

A voice from the field



“My name is Bassira Oumarou. My daughter Assamaou Moussa is 13 months old. We have traveled 180km from Filingué to the Niamey national hospital. The centre in Filingué (*editor's note: Integrated Health Centre*), treated her for four months. My daughter became too sick – further treatment was needed urgently. I do not want to lose her. I have already lost four children – all of them babies. The problem is that I do not have enough milk to feed her. When we arrived here three weeks ago, she weighed less than 3 kilos.”

My husband stayed in our village to harvest the crops. He has come to see us only once. Luckily, my grandmother lives not too far away from here so I can sleep at her place. Here in the hospital, I speak a lot with the other mothers and I do not feel too lonely.

I hope with all my heart that my little Assamaou will get better. I would like the diarrhea and the vomiting to stop and for her to breath normally. She has gained a little weight. They tell me she now weights 3.2kg. I have not lost hope (*editor's note: the infant is very weak she has severe anemia and a fungus infection of the upper digestive tract*).”

Focus

The challenge of working in a Complex Emergency

When I did my rapid assessment on malaria control in Niger, I realized the extent of the response needed. Partners were applying different approaches in tackling malaria case management. To test for malaria, partners have been using a variety of methods: - diagnosis microscopy, Rapid Diagnostic Tests and most commonly, clinical diagnosis. Chloroquine, Artemether/lumefantrine, Artesunate+Amodiaquine, Artesunate+SP, Artesunate and quinine have been used as treatment of uncomplicated malaria. Partners have treated malaria with what they have had in hand. But what about the quality of the intervention? What about accuracy of clinical diagnosis? What about the correct dosage? What about the patient compliance and curative rate?

WHO has been able to work closely with the Ministry of Health and issue two technical notes. One technical note was issued on the use of artesunate for the treatment of malaria. The second technical note was issued on case management of uncomplicated and severe malaria.

Guidelines have also been provided on how to best to use bed nets (Long Lasting Insecticidal Nets) in Therapeutic Feeding Centres.

The successful part of working in a complex emergency is to be able to operate in a well coordinated structure and to look for ways to facilitate coordination among partners. WHO's Health Action in Crisis team, the Niger WHO Country Office (WR office) and the operations office set up as part of the Niger WR office, provided an appropriate setting to respond to the needs of the population affected by the crisis, mainly children under five and pregnant women.

In terms of malaria control, the main challenge was to find the correct balance

between what is in line with the Ministry of Health (MoH) policy and how to improve the health status of those suffering.

Training was a great opportunity for healthcare workers to learn about Artemisinin-based Combination Therapies (ACTs). Healthcare workers received ACTs and artesunate from different sources, but did not always have the knowledge for the correct use of the medication. For some healthcare workers the training provided was the first time for them to see or hear about ACTs.

To be productive in any emergency setting, one needs to keep in mind the following recommendations:

- the country in question should own all our recommendations

- communications among colleagues, senior officials within the MoH, partners, donors and people at community level is key for any intervention to be successful

- commitment and compassion will always boost the quality of any interventions.

My sincere desire is to see similar collaboration during response to complex emergencies from all of WHO's various departments I am ready to go back.

Docteur José Z NKUNI, WHO

inside

The trainings

An attempt to provide an explanation about choléra

Meeting with MSF-France

The Fond de solidarité 'Santé Proximité'

Health card of the Niger

Impressions of the humanitarian crisis in Niger (30.8 - 6.9.05 in Niamey, Maradi, Tillaberi)

« The majority of the work needs to take place in the local communities... »

The millet and sorghum fields along the roadside from Niamey to Maradi were ready for harvesting and a few farmers could already be seen transporting harvested millet on donkey carts. Potatoes, onions and goat meat were being sold in the markets. However, many households do not have access to enough food even if the market stalls appear to be gradually filling with various agricultural produce.



A lot of resources are being directed to saving the lives of children who are severely malnourished. No data is available on the number of children who return to their homes after being discharged. Many children are trapped in the cycle of malnutrition and disease hindered by poverty and food insecurity.



In the CRENI in Gulmi Hospital about half way from Niamey to Maradi, the mother of Abdul, a 7-month old severely malnourished boy, told us that her son was the only child still alive from all her 6 children. The others had died at the ages of 3 to 7 months because of diarrhoea, fever and malnutrition. She was happy that Abdul was improving in the centre but said that it would be difficult once she got back home since she could not afford the milk and porridge that was being given in the centre. The mother of a 2-year old boy said her son had always been thin since birth and that this was the sixth time she had been in the centre. Her first born had died. She said that this year there were more children in the centre than the same time last year.

The additional burden of malnutrition being a risk factor for morbidity and mortality is not understood by most mothers. One of the mothers in the CRENI in Tilleberi called me to express her concern that her 2-year old child was not walking and said that something was wrong with his legs. She was not concerned that he was severely malnourished. Two other mothers came with their infants and explained to us that they had gone to a traditional medical practitioner because their infants had sunken fontanels (gaps between the incompletely formed cranial bones) which needed special treatment.

The Médecins Sans Frontières (MSF) Nutritionnal Rehabilitation Centers (CRENI) in Maradi had 300 severely malnourished children coming from the surrounding communities and also from across the border in Nigeria. The numbers had been stable over the past weeks but numbers were expected to rise in the coming weeks because of an increase in malaria and diarrhoeal cases.



A lot more work needs to be done at the community level regarding awareness raising of caretakers on adequate growth and health of their children. Short-term measures such as blanket supplementary feeding of all children and pregnant/lactating women in vulnerable communities, need to be carried out to prevent moderately malnourished children from becoming severely malnourished. This humanitarian crisis needs an intersectoral approach to improve access of all households to adequate food and health care to have a positive impact on levels of malnutrition.

Zita C.WEIZE PRINZO, WHO

Multi-stage training

Training health workers to treat malnutrition in Niger

An initial phase of training for health workers in treatment of malnutrition took place between the end of July and mid September. Twelve training sessions (from 4 to 7 days) were held in the regions of Maradi, Tillabéri, Tahoua, Niamey, Diffa, Dosso, Zinder and Agadez. A total of 233 health-care providers were trained.

However, on account of the extent of the food crisis the Ministry of Public Health and Endemic Disease Control (MSPLCE) decided to implement a vast training programme, in collaboration with WHO, UNICEF and selected NGOs. As a result, a national protocol for case management of malnutrition was drawn up and approved. At the request of health districts and NGOs, it is also planned to organize training workshops on rapid and generalized case management of malnourished children.

The second phase of training, which is planned to last from October until the end of December, comprises modules (see box) which will provide training for health workers from CRENI (intensive nutritional rehabilitation centres) and CRENA (outpatient nutritional rehabilitation centres), as well as community health workers.



An example of training for trainers and care providers in the Nutritional Rehabilitation Centres for Moderate malnutrition (CRENAM)



Module 1 : Basic concepts about nutrition (theoretical lesson).

Module 2 : Types and causes of malnutrition (theoretical lesson and exercise using photographs and video to identify the different types of malnutrition).

Module 3 : Evaluation of nutritional status (theoretical part; exercises on use of the malnutrition reference and classification table; clinical practice involving anthropological measurements, clinical examination, recognition of types and signs of malnutrition to decide, depending on the type, whether to refer the child to the Intensive Nutritional Rehabilitation Centers (CRENI)).

Module 4 : Physiology (theory).

Module 5 : Case management regimens and programme (theory).

Module 6 : Case management at CRENAM (theoretical part; exercises on how to complete the registers, treatment booklets, proper case management, plotting weight curves, writing monthly reports and clinical practice with organization of the CRENAM, performance of tasks such as completing the register, the treatment booklet, proper case management, plotting weight curves, writing monthly reports and preparation of the premix of vitamins, minerals, and calories).

The emphasis is on practice, which includes clinical practice in case management of severe non-complicated malnutrition.

Other modules combine theory, exercises and clinical practice.

Assessment of training in malaria case management

The World Health Organization team helped Ministry of Public Health and Endemic Disease Control (MSP/LCE) to organize case management of malaria in the regions of Dosso, Maradi et Tahoua.

Assessment of training courses carried out found: participants' understanding of treatment using Combined Treatment (ACT) needed improving. The results of the pre- and post-tests showed that their understanding of case management of simple and severe malaria had improved. These training sessions should facilitate implementation of the new national malaria treatment policy for which the GlobalFund has taken responsibility.

A total of 39 trainers from the 8 regions received training and should be able to provide cascade training for providers. To help them do so, they have been provided with a training manual on malaria case management in peripheral health facilities.

The training sessions were also an opportunity to gather a range of information:

- 1) although artemether/lumefantrine has been adopted by national policy to treat simple malaria, several NGOs use artesunate/artemether, but in separately prescribed tablets;
- 2) health facilities have no nasogastric tubes and too few hypotonic solutions to provide proper treatment for hypoglycaemia;
- 3) the dosages prescribed for quinine salts vary considerably because several sorts of quinine salts are available in the field with very different quinine content;
- 4) finally, in this food crisis situation, fever and malnutrition should both be treated.



Recommendations from the training for trainers workshop held in the region of Dosso

Design wall posters illustrating the current malaria treatment regimen and distribute them widely in all the country's health facilities.

Publicize information on WHO's recommendations against using single-drug treatment, and specifically artemisinin derivatives to treat malaria.

Ensure that 10 or 30% HGS is available in health facilities in order properly to treat hypoglycaemia, an often fatal complication of severe malaria.

Provide health workers with sufficient information on the need to take account of the quinine base content of quinine salts in order to avoid errors of dosage when treating severe malaria.

Issue clear recommendations on ACT in case of failure to respond to treatment with artemether-lumefantrine.

Train at least on provider per CSI (integrated health centre), on completion of this training.

The WHO Emergency Task Force

Task Force :
nctf@ne.afro.who.int

Coordination :
nctfcoord@ne.afro.who.int

Information :
nctfinfo@ne.afro.who.int

Surveillance :
nctfsurv@ne.afro.who.int

Nutrition :
nctfnut@ne.afro.who.int

Health System :
nctfhsys@ne.afro.who.int

Cholera : the effort to control the epidemic continues in the region of Tahoua, in which the three districts of Bouza, Konni and Madaoua have been affected.

An attempt to provide an explanation

Conditions of hygiene and sanitation are precarious in the regions affected by the cholera epidemic. The villages are located on the marshy areas of the Maggia River. Lack of information and awareness can affect behaviour in the communities.

Sumps being dug in the river beds which are also used to evacuate waste, including faeces, can explain in part, the propagation and increase in the number of cases in the villages.

The local information teams that have visited the villages have generally been successful at information and advice. However, this is not always the case. Evidence suggests that villages such as the village of Ganfa (Konni district), which has been visited eight times by the teams have not heeded the advice.

As soon as there is a declaration cholera action is taken quickly to interrupt the water sources that are transmitting the disease to the community. This was the case at Illégawane (Madaoua district), at Kéléme (Bouza district), at Sabonga (Bouza district), Gounfara and Dogherawa (Konni district).

Chlorination is also advised, though the health services are unable to provide enough chlorine and the populations are too poor to purchase it themselves. Overall, home treatment, disinfection of patients and treatment of water sources is satisfactory.

Exemplary community participation

Illégawane, is village with almost 2000 inhabitants located in a valley where there is no stream but which does have a modern water source.

Villagers from Illégawane, often visit the the weekly markets in Sabonga and Tama, two villages where there had been cases of cholera since 29 July 2005. Basic necessities were not the only thing the villagers of Illégawane brought back from the market; they also brought back cholera vibrios. The village chief's 14-year-old son was the first declared case in the village. The boy died.

In reaction to the outbreak, the villagers led by their chief decided to respond collectively to the cholera outbreak in their village. Special huts to isolate patients were built rapidly. An information campaign was organized in collaboration with a team from the Madaoua health district. With the assistance the local committee, the villagers created their own surveillance system, immediately reporting the slightest signs (diarrhoea, vomiting) each day.

The Director of the local primary school authorized the treatment of patients in the school's classrooms, which were not being used due to school holidays and harsh weather. The Director also provided vital daily assistance with his own mobile phone and motorcycle for collection and transmission of cases to the integrated health centre at Azerori, from where the information was then transmitted to Madaoua health district. These measures were used every day until the outbreak was effectively brought under control in the village. The Director then volunteered to take part in active case detection team after the treatment facility had closed.

In this village, there were 33 cases and 3 deaths. As a result of the community's actions, the outbreak was stopped two weeks after it broke out.



The presence of NGOs in Niger:

The example of Médecins sans frontières (MSF) France



The MSF-France Representative in Niger

Johanne Sekennes, who is from Norway and has worked for MSF-France for ten years. She has been head of the MSF-France mission in Niger since October 2004.

About the organization

Médecins sans frontières-France (MSF-France) is an NGO that is known worldwide. It was established in 1971 and was awarded the Nobel Peace prize in 1999. In Niger, the MSF-France has focussed on the treatment of severe malnutrition and initiated a global publicity campaign to increase international attention to the crisis. In 2005, MSF-France has provided treatment for more than 26 000 severely malnourished children in the regions of Tahoua and Maradi, and Zinder (where it is represented by MSF-Switzerland). The majority of the MSF-France teams are based in the Maradi region and comprise of approximately 600 to 700 national staff (hygiene specialists, logistic specialists, nurses, nutritionists and physicians) and 50 to 55 international experts (physicians, nurses, logistic specialists and administrative staff).

MSF-France's budget for Niger is •10 000 000.

Main area of activity

Control of malnutrition: treatment of children with moderate and severe malnutrition and distribution of food to the most vulnerable families, especially those with infants aged below six months.



Children in the intensive care tents are monitored 24 hours a day. They suffer from severe illnesses associated with malnutrition such as: gastroenteritis, measles and tuberculosis. In the other tents, children are monitored according to the evolution of their illness.

(photos MSF-F)

Perspectives

MSF-France has been present to provide emergency humanitarian assistance in Niger since 2001. The main focus of its action is malnutrition.



The 'Santé Proximité' Solidarity Fund, details and distribution

The economist from the WHO team in Niamey explains the meaning of this Solidarity Fund

One of the consequences of the food crisis affecting Niger is the worsening of the state of health of the populations in the areas affected, and more particularly the vulnerable populations, i.e. women and children. Some 3.5 million people are hit by the crisis, which is compounded by malnutrition and diseases such as malaria, diarrhoea, cholera and acute respiratory infections against a background of extreme poverty.

Four focuses for intervention have been adopted: epidemiological surveillance (including the introduction of malnutrition-warning indicators) nutrition, capacity building and adjustment of methods of cost recovery.

On the basis of existing facilities and mechanisms, the working group that was formed came to a consensus on the establishment of a 'Santé Proximité' solidarity fund.

This involves the provision of financial support for a transitional six-month period from September 2005 to February 2006.

The Fund will be integrated within the national food crisis prevention and management mechanism, whose food crisis cell (CCA) will provide the secretariat, in the shape of an additional focus centred on health. It will provide funds, drawn from a health account under the auspices of the Common Donor Fund (CDF), for the decentralized health-care-providing facilities of the Ministry of Health, of the health districts and of the regional public health directorates (DRSP).

Its total cost is estimated to be US\$ 4 630 231. The Fund will benefit a total population of some 4.5 million people and focus primarily on children aged below five years, pregnant women, nursing mothers and women in the post partum period and practising birth control.

The details

The 'Santé Proximité' Solidarity Fund is to be managed in the same way as the other tools that already exist, with in particular a CDF. An ad-hoc committee for health is to be set up to manage the

fund. The Committee will include members of the Restricted Coordination Committee (RCC) and representatives from an ad-hoc cell of the Ministry of Public Health.

An advance on expenditure will be paid into each of the accounts of DRSP and of the health districts. The amount of the advance will be estimated (see box on the distribution of funds) at the central level in terms of the forecast expenditure of each DRSP and district calculated in terms of the size of the population concerned. This will cover a two-month period. The accounts will be replenished subject to justification of 50% of the expenditure for the initial tranche. The amount of the subsequent tranche will be adjusted depending on the actual activity of each district and DRSP.

There will be regular monitoring at all levels of the system to enhance the efficacy of the Fund's management. A flexible monthly rapid evaluation process will be introduced to ensure that the response is tuned to the evolution of the situation. During the sixth month, a formal evaluation, including an audit, will be necessary to define the next steps.

Outlook

The results of the current study of cost recovery initiated by the World Bank and those of the final evaluation of the 'Santé Proximité' Solidarity Fund will provide further food for thought in order to define the practical ways of ensuring the long-term existence of the Fund. It will be necessary to define appropriate health funding mechanisms which would take into account the needs of the most destitute, as provided for in the Health Development Plan 2005-2009.

Moussa BIZO, WHO

PROPOSITION BY THE SOLIDARITY FUND FOR 16 DISTRICTS

The vulnerability index (VI) for each district is calculated using factors reflecting agricultural production in and out of season and the population's financial situation. The lower the vulnerability index, the greater the population's supposed means of subsistence. However, the reason why the first four districts are in the highly critical category, despite their low vulnerability index is due to the fact that the level of nutrition is lower there than elsewhere

For the highly critical areas: Mirriah (Zinder region, VI 40); Madarounfa (VI 37), Aguié (VI 27), Guidan Roundji (VI 25) all three of which are in Maradi region.

For the critical area: Téra (Tillabéri region, VI 72); Agadez (VI 71); Tillabéri (VI 70); Keita (VI 68); Arlit (Agadez region, VI 66); Tchintabaraden (Tahoua region, VI 66); Illéla (Tahoua region, VI 64); Ouallam (Tillabéri region, VI 63); Filingué (Tillabéri region, VI 62); Tahoua (VI 62); Mainé soroa (Diffa region de, VI 61); Diffa (VI 61).



World Health
Organization

The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on map represent approximate border lines for which there may not yet be full agreement. WHO 2005. All rights reserved.

CARD

RIVIERES PERMANENTES



DEPARTEMENT



HÔPITAL NATIONAL



CENTRE HOSPITALIER DEPARTEMENTAL



HÔPITAL DE DISTRICT



HÔPITAL COMMUNAL



CENTRE DE SANTE INTEGRE



CENTRE DE SANTE PRIME



MATERNITE



HÔPITAL PRIME



INCONNU



CANTON



DENSITE DE POPULATION (IMAGE) (PERS_300KM)

Moins de 5

6 - 10

11 - 50

51 - 100

101 - 250

251 - 500

501 - 750

751 et plus

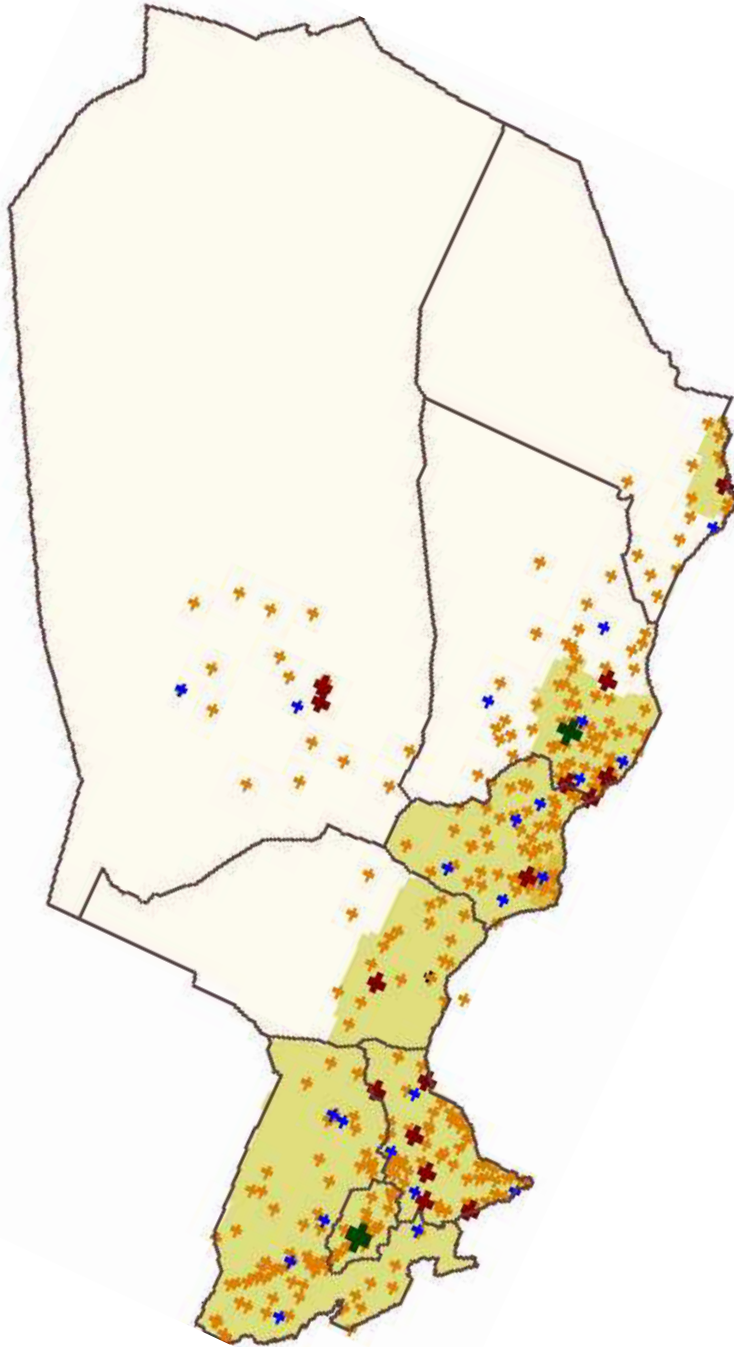
APPRODISSEMENT



DEPARTEMENT



PAYS



HEALTH CARD OF NIGER