIV-positive mothers**.

6) Recommendations on breastfeeding by the Committee on the Rights of the Child

The **Convention on the Rights of the Child** has placed breastfeeding high on the human rights agenda. Article 24[20] mentions specifically the importance of breastfeeding as part of the child's right to the highest attainable standard of health. Better breastfeeding and complementary feeding practices, the right to information for mothers and parents, the protection of parents by aggressive marketing of breastmilk substitute products – through the implementation of and compliance with the International Code of Marketing of Breastmilk Substitutes (WHO/UNICEF, 1981) - as well as the need for strong and universal maternity protection are now systematically discussed during State parties reviews by the CRC Committee.

At the last review in 2014 (session 66), the CRC Committee did refer specifically to breastfeeding in its

[16] *2010 WHO Guidelines on HIV and infant feeding*: http://whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf
[17] Affordable, feasible, acceptable, sustainable and safe (AFASS)
[18] UNICEF, Country Statistics, available at : www.unicef.org/infobycountry/kyrgyzstan_statistics.html
[19] UNICEF, Kyrgyzstan, available at : www.unicef.org/kyrgyzstan/health.html
[20] *"States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures: […] (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents."* Art 24.2 (e), CRC

Concluding Observations. In particular, the CRC Committee noted the Act on the promotion of breastfeeding practices of March 2009 regulating the advertisement and promotion of infant formulas, expressing however its concerns about *"the **poor implementation of the law** and reported complicity between medical personnel and the baby-food industry, which has led to **inadequate information and free samples of baby-food products being given to mothers**."* (para 53, emphasis added) Therefore, the CRC Committee recommended that the State party *"**take all necessary measures to implement its legislation promoting breastfeeding practices** and ensure that all mothers receive adequate information on the benefits of their breastmilk. It also recommends that the **State party adopt the International Code for Marketing of Breast-milk Substitutes**."* (para 54, emphasis added)

About the International Baby Food Action Network (IBFAN)

IBFAN is a 35-year old coalition of more than 250 not-for-profit non-governmental organizations in more than 160 developing and industrialized nations. The network works for better child health and nutrition through the protection, promotion and support of breastfeeding and the elimination of irresponsible marketing of breastmilk substitutes. IBFAN is committed to the Global Strategy on Infant and Young Child Feeding (2002) – and thus to assisting governments in implementation of the International Code of Marketing of Breastmilk Substitutes (International Code) and relevant resolutions of the World Health Assembly (WHA) to the fullest extent, and to ensuring that corporations are held accountable for Code violations. In 1998, IBFAN received the Right Livelihood Award "for its committed and effective campaigning for the rights of mothers to choose to breastfeed their babies, in the full knowledge of the health benefits of breastmilk, and free from commercial pressure and misinformation with which companies promote breastmilk substitutes".