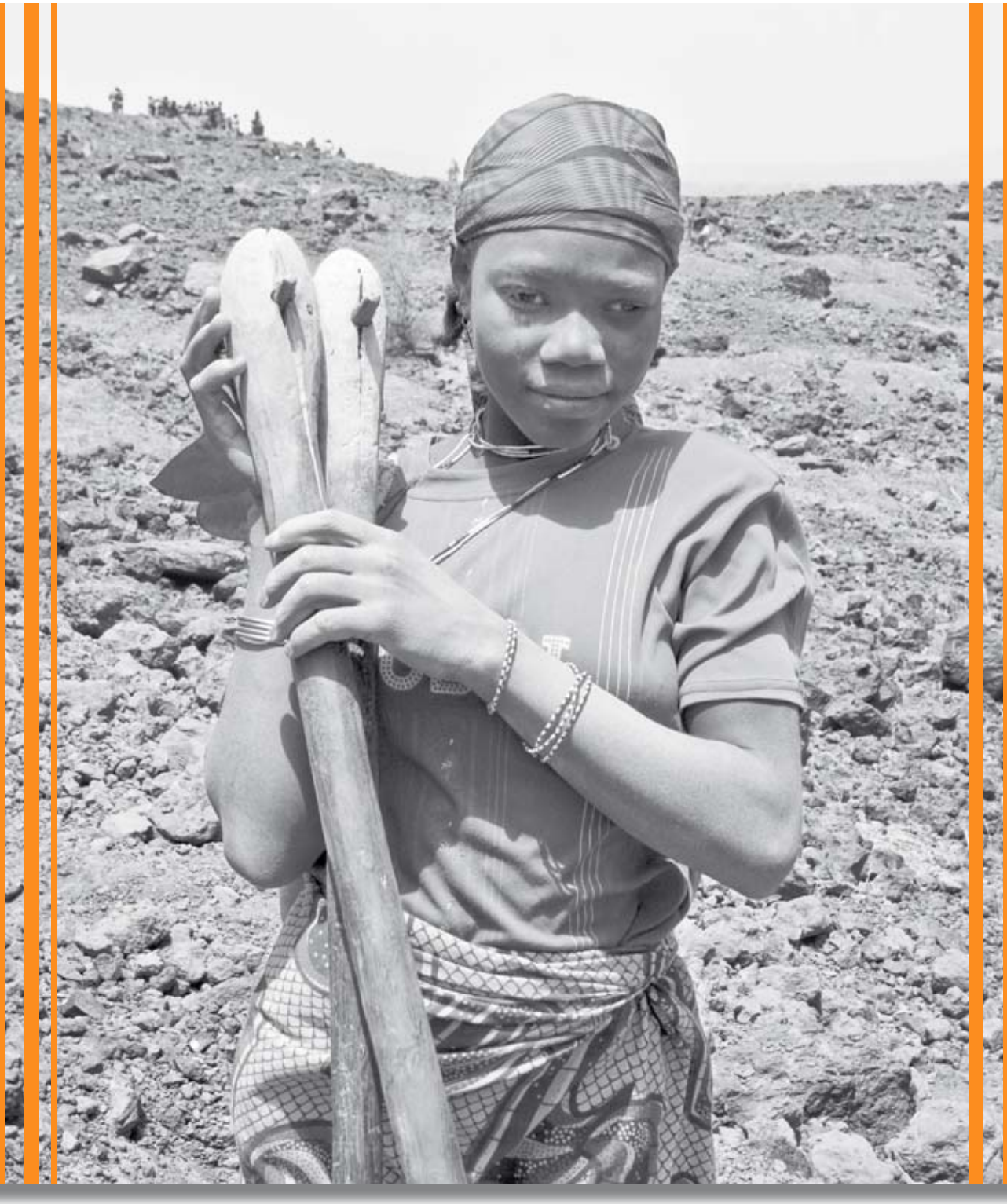
ZERO HUNGER: PHASE 2

UNDERNUTRITION: LESSONS FROM NIGER

Harmonising proven strategies beyond the emergency phase



ACF INTERNATIONAL

TRIPODE

Undernutrition: Lessons from Niger

Harmonising proven strategies beyond the emergency phase

ZERO HUNGER: PHASE 2

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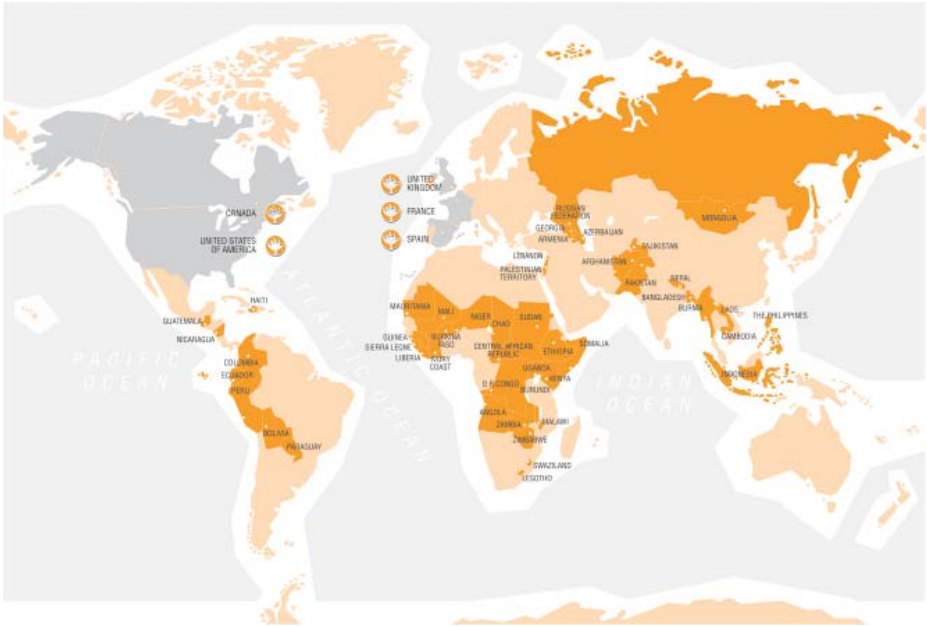
ACF International Network

Action Against Hunger | ACF International (ACF)[1] is an international humanitarian organisation committed to ending child hunger. Recognised as a leader in the fight against malnutrition, ACF works to save the lives of malnourished children while providing communities with sustainable access to safe water and long-term solutions to hunger. With 30 years of expertise in emergency situations of conflict, natural disaster and chronic food insecurity, ACF runs life-saving programmes in some 40 countries, benefiting nearly 5 million people each year.



Tripode Proyectos

Tripode Proyectos is a non-profit organisation coordinated from Madrid, integrating a network of experienced professionals in Development Cooperation and Humanitarian Action based in different countries of Europe, Africa, Asia and Latin America. Our goal is to help in improving the quality and impact of aid through three main pathways: research, technical assistance and evaluation plus knowledge management (training and dissemination).

Our clients range from donor and partner governmental bodies, implementing agencies, think tanks, training institutions and community-based organisations.

1 Derived from the French name: Action Contre la Faim

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List of abbreviations

ACFIN	Action Against Hunger International Network (see Footnote 1)
AECID	Spanish Development Cooperation
AFD	French Development Agency
AGRHYMET	Regional Centre for Training and Application in Agrometeorology and Operational Hydrology
AMAI	Acute Malnutrition Advocacy Initiative
BMI	body mass index
CAADP	Comprehensive Africa Agriculture Development Plan
CAP	Consolidated Appeal Process (OCHA)
CCA	Food Crisis Committee
CCN	National Advisory Council
CEDEAO	Communauté Économique des États de l'Afrique de l'Ouest
CENSAD	Communauté Économique et de Développement des États Sahélo Sahariens
CFSAM	Crop and Food Security Assessment Mission
CIC	Centre for Information and Communication
CILSS	Permanent Interstate Committee for the Fight against Drought in the Sahel
CMAM	community-based management of acute undernutrition
CMC	Joint State Commission Government-Donors
CNPGCA	National Committee for Prevention and Management of Food Crisis
CPN	antenatal care centre
CRC	Limited Consultation Committee
CSI	integrated health centre

CSRD	Supreme Council for the Restoration of Democracy
DFID	Department for International Development (UK Aid)
DHS	demographic health surveys (WHO)
DNPGCA	National Food Crisis Management and Prevention Agency
ECHO	European Commission Humanitarian Office
EDF	European Development Fund
EHAP	Emergency Humanitarian Action Plan (WHO)
FAO	Food and Agriculture Organization
FCD	Donors Common Fund
FEWSNET	Famine Early Warning System Network (USAID)
FDI	foreign direct investment
FORSANI	Niger Health Forum
GAM	global acute undernutrition
GDP	gross domestic product
GNI	gross national income
GoN	Government of Niger
GTI	interdisciplinary working group
HASA	Haute Autorité à la Sécurité Alimentaire
HKI	Helen Keller International
IDA	International Development Association
IMF	International Monetary Fund
LRRD	Linking Relief with Rehabilitation and Development
MAM	moderate acute undernutrition
MDG	Millennium Development Goal
MDM	Medicins du Monde
MDRI	Multilateral Debt Relief Initiative
MICS	Multiple Indicators Cluster Survey (UNICEF)
MoH	Ministry of Public Health
MSF	Medicins Sans Frontières
NCHS	National Centre for Health Statistics
NEPAD	Nouveau Partenariat pour le Développement de l'Afrique
NGO	non-governmental organisation
OCHA	Office for the Coordination of Humanitarian Affairs
ODA	official development assistance
ODI	Overseas Development Institute
OFEDES	Office des Eaux du Sous-sol
ONPPC	National Office of Pharmaceutical and Chemical Products
OPVN	Office of the Food Products of Niger
PAA	Annual Action Plan
PASOC	Alliance with Civil Society Programme
PDS	Health Development Plan
PNAN	National Plan of Action for Nutrition
PNGSA	Global National Programme of Food Security
PRGF	Poverty Reduction and Growth Facility
PTF	technical financial partners
ROASN	Réseau des Associations et ONG Oeuvrant dans le Secteur de la Santé
ROPPA	Réseau des Organisations Paysannes et des Producteurs Agricole de l'Afrique de l'Ouest
RUTF	ready to use therapeutic food
SAM	severe acute undernutrition
SAP	early warning system
SCF	Save the Children
SDR	rural development strategy
SDRP	Poverty Reduction Strategy Paper
SMART	Standardised Monitoring and Assessment of Relief and Transitions
SNE	Société Nationale des Eaux
SNIS	National Health Information System
SNS	National Grain Reserve
SOSA	Operational Strategy for Food Security
UEMOA	Union Économique et Monetaire Ouest Africaine
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNICEF	United Nations Children Education Fund
USAID	United States Aid
WASH	water, sanitation and hygiene
WB	World Bank
WFP	World Food Programme
WHO	World Health Organization

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Executive summary

This paper is the outcome of Phase 2 of ACF's Zero Hunger project.[2] The relevance of best practices and policies identified during Phase 1 are examined in the context of Niger, a country in which undernutrition rates remain persistently high (Global Acute Malnutrition was 16.7% in June 2010).[3]

The six key enabling factors identified during Phase 1 are evident in Niger. However, the degree to which they are adhered to by government, the international community or civil society is variable. Success at fighting undernutrition will require close follow-up by all stakeholders involved.

- **Addressing undernutrition is a long-term issue which goes far beyond the emergency phase and is a prerequisite for future development.** This requires well coordinated responses from the Government of Niger, the international community and civil society through an integrated multi-phase approach with consistent, predictable funding.
- **There is a need to reinforce the fledgling political profile given to nutrition**, by promoting good coordination initiatives (such as those conducted through the National Food Crisis Management and Prevention Agency) and ensuring the necessary resources for effective management and implementation of the nutrition agenda. Together with the Government of Niger, the donor community must ensure consistent adequate funding for such initiatives.
- **A multi-sectoral approach to undernutrition** is followed by most relevant stakeholders. It needs to be reinforced and coordinated more effectively to achieve a truly integrated approach to undernutrition at implementation level.
- **A strengthened civil society** offers significant added value to NGOs' advocacy and implementa-

2 Sanchez-Montero, M et al (2010)

3 INS, 2010

Photo: © ACF / S Hauenstein Swan

tion agendas. Nigerien civil society is still relatively young and most local NGOs are implementing actors, rather than being involved in advocacy or accountability processes. The ongoing development of this sector depends on the Government of Niger's support, backed by the international community's efforts to build capacity.

- **The positive, sustainable impact of the multi-phase approach is clear.** Long-term policies which are also appropriate for transitional phases should also be encouraged. Some actors are investing in covering the needs of extremely vulnerable populations while, at the same time, supporting their social and economic reintegration. This is an approach that needs further consolidation at policy and strategy level of both the Government of Niger and main implementing partners.
- **There is a need to support the Government of Niger's nutrition institutions to ensure effective institutionalised coordination.** The UN Nutrition Cluster is currently co-chaired by the Nutrition Directorate and UNICEF, with UNICEF taking the lead role. There is an urgent need to strengthen the human resources capacity of the Nutrition Directorate, while ensuring sufficient resources are available. Currently the Nutrition Directorate has no direct budget, but is managed by the Mother and Child Health Directorate.
- **The international community's response** to the food crisis in 2010 was significantly improved and better coordinated than the crisis in 2005, mainly due to the more prominent coordination role taken by the government along with its deeper commitment to addressing the crisis.

Niger presents a unique opportunity for the development sector. Now is the time to recognise, further integrate and develop nutrition as a strategic sector on the Government of Niger's political agenda. By addressing and targeting the challenges and limitations identified, ACF and other stakeholders can ensure better and more efficient preventive responses to cyclical food crises.

1. Introduction

This is the second of the three-part Zero Hunger Series. It builds on research carried out in Phase 1, which identified five case study countries that have had relative success in reducing rates of childhood undernutrition over the past fifteen years (Brazil, Peru, Mozambique, Malawi and Bangladesh) in the quest to find out how and why these countries in particular have been successful. Six key success factors were identified which, if in place, create an ideal 'enabling environment' which should facilitate a reduction in rates of undernutrition:

- **a strong political will to fight against hunger and nutrition**
- **a multi-sectoral approach**
- **civil society participation and ownership**
- **a multi-phase approach**
- **institutionalised coordination**
- **continuity of sustainable financial investment.**

Through a combination of effective policy development and good practice at programme level, and supported by sustained investment, these case studies demonstrate that reducing hunger and undernutrition are attainable goals.

This research – Phase 2 – focuses on analysing how the sound policies and best practices identified are applicable in a context where undernutrition is a recurring problem; namely Niger. Niger was selected as it has among the highest rates of undernutrition worldwide; rates which have remained unacceptably high over recent years. Niger has among the highest rates of undernutrition worldwide. In 2010, 313,000 [4] children under five suffering from severe acute malnutrition (SAM) were treated in public health facilities, representing one fifth of severely malnourished children worldwide.[5]

4 Of those, nearly 38,000 children were hospitalised and more than 275,000 were treated at home.

5 UNICEF, 2011. Data available in December 2010.

Photo: © ACF / S Hauenstein Swan

2. Methodology

2.1 Objectives

General objective

- The main aim is to identify how the sound policies and best practices identified during Phase 1 of the Zero Hunger Series are applicable to Niger.

Specific objectives

- To identify major knowledge and practice gaps in Niger, through the analysis of existing policies (food security, nutrition, water and health-related) and practices, and through the analysis of the degree of accountability in the process.
- To put forward recommendations aiming to minimise shortfalls in knowledge and practice.

2.2 Methodology

The case study focused on the objectives set out above. Methodology included both a desk review and field visits:

- **LITERATURE REVIEW** (see *Bibliography* in *Annex 2*):
  - Internal documents: ACF's country strategy, White Paper, AMAI project and associated documents
  - External documents: Food security, health, nutrition, water and sanitation policies.
- **INTERVIEWS WITH KEY INFORMANTS** of government, United Nations agencies, NGOs, donors, ACF mission staff: Head of mission, health and nutrition coordinator and communication and advocacy officers.

This methodological approach was conducted in three steps: (1) Preparation, (2) Field data collection and

Photo: © ACF / S Hauenstein Swan

initial analysis, and (3) Analysis, report writing and presentation of results.

Step 1: Preparation

The team developed the methodology, including field activities and data collection tools during the preparatory stage. Key Informants Interviews were chosen as the main data collection tool (see *Data collection tool* in *Annex 3*). Interviews were structured based on the findings of Phase 1 and the objectives of Phase 2. During this stage, an extensive literature review was carried out and some initial interviews of ACF technical and operations teams were conducted in Madrid.

Step 2: Field data collection and initial analysis

Main activities included:

– initial analysis of the literature review and programme data
– field visit to Niamey and some key informant interviews
– informal discussion with the ACF Niger team and analysis of data collected.

Step 3: Analysis, report writing and presentation of results

The final analysis of the data collected and the report writing were completed during this stage. The first draft report was submitted to ACF for internal discussion and comments on 21 December 2010. The final version of the report, incorporating the feedback, was presented in February 2011.

2.3 Limitations

The authors faced three key limitations during their research:

- Key ACF field staff were not as readily available as anticipated due to programme commitments.
- Interviews with some key stakeholders (USAID, the Ministry of Water Resources, UNDP, MSF-Belgium and French Red Cross) were cancelled on the day of the appointment, and it was difficult to reschedule due to time constraints.
- It was not possible to consult key donors based in Dakar, such as DFID.

3. Harmonising proven strategies

3.1 Niger country situation

3.1.1 General context [6]

Niger is a vast, landlocked country with an estimated population of 16 million, the majority of whom live along a narrow band of arable land on the country's southern border. The economy is dominated by agri-cultural activity, including pastoral activities. Mining (uranium) and informal trading activities also feature. The primary sector, which accounted for about 40.8% of GDP in 2007, is dominated by rain-fed agriculture, while livestock production accounts for about a third of the value added in the sector.

In 2009, Niger was ranked 182 out of 182 countries in the UNDP's Human Development Index. Sixty-one percent of Niger's population live in extreme poverty on less than a dollar a day, and the average per capita income was estimated at US$330 in 2008. Social indi-cators are low; in 2007 the infant mortality rate was 81 per 1,000 live births, life expectancy was 50.8 years,

Map Sources: ESRI, UNCS.
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations. Map created Jun 2010 – *www.reliefweb.int*

and the literacy rate was 28.7%. Gross primary school enrolment preliminary estimates were around 67.8% in 2008/09. GDP growth has been highly volatile but consistently low, outpaced by the population growth rate which was estimated at 3.4% in 2008.

6 World Bank Country profile, 2010

Name: Republic of Niger

Population: 16,300,000 (2010 estimated)

Annual growth rate: 3.3% (2010)

Capital: Niamey (population approx 1.4 million)

Other major cities: Tahoua, Konni, Maradi, Zinder, Diffa, Dosso, Arlit and Agadez

Area: 490,000 sq miles – about three times the size of California

Currency: West African CFA Franc

GNI per capita: $340

Languages: French (official), Hausa, Djerma, Fulfulde, Kanuri, Tamachek, Toubou, Gourmantche, Arabic

Religions: Islam (97%); remainder traditional and Christian

Ethnic groups: Hausa 53%, Djerma (Zarma) 21%, Fulani 7%, Tuareg 11%, Beri Beri (Kanuri) 6%; Arab, Toubou, and Gourmantche 2%

Education: Six years compulsory. Attendance: men 45%, women 31%. Literacy in 2008: 30% (15% for women)

Life expectancy: 51 years

Terrain: About two-thirds desert and mountains, one-third savanna

Climate: Hot, dry, and dusty. Rainy season June – September

Source: WB development indicators

GDP growth was estimated at 9.5% in 2008 (compared to 3.3% in 2007 and 5.2% in 2006, after reaching 7.4% in 2005), reflecting the strong performance of the agriculture sector (about 26% growth in real terms) following its recovery from the 2004 drought (when GDP growth stood at 0.8%).[7]

3.1.2 Political context

The northern region of the country has been affected by conflict since early 2007. This has now almost dissipated with no reports of armed attacks since June 2008. However, the government considered the northern region a military zone as recently as November 2008. Under the auspices of Libya, the government and rebels recently signed an agreement, the implementation of which will help resolve the crisis. The then president, Mamadou Tandja, proposed a three-year extension to his second presidential term through a referendum; this was expected to end in December 2009. The President dissolved the National Assembly and the Constitutional Court, actions which did not favour his plan to change the Constitution.

President Mamadou Tandja gained a high percentage at local and parliamentary elections held in October 2009. Against this backdrop, a military coup took place on February 18, 2010. The junta announced the creation of the Supreme Council for the Restoration of Democracy (CSRD), which is presided over by Major Salou Djibo. The creation of CSRD has been welcomed by Nigeriens, many of whom expressed their support through rallies in Niamey and across the country. Salou Djibo has initiated a series of consultations with political parties, social and professional groupings, as well as with Niger's development partners. He maintains that the junta will only run the country for a transition period and has no desire to retain power. He has proclaimed three pillars for the transition: sound management, reconciliation and the restoration of democracy. The junta has also stated that it will tackle the looming threat of a food crisis. There are legislative and presidential elections planned for 2011 that should end the term of the transitional government.

3.1.3 Economy

Niger's economy is reliant on rain-fed agriculture, mining and official development assistance. Agriculture is highly vulnerable to climatic fluctuations and locust invasions. The mining sector is susceptible to changes

7 Ibid

in global demand and prices for its mineral exports, and the country is also vulnerable to fluctuations in donor financing. In addition to these specific vulnerabilities, Niger has also been hard hit by recent global crises, including the food, fuel and financial crisis.

These vulnerabilities are reflected in large year-on-year fluctuations in economic growth, exports, and government revenue and expenditures. With a large proportion of households living near or below the poverty line, negative shocks translate directly into households that are not able to cover basic needs, further exposing them to hunger and undernutrition. The ability to build human capital though education and adequate healthcare and nutrition then becomes a challenge.

Following the severe drought experienced in 2004, an increase in rainfall allowed a return to normal agricultural activity, up until 2009. However, in 2010 inadequate rains early in the year led to insufficient cereal harvest for approximately half the population, therefore reversing this positive trend.

In addition to the food crisis, the prolonged political crisis also threatens the continued flow of much-needed donor assistance. With official development assistance financing about 45% of Niger's budget,[8] a sustained decline in development assistance would threaten whatever progress has been made in recent years to increase access to health and education.

In the mining sector, Niger is only partially benefiting from the upward trend in uranium prices, as a large share of its uranium export is sold at fixed prices. A resolution of the political crisis will also be important to ensure that foreign direct investment (FDI) in the mining sector proceeds at the expected pace and is able to sustain employment in construction and other related sectors.

Based on its Poverty Reduction Strategy Paper (SDRP) (developed further in *Section 3.3.3.1*), the government has embarked on a range of critical reforms in recent years.[9] These will need to be sustained and deepened if tangible progress in poverty reduction is to be achieved. Reforms include a focus on macroeconomic and debt sustainability, strengthening public expenditure and debt management, transparent management of mining revenue, restructuring and privatisation of state-owned enterprises, increasing access to social services, measures to manage the rate of population growth and enhancing the environment for private sector activities, especially in the agriculture sector.

In April 2004, Niger reached the Heavily Indebted Poor Countries (HIPC)[10] Completion Point and received debt relief from the International Development Association (IDA), which was, including topping-up, equivalent to US$142 million. The country also qualified for US$300 million in debt relief from the Multilateral Debt Relief Initiative (MDRI). A three-year Poverty Reduction and Growth Facility (PRGF) arrangement with the International Monetary Fund (IMF) was approved by the Fund's Board in May 2008 for a total amount of US$23 million. The third review was completed by the IMF's Board in February 2010, allowing a disbursement of about US$5 million.[11]

3.2 State of undernutrition in Niger

Niger's weak economic structure (it is highly dependent on agro-pastoral activities with volatile agricultural production and market prices), is one of the core causes of the country's food insecurity and high levels of undernutrition. Besides this weak economy, there are also a variety of significant structural socio-economic pressures, including high population growth, low coverage of water, sanitation and health services and a low education level. (Refer to *Niger country fact sheet* in *Annex 1* for overall indicators.)

Over the last decade three major production shocks caused by drought and/or locust invasions occurred in 2000/2001, 2004/2005 and 2009/2010. These production shocks resulted in a drastic drop in grain produc-

8 World Bank, 2010

9 Cabinet du Premier Ministre (2007b)

10 HIPC includes the 40 least developed countries (high levels of poverty and debt overhang). These countries are eligible for special assistance from the International Monetary Fund (IMF) and the World Bank.

11 Ibid

tion, increased grain prices and lower farm income and a subsequent food crisis, the magnitude of which varied across the country. The failure of agricultural production to meet the food needs of this growing population (average rate of 3.3% per year) forced the country to import the shortfall. On average, Niger imports between 250,000 and 300,000 tonnes of grain per year.[12] In this context, fluctuations in grain production and prices have a major impact on household access to food and, overall, on food security.

Although the drought of 2000/2001 resulted in a grain deficit (over 50% in 31% of departments), it was not classified as a severe food crisis by the Niger Government. The data needed to analyse the impact of the crisis on nutritional status in 2001 is not currently available.

In 2005, severe food shortages and a food crisis affected around 3.2 million Nigeriens, with 800,000 people affected by critical food insecurity.[13] Unexpectedly, the 2009 food crisis affected 7.1 million people, including 3.3 million who were severely affected.[14] The 2009 crisis arose from a major deficiency in production; a cereal production deficit (30% decrease from 2008) combined with two consecutive forage deficits (31% of needs in 2008 and 67% in 2009). *Figure 1* shows the evolution of grain production per capita, and gross cereal balance in Niger over the last 10 years. The graph also highlights the impact of the three shocks mentioned above.

As an overall consequence of all these factors, undernutrition of children under five years remains a major concern in Niger. The evolution of global acute malnutrition (GAM) rates since 2005 shows that the peak periods of undernutrition correspond to years of food crisis. However, undernutrition rates are always critical, even in normal years. The rate of global acute malnutrition is very volatile. Acute malnutrition rates were above the emergency threshold (15%) in both 2005 and 2010. Overall rates ranged between 10% and 12% between 2005 and 2010. *Figure 2* (overleaf) shows acute malnutrition rates over the last 12 years.

12 World Food Programme (2010)

13 23% decrease in cereal production in 2004, compared to 2003 (USAID and FEWS-NET, 2009)

14 SAP 2010

Figure 1 Grain production per capita and gross cereal balance in Niger (2000–2010)

Source: Ministry of Agricultural Development

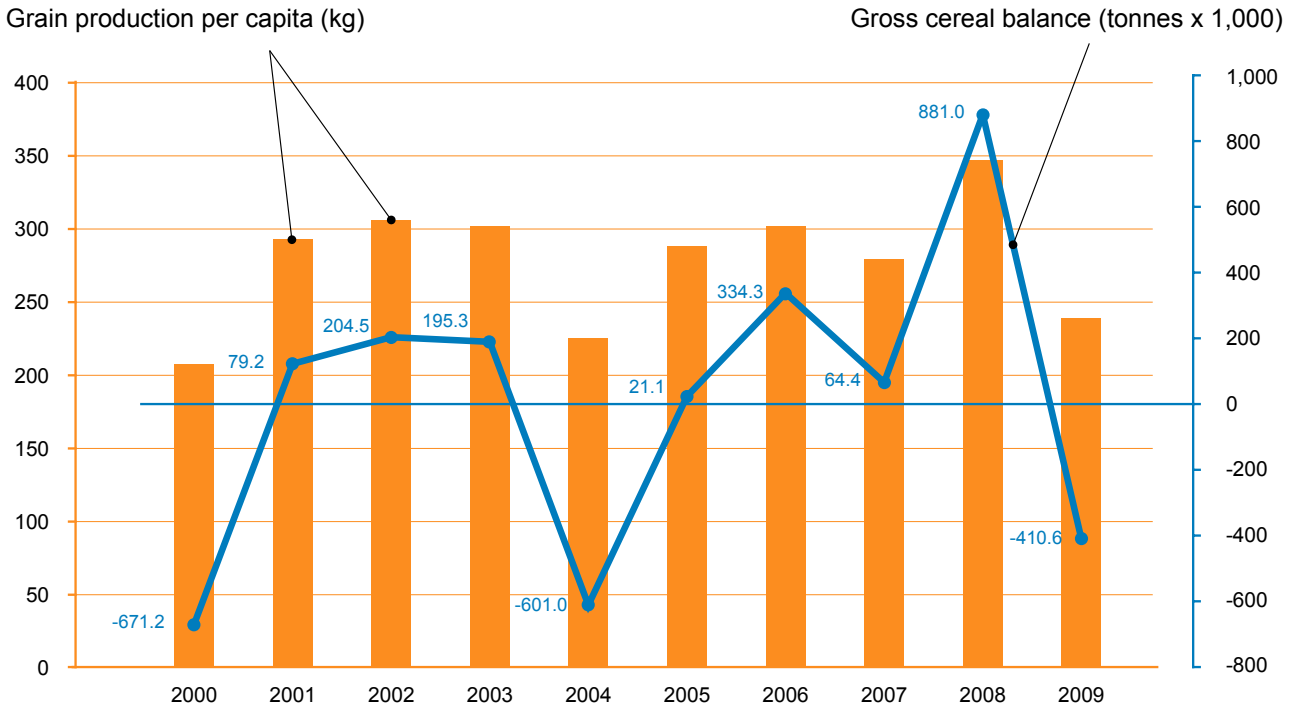
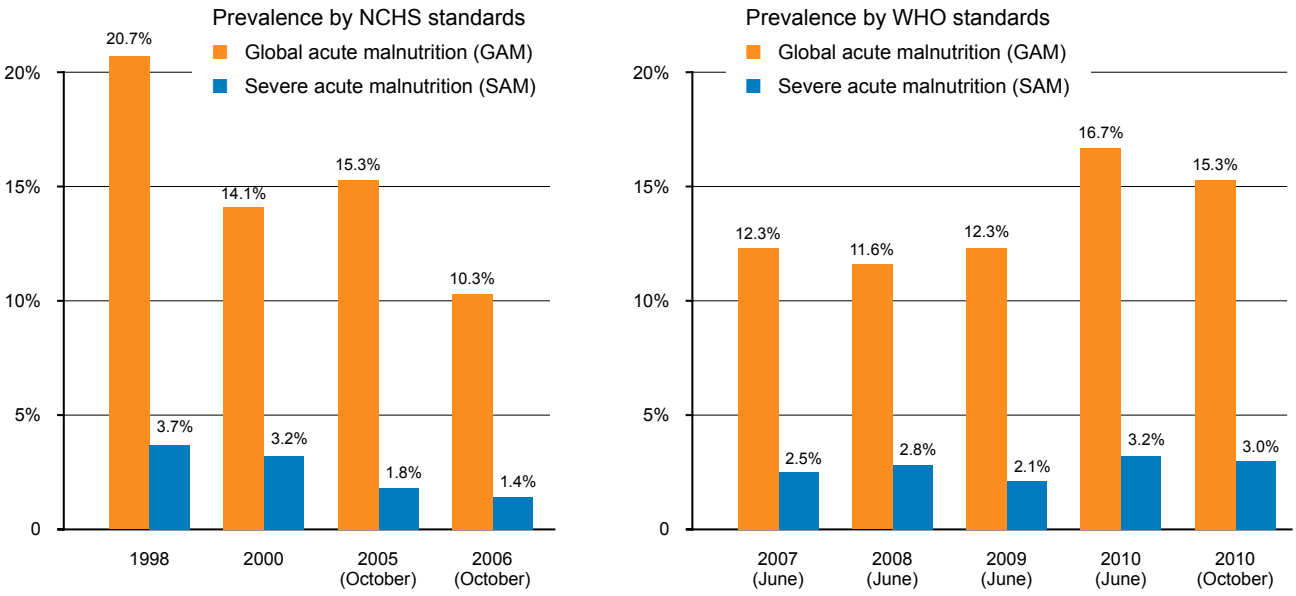


Figure 2 Acute malnutrition rates, 1998–2010 [15]



Acute malnutrition rates are extremely volatile and all regions in Niger are affected. For the past four years, the region of Diffa has recorded GAM rates above the emergency threshold of 15%, and the region of Zinder reported similar figures in three years out of four. In 2010, before the hunger season, there was a severe degradation of the nutritional status of children, with GAM rates ranging from 22.1% (Diffa region), 19.7% (Maradi region), 17.8% (Zinder region) and 15.8% (Tahoua region). As shown in *Figure 2*, there are alarmingly high acute malnutrition rates throughout the country between October and November (following the harvest period). The same rates (over 15%) were recorded in these areas during the 2005 food crisis.

Chronic undernutrition rates, which varied from 40% to 50% between 1998 and 2010 (according to both NCHS and WHO standards) also indicated abnormally high levels of undernutrition that have existed in the country for years. Underweight rates in children under five have stabilised in recent years (1998–2010) between 40 and 49% [16] (NCHS) without showing any improvement. Women and newborns are particularly affected; according to the Demographic and Health Survey 2006, 19% of women of childbearing age are malnourished (BMI below 18.5). In addition, the proportion of children born weighing less than 2.5kg ranges from 7.5% in Tillaberi to 43% in Tahoua. According to the same survey, the prevalence of anaemia among children from six to 59 months is 84%, 61% in pregnant women and 42% in lactating women.

3.3 Analysis of success factors

Six key success factors were identified in Phase 1 of the Zero Hunger Series as contributing to an ideal 'enabling environment'. Analysis has been conducted to establish the extent to which the poor state of nutrition in Niger is attributable to and could be improved by the implementation of these factors.[17] The factors include:

- **strong political will**
- **civil society ownership and participation**
- **a multi-sectoral approach**

15 Institut National de la Statistique (INS) (2006); Institut National de la Statistique (INS) (2007); Institut National de la Statistique (INS) (2008); Institut National de la Statistique (INS) (2009); Institut National de la Statistique (INS) (2010).

16 38% to 40% between 2007 and 2010 respectively according to WHO standards. The hunger season in Niger usually runs from June to October.

17 Sanchez-Montero, M et al (2010)

- **institutional coordination**
- **a multi-phase approach**
- **continuity of financial investment.**

3.3.1 Strong political will

3.3.1.1 Nutrition on the political agenda

Although nutrition is not yet a top priority for Niger's government, it is now firmly on the political agenda; undernutrition itself is also addressed as a public health problem in Niger. Indeed, since the 'transition' government took power in March 2010, there has been a significant and positive change in the way the government has integrated nutrition into its national priorities. In the past, and especially in the pre-2010 government, undernutrition was rarely on the political agenda. In fact, for a short legislative period the government denied the existence of undernutrition in the country,[18] supposedly for political reasons.

In March 2010, when the transitional government was established, severe food crises in the country were already expected. The government reaction at the time was to address the potential consequences of a looming food crisis by coordinating existing resources and launching the Annual Response Plan (see page 28). The agreed actions focused on preventing further crises and building the national response capacity.

The positive impact of these planned and coordinated actions has helped the government recognise the importance of addressing undernutrition as a cross-cutting intervention and as a public health problem. This is especially significant due to the magnitude and severity of undernutrition in Niger. In addition, as Niger regularly faces nutritional crises, international aid and relevant nutrition actors have a 'window of opportunity' to reinforce the government's agenda to tackle undernutrition. However, despite the positive impact of putting undernutrition on the national political agenda, progress remains slow and the leadership of the Nutrition Directorate within the MoH is weak; so too are nutrition actors. Limited organisational capacities and resources mean that many nutrition prevention and curative services only exist on paper.[19] In addition, the MoH and the National Food Crisis Management and Prevention Agency do not sufficiently address nutrition at institutional and strategic level.

3.3.1.2 Organisational structure

Niger has a Nutrition Directorate which, since 2008, has depended directly on the Ministry of Public Health (see *Organisation chart of the Ministry of Public Health* in *Annex 4*). In the past, the Nutrition unit was not a directorate; it was a division of the Directorate of Mother and Child Health. The creation of a Nutrition Directorate is a positive move, though functional changes were not in line with institutional capacity and there is still a need to improve resources for effective nutrition management. Major weaknesses addressed by stakeholders include:

- limited technical capacity
- lack of specific budget line allocated to the National Plan of Action for Nutrition
- at regional and district level, the nutrition focal point still depends on the Mother and Child Health directorate, preventing an efficient decision-making process and resource management.

3.3.1.3 State implementation of policies, strategies and programmes

Overall, Niger has a good information management approach (documents, policies and protocols on nutrition are available). However, implementation is a major concern, particularly at the local level, where the lack of technical and human resources capacity at MoH level is evident.

In particular, the Ministry of Public Health's capacity to effectively implement acute undernutrition pro-

18 Some agencies such as MSF France and ACF were asked to stop their nutrition activities in the country.

19 Prevention services are not prioritised in the strategic axes of the PDS. The fact that Nutrition is placed under the umbrella of the Mother and Child Health sector prevents resources reaching nutrition, as nutrition is not the main priority in the Mother and Child Health Directorate.

grammes or nutrition surveillance systems is weak. There are limited human resources skills, both in terms of quantity and quality. Most NGO staff interviewed remarked that the minimum number of two people required to run CSIs (Integrated Health Centres) was not always achievable.[20] NGOs usually address this weakness by strengthening the logistics and personnel needs of the government health structures. In areas where NGOs are not present, the shortage of staff in the Ministry of Public Health is often supported by UNICEF and WFP through direct contracts.[21] Not surprisingly, prevention activities, as set out in the Health Development Plan (PDS), are also affected by the limited knowledge and numbers of staff at health centres. Furthermore, the poor performance of the Mother and Child Health programme is largely due to the lack of skilled human resources and poor overall management of health centres.[22]

In order to better understand the government's political will, and how it is reflected in its institutional capacity and existing dynamics with other nutrition stakeholders, the response to food crises since the crisis of 2005 is examined below. This has been done through analysis of mechanisms set in place during the 2009/2010 crisis. Despite severe weaknesses in early warning and response management, the 2010 food crisis showed significant improvement in the activation of the early warning system, and in stakeholders' management approach, especially when compared to 2005. These improvements meant that the impact of the food security and nutrition crisis in 2009/2010 was not as damaging as expected.

In comparison to 2005, the 2009/2010 nutrition crisis response was characterised by the following good practices:

EARLIER GOVERNMENT RECOGNITION OF THE CRISIS Political changes created a more proactive climate both towards humanitarian action and supporting people affected by the crisis. The new military government, which took power after the state coup in February 2010, recognised and accepted the impending crisis and launched an international emergency appeal in March 2010 to mobilise resources. Prior to the military coup, humanitarian response was delayed partly because of the perception that hunger was associated with political instability, and was therefore considered a taboo subject.

EARLIER ACTIVATION OF EARLY WARNING SYSTEM TRIGGERED MECHANISMS TO PREVENT FURTHER DETERIORATION In October 2009, food security indicators already suggested production deficits could lead to increased food insecurity in Niger during 2010.[23] Food assistance needs were expected to be large and to begin earlier than the normal hunger season (June).

Despite measures adopted by the Government of Niger and its partners during the 2009/2010 food crisis response, levels of acute undernutrition remain extremely worrying (as seen in *Figure 2*). According to the most recent nutrition survey conducted during the harvest period in the country (October–November 2010), acute undernutrition reached over 15% at the national level (and over 17% in Agadez and Zinder). GAM and SAM did not show any significant improvement from June to October 2010 (from 16.7% to 15.3% and from 3.2% to 3% of GAM and SAM respectively).

Early warning (SAP) information is based on food price indicators, and therefore failed to take into consideration other key indicators that could have shown a more realistic and holistic picture of vulnerability per area (household income, food consumption, nutritional morbidity etc). Moreover, the geographical approach which was implemented failed to identify particularly vulnerable zones. The SAP used an overall district approach, which does not include detailed informa-

20 Ministère de la Santé Publique. Secrétariat Générale (2010a)

21 According to UNICEF and WFP personnel (key informants interviewed during the field visit), management of the nutrition contracts remains a major challenge.

22 Ibid

23 The Crop and Food Security Assessment Mission (CFSAM) jointly conducted by CILSS, FEWSNET, FAO, WFP, and the Government of Niger estimates below-average millet and sorghum yields. At that time, overall, yield-per-hectare was expected to be 24% below average. Crop conditions closely resembled those of 1997/98, when final production was 22% below estimated national needs. However, deficits were expected to be larger because planted area was low due to re-sowing and the late start of season and because the population of Niger has grown substantially over the past decade. (USAID and FEWS-NET, 2009)

tion on villages or households. Consequently, some extremely vulnerable households did not receive any support, while other less vulnerable households did benefit from district-wide blanket feeding programmes.

3.3.2 Civil society ownership and participation

Niger's civil society [24] is young and not yet well structured. Nevertheless, it has evolved due to the lack of strong and grass-rooted political parties. NGOs are invited to consultations, but they are not always included at the decision-making level. The National Advisory Council (CCN), which replaced the dissolved National Assembly, includes representatives from women's organisations, rural and farmer associations and traditional leaderships. This is the forum where laws are opened for consultation and amendments before being passed.

There is an incipient network of national associations focused on human rights (such as Croissade, a federation of Human Rights NGOs, with its leading organisation, the Association Nigerienne pour la Defense des Droits de l'Homme), rural development, gender and health which play a part in the consultation processes for policy making. Many of them are supported by INGOs. This is a practice which has increased since the expulsion of several INGOs by the previous government in 2009. Expulsions resulted in INGOs increasing their involvement in this sector and often networking with local counterparts in order to expand their operational coverage and advocacy reach. Institutional capacity-building programmes exist – such as the one run by Oxfam Novib – which aim to upgrade the profile of local civil society.

There are two significant well organised and active networks:

ROPPA – (Réseau des Organisations Paysannes et des Producteurs Agricole de l'Afrique de l'Ouest), the rural and farmers network, which is representative of small farmers and is a member of a regional network, Arene (involved in the livestock sector).

ROASN – (Réseau des Associations et ONG Oeuvrant dans le Secteur de la Santé), a network of health sector NGOs, which actively participated in drafting the PDS. In general terms, networks are more likely to be involved in programme implementation and sensitisation as opposed to advocacy. Some commentators note that many existing networks are not significantly representative of their sector as a whole.

Some key donors have integrated local civil society advocacy capacity building as a strategic priority. In an effort to reinforce the dialogue between civil society stakeholders and the state, some donor strategies are both encouraging and demanding institutional accountability. An example of this is the EU Alliance with Civil Society Programme (PASOC). Accountability mechanisms for citizens and civil society overall are not in place, as internal accountability is often understood as a bottom-up exercise only (inside the government), not a top-down exercise (towards citizenship).[25]

Moreover, as already explained in a previous chapter (see *Section 3.3.1.3*), Niger has a government with a limited and restrictive implementing capacity. Policies, programmes and planned services cannot be fully operationalised due to weak monitoring and evaluation mechanisms. However, in an attempt to counteract this, the current government has created the Court of Auditors; this is the first government action to increase transparency within management and is welcomed.

3.3.3 Multi-sectoral approach

The general endorsement of an integrated approach to undernutrition by many key actors (Ministry of Public Health, the National Food Crisis Management and Prevention Agency, most donors interviewed – EU, France, Spain, Switzerland – and implementing agencies, both UN and NGOs) has been initiated, albeit

24 Understanding civil society as all sorts of non-governmental initiatives related to promotion of general or specific groups of population's interests through all kinds of approaches: advocacy, information or operational activities.

25 Some other donors, however, have a very low accountability demand profile (French Government), as other agendas, such as anti-terrorism or energy security, are being prioritised.

slowly. In reference texts (policy and strategies) the Health sector appears to be quite well integrated with Food Security and WASH policies. Nutrition is also, theoretically at least, included in global poverty reduction plans (Poverty Reduction Strategy) and other sectors' policy documents, such as the Health PDS and the Food Security SDR, but not in the water and sanitation sector. However, even though nutrition is included in these plans, in practice implementation is ineffective at regional and departmental levels.

An overview of the different sectoral public policies is presented below. The need for a more closely integrated approach, from implementation right up to policy level, is clear.

3.3.3.1 Poverty reduction strategy

The reference policy in Niger is the Poverty Reduction Strategy Paper (SDRP) which lasts five years, from 2008 to 2012. The vision of the SDRP is aligned with the first of the Millennium Development Goals (MDG) (To *'eradicate extreme poverty and hunger'*), and with strategies for regional integration and poverty reduction developed at continental level (African Union and NEPAD), and regional and sub-regional levels (CEDEAO, CENSAD, UEMOA).

Furthermore, the SDRP is consistent with various international resolutions and declarations; The Ouagadougou Conference on Primary Health Care and Health Systems in Africa, the six pillars defined by WHO to strengthen health systems and the Paris Declaration on Aid Effectiveness, among others. The SDRP is also in line with the policy of 'Health for All' in the 21st century, including Agenda 2020 and the strategic guidelines of the WHO African Region 2010–2015. The estimated budget for implementation of the SDRP for the period 2008–2012 is US$15.203 billion: 27.9% will be funded internally and the remainder will be covered by external resources.

There are seven main axes within the SDRP:

- strong, diversified, sustainable and job-creating growth
- equitable access to quality social services
- addressing the demographic challenge
- reduction of inequalities and strengthening of social protection for vulnerable groups
- infrastructure development

- promotion of good governance
- effective implementation of the strategy.

Nutrition objectives are mentioned within the second priority (equitable access to quality social services) alongside the education, health, water and sanitation, modern energy services, employment and sport promotion objectives. This clearly demonstrates that nutrition is perceived as one of a number of diverse issues. Both preventive and curative nutrition actions are mentioned. The nutrition indicator used in the SDRP is underweight rates; the objective is to reach an underweight rate of 24% in 2012, and 18% in 2015, in line with MDG 1. To put this in context, underweight rates stood at 43% in 2008 (using NCHS/WHO standards), so to achieve a prevalence rate of 24% by 2012 would require a 55.8% reduction; an extremely ambitious target.

In order to make the SDRP operational, several sector policies and programmes were developed. In line with the current case study objective, the most relevant policies include the following: the Health Development Plan (PDS), the Rural Development Strategy (SDR), the Policy and Strategy for water and sanitation and the social policies coordinated by the Ministry of Population, Childhood Protection and Female Promotion.

3.3.3.2 Health and Nutrition Policies

The Ministry of Public Health developed its Health Development Plan (PDS) with the participation of civil society (UNICEF, WHO, WFP, international and local NGOs) for the period 2005–2010. Every year, Annual Action Plans (PAA) are devised based on the PDS and are implemented and monitored at each level of the health pyramid (central, regional and peripheral). A new PDS [26] covering 2011–2015 (ongoing at the time of the field visit) is already available (PDS3) in draft. The PDS3 2011–2015 integrates SDRP 2008–2012 sector guidelines and the MDGs. It constitutes the framework for all health interventions between 2011 and 2015. It is one of several new government initiatives such as the country COMPACT.[27]

Despite many efforts of UN agencies and nutrition actors, the nutrition component is not included in the PDS as a strategic programme. Instead, it is one component of the eight strategic programmes that together make up the programme: Mother and Child Health. The Mother and Child Health programme includes four types of intervention:

- family planning
- health of adolescents and young
- child health coverage
- mother and newborn health coverage.

Main nutrition interventions are included in the child health coverage. Priorities are:

- exclusive breastfeeding up to six months
- screening for undernutrition and referral where necessary
- complementary feeding of infants
- treatment of acute undernutrition in children under five according to the national protocol.

Table 1 (overleaf) summarises the different strategic priorities and the budget allocated. The budget allocated to the Mother and Child Health sector is the largest, receiving 31.1% of the total budget. According to the Joint Review of the Health Sector conducted in 2009, budget allocation for nutrition is not specified in the PDS.[28] Indeed, there is **no** budget allocated for the Nutrition Directorate for 2007, 2008, 2009 or 2010.

The Government of Niger developed a National Food and Nutrition Policy and a National Plan of Action for Nutrition (PNAN) in 1996 (amended in 2002 and revised in 2006). These documents served as a refer-

26 Ministère de la Santé Publique. Secrétariat Générale (2010a)

27 A country COMPACT will be signed between the Ministry of Public Health and various technical and financial partners to improve sector performance. The Compact is a mutual commitment between the Government of Niger and the various national, regional and international agencies and organisations to jointly achieve the CAADP (Comprehensive Africa Agricultural Development Programme) Goals. (Ministère de la Santé Publique. Secrétariat Générale (2010a))

28 Ibid

Table 1 Budget breakdown of total PDS 2011–2015 by strategic priority (US$ millions) [29]

Source: Plan de Développement Sanitaire (Government of Niger)

	2010	2011	2012	2013	2014	2015	Total	
Health coverage	20.05	35.63	36.82	38.01	39.20	40.39	190.05	7.7%
Mother and child health	113.93	127.66	140.47	153.28	166.08	178.90	**766.39**	**31.1%**
Human resources	40.23	46.44	52.06	57.69	63.32	68.94	288.45	11.7%
Drugs and other inputs	97.17	103.69	106.95	110.20	113.46	116.72	551.02	22.4%
Fight against diseases	82.50	95.88	101.01	106.15	111.28	116.42	530.74	21.5%
Governance and leadership	11.67	20.87	23.59	26.32	28.95	31.58	131.31	5.3%
Financial mechanisms	0.20	0.40	0.32	0.22	0.22	0.22	1.40	0.1%
Health research	0.91	0.92	0.93	0.93	0.94	0.94	4.65	0.2%
TOTAL	**366.66**	**431.49**	**462.15**	**492.80**	**523.46**	**554.12**	**2,464.03**	**100%**

ence for the revised National Plan of Action for Nutrition (PNAN 2007–2013) and programme implementation. 'Fight against nutritional deficiencies', the specific programme within the National Plan of Action for Nutrition, included preventive and curative actions with a budget of US$9.45 million. So far, it has failed to meet its ambitious objectives; namely to:

- reduce the rate of undernutrition by 50% by 2015
- increase the rate of mothers practising appropriate weaning by 2015 to 50%
- halve the rate of children with a birth weight below 2.5 kg by 2015
- halve the proportion of women and children suffering from iron deficiency anaemia by 2015
- eliminate vitamin A deficiency among children under five and women of childbearing age by 2015
- eliminate iodine deficiency by 2015.

The Ministry of Agriculture has a Food and Nutrition Service that has been involved in the development of the PNAN and is responsible for coordinating and implementing it. However, the PNAN has not been officially adopted and approved by the government, clearly showing that it is not a priority. Effective implementation of the PNAN requires inter-ministerial coordination (a multi-sectoral approach) between the Health and Agriculture sectors, with one of them taking clear leadership. Furthermore, within the Ministry of Agriculture, nutrition is not seen as a priority of the Food and Nutrition Service. The Ministry of Agriculture is focused on agricultural and livestock production and commercial promotion. In 2011, new updated versions of the PNAN, supported by UNICEF, will be created.

Moreover, since 2005, Niger has had a National Nutrition Protocol for the treatment of acute undernutrition which follows WHO's approach of Community Based Management of Acute Malnutrition. This has been updated and improved several times (2006 and 2009), according to new international protocols, nutrition experts' support and the inclusion of the new WHO Child Standards. Since 2009, Niger has integrated the new WHO Child Growth Standards. A further revision of the protocol will be carried out in 2011, when it will include improvement of registers and data collection tools.

29 Ibid

Since 2007, the Government of Niger has made steps to integrate CMAM programmes into the health structures at policy level. However, insufficient resources have been allocated to CSIs and many challenges are still present. That said, nutrition therapeutic products, such as Plumpy Nut, are included in the list of essential drugs in Niger. A major challenge now is setting up the necessary logistical requirements to include them in the national supply channels (ONPPC [30]) of the MoH, which is already affected by budgetary problems.[31]

The on-going national Strategy for Child Survival,[32] which focuses on MDG4 (*'reducing the child mortality rate'*) is also important. This strategy has been implemented since 2008 and includes nutrition actions, which are mostly preventive.

The National Health Information System (SNIS), which sits within the Public Health system, is currently performing below expectations: particularly in the areas of epidemiology surveillance and health activity monitoring. The information system does not take private sector data into account, and data quality and availability remains a challenge. As an overall observation from stakeholders interviewed, the acute undernutrition data of the SNIS should be reviewed, as it only includes the number of cases identified (and not necessarily the number of cases treated). As a result, this data should not be used as a surveillance system on its own; it needs to be studied together with other surveillance systems such as SAP, CILSS [33] or FEWSNET.

Another key policy issue is free healthcare for children under five and pregnant women. This has existed in Niger since 2006/2007. The implementation of free healthcare has shown a marked improvement in some maternal indicators:[34]

- The utilisation rate of antenatal care (CPN), rose from 37.9% in 2004 to 90% in 2009.
- The caesarean rate has changed from 0.7% in 2004 to 1.5% in 2009.
- The number of screening tests for gynaecological cancers has significantly increased (83 cases in 2007 compared to 5,184 in 2009).

However, many limitations have been identified in the functioning of free healthcare. Stocks of essential drugs have run out due to invoices not being paid by the government. This has meant that some health structures have been unable to provide free care to target populations. The current problem essentially relates to the inadequacy of resources needed to support the cost of free healthcare. This is compounded by the the uncertainties that exist about reimbursing health facilities (fiduciary risk). There are also structural problems, including a weak supply chain for drugs.

To this end, some NGOs working in the health sector, such as MSF/Belgium, MDM, Save the Children UK, Help and UNICEF, are advocating for donors to increase funding for the implementation of harmonised and coordinated mechanisms for disbursement. Advocacy targeted at the government focuses on achieving a gradual increase in the state budget allocated to health.

3.3.3.3 Rural Development Strategy

The Rural Development Strategy (SDR), issued in 2003 by the Prime Minister, aims to implement the Poverty Reduction Strategy Paper (SDRP) in the rural development sector and to develop the Government of Niger's commitment to Poverty Reduction. It is the sole reference framework for economic and social policy in the rural sector.

The SDR aims to reduce the incidence of rural poverty by creating conditions for sustainable economic and social development to ensure food security of populations and sustainable management of natural resources. It states as a general objective *'the reduction of rural poverty from 66% to 52% in 2015'*, in order

30 National Office of Pharmaceutical and Chemical Products

31 At the moment, ACF is implementing a project that supports the MoH supply channel for nutrition products.

32 Ministère de la Santé Publique. Secrétariat Générale (2008) *Document de la stratégie national de survie de l'enfant*

33 Permanent Interstate Committee for the Fight against Drought in the Sahel

34 Ministère de la Santé Publique du Niger, Secrétariat Générale (2010b)

to achieve the first MDG.[35] The SDR approach and priorities are largely focused on promoting productive and economic growth.

One of its three strategic aims is to prevent risk, improve food security and sustainable management of natural resources in order to secure living conditions of populations.[36] Within this there are two work streams specifically devoted to improving food security of the most vulnerable (among the rural population), and improving nutrition, health and food quality of rural households. With the aim of diminishing the impact of the cyclical food crises, the first work stream has concentrated on the establishment of surveillance systems and food aid mechanisms.

The improvement of the nutritional situation of rural households is well represented in the SDR through the inclusion of food production, consumption diversification, quality control of food available on markets, hygiene education and WASH services. On paper, this policy appears to be an example of the multisectoral approach (it reaches several ministries, and is a key reference document). In practice, however, this is not the case. Despite the existence of an Action Plan[37] designed to implement the strategy (with a subprogramme on nutrition), the policy is not effectively implemented by the different responsible institutions. The strategy is highly ambitious and unrealistic. It covers many different sectors with no specific leadership for the overall approach.

3.3.3.4 Water and sanitation sector

Issued by the Ministry of Water and Sanitation in April 1999, *Policy and Strategy for Water and Sanitation*[38] is the most recent reference document for this sector. Again, this was an overly ambitious plan that was impossible to put into operation effectively, mainly due to the fact that decentralised decision-making was a prerequisite for it to function properly. However, this type of decision-making does not yet exist. This was not helped by inadequately developed governance and institutional instability. The policy sets out three main priorities (social, economic and environmental), and its overall objective is *'the satisfaction of essential needs of the population in order to improve the Nigeriens' health and living standards and reserving the water resources to economic added value activities always guaranteeing the sustainable management of the resource.'*

Despite reference to the nutritional status of the population, there is no specific mention of the link between water and sanitation and nutrition. The only time that the health sector is mentioned in the policy is in the recognition of the role of the Ministry of Public Health in water quality control and treatment and the protection of water points.

Nevertheless, a clear theoretical framework is provided by the Water and Sanitation Policy. This framework includes three focus areas with the aim of improving health status:

WATER SUPPLY AND SANITATION IN VILLAGES AND RURAL AREAS, aims to provide access to fresh and high quality water for all villages of Niger with goals based on international standards (access to a minimum of 20 litres of fresh water per person per day, a Modern Water Point[39] for any village of 250 inhabitants or any human concentration located more than 5km from a Modern Water Point. For human concentrations between 1,500 and 2,000 inhabitants it is recommended that a well serviced mechanical pump and reservoir are installed).

WATER SUPPLY IN URBAN CENTRES In 1999, secondary water distribution networks were installed in 51 urban centres, providing 38 litres of fresh water per person per day to 1.8 million people. This shows that there was an insufficient coverage of needs.

35 Cabinet du Premier Ministre, 2003

36 B.2: *'Prévenir les risques, améliorer la sécurité alimentaire et gèrer durablement les resources naturelles pour sècuriser les conditions de vie des populations.'*

37 Cabinet du Premier Ministre, Secretariat Permanent de la SDR, 2006

38 Ministère de l'Hydraulique et l'Environnement du Niger (1999)

39 MWP are those protected with cement and fitted with a water pump.

SANITATION IN URBAN CENTRES Based on the data available (policy document, 1999), there were sanitation plans in just three urban areas, the Urban Communities of Niamey, Zinder and Maradi. In general, the infrastructures available are old and poorly maintained. Despite the slow growth of the urban population in Niger during the last years (16.2% to 16.55% between 2000 and 2010),[40] the financial breakdown of the municipalities and the mismanagement of waste, at both municipal and family level, results in a highly vulnerable situation regarding the risk of propagation of water-related diseases.

In an effort to integrate support to some of these initiatives, the Ministry of Public Health has also taken action to prevent water-related diseases. Consequently, some measures adopted also highlight the need to improve hygiene education and basic household sanitation.

In addition to the fact that there is a lack of coordination and collaboration between ministries, the majority of responsibilities[41] of the water and sanitation sector are divided between two different public enterprises:

OFEDES (Office des Eaux du Sous-sol) is responsible for water points, well construction and maintenance, and the development and management of water distribution networks in the rural areas.

SNE (Société Nationale des Eaux) is a public-private enterprise responsible for planning water supply in urban centres. It is also involved in the study, development and management of installations for fresh water production, commercialisation, transportation and distribution.

As a consequence, there are major overall institutional blockages, which are mainly due to two factors:

- The absence of appropriate community-based organisations (mainly in the rural environment) to engage in relevant negotiations, which are capable of defending their interests and capacities.
- Despite the decentralisation process, the water and sanitation administration lacks capacity and remains asymmetric. Strong technical and financial capacities are found at central level, however weak capacity exists at regional and local levels.

3.3.3.5 Social affairs

The social sector appears to be weak at both policy and institutional level. Social policies are established within the Ministry of Population, Childhood Protection and Female Promotion. They are, therefore, one of many other priorities and there is also no reference policy document.

Governmental social programmes do not exist, and those that are run by international actors are afflicted by serious coordination gaps. There is no common understanding among international actors of the approach needed in this sector. This can be partly explained by the difficulty most international agencies have in separating social assistance from emergency situations; the only free services delivered to the population are health (with an intense debate about its lack of viability and sustainability) and the economic and food aid programmes, usually launched when emergencies are declared. There are no long-term social assistance programmes implemented on a regular basis by the state.

The few social aid initiatives in place are usually undertaken by international NGOs.[42] A more comprehensive approach to the nutrition agenda includes one based on reducing the causes of undernutrition by working simultaneously on two levels:

- Ensuring access of vulnerable households to the food basket through different methods (blanket distributions, cash transfers, etc). Implementation is

40 World Bank, 2010

41 In fact, the weak staff capacity and scarce revenue collected by the local governments makes the current distribution of responsibilities between central government (main infrastructures construction) and regional/local (management and maintenance of the main infrastructures and secondary distribution networks) quite unrealistic and non viable (any improvement at planning, construction and management relies heavily on Niamey's capacities and political will).

42 Save the Children, for instance, is developing a comprehensive approach to the nutrition agenda.

based on the economic vulnerability of the target population, and programmes are implemented for as long as the level of extreme vulnerability lasts.

- Ensuring adequate food intake by identifying appropriate humanitarian, social assistance and other essential services. Economic and social needs are addressed through implementation. These sorts of actions promote economic reactivation by ensuring access to inputs, and by reinforcing skills and organisational capacities. The World Bank is planning to launch a pilot social programme which will test this approach.

Overall there are three major obstacles obstructing the promotion of social policies and interventions:

- Limited capacity to identify extreme vulnerability – most emergency actors usually focus their interventions on quick impact assistance. Consequently, these sorts of interventions do not address the different needs of the already extremely vulnerable due to structural factors, which are increasingly damaged by cyclical crisis.
- Weak capacity to integrate wider economic factors that have an effect on vulnerability.[43]
- Lack of national policy and institutional capacity and resources.

Despite being expressed in many key documents, the multi-sectoral, integrated approach is not evident in the practical functioning of ministries' dynamics. There is a vertical silo approach which results in sectors failing to communicate internally and externally. At the core of this, there is competition for financial resources between ministries and inside ministries (as is the case between the Directorates of Nutrition and Mother and Child Health at the MoH). Consequently, it is fair to say that coordination between ministries is weak, as it is focused on the Prime Minister, whose sole concern is the response to crises through the Crisis Prevention and Response Body.

3.3.4 Institutionalised Coordination

The forum where inter-ministerial coordination is strongest is the National Food Crisis Management and Prevention Agency (DNPGCA). This is directly headed by the Prime Minister, with active participation of the Departments of Health, Agriculture and Social Affairs. However, it is again important to highlight that, overall, nutritional issues are not set as a priority within the National Agency.

The National Agency is the cornerstone of the crisis prevention system in the short term (*Box 1*). It was created in 1988 by the Nigerien government and major food aid donors (France, Germany, Switzerland, Italy, WFP, EU, UNDP and FAO) with the purpose of improving management and coordination among stakeholders.

The Operational Strategy for Food Security (SOSA) sets out the direction for sustainable improvement for food security. This includes development of agro-pastoralism and food production, alongside prevention and mitigation of food crises. In so doing, it takes into account both cyclical and chronic food insecurity.

The Global National Programme of Food Security (PNGSA) is supported by the FAO. It aims to serve as a tool for ensuring coherence, coordination and flexible and pragmatic implementation of food safety programs targeted at vulnerable groups and food insecure areas.

Unfortunately, neither the SOSA nor the PNGSA have been made operational. This is partly due to the fact that the previous Government of Niger refused to recognise that undernutrition was a significant issue within the country. However, the development of the SDR and updating of programmes in the rural sector, following the revision of the SRP, have taken key aspects of these two documents into account. Currently, the FAO is funding and developing a National Food Security Strategy to replace the SOSA, and

43 Save the Children and ECHO have produced a report which aims to identify the economic patterns and factors of vulnerability. It argues that rural households' food security is ensured by food production activities (two-thirds of total consumption) but also by earnings coming from remunerated jobs. (The Save the Children Fund and ECHO (2009))

Box 1 National Food Crisis Management and Prevention Agency (DNPGCA) structure

The Agency mobilises two main features:

THE DONORS COMMON FUND (FCD) This is the first level of resources mobilised to cope with food crises. Its mission is to fund prevention efforts aimed at supporting households in their efforts to ensure food security during food crises (cereal banks etc). It also funds assistance actions such as sale of cereals at affordable prices.

THE NATIONAL GRAIN RESERVE Including a physical inventory (the stock of national safety, SNS): Used only in years of a major crisis. It exists at national or regional level to implement quick actions pending the mobilisation of international humanitarian assistance.

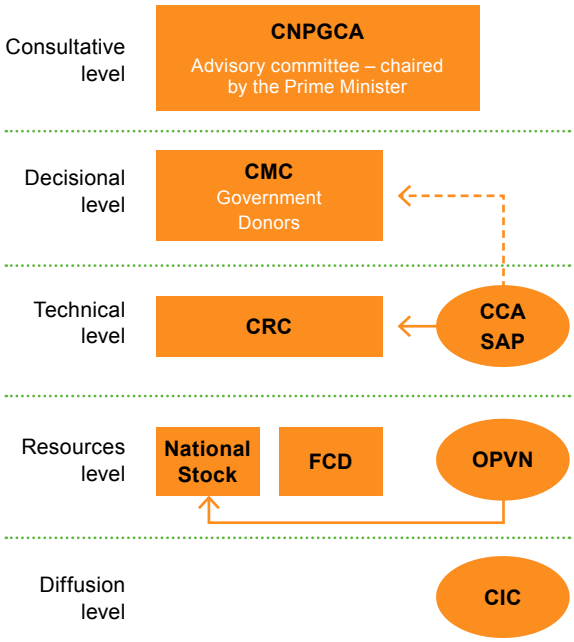
The DNPGCA consists of:

A CONSULTATIVE STRUCTURE: National Committee for Prevention and Management of Food Crisis (CNPGCA). It is chaired by the Prime Minister (coordinator of emergency food aid) and is responsible for alerting the government to situations of potential food and nutrition crisis. It also defines the severity of the emergency and ensures implementation of interventions.

A DECISIONAL, COORDINATION AND SUPERVISION STRUCTURE: Joint State Donors Commission (CMC), chaired by the Prime Minister. This commission is formed by the state and Technical Financial Partners [44] (PTF). The CMC has a technical body called the Limited Consultation Committee (CRC) which is mandated to oversee management actions and CMC decision making. The CRC meets twice a month and five NGOs have been involved in a committee for the nutrition sector since early 2011 (three international [45] and two local [46]). The CRC manages the FCD.

TECHNICAL OPERATIONAL STRUCTURES:

- **The Management Unit of the Early Warning System** (SAP), also attached to the Prime Minister through the **Interdisciplinary Working Group** (GTI), collects data to establish the risks of crises and prepares recommendations for action for decision makers. The **Office of Niger's Food Products** (OPVN) is tasked with the storage and maintenance of national food stocks.
- **The Food Crisis Committee** (CCA), chaired by the Prime Minister, is the executive body of the DNPGCA (CMC and CRC). It is responsible for assessing aid needs, formulating applications and ensuring coordination of aid pledges.
- **The Centre for Information and Communication** [47] (CIC) is responsible for analysing and diffusing information relating to food security and nutrition.
- The **regional and sub-regional committees** of the prevention and management of food crises, chaired by the deputy secretaries of governorates and prefectures, collect, validate and analyse information on the situation and coordinate responses in the field.



44 The PTF are Germany, Belgium, France, Italy, Switzerland, USA, Canada, EU, Luxembourg, WFP, FAO, UNICEF and UNDP.

45 MSF-Switzerland, CRF, Oxfam

46 AREN (Association pour la Redynamisation de l'Élevage au Niger) and Afrique Verte

47 Le Centre d'Information et de Communication (CIC) du Dispositif National de Prévention et de Gestion des Crises Alimentaires du Cabinet du Premier Ministre.

to make it more operational. The strategy should be finalised in March 2011, and nutrition activities are expected to be included.

Recently, as a result of the increased institutional interest which has been accorded to food security issues, a new institution named HASA (High Authority on Food Security) has been created by the new government. The HASA aims to improve coordination between different emergency and prevention actions addressing food security. In spite of this, it is still unknown how nutrition will be integrated into this institution.

During the 2009/2010 crisis, the National Agency ensured coordination between the Early Warning System (SAP) and food security surveillance information system to help identify risk areas and potential actions to take to mitigate the crisis. The Food Crisis Committee (CCA) evaluated needs and formulated requests for stakeholders, ensuring good coordination of aid. At regional and sub-regional levels, the governorates and prefectures (including stakeholders such as government departments, NGOs and civil society) coordinated crisis management and prevention interventions within their jurisdictions. The National Agency, however, did not coordinate well with the Nutrition Directorate.

Contrary to 2005, the role of the government increased in 2010, leading the response (Nutrition cluster and CCA) and drafting the 'Response Plan' (led by the CCA, *Box 2*) to coordinate all actions, and allocate the funding and actors that would implement them. The nutrition cluster (led by the nutrition directorate of the government in collaboration with UNICEF) coordinated the nutrition response plan. The plan was supported by the international community through an Emergency Humanitarian Action Plan (EHAP) launched in May 2010 and revised in July to address the deteriorating humanitarian situation. Aid agencies claimed that they were better funded and coordinated than they had been previously.

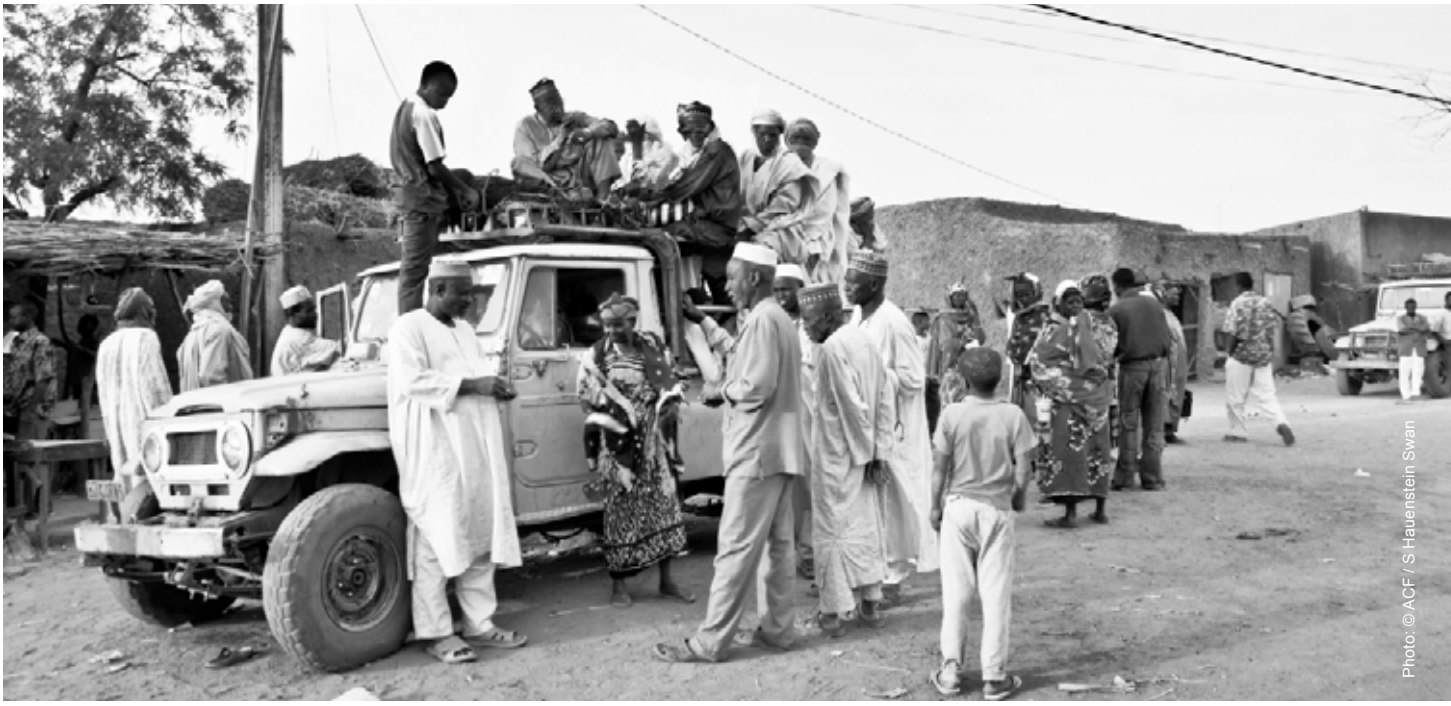
Despite some progress in terms of government leadership, weaknesses were still identified, and stakeholders also noted that inter-cluster coordination (especially Nutrition, Health and Food Security) failed to function effectively. For example, while the treatment of undernutrition was within the nutrition cluster, prevention activities remained within the food security cluster; efficient coordination of both approaches was therefore severely lacking.

Apart from the National Food Security and Nutrition Crisis Management and Prevention system, there is no institutionalised coordination in place, and no local nutrition coordination council. Currently, the UN Nutrition Cluster is acting as the coordination body. The cluster is, however, very active and participative, managing to engage all nutrition actors. The Niger Nutrition Cluster is chaired by the MoH Nutrition Directorate and co-chaired by UNICEF. Its aim is to empower the Nutrition Directorate and increase its ownership of the decision-making and coordination process.

In spite of the positive perception of the role of the UN cluster, according to all stakeholders interviewed, there is still a long way to go to achieve the cluster's aim. At present the Nutrition Directorate has not taken steps to lead the cluster; UNICEF still takes the major leadership and coordination roles, mainly due to limited technical knowledge and coordinating capacity within the Nutrition Directorate.

Box 2 'Response Plan' mechanism (Plan de Soutien)

CCA uses the baseline provided by SAP to establish an Annual Response Plan for vulnerable populations. The plan's aim is to strengthen the capacities of vulnerable populations to cope with food insecurity. It provides an estimate of the overall needs that should be met by all partners through effective coordination. It also specifies the types of prevention and mitigation activities required. In the plan, the government provides guidance based on priorities through a plan of action (including a chronogram and funding shortfalls) in which all activities and partners must be integrated.



3.3.5 Multi-phase approach

The ongoing debate about emergency/development approaches (which blocked many decisions during the 2005 food crisis), has finally moved forward. Currently, donors and implementing partners are working towards a common understanding; there is recognition that integrating a multi-phase approach is crucial for positive and sustainable impact. Efforts are in place to ensure that short-term impact actions, recovery actions and long-term actions are implemented.

Furthermore, a large number of key actors already implement the multi-phase approach. The National Food Crisis and Prevention Agency (DNPGCA) leads these efforts at government level. At present, the DNPGCA is ensuring that the coverage of the 2010 food crisis nutritional programmes continue into 2011 and is setting up preventive strategies. The multi-phase approach is also currently implemented by the European Commission, through its Humanitarian Agency (ECHO).[48] UN agencies also hold a similar view, advocating a multi-phase approach to crisis response in Niger. As such, the crises are seen as structural problems to be addressed by both direct urgent assistance and long-term economic recovery actions, including sustainable social integration and basic service coverage for the most vulnerable populations.

In addition, the twin-track interventions used during the 2010 crisis, targeted both emergency food access needs and nutritional treatment as well as more innovative safety net actions. These improved coverage and set the basis for further recovery actions from the start of the response to the crisis. The assistance efforts implemented during the crisis were jointly operated by the Government and humanitarian partners (UN and NGOs). Some of these actions represented innovative actions for Niger (*Box 3*, overleaf). The response was facilitated by a large network of NGOs involved in the management of acute malnutrition in Niger's health centres.

Emergency oriented NGOs are also engaged in this twin-track approach, with the aim of increasing the sustainability of health and nutrition services and ensuring advocacy campaigns have a positive impact in the long term.

48 This approach is integrated in the Sahel region in order to cover the rehabilitation phase, and to ensure good coordination with the long-term programme of the 11th European Development Fund. (EU 10TH European Development Fund (EDF)(n.d.))

Box 3 Types of food security and nutrition interventions used during the 2010 food crisis

- Cash transfer activities and blanket supplementary feeding operations for 644,000 children aged 6–23 months from May to August
- The medical treatment of severe acute undernutrition (SAM) of children under five and of moderate acute undernutrition (MAM) in children and pregnant/lactating women
- Free targeted food distributions launched in mid-May, targeting approximately 1.5 million people during the hunger season
- The subsidised sale of cereals to improve access to 30% of food-insecure populations for three months
- The subsidised sale or free distribution of livestock feed and livestock vaccinations
- De-stocking activities
- Cash for work activities targeting 30% of the food-insecure population for three months

However, capacity within the Ministry of Public Health is a major obstacle to success, despite its commitment and willingness. Barriers identified include weak coordination between ministries and limited implementing capacity, due to the lack of funding and human resources. The way in which the new government addresses these problems needs to be closely monitored.

3.3.6 Continuity of financial investment

Niger's state budget depends massively on international support; 40% of the government's annual revenues and 8.5% of GDP [49] is derived from international support. Donors, therefore, play a key role in Niger's future and many international donor agencies are present throughout the country. However, despite increasing interest in deploying long term strategies,[50] most are fully committed to crisis response interventions.

A comparative overview of the response to the 2005 and 2010 crises already shows improved resource mobilisation by the government and the international community.

In 2010, mobilisation of government resources, supported by technical and financial partners, helped build a concerted and massive response to the food security and nutrition crisis. By November 2010, US$275,801,914 [51] had been mobilised for the humanitarian emergency compared to the US$121million provided in 2005, reflecting an increase of over 40%.[52] Similarly, according to WFP and UNICEF key informant interviews, the quantity of food distributed in 2010 was approximately 200,000 tons, compared to 20,000 tons in 2005.

Despite the increase of available funds in 2010, donors' reactions were too slow to prevent a severe crisis. Although indicators pointed to a looming crisis from October 2009, prevention activities were not implemented due to delayed response and action was only taken from May 2010. The annual hunger season began at this time (earlier than usual), with admissions to emergency feeding clinics for severely malnourished children peaking in mid-May.[53]

Both strategy and communication in the international community showed remarkable improvement during the 2010 crisis in comparison with that of 2005. The UN agencies played a more supportive role with effective direct logistical support of the Ministry of Public Health (MoH), favouring the integration of nutrition activities into health structures. UNICEF and WFP directly managed contracts for nutritional products with the MoH, without the support of any intermediate NGOs.

During 2009 and 2010, the government and nutrition cluster coordinated messages to avoid contradictions and promote the same line of communication. It is also worth noting the LRRD (Linking Relief with Rehabili-

49 US State Department (http://www.state.gov/r/pa/ei/bgn/5474.htm#econ)

50 Also by 'non traditional donors' in this region (USAID).

51 OCHA (2011a)

52 European Development Research Network (Cornia GA and Deotti L, 2008)

53 Loewenberg S (2010)

tation and Development) approach which is adopted by some donors (such as ECHO or AECID), most of the Technical and Financial Partners (UN agencies) and INGOs. This approach ensures better coverage of the needs of the most vulnerable during the 'grey zone', the transitional phase between emergency and development.

On the whole, donors are committed to a long-term presence in the country due to local institutional uncertainty and the strategic benefits of maintaining their profile in the region.

A list of major operational and policy stakeholders is included in *Annex 5*. An overview is provided below of the most important donors in the country.

UN Development Assistance Framework (UNDAF)

The UN system has approved a Development Assistance Framework for the period 2009-2013 with a total of US$1.05 million. This incorporates an integrated approach which aims to reduce poverty in Niger through an ambitious and comprehensive plan across three sectors: Sustainable Development, environment and food security; Human Capital, demography and basic social services; and Governance. Budgetary distribution between all sectors is coherent and balanced, reflecting an integrated approach.

The alignment between the UNDAF and the government priorities expressed in the SRP is excellent. In particular, UNDAF's commitment to fighting undernutrition is demonstrated by the inclusion of specific goals to increase the treatment of acute undernutrition from 17% to 50% of cases and to reduce maternal mortality by 75%, and infant-juvenile mortality by 66%.[54]

Office for the Coordination of Humanitarian Affairs (OCHA)

The government's demand for aid in March 2010, largely influenced a positive and higher CAP response (76% of the US$371million covered).[55] This was also facilitated by the timely drafting of the 'Response Plan' (Plan de Soutien), the main tool used by the National Food Crisis Management and Prevention Agency to channel international support.

The 2010 CAP concentrated on food security and nutrition (including water sanitation and health sectors). Nutrition programmes were focused on the treatment of Severe Acute Undernutrition. The 2010 CAP shows that both sectors were able to mobilise significant resources (71% coverage for food security and 58% for nutrition, the two highest funded clusters).

OCHA is sensitive to the cyclical nature of food crises in Niger, and is, together with UN agencies, consequently engaged in both preventive and LRRD approaches. OCHA is also active in trying to attract other donors to work on long-term strategies, and in promoting an integrated approach of the UN sector agencies (through the inter-cluster coordination of Food Security, Nutrition, WASH and Health).

European Union

The EU is Niger's major donor, with a €458million National Indicative Plan budget for 2008–2013, plus other complementary budgetary lines and instruments such as Food Facility (€10million from 2008–2011), co-funding of NGOs (€1million for 2009–2010 period) and ECHO programmes (€43million from 2010).[56]

As a consequence of the country's political crisis, Niger's funding is currently under consultation (under article 96 of the Cotonou Agreement), and cooperation is restricted. However, Nigerien authorities have demonstrated that they are willing to return to constitutional proceedings. The stages and related government commitments of this democratic transition appear to have been clearly identified. This will allow a gradual return to full cooperation, as long as commitments are met.

54 UNDAF (2008)

55 OCHA (2010a)

56 European Commission Humanitarian Aid Department (ECHO) (2011)

The fight against poverty is at the heart of the EU's relations with the country, in coordination with other partners. Priority areas for cooperation under the 10th EDF include major macroeconomic budgetary support, governance, economic reforms, support for growth in rural areas, regional integration, infrastructure and food security.

Due to the reluctance of the previous Government of Niger to include Mother and Child health and nutrition in the current National Indicative Plan (signed in 2008), nutrition is mainly covered by the Food Facility and co-funding of NGOs. The 11th EDF will include Food Security and Health as priority sectors, thanks to the transitional government's support. The EU supported the 2010 food crisis through direct government support and ECHO funding; the role of ECHO is crucial in this context. ECHO is engaged in a three-year programme (initiated during the 2005 crisis), which is extended on an annual basis. This funding programme plays a key role to ensure the use of the LRRD approach in the food security and nutrition sectors.

Other donors

Donors such as USAID and Spanish Development Cooperation (AECID) have increased their profile in Niger since the 2005 food crisis. Spain contributed to the crisis through the 2010 CAP with an initial €5.4million, followed by a further €4.1million, with a focus on food and nutritional security during the emergency phase. Further support to the Nigerien government is expected in the health and rural development sectors.

USAID/OFDA has developed a regional Crisis Prevention and Mitigation Plan in which risk reduction and the mitigation of the effect of acute undernutrition are two of the main priorities in the 2008–2010 strategy. The USA was the first country-donor to respond to the crisis in 2010, with OFDA's contribution of US$54million[57] to the CAP.

57 OCHA (2010b)

Photo © ACF / Stephenstein Swan

4. Beyond the emergency phase

The focus that the new transitional government in Niger gave to the coordination and prevention of the 2009-2010 food security crisis has provided new opportunities for the development sector. Now is the time to recognise, further integrate and develop nutrition as a strategic sector within the political agenda of a country that is highly vulnerable to food crises. By addressing and targeting the identified challenges and limitations found in Niger, better and more efficient preventive responses to the cyclical food crisis can be assured.

As demonstrated by this case study, there are key issues which require the attention of both the development sector and the Government of Niger. It has also identified outstanding good practices that can improve food and nutritional security.

- **Nutrition now has a defined political profile within Niger.** The food crisis of 2009-2010, and the associated response, helped push nutrition up the political agenda in Niger. The government agency responsible for food crisis management and prevention (DNPGCA) has now committed to integrate nutrition into its activities. However, the effective implementation of the nutrition agenda is currently damaged by lack of budget and overall weak management. This is compounded by the low priority given to nutrition by the Mother and Child Health Directorate, which directly supervises the nutrition agenda. Moreover, nutrition's political standing is threatened by the long-term strategies of donor's. These often fail to address nutrition directly and tend to include it within existing Mother and Child health strategies, typically through emergency response.

- **The majority of key stakeholders have adopted a multi-sectoral approach.** Although the integrated approach is included in reference policies and strategies which address undernutrition, there is still a long way to go for it to be fully practiced at implementation level. The National Food Crisis Management and Prevention Agency acts as a successful coordination body at government level. However, it is the only one at this level and struggles to coordinate its activities with the Nutrition Directorate. Initiatives need to be promoted at government level to ensure a comprehensive, multi-sectoral approach to the treatment of hunger, and consequently better coordination of all relevant sectors, donors and implementing agencies.

- **Progress has been made to promote civil society advocacy activities for rural development lobbies, farmer's associations and women's organisations.** There is an increased trend in Niger to strengthen the capacity of civil society and to enhance its ability to contribute to policy and dialogue. This could be further promoted by the whole donor community. Civil society groups offer INGOs unique opportunities for partnership through ensuring the implementation of long-term advocacy strategies in the unstable political context of the Sahel region. There are also a significant number of INGOs that have taken forward weak initiatives on behalf of local organisations. However, Nigerien civil society is still relatively young and disorganised. Most local NGOs are implementing actors, rather than supporters of advocacy or accountability. The ongoing development of this sector depends on the support of the Government of Niger and the international community, and requires close follow-up.

- **All relevant stakeholders in Niger have adopted the multi-phase approach.** Stakeholders aim to coordinate recovery, rehabilitation and longer-term development policies throughout 2011. Interesting initiatives exist which favour the transition between emergency and development. Some actors are investing in covering the needs of the extremely

vulnerable, while at the same time, supporting their social and economic reintegration. This twin track approach needs further consolidation at the policy and strategic levels of both the Government of Niger, and main implementing partners. INGOs are also starting to provide more institutional support to the Government of Niger by promoting government capacity, improving needs analyses and engaging in long-term strategies.

- **The lack of institutional coordination in the nutrition sector remains an issue in Niger.** The Nutrition Cluster in Niger is formally chaired by the Nutrition Directorate and co-chaired by UNICEF. However, the limited knowledge and capacity of the Directorate has resulted in UNICEF taking full responsibility for coordination. The Directorate needs to increase its capacity and resources (currently management is undertaken by the Mother and Child Health Directorate and no direct budget is available). There is a need for structural reorganisation within the government if nutrition policies are to be effective and coordination is to be sustainable. Moreover, structural problems relating to the coordination of the National Institute of Statistics and MoH need to be addressed. This will ensure that the quality and relevance of information produced to prevent future food and nutritional crises is improved. The only institutional coordination is that currently done by the National Food Crisis Management and Prevention Agency (DNPGCA) which focuses predominantly on crisis response and has a bias towards food assistance.

- **International community response to the crisis**[58] **has been positive both for humanitarian and political reasons.** The more prominent role taken by the government to address the recent food crisis has resulted in the international community supporting nutrition initiatives. The response of the international community has also been better coordinated than in previous years. The international community has committed funds [59] through the Donors Common Fund, coordinated and monitored by the Joint State Commission (State and Donors). However, Niger's unstable political situation has blocked the delivery of structural funds. Donors are now more committed to supporting coordination and accountability,[60] providing opportunities to influence and guide national policies and to harmonise donor strategies. The FCD harmonisation strategy has had a positive effect on needs coverage (free distributions in targeted areas, nutritional treatment reinforcing the public health network at district levels, logistical support of the Ministry of Public Health etc). The capacity of donors to influence Niger's policies and strategies has been increased through direct funding. This is especially relevant within the National Food Crisis Management and Prevention Agency (DNPGCA).

58 OCHA (2010a)

59 It is important to highlight the incognita on how the economic crisis will affect to some of the donors (the cases of the UK or Spain) and how it will affect their profile (in terms of volume and length of their commitments).

60 Some donors keep a very politically biased relationship with Niger (especially US and France), due to heavy anti-terrorist and energy security agendas. This is promoting a very interesting approach to the government, with an impact on issues such as soft mainstreaming of national policies, and weak accountability request towards the government's implementation.

5. Recommendations

Recommendations are targeted at both the Government of Niger and the international community. The Government of Niger should take the lead, ensuring civil society participation from planning to implementation of policies and programmes. Donors must support country-led initiatives.

Recommendations for the Government of Niger

The Office of the President should:

- **Place undernutrition at the centre of the political agenda**

  Good nutrition is the foundation for human development and nutrition must be at the forefront of all development and poverty reduction policies. A multi-phase approach that combines both short-term interventions and long-term solutions to address the structural causes of undernutrition (detection, prevention and treatment approaches) must be prioritised to achieve impact immediately and in the long-term.

- **Address undernutrition through a holistic approach**

  Addressing undernutrition through a holistic approach which encompasses agriculture, health and water and sanitation activities is key for long-term sustainable solutions to undernutrition. Nutrition is a multi-sectoral issue which requires appropriate interventions across all sectors if it is to be tackled effectively.

The 'National Agency' (the DNPGCA) should:

- **Strengthen and reinforce coordination mechanisms at policy making, resource allocation and operational management levels**

  COORDINATION MECHANISMS must be strengthened between the Ministries currently involved in food and nutrition security (primarily the Ministries of

Photo © ACF / S Hauenstein Swan

Health, Agriculture and Livestock). This should also include those Ministries that will be responsible for the most vulnerable populations in the future (Ministries of Social Affairs and of Women's Promotion and Child Protection).

BUDGET ALLOCATION must take into account the basic costs necessary to implement existing nutrition programmes. Nutrition programmes need to have predictable, secure funding in both the short and long term.

A MULTI-SECTORAL APPROACH at this level must be supported. Despite the fact that the National Agency's mandate currently includes both crisis prevention and response, its activities are limited to crisis response and are food security oriented. Activities must be developed to ensure long-term structural food and nutrition security.

THE MANDATE OF THE NATIONAL AGENCY should be expanded to promote and coordinate future policy initiatives with food and nutritional security as a central issue. To this end, the emergency-oriented 'Plan de Soutien' could be developed into a 'Plan Against Hunger and Undernutrition', addressing structural causes and preparing for future crises.

- **Introduce a socio-economic nutrition-focused perspective to programmes targeting crisis affected populations**

  This should be done in partnership with the Ministries of Social Affairs and Women's Promotion and Child Protection, and should strengthen social assistance programmes to improve access to adequate food and essential services for those regularly affected by crises. This should also be done in conjunction with economic development initiatives.

- **Promote social policies related to undernutrition**

  In order to ensure that undernutrition is recognised as a development issue and not just an emergency issue, long-term, preventive approaches to undernutrition must be developed. These should promote nutrition security through improved household food security (e.g. safety nets) and access to health services. The importance of addressing undernutrition through a holistic approach, involving agriculture, education, health and water and sanitation activities, is crucial.

The Ministry of Public Health should:

- **Upgrade the status of Directorate of Nutrition within the Ministry of Public Health**

  This would reinforce its capacity to diagnose the nutritional situation in the country, to propose policy and strategic initiatives in a coordinated and coherent manner with other MoH stakeholders and to implement and monitor activities undertaken in the field. It would also increase the institutional and technical capacity of the Directorate of Nutrition to promote the nutrition agenda within public health policy making. It would ensure the effective management and follow-up of national programmes, particularly at the local level. It would also result in the Directorate having its own budget (independent of the Directorate of Reproductive Health) and would secure staffing and ensure the regular upgrade of technical capacity.

- **Continue working to integrate CMAM into health structures by building on the work already initiated by the Government of Niger and ACF**

  The integration process can be improved by strengthening the Nutrition Directorate (at the local health centre level) through better training of human resources and investment in supply management training for nutrition products.

The Ministry of Agriculture and Livestock should:

- **Upgrade the Nutrition and Food Security service**

  Particularly in terms of staff (number and appropriate profile), necessary budget and stronger institutional and political support. This will promote more efficient interaction with the Directorate of Nutrition in efforts to integrate nutrition into food policies.

Recommendations for the international community

Donors and implementing agencies should:

- **Engage in constructive policy-oriented dialogue with the Government of Niger in order to put food and nutritional security at the top of the agenda**

  Nutrition needs to be a cornerstone of future SDRPs; recognition that nutrition requires appropriate interventions across sectors (health, agriculture, WASH, education), is a prerequisite for effective policy making.

- **Adopt the multi-phase approach in long-term strategies and prioritise nutrition programmes**

  Tackling undernutrition must be perceived as an imperative of long-term development, addressing the structural causes of the problem, rather than just emergency needs.

  In harmony with the government's nutrition political agenda, implementing agencies must consolidate the multi-phase approach by promoting continuous prevention, assistance and rehabilitation initiatives.

- **Provide strategic and institutional support to Nigerien civil society**

  The aim should be to enhance the participation of civil society organisations in policy debate and in their capacity to solicit government accountability. Grassroots participation and governance in nutrition activities should also be promoted in order to reinforce the sustainability of both preventive and treatment programmes.

  Implementing agencies and donors should work in partnership with civil society organisations to build capacity through operational and technical assistance, financial support and institutional backup. Maintaining a permanent surveillance system will also allow preparation for response and redeployment when national capacities are overwhelmed.

- **Increase investment in strengthening institutional capacity**

  Investment should integrate training, budgetary support and the rebalancing of capacities between central and local administrations. This implies a strategic commitment to be involved as a long-term player (with all the institutional, financial and personnel implications that this brings).

- **Promote a more efficient nutrition institutional architecture between sectors**

  This can be achieved by reinforcing the nutrition directorate in the Ministry of Public Health (MoH) and promoting an active coordination body. The MoH can also upgrade their counterpart services at the Ministry of Agriculture and Livestock (the Food and Nutrition Service) with a transversal approach to Health, Food, Water and Social policies.

- **Maintain financial support to food and nutrition security through transitional post-emergency programmes**

  Due to the cyclical nature of the crisis in Niger, continuous financial support must be maintained by donors through consistent budget support to the government.

- **Promote and maintain a multi-sectoral approach**

  The most effective way to prevent and treat undernutrition is to implement appropriate interventions across sectors – this should be promoted in all relevant government ministries and with local civil society.

  Implementing agencies should also promote participation and coordination of the different cluster leader agencies (within the UN system) and specialised organisations.

Annexes

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Annex 1: Niger country fact sheet

Table 2 Niger nutrition, mortality, health coverage, morbidity, environment, education and poverty indicators 1995–2009

NUTRITION INDICATORS

Indicators [61]	1998	2000	2006	2008	2010	Source
Chronic malnutrition rates	47%	50%	43.8%	39% [47%]	40.9% [48.6%]	MICS 2000 DHS 1998-2006 Enquête Nutrition et Survie de l'Enfant (2006, 2007, 2008, 2009, 2010) Figures in [ ] are WHO, otherwise NCHS/WHO
Underweight rates	49%	40%	44%	43% [36%]	NA	
Acute malnutrition rates	20.7%	14.1%	15.3%	[11.6%]	[15.3%]	
Exclusive breastfeeding up to 6 months	1%	1%	14%	4%	NA	
Proportion of the population below the minimum level of dietary energy consumption	1991		2004			MDG Report Card. ODI 2010
	38%		29%			

MORTALITY

Children [62]	1990		2008		Source
Under-five mortality rate [63]	305		167		UNICEF Country profiles 2009
Women	1995	2000	2005	2008	Source
Maternal mortality ratio [64]	1,300	1,100	910	820	WHO, UNICEF, UNFPA, World Bank [65]

HEALTH COVERAGE

Immunisation	1990		2007		Source
Measles: fully immunised 1 yr olds	25%		47%		MDG Report Card. ODI 2010
Micronutrients	2005	2006	2007	2008	Source
Vitamin A supplementation [66]	94%	88%	100%	92%	UNICEF Country profiles 2009
Women	1990		2007		Source
Antenatal care coverage at least once	30%		46%		MDG Report Card. ODI 2010
Iodine in households	1996		2006		Source
Households consuming adequate iodised salt	7%		46%		UNICEF Country profiles 2009

61 Anthropometrical data is expressed in NCHS/WHO references to allow comparison.

62 Niger is the country with the highest average annual rates (-7.5) of absolute progress during 1990–2007 of under-five mortality per 1,000 live births. It has reduced its child death rate by more than 100 per 1,000 births over the period (Source: MDG Report Card. ODI 2010).

63 Probability of dying by age 5 per 1,000 live births

64 Deaths per 100,000 live births

65 Trends in Maternal Mortality: 1990 to 2008 estimates developed by WHO, UNICEF, UNFPA and The World Bank

66 Percentage of children 6–59 months old receiving two doses of vitamin A supplementation during the calendar year

MORBIDITY

Indicator	2006		Source
Anaemia: children 6–59 months (Hb<110 g/L)	84%		UNICEF Country profiles 2009 (DHS 2006)
Anaemia: non pregnant women 15–49 yrs	43%		
HIV[67]	2001	2007	MDG Report Card. ODI 2010
	0.7%	0.8%	

ENVIRONMENT

Indicator	Area	1990	2008	Source
Access to improved drinking water	Urban	57%	96%	Progress on Sanitation and Drinking-water: 2010 Update. WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation[68]
	Rural	31%	39%	
	TOTAL	35%	48%	
Access to improved sanitation facilities	Urban	19%	34%	
	Rural	2%	4%	
	TOTAL	5%	9%	

EDUCATION

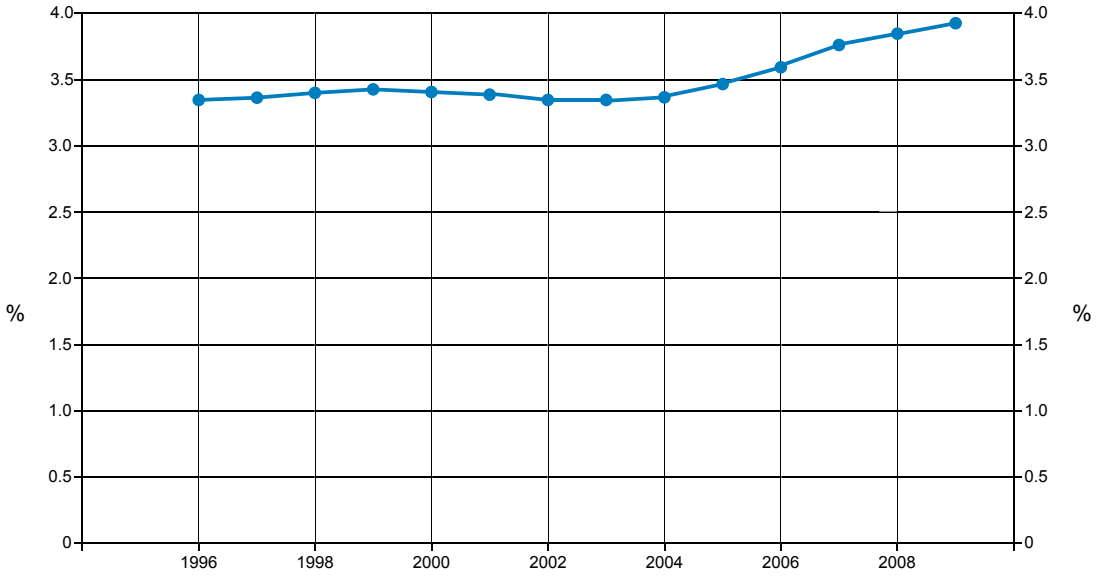
Indicator	1991	2006/2007	Source
Primary school enrolment (6–11 years)	26%	67.8%	MDG Report Card. ODI 2010 / World Bank

POVERTY

Indicator	1997	2010	Source
Proportion of population below $1 per day	73%	61%	MDG Report Card. ODI 2010 / World Bank

Figure 3 Niger population growth 1996–2009

Source: TradingEconomics.com



67 Percentage of people aged 15–49 years of age who are HIV infected

68 ISBN: 978-92-4-156395-6

Figure 4 Niger Food Production Index 1996–2008

Source: TradingEconomics.com (1999–2001 = 100)

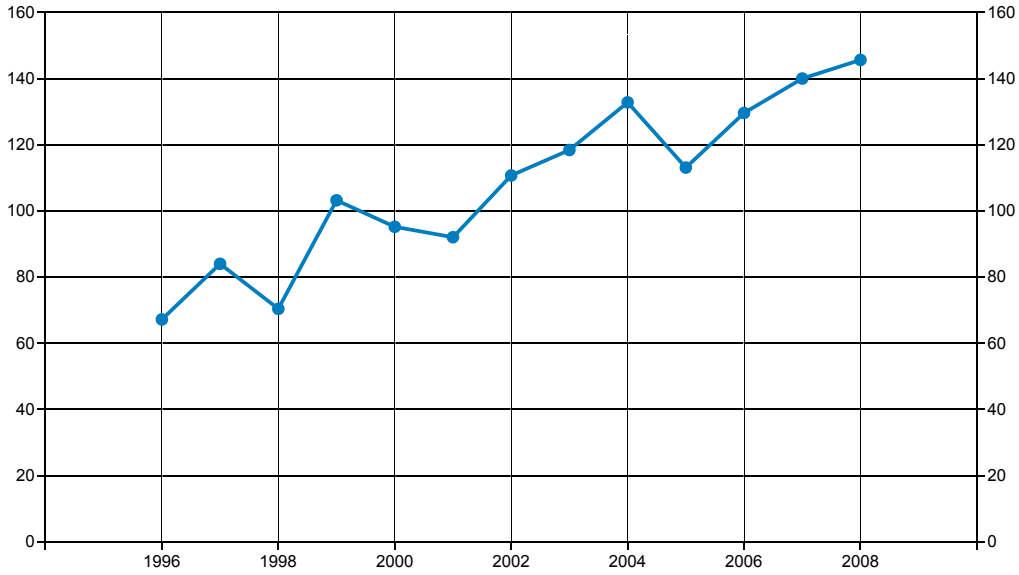
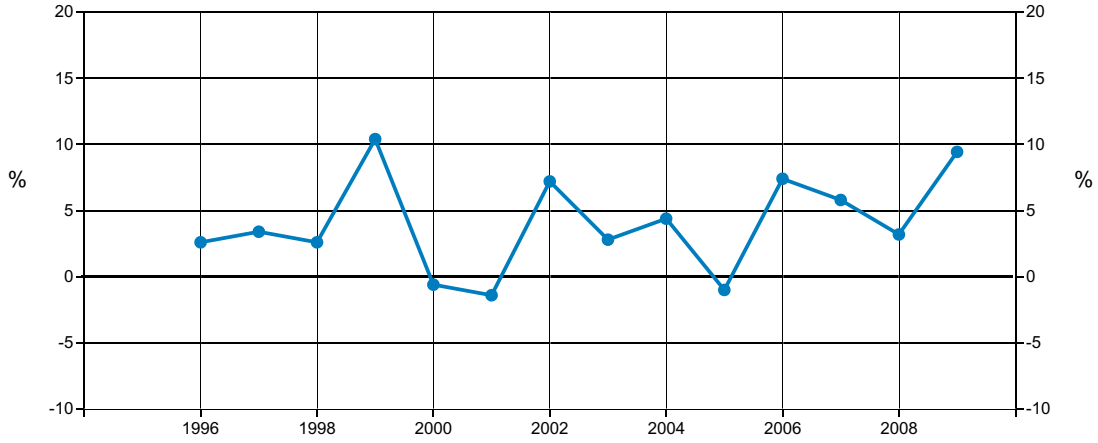


Figure 5 Niger economic (GDP) growth 1996–2009

Source: TradingEconomics.com



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Annex 3: Data collection tool

Key informant interviews (ACF Headquarters Advisors and Field Team)

National policies

- What are the current national policies and practices relating to undernutrition (policies in poverty reduction, nutrition, health, agriculture and water and sanitation)?
- Since when have they been operational, and how long is their duration?
- Quality of their design. Are they updated according to international standards?
- Quality of the implementation of the policies, action plans, strategies in place. To what scale have the policies been implemented? What degree of coverage is there?
- What social protection programmes and policies exist? Safety nets?
- Is nutrition or hunger in the political agenda?
- How is undernutrition (specifically) and hunger (more broadly) represented in political speech (from non-recognition to flagship objective).
- Is nutrition mainstreamed into other related policies, such as agriculture/food security, public health, social development, social assistance?
- Is there any gender policy in place?
- How are the policies coherent with the MDG related to reduction of hunger and undernutrition?
- Is there an interministerial body to coordinate policies?
- How were nutritional, public health and food security/agriculture policies debated and designed? Other ministries' participation? Civil society engagement?
- Is there reliable nutritional status information available from the public health system?
- What is the coverage of public health services (basic package) and, especially, nutritional services in the country? Any region or community excluded or less covered? Why?
- Is there an appropriate operational deployment (qualified human resources available around the country) and financial investment on nutrition and related sectors? Please describe its profile.

Government

- Is there a clear, functional and transparent policy design mechanism in the country? What are the effective roles of the government, the parliament and the civil society? Please describe the process of law-making.
- Is the public financial system working properly? Are taxes collected proportionately and managed transparently according to priority objectives? Please describe the process of collection and investment.

- Has the country been involved in any violent process? If so, please briefly describe chronologically.
- Is there any controversial relationship between communities or between the State and communities? (e.g. a marginalised population group). Please briefly describe it and identify the key players.
- Is there a fluent political participation in the country? Are elections held? Are they relevant and reliable? Is there a meaningful political dialogue between parties, stakeholders and the State?

Donors

- Who are the key donors?
- Is nutrition mainstreamed in general and country strategy papers? If so, how? (Earmarking, nutrition as central strategic or collateral axis, nutrition in other related sectors' strategies.)
- What is the donors' level of financial investment in nutrition in the country?
- Do the donors have a monitoring and evaluation strategy in place regarding nutritional outcomes on programmes and national policies? Is it functional? Does it feed the debate between them and the government?

NGOs and civil society

- Who are the key actors working on nutrition, food security and water and sanitation?
- What synergies exist between civil society action and national policies?
- What is the role of NGOs within the debate, design and monitoring of national policies and their implementation?
- To what extent do civil society's actions contribute to the reduction of malnutrition?
- What role have social protection and safety nets played?
- What is the priority level of nutritional programmes at their country strategies (volume, coverage, experience)?
- Which approach do they undertake to fight undernutrition, a short- or long-term approach (substitution or reinforcement)?

Coordination

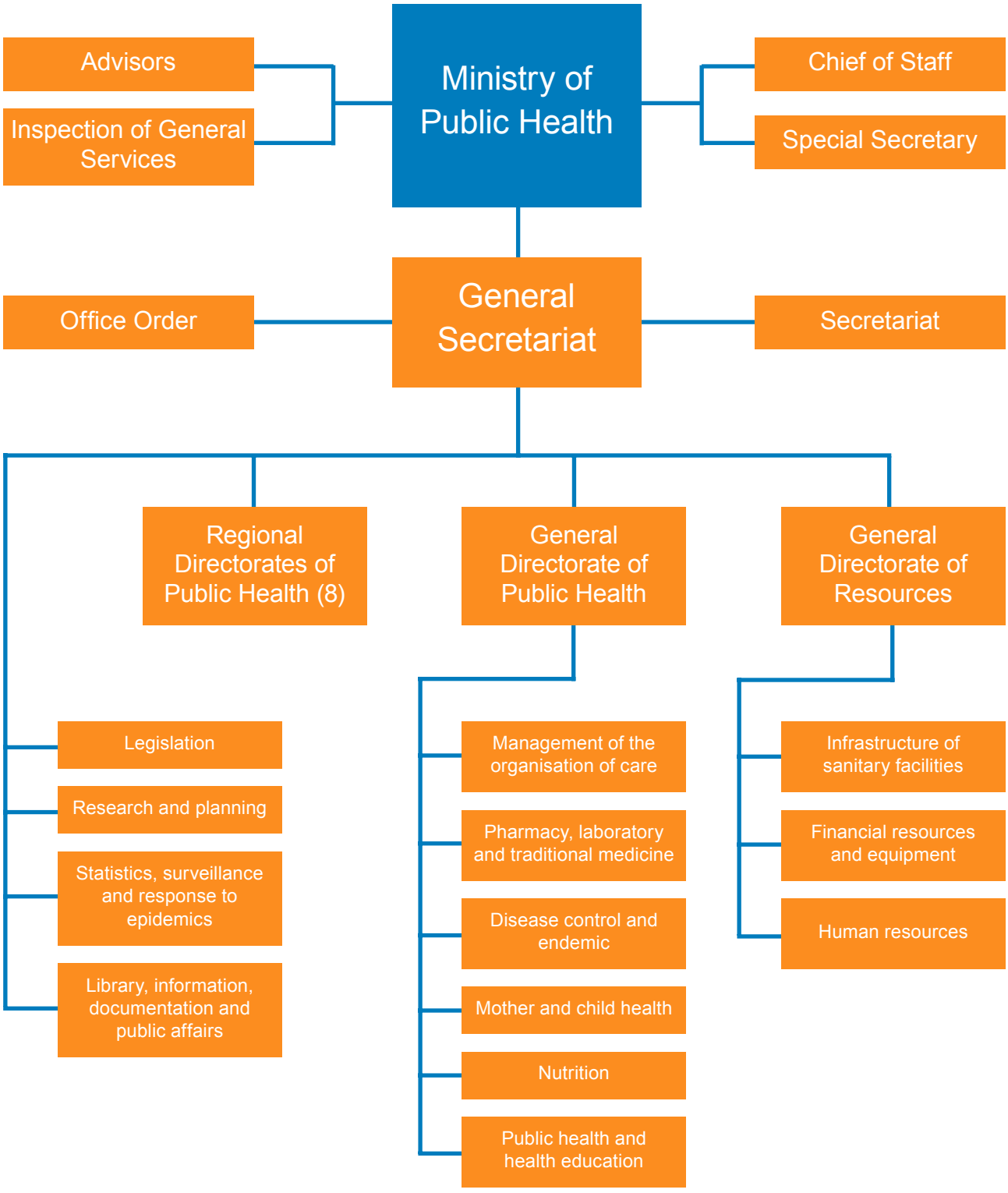
- How is the coordination between donors and agencies? Which mechanisms? Clusters?
- Is there a coordination body to share information, discuss and take decisions on nutrition between sectors and players (operational agencies, government, donors and between themselves)?

Existing gaps

- Where are the gaps preventing reduction in malnutrition (e.g. income distribution, health services coverage, marginalisation of a specific population, distorted food market…)?
- How can these gaps be filled? How have they been filled so far?

Annex 4: Structure of the Ministry of Public Health

Figure 6 Ministry of Public Health organisational chart



Annex 5: Donors' approach to hunger in Niger

There is a large presence of donors in Niger, most of them involved in crisis response, although there is an increasing interest in deploying longer term strategies by 'non-traditional donors' in this region, such as USAID. A review of main donor strategies is presented below.

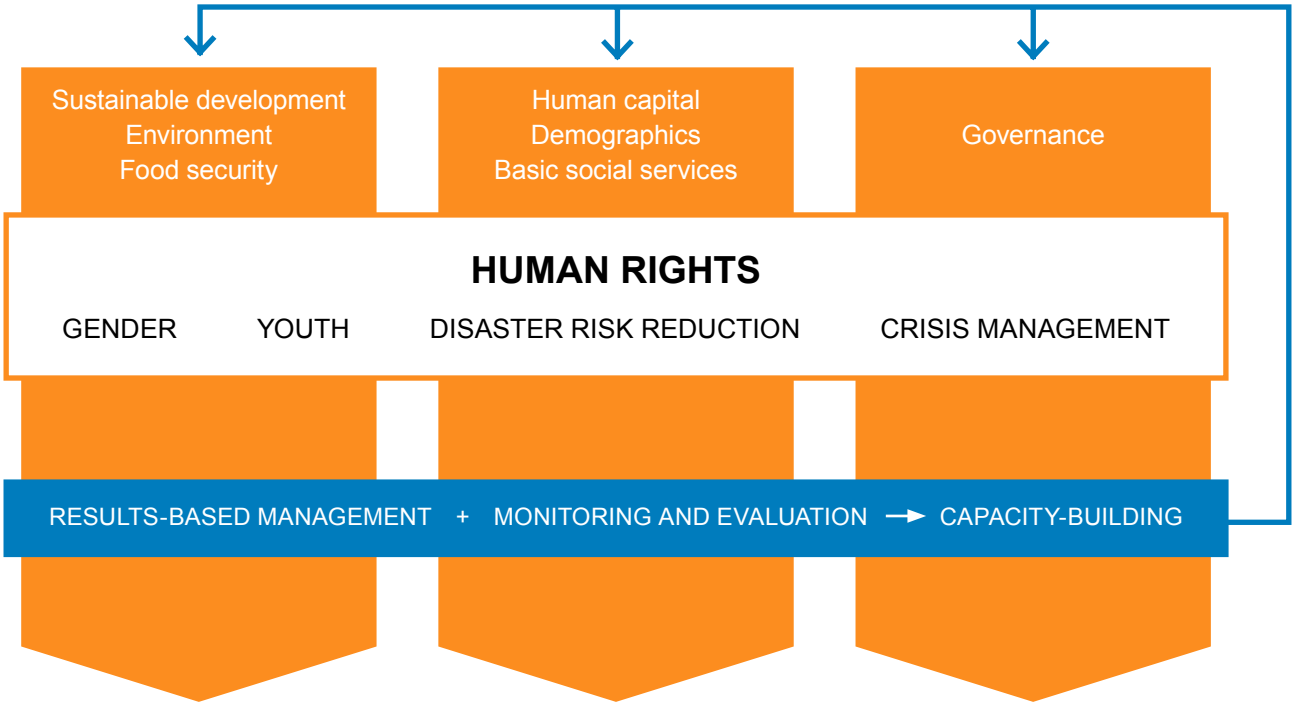
UNDAF

The UN system has approved a Development Assistance Framework for the period 2009–2013 with a total amount of US$1.05 million. The framework has an integrated approach to poverty reduction in Niger with a comprehensive, ambitious plan. *Figure 7* gives a graphic representation of the sectors and their goals.

The three sectors follow a coherent and balanced approach. Sustainable Development, Environment and Food Security plus Human Capital, Demographics and Social Services are allocated 84% of the overall budget and Governance receives the remaining 16%.

The first strategic axis is closely linked to MDGs 1, 3, 7 and 8, seeking reduction of inequality by increasing income-generating potential. It also relates to the

Figure 7 UNDAF framework 2009–2013
Source: UNDAF 2008



UNDAF OUTCOME By 2013, vulnerable populations improve their food security, contribute to the sustainable management of natural resources and diversify their sources of income.

UNDAF OUTCOME By 2013, vulnerable populations use basic social services and participate in quality control of population growth.

UNDAF OUTCOME By 2013, national institutions and local government act democratically in accordance with human rights, gender equity and contribute to peace-building.

social protection of the most vulnerable. The UN system has adopted the role of advisor to the Government of Niger following the main axes developed in the SDRP, which are the following:

- development of economic sectors with high potential of job creation (rural development, tourism and mining)
- promotion of regional development strategies related to each local economic opportunity
- reinforcement of global economic competitiveness by improving the microeconomic business environment (more solid legal framework and better access to financial services)
- better integration of Niger's economy in regional and global dynamics
- improving social protection of children and the most deprived in society.

More specifically, the UN system makes a contribution to improving food security of the most vulnerable groups by facilitating their access to credit, consequently permitting them to manage economically viable activities. It also supports the DNPGCA in preventing and managing food crises. Finally, it supports improvements in productivity for agro-pastoral populations.

The second main chapter of the UNDAF seeks to develop human capital, equitable access to social services and to manage demographic growth. These targets relate to MDGs 2, 3, 4, 5, 6 and 7.

Again, the UNDAF is aligned with the Government of Niger's priorities expressed in the SDRP, with special emphasis on education, public health (especially reduction of prevalence of HIV/SIDA, tuberculosis and malaria, but also to improve the access to quality health services) and access to fresh water. It is worth noting that there is particular mention of 'reducing malnutrition' as one of the main objectives. In fact, UNDAF states a specific goal of increasing the treatment of acute malnutrition from 17% to 50% of the cases, reduction of maternal mortality by 75%, and infant mortality by 67%.

In addition, the UNDAF intervention line on governance has a goal of increasing the capacity of the State to deliver services and also being accountable to citizens and partners. The institutional support for the State is accompanied by reinforcement of civil society and the institutionalisation of accountability mechanisms.

UN (OCHA)

The coordination of the humanitarian response to the crisis in 2010 was better than in 2005. The CAP response was high; an estimated 76% of needs – US$371 million – were covered.[69] This was largely influenced by the government's demand for aid in March 2010 and facilitated by drafting the 'Response Plan' (Plan de Soutien) as the main channel for international support.

Priorities identified in the 2010 CAP were food security (including assistance to pastoralists) and nutrition (including water, sanitation and health activities related to the treatment of SAM cases with medical complications, and preventive actions such as intensifying the promotion of breastfeeding to protect infants under 6 months). Significant resources were raised from donors, as shown in *Table 3*.

Even though OCHA has focused attention on the effects of the crisis, it has also been involved in enhancing preventive and LRRD approaches in conjunction with main UN agencies (mainly WFP, UNICEF, WHO and FAO).

OCHA has also promoted an integrated approach of UN agencies through inter-cluster coordination of food security, nutrition, WASH and health. However, according to OCHA, the inter-cluster coordination has been weak. In a sensitive approach to work on the causes of the crises, clusters were co-coordinated by the relevant ministries of the Niger government. This resulted in better integration of national and international responses, and reinforced the government's

69 OCHA 2010a

Table 3 Summary of requirements (grouped by cluster)
Source: OCHA 2010a

	Project request March 2010 ($)	Revised at mid-year review ($)	Funding to date ($)	Percentage covered	Unmet requirements ($)
Coordination and support services	5,113,588	31,167,809	4,435,224	14%	26,732,585
Emergency preparedness	0	548,910	0	0%	548,910
Food security	155,915,666	165,506,064	117,989,504	71%	47,516,560
Nutrition	27,706,630	38,039,070	22,035,839	58%	16,003,231
Health	635,580	9,977,581	706,526	7%	9,271,055
Protection	0	5,548,000	0	0%	5,548,000
Water, sanitation and hygiene	1,391,000	2,401,866	801,309	33%	1,600,557
TOTAL	**190,762,464**	**253,189,300**	**145,968,402**	**58%**	**107,220,898**

coordination role. However, as a result, coordination and decision-making has sometimes been slower.

OCHA will release the 2011 CAP to cover remaining needs and ensure the LRRD approach once the new government is in place.

European Union

The EU includes nutrition as a component of reproductive health, although it isn't included as a priority sector in the current National Indicative Plan (PIN)[70] for the 2008–2013 period of the 10th European Development Fund (EDF). It was not possible to include nutrition on the agenda when the PIN was negotiated with the previous government, as it did not accept nutrition as a key problem in Niger. Reproductive health (nutrition included) is only covered via complementary budget lines outside the PIN. These include the Food Facility and co-funding of NGO lines, which were not negotiated with the Government of Niger, so were not affected by restrictions. Investment has been varied and mainly related to the response to the 2010 crisis: €1 million was provided through the Food Facility in order to reduce moderate malnutrition and promote family planning through a set of NGOs (MdM, CARE UK, Helen Keller International and Aquadev).

In support of ECHO's efforts, the EU also mobilised €14.8 million through the National Dispositive for reconstitution of food stocks and food aid to the victims of the 2010 food crisis. The EU released budgetary support to the National Dispositive which is perceived to be the most coordinated and effective governmental instrument for channelling aid.

The EU has also invested in research-action pilot projects on rural development and irrigation through the PIN budget. For the 11th EDF the EU is considering including health and food security as priority sectors. This should allow increased availability of funds, as well as stronger cooperation instruments through budget support to the government. Social assistance plans are potential lines of intervention within the food security sector (the same is being done by the World Bank and DfID).

At the same time, the EU is trying to coordinate within their different mechanisms (Directorate General Development and ECHO) to make the LRRD approach possible. It is doing this by taking on initiatives from ECHO's Sahel Strategy of household food security support and by reinforcing the Ministry of Public Health's treatment of undernutrition.

The EU participates actively in the CMC, considering it the key and most operational forum of donor and government debate.

70 The current PIN has €458 million for the 2008-2013 period of the 10th European Development Fund

The overall budget of the PIN for the 2008–2013 period is €458 million, with €160 million earmarked for rural development and food security and €180 million for general initiatives of poverty reduction,[71] the rest being allocated to sectors such as governance, macroeconomic budget support, infrastructures and regional cooperation.

Within the EU, the role of ECHO deserves particular mention. After the 2005 crisis, it launched the Sahel Strategy (initially a three year programme and subsequently extended on an annual basis). The programme aims to link relief with rehabilitation and development in nutrition and food security fields. WASH is included but delegated to other donors due to lack of funding. ECHO is currently negotiating a hand-over to the 11th EDF to include nutrition/health as a priority. Although this is not yet guaranteed, ECHO has set out an innovative approach with mid-term commitment, a prevention/response approach and institutional support and advocacy components.

The two priorities of the Sahel Strategy are:

- consolidating current initiatives and actions (treatment, surveillance)
- advocating the inclusion of prevention activities (i.e. treating chronic malnutrition).

There are three strategic axes:

REINFORCEMENT OF THE INFORMATION SYSTEM by integrating the SMART survey methodology into the SAP (funded long-term by the EU), improving its methodology by targeting the most vulnerable and including a methodology with analysis of the household economy (SCF developed methodology). There are also plans for reinforcement of the information system at regional level (CILLS and FAO).

INTEGRATING MALNUTRITION INTO HEALTH SERVICES by providing training, infant malnutrition coverage, supplies (including essential drugs) and infrastructure adaptation and growth.

ADVOCATING FOR A HIGHER PROFILE FOR MALNUTRITION in the national policies throughout the region through operational research. Themes that have been studied are: household economy analysis, conditional cash transfer pilot project (nutrition training), free healthcare.

ECHO is engaged in direct debates with the government on several issues based on partners' experiences. These include improving the National Health information system (SNIS) to capture malnutrition cases treated by NGOs and UNICEF and cases detected at health centres. A bottom-up approach is also encouraged by ECHO in order to support local civil society organisations at implementation, sensitisation and advocacy levels through their traditional partners. ECHO has a regional approach for several initiatives:

- surveillance (SAPs of different countries and AGRHYMET)
- prevention and treatment nutritional protocols and policies
- baseline analysis (household economic analysis) of vulnerable populations in all countries.

ECHO engages with some coordination forums such as the Nutrition Cluster and the Humanitarian Team Group (Equipe Humanitaire Pay) which is a small group of donors and some humanitarian NGOs creating a parallel forum (without the presence of the government) for coordination.

At technical level they participate actively iin the CRC (where donors, the UN and NGOs have a seat) where they can comment on government policies.

AECID

Spanish Cooperation has deployed significant resources in Niger and has boosted the donor community since it arrived in the country just four years ago. In fact, Spain has become the fourth largest State donor to contribute to the coverage of the 2010 crisis with a €5.4 million contribution to the CAP.

71 www.acp-programming.eu/wcm/dmdocuments/scanned_ne_csp10_fr.pdf

AECID approaches the food and nutritional security issue through three main axes:

- mother and child health strategy, where nutrition is treated at the emergency stage
- food security, through support for food production (long-term measures)
- support of the National Dispositive to reinforce food stocks and address gender issues by supporting government initiatives (at central and regional level) to enhance the role of women in society, and centres for promotion of women's activities.

AECID is endeavouring to integrate preventive measures (food production) with those of treatment (nutrition and food aid).

The health programme has released €5 million to the Health Fund to support the Directorate of Nutrition with the following strategic lines:

- analysis of Free Healthcare ('gratuité des soins') due to the fact that the current system is in significant debt (a debt of 12,000 million FCFA owed by the state to suppliers)
- capacity-building and training of members of staff working in the nutrition department of the Ministry of Public Health.

Spain is already drafting the Association Framework for 2012, where food security and rural development and mother and child health will be the priorities. AECID oversees the implementation of the Paris Declaration guidelines through mechanisms such as budget support. AECID also plans to continue budgetary support to the Health Fund, in order to secure coverage of sectors where the State might be reluctant to invest (such as rural health coverage, and nutrition). AECID's strategy is to approach investment by reinforcing local capacities. It is likely that current levels of investment will be maintained, after a dramatic increase this year (€16 million in 2009 to €30 million in 2010).

OFDA/USAID

We have found evidence of the US government crisis prevention and mitigation approach. However, no structural development plans are available.

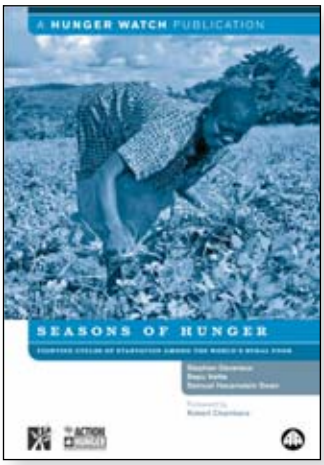
In its West and North Africa DRR Strategy 2008–2010,[72] OFDA identified acute malnutrition as one of the four major risks on which they focus within the region, the others being violence, displacement and morbidity. They attribute these risks to several causal factors: occurrence and recurrence of hazards such as market shocks, drought, locusts, floods, conflict, and epidemics.

Interventions take place at both community and household levels, but also at institutional level through the strengthening of capacities. The three-phase approach (risk reduction, preparedness and recovery) is based on a multi-sectoral approach which suits the profile of vulnerability found in the region. Sectors identified as priorities are nutrition, WASH, economic recovery and market systems, humanitarian coordination, information management, and agriculture and food security.

No figures about the amount of financial commitment are available but, according to OCHA's Emergency Humanitarian Plan revision (July 2010), OFDA's response to the 2010 crisis amounts to US$54 million.

72 West and North Africa DRR Strategy 2008–2010

ACF publications

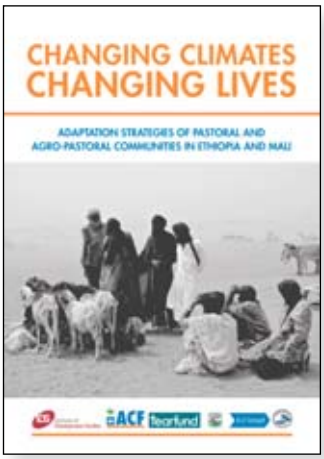


Seasons of Hunger:

Fighting cycles of quiet starvation among the world's rural poor

Documenting hunger in three countries – India, Malawi and Niger, this book explores the issue of seasonality and why the world does not react to a crisis that we know will continue year after year. Personal stories and country-wide data show the magnitude of seasonal hunger, which is caused by annual cycles of shrinking food stocks, rising prices and lack of income. This hidden hunger pushes millions of children to the brink of starvation, permanently stunting their development, weakening their immune system and opening the door for killer diseases.

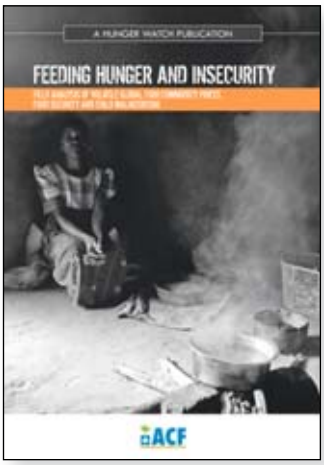
Written and edited by Stephen Devereux, Bapu Vaitla and Samuel Hauenstein Swan, Foreword by Robert Chambers, Published 2008 by Pluto Press London, ISBN: 978-0-7453-2826-3, 148 pages.



Changing Climate, Changing Lives

A joint report launched by IDS, Action Against Hunger and Tearfund reveals that pastoral households in Ethiopia and Mali are finding it increasingly difficult to tackle current climate risks and meet their food and nutrition needs. The focus of the report is local perceptions of changes in climate shocks and stressors. It examines how people respond to these changes, and what constraints they face. Examining local perceptions and responses to change is important because these can help to identify more precisely what support people require to strengthen their climate resilience. It will also help identify specific constraints that different actors and groups face, and also uncover a more holistic understanding of adaptation in relation to particular socio-economic, political or historical contexts.

Written by Lars Otto Naess, Morwenna Sullivan, Jo Khinmaung, Philippe Crahay and Agnes Otzelberger, Published 2010 by ACF International, Tearfund, International Development Institute, 57 pages.



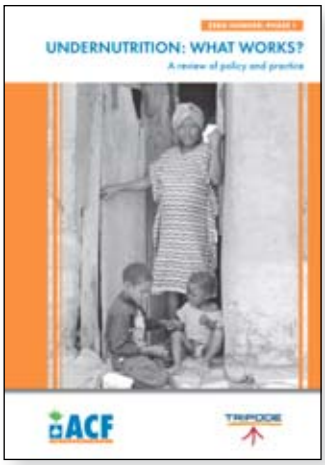
Feeding Hunger and Insecurity

Field analysis of volatile global food commodity prices, food security and child malnutrition

This publication presents field analysis of volatile global food commodity prices, food security and child malnutrition.

Rapid price increases in early 2008 led to riots in over 30 countries that sparked international calls for action and repositioned as global priorities the need to combat hunger and reinvigorate local agriculture. Action Against Hunger's in-depth field study, *Feeding Hunger and Insecurity*, reminds us the crisis is far from over and that urgent funding is needed to translate global policy into effective, targeted responses addressing the needs of those most affected.

Written by Samuel Hauenstein Swan, Sierd Hadley and Bernardette Cichon. Published 2009 by ACF International. ISBN: 978-0-9557773-2-5, 74 pages.



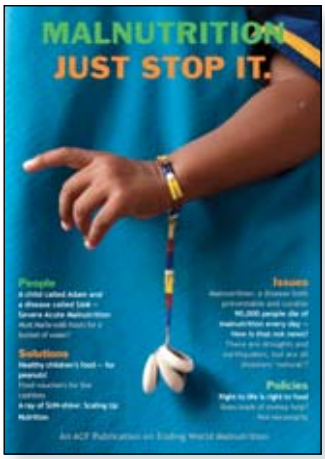
Undernutrition:what works?

A review of policy and practice

This book provides insights into why and how some countries have managed to bring down rates of childhood undernutrition, while others have not.

Worldwide progress in reducing rates of childhood undernutrition has been relatively slow over the past fifteen years. In too many countries, rates remain unacceptably high. Nevertheless, behind the global statistics lie some success stories. This briefing is based on the outcome of secondary research which examines five such stories – Brazil, Peru, Mozambique, Malawi and Bangladesh – which have had relative success in bringing down their rates of undernutrition, in the quest to find out why and how these countries in particular have been successful. The report identifies policies and practices implemented to facilitate the success and analyses the extent to which a reduction in undernutrition has been achieved due to a responsive policy environment and or social/civil initiatives.

Published 2010 by ACF International and Tripode, 84 pages.



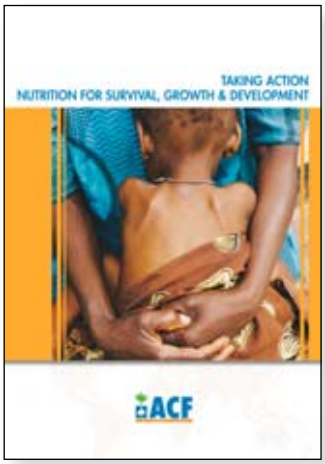
Malnutrition: Just Stop It

Action Against Hunger's annual publication provides an insightful overview of global child and maternal malnutrition in 2010 and 2011. What is malnutrition? Who is at risk from it? Where in the world? Why is it causing deaths and suffering? What is being done to tackle it?

Malnutrition: Just Stop It narrates and illustrates the complexities of the problems, issues and policies linked to the world's most serious public health problem – malnutrition. It tells the stories of people living with malnutrition such as Maria from northeast Uganda, who struggles to feed her large family without a regular income, and Dorméus in Haiti who lost his wife in the earthquake in January 2010 and now provides for his three daughters. It also introduces children like one year old Adam in Chad and nine month old Awalou in Niger, both of whom live in the Sahel region of West Africa which experienced a severe food crisis in 2010.

In highlighting the role that individuals and organisations like Action Against Hunger can continue to play, the publication outlines successful solutions to end child malnutrition.

Published 2011 by ACF International, 27 pages.



Taking Action: Nutrition for Survival, Growth and Development

ACF International White Paper

This paper advocates increased attention to the problem of undernutrition. In particular, it focuses on the urgent and life-threatening issue of acute malnutrition and is intended for policy-makers at global and national levels.

Today, 55 million children under five years old around the world are acutely malnourished. Over a third of these children, an estimated 19 million, suffer from the most severe form of acute malnutrition. Without treatment, these children are at imminent risk of dying and of never achieving their growth potential.

Taking Action: Nutrition for Survival, Growth and Development presents ACF's proposed strategy for ending malnutrition. It is an urgent call for a worldwide response to acute malnutrition to ensure survival, growth and development.

14 June 2010, ACF International.

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