EUROPEAN COMMISSION
DIRECTORATE-GENERAL FOR HUMANITARIAN AID - ECHO

Humanitarian Aid Decision

23 02 01

Title: Humanitarian aid to reduce acute child malnutrition and mortality in Niger.

Location of operation: NIGER

Amount of Decision: EUR 10,000,000

Decision reference number: ECHO/NER/BUD/2006/02000

Explanatory Memorandum

1 - Rationale, needs and target population.

1.1. - Rationale :

The spill over from the 2005 nutritional crisis resulting in the continuing unacceptably high rates of admission in early 2006 of severely malnourished children to feeding centres justify the maintenance of humanitarian aid operations in Niger in 2006.

Despite the adequate 2005 rains and the hope of a reasonable harvest (FAO projection of a small surplus of 21,000 tones), the very high levels of indebtedness incurred in 2005 by the poorest households and the continued abnormally high prices of millet on local markets continue to exclude many of the most vulnerable from access to food. Household coping mechanisms have been severely damaged and the government's food emergency stockpiles exhausted. There is a high risk of another major nutritional crisis in 2006.

The recently published UNICEF/CDC (Centre for Disease Control) national nutritional survey indicated a national average of Global Acute Malnutrition (GAM) of 15.3 % (far above the 10% emergency threshold). Four regions in particular showed very worrying figures with a GAM of 18% in Tahoua, 16% in Maradi, 16% in Diffa and 16% in Zinder. Nutritional surveys carried out by CONCERN, MSF (Médecins Sans Frontières), and ACH (Accion Contra el Hambre) confirm the negative indicators for nutritional status. Another survey carried out by CONCERN in Tahoua in December 2005 showed a GAM of 19.2% despite what had been considered an intensive food aid operation in the previous months in the area. Under-

five mortality in particular is of great concern. The CONCERN survey showed a 3 month retrospective under-five mortality of 3.7/1000/day, when the accepted emergency threshold is 2/1000/day. UNICEF estimates are that 50% of infant mortality in Niger is caused by under-nutrition.

During the first 3 months of 2006, 53, 463 malnourished children, of whom 9,600 were registered as being severely malnourished, were admitted to nutritional centres (UNICEF figures). Current Commission humanitarian aid programmes have supported partners in the treatment of over 11, 500 of this caseload of 53, 463 (more than 20%). New admissions doubled in MSF F in Maradi from around 500 in mid-February to 1,000 in mid-March 2006. In south Zinder the French Red Cross has reported an increased caseload from 250 to 350 between the beginning of March and mid April 2006. Many other partners have reported the same tendency. It should be noted that the big increase in the malnutrition caseload in 2005 started as of end of May.

Recurrent malnutrition with consequent high infant mortality has been a problem in Niger for years. The situation was aggravated in 2005 by drought and the effects of the locust invasion in 2004. The current scale of acute chronic malnutrition and infant mortality in Niger is abnormal and unacceptable under humanitarian principles and in the context of achieving the Millennium Development Goals.

An aggravating factor is the limited access for the poorest to good quality primary health care. Many of the health centres especially in rural areas are dysfunctional and the previous cost recovery policy of compulsory high consultation fees (relative to income levels) excluded many of the poorest. The extent of child mortality caused by the crisis in 2005 was hidden at first by the fact that many of the families could not afford to bring the children to health centres. An opportunity was therefore lost to spot the growing problem through data on admissions and consultation. Only where malnourished children were sick with some other pathology and were registered did the health system start to uncover the scale of the crisis. MSF and ACH surveys showed that the number of consultations at the public health centres was very low. The UNICEF/CDC survey showed the strong relationship between malnutrition and level of child mortality. MSF CH reported that 90% of the children registered in their feeding centres in 2005 tested positive for malaria.

A number of aid agencies are working closely with local health officials to facilitate free access to health care for the under 5 years and for lactating mothers. That this works can be seen from the fact that in Mayahi district, the number of primary health consultations multiplied by a factor of 5 and in some cases by a factor of 10 when an aid agency (HELP) worked with the local health workers to facilitate free access against in-kind support (medicines and equipment to health centres).

The need for free access to health care for infants from 0 to 5 years of age is one of the key lessons learned from the 2005 crisis. This has been fully taken on board by the Government who on 26th April 2006 decreed the right to free access to health care for all children up to the age of 5. However, the details of how to do this have yet to be worked out and much assistance is still needed at local level to facilitate this.

Family coping mechanisms were also very badly damaged as a result of the 2005 crisis. Many households incurred a massive debt burden to obtain food during the

lean period. The replacement cost of one sack of millet purchased during the hungry period (peak prices) is three sacks after harvest. The traditional market mechanism is that traders buy up the harvest when prices are low, store the food and resell on the market when the prices rise during the hungry period. Decapitalisation also meant that households were forced to sell assets such as seeds and tools. Helping to restore local food self-sufficiency and improve revenue generating capacity is an important objective for aid agencies and for this decision. The families of children being treated in the feeding centres will be especially targeted for assistance to improve food security. Tracking the village of origin of the children registered as malnourished will facilitate identification of the regions hardest hit by the crisis. Distribution of seeds and tools and other agricultural inputs will improve food security and revenue generation.

Many of the poorest households in Niger were dependent on poultry as a source of protein and revenue. The recent massive non-compensated culling of chickens as a result of the outbreak of Avian Flu is another aggravating factor causing considerable hardship and stress.

The clear structural causes of malnutrition and mortality in Niger, one of the poorest countries in the world (officially classified at last position on the 2005 UN Human Development Index), are multiple and complex: acute poverty, mismanagement of natural resources, very low level of female literacy, limited family planning and changes in the pattern of regional trade in foodstuffs amongst others. Over 70% of the population of nearly 13 million are ranked at living below the poverty level. This situation calls for a comprehensive and articulated aid strategy linking short, medium and long term aid instruments.

The Commission has therefore drawn up an aid continuum policy linking relief, rehabilitation and development aid (LRRD) to respond to Niger's problems. This will use humanitarian aid through this decision to respond to the immediate life threatening circumstances, caused by short-term nutritional crises. Humanitarian aid will be followed closely by medium-term food security operations through the "B" envelope of the 9th EDF. In the longer-term, food security has been identified as one of the priority objectives in the programming of the 10th EDF.

Another major lesson learned from the 2005 crisis was the need to review the functioning of existing early warning systems. Data currently provided gives a quantitative picture of food security but does not adequately cover the nutritional status of the most vulnerable. Some of the highest levels of registrations for acute malnutrition in 2005 were in regions previously considered to be of low risk of food insecurity.

2005 also took the lid off the previous "tolerance" of recurrent acute malnutrition in the Sahel, and lead to an active discussion in the aid community about what could be accepted as a "normal" rate of malnutrition in the Sahel, bearing in mind the complex structural causes. While the solution is clearly through long-term aid interventions, the current aggregated acute malnutrition rate for the under 5 population at 15.5% GAM is far above the emergency threshold limit and in any other zone would have already triggered an appropriate humanitarian response. A continued humanitarian response is required in Niger in 2006 while the longer term instruments are put in place.

1.2. - Identified needs :

- Therapeutic and supplementary feeding programmes are required to treat malnourished children under 5 years of age. Both intensive and ambulatory centres are needed and the distribution of specialised foodstuffs. Nutritional surveys need to be carried out.
- Improved access to primary health care is required to ensure the early warning of increased infant malnutrition and to provide preventive health care, vaccinations and hygiene awareness..
- Food security activities need to be promoted to help the poorest families recapitalise after their losses in 2005. Both food security and income earning activities need support. This is of particular important for the families of children registered as being malnourished in the feeding centres.
- A permanent technical assistance is required to ensure constant monitoring of the situation and effective coordination with the other main donors and agencies, notably the UN system.

1.3. - Target population and regions concerned :

Beneficiaries of this decision will be the most food insecure and most vulnerable population in Niger, in particular in the regions of Tahoua, Zinder, Tillabery and Maradi. On the 7th February 2006, the Government of Niger launched a major "programme de soutien aux populations vulnerable 2006" declaring that 1.8 Million (14%) of the nearly 13 million population of Niger were at high risk.

The numbers of expected beneficiaries of the decision by component are:

Nutrition: 500 000 malnourished children under 5 years old, out of which 55 000 are expected to be severely malnourished .

Health: 400 000 children and pregnant/lactating mothers .

Food security: 42 000 households .

1.4. - Risk assessment and possible constraints :

The success of the programme depends on the capacity of partners to mobilise adequately for the expected rapid increase in caseload during the harshest part of the "periode de soudure" from June to September. This requires close cooperation with government departments in a constructive atmosphere to facilitate efficiency, cost effectiveness and professionalism in project implementation.

2 - Objectives and components of the humanitarian intervention proposed:[1]

1. Grants for the implementation of humanitarian aid within the meaning of Council Regulation (EC) No.1257/96 of 20 June 1996 concerning humanitarian aid are awarded in accordance with the Financial Regulation, in particular Article 110 thereof, and its Implementing Rules in particular Article 168 thereof (Council Regulation (EC, Euratom) No 1605/2002 of 25 June 2002, OJ L248 of 16 September 2002 and No 2342/2002 of 23 December 2002, OJ L 357 of 31 December 2002).

2.1. - Objectives :

Principal objective:

Reduction of acute child malnutrition and mortality in Niger

Specific objectives:

- Child mortality is reduced.
- Family coping mechanisms are improved .
- Technical assistance capacity is enhanced to continue needs assessment, appraise project proposals and to coordinate and monitor the implementation of projects.

2.2. - Components:

- Maintenance and support of existing feeding centres run by partners in conjunction with WFP and UNICEF as suppliers of specialised foodstuffs to provide nutritional care to malnourished children. The children are referred to the centres from public health centres identified in outreach operations by aid agencies into isolated villages. Depending on the degree of malnourishment (measures by MUAC middle upper arm circumference and weight by height) children are directed to either a CRENAM (Centre de Recuperation Nutritionelle Ambulatoire Modere) for the moderate cases, a CRENAS (Centre de Recuperation Nutritionelle Ambulatoire Severe) for the more severe cases or a CRENI (Centre de Recuperation Nutritionelle Intensif) for the most severe cases.

  Both CRENAM and CRENAS make large scale use of specialised foods to reduce the in-patient cost and treatment time and thus allow the accompanying adult (usually the mother or grandmother) to return quickly to the home. Treatment of the child continues at home as the mother is provided with enough rations of a mix such as "PlumpyNut" (which is easily digested by children and requires no preparation). The quick results and shortened in-patient time that this treatment requires has eased some of the cultural problems that some mothers faced in having to leave the village for long periods to be with the child as it was being treated.

- Support to primary health care centres (case de santé) to improve the provision of health services to children from 0 to 5 years and to their mothers. This includes support and training of health workers and in-kind assistance such as

medical supplies and medicies. Emphasis is placed on early diagnosis and preventive health care. Many of the exisitng health care centres are poorly equipped and manned. Health workers are demoralised and under-trained. The previous cost recovery policy of the Health ministry put enormous strain on household finances. The poorest households could not afford the consultation fees, in particular in the context of the large family size in Niger (average of 8 children per family). The Government of Niger's recent decision to waive the consultation fees for children from 0 to 5 years of age has therefore been welcomed by the aid community. However the details of how this will actually work in practice have still to be worked out.

- Provison of seeds, tools and other inputs to promote food security to the families of childeren registered in the nutritional recuperation centres. Niébé and sorghum seeds will be distributed to 30,000 families which small ruminants will be provided to 12,000 families. This will provide food as well as cash to families.

- The DG ECHO[2] Regional Support Office (RSO) in Dakar will be responsible for appraising project proposals, co-ordinating and monitoring the implementation of humanitarian operations financed by the Commission and for providing technical assistance capacity and the necessary logistics for the achievement of these tasks. To facilitate this a technical support sub-office of the RSO will be set up in Niamey in the premises of the EC Delegation..

3 - Duration expected for actions in the proposed Decision:

This decision continues DG ECHO's support to partners which have maintained their presence on the ground to ensure a timely and adequate response to the crisis. Most partners are in place and the operations to be funded under this decison will follow the end of funding of operations under previous Commission humanitarian aid decisions for Niger. The objective is to maintain a high level of humanitarian intervention during the lean period from May to October with a downscaling and phasing out toward the end of the year. Some partners will be maintained until early 2007 to provide a rapid response capacity to residual cases of malnutrition.

The duration for the implementation of this Decision shall be 12 months from 1st May 2006. Humanitarian operations funded by this decision will be implemented within this period. Expenditure under this Decision shall be eligible from 1st May 2006. This both coincides with the end of funding of most current humanitarian operations and makes funds available for humanitarian action at the beginning of the expected difficult "periode de soudure".

If the implementation of the actions envisaged in this Decision is suspended due to *force majeure* or any comparable circumstance, the period of suspension will not be taken into account for the calculation of the duration of the humanitarian aid operations.

Depending on the evolution of the situation in the field, the Commission reserves the right to terminate the agreements signed with the implementing humanitarian organisations where the

[2] Directorate-General for Humanitarian Aid - ECHO

suspension of activities is for a period of more than one third of the total planned duration of the action. In this respect, the procedure established in the general conditions of the specific agreement will be applied.

4 - Previous interventions/Decisions of the Commission within the context of the current crisis

List of previous DG ECHO operations in NIGER

Decision Number	Decision Type	2004 EUR	2005 EUR	2006 EUR
ECHO/NER/EDF/2005/01000	Emergency		4,600,000	
ECHO/NER/EDF/2005/02000	Emergency		1,700,000	
ECHO/NER/BUD/2006/01000	Non Emergency			2,000,000
Subtotal		0	6,300,000	2,000,000
Grand Total		8,300,000		

Dated : 04/04/2006
Source : HOPE

5 - Other donors and donor co-ordination mechanisms.

Donors in the food security sector (France, Belgium, Germany, European Commission,

Donors in NIGER the last 12 months

1. EU Members States (*)	EUR	2. European Commission	EUR	3. Others	EUR
Austria		DG ECHO	8,373,529		
Belgium	2,500,000	Other services	3,600,000		
Cyprus	26,316				
Czech republic	167,000				
Denmark	3,166,290				
Estonia					
Finland	300,000				
France	5,373,257				
Germany	5,264,200				
Greece					
Hungary					
Ireland	3,324,000				
Italy	2,020,000				
Latvia					
Lithuania					
Luxemburg	850,000				
Malta					
Netherlands	2,075,000				
Poland	41,000				
Portugal					
Slovakia					
Slovenia					
Spain	1,550,000				
Sweden	201,900				
United kingdom	3,357,722				
Subtotal	30,216,685	Subtotal	8,373,529	Subtotal	0
		Grand total	38,590,214		

Dated : 04/04/2006
(*) Source : DG ECHO 14 Points reporting for Members States. https://hac.cec.eu.int
Empty cells means either no information is available or no contribution.

World Food Programme) are coordinated through the Government's "Dispositif National de Prévention et Gestion de crises Alimentaires, DNPGCA" (National mechanism for the prevention and management of food crises). The Commission Delegation is the lead agency for donor coordination in this sector.

Coordination for nutrition in the health sector is done through the Ministry of Public Health within the framework of the Plan National de Développement Sanitaire (National Health Development Plan). Belgium is the lead agency for donor coordination in the health sector.

At a technical level there are weekly meetings in Niamey between UN agencies, NGOs and government services to improve operational and policy coordination. A second layer of local coordination takes place at regional and district level.

6 - Amount of decision and distribution by specific objectives:

6.1. - Total amount of the decision: EUR 10,000,000

6.2. - Budget breakdown by specific objectives

Principal objective: *Humanitarian aid to reduce acute child malnutrition and mortality in Niger*				
Specific objectives	**Allocated amount by specific objective (EUR)**	**Geographical area of operation**	**Activities**	**Potential partners**[3]
Specific objective 1: Child mortality is reduced	8,350,000	Niger and in particular the regions of Tahoua, Zinder, Maradi and Tillabery.	- Treatment of severe and moderate acute malnutrition. - Primary Health care programmes. - Improved nutritional surveillance of the most vulnerable.	- ACH- ESP - CONCERN WORLDWIDE - CROIX-ROUGE - FRA - HELP - MDM – FRA - MDM - BEL - SAVE THE CHILDREN – UK - MERCY CORPS - ISLAMIC RELIEF - OXFAM - TSF - UN - UNICEF - BEL - UN - WFP-B
Specific objective 2: Family coping mechanisms are improved	1,000,000	Niger	Distribution of seed and tools and small animal to families of beneficiaries of nutrition centres. Improved functioning of the early warning systems.	- UN - FAO-I

[3] ACCION CONTRA EL HAMBRE, (ESP), CONCERN WORLDWIDE, (IRL), CROIX-ROUGE FRANCAISE, HELP- HILFE ZUR SELBSTHILFE E.V. (DEU), MEDECINS DU MONDE, MERCY CORPS, ISLAMIC RELIEF, OXFAM, TELCOMS SANS FRONTIERES, THE SAVE THE CHILDREN FUND (GBR), UN - WORLD FOOD PROGRAM - LIAISON OFFICE, UNICEF, UNITED NATIONS - FOOD AND AGRICULTURE ORGANIZATION

Specific objective 3: Technical assistance capacity is enhanced to continue needs assessment, appraise project proposals and to coordinate and monitor the implementation of projects	150,000	Niger	Open a technical assistance office in Niamey.	
Contingency reserve	500,000	Niger		
TOTAL:	10,000,000			

7 - Evaluation

Under article 18 of Council Regulation (EC) No.1257/96 of 20 June 1996 concerning humanitarian aid the Commission is required to "regularly assess humanitarian aid operations financed by the Community in order to establish whether they have achieved their objectives and to produce guidelines for improving the effectiveness of subsequent operations." These evaluations are structured and organised in overarching and cross cutting issues forming part of DG ECHO's Annual Strategy such as child-related issues, the security of relief workers, respect for human rights, gender. Each year, an indicative Evaluation Programme is established after a consultative process. This programme is flexible and can be adapted to include evaluations not foreseen in the initial programme, in response to particular events or changing circumstances. More information can be obtained at:

http://europa.eu/comm/echo/evaluation/index_en.htm.

8 - Budget Impact article 23 02 01

-	CE (EUR)
Initial Available Appropriations for 2006	470,429,000
Supplementary Budgets	-
Transfers	-
Total Available Credits	470,429,000
Total executed to date (by 10/05/06)	307,550,000
Available remaining	162,879,000
Total amount of the Decision	10,000,000

COMMISSION DECISION
of
on the financing of humanitarian operations from the general budget of the European Union in Niger

THE COMMISSION OF THE EUROPEAN COMMUNITIES,

Having regard to the Treaty establishing the European Community,
Having regard to Council Regulation (EC) No.1257/96 of 20 June 1996 concerning humanitarian aid[4] and in particular Article 15(2) thereof:

Whereas:

1. The continuing nutritional crisis in Niger gives rise to great concern about the risk of another food crisis similar to that of 2005;

2. The capacity of local government food security emergency response mechanisms and the national health system to cope with a repeat of such a crisis has been severely weakened;

3. Ongoing nutritional surveys indicate abnormally high registrations of acutely malnourished children;

4. An assessment of the humanitarian situation leads to the conclusion that humanitarian aid operations should be financed by the Community for a period of 12 months;

5. In order to maximise the impact of humanitarian aid for the victims, it is necessary to set up a technical assistance capacity in the field;

6. It is estimated that an amount of EUR 10,000,000 from budget line 23 02 01 of the 2006 general budget of the European Union is necessary to provide humanitarian assistance to over 500,000 children in Niger taking into account the available budget, other donor's contributions and other factors;

In accordance with Article 17 (3) of Regulation (EC) No.1257/96, the Humanitarian Aid Committee gave a favourable opinion on 22 June 2006.

HAS DECIDED AS FOLLOWS:

Article 1

1. In accordance with the objectives and general principles of humanitarian aid, the Commission hereby approves a total amount of EUR 10,000,000 for humanitarian aid operations Humanitarian aid to reduce child malnutrition and mortality in Niger by using line 23 02 01 of the 2006 general budget of the European Union.

OJ L 163, 2.7.1996, p. 1-6

2. In accordance with Article 2 (a) of Council Regulation No.1257/96, the humanitarian operations shall be implemented in pursuance of the following specific objectives:

- Child mortality is reduced.
- Family coping mechanisms are improved.
- Technical assistance capacity is enhanced to continue needs assessment, appraise project proposals and to coordinate and monitor the implementation of projects.

The amounts allocated to each of these specific objectives and to the contingency reserve are listed in the annex to this decision.

Article 2

Without prejudice to the use of the contingency reserve, the Commission may, where this is justified by the humanitarian situation, re-allocate the funding levels established for one of the specific objectives set out in Article 1(2) to another objective mentioned therein, provided that the re-allocated amount represents less than 20% of the global amount covered by this Decision and does not exceed EUR 2,000,000.

Article 3

1. The duration for the implementation of this decision shall be for a maximum period of 12 months, starting on 01 May 2006.
2. Expenditure under this Decision shall be eligible from 01 May 2006.
3. If the operations envisaged in this Decision are suspended owing to *force majeure* or comparable circumstances, the period of suspension shall not be taken into account for the calculation of the duration of the implementation of this Decision.

Article 4

This Decision shall take effect on the date of its adoption.

Done at Brussels,

For the Commission

Member of the Commission

Annex: Breakdown of allocations by specific objectives

Principal objective: Humanitarian aid to reduce acute child malnutrition and mortality in Niger	
Specific objectives	**Amount per specific objective (EUR)**
Child mortality is reduced	8,350,000
Family coping mechanisms are improved	1,000,000
Technical assistance capacity is enhanced to continue needs assessment, appraise project proposals and to coordinate and monitor the implementation of projects	150,000
Contingency reserve	500,000
TOTAL	10,000,000