

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



May 2017

Data sourced from:

Niger DHS 2012
Niger WBTi report 2016
Niger MICS 2012
UNICEF

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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 feeding¹ (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 development². 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, 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 Niger

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

Despite 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.

General data⁴

	2013	2014	2015
Annual number of birth, crude (thousands)	-	-	983
Neonatal mortality rate (per 1,000 live births)	28.1	27.3	26.8
Infant mortality rate (per 1,000 live births)	59.8	58.4	57.1
Under-5 mortality rate (per 1,000 live births)	104.1	99.6	95.5
Maternal mortality ratio (per 100,000 live births)	-	-	553
<i>Delivery care coverage:</i>			
Skilled attendant at birth	-	-	39.7%
Institutional delivery	-	-	59%
C-section	1%	-	-
Undernourished women (BMI ≤ 18) ⁵	16%	-	-
Overweight or obese women (BMI ≥ 25) ⁶	14%	-	-

Breastfeeding and child nutrition data⁷

	2012
Early initiation of breastfeeding (within one hour from birth)	53%
Exclusive breastfeeding under 6 months	23.3%
Introduction of solid, semi-solid or soft foods (6-8 months)	65%
Continued breastfeeding at 2 years	50.1%
Median duration of any breastfeeding (in months)	20.2

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

⁴ UNICEF data

⁵ Source: Niger DHS 2012

⁶ Idem

⁷ The data retrieved from the 2012 Niger DHS and MICS Survey, available at :

<http://dhsprogram.com/pubs/pdf/FR277/FR277.pdf>

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Median duration of exclusive breastfeeding (in months)	2.1
Severe wasting (in children aged 0-59 months)	6.9%
Wasting (in children aged 0-59 months)	18.7%
Stunting (in children aged 0-59 months)	43%
Underweight (in children aged 0-59 months)	37.9%

The last data on breastfeeding available date back to only 2012: there is no regular and systematic collection of disaggregated data on Infant and Young Child Feeding (IYCF) practices in Niger. In general, 49% of breastfed children have received other foods before breastmilk. This practice regards 51% of children in rural areas and 38% of children in urban areas.⁸

Before two months of age, only 34% of children are exclusively breastfed: **more than 7 children out of 10 interrupt breastfeeding before reaching three months of age. This number is particularly worrying in a country where child malnutrition is such a problematic issue.** Suboptimal breastfeeding can be caused by several factors: lack of knowledge, lack of support by the community or by the health care system itself, lack of support in the workplace (inadequate maternity protection), lack of protection of breastfeeding from the undue commercial pressure of breastmilk substitutes' manufacturers. All these points will be addressed in the following sections.

It is important to highlight also that the median duration of exclusive breastfeeding is only 2.1 months, way too far from the 6 months recommended by the World Health Organization.

The maternal mortality rate is extremely high and worrying in Niger. 553 women died in 2015 because of complications from pregnancy or childbirth. This is to be considered together with the data on institutional deliveries and skilled attendants at birth, which are both quite low: respectively 59% and 39.7% (2015).

2) Maternity protection for working women

The main reason given by the 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.

Maternity protection is regulated in Niger under the following Acts and Regulations:

- Ordinance No. 96-039 establishing a Labour Code, 1996.

⁸ Niger DHS and MICS Survey, 2012

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

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- Decree No. 67-126/MFP/T, 1967, to issue Regulations Pursuant to the Labour Code, amended to Decree No 90-203/PRN/MFP/T, 1990
- Decree on the Management of the Family Allowances Scheme of the National Security Scheme, Decree No. 65-116 , 1965, amended in Decree No. 69-148/MFP/T, 1969
- Decree No. 2005-316 establishing Free Medical Care for Women Hospitalized on Grounds of Caesarian Section, 2005
- Inter-professional Collective Agreement, 1992.

Maternity leave

Scope: In accordance with the *Labour Code*, maternity leave covers all employed women in the public and private sectors, with the exception of permanent civil servants.

Duration: 14 consecutive weeks. **Compulsory leave:** 8 weeks after confinement. **Extension:** 3 weeks, on medical grounds.

Benefits: The amount paid to the worker differs depending on the period of time she has worked for the employer. Women covered by the ***Labour Code*** who have at least 6 consecutive months of work with one or more employers, and at least 18 days or 120 hours of work per month and a monthly income of at least the minimum inter-occupational guaranteed wage, are entitled to 50% of their wages plus birth charges, and eventually medical care. If justified, they may receive also the same amount for the week extension for medical reasons. Moreover, they have the right to request the balance of payment (50%) in kind from the employer.

Those women covered by the ***Labour Code*** who have worked for at least 2 years at the same company shall receive from the employer the totality of her salary (100%), being deducted from it the amount already given by the Social Security or any other fund replacing this service.

Benefits are paid in part by the employer (50%, in cash or in kind depending on the original period of work) and in part by Social Security (50%). If the employee receives any payment in kind from the employer, this payment should continue - in the charge of the employer - from the start until the end of the maternity leave. The employer pays the totality less the amount paid by Social Security.

Paternity leave: The above-mentioned acts and decrees do not provide for any paternity leave.

Breastfeeding breaks: 1 hour per day during the year following the child's birth. No mention of these breaks being paid or not. The Labour inspector may require that a nursing room be provided in or near establishments employing more than 25 women.

Major problems related to the ability of women to continue breastfeeding arise from the fact that often **breastfeeding breaks are not long enough and in many cases there are no breastfeeding rooms or facilities in the workplace.**

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

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.

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Many provisions of the International Code of Marketing of Breastmilk Substitutes and subsequent relevant WHA Resolutions have been integrated in the national law in Niger. However, according to the WBTi report of 2016, there is a **lack of financial resources for the implementation of an effective monitoring system, as well as a lack of knowledge on the existing regulations on the matter**. It is very important to raise public awareness on the role of the Code, the risks behind its violation, and the fact that such violations are not being effectively monitored and reported. Even more important is to ensure that the health professionals are aware of the Code and subsequent WHA Resolutions, since they are more exposed to its violations.

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

Lack of support 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*"¹⁰, 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.

The BFHI was implemented in Niger in 1992, for the first time. The last evaluation for designation of Baby-Friendly Hospitals has been carried out in 2007, with no subsequent evaluations for re-assessment.

¹⁰ CEDAW, art. 12.2

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As of 2016, 13 out of 36 health facilities (public and private) in Niger have been designated as Baby-Friendly. **This corresponds to only 36% of the total.** The major problems arising in the implementation of the BFHI include: a poor system of re-assessment of the previously designated Baby-Friendly facilities, including the non-respect of the deadlines for re-evaluation processes; the lack of budgetary resources for the implementation of the Initiative; the need for an update in the evaluation tools.

With regards to the training of health professionals, there is no information on a standardized national training program aimed at the health professionals and focused on IYCF and on breastfeeding in particular. The existing documents for the health curricula/trainings are not updated on the last directives on IYCF. In general, a lack of resources for an adequate implementation of training of health personnel has been highlighted¹¹. The National Action Group for Child Feeding Promotion¹² has been working actively in the training of health professionals, together with UNICEF and the Ministry of Health. Unfortunately, the activities of the Action Group do not cover the whole territory and there is a lack of resources to fund such trainings at community level.¹³

5) HIV and infant feeding

The HIV virus can be passed from mother to the infant through pregnancy, delivery and breastfeeding. The *2010 WHO Guidelines on HIV and infant feeding*¹⁴ call on national authorities to recommend, based on the AFASS¹⁵ 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.

HIV prevalence in the adult population in Niger is 0.5%, according to UNICEF (2015). The number of pregnant women living with HIV is about 3,500, of which only 981 reported cases of treatment with ARVs for prevention of mother-to-child transmission of HIV (28%). Furthermore, the estimated number of children (aged 0-15) recently infected with HIV is close to 1,000 (UNICEF, 2015) and the estimated **mother-to-child transmission rate for the same year is as high as 25%.**

The role of women in society, their low economic power and education level, together with the socio-cultural obstacles explain their vulnerability to HIV infection. The health professionals are trained to detect HIV-positive pregnant women and to provide them with some counseling on infant feeding and with ARVs. This counseling has been reported to be insufficient in terms of duration and also in terms of coverage of the targeted women. In general, **the still high mother-to-child transmission rate shows that a more structured and methodic programme on infant feeding and HIV should be implemented in Niger**, in order to reach all the women concerned, increase the trained personnel and the support and counseling activities.

¹¹ Source: Niger WBTi report, 2016

¹² GAPAIN: Groupe d'Action pour la Promotion de l'Alimentation Infantile au Niger

¹³ Source: Niger WBTi report, 2016

¹⁴ *2010 WHO Guidelines on HIV and infant feeding*: http://whqlibdoc.who.int/publications/2010/9789241599535_eng.pdf

¹⁵ Affordable, feasible, acceptable, sustainable and safe (AFASS)

6) Government measures to protect and promote breastfeeding

Adopted in 2002, the ***Global Strategy for Infant and Young Child Feeding*** defines 9 operational targets:

1. Appoint a **national breastfeeding coordinator** with appropriate authority, and establish a multisectoral **national breastfeeding committee** composed of representatives from relevant government departments, non-governmental organisations, and health professional associations.
2. Ensure that every facility providing maternity services fully practises all the “**Ten steps to successful breastfeeding**” set out in the WHO/UNICEF statement on breastfeeding and maternity services.
3. Give effect to the principles and aim of the **International Code of Marketing of Breastmilk Substitutes** and **subsequent relevant Health Assembly** resolutions in their entirety.
4. Enact imaginative **legislation protecting the breastfeeding rights of working women** and establish means for its enforcement.
5. Develop, implement, monitor and evaluate a **comprehensive policy on infant and young child feeding**, in the context of national policies and programmes for nutrition, child and reproductive health, and poverty reduction.
6. Ensure that the health and other relevant sectors **protect, promote and support** exclusive breastfeeding for six months and continued breastfeeding up to two years of age or beyond, while providing women access to the support they require – in the family, community and workplace – to achieve this goal.
7. Promote timely, adequate, safe and appropriate **complementary feeding with continued breastfeeding**.
8. Provide guidance on feeding infants and young **children in exceptionally difficult circumstances**, and on the related support required by mothers, families and other caregivers.
 - Consider what **new legislation or other suitable measures may be required**, as part of a comprehensive policy on infant and young child feeding, to give effect to the principles and aim of the International Code of Marketing of Breastmilk Substitutes and to subsequent relevant Health Assembly resolutions.

Niger has a National Nutrition Programme, a National Strategy for the Prevention of Chronic Malnutrition and a National Strategy on Infant and Young Child Feeding (ANJE). These two strategies derive from the National Nutrition Programme and the IYCF Strategy has been completed by an Action Plan, providing for specific training of health professionals, the creation of action and support groups, counseling activities. However, the above-mentioned very good documents are not being effectively implemented because of the lack of resources. In addition, there is no National IYCF Committee and no Coordinator. **There is need for more resources in order to fully implement the IYCF Strategy and Action Plan.**

7) 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 24¹⁶ 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 2009 (Session 51), in its [Concluding Observations](#), the CRC Committee expressed its concerns about the fact that *“while rates of acute and chronic malnutrition and maternal mortality remain at a very high level, the attention paid to those critical issues seems to be underestimated”*, and about the *“low performance of health services in terms of access, utilization and quality.”* (§ 55) The CRC Committee urged Niger to take the following measure: ***“strengthening its efforts to further reduce infant and child mortality, especially by focusing on preventive measures and treatment, including vaccination uptakes, improved sanitary conditions, greater access to clean drinking water, and the management of communicable diseases and malaria; increasing its efforts to further reduce maternal mortality throughout the country, including generalization of specific actions to prevent post-partum bleeding and other major causes of maternal death; [...] ensuring that all segments of society are informed, and have access to education and support on the use of basic knowledge of child health and nutrition, including the advantages of exclusive breastfeeding for children up to 6 months.”*** (§ 56, emphasis added)

¹⁶ *“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

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About the International Baby Food Action Network (IBFAN)

IBFAN is a 37-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”.