UNICEF NIGER

# Health
# Thematic Report

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**Prepared by**

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## Contents



## I. Abbreviations and Acronyms

| | |
|---|---|
| ANC | Antenatal Consultation |
| Comdeco | Convergence Municipalities |
| EVM | Effective Vaccine Management |
| iCCM | Integrated community case management |
| IMCI | Integrated management of childhood illness |
| IPT | Intermittent preventive treatment for malaria |
| LB | Lives Births |
| LQAS | Lot Quality Assurance Sampling |
| MDG | Millennium Development Goal |
| MOH | Ministry of Health |
| ORS | Oral Rehydration Salt |
| PMTCT | Prevention of mother to child transmission of HIV |
| PSM | Supply chain management |
| SAM | Severe Acute Malnutrition |
| SDG | Sustainable Development Goals |
| SMC | Seasonal Malaria Chemoprevention |
| UNFPA | United Nations Populations Funds |
| WHO | World Health Organisation |

## II. Executive Summary

This report presents the activities and results achieved by UNICEF in collaboration with partners in the Health sector in 2016.

This year, UNICEF supported the development and accessibility to quality healthcare in Niger through the implementation of high impact preventive and curative interventions. Some activities were implemented nationwide, while others focused on a number of the most vulnerable municipalities that benefit from support from different UN agencies (‘convergence municipalities’).

**Nationwide:**

Structural interventions were implemented nationwide to improve the national health care system and performances.

A major achievement in 2016 was the validation of the elimination of Maternal and Newborn Tetanus. The validation survey, led by the World Health Organization, was preceded by a pre-

validation exercise led by UNICEF in the poorest, underperforming districts of Nguigmi, Gouré and Tanout. The results indicated less than 1 case per 1,000 live births and elimination was validated. A Maternal and Newborn Tetanus 'maintain plan' has been developed and is being implemented.

Performance of routine immunization still faced important challenges this year. Administrative data reported high immunization coverage, with Penta3 coverage increasing from 82% in 2015 (third quarter) to 91% for the same period in 2016; however, WHO-UNICEF estimates indicate a Penta3 coverage of only 65% for 2015, with evidence of a declining trend in 2016, as well as a drop-out rate between Penta1 and Penta3 of 24%. Those discrepancies highlight the challenge that represent accurate data collection in the country for better planning and response.

According to the same estimates, measles vaccination coverage is stagnating at 73% and large pockets of children are left unvaccinated (more than 270,000 in 2016). Recurrent measles outbreaks are the consequences of this gap, with 1,342 cases and 11 deaths reported in 2016. The national immunization system is struggling to cope with demands placed on it by the introduction of new vaccines. Despite huge investments in the cold chain, national capacities in vaccine management and data quality require further strengthening.

To address the gap in access to care that affects more than half of the population, UNICEF supported the Ministry of Health to initiate integrated Community Case Management of malaria, diarrhea and pneumonia, the three main killer diseases for children. In six districts, 423 community health workers were trained and equipped to offer an integrated curative, preventive and promotional package to the population living more than 5 km from a primary health care center. As of November 2016, more than 4,000 children received medical consultations and / or treatment during the second half of the year.

As for the preceding year, 2016 annual work plans was implemented in the context of responding to several emergency situations in different regions of the country.

- During the year, 2,534 cases of measles were reported, with 11 deaths nationwide. A response was organized for each outbreak. In Diffa region, measles immunization activities reached 112,725 children aged between 9 months and 14 years, including refugees and returnees. In Maradi region, similar response reached 22,721 children of the same age group. These actions were made possible through UNICEF funding of vaccines and supplies, plus additional support from other partners.
- The emergence of the Rift Valley Fever in Niger, which started in July in Tahoua region, required intervention from health sector to mitigate the epidemic. In total, 397 symptomatic cases with complications were reported and 34 deaths were registered. The Government of Niger opted for the symptomatic treatment for patients and awareness raising toward the population of the region. UNICEF supported those efforts through treatment for all reported cases by providing the necessary drugs and by funding mass communication activities.
- In the humanitarian context of Diffa region, affected by a large-scale security crisis causing mass displacements of populations, UNICEF continued its support to 37 health facilities through the provision of essential drugs on quarterly basis. Financial and logistic support is also offered to the medical teams for mobile clinics outreach activities.
- UNICEF provided four months of seasonal malaria chemoprevention, coupled with screening for malnutrition, to about 500,000 under-five children in the most deprived municipalities, and funded screening for 2,233,062 nationwide.
- Much attention was also given to polio campaigns, in response to cases of wild polio virus in Nigeria. Several campaigns were held in Diffa, Maradi and Zinder, with

substantial UNICEF support – provision of vaccines, technical assistance for planning, implementation and monitoring, and support to operational costs, including for communication / social mobilization activities. These campaigns touched close to 2.8m under-five children, meeting the planned target. In Diffa, immunization activities also took place in refugee camps and displacement sites, and during the December campaign 38 440 children from the refugee, displaced or returned population were vaccinated.

The recurrent unset of epidemics in Niger remains an ongoing health risk. As for the past year, the outbreaks of meningitis, measles, cholera, and for the first time Rift Valley Fever were recorded in 2016.

**In convergence municipalities:**

Some of the interventions were focused on the 35 convergence municipalities. These municipalities, located in the eight regions of Niger and concentrating 14% of the national population, were selected based on their degree of vulnerability (level of food insecurity, malnutrition and access to social services) and on the pre-existing target areas of the various UN agencies.

- A recent Lot Quality Assurance Sampling survey conducted in 17 convergence municipalities in June 2016 revealed improving trends for diarrhea treatment: access to treatment for under-five children with diarrhea and malaria improved from 45 to 65% in the convergence municipalities thanks to UNICEF support.
- High performance was also recorded on Malaria: with 94% of under five children tested positive being treated (38.8% at national level in 2015 for the same indicator).
- Significant improvement was recorded for attendance to antenatal care (from 38% to 58% for the four consultations, and from 85% to 89% for the first consultation). The proportion of pregnant women attending the recommended minimum of four antenatal consultations still needs to improve.
- The percentage of pregnant women who delivered with medical assistance increased from 46.7% in 2015 to 54.3% in 2016.

In 2016, according to WHO-UNICEF Estimates of National Immunization Coverage, the trend for under-five children mortality continued to be stable, with a mortality rate of 96 per thousand live births, compared with 95.5 per thousand at the end of 2015 and 99.6 at the same time in 2014. Niger is one of sixty-two countries that met Millennium Development Goal fourth target of a two-thirds reduction in under-five mortality by 2015. Implementing integrated high impact interventions, as coupling nutrition screening to seasonal malaria chemoprevention and the integrated community case management approach, is likely to have saved the lives of many children in 2016. No such results could be achieved without the support of UNICEF's resource partners and the collaboration of the Government of Niger.

## III. Strategic Context of 2016

The under-five mortality rate is currently of 96 deaths per 1000 live births (LB) according to UNICEF-WHO estimates. Although a slow improvement in maternal mortality trend was observed between 2006 and 2012, passing from 648 to 535/100,000 live births, maternal mortality rate is still high (no recent reliable data currently available). Young and adolescent mothers remain the group at higher risk of death.

Following the end of the MDG and the launch of the Sustainable Development Goals (SDG), the Ministry of Health (MoH) renewed in 2016 several policy documents: Health Policy 2016-2035, Health Development Plan 2016-2020, Comprehensive Multi-Annual Immunization Plan

2016-2020 and the Child Survival Strategic Plan 2016–2020. All these documents were finalised, validated and disseminated. Technical support was provided by health sector partners in the evaluation of prior plans and development of the new documents.

UNICEF Niger's health programme fits into the overall 2014-2018 cooperation programme between the agency and the Government of Niger. This programme follows the Government's Health Development Plan 2010-2015; a new policy and health development plan was developed and endorsed by the Council of Ministers. It aims to ensure that under-five children and pregnant women, particularly the most vulnerable, benefit more from quality high-impact interventions for the prevention and management of maternal and childhood illnesses. To achieve these results, the programme focuses also on the strengthening of the national health system.

In Niger, the weak health coverage (48.4%) remains the major bottleneck for access to health services, leaving behind more than half of the population without access to proper care. Moreover, despite a huge effort in reducing child mortality, common preventable diseases are still claiming the majority of children's lives. National data for malaria, diarrhoea and pneumonia treatment in 2016 are not yet available. However, Lot Quality Assurance Sampling (LQAS) conducted in 17 convergence municipalities in 2016 revealed improving trends for diarrhoea (65% of children received adequate treatment with ORS+Zinc) and malaria (94% of children under five years of age who tested positive for malaria received treatment).

In order to tackle the long lasting low health coverage in the country, UNICEF launched in 2015 the integrated community case management approach (iCCM) with the purpose of extending a minimum package of services to the children living 5 km or more from health facilities. This initiative inspired high-level political engagement which led to the validation of the National directive for iCCM, an important step towards scaling up.

Malaria continues to represent a major threat to children's health in Niger, particularly during the peak season (July to October) when it accounts for 80% of all medical consultations. Seasonal malaria chemoprevention (SMC) was only introduced recently in Niger. In 2016, the SMC intervention coupled with nutritional screening reached 2,233,062 children nationwide and covered 28 of the 44 health districts (compared to only eight in 2015). Preliminary analysis suggests that there was a decrease in the number of malaria cases and complicated severe acute malnutrition cases (SAM) requiring hospitalization thanks to such initiative.

It was acknowledged that investments made by the Government in the past years to increase access to health services have not met the objectives set. Indeed, in the absence of a comprehensive mapping of health facilities and their catchment areas, construction of new Health Care Centres and upgrading of Health Posts did not result in a commensurate increase in health coverage. In 2016, sector partners supported the Ministry to finalize the mapping of health services, and this should be in use by end of 2017.

Despite significant challenges, the efforts and investments made by the Government and its partners have yielded improvements in child survival indicators. However, many constraints and challenges remain and prevent the delivery of quality and accessible care in Niger:

1) Insufficient investment and weak supply chain management (PSM) for essential medicines by the MoH, which caused frequent shortage of drugs for the main child killer diseases in 2016, especially at the peripheral level;
2) High dependency on external partners, namely technical and financial partners. In 2016, the national budget allocation to the Ministry of Health increased to 6.6%, compared to 6% in 2015. Due to the financial difficulties experienced by Niger in 2016,

the full monetary value of the budgetary allocation for health may not have been disbursed.

3) Poor quality and distribution of human resources: only 30% of health centres, 10% of health districts and 17% of Referral Hospitals are staffed according to national norms.

In response to the frequent drugs shortages, the main health partners (World Bank, Global Fund, UNFPA, WHO, UNICEF) worked together to optimize the supply chain, including the development of a three-year PSM plan.

In 2016 some responses were brought to those major challenges. As the Common Basket already in place continued to be a preferred financing mechanism for some bilateral partners (France, Spain) and multilateral partners (GAVI, UNFPA, UNICEF) financing mechanism, this tool was reinforced with the World Bank joining the group of partners and the starting of discussions to include the Global Fund.

## IV. Results in the Outcome Area

| Health – 2016 Results | | | |
|---|---|---|---|
| **Health Indicators** | **Baseline 2013 (% and/or #)** | **Target 2018 (% and/or #)** | **Progress 2016 (% and/or #)** |
| **Health Outcome: Children under 5 years of age and pregnant women, particularly the most vulnerable, increasingly benefit from quality high-impact interventions for the prevention and management of maternal and childhood illnesses, including in emergency situations.** | | | |
| Children < 1 year receiving DTP-containing vaccine at national level | 68% | 85% | 70% |
| Children < 1 year receiving measles-containing vaccine at national level | 75% | 85% | 80% |
| Children 0-59 months vaccinated with polio through a UNICEF-supported program during campaigns | 103% | 98% | 98% |
| Women attended at least four times during their pregnancy by any provider (skilled or unskilled) for reasons related to the pregnancy | 33% | 60% | 37% (National health information system data) |
| Children aged 0-59 months with symptoms of pneumonia taken to an appropriate health provider | 58% | 80% | NA (target value for 2016: 65%) |
| National budget allocated for health (Target: 15% as per Abuja declaration) | 6% | 10% | 6.6% |
| Number of cases of polio | 0 | 0 | 0 |
| % of children aged 12-23 months vaccinated against measles | 75% | 85% | 45% |
| % of children under 5 years of age with malaria treated | 39% | 80% | 45% |
| % of children under 5 years with diarrhea who sought treatment from a health facility | 55% | 75-80% | 58% |
| Proportion of births assisted by qualified | 29% | 60% | 38% |

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| personnel | | | |
| **Output 1.1: By 2018, targeted health facilities offer a comprehensive evidence based packages of high impact quality preventive, promotional and curative interventions for maternal, neonatal, child and adolescent health and support improved demand for services** | | | |
| Policy on Focused Antenatal Care has been developed, adopted and implemented | No | Yes | Yes |
| Proportion of facilities offering delivery services that have guidelines for essential childbirth care (observed in the service area where relevant) | 80% | 100% | 100% |
| Percentage of health facilities offering delivery services with functional newborn resuscitation equipment (functional bag and mask in neonatal size) | 9% | 80% | 20% |
| Primary Health Care facilities providing clinical care to children under five using the IMNCI approach | 30% | 80% | 76% |
| Health workers in UNICEF supported programmes trained in Rapid Diagnostic Testing for malaria in children | 20% | 100% | 85% |
| % of children under 5 years of age who benefited from a 3rd dose of seasonal malaria chemoprophylaxis in the 35 Convergence Municipalities (Comdeco) | 0 | 80% | 86% |
| % of pregnant women benefiting from IPT2 as part of ANC in districts containing convergence municipalities (with particular attention on adolescents) | 35% | 60% | 74% |
| **Output 1.2: By 2018, targeted community health workers (male and female) offer a simplified package of evidence based quality, high impact preventive, promotional and curative interventions for maternal, neonatal, child and adolescent health and support improved demand for services** | | | |
| Existence of Policy for Community Health Workers to provide antibiotics for pneumonia | No | Yes | Yes |
| Health workers in UNICEF supported programmes trained in Rapid Diagnostic Testing for malaria in children | 0 | 100% | 100% |
| Months country had full stock access to ORS at the national level | N/A | 12 | 12 |
| Investment case in Health initiated/ finalized with focus on I-CCM | No | Yes | Yes |
| Accountability framework on ICCM developed and validated (between MoH , Min community Dev , Municipalities, NGOs) | No | Yes | No |
| **Output 1.3: By 2018, health facilities offer effective vaccination services using fixed (<5km), outreach (between 5 and 15 km) and mobile (>15 km) strategies to reach all children, including the hardest to reach as a result of geographical, cultural or other reasons. Equity-based approaches will be adopted** | | | |
| Existence of a Multi-Year Plan (MYP) for immunisation | Yes | Yes | Yes |
| Months with stock out of measles vaccine at the national level (Target: 0 month) | N/A | 0 | 0 |

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| IPV introduced into routine immunization schedules and country switched from trivalent Oral Polio Vaccine (tOPV) to bivalent Oral Polio Vaccine (bOPV) | No | Yes | Yes |
| Planned supplemental implementation activities that were cancelled, postponed or reduced in size, during the previous 6 month due to gaps in vaccine supply | 0 | 0 | 0 |
| Number of weeks of stock out of any vaccine at health district level in convergence municipalities | 0 | 0 | 0 |
| % of activities in the Effective Vaccine Management (EVM) improvement plan implemented | N/A | 90% | 48% |
| % of health districts in convergence municipalities having less than three confirmed cases of measles | 5.5% | 90% | 50% |
| Analysis of "Equity in Immunisation" has been conducted and corrective actions are identified | No | Yes | Yes |
| **Output 1.4: By 2018, all levels of the health system, community structures and local authorities have strengthened capacities in planning and monitoring in accordance with equity- and gender-based approaches, in supply management (including supplies aimed at the prevention, detection and case management of HIV) and in logistics** | | | |
| Health Management Information System generates periodic reports with data disaggregated by age and sex (for relevant indicators) at national and sub-national level | Yes | Yes | Yes |
| An analysis of sex-disaggregated infant and child mortality estimates is produced | Yes | Yes | Yes |
| Relevant essential commodities registered with the relevant regulation authority and guidelines for use in facilities available | No | Yes | Ongoing |
| HMIS generates annual reports of health facility and HRH distribution according to national guidelines | Yes | Yes | Yes |
| Number of health districts with convergence municipalities with at least 30% of their micro-plans funded, having improved their performance from one monitoring to the next | 0 | 100% | 25% |
| An analysis of the Essential Medicines and other health commodities supply system conducted at national level (2016) | No | Yes | Yes |
| The supply system for Essential Medicines and other health commodities optimized (2017-18) | No | Yes | Yes |
| % of health districts in convergence municipalities that submit their Notifiable Diseases report timely and with 100% completeness | ND | 50% | 78% |
| % of districts in convergence municipalities | 0 | 50% | 38% |

| | | | |
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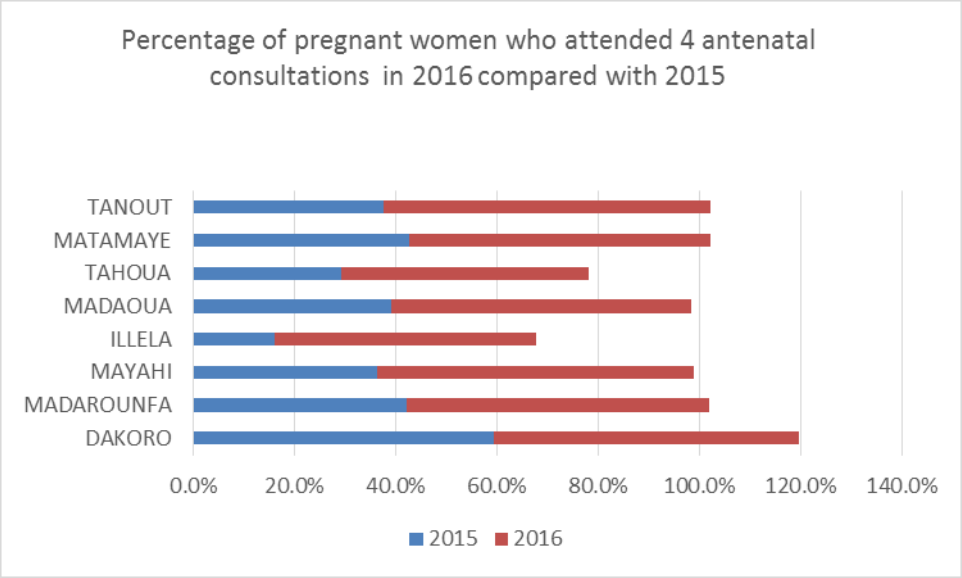
| having an operational and functional cold-chain and oxygen concentrator maintenance/repair system | | | |
| **Output 1.5: By 2018, health facilities and community structures have strengthened capacities to prepare for and respond to epidemics, natural disasters and population displacement.** | | | |
| Comprehensive multi-sectoral cholera preparedness plan available | Yes | Yes | Yes |
| Number of children aged 9 months to 14 years vaccinated against measles in Diffa Region | ND | 300,000 | 112,725 |

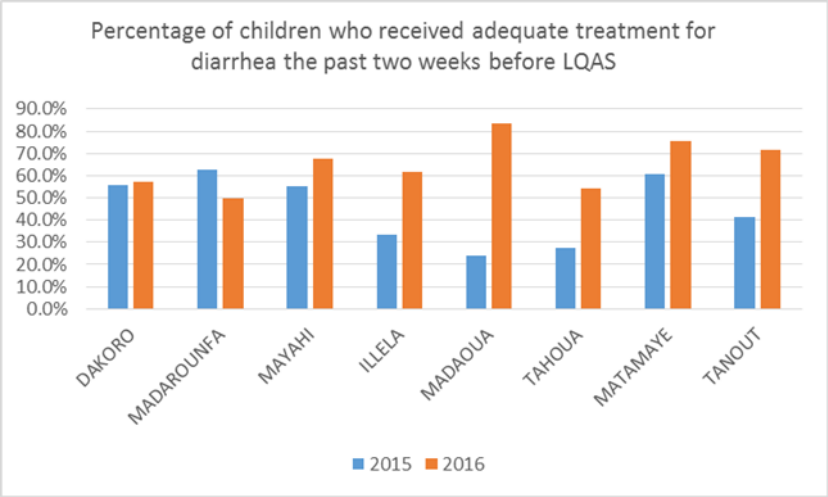
As per LQAS finding, the health service utilization, the percentage of pregnant women attending four antenatal consultations (ANC), and proportion of children receiving treatment for malaria and diarrhea all increased from 2015 to end 2016 thanks to joint efforts in securing drugs, conducting rapid tests and screening, and launching integrated community cases management in the convergence municipalities. Ensuring adequate communication was also key to enhance service demand.

Figure1: Antenatal consultations trends 2015-2016




The same trend have been observed for diarrhea treatment in the health districts

Figure2: % of children 0 to 59 months with fever during the past two weeks before LQAS who received anti malaria treatment from qualified health personnel

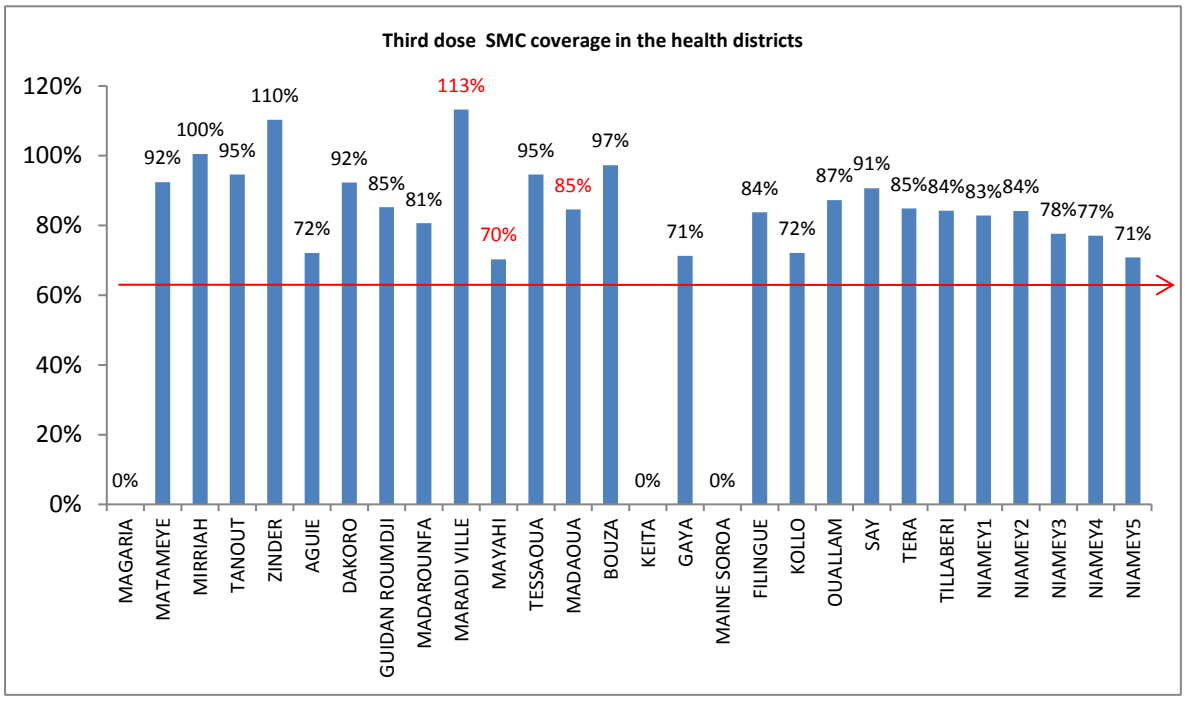



**Output 1: By 2018, targeted health facilities offer a comprehensive evidence based packages of high impact quality preventive, promotional and curative interventions for maternal, neonatal, child and adolescent health and support improved demand for services**

Results of the 2016 LQAS conducted in 17 out of the 35 convergence municipalities revealed an improvement in the number of children receiving adequate treatment for diarrhea with ORS+Zinc, passing from 45% in 2015 to 65% in 2016. Moreover, according to Health Information System data from convergence municipalities, 33% of children aged 0-59 months with symptoms of pneumonia were taken to an appropriate health provider. Although this result represents an improvement in the recent years, it remains far from the objective set for 2018; the limited access to health services, particularly in remote areas, and a tendency to auto medication can explain such situation, and efforts will continue in the coming years to increase access to health services and information to population.

In 2016, UNICEF provided support for SMC coupled with malnutrition screening, using Mid-Upper Arm Circumference. Nationwide, this high impact intervention reached 2,233,062 with the first dose. Of these, more than 500,000 children under five years of age were directly supported by UNICEF. Coupling malnutrition screening with the SMC allowed to reach 1,400,032 children aged 6 to 59 months for checking of their nutritional status. In the most deprived convergence municipalities, joint partner efforts made it possible to reached 354,772 children (out of a target of 413,332), of whom 217,644 were directly supported by UNICEF (16,569 in 2015).

Figure 3: SMC third administration to under-five children




Impact data were not available in time for this report; however, preliminary indications are that both severe malaria and complicated SAM cases decreased as a result of the intervention. In addition, 94% of children under 5 years of age who were tested positive for malaria received effective treatment in health facilities. The procurement of antimalarial drugs was funded by partners (Global Fund, UNICEF, and others).

Development of a Focused Antenatal Care Policy continued in 2016. The LQAS recorded a slight improvement in the proportion of pregnant women attending at least one antenatal consultation (ANC1) from 85% to 89% in convergence municipalities. The proportion of women who attended the recommended minimum four antenatal consultations (ANC4) improved significantly, from 38% in 2015 to 58% in 2016, but more work is required to identify the reasons why pregnant women do not complete four antenatal visits and design appropriate interventions. UNICEF directly supported antenatal care consultations in the convergence municipalities through provision of equipment, drugs, training and supervision. UNICEF supported inclusion of sensitization activities for pregnant women in the service package of community health volunteers. In the convergence municipalities, 79,548 pregnant women attended one antenatal consultation during the first six months of 2016, and of those 77,540 received Intermittent Preventive Treatment dose 1 for malaria (IPT1) and 72,263 received a second dose (IPT2). Not all women attending antenatal clinics received intermittent preventive treatment due to a global shortage of sulphadoxine-pyrimethamine.

All Primary Health Centers in Niger now have guidelines for essential childbirth care. Assisted delivery coverage improved from 46.7% in 2015 to 54.3% in the convergence municipalities (40% nationally). In 2016 only 17 of 152 health facilities in convergence municipalities had adequate equipment and skills for newborn resuscitation and care; UNICEF updated its targeted indicators and new orientations are proposed to address the weak availability of structures capable of performing new born resuscitation. For 2016, UNICEF supplied in needed material and capacity-building of the health staff is ongoing to reinforce new born resuscitation in emergency obstetrical care facilities, and this will be an area of focus in 2017.

***Targets set for 2018 in access to quality, high-impact interventions in health facilities face several challenges and constraints:***

- Persistent quantitative and qualitative deficit in midwifery in rural area which represents about 70% of the population;
- Difficulties in collecting reliable and accurate data;
- Poor investment in supply related to maternal and neonatal care and very weak supply chain management from national level down to health districts, health centers and health posts;
- High dependency on external partners, namely agencies. The free of charge ANC package and cesarean sections is, at present, mostly supported by partners, including UNICEF;
- Financial barriers for delivery at facility level (costs linked to transportation, fees for care and costs of drugs);
- Non-compliance of mothers to maternal services due to frequent poor capabilities of health workers, linked to lack of knowledge, motivation and high turnover;
- Resistance of mothers to deliver in health facilities due to traditional behaviors.

**Output 2: By 2018, targeted community health workers (male and female) offer a simplified package of evidence based quality, high impact preventive, promotional and curative interventions for maternal, neonatal, child and adolescent health and support improved demand for services**

To address the gap in access to care that affects more than half of the population, UNICEF Niger supported the Ministry of Health to implement integrated Community Case Management of malaria, diarrhea and pneumonia. The approach foresees the installation of one community health volunteer per 50 households, with responsibility for providing an integrated curative, preventive and promotional package to the population living more than 5 km from a Health Centre or Health Post. Community health volunteers covering the population living within 5 km offer only the preventive and promotional package.

The iCCM training manuals were revised with the support of UNICEF DRC and UNICEF Togo country offices to capitalize on their experiences. They have been tested in four districts and their use has been scaled-up in two additional districts (covering eighteen municipalities) where 454 community health volunteers had been trained, equipped and installed in their villages as of December 2016. More than 4,000 children living more than 5 km from a Health Centre received medical consultations and/or treatment during the second half of 2016.

Partnership with the Global Fund will contribute to the scaling-up of iCCM in the coming years, as their funding will support procurement of antimalarial drugs and will contribute to the training, supervision and motivation of community health workers. The main challenge is securing financial contributions from the Government of Niger, which will be required to ensure long-term sustainability. An investment case for iCCM is being developed. It will be a useful tool for the MoH to advocate with donors as it will link financial investment and results in terms of mortality reduction.

**Output 3*:* By 2018, health facilities offer effective vaccination services using fixed (<5km), outreach (between 5 and 15 km) and mobile (>15 km) strategies to reach all children, including the hardest to reach as a result of geographical, cultural or other reasons. Equity-based approaches will be adopted**

In 2016, Niger conducted a Maternal and Neonatal Tetanus assessment and validated its elimination from the country. This is a major milestone and correspond to the efforts put in place by UNICEF and its partners, with the help of its donors, for its immunization programme.

Based on administrative data, and using Penta3 coverage as a proxy for overall coverage, 91% of children less than one-year-old were vaccinated in 2016 (82% for the same period in 2015). Measles vaccination coverage was 89% by September 2016 (81% for the same period in 2015). However, according to World Health Organization-UNICEF estimates national immunization coverage in 2015 was only 65% for Penta3 and 73% for measles, which equates to more than 270,000 children unprotected by measles vaccination. The recurrent measles outbreaks experienced in Niger are a consequence. UNICEF supported the measles outbreak response to cover the pockets of unvaccinated children. An extensive equity analysis will be conducted in 2017 to better understand the bottlenecks constraining full access and action plans will be developed. Data quality also needs to be addressed.

In response to identified weaknesses and in accordance with the 2014 Effective Vaccine Management Assessment Improvement Plan, the cold chain storage capacity was increased in 2016 through construction of a warehouse incorporating walk-in cold rooms. The process of installing 160 Solar Direct Drive refrigerators in six regions was finalized and an additional 265 units were received, ready for dispatch and installation across the eight regions. Temperature mapping has been completed in all the central cold rooms and the cold chain temperature monitoring system from central to the periphery is being assessed through a study that commenced in July 2016. An Expanded Programme on Immunization performance dashboard is being developed. Despite those improvements, only 48% of the activities contained in the Plan, showing that the country is late toward reaching this objective.

In 2016, seven rounds (6+1) of polio campaigns were planned: two national campaigns, plus five local campaigns targeting 2,731,470 children in response to four cases of Wild Polio Virus reported from Nigeria. One additional campaign with monovalent Oral Polio Vaccine was added for December 2016. Six of the planned campaigns had been executed as of November. Data for four of the local rounds already conducted indicate an average coverage of 91%, with lower coverage in Diffa region, due to the on-going security situation. The need to organize very demanding response campaigns at short notice, could negatively impact routine activities and other campaigns, including seasonal malaria chemoprevention. To address the challenges facing delivery of quality Polio campaigns, UNICEF recruited additional short-term personnel for communication toward populations and vaccine management.

Enlarged Program of Immunization effective coordination is a challenge in Niger. Indeed, the Inter Agency Coordination Committee only meets occasionally. However, there is a need to strengthen the coordination with supporting groups such as the Technical working group backed by the finance, communication, logistics, training and M&E working committees. Many effort has being done for internal funding of vaccine, but operation and material costs are still dependent from external support.

**Output 4: By 2018, all levels of the health system, community structures and local authorities have strengthened capacities in planning and monitoring in accordance with equity- and gender-based approaches, in supply management (including supplies aimed at the prevention, detection and case management of HIV) and in logistics**

Procurement and Supply management in Niger is weak from central level down to the Health Post. In the first six months of 2016, against a target of zero stock-outs of the eight drugs included in the common basket, stock-outs occurred in Health Posts (2.3%), in Health Centers (2.2%) and in Health Districts (3.7%). Inefficiencies and duplication of distribution channels at regional and district levels, linked to a lack of integration across programmes, multiplication of intermediate storage levels, and the near absence of an effective distribution system from higher to lower levels of the health system, especially from districts to the peripheral level, are the main bottlenecks. The existing situation impeded efforts to reduce morbidity and mortality, and resulted in significant inequalities in accessing health care services, especially for those interventions protecting children against the main causes of death.

After a pilot Procurement and Supply Management project that was conducted in 2015 in two districts and solely considering UNICEF supplies, UNICEF decided to broaden the scope and in 2016 re-organized its structure and human resources to facilitate action in 2017. In 2016, UNICEF contributed to partners' (World Bank, Global Fund, UNFPA, WHO) combined efforts to optimize the supply chain through the development of a three-year plan. The detailed and fully budgeted action plan integrates Health Systems Strengthening components and aims to strengthen the supply chain and eliminate stock-outs up to the last kilometer. The plan is also intended to serve as a potential model for the development of a comprehensive national plan for the transformation of the pharmaceutical supply system integrating quality management, regulation, acquisition of inputs, pharmaco-vigilance, treatment of waste and other components.

With support from its regional office, UNICEF made efforts in joint partnership to strengthen Procurement and Supply Management in Niger. A 2016 rapid evaluation made the following findings: i) weak leadership of the national authorities; ii) lack of a national coordination mechanism; and iii) inadequate management systems at central level, including the regulatory authorities. The weakness of the central level is reflected throughout the supply chain as far down as community level. A Health Systems Strengthening specialist will be recruited in 2017 to support actions in this critical area.

In 2016 UNICEF Niger launched an Investment Case for community health system strengthening, which will address: i) the development of a strategy document that incorporates an equity-focused health system bottleneck analysis, priority strategies to strengthen community health systems, cost estimates, and financing opportunities; and ii) capacity-building of stakeholders extending to evidence-based planning and costing. The Investment case will serve as the primary advocacy tool of the Ministry of Health, especially in relation to signing a new compact with health sector partners in 2017.

In the Convergence Municipalities, the process to develop micro-plans for community health care planning and monitoring have started in mid-2016, and the implementation will be done during 2017.

**Output 5: By 2018, health facilities and community structures have strengthened capacities to prepare for and respond to epidemics, natural disasters and population displacement.**

The occurrence of epidemics in Niger remains an ongoing risk, as witnessed by the outbreaks of meningitis, measles, cholera, and for the first time Rift Valley Fever, during 2016.

In 2016, 2,534 cases of measles were reported, with 11 deaths nationwide. A response was organized for each outbreak. In Diffa region, measles immunization activities reached 112,725 children aged between 9 months and 14 years, including refugees and returnees. In Maradi region, similar response reached 22,721 children of the same age group. These actions were made possible through UNICEF funding of vaccines and supplies, plus additional support from other partners (WHO and MSF for transportation and cold chain) and NGO implementing partners. The recurrent outbreaks highlight the weaknesses in the routine immunization system.

2016 saw the emergence of Rift Valley Fever in Niger, commencing in July in Tahoua region. At the end of the year, 397 symptomatic cases with complications had been reported and 34 deaths recorded. Following the first cases, UNICEF immediately reacted by purchasing and delivering 800 vials of vitamin K1 to the treatment centers, which helped support effective case management. Sensitization campaigns were conducted to raise awareness of this disease among the population at risk.

Meningitis C (W135) also occurred during the year, with 1,969 cases recorded with 146 deaths in Niamey, Dosso, Tahoua and Tillabery regions. Despite the shortage of vaccines, a vaccination response was organized with UNICEF support, reaching 206,755 persons at risk, aged 2 to 29 years old. Niger is part of meningitis belt and the risk of annual epidemic remains high.

Cholera outbreaks remain a high risk in Niger. After a full year of no cholera outbreaks, cases began to be reported from Dosso and Gaya health districts in October, and 38 cases and 8 deaths had been reported at the end of the year. Within the scope of the regional cholera eradication programme, the epidemic response consisted of commodities prepositioning and training of health workers. No new cases were registered during the three weeks prior to compilation of this report in 2017.

UNICEF continues to provide essential medicines for the treatment of common diseases to 37 health facilities and mobile clinics in Diffa region, affected by a major humanitarian crisis. As of end October, 80,748 children under five had utilized health services, and 4,719 benefitted from mobile health services.

The major constraint to adequate preparation to epidemics and other health emergencies remain the high level of dependency of humanitarian responses on external funding and implementing organizations. National coordination is difficult, in part due to the fact that many ministries must cooperate for prevention and response to epidemics, such as cholera, and that the security crisis in the Diffa and Tillabery regions make it difficult to conduct a coherent, sustainable response. Efforts are being made by UNICEF and other technical and financial partners to strengthen the capacities of the Government and actors on the field, through trainings, development of action plans and prepositioning of drugs and equipment, and to increase the resilience of the population, even in mass displacement areas.

## V. Financial analysis

The funds were put toward the fulfillment of outcome 1, in the UNICEF programme of cooperation with the government of Niger for the period 2014-2018 which emphasizes the following effect: "Children under 5 years of age and pregnant women, particularly the most vulnerable, increasingly benefit from quality high-impact interventions for the prevention and management of maternal and childhood illnesses, including in emergency situation".

**Table 1: Planned Budget by Outcome Area (in USD)**

| Intermediate Results | Funding Type [1] | Planned Budget [2] |
|---|---|---|
| 01-06 Health and emergencies | RR | 12,420 |
| | ORR | 39,620 |
| | ORE | 980,000 |
| Unknown | RR | 1,466,500 |
| | ORR | 3,917,420 |
| **Total Budget** | | **6,415,960** |

[1] RR: Regular Resources, ORR: Other Resources - Regular *(add ORE: Other Resources - Emergency, if applicable).*
[2] Planned budget for ORR *(and ORE, if applicable)* does not include estimated recovery cost.

For 2016, Niger planned USD 6.4 million budget for its health emergency programme. The Diffa humanitarian context, and the outbreaks of epidemics in Niger, increases considerably the allocated budget to emergencies situation above the common planned budget from 2015. Some activities that were not planned required important additional funds and efforts, namely for meningitis, cholera and measles epidemic responses, and interventions in the rapidly evolving humanitarian context of the Diffa region.

**Table 2: Country-level thematic contributions to outcome area received in 2016 (in USD)**

| Donors | Grant Number | Contribution Amount | Programmable Amount |
|---|---|---|---|
| French Committee for UNICEF | SC149901 | 13,029.05 | 12,408.62 |
| **Total** | | **13,029.05** | **12,408.62** |

UNICEF Niger Health programme benefited from a thematic contribution from the French National Committee which was used particularly in implementing output 2 related to care services delivery by community health workers. The health workers were trained to offer a simplified package of evidence based quality, high impact preventive, promotional and curative interventions for maternal, neonatal, child and adolescent health care. Drugs supply is the spin bone of the iCCM approach in link with the wide geographic location of the villages covered by the community relay to be provided regularly in drugs. The contribution of the Thematic Funds allowed drugs provision and distribution.

**Table 3: Expenditures in the Outcome Area (in USD)**

| Organizational Targets | Expenditure Amount* | | | |
|---|---|---|---|---|
| | Other Resources - Emergency | Other Resources - Regular | Regular Resources | All Programme Accounts |
| 01-01 Immunization | - | 720,423 | 884,323 | 1,604,746 |
| 01-02 Polio eradication | 188,203 | 2,615,756 | 1,883,266 | 4,687,225 |

| | | | | |
|---|---|---|---|---|
| 01-03 Maternal and Newborn health | - | 883,762 | 282,232 | 1,165,994 |
| 01-04 Child health | 765,429 | 127,709 | 532,968 | 1,426,106 |
| 01-05 Health systems strengthening | - | 870,826 | 487,831 | 1,358,657 |
| 01-06 Health and emergencies | 485,780 | 768 | 48,976 | 535,524 |
| 01-07 Health # General | 355,144 | 405,016 | 2,139,341 | 2,899,501 |
| **Total** | **1,794,556** | **5,624,261** | **6,258,937** | **13,677,754** |

In 2016, approximately USD 13,677,804 million were spent on health programme interventions, contributing to the five mains outputs. As shown in the table above, Regular Resources (46% of expenditures) are the major source of funding closely followed by the Other Resources - Regular - (41%). The part of the programme budget spent on Other Resources - Emergency represents (13%). With the notification of four Wild Polio Virus cases in Borno state in Nigeria, following two polio-free years in Nige, countries surrounding the Lake Chad Basin were called for reinforcing actions against the disease. Many synchronized polio campaigns were organized. Response to measles outbreak also necessitated additional resources. The same year, the switch from trivalent Oral Polio Vaccine to bivalent vaccine was successfully implemented. As shown in the table, immunization intervention and polio eradication actions were funded for USD 6.3 million, which represents about 46% of the total expenditures.

**Table 4: Thematic expenses by programme area (in USD)**

| Row Labels | Expense |
|---|---|
| **Other Resource - Emergency** | **457,272** |
| 01-02 Polio eradication | 8,423 |
| 01-04 Child health | 501 |
| 01-06 Health and emergencies | 158,501 |
| 01-07 Health # General | 289,847 |
| **Other Resources - Regular** | **43,686** |
| 01-04 Child health | 12,105 |
| 01-05 Health systems strengthening | 23,960 |
| 01-07 Health # General | 7,621 |
| **Grand Total** | **500,959** |

As shown in the above table, the thematic funding was used in 2016 to support humanitarian interventions in response to the security crisis in Diffa region and diseases outbreaks in several regions of the country (91.3%).

**Table 5: Expenses by Specific Intervention Codes (in USD)**

| Row Labels | Expense |
|---|---|
| 01-01-05 Measles or MMR vaccines and devices | 480,834 |
| 01-01-09 Cold chain support | 635,728 |
| 01-01-10 Logistics support for immunization | 36,120 |
| 01-01-14 Immunization # General | 90,343 |
| 01-02-01 Polio vaccines and devices | 2,416,789 |
| 01-02-05 Polio social mobilization for campaigns | 1,358,494 |
| 01-02-08 Polio operational costs | 35,243 |

| | |
|---|---|
| 01-03-02 MNTE # General | 38,813 |
| 01-03-04 Maternal and newborn care including Emergency Obstetric care | 671,171 |
| 01-03-07 Other maternal and newborn activities | 331,511 |
| 01-04-09 IMNCI # community | 203,094 |
| 01-04-10 IMNCI # facilities | 382,078 |
| 01-04-13 Child health # General | 1,042,194 |
| 01-05-01 Health management at district or sub-national levels | 123,337 |
| 01-05-02 Health # MIS | 8,833 |
| 01-05-04 Health barriers-bottleneck analysis # investment case | 163,173 |
| 01-05-05 Health systems strengthening # General | 844,722 |
| 01-06-01 Health cluster coordination # humanitarian action | 386,942 |
| 01-07-05 Health technical assistance to regional and country offices | 1,872,942 |
| 08-01-02 Annual review | 3,971 |
| 08-01-06 Planning # General | 5,761 |
| 08-02-04 DevInfo | 13,337 |
| 08-02-05 Other multi-sectoral household surveys and data collection activities | 30,493 |
| 08-02-06 Secondary analysis of data | 14,205 |
| 08-02-08 Monitoring # General | 28,824 |
| 08-03-01 Cross-sectoral Communication for Development | 236,098 |
| 08-03-02 Communication for Development at sub-national level | 141,177 |
| 08-05-01 Supply # General | 163,970 |
| 08-06-02 Building global/regional/national stakeholder evaluation capacity | 27,193 |
| 08-07-01 Adolescent development # General | 68,968 |
| 08-07-02 Adolescent development # emergency preparedness and response | 52,542 |
| 08-09-06 Other # non-classifiable cross-sectoral activities | 1,830,531 |
| 08-09-07 Public Advocacy | 45,829 |
| 08-09-08 Engagement through media and campaigns | 3,038 |
| 08-09-09 Digital outreach | 6,246 |
| 08-09-10 Brand building and visibility | 14,387 |
| 08-09-11 Emergency preparedness and response (General) | 259,388 |
| 1041 Maternal/Neonatal tetanus elimination | 43 |
| 1046 Health intervention packages # general (including deworming) | 11,459 |
| 1049 Integrated YCSD package including Child Health Days | 927 |
| 1061 Integrated Management of Childhood Illnesses | 6,918 |
| 1072 Maternal health/Safe motherhood # general | - |
| 1092 Malaria treatment | -448,243 |
| 1146 Other health interventions in humanitarian response and post-crisis recovery | 28 |
| 1902 Operating costs to support multiple OTs within FA1 | 15,242 |
| 6902 Operating costs to support multiple focus areas of the MTSP | 12,926 |

| | |
|---|---|
| 7911 Representative and governance | 1,297 |
| 7921 Operations # financial and administration | 8,887 |
| **Grand Total** | **13,677,804** |

As per expenditures figure, about half of the budget (48%) was spent on EPI expenses (cold chain, vaccines provision, outreach activities), followed by maternal and child health (19%) and technical assistance (14%). In 2016, UNICEF emphasized the reinforcement of EPI logistics and the improvement of storage capacity. Among the EPI expenses, 44% was used to procure essential vaccines.

**Table 6: Planned budget for 2017 (in USD)**

| Intermediate Result | Funding Type | Planned Budget [1] | Funded Budget [1] | Shortfall [2] |
|---|---|---|---|---|
| Output 1 | RR | 660 000 | 660 000 | 0 |
| | ORR | 950 000 | 571 425 | 378,575 |
| Output 2 | RR | 600 000 | 600 000 | 0 |
| | ORR | 1 210 000 | 310 329 | 899,671 |
| Output 3 | RR | 370 000 | 370 000 | 0 |
| | ORR | 1 400 000 | 150 390 | 1,249,610 |
| Output 4 | RR | 1 351 000 | 1 351 000 | 0 |
| | ORR | 300 000 | 53 000 | 247,000 |
| Output 5 | RR | 167 000 | 167 000 | 0 |
| | ORR | 1 500 000 | 530 000 | 970,000 |
| **Sub-total Regular Resources** | | **3 148 000** | **3 148 000** | **0** |
| **Sub-total Other Resources - Regular** | | **5 360 000** | **1615144** | **3,744,856** |
| **Total for 2017** | | **8 508 000** | **4,763,144** | **3,744,856** |

[1] Planned and Funded budget for ORR *(and ORE, if applicable)* excludes recovery cost. RR plan is based on total RR approved for the Country Programme duration

[2] Other Resources shortfall represents ORR funding required for the achievements of results in 2017.

The planned budget to carry-out planned activities for 2017 is USD 8.5 million. Only USD 4.8 million are currently available. To implement all the planned activities of health programme in Niger in 2017, UNICEF currently faces a funding shortfall of USD 3.7 million.

UNICEF counts on the support of resource partners to help bridge this funding shortfall to attain its objectives in Niger.

## VI. Future Work Plan

In 2017, UNICEF will continue emphasizing and scaling up high-impact interventions in both health facilities and community settings. Interventions will be structured around five outputs (see above).

The main implementation strategies are:

- Capacity building through training, formative supervision, exchanges of experience for staff, and equipment of facilities and provision of inputs;
- Evidence generation: collecting, analysing, organizing and sharing information to achieve results. This includes operational research, coverage surveys and LQAS;
- Political dialogue and advocacy to persuade opinion leaders, decision-makers, donors to support and implement actions that contribute to maternal and child health;
- Developing partnership is a key UNICEF strategy and an essential prerequisite for scaling up priority interventions. As a leader in health sector, UNICEF is able to facilitate this dialogue between partners at all levels. UNICEF, as lead of the adolescent sub-working group on health and nutrition interventions, will strengthen its collaboration with UNFPA (co-lead of the group) to harmonize the package of services to be offered to beneficiaries. With the Global Fund / CRS, the ongoing partnership will be maintained to ensure the scaling up of the iCCM, and create additional partnerships with local and international NGOs for monitoring community relays. The partnership with GAVI will be maintained for strengthening the health system and immunization, through improving cold chain storage capacity and real time monitoring of the cold chain temperature throughout the delivery from the national to peripheral levels.
- Finally, the implementation of the new Niger Health Development Plan will be supported through the Common Basket Fund with all of the partners;
- Quality and effectiveness of interventions will be developed in innovative way through improved cold chain equipment and maintenance with the adoption of solar technologies for appliances and digital technologies for temperature monitoring.
- As several interventions have the same gateway and the same targets (PMTCT integrated to the ANC, paediatric management of infected children during postpartum and IMCI, malnutrition screenings during immunization campaigns), efforts will be put on intra and inter-sectoral integration. Same complementarity will be developed with other sectors, such as nutrition, especially in the follow-up promotion of growth, IPT and vitamin A supplementation, and deworming during vaccinations.
- Decentralized monitoring will be optimized to ensure better impact. UNICEF has been supporting the decentralised monitoring in Niger since 3 years. A recent analysis of the monitoring results showed that a district can conduct many successive monitoring without any performance improvement. Following this analysis, a need to invest in bottleneck reductions was identified, which most of the time are linked with lack of qualified human resources, drugs shortages, inadequate services and deficient monitoring and supervision. UNICEF will support bottlenecks reduction through results based funding of specific identified solution. At least 30% of supported health district should improve consistently theirs performance form one monitoring to other.

The targets of this program are mainly under-five children, women, adolescents and young people living in all regions, particularly in the 18 health districts housing the 35 convergence municipalities. Humanitarian response will once again be provided countrywide, thanks to flexible funds allowing to respond to emergencies, epidemics or crisis that could occur during 2017.

## VII. Expression of Thanks

On behalf of the children and women of this country, UNICEF Niger would like to thank the donors who are supporting its Health Programme. No development is possible without ensuring healthy lives and access to care for the most vulnerable, especially girls and boys, and the support of resource partners is essential to achieve meaningful results. We would also like to thank the Government of Niger and other major partners, whose collaboration was instrumental in achieving these results.

## Annex 1: Human Interest Story and visibility

**It's officially the end of tetanus in Niger!**

A post on UNICEF Tumblr blog was published on the validation of the elimination of maternal and neonatal tetanus. The post can also be accessed at the following link: http://unicefniger.tumblr.com/post/145602992744/its-officially-the-end-of-tetanus-in-niger

The elimination of Maternal and Neonatal Tetanus is now a reality for thousands of women and children thanks to the joint efforts of the Government of Niger, UNICEF and the World Health Organization.

A validation survey launched in May 2016 just render its verdict yesterday, final step in a long process to declare Niger free of tetanus.

This disease is among the most common lethal consequences of unclean deliveries and umbilical cord-care practices. In Niger, women and children are particular vulnerable to tetanus because many women give birth at home in poor hygienic conditions. When babies contract tetanus, the infection causes muscle spasms that can stop them from breathing. These extreme situations can however be easily prevented by immunizing mothers with the tetanus vaccine, while emphasizing hygienic delivery.

Although the number of Maternal and Neonatal Tetanus (MNT) cases has gradually declined in Niger, from 29 cases in 2006 to 8 cases in 2015, it remained a killer disease. Until today.

To obtain the elimination status, a country has to record less than one case per 100,000 inhabitants. In Niger, the three most poorly performing districts, (chosen by their low rates of tetanus immunization coverage, and at least one MNT case per 1,000 live births), Goure, N'Guigmi and Tanout, were carefully evaluated to verify the eradication of Tetanus.

Those districts, who have particularly low rates of access to health center (due to various factors, including remoteness or security issues) were confirmed at “low risk” for MNT and the country obtained this most wanted elimination status.

Niger is now facing a new challenge: maintain this status. UNICEF is working around the clock to improve immunization and prenatal consults coverage and make sure that more women give birth in good hygienic conditions with professional care.

Photo credit © UNICEF Niger/2015/Vincent Tremeau

**Malnutrition et paludisme: la double peine des enfants nigériens**

A Human Interest Story was published on UNICEF Niger Tumblr blog (in French) and can also be accessed at the following link:
http://unicefniger.tumblr.com/post/149371527289/malnutrition-et-paludisme-la-double-peine-des

*Mariatou Moutari consulte Moussa, 2 ans, sous les yeux de sa mère Rabia, avant son départ du CRENI du CHR de Maradi*

Maradi, 7 h 30. Comme tous les matins en entrant dans son bureau du Centre Hospitalier Régional (CHR) de Maradi, Mariatou Moutari se prépare un thé avant de commencer sa longue journée de travail. Elle prend cinq minutes pour mettre en ordre ses affaires, jette un coup d'œil sur le planning de ses collègues, et essuie la buée sur ses lunettes provoquée par la vapeur d'eau bouillante.

Mariatou supervise le Centre de Récupération et d'Education Nutritionnelle Intensif (CRENI) du CHR de Maradi, qui accueille et soigne les enfants de la région souffrant de Malnutrition Aiguë Sévère (MAS). A peine sa dernière gorgée de thé avalée, cette technicienne supérieure en santé de la reproduction de 28 ans se lève et démarre sa visite des quatre salles du CRENI.

Les journées sont particulièrement chargées en ce moment pour Mariatou. « Le paludisme a un impact énorme sur la situation nutritionnelle des enfants. Pendant la période de soudure qui coïncide avec le pic de paludisme, nous accueillons entre 15 à 20 enfants par jour, parfois plus » affirme-t-elle, en inspectant le dossier de Baraou, sept mois, qui est arrivé la vieille.

Baraou souffre à la fois de malnutrition et de paludisme et a été placé directement en « phase 1 », dans la salle de traitement intensif pour les cas les plus graves. A cause du nombre élevé d'admission, il doit partager son lit avec deux autres enfants malnutris, sous les yeux de sa

mère, Maïmouna Issaka, qui agite régulièrement un bout de carton, pour faire fuir les mouches du visage de son fils.

Mariatou termine sa visite matinale vers neuf heures par la salle de « phase 3 », consacrée aux enfants en phase de récupération. Elle s'arrête devant le lit de Moussa Aminou, un garçon de 24 mois, qui a été hospitalisé il y a huit jours car il souffrait également du paludisme et de malnutrition.

« Nous habitons à Tibiri, à dix kilomètres de Maradi. Son état s'est empiré de jour en jour. Heureusement qu'il a été pris en charge gratuitement ici » déclare Rabia, la mère de Moussa âgée de 23 ans, qui est enceinte de son quatrième enfant.

Après avoir inspecté la salle de lait et les douches, Mariatou est également obligée d'assurer la consultation des enfants atteints de VIH. « Nous devons faire face à un manque de personnel en pédiatrie, notamment dans le CRENI. Certains jours, une infirmière doit s'occuper de 40 enfants, alors qu'il devrait y avoir une infirmière pour 10 enfants maximum » regrette-t-elle.

Il est déjà midi passé quand Mariatou débute la distribution des intrants aux différents services. Elle assure ensuite ses consultations jusqu'à 15h30, et part se reposer pendant quatre heures, avant de revenir au CHR pour assurer la supervision des 45 agents de santé dont elle est responsable, jusqu'à 22 heures. Elle constate : « Je travaille tous les jours, même si le week-end je travaille un peu moins. A part recruter plus de personnel, pour vraiment nous soulager il faudrait privilégier la prévention plutôt que le curatif, et que les parents arrêtent d'attendre le dernier moment pour amener leurs enfants malnutris ».

Assise à son bureau, Mariatou parle d'un dernier patient avant de partir avec Aminatou Matal, une infirmière de 32 ans, qui travaille au CRENI depuis 2011. Cette dernière tient à ajouter avant de reprendre sa garde que : « même la nuit s'il y a un besoin urgent, Mariatou est disponible. Elle est là très tôt le matin et part très tard le soir. Elle est vraiment très compétente ».

Cet avis est partagé par le Directeur du CHR de Maradi, M. Ibrah Boukary, qui loue la disponibilité, l'engagement, la fiabilité et la patience de Mariatou. Comme elle, il est convaincu qu'il faut changer d'approche dans la lutte contre la malnutrition, en privilégiant dorénavant la prévention. « Ici à Maradi, vous trouvez des individus avec des greniers pleins, des vaches, des pintades, etc. mais avec des enfants malnutris. C'est avant tout un problème de comportement. Il faut renforcer la sensibilisation communautaire » conclut-il.

L'UNICEF appuie de nombreuses activités curatives pour lutter contre la MAS dans cette zone, notamment en soutenant techniquement et financièrement le CRENI de Maradi, ainsi que d'autres CRENI de la région, et en leur assurant la fourniture d'intrants. L'UNICEF cherche également à renforcer la prévention en mettant en place des activités de sensibilisation et de mobilisation communautaire pour lutter en amont contre la malnutrition.

L'UNICEF et d'autres partenaires internationaux, grâce notamment à un financement d'ECHO, soutiennent le Ministère nigérien de la Santé Publique qui a lancé le 4 août 2016, la première campagne nationale conjointe de Chimio-prévention du Paludisme Saisonnier (CPS) couplée au dépistage de la MAS. Cette campagne vise à prévenir le binôme malnutrition-paludisme, qui a un énorme impact sur la morbidité et la mortalité des enfants de moins de cinq ans. Elle se déroule pendant quatre mois, dans 27 districts sanitaires du pays, au profit de 2,6 millions d'enfants de 3 à 59 mois.

Photo Credit: © UNICEF Niger/2016/V.Fleury