

## Niger (the)



Total population (2005) <sup>1</sup>	13 597 000
% under 15 (2005) <sup>1</sup>	49
Population distribution % rural (2005) <sup>1</sup>	77
Life expectancy at birth (2005) <sup>2</sup>	49.2
Under-5 mortality rate per 1000 (2004) <sup>2</sup>	259
Maternal mortality ratio per 100 000 live births (2000) <sup>3</sup>	1 600
Total expenditure on health % GDP (2004) <sup>4</sup>	4.8
General government expenditure on health as % of general government expenditure (2004) <sup>4</sup>	12.3
Human Development Index Rank, out of 177 countries (2003) <sup>5</sup>	177
Gross National Income (GNI) per capita US\$ (2004) <sup>6</sup>	230
Population living below national poverty line % (2004) <sup>7</sup>	70
Adult (15+) literacy rate (2000-2004) <sup>8</sup>	14.4
Adult male (15+) literacy rate (2000-2004) <sup>8</sup>	19.6
Adult female (15+) literacy rate (2000-2004) <sup>8</sup>	9.4
% population with sustainable access to an improved water source (2004) <sup>5</sup>	46
% population with sustainable access to improved sanitation (2002) <sup>5</sup>	12

### Sources:

- <sup>1</sup> United Nations Population Division
- <sup>2</sup> General Census of the Population 2001
- <sup>3</sup> World Health Report (2005)
- <sup>4</sup> WHO data on National Health Accounts
- <sup>5</sup> Human Development Report 2005
- <sup>6</sup> World Development Indicators 2005 (World Bank)
- <sup>7</sup> Profil de la pauvreté au Niger, 2004-INS, janvier 2006
- <sup>8</sup> UNESCO Institute for Statistics

With a total population of about 13 million and 70%<sup>a</sup> of them living on less than US\$ 1 per day, Niger ranks at the bottom of UNDP's Human Development Index list.<sup>b</sup> Growing at an annual rate of 3.3%, with an aggregate fertility index of 7.5,<sup>c</sup> the population relies on subsistence agriculture which covers 30% of needs. Low education levels, poverty, malnutrition and limited access to drinking water and basic sanitation have led to health indicators being well below minimum international standards. Gender imbalances favouring men exist in key areas of representation in decision-making processes, education, employment, and access to health services. In 2005, Niger experienced a serious food crisis. In collaboration with other development partners, WHO provided support through a response aiming at reducing morbidity and mortality among malnourished children, and strengthening the primary health care system. The occurrence of avian influenza in February 2006 may further threaten the nutritional and economic status of the population.

## HEALTH & DEVELOPMENT

**Niger's economy has undergone structural adjustment since 1982.** In 2000, the country was eligible for the Heavily Indebted Poor Countries (HIPC) Initiative and in 2002 it adopted the Poverty Reduction Strategy now under review after three years of implementation. In 2004, the outstanding debt amounted to about CFA Francs 1093.2 billion. Niger's multilateral debt was cancelled in 2005. Weak growth is a major feature of the economy; in 2000-2003, growth accelerated at an average annual rate of 4.2% but its recession in 2004 caused a -0.6 point decline, that is, 3.2% in 2004 against 3.8% in 2003.<sup>a</sup>

**The health system performance is poor:** limited and unequally distributed human resources; structural adjustment impeding recruitment; population/health facilities ratios varying between 8950 and 30 680 and dysfunctional referral and counter referral systems. Only one third of the population has access to health services, with the vast majority relying on traditional medicine.

**Under five mortality is high** (259 per 1000), and varies significantly between rural and urban settings. The main causes are acute respiratory infections, malaria, diarrhoea, and injuries and burns.<sup>d</sup> Poliomyelitis and neonatal and maternal tetanus are also major public health concerns.

**Maternal mortality rates remain high** (1600 per 100 000 live births): only 5% of obstetrical care is covered and access to antenatal is 40%.<sup>e</sup>

**Malaria is the leading cause of morbidity and mortality** with an average of 850 000 cases per year, children under five and pregnant women being most vulnerable. Only 15.3% of patients seek care and two thirds of the severely hospitalized forms of malaria are inadequately managed. Only 11% of pregnant women and 15% of under-five children use insecticide treated nets (Centers for Disease Control and Prevention (CDC) Survey, February 2006).

**Low prevalence of HIV/AIDS infection** is indicated by the 2002 seroprevalence survey, with 0.87% positivity in the adult (15-49 years old) population, 25.6% among sex workers and 3.6% among the military. The survey also confirms vulnerability of women to HIV, with a seroprevalence rate of 3.8% versus 2% among men in the uneducated segments of the population. There is therefore a significant risk of rapid expansion of the epidemic.<sup>f</sup>

**Tuberculosis is a major public health problem**, with an incidence of 1.5 per 1 000 and an annual infection risk of about 2 to 3%. Effective control is impeded by low rates of screening (58%), cure (57%), high drop-out rates (16%), and erratic supply of drugs and reagents.<sup>g</sup>

**Diseases with high epidemic potential occur frequently**, such as meningococcal meningitis, as well as cholera which threatens about 83% of the population. The first shigellosis epidemic outbreak occurred in 2000 and the number of cases is increasing. Over the past two years, there has been a major decline in the incidence of measles due to improved immunization coverage.

**Malnutrition is the main aggravating factor of all these diseases.** The nutritional survey carried out by the Government of Niger, UNICEF and CDC at the end of 2005 reveals a 15.3% acute malnutrition rate among Niger's children aged 6 to 59 months, ranging from 9% in the Niamey region to 28% in the Taoua region. In 2005, public health facilities and nongovernmental organizations (NGOs) reported 274 959 malnutrition cases, of which 73 080 were acute and 201 879 moderate malnutrition cases.

**The health system is mainly funded through external resources.** Between 1994 and 2004, the Government allocated an average 6% of its budget to the health sector while foreign aid accounted for 27.48% of overall health expenditure (around US\$ 26 million, i.e. 71% of Government health funding (interim report of the 2004 National Health Accounts, *Plan de Développement Sanitaire - PDS 2005-2009*). In terms of expenditure per inhabitant, investments remain low at US\$ 7.82 in 2004. Several bottlenecks impede community participation, namely, insufficient information and training, poor management transparency and lack of care and provision to the poorest segments of the population. Mutual health organizations are only beginning to develop and private health insurance schemes cover less than 1% of the population.

<sup>a</sup> Profil de la Pauvreté au Niger, 2004 – INS janvier 2006.

<sup>b</sup> UNDP Human Development Report 2005.

<sup>c</sup> Recensement 2001.

<sup>d</sup> Ministère de la Santé : Santé et Pauvreté au Niger Vers les Objectifs Internationaux, Rapport préliminaire, juillet 2002.

<sup>e</sup> Enquête Démographique et de Santé, DHS 1998, NIGER.

<sup>f</sup> Cabinet du Premier Ministre : Plan cadre stratégique de lutte contre les IST/VIH/SIDA.

<sup>g</sup> Ministère de la Santé Publique et de la Lutte contre les Endémies : Plan national de lutte contre la tuberculose 2002-2006.

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none"> <li>• Political stability</li> <li>• Health policy; norms and legislative documents in place</li> <li>• Health system decentralization</li> <li>• Involvement of several partners</li> <li>• Established dialogue framework among actors in the health sector</li> <li>• Training institutions</li> <li>• Improved health coverage (new health huts)</li> <li>• Upgraded technical support centres at several district hospitals</li> <li>• Community-based participation structures.</li> </ul>	<ul style="list-style-type: none"> <li>• Population in extreme poverty</li> <li>• Lack of care provision to the poorest</li> <li>• Underutilization of health services</li> <li>• Need to improve health sector achievements and management</li> <li>• Weak capacities for resource mobilization and absorption</li> <li>• Fragile food situation</li> <li>• Insufficient community involvement in management of health-related interventions.</li> </ul>

## PARTNERS

Development aid is focused on investments. Overall, it accounts for more than half the total annual Government expenditure in health, with the Government covering basic operating expenses. The main contributors are the United Nations (UN) system agencies and the Bretton Woods institutions: FAO, ILO, IMF, UNDP, UNFPA, UNICEF, UNIDO, WFP, WHO, World Bank. The European Union, several bilateral partners (Belgium, Canada, China, Cuba, Denmark, France, Japan, Luxembourg, Switzerland, and the United States of America), and an increasing number of NGOs also contribute to the health sector. In 2003, total aid flow to Niger, regardless of sources, amounted to US\$ 453 million.

The Ministry of Finance and Economy is responsible for aid coordination; new coordination mechanisms however have been set up with the Poverty Reduction Strategy. Thematic Groups also exist, namely for UNAIDS, food security, gender and communication. In 2001, the UN System adopted the Common Country Assessment (CCA), followed in 2003 by the UN Development Assistance Framework (UNDAF) 2004-2007. In March 2006, UNICEF, WFP, and WHO signed the "Common Strategy Paper for the Integrated Approach of Nutrition in Niger" in order to address the food and nutritional situation in a more coordinated fashion.

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none"> <li>The Global Alliance for Vaccines and Immunizations (GAVI), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)</li> <li>HIPC</li> <li>UNDAF</li> <li>WHO facilitating coordination.</li> </ul>	<ul style="list-style-type: none"> <li>Health system highly dependent on external funding</li> <li>National priorities not taken into account by some partners</li> <li>Weaknesses in current coordination mechanisms</li> <li>Weak capacity for aid absorption.</li> </ul>

## WHO STRATEGIC AGENDA (2004-2007)

WHO aims to respond to Niger's health development objectives through the improvement of the population's health status, particularly for the most vulnerable groups. While focusing on the response to specific national needs, the strategy takes account of the country's priorities, relevance with its own sub-components, comparative advantages of the Organization, opportunities offered by national, regional and global initiatives, and the complementarity with various partners operating in the health sector. Three strategic areas have been identified:

### Improvement of the achievements of the health system

- Institutional capacity building and strengthening the stewardship of the Ministry of Public Health and Control of Endemic Diseases;
- Facilitation of coordination for health sector partners;
- Improving quality of services (better use of standards and norms, monitoring and quality control of care, hospital reform implementation); developing human resources;
- Developing mechanisms for equitable funding of health (advocacy, analysis of current mechanisms for more efficient allocation of available resources, and strategic vision of the sector);
- Strengthening district level implementation.

### Disease control and management of emergencies and disasters

- Intensifying health interventions for high burden, with special focus on the most vulnerable groups to reduce maternal and child mortality (poliomyelitis, neonatal and maternal tetanus, measles, acute respiratory infections, diarrhoea, malnutrition, malaria, HIV/AIDS, tuberculosis, other diseases to eradicate and/or to eliminate, Expanded Programme on Immunizations (EPI) diseases, and non-communicable diseases (surveillance);
- Strengthening integrated surveillance of diseases (epidemiologic data collection/analysis, creating a network of laboratories to reinforce integrated surveillance of diseases and response);
- Improving preparedness, response and management of emergencies and disasters (droughts, famines, inundations, and epidemics) focussing on risks identification, needs assessment, capacity-building, and communication.

### Health and environment

- Promoting healthy behaviours (development of legislation frameworks);
- Promoting healthy settings (encouragement of community-based hygiene and sanitation methods, quality control of water, Health-Cities programmes);
- Strengthening surveillance for food safety (situational analysis of food safety and programme development); empowering communities to improve their health status.

Throughout the implementation process of this agenda, WHO will provide advice, coordinate interventions, facilitate exchanges, and advocate for resource mobilization. The Organization will pay particular attention to the needs assessment, monitoring and evaluation of the achievements of the health system.

## ADDITIONAL INFORMATION

WHO country page <http://www.who.int/countries/ner/en/>

WHO's Department for Health Action in Crises (HAC) country page <http://www.who.int/hac/crises/countries/ner/en/>

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