UNICEF NIGER

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RESPONSE TO CHILD MALNUTRITION
2006 ANNUAL REVIEW

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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SUMMARY

List of abbreviations and acronyms

CIDA/IHA	Canadian International Development Agency/International Humanitarian assistance	NH	National Hospital
HO	Health Officer	NIS	National Institute of Statistics
CHO	Community Health Officer	JNM	Journée Nationale Micronutriments/National Micronutrients Day
CAP OCHA	Consolidated Appeal Process – Office for the Coordination of Humanitarian Affairs	MAD	Ministry of Agricultural Development
KAP	Knowledge, Attitudes, Practices	MAR	Ministry of Animal Resources
CDC	Center for Disease Control and Prevention	MSP/LCE-MPH/CED	Ministry for Public Health and Control of Endemic Diseases
RHC	Regional Hospital Centre	MSF	Médecins sans frontières (MSF)
CREN	Nutritional rehabilitation centres	OFDA	Office of Foreign Development Aid - USA
CRENI	Intensive Nutritional Rehabilitation Centre	WHO	World Health Organization
CRENAM	Centre for Outpatient Nutritional Rehabilitation for Moderate Malnutrition	NGO	Non-Governmental Organization
CRENAS	Centre for Outpatient Nutritional Rehabilitation for Severe Malnutrition	WFP	World Food Programme
IHC	Integrated Health Centre	EWS	Early Warning System
CUN	Niamey Urban Community	IBS	Integrated Basic Services
DFID	Department for International Development – United Kingdom	AMIS	Agricultural Market Information System
PHRHO	Public Health Regional Head Office	UNS	United Nations System
ECHO	European Commission's Humanitarian Aid Office	STA	Société de Transformation Alimentaire
FEWSNET	Famine Early Warning System	UNDAF	United Nation's Development Assistance Framework
UNFPA	United Nations Population Fund	UNICEF	United Nations Children's Fund
HKI	Helen Keller International (HKI)	CHS-URC	United Research Corporation

Introduction

The year 2006 was characterized in Niger by a strong mobilization of all humanitarian actors towards acute malnutrition treatment in children under five. Thanks to this large scale effort, 382,400 children suffering from acute malnutrition were treated and, through a blanket feeding operation, acute malnutrition was prevented in close to 355,000 children under three.

As United Nations' lead agency for emergency response to nutritional crises, UNICEF helped in mobilizing resources, equipping treatment facilities with materials and therapeutic foods, creating an extensive partnership network, coordinating and monitoring all nutrition activities, as well as building the capacities of treatment stakeholders.

It is believed that this treatment effort was instrumental in reducing acute malnutrition prevalence, which dropped from 15.3% in October 2005 to 10.3% in October 2006.

However, acute malnutrition prevalence level is still higher than the internationally recognized alarm point and requires a constant large-scale mobilization of the humanitarian community. Moreover, the level of chronic malnutrition in children under five is still high and calls for the adoption of specific strategies, to complement strategies to manage acute malnutrition.

Some of the challenges faced by the Government and its partners include maintaining the level of mobilization towards acute malnutrition treatment in a bid to cope with the huge number of children suffering from acute malnutrition, mainstreaming and integrating malnutrition treatment into the health system in order to ensure its sustainability, involving the communities in the identification of acute malnutrition cases, and finally, the major challenge of adopting prevention strategies involving communities in acute and chronic malnutrition control.

This annual review presents the achievements of UNICEF and its partners within the framework of the emergency response in the field of nutrition, in 2006. It presents the status of resources mobilization and utilization, the situation of inputs stock made available to partners, the situation of admissions in nutritional rehabilitation centres, the effects and impacts of treatment on children as well as a wrap-up of other activities carried out in the area of nutrition.

Status of resources mobilization and utilization

As of 31 December 2006, as shown in table 1, UNICEF Niger had mobilized **US$9,225,705.35** for the emergency programme in the area of nutrition. Out of this amount, **US$5,885,711.36** was committed in 2006 and **US$3,339,993.99** was programmed for the continuation of activities in 2007. The needs expressed within the CAP launched by OCHA in March 2006, i.e. **US$8,946,794**, were covered by more than 100%. The availability of emergency funds was instrumental in achieving the programme results recorded in 2006, especially in the area of procurement and other services.

Table 1: Situation of funds mobilized and used by UNICEF in 2006 for nutritional emergency response

Name	Reference	Programmable Amount	Amount committed in 2006	Amount programmed in 2007
Finnish Committee for UNICEF	SC/2005/3112-01	2,083.11	1,870.66	212.45
Belgian Committee for UNICEF	SC/2005/3121-01	63,291.47	47,566.84	15,724.63
Thematic funds for humanitarian assistance	SM/2003/9906-71	950,793.42	726,978.76	223,814.66
Liechtenstein	SM/2005/0381-01	16,589.55	16,589.55	-
United Kingdom	SM/2005/0439-01	17,036.44	16,124.69	911.75
CIDA/IHA	SM/2005/0461-01	401,091.47	401,101.30	-9.83
France	SM/2005/0577-01	248,689.92	159,119.79	89,570.13
Spanish Committee for UNICEF	SM/2005/0735-01	175,972.99	108,357.43	67,615.56
German Committee for UNICEF	SM/2005/3243-01	533,346.43	331,413.66	201,932.77
English Committee for UNICEF	SM/2005/3326-01	108,383.36	104,514.51	3,868.85
Italian Committee for UNICEF	SM/2005/3332-01	188,991.59	177,326.97	11,664.62
French Committee for UNICEF	SM/2005/3339-01	895,767.25	441,150.00	454,617.25
English Committee for UNICEF	SM/2005/3406-01	12,625.96	12,575.50	50.46
Spain	SM/2006/0054-01	549,637.31	549,461.31	176.00
Belgian Committee for UNICEF	SM/2006/0134-01	109,758.09	-	109,758.09
Denmark	SM/2006/0197-01	314,679.82	229,525.78	85,154.04
ECHO	SM/2006/0198-01	2,140,419.46	1,916,802.06	223,617.40
USAID/OFDA	SM/2006/0213-01	118,226.90	-	118,226.90
CIDA/IHA	SM/2006/0221-01	413,541.00	412,991.17	549.83
United Kingdom	SM/2006/0309-01	636,704.07	6,000.00	630,704.07
Spain	SM/2006/0404-01	614,868.67	0	614,868.67
Thematic funds for humanitarian assistance	SM/2006/9906-05	713,207.07	226,241.38	486,965.69
Sub total 1		**9,225,705.35**	**5,885,711.36**	**3,339,993.99**

Out of the amount of resources mobilized in 2006, UNICEF Niger spent US$5,296,588.25, classified under four headings as illustrated in table 2. The bulk of this amount, that is 59.44%, was used to purchase therapeutic foods, pharmaceutical products, measuring equipment and others, including international transport. A significant part of the funds, that is 36%, was directly transferred to partners, notably as support to governments (training and surveys) and as operational support to NGOs participating to the blanket feeding operation (evaluations). Services and contracts represented 3.5% of total funds whereas a small percentage of 1.15% covered mission allowances and other travel expenses related to studies.

Figure 1 : Expenditures

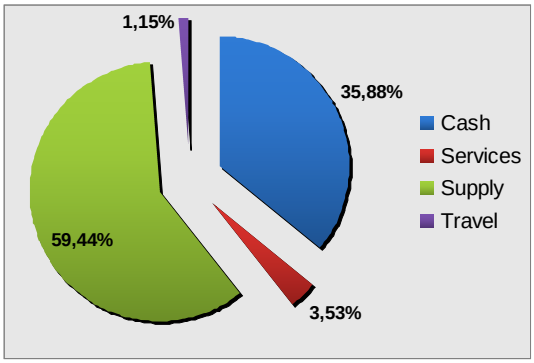


Table 2 : Expenditures

Heading	Amount	%
Cash	1,900,330.82$	35.88%
Services	187,110.03$	3.53%
Supply	3,148,166.95	59.44%
Travel	60,980.45	1.15%
Total	**5,296,588.25**	**100.00%**

Status of inputs stock made available to partners

From January to December 2006, UNICEF procurement plan recorded a relatively high implementation rate for all products distributed to partners. Over-run observed with respect to initial projections were mostly due to the scope of the malnutrition treatment programme, notably in terms of inputs volume injected into the blanket feeding operation for children under three, and the support provided to hospitals for the control of endemic diseases, notably the meningitis and cholera epidemics, as well as floods. Some of the over-run is equally accounted for by the increase in the needs of partners during the year, upon receipt of additional funds or in a bid to meet demand. Furthermore, some NGOs started their activities in the middle of the year, whereas their needs had not been taken into consideration in the initial budget. Most of the requirements of partners were met, as illustrated in table 3.

Table 3: Supply plan implementation follow-up

ITEMS	UNITS	REQUIRED QUANTITIES	DISTRIBUTED QUANTITIES
THERAPEUTIC FOODS			
F100	Cartons of 30 sachets	2643	1345
F75	Cartons of 20 sachets	723	481
Vegetable oil	Litres	179000	370712
Plumpy'nut©	Cartons of 150 sachets	42051	33470
RESOMAL	Cartons of 130 sachets	47	99
UNIMIX	Tons	1796	3266,535
MEASURING EQUIPMENT AND OTHERS			
Salter SCALES	Units	473	828
BREECHES	set of 5	473	742
FAMILY KIT	Kit for 10 families	500	385
Treated MOSQUITO NETS	Units	60935	34205
SOAP	Units	200954	91680
Imported measuring rods	Units	101	160
local measuring rods	Units	212	376
Dim wool blankets 150 cm x 200 cm	Units	28218	25229
PHARMCEUTICAL PRODUCTS			
FOLIC ACID (5mgtabs/pac-1000	pac-1000	3698	323
ALBENDAZOLE 400 mg tabs/pac-100	pac-100	42	457
AMOXICILLIN 250 mg/caps/tabs/pac-1000	pac-1000	740	212
AMOXICILLIN sus 125 mg/5 ml/bot-100 ml	Bot	292	4245
BENZYL BENZOATE LOTION 25% bot-1000ml	Bot	370	59
IRON SALT+ FOLIC ACID pac-1000	pac-1000	395	1860
NYSTATIN oral sus 100.000IU/BOT-30ml	Units	15500	5604
SYRINGE 10ml	Units	12000	9500
TRETRACYCLIN eye ointment 1% tube-5g	Tube	19834	8232
VITAMIN A 100 000 UI	Container of 500 capsules	8	107
VITAMIN A 200 000 UI	Container of 500 capsules	54	446
ZINC OXYDE 10% jar-500g	jar-500	7053	1462

Admissions to nutritional recovery centres

Overall, 382,400 children suffering from acute malnutrition, including 314,667 moderate malnutrition cases and 67,733 severe malnutrition cases, were admitted to CRENs in 2006.

Trends of aggregate admissions to the nutritional rehabilitation centres for the entire programme are illustrated in figure 2a. The blue curve corresponds to the trend expected in 2006, based on a hypothetical scenario identical to that of 2005. The red curve represents actual admissions as from week 1 of 2006. These curves reveal that the number of children suffering from acute malnutrition and admitted to the rehabilitation centres was lower than expected for the year 2006, except for the months of June and July, where the two curves superpose. Several reasons account for this situation, notably: i) the projections were made based on a crisis year (drought, locust infestation, food insecurity, etc.) ; ii) the projections did not take into account the impact on the improvement of the situation resulting from treatment efforts since July 2005; iii) the 2005 farming season was considerably better than the previous ones. The increasing variance between the two curves as weeks go by illustrates the buffer effect and the impact of interventions in the treatment of acute malnutrition through a network of about 949 CRENs, in line with the response mechanism put in place in the second half of 2005.

Figure 2.a: Admissions trends compared with 2006 projections

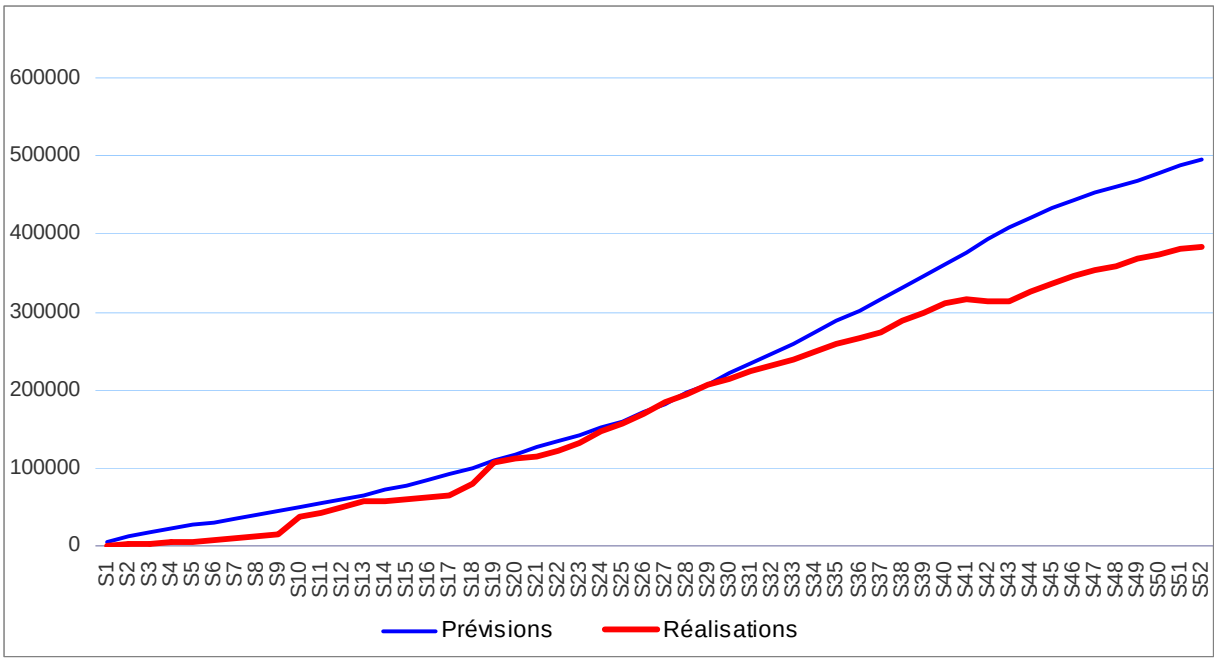


Figure 2.b : Comparative trends of new admissions per month for the period of September to December 2005 and 2006

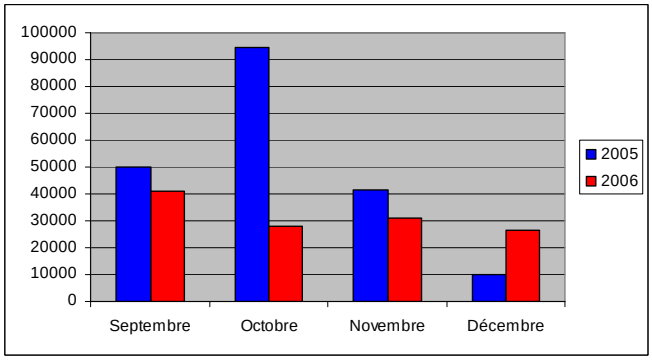
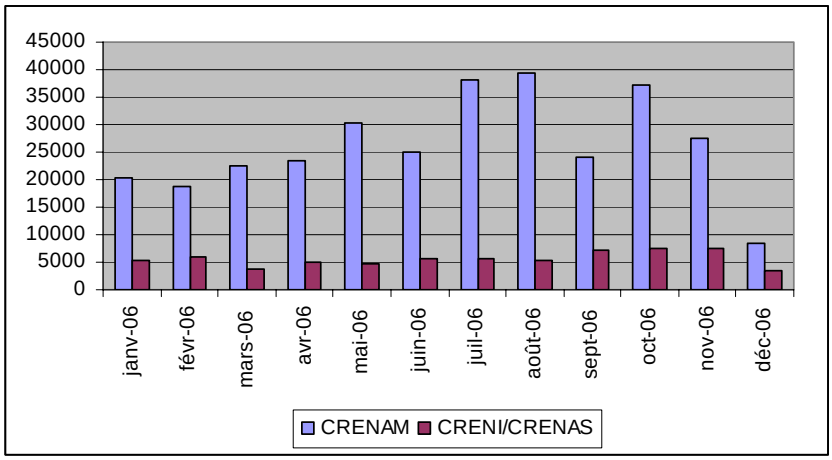


Figure 2.b shows the comparative trends of new monthly admissions for the months of September to December, respectively in blue and red for 2005 and 2006. It can be used to evaluate and compare the impact of admissions during both periods, bearing in mind that the logistical means are similar. During this 4-months period, the number of children admitted to nutritional rehabilitation centres is slightly lower in 2006 compared to 2005 except for December. The decline witnessed in December 2005 admissions is probably due to the incidental slowdown of activities in the field at this period as a result of the concomitant discussions on mainstreaming and integrating treatment of acute malnutrition into government facilities.

The graph of new monthly admissions to CREMAMs shows a peak of admissions during the months of July, August, September, and October, before dropping gradually till December.

At the level of CRENI/CRENAS, admissions virtually remained stable all through the year, thus suggesting that the severe malnutrition treatment programmes were effective.

figure 2.c : Monthly evolution of new admissions into CRENIs/CRENASs and CRENAMs in 2006



Source : UNICEF

Table 4: Distribution of admissions to rehabilitation centres and distribution of sites according to partners, from 01 January to 31 December 2006.

Partners	Nutritional rehabilitation centres						Admissions					
	Planned			Functional			Planned			Actual		
	MS	MM	Total	MS	MM	Total	MS	MM	Total	MS	MM	Total
ACF	27	49	76	21	34	55	9600	38000	47600	3995	40288	44283
AFRICARE	0	5	5	0	5	5		4582	4582	0	2633	2633
AMURT	7	23	30	7	22	29	960	4100	5060	73	5001	5074
CADEV	10	12	22	10	12	22	1080	2300	3380	1523	9186	10709
CARE	0	25	25	0	26	26	0	12800	12800	1651	10748	12399
CONCERN	14	9	23	14	10	24	11300	17800	29100	6229	14458	20687
CRF	6	16	22	6	17	23	1000	25000	26000	547	20311	20858
CRN / IFRC	0	15	15	0	14	14	0	6000	6000	0	2585	2585
GOAL	0	12	12	0	12	12	0	22000	22000	0	14441	14441
HAI	2	4	6	1	4	5	1900	5000	6900	432	3897	4329
HKI	64	103	167	53	144	197	3800	27680	31480	2311	30070	32381
Humedica	1	1	2	1	1	2	150	900	1050	194	1473	1667
IR	18	14	32	4	31	35	1891	13241	15132	816	8306	9122
M.CORPS	36	105	141	46	100	146	1200	19300	20500	980	28556	29536
MSF-F	12	12	24	12	12	24	15000	45000	60000	4948	68438	73386
MSF-F	12	0	12	15	3	18	11000	9000	20000	13504	4855	18359
MSF-Es	11	6	17	11	6	17	1221	10992	12213	3014	8379	11393
MSF-B	1	4	5	1	3	4				940	2022	2962
PLAN	50	50	100	44	42	86	2825	5745	8570	694	4168	4862
SC-UK	33	33	66	33	27	60	6446	31339	37785	19873	20068	39941
S.PURSE	4	6	10	1	11	12	200	1000	1200	37	1332	1369
URC/CHS	10		10	10		10	6500		6500	726		726
Valpro	0	40	40	0	37	37	0	26831	26831		15850	15850
WV	45	104	149	40	46	86	2525	12566	15091	1150	3653	4803
Total	**363**	**648**	**1011**	**330**	**619**	**949**	**78598***	**341236***	**419834***	**63637****	**320718****	**384355****

Source: Weekly reports of partner NGOs

*These admissions correspond to results commitments taken by partner NGOs in agreements signed with UNICEF for 2006 in the beginning of the year. UNICEF had, prior to the signing of these agreements, planned to treat 500,000 malnourished children based on theoretical projections.

**See note in the next table

Table 5 shows the distribution of new admissions by region and by type of CREN in the year 2006. Admissions to CRENAM represent 82.30% of all the admissions. Concerning treatment in CRENAM, more admissions were recorded in the Maradi region – 94,897 admissions, that is 31.2% of the total number of admissions for the whole country, followed by the region of Zinder, with 21.3%, then Tillaberi and Tahoua with respectively 20.5% and 16.4%.

Concerning CRENIs and CRENAS, the region of Zinder comes first with 43% (29,130) of new admissions, followed by Maradi with 32.3% and then the Tahoua region with 3.4%. The regions of Agadez and Diffa recorded the lowest admissions rate with 0.71% and 0.44% for CRENIs/CRENAS respectively.

The fact that three regions of Niger (Maradi, Zinder and Tahoua) recorded the highest number of admissions to the centres is understandable given the high rates of malnutrition in these three regions, their population and the great number of partners operating there.

Table 5: Distribution of new admissions by administrative region, from January to December 2006

REGIONS	J	F	M	A	M	J	J	A	S	O	N	D	Total
CRENAM	**20608**	**18971**	**22495**	**23662**	**30501**	**25286**	**38400**	**39852**	**24018**	**35983**	**26459**	**8432**	**314667****
AGADEZ	279	184	149	179	120	317	181	553	346	474	189	167	3138
DIFFA	337	404	629	1262	1919	1640	1440	995	955		742		10323
DOSSO	775	940	1089	1263	1222	1078	210	1535	623	1216	479	210	10640
MARADI	4948	3650	1995	2130	3623	5196	13847	11694	12303	23766	8053	3692	94897
NIAMEY	241	1389	1346	1393	1295	1043	3250	128	706	967	584	52	12394
TAHOUA	3266	4385	5055	4402	3886	6158	5900	4546	3715	4640	4146	1419	51518
TILLABERI	8854	4324	6959	9051	13967	4497	8392	1039	2742	1848	2540	393	64606
ZINDER	1908	3695	5273	3982	4469	5357	5180	19362	2628	3072	9726	2499	67151
CRENI/CRENAS	**5270**	**5918**	**3903**	**5008**	**4623**	**5774**	**5687**	**5475**	**7032**	**7379**	**8217**	**3447**	**67733****
AGADEZ	28	32	20	10	11	62	32	42	49	89	71	36	482
DIFFA	37	42	70	24	40	45		3	26		9		296
DOSSO	103	122	145	179	218	228	201	72	52	51	955	32	2358
MARADI	1054	3243	1189	1386	1412	2513	1208	1689	1873	2514	2220	1570	21871
NIAMEY	158	236	237	220	398	124	350	76	203	324	129	138	2593
TAHOUA	993	469	125	415	301	1082	1271	576	918	786	1370	385	8691
TILLABERI	361	234	178	92	58	328	184	48	256	251	287	35	2312
ZINDER	2536	1540	1939	2682	2185	1392	2441	2969	3655	3364	3176	1251	29130
Total	**25878**	**24889**	**26398**	**28670**	**35124**	**31060**	**44087**	**45327**	**31050**	**43362**	**34676**	**11879**	**382400****

Source: Monthly reports of partner NGOs

** The total cumulative number over 12 months, based on monthly reports, corresponds to the number of children treated. It is slightly different from the total number of admissions based on weekly reports (previous table), forwarded each week by partner NGOs, based on the number of food rations served. It should be noted that, in a weekly desegregation one child can be counted three times if he or she has been admitted in a CRENI, a CRENA and then to a CRENAM. Such duplication is corrected in the monthly count of children admitted to the centres.

Effects and impacts of treatment on children

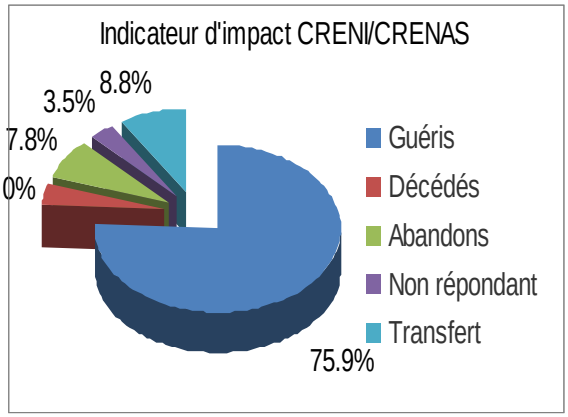
Table 6 and figure 3 show performance indicators by type of CREN. In CRENAM, out of 265,412 children discharged, 208,194 recovered, representing a recovery rate of 79%. The deceased and dropouts rates, which are respectively 0.8% and 8.3%, are below accepted standards. Non-respondent cases represented 9.5% of the total. With regard to children admitted to the CRENI/CRENAS programmes, out of 68,840 discharged, 50,378 children recovered, representing a recovery rate of 75.9%. Deceased and dropouts rates respectively of 4% and 7.8% are below the acceptable standards (10% and 15% respectively). Non respondent cases represented 3.5% of the total number of children suffering from severe malnutrition.

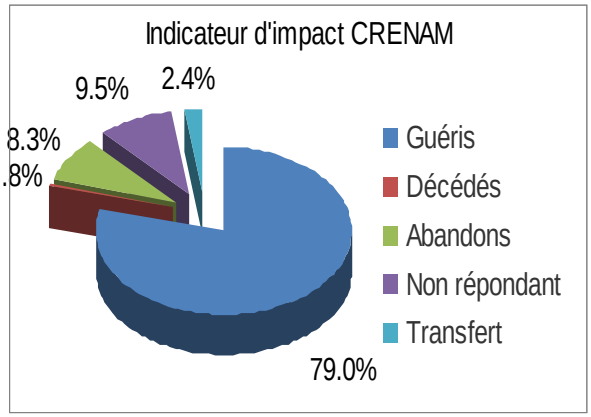
It should be noted that the calculation method used for these indicators considers dropouts and transferred cases in the denominator, whereas these children did not complete the treatment required to get well (dropouts) or were transferred elsewhere to receive more appropriate treatment (transferred). These considerations imply that the rates of recovered and deceased cases calculated do not only encapsulate the efficiency of the therapeutic protocol, but also includes other aspects concerning the functioning of centres which justify the high rates of dropouts and transferred cases. Moreover, research efforts have been made this year to track children considered as “dropouts” cases. It showed that dropouts cases can be children considered by their mothers to have recovered or whose mothers did not have time to return to the centre or children who died in the course of the treatment but are not registered as such.

As per non-respondent cases, we do not have any reference to assess the level of this indicator. However, it is considered very important and during the revision of the national Protocol, procedures have been adopted to improve this indicator.

Table 6 and figure 3: Evaluation of discharge indicators per type of centre

CRENI/CRENAS		Reference	CRENAM		Reference
Recovered	75.9%	75.0%	Recovered	79.0%	70.0%
Deceased	4.0%	10.0%	Deceased	0.8%	3.0%
Dropouts	7.8%	15.0%	Dropouts	8.3%	15.0%
Non respondent	3.5%		Non respondent	9.5%	
Transferred	8.8%		Transferred	2.4%	
	100%			**100%**	

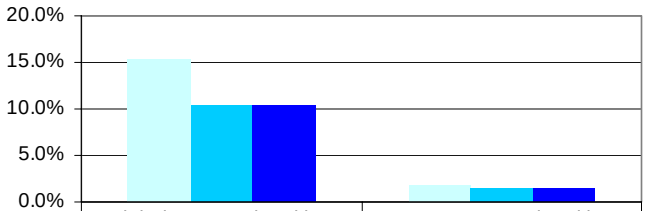




Medium-term impact

The evaluation of the impact of management of acute malnutrition interventions at the national level is complex due to the concurrence of other activities in other sectors also having an impact on malnutrition. However, the comparison of acute malnutrition prevalence at various times as indicated in various national surveys, conducted during similar periods of the year and based on identical methods (e.g. October 2005 UNICEF/CDC/Niger Government survey and the October 2006 UNICEF/WFP/ Niger Government survey), has helped in highlighting the plausibility of the impact of a large-scale intervention in response to acute malnutrition in Niger.

Figure 4.a: Trends of global acute and severe acute malnutrition from 2005 to 2006 in children aged 6 to 59 months



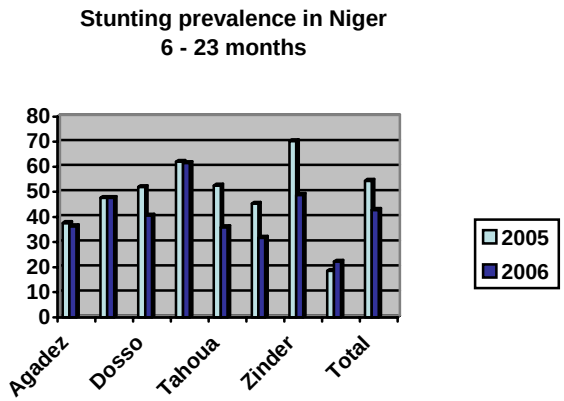
	Global Acute Malnutrition	Severe Acute Malnutrition
October 2005 UNICEF/CDC/GoN	15.3%	1.8%
May 2006 MICSIII	10.3%	1.5%
October 2006 UNICEF/INS/PAM	10.3%	1.4%

The results of various nutritional surveys (Figure 4.a) reveal that the rate of acute global malnutrition has significantly declined, dropping from 15.3% in October 2005 to 10.3% in May 2006 as well as in October 2006, which is still above the intervention threshold (> 10%). A similar observation was made for severe acute malnutrition, though to a lesser extent. This significant reduction of moderate acute malnutrition prevalence can be associated with the huge effort made and the effectiveness of the response to malnutrition by all the partners supporting the government, including the United Nations, donor agencies and NGOs. The establishment of a network of more than 900 rehabilitation centres with the support of 24 NGOs, where, at the beginning of 2005, there was only one CRENI, has been instrumental in achieving these results.

The existence of this network, as well as the significant effort towards the management of acute malnutrition, largely account for the net improvement witnessed by the three regions (Tahoua, Maradi and Zinder) which recorded the highest rates of acute malnutrition in 2005. The rate in the regions of Maradi (6.8%) and Zinder (9.7%) are now below the threshold of 10% whereas one year ago, the malnutrition prevalence in these regions was above the critical level of 15%. With 12.5%, the regions of Agadez, Dosso and Tahoua now have the highest acute malnutrition rates in the country. According to the October 2006 national nutritional survey, the situation is still severe (> 10%) in 5 out of 8 regions.

However, one cannot overlook the concurrent effect of all actions which indirectly contribute to the improvement of the nutritional situation, as well as to the reduction of mortality rates in children under five, as revealed in the EDS/MICS3 survey (between 2000 and 2006, under five child mortality has fallen from 280 ‰ to 198 ‰).

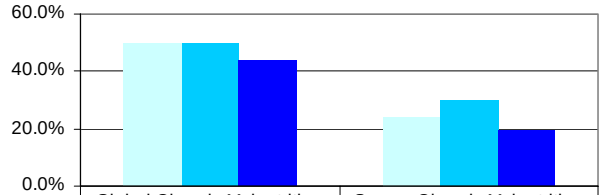
Figure 4.a: Comparison of chronic malnutrition (stunting) from 2005 to 2006 in children aged 6-23 months



It can also be observed that chronic malnutrition prevalence has reduced, dropping from 50% in October 2005 and May 2006 to 43.8% in October 2006. A more detailed analysis of the trend of chronic malnutrition reveals that this reduction in prevalence is greater and more significant in younger children (Figure 4.b). Such an output attests to the fact that the treatment of acute malnutrition, associated with communication initiatives towards behavioural change, has a positive impact on acute malnutrition prevalence for all children under five. However, the treatment of acute malnutrition, in the short term, has only a slight impact on the prevalence of chronic malnutrition. Moreover, this impact is only perceptible in younger children.

Even though the rate of chronic malnutrition has dropped, its level is still high – 4 children under five out of 10 are stunted - and requires the mobilization of all actors. In order to address this issue, it is necessary to develop programmes to curb chronic malnutrition through prevention and monitoring activities, centred on an intervention package for households, comprising exclusive breastfeeding for infants and adequate feeding of young children, hygiene and public health actions.

Figure 4.c: Evolution of global chronic and severe malnutrition among children between 6 to 59 months from 2005 to 2006



	Global Chronic Malnutrition	Severe Chronic Malnutrition
October 2005 UNICEF/CDC/GoN	50.0%	23.9%
May 2006 MICSIII	50.0%	29.8%
October 2006 UNICEF/INS/PAM	43.8%	19.5%

Other nutrition activities

1) National Food and Nutrition Policy and National Nutrition Plan of Action

Following the 11 to 13 October 2006 workshop on the validation of the National Food and Nutrition Policy and of its implementation plan, the Ministry of Public Health and Endemic Diseases Control is in possession of the final validated versions to be submitted to the Government Secretariat for adoption.

In summary, the National Food and Nutrition Policy acknowledges the importance of nutrition in the country's social and economic development and promotes the following strategies:

- Prevention strategies, namely: fight against food and nutrition insecurity in households, promotion of the production of food rich in micronutrients, nutritional monitoring, nutrition of young children in schools, implementation of essential nutrition interventions, promotion of the development and use of adequate food supplements, fortified food ;
- Remedial strategies such as the improvement of access to dietetic and medical treatment, control of interaction between nutrition and HIV, treatment of emerging diseases linked to over-feeding, diabetes, obesity, hypertension and cardio vascular diseases;
- Cross-cutting strategies including the development of a holistic approach towards nutrition issues (under-nutrition and over-nutrition), development of an efficient nutritional communication, poverty reduction and women empowerment, the operational integration among MPH/CED nutrition sections, the MAD and MAR vulgarization facilities and the communication and education services, the coordination of nutrition and development activities, the reinforcement of human resources, the national capacity building for the management and prevention of malnutrition, and the involvement and participation of community structures.

The National Nutrition Plan of Action for the period 2007-2013 is an effective framework for the implementation of the national policy. It includes eight (8) major programmes directly oriented towards food security and malnutrition control. They include:

- Diversification of food production and enhancement of nutritional value;
- Control of malnutrition and specific deficiencies;
- Treatment of socio-economically underprivileged and nutritionally vulnerable persons;
- Promotion of healthy diets and ways of life;
- Promotion of good feeding practices for infants and young children;
- Promotion of food quality and safety;
- Evaluation, analysis and control of the food and nutrition situation, capacity building and evaluation/monitoring;
- Coordination, training and research

2) Blanket Feeding Operation

One of the lessons learnt from the management of the 2005 crisis is the necessity to pre-empt the malnutrition spiral by distributing food supplies right on the onset of the lean period. Thus, in 2006, a blanket feeding operation was conducted in the regions of Tahoua, Maradi and Zinder, thanks to the financial support from UNICEF, WFP and 5 NGOs (Amurt, CARE, CRS, Valpro and World Vision). It consisted in deploying a preventive food safety net as a complement to the emergency programme. Despite the initial delay suffered at the beginning, this programme made it possible to reduce the risk of malnutrition in more than 350,000 children under three.

This target distribution of supplementary food (CSB or UNIMIX) focused on children under three living in areas situated more than 10km away from rehabilitation centres (outside of the CREN coverage area), in regions where acute malnutrition was rife (Maradi, Zinder and Tahoua). The areas were also selected based on the results of the Emergency Food Security Assessment (EFSA) conducted by the WFP.

For three straight months, a monthly food package comprising 12.5 kg of CSB/UNIMIX, 1.25 kg of vegetable oil and 0.94 kg of sugar (for CSB packages only) was distributed to a total of 354,889 beneficiaries (93,959 under three children in Maradi, 125,747 children in Tahoua and 135,183 children in Zinder). In total, 14.1 tons of cereal flour was distributed.

An initial assessment was conducted prior to the distributions to determine the nutritional status (through measuring of the mi-upper arm circumference) and the food security conditions of the

target populations. The distribution operation ended late December. Partner NGOs are presently taking final stock of the operation with a view to assessing the impact and getting feedback from the targeted families vis-à-vis the distribution. It should be noted that UNICEF regrets the fact that this operation started late and strongly recommends that it should start on the onset of the lean season, between May and August, if it is to be carried out in 2007.

3) Integration of nutritional indicators into EWS follow-up

The year 2006 witnessed the introduction of nutritional indicators in the monitoring of the EWS (SAP in French) vulnerable areas. As a reminder, up to the end of 2005, the monitoring of EWS vulnerable areas used to use only agro-ecological and economic indicators, based on a monthly data collection, in assessing changes in the vulnerability situation of the monitored areas.

Following the food and nutrition crisis of 2005, UNICEF provided financial, technical and logistic support to the introduction of nutritional indicators in the monitored areas of 12 departments covered by the UNICEF cooperation programme. The 2006 experiment answered a need for analysis and an expectation of different partners but it encountered some difficulties due to the poor quality of data collected. Given this situation, UNICEF requested that the project's implementation procedures be reviewed.

In this regard, meetings held with the EWS coordination body enabled the following measures to be recommended:

- Recruitment and training of agents in each region to collect monthly data. Part-time employment of agents rather than making use of state agents.
- Close supervision by state agents in charge of monitoring EWS zones;
- Advocacy to invite other partners to strengthen and scale up the system in areas outside UNICEF's main intervention area, particularly in regions characterized by severe food insecurity such as Tillabéri and Ouallam;
- Mobilization of technical assistance in nutrition within the EWS to be charged of preparing EWS technical tools and managing the results. This would greatly contribute to an in-depth improvement of this data-collection tool.

A report being prepared at the level of the EWS should help in formulating new strategies aiming at rapidly revamping the activity.

4) KAP study on determinants of young children nutrition and feeding practises

In August 2006, UNICEF conducted, in the region of Maradi, a quantitative and qualitative study on nutrition-related knowledge, attitudes and practices comprising the issues of access and resort to primary health care services for pregnant and nursing mothers, new-born babies and young children, access to drinkable water, hygiene and sanitation. The study established a comparison between the practices observed in the area of nutrition and those recommended. The characteristic features of these inefficient practices were examined and possible strategies ultimately defined in a bid to promote best practices and adequate behaviours. The priorities highlighted by this study were as follows:

- Exclusive breastfeeding in the first 6 months of life;
- Food supplements for children after 6 months to complement breast milk;
- Practices to be adopted for children aged 0 to 5 years;
- Nutrition for girls aged between 10 to 15 years, pregnant and nursing mothers (mothers of babies aged between 0 - 6 months).

Thanks to this study, UNICEF has detailed information on the behavioural determinants of targeted groups in their socio-cultural environment. Based on the findings, it is possible to provide adequate solutions to the needs of targeted groups and to design an integrated communication plan, in 2007. This plan will comprise communication strategies and tools for behavioural change adjusted to the local context.

The communication tools and techniques so developed will be implemented, in a pilot phase, in four departments (Tessaoua, Madarounfa, Mayahi, and Dakoro) of the Maradi region, one of the areas most hit by the food and nutritional crisis in 2005.

5) Support for the local production of Plumpy'nut©

In order to support the local production of therapeutic foods for severely malnourished children, UNICEF, with the financial support of ECHO, purchased, in 2006, close to 130 tons of Plumpy'nut©, manufactured by STA (Société de Transformation Alimentaire) in Niamey. It made possible to attend to 13,000 severely malnourished children treated in 2006. This collaboration with STA will continue in 2007 in order to promote the local production of this vital therapeutic food in the treatment of severe malnutrition. According to UNICEF, such experience should be significantly and constantly encouraged, especially as STA is the only company in the sub-region manufacturing this therapeutic food. Furthermore, under UNICEF's strict quality control, Plumpy'nut© packaging will, in 2007, undergo some modification aimed at easing its use by under five children (sachets instead of cans).

6) Training

Training sessions on the Protocol of management of malnutrition were organized for health agents from both public sector and ngos. Overall, 718 service providers benefited from capacity building trainings in 2006. In addition, 169 community health officers were trained in the screening and referral of malnutrition cases. Table 7 shows a breakdown of training beneficiaries.

Table 7: Summary of agents trained in 2006

Training venue	Place of origin	Number	Observations
Training sessions conducted in January 2006			
NIAMEY	CUN, Tera District	65 HOs	Completed
ZINDER	Zinder region	52 HOs	Completed
Tillaberi	Tillaberi District	14 HOs	03 - 06 April 2006
Training sessions conducted in May 2006			
NIAMEY	Dosso region (CHR, DRSP, CSI Boboye)	25 HOs	Completed on 20 May 2006
Tahoua	Zinder region	130 targeted	04 – 29 May 2006
Filingué	Filingué	13 HOs and 19 CHO	Completed
Training sessions conducted in July 2006			
DOSSO	Loga District	12 HOs	Completed on 05 May 2006
Tillabéri	Kollo and Say (Valpro) District	46 HOs	Completed
Mayahi	Mayahi	50 HOs	In two sessions
Training sessions conducted in July and August 2006			
Tillabéri	Ouallam – Fillingué -Tillabéri and Téra	72 HOs	Completed (5 sessions)
DOSSO	Dosso Region (DRSP)	96 HOs	Completed (4 sessions)
Training sessions conducted in November 2006			
Zinder	Mirriah, Matameye, Magaria, HN Zinder	26 HOs	13 – 19 November 2006
Maradi	Dakoro, Maradi Council, Aguié, Mayahi, Tessaoua and Guidan Roumdji	117 HOs	Completed in December 2006
Tahoua	Tahoua region	150CHOs	Completed
Total number of Health Officers		**718 HOs**	
Total number of Community Health Officers		**169CHOs**	

7) Review of the National Protocol for the management of acute malnutrition

The National Protocol, first drafted and validated in August 2005, was reviewed following a participative process which involved all partners (Government of Niger, NGOs, UNICEF, WFP and WHO). This review addressed concerns about adapting the initial protocol to operations implementation requirements particularly geared towards greater community involvement.
It equally enabled the integration of new knowledge on malnutrition treatment. A whole chapter is henceforth devoted to community involvement, especially with regard to the treatment, screening and referral of cases. An appetite test was included amongst the conditions for admitting severe malnutrition cases and a more detailed description is provided on pathological complications.
Training modules and fast reference booklets will be adapted as recommended in the new protocol. In 2007, health officers will be re-trained or trained in this reviewed Protocol.

8) Quality assurance in nutritional rehabilitation centres

In line with UNICEF's support for the integration of malnutrition management interventions in Government health centres, and considering CHS-URC quality assurance experience in the health facilities of Niger, this NGO was solicited in order to improve the quality of the treatment of severe acute malnutrition in some hospitals and the scaling up of such treatment to other health facilities. The project equally aims, in 2007, at testing the quality approach in integrated health centers for the outpatient treatment of moderate malnutrition.

Conclusions and way forward for 2007

The year 2006 witnessed, following the 2005 acute crisis, a high mobilization of national and international actors for the management of acute malnutrition in children in Niger. The State of Niger showed a committed and collaborative attitude which facilitated the support provided by partners.

Significant results were recorded: 382,400 children were admitted to different nutritional rehabilitation centres, 355,000 children benefited from a blanket feeding operation, the coordination of a network of 24 NGOs and national health facilities was undertaken, capacity building through the training of over 700 health officers, and the monitoring of the nutritional situation, thanks to which, on two occasions, a snapshot of the national and regional situation was presented.

In terms of impact, the reduction of acute malnutrition rate and its levelling at 10.3% throughout 2006 constitute a major achievement which can be associated with the large scale effort made by all partners. However, the rate of global acute malnutrition is still above the alarm threshold, thus requiring a consistent commitment of all stakeholders.
The efforts made towards fostering the mainstreaming and integrating of acute malnutrition treatment into Government health facilities constitute a great challenge. Moreover, considering the large number of children suffering from moderate acute malnutrition and the high level of severe malnutrition, it is imperative to concurrently invest in preventive strategies at the community level. The high level of chronic malnutrition in under five children, particularly in younger children, should draw the attention of the humanitarian community, despite progress made.

By and large, the following lessons and avenues for reflection can be drawn from the 2006 review:

- ✓ The strong mobilization for the management of acute malnutrition has a significant impact on the prevalence of acute malnutrition, particularly in its moderate form;
- ✓ The treatment of malnourished children is effective;
- ✓ The prevalence of acute malnutrition requires a consistent commitment;
- ✓ The treatment of acute malnutrition has only a limited impact on chronic malnutrition on the short term;
- ✓ It is fundamental to integrate into future strategies a greater malnutrition prevention dimension, associated with sustainable strategies for the management of acute malnutrition, both of which should be centred on community involvement;
- ✓ Prevention should be included in an integrated package of activities aiming at improving family practices for child survival and development;
- ✓ Activities contained in the family care package should be based on scientifically proven high impact, yet low cost activities;
- ✓ The promotion of food diversification, component of the long-term solution, should constitute the focus of youth-centred initiatives;
- ✓ Scaling up is crucial for the realisation of Millennium Development Goals.

Within this context, UNICEF, on behalf of all the children of Niger, appeals to the Government, partners, donors and communities to strengthen the partnership in favour of the management of malnutrition, by focusing their actions even more towards the survival and development of under five children.

UNICEF's strategic lines of action for 2007

The objective of the response to child malnutrition in Niger in 2007 is to control malnutrition and associated mortality in children under five. To this end, it would be appropriate to simultaneously ensure the treatment of malnourished children in adequate facilities and develop malnutrition prevention activities at the community and household level.

The target population comprises all children under five who suffer from malnutrition or are vulnerable to malnutrition, bearing in mind that children under three are the most vulnerable in this target group.

In this context, strategic objectives have been set as follows:

- Ensure the dietetic and medical treatment of malnourished under five children in the existing network of nutritional rehabilitation centres.
- Increase the access of children under five to adequate foods (enriched flour, ready-for-use therapeutic products,…)
- Establish an effective nutritional monitoring system for children under five
- Implement a communication plan on better exclusive breastfeeding and complementary food practices for infants and toddlers
- Prevent malnutrition in children under three; especially during the lean season, by distributing complementary foods through a blanket feeding operation conducted immediately right on the onset of the lean though its end.
- Target pregnant and nursing mothers in nutritional activities.
- Step up the monitoring and evaluation of the nutritional situation of under-fives
- Strengthen the community approach
- Enhance the mainstreaming of nutritional recovery activities into government structures;

The intervention strategies are as follows:

At the institutional level

- High-level advocacy aimed at securing the approval and support of the authorities for nutrition activities
- Launch a national conference on the long-term treatment and prevention of malnutrition which should come out with an action plan
- Finalize and institutionalize the integration and operating procedures of partner NGOs
- Specify communication methods of NGOs and UN agencies and promote planned and/or common actions based on the results of surveys and other key events
- Build Government's coordination capacities.

At programme level

- Groups targeted by the activities:
  - -All malnourished under-fives for malnutrition treatment, with priority given to under-threes;
  - -Children under five for prevention;
  - -Pregnant and nursing mothers;
  - -Malnourished women of child-bearing age
- Dietetic and medical treatment of malnutrition cases in nutritional rehabilitation centres
- Free access to health care, including to therapeutic foods
- Growth monitoring, treatment and prevention activities at the community level and by the community
- Increased access of infants and young children to adequate foods
- Nutritional monitoring activities at national level.

Based on these defined lines of action, UNICEF's strategy in response to child malnutrition aims at ensuring the achievement of the Millennium Development Goals 1 and 4, namely: halve the proportion of people who suffer from hunger and reduce by two-thirds the under-five mortality rate, between 1990 and 2015,.

To this end, UNICEF has budgeted, for its 2007 nutrition programme, the amount of US$8,970,400, as summarized in table 8. Within this budget and against the CAP launched by OCHA in December 2006, UNICEF Niger is seeking to mobilize US$5,879,318 in order to treat 300,000 malnourished under-fives in 2007.

Table 8: Summary of UNICEF 2007 nutrition programme

SUB PROJECTS	EXPECTED OUTPUTS	BUDGET
Malnutrition prevention	***Output 1.1*** Proportion of women who exclusively breast-feed their children (0 to 6 months) increased from 1% to 5% and Proportion of children between 6 to 24 months receiving adequate complementary feeding increased by 30%	$1,670,700
	Output 1.2 Effective micronutrient supplementation for target groups (100% of children between 6 to 59 months, 60% of post partum women) and effective fortification of food (extensive use of iodized salt in households and identification of foods containing Vitamin A and iron) countrywide.	$1,269,500
	Output 1.3 Good family practices concerning nutrition for women and adolescents promoted	$508,000
	Sub total 1 Malnutrition prevention	**$3,448,200**
Malnutrition treatment	***Output 2*** Response to the treatment of 350,000 children (30,000 severe cases) and 65,000 pregnant and nursing women suffering from moderate and severe malnutrition effective in all districts and response to localized crisis	$4,221,000
	Sub total 2 Malnutrition treatment	**$4,221,000**
Nutritional monitoring	***Output 3.1*** Community-based nutritional monitoring system reinforced	$527,500
	Output 3.2 Institutional nutritional monitoring system reinforced	$483,000
	Output 3.3 Institutional support and advocacy ensured	$290,700
	Sub total 3 Nutritional monitoring	**$1,301,200**
TOTAL		**$8,970,400**

UNICEF heartily thanks donors and partner NGOs:	
Donors Canadian Development Agency English Committee for UNICEF German Committee for UNICEF Belgian Committee for UNICEF Danish Committee for UNICEF Spanish Committee for UNICEF French Committee for UNICEF Finn Committee for UNICEF Italian Committee for UNICEF Danish Government Department of International Development - DFID Government of United Kingdom Humanitarian Aid office of the European Union (ECHO) Spanish Government Thematic funds for humanitarian response French Government Liechtenstein Government Government of the United Kingdom Office of Foreign Development Aid USAID/OFDA	**Partner NGOs** Action Contre la Faim Africare AMURT CADEV CARE CONCERN French Red Cross Society International Red Cross and Red Crescent Societies GOAL Human Appeal International (HAI) Helen Keller International (HKI) Humedica Islamic Relief Mercy Corps Médecins sans frontière (MSF) Belgium Médecins sans frontière (MSF) Spain Médecins sans frontière (MSF) France Médecins sans frontière (MSF) Switzerland Plan international Niger Samaritan Purse Save the children UK URC Valpro World Vision

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