



## What we do in Niger

- We're saving lives by providing milk and food supplements for 48,131 acutely malnourished children
- We're providing free healthcare for 162,000 children under five
- We're vaccinating 229,233 children against measles
- We're providing cash grants to 6,000 of the poorest families



Niger is one of the poorest countries in the world, ranked 174 out of 179 countries in the United Nations Human Development Index. Six out of ten people live in extreme poverty, on less than \$1.25 a day. **One in five children die before their fifth birthday**, and the country's child mortality rate is the 11<sup>th</sup> highest in the world. Nearly half of the country's 14 million people are under 15. Most children have to do some sort of paid work to help their families get by, which means they miss out on school.

Landlocked, mainly desert and drought-prone, Niger does not grow sufficient food to feed its rapidly expanding population. In 2005, lack of rain, swarms of locusts and the high price of food meant that more than 3.6 million people needed food aid. Many families are still feeling the effects of this crisis. Crop failures, fluctuating prices, livestock disease and poor transport networks make life in rural areas particularly difficult. The global food price crisis has compounded these problems, pushing more and more people into extreme poverty. Children are bearing the brunt of the crisis: they have less to eat, they eat less nutritious foods, and many have dropped out of school to help their families earn more just to afford the basics.

Most Nigeriens live in the south, near the border with Nigeria, and in the west, near the Niger River. Tensions remain between the government and Tuareg nomads who live in the north, after a five-year rebellion during the 1990s. The country has been relatively stable since then, but recent political developments could threaten this, since opposition groups have strongly reacted to changes to the constitution that have prolonged President Mamadou Tandja's stay in power.

## Save the Children in Niger

We began work in Niger during the food crisis of 2005 when we launched an emergency response, setting up a community therapeutic care programme covering 17 sites in Zinder and Maradi regions in the south. We're working to ensure that children get regular, nutritious food, and better access to healthcare, and to help their families earn a decent livelihood.

We work in Tessaoua and Aguié districts (Maradi region) and Matameye and Magaria districts (Zinder region). We work closely with local district authorities and national authorities, and we're looking at possibilities for developing partnerships with local organisations.

We have gained strong credibility through our work with children and have become a key player in Niger in the fields of nutrition, food security and livelihoods, and health.

## We're working to reduce hunger

High levels of food insecurity, coupled with low purchasing power of the poorest households, create a grave situation for Niger's rapidly expanding population. Malnutrition is one of the main reasons for the high number of child deaths – half of all children under five suffer from moderate and severe stunting, which hinders their physical and mental development. In Zinder, one of the areas where we work, the global acute malnutrition level for children under five is 16%. And one in five children under three years old is acutely malnourished. Mothers are often not sufficiently well nourished themselves to produce enough breast milk for their babies. Only 13% of mothers give their babies breast milk for the first six months of life, which provides the best nutrition during that time.

We're working hard to reduce the number of children who die needlessly from malnutrition and other preventable causes. Our aim is to build a hunger reduction strategy that tackles the root causes of malnutrition, rather than just treating the symptoms. So there are three main aspects to our nutrition work.

## We're treating malnourished children

Working with the Ministry of Health in 2008, we have treated over 48,000 children suffering from acute malnutrition in the four districts where we work. We provide therapeutic milk and ready-to-use food supplements for malnourished children, either in their homes (as outpatients) or in health centres (as inpatients), until they've reached a certain weight. We're also providing fortnightly food supplements to children who are moderately acutely malnourished.

In the past year, we've committed to a major change in our nutrition strategy. We're moving away from a large-scale programme that we implement ourselves, towards integrating our nutrition work into the national primary healthcare system. This means we'll be working closely with the Ministry of Health and district-level authorities, who will manage and carry

out nutrition screening and treatment in 37 health centres in the areas where we work. We'll contribute by training health workers to screen and treat malnourished children, as well as providing the equipment they need. We'll also make sure that pharmacies have enough drugs and food supplements to treat the children who need it.

### **We're providing a safety net for the poorest families**

In Tessaoua district, between June and September 2008 (the 'hunger gap' months), we carried out a pilot project providing a 'safety net' for 1,500 of the poorest households. We gave three cash grants, totalling 60,000 CFA francs (about £82), to women in these households. The 'condition' for getting the grant was that they took part in information sessions on malnutrition and other aspects of public health and hygiene (including setting up community health committees). We evaluated the project fully and were able to draw some strong conclusions to inform future safety net projects. Generally, the cash was spent on buying food (like millet, the staple), milk, meat and oil, and clean water and soap, which had a knock-on effect on children's health.

Building on the success of this first cash transfer project, we're running another to begin at the start of the 2009 hunger gap in Tessaoua and Aguié districts, Maradi region. In 2010 we will scale this up, ensuring that 6,000 children from the poorest households have access to a nutritious balanced diet thanks to cash transfers. We want to use the results of these pilots to demonstrate to the government that cash transfers should be an important part of the social protection system it is developing.

As part of our plans to prevent hunger and poverty, in 2010 we'll strengthen the livelihoods of 6,150 of the poorest households through livestock rearing and vegetable growing projects, to improve local production and increase their access to nutritious foods such as milk, meat and vegetables.

### **We're doing research to inform programmes and advocacy work**

We're also tackling the underlying causes of child malnutrition by focusing on women and children's access to healthcare and the links between malnutrition and household economy. We've carried out extensive research looking at how people earn their livelihoods, how they get enough food to live on, where they get that food, and how much it costs them to eat a nutritious diet.

We're using the results of all this research to make our own programmes as effective as possible, but also to influence the development of larger-scale nutrition and safety net programmes implemented by the government, UN agencies, the European Commission's Humanitarian Aid Office (ECHO), and other non-government organisations (NGOs). We hope to change policies and practice so that many more children benefit.

An important area of our food security work is our support for the government's national early warning system (SAP). We're providing technical support to staff at regional and sub-regional

levels to carry out food security assessments, so that they can collect accurate and reliable data, and communicate the results to structures at national level. We're also planning to commission a consultant to work with SAP to update the indicators they use, to include key data from household economy analysis surveys. The early warning system means we and other agencies are quickly able to identify those communities and families most at risk of food shortages, responding quickly before shortages lead to hunger and starvation.

## **We're providing better healthcare for children**

Niger is one of the most dangerous countries in the world in which to be a child. In 2006 it was estimated that 20% of Nigerien children died before their fifth birthday. The most common illnesses are malaria, diphtheria, tuberculosis, acute respiratory tract infections and diarrhoea.

Niger's health system does not have enough clinics, medicines or trained staff. Malaria – a disease that's easy to prevent and treat – accounts for half of all deaths among children under five. The government has been implementing a policy of free healthcare for pregnant women and children under five since 2006, but does not have sufficient funds to make this a reality. We're supporting the health system to ensure that mothers and children get the free care they're entitled to, by providing essential medicines and equipment, as well as training for staff.

Niger is a key country for Save the Children's newborn and child survival campaign. The Nigerien government is currently not 'on track' to achieve MDG 4 – to cut the rate of child deaths by two-thirds by 2015. We want to help it get back on track.

In 2008/09, we provided 318,551 free medical consultations for children under five in Tessaoua and Aguié districts (Maradi region). We're providing essential drugs and basic medical equipment to 32 health centres and 40 health posts. We're saving lives by vaccinating 17,474 babies in their first year of life against five of the big killer diseases: tuberculosis, polio, diphtheria, measles and pertussis (whooping cough). We're working closely with district health authorities to carry out large-scale vaccination campaigns against measles (reaching 229,233 children) and meningitis (reaching 50,097 people). And we're also saving lives by distributing mosquito nets to 16,500 children.

We're also working hard to increase women's access to better ante-natal and postnatal care. In 2008, 25,503 women attended ante-natal consultations in the clinics we support, and 5,394 babies were delivered by qualified health staff. Many women live too far away from a health centre to travel there, so we've helped fund an ambulance and provided fuel for district ambulances. We've also trained 60 traditional birth attendants on dealing with high-risk pregnancies, and provided 42 other staff with training in ante-natal and postnatal care, including caring for newborns, with support for exclusive breastfeeding, as this is the best start a child can have.

In 2010, we're planning to start a similar programme in Matamaye and Magaria districts (Zinder region). Our overall goal for 2010 is that we will have improved access to good quality healthcare for 250,000 of the poorest children under five and 280,000 women of childbearing age in the four districts where we work. We'll continue to work with the government to provide free healthcare for pregnant women and children under five, and advocate for more funding to help it deliver on its promise.

## We're planning work on protection and education

Niger is a source, transit, and destination country for children and women trafficked for forced labour and sexual exploitation.

Caste-based slavery practices, rooted in ancestral master-slave relationships, continue in isolated areas of the country. An estimated 8,800 to 43,000 Nigeriens live under conditions of traditional slavery.

In 2010, Save the Children will begin to develop new strategies that will deal directly with children's protection and education. We will work to help communities prevent the trafficking, exploitation and abuse of children. And we will increase the emphasis on protection across our existing programmes.

We will also focus our efforts on how we can increase children's participation in our work, including our advocacy activities.



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