MEDECINS SANS FRONTIERES

Niger: Pay or Die

June 28th 2005

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 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.

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?

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.**

June 2005. Child suffering from severe malnutrition in intensive care at MSF's Feeding Centre.

Abou Soufiane is in a coma and will die shortly afterward. At his side, Michel, an MSF doctor, and his mother.

Report:

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.

The mortality rate of children under five in Niger has exceeded the emergency threshold. This nutrition survey revealed that the mortality rates of children under five in the villages are above the emergency threshold of 2 per 10,000 children per day. In our therapeutic feeding centres, the presence of doctors has enabled us to reduce the mortality rate to 6% in our severe malnutrition programme. But given the gravity of the current crisis, we are still recording 10 to 15 deaths a week, mainly in the intensive care centres where the most severe cases are treated.

According to a nutrition 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 (see appendix). In certain villages in the district of Keita, the severe malnutrition rate is around 6%.

Since January, MSF has treated 9,000 children in its severe malnutrition programmes in the provinces of Maradi and Tahoua: 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 two 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 such diseases as diarrhoea and malaria during the rainy season.

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

At this admission rate, we expect to treat 20,000 children in our programmes through autumn 2005. In 2004 MSF treated 10,000 severely malnourished children in Niger, this represented one-third of all admissions in the French section’s feeding programmes worldwide.

Response of the humanitarian aid system:

an ineffective response, unable to respond to the emergency

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

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 tonnes of cereals monthly beginning in November, only 700 tonnes had reached the district by early May – 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: lack of money (around 45%) or the distant location of the sale point. Those who were able to buy millet once or twice received 20 - 70 kilos per family, which amounts to enough food for 4 to 14 days.

Very poor nutritional quality compounds the problem of low quantities of food. 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 food aid that must be paid for. Farm credit is clearly purchased aid because the maximum 300 kilos of millet provided to families during the lean period must be repaid after the harvest.

The food crisis has been officially acknowledged, yet effectively denied, as evidenced by the lack of emergency free food distributions. The government and institutional donors are leaving NGOs to set up this "appropriate method of free, targeted food distributions", while their main preoccupation is to protect the market.

This has not prevented the French ambassador (France was once Niger's major donor) from calling upon the generosity of French people living in Niger to reduce prices (see appendix).

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 (7-15 June) of the joint WFP and FEWS NET (CC/SAP)[1] 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".*

But what are the solutions recommended in this same document?
"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 programmes, cereal banks and farm credit, all of which should target the most vulnerable households".

[1] World Food Programme/Famine Early Warning Systems

Emergency:

Exceptional measures 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
- Mobilisation of other NGOs to treat acute malnutrition

Free access to food

A bag of 100 kilos of millet costs CFAfr 23,000 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, firstly affecting children under five. Young children need food high in nutrients that meets 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 continue to get worse.

Free access to medical care

A health card costs CFAfr 500, and medical consultations for children cost 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 centres do not have malnutrition-screening equipment, therapeutic foods or sufficient stocks of medicine.

Niger's prime minister has made a commitment to provide free care for malnourished children in health care centres. MSF applauds this decision and is waiting for the fast, concrete implementation of this commitment, announced in early June. We are asking that all sick children under the age of five receive free medical care. There is an increased incidence of such diseases as diarrhoea and malaria during the rainy season and children who go untreated are at risk of malnutrition.

Mobilisation of other NGOs

Several NGOs will start moderate malnutrition-treatment programmes in Niger in July. But the programmes will mainly involve the villages of 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. The involvement of other key participants is urgently needed.

MSF's response:

One of the largest feeding programmes

With a capacity for treating 20,000 severely malnourished[2] children per year, five therapeutic feeding centres, 27 ambulatory centres, a budget of around €10 million, about 50 expatriate staff members and a planned 6,000 tonnes of food aid, Niger represents one of the largest malnutrition-treatment programmes in MSF's history.

Five intensive therapeutic feeding centres

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

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

Intensive care at the Maradi therapeutic feeding centre.

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

[2] *There are different types of malnutrition:*
- *Chronic malnutrition, manifested by retarded 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.

medical surveillance and having regained their appetite can go onto the ambulatory care stage.
The four feeding centres are in Maradi, Dakoro, Keita and Tahoua: a fifth centre is opening in Aguié.

27 ambulatory centres treating severe malnutrition

A new way of treating severe malnutrition was set up in Niger in 2003. Before, patients were hospitalised 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 we 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 hospitalised.

Children are hospitalised on average for one week only in the therapeutic feeding centres. Some do not even have to be hospitalised 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 sachets of plumpy nut © per day).

In order to avoid children abandoning their treatment the therapeutic feeding centre must be near their home.
In Maradi, for example, 11 ambulatory centres have been set up in 11 villages. Every week a medical team goes to each centre. They screen new cases, ensure the follow-up of children already enrolled in the programme and refer children that require intensive care to the CRENI.
The number and location of these ambulatory centres is adapted according to the needs. We have opened 27 CRENA (*centres de nutrition thérapeutique amabulatoire* – ambulatory therapeutic feeding centres) in the provinces of Maradi and Tahoua.

MSF is currently treating over 3500 severely malnourished children: 600 in the internal phase and 3000 in the external phase. The average length of hospitalisation is 5 days, total treatment duration is one month.

Distribution of food and access to healthcare

Since the beginning of May, MSF has been distributing food rations to children in our programmes. During the treatment the child is given a weekly protection ration of 25 kilos of enriched flour and five litres of vegetable oil. When the child is cured and leaves the programme, the child and his family are given 50kg of millet, 25kg of niebe (beans) and 10 litres of oil.
This involves enormous logistics, including two warehouses with a capacity of 500-1000 tonnes in Maradi and Tahoua. Two other warehouses in Keita and Dakoro each have a capacity of 100 tonnes and there are daily deliveries to the ambulatory centres.
MSF is reinforcing its food distributions. South of Maradi, moderately malnourished children who come to our ambulatory centres will be given food rations.
Concerning access to healthcare, the ambulatory centres 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 healthcare every day of the week and not just on the day the MSF ambulatory centre is present. We also want to improve the referral of patients to hospitals or our feeding centres.