Pay or Die: Nutritional Crisis in Niger
28 June 2005

Tens of thousands of lives threatened in Niger: where is the humanitarian assistance?

No money, no food aid. Such is the reality today in Niger for families suffering from food shortages. And yet, the government and institutional donors had announced in October 2004 that one-quarter of the population – around 3.5 million people – were threatened by this serious crisis.

Nine months later, even though supplies are available, millet is still inaccessible to those most affected by the lack of food.

June 2005. Child suffering from severe malnutrition in intensive care at MSF's feeding center. © Didier Lefèvre / imagesandco.com

Nine months later, there have been no free food distributions so that families without resources can obtain Niger's staple food – millet.

When will effective and exceptional emergency measures finally be implemented in response to this crisis?

Doctors Without Borders/Médecins Sans Frontières (MSF) calls upon the government, institutional donors and aid organizations to provide immediate emergency assistance to populations in the most affected villages by setting up **free food distributions** and providing **free medical care for children under five.**

Tens of thousands of lives in danger

Tens of thousands of young children are suffering from malnutrition in Niger. Thousands are in a serious condition, likely to die if they are not immediately treated.

According to a nutritional survey conducted by MSF and Epicentre in April in villages in the northern parts of the provinces of Maradi and Tahoua, one child in five suffers from malnutrition. The severe malnutrition rates in children under five are 2.4% in northern Maradi and 2.9% in northern Tahoua. In certain villages in the district of Keita, the severe malnutrition rate is around 6%.

Since January, MSF has treated 9,000 children for severe malnutrition at its programs in Maradi and Tahoua provinces: nearly triple the number compared to the same period last year.

MSF is expecting another increase in malnutrition during the critical "lean" period. From June to October, the major causes of malnutrition – poor quality or insufficient quantity of food and/or diseases – are at their highest level in Niger. It is a period marked by the end of food reserves, four months away from the next harvest in October, as well as the peak incidence of diarrhea and malaria during the rainy season.

The mortality rate of children under five in several villages in Niger has exceeded the emergency threshold of 2 deaths per 10,000 children per day. In MSF's therapeutic feeding centers, the presence of doctors enabled MSF to keep the mortality rate at 6% in 2004 in our treatment centers. But given the gravity of the current crisis, 10 to 15 children are dying each week, mainly in the intensive care centers where the most severe cases are treated.

In June, more than 1,000 children were admitted every week into feeding programs in Maradi, Dakoro, Kieta and Tahoua.

At this rate, MSF expects to treat 20,000 children in our programs through autumn 2005. In 2004 MSF treated 10,000 severely malnourished children in Niger, representing one-third of all those admitted to MSF's feeding programs worldwide.

The humanitarian aid system: an ineffective response to the emergency

Far from being a natural disaster, this serious food crisis was predictable. Development policies in Niger have deprived part of the population of vital resources. Furthermore, people must pay for medical care and the most disadvantaged cannot afford staple foodstuffs. Despite a food security initiative co-managed by the government and institutional donors, committing in writing to assist this population, it is clear today that it is incapable of responding effectively to this emergency.

Nutritional survey in villages in the district of Keita

During a food security survey conducted in four villages in the district of Keita in late May, MSF discovered that food aid was not reaching those most in need. While the district of Keita (Tahoua province) was supposed to receive 300 tons of cereals each month beginning in November 2004, only 700 tons had reached the district by early May 2005 – three times less than planned. In these four villages 60-100% of families had not been able to buy millet at a reduced price for two major reasons: they lacked money (45%) or were too far from where the food was being sold. Those who were able to buy millet once or twice received 20-70 kilograms (44-154 lbs) per family, which amounts to enough food for 4 to 14 days.

Very poor nutritional quality of food compounds the problem. During the food security survey, which began in April, nearly half the families interviewed said they ate only one meal a day and that every meal consisted solely of water and millet. This year, the consumption of milk, *niebe* (beans) and vegetable oil has greatly decreased, while the consumption of wild plants, particularly *anza*, has risen. This low-nutrient food does not provide nearly enough calories for growing children and for adults working in the fields.

Absence of free food distributions

In order to avoid further destabilising a market which has already been strongly affected by speculation, institutional donors and the government refuse to change strategies and allocate available resources for the free distribution of food in villages with the highest rates of malnutrition. They acknowledge however that the measures taken are not effective and that a large portion of the population has no access to the for-pay food aid. In addition, farm credit for the maximum 300 kilograms (600 lbs) of millet provided to families during the lean period must be repaid after the harvest.

This food crisis has been officially acknowledged, but no effective actions have been taken, as evidenced by the lack of emergency free food distributions. The government and institutional donors are leaving it to non-governmental organizations (NGOs) to set up an "appropriate method of free, targeted food distributions," while their main preoccupation is to protect the market.

Excerpts from a joint WFP and FEWS NET (CC/SAP) report

The measures implemented by this initiative are insufficient and ineffective. This is acknowledged in the latest report (June7-15) of a joint World Food Program (WFP) and Famine Early Warning Systems (FEWS NET) mission in charge of supplying food aid:

"Throughout the entire region visited, the mission noted a continuing food crisis related to the populations' limited coping capacity, insufficient resources and the problem of inadequate targeting of the support provided by the government and its food security partners.
At this point, the basic measures taken to alleviate the crisis can be summarised as follows:

- *The sale of cereals at reduced prices, which is in its fourth phase in many of the areas visited. This operation, even though it is welcomed by the affected populations, is considered highly inadequate in terms of the quantity available compared to actual needs and its affordability for poor households;*
- *Food-for-work and food-for-cash programs (FFW and CFW), which have the advantage of benefiting all households, reach very few families and provide relatively insufficient quantities of food supplies.*
- *Cereal and animal feed banks for livestock are deemed highly efficient but their number and stocks are insufficient.*
- *The free distribution of food rations by Médecins Sans Frontières to households with malnourished children under the age of five is an appropriate method of free, targeted distribution."*

The document, though, continues with recommendations that do not address the emergency:

"The mission noted an availability of basic cereals in the markets. However, their affordability poses a serious problem for particularly poor households, which have reached the limit of their coping strategies, including the sale of livestock, straw, wood and legume pods, moving to another area, gathering of wild plants and consumption of scarce foods, etc.

To allow affected populations to devote themselves exclusively to farm work, the mission recommends the continuance, reinforcement and close monitoring of actions undertaken to alleviate the crisis: the sale of cereals and animal feed at reduced prices, food-for-work and cash-for-work programs, cereal banks and farm credit, all of which should target the most vulnerable households."

Exceptional measures needed immediately

To face this emergency, three measures must be taken as soon as possible:

- Distribution of free food, part of which should be adapted to the special needs of children
- Access to free medical care for children under five years of age
- Mobilization of other NGOs to treat severe acute malnutrition

Free access to food

A bag of 100 kilograms (220 lbs)of millet costs 23,000 CFAfr (1USD is approximately equal to 500 CFAfr) on the market, which is not affordable for the majority of the population. Food aid measures that require payment have failed. The food crisis has advanced to the stage of FEW NET's emergency alert status, a system set up for famines.

Without general food distributions in July, August, and September, malnutrition will again increase, first affecting children under five. Young children need food that is high in nutrients to meet their calorie needs.
If the 2005 harvest is used by families to repay loans taken out during these months of scarcity, they will again have no food reserves after a few weeks and the crisis will only worsen.

Free access to medical care

A health card costs 500 CFAfr, and medical consultations for children cost between 300-600 CFAfr. Medications are officially free but because generic drugs are frequently unavailable, brand-name drugs are often prescribed. Most families with malnourished children cannot afford the thousands of CFA francs necessary to receive medical care. In Tahoua hospital in April, MSF calculated that drugs prescribed for malnourished children cost an average of CFAfr 15,000. In addition, health care centers do not have malnutrition-screening equipment, therapeutic foods or sufficient stocks of medicine.

Niger's prime minister made a commitment in early June to provide free care for malnourished children in health care centers. MSF welcomes the decision and is waiting for the fast, concrete implementation of this commitment. MSF asks that all sick children under the age of five receive free medical care. There is an

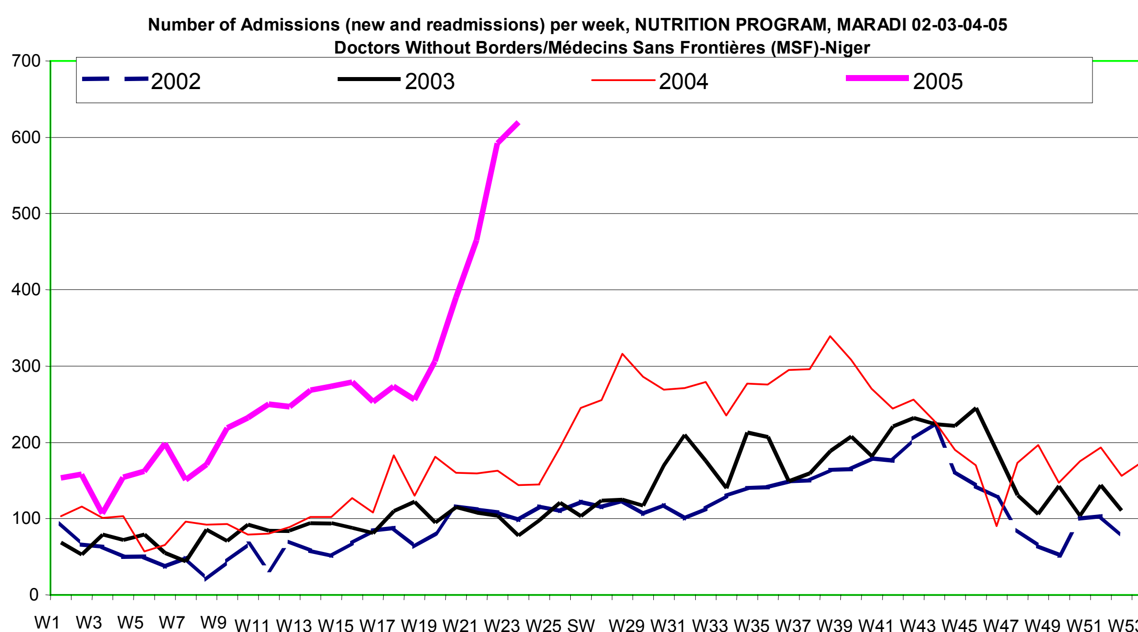
increased incidence of diseases like diarrhea and malaria during the rainy season and children who go untreated are at risk of malnutrition.

Mobilization of other NGOs

The involvement of other key participants is urgently needed. Several NGOs will start moderate malnutrition-treatment programs in Niger in July. But the programs will mainly involve villages in Zinder, northern Maradi and northern Tahoua. In other regions, medical care has generally not been set up for malnourished children, including those suffering from severe malnutrition.

MSF's response: One of the largest feeding programs

Niger represents one of the largest malnutrition-treatment programs in MSF's history, with a capacity for treating 20,000 severely malnourished[1] children per year, five therapeutic feeding centers, 27 ambulatory centers, a budget of around €10 million ($12 million), nearly 50 international staff members and a planned 6,000 tons of food aid.



Five intensive therapeutic feeding centers

MSF's intensive nutritional rehabilitation centers (CRENI) in Niger provide nutritional and medical treatment for children between the ages of six months and five years suffering from severe malnutrition.

The availability of doctors in each therapeutic feeding center results in a relatively low mortality rate – 6% for all children released from the program in 2004. There are four doctors in each feeding center for hospitalizations, plus a few doctors for several ambulatory centers. The most severe cases are closely monitored in the intensive care units.

[1] *There are different types of malnutrition:*

- *Chronic malnutrition, manifested by stunted growth.*
- *Acute malnutrition, characterized by a weight/height ratio between 70% and 80% of the median*

Each of these two forms (chronic and acute) can be further characterized as severe or moderate based on the degree of severity.

The most lethal form is severe acute malnutrition, with a weight/height ratio below 70% of the median.
Severe acute malnutrition leads to immunosuppression in children, which leaves them very susceptible to infection.
Without intensive care, this vicious circle leads irreparably to death.

During the first phase of treatment, children are given therapeutic milk eight times a day. In phase two, the number of calories is increased and spread out over six meals; the children drink therapeutic milk at three meals and eat a peanut-based therapeutic food called Plumpy Nut ™ during the other three. In phase two the children no longer require close medical surveillance and having regained their appetite can go onto the ambulatory care stage. The four feeding centers are in Maradi, Dakoro, Keita and Tahoua: a fifth center is opening in Aguié.

Twenty-seven ambulatory centers treating severe malnutrition

A new way of treating severe malnutrition was set up in Niger in 2003. Before, patients were hospitalized with their mothers for the entire duration of their treatment. One month away from home is a lot both for the child and for the mother, as well as for the other children left at home. However there was no other solution as therapeutic milks are highly perishable and can therefore only be consumed in a medical facility. Finally, five years ago, solid therapeutic foods became available that can be stored for several months. They do not require any preparation, not even drinking water or a receptacle is necessary, and can therefore be consumed at home. When a child's health does not require close medical surveillance, the child no longer has to be hospitalized.

Children are hospitalized on average for one week in the therapeutic feeding centers. Some do not even have to be hospitalized at all. As soon as their health permits, they can go home and once a week a medical team checks their weight and health status and gives them enough therapeutic food for one week (2 packets of Plumpy Nut ™ per day).

In order to prevent children from abandoning their treatment, the therapeutic feeding center must be near their home. In Maradi, for example, 11 ambulatory centers have been set up in 11 villages. Every week a medical team goes to each center. They screen new cases, ensure the follow-up of children already enrolled in the program and refer children that require intensive care to the CRENI.

The number and location of these ambulatory centers is adapted according to the needs. We have opened 27 CRENA (*centers de nutrition thérapeutique amabulatoire* – ambulatory therapeutic feeding centers) in Maradi and Tahoua provinces.

MSF is currently treating more than 3,500 severely malnourished children: 600 in the internal phase and 3,000 in the external phase. The average length of hospitalization is 5 days, while total treatment duration is one month.

Distribution of food and access to health care

Since the beginning of May 2005, MSF has been distributing food rations to children in our programs. During treatment, the child is given a weekly family protection ration of 25 kilograms (55 lbs)of enriched flour and five liters of vegetable oil. When the child is cured and leaves the program, the child and his family are given 50kg (110 lbs)of millet, 25kg (55 lbs) of *niebe* (beans) and 10 liters (22 gallons) of oil.

This involves enormous logistics, including two warehouses with a capacity of 500-1,000 tons in Maradi and Tahoua. Two other warehouses in Keita and Dakoro each have a capacity of 100 tons and there are daily deliveries to the ambulatory centers.

MSF is reinforcing its food distributions. South of Maradi, moderately malnourished children who come to our ambulatory centers will be given food rations.

Concerning access to health care, the ambulatory centers carry out consultations and give medications to moderately malnourished children or children who are ill. This activity is going to be reinforced so that the children can have access to health care every day of the week and not just on the day the MSF ambulatory center is present. MSF also wants to improve the referral of patients to hospitals or our feeding centers.

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